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VIOLENCE AGAINST WOMEN AND GIRLS: ANALYSIS AND PROPOSALS FROM THE PERSPECTIVE OF PUBLIC HEALTH

Violence against women and girls is a public health problem that is receiving increasing recognition in the health sector. For many reasons this problem has remained hidden, which has prevented full awareness of its true magnitude. This document seeks to shed light on some of the difficulties deriving from the conceptions and health practices inherent in the current biomedical model. It also examines difficulties arising from the ideas about affectivity and private and family life that are commonly held by health workers and even by women who are the victims of, or are vulnerable to, abuse.

Despite the social invisibility of this problem, the international agencies of the United Nations system, academic and women's nongovernmental organizations, and certain public sectors are studying the harmful physical and emotional impact of violence on women and girls and their self-esteem, as well as on the family group, on other areas related to women, and on women's participation in development.

Violence against women and girls in its various manifestations results in a kind of social relationship that inhibits the full human development of women and girls, since it is an extreme form of denial of their rights to life, liberty, and human integrity and dignity.

Following an examination of the problem, this document presents for consideration by the Subcommittee a proposal for strategies and lines of action designed to give the issue of violence against women a central place in the agendas of the health sector. The aim is to mobilize efforts to prevent the problem; offer treatment and rehabilitation for survivors of violence; provide assistance for women, girls, and families who are vulnerable or at risk; and seek social rehabilitation for the perpetrators of violence so as to reintegrate them as peaceful members of society

VIOLENCE AGAINST WOMEN AND GIRLS: ANALYSIS AND PROPOSALS FROM THE PERSPECTIVE OF PUBLIC HEALTH

I. BACKGROUND

Women's organizations and United Nations agencies have in recent decades called attention to the many problems created by the various forms of violence perpetrated against women and girls.

In spite of the progress achieved to date in incorporating women into development, numerous forms of discrimination and active denial of the fundamental human rights of women persist.

Violence against women and girls is considered an extreme form of denial of rights and a reflection of the profound inequalities in human relationships.

The problem of violence against women and girls, despite the efforts that have been made to bring it to the fore on the political agendas of governments, continues to be neglected by health, education, and even law enforcement authorities.

This situation is exacerbated by concepts, practices, and prejudices that disregard the seriousness of the problem and legitimize violence against women and girls. Attitudes toward violence range from considering it a private matter to tolerating it as a right or a means of discipline exercised by adult males in the family, in the workplace, at school, etc.

In addition, the centralized approach to the treatment of injury makes it difficult to perceive violence as a phenomenon that affects human relationships at the most basic level--the family and couples--and eventually leads to impairment of the physical, mental, and social health of individuals and groups.

Estimates by nongovernmental organizations and the United Nations specialized agencies indicate that there is significant underregistration of the violent episodes that undermine the quality of life of women and girls.

Nevertheless, the studies that have been carried out, mainly by nongovernmental and human rights organizations within the United Nations system, clearly reveal the gravity of the situation.

These reports point out the qualitative change that takes place in the nature of human relationships between men and women when violence becomes instilled as a basic form

of social interaction and an expedient means of resolving conflicts and legitimizing power and domination in a social order characterized by the persistence of a variety of forms of discrimination and subordination of women.

The issue has been made more manifest recently by the first Central American seminar on violence against women as a public health problem and by studies carried out in the last decade on the basis of the meager police and hospital emergency room records, as well as the research conducted among groups of women in various countries in the Region. These efforts have all underscored the magnitude of the problem and its impact on the family and social relations, as well as the physical and emotional health, of those touched by violence.

II. CURRENT SITUATION

The studies that have been carried out basically report on the violence perpetrated against women in the family context, particularly violence against children.

These various studies reached a number of the same conclusions, including the following:

1. Between 50% and 80% of women report having been subjected to some form of abuse (violence, incest, insults, beatings, etc.).

2. In 70% to 90% of the cases the abuse of women is perpetrated by their mates or another male living in the same household.

3. Women aged 20-39 are at the greatest risk of abuse in the home, most commonly spousal abuse.

4. Abuse of women and wives in the home is frequently associated with child abuse. Abuse is cited as one of the most frequent causes of divorce.

5. It has been shown that both aggressors and victims have family histories of violence; however, violence should be understood not as an inherited trait but as a socially learned and transmitted behavior.

6. Violence is not a random or isolated occurrence in the lives of women and girls; rather, conjugal and sexual abuse is a systematized form of relationship.

7. Research reveals that reports received by forensic medicine offices in Central American countries are made primarily by children who have been sexually abused.

Furthermore, it has been shown that in more than 70% of the cases the victimizers were family members or known adult males, frequently fathers. Although sexual abuse of boys also occurs, nearly 80% of the cases involve girls. The age at which girls are most vulnerable to sexual abuse was found to be between 11 and 16, while abused boys whose are most frequently between the ages of 5 and 9, and their abusers are usually persons unknown to them.

8. Rapes of women and girls in more than 50% of all cases are perpetrated by family members or males known in the homes of the victims. The strong guilt feelings of the victims tend to deter them from seeking legal, psychosocial, and medical help, and therefore most of them do not receive comprehensive care.

9. Some studies have found an association between adolescent pregnancy, and in particular unwanted pregnancy, and sexual abuse.

10. Between 45% and 60% of all female victims of homicide are slain in family surroundings, and very frequently the killer is the spouse.

11. The aggressor is not usually a mental patient, a deviant, or an unknown person; more frequently than usually imagined it is someone with emotional ties to the victim (boy friend, husband, father, relative).

12. Most violations of the physical, mental, and social integrity of women are not considered violations of human rights or life-threatening crimes; they consequently remain unpunished and adequate medical and psychological care and legal assistance are not provided to the victims.

Violence is a daily occurrence in the emotional and family lives of women and girls, and, as a form of denial of their rights, it is associated with the subordinate position they occupy in the social structure of power, both within the family and in the outside world, at school, at work, and in the health system.

The situation is extremely complex, especially since research reveals that the family is the social setting in which violence against the weak is primarily practiced. The same opinion is held by those who study child abuse.

Although it is recognized that abuse has multiple causes, several authors coincide in affirming that violence against women and girls is aimed at perpetuating relations of domination and discrimination and upholding male privilege. This situation is associated

with the glorification of males and the alienation of females, and with a complex system of values, practices, and symbols.

Violence against women and girls pervades all social spheres: the couple, the family, school, work, and the health system. Simply stated, it is everywhere. Furthermore, the forms of violence are multiple (political, sexual, familial, racial, economic), and each warrants specific treatment and study and the adoption of different strategies adapted to particular situations and to the sectors and institutions that are involved in preventing and dealing with violence. For example, sexual harassment in the workplace requires the intervention of employers, employees' associations, and union organizations; and sexual blackmail at school requires the active commitment of school authorities, students, and parent-teacher associations. In the health system, the approach taken must be two-pronged: one concerned with the system itself and health care providers, including women providers, who reproduce practices that discriminate against women; and the other, with the users of health services and the members of their families.

III. THE HEALTH SECTOR AND VIOLENCE AGAINST WOMEN AND GIRLS

A comprehensive concept of health takes into account the complexity of various biopsychosocial factors that have an impact on the quality of life of human beings. Such a concept is not only curative--that is, centered on the treatment of disease--but also aims at intervening in the social relations that human beings establish between themselves and with the environment, which have an impact on health and the quality of life.

In this context, in order to be able to provide adequate and timely responses, the health sector must consider that violence against women and girls not only does bodily harm, but also affects their emotional and social lives.

The impact of violence on health and life, as a form of denial of rights, is multiple in nature and is not limited to merely to the female body; rather, it is pervasive and impairs both affectivity and human relations. Above all, it is a violation of the human right to health and of the right of pursue full and dignified personal development.

Investigators have pointed out that violence against women and girls diminishes the integrity of the female personality and undermines women's self-esteem, autonomy, and self-determination, particularly as regards their bodies, their sexuality, and their affectivity. It is thus an assault on their freedom and dignity as human beings.

Those who have studied the topic of women and development point out that it is also important to note that violence inhibits women's participation in decision-making, both in the family and in other areas of human endeavor, such as paid work, community activities, and social and political leadership, thereby marginalizing them and preventing them from participating more actively in the socioeconomic development of their local or regional communities and developing themselves as people with inherent rights.

The participation of women in activities outside the home often serves as a pretext for violence against women and a source of family conflict.

Following are some examples of the impact of violence on the health of the women:

1. Various physical injuries that threaten the physical, psychological, and social integrity of women and girls, causing them harm and even death. The killing of women by their spouses is often prefaced by a long-standing history of physical abuse.

2. Abused women have more abortions than women who have not suffered abuse. One of the "reasons" adduced for abuse by spouses is unwanted pregnancy.

3. Violence against women and girls endangers the family unit its stability, and its permanence as a group.

4. The psychological impact of violence damages women's self-esteem, diminishes their ability to act for themselves, and generates feelings of incompetence.

5. Attempted suicide is 12 times more frequent among abused women than among other women.

6. Abused women are at greater risk of using alcohol and other substances harmful for health.

7. Abused women are subject to depression and suffer from personality disorders and insecurities. Some investigators speak of abuse syndrome, traumatic abuse syndrome, and traumatic rape syndrome in women.

8. Abused women show great fear, anguish, and anxiety, which frequently paralyzes them, prevents them from acting in their own defense, and inhibits their self-determination.

9. Rape, sexual abuse, and sexual mistreatment prevent the exercise of free and healthy sexuality; they expose women to unwanted pregnancies and sexually transmitted diseases such as AIDS, and consequently impinge negatively on their sexual and reproductive health.

10. In many instances violence inhibits women's decisions to use contraceptive methods and their choice of how, when, and with whom to have or not have sexual relations, children, or affective relations--that is, it is an obstacle to women's freedom to make decisions concerning their sexual and affective life.

Characterization of the issue of violence against women requires multisectoral responses, inasmuch as violent acts are the outcome of a process of socialization practices, sexist values, and permissive laws; they are the harmful outcome of histories of violence that originate and develop in other areas of social life. The health sector, which is concerned with more than treating the injury, should intervene in order to prevent violence from affecting the quality of life of women and girls.

There is consensus both in the United Nations specialized agencies and in the nongovernmental organizations that violence against women and girls is a problem of a multidimensional nature--legal, ethical-moral, and health--that is, a problem that involves the rights and the human and socioeconomic development of more than half the earth's population and one that requires priority attention by health, education, and legislative authorities. Despite the international recommendations that have been made and the growing awareness among women of the magnitude of the problem, the issue of violence has still not been given a prominent place on the political agendas of governments.

Institutional responses have so far been limited and weak, both with regard to legal mechanisms and to the care and rehabilitation of the victims by the health sector, and this has been true even in programs designed to prevent family violence. Between 1988 and 1990, ISIS International conducted a study-survey of the programs that were in some way responding to the problem of violence against women in Latin America and the Caribbean. It found that 87 programs had been initiated by nongovernmental organizations, only 15 by government entities, 4 by academic institutions, and 3 by regional networks, for a total of 109.

The conclusion derived from this study is that institutional response has been insufficient, and there is a need for positive and decisive intervention to establish and/or reorient the health services so that they will be in a position to provide a comprehensive response to protect, care for, and rehabilitate the victims of violence.

IV. PROPOSED STRATEGIES AND LINES OF ACTION

This section presents several proposed lines of action for addressing the problem which might be considered by the countries, in addition to possible lines of technical cooperation for PAHO.

1. Preparation and Adoption by the Member Countries of the Pan American Health Organization of a Charter of Health Rights for the Women of the Americas

In keeping with the international legal instruments that call for the protection of women against abuse and other forms of discrimination, it is proposed to draw up a Charter of Health Rights for the Women of the Americas as a creative vehicle for giving effect to these instruments. Particular account would be taken of the Convention on the Elimination of all the Forms of Discrimination against Women, considered to be the Magna Carta of women's rights, and the Nairobi Forward-looking Strategies for the Advancement of Women. The recommendations of international agencies, despite the efforts made to disseminate them, still have only limited public circulation.

