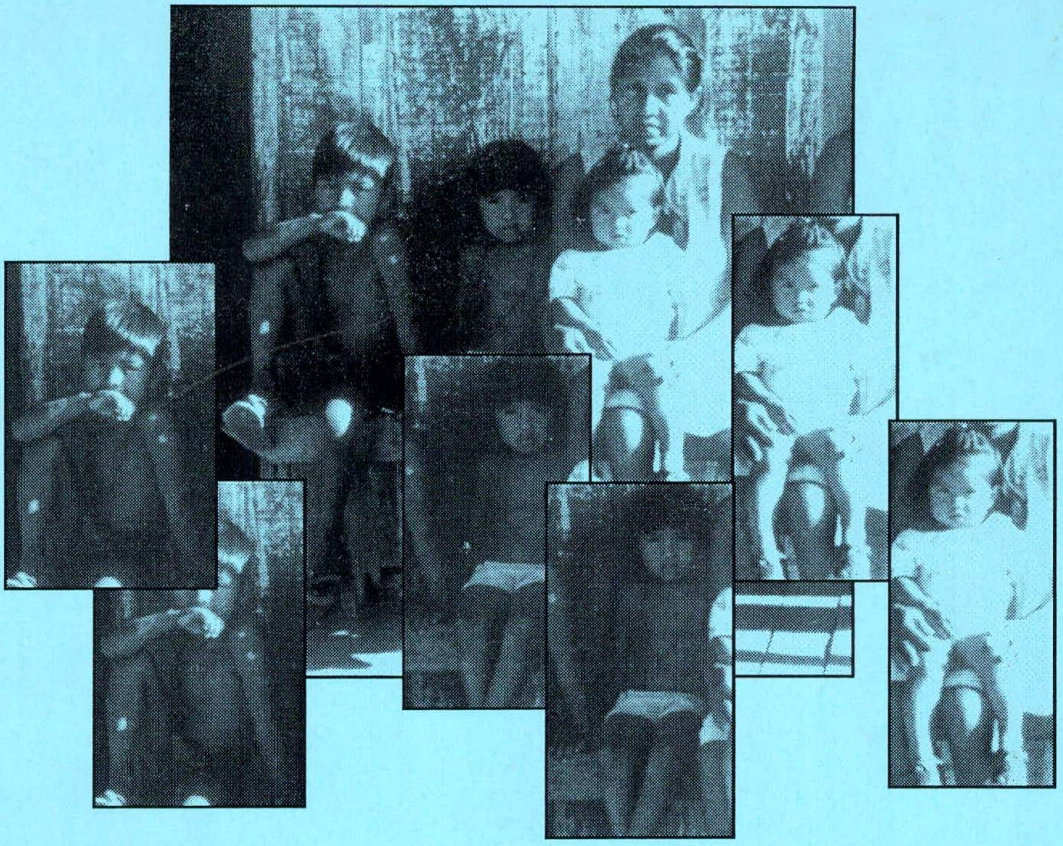

Violence, pregnancy and abortion
Issues of women's rights and public health

A review of worldwide data and recommendations for action

Ipas

Maria de Bruyn

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PREFACE

The available statistics are both astounding and horrifying. From 10-50% of all women in societies around the world are estimated to have suffered physical violence from their male partners [1]. Girls and women are also physically assaulted by other people they know such as relatives, neighbors, teachers, employers and co-workers as well as strangers. According to population-based surveys, 12-25% of women suffer an attempted or completed rape on at least one occasion [2].

Freedom from violence is a basic human right. Yet violence in various forms affects women of all ethnic backgrounds and socioeconomic classes in all countries. The risks of violence are even greater for homeless women and women living in situations of civil unrest, conflict and war.

> ***"When it comes to violence against women, there are no 'developed' countries"*** - Charlotte Bunch, Center for Women's Global Leadership [3]

Age is no barrier - female children, adolescents and adults all are affected, suffering both physical and psychological injury and, in extreme cases, death. But it is women of reproductive age who face the most extensive consequences because violence may be associated with an inability to prevent unwanted pregnancies, pregnancy itself, pregnancy loss (miscarriage and stillbirths), abortion and abuse of women who present for abortion-related health care. Yet the possible links between violence, pregnancy and abortion remain an area of public health policy that has received insufficient attention.

This review of the literature aims to motivate researchers, policy-makers, health professionals, personnel of the legal and law enforcement sectors, and NGO program implementers to increase their efforts to address the problem of violence in relation to pregnancy and abortion. The monograph first presents information on the possible links between violence, pregnancy and abortion in Section 1 and then discusses measures that can be taken to address the problem in Section 2.

Chapter 1 introduces the context of the problem, describing the sexual and reproductive health problems that violence against women can cause. It also briefly mentions relevant international human rights standards and addresses the social environment that allows violence against women to persist. Chapters 2-5 describe the ways in which violence may be related to pregnancy and abortion. Chapter 6 addresses measures that can be taken using the health promotion approach at the international, national, community and individual levels, while Chapter 7 presents checklists of

possible measures for different sectors of society: policy-makers, researchers, members of the judicial and legal sectors, health-care providers and civil society organizations.

The extensive reference list is intended to serve as a resource for those interested in the topic. The 1999 *Population Reports* on ending violence against women was a valuable resource [1]. However, because relatively little research has specifically examined violence in relation to pregnancy and abortion worldwide, much of the evidence presented in this monograph is anecdotal or comes from studies that did not focus specifically on violence in relation to pregnancy. In addition, many of the studies cited included only small samples; in some cases, the reports were not methodologically precise. Because studies related to violence around the time of pregnancy differ in their methods and approaches to measuring violence, generalization of findings is difficult [4]. Nevertheless, the literature does provide preliminary data that can serve as a basis for further research and action.

1. Introduction

She may be 11, 20 or 35 years old, unwed or married, an urban or rural resident or a woman without a home. Regardless of her circumstances, however, on a global scale every woman runs a one in three chance of being abused in some way - psychologically, physically or sexually. One woman in four may suffer violence during pregnancy. The abuser will most often be found in her immediate domestic surroundings, though strangers, fellow students, teachers, employers and others are also perpetrators.

The consequences will be both immediate and long term, affecting her mental and physical health. The effects can range from anxiety, depression and physical injury to HIV/STI infection, unwanted pregnancy and unsafe abortions.

Both men and women, boys and girls, are the targets of personal violence around the world, but the violence perpetrated against women is frequently gender-based. In the majority of cases, the perpetrators are male and the violent behaviors that they impose on women are reflections of gender biases. Not all men are abusers, of course, and growing numbers of men are actively campaigning to end violence against women. Nevertheless, gender-based norms emphasizing male 'superiority' and dominance versus female 'inferiority' and subordination continue to support perceptions that men are entitled to use any means necessary to control women. Men who subscribe to such norms may use verbal mistreatment, physical attacks or sexual assaults to answer perceived challenges to their authority by their female partners, mothers and daughters. Many men lack skills in managing stress (e.g., brought on by economic demands) or resolving conflicts. Large numbers of men have also been encouraged to engage in risky behaviors such as alcohol and substance abuse. Such factors can lead some men to express their frustration and anger by choosing others to victimize - women and children often bear the brunt of such abuse.

When women are the victims of violence, they suffer repercussions that can have life-long effects. Women who suffer abuse during childhood are at greater risk than other women of becoming victims of violence as adults. When women suffer ongoing domestic abuse by their intimate partners, their children are at considerable risk of becoming victims as well, and a repetitive cycle may be set into motion.

For abused women of reproductive age, the effects are compounded. Adolescent and adult women who are physically and sexually assaulted may face HIV/STI infection, unwanted pregnancy, miscarriage, stillbirths and even death. In the case of pregnancy resulting from rape, the psychological effects may be devastating, particularly for girls whose first sexual experience consisted of rape or incest. Young teenagers who become pregnant at a very early age, moreover, face risks to their health because skeletal growth is incomplete in many women until the age of 18, while the birth canal may not mature until they reach 20–21 years. Deaths related to pregnancy and childbirth are two to five times higher among women under 18 than among those aged 20–29 years [5].

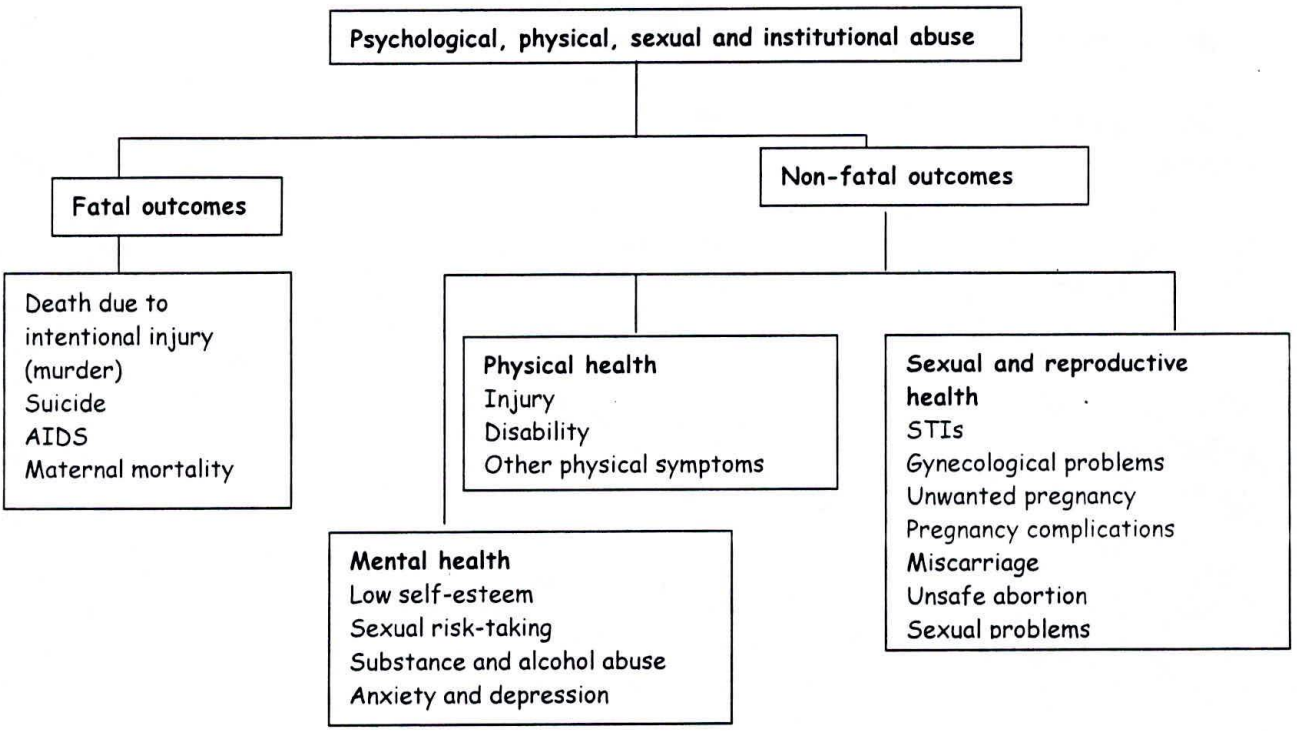
A woman who becomes pregnant due to rape must also make decisions that will affect the continuing course of her life [6]:

- She may choose to carry the pregnancy to term and keep the child that is born. Though a loving and rewarding parent–child relationship may result, she faces difficult decisions (e.g., telling the child how the pregnancy came about). She may also encounter difficult situations for which she is totally unprepared, for example, having to raise a child as a single parent, possible rejection of the child by her partner, the need to end her education, effects on her employment status, etc.

- She may choose to carry the pregnancy to term and offer the child for adoption. In some societies this option may be difficult since adoption is scarcely practiced and a woman knows that the child probably will grow up without parents. The woman herself may also suffer stigmatization for 'abandoning' her child.

- She may choose to have an abortion. Some countries and states do not permit abortion in cases of rape and incest, so that the woman will seek a clandestine abortion; in many cases it will be unsafe and endanger her health and even her life. Due to the stigma surrounding abortion, women who choose this option may also face abuse when they seek assistance and care from the legal system and the health-care system.

Possible health outcomes of violence against women [7]



1.1. Defining violence against women

The Declaration on the Elimination of Violence Against Women, adopted by the United Nations General Assembly in 1993, defines violence against women as: "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

Using this definition as a point of departure, the following terms will be used in this monograph (with the term 'abuse' used as a general term) [8].

- ***Psychological violence*** includes threats of harm, physical or sexual violence and abandonment; intimidation; humiliation; insults and constant criticism; accusations; attribution of blame; ignoring, giving insufficient attention or ridiculing the victim's needs; controlling what the victim can or cannot do; withholding basic needs (such as food, shelter and medical care) and deprivation of liberty
- ***Physical violence*** comprises use of physical force or weapons in attacks that injure or harm a woman, including beating, kicking, pulling hair, biting, acid throwing, burning, attacks with weapons and objects and murder.

- *Sexual violence* comprises actions that force a person to engage in sexual acts against her (or his) will, without her consent; it includes economically coerced sex, date rape (including administering drugs to women), marital rape, gang rape, incest, forced pregnancy and trafficking in the sex industry.[1]

Institutional violence has also been identified as a specific form of abuse. It comprises physical and psychological harm to persons as a result of structurally inadequate conditions in institutions and public systems. It is closely related to quality of health care - Article 14.2(b) of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) declares that States must take measures to ensure that women have access to adequate health-care facilities. Institutional violence may also be related to the right to be free from degrading treatment [9-11]. Amnesty International has pointed out that acts of violence against women causing severe physical or mental pain or suffering, and which can be prevented by States, are prohibited by the UN Convention against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment [12].

> *"...torture includes acts of violence by private individuals in certain circumstances. When the state is complicit in the acts of violence, has acquiesced in them or has failed to take the necessary measures to prevent them, and when the violence is intentionally inflicted and causes severe pain or suffering, these acts are torture."* - Amnesty International

Examples of such institutional violence include: withholding treatment without providing referrals for prompt treatment elsewhere, deliberate provision of faulty or incomplete information, lengthy waiting times for treatment within health facilities that may contribute to psychological distress and physical harm (e.g., leaving women who present for postabortion care aside in order to treat all other patients first), intimidation, verbal mistreatment, threats, withholding of medications as 'punishment' and excessive fees for services.

The various forms of violence are interrelated and frequently occur together, especially in intimate relationships. Psychological, physical, sexual and institutional violence can also be exacerbated by other factors such as racism, sexism and ethnic discrimination - all of which may reinforce prevalent ideas concerning the superiority of men and the inferiority of women.

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[1] Generally, sexual violence is also considered to include coerced non-penetrative sexual activity as well as sexual harassment.

An increasing number of studies, including national health surveys, are beginning to investigate levels of violence against women. Research protocols are not yet standardized; definitions of violence, sample selection methods and data collection methodologies vary, which partly accounts for a wide variation in statistics. For example, a WHO review of national studies on women who said they had ever been physically assaulted by an intimate partner showed figures ranging from 5.1% of women in the Philippines, 12.6% in Switzerland, 19.3% in Colombia, 20.8% in The Netherlands, 22.1% in the USA, 29% in Canada, 34.4% in Egypt, to 47% and 67%, respectively, in villages of Bangladesh and Papua New Guinea [13]. Percentages of women who report experiencing some kind of physical or sexual assault during their lifetimes have ranged from 9% in Poland, 20% in Switzerland, 21% in India to 52% in Finland and 68% in Belgium [14-18]. Assessment of a weighted sample of 1821 women from a 1998 national cross-sectional survey of women in the USA showed that 43.7% of women aged 18-64 years reported at least one episode of violence in their lives: 17.8% suffered physical and/or sexual assault during childhood, 19.1% were physically assaulted as an adult, 20.4% had been sexually assaulted and 34.6% had experienced violence from their partners [19].

"From the moment Rodi Adalí Alvorada Peña married a Guatemalan army officer at the age of 16, she was subjected to intensive abuse, and all her efforts to get help were unsuccessful. Her husband raped her repeatedly, attempted to abort their second child by kicking her in the spine, dislocated her jaw, tried to cut off her hands with a machete, kicked her in the vagina and used her head to break windows. He terrified her by bragging about his power to kill innocent civilians with impunity. Even though many of the attacks took place in public, police failed to help her in any way. After she made out a complaint, her husband ignored three citations without consequence" [12].

Adolescent women and girls suffer high levels of sexual violence, often within their homes. Among 106 adolescent rape victims seen in the sexual abuse clinic of the Dr Manuel Gea González General Hospital of Mexico City in 1995, 53.9% had been attacked by someone they knew, usually at home [20]. In a study by UNICEF in São Paulo, Brazil, more than 75% of sexual attacks reported by minors to an NGO from 1988-1993 were committed by family members [21].

1.2. Violence as a violation of women's rights

Some international human rights treaties, such as the Covenant on Civil and Political Rights, were adopted without a specific gender perspective. Radhika Coomaraswamy, the United Nations Special Rapporteur on Violence against Women, asserts that these

treaties nevertheless provide a basis for addressing violence against women [22]. Several more recent international treaties and consensus statements endorsed by governments have specifically addressed violence against women as a violation of human rights. These include the Declaration on the Elimination of Violence against Women (1993), the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belém do Pará, 1994), the Cairo Programme of Action from the International Conference on Population and Development (1994), and the Beijing Platform for Action adopted at the Fourth World Conference on Women (1995).

Monitoring Committees established by the United Nations assess governments' efforts to implement and comply with the provisions stipulated in international treaties. For example, the Human Rights Committee monitors compliance with the International Covenant on Civil and Political Rights, while the Committee on the Elimination of Discrimination against Women assesses implementation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Both of these Committees have recently issued updated recommendations that further define how the treaties' provisions are related to violence against women and gender bias. Relevant citations from these international instruments are provided in Appendix 1.

1.3. Social tolerance of violence against women

Policy-makers, legislators and communities around the world have begun addressing violence against women as a violation of human rights. However, the prevalence of such violence is not decreasing and the World Health Organisation (WHO) has noted that a common societal reaction towards victims of violence is to blame them for the abuse [23].

> ***"We often use the passive voice to talk about crimes against women. How many girls were assaulted by their boyfriends? How many girls were raped? Compare that language to 'How many boys and men raped girls? How many men assaulted women?' The passive construction of describing the problem focuses on victims and perpetuates the problem."*** - Jackson Katz, violence prevention trainer [24]

In many societies, there is a general 'tolerance' of abuse, which both women and men internalize as a norm. As a 16-year-old mother in Zimbabwe commented, "A woman can refuse [sex], but then this woman will run the risk that she will be forced into sex. I would like to change it, but it cannot be done, because a woman needs to follow the man" [25].

