Raising Awareness about Violence among Women with Disabilities

Includes:
Final Report

By Jennifer Morand, Kaitlyn Murray, Lisa Kuipery

Completed for: YWCA Peterborough
Supervising Professor: Peggy Watton, Trent University
Trent Centre for Community-Based Education

Department: Nursing
Course Code: NURS 3020H
Course Name: Community Health Nursing Care
Term: Fall 2010
Date of Project Submission: December, 2010

Project ID: 4150

Call Number:

Learning Goals

1) Realistic and manageable plan of action on how to raise awareness about violence against female students with disabilities at Trent University and Fleming College.

2) Creating a sense of community and support for female students with disabilities at Trent University and Fleming College experiencing violence through promoting and holding a focus group.

3) Creating a network of people to be involved in and support the issue as well as creating a trusting relationship with the students involved.

Definitions

Violence:

Intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. (Krantz &Garcia-Moreno, 2005)

Disability:

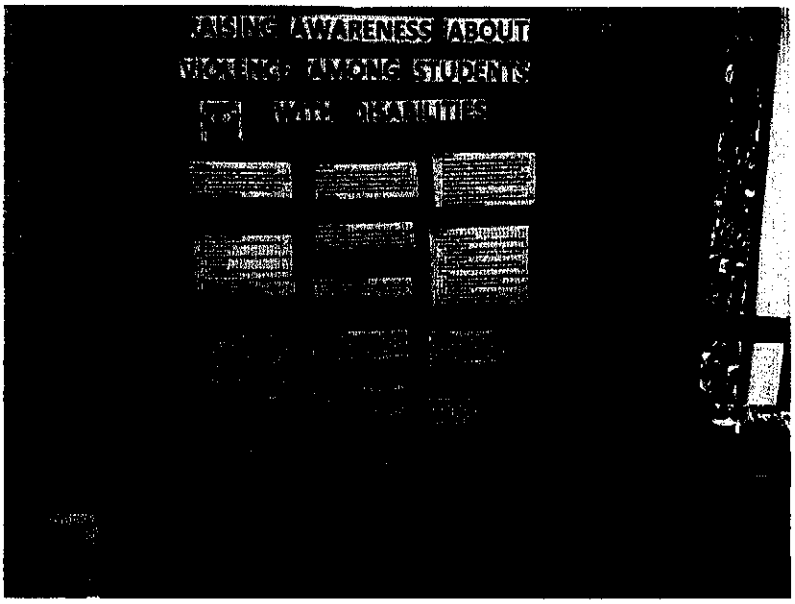
A condition or function judged to be significantly impaired relative to the usual standard of an individual or group. (Disabled World, 2010)

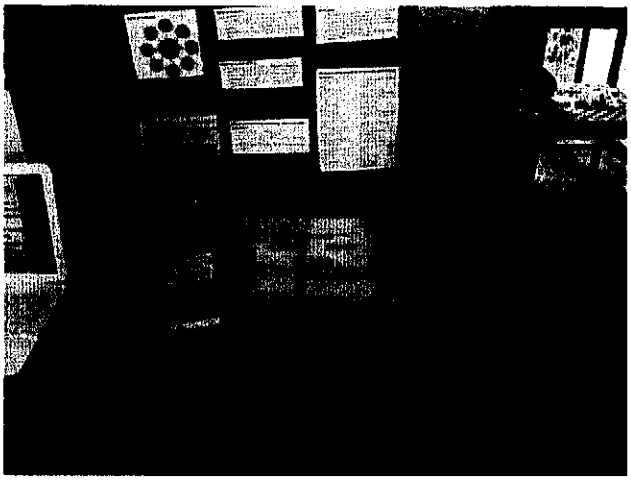
Violence and Disability:

In the context of violence against women with disabilities, refers to physical, psychological or sexual maltreatment, abuse or neglect of a woman with disabilities by a relative or caregiver. It is a violation of trust and abuse of power in a relationship where a woman should have the right to absolute safety. (DAWN)