The proposed Charter is considered an educational medium that will enumerate the commitments to women made by the health sector and point out policy and program orientations that should be promoted by the sector in order to guarantee full exercise of the right to health by the women of the Americas. The aim is to convert the health services into instruments that will enable women to exercise their rights to health.

The Charter of Health Rights for the Women of the Americas should expressly set forth:

- The right of women to decide freely on matters that concern their own lives, their bodies, their emotional lives, their sexuality, and their health.

- The right to health education that promotes women's autonomy, self-determination, and self-care based on self-respect and reaffirmation of their rights.

- The right to comprehensive care geared to their specific needs, taking into account age, ethnicity, social class, place of origin, and sexual orientation.

- The right to receive dignified treatment in the health services that takes into account the particularities of their biological, psychological, and social histories and ensures respect for their intimacy and privacy.

- The right to freely chosen, safe motherhood.

- The right not to be discriminated against for exercising their sexuality and the right to have their reproductive choices respected.

- The right to have the processes associated with their biological condition, such as menstruation, pregnancy, delivery, the puerperium, menopause, and aging, approached as natural processes, not diseases.

- The right to adequate and sufficient information for the free, satisfying, responsible, and safe exercise of their sexuality, without this necessarily being linked to reproduction.

- The right to health services that provide comprehensive attention to the problems of women who are victims of abuse or at risk of abuse--that is, access to programs to prevent various forms of abuse and to provide care and rehabilitation.

Lines of action:

The countries might consider the following actions in the short and the medium term for development of primarily individual activities that respond to the particular situation of each country.

a) Advisory meetings with the specialized agencies and nongovernmental organizations concerned with the advancement of women and the promotion to women's rights to encourage such organizations to present their initiatives.

b) Formation of high-level, interdisciplinary commissions to guide national consultation processes.

c) Organization of national, regional, or local events on the health rights of women in which international instruments on nondiscrimination will be disseminated, with particular emphasis on the right to health as a substantive part of the right to life. From the health

perspective, this is one way of helping to ensure that the instruments are publicized and implemented by the sector.

d) Health sector educational plans that include the topic of women on their agendas, particularly with regard to their human rights, including the fundamental right to health.

e) Identification of mechanisms to allow broad participation by sectoral organizations and trade and workers' associations in the discussion on the proposed Charter of Health Rights for the Women of the Americas, with a view to raising awareness among them of the situation of the health rights of women.

2. Coordination and Harmonization of Intervention Policies and Programs

As already noted, the problems posed by violence against women are of a profoundly cultural nature, and accordingly do not fall solely within the competency of the health sector. Efforts to address these problems, led by the health sector, must be intersectoral, given the broad range of forms and places in which violence occurs. Large-scale community mobilization is required in order to promote the implementation of prevention policies, plans, and programs on the part of the State and civil society.

The communications media; social and family welfare institutions; political parties and organizations; scientific academic, and professional institutions; nongovernmental organizations; women's and human rights organizations; churches; and volunteer organizations in the area of health should coordinate and pool their efforts in order to augment their resources and respond more effectively to this problem.

Suggested Lines of Action for the Countries:

a) Encourage the various governmental agencies and the institutions of civil society to assess the situation of violence against women and girls in different social settings.

b) Disseminate information regarding the problem through the mass media and encourage academic and scientific institutions to present their research and recommendations on prevention, assistance, and rehabilitation.

c) Facilitate intersectoral meetings to obtain further knowledge of the problem of violence against women and girls and to move forward in adopting plans to commit the various social sectors.

d) Promote the establishment, under the leadership of the health sector, of national coordination offices for programs to support female victims of violence, in the public, nongovernmental, church, and private sectors in order to strengthen their resources and effectiveness by promoting legislative, educational, and health proposals. These mechanisms might be of an interinstitutional nature. Nongovernmental organizations should also be encouraged to participate in such efforts.

e) Introduce legal reforms, since the laws of the various countries are founded on patriarchal concepts that result in impunity of crimes committed against women and constitute inadequate legal responses to the problem.

f) Approach sexual harassment as a work-related problem and consider it a form of discrimination that must be resolved by workers' organizations, since it affects safety in the workplace. It is recommended that union organizations adopt a contractual clause under which employers commit themselves to ensuring that their employees understand that "sexual harassment is unacceptable behavior in the company" and to imposing sanctions on those who engage in any activity considered to constitute harassment. In addition, employers should be asked to agree to transfer the instigator of the harassment, not the victim, to a different work situation.

g) Seek a closer relationship between the health sector and the sector responsible for social and family well-being through family institutions and family welfare centers. In this connection, it is considered very important to question the traditional concept of family: child abuse may divert attention from the fact that the mother is also being abused. There may be a certain fixation on preserving the family unit at the expense of the equilibrium and integrity of women, thereby perpetuating their subordination in the family.

h) Establish ties between the health sector and the education sector in order to provide training for life that will promote the exercise of autonomy and self-determination, especially as regards the exercise of sexuality, and will help to destroy the myths and stereotypes about what is feminine and what is masculine, thereby making it possible to generate skills for the appropriate management of family conflicts.

i) Promote, through coordination of the efforts and resources of the health and education authorities, the formation of groups in primary and secondary schools to address the subject of human sexuality and the rights of women, emphasizing the health rights of women and encouraging open debate on matters such as rape, incest, physical abuse, and sexual harassment in school and in the family. These groups will promote respect for differences.

These actions are vital, since the early years are crucial in forming the adult personality. It is at this time that it is possible for children to be molded so that they become men and women capable of accepting each other and living together in mutual respect.

j) Likewise, as a contribution to undergraduate and graduate training, it is important to create university departments to deal with human ties from the perspective of power and its impact on health, taking into account gender-specific differences. In addition, the gender perspective should be promoted in the study of social issues and in reflection on matters pertaining to health and education.

3. Development of Health Service Models for Women and Girl Victims of Violence

a) The health organizations should increase their mental health care and education programs to promote the healthy exercise of sexuality. For this purpose there is an urgent need to expand professional psychological and social services.

b) Ties between the health sector and the legal sector should be established and consolidated with a view to providing immediate care for the victims of violence. There is an urgent need to link institutional legal services and forensic medicine offices with emergency health services in order to provide mutual feedback. In addition, legal aid services that provide assistance to women and girls who are the victims of violence or who are at risk of violence should be prepared to provide guidance and refer them to the appropriate health sector institutions.

c) Workers in the health sector should be informed as to how to interview and refer victims of violence. From the legal standpoint, health sector workers should be capable of directing victims of violence to other institutions that can provide assistance. Workers in the legal area should also be similarly trained.

d) Training programs should also be promoted for the health officials and providers who are responsible for the care of women, particularly at the local level.

e) Programs should be set up and educational strategies employed to rehabilitate victimizers and to teach men to control their aggressiveness. Rehabilitation programs are primarily aimed at abused women, but the aggressors should also be a focus of intervention. In this connection, a possible approach might be self-help groups for men designed to help them reassess male and female stereotypes.

f) The health services should do everything in their power to ensure that abused women receive information on the internal and external institutional resources available to assist them. Prevention measures should include public information and educational programs designed to promote women's autonomy, self-respect, and self-determination with regard to their lives, their bodies, their sexuality, and their emotional relationships.

g) The sector should promote the preparation of directories of governmental and nongovernmental health and legal resources that provide assistance to victims of abuse and disseminate them widely among the population seen by the services. In addition, there should be mass dissemination through the communications media, churches, community organizations, etc.

h) Both sectors should envisage shelters, 24-hour hot lines, (which could be attended by volunteer personnel, students performing social service, trained students, etc.), counseling services, rehabilitation of survivors, and support services for women and girls who are victims of violence and at risk of violence.

i) Efforts should be focused on characterizing high-risk situations, and due account should be taken, inter alia, of family history, the number of violent episodes, the use of psychoactive drugs, and the exercise of authority. The international organizations also recommend considering as potentially violent situations in which women are discriminated against by virtue of their ethnicity; their status as migrants, refugees, or displaced persons; pregnancy, age, disability, or poverty; or armed conflict or imprisonment.

j) The experience of organizations for the advancement of women must be put to good use. Health institutions have a limited capacity to respond to the problem of violence against women, with regard to both prevention and care, and therefore the practical and theoretical experience of the nongovernmental organizations should be used to the fullest extent. The strength of the nongovernmental organizations lies in their broad experience in training and education, both of women's groups and institutional sectors, in areas such as the training of monitors, legal procedures, self-help, research, and advisory services.

k) Legal assistance should be provided for abused women and girls in health centers and units in coordination with specialized police organizations and legal aid offices set up as a component of social service in university training programs. For this purpose training should be provided for the workers responsible for assisting women.

l) The establishment of epidemiological surveillance systems should permit timely detection of women and girls who have been abused or who are at risk of violence. Assaulted women may be admitted to the health services on an emergency basis in

extreme instances, but it should not be forgotten that most abused women will be detected in outpatient consultation. Accordingly, it is necessary to formulate questions and setting up monitoring systems that will make it possible to identify them so as to provide the necessary institutional assistance, both psychological and social.

The aim of recording and follow-up is to enhance the monitoring system; however, the collection of statistics to serve as a data base for research on the subject will make it possible to gain a more accurate picture of the problem, so that the findings can be disseminated among the population in order to increase awareness of the problem.

Epidemiological surveillance systems for abused women should design registries that not only record the type of injury involved, the time of the incident, and its history and frequency of occurrence, but also clearly identify the relationship between the victim to her aggressor. Although the surveillance system focuses on the victim, the focus of intervention should be the social relationships in which she is involved and that have enabled her victimization, so as to determine the appropriate areas for intervention.

m) Community participation is fundamental to the establishment of epidemiological surveillance systems within local health systems. Organizations for the advancement of women and other organizations in which women traditionally participate (mostly invisibly, as in parent-teacher associations, church organizations, the Red Cross, and volunteer organizations) can become essential elements in the process of providing support for abused women.

n) In local neighborhoods organized groups of women can set up networks for referral to local health systems, family councils, the police, or whatever other related institutions may exist. Women's institutions and organizations can also help to do away with the situation of official impunity that exists with regard to violence against women, and with the support of governmental institutions they can promote educational campaigns concerning the rights of women and children.

o) Self-help groups for women who have been assaulted, raped, or abused are forms of self-management in which women take matters into their own hands in confronting such violence and its origins. Group discussion of the isolated incidents experienced by each woman makes it possible to put them in a social context, thereby contributing to collective management of the problem.

Joint intervention programs to be carried out between the health sector and women's organizations would make it possible to promote participatory policies of greater scope and coverage and would sensitize the sector to alternative, gender-based proposals for the prevention of violence against women.

p) The health sector should promote community participation by women in creating and disseminating means for controlling and condemning abuse, with a view to dissuading or shaming aggressors and formulating community mechanisms to provide assistance to victims of violence and abuse.

4. Promotion of Research

a) Promote research on alternative methodologies for the care and protection of victims, in addition to developing prevention methodologies and designing programs to teach crisis intervention and methodologies for providing systematic support to victims of various kinds of violence.

b) Investigate new ways of interpreting the phenomenon of violence and its etiology, since the design of intervention policies is directly related to the study of causality, particularly as regards the relationships between family violence and female suicide, poor mental health, abortion, unwanted pregnancy, and sexuality.

c) Design of specific research-action programs that will lead to the development of intervention and care methodologies--for example, in relation to conjugal violence, incest, women victims of political violence, and women victims of rape--that can be disseminated in the Region in order to train human resources for intervention in the problem.

