WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR SOUTH-EAST ASIA

Regional Consultation on World Report on Violence and Health, SEARO, New Delhi 16-17 November 2000

SEA/DPR/Meet/2/1
14 November 2000

Registry file No. R4/48/1

OBJECTIVES

1. **To summarize report goals, objectives, methodology and progress made to date;**

2. **Provide an overview of the report's content (major pattern, risk factors, prevention and policy responses for the various types of violence) and to identify important gaps;**

3. **To solicit regional perspectives on future directions for violence prevention; and**

4. **To determine regional strategies for the release of report.**

WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR SOUTH-EAST ASIA

Regional Consultation on World Report on Violence and Health, SEARO, New Delhi
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14 November 2000

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PROVISIONAL AGENDA

1. Inauguration

2. Opening of the Consultation

3. Goal, objectives and methodology for development of World Report on Violence and Health

4. Regional public health challenges in the field of violence

5. Regional activities involving release of the Report

6. Closing

WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR SOUTH-EAST ASIA

Regional Consultation on World Report on Violence and Health, SEARO, New Delhi
16-17 November 2000
Registry file No. R4/48/1

SEA/DPR/Meet/2/3
14 November 2000

TENTATIVE PROGRAMME
(VENUE: COMMITTEE ROOM, 1ST FLOOR)

Registration for the meeting will begin at 8:30 on 16th November in the Conference Hall Lobby of SEARO

DAY ONE: Thursday, 16 November 2000		
09:00-9:30	Inauguration	
09:30-09:45	***Tea/Coffee Break***	
9:30-10:00	World Report on Violence and Health: goals, objectives, methodology, content and progress made to date Presentation of format of consultation Introduction of five discussion points on regional public health challenges in the field of violence prevention	Etienne Krug WHO HQ
10:15-12:00	Availability and collection of data *Discussions*	• Wang Yan (WPR) • Gopalkrishna Gururaj (SEAR)
12:00-13:00	***Lunch***	
13:00-14:45	Improving our understanding of the aetiology of violence *Discussions*	• Liz Eckerman (WPR) • Srikala Barath (SEAR)
14:45-15:00	***Tea/Coffee Break***	
15:00-16:30	*Prevention and policy responses* *Discussions*	• Simon Yanis (WPR) • Panpimol Lotrakul (SEAR)

DAY TWO: Friday, 17 November 2000		
09:00-10:45	Contributions and limitations of the public health approach to violence *Discussions*	• Sham Kasim (WPR) • Mintasih Latief (SEAR)
10:45-11:00	*Tea/Coffee Break*	
11:00-12:45	Role of the health sector and other sectors *Discussions*	• Bernadette Madrid (WPR) • Prawate Tantipiwatanaskul (SEAR)
12:45-14:00	*Lunch*	
14:00-15:00	Regional strategies for the release of the report *Discussions*	• Harsaran Bir Kaur Pandey, Information Officer SEARO
15:00-15:15	*Tea/Coffee Break*	
15:15-16:30	Reporting on the out come of the consultation CLOSING	• Sawat Ramaboot (SEARO) • Pang Ruyan (WPRO)

WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR SOUTH-EAST ASIA

Regional Consultation on World Report on Violence and Health, SEARO, New Delhi 16-17 November 2000

SEA/DPR/Meet/2/4
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Registry file No. R4/48/1

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WPRO

Dr. Pang Ruyan	**Regional Adviser, Reproductive Health**

Regional Consultations
Public Health Challenges

Guidelines for Brief Presentations and Discussion

The regional consultations will focus on five major public health challenges. For each challenge, there will be a 15-minute presentation by a member of the region, a discussion period, and a summary of the top 5 recommendations related to the particular challenge. The purpose of the brief presentations is to provide background information to help guide and facilitate the discussion. The presentations should be brief – *no more than 15 minutes* – and should provide an *overview* of what is known in the region with respect to the particular challenge. Listed below are guidelines for the regional members to consider when developing the presentations.

Challenge 1: Improving the Availability, Collection and Quality of Data

1. **Provide a brief overview of the types of data available within the region to describe the magnitude and impact of violence (e.g., vital statistics, data from other registries, police, health, judiciary data, crime surveys, community surveys, etc.).**

2. **Provide an overview of what types of information are collected across these various data sources; how often is information collected, etc.**

3. **Discuss the adequacy of the data for capturing different types of violence and for measuring fatal and non-fatal outcomes, morbidity, and other health consequences.**

4. **Provide a brief overview of the major strengths and limitations of the available data sources. What are some possible strategies for improving the availability, collection, and quality of data?**

Challenge 2: Improving Our Understanding of the Etiology of Violence

1. **Provide an overview of how well the problem of violence is understood in the region (i.e., how much research on violence is being conducted in the region, by whom, and for what purposes?).**

2. **Are all types of violence (e.g., child abuse, youth violence, violence against women, elder abuse, suicide, collective violence, etc.) being adequately researched or are some receiving more widespread attention?**

3. **Which groups, agencies, or institutions are primarily involved in the study of violence within the region? Are any agencies or groups responsible for stimulating or coordinating violence research?**

4. **Is research primarily focused on individuals? Any research being conducted on ecological factors (e.g., larger social, economic, and cultural factors)?**

5. **What are some of the major barriers to studying violence in the region? What are some of the possible avenues for overcoming these barriers?**

Challenge 3: Prevention and Policy Responses

1. **Provide a brief overview of the nature and extent of prevention and policy responses within the region?**

2. **Are some types of violence receiving more attention than others?**

3. **Which groups, agencies, or institutions are primarily involved in developing, implementing, and evaluating prevention programs and policy responses?**

4. **What are the major barriers to developing and implementing prevention programs? What are some of the possible avenues for overcoming these barriers?**

5. **Are prevention programs ever evaluated? What is the nature and extent of evaluations (e.g., process evaluations, impact or outcome evaluations?).**

Challenge 4: Contributions and Limitations of the Public Health Approach

1. **Provide a brief overview of the public health approach to violence.**

2. **How well is the public health approach understood and practiced in the region?**

3. **Describe how the public health approach can possibly contribute to understanding violence within the region.**

4. **What are some of the major drawbacks to using this approach?**

Challenge 5: Role of the Health Sector and Other Sectors

1. **To what extent is the health sector in your region involved in violence prevention efforts?**

2. **How can the health sector within your region be better utilized for data collection, research and prevention purposes?**

3. **Are other sectors within the region involved in violence prevention efforts?**

4. **What are some of the major barriers limiting involvement of the health sector and other sectors (e.g. criminal justice, education, labour, and social services) in violence prevention efforts?**

5. **What are some of the possible avenues for advocating or facilitating the involvement of these sectors in violence prevention efforts?**

World Health Organization
Organisation mondiale de la Santé

Violence and Injury Prevention Department
Non-communicable Disease and Mental Health

World Report on Violence and Health
Review Form for Participants in Regional Consultations

Thank you very much for your willingness to provide comments on the draft World Report on Violence. Your input is very valuable. We ask that you make your comments in writing, in advance of the consultation and bring them with you to the consultation or send them by e-mail to Ms L. Sminkey at sminkeyl@who.int *Please use this form to make your comments and add additional pages if needed. We will also send the form to you by e-mail. If you have not received the electronic version of this form at the time of receiving the draft report by express mail, then please let Ms Sminkey know and we will send it again.*

We will try as much as possible to address the comments that you will make. To facilitate that process, please make your suggestions as specific and concrete as possible. For example, if you would like additional information to be discussed, suggest the topic, the chapter in which to include it, the experts to approach, citations for the relevant literature to include, case studies or country examples, etc. If possible bring copies of the material that should be incorporated/cited to the consultation. The more concrete you will be, the more likely it is that we will be able to include this additional information.

World Report on Violence and Health
Review Form for Participants in Regional Consultations

Name participant: _____ **Date of review:** _____

1. **Even though the report is in draft form, do you feel that it will achieve the planned objectives as discussed in "Why this Report"?**
   Yes
   No. If no, please explain why not and how this could be addressed:

2. **Please describe how useful the Report will be for violence prevention in your region.**

3. **Does the Report address the issue of violence in a cross-cultural/international way?**

4. **What are the main strengths of the report?**

5. **What are the main weaknesses of the report?**

6. **How should these weaknesses be addressed?**

7. **Is the style appropriate for the target audience as described in "Why this Report"?**

8. **Is the content of the Report relevant for your region?**

9. **Are there important violence-related issues in your region that should have been included in the Report or should have been discussed in more detail? Please explain which, why they should be included, and provide suggestions on how to do that.**

10. Please provide chapter specific comments on:

Introduction:

- ❑ **I did not read this chapter**
- ❑ **I read this chapter and have no comments**
- ❑ **I read this chapter and would like to make the following suggestions:**

Youth violence

- ❑ **I did not read this chapter**
- ❑ **I read this chapter and have no comments**
- ❑ **I read this chapter and would like to make the following suggestions:**

Child Maltreatment

- ❑ **I did not read this chapter**
- ❑ **I read this chapter and have no comments**
- ❑ **I read this chapter and would like to make the following suggestions:**

Intimate partner violence

- ❑ I did not read this chapter
- ❑ I read this chapter and have no comments
- ❑ I read this chapter and would like to make the following suggestions:

Elderly abuse

- ❑ I did not read this chapter
- ❑ I read this chapter and have no comments
- ❑ I read this chapter and would like to make the following suggestions:

Sexual violence

- ❑ I did not read this outline
- ❑ I read this outline and have no comments
- ❑ I read this outline and would like to make the following suggestions:

Organized violence:

- ❑ **I did not read this chapter**
- ❑ **I read this chapter and have no comments**
- ❑ **I read this chapter and would like to make the following suggestions:**

Self-directed violence:

- ❑ **I did not read this chapter**
- ❑ **I read this chapter and have no comments**
- ❑ **I read this chapter and would like to make the following suggestions:**

List of tables:

- ❑ **I did not read the list of tables**
- ❑ **I read the list of tables and have no comments**
- ❑ **I read the list of tables and would like to make the following suggestions:**

Table with proposed testimonies:

- ❑ **I did not read this table**
- ❑ **I read this table and have no comments**
- ❑ **I read this table and would like to make the following suggestions:**

Useful resources:

- ❑ **I did not read this section**
- ❑ **I read this section and have no comments**
- ❑ **I read this section and would like to suggest that the following resources be added:**

11. Other comments?

12. Overall rating of the Report: 1.....5.....10
Very weak Excellent

COMH-47

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

October 27, 2000 / Vol. 49 / No. RR-11

MMWR™
MORBIDITY AND MORTALITY
WEEKLY REPORT

Recommendations and Reports

Building Data Systems for Monitoring and Responding to Violence Against Women

Recommendations from a Workshop

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, GA 30333

for CHC
Violence against Women
Reference file
(or Violence & Health)
JN
20/11/2000

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Contents

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Building Data Systems for Monitoring and Responding to Violence Against Women

Recommendations from a Workshop

Summary

This report provides recommendations regarding public health surveillance and research on violence against women developed during a workshop, "Building Data Systems for Monitoring and Responding to Violence Against Women." The Workshop, which was convened October 29–30, 1998, was co-sponsored by the U.S. Department of Health and Human Services and the U.S. Department of Justice.

BACKGROUND

Available data suggest that violence against women (VAW) (i.e., both adolescents and adults) is a substantial public health problem in the United States. Law enforcement data indicate that 3,419 females died in 1998 as a result of homicide (*1*), and approximately one third of these women were murdered by a spouse, ex-spouse, or boyfriend. Data regarding nonfatal cases of assault are less accessible and are often inconsistent because of methodologic differences. However, recent survey data collected during 1995–1996 suggest that approximately 2.1 million women are physically assaulted or raped annually; 1.5 million of these women are physically assaulted or raped by a current or former intimate partner (*2*). Based on survey data from the Bureau of Justice Statistics' National Crime Victimization Survey, in 1998, women were victims in nearly 900,000 violent crimes committed by an intimate partner (*3*). Although these and other statistics suggest the magnitude of the problem, some experts believe that statistics on violence against women underrepresent the problem; others believe that some studies overestimate the extent of violence against women. Such lack of consensus and confusion about the different findings from various data sources prompted the establishment of the Workshop in October 1998.

INTRODUCTION

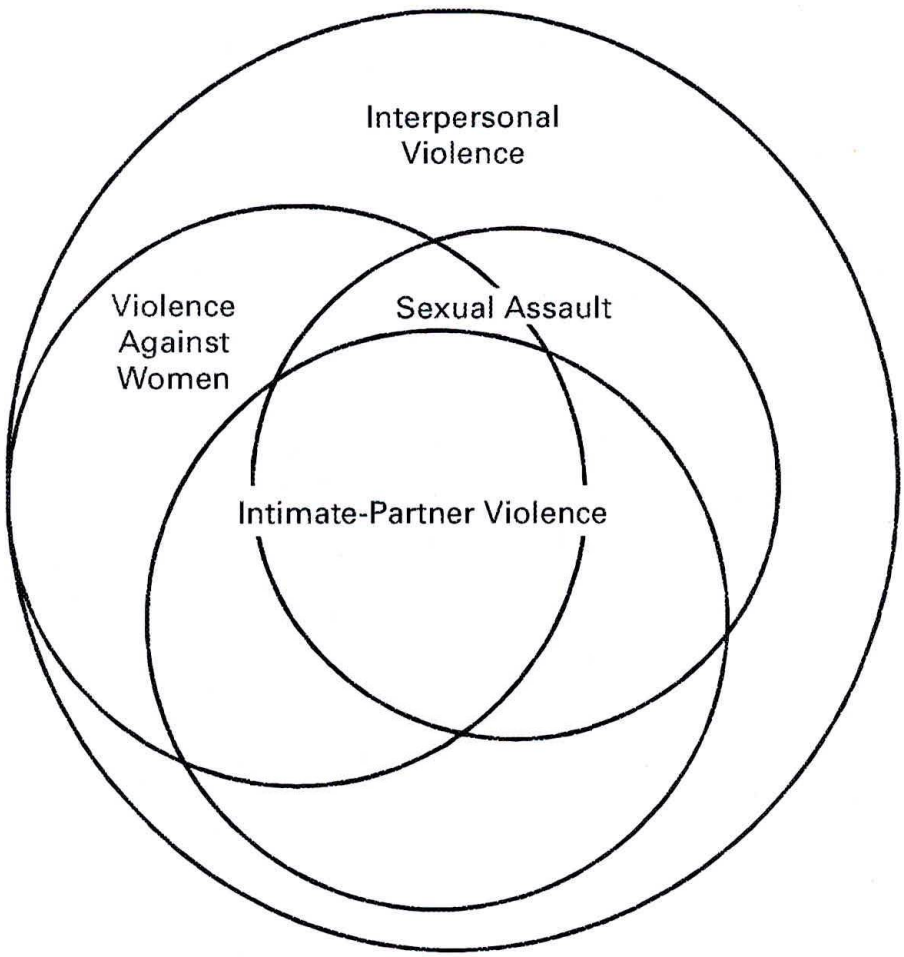
The U.S. Department of Health and Human Services (DHHS) and the U.S. Department of Justice (DOJ) co-sponsored the workshop "Building Data Systems for Monitoring and Responding to Violence Against Women" in October 1998. The 2-day invitational workshop, funded by CDC's National Center for Injury Prevention and Control (NCIPC) and National Center for Health Statistics (NCHS) along with the Bureau of Justice Statistics (BJS) and the National Institute of Justice (NIJ), brought together researchers and practitioners from the public health and criminal justice fields.

Earlier in 1998, the U.S. Secretary of Health and Human Services and Attorney General held a joint briefing that focused on the nature and extent of VAW. During the briefing, concerns were raised over differences among published estimates of rape, sexual assault, and intimate-partner violence and the resulting difficulties for developing and implementing effective programs and policies. The briefing also highlighted

current knowledge about the magnitude of violence against women and identified areas in which more information is needed. The Workshop was an outcome of this briefing and was conceived as a first step in a long-term effort to more accurately measure VAW and to conduct sound research.

In planning the Workshop, the Steering Committee* conceptualized VAW as encompassing many types of behaviors and relationships between victims and perpetrators. The Committee decided to focus on that subset of VAW categorized as intimate-partner violence and sexual violence by any perpetrator (Figure 1). In addition, several issues

FIGURE 1. Categories of interpersonal violence



NOTE: Because the exact proportions of these categories are unknown, the areas in the figure are not drawn to scale.

*Steering Committee members from the U.S. Department of Health and Human Services (DHHS) included Linda E. Saltzman (National Center for Injury Prevention and Control [NCIPC], CDC), Lois A. Fingerhut (National Center for Health Statistics, CDC), James A. Mercy (NCIPC, CDC), Jerry Silverman (DHHS), and Malcolm Gordon (National Institute of Mental Health, National Institutes of Health). Members from the U.S. Department of Justice included Christy Visher (National Institute of Justice [NIJ], Office of Justice Programs [OJP]), Michael R. Rand (Bureau of Justice Statistics, OJP), and Bernard Auchter (NIJ, OJP).

were identified as needing to be addressed, including a) collection of national, state, and local VAW data from both public health and criminal justice sources to represent different perspectives; b) definitions and methodologies; and c) concerns about the availability of social services for VAW victims. The Steering Committee commissioned six background papers that targeted these issues. All Workshop participants were provided copies of these papers before the workshop. Each paper was presented at the Workshop, followed by comments from one or more respondents.*

This Workshop addressed the opportunities and challenges associated with public health surveillance (i.e., the ongoing and systematic collection, analysis, and interpretation of information) and research relating to VAW. The goals of the workshop were to

- develop information and make recommendations enabling researchers to better describe and track VAW;
- share information about data collection for VAW, with emphasis on intimate-partner violence and sexual violence; and
- identify gaps and limitations of existing systems for ongoing data collection regarding VAW.

THE WORK GROUPS

Workshop attendees were divided into four work groups that met twice during the 2-day meeting. The groups were asked to develop recommendations on the following four topics related to the background papers and presentations:

- defining and measuring VAW;
- state and local data for studying and monitoring VAW;
- national data for studying and monitoring VAW; and
- new research strategies for studying VAW.

Work Group on Defining and Measuring VAW

The purpose of this work group was to identify and make recommendations about resolving problems resulting from the absence of uniform definitions associated with VAW. VAW is a broad term, encompassing a wide range of behaviors. Definitions of VAW should be established that are comprehensive enough to encompass women's physical and psychological experiences of violence, yet that are not so broad that they encompass behaviors that cannot be validly defined as VAW. It is unknown which data elements are most critical, or even possible, to collect. In addition to identifying components that are critical to defining and measuring VAW, this work group was asked to address questions about how to develop new measurement instruments or enhance existing ones to improve the quality of VAW data collected. The work group was directed to address which aspects of VAW should be measured (e.g., the occurrence of acts and the number of victims).