POSTER PRESENTATION

Trent University - November 29th, 2-4pm





Trent Windshield Survey

***Boundaries*:** Trent University Symons campus. West bank drive, Nassau Mills road, East Bank drive, River road.

Housing: Residences for on campus living comprised of our residence buildings, Otonabee College, Lady Eaton College, Gzowski College, and Champlain College. All have single and double and triple rooms available. There are common co-ed bathrooms in all residences except for Gzowski College which is all single rooms with private shared bathrooms between two rooms. Gzowski College is also the only residence building accessible by elevator all other residences are stairs access. Lots of off campus student housing is available downtown Peterborough which can be access by Trent express bus system.

Signs of decay and/or pollution: Campus is well maintained throughout all seasons. Trent is an environmentally friendly school so pollution is kept at a minimum.

Colleges on Campus:
Trent University:
- Otonabee College
- Lady Eaton College
- Champlain College
-Gzowski College
- Catherine Parr Trail College (downtown Peterborough)
- Blackburn
- Bata Library
- Athletics Centre
- Day Care Centre

Parks, recreational areas: Well kept green space areas with benches throughout the campus. Playground area at Trent Children Daycare, well kept and appears to be in safe working condition. Trent Community Sport and Recreation Centre is available to students on campus with stadium access for sports teams and recreational use.

Religion: Posters promoting church services at Lady Eaton College. Chapel located in Blackburn college.

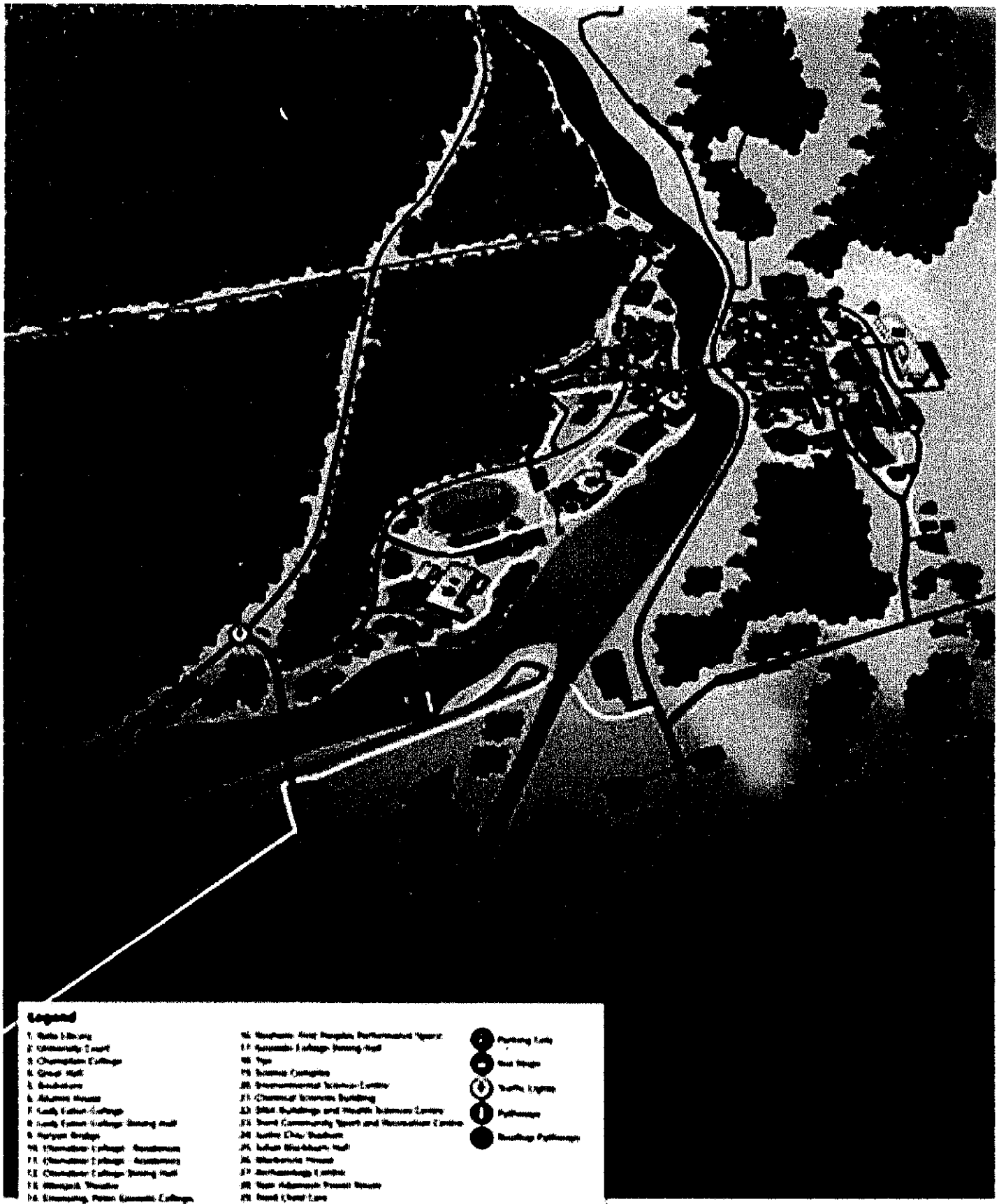
Transportation: Multiple parking lots around each of the major buildings, which are pay and display. Parking passes available. As well as Trent express buses on each side of campus every 20minutes and public transportation bus (George North, Nicolls Park) stop at the campus every 40minutes.