Violence within the domestic sphere is often considered private business, not to be discussed outside the home. When women suffer sexual violence, they are commonly blamed for having caused it themselves. Such perceptions are partly caused by the above-mentioned gender norms that emphasize male 'superiority' and female 'inferiority' - reference is made to women's behaviors as triggers for 'justifiable' acts of violence rather than to aberrant and unacceptable behavior on the part of the perpetrators. Professionals in various sectors and persons in positions of authority who also reflect such attitudes can impede the enforcement of relevant laws and sanctions against perpetrators of violence against women (also see Appendix 2).

Tolerance of violence against women - reinforced by the legal system

- A judge of the South African Cape High Court declined to give the required life sentence to a man convicted of raping his 14-year-old daughter because he said the crime did not threaten society at large since it occurred within the family [26].
- "A man who beats his wife must have a good reason for it; surely she did something to provoke it." - Nicaraguan Supreme Court judge speaking in a public forum in 1996 [27]
- "Be thankful that someone was still attracted to you" - a local police official in the Philippines addressing a 32-year-old rape victim [28]
- "The child was sexually aggressive" - Canadian judge suspending the sentence of a man who sexually assaulted a 3-year-old girl [29]
- "We are going through a process of nation-building, and we face many political challenges. It is wrong for us at the present moment to address and deal with such issues [of sexual abuse] publicly. We are busy dealing with very serious matters; I am not willing to spend my energy on the problems of little girls" - police officer in Palestine [30].

Such reinforcement of 'tolerated violence' by community leaders and people in positions of power helps create an environment in which men feel they may abuse women with impunity. Women themselves also learn to believe that such violence can be justified, as documented by studies in Bangladesh, Cambodia, Chile, Colombia, Egypt, Indonesia, Mexico, Nigeria, Pakistan, Papua New Guinea, Peru, the Philippines, South Africa, Tanzania, the United Kingdom, Venezuela and Zimbabwe [1, 31-37]. For example, data from the 1998-99 National Family Health Survey in India indicated that 56% of 89,199 women believed there was at least one reason why a husband would be justified in beating his wife [18].

Women who do recognize violence as a crime may lack knowledge about relevant laws to help remedy their situation. And even when they know their legal rights, a lack of

confidence in the legal system can prevent them from reporting abuse.[2] Surveys in Africa, Asia, Latin America and industrialized countries revealed that 22–70% of women did not tell anyone about being abused before their participation in the studies or that they never made official reports to the police [1, 38–42]. Research in four major cities of Bolivia demonstrated that women who report abuse are mistreated by authorities, leading to reluctance to make official complaints; the abuse includes judges deciding in advance that both spouses must be at fault as well as discrimination by social workers against poorer women [43].

One consequence of this violence-tolerant shroud of silence is that many women who seek help for the physical repercussions will attempt to hide the real cause of their injuries and thereby miss out on possible support and care.

Shrouded in silence – violence goes unreported

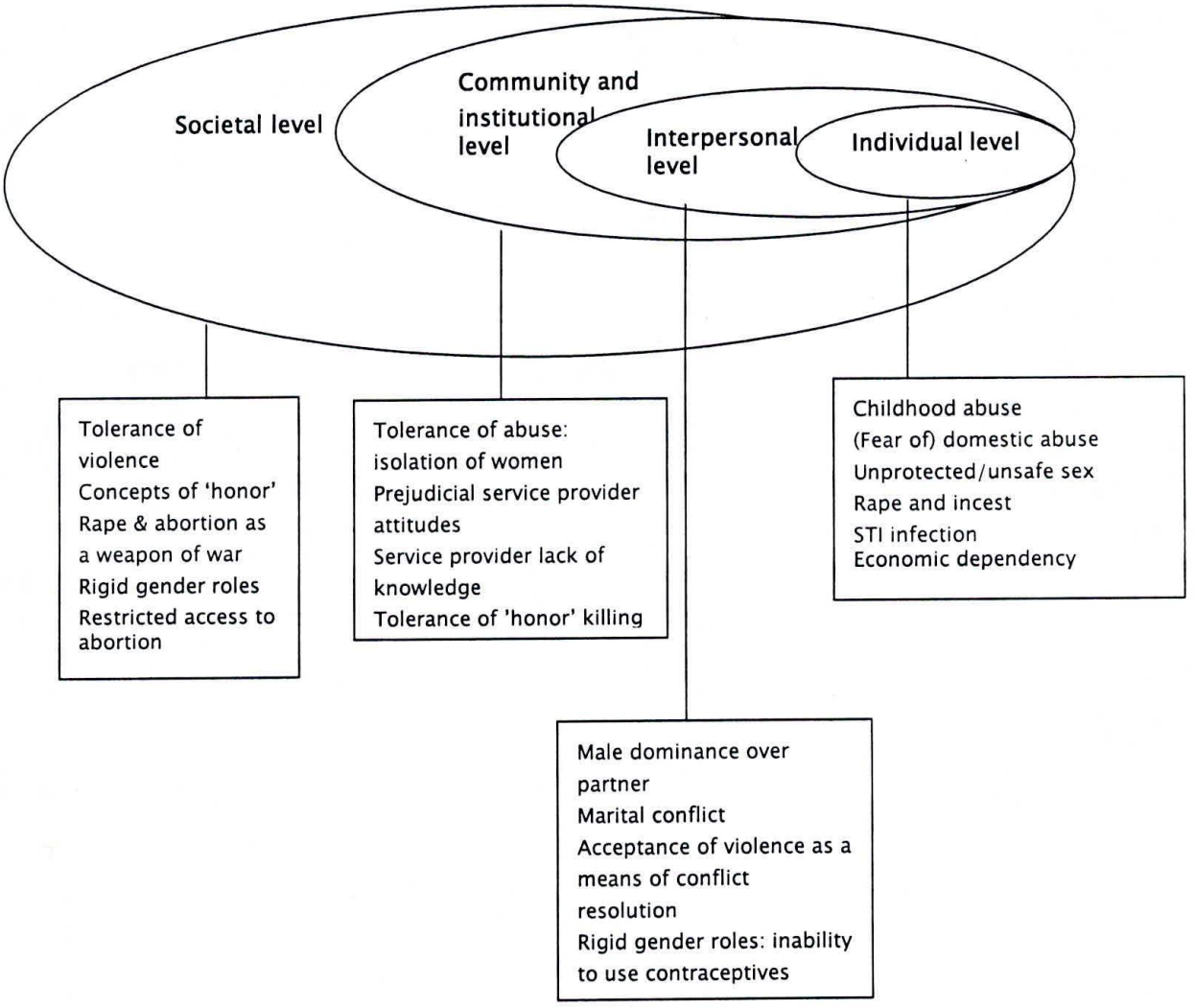
- The British Medical Association estimated that only 25% of domestic abuse cases are reported to the police, with only 36% of women seeking any outside help [44].
- In India, it has been estimated that 70 cases of rape are unregistered for each case that is reported to the police [45].
- Only 21% of 86 abused women in a Mexican study attempted to lodge a formal complaint [46].
- Only four of 121 survivors of rape studied in Colombia reported the crime to police; only seven sought medical care, and 52 told no one about the rape [6].

1.4. A conceptual model for linking violence to pregnancy and abortion

Heise has provided a conceptual model for identifying how violence against women can be linked to pregnancy and its outcomes [47]. The individual level includes factors that may increase a person's risk of perpetrating or suffering violence, while the interpersonal level incorporates factors related to relationships with partners or family. The community level includes factors in people's immediate surroundings, e.g., the community in which they live (including local norms and beliefs), social networks and institutions that provide services. The societal level factors include cultural values and beliefs that influence the other three levels.

[2] Other reasons include economic dependence on an abusive partner; fear of discrimination, stigmatization and retaliation; lack of support from their social network; love for an intimate abusive partner; and beliefs that women should avoid burdening the family with extra problems.

Framework of inter-related factors that can affect links between violence, pregnancy and abortion (adapted from [47])



1.4.1. The individual level

Violence is indirectly associated with unwanted pregnancies through its effect on contraceptive use by individual women. For example, women with a history of childhood abuse may more often have unprotected sex than other women. Rape and incest directly cause unwanted pregnancies, and considerable numbers of women who have been raped will choose to terminate such pregnancies.

1.4.2. The interpersonal level

Women who fear or suffer violence from their partners often find it difficult or impossible to discuss contraception with them; they may also fear or suffer abuse if they

use contraceptive methods without spousal permission. In some cases, pregnancy may trigger episodes of partner abuse, e.g., when a partner is jealous or becomes angry because a child will place additional economic demands on the household. Acceptance of violence as a means to settle marital disputes or as a form of male control leads to physical violence against women; when they are pregnant, a miscarriage can be the result. The risks of miscarriage and stillbirths are also increased when sexually transmitted infections (STIs) are transmitted through rape and incest and left untreated in a pregnant woman. Women living in situations of ongoing marital conflict and domestic violence may choose to terminate a pregnancy rather than bring a child into a situation of violence.

1.4.3. The community and institutional level

A woman's social environment may involve violence related to abortion in various ways. Some women experience pressure or coercion to have an abortion, e.g., through intimidation or threats from partners, family members and others (e.g., service providers in the case of women living with HIV/AIDS, or brothel owners in the case of women who are sexually exploited).

Women who attempt to obtain abortions permitted by law or who present for treatment of incomplete abortions may face abuse on the part of service providers. Examples include threats of legal action, intimidation, humiliation and retribution in the form of delays in granting treatment, inadequate pain control, excessive fees for the service and coercion to accept particular contraceptive methods.

Women may further be prevented from obtaining legal abortion services through abusive actions by third parties (e.g., violence against service providers and clinics). In such cases, they may resort to clandestine and unsafe abortions that can damage their health or even lead to death.

Sex-selective abortion, usually to prevent the birth of female children due to norms promoting preference for sons, constitutes a form of severe discrimination against women. Health sector personnel may even support it, because they adhere to the norm or because they may profit from the practice (collecting fees for sex testing of fetuses).

> ***"We have two daughters. We had already decided to do curetting and have an operation. I had gone to the hospital. The doctor there said, 'You check it (the sex) first. Why should you go for it if it is a boy!"*** - 20-year-old mother of two daughters in India [48]

1.4.4. The societal level

Cultural norms concerning male dominance and men's sexual entitlement to women contribute to the direct associations between violence, pregnancy and abortion. Adolescent and adult women are raped both by strangers and men they know; rape is used as a weapon of war (resulting in forced and unwanted pregnancies). Cultural norms regarding family and clan honor can lead to violence against women who have extramarital pregnancies or abortions in some societies (e.g., so-called 'honor killings').

More information on how these environmental factors interact with regard to violence, pregnancy and abortion is given in the following chapters.

2. Violence associated with pregnancy

Violence may be associated with pregnancy at different levels. At the individual level, there is evidence that female victims of childhood abuse tend to engage in risk behaviors later in life that can affect their use of contraceptive methods. At the interpersonal level, women may be prevented from using contraceptives because they fear violence from partners who oppose limiting the number of children in the family.

When women and girls who do not use contraceptives are raped, pregnancy can be a direct result. If they are moreover denied the option of emergency contraception even when they report to a hospital or clinic immediately after the traumatic event, institutional violence at the community level comes into play.

Pregnancy itself may be a precipitating factor for violence inflicted by some women's partners. Some women suffer psychological or physical violence as 'punishment' for getting pregnant - especially if the pregnancy occurs outside marriage. Such violence may be carried out against them because they are seen as challenging gender norms concerning the 'proper' behavior of 'good' women. Family members may also be pressured by community norms and attitudes to restore the 'honor' of the family name which has been perceived to be 'damaged' by the women's condition (societal and community level factors). In extreme cases, a woman may be murdered.

2.1. Violence as a co-factor for lack of contraceptive use

Some studies have shown that women who suffered sexual abuse during their youth may more often have unplanned and/or unwanted pregnancies than other women. The same may be true for women living in situations of habitual domestic psychological and physical violence. The reasons suggested are multiple: abuse has been associated with low self-esteem, anxiety, fear, substance abuse and loss of control. These factors can all contribute to risky sexual behavior (unprotected sex without condoms or contraceptives), impair a woman's ability to use contraceptives consistently, or make it difficult for her to negotiate contraceptive use with a partner.[3] Thus, violence becomes an indirect factor contributing to unwanted pregnancies.

Three studies from the USA provide some relevant data. One survey of 1193 women aged 20-50 years showed that women who suffered frequent physical violence were 1.5 times more likely to have an 'accidental' first pregnancy than non-abused women [50].

[3] There is at least one study from the USA that also showed an association between childhood abuse and male involvement in adolescent pregnancy [49].

An analysis of adverse childhood experiences among 1193 women who had their first pregnancy at 20 years or older looked specifically at whether the pregnancy was intended. The data indicated that the first pregnancy was unintended among 31.9% of women with no exposure to childhood abuse and household dysfunction, as opposed to 63.7% of women who had suffered 4 or more types of exposure (e.g., psychological, physical or sexual abuse, physical abuse of the mother, substance abuse, mental illness) [51]. In another study of 535 adolescent mothers, only 28% of those who suffered abuse had used contraceptives for their first sexual experience compared to 49% of the adolescents who had not been abused [29]. Research in Barbados found that experience with violence in childhood was the single best predictor of adolescent pregnancy [52].

Violence and contraception

- "If the woman tries to take birth control pills, for example, the man hits her...This happened to my mother...my father discovered that she was taking pills and smacked her and said that she was to receive all the children God sent her. The same thing happened to my aunt who also who was beaten." - 18-year-old woman in Nicaragua [53]
- "We don't want to sleep with our husbands because we don't want babies...They don't allow us to use contraceptives, but they still want us to sleep with them. And when we refuse, we get beaten." - two women in Sri Lanka [54]
- "What is clear is that a woman who decides alone, without taking into account her husband's opinion, deserves punishment" and "If my wife makes the decision to use family planning without my consent, I would divorce her." - men interviewed in Mali for a family planning study [55]
- Some pregnant adolescents in South Africa commented that their partners had torn up their contraceptive cards, claiming that contraceptives caused disabled babies, infertility and diminished male sexual pleasure [56]

Women who attempt to make independent decisions on contraceptive use may face partner violence, especially in societies where prevailing gender norms dictate that men be the decision-makers regarding fertility and family affairs. During focus-group discussions in Mexico and Peru, women said that they do not discuss family planning with their spouses for fear of being abused [27]. In Bangladesh, women have been beaten by their husbands over conflicts regarding contraception [57], while women in a Filipino study who used contraceptive methods were more likely to suffer domestic violence than non-users [55]. The situation can be even more difficult if women want to use a contraceptive method that requires male cooperation. In Zimbabwe, a woman in a

focus-group discussion commented: "If a woman would insist to the husband that he wear a condom, then obviously the abuse comes in" [58].

Many men prefer to leave the responsibility for using contraceptive methods to women, but they often feel that the decision to use a method in the first place should be theirs. Women's independent choices to use contraceptives may then be seen as an effort to escape male control or as evidence that a woman is or intends to be unfaithful. Women know that such challenges to male authority can result in threats, beatings and abandonment, leading to various consequences:

- Women will not use any contraceptive method at all and be unable to prevent unplanned and unwanted pregnancies: "When you go to adopt a method of family planning with the consent of your husband, you do not face problems, but if you go and use a method without his approval, immediately after you get home, you will be beaten seriously" - woman in Ghana [59]

- Women may be forced by their partners to use a method that is ineffective: "I only had a douche that my husband bought so I could wash with water containing mallow or chamomile after I had relations with him. I thought that with this, I could avoid [pregnancy] but that wasn't the case. Sometimes I talked with him about taking care [using contraceptives] because I was worried about my children, I didn't want to leave them orphans. He reacted violently. He didn't care what I said to him and so I used the douche; I didn't know another method" - 45-year-old mother of five in Bolivia [60]

- Women may be forced to hide their contraceptives for fear of violence, which could lead to inconsistent or incorrect use [57]. Zimbabwean women who suffered abuse were reported to be hiding oral contraceptives in bags of maize or burying them in the garden because they were afraid of their partners' violent reactions [52].

- Women may be forced to use contraceptives without their partners' knowledge, risking violence if they find out about this. A clinic in Jinja, Uganda, hides appointment cards for women using contraceptives, mainly because their clients do not want their spouses to know they are using contraceptives and fear reprisals; staff say that injectable contraceptives are popular (52% of clients) because they can be used secretly [61].

2.2. Rape as a cause of unwanted/forced pregnancy

When girls and women who do not use contraceptives suffer incest and rape, they can be confronted with unwanted pregnancies.[4] Some researchers now prefer to speak of 'forced pregnancy' following all cases of rape,[5] while others use the term to refer specifically to pregnancy resulting from the use of rape as a weapon of war [63]. Coerced sex within marriage is not still considered rape in many places. Such abuse and many cases of 'recognized' rape - by perpetrators other than intimate partners - go unreported. The number of pregnancies resulting from rape can therefore only be estimated. Women who have knowledge of, and access to, emergency contraception can avert unwanted pregnancies; however, knowledge and availability of this contraceptive option are lacking in many places.

A national 3-year longitudinal telephone survey involving a probability sample of 4008 women in the USA revealed 34 cases of rape-related pregnancy among 32 women (5%). Of these women (48% of whom became pregnant at ages 12-17 years), 47% did not receive medical attention for the rape and 32% only became aware of their pregnancy during the second trimester [64]. Based on these data, the authors estimated that there may be more than 30,000 rape-related pregnancies among adult women in the United States each year. Other researchers have estimated a number of about 25,000 rape-related pregnancies per year in the USA, commenting that as many as 22,000 could be prevented if all women received prompt medical care and emergency contraception if needed [65].

Data from various studies in Mexico have found that 7.4-26% of women suffering sexual violence became pregnant as a result [66-69]. At a maternity hospital in Lima, Peru, up to 90% of young women aged 12-16 years reported they had been raped, the majority by members of their own family [70]. A survey in a Costa Rican shelter revealed that 95% of the pregnancies among girls aged 15 years or less were due to incest [71].

In Asia, a study comparing non-abusive and abusive men in India showed that unplanned pregnancies were significantly more common among the men who forced their partners to have sex [72]. Among adolescents seeking abortions in Mumbai, India, 20% of the pregnancies resulted from forced sex [73]. Data from the 1993 Philippines

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[4] The literature on reproductive health refers to pregnancies that are unplanned, unintended and unwanted. These terms are sometimes used interchangeably, although one study suggested that planning and intentionality of pregnancy are associated with people's preparations, life goals and education, while the wantedness of a pregnancy is linked with people's values about childbearing and their relationships with their partners and community [62]. Studies need to define these terms so that data can be interpreted more precisely.