5. International Technical Cooperation

a) International technical cooperation should promote the exchange of the experiences of different countries in approaching the problem, from the standpoint of prevention and assistance. In addition, it should provide assistance in the preparation of integrated legal, educational, and health policies and programs, and should encourage the countries to gather information on violence, on studies of the subject, and on proposals for intervention as a means of enriching regional knowledge.

b) The Pan American Health Organization will seek to disaggregate data on external causes of death in order to reveal those associated with domestic and/or conjugal violence and other forms of abuse, especially with regard to conjugal homicide, in order to establish unified record-keeping systems throughout the Americas that will make it possible to quantify the problem of violence in its real dimensions, with a view to formulating more realistic policies and programs.

c) The Pan American Health Organization should support the initiatives proposed by the countries for preparation of a Charter of Health Rights of the Women of the Americas. At the same time, PAHO should promote the coordination of efforts and resources in the United Nations system to support country initiatives for the dissemination of information about the problem of violence. The Organization should also participate in the initiatives of other organizations in order to ensure a more effective response to the problem, particularly with regard to human rights.

d) Programs and policies for the training of human resources for the sector should include the issues relating to gender and health, as well as power relations and the abuse of women and girls.

e) The progress made in knowledge, diagnosis, and prevention and rehabilitation programs, as well as progress in raising awareness in the international community of this problem as a public health priority, should be disseminated by means of already existing regional bulletins or bulletins to be created especially for this purpose.

f) A recommendation should be made to the governments of the Region to treat violence against women as a priority public health problem and to promote the establishment of support services for women and girls who are victims of violence or at risk of violence.

g) Technical cooperation should be provided to facilitate the training of national human resources, both governmental and nongovernmental, and to promote various initiatives, such as meetings, seminars, and publications, as well as the development of programs and proposals for intervention, in terms of both prevention and assistance and rehabilitation.

Annex

VIOLENCE AGAINST WOMEN AND GIRLS: ANALYSIS AND PROPOSALS FROM THE PERSPECTIVE OF PUBLIC HEALTH

CONTENTS

I. THE INVISIBILITY OF VIOLENCE AGAINST WOMEN AND GIRLS

Both women and men can be the victims of violent acts, but it is men who more frequently meet with fatal violence. This disadvantage of males in relation to females reaches proportions of 2:1, 3:1, and 4:1 in the different countries of the Region, and has been explained by the greater exposure of males to risky environments and behaviors.

In general, it can be said that this greater male vulnerability to violence is linked to the social construct of masculinity, which emphasizes and glorifies violence as a response to individual and social conflicts. Males therefore are both the principal victims and the principal perpetrators of violent acts. Why, then, is there such concern about violence against women as a social and a public health problem?

The statistics on morbidity and mortality for women do not reflect a major problem in this regard. However, studies on the subject suggest that certain factors render the impact of violence against women "invisible" to the health sector, concealing its social nature. There is substantial underregistration of violent episodes, both by health care and law enforcement institutions, since the statistics of these institutions generally reflect only women who have turned to them in intolerable crisis situations.

Within the health sector, the "invisibility" of violence as a social problem results in large part from the attitudes that shape the delivery of health care. These include:

- An emphasis on violent acts that result in death, when in reality death is only one of the various social expressions of violence. Although the indicator most often used to analyze the impact of violence is the number of homicides or accidental deaths, there exist other forms of violence which are not necessarily fatal but which lower people's quality of life. These may not be recorded in the statistics on morbidity and mortality.

- A focus on the injury itself. This diverts attention from the fact that the injury resulted from problems involving human relationships, and it tends to obscure the scenario and actors involved in the violence.

  Simply treating the injury, isolated from the context in which it occurred, leads to an inaccurate picture of the situation in which human beings resorted to violence. As a result, the most subtle and intangible aspects of the violence may be overlooked. When the injured person is basically considered as an organism that has suffered physical trauma, the health services naturally concentrate their efforts on curing, relieving, or repairing the trauma. Basing its recommendations and actions on the physical injury, medical practice fails to visualize the social context in which the violence took place.

- The mind/body dichotomy which forms the basis of the biomedical model, and which accords greatest importance to processes that affect physical well-being at the expense of those which are primarily emotional and affective.

- This separation underlies the division between the different branches of medicine concerned with physical and mental health; they become two separate worlds with few points of encounter. This over-emphasis on the physical as compared to the mental means that little attention is given to abuse which is fundamentally emotional and social in nature.

- Difficulty in understanding the body as an integrated whole, and as a consequence, an inability to correctly interpret female symptoms. Such symptoms can signal an organic disorder, but they can also reflect problems with a woman's relationships and identity. A medical practice which is primarily concerned with physical symptoms as expressions of organic disorders will be unable to look behind the symptom to examine the nature of the woman's social relationships and the quality of her daily interactions--a line of inquiry which could yield a new and comprehensive analysis of her problem.

- The attitude of health care workers of both sexes, who share the social bias that violence against women and children, in particular girls, is a normal part of family life. It is presumed that all couples and families experience conflicts that are more or less severe, but that these situations ultimately can be overcome with patience. Such an attitude leads to the acceptance of violence as a factor inherent in affective relationships, and to the downplaying of violent acts against women.

- The acceptance of violence against women and children in families, on the assumption that this is a private matter and that it is not up to the health sector to solve the problem. It is also considered that these acts, when they are especially serious, constitute crimes that should be dealt with by the police and that lie outside the jurisdiction of the health sector.

- The perception that violent acts against women and girls are isolated, chance occurrences in the life of a couple or family. Although it can happen that a single violent episode occurs in a family whose relations are not normally marked by violence, abuse against women and girls most often presents as a continuing pattern of relations, as a logic of daily behavior.

- The belief that violence is inherent in the male character, and that the use of violence is a legitimate expression of innate masculinity. Popular explanations along these lines attempt to find a basis for violent behavior in the biological differences between the sexes, differences that supposedly predispose men more than women to the use of violence. By contrast, personality traits considered "feminine" include susceptibility to pain, a tendency to cry easily, emotional fragility, and moodiness. This conception of the female character in itself undervalues the psycho-affective impact of violence against women, leading frequently to suggestions that women exaggerate their accounts

of violence against them. In the health sector this translates into a tendency to minimize the importance of women's symptoms, such as weeping and suffering, simply because women are "more sensitive," while weeping and suffering on the part of men are treated as signs that something very serious has happened.

- Interpretations that consider violence to be behavior associated with specific personalities, or that see the existence of violent personalities as behavioral deviations. By reducing violence to an individual behavior problem, these interpretations obscure the interpersonal dimension and the central role of violence in the exercise of power and domination. The behavior of the attacker is explained primarily in psychopathological terms; he is considered mentally ill. Such a man may be considered to have a sadistic personality or one which is passive-aggressive with paranoid features.[1]

- Confusion between the actual cause of violence and related problems which may predispose a person to violence--risk factors such as alcohol or drug abuse, unemployment, economic hardship, and social, political, or labor instability. The cause is the existence of relations of power and domination that legitimate violence as a way of solving conflicts.

- The maternal focus in health care: an emphasis on reproductive function that encourages the health sector to give greatest importance to caring for the mother/child dyad. This tends to divert attention from women's other health needs, such as those stemming from the exercise of non-reproductive sexuality, the aging process, and violence, thus excluding large sectors of the female population from receiving health services.

- The inadequate assessment of female symptoms, stemming from a widespread lack of information among health personnel regarding the nature and magnitude of the problem of abuse against women and girls.[2]

Women frequently do not report incidents of abuse, or they do so in vague terms. During a medical consultation they may complain of non-specific symptoms such as headache, depression, or anxiety, seeking an explanation. At other times, although the signs of abuse are obvious, the physician accepts the woman's story that her bruises are the result of an accident. Both attitudes serve to render the abuse invisible and lead to mistaken diagnoses and faulty policies of prevention and treatment.

All these elements together keep violence against women from being understood as a health problem of the first order. Moreover, society's silence on the subject is reinforced by the silence of women themselves; both contribute to keeping the problem hidden.

If the health sector is limited in its ability to grasp the real dimension of the problem posed by violence against women, women themselves manifest similar biases. For example:

- The victim of violence often believes that she is the only one who is attacked in this way. In her perceived isolation she thinks it is futile to seek treatment or help. Women frequently cannot accept the fact that they are living in a violent relationship. They are reluctant to approach the health institutions when a violent episode occurs, except when the impact is so traumatic that they go to the emergency room or to the police seeking treatment or protection. Often a long time elapses between the first violent incident and the time when the woman finally seeks medical or legal assistance.

- The violent act appears as an isolated occurrence, stripped of the internal logic that gives it meaning. The woman sees only part of the reality, which keeps her from linking the various violent acts against her into a coherent pattern. The mystification of certain traits associated with masculinity is an inherent part of patriarchal thinking.

- Society's concept of femininity places women in the position of accepting abuse and mistreatment, since women are expected to be passive, docile, and receptive. The qualities associated with being female--submission and compliance--are turned into virtues, into positive and desirable values. Women's personalities are shaped in a way that makes them unable to display hostility in their own defense.

- The woman is paralyzed by fear. The violent act is accompanied by repeated threats of physical harm to the victim, or to people or property that have special significance for her, if she dares to seek assistance or break the silence.

- The woman blames the violence on her companion's individual traits, such as a bad temper, excessive drinking, or problems he is experiencing in the street or at work.

- Many women believe that the husband or companion has the right to use physical force to punish transgressions, imaginary or real, of the rules governing the life of the couple or family. They do not know that they have rights and that their most basic right is that of respect for their physical, emotional, and social integrity.

Living as part of a couple, a woman can gradually give up the right to space and time of her own; to privacy and intimacy; to solitude and to her personal past as something that is hers alone; to express her own ideas and feelings; to choose a type of work; to have her own friendships; to occasionally spend money on herself; and even to choose the time to have, or refuse to have, sexual relations.

Women tend to blame themselves for triggering violent episodes. Part of women's social burden is the assumption that they are the ones who are responsible for ensuring a harmonious family life and who must make the greatest sacrifices to achieve it. Guilt feelings and a sense

of failure are the constant companions of the victimized woman. Obliged to perform as good wives, mothers, and lovers, they are constantly aware of ways in which they fall short of this social ideal, and they may legitimate abuse as atonement for their imperfections. They have difficulty believing that their deficiencies and imperfections need not be atoned for and do not give others the right to punish them.[3]

The mystification of the family and the couple, which are seen as the fundamental or the only contexts in which women can play legitimate social roles, makes it difficult for a woman not to aspire to find a mate and form a family, even if this is at the cost of her integrity as a human being. Forming a couple relationship and later a family is considered the normal thing to do, and the worship of this institution encourages many women to remain in harmful relationships. The stereotypes surrounding family life are so powerful that they obscure the perception of harm. Furthermore, because society links a woman's effectiveness to her success choosing a partner, her failure in this area becomes dramatic evidence of failure in life as a whole.

Raised to depend on others, to exist in relation to others, and denied autonomy as a human being, the woman fears freedom. Once on her own, she does not know what to do with herself, nor how to lead her own life, which all too often has not been her own. Socialized as property, the woman does not belong to herself; she has not exercised control over her own life, body, sexuality, or emotions.

The culture has encouraged women to fuse their personal lives with the lives of their husbands or companions and of their children; as a result, women lack lives of their own and their personal relationships with others seldom extend beyond the family circle. Confronted with continuous abuse, they find themselves in a dilemma: they can watch their living conditions continue to deteriorate, or they can abandon the aggressor and face the consequences, together with their children. Many women postpone indefinitely the decision to break the cycle of violence, because they fear the onset of new responsibilities: finding work with low levels of education, raising the children alone, etc.

A complex set of elements thus interact to render the violence against women and girls "invisible." As has been shown, most of the factors are linked to women's subordinate social position, and thus are deeply rooted in cultural values and practices. This in turn hinders recognition of the problem at the institutional level. It also obscures the close ties between the victimization of females and the social status that historically has been assigned to women, and their own perception of their subordinate condition.