Health and social service agencies: Trent health services is located in Blackburn college as well as counseling services.

Economic: Student jobs possible at the Athletics centre, bookstore, TCSA, library, Blackburn, Campus pub.

Protective service: Trent security systems. They are evident driving around campus as well as emergency button poles well placed all over campus. Security office is located in Blackburn hall. Walk-home services available on campus and downtown. TUEFRT – emergency first response team.

General: Some graffiti around the campus, does not seem gang related. There is an abundance of posters promoting student events both on campus and downtown. As well, there are many posters raising awareness for a variety of issues. Trent has a wide range of cultural and religious groups; all groups appear to co-habitat very well, there does not appear to be any discrimination or domination by one group. Does not appear to be very accessible. Few buildings have elevators and ramps and the campus is filled with stairs and steps, awkwardly placed ramps which some are very steep.


Legend
Parking Lots
Bus Stops
Traffic Lights
Pathways
Roadway Pathways

Tuesday, October 12th, 2010

Meeting/ interview with Eunice Lund – Lucas, Trent D.S.O Manager @ 11:00.

Overview of Interview:

Our team introduced the project and asked general questions about the prevalence and some suggestions in ways to gather more information and other contacts to reach to help make this project successful.

Information Gathered:

- Her impression was that over the last 20 years she was dealt with very few incidences. In that often times it was the employed caretaker that was doing the violent act due to their disability. She believes that these violent acts are often the outlet of frustration and most often lack of knowledge about individuals with disabilities.
- The number of students attending Trent University with dependant disabilities is low therefore, the incidence is low. Often times the act of indifference that could be provoked by a mental illness can also cause that student to become a target for violence.
- She suggested that we look at violence against women because you cannot depict whether is it caused by their gender or that they live with a disability.
- She also recommended booking the B1, 107.1 Room for our focus group that will be held at Trent University, because it is close to the disabilities office and they may feel more at home there.
- Another suggestion was to facilitate 2 different focus groups. The first, targeting the audience with disabilities. And the second, for the broader Trent University community to support the cause and possibly discuss other strategies.
- Increasing awareness through e-mail distribution was another suggestion. Eunice Lund – Lucas also offered her help with this and giving us an area to put our poster up.

Monday October 18th, 2010

Meeting/ interview with John Paul Nyereka, Trent Vice President of student issues @ 11:00

Overview of Interview:

Our team introduced the project and asked about possible positions on the Trent Central Student Association (TCSA) that could help increase awareness about violence occurring among students with disabilities. Furthermore, we asked about his experiences we came to raising awareness what strategies worked for him and what did not.