[5] Other researchers characterize forced pregnancy as any pregnancy that a woman considers dangerous to her health, life and integrity [63].

National Safe Motherhood Survey showed that 10% of 8481 ever-pregnant women had been abused, with 24% reporting unwanted pregnancies as a result [74]. Rape crisis centers in Thailand and Korea have reported that 15-18% of their clients became pregnant due to rape [75, 76].

2.2.1. Increased vulnerability: the role of economics

Poverty that forces women into situations where physical and sexual violence are common has been called 'economic violence'. Homeless women and street girls are often subject to economic violence as they may be forced to engage in sex work in order to gain an income. Their particularly vulnerable situation makes it extremely difficult for them to demand or negotiate condom use by clients; moreover, they are also vulnerable to rape from men on the street and even law enforcement officials. More than 80% of street girls studied in Dhaka, Bangladesh, were impregnated by their clients or unknown men and in about 95% of cases terminated the pregnancy through unsafe methods [77]. Women in bonded labor situations or who work as domestic servants in countries around the world are vulnerable to sexual abuse by their employers.

> ***"All of us women were gang-raped. What could we do if they called us to come out? Sometimes they did not even bother but took us right in front of our husbands and children. They did not care about our shame....they also raped some of our girls, some only 10, 11 years old.... Several of us bore children as a result of such rapes....Our husbands could do nothing, they were locked up or sent away if they disobeyed."*** - Woman bonded laborer in Pakistan [12]

2.2.2. Rape and forced pregnancy as a weapon of war

The United Nations and organizations working with refugees recognize that rape and forced pregnancy have become a weapon of war and retaliation; this form of abuse has been documented in conflicts occurring in Bangladesh, Chechnya, Guatemala, Korea, Liberia, Rwanda, Sierra Leone, Somalia and the former Yugoslavia. UNIFEM has noted that some rape victims are forced to carry unwanted pregnancies to term, either because they are detained so long that they can no longer terminate the pregnancy safely or because they simply have no access to safe abortion services [78].

Women are raped during war because they themselves are seen as the enemy; it was estimated that two to five thousand 'children of bad memories' were born in Rwanda as a result of rape during the genocidal war [79]. Men also sexually assault women as an indirect form of reprisal against their male opponents. UNFPA noted: "by raping the women, the Serbians are violating even those Kosovar men who are inaccessible and

hidden in the mountains" [80]. Kosovar refugees reported that they had been warned of impending violence against women through a written message on the wall of a high school building: "We're going to rape your women, and they will give birth to Serbian children" [81]. In 2001, a UN war crimes tribunal sentenced three Serb men to imprisonment for such crimes.

Women living as refugees are also highly vulnerable to rape as seen in attacks on Vietnamese boat people and women living in camps in Kenya, Tanzania and Zaire. The International Rescue Committee found in 1996-97, for example, that 27% of women aged 12-49 years living in Kibondo District, Tanzania, had experienced sexual violence while living in refugee camps [82].

> ***"After my arrival in the concentration camp, they...raped me...in front of all the rest of the women...who were yelling and defending me, but they were beaten. The [soldiers] said 'you will give birth to a Serbian child, we're doing that out of revenge'...[O]ut of the 24 women, 12 of us were raped many times over...Now I am 4 1/2 months pregnant."*** - testimony of a Bosnian woman [83]

Rape as a form of armed conflict does not only affect women during all-out war. In countries with guerrilla movements that oppose the presiding government, they may suffer sexual assault by government soldiers or insurgents. In such cases, the assaults may be used as a means of instilling terror among a community's members.

> **A 23-year-old woman, her mother, daughter and grandmother were sleeping in their house in Cauca, Colombia, when more than 10 armed men entered the dwelling by force. Shouting that they were guerrillas, they began assaulting the woman; when her grandmother intervened, they shot her and told the victim to cease her resistance or they would also kill her mother and daughter. She became pregnant as a result [6].**

2.2.3. Institutional abuse: impeding the prevention of unwanted pregnancy due to rape

When organizations that provide or fund reproductive health services for rape survivors oppose or prevent the provision of emergency contraception, this may be viewed as a form of institutional abuse. Institutions may choose not to provide this service, but they must have standing arrangements to refer patients safely and conveniently to other facilities that do so [84].

In the United States, for example, many secular hospitals have merged with Catholic facilities over the last five years; some mergers have required the secular hospitals to discontinue offering contraceptive services. A telephone survey of 58 urban hospitals in 1998 showed that 12 of 27 Catholic hospitals had policies prohibiting staff from discussing emergency contraception with rape victims, although health-care providers even at these hospitals said they would address the issue if specifically asked. None of the other hospitals prevented discussion of emergency contraception [85]. Such policies have created a situation in which women who have been raped may be denied access to a means to prevent an unwanted pregnancy. The Catholic Church has also taken action to influence reproductive health policies offered by international organizations to refugees. In 1999, a Papal spokesman erroneously claimed that UN agencies were promoting abortions by distributing emergency contraception to raped refugee women in Kosovo; the Vatican had already withdrawn its financial contributions to UNICEF because the agency provided the 'morning-after pill' to refugee women during the Bosnian war [86].

> ***"This blatant misinformation [from the Vatican claiming that emergency contraception is abortifacient] is intended to further a political agenda to prevent access to contraceptives in general and specifically to emergency contraceptives, which enables the prevention of unwanted or enforced pregnancy, clearly an urgent need of some women in a war situation such as Kosovo."*** - IPPF Director-General Ingar Brueggemann [87]

Emergency contraception is especially needed for women living in and fleeing from situations of armed conflict. The Sexual and Gender-Based Violence Program for Burundian refugees living in Tanzanian camps not only ensured that rape victims were offered medical examinations for trauma, HIV/STIs and pregnancy, but also emergency contraception [88]. UNFPA also provided emergency contraception along with supplies for dealing with complicated deliveries and complications of unsafe abortions and miscarriages in their emergency reproductive health kits for Kosovo refugees in Albania and women in camps in Thailand on the borders with Cambodia and Myanmar [89, 90].

2.3. Violence during pregnancy

Relatively few studies have concentrated specifically on violence during pregnancy; some of the available data therefore come from research on violence in general and studies on pregnancy-related morbidity. Other data are based on records kept by services offering assistance to survivors of violence.

The estimates of violence suffered by pregnant women vary considerably; this is partly due to differences in research methodologies and data collection methods. The reports given by women thus range from 6.6% in Zimbabwe to percentages as high as 68% in Malaysia [45, 75, 91-98]. One researcher calculated that even lower estimates of 4-8% would imply that some 156,000-332,000 pregnant women in the USA suffer violence during pregnancy each year [99].

There are some indications that if research on violence during pregnancy were to include murder as a cause of maternal mortality, estimates could go up. For example, some studies in the USA have placed the prevalence of violence during pregnancy at 3.9-8.3% of women; however, three investigations of pregnancy-associated mortality revealed homicide as the cause of death among 13-25% of cases studied [4, 100, 101].

During a 1997 trial in Namibia, a 54-year-old man stated that he had not intended to beat his eight-month pregnant wife to death with an axe handle - he had only meant "to beat her like all wives are beaten." In sentencing him to 12 years' imprisonment, the judge said that that men should learn that such behavior was unacceptable [102].

There is no conclusive evidence to date that pregnancy itself may be a trigger for increased violence against women in epidemiological terms. However, a review of available data in 1998 noted some indications that the prevalence of physical and sexual abuse may be higher and more severe among pregnant than other women [96]. The reasons why a woman's partner may resort to violence particularly during pregnancy are varied:

- He does not want the pregnancy carried to term.
- He suspects that another man has caused the pregnancy.
- He views the pregnancy as an economic burden, either because his pregnant partner works less in- or outside the home or because the impending birth of a child will pose new economic demands on a financially-vulnerable household
- He becomes jealous when the pregnant woman is perceived to devote less attention to his needs and wishes.
- He sees the woman as more vulnerable due to her pregnant condition and less able to retaliate or defend herself.

A national study in the USA showed that pregnant women were more likely than non-pregnant women to have suffered violence during the previous year (17% vs. 12%); however, this study did not control for factors such as age, which may be a stronger predictor (i.e., younger age being associated with greater vulnerability to violence) [103]. Another US household survey found that that there was a 60.6% greater chance that

pregnant women would be beaten than non-pregnant women [104]. In a survey of pregnant women in the United Kingdom, Russia and the Czech Republic, physical violence during pregnancy was reported by 2, 4 and almost 10% of women, respectively [105].]. A retrospective study of death records in Bangladesh indicated that the risk of death from injuries was three times higher for pregnant women aged 15-19 years than non-pregnant women [106]. About one-third of women outpatients in a small-scale study in Pakistan reported being beaten while pregnant, while 42% of women studied in Sri Lanka reported the same [105]. About 40% of battered wives interviewed in Santiago, Chile, said that abuse in the domestic sphere increased during their pregnancy [107]. While pregnancy may not be a population-attributable risk for violence - indicating that the overall percentage of the problem would be reduced if the risk factor were reduced - for individual women, pregnancy may indeed be the time when they begin to suffer violence by an intimate partner.

> ***"I was pregnant the first time he beat me; I was stunned. But now, I can't remember...[When] it was over...I did not tell anyone. I was so scared. And anyway, his family lives all around."*** - woman in Sri Lanka [54]

2.4. Violence as a punishment for pregnancy

In some societies, violence against women who become pregnant outside marriage may not only be tolerated but also condoned. It can range from humiliation, expulsion from the home and beating to 'honor killings' to avenge the family name. The perpetrators of such violence are often men from poorer sectors of society - with approval from female family members who have also internalized the honor code - but their actions are implicitly supported by judicial systems that impose no or only light sentences on the men charged for the crime. In the words of Mohammed Ajjarmeh, chief judge of the High Criminal Court in Jordan, "Nobody can really want to kill his wife or daughter or sister. But sometimes circumstances force him to do this. Sometimes, it's society that forces him to do this, because the people won't forget. Sometimes, there are two victims - the murdered and the murderer" [108]. Some examples:

- In 2001, a 17-year-old woman in Zamfara State, Nigeria, received 100 lashes in a public flogging. The crime was 'premarital sex'; the evidence was that she had become pregnant out of wedlock. The court that sentenced her dismissed her claims of rape by three men by adding 80 lashes to her sentence for 'false accusations' [109].

- An Islamic tribunal in the emirate of Fujairah ordered a pregnant woman to be stoned to death for adultery; police had arrested her after it was reported that she was unmarried and pregnant [110].
- A 21-year-old woman was shot to death by her brother in Jordan because she was pregnant outside marriage. Her brother said he killed his sister to "wash the family honor" [111].
- A 14-year-old mentally retarded Arab girl was raped in the street. When her pregnancy became apparent, she was put to death [112].
- In a case reported to an international hearing, a 35-year-old woman from an unidentified country who had been separated from her husband for more than a year was shot dead by him upon his return. He assumed her swollen stomach indicated she had become pregnant when in reality she had neglected to seek treatment for an acute liver inflammation that caused extreme swelling of her abdomen [112].
- In Bangladesh, an adolescent girl was poisoned by her parents when they discovered her extramarital pregnancy [113].
- In Egypt, a woman electrocuted her pregnant daughter because she would not reveal the name of the man who had caused the pregnancy [114].
- In a study of 38 cases of sexual abuse among Palestinian girls aged 2-19 years, 11 of the victims had sought help in order to terminate a resulting pregnancy. Three of them were murdered by a family member; two had been incarcerated by authorities to save their lives but one was killed by a sister who slipped poisoned food into her cell [30].

> ***"Corporal punishment is never defensible, and it's particularly offensive....where a young girl has been charged with a crime because she gave birth"*** - Regan Ralph, Human Rights Watch [115]

Such violence against women most often takes place in countries with a predominantly Muslim population according to the UN Special Rapporteur on Extrajudicial, Summary and Arbitrary Executions. However, attempted or completed 'honor killings' (also for perceived transgressions such as socializing with men or choosing a marriage partner without family sanction) have been reported in Brazil, Ecuador, Italy, Sweden, Uganda and the United Kingdom as well [116].

3. Violence associated with pregnancy loss

Violence against women may contribute both directly (through physical and sexual assault) and indirectly (through possible STI infection) to pregnancy loss. At the societal and community levels, social norms that encourage tolerance of violence can make it difficult or impossible for women to report physical and sexual abuse during pregnancy. They thereby deprive themselves of the possibility of receiving assistance to cope with the problem and its possible effects on their pregnancy outcome. At the community level, health-care providers may lack the capacity to deal with patients' abuse problems; their reluctance or refusal to screen women for violence then inadvertently helps perpetuate it.

Despite the fact that cultural norms attribute great value to motherhood in all societies, pregnancy does not always appear to offer 'protection' from violence by abusive intimate partners. On the contrary, as noted in the previous chapter, women may suffer more or graver violence during pregnancy than at other times. Women may furthermore suffer miscarriages and stillbirths as a result of STIs transmitted during unsafe coerced sex.

3.1. Non-recognition of violence as a contributory factor

It is difficult to find information and statistics on the contribution of physical and sexual violence to pregnancy loss. On the one hand, the lack of data can be attributed to women's reluctance to identify abuse when they seek care for injuries. On the other hand, many health providers do not address this issue, either because they simply do not consider it or because they wish to avoid discussing a sensitive topic.

When women believe that domestic abuse is simply their lot, they are unlikely to mention it to health-care providers as a cause of injury or a potential cause of miscarriage. In Sri Lanka, a survey of abused women showed that a majority had been battered while pregnant; only 25% of them told health workers the reason for their injuries [117]. Women may also believe - sometimes correctly - that health providers will not provide them with any assistance for the abuse suffered so that there is no reason to mention the violence.

> *"When the doctor attended me, I explained to him what happened, that I had been beaten, and I said, 'I know this isn't your job, but I need a favor. My husband is outside in the hallway, and I need you to call a policeman to help me stop him before he catches me again.' The doctor answered that this wasn't his problem, that I was free to leave however I wanted. He just said, 'Take this for the swelling' and left me alone in the room."* - woman in Panama who suffered a miscarriage when her husband beat her [1]

Health-care providers who have a predominantly biomedical orientation (focusing on somatic etiologies) may neglect to inquire about 'social' factors such as violence when they attend women seeking treatment for injuries and miscarriages. A survey of American and Canadian medical schools revealed that fewer than 50% addressed family violence in their curricula [118]. The medical literature that informs them reflects this bias. For example, two websites focusing on spontaneous abortion failed to mention violence as a possible cause of pregnancy loss [119, 120]. A book devoted entirely to spontaneous abortion does not mention abuse, with one author commenting: "Women commonly attribute pregnancy losses to trauma, such as a fall or a blow to the abdomen. However, fetuses are actually well protected from external trauma by intervening maternal structures and amniotic fluid..." [121]. Given this background, it is perhaps not surprising that a survey of US gynecologists and obstetricians found that only 17% screened their patients for possible domestic violence during a first visit despite professional recommendations that this should be routine practice [101].

> *"The women who visit gynaecologists...are those who are pregnant and think the baby could have been hurt or who have been severely hurt themselves...Some will say they have been burnt by an iron, and yet it is clear they have been abused by their husbands."* - Dr Robert Busingye, obstetrician-gynecologist in Uganda [122]

Health workers may also (sub)consciously avoid addressing the topic of violence; various barriers may contribute to this [8, 118]:

- discomfort through identification with the problem or client (e.g., when health workers have a personal history including violence)
- fear of offending the patient or putting the patient-doctor relationship at risk
- disbelief that violence is actually occurring
- suspicion that the patient is lying
- feelings of powerlessness, inadequacy and lack of knowledge about appropriate help
- lack of knowledge concerning the magnitude of the problem

- beliefs that do not support interventions by health professionals
- overwork and lack of time
- prejudicial attitudes that blame victims for their situation.

The director of the US Hospital Crisis Intervention Project noted: "The 'nonrecognition' of abuse by clinicians evolves from a constellation of factors...Given a range of information provided by a patient, including clues about abuse, physicians will tend to focus on the physical....When the addressing of psychosocial issues isn't supported or valued by the educational system, the institution, or the payor, physicians are less likely to develop their own capacities to do so....In addition, when one's sense of professional competence is tied to being able to solve problems, it is particularly frustrating to deal with situations we are unable to fix...Of course, they are only overwhelming because we haven't learned to address them" [123].

Physical violence and miscarriage

- "In 1987, I was a victim of a murder attempt carried out by my former boyfriend...Full of anger, he set my body on fire in front of my four year old son....I was pregnant. Besides being seriously hurt as a consequence of the burning, [the hospital] told me I had had an abortion." - woman from Brazil [124]
- "I tried to protect my eyes when he beat me...I used to go to hospital with a sore face and the whole body. I protected only my eyes....The first two babies were miscarried because I was beaten." - woman in Namibia [102]
- "I was subjected to constant physical abuse throughout the marriage. But pregnancy was the worst time for me. I had five miscarriages. Every time I fell pregnant he would target the belly whenever he gets violent. It happened all the time until I realised he didn't want me to have a baby." - woman in Australia [125]
- "...He beat me so hard that I lost my teeth. The beatings happened at least one time each month. He used his fists to beat me. He beat me most severely when I was pregnant...The first time he beat me, and I lost the baby. I was in the hospital. The second time was only a few days before a baby was born, and my face was covered with bruises. He beat me and I went to my parents. My father refused to take me to a doctor. He said, "What will I say, 'her husband beats her?'" - woman in Uzbekistan [126]

Despite the scarcity of data, it is apparent that violence during pregnancy does contribute to miscarriage. Among 100 women aged 13-21 years receiving prenatal care in the USA, 42.3% of those reporting any kind of current abuse said they had suffered

miscarriages as opposed to 16.2% of women who were not subject to abuse [127]. In a 1995 study of 17 midwives in Morelos, Mexico, the respondents mentioned violence as an important cause of spontaneous abortion [128]. Aymara and Quechua women in Peru identified domestic violence - and particularly spousal abuse resulting in miscarriage - as one of their main reproductive health problems during qualitative research [129]. A large proportion of women living in slums in Mumbai, India, associated their miscarriages with violent assaults by their spouses [130]. In Costa Rica 7.5% of battered women reported that abuse was responsible for their miscarriages, while 23 of 150 Pakistani women said they were physically abused while pregnant, leading to miscarriage in eight cases (5%) [131, 132].