*Revisions of the background papers have been peer-reviewed and published (*4–11*).

Work Group on State and Local Data for Studying and Monitoring VAW

This work group was charged with developing recommendations regarding how state and local data systems could be improved for monitoring and characterizing VAW. They were asked to identify the key opportunities and methodologic challenges in using state and local data sources and to offer potential solutions for overcoming the identified challenges. The work group considered what types of data items should be collected; which data systems have the greatest utility for monitoring and characterizing VAW at the state and local levels; how greater uniformity in definitions and types of data collected on VAW can be fostered; and the challenges of data linkage.

Work Group on National Data for Studying and Monitoring VAW

This work group was charged with developing recommendations regarding how to improve and optimize national data for monitoring and characterizing VAW and its key dimensions (e.g., intimate-partner violence and sexual assault). The work group recognized that national data are collected from various data sources designed for different purposes. The group considered 18 surveys and surveillance systems that either contribute data or have the potential to contribute data toward measuring some aspect of VAW (Table 1). Although this list is not comprehensive, it served as a reference for a discussion about what makes a survey or a data system useful for monitoring VAW.

In addition, the group considered some of the factors that determine the utility and reliability of VAW estimates (Table 2). None of the 18 surveys or surveillance systems considered by the work group are ideal for measuring VAW; however, four surveys (i.e., the National Crime Victimization Survey, the National Violence Against Women Survey, the National Youth Survey, and the National Women's Study) are likely the most useful and reliable. Data from each of these surveys can be used to produce estimates of prevalence, incidence, and chronicity.

Some surveys (e.g., the National Family Violence Survey) can be used to derive prevalence estimates but are not conducted on an ongoing basis. One reporting system, the National Incident-Based Reporting System, is ongoing but is being used by only a few states and thus does not provide nationally representative data. In addition, none of the ongoing surveys collect detailed VAW data. Some of the surveys and surveillance systems could potentially be modified to include additional questions related to VAW (e.g., the National Health Interview Survey and the National Electronic Injury Surveillance System). Although several factors (e.g., comorbidity and etiology) are addressed by a few surveys, these surveys do not provide incidence or prevalence estimates.

Work Group on New Research Strategies for Studying VAW

The purpose of this work group was to make recommendations for new methods of data collection and data analysis to better understand and characterize VAW. The group considered new data sources, ways to improve identification of VAW in existing databases, and data linkages. In addition, they discussed new methods of assessing a) exposure to violence and b) intervention outcomes, with emphasis on service delivery settings that can become sources of data regarding the prevalence and experiences of battered women.

TABLE 1. Sources and potential sources of national data on violence and abuse against women

Source	Web site(s)	Sponsor(s)
Criminal justice		
Supplementary Homicide Reports (SHR)*	www.fbi.gov/ucr.htm www.ojp.usdoj.gov/bjs/homicide/addinfo.htm	FBI
National Crime Victimization Survey*	www.ojp.usdoj.gov/bjs/	BJS
National Incident-Based Reporting System*	www.fbi.gov/ucr.htm	FBI
Health care		
National Ambulatory Medical Care Survey	www.cdc.gov/nchs/about/major/ahcd/namcsdes.htm	CDC (NCHS)
National Hospital Ambulatory Medical Care Survey	www.cdc.gov/nchs/about/major/ahcd/nhamcsds.htm	CDC (NCHS)
National Hospital Discharge Survey	www.cdc.gov/nchs/about/major/hdasd/nhds.htm	CDC (NCHS)
National Health Interview Survey	www.cdc.gov/nchs/nhis.htm	CDC (NCHS)
National Survey of Family Growth	www.cdc.gov/nchs/nsfg.htm	CDC (NCHS)
National Vital Statistics System	www.cdc.gov/nchs/about/major/dvs/mortdata.htm	CDC (NCHS)
National Electronic Injury Surveillance System	cpsc.gov/cpscpub/pubs/3002.html	CPSC
Monitoring the Future	165.112.78.61/DESPR/MTF.html	SAMHSA, University of Michigan
Other		
Youth Risk Behavior Surveillance System	www.cdc.gov/nccdphp/dash/yrbs/ov.htm	CDC (NCCDPHP)
Behavioral Risk Factor Surveillance System	www.cdc.gov/nccdphp/behavior.htm	CDC (NCCDPHP)
National Violence Against Women Survey (1995–1996)*	ncjrs.org/pdffiles1/nij/181867.pdf ncjrs.org/pdffiles/172837.pdf ncjrs.org/pdffiles/169592.pdf	NIJ, CDC (NCIPC)
National Family Violence Survey (1975, 1985)*	www.icpsr.umich.edu/cgi/ab.prl?file=9211 www.icpsr.umich.edu/cgi/ab.prl?file=7733 socio.com/srch/summary/afda/fam31.htm socio.com/srch/summary/afda/fam32.htm	NIH (NIMH)
National Youth Survey (1976–1989)*	www.sscnet.ucla.edu/issr/da/index/techinfo/m2491.htm	NIH (NIMH, NIDA), OJJDP, NIJ
National Survey of Family and Households (1987–1988 and 1992–1994)*	156.40.88.3/about/cpr/dbs/res_national4.htm socio.com/srch/summary/afda/fam01-05.htm	NIH (NICHHD)
National Women's Study (1989)*	www.musc.edu/CVC/NIDApubs/htm	NIH (NIDA)

NOTE: FBI=Federal Bureau of Investigation; BJS=Bureau of Justice Statistics; NCHS=National Center for Health Statistics; CPSC=Consumer Product Safety Commission; SAMHSA=Substance Abuse and Mental Health Services Administration; NCCDPHP=National Center for Chronic Disease Prevention and Health Promotion; NIJ=National Institute of Justice; NCIPC=National Center for Injury Prevention and Control; NIH=National Institutes of Health; NIMH=National Institute of Mental Health; NIDA=National Institute of Drug Abuse; OJJDP=Office of Juvenile Justice and Delinquency Prevention; NICHHD=National Institute of Child Health and Human Development.

*Includes specific data or direct questions regarding violence against women.

TABLE 2. Questions to consider in determining the utility and reliability of surveillance-based estimates of violence against women (VAW)

Factor	Questions to consider
Periodicity	Is the survey ongoing or periodic (i.e., repeated over time), as opposed to a one-time survey?
Precision	Are the survey results based on large samples so that standard errors are minimized, or are data based on a census or complete count?
Supplement	Does the survey include or have the potential to include a supplement or a follow-back component (i.e., a mechanism to recontact survey respondents for additional information) to better estimate VAW?
Health services	Does the survey measure health-care utilization for VAW?
Social services	Does the survey measure social-services utilization for VAW?
Etiology	Can risk factors be estimated?
Co-morbidity	Does the survey include drug or alcohol abuse or other conditions that could affect the magnitude of VAW?
Methodology	Can the survey be used to explore methodologic questions?
Prevalence	Can the survey be used to estimate annual or lifetime prevalence of VAW?
Incidence	Can the survey be used to estimate incident cases of VAW?
Chronicity	Can the survey be used to estimate the number of episodes of violence/abuse per victim per year?

RECOMMENDATIONS

The following recommendations, which were developed by the four work groups, are categorized by several broad topics. Because the workshop was organized into four work groups, similar recommendations were conceived for several topics. Some of the recommendations could have been categorized under more than one topic; however, to avoid repetition, these recommendations are listed only in the most appropriate category.

Although some recommendations may seem similar, they are not identical and were developed by different work groups and from different perspectives. The recommendations do not reflect consensus from the entire workshop. Thus, for each bulleted recommendation, the work group responsible for its conception is identified in parentheses following the statement.

Defining the Scope of the Problem

- CDC has initiated a process to develop and pilot test uniform definitions associated with intimate-partner violence (*12*). These uniform definitions should be used as the basis for defining and measuring VAW, with the following modification. The term "violence and abuse against women" (VAAW) should become standard. The "VAAW" term can provide a middle ground between the desire not to muddle the generally understood meaning of the term "violence" (i.e., actions that cause or threaten actual physical harm) and the desire not to overlook psychological/emotional forms of abuse and the trauma and social costs

they cause to victims. Continuing to use only the term "VAW" supports the misconception that a woman is only abused if she has broken bones or other physical injuries. Both practice guidelines and published research document the psychological and psychiatric sequelae of violence against women (*13*) and the substantial use of mental health services by victims of intimate-partner violence (*14*).* **(Work Group on Defining and Measuring VAW)**

- "Violence" is a term that encompasses a broad range of maltreatment against women. The phrase "violence and abuse against women" should be used to refer to the combination of all five of the following major components of such maltreatment:

  – physical violence;

  – sexual violence;

  – threats of physical and/or sexual violence;

  – stalking; and

  – psychological/emotional abuse.

  The first three components — physical violence, sexual violence, and threats of physical and/or sexual violence — should comprise a narrower category of VAW. Accusations have been made that VAW statistics are falsely inflated with subjective measures of psychological abuse (*5*). With the recommended terminology and classification scheme, the first three categories can be combined and reported as VAW. All five components of maltreatment against women can still be used to represent a larger spectrum of behaviors harmful to women.