II. THE TIP OF THE ICEBERG

Over the past three decades, in response to the International Year of Women and the social movement for women's rights, international agencies, especially those within the United Nations system, have made alternative proposals for the prevention of violence against women and the care of women who are victims of abuse. They have argued that analysis of the phenomenon must go beyond the statistics or records kept by the health services and the police, because these records fail to reveal the true extent of the problem.

Research carried out by organized women's groups in the Region has revealed the magnitude of the problem. The research is based on the documented cases of victims who have sought help from the various nongovernmental organizations that have formed in recent decades to respond to such situations, and on investigations using police records and data from offices of forensic medicine in the different countries of the Region.

The following section presents information from selected countries that serves to illustrate the situation. In analyzing the data, however, one should keep in mind the circumstances outlined above regarding the underregistration of violent acts against women and girls, given the nature of the phenomenon.

ARGENTINA

In Buenos Aires province, statistics show that 22 of every 100 abused women initiate legal action. This high percentage is associated with the existence of the Women's Commissariats and the Provincial Centers for the Prevention of Family Violence.[4]

BELIZE

In 1988, an average of 34.3 cases of violence against women were reported to the Belize District Police Department each month; in 1990-91 it was 48.3 per month.[5]

BOLIVIA

During 1986 the forensic clinic of La Paz registered a total of 1,432 cases of bodily assault, in which 66% of the victims were women. Of these, 60% were attacked by the husband; 22% were raped; and 16.7% suffered violence at the hands of neighbors or family members.[6]

CANADA

In a sample of 222 women, 86.2% claimed to have suffered some form of violence. In 94% of these cases it was stated that the violence came from the woman's partner. Data from 1964 to 1974 reveal that 60% of all female homicide victims were killed in the family setting, and that very frequently the killer was the husband.[7]

A 1984 study on urban crime in seven large cities reported that 90% of the victims were women.[8]

CHILE

In Santiago, an investigation revealed that 80% of the women surveyed had suffered physical, emotional, or sexual abuse at the hands of their partner or another known person. The actual proportion could be even higher, given the fact that 9.4% of the 222 women surveyed did not answer the question, even though they had the option of choosing as an alternative response, "I have not suffered violence."[9]

A study carried out in two Santiago hospitals showed that of the 10,545 assault victims treated in the emergency room, 2,618 were women, and 1,884 of these were victims of violence within the family. The follow-up was carried out between October and November 1986.[10]

COLOMBIA

The National Survey on Prevalence, Demography, and Health revealed that 65% of the women in unions state that they have been attacked by their spouses or companions. Thirty-three percent have been insulted; 20% beaten; and 10% have been forced by their partner to have sexual relations. In 70% of the cases children witnessed the violent scene. Thirty-six percent of the mothers acknowledged that they or their partners abuse the children.[11]

In the majority of cases it is the man who attacks the woman: the victims are women in 90% to 95% of the cases.[12] In 90% of cases the violence is perpetrated by the husband, companion, or lover; in the remaining 10%, it is stepfathers, fiances, neighbors, brothers, or mothers.[13]

Conjugal violence is not an isolated incident in the life of a family. In 49% of cases it is accompanied by child abuse; in 95% of cases the victim recognizes that the episode is not the first or only one. Both aggressors and victims recount personal histories of family life affected by violence, either against their parents or against they themselves.[14]

COSTA RICA

One out of every two women who lives or has lived in a couple relationship has been abused physically by her companion, and nearly 40% of the girls who are victims of incest have been abused by their fathers. Reports of rape reveal that in most cases the aggressors are acquaintances or close friends.[15] Of the 14 rapes reported every day by the Women's Delegation, the majority are committed against girls from 11 to 16 years of age.

Incest, which is considered to be sexual victimization of the child and an invasion of the child's body and emotions, tends to repeat itself. In more than 60% of the cases the abuse begins before the victim is nine years old, and in 18.7% of cases before age five.

In the cases of incest handled by the office of forensic medicine in the judicial research agency, 94% of the victims were found to be girls, while 32% of the aggressors are the fathers. In 67% of the cases the assault occurred in the victim's home. The relationship of the attackers to surviving victims were: father (42.4%), uncle (17.4%), brother (15.2%), stepfather (6.5%), and grandfather (6.5%).

Ninety percent of the cases of teenage pregnancy were found to be the result of sexual abuse.[16]

EL SALVADOR

In a study carried out by the Center for the Prevention of Child Abuse (CEPREMIN), 62% of the 92 cases examined involved females and 35% involved males. In cases of sexual abuse, 79.2% of the victims were female.

The First Penal Court registered 132 cases of "indecent abuse" between January and June 1991; 82 of these were rapes and of that group, 76 were committed against females. Rapes of girls involved mainly children between 11 and 15 years of age, while boys victimized in this way were younger than 10. The attacks were perpetrated by persons known to the victim or by close relatives, such as stepfathers, fathers, and uncles.[17]

ECUADOR

A survey carried out in Quito, as part of an education and communication project on family violence undertaken by CEPLAES, revealed that 60% of the women surveyed had suffered physical abuse at the hands of their partner.[18]

GUATEMALA

According to a study by Federico Coy, carried out in the city of Antigua between June and September 1989, 48.7% of a group of 1,000 women said they had suffered abuse. The age group most affected was from 20 to 39 years of age. Seventy-four percent of the assaults were committed by the woman's male partner, 11% by the children, and 4% by mothers-in-law, brothers-in-law, and neighbors.[19]

HONDURAS

The Center for Women's Studies in Honduras carried out research on violence against children between January 1988 and July 1989. The study found that in the Department of Forensic Medicine of the Supreme Court of Justice, one of every four complaints involved aggression against children. Seven of every 10 victimized children had been subjected to sexual violence by male family members; in several cases repeated abuse was documented over periods ranging from a month to a year. In terms of the sex ratio of the victims, 6.4 girls were abused for every 1.6 boys abused, confirming the greater vulnerability of girls to assault. The majority of the victimized boys were between five and nine years of age, while the girls were aged 13 to 16.

In Tegucigalpa each week, two children under 18 are raped and four suffer sexual abuse. Of every 10 children who are attacked sexually, six are subjected simultaneously to other forms of violence, such as threats of death with a firearm. Eight out of 10 rapes were committed by a person known to the victim, such as a family member, neighbor, or friend. In one out of every five rapes of children the aggressor was a relative, most often the father. More than two-thirds of the incidents happened in places frequented by both the victim and the attacker, principally the home.[20]

JAMAICA

The statistics for 1980 indicate that 16% of the total number of divorces were for reasons of cruelty.[21]

NICARAGUA

In the National Police records, of the total of 608 crimes reported between May and September 1990, rapes accounted for 390. In 87% of the cases the aggressors were male relatives or acquaintances of the victim, in declining order: fathers, stepfathers, uncles, brothers, stepbrothers, grandfathers, cousins, husbands, neighbors, friends, and coworkers. In 50.8% of the cases the rape took place in the victim's home; 43% were rapes of minors.

PANAMA

When children are the victims of sexual violence, it is the mothers who go to register the complaint. The perpetrators of physical violence are spouses, companions, fiances, former spouses, former boyfriends, brothers, and brothers-in-law. In cases of sexual violence the victimizer is the father, stepfather, uncle, brother, godfather, or family friend.

PERU

Seventy percent of the crimes reported to the police involved women beaten by their spouses.[22] According to data for the first months of 1989 supplied by the Women's Commissariat of Lima, 2,449 out of 2,641 complaints referred to the partner or former partner; and of those citing the partner, 1,413, or 88%, mentioned physical abuse.[23]

PUERTO RICO

A study on sexual violence, reported in the September 1985 issue of *Quehaceres*, found that the offenders were people known to the victims in 70% of rape cases and 80% of cases of sexual abuse of girls.[24]

UNITED STATES OF AMERICA

Every 15 seconds a woman is struck, and 4 women per day sustain injuries from being beaten.[25] It has been calculated that a woman is raped every six minutes.[26] National statistics show that 50% of married women have been the victim of violence at least once in their life, regardless of race and socioeconomic status, and that 25% of married women live in a situation of chronic violence. Most of the injuries suffered by women are the result of domestic violence. These exceed the injuries from automobile accidents, rapes, and assaults combined.[27] Police sources report that between 40% and 60% of the calls they receive, especially on the night shift, are the result of domestic disputes.[28]

The United States of America has 870 shelters exclusively for battered women.[29] Between 22% and 35% of the women who seek treatment in emergency rooms in the United States of America do so because they have symptoms of some type of abuse.[30]

Violence is cited as one of the most frequent causes of divorce in the United States of America, the United Kingdom, Canada, Egypt, and Greece.[31]

VENEZUELA

In Caracas in 1985, during the first week of operation of a municipal service offering care to women, 89% of the intake cases involved severe physical abuse of women by their partners.[32]

The foregoing data present a picture, albeit partial, of the situation in the Americas. However, the United Nations has documented the problem of violence against women in other countries of the world as well. The problem cuts across regions, societies, classes, and spans age groups, ethnic groups, and religious or political groups. Violence against women crosses all national borders; it is as universal as the patriarchy; its logic spans all social systems. It is not unique to the Third World or to poor countries.[33]

Data from the countries of the Americas reveal that substantial sectors of the female population are subjected to violence, and that violence as way of relating is entrenched in the daily lives of couples and families. There are, in addition, other forms of violence--social, political, religious, and ethnic--that affect the quality of life and that take on specific characteristics when women are involved. This is true, for example, of the treatment accorded women who are victims of political persecution, who are detained or imprisoned, or who are abused by conquering troops or by soldiers during armed conflicts. Political violence and other forms of social violence are often so closely intertwined that it is difficult to determine where the former leaves off and gender-specific violence against women begins.

The phenomenon of violence against women and girls within the family is not unique to the lowest socio-economic stratum, although most of the violent acts that are the subject of complaints or legal action occur in this social setting. Upper-class women, much more than others, are inhibited by what might be called "class modesty" from lodging complaints and even from seeking help. On the other hand, while social class does not eliminate the use of violence as a means of asserting power, the violence does take on specific characteristics depending upon the socio-economic level.

The aggressors tend to be fathers, husbands, companions, and relatives: that is, people who are emotionally close to the victim and a constant presence in her day-to-day life. Strangers can also commit violent acts; however, the most striking involvement is of persons who have daily contact and emotional ties with the victim. In most cases the aggressor is male and the victim is a woman or girl, although there are recorded cases in which young boys have been abused, especially physical abuse and rapes, and especially among boys younger than 10.

The typical aggressor is not a sick person, a marginal person, or an unknown assailant. Rather, it is a man who is older than the victim, from whom she seeks solidarity, support, companionship, friendship, affection, or erotism in day-to-day interactions, and with whom she shares living space. The male aggressor is someone who is important to the victim from an emotional standpoint; and he is important in that he exercises power and authority in that most fundamental social setting, the family.

This scenario stands in contrast to the widespread image of sexual abuse and rape of women and children as carried out principally by an unknown assailant in a dark street or deserted area.

Violence against women and girls, as an ongoing pattern of social and emotional relations in family life, is the most striking evidence that a fundamental imbalance exists in the relations between human beings--that is, between men and women.

Women, girls, and children are the most frequent victims of this type of violence. Their vulnerability stems from the positions they occupy in the network of family relations: boys and girls, because of their young age, and women, because of their sex, are the targets of the greatest aggression.

The home, the family, and the couple are not the idyllic social settings enshrined in myth and seen as synonymous with safety, protection, and love. On the contrary, they must be seen as intricate and complex networks of power relationships which flow in various directions: fathers/young daughters; husband/wife; uncles/young nieces; boyfriend/girlfriend; stepfather/wife's daughter, etc. Within this complex structure the exercise of violence and of sexual abuse are not random events but a continuing pattern of relations.