Information Gathered:

- He suggested that we get into contact with Jess Sachse, who has not only worked for the YWCA in the past, but also works with the Trent Arthur. Therefore if there is a time where we would like to post information or our raising awareness posters we could contact her at jes.sachse@gmail.com
- It was also pointed out to us that the Student with Disabilities Commissioner position was vacant. Therefore, this whole semester there had been no one elected to advocate for these individuals.
- The TCSA is also in charge of certain spots throughout the Trent University, for example the booth outside the library. If there was every a time that we wanted to raise awareness we could book one of these spots.
- If we wanted to communicate with the larger population he also offered us access to their e-mail distribution list.
- John Paul also made it clear that his position as V.P of student issues has a high turn over rate but this e-mail address: vpissues@trentu.ca will always link students to the individual who is filling that position at that time.
- This research study will also be included in his write up when he decides to step down from this position. The write up will include what our research is about and how the V.P of student issues can aid in the continuation of raising awareness and the importance of filling in the Student with Disabilities Commissioner position.

Hi Everyone,

We are from the Nursing 302 class and for our Community placement we are doing research for the YWCA on how to raise awareness about violence against female students with disabilities at Trent and Fleming. We are focusing on the student population as a small part of a larger project geared towards the raising awareness in the community. We are trying to gather ideas and suggestions on how to effectively raise awareness on campus here at Trent as well as we are open to hearing your ideas about suggestions for the community.

We are planning to meet on Tuesday, November 30th at 3:00-4:00pm and 4:00-5:00pm in Room BL 107.1 in the Bata Library. We would greatly appreciate if you would come on out and share your thoughts and suggestions on this important issue with us. Feel free to drop by for 5min or for an hour. We will ensure your confidentiality.

Please note that we have attached a copy of the questions we may be covering at the meeting so you can come prepared with your ideas. Also, if you are unable to make it and would still like to contribute your suggestions please feel free to email us at kaitlynmurray@trentu.ca

Thank you and hope to see you on Tuesday!

Kaitlyn, Jennifer and Lisa

Trent Focus Group

Time Period: 3-4pm 4-5pm E-mail

Number of Participants: _____

1) Do you think the issue of violence against women with disabilities is problematic on the Trent University campus?

2) What do you feel the key ingredients of a healthy relationship are?

3) What, in your opinions, may be indicators that a relationship is not healthy?

4) Do you feel there are adequate services, for help or support if you need it? Do you feel you have somewhere to go if you need help?

5) What would you like to see done, in the aspect of raising awareness? Example, putting up posters, e-mail distribution, pamphlets, etc.

Trent Focus Group

Time Period: 3-4pm 4-5pm **E-mail**

Number of Participants: 1

1) Do you think the issue of violence against women with disabilities is problematic on the Trent University campus?

   "I am not aware of how much violence against women there is on campus however, I am aware that there is a lot of violence against women with mental and physical disabilities."

2) What do you feel the key ingredients of a healthy relationship are?

   "Trust, good communication, loyalty, healthy conflict resolution, respect, support, unconditional caring and commitment."

3) What, in your opinions, may be indicators that a relationship is not healthy?

   "Verbal abuse, physical abuse, lack of trust and jealousy"

4) Do you feel there are adequate services, for help or support if you need it? Do you feel you have somewhere to go if you need help?

   "Counselling services at Trent. Otherwise, I am not aware of other services at Trent."

5) What would you like to see done, in the aspect of raising awareness? Example, putting up posters, e-mail distribution, pamphlets, etc.

   "email distribution and teaching students (males and females) about healthy relationships, phamplets, posters for both males and females."

6) Where do you think violence usually occurs, at school or at home, between intimate partners or caregivers?

   "Violence usually occurs at home between intimate partners."

7) If you were in charge of conducting an awareness campaign for this issue, what would you do?

"Educate people on healthy relationships and the issue of violence against women with disabilities especially women with mental or physical disabilities."