  Consensus was reached that stalking should be included as a component of VAAW; however, no consensus was reached regarding whether stalking should be included in the narrower category of VAW, considered psychological/emotional abuse, or treated as a discrete category. Whether stalking requires the presence of a clear threat to do physical harm is an unresolved issue. Future research on stalking may help clarify the category in which stalking should be included.* **(Work Group on Defining and Measuring VAW)**

- Data should be collected on as many of the five major components of VAAW as possible, and data collection should allow for examination of the co-occurrence of the components.* **(Work Group on Defining and Measuring VAW)**

- Research, program, and public health surveillance data should report disaggregated statistics for each of the five forms of VAAW. Presentations of VAAW data should show cross-tabulations or Venn diagrams for all of the forms of maltreatment.* **(Work Group on Defining and Measuring VAW)**

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- The use of common definitions and data elements should be encouraged. Uniformity of definitions and data elements will increase the reliability of VAW estimates across locale and time. A CDC-sponsored panel of invited experts developed uniform definitions and a recommended set of data elements for intimate-partner violence surveillance that are being tested by three states (*12*). In addition, guidelines for public health surveillance of intimate-partner violence are needed on local levels, potentially serving as a model for surveillance of other forms of VAW. Federal agencies (e.g., those responsible for addressing the legal or public health consequences of VAW) should jointly fund local surveillance efforts. **(Work Group on State and Local Data for Studying and Monitoring VAW)**

Need for Multiple Measures/Collaboration Across Disciplines and Agencies

- Personal interview surveys (national, state, and local) are a better tool for measuring the extent of VAW than record reviews (e.g., medical, crime, and other service delivery); however, no single or existing tool is sufficient to gauge and track all dimensions of VAW. Multiple data collection efforts and funding of health, criminal justice, and social services are needed. **(Work Group on National Data for Studying and Monitoring VAW)**
- Because no single measurement tool can capture all of the elements of VAAW, researchers and programs must continue drawing from existing tools and developing new measures.* **(Work Group on Defining and Measuring VAW)**
- Multi-disciplinary research should be strongly encouraged. **(Work Group on New Research Strategies for Studying VAW)**
- Experts in several different disciplines should be encouraged to collaborate with researchers who specialize in VAW and to initiate similar research in their own fields. Disciplines that currently or could potentially conduct research on VAW include anthropology, business/management, criminal justice, demography, economics, education, epidemiology, geography, journalism/mass communication, philosophy/ethics, psychology, public health, social work, sociology, substance abuse, suicidology, system analysis/operations research, theology, urban/rural planning, and women's studies. In addition to these discipline-based groups, such collaboration might also include persons whose research areas focus on ethnicity, the behavior of boys and men, and research methodology (e.g., survey methodologists). **(Work Group on New Research Strategies for Studying VAW)**

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- A chartbook or annual report should be produced to present the current available data regarding VAW. In addition to describing the current state of VAW, such a report would help identify areas in the data systems that need improvement or areas in which more information is needed. **(Work Group on National Data for Studying and Monitoring VAW)**
- DHHS and DOJ should jointly conduct methodologic research on VAW. Such research could focus on several issues, such as the effect of context on prevalence estimates (e.g., health versus criminal justice) and definitions (e.g., narrow versus broad). **(Work Group on National Data for Studying and Monitoring VAW)**
- Collaboration between service providers and researchers in the conduct of research activities will improve the quality of information collected about VAW. Such collaboration requires the development of a true partnership at the start of research activities (i.e., a partnership that includes the joint planning and implementation of the research methodology, presentation and dissemination of study findings, and using the research results to refine the services for victims and perpetrators of violence). Such partnerships between researchers and service providers should be studied to identify the types of activities and procedures that are most useful. **(Work Group on New Research Strategies for Studying VAW)**

Developing Strategies to Collect Data on VAW

Building/Enhancing Measures of VAW

- The potential of existing data sets for characterizing and monitoring VAW should be assessed. Data can be organized into four major categories: nationally representative surveys, local health data, local criminal justice data, and non-nationally representative data from service providers. Ongoing, population-based surveys developed for other local or state purposes should be considered as potential opportunities for studying VAW. Other ongoing surveys that contain questions concerning VAW (although not all are currently conducted at the local level or in all jurisdictions) include the Pregnancy Risk Assessment Monitoring System (PRAMS) and the National Crime Victimization Survey (NCVS). Modules or specific questions pertaining to VAW could also be added routinely to the Behavior Risk Factor Surveillance System (BRFSS) or the Youth Risk Behavior Surveillance System (YRBSS). Potential sources of local health data include emergency departments, hospital discharge records, the Health Employer Data Information System (HEDIS), sexual assault nurse examiner (SANE) programs, mental health databases, medical examiner data, and trauma registries. Possible sources for local criminal justice data include databases for misdemeanors, restraining orders, court probation, and court-case tracking. Police departments, forensic labs, and district attorney offices may also provide local criminal-justice data. Service-provider data might be collected from battered women programs, rape crisis centers, protective-service programs, victim-witness advocates, teen dating violence prevention programs, child and family services, welfare offices, and school counselors. **(Work Group on State and Local Data for Studying and Monitoring VAW)**

- Questions or supplements can be added to existing continuous surveys (e.g., the National Survey of Family Growth, the National Health Interview Survey, and BRFSS). Although supplements to surveys can be costly, adding questions to ongoing surveys or conducting periodic supplements can be more cost-effective in producing detailed data sets than creating new surveys. **(Work Group on National Data for Studying and Monitoring VAW)**

- As a cost-effective and efficient strategy for gathering data, questions or modules concerning VAW could be added to numerous ongoing surveys. This activity might be particularly useful if the survey is representative of a well-defined population (e.g., persons living within a particular geographic region or persons with other common characteristics) and is ongoing (e.g., following the same persons or monitoring a changing population over time). **(Work Group on New Research Strategies for Studying VAW)**

- Monitoring efforts should focus on counting the number of women who are victimized by VAAW. Future consideration should also be given to adding measures that capture more accurately the number of perpetrators in the population for each of the components of VAAW.* **(Work Group on Defining and Measuring VAW)**

- Data used for monitoring should include past year prevalence, past year frequency, and lifetime prevalence. The lifetime prevalence calculation represents the physical health, mental health, and social consequences that can occur years after violence or abuse has stopped. **(Work Group on Defining and Measuring VAW)**

- Improved estimation of lifetime prevalence of VAW is needed. Of the ongoing surveys, none can estimate lifetime prevalence of violence. **(Work Group on National Data for Studying and Monitoring VAW)**

- Etiologic and co-morbidity information periodically should be collected (e.g., approximately every 5 years) as a supplement to a more routine monitoring system because these data are relatively stable and because including such information on a more frequent basis is costly. **(Work Group on National Data for Studying and Monitoring VAW)**

- Collecting data within various settings and populations enhances perspectives about VAW. Data from diverse settings and populations can provide information regarding risk factors, consequences of violence, and service needs of particular populations as well as how victims of violence fare in different health, judicial, or social service systems. Settings and sources of information concerning VAW include employment locations; faith communities; health-care settings (e.g.,

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emergency departments, migrant-health programs, community-health programs, maternal- and child-health programs, managed care programs, and military/veterans health services); community-based service agencies (e.g., welfare offices, child development and child care services, Head Start locations, and day care centers); and programs for children (e.g., schools, Boys and Girls Clubs, gang programs, and programs for runaway children). In addition, other places where women and men congregate may provide venues for collecting information, including laundromats, hair salons, Internet chat rooms, and job training programs. Data should be collected from underserved populations, including Native American, Asian, Latino, and African-American communities. **(Work Group on New Research Strategies for Studying VAW)**

- Because some victims and perpetrators of violence never seek violence-related services, monitoring systems should be implemented to estimate a) the prevalence and incidence of VAW in the general community and b) the number of persons in need of services who are not receiving them. Persons who seek such services are not likely to be representative of all victims or perpetrators of violence. **(Work Group on New Research Strategies for Studying VAW)**

- A nationally representative system for monitoring VAW should be developed. Although data from state and local agencies (e.g., social service and criminal justice agencies) help document the extent of the problem, data from these sources are likely to be skewed because few female victims of violence ever seek help from those agencies. Therefore, core monitoring efforts should be based on national samples of the total population (i.e., population-based). In addition, BJS should explore the feasibility of developing local or state estimates of VAW from representative samples in states, cities, or defined metropolitan areas. However, measuring VAW (especially intimate-partner violence, rape, and sexual assault) in smaller geographic areas is problematic because of infrequent occurrence of VAW. **(Work Group on State and Local Data for Studying and Monitoring VAW)**

- Incident-based reporting that includes information on the victim-perpetrator relationship should be employed within the criminal justice system. Use of incident-based data would allow estimation not only of how many women are affected by VAW but the frequency of its occurrence. **(Work Group on State and Local Data for Studying and Monitoring VAW)**

- Offender-based data systems should be considered for measuring and tracking VAW. Offender-based data sources (e.g., arrests and court-based statistics) can help estimate some elements of the VAW problem. However, these data sources exclude victims and offenders who do not come to the attention of the criminal justice system; hence, these data sources should not be used as a sole method for estimating VAW. **(Work Group on State and Local Data for Studying and Monitoring VAW)**