The patriarchal family and couple are far from being settings where the human potential of their members can be unlocked and developed. In such relationships, women and children lack space of their own in which to enrich their personal lives.

It is painful to recognize that women and girls can be at risk within their own families. The situation becomes even more complicated when it is taken into account that the family and couple are not the only settings in which violence against women occurs. Families reflect the social conditions of the times; they reproduce and recreate the imbalances within the larger society.

The inequalities between men and women are played out in a wide variety of social interactions. Violence against women as an instrument of social inequality extends to other settings as well: schools, workplaces, the streets, and the health services, among others.

Violence, in this sense, is a symptom of profound disequilibrium, of the inequalities and imbalances that exist between men and women, and that clearly also occur in social relationships shaped by social structures other than the patriarchy.

The violence thus extends beyond the family. Indeed, it even precedes the formation of the family in which the violent act ultimately occurs. The selection of a companion or a mate is already marked by deep inequality: men prefer women who are younger and smaller in stature than they are, with less life experience, sexual experience, and even educational and work experience; while women prefer companions who are stronger than they are in every way. Choosing a partner on these criteria in effect already creates a power gap between the man and the woman. The woman does not become a victim within the couple relationship; she is already

a victim at the moment when the couple is formed. The man, for his part, does not become a victimizer when he becomes part of a couple, but carries stereotypes of masculinity that have turned him into a victimizer long before.

Masculinity and femininity are two sides of the same coin: the patriarchy. Social beings carry these attributes and reproduce them in the daily life that takes place in different social spaces. The destruction of the patriarchy as a model of gender-based domination supposes the destruction of an alienated masculinity and femininity, and the construction of democratic and mutually supportive models of relations based on equality between the sexes.

The history of the relations between men and women has been socially constructed as complex systems of differences and disadvantages, reinforced by the social allocation of functions by gender, which rests in turn on a symbolic scheme that assigns dissimilar qualities to the different sexes. Society's treatment of sex and gender places women at a disadvantage in relation to men, a situation that affects their quality of life and shapes their patterns of illness and death, their life styles, and their relationships with everything around them.

A gender-based approach to the question of violence against women and girls requires taking a close look at social relationships. Violence may be seen as a privileged form of the exercise of power and domination, as one of its instruments. If it is true that violence is not an isolated act, but a generalized pattern of social relations--and this is indeed true--this must be taken as a sign that something is lacking in the creation of human relationships; that something is amiss in the emotional realm; that something is happening in the loving and erotic ties we form with others that causes injury and harm, especially to women and girls.

Such an approach assumes that the quality of human relationships affects people's health either positively or negatively, and that this effect is as important as the effect of people's socio-economic status, their relationship to the environment, etc. Social relationships thus become one of the factors that help to explain the profiles of morbidity and mortality for different groups of people, particularly when violence is involved. The quality of human relationships has, accordingly, a fundamental impact on public health.

III. THE IMPACT OF VIOLENCE ON WOMEN'S LIVES

Violence may be understood as an act of negation of the other, denying the victim the exercise of his or her rights as a biological, psychological, and social being. It reveals that human relationships are affected by high levels of conflict that have not been resolved through discussion, negotiation, consensus, etc. Violence becomes an instrument through which power is exercised, a recourse to which the aggressor turns in order to perpetuate, subvert, or change an existing social order. Violence against women is used to perpetuate an inequitable social arrangement in various contexts, and has a negative impact on women's quality of life.

The World Conference of the United Nations Decade for Women, held in Copenhagen in 1980, affirmed that to improve the physical and mental health of all society's members, steps should be taken to develop programs aimed at eliminating all forms of violence against women and children. This statement signals the recognition of the impact of violence against women in the global community. Similarly, the seventh United Nations congress on crime prevention and the treatment of offenders (Milan 1985), pointed out that mistreatment and violence in the home are a problem with serious physical and psychological consequences, since it endangers the health and survival of the family unit.[34]

Studies on the subject reveal that the physical and psycho-social effects of violence against women are immeasurable, especially if it is taken into account that the violence affects not only a woman's body, but also her emotions and interpersonal relationships, given that the purpose of violence is to induce submission and to actively deny the woman her rights.

1. Physical Impact of Violence Against Women

The separation between the physical, psychological, and social aspects of the problem is unfounded from a conceptual point of view, given the continuity in the health/disease process; and disassociating them affects both the approach to treatment and the design of policies and programs aimed at prevention. Nonetheless, it is possible to set forth considerations in each area without losing sight of the fact that no violent act can be considered strictly physical since the body is the home of the emotions. On the other hand, the body itself is an arena, as well as an instrument, of social relationships.

Among the most obvious effects of violence against women are injuries that in certain cases result in death. When homicides of women are subjected to thorough investigation, it is found that the deaths are preceded by a long history of physical abuse. Studies indicate that women who are victims of abuse suffer more miscarriages than women who have not been abused; suicide attempts are 12 times more frequent among women who are subjected to mistreatment than among others; and women victims are at high risk of abusing alcohol and other substances.[35]

2. Impact of Violence on Women's Self-esteem

The abuse a woman suffers diminishes her self-love and self-esteem. It produces strong feelings of mental and sexual incompetence, resulting frequently in a loss of vital energy. These women feel incapable of assuming responsibility even for minor tasks or for the care of children; they show signs of passivity, and lose the capacity to act autonomously. They manifest symptoms of depression, and feelings of insecurity and indecision. The greatest humiliation comes from the fact that the woman is abused by the very person she chose as her mate.

Women who have been attacked manifest high levels of anxiety and somatic disorders. They often present what may be termed the traumatic syndrome of the abused woman. This may be compared to the syndrome of the raped woman and the syndrome of the woman who has been the victim of incest. After the immediate effects, including fear, anguish, and the lack of volitional autonomy, the psychological pressure and trauma often continues and renders women vulnerable to alcoholism, drug abuse, depression, and suicide attempts.[36]

Sexual abuse and rape injure the woman physically and lead to negative feelings toward herself, especially if the attacks came from someone close to her. These acts can be considered extreme violations of the right to freedom and to sexual self-determination of women and children, and are the consummate exercise of power and domination.

A woman's sovereignty over her body is violated when she is opposed in making decisions about matters that concern her bodily integrity--for example, when, how, and with whom to establish emotional ties; whom to choose as a sexual partner or as friends; whether to refuse or agree to have sexual relations; whether to use family planning methods, and how many children she will bear. The exercise of the right to sexual freedom, in its fullest sense, includes both the option of refusing sexual demands and the option of responding positively.

While the male has relative freedom to explore his sexuality and engage in sexual relationships, the woman is under greater obligation to be faithful and monogamous. Possession of the partner's body forms part of the cultural ideology of love; however, the same culture restricts far more severely the exercise of sexuality by women, in the name of love, family, marriage, etc.

Female workers who are victims of abuse report the feeling of fear that haunts women after a violent episode. This dominates their actions and produces insomnia and nightmares, a logical outcome given that the violence is not usually a finite act but rather part of an abusive process, accompanied by threats of increasingly serious attacks.[37]

The reaction of victims has been described as a loss of hope. Feeling escape to be impossible, they sink into bitter despair. The victim feels degraded and powerless; she tends to withdraw from her family members, and feels alone. Women who have been abused sexually may become frigid, rejecting their womanhood.

3. Impact of Violence on Women's Role in Development

Acts which impede the development of women's potential serve to deny them the exercise of their rights, and this in turn hinders the full participation of women in social development. Women who have been intimidated and prevented from establishing social ties beyond the home are, as a result, devalued as social actors and very probably marginalized and excluded from decision-making, both within their families and in the communities where they live.

Those women who do participate in community activities report that their partners distrust their sexual behavior when they take part in social action groups. Frequently the men not only oppose women's participation in such groups, but also hinder their possibilities of taking on leadership roles. The husbands or companions refuse to allow them to attend meetings; they are jealous, and refuse to assist with household tasks. Women's participation in community activities is a source of major intrafamily conflict, a fact that should be considered when steps are taken to promote the incorporation of women into local, regional, or national development processes.

The persistence of the traditional sexual division of labor, which restricts female participation in public life, perpetuates the social image of women as second-class citizens. It hinders their political participation and keeps them from taking part in decisions that affect the collective welfare. The structuring of citizenship and democracy to exclude female participation make these areas a patriarchal province.

The victimization of females is associated with the socio-economic condition of women and with the persistence in the culture of models of discrimination against them. It reveals the society's failure to guarantee the right to respect and the right to freedom for more than half its members, as well as its failure to promote negotiated solutions to conflicts.

A report by the Secretary General of the United Nations on efforts to eradicate violence against women in the family and in society (32nd session), points out that the economic costs to society are considerable. Studies carried out in some countries have found very high costs for providing medical treatment and social services to victims, dealing with offenders, and promoting preventive measures.[38]

4. Impact of Violence on Women's Interpersonal Relationships

Violence against a wife affects her sons and daughters, and vice versa. Its impact extends beyond the family setting to affect the victims' entire lives: their performance in school, their ability to act appropriately in other social contexts such as in the workplace and in their relations with others. Violence against women has a radial impact as well, since it affects not only a woman's body but also her emotions and conscience. The most injurious effect is linked to the real objective of the violence: forcing submission to inequitable relations, perpetuating an order of domination. In addition to diminishing a couple's quality of life together and the stability of the family group, it endangers the psychological well-being of the children by creating a permanent climate of anxiety, fear, and insecurity.

Perhaps one of the most serious effects in strategic terms is the creation of a basic mistrust of males that makes it impossible for men and women to live together in loving freedom or even to get along day by day. Women internalize as a fundamental social rule that men are dangerous. The confirmation of this age-old idea becomes an obstacle to sharing lives.

In the institutional context there is resistance to a radical analysis of the problem, a resistance rooted in the mystification of the family as an abstract institution that exists apart from the experiences of its members. This concept encourages institutional practices that strive for reconciliation, even at the cost of the vital integrity of the abused women and children; it overlooks the fact that, in reality, the victimizer is the one who is endangering family unity, while the woman is the injured party. But the existence of strong stereotypes about family life obfuscates this reality and turns the ethical issue upside down.

Adolescent children who run away from home are often found to have been subjected to ill-treatment. The data suggest that in homes where the wife is abused, the children are also mistreated. Abused women become in turn the abusers of other, more vulnerable members of the family. It is also likely that when abused children form their own families they will repeat the patterns of behavior they have learned.[39]

Violence against women cannot be explained solely in terms of family relations. It is, rather, the product of a social history that precedes the formation of the family and the conjugal union, and that is related to the social hierarchy in which men and women occupy roles of domination and submission.[40]

Other studies suggest that persons whose family relations are shaped by the daily practice of violence learn behaviors that carry over into other social contexts and may lead to criminal conduct.

Violence against women, girls, and children springs from the same root: the attempt to strengthen, perpetuate, or sustain power and authority as an exercise in domination.

Women in some cases respond to violence with violence. The killing of men by their partners or wives is a defensive response to a pattern of continuing assault.

If violence is considered to be a pattern of interpersonal relations, it must be assumed that the aggressor does not abuse only his partner, but relates in this way to the entire family. All family members can be vulnerable, and indeed are vulnerable, to ill treatment. The goal of the violence is to induce submission, and in that sense it affects all the weaker members.

This overview attempts to analyze the biological, psychological, and social effects of violence, to explain it as a process, and to make clear that it is a symptom of the existing inequalities between men and women--that is, to analyze the phenomenon of violence within a framework of social relationships that can help to clarify its nature.

5. Violence Against Women and Human Rights

Linking the subject of violence against women to the theme of human rights opens new analytical perspectives. Indeed, violence against women is a negation of their fundamental rights as human beings, especially the right to life and to physical, psychological, social, and moral integrity.