8) What are the greatest barriers in raising awareness?
"It's a taboo topic."

9) Are there any helpful resources within the community that you feel comfortable going to?

"Trent students aren't informed about community services they can access."

Other comments made:

Data Collection and Findings

The main source of data collection was through e-mail distribution. Consent was obtained and participants were asked to respond to 9 questions. Our main goal was to collect the majority of our data through a focus group, however our focus group proved unsuccessful and no data was gathered through this source. One participant responded to our e-mail. The message that was sent out by e-mail distribution was friendly and informal; we did this in order to create a comfortable atmosphere. The e-mail briefly introduced the researchers as well as the project.

Our focus group demonstrated certain limitations. The date organized for the focus group was close to the Trent University examination period. As a result, students may have had hectic schedules and been under pressure and did not have the time to attend our focus group. The focus group was also directed to a specific population; only students who were using the disability service office. With the wide ranges of class schedules it was also difficult to organize a time to facilitate a focus group where most of the students were available to attend.

Feedback from the participant indicates that this it still a *"taboo topic"* and stresses that *"Trent students aren't informed about community services they can access"*. The participant also mentioned that other than the counseling services at Trent University, there was not another service that they were aware of. Therefore, this informs us that there is room for the expansion of this project in the future. The participant suggested that the researchers should continue to use e-mail distribution to raise awareness about this issue, as well as distributing posters and pamphlets for students across campus. Moreover, the participant suggested shifting the aim of our project from gender-specific to a more universal perspective.

"I am not aware of how much violence against women there is on campus however, I am aware that there is a lot of violence against women with mental and physical disabilities" (participant 1) The statement above suggests that there is a need for health promotion at the Trent University campus when referring to this issue. There is also a need for further research on raising awareness for students with disabilities.

Our group has put together a portfolio with our recommendations in hopes that next semester or in the future, a group of nursing students will be able to use our research as a guide to continue this project.

Fleming Windshield Survey

***Boundaries*:** Lansdowne Street, Brealey Drive.

Housing: Residences available on campus: Sutherland Residence Village. Suite style living accommodating six students with single bedrooms, shared kitchen, living room and washroom facilities - completely furnished. Floors are co-ed with separate suites for females and males. Accessible rooms are available at both campuses, accommodations are provided for physically challenged students. Smoke Free Living Environment and air Conditioned in summer months. On-site laundry facilities and limited indoor bike storage. Games room, fitness room and quiet study areas, with wireless capability. Off-campus housing available around the campus and downtown Peterborough.

Signs of decay and/or pollution: No signs of decay but current construction occurring so clutter and construction equipment around. No evidence of large pollution, some litter on the ground though.

Parks, recreational areas: 200 acres of park-like green space. Sports fields around the campus well maintained. Fleming wellness centre at one end of the campus.

Religion: Nothing apparent.