3.2. Targeted violence during pregnancy

Not all violence suffered by pregnant women leads to pregnancy loss. However, research shows that the kind of habitual violence suffered by women may change during pregnancy: instead of receiving strikes against the head, they suffer beatings directed towards the abdomen and chest [133]. This was the case in a US study where pregnant women were hit in the abdomen twice as often as non-pregnant women [134]. In León, Nicaragua, 31% of 194 women who suffered physical abuse by their male partners were assaulted while pregnant, half of them receiving blows to the abdomen [42].

Researchers in Mexico noted that: "The effect [of violence] may not only be on the actual pregnancy but moreover may convert itself, depending on the type of physical lesion, into a reproductive risk for subsequent pregnancies" [69]. Moreover, women who have been physically assaulted may be prevented by the abuser from seeking prenatal or emergency care, whereby a miscarriage might be prevented [135].

It is such targeted violence that might account for the higher rates of miscarriage seen among abused women than non-abused women in some studies. A Brazilian study of women with a history of abuse showed that they had a significantly greater rate of miscarriage than other women [96]. The 1993 Philippines National Safe Motherhood Survey showed that one-third of women who miscarried had suffered violence in comparison to 28% of those who reported no abuse [74]. In the states of Tamil Nadu and Uttar Pradesh, India, women who had been beaten were more likely than non-abused women to have had pregnancy loss from miscarriages and stillbirths [1].

Women living in situations of extreme violence may also be more prone to miscarriage. Chilean women living in neighborhoods characterized by violence in general were reported to have had a five times higher risk of suffering pregnancy complications than women living elsewhere. Heise points out: "If the stress and trauma of living in a violent neighbourhood can induce pregnancy complications, it is reasonable to assume that

living in the private hell of an abusive relationship could as well" [27]. The main hospital in Pristina, Kosovo, saw a higher than normal incidence of miscarriages and stillbirths in 1999 [136]. Community members living in areas of ongoing armed conflict in Sudan spontaneously commented that women were suffering a large number of miscarriages and stillbirths. They attributed many of these cases to STIs such as syphilis (and cited rape as a cause of STI infection) and to the armed conflict itself [137].

3.3. Violence and sexually transmitted infections

In addition to unwanted pregnancy, women who are raped may contract an STI. Researchers in the USA reported that an estimated 4–30% of rape victims contract an STI [103], while in Thailand 10% of rape survivors were infected [73]. Among adolescent prenatal clinic attenders younger than 18 years seen during a three-year period at one US hospital, the abused adolescents were more likely to have an STI than the non-abused teenagers (71% versus 43%) [138]. At the Isiolo District Hospital in Kenya, a nurse reported that from 1997 to mid-1998 two of every five women and children who had been raped were infected with STIs [139]. The risks may be especially great for girls and women living on the street who are subject to sexual exploitation. For example, 100% of an unspecified number of street girls studied in Dhaka, Bangladesh, suffered from STIs [77].

When a woman is raped, infected with syphilis and receives no treatment, she may transmit the infection to a fetus during pregnancy, resulting in a higher risk of fetal death [140, 141]. Violence may play a role in lack of treatment; during interviews with an unselected group of 184 pregnant women with syphilis in Nairobi, Kenya, 12 (6%) said that they had not informed their partners so that they could be treated due to a fear of violence or being blamed for having the illness [142]. Data from another study in Nairobi showed an increased risk of 4.3% for spontaneous abortion in women with syphilis; estimates for Ethiopia indicate that 5% of miscarriages result from this STI [140]. In Zambia, syphilis has been reported to be a leading cause of miscarriage and stillbirths [143]. Estimates on the contribution of syphilis infection stillbirths have ranged from 21% in Malawi to 42% in Zambia [140].

When a woman contracts genital chlamydia through rape, she may subsequently suffer pelvic inflammatory disease; this in turn can increase her risks of ectopic pregnancy, which causes 1–5% of maternal mortality [144]. Chlamydia and bacterial vaginosis have been associated with premature rupture of the membranes and premature deliveries; a comparative study of 701 pregnant women in the USA showed that the prevalence of bacterial vaginosis was significantly higher among abused than non-abused women [145].

4. Violence associated with induced abortions

Violence may be related to induced abortions in several ways. At the individual level, women who are coping with situations of ongoing violence by an intimate partner or who have been raped may feel compelled to terminate a pregnancy because it is unwanted and experienced as forced pregnancy. At the interpersonal and community levels, women may be pressured or forced against their will into having an abortion by their partners, family members, service providers or other parties. Women who have opted for an abortion may suffer violence in retaliation.

4.1. Termination of pregnancy due to violence

Often women and girls do not wish to carry a pregnancy to term when it is the result of rape. If emergency contraception to prevent the pregnancy is unavailable, many of these women may seek an abortion. For example, in a study of 249 married women who had had abortions in the USA, 17% reported being raped by their husbands in the previous 6 months; women who had been forced to have sex repeatedly were more likely to have decided on their own to have an abortion [103]. Another US study of 486 women seeking abortions showed that the only significant difference between abused and non-abused women regarding their reasons for terminating a pregnancy concerned relationships; women with a history of abuse were more likely to state relationship issues as the primary reason [146].

Women living in situations of habitual domestic abuse and marital conflict may choose to terminate pregnancies because they do not wish to bear a child that resulted from marital rape or because they do not want to expose (another) child to a situation of domestic violence. A 1993 US telephone survey with 1426 women revealed that women who had had abortions were significantly more likely than other women to have conflictual relationships (64.6% versus 44.9%) [103]. A Thai study of 114 women who sought hospital care for unsafe induced abortions found that most of them had decided to terminate the pregnancy because their husbands quarreled with them, did not provide them with enough money or because they had other wives [147].

> ***"I had been married a year and became pregnant...I did not want the pregnancy. At that time, the situation was bad with my husband.... The bad treatment and constant jealousy on his part made me decide that I shouldn't continue with my pregnancy...I am angry that I decided to have an abortion because of the relationship I had with my husband. He always mistreated me and it was not worth the effort to have a child in those conditions."*** - 25-year-old in Bolivia [60]

When women suffer forced pregnancy because rape is used as a weapon of war, they also want to have abortions. In 1995, the gynecologist at the Kigali Central Hospital in Rwanda received 5 requests per day for abortions by women who had been raped by Hutu militiamen; since abortion was illegal, he also saw patients with perforated uteri resulting from unsafe abortions [148]. In Kosovo, rape carries a tremendous social stigma for women and their families; this probably contributed to a tripling of abortions at the maternity hospital of one town in Albania where 120,000 refugees stayed during the war [81, 149].

> ***"I didn't know what I should do, but I knew that I wanted an abortion at all costs. I just didn't know how. Because it was torture to carry this pregnancy to term. I just couldn't do it. I had heard that there were doctors here who wanted to help...It's against the law, but I cannot care for the child of a murderer. God forgive me, but I didn't want that. After the abortion I went home again."*** - 30-year-old woman in Rwanda raped by five men during the war [148]

One final circumstance in which pregnancies are terminated through violence needs to be mentioned in the context of war: attacks on pregnant women with the intention to prevent the birth of their babies. In Guatemala, for example, soldiers engaged in destroying villages suspected of harboring armed opponents were reported to cut fetuses out of pregnant women in front of their families as a way to show that they would destroy the guerrilla movement from its very beginnings [150].

4.2. Coerced abortion

Women are coerced to undergo abortions for varying reasons: they may be living with HIV infection, have socially-stigmatized pregnancies (i.e., outside marriage), be expecting the birth of a female child or be 'transgressing against' governmental population policies.

Some instances have been reported of pregnant women living with HIV/AIDS being pressured by service providers to have an abortion [151]. A health worker may not consider his/her advice to be coercive, but it may be perceived that way, especially by women who are accustomed to relying on health workers' expertise and women who will not challenge persons of authority given gender-based norms that dictate female subordination. One Thai counselor noted: "[two women] were told by the doctor to have an abortion. They got no counseling at all. They were surprised to hear that the child possibly wouldn't have been infected [with HIV]". A researcher in the same country observed: "In my study, the women had only 7 days to make their decisions. That is too

short to think over the various options. The counselors tell them it is possible to change their mind, but many women will not change something they said to a doctor or a nurse" [152]. A proposal to make abortion and sterilization mandatory for pregnant women living with HIV/AIDS was even published in an African professional journal as recently as 1998 [153]. As drug treatments that reduce mother-to-child transmission of HIV become more widely available, such coercion and pressure on the part of health-care workers may decrease but counselor training is essential in this regard.

Adolescents may be particularly susceptible to pressure to have an abortion because of their dependent position [154]. Some parents fear social discrimination and stigmatization due to a daughter's extramarital pregnancy and force her to abort. Other parents may feel it is in a girl's best interests; however, when they pressure a daughter to terminate a pregnancy against her will, the parents are still involved in coercion which negates a young woman's right to make her own reproductive health decisions. In other instances, families' main concern is preservation of family honor by avoiding extramarital pregnancy; reports have come from Asia that parents have beaten or starved daughters for prolonged periods of time as a means of forcing them into having an abortion [113].

Partner coercion may be related to a desire to avoid responsibility for a child. A review of 80 testimonies by Chilean women in 1996 reported that four women had been forced by their partners to have abortions through threats and beating [107]. In the case of girls and women who have been abducted and tricked into the sex trade, coercion may come from brothel owners who do not want their 'employees' to take time off for maternal leave. Thus, researchers noted that girls purchased for brothels in Cambodia "must then work until their so-called debt to their purchasers is paid off, or face beatings. This is difficult, if not impossible, since the owners consider the girls indebted to them for their constantly mounting expenses for food, clothing, medical costs and abortions" [155].

Coercion and abortion [60]

- "I had to have an abortion because of pressure from my parents. When they heard I was pregnant, they pressured me to abort for my own well-being and that of the family." - 21-year-old woman in Bolivia
- "They [parents] are Evangelicals and they were worried about the social situation - 'what will they say to us at church?'... Think about it - they said to me - what would be best for you is not to have it but this is your decision. We will support you in what you decide. Afterwards, they pressured me to have an abortion and I agreed. I never decided, they did." - 21-year-old women in Bolivia
- "My husband decided on all [five of] my abortions; I only did what he ordered. I lacked personality at these times." - 45-year-old women in Bolivia

The concept of 'honor' may also be used in attempts to force abortions or "punish" women who refuse them. For example, in Egypt, one woman was murdered by her brother in front of her four children for refusing an abortion; he wanted her to have it to "avoid scandalising her family and husband" [114].

Pressure to abort can also be indirect in the form of social norms and family pressures that favor son preference.[6] In such cases it is commonly held that daughters pose a burden on the family, because they will require dowries upon marriage that will consume a household's resources. Or it is believed that sons will continue to support parents when they are adults, whereas daughters will become a part of their husbands' households; any economic investments in daughters are therefore considered wasted resources. As a result, women are under enormous pressure 'to produce sons'.

UNFPA estimates that millions of girls have not been born because they were aborted after ultrasound testing. The practice is best documented in India, where the Indian Medical Association has estimated that three million female fetuses are aborted each year, despite the existence of the Pre-Natal Diagnostic Techniques (Prevention) Act, which prohibits the widespread use of ultrasound testing to determine the sex of a fetus [156-158]. A community-based study of abortions carried out in a rural community of Western Maharashtra in 1996-98 showed 17.6% were done to prevent the birth of female children. Compared to women who had abortions for other reasons, the women

[6] It has been reported that poor families who cannot afford testing to determine a fetus' sex resort to infanticide if a girl child is born. An informal study carried out by Adithi, an NGO, found that midwives in several districts of Bihar, India, each killed up to five female infants each month [48].

presenting for sex-selective abortions had less autonomy, less power in family decision-making and were under greater pressure from family, community members and even medical practitioners to terminate their pregnancies [48].

Sex-selective abortion - social norms and violence against women [48]

- "My mother-in-law used to say, 'I won't say anything, but tomorrow if my son starts feeling that he should have a son and if [he] thinks about remarrying, then don't blame me at that time. You manage with that.' After all such things, I am having fear in my mind, so I thought let's try and go for checking (the sex)." - 21-year-old woman in India with two daughters
- "This time my mother-in-law wanted a boy. So she decided we should check it. My husband did not say anything. What can I say? I do whatever elderly people in the family say." - 21-year-old woman in India who had two sex-selective abortions
- "The hope for a son was so much that I didn't have any other feeling. I felt sad, but what to do? One has to burn one's mind. There are two daughters, what to do with a third daughter? Nothing else, a son is wanted. Only that is in my mind." - 23-year-old woman in India who had two sex-selective abortions

The Chinese government has been accused of indirectly supporting sex-selective abortions by couples due to its one-child policy for urban residents (and two children for rural inhabitants if the first child was a girl). Since families with more than one child can be fined or women who have more than one child may be sterilized, those wishing to have sons feel compelled to abort female fetuses. A recent study among 820 women in Central China found that almost half had ultrasound examinations to determine the sex of the fetus; 90% of the female fetuses in second pregnancies were aborted if the couple already had a daughter [159]. There have also been reports of abortions forced on women who have not complied with the child-limitation policy. According to official statistics, 12% of all female fetuses have been aborted or been otherwise unaccounted for [160-162].

> *"If the woman does not show up at the clinic on time (for abortion or sterilisation), we go to her house trying to find her. If she is not at home, we go again at night, often with 4 or 5 tractor-loads of local militia or police, each carrying a large flashlight. We go into the village quietly, surround the woman's house and then knock on her door. When someone opens the door we try to take the woman away...if we catch the woman, she is sent to the township clinic to get sterilised in the middle of the night by half-asleep nurses and doctors. The woman usually screams and kicks, and our men hold her down for anaesthesia."* - former population control officer in Northwestern Province, China [114]

While every woman must have the right to legal abortion, the aspects of violence and discrimination against women implicit in sex-selective abortion cannot be ignored. When such abortions take place on a large scale, they are evidence of deep-rooted societal attitudes that accord less value to female children and adults as human beings. This practice is not simply a matter of individual preference but reflects processes of discrimination against women that begin even before birth - laying the basis for a tolerance of various forms of abuse and violence throughout women's entire lives.

4.3. Violence as punishment for abortion

Honor killings are not only carried out in connection with extramarital pregnancies but also in relation to abortion. Some women may want to carry such pregnancies to term but feel pressured to have an induced abortion in order to escape potential assassination. The *Daily Star* newspaper in Beirut, Lebanon, reported that women: "are prepared to risk everything - even their lives - at the hands of unqualified doctors and midwives to get rid of an unwanted pregnancy" [163]. Women who attempt or actually have an abortion may also be murdered. Two examples in 1999:

- An 18-year-old woman died in Bangladesh after an Islamic cleric ordered her buried to the waist in mud and lashed 101 times with a bamboo cane for having premarital sex and then inducing an abortion with herbal medicines. The cleric prevented her family from taking her to a hospital [164].
- A 17-year-old Jordanian girl, Amal, told her family that she became pregnant after being raped by her father's friend. To pay for an abortion, her sister-in-law sold her gold jewelry but the doctor refused to perform the abortion as it is an illegal procedure. Her father then used the money to buy a gun, and he and her 22-year-old brother shot Amal eight times, leaving her for dead. Her brother was kept in jail but her father was freed on bail. Amal herself, six months pregnant, was in jail as well, being held for her protection since her father, brother and cousins still wanted to kill her [108].

5. Institutional violence associated with abortion-related care

Women who seek postabortion care for the treatment of incomplete abortions - whether spontaneous or induced - frequently face violence within the health-care system. Women who seek abortions permitted by law may suffer abuse as well, both in the legal and health-care sectors. When their reason for terminating an unwanted pregnancy is that it resulted from rape or incest, they then suffer re-victimization at the institutional level.

The UN Declaration on the Elimination of Violence against Women states explicitly in Article 2 that violence against women includes "physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs" [165]. As mentioned in Chapter 1, women may suffer physical and psychological harm as a result of structurally inadequate conditions in institutions and public systems; when governments tolerate such conditions, they are in effect condoning violence against women.

Women may suffer physical harm when postabortion care is delayed or they are treated inadequately or unsafely. The most frequent type of harm that women seeking abortion care encounter when dealing with the legal and health-care systems, however, is psychological in nature. Such psychological violence includes: threats of harm and intimidation, withholding a basic need to which they have a right such as medical care, and inhuman and degrading treatment in the form of accusations, attribution of blame, humiliation and insults.

5.1. Physical and mental harm resulting from unethical medical care

Large numbers of women around the world need treatment for the complications of incomplete abortions that can lead to high rates of morbidity. For example, in Peru about 30% of obstetrical and gynecological ward beds in 1994 were used to treat women for abortion complications [166]. In the same year, 27% of available blood and 29% of the gynecological-obstetric ward beds were needed to treat complications of abortion throughout Latin America [167]. About 50% of gynecological admissions in Kenya are for abortion complications [38].

Thirteen percent of maternal mortality worldwide is due to unsafe abortions; this is equivalent to 70,000 deaths and 99% of these unsafe abortions take place in developing countries. It is particularly important that agencies dealing with refugees and women in emergency situations are equipped to offer postabortion care, since UNFPA estimates

that 25-50% of maternal deaths in refugee situations are due to abortion complications [168].[7]

Such statistics led the International Conference on Population and Development (ICPD) to conclude that all governments, intergovernmental organizations and NGOs should consider the health effects of unsafe abortions an important public health problem. The five-year review of the ICPD Programme of Action during a special session of the UN General Assembly in 1999 concluded that all women should have access to high-quality services to manage abortion complications; counseling, education and family planning services should be offered promptly to contribute to the avoidance of future abortions [169]. In addition, governments agreed in paragraph 63(iii) that where abortion is not against the law, "health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health."

When treatment for the complications of incomplete abortions is delayed, women may face grave harm to their health, including serious infections, sterility and even death. Punitive attitudes on the part of health providers may lead to delays in care. In Nepal, where abortion is not permitted by law for any reason, it was reported at one time that women presenting with complications at the national maternity hospital had to wait 1-7 days for treatment, partly as a form of punishment [170].

When women suffer unnecessary pain because of negative health provider attitudes, this may be considered abusive. For example, a study in Peru on providers' attitudes stated that: "The group of medical professionals indicated that the lack of adequate anesthesia [for postabortion care] was a type of mistreatment that the woman should put up with...." [171]. While abortion is legal in Albania, the care given for first-trimester procedures in some health facilities can be abusive because it is performed without anesthesia and using rusty instruments that can lead to infections [172].