Studies dealing with the human rights of women affirm that violence against women constitutes a basic assault on their freedom, autonomy, will, and dignity, damaging their integrity as human beings who have fundamental rights. Violence denies women self-determination in regard to their lives, bodies, health, sexuality, and emotions, and even their dignity. The latter is more than just a right: it is a personal quality that is intimately linked to a person's sense of self and self-esteem.[41]

Violence against women is also an assault on the right to health, meaning the right to live in conditions that make possible the full development of a person's physical, psychic, and social potential; and to enjoy the benefits of development through exercising the rights to social participation, education, security, and affection--that is, the right to lead a worthwhile life.

The right to freedom includes, in particular, freedom to make choices about sexuality and reproduction, especially as regards the option of childbearing. Steps should be taken to eliminate the norms which give the husband veto power over his wife's access to resources and methods for family planning; this access should be guaranteed as a fundamental human right.

IV. TYPOLOGY OF VIOLENCE AGAINST WOMEN

Violence against women is multi-dimensional. It involves multiple actors, is perpetrated in a variety of settings, and takes various forms. Social scientists attempt to classify it according to the social context in which it occurs: political, economic, sexual, racial, etc. In this sense, violence affects men and women in all the different relationships in which they are involved as part of their lives in society.

Other typologies employed, especially by medical and law enforcement institutions, are based on the object or instrument used in the attack (motor vehicle, knife, or firearm, for example) or the type of injury and part of the body affected (wounded in the head, thorax, neck, abdomen, back, pelvis, etc.)

Depending upon the type of violent act, various terms may be applied: rape, assault, hanging or strangulation, threat, insult, homicide, poisoning, suffocation or drowning, abandonment, scorn or humiliation, mutilation, sexual abuse, striking, whipping. The aggressor may be a husband, father or mother, companion, relative, friend, or stranger. This classification explains the type of relationship, in terms of acquaintance or family ties, between the aggressor

and the victim. In other cases an attempt may be made to identify the perpetrators of the act and describe the type of violence, for example, criminal violence, violence linked to drug trafficking, guerrilla violence, etc.

The possible typologies are varied; however, it is the relational or spatial typology that perhaps goes farthest toward explaining the human dimension, the importance of the links between the actors as social beings. Such a typology goes beyond the injury itself to make possible the analysis of violence as a process.

In various social contexts women can be victims of violence or affected by violent events in the same way as any other individual. However, the violence under discussion here refers to that which is directed against women because of their gender. Violent acts committed against women simply because they are women reflect the socially disadvantageous position of women that renders them vulnerable.

In keeping with this classification, it becomes possible to distinguish types of violence according to the relational space in which the acts occur: for example, the school, the family, the health services, the communications media. Violence may be characterized as political, racial, sexual, or labor-related; or it may be violence directed specifically against women because they are women.

In certain areas the use of violence against women is particularly acute because these are also settings in which power relationships come into play. Some of these areas are analyzed below.

1. Sexual Harassment in the Workplace

Although the workplace is not the only place where women are harassed (everyone is familiar with attacks on women in the streets, in public transportation, in crowds, etc.), it is in places of work where sexual harassment is most persistent. Sexual harassment of women may be defined as repeated sexual acts or insinuations which the woman does not invite, consent to, or desire, and which are aimed at diminishing her sovereignty over her own body and sexuality.

Sexual harassment cannot be confused with mutual and voluntary flirtation. Harassment is a form of persecution, a persistent and unwelcome sexual demand whose object is to obtain favors from the woman who often, due to the social conditions of the female labor market, occupies an inferior or dependent position in the hierarchy of the workplace.

Sexual harassment makes a woman feel threatened and undermines her trust in herself; she may fear losing her job or her chance at a promotion or raise. It is frequently followed by blackmail.

Sexual harassment may involve unsolicited sexual advances of various types. Among the more easily recognizable are:

- Unnecessary physical contact, such as rubbing and patting.
- Suggestive or unpleasant remarks about a woman's sexuality, past history, and sex life.
- Jokes, words, messages, insinuations, or *double entendres* that are degrading to women and their sexuality.
- Insulting remarks about a woman's appearance.
- Undesired verbal abuse.
- Immodest or compromising propositions.
- Demand for sexual favors in exchange for work-related favors.
- Use of pornographic images in the workplace.
- Physical aggression.

The Office of Women's Affairs of the International Confederation of Free Trade Unions (ICFTU), considers women to be the group most vulnerable to sexual harassment, and it identifies as a high-risk group those women who are younger than 30, single, widowed or divorced, and especially those who have dependents.

Sexual harassment is often associated with the abuse of authority in a hierarchical labor environment, but it can also be used to undermine female authority when the woman occupies a supervisory or management position.

A study by ICFTU on sexual harassment in the workplace found that when it takes the form of suggestive remarks and demands, it tends to come from the woman's immediate superiors or from management personnel; when it is expressed through unwelcome physical contact the woman's colleagues are most often involved; while compromising invitations and lascivious stares are basically used by customers or clients.

Research carried out in Puerto Rico revealed that more than 98% of the victims of sexual harassment in the workplace are women. In Japan, the Tokyo Lawyers Association, which set up a telephone line to handle complaints from women who had problems with sexual harassment on the job, found that of 137 complaints received, 40% came from women who had been obliged to have sexual relations with their superiors; 10% of the cases were classified as rape or attempted rape.[42]

A woman's labor rights also can be violated when the exercise of her sexuality, her choices regarding childbearing, or her age are used to place her at a disadvantage in the job market. This can occur in various ways:

- Loss of job security or seniority during times when a woman is nursing a baby, raising young children, or on maternity leave.
- Dismissal on account of pregnancy or marriage.

- Requiring women to control their fertility as a condition of employment.
- Discrimination against married women with respect to single women, or against middle-aged and older women, in hiring and in continued employment.

2. Violence in Educational Institutions

The principal victimizers of female students are school administrators, teachers, and even parents: they may threaten to withdraw a student from school, assign her low grades, or spread rumors among the other students aimed at ruining her reputation. The educator takes advantage of the student's subordinate status and the unequal relationship between teacher and student to bring pressure or obtain sexual favors through harassment or sexual blackmail.

3. Violence in the Health Sector

The average person, defenseless in the face of illness and ignorant of how the body works, is placed in a submissive relationship to the medical system. This leaves patients vulnerable to practices which compromise their dignity, their knowledge, their feelings, etc. The demand that someone else provide one with health, which supposedly guarantees a healthy outcome, places the claimant in a subordinate position.

The use of the term "patient" to describe someone who requests medical care or health services suggests the role that such a person assumes. A "patient" is one who has patience, or the ability to endure afflictions with resignation. In this sense, men and women who are patients can be subjected to practices which degrade their integrity and human dignity.

Women in particular have many questions about their bodies, their sexuality, and its processes. Plagued by fantasies and fears, they frequently feel estranged from themselves and experience their own bodies as something alien. Women's perceptions of their bodies and their sexuality make it difficult for them to be frank with medical providers. Similar biases are manifested in turn by health personnel; thus medical practice is affected by two value systems, each with its perceptions and confusions.

Women frequently are faced with unanswerable questions about technologies, bodily changes, sexuality, desire, old age. At times they even feel disgust toward their own bodies or those of others, so brainwashed are they by the cultural ideal of what a woman's body should be--an ideal unattainable for hundreds of women. Women become frightened by the prospect of disease and death; they live an ambivalent and confused sexuality that vacillates between pleasurable and painful experiences.

Women do not have an easy time relating to their bodies and their natural processes. Many contradictions surround a woman's relationship to herself, to her body, and to her sexuality.

The relationship between women and the medical profession is complex. In reality, the encounter brings into contact two histories, two world-views, and two sets of discourse, practices, feelings, and beliefs about the body, the social order, and power relationships. Medical knowledge is accorded high status and its bearers are privileged in their relations with others. Women, by contrast, occupy a subordinate social status on account of their gender and this adds to their feeling of inferiority in their dealings with the medical profession.

The woman vis-à-vis health care providers is not simply a body to be medicated or manipulated, the object of medical interventions. The person who goes to the health services seeking support and answers is a human being who suffers, and who may be a woman, girl, adolescent, mother, adult, or elderly woman; she has a life history that includes sexuality, joy, suffering, patience. She is a complex woman who attracts or repulses others; a body that seduces, that provokes tenderness, affection, annoyance, upset. A woman who is ill, or healthy, and who seeks health care services needs to have someone listen to her about her symptoms, interpret the signals her body is sending, and endeavor to understand her day-to-day reality.

As medicine becomes increasingly biologized, health personnel come to think of themselves as dealing with a disease housed in a body. The body becomes an organ affected by disease, separated from its history--a mere symptom. In this fragmented relationship the person disappears, ceases to exist; it is necessarily a depersonalized and inhuman relationship. Since the other person does not exist as a whole human being, the relationship becomes an abstraction: the disease, the symptom, the causative agent.

Disease exists as a concrete thought, not as a concrete reality. In reality it is not just healthy or sick bodies that exist but human beings--people, who are sick or healthy.

When doctors treat women, they are likely to see the pregnancy but not the pregnant woman; old age but not the aging woman; the patient, the mother, but not the total woman. The woman, ceasing to exist as a person, is dispossessed anew by the medical profession; she is treated as a body without history, objectified, reconstructed, transformed into an object. The violence against women of which the medical system stands accused relates in part to this tendency to rob the patient of her history.

Thus objectified, the woman disappears as a subject of free will and liberty, and is turned into an object of the actions, plans, and programs of the health system. The interventions performed on her body and the processes that affect her are not subject to deliberation, but are carried out on the basis of commands, orders, instructions, and prescriptions. She is not consulted; she is a client, a patient, not an actor. Medical treatment, then, is an authoritarian and unilateral act, although there is pressure in some quarters to democratize medical knowledge and improve the quality of care by humanizing the health services. The most frequent complaints about the health system, especially in regard to physicians, are that he "does not look at me," "does not listen to me," "does not explain to me." Such comments indeed reflect the patient's perception that she does not exist as a person.

Some practices identified as violent in the relationship between health personnel and patients are:

- Lack of sufficient, timely, appropriate, or intelligible information about treatment and the problems that prompted the consultation.

- Dehumanization of health care. Diseases or injuries are cared for, rather than people with a specific psycho-social history.

- Thoughtless remarks or value judgments concerning the patient's organic bodily functions.

The following are frequent with female patients:

- A vulgar approach to the biological functions associated with reproduction and sexuality.

- Verbal violence against women in labor in the obstetric rooms.

- Treating as guilty or criminals women who are faced with an unwanted pregnancy and who seek information to clarify their options.

- Ridiculing obese or "ugly" women when they seek help with concerns about their sexuality, control of fertility, menopause, sterility, loss of sexual desire, etc.

- Rejection, disdain, or ignorance on the part of health personnel regarding a woman's own knowledge of her body and its processes, and regarding traditional practices of disease prevention and healing.

- Violation of the patient's privacy by using her body, without consulting her, as a convenient model for teaching purposes; especially when this involves touching the genitals. Medical acts are performed without asking the patient's consent.

- Taking advantage of the health professional's superiority and authority in order to fondle a woman's body.

- Subjecting women's bodies to drug abuse, particularly those drugs associated with birth control or reproductive functions, while concealing or minimizing the drugs' adverse effects. Abuse also occurs with psychotropic drugs, antidepressants, and stimulants, particularly with women in crisis.

- Use of certain technologies more for the convenience of the health personnel than for the patient's convenience or comfort or to meet technical specifications.

- Abusive use of mutilating surgery on the reproductive organs. Examples include mastectomies and especially hysterectomies, as well as the indiscriminate and unnecessary use of cesarean sections which respond more to the profit motive than to the patient's needs.

- Medical control of infertility and human fertility, especially of women, without the voluntary consent of the subjects. A case in point is the forcible sterilization of women in the "Third World," or the forced use of birth control.