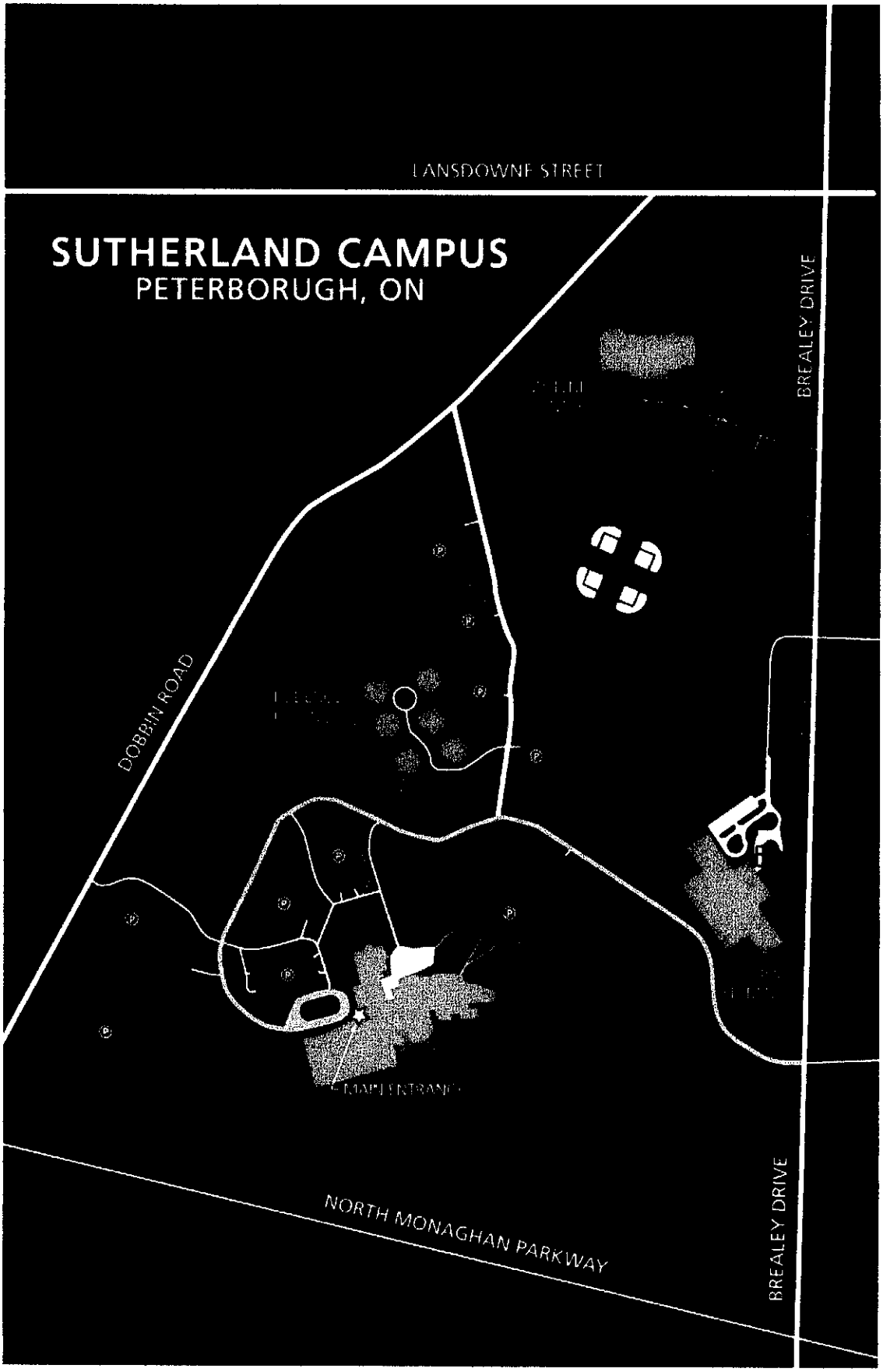
Transportation: Fleming Express, Lansdowne public transit, SSFC/Kawartha public transit all stop on campus every 40minutes.

Health and social service agencies: Health services and social services available on campus. Also career services, counseling services, disability services, learning support services and learning resources are all available on campus.

Economic: Jobs available at the Fleming Wellness centre, bookstore, student union, and campus bar and through career services.

Protective service: Uniformed guards patrolling the campus and residences. House Safety Phones and Code Blue Emergency Posts, located throughout the College. Surveillance cameras located inside and outside the College to deter unwanted behaviour. An Emergency Notification System is in place to provide information to the community during an emergency. Emergency Procedures are posted in public areas, lecture theatres and in classrooms. A Safe Walk Service is available in the evenings to walk with you while on campus. Contact Security at the Information Kiosk or at extension 8000 to arrange for a guard to meet you.

General: Some obvious segregation through school due to uniforms worn by certain programs (paramedics, nursing), people in these uniforms can most often be seen together. There are lots of posters and promotional flyers up around the campus promoting student events. There is a different atmosphere in the student centre (bar, lounge) than throughout the rest of the building.