- An improved identification system for homicides is needed. Only three identified data systems — the Supplementary Homicide Reporting System (SHR) and NIBRS (both part of the Uniform Crime Reporting System) and the National Vital Statistics System (NVSS) — measure the incidence of homicide. However, NIBRS has not been implemented nationally, SHR is missing substantial amounts of data

regarding victim-offender relationships, and NVSS can not identify offenders or specifically identify victims of intimate-partner violence. **(Work Group on National Data for Studying and Monitoring VAW)**

Building Partnerships

- Each state should provide funds for a position to oversee data collection and monitoring of VAW. The interests of both the criminal justice and health fields must be represented, and technical assistance must be provided to state and local entities collecting data for studying VAW. **(Work Group on State and Local Data for Studying and Monitoring VAW)**
- Stakeholders should be involved in the development of data systems. From its inception, any data system should include input from victims and service providers. Service providers need to be better informed about data systems to understand the purposes of public health surveillance and the usefulness of the information that such systems provide. **(Work Group on State and Local Data for Studying and Monitoring VAW)**

Developing Strategies Related to Subpopulations

- Data should be gathered for groups that have been omitted from national surveys. No national studies focus on immigrant or homeless women, women with disabilities, women in the military, or women in other institutional populations. **(Work Group on National Data for Studying and Monitoring VAW)**
- The terms "cultural sensitivity" and "competency" must be clearly defined. Research strategies should then be designed to meet those definitions and should be sensitive to the situations of victims of violence. Populations at higher risk for VAW must be identified to ensure the implementation of appropriate preventive and therapeutic services. Several methodologic concerns may arise when researching VAW among persons in these high-risk groups. The research conducted must be relevant to the community being studied. In addition, to thoroughly understand the role of violence in the lives of culturally diverse populations, researchers must examine both protective factors and risk factors that may affect those populations. Developing true partnerships with service providers and recipients may improve data quality. **(Work Group on New Research Strategies for Studying VAW)**

Improving Measures of Service Provision

- Service providers should be involved in local data-collection efforts, both to enhance data collection and to encourage wider acceptance, use, and dissemination of results. **(Work Group on Defining and Measuring VAW)**
- Data concerning how VAW victims utilize health and social services should be collected periodically. Collection of such data has been limited, often because of ethical issues (e.g., privacy, confidentiality, and safety). Methods of documenting the use of health, social, and legal services that will not compromise the privacy

and safety of the respondent should be developed. **(Work Group on National Data for Studying and Monitoring VAW)**

- Rigorous evaluations of the effectiveness of various services are needed. Limited information is available regarding the effectiveness of services for victims and perpetrators, and this information is needed to guide program and policy development. Service providers and recipients may define positive outcomes in different ways. Evaluation activities should address the financial costs of various violence-related services, including primary prevention activities. **(Work Group on New Research Strategies for Studying VAW)**

- The feasibility of universal screening and documentation within local health systems (e.g., emergency departments, health departments, mental health centers, primary outpatient care centers, and school health centers) should be investigated as a possible mechanism for surveillance of VAW. In addition, the reliability and validity of screening questions should be assessed. Consensus has not been reached regarding whether universal documentation of intimate-partner violence should be used within health-care settings, because such documentation could have negative effects for victims of VAW. For example, documentation of repetitive injuries resulting from intimate-partner violence could result in denial of health insurance claims or future denial of health insurance benefits. **(Work Group on State and Local Data for Studying and Monitoring VAW)**

Methodologic Concerns

- When feasible, measurements should include open-ended questions or variables. Data from such questions can be re-coded into existing categories or may serve to clarify the need for additional categories. In situations where data are gathered using survey methodology, these open-ended questions can serve to humanize the data-collection process and add rapport with the respondents. **(Work Group on Defining and Measuring VAW)**

- Questions and data elements should be pretested (e.g., through focus groups and in-depth interviews) to explore how respondents interpret questions. **(Work Group on Defining and Measuring VAW)**

- Information is needed regarding which data elements are common across surveys and whether data can be linked. Data rarely are coordinated between existing data sources, despite the need for comparability of estimates across data systems. With new data sources, using variables and questions similar to those used in existing surveys should be explored. **(Work Group on National Data for Studying and Monitoring VAW)**

- Several scientific methods should be used to study VAW. No "gold standard" scientific methodology exists. The study methodology should fit the study question being posed, and some study questions may be best addressed by using multiple types of study designs and assessment measures. **(Work Group on New Research Strategies for Studying VAW)**

- Both quantitative and qualitative methods may be useful in the study of VAW, particularly when used in combination. To better understand the complexity of VAW, study methodologies should account for contextual issues surrounding the violence (e.g., whether a violent episode represented a discrete event or was part of ongoing violence in the relationship or whether violence was defensive in nature). **(Work Group on New Research Strategies for Studying VAW)**

- The development and use of psychometrically sound assessment techniques should be encouraged within all areas of VAW research, including assessments based in service settings. Research on the reliability and validity of various assessment techniques for measuring VAW is limited. **(Work Group on New Research Strategies for Studying VAW)**

- Whenever data about VAAW are reported, the actual data elements or questions used to gather the information (i.e., the operational definitions of VAAW) and a description of the human subjects methods used to protect the confidentiality and safety of those from whom data are gathered should also be reported. Because data on VAAW can be affected by the wording of a survey question or the method of data collection used, making this information available allows users of the data to more accurately interpret the numbers presented.* **(Work Group on Defining and Measuring VAW)**

- Establishing a unique identifier for victims of VAW is essential for recordkeeping and protecting confidentiality. However, each system may have its own method of coding: one victim may be assigned a unique identifier by the local police department and another by a rape crisis center. The feasibility of using common unique identifiers to enhance linkage across data systems and to ensure that victim safety is not compromised should be explored. Linking criminal-justice, health, and service-provider data for monitoring purposes could minimize the probability of duplicating counts and allow for the analysis of repeat victimization. Common unique identifiers would make such a linkage feasible. **(Work Group on State and Local Data for Studying and Monitoring VAW)**

- The context of a survey (e.g., whether it addresses health, crime, or personal safety issues) should be explicit to allow appropriate interpretation of findings. **(Work Group on National Data for Studying and Monitoring VAW)**

Confidentiality and Safety

- The safety of victims and the confidentiality of data collected must be given a high priority. Data collected regarding VAW must be designed to ensure confidentiality

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and to avoid potentially dangerous situations that could compromise the safety of victims. **(Work Group on State and Local Data for Studying and Monitoring VAW)**

- The confidentiality and safety of VAW study participants must be protected. Although standard procedures used in conducting research with human populations should be followed, sometimes procedures must be modified to ensure the safety of VAW victims. Although several specific actions have been developed to increase safety for victims, no guidelines are available for researchers concerning the safety and confidentiality issues that can arise in VAW studies and the practices that have been used to address these issues. Therefore, guidelines concerning confidentiality should be developed and disseminated. For example, federal agencies could solicit papers on these issues and then use them to prepare a handbook to guide future research. **(Work Group on New Research Strategies for Studying VAW)**
- The safety of staff members who conduct research (e.g., interviewers) should also be considered. Study staff may suffer psychological distress after interviewing multiple violence victims or may fear attack from violent perpetrators. **(Work Group on New Research Strategies for Studying VAW)**
- Research should be conducted on the potential effects of participating in VAW studies. Limited empirical evidence exists concerning how participating in such research affects study participants. **(Work Group on New Research Strategies for Studying VAW)**

CONCLUSIONS

Summary remarks presented by representatives from all four work groups emphasized that the work group deliberations represented only a beginning to the process of developing uniformity across the numerous sectors and disciplines concerned with VAW. Further input from researchers and practitioners concerning the feasibility of these recommendations is needed. In addition, the specific recommendations that are most essential to the process of building VAW data systems must be identified. Agency leaders from BJS, NIJ, and two centers within CDC (NCHS and NCIPC) affirmed that the Workshop itself was an initial cross-departmental step in a long-term, coordinated effort to improve the monitoring of VAW and to develop programs to respond to such violence.

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Challenge 2: Improving our understanding of the etiology of violence in the Western Pacific Region

Dr Liz Eckermann
Temporary adviser WHO, WPRO.

What is known in WPR

- Limited data on violence in war (Cambodia), elder abuse (Singapore), child abuse (Philippines, Hong Kong), trafficking in women (Lao PDR, Cambodia), sexual abuse (Philippines), bullying in schools(Australia), workplace violence (NZ).
- Some data on suicide (all countries)
- increasing data on domestic violence but still only the tip of the iceberg (Cambodia, Malaysia, Philippines, Australia, Pacific Is)

Research by whom

- **Domestic Violence: Major GBD**
- WHO: WHD 1998-9 multi-country study
- UNFPA 1999-2000: 7 Pacific Islands
- Malaysian govt
- Philippines govt and NGOs
- Govt/NGO Cambodian study
- Hong Kong: Chinese govt/courts/ welfare/police/NGOs
- Australia: longitudinal study (University of Newcastle)

CAMBODIA: 'Domestic violence is a burden on numerous sectors of the social system and quietly, yet dramatically, affects the development of a nation ... batterers cost nations fortunes in law enforcement, health care, lost labour and general progress in development. These costs do not only affect the present generation; what begins as an assault by one person on another reverberates through the family and the community into the future' (Zimmerman, 1994:184)

Global Concern

- 1948 Universal Decl of Human Rights
- 1966 International Covenant on Civil and political rights
- 1975 Nairobi Forward Looking Strategy
- 1979 Convention on the Elimination of Discrimination Against Women
- 1984 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Global Concern

- 1989 Convention on the Rights of the Child
- 1993 World Bank Report: GBD
- 1994 ICPD
- 1995 BPFA
- 1996 WHA 49.25 Violence a public health priority issue

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Regional Concern

- 1998 Monograph: Domestic Violence a priority public health issue in WPR -response to member countries request at 1997 RCM
- Papua New Guinea to 'develop community-based activities in respect of the attitude of men towards women'.