- Exercise of further violence by health personnel and the police against women who have been raped, abused, or mistreated, by making the woman feel guilty when she brings a complaint or her injury is treated. The woman may also be subjected to violence during the interrogations and examinations to which she must submit in order to certify or record the facts. The violence she has suffered is often minimized, and the attacked woman is treated as a psychiatric case. The woman may be considered the guilty party, or it may be claimed that she provoked the situation, that she is making it up, or that she is simply crazy.

Mistreatment of women in the context of health care impedes the development of a humanized relationship, that is above all a democratic relationship, where there is full recognition that the other exists and that she is her own person, in charge of her body, her life, her sexuality, her desire, and her emotions. A humanized relationship is one in which two persons--with histories of their own, which may be different, and with different knowledge about the body and health processes--enter into a dialogue regarding a medical act.

4. Violence Against Women in the Home

The family, as an arena in which power is exercised, is made up of a complex network of interpersonal relationships: relations between spouses or partners, between parents and children, between young people and old people, and even between employers and domestic workers. The category of intrafamily violence includes many different forms of abuse within the family group, including abuse of children, of the elderly, of domestic employees, etc. These particular forms of abuse should be considered separately, given their specificity.

In this sense, violence against women is frequently classified as public and private violence, or alternatively as public and domestic violence. This stems from the dichotomy established between those social spaces considered to be reserved to men and those assigned to women.

Domestic violence can be defined as "an act committed within the family by one of its members, that seriously harms the life, bodily integrity, psychological well-being, or freedom of another member of the family."[43]

Within this framework, conjugal violence occurs within the family and is defined as purposeful efforts by the husband or partner to psychologically intimidate the woman, or to demean her physically, intellectually, or morally, for the purpose of making her life, body, and sexuality submit to his will and fulfill his needs.

The argument that such an order is common sense, natural, or logical is used to legitimate the unequal distribution of responsibilities within the family and of the economic, affective, and social roles that different family members should play. The arrangement assigns different and unequal value to males and females, to children and adults, to youth and old age. Women and children, boys and girls are not seen as social actors with equal weight and status within the household; they are not accepted as valid subjects or "others" in daily interactions.

When women declare themselves as having full rights and as legitimate actors in family life, they may become a threat to male domination that is based on the negation of women and children as people and that conceives of them as simply fulfilling useful roles.[44] Violence against women and children seeks to limit them to these roles, to prevent them from acting autonomously.

Within the family, and in social life in general, the man is recognized on his own merits while the woman is recognized and her role constructed in relation to others. The woman is thus first and foremost someone who performs duties, rather than a person in her own right. She is, above all, a wife, mother, and housewife, a bearer of responsibilities that subject her to the demands of others. The women's own image of herself makes it possible to use violence against her.

Marriage, motherhood, and domesticity are the critical elements in the oppression of women. These are not presented as options to be chosen of one's free will; rather, they are perceived as destiny, obligation, or cultural imperative. In this way the woman, dispossessed of her selfhood, lives her life in relation to others.

Society's definition of the love relationship does not involve full acceptance of the female partner as a legitimate and separate person within the couple.[45] On the contrary, the system is one of emotional alienation, in which children are subordinated to adults and women to men; we establish relations of dependency, not of support and assistance.

Within the family, the woman is valued not as an individual but as a provider of services: household labor, conjugal duties, mothering. These three intertwined types of service to others are expected and demanded by the male. The opportunity to be herself, to live for herself, is not part of the woman's experience. She is not loved for herself, but rather needed for the services she provides.

The differences between the roles of men and women have been transformed through the authoritarian exercise of power into a means of keeping the woman subordinate. The culture assigns authority within the family to the male as head of the household, while the woman merely substitutes in his absence; the man's role, accordingly, is to uphold the norm and enforce the woman's performance of her duties.

In the short-term violence may appear to be an extremely effective means of exercising this authority since it usually serves to paralyze the victim, rendering her incapable of displaying hostility, much less violence, in her own defense.

Violence against women in the home can be seen as an instrument of power and domination, which seeks to:

- Reaffirm male authority in relation to the woman and the family group.

- Ensure that the woman fulfills the duties and obligations assigned to her within the family. To the extent that the requirement of these duties is seen by society as a masculine right or privilege, the use of violence as a resource is validated and is not considered arbitrary or unjust.

- Impose the man's wishes in terms of the couple's relationship, sexual relations, the family, and child-rearing.

Violent acts tend to be triggered by the woman's "noncompliance" or failure to fulfill some function or task associated with her role as wife, mother, and housekeeper, or they may be responses to demands by the woman regarding the roles assigned to her partner. The most frequent pretexts for resorting to violence in the home are the woman's:

- Refusal to serve as a sexual object and/or refusal to fulfill conjugal sexual duties.
- Breaches, alleged or real, of sexual fidelity.
- Lack of promptness in performing domestic tasks: serving food, washing clothes, caring for the children, etc.
- Demand that her partner fulfill his responsibility as economic provider.
- Pregnancy.
- Objections to her partner's use of drugs or alcohol.

The violence seeks to compel obedience, punishes the woman for her transgression or deviation from gender stereotypes, and forms part of the system of social control that enforces socially determined roles for women. In this sense, the violence becomes functional in nature.

Women often accept their partner's blows as an exercise of the male prerogative. The assumption that "there must be some reason for it," that underlies society's general judgement of such situations, tends to condemn *a priori* the woman and vindicate the attacker.

When marriage and family life are based on relations of power and domination they become potentially violent, and in that sense they become risk factors for all family members in subordinate positions. Married women are expected to have sexual relations and thus are exposed to the risk of pregnancy, especially when access to family planning is impeded at the same time.

"Home sweet home" is a popular phrase that hides the ways in which the family and the couple function to reproduce social inequalities based on gender and age.

The family and the couple are not settings where everyone lives together peacefully, a paradise free of contradictions where love prevails and tyranny is unknown. The task is to examine critically the idealization of these institutions in our culture.

The demythification of the family and couple will open the way for the building of mutually supportive relations between family members: democratic relationships that make it possible to harmonize diverse interests and needs, and to exercise freedom and affection without coercion.

Love, according to Maturana, is the emotion that causes our repeated interactions with "another" to convert him or her into a legitimate other in our shared lives.[46] In this sense, democracy in the home and at the national level is first and foremost a form of social relationship that presupposes the acceptance of the other. It is an act of love; and more than an act of love it is a behavior, a way of relating to others, male and female, that makes violence impossible, since violence is a way of negating the other with whom we live.

It has been pointed out that the exercise of power/domination is not unidirectional, from top to bottom. Rather, the woman develops certain attitudes and practices in order to deal with it and turn it to her advantage, to find support against the aggressor and sympathy with her role of victim. The woman makes use of opportunities to exercise power and domination in order to impose her own authority, and to turn abusive conditions in her favor by using her affection, children, or sexuality as bargaining chips. Women will utilize emotional/sexual elements as a strategy to resist power and to influence decisions made inside and outside the family (exchange of sex for decisions, blackmail using the children, manipulation). Rendered helpless by the culture to openly challenge the power held by men, she is a patriarchal woman; she develops covert ways of resisting and of exercising power and authority that involve other members of the family, who in turn are subordinate to her; in other words, she constructs "parallel channels of authority."

Perpetrators and victims of the violence take part, each in his or her own way, in a consuming and deceptive dynamic in which the male exercises his rights as defined by the culture. Tied structurally to the authoritarian and patriarchal family, he applies measures, sanctions, and punishments in order to preserve and strengthen his role as possessor of the

woman and of the children, and as the one who keeps order within the family. The woman, in turn, assumes the role of victim, and from this position often attempts to undermine her partner.

Breaking out of a relationship of dependence and violence implies, for the woman, the search for an identity that calls into question the structure of social relations that serves to legitimize its use and allows her to move from the role of victim to liberation and self-affirmation.

V. PROPOSED STRATEGIES AND LINES OF ACTION

1. Preparation and Adoption by the Member Countries of the Pan American Health Organization of a Charter of Health Rights for the Women of the Americas

In keeping with the international legal instruments that call for the protection of women against abuse and other forms of discrimination, it is proposed to draw up a Charter of Health Rights for the Women of the Americas as a creative vehicle for giving effect to these instruments. Particular account would be taken of the Convention on the Elimination of All Forms of Discrimination against Women,[47] considered to be the Magna Carta of women's rights, and the Nairobi Forward-looking Strategies for the Advancement of Women. The recommendations of international agencies, despite the efforts made to disseminate them, still have only limited public circulation.

The proposed Charter is considered an educational medium that will enumerate the commitments to women made by the health sector and point out policy and program orientations that should be promoted by the sector in order to guarantee full exercise of the right to health by the women of the Americas. The aim is to convert the health services into instruments that will enable women to exercise their rights to health.

The Charter of Health Rights for the Women of the Americas should expressly set forth:

- The right of women to decide freely on matters that concern their own lives, their bodies, their emotional lives, their sexuality, and their health.

- The right to health education that promotes women's autonomy, self-determination, and self-care based on self-respect and reaffirmation of their rights.

- The right to comprehensive care geared to their specific needs, taking into account age, ethnicity, social class, place of origin, and sexual orientation.

- The right to receive dignified treatment in the health services that takes into account the particularities of their biological, psychological, and social histories and ensures respect for their intimacy and privacy.

- The right to freely chosen, safe motherhood.

- The right not to be discriminated against for exercising their sexuality and the right to have their reproductive choices respected.

- The right to have the processes associated with their biological condition, such as menstruation, pregnancy, delivery, the puerperium, menopause, and aging, approached as natural processes, not diseases.

- The right to adequate and sufficient information for the free, satisfying, responsible, and safe exercise of their sexuality, without this necessarily being linked to reproduction.

- The right to health services that provide comprehensive attention to the problems of women who are victims of abuse or at risk of abuse--that is, access to programs to prevent various forms of abuse and to provide care and rehabilitation.

Lines of Action:

- The Pan American Health Organization (PAHO) will encourage the countries to present initiatives for the drafting of the Charter of Health Rights for the Women of the Americas. PAHO can promote the coordination of efforts and resources within the United Nations system in order to support the countries and participate in the initiatives of other agencies.

- The countries will hold advisory meetings with the specialized agencies and nongovernmental organizations concerned with the advancement of women and the promotion to women's rights to encourage such organizations to present their initiatives.

- The countries will form high-level, interdisciplinary commissions to guide national consultation processes.

- The countries will organize national, regional, or local events on the health rights of women in which international instruments on nondiscrimination will be disseminated, with particular emphasis on the right to health as a substantive part of the right to life. From the health perspective, this is one way of helping to ensure that the instruments are publicized and implemented by the sector.

- Health sector educational plans will include the topic of women on their agendas, particularly with regard to their human rights, including the fundamental right to health.

- The countries will seek mechanisms to allow broad participation by sectoral organizations and trade and workers' associations in the discussion on the proposed Charter of Health Rights for the Women of the Americas, with a view to raising awareness among them of the situation of the health rights of women.

- The countries will be asked to commit themselves to sign the Charter of Health Rights of the Women of the Americas, to disseminate it widely in the institutions of the sector and related agencies, and to initiate processes to educate people about the Charter.

2. Coordination and Harmonization of Intervention Policies and Programs

As already noted, the problems posed by violence against women are of a profoundly cultural nature, and accordingly do not fall solely within the competency of the health sector. Efforts to address these problems, led by the health sector, must be intersectoral, given the broad range of forms and places in which violence occurs. Large-scale community mobilization is required in order to promote the implementation of prevention policies, plans, and programs on the part of the State and civil society.

The communications media; social and family welfare institutions; political parties and organizations; scientific academic, and professional institutions; nongovernmental organizations; women's and human rights organizations; churches; and volunteer organizations in the area of health should coordinate and pool their efforts in order to augment their resources and respond more effectively to this problem.