LANSDOWNE STREET
SUTHERLAND CAMPUS
PETERBORUGH, ON
BREALEY DRIVE
DOBBIN ROAD
NORTH MONAGHAN PARKWAY
BREALEY DRIVE

Monday, October 18th 2010

Meeting/ Interview with Audrey Healy, Fleming Counsellor @ 3:00pm.

Overview of Interview:

Our team introduced the project and asked general questions about the prevalence and some suggestions in ways to gather more information and other contacts to reach to help make this project successful.

Information Gathered:

- Counselling services don't keep track how many people report cases of violence as a whole, but categories are a lot more specific and it would be hard to delegate how prevalent the issue is.
- Main issue that counselling services deals with is, drinking and substance abuse problems.
- The demographic isn't at Fleming, a lot of 18-19 year olds and older part time students, only at the school for approx 2 years.
- Focus group would be unsuccessful and no one would likely show up, if wanted to reach out to students it might be more successful out in the community
    - Since the campus is small and is all mainly one building it is hard to maintain privacy going to a focus group.
- Posters and posting information on new TV`s that are put up around the school.

Monday, October 18th 2010

Meeting with Jessica Spooner, Fleming Services and Sustainability Coordinator @ 2:00pm.

Overview of Interview:

Our team introduced the project and asked general questions to get some suggestions of ways to reach out to students on Fleming campus and the most efficient ways to raise awareness at Fleming.

Information Gathered:

- Fleming population is apathetic, students are very busy and it is difficult to reach them.
- Posters and booths set up are effective.
- Most of the students live in the 6 residence buildings on campus and Old residence off campus. Making a flyer that can be distributed into residents mailboxes.
- Student representatives could make announcements before classes start.
- As well as making announcements or have a booth in the student bar/common area.

Social Policy & Society 8:4, 475–485
© Cambridge University Press 2009 doi:10.1017/S1474746409990054

Defining the Issue: The Intersection of Domestic Abuse and Disability

Jennifer Nixon

Ruskin College, Oxford and an Associate Fellow at the Rothermere American Institute at the University of Oxford
E-mail: jnixon@ruskin.ac.uk

This paper reports the findings of a qualitative study on the politicisation of domestic violence as it relates to the experiences of disabled survivors and argues that definitions of domestic violence are currently being debated within the disability and domestic violence spheres. Data are drawn from interviews with participants who have been active in politicising this issue and are affiliated to either the disabled people's movement or the movement against domestic violence in England and North Carolina. Although this issue is becoming increasingly politicised, this paper argues the process is currently marked by widespread discrepancies in defining domestic violence experienced by disabled people.

Introduction

This paper will explore ongoing efforts to politicise the needs of disabled women who experience domestic violence and examine some emerging issues that are likely to presage the way in which services for these survivors are developed and resources for these services are obtained. First, however, we must consider two different ways in which an issue can be considered political. An issue can be deemed politicised when it is 'contested across a range of different discursive arenas' (Fraser, 1989: 166). Politicised needs, then, will be the subject of wide-ranging debate and discussion that goes beyond the boundaries of a single activist, economic, political or domestic sphere. In a second sense, political issues and related needs are those that are administered directly by the state and its agencies, in contrast to those issues handled within either the family or the market economy. We can thus surmise that social issues will become politicised through widespread debate and contestation before they become objects of state intervention; in this way, the two meanings are closely connected (Fraser, 1989).

The needs of disabled women survivors of domestic violence are clearly in the process of politicisation, as efforts to define, address and meet these needs are ongoing in a number of spheres, including sites of social movement activism where this research is situated. Two key spheres of activism, the disabled people's movement and the movement against domestic violence, are taking up this issue in efforts to both increase awareness of this set of needs and to shift responsibility for meeting these needs away from the private or family sphere, where domestic violence is characterised as primarily occurring, and into the public sphere, where social needs are addressed through service provision and resource allocation.