Even when abortion is permitted by law for a variety of reasons, women still seek out illegal providers because they are unaware of their rights. In such circumstances, it has been noted that the power imbalance between the abortion provider and the woman is heavily weighted towards the provider. This permits him/her to carry out abuse such as forcing a woman to accept certain kinds of treatment. In Indonesia, for example, one illegal provider coerced women into accepting Norplant for postabortion contraception

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[7] Postabortion care includes: emergency treatment services for incomplete abortion and its complications, effective postabortion contraceptive counseling, linking abortion treatment services to comprehensive RH care services, and reducing the need for such care through community education and action.

because the provider was studying the method [113]. In India, women have been refused abortions permitted by law unless they accept long-acting contraceptives; some women have had IUDs inserted after the procedure without their knowledge [113].

5.2. Threats of harm and intimidation

Violence in the form of threats and intimidation may affect both women who receive abortion-related care and health professionals who provide such care.

5.2.1. Women as the targets

The UN Monitoring Committee for CEDAW stated in May 1999: "When possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion" [173]. The Committee's recommendation resulted from the fact that, in countries where induced abortion is legally restricted, health professionals may be required to report abortions to the legal authorities and women may be subsequently imprisoned for exercising their human right to decide on whether and when to have a child.

A result of this requirement is that some health-care providers threaten legal action against women presenting for the treatment of incomplete abortions and in some cases they actually denounce patients to law enforcement authorities. In Chile, 80% of all women in prison for abortion have been denounced by public health system staff; the majority of these women are members of the poorest social sectors [174]. It has been estimated that 20% of women imprisoned in Nepal were jailed for having had abortions or infanticide [175]. In addition, the penalty in Nepal may include confiscation of a woman's property. The women's subsequent lack of economic resources, coupled with rejection by their families and communities, has forced some of these women to turn to sex work after their release from prison [176].

Criminal charges against women who present for postabortion care

- In Chile, a 14-year-old girl was charged with an illegal abortion when she was discharged from the hospital for postabortion care. The police officer remarked: "Probably sexually abused...But the law is the law. Find out if she did it herself or if she's covering up for someone" [107]
- Maya, in Nepal, took pain medication during her seventh month of pregnancy and subsequently miscarried. She was accused of having induced an abortion and imprisoned [175].
- "After finishing my medical college I started working in a maternity centre....Later on I found that women who have abortions are put in jail...The women do abortion because they cannot talk to their husband or mother-in-law about family planning...Many times there are rape and incestuous relationships." Female physician in Nepal [105]

Women, girls and their families may also suffer psychological violence from persons outside the health sector when they seek abortions permitted by law. In Brazil, abortion opponents filed an injunction to block an abortion for a 10-year-old girl who had been raped but a court granted permission. However, the family's lawyer received abusive letters and phone calls calling her a murderer, while the family itself was intimidated by religious groups, leading them to move to another city [177]. In Italy, the parents and family physician of a 13-year-old mentally retarded girl who was impregnated by a 14-year-old boy (also mentally retarded) sought a legal abortion for her. A judge prohibited the procedure, removing the girl from her parents' care after a local priest led a campaign to prevent the abortion [178].

Lucila, a 12-year-old girl with the mental age of an 8-year-old, became pregnant after being raped by her father in April 2001. The Mexican state of Sinaloa, where she lives, permits abortions in cases of rape and Lucila's mother, Lucia, therefore sought a legal termination of pregnancy. On 27 May, Lucia pressed charges against Lucila's father, who was arrested. Lucia then requested an abortion at two local hospitals, where officials said the request had to be made to the State Department of Justice. On 4 June, a judge said he would only issue an order after receiving written opinions from two medical specialists but the physicians said that the judge must resolve the issue because it was a legal case. The state prosecutor said that if a doctor performed an abortion, her office would decide afterwards whether the action was legal. Lucia visited various offices and the local Human Rights Agency to seek authorization through the fourth month of Lucila's pregnancy, when physicians warned her that an abortion at this point in the pregnancy could pose a danger to her daughter's life. Finally, 4.5 months after the rape, Lucila was granted an abortion [179].

Amnesty International has pointed out that states are accountable for abuses committed by non-state actors; states are obliged to take action to prevent such abuses. On 20 July 2001, the Sinaloa State Attorney General announced that a department had been established to handle abortions sought after rape [180].

5.2.2. Health-care providers as targets

Health-care providers may fear threats of legal action against themselves if they provide postabortion care. In Mexico, for example, a midwife said that she was reluctant to help women with spontaneous abortions because she had had problems in the past:

> *"I have only attended two abortion cases in all the time that I have been a traditional birth attendant (more than 30 years) and these were for special reasons. The first was 5 months pregnant and she came to me with pains about eight days after her husband beat her. She came hemorrhaging and weak and for that reason I took her with me.... The other woman that I attended had also been beaten, this time by her landlord since she owed a few months rent...She also was bleeding...In both of these cases I had problems with the police. They put me in jail and cited me many times to make a declaration but since I wasn't guilty, I never did so. But the police continued to bother me and they threatened to take away my permit to attend births. They finally left me in peace when witnesses and the women's families, as well as a nurse at the health center, told the police that they knew me well and that I was a TBA with a good reputation. This still didn't save me from appearing on the front page of the newspapers for several days"* **[181]**

Physicians and clinic staff who provide abortions permitted by law may be at risk of violence from anti-abortion groups. Abortion-care providers in Latin America have reported threats of violence as well as attempts at extortion [182]. In the USA, seven persons working for clinics that provide abortion services have been murdered since 1993, and since 1991 there have been 16 other attempts to murder staff. In addition, clinics and their staffs have suffered bombings, arson, assault, kidnapping and threatening phone calls [183].

5.3. Inhuman and degrading treatment

Institutional violence in the provision of postabortion care includes inhuman and degrading treatment in the form of accusations, humiliation and psychological aggression. One clinician in an unspecified Latin American country commented on his time as an intern in a unit that treated women with septic infections, most caused by unsafe abortions: "fellow students and professors...would scold the patients and make them feel worse than they were already feeling, but I felt very sorry for them" [184].

Health professionals may pressure women presenting with complications of incomplete abortions to admit so-called 'guilt' regarding their condition. On the other hand, women seeking postabortion care at a Catholic hospital in Bolivia have been forced to say that they are suffering a miscarriage in order to receive treatment [185]. Research in Peru has documented frequent aggression by health-care providers against women who present for treatment of incomplete abortions, including abandonment, branding them as liars (if they say they have suffered a miscarriage) and stigmatization [166, 171]. In Brazil, women who had induced abortions have reported negligence, lack of privacy during physical examinations, and even sexual abuse by providers [186].

> ***"The patients [women presenting with complications of incomplete abortions] are generally handled as criminals or sinners."*** - health provider in Kenya [170]

In Argentina, it has been stated that 'avoiding abortion is the institutional goal for hospitals'; as a consequence, some physicians attempt to maintain a pregnancy when possible instead of consulting with the woman and completing the abortion if that was her intention. As one woman said: "When they realized what I had done, they scolded me a lot and told me they would only do the curettage if it was absolutely necessary..." [187]. This practice leads to a situation in which women return home and resort to more drastic alternatives to complete the abortion, running more risks to their health and lives.

A Bolivian health-sector official has commented that: "the only thing that we will accomplish [with such repressive measures] is that complications of induced abortions will be attended clandestinely in the same way as [the abortions themselves], whereby we immediately increase women's mortality rates" [185].

5.4. Further institutional violations of women's human rights

There are other actions taken by personnel in the judicial/legal and health-care sectors which, in and of themselves, are not forms of violence. However, they do constitute violations of women's rights and the effects may be experienced by women as a form of psychological violence.

5.4.1. Delayed abortions due to legal impediments

In some countries, women who have been raped must request court permission for an abortion; sometimes the delays in obtaining this approval mean that the pregnancy is too far evolved for an abortion to be performed. An extreme example comes from Zimbabwe where a raped woman only received permission for a legal abortion a month after she had given birth [188]. In other countries, such as Korea and Taiwan, spousal consent is required. In Bangladesh and India, where there is no legal requirement for a woman to obtain her partner's permission for an abortion, physicians and public health sector staff refuse to carry out the procedure without such consent [113].

Even when adult women are allowed to make their own decisions regarding abortion, adolescents may need the consent of parents or guardians to undergo a legal induced abortion. This can constitute a barrier to care for young women who do not wish to talk about the cause of an unwanted pregnancy, for example, rape by family members [70].

Legislation may provide 'bypass provisions' that allow adolescent women to seek a court's permission rather than that of their parents, but they then must depend on a judge's consent. In the USA, the Supreme Court has ruled that teenagers must be granted such a bypass if they are mature or if an abortion is in their best interests. Judges may nevertheless deny a bypass, as in the case of a 17-year-old woman in Ohio. She testified that she was planning to attend university and was not financially or emotionally prepared to study and be a mother at the same time - the judge denied her petition saying that she had "not had enough hard knocks in her life" [189].

5.4.2. Conscientious objection as a barrier to abortion

Some health professionals do not want to perform legal abortions because they consider such actions to be a moral transgression. While individual health providers' right to refuse this medical care on grounds of conscience is recognized, they are usually legally obliged to refer women to trained staff who will perform abortions permitted by law. Moreover, health institutions in most countries do not enjoy the same exemption as individual health-care providers based on conscientious objection, so they are obliged to see that patients receive all care to which they are entitled [84].

Nevertheless, some service providers and institutions that will not perform abortions due to conscientious objection do not always make referrals to physicians who will perform the procedure. This is the case for US hospitals run by Catholic organizations (10% of the nation's total), for example [190].

The right to conscientious objection may also be abused. It was reported that all physicians at public hospitals in Split and Tula, Croatia, at one time refused to perform abortions on grounds of conscience yet they were willing to perform them for high fees in private practice [191]. A similar practice was reported in Poland [172]. Some health-care providers may also attempt to impose their own religious beliefs on patients by deliberately providing faulty information in an effort to persuade them to forego an abortion.

In Baja California, Mexico, a 14-year-old girl reported to have been impregnated by a robber was prevented in 2000 from having an abortion permitted by law through the actions of both legal and health system officials. First, physicians at the hospital refused to carry out the procedure; then the state Attorney General took her and her mother to a Catholic priest who tried to dissuade them from the procedure. Finally, minutes before the abortion, the hospital director misinformed the young woman's mother about the dangers of the abortion, stating that she could die or be left infertile, whereupon the mother decided against the procedure: "I thought it was better for my daughter to have the baby than to die," she said. "Probably nothing would happen to her, but if everyone was so angry about the operation, maybe the doctors would do it badly on purpose." The National Commission on Human Rights found that the girl's right to terminate her pregnancy had been violated because public authorities had "confused their religious beliefs with their legal obligations" [192].

6. Measures and interventions: a health promotion approach

Heise's conceptual model, introduced in Chapter 1, indicates that measures should be taken to address violence in relation to pregnancy and abortion at different social levels through a multi-faceted approach. The health promotion concept provides a model for action in this regard.

In November 1986, participants in the First International Conference on Health Promotion adopted the Ottawa Charter for Health Promotion [193], which has been promoted as a means of action by WHO. The Charter focuses on enhancing advocacy, suggesting ways to create an environment that creates equity in health, and promoting multisectoral collaboration. Its health promotion framework is based on five inter-related strategies that can be used to reduce violence against women and its consequences. The five strategies are to:[8]

- build healthy public policies by placing health on the policy agendas of multiple governmental and nongovernmental sectors and actors
- create a supportive environment by enabling people to take care of one another and their communities through safe and healthy living conditions
- strengthen community action by enhancing public participation in matters connected with health
- reorient health and legal services by going beyond the provision of technical services so that sufficient attention is given to research, prevention and training
- develop personal and institutional skills through information, education and development of capacity to act.

[8] The author has added legal services to the strategy of "reorienting health systems" and institutional skills to the strategy of "developing personal skills".

Action chart: recommendations for addressing violence related to pregnancy and abortion

INTERNATIONAL LEVEL	NATIONAL (SOCIETAL) LEVEL	COMMUNITY INSTITUTIONAL AND INDIVIDUAL LEVELS
Build healthy public policies		
➢ Use international treaties	➢ Data collection: research on violence, pregnancy and abortion ➢ Legal & regulatory reform	
Create a supportive environment & strengthen community action		
➢ Advocacy: meetings ➢ Use the Internet and mass media	➢ Advocacy: public events and meetings with media attention	➢ Advocacy and other actions to challenge norms tolerating violence ➢ Behavior change interventions
Reorient health and legal services		
➢ Professional advocacy	➢ Professional advocacy	➢ Specialized services for legal aid ➢ Health system protocols on violence, emergency contraception and abortion
Develop personal and institutional skills		
	➢ Capacity-building regarding the law for judiciary and legal personnel ➢ Health system training	➢ Education for youth on violence and its consequences ➢ Legal literacy: information & education on women's rights ➢ Comprehensive care services

Nationally, policy measures can be taken that affect both the societal and community and institutional levels: they include use of international human rights treaties, research, advocacy, and legal and regulatory reform (including the revision of laws and policies and the introduction of new regulations). The creation of a supportive environment and strengthening of community action can focus on raising recognition of the fact that violence related to pregnancy and abortion is a public health problem. Such recognition is influenced by the perceptions of the general public - showing how societal and community factors can interact.

Community groups have begun taking innovative measures to bring home the message that violence against women is unacceptable - their actions seek to challenge social norms that permit tolerance of violence against women. This is an example of how community influences can affect the interpersonal level.

Reorientation of the health-care and legal systems will affect the extent to which individual women suffer from the consequences of violence. The development of personal and institutional skills to better address violence linked to pregnancy and abortion has effects at the community, interpersonal and individual levels. When staff working in the health, social, judicial/legal and law enforcement sectors are enabled to recognize violence against women as a public health problem, they will be better able to intervene and assist in cases of ongoing abuse. The situation can be changed for individuals by helping young people develop more gender-sensitive behaviors that condemn violence and by empowering women to recognize and exercise their rights to just treatment and adequate care when abuse occurs.

This chapter gives examples of measures and interventions that can be included in the five health promotion strategies. They are not provided in order of importance since action must be taken in all the aforementioned areas simultaneously in order to achieve a comprehensive multidisciplinary approach. Such an approach should involve the health, judiciary/legal and law enforcement sectors, researchers, the media, NGOs and communities to ensure that the different aspects of the problem are addressed.

6.1. Build healthy public policies

In the health promotion framework, healthy public policies are those that have any effect on promoting health, that is, they are not restricted to policies in the health sector alone.

6.1.1. The national level

➢ ***Use of international treaties***

International treaties can provide a strong basis for the creation of public policies that adequately address violence in relation to pregnancy and abortion. Government officials and parliamentarians need to:

- take action to ratify relevant treaties and ensure their use as points of reference in the national judicial system
- provide information on violence and abuse related to pregnancy and abortion in official reports to the UN Committees that monitor the implementation of international treaties.

NGOs that work on human rights issues and sexual and reproductive health are well-placed to carry out the advocacy needed to promote ratification of treaties. NGOs and researchers can also be instrumental in providing information for governmental and shadow (i.e., NGO/civil society) reports that are used by treaty monitoring bodies to

assess how well governments comply with treaty provisions. Such information needs to be disseminated to national human rights commissions, the media and the general public as well.

The Human Rights Committee urged Ecuador in 1998 to provide adolescents with adequate health care and education due to the high rate of suicides among girls "which appear in part to be related to the prohibition of abortion". In the same year, the CEDAW Committee recommended that the Peruvian government review its laws to ensure that women have access to emergency treatment of abortion-related complications and safe abortion care [116].

➢ *Data collection*

Because relatively little information is available concerning the specific links between violence, pregnancy and abortion-related issues, policy-makers may believe that the problem is not "quantitatively significant" and therefore not a public health problem. They therefore need to receive data so that they can revise policies, regulations and legislation appropriately.

Research on violence and pregnancy: Following guidelines set by WHO, maternal mortality has been defined as deaths that are related to or aggravated by pregnancy complications occurring during pregnancy or within the first 42 days after pregnancy has ended (excluding accidental or incidental causes). Because this definition is quite narrow, some researchers are now advocating use of the term 'pregnancy-associated death' in research protocols as this will provide broader scope for considering factors such as violence against women as a cause of maternal mortality. In order to capture the non-fatal outcomes of such violence, studies could further investigate 'pregnancy-associated morbidity and death'.

"Another factor that limits our ability to understand the association between pregnancy and violence or to be certain that there is less abuse during pregnancy may be that women in abusive relationships with unwanted or unplanned pregnancies could be more likely to terminate their pregnancies. Data from...studies of pregnancy outcomes are only telling us about women who carried their pregnancies to term." - Linda Koenig, Centers for Disease Control and Prevention, USA [99]

Recommendations prepared for the US Centers for Disease Control and Prevention have suggested the following topics for research [4]:

- standardized research methodologies regarding violence that allow comparisons between pregnant and non-pregnant women
- the prevalence of violence related to pregnancy
- the characteristics of such violence
- causality: when and why does pregnancy precipitate violence and how often is pregnancy a result of sexual violence?
- risk or protective factors for victimization
- adverse outcomes of violence during pregnancy.

Based on this literature review, other topics that can be added include:

- the influence of gender norms on community tolerance of violence, especially with regard to pregnancy and abortion-related issues
- the influence of violence on women's experience with contraceptive use, unwanted pregnancy and ways of coping with it
- the perceptions, beliefs and attitudes of (legal and health-care) service providers, as well as other relevant actors such as judges and law enforcement officials, regarding violence related to pregnancy and abortion
- the prevalence of institutional violence experienced by women who present for care and assistance to legal, social and health services in connection with physical and sexual violence linked to pregnancy and abortion
- the perceived barriers in different sectors regarding multisectoral collaboration to address the problem as well as the outcome and impact of multisectoral collaboration efforts
- the outcome and impact of institutional and community-based interventions to change gender norms in relation to violence, unwanted pregnancy and unsafe abortions.

Research on violence and abortion: It is important that abortion-specific research also examine the issue of violence. Studies conducted in countries with few restrictions on legal abortion (e.g., China, Cuba) regarding women's reasons for terminating pregnancies typically include broad and non-specific categories of response ('unintended pregnancy', 'family or marital problems') or more specific responses that do not include violence (contraceptive failure, being unmarried, economic problems, fetal condition, health problems) [194, 195].

Where abortion is legally restricted and also highly stigmatized, abortion research may be more difficult and lead researchers to exclude a second 'sensitive' topic such as violence. Even questions regarding causes of spontaneous abortions often omit abuse as a possible cause. Researchers not uncommonly assume that women's failure to indicate a cause of miscarriage simply indicates their reluctance to admit to having had an induced abortion; they do not appear to consider that violence might be involved. This paucity of relevant data led participants in a 1999 US national conference on violence

and reproductive health to recommend that researchers examine violence and pregnancies not carried to term since "the largest data sets...only look at pregnancies resulting in live births, thus leaving out pregnancies that do not result in live births" [196].