Lines of Action:

- Encourage the various governmental agencies and the institutions of civil society to assess the situation of violence against women and girls in different social settings.

- Disseminate information regarding the problem through the mass media and encourage academic and scientific institutions to present their research and recommendations on prevention, assistance, and rehabilitation.

- Facilitate intersectoral meetings to obtain further knowledge of the problem of violence against women and girls and to move forward in adopting plans to commit the various social sectors.

- The Governments of the Region, under the leadership of the health sector, should promote the establishment of national offices to coordinate programs of support for female victims of violence. These programs will include the public, nongovernmental, church, and private sectors in order to strengthen their resources and effectiveness by promoting legislative, educational, and health initiatives. These mechanisms might be

of an interinstitutional nature. Nongovernmental organizations should also be encouraged to participate in such efforts.

3. Legislative changes

It is important to introduce modifications into the laws, since the standards of various countries are based on patriarchal value systems that favor impunity for crimes against women, resulting in an inadequate legal response to the problem.

On this basis, it is necessary to support the elimination of penal codes that include crimes against honor, sexual modesty, chastity, and the family, and to propose their treatment as crimes against personal freedom and integrity. The continuing existence of these biases in the law is based on a concept of women that relates primarily to the exercise of sexuality and on patriarchal moral guidelines that define crimes in accordance with such parameters as female chastity, associated with sexuality and a good name and reputation.

In some cases the victim's sexual past is used as a pretext to reduce the penalty in case of rape or sexual abuse. Thus, in cases involving a domestic servant, prostitute, married or divorced woman, woman in a free union or with sexual experiences, the exercise of her sexuality becomes a basis for discrimination in applying the law. In contrast to this, the offense should be considered more serious when the offender is related to the victim, lives with her, or is in a position of authority over her.

When such crimes are treated as crimes against the family--especially in the case of incest--it is suggested that reforms be undertaken that would focus on protecting the woman, since it is she who has suffered the assault, and it is her basic human rights that are violated. Also, it is urged that the woman's style of dress, or her consumption of liquor or drugs, not be considered as circumstances lessening the gravity of the offense. Circumstances that may have affected the aggressor (an abusive family history, alcoholism, consumption of psychoactive drugs, emotional deprivation, etc.) should be taken into account in designing a plan for his rehabilitation, but should not reduce the sentence.

Sexual harassment should be approached as a work-related problem and considered a form of discrimination that should be addressed by workers' organizations, since it affects security in the workplace. It is recommended that union organizations adopt a contractual clause under which employers commit themselves to ensuring that their employees understand that "sexual harassment is unacceptable behavior in the company" and to imposing sanctions on those who engage in any activity considered to constitute harassment. In addition, employers should be asked to agree to transfer the instigator of the harassment, not the victim, to a different work situation.

The health sector should seek closer working relationships with the sector responsible for social and family welfare, and with such institutions as family commissariats, family welfare, etc. In this sector it is very important to question the traditional concept of the family: the abuse of a child can cause abuse of the mother to be overlooked. There is often a kind of fixation on preserving the family unit at the expense of the woman's well-being and integrity, the result of which is to perpetuate her subordinate status within the group.

The health sector will seek links with the education sector to develop programs of training for life. These should promote autonomy and self-determination, especially as regards the exercise of sexuality, and contribute to the destruction of myths and stereotypes concerning what is feminine and what is masculine. This in turn should help to develop skills for the appropriate management of family conflicts.

By coordinating efforts and resources, the authorities in the health and education sectors can promote the formation of working groups in primary and secondary schools that deal with the subject of human sexuality and women's rights, with emphasis on the health rights of women. These will encourage open discussion of topics such as rape, incest, physical abuse, and sexual harassment in the school and in the family. The groups will carry out training on the subject of respect for human differences. These actions are of fundamental importance, given that the school years have a definitive influence on the formation of the adult personality. It is during this period that individuals have the potential to develop as human beings capable of accepting others, both male and female, and of living together in mutual respect, with self-acceptance the basis for recognition of the other.

Similarly, it is important to introduce into the university curriculum, at the undergraduate and graduate levels, subject matter that deals with the exercise of power in human relationships and its impact on health, taking into account the differences between the genders. By the same token, it is necessary to advocate the incorporation of the gender-specific approach in the analysis of social dynamics and in the treatment of health and educational topics by the health sciences.

4. Development of Health Care Models for Women and Girls who are Victims of Violence

Health care agencies should increase their mental health care and education programs to promote the healthy exercise of sexuality. For this purpose there is an urgent need to expand professional psychological and social services.

Ties between the health sector and the legal sector should be established and consolidated with a view to providing immediate care for the victims of violence. There is an urgent need to link institutional legal services and forensic medicine offices with emergency health services in order to provide mutual feedback. In addition, legal aid services that provide assistance to women and girls who are the victims of violence or who are at risk of violence should be prepared to provide guidance and refer them to the appropriate health sector institutions.

Workers in the health sector should be informed as to how to interview and refer victims of violence. From the legal standpoint, health sector workers should be capable of directing victims of violence to other institutions that can provide assistance. Workers in the legal area should also be similarly trained.

Training programs should also be promoted for the health officials and providers who are responsible for the care of women, particularly at the local level.

It is also important to pursue educational strategies to rehabilitate victimizers and to teach men to control their aggressiveness. Rehabilitation programs are primarily aimed at abused women, but the aggressors should also be a focus of intervention. In this connection, a possible approach might be self-help groups for men designed to help them reassess male and female stereotypes.

The health services should do everything in their power to ensure that abused women receive information on the internal and external institutional resources available to assist them. Prevention measures should include public information and educational programs designed to promote women's autonomy, self-respect, and self-determination with regard to their lives, their bodies, their sexuality, and their emotional relationships.

The sector should promote the preparation of directories of governmental and nongovernmental health and legal resources that provide assistance to victims of abuse and disseminate them widely among the population seen by the services. In addition, there should be mass dissemination through the communications media, churches, community organizations, etc.

One of the measures suggested for linking the medical and legal aspects of the problem is to stipulate that the victimizer must pay for medical and psychotherapeutic treatment for both the victim and her family, and also that the aggressor must submit to psychological treatment or counseling as part of the penalty.

The two sectors should envisage shelters, 24-hour hot lines, (which could be staffed by volunteer personnel, students performing social service, trained students, etc.), counseling services, rehabilitation of survivors, and support services for women and girls who are victims of violence and at risk of violence.

In order to characterize a situation as high-risk, various criteria should be considered, including the family history, the number of violent episodes, use of psychoactive drugs, the exercise of authority, etc. International organizations also recommend considering as potentially violent situations in which women are discriminated against by virtue of their ethnicity; their status as migrants, refugees, or displaced persons; pregnancy, age, disability, or poverty; or armed conflict or imprisonment.[48]

Health institutions have a limited capacity to respond to the problem of violence against women, with regard to both prevention and care, and therefore the practical and theoretical experience of the nongovernmental organizations should be used to the fullest extent. The strength of the nongovernmental organizations lies in their broad experience in training and education, both of women's groups and institutional sectors, in areas such as the training of monitors, legal procedures, self-help, research, and advisory services.

In cooperation with the specialized police units and the legal aid services offered by university law programs, legal assistance can be made available to abused women and girls in hospitals and health centers. This approach will require that prior training be provided to the workers responsible for assisting women.

There is a need to establish systems of epidemiological surveillance that permit the early identification of abused women and of women and girls in high-risk situations. Abused women may be admitted to the health services on an emergency basis in extreme instances, but it should not be forgotten that most abused women will be detected in outpatient consultation. Accordingly, it is necessary to formulate questions and set up surveillance systems that will make it possible to identify these women, so as to provide the necessary institutional assistance, both psychological and social.

Registry and follow-up are intended to gather data for the surveillance system; however, statistical surveys can also provide a data base for research and give greater insight into the problem, so that the findings can be disseminated among the population to raise public awareness of the problem.

Systems of epidemiological surveillance for abused women should design their own registries that not only record the type of injury, the time of the event, the history and frequency of occurrence, but that also clearly identify the relationship between the victim and the aggressor. Although the surveillance system focuses on the victim, the focus of intervention should be the social relationships in which she is involved and that have enabled her victimization.

Community participation is fundamental for the establishment of systems of epidemiological surveillance within the local health systems. Women's rights organizations and other organizations in which women traditionally participate, most often invisibly (parent-teacher associations, church groups, the Red Cross, voluntary agencies, etc.), can make a fundamental contribution to the process of assisting abused women.

In neighborhoods, organized groups of women can set up networks for referral to local health systems, family councils, the police, or whatever other related institutions may exist. Women's institutions and organizations can also help to do away with the situation of official

impunity that exists with regard to violence against women, and with the support of governmental institutions they can promote educational campaigns concerning the rights of women and children.

Self-help groups for women who have been assaulted, raped, or abused are forms of self-management in which women take matters into their own hands in confronting such violence and its origins. Group discussion of the isolated incidents experienced by each woman makes it possible to put them in a social context, thereby contributing to collective management of the problem.

Joint intervention programs involving the health sector and women's organizations would provide an opportunity to stimulate participatory policies of greater scope and coverage, and to raise awareness within the health sector of alternative gender-based methods of preventing violence against women.

The health sector can promote community participation by women in creating and disseminating means for controlling and condemning abuse, with a view to dissuading or shaming aggressors. Examples of such means include publicity posters; the setting up of social tribunals to judge and make an example of crimes and violations of women's human rights; creation of committees to monitor sexual harassment in workplaces, schools, neighborhoods, etc.; and formation of networks of temporary housing to shelter victims of violence and abuse.

5. Promotion of Research

There is a need to promote research on alternative methods of providing care and protection to victims, and to work to design methodologies of prevention and crisis intervention, as well as ways of providing systematic support to victims of various kinds of violence.

Efforts should also be made to investigate possible new interpretations of the phenomenon of violence and its etiology, since the design of intervention policies is directly related to the study of causality, particularly as regards the relationships between family violence and female suicide, poor mental health, abortion, unwanted pregnancy, and sexuality.

Steps should be taken to design research/action programs on specific topics with a view to developing methodologies of intervention and care. Such topics might include, for example, conjugal violence, incest, women who are victims of political violence, women who are victims of rape, etc. The programs can then be disseminated in the Region in order to train human resources to carry out interventions on the problem.

6. International Technical Cooperation

International technical cooperation should promote the exchange of the experiences of different countries in approaching the problem, from the standpoint of prevention and assistance. In addition, it should provide assistance in the preparation of integrated legal, educational, and health policies and programs.

The countries will be encouraged to gather information on violence, on studies of the subject, and on proposals for intervention as a means of enriching regional knowledge.

The Pan American Health Organization will urge that the records of deaths from external causes be disaggregated so as to reveal those deaths related to domestic and/or conjugal violence or other forms of abuse, especially conjugal homicide, with a view to establishing unified record-keeping systems throughout the Americas that will make it possible to quantify the problem and gain a more accurate picture of its true dimensions, as a basis for the formulation of more realistic policies and programs.

Programs and policies on the training of human resources for the sector should include issues relating to gender and health, as well as power relations and the abuse of women and girls. Regional bulletins that already exist or that may be created for this purpose will be used to disseminate progress in knowledge, diagnosis, and prevention\rehabilitation programs, and to publicize steps taken by the international community to recognize violence against women as a priority public health problem.

Further, PAHO will recommend that the governments of the Region treat violence against women as a priority public health problem, and the Organization will promote the creation of support services for women and girls who are victims, or are at risk, of violence.

Technical cooperation should be provided to facilitate the training of national human resources, both governmental and nongovernmental, and to promote various initiatives, such as meetings, seminars, and publications, as well as the development of programs and proposals for intervention, in terms of both prevention and assistance and rehabilitation.

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