Research (WHO, WHD: UNFPA, Cambodia study)

Domestic Violence

- Domestic violence evident to some degree in every society in the world.
- 'research consistently demonstrates that a woman is more likely to be injured, raped or killed by a current or former partner than by any other person'

Hidden in the family

- Data on rape and violence injury, from a woman-friendly hospital in Cebu, the Philippines, reveals that in 1997, of the 218 cases of rape which were treated in the hospital 50 per cent had been committed in the victim's or the offender's house and less than 10 per cent of rapes were committed by a person unknown to the victim.

Causes: need for a multi-level model

- causes are multiple and complex.
- Patriarchy **and**
- stress,
- social learning,
- personality disorders
- alcohol abuse
- proximity(paradox)

Multi-level Theory: Adapting the Heisse model to WPR

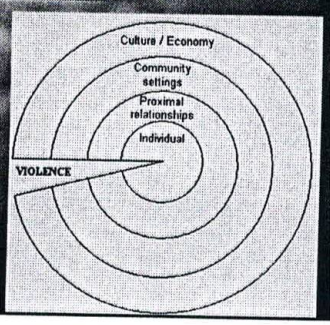
- Theory must be able to account for both why individual men become violent and why women as a class are so often their target' (Heisse, 1997).

Theory must be adaptable to move beyond a Eurocentric orientation

Ecological approach

- Heisse (1997:3) argues for the adoption of an 'ecological approach to abuse' which 'conceptualizes violence as a multifaceted phenomenon grounded in an interplay between personal, situational and sociocultural factors'.

ECOLOGICAL MODEL



Multiple levels

- personal history (at the individual level)
- microsystems (at the family level),
- exosystems (at the community and societal level) and
- macrosystems (at the cultural and belief system level).
- In developing prevention programmes all levels must be addressed.

Personal history includes factors such as:

- Witnessing violence as a child
- Being abused oneself as a child
- Absent or rejecting parent
- Unresolved anger
- Feeling powerless
- emotional violence (e.g. unintended consequences of China's one child policy)

Microsystem influences include:

- Male dominance in the family
- Male control of wealth in the family
- Use of alcohol
- proximity and intimacy (paradox in Cambodia)
- Marital/verbal conflict.
- Backlash against women's changed roles (Solomon Is)

Exosystem factors include:

- Low socioeconomic status/unemployment
- Isolation of woman and family
- Delinquent peer associations
- Environmental factors (e.g. haze =closed windows=less neighbour surveillance=more family violence) (Singapore)
- recent migration (Hong Kong)

Macrosystem factors include:

- Male entitlement/ownership of women (e.g. polygamy in Hong Kong)
- Masculinity linked to aggression and dominance
- Rigid gender roles
- Cultural acceptance of interpersonal violence and physical chastisement
- (adapted from Heisse, 1997:3)

Skewed Explanations

- Sarawak Tribune "How do I protect my child from abuse?"
- The solutions offered were all individually oriented and included support, security and confrontation.

The key tips offered to parents were:

Tips

- " Teach children to say no to those they know as well as to strangers
- " Tell children to trust their instincts
- " Offer comfort and support if they have had a bad experience
- " Reassure the victim that they have done nothing wrong.
- *(Sarawak Tribune, March 25 1998, Outlook page 3)*

Broaden explanation

- No attempt was made to address the broader familial, community, societal or cultural factors that contribute to child abuse or to acknowledge that the people in charge of the child's welfare may be the actual perpetrators of the abuse.

Combining Levels (Macro – Micro) e.g.

- 1.social construction of femininity and masculinity (macrosysytem)
- 2.paradox of proximity (exosystem) [helps explain many cases of domestic violence in Cambodia]

3.use of alcohol (microsystem)

1: social construction of femininity and masculinity

- The gender imbalance in domestic violence is partly related to differences in physical strength and size.

Because females are typically shorter and lighter than males, and have learned fewer skills of self-defence, women are often poorly equipped to protect themselves if their partner becomes violent. (Broom, 1998:45)

Gender socialization

- However, much of the disparity relates to how men and women are socialized into their gender roles in different societies throughout the world. In societies with a patriarchal power structure 'definitions of femininity (dependence, fearfulness) amount to a cultural disarmament that may be quite as effective as the physical kind' (Connell, 1995:83).

Gender roles

- Domestic violence : playing out of definitions and shared understandings of femininity and masculinity deeply embedded in the culture and in the psyches of both men and women within that culture. i.e. "normalized"
- but resistance possible (e.g. Malaysian woman who challenged syariah law)
- "This is the woman who would prostrate to kiss her husband's hands and feet to pacify him so that he would not continue hitting her" *(New Straits Times* , Malaysia,1998).

Gender dimensions

- Women can be perpetrators of violence, violence is not an exclusively male domain
- 'husband battering' maybe under-reported: given that 'confessing to being knocked around by another man is a piece of cake compared to admitting being victimized by a woman' (Brott, 1993).

- " privileged group use violence to sustain their dominance. Intimidation of women ranges ...from wolf-whistling in the street to office harassment, rape and domestic assault, to murder by a woman's separated husband. Physical attacks commonly accompanied by verbal abuse (calling women "whores" and "bitches"...). Most men do not attack or harass women; but those who do are unlikely to think themselves deviant. On the contrary they usually feel they are entirely justified, that they are exercising a right...authorized by an ideology of supremacy'. (Connell, 1995:83)

2: proximity & intimacy

- physical proximity and emotional intimacy of the household makes it the most likely site for psychological and emotional abuse.
- Cambodia: 43 of 50 women reported physical abuse by husbands, 24 reported physical abuse of their children by their husbands yet only 7 of 50 reported husbands abusing people outside of the household.
- But proximity (geographical and emotional) of parents prophylactic against violence. Closer = better outcome.

Proximity and intimacy

- E.g. Philippines violence injury, 363 cases treated in 1997,
- 73% took place in the victim's own home and
- only 6 % perpetrators were not related or not in a relationship with the victim.
- 76 % of perpetrators were husband, a live-in partner or a boyfriend. (Vincente Sotto Memorial Center, 1997).

3: Alcohol

- Cultural acceptance of alcohol as a social drug, exacerbates domestic violence
- often involves complicity from the victim of violence.
- "out of character" behaviour often excused by the perpetrator and the victim of the violence

Alcohol

- ("It wasn't really me/him, it was the drink").
- 'some individuals become intoxicated in order to carry out the violent act'.
- alcohol operates largely as 'a situational factor, increasing the likelihood of violence, by removing inhibitions, clouding judgement, and impairing an individuals ability to interpret cues',

Alcohol

- 'abusive men with alcohol problems tend to be violent more frequently and inflict more serious injuries on their partners than do men without alcohol problems'.
- 'treating an underlying alcohol problem can help reduce the incidence and severity of assaults, **but it seldom "solves' the violence'** (Heisse, 1997:9)

Cultural relativity vs universal principles

- Why is domestic violence a problem if there is some consensus between men and women in particular cultures as to its role as a normal part of social life? Why should universal values be imposed on situations which appear to be an integral part of specific cultures.

Violence not negotiable

- Some issues are negotiable and can take account of cultural sensitivities and customs, others, especially those which compromise the health and wellbeing of particular groups in society, are not negotiable. Domestic violence fits the latter category because of its devastating short term and long term physical, psychological, emotional and social effects on the victims of such violence, in this case predominantly women and children.

Barriers

- Every country in WPR reports difficulty in gathering accurate data on violence.
- problem of definition
- the sensitivity of the topic and cultural taboos surrounding discussion of it,
- the 'normalcy' of domestic violence
- lack of public authority recognition of violence as a public health issue worthy of investigation.

Barriers cont:

- very little data is available for most countries in the Western Pacific Region.
- exceptions :Cambodia, the Philippines and Malaysia comprehensive data has been gathered by NGOs and U N funded research
- Even in these countries, information represents only the tip of the violence iceberg.

Policy implications

- Need an intersectoral approach, violence is a health issue & human rights, education, housing etc.
- Need global consensus to override specific cultural traditions of violence
- political will to declare violence a public health priority issue
- translate CEDAW etc. commitments into policies, laws, services and grass root activities.

Recommendations 1

- Disaggregate violence statistics by cause and by source (police, courts, hospitals, clinics, social services, neighbours, family members).
- If direct data is not available, use indirect indicators e.g. level of family support, level of alcohol consumption, customs relating to women, suicide rates?, divorce rates.