Operations research on violence and abortion can contribute to the development of appropriate care and referral protocols for health services and agencies assisting survivors of violence. Such studies should investigate the women's perceptions and needs regarding treatment for incomplete abortions and induced abortions. From a gender perspective, it is also important to include, with women's informed consent, family members and male partners. Broadening the study population in this way can contribute to better understanding of the taboos and prejudices that impede discussion of violence and abortion. It can further help identify which factors need to be addressed through interventions with both men and women. Data are also needed regarding health-care providers' perspectives - their attitudes, knowledge and needs - so that appropriate interventions can be developed to help them address the issue of violence and make referrals for further assistance to patients who seek postabortion care and induced abortions.

Researchers' ethical responsibilities: Various researchers have noted their ethical responsibilities towards women who participate in studies on sensitive subjects such as violence and abortion [4, 197]. Researchers who compared two studies specifically on violence against women and data on such violence from a demographic health survey in Nicaragua concluded that researchers should be cautious about including questions concerning violence in surveys that focus primarily on other issues. The main reason is that smaller studies, in which there is more interaction between researchers and study respondents, offer more opportunities to refer abused women for psychological and other support [198].

Respondents' safety during studies should be ensured by refraining from inquiries about violence in the presence of other family members, interviewing them in private and ensuring their confidentiality. Techniques to guarantee anonymity can be adopted. For example, a study in India on induced abortion included both women who had been identified as having had the procedure as well as other women in the same communities ('dummy respondents'). All of the women were told they would be interviewed about health problems and the same questionnaire was used with all of them. When the 'study respondents' mentioned their abortions, the researchers then proceeded to question them about their experiences [199]. Such methods may also prove useful in research on violence, pregnancy and abortion. Researchers should have available referrals for organizations that can offer respondents support and services, for example, small (easily hidden) cards with information about assistance services [197].

WHO further notes that: "Researchers have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy development and programmes" [200]. For example, study findings can be related to national and international human rights standards as a means of advocating for increased attention to violence, pregnancy and abortion as a public health problem.

➢ *Legal and regulatory reform*

It is important that members of parliaments work to reform laws so that violence against women is addressed effectively. For example, the Asian Forum of Parliamentarians on Population and Development (AFPPD), the Japan Trust Fund for Parliamentarians and UNFPA organized a meeting on violence against women in June 2001. The participants drafted a plan of action to address domestic violence, sexual assault and harassment and trafficking of women in their respective countries and AFPPD allocated funds for national follow-up [201]. In Nicaragua, the Network of Women against Violence presented a draft bill to reform the penal code regarding the prevention and punishment of intra-familial violence [202]. This law, which was enacted at the end of 1996, provides protective measures for women who denounce violent attacks by their spouses and broadens the concept of violence to include psychological harm.

In some cases, legal and regulatory policy reform will be somewhat easier at the state/provincial and municipal, laying the groundwork for actions that can be taken nationally. The municipal legislature of Buenos Aires, Argentina, took action in June 2000 to help prevent unwanted pregnancies and subsequent unsafe abortions by passing a law that makes reproductive health information and contraceptives available free of charge to women of any age. Proponents of the law overcame opposition to provisions that permit adolescent girls to obtain contraceptives without parental permission and that incorporate the IUD into the list of authorized contraceptives, commenting that they would push for similar legislation in the national Congress [203].

"Not all families are safe environments", stated Mabel Bianco of the National AIDS Programme, in support of a Buenos Aires law making contraceptives available to adolescents. She noted that the State must therefore make its presence felt for the benefit of children who suffer domestic violence and sexual abuse.

Unwanted pregnancies can be prevented if women who have been raped are offered emergency contraception (EC) within 72 hours of a sexual assault; a campaign in 2001 by Peruvian NGOs contributed to EC being added to the list of facilities that the public health system should provide. However, health systems must have policies in place to

support EC provision. In Mexico City, it has been estimated that 72% of women who officially report rape do so within three days of the crime so that providing them with EC could prevent more than two-thirds of possibly resulting pregnancies. Psychologists at the Center for Therapeutic Help and the Public Ministry's agencies specialized in sex crimes were therefore trained to offer their clients EC information [204]. At first, the psychologists were reluctant to do so because they did not have written orders and were afraid they would be associated with induced abortion. However, after distribution of an EC brochure signed by the Mexican Family Planning Association and the establishment of 11 medical referral centers, they incorporated EC counseling as a routine element in the care provided. Similarly, in Ecuador, only 36% of physicians, nurses and nurse-midwives agreed totally with the provision of emergency contraception to their patients before participating in a focused intervention. After training and focus group discussions, 95% accepted EC provision as a valid option [205].

It is essential that hospitals have clear and unambiguous policies on the provision of emergency contraception. For example, of 26 hospitals surveyed in New York state, USA, 12 had ambiguous or no EC policies at all. A contributory factor appeared to be unclear directives issued by the National Conference of Catholic Bishops on the treatment of rape victims, which left the Catholic hospitals in a quandary. The directives state that raped women should be able to protect themselves against possible conception from a sexual assault after pregnancy testing; however, such tests are only reliable after 10 days while emergency contraception must be given within 72 hours. According to a local theologian, Reverend Gregory Faulhaber: "There's a gray area here, and it's also true that emergency room physicians don't have time for a lot of debate on the matter while they're at work. Still, we believe the directives offer a way to retain respect for life and treat the victim" [206]. To ensure that women have the option of preventing pregnancy after rape, hospitals should ensure that emergency room physicians have completely clear written guidelines (in contrast to that mentioned above) that permit them to offer emergency contraception in the hospital.

Even where abortion is restricted by law, governments must take measures to ensure that health workers and judicial sector officials (the police, lawyers, judges) know that postabortion care is not a crime since this belief can impede provision of treatment. To further ensure women's access to such care and to resolve doubts experienced by health professionals, authorities must adapt their hospital regulations and make health providers aware that they are obligated to treat abortion complications.

When abortion is permitted by law, it is important that the health system include this option in regulations concerning cases of violence. The Brazilian Ministry of Health issued a technical norm in 1999 on *The prevention and treatment of injuries resulting from sexual violence against women and adolescents* which gives specific recommendations for comprehensive care. The recommendations pertain to recording

instances of violence in medical records, collecting medical evidence that can help identify rapists, guidelines on providing emergency contraception, HIV/STI testing and treatment, guidelines on abortion methods and a stipulation that abortion providers receive training in the provision of humane care [207].

6.2. Create a supportive environment and strengthen community action

The health promotion framework considers an environment to be supportive when it promotes actions that enable individuals to ensure their health; community action is seen as a vital component of such actions.

6.2.1. The international level

When a problem is defined internationally as a public health problem, governments and national health systems perceive much more pressure to recognize and address the problem. UN agencies, international NGOs, NGO federations and alliances that cross borders can play an important role in this regard. Three examples of strategies that can be used to highlight the links between violence, pregnancy and abortion include:

- organizing international meetings to focus on research, prevention and intervention needs, where experience, lessons learned and best practices can be shared across borders
- organizing and supporting international tribunals in which women can offer their testimonies concerning such cases of violence, ensuring press coverage so that the general public becomes more conscious of the problem
- using the Internet to provide resources to address the issue. Several websites have been created to disseminate information and make articles and graphics available for presentations on violence and pregnancy (see Appendix 4). In addition, NGOs are using the Internet to support campaigns against rape and other forms of violence; in the Philippines, one such project has collected 2000 women's stories regarding their experiences with family violence [116].

6.2.2. The national level

Public events that attract media attention can be effective ways of beginning and stimulating public debate on an issue. When the issue is a problem that primarily affects women, such as violence in relation to pregnancy and abortion, such events and the ensuing media coverage may have even more impact when the key players include men.

➢ ***Public events***

Men in Kenya have formed a coalition against violence; one of their first actions was the organization of a public march against gender-based violence in Nairobi in 1999 [1]. The city of La Paz, Bolivia, publicly announced the creation of a Municipal Network to

Fight against Violence in 2001, highlighting the need for a multisectoral approach to prevention and interventions [208].

The adoption of policy statements and petitions by civil society organizations is an important way to support government action. The Latin American and Caribbean Women's Health Network collected 600 signatures in 2000 for a public statement endorsing the Chilean government's decision to allow the sale of emergency contraception; however, the country's Supreme Court later banned this form of contraception, leading to opposition between the Court and the Ministry of Health [209]. In Bolivia, 50 institutions and individuals publicized *The Declaration of Cochabamba* in March 2001 as an advocacy tool to persuade governmental agencies and the health sector to allow women to exercise their rights to abortion permitted by law in cases of rape and incest.

➢ ***Meetings***

Public meetings that bring together members of the health, judicial/legal, law enforcement, education, social assistance sectors are important advocacy tools. The Legal Assistance Centre in Windhoek, Namibia, organized a national conference on violence against women in February 2000, to which 15 men from each region in the country were invited along with representatives of various governmental ministries. Follow-up activities included a panel discussion with students at the Polytechnic and University of Namibia, a panel discussion among religious leaders and a TV program on the topic [210]. In August 2000, a similar multisectoral meeting was organized in Monterrey, Mexico, by the Nuevo León and Mexican Societies of Gynecology and Obstetrics, the Secretariat of Health, University of Monterrey and Ipas. Some 450 participants discussed violence against women in relation to ethics and human rights and the conference organizers disseminated recommendations from the meeting nationwide, including measures needed to address violence in relation to pregnancy and abortion. The success of the event, which received widespread local press coverage, led to plans for replicating the conference in other Mexican states, Bolivia and Brazil.

The obligation to treat the complications of incomplete abortions is still not adequately fulfilled in many places. Researchers, NGOs and other members of civil society can advocate for policies to ensure compliance with this obligation. In November 1998, more than 200 representatives of women's organizations, NGOs, international organizations and donors met in Morelos, Mexico, to review progress made in implementing ICPD recommendations. Their demands included a requirement for governments and health organizations to ensure that health professionals always offer abortion-related emergency services to save women's lives [211].

6.2.3. The community level

➢ *Community action*

As stated above, community action is vital to creating an environment that is supportive to women who suffer violence. Kalyanamitra, an NGO in Indonesia, helps find foster families for abused women, while in the Indian state of Madhya Pradesh, groups of highly respected religious singers openly confront families where violence is evident, making it clear that this behavior is against the norm [35, 212]. In other Indian communities, people beat pots outside the houses of abusers; in Peru whistle blowing is a strategy used to identify and shame perpetrators of violence [213]. Community activists in Concepción, Chile, urge women to use the 'Can I borrow a red thread' strategy - neighbors are urged to run next door to help a woman if they hear violence and abuse taking place [107].

➢ *Behavior change interventions*

Because most violence against women is gender-based, interventions that address prevalent norms on masculinity and femininity are needed. Such action can help address community factors (e.g., tolerance that allows women to suffer violence in isolation) as well as interpersonal factors (beliefs that men have a so-called 'right' to dominate, chastise and physically harm women). The UNICEF Regional Office for South Asia carried out a project in 1997 to identify why activists were working on gender-based violence [214]. The findings included observations that:

- Many men who work to stop violence against women had male or female role models who contradicted stereotypes concerning male-female relationships based on male dominance and female submission.
- Both women and men activists tended to have close relationships with parents of the opposite sex.

> ***"We, men, realizing that no sustainable change can take place unless we give up the entrenched ideas of male superiority, commit ourselves to devising new role models of masculinity. We shall endeavour to 'take off the armour' and move forwards to becoming a more developed and complete being. We urge international bodies to focus on and explore the destructive consequences of patriarchy."*** - Kathmandu Commitment on Ending Violence against Women and Girls in South Asia [215]

Men's groups dedicated to fighting violence in other regions are working to achieve the conditions found to support activism in Asia. For example, "Men in the Know", a project carried out by Care International in Vietnam, trained 2000 men through workshops that

challenged socio-cultural factors influencing sexual encounters. Both the men and their partners responded positively [216]. Male staff of NGOs united in the Nicaraguan Group of Men Against Violence work with men and youth in small groups and organize national workshops to help men analyze gender-based factors that contribute to violence against women. Women interviewed about the effect of this work have noted positive changes in the male participants' behavior [217]. In Mexico, CORIAC (Men's Collective for Equal Relationships) initiated workshops to reduce male violence in 1993 [218]. Their strategy is to inform men about the risks of macho attitudes for their own health (stress and heart attacks) and thereafter to teach them different methods for decreasing stress. Another of their projects, "Men Renouncing Violence", works through men's groups to help participants: 1) acknowledge that their violence is learned and that they can decide to stop using it; 2) examine their emotions and emotional reactions in order to understand how these contribute to violence; and 3) develop skills of intimacy and negotiation to construct non-violent relationships to deal with partner conflict [219].

In the USA, a national network of professional Latino men, Red Nacional de Compadres, is working to transform the prevalent macho masculine identity in their communities as a means of decreasing violence against women and children [220]. The White Ribbon Campaign in Canada and other countries not only encourages men to publicly show their stance against violence against women but also promotes their involvement in changing norms (e.g., identifying and opposing sexual harassment and violence in schools, the workplace and homes) [221.

Men speak out about violence and its consequences

- "Rape is one [form of violence]. Here a woman's helplessness is taken advantage of. If she is not safe with me, as I am a male, then what is the difference between me and a beast? It is an onslaught on women....To change this situation of the woman, they must be made self-reliant. The best way is to increase awareness among the men and motivate them to play the leading role." - Bai Sab, police officer in Bangladesh [105]
- "What is very important is, in our society we say that violence against women is a women's issue and only women should get involved. But I believe that this is an issue that is of concern to all of society, not just to males or females. It is our concern..." Kiran Tewari, NGO worker in Nepal [105]
- "The harsh reality is that many of the instances of mistreatment that women are forced to endure are rarely brought to the public's attention. ...We must ensure that any male responsible for violence against a woman is considered deviant from social norms and therefore ostracised or regarded as a social outcast." - Dr. Boonton Dockthaisong, Second Vice-President of the Senate, Thailand [222]

Programs that work with men who are abusive are also needed. García-Moreno notes that although many batterer intervention programs have not been systemically monitored and evaluated, there are indications that they may contribute to ending physical domestic violence among 53-85% of men who complete the programs [213].

6.3. Reorient legal and health services

The global prevalence of norms that tolerate violence against women, as well as service providers' reluctance to address violence in relation to pregnancy and abortion, require that legal and health services be reoriented.

6.3.1. The international level: professional advocacy

Professional associations influence their members through the provision of information and guidelines and play a key role in highlighting neglected areas of law enforcement and public health. The International Women Judges Foundation has worked with national associations of women judges in Argentina, Brazil, Chile, Ecuador and Uruguay to offer workshops on the application of international human rights law to cases of violence against women [223]. In the health field, the International Medical Advisory Panel of the International Planned Parenthood Federation (IPPF) has issued a policy statement on gender-based violence that includes action suggestions for family planning associations [224].

6.3.2. The national level: professional advocacy

In the Philippines, the Women's Legal Bureau has developed a protocol for handling cases of abuse against women and children on behalf of the Legal Advocates for Women Network. The protocol stresses the obligations of lawyers to address their clients' multiple needs through referrals to counseling, psychosocial and emotional support [225].

The South African Medical Association is creating a rape protocol to guide its members [194]. On the other side of the globe, the Brazilian Federation of Gynecologists-Obstetricians (FEBRASGO) co-sponsored a professional forum on the topic of sexual violence against women. The outcome document included recommendations to: publicize the magnitude and gravity of violence against women through periodicals, training courses and meetings; help finance campaigns and educational materials on the subject; and incorporate gender and sexual violence topics into medical school curricula. In addition, the Federation is promoting multisectoral collaboration among the health, legal and educational sectors.

> ***"Doctors also need to advocate for action as influential members of society. There needs to be a strong, coordinated, bottom up approach to the problem of sexual violence as well as a top down one. Sexual assault is still talked about only in hushed whispers, making it even harder for victims to come to terms with their ordeal and seek the help they need. We need to brush aside the taboos and talk more openly about this huge problem and the practical ways of tackling it."*** - Rhona MacDonald, *British Medical Journal* editorial registrar [226]

6.3.3. The community level

➢ ***Specialized services for legal aid***

Agencies where women and children can go for specific legal and other aid in connection with violence are increasing in number. In July 2000, a rape crisis center for minors was opened in Delhi, India [227]. All 22 investigating police officers associated with the center received gender training, and links were established with agencies that provide programs for rape survivors. In addition, a team of physicians, lawyers and public prosecutors was formed for the center, and two agencies committed to providing financial assistance for the abused children. The police department of Osaka, Japan, is collaborating with the Osaka Society of Obstetrics and Gynecology to set up a system in which physicians, psychologists and lawyers are available 24 hours per day to assist police in collecting forensic evidence for sex crimes and providing psychological and health care to survivors of sexual violence [228].

The Nicaraguan Women's Institute, women's organizations and the national police initiated a Commissariat for Women and Children to attend victims of abuse [202]. The police in particular were trained to assist women by making referrals to legal, psychological and medical care. More than 70 all-female police stations have been established to assist female victims of violence in Brazil with social and psychological support; similar facilities have been established in Argentina, Colombia, Costa Rica, India, Pakistan, Peru, Uruguay and Venezuela [229]. Despite the presence of such specialized facilities, it is important that the entire law enforcement sector continues to be sensitized to the needs of women who suffer violence. For example, many women will not live near the special units; this has created problems in India, where women have been pressured to register their complaints only at the female police stations [230].

➢ *Health system protocols*

Health-care providers are well-placed to serve as a pivotal point in a comprehensive approach to dealing with violence against women. They see women in emergency services who have been victims of rape, incest and physical violence; midwives, nurses, obstetricians, gynecologists, general practitioners and other doctors attend women who may show signs of abuse though they do not come specifically to the health providers to report it. Health professionals can therefore play a role in helping to detect cases of violence against women, addressing the consequences and referring women to other specialized agencies for further legal, medical and social help.

WHO recommends that health providers document instances of abuse in clients' medical records, including details about the perpetrators. Establishing protocols for responding to abuse which include referral systems for psychological and legal help can enable health professionals to respond more effectively. In Queensland, Australia, domestic violence screening of all women who come to public prenatal, gynecology and emergency clinics is being introduced; 97% of women surveyed have supported the initiative [231]. In Sweden, 80% of prenatal clinic attenders said that they found questioning about violence by their midwives to be acceptable [232]. Sexual assault nurse examiners provide emergency care in Ottawa, Canada, for 80% of all emergency care patients, including testing for STIs and pregnancy [233]. In São Paulo, Brazil, one hospital offers survivors of rape a comprehensive package of services that includes administration of analgesics, hepatitis B prophylaxis, testing and treatment of STIs, post-exposure prophylaxis for HIV infection and emergency contraception when the women report within 72 hours of the crime, and abortion for unwanted pregnancies [234].

Screening for violence has also been incorporated into some abortion clinic procedures. Adhering to screening protocols in this type of setting may be more challenging due to the stigma that already often exists around abortion. One study examined adherence to a universal screening protocol at an urban Canadian clinic. Service providers were trained and expressed enthusiasm for incorporating violence screening into their counseling; however, during the study period, only 50.9% of the women seen were asked the screening questions. The reasons for non-compliance with the protocol were varied, including language difficulties with immigrants, the counselor feeling rushed or the fact that the woman's partner was present. The researchers nevertheless stated that the introduction of the protocol was valuable because cases of abuse were identified among 38 women (15%) and the counselors could address issues of concern, such as recommending types of contraceptives that women could hide from their partners [235].

Such protocols should be accompanied by staff training but may need to be reinforced by other measures. A hospital in the USA found that after a 90-minute violence screening training, which was a condition for nurses' employment in the emergency

department, there was only 21% compliance with the mandatory screening. After formal disciplinary action was instituted for non-compliance (comprising a four-step procedure that involved reviewing the screening policy, seeking solutions for non-compliance, further counseling, written warnings and finally termination of employment), all staff participated in screening patients for cases of abuse [236]. A review of 24 studies on screening programs in the USA found that interventions that included institutional support (e.g., a designated staff-member serving as a violence specialist and emotional support through staff meetings and training) had a greater chance of increasing routine screening [237].

6.4. Develop personal and institutional skills

Once service providers can count on public policy guidance, supportive environments and sectoral improvements to enhance interventions, they will still need skills-building and training to address issues of violence, pregnancy and abortion.

6.4.1. The national level

Many women still do not report cases of rape to persons other than family members or friends. When they do, they often first go to law enforcement officials or health providers. It is important that the legal and health systems equip service providers to treat survivors of violence respectfully and provide them with appropriate referrals for further assistance and care. As noted above, such referrals need to be prompt in the case of medical care because this can ensure that women gain access to emergency contraception to prevent pregnancy and antiretroviral therapy to prevent HIV infection. Providers also need to know national and local regulations concerning rape, domestic violence, other forms of abuse, postabortion care and abortion permitted by law. Unfortunately, their familiarity with all laws and regulations cannot be assumed, even if they are working in the law enforcement field.

➢ ***Capacity-building regarding the law and gender***

Appropriate laws to assist survivors of violence are not sufficient in themselves to effect systematic change for the benefit of women. For example, when applying a law that increased penalties for rape, judges in Nicaragua tended to acquit rapists in order to avoid applying what they considered to be excessive sanctions.

To change underlying attitudes in this regard, action is needed to address prejudicial attitudes and influence norms. In Peru, the NGO DEMUS organized a workshop on penal laws and sexual violence from a gender perspective for 42 judges and 7 other judicial professionals [238]. At its conclusion, 57% of the judges said it was necessary to change

the laws to allow punishment for rape within marriage; they also reached a consensus that sexual abuse is not only a sexual but also a violent offense.

Law enforcement officials are also beginning to speak out publicly on the need for attitudinal training. The Chief Commissioner of the Uppsala County Police Department in Sweden, Goran Lindberg, is an expert adviser on gender equality for his government. Through public speaking engagements and talks for men in influential social positions, he is working to change attitudes towards violence and promote women's rights. Lindberg also refuses to employ police officers in high ranks who cannot prove that they have taken care of children because he considers this evidence of efforts to break out of traditional masculine roles [24]. In Rajasthan, India, authorities have amended the State Service Rules for government employees: a man who beats his wife can be dismissed from his job or have his salary transferred in her name if his battered wife complains to the man's boss [239].

> ***"If you look upon a person as being of the same value as yourself, you are not very likely to hit, harass, ridicule, humiliate or rape her....A lot can be done in this matter - but the most important is that we men change our attitude to violence - we need to go from physical violence to mental strength."*** - Goran Lindberg [240]

The Centre for Women and Children Studies (CWCS) in Bangladesh has carried out a Project for Police Training and Community Sensitization on Women and Child Rights in which police and community members participate in separate two-day workshops, thereafter coming together in a combined interactive one-day training. At follow-up meetings a month later, the law enforcement officials and community members report back on action taken as a result, such as collaboration in addressing specific instances of abuse [241].

> ***"As legal professionals and those involved in the formulation and enforcement of laws, we shall advocate and contribute to the reform of discriminatory laws and to the sensitive and effective enforcement of law, promoting awareness of the law and its proactive use in countering violence against women and girls"*** - The Kathmandu Commitment on Ending Violence against Women and Girls in South Asia [215]

Health providers not only need training in gender-sensitive approaches towards women who have suffered abuse; they also may need training regarding laws related to violence

and its consequences. IPPF has developed a checklist of questions to help health-service providers determine the legal framework in which they can address violence against women [242]. According to the UN Population Division, 83 of the world's 193 countries permit induced abortion in cases of rape and incest [243]. Nevertheless, many women are unaware of this right and consequently resort to clandestine abortions in unsafe conditions. Moreover, even though abortion is permitted following rape in many countries, few health professionals perform such induced abortions because they incorrectly believe they are illegal or they do not know the necessary and/or legal procedures to follow. The law in Mexico is imprecise regarding judicial-legal procedures for granting women access to legal induced abortion, i.e., interpretation of the law is at the discretion of the public ministries, judges, hospital ethical committees and service providers [244]. Health professionals in Brazil are reluctant to perform legal abortions because "they are afraid they will incriminate themselves if they comply with the law, a situation which has become an insurmountable obstacle for the majority of rape victims" [245].

A course developed by Ipas-Mexico and the Safe Motherhood Committee in San Luís Potosí was designed to address such health-care provider concerns. The training module focuses on violence among pregnant women, covering Mexican laws and health system regulations for dealing with family abuse, participants' own beliefs, values and attitudes towards violence against women, and elements necessary for the development of comprehensive protocols [246]. In Brazil, a women's organization investigated community opinions on abortion and produced a video on their study that was used in awareness-raising workshops for health workers and the general public. Thereafter they were able to work with the health and judicial systems to reinforce community support for legal abortion services and to establish standard procedures to help women comply with the legal requirements for obtaining an abortion [247].

➢ ***Health system training***

Women living in situations of ongoing violence use medical services more frequently than non-abused women [134]. Nevertheless, they often do not talk about domestic abuse as a cause of their medical problems because they think that health professionals are not interested or only have enough time to treat their urgent physical problems [248]. Health-care workers are often the only professionals who see these women, and those providing gynecological, obstetric and emergency care may be in the best position to help them since they see some of these women periodically.

Though violence care protocols are an essential component of reoriented health services, health professionals need information and training to help build their capacity to respond to documented cases of abuse. One US study on the use of a violence protocol in emergency care, for example, showed that staff failed to adhere to the

instructions on notifying police and social workers, indicating that research is needed on easy-to-implement procedures [17]. An assessment in the Kibondo refugee camps in Tanzania, revealed that up to March 1998, only 19 (6%) of 316 women who had been raped used emergency contraception after counseling and medical referrals; the International Rescue Committee that works in the camps acknowledged that staff need both education for themselves on how to provide emergency contraception effectively and for the refugees on what emergency contraception is [249].

A first step involves training health-care providers to recognize the possible signs of violence in abused women. The physical signs may include: wounds and lesions to the chest, abdomen and genital area; inexplicable pain; substance abuse; poor or malnutrition; depression; late or sporadic attendance at appointments [8]. Another sign can be an etiological history given by a woman that is inconsistent with the type of lesions that she presents [23].

Such training must go further than learning to detect the signs and symptoms of abuse, however. García-Moreno, the coordinator of a WHO multi-country study on violence against women, notes: "Training is [traditionally] focused exclusively on technical content and does not address the attitudes and values of the providers. For example, a health care setting which is not welcoming and where women are not treated respectfully or listened to, as a matter of course, can hardly provide an appropriate environment for addressing violence against women" [213]. It is important that all health personnel realize their responsibilities in this area; if they feel unable to offer assistance, at the very least they should express sympathy and care and help facilitate referrals to health workers who can provide assistance.

A Colombian woman who suffered rape first sought help at a hospital. The doctor who attended her said: "I was wasting time, I should go to the forensic physician." She reported to the police station, where she was respectfully questioned and referred to the forensic physician who examined her, requested some medical tests and gave her emergency contraception [6].

A second step therefore comprises giving health professionals gender-based attitudinal training on violence against women. Such training should include how to facilitate conversations with patients on violence in a sensitive and respectful manner. Because definitions of violence vary individually and culturally, it is best that questions focus more on specific behaviors rather than 'abuse' or 'rape' in general, e.g., in many cases, coercive sex within marriage is not considered rape (Appendix 3) [1, 73].

Educational tools, such as the IPPF newsletter *¡Basta!,* offer sample screening tools, guidelines for creating referral networks, ideas on how to address violence against women without additional funding, and checklists for managing the integration of violence issues into regular health services. UNICEF has developed working notes on questions to be answered regarding violence in relation to pregnancy and abortion and other resources are available via the Internet (Appendix 4).

Attitudinal training combined with provision of facts on violence against women has been successful with staff of a general hospital and community center medical clinics in Mexico [250]. The workshops increased their knowledge on the subject and had a qualitative impact on their medical practice. In Honduras, the family planning association ASHONPLAFA has incorporated a gender perspective into staff training. Exercises help staff reflect on the advantages and disadvantages of being female or male in their cultural context and list factors that may affect their clients' decisions regarding contraceptive use, including fear of domestic violence and the influence of or coercion by spouses [251].

> ***"As medical professionals, we shall advocate and work towards increasing awareness and recognition among all health personnel, about acts of violence against women and children and to take appropriate, preventive, curative, rehabilitative medico-legal action"*** - The Kathmandu Commitment on Ending Violence against Women and Girls in South Asia [215]

After hospital staff in Kenya were trained in women-centered treatment for the complications of incomplete abortions, the percentage of patients who suggested that staff attitudes needed to be changed fell from 25% to 10%. One training participant remarked: "[the training] has made me change and have a good attitude towards patients who have procured an abortion whether induced or not. They all need love and care" [252]. A video filmed in Zambia, *Put Yourself in Her Shoes: Family Planning Counseling to Prevent Repeat Abortion,* addresses negative provider attitudes by showing how a maternity ward nurse re-examines her attitudes in dealing with four postabortion care patients [170].

Where abortion is permitted by law in cases of rape and incest, health systems need to ensure that sufficient numbers of staff are trained and available to offer the procedure without the punitive attitudes and systematic actions that constitute institutional violence. Such capacity building is taking place in a number of countries [247, 253]. In Mexico City, the Ministry of Health and a group of NGOs are collaborating to improve the quality of legal abortion and other services for rape survivors. NGOs and the health system in Brazil have trained health professionals in outpatient treatment and

postabortion counseling; there are now 13 public hospitals in seven cities with protocols to offer high-quality legal induced abortion services. To cope with a lack of doctors in rural areas, midwives in South Africa are being trained and equipped to provide legal abortion services [254].

During training on violence, special attention should be given to postabortion contraceptive counseling. This type of counseling should identify the causes of unwanted pregnancies including violence or the fear of violence. If an abortion has resulted from lack of contraceptive use because a woman fears abuse from her partner, it can be useful to discuss with her an option that is 'invisible' to him (e.g., implants or injections). When a miscarriage has been caused by physical violence and a woman continues living in the situation of abuse, she must be informed about the potential risks of various contraceptive methods. For example, an IUD may be inappropriate because there is a risk of uterine perforation if the woman suffers blows to the abdomen [255]. In both cases it is necessary to advise women that only condoms will protect them against HIV/STI infection, while acknowledging that this option may be difficult for women with abusive partners.

The results of such programs for addressing violence during pregnancy and abortion care should be documented and widely shared. Useful indicators would include numbers of women receiving violence screening at different health services, numbers of referrals made for psychological, legal and other types of help, and reductions in the number of spontaneous abortions.

6.4.2. The community and individual levels

➢ ***Education for youth on violence and its consequences***

To achieve long-term change in social norms that condone violence against women, it is necessary to educate young women and young men on gender issues, violence and its consequences. School-based and other youth programs can contribute to changes in these norms.

The Canadian group Men for Change developed a tool called *Healthy Relationships - a violence prevention curriculum*; which has been used in schools, youth centers, juvenile detention centers, women's centers, battered women's shelters, conflict resolution centers and community health centers. The study plan enables adolescents to practice behaviors that can prevent violence such as controlling anger, expressing emotions in a healthy way and resisting negative peer pressure. The first evaluations showed that the young men who participated in the program more frequently opposed sexual violence [256, 257]. CORIAC, in Mexico, focused its 2000-2001 annual campaign on gender

violence towards young men aged 13-18 years, including research on young men's perceptions of violence [258]. A group of male film-makers in South Asia worked on a series of videos on alternative models of masculinity for use in schools, while in Bangladesh a UNICEF project collected profiles of men active in campaigns against violence against women and girls to orient discussions with youth [214].

➢ ***Information and education on women's rights***

Women who have been raped must be informed about their rights to emergency contraception, HIV/STI testing and treatment, and abortion; at the least, police stations, social services, hospitals, clinics and NGOs should have literature available on telephone hotlines and organizations that can provide assistance.

The Musasa Project in Zimbabwe developed a comprehensive manual for persons and organizations that wish to offer assistance to women and children who have suffered sexual assault and domestic abuse. It covers legal and medical regulations, counseling, and guidelines for social action, as well as examples of information materials that can be given to women to inform them of their rights (including emergency contraception) [259].

In Mexico, a consortium of NGOs and the Mexico City Assembly's Health and Social Welfare Commission united to produce and distribute a leaflet on emergency contraception and legal abortion for rape victims [260]. The text states:

- "Emergency contraception: is a contraceptive method that prevents pregnancy during the first three days after a rape. It is 98% effective.
- Article 333 of the Mexico City Penal Code: Abortion is not punishable [...] when pregnancy results from rape."

About 113,000 copies of the leaflet were distributed in late 1999 via health institutions, agencies involved in care for crime victims, NGOs, governmental agencies, supermarket chains, conferences and the mass media. Radio ads were also broadcast. In addition, Ipas-Mexico and the Mexican Safe Motherhood Committee produced two compact discs for radio broadcasts and presentation in health center waiting rooms. One, the result of a competition for young people, features four messages on preventing unwanted pregnancy, including emergency contraception. The second presents the message that pregnancy does not offer protection against domestic abuse and that women have a right to legal, medical and psychological assistance.

In South Africa, the Rape Crisis Cape Town makes information on handling rape available through their website on the Internet, advising rape victims that:

- "If you are afraid of falling pregnant, you can ask the district surgeon to give you the 'morning after pill'.

- "If you do fall pregnant as a result of being raped, you may choose to have an abortion. If you decide to do this it is vital that it be done as soon as possible, it is best to do this within the first three months. After that it is a lot more difficult to get the abortion, as it becomes much more dangerous, after six months it is unlikely that you will get an abortion unless your life is in danger from being pregnant" [261].

> ***"As educators, we shall advocate and work towards education for equality, non-violence and peace, support research and training on gender violence, legal literacy, develop gender sensitive curriculum and pedagogical training"*** - The Kathmandu Commitment on Ending Violence against Women and Girls in South Asia [215]

➢ ***Comprehensive care for abused women***

Even when women know and exercise their rights, cases of abuse will continue to occur. To address their multiple needs in such circumstances, there is a growing trend to establish rape crisis and battered women's shelters. They work best when a multisectoral approach is used that combines the expertise and resources of both governmental and non-governmental agencies.

In Nuevo León, Mexico, one of the countries' four shelters for battered women and their children works with a multisectoral committee sponsored by the government. A coordinated protocol for interagency referrals for victims of abuse enables women in need to reach the shelter; the protocol also ensures that women receive psychological, legal and medical care (including emergency contraception, abortion and postabortion care).

An important component of the assistance provided to women who are the victims of ongoing violence is the formulation of safety action plans [1]. Such plans, taking into account an individual woman's specific circumstances, can help her devise methods to react quickly to incidents of abuse and to seek help. Elements of such plans can include identifying neighbors who are willing to offer assistance, knowing the addresses and contact information of agencies that can provide emergency assistance (e.g., emergency contraception, shelter) and keeping a bag packed with money, clothes, and important documents in case a woman needs to leave the home quickly. Research in the USA assessed the impact of such interventions among prenatal clinic attenders who reported abuse in the year before or during their pregnancy; participation in three educational referral sessions led to an increase in the adoption of "safety behaviors" [99].

7. Suggestions for sectoral action

The previous chapter provided indications for action to be carried out at different levels of society. Agencies and organizations will only take such actions, however, when individuals in various sectors assume personal responsibility for seeing that they are achieved. The following summary for individual actors contains suggestions that may seem repetitive, but this highlights the fact that collaboration across sectors is essential.