Recommendations 2

- Such data must be complemented with qualitative data and explanations of the relationship between the indirect indicator and domestic violence
- collect data which reflects that violence is a complex behavioural phenomenon involving emotional, physical and sexual abuse against a partner, not just simply physical incidents' (Hegarty & Roberts, 1998:49)

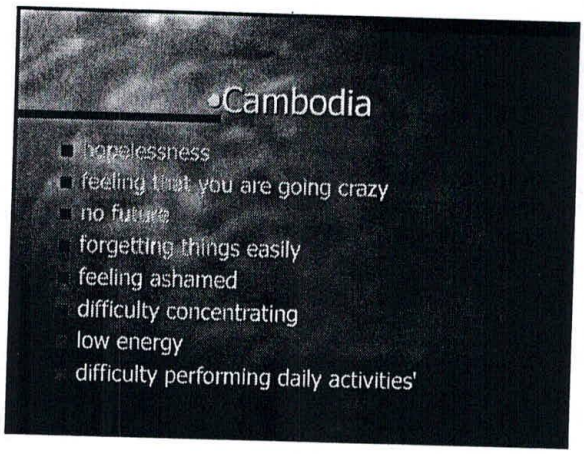
"In fact the body mends soon enough. Only the scars remain...But the wounds inflicted upon the soul take much longer to heal. And each time I re-live these moments, they start bleeding all over again. The broken spirit has taken the longest to mend; the damage to the personality the most difficult to overcome." (Domestic violence survivor quoted in WHO, 1996b)

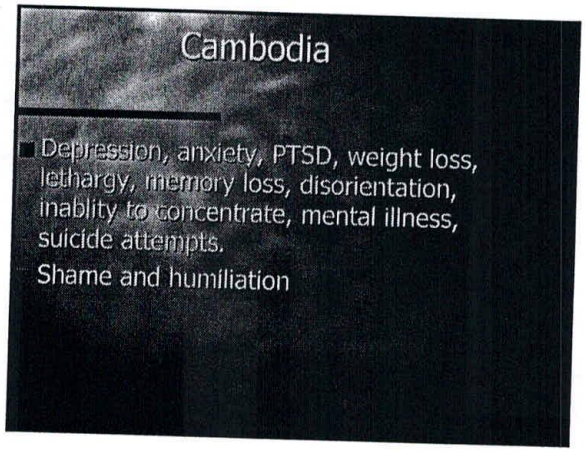
Research implications

- variety of measures (mortality, morbidity, social indicators, quality of life)
- causes of violence multi-levelled (individual - macro)
- examine across cultures and contexts
- across time (intergenerational effects).
- Collaboration between governments, international agencies, universities, NGOs
- generic causes and effects e.g. war & dv

Parallels With PTSD

- psychological effects of domestic violence in a Cambodia resemble the symptoms of post traumatic stress disorder experienced by Cambodian refugees after the Khmer Rouge period. (Zimmerman (1994:94


•Cambodia
hopelessness
feeling that you are going crazy
no future
forgetting things easily
feeling ashamed
difficulty concentrating
low energy
difficulty performing daily activities'


Cambodia
Depression, anxiety, PTSD, weight loss, lethargy, memory loss, disorientation, inablity to concentrate, mental illness, suicide attempts.
Shame and humiliation

Challenge 1:
Improving the Availability, Collection and Quality of Data

Dr. Yan Wang
Department of Maternal and Child Health
Beijing Medical University

Contents

- Available Data and Provided Information on Violence
- Limitations of Available Data
- Strategies for Improving the Availability, Collection, and Quality of Data

Sources : vital statistics

the most widely collected and available data;
mortality caused by homicide by sex, age, areas;
mortality caused by suicide by sex, age, areas;
neonatal/ infant/ child mortality by sex, cause, which could provide information on neglect of children.
Usually reported annually with other death rates; providing information on:
- comparison with other deaths;
- trend analysis;
- identifying high risk groups (age/sex);
- within country or between country comparison.

"the tip of violence iceberg"

Sources: Surveys

- non-fatal violence
- marriage & the family survey:
  providing information on physical fighting, sexual assaults in the family by intimate partner.
- health survey:
  providing information on injury or disability caused by violence;
- special studies/ surveys on violence to different population group (women/ elder/ children):
  providing any certain issue on violence.

Sources: Records

- Hospital or clinic records
  the information on diseases/ injury as well as mental disorders caused by violence and the cost of medical treatment for the disease/ injury.
- Records from civil administration office, e.g. divorce registry.
  A report indicated that the reason of divorce, for one fourth of divorced couples (1+ million a year) in China, was due to the violence.

Sources:Records

- Records from police/ judiciary departments:
  the information on the violence offenders, such as their demographic characteristics, relationship with the victim, methods used, the motivation of perpetrating and so on.
- Records from telephone hot-line

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25/11/2000

Limitations

1. Even if the vital statistics could only capture "the tip of violence iceberg", it could be incomplete or under-report, and in some counties it is still unavailable.

Limitations

2. For the data from survey, the comparability is poor. The prevalence figures on violence from different studies usually were not comparable due to:

- •the inconsistencies in the way that violence is defined and measured;
- •the skill of survey (how to enhance disclosure);
- •the ethical reasons;
- •the selection of study population.

Limitations

3. Hospital/ clinic records could be unusable/ unsuitable for violence measure, since the medical records, which usually served to medical treatment, did not necessarily include the causes/ reasons of injury or diseases.

Limitations

4. There is still gap in the availability of information on the magnitude and characteristics of violence, especially,

- lack of data on elder abuse;
- lack of data on morbidity caused by violence;
- lack of the utilization of the data from police office/ judiciary office by public health professionals in order to get the characteristics of offenders;
- lack of data on the effectiveness of the intervention programs against violence;
- lack of the use of qualitative methods in research violence,
- insufficiency of specific studies on risk factors or protect factors related with violence;

Strategies

1. For the countries of the Region, where vital statistics on death from violence are currently lacking, it is urgent to built surveillance or registry system to report the fatal losses due to suicide or homicide.

2. To set uniform standards for defining and measuring different types of violence. Thus,

- need to develop uniform indicators,
- need to develop comparable tools, questionnaires, scales

Strategies

3. To develop guidelines for rapid assessment on perspective and magnitude of violence.

4. To set clinic/ hospital- based surveillance system for reporting the incidence of injuries, diseases or mental disorders caused by violence.

5. To set coordination between different agencies (health, police, school, women's federation, elderly union, bureau of statistics, etc.) to collect and share the information.

Strategies

6. To develop a simple question list regarding violence, in order to integrate the question list into other national surveys.

7. To pay attention to collect data on assessment of the effectiveness of any intervention strategies/ program on violence prevention.

Comm-47

World Health Organization *Violence and Injuries Prevention Department*
Organisation Mondiale de la Santé *Non-communicable Diseases and Mental Health Cluster*

DRAFT AGENDA

REGIONAL CONSULTATIONS

WORLD REPORT ON VIOLENCE AND HEALTH

Objectives:

1. Summarize Report goals, objectives, methodology, and progress made to date
2. Provide an overview of the report's content (major patterns, risk factors, prevention and policy responses for the various types of violence). Identify important gaps.*
3. Solicit regional perspectives on future directions for violence prevention
4. Determine regional strategies for the release of the Report

The information gained from the discussion of point 3 will form the basis of the Report's summary chapter and concluding remarks.

*Participants will receive a copy of the report in advance of the meeting and a review form to provide written input on the report.

for CDC
Violence + Health Resource file
Jw
20/11/2000

Day 1

9:00-9:15	Opening and adoption of the agenda
9:15-9:30	Goals and objectives of the report; methodology used to develop the report; progress made to date
9:30-10:00	Overview of the report's content (major patterns, risk factors, prevention and policy responses for the various types of violence)
10:00-10:15	Coffee Break
10:15-10:30	Introduce five discussion points on regional public health challenges in the field of violence (Appendix I)
10:30-12:30	Challenge 1: Availability and Collection of Data a) Overview of what is known in the region – 15 minute presentation by member of the region b) Discussion c) Summary of top 5 recommendations to improve the collection, availability, and quality of data in the region
12:30-13:30	Lunch
13:30-15:30	Challenge 2: Improving our understanding of the etiology of violence a) Overview of what is known in the region – 15 minute presentation by member of the region b) Discussion c) Summary of top 5 recommendations for improving our understanding of the etiology of violence in the region and the contribution of social and cultural factors to violence.
15:30-15:45	Coffee Break

15:45-17:45	Challenge 3: Prevention and Policy Responses a) Overview of what is known in the region – 15 minute presentation by member of the region b) Discussion c) Summary of top 5 recommendations for developing, implementing, and evaluating prevention programs and policy responses throughout the region.

Day 2

9:00-10:00	Challenge 4: Contributions & Limitations of the Public Health Approach to Violence a) Overview of what is known in the region – 15 minute presentation by member of the region b) Discussion
10:00-10:15	Coffee Break
10:15-11:00	c) Summary of top 5 contributions and limitations of the public health approach to violence
11:00-12:30	Challenge 5: Role of the Health Sector and Other Sectors a) Overview of what is known in the region – 15 minute presentation by member of the region b) Discussion
12:30-13:30	Lunch
13:30-14:00	Challenge 5 cont'd

c) Summary of top 5 recommendations for the health sector; major priorities for the health sector; involvement of other sectors

14:00-14:30	Open Discussion of Other Challenges and Questions
14:30-14:45	Coffee break
14:45-15:30	Discuss and plan regional activities involving the release of the Report
15:30-16:00	Steps ahead and closing.