7.1. Actions for governmental policy-makers

- Sign and ratify international treaties that provide a basis for addressing the problem of violence in relation to pregnancy and abortion
- Incorporate such treaties into the national legal system
- Include the issue of violence linked to pregnancy and abortion in reports to international treaty monitoring bodies
- Revise national and local laws and regulations so that violence related to pregnancy and abortion is addressed adequately and appropriately from a gender-based and human rights perspective
- Introduce new national and local laws and regulations to address the factors that contribute to the problem (e.g., expanding definitions of violence to include marital rape and domestic abuse, provision of legal assistance and health-care provision that includes counseling, emergency contraception, treatment of HIV/STIs, abortion and postabortion care)
- Promote and support multisectoral interventions to address violence against women
- Provide financial and human resources support for services that address the problem of violence against women, particularly when it is linked to pregnancy and abortion

7.2. Actions for researchers

- Promote and carry out research on violence related to pregnancy and abortion
- Promote and carry out operations research to assess the outcome and impact of interventions that address the problem
- Ensure that all research on violence linked to pregnancy and abortion conforms to ethical standards
- Provide research data to governments and NGOs for inclusion in reports to international treaty monitoring bodies and national human rights commissions
- Widely disseminate research findings as a means of contributing to the recognition of violence related to pregnancy and abortion as a public health problem and violation of human rights (conferences, publications, the Internet)

7.3. Actions for judicial, legal and law enforcement personnel

- Promote and implement education on international, national and local laws and regulations related to violence and its consequences for women
- Promote and implement attitudinal and values training to promote gender-sensitive treatment of women who are survivors of violence
- Promote and implement specialized legal services to assist women who are survivors of violence
- Develop protocols for the ethical provision of services to abused women
- Promote and implement collaboration with health facilities, social welfare services and NGOs that serve female survivors of violence
- Promote legal literacy education, including the development and dissemination of educational materials, regarding women's rights in cases of violence, in particular when it is linked to pregnancy and abortion
- Share best practices related to interventions regarding violence against women (meetings, conferences, publications, the Internet)

7.4. Actions for health system personnel

- Formulate and promote policy guidelines related to violence, pregnancy and abortion through international and national professional associations (conferences, publications, the Internet)
- Formulate and implement protocols for addressing violence in relation to pregnancy and abortion that include the provision of counseling, emergency contraception, treatment of HIV/STIs, abortion and postabortion care)
- Promote and implement education on relevant international, national and local laws and regulations
- Promote and implement attitudinal and values training to promote gender-sensitive treatment of women who are survivors of violence
- Promote and implement training on the use of violence protocols and gender-sensitive care for survivors of violence
- Promote and implement collaboration with the legal, law enforcement and social welfare sectors as well as with NGOs that serve female survivors of violence
- Assist individual women in situations of ongoing abuse in the preparation of safety action plans
- Share best practices related to interventions regarding violence against women (meetings, conferences, publications, the Internet)

7.5. Actions for civil society and community members

- Promote the ratification of relevant international treaties
- Provide information on violence related to pregnancy and abortion for official and shadow reports to international treaty monitoring bodies
- Provide individual women with a "voice" through opportunities to gain public recognition of the problems they suffer when violence is related to pregnancy and abortion (tribunals, publications)
- Collaborate with UN agencies, governments, NGOs, community-based organizations and the media to raise public awareness of the problem and advocate for appropriate measures (campaigns, meetings, public events including the dissemination of policy statements and petitions, the Internet)
- Collaborate in the development, dissemination and use of training courses and educational materials for the judicial, legal, law enforcement and health sectors regarding gender and human rights aspects of violence linked to pregnancy and abortion
- Develop community interventions that work towards changing gender-biased norms that tolerate and condone violence against women (education of young people, campaigns, promotion and recognition of positive male role models)
- Develop interventions that promote behavioral change in order to reduce the incidence and prevalence of violence against women (capacity and skills-building)
- Collaborate with legal system professionals to promote legal literacy education, including the development and dissemination of educational materials, regarding women's rights in cases of violence, in particular when it is linked to pregnancy and abortion
- Develop community interventions to assist women who suffer incidents of violence
- Share best practices related to interventions regarding violence against women (meetings, conferences, publications, the Internet)

CONCLUSION

The literature reviewed for this monograph indicates that awareness of violence against women as a public health problem is increasing. Nevertheless, there are no indications that the overall prevalence of such violence is decreasing. Neither is there sufficient recognition of the fact that when women are subjected to violence in association with pregnancy, abortion and abortion-related care, their rights are doubly violated - their integrity, security and lives are endangered, while their sexual and reproductive rights are negated.

When women are psychologically and physically abused, they are placed into circumstances which make it difficult for them to use contraceptives; their right to choose whether and when to have children through voluntary, non-coerced decisions is violated. When an adolescent or adult woman becomes the victim of incest or rape, not only is her right to bodily integrity and security violated, she once again faces the prospect of unwanted and forced pregnancy.

Once women have become pregnant as a result of violence, they may face further abuse. For considerable numbers of women living in situations of ongoing abuse, pregnancy offers no protection against such violence; indeed, for some women, pregnancy is a time when physical abuse begins, intensifies or worsens in gravity. In some societies, when pregnancy occurs outside marriage, women face violence as well, both psychological and physical, leading in extreme cases to death. Pregnant women who wish to carry a pregnancy to term may be coerced into having abortions, either through direct pressure and abuse on the part of partners, family members or health-care providers or through pressures exerted by social norms that favor the birth of sons over daughters. Conversely, when other pregnant women wish to prevent or terminate an unwanted pregnancy through the options of emergency contraception and abortion, the possibility of violence again arises, this time at the institutional level. They may be denied their rights to contraceptive use and abortion permitted by law and face abuse when seeking care.

The ways in which violence may be related to pregnancy and abortion are therefore complex. This complexity does not mean the problem cannot be addressed, however. Research on the epidemiological aspects of the problem should be intensified, along with studies on the effects of such violence on women's individual lives. Concerted action can be based on the premise that every woman must be assured her rights to protection from violence and freedom to make reproductive decisions freely and voluntarily. Governments, different social sectors, research institutions, civil society organizations and communities must collaborate to develop multisectoral approaches so

that consistent policies are implemented and women see continuity in violence prevention efforts and interventions. Such measures do require commitment to dealing with two subjects that are still surrounded by taboos, prejudice and controversy – violence against women and abortion. But the benefits for women's health and lives – as well as for their families and communities – warrant such commitment.

Appendix 1: Human rights instrument citations

It can be useful for those working on violence in relation to pregnancy and abortion to be aware of the way in which human rights instruments - treaties and consensus statements from international UN-sponsored conferences - can be applied to the issue. Pertinent citations from a number of these instruments are given below: they may be cited in research reports, policy documents, presentations, training courses and educational materials.

Defining violence against women as a violation of human rights

- **General Comment 28, Human Rights Committee:** "Women are particularly vulnerable in times of internal or international armed conflicts. States parties should inform the Committee of all measures taken during these situations to protect women from rape, abduction and other forms of gender based violence."
- **Article 19.1, Convention on the Rights of the Child:** "States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."
- **Paragraph 114, Beijing Platform for Action:** "...acts of violence against women include violation of the human rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery and forced pregnancy."
- **Paragraph 96, Beijing Platform for Action:** "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."
- **General Comment 28, Human Rights Committee:** "Inequality in the enjoyment of rights by women throughout the world is deeply embedded in tradition, history and culture, including religious attitudes. The subordinate role of women in some countries is illustrated by the high incidence of pre-natal sex selection and abortion of female fetuses. States parties should ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's right to equality before the law and to equal enjoyment of all Covenant rights... The States parties should also provide the Committee information on measures to prevent forced abortion or forced sterilization... The information provided by States parties on all these issues should include measures of protection, including legal remedies, for women whose rights under article 7 have been violated."

- **Paragraph 115, Beijing Platform for Action**: "Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection"

Data collection and research

- **General Recommendation 24, CEDAW Committee**: "States parties are in the best position to report on the most critical health issues affecting women in that country. Therefore, in order to enable the Committee to evaluate whether *measures to eliminate discrimination against women in the field of health care* are *appropriate*, States parties must report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost-effectiveness of preventive and curative measures. Reports to the Committee must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture."
- **Paragraph 129, Beijing Platform for Action**: "(a) Promote research, collect data and compile statistics, especially concerning domestic violence relating to the prevalence of different forms of violence against women, and encourage research into the causes, nature, seriousness and consequences of violence against women and the effectiveness of measures implemented to prevent and redress violence against women; (b) Disseminate findings of research and studies widely; (c) Support and initiate research on the impact of violence, such as rape, on women and girl children, and make the resulting information and statistics available to the public"

Legal and regulatory reform

- **General Comment 28, Human Rights Committee**: "States parties should give information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undertake life-threatening clandestine abortions....To assess compliance with article 7 of the Covenant, as well as with article 24, which mandates special protection for children, the Committee needs to be provided information on national laws and practice with regard to domestic and other types of violence against women, including rape. It also needs to know whether the State party gives access to safe abortion to women who have become pregnant as a result of rape....The information provided by States parties on all these issues should include measures of protection, including legal remedies, for women whose rights under article 7 have been violated."
- **General Recommendation 24, CEDAW Committee**: "The obligation to *respect rights* requires States parties to refrain from obstructing action taken by women in pursuit of their health goals...Other barriers to women's access to appropriate health care

include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures."

- **Paragraph 124g, Beijing Platform for Action:** "develop strategies to ensure that the revictimization of women victims of violence does not occur because of gender-insensitive laws or judicial or enforcement practices"

Reorientation of health and legal services

- **General Recommendation 24, CEDAW Committee:** "Since gender-based violence is a critical health issue for women, States parties should ensure: (a) The enactment and effective enforcement of laws and the formulation of policies, including health care protocols and hospital procedures to address violence against women and abuse of girl children and the provision of appropriate health services"
- **Article 24.1, Convention on the Rights of the Child:** "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."
- **Article 39, Convention on the Rights of the Child:** "States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child."
- **General Comment 28, Human Rights Committee:** "Another area where States may fail to respect women's privacy relates to their reproductive functions, for example...where States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion. In these instances, other rights in the Covenant, such as those of articles 6 and 7, might also be at stake....States parties should report on any laws and public or private actions that interfere with the equal enjoyment by women of the rights under article 17, and on the measures taken to eliminate such interference and to afford women protection from any such interference."
- **General Recommendation 24, CEDAW:** "While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for...incomplete abortion and in cases where they have suffered sexual or physical violence."

Training and capacity-building

- **General Recommendation 24, CEDAW Committee:** "Since gender-based violence is a critical health issue for women, States parties should ensure:...(b) Gender-sensitive

training to enable health care workers to detect and manage the health consequences of gender-based violence...States parties should also, in particular:...(f) Ensure that the training curricula of health workers includes comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence"

- **Paragraph 124n, Beijing Platform for Action**: "Create, improve or develop as appropriate, and fund the training programmes for judicial, legal, medical, social, educational and police and immigrant personnel, in order to avoid the abuse of power leading to violence against women and sensitize such personnel to the nature of gender-based acts and threats of violence so that fair treatment of female victims can be assured"
- **Paragraph 106g, Beijing Platform for Action**: Actions to be taken by Governments, in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions:...develop supportive programmes and train primary health workers to recognize and care for girls and women of all ages who have experienced any form of violence especially domestic violence, sexual abuse or other abuse resulting from armed and non-armed conflict

Provision of relevant services

- **Paragraph 125h, Beijing Platform for Action**: "Disseminate information on the assistance available to women and families who are victims of violence"
- **General Recommendation 24, CEDAW Committee**: "The obligation to *respect rights* requires States parties to refrain from obstructing action taken by women in pursuit of their health goals. States parties should report on how public and private health care providers meet their duties to respect women's rights to have access to health care. For example, States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women."
- **General Recommendation 24, CEDAW Committee**: "Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."
- **Paragraph 63(iii), Five-year review of the ICPD Programme of Action**: "In circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take measures to ensure that such abortion is safe and accessible"

Action to change norms regarding gender bias and violence

- **Paragraph 125g, Beijing Platform for Action:** "Organize and fund information campaigns and educational and training programmes in order to sensitize girls and boys and women and men to the personal and social detrimental effects of violence in the family, community and society; teach them how to communicate without violence and promote training for victims and potential victims so that they can protect themselves and others against such violence"
- **Paragraph 107a, Beijing Platform for Action:** "Give priority to both formal and informal educational programmes that support and enable women to develop self-esteem, acquire knowledge, make decisions on and take responsibility for their own health, achieve mutual respect in matters concerning sexuality and fertility and educate men regarding the importance of women's health and well-being, placing special focus on programmes for both men and women that emphasize the elimination of harmful attitudes and practices, including...son preference (which results in female infanticide and prenatal sex selection)...violence against women, sexual exploitation, sexual abuse, which at times is conducive to infection with HIV/AIDS and other sexually transmitted diseases...recognizing that some of these practices can be violations of human rights and ethical medical principles"

Information sources

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Appendix 2: Social tolerance of violence against women

Persons in positions of authority may reflect gender biases against women that are prevalent in their societies. When they make public pronouncements expressing such prejudices, they reinforce the norms that permit others to tolerate or even condone violence against women. And when they occupy positions involved in policy-making, legislation and law enforcement, their attitudes sustain an environment in which physical and sexual abuse continue, endangering women's health and lives in connection with pregnancy and abortion. It is sometimes difficult for people to believe that such prejudice exists at high levels; some examples from around the world:

- "Scriptures must be fulfilled. Violence against women is a sign of the end times, which we can't do anything about." - Nairobi pastor citing 2 Timothy 3: 1-5 [262]
- "Wife beating is an accepted custom...we are wasting our time debating the issue." - Papua New Guinea member of Parliament during a debate on wife battering [29]
- "'First I see the woman alone, calm her down, offer her tea and ask her what the problem is. Then I call in the husband and hit him, which is very humiliating for him ... to be hit by a woman. I ask him if he mistreats his wife. He doesn't have the courage to lie to me by then. Usually, it is a lie and they (the husbands) tell me what the real story is. Then I turn to the woman and ask her if he is telling the truth....usually she says yes, he doesn't mistreat me, I was lying ...they (the woman) are usually after some money or something like that. You women's organizations don't realize that women are often very *chalak* (cunning) also'" - Senior Head Officer of a Women's Police Station in Pakistan describing how she handles domestic abuse cases [263]
- "If you are married...you must fulfil his needs. That is the duty of a wife" and "Men have a higher sex drive than women. If a woman wants to refuse to have sex with her husband, why did she marry him?" - a counselor and senior colleague at one of Sri Lanka's two women's shelters [54]
- Women should wear *purdah* to ensure that innocent men do not get unnecessarily excited by women's bodies and are not unconsciously forced into becoming rapists. If women do not want to fall prey to such men, they should take the necessary precautions instead of forever blaming men." - Malaysian member of Parliament during debate on reform of rape laws [29]
- "Women's faces are a source of corruption for men who are not related to them" - Afghanistan Attorney General's Office, explaining why windows should be covered so that women cannot be seen from outside [264]

- "...through questions related to her sexual life it is possible to tell if the woman is responsible for the attack, because in most cases, it is the woman who provokes the aggression" - agent from the Mexico City Attorney General's Office [67]
- "Are you a virgin? If you are not a virgin, why do you complain? This is normal." - assistant to public prosecutor in Peru answering a woman who reported sexual abuse by police officers while in custody [29]
- "When women are truly raped, the juices don't flow, the body functions don't work and they don't get pregnant." US North Carolina state representative, Henry Aldridge, on denying women abortion rights for rape
- "The police and courts treat rape as an everyday incident resulting from the provocative behaviour of women. The preparatory and judicial proceedings are gender biased and the women victims are recurrently treated as if they were the accused." - report by The Women's Rights Center in Poland [16]

Appendix 3: Questions to guide health workers in relation to violence, pregnancy and abortion

Some authors recommend that screening questions be posed to women both orally and through written questionnaires, noting that it is especially important to ask about 'forced sex' in addition to rape because many women will not characterize forced sex within marriage as rape [265].

Sample screening questions for violence

- Because violence is so common in women's lives, I now ask every woman I see about it. Have you ever been hit or physically punished by your partner?
- Has your partner ever physically forced you to have sex when you don't want to?
- Has anyone else physically forced you to have sex?
- You mentioned that your partner drinks alcohol (or becomes very angry). Does he ever become violent?
- Have you been hurt during your pregnancy in some way?
- Sometimes when I see a woman with an injury like yours it is because somebody hit her. Did this happen to you?
- Sometimes when people come to the clinic with symptoms like yours we find that there may be trouble at home. Has someone been hurting you?

Sample questions for taking action on violence in relation to pregnancy and abortion [266]

- Are local studies available concerning physical and sexual violence during pregnancy? What do they suggest? What to do?
- Do health staff already screen for physical and sexual violence in pregnancy?
- What are the conditions under which this is most likely to be discussed?
- What models and resources are needed for physicians or other health staff to begin screening and counseling?
- Are there any programs for men who are batterers for referral purposes?
- Are there any programs for women who are battered for referral purposes?
- Could other causes of maternal mortality mask gender-based violence, e.g., when pregnant women die without receiving medical care?
- Are girls and women terminating pregnancies because they were raped or suffered incest?
- Are girls and women terminating pregnancies because they fear psychological or physical violence?
- Could health staff help prevent the circumstances that led to unwanted pregnancies?

Appendix 4: Resources available via the Internet

- *12 Teaching scenarios: responding to rape, domestic violence, and child abuse.* Women's Justice Center. http://www.justicewomen.com/help_teach.html (accessed 20 September 2001)
- *SIVIC - a site specializing in the treatment of domestic violence for health sector professionals.* http://www.sivic.org/uk/site-uk/index.html (accessed 20 September 2001)
- *Addressing intimate partner violence in primary care practice.* Leigh Kimberg. Medscape Women's Health, 2001, 6(1) http://womenshealth.medscape.com/Medscap...v06.n01/wh7556.kimb/pnt-wh7556.kimb.html (accessed 21 September 2001)
- *Global violence prevention - an interactive website designed to teach professionals about violence prevention and intervention.* Minnesota Center against Violence and Abuse. http://www.globalvp.umn.edu/ (accessed 20 September 2001)
- *Basta! IPPF-WHR newsletter on addressing violence.* http://www.ippfwhr.org/whatwedo/basta.html#latest (accessed 24 October 2001)
- *Violence issues: an interdisciplinary curriculum guide for health professionals.* Lee Ann Hoff. National Clearinghouse on Family Violence Canada. http://www.hc-sc.gc.ca/hppb/familyviolence/html/violencei/1violencei.htm (accessed 24 October 2001)
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- *Methodologies to measure the gender dimensions of crime and violence.* Elizabeth Shrader, Washington, D.C., July 2001. http://econ.worldbank.org/files/2327_wps2648.pdf (accessed 27 September 2001)
- *Slide show from the US Centers for Disease Control (CDC) on intimate partner violence during pregnancy.* http://www.cdc.gov/nccdphp/drh/violence/ipvdp.htm (accessed 21 September 2001)

- *Gender-based violence: an impediment to sexual and reproductive health. The Women's Advocacy Session at IPPF Members' Assembly, Prague, The Czech Republic, 29th of November 1998.* IPPF. http://www.ippf.org/resource/gbv/ma98/index.htm (accessed 20 September 2001)
- *Healthy Relationships violence prevention curriculum for adolescents.* Men for Change. http://www.chebucto.ns.ca/CommunitySupport/Men4Change/m4ccuric.html (accessed 20 September 2001)
- *When Love Hurts - A Guide for Girls on Love, Respect and Abuse in Relationships.* Domestic Violence & Incest Resource Centre. http://www.dvirc.org.au/whenlove/ (accessed 20 September 2001)
- *Communities Against Violence Network.* http://www.asksam.com/cavnet/ (accessed 20 September 2001)
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- *Manifesto of Latin American men against violence towards women.* UNDP. http://www.undp.org/rblac/gender/mens.htm (accessed 20 September 2001)
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