World Perspectives on
CHILD ABUSE

The Fourth International Resource Book

An Official Publication of the
International Society for Prevention of Child Abuse & Neglect

Prepared by
KEMPE CHILDREN'S CENTER
University of Colorado School of Medicine

Rapid assessment - questionnaire
102 sent
58 responses

for CHC
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LN
20/11/2000

Countries That Have An Official Government Policy Regarding Child Abuse & Neglect

KOREA
MALAYSIA
PHILIPPINES
SINGAPORE
TAIWAN

Type of Reporting System

MANDATORY REPORTING SYSTEMS	VOLUNTARY REPORTING SYSTEMS
Australia	Hong Kong
Malaysia	Indonesia
Philippines	New Zealand
Singapore	
South Korea	
Sri Lanka	
Taiwan	

Typical Response to a Reported Case of Physical Abuse

RESPONSE	NUMBER	PERCENT
If enough evidence, criminal charges against abuser	52	89.7
Child treatment required by formal/informal processes	41	70.7
Child removed during investigation	40	69
Investigation within 48 hours	32	55.2
Investigation within 2 weeks	31	53.5
Parent treatment required by formal/informal processes	31	53.5
Other	5	8.6

Activity Level of Each Type of Organization that Provides Child Abuse Treatment or Prevention Services by Country

	AUSTRALIA	HONG KONG
Hospital	Totally Active	Totally Active
Mental Health	Totally Active	Somewhat Active
Other Health Providers	Totally Active	Somewhat Active
Business/Factory	Totally Inactive	Somewhat Inactive
Schools	Totally Active	Somewhat Active
Social Service	Totally Active	Somewhat Active
Volunteer Organization	Totally Active	Somewhat Active
Religious Institutions	Totally Active	Somewhat Inactive
Juvenile or Family Court	Totally Active	Somewhat Active

Activity Level of Each Type of Organization that Provides Child Abuse Treatment or Prevention Services by Country *(continued)*

	INDONESIA	JAPAN	KOREA
Hospital	Somewhat Active	Totally Inactive	Somewhat Inactive
Mental Health	Somewhat Active		Somewhat Active
Other Health Providers	Somewhat Active	Totally Inactive	Totally Inactive
Business/Factory	Somewhat Inactive		
Schools	Somewhat Inactive	Totally Inactive	Totally Inactive
Social Service		Somewhat Inactive	Somewhat Active
Volunteer Organization	Totally Active	Somewhat Active	Totally Active
Religious Institutions	Somewhat Active	Totally Inactive	Somewhat Active
Juvenile or Family Court	Somewhat Active	Totally Inactive	Somewhat Inactive

Activity Level of Each Type of Organization that Provides Child Abuse Treatment or Prevention Services by Country *(continued)*

	MALAYSIA	NEW ZEALAND	PHILIPPINES
Hospital	Totally Active		Somewhat Inactive
Mental Health			Totally Inactive
Other Health Providers	Somewhat Inactive		Totally Inactive
Business/Factory	Somewhat Inactive		
Schools	Somewhat Active	Totally Active	Totally Inactive
Social Service	Totally Active		Somewhat Active
Volunteer Organization	Totally Active		Somewhat Active
Religious Institutions	Somewhat Active		Totally Inactive
Juvenile or Family Court	Somewhat Inactive		Somewhat Active

Activity Level of Each Type of Organization that Provides Child Abuse Treatment or Prevention Services by Country *(continued)*

	SINGAPORE	SRI LANKA	TAIWAN
Hospital	Totally Active	Somewhat Active	Somewhat Active
Mental Health	Somewhat Active	Somewhat Inactive	Somewhat Inactive
Other Health Providers	Somewhat Active		Somewhat Inactive
Business/Factory	Somewhat Inactive	Totally Inactive	Somewhat Inactive
Schools	Somewhat Active	Somewhat Inactive	Somewhat Active
Social Service	Totally Active	Somewhat Active	Totally Active
Volunteer Organization	Totally Active	Somewhat Active	Somewhat Active
Religious Institutions	Somewhat Active	Somewhat Inactive	Totally Inactive
Juvenile or Family Court	Somewhat Active	Somewhat Active	Somewhat Inactive

Number of Organizations That Provide "Active" Child Abuse Treatment or Prevention Services by Country*

	AUSTRALIA	HONG KONG	JAPAN	MALAYSIA
1998 Active	4	7	1	3
2000 Somewhat or Totally Active	10	8	1	5
2000 Totally Active	10	2	0	3

Number of Organizations That Provide "Active" Child Abuse Treatment or Prevention Services by Country*

	NEW ZEALAND	SINGAPORE	SRI LANKA	TAIWAN
1998 Active	2	9	0	3
2000 Somewhat or Totally Active	1	10	6	5
2000 Totally Active	1	4	0	2

Four Years of Data That Depicts Activity Level of Each Organization Which Provides Child Abuse Treatment of Prevention Services

COUNTRY	HOSPITAL			
	2000	1998	1996	1992
Australia	TA	TA	Y	Y
Hong Kong	TA	TA	Y	
Japan	TI	NU		
Malaysia	TA	TA		Y
New Zealand		SA	Y	
Philippines	SI		Y	
Singapore	TA	TA	Y	
Sri Lanka	SA	NU		
Taiwan	SA	SI		

SA Somewhat Active
TA Totally Active
NU Neutral
SI Somewhat Inactive
TI Totally Inactive
UK Unknown
Y Yes

Four Years of Data That Depicts Activity Level of Each Organization Which Provides Child Abuse Treatment of Prevention Services

COUNTRY	MENTAL HEALTH			
	2000	1998	1996	1992
Australia	TA	SA	Y	Y
Hong Kong	SA	SA		
Japan		SI		
Malaysia				
New Zealand		SI	Y	
Philippines	TI		Y	
Singapore	SA	TA	Y	
Sri Lanka	SI	TI		
Taiwan	SI	TI		

SA Somewhat Active
TA Totally Active
NU Neutral
SI Somewhat Inactive
TI Totally Inactive
UK Unknown
Y Yes

Four Years of Data That Depicts Activity Level of Each Organization Which Provides Child Abuse Treatment of Prevention Services

COUNTRY	OTHER HEALTH			
	2000	1998	1996	1992
Australia	TA	NU	Y	Y
Hong Kong	SA	NU	Y	Y
Japan	TI	TI		
Malaysia	SI	SI		
New Zealand		NU	Y	
Philippines	TI			
Singapore	SA	TA	Y	
Sri Lanka				
Taiwan	SI	TI		

SA Somewhat Active
TA Totally Active
NU Neutral
SI Somewhat Inactive
TI Totally Inactive
UK Unknown
Y Yes

Four Years of Data That Depicts Activity Level of Each Organization Which Provides Child Abuse Treatment of Prevention Services

COUNTRY	BUSINESS			
	2000	1998	1996	1992
Australia	TI	SI		
Hong Kong	SI	SI		
Japan		TI		
Malaysia	SI	SI		
New Zealand		TI		
Philippines				
Singapore	SI	TA		
Sri Lanka	TI	TI		
Taiwan	SI	TI		

SA Somewhat Active
TA Totally Active
NU Neutral
SI Somewhat Inactive
TI Totally Inactive
UK Unknown
Y Yes

Four Years of Data That Depicts Activity Level of Each Organization Which Provides Child Abuse Treatment of Prevention Services

COUNTRY	SCHOOLS			
	2000	1998	1996	1992
Australia	TA	NU	Y	
Hong Kong	SA	SA	Y	
Japan	TI	TI		
Malaysia	SA	NU		
New Zealand	TA	SI	Y	
Philippines	TI		Y	
Singapore	SA	TA	Y	
Sri Lanka	SI	TI		
Taiwan	SA	SI		

SA Somewhat Active
TA Totally Active
NU Neutral
SI Somewhat Inactive
TI Totally Inactive
UK Unknown
Y Yes

Four Years of Data That Depicts Activity Level of Each Organization Which Provides Child Abuse Treatment of Prevention Services

COUNTRY	SOCIAL SERVICE			
	2000	1998	1996	1992
Australia	TA	TA	Y	Y
Hong Kong	SA	TA	Y	
Japan	SI	NU	Y	
Malaysia	TA	TA	Y	Y
New Zealand		NU	Y	
Philippines	SA		Y	
Singapore	TA	TA	Y	
Sri Lanka	SA	NU		
Taiwan	TA	SA		

SA Somewhat Active
TA Totally Active
NU Neutral
SI Somewhat Inactive
TI Totally Inactive
UK Unknown
Y Yes

Major Reasons for an Increase in Public Awareness Concerning Child Abuse & Neglect

COUNTRY	PUBLIC AWARENESS	PROFESSIONAL EDUCATION	GOVERNMENT ACTION	DEMAND FOR CHANGE	OTHER
Australia	YES	YES	YES	YES	
Hong Kong	YES	YES	YES	YES	
Japan	YES				
Korea	YES				
Malaysia	YES	YES	YES	YES	
New Zealand					
Philippines	YES	YES	YES	YES	
Singapore	YES	YES	YES		
Sri Lanka	YES	YES	YES	YES	
Taiwan	YES	YES		YES	

Major Barriers Limiting Involvement of the Health Sector & Other Sectors

- Resources
- Political Will
- Lack of Awareness of the Problem
- Lack of Trained Personnel
- Prevailing Attitudes - roles, territory
- Lack of Research on "What Works"

Possible Avenues for Increased Involvement of Different Sectors In Violence Prevention Efforts

- Recruitment of Key Persons per Agency
- Preferred Funding Streams
- Partnerships between NGOs/Private Academic & Government Agencies
- Identification of "Champions"