This instance of need is primarily in what Fraser (1989) identifies as the second phase of politicisation, in which the parameters around this area of debate are being drawn. This paper will explore one key area where these efforts at politicisation are diverging:

in the definition of domestic violence in relation to disability. The focus will be primarily on disabled women who experience domestic violence. Much of the work being done within the movement against domestic violence is directed towards women experiencing violence at the hands of a male perpetrator, which is the usual pattern of abuse (Tjaden and Thoennes, 2000; Walby and Myhill, 2004; US Department of Justice, 2005; Home Office, 2007). Nonetheless, the complex dynamics of domestic violence do not always conform to this gendered model. Heterosexual men can experience abuse from female partners, abuse can occur in same-sex and LGBT relationships and, crucially, an imbalance of power and control can result in abuse in caring relationships.

The paper begins with review of widespread discourses and definitions in use around disability and domestic violence. It then moves on to examine data from interviews with activists and professionals working to politicise the needs of disabled women experiencing abuse in both England and North Carolina. It explores how individuals from these two politically active spheres are conceptualising the issue in their efforts to raise awareness of this particular set of social needs. The aim of this paper is not to draw comparisons between the two sites but instead to explore existing tensions around defining domestic violence as it relates to disabled people in terms of intimacy, caring and gender. These issues will be considered alongside the possibilities for expanding current conceptualisations of domestic violence.

Disability and domestic violence discourses

Evidence of shifting concepts of disability is apparent in changing discursive practices. Disability has historically been missing from discourses that are not health-specific (Fawcett, 2000). Where mainstream health discourses have been disability-specific, they have tended to focus largely on the impairment and treatment of disabled individuals, locating the problem within the body of the disabled person and seeing the causes of disability as 'physical, behavioural, psychological, cognitive and sensory tragedy' (Depoy *et al.*, 2003: 177). Medicalised discourses like these emphasise the potential for diagnosis, treatment, adaptation and medical interventions intended to bring about recovery or, at the least, to mitigate the effects of the impairment. This leads to a focus on body, the impairment itself and the limitations it causes rather than the person and their capabilities (Crow, 1996; Stone and Priestly, 1996; Corker, 1998). These dominant medicalised discourses have historically held strong footholds in a variety of institutional sites, including health care, educational and social service arenas. Nonetheless, they have been the subject of a sustained challenge by the disabled people's movement that has brought about significant changes in the way disability is conceptualised and treated.

The disabled people's movement in both the UK and US has been a key site of activism for addressing the exclusion of disabled people from public and social life for more than three decades. The movement began in the UK with the formation of the Union of the Physically Impaired Against Segregation in 1972 and continues to be an active force in shaping personal, academic and professional thinking around disability (Shakespeare, 2006). In the past, disability policy has legitimated the segregation of disabled people from the non-disabled population (Morris, 1991; Drake, 1999), which can be seen in the institutionalisation of disabled people in both the UK and the US (Finkelstein, 1980; Murray, 2003). The movement's opposition to segregation is reflected in the way in which

disabled people have rejected medicalised categorisations of disability as divisive (Corker, 1998) and instead emphasised the common forms of oppression and marginalisation that all disabled people can experience solely as a result of their disability (Rioux *et al.*, 1997).

The movement has worked to change disability discourses and thus transform the lived experiences of disabled people by resisting those discourses that construct the disabled identity as one of tragedy, loss and dependence, putting forward a model that focuses on the shared experiences of disabled people in society (Corker, 1998). Social model discourses of disability are based on the concept that 'social, environmental and attitudinal barriers' dis-able people with impairments from being full participants in society (Crow, 1996: 208). Rejecting the idea that disability is a construct of physical, psychological or intellectual deficiency, the social model instead focuses on ways in which the mainstream environment, both physical and social, can be adapted to accommodate the needs of people with impairments. While the social model has recently been challenged for being reductionist (Shakespeare, 2006), it has had an undeniable impact on the way in which some disability-related services are delivered, despite not being implemented uniformly or across all care sectors (Priestly, 1999).

Similar to the way in which disability activism can trace its ideological foundations to the rejection of institutionalisation and the development of the social model of disability, much domestic violence activism, service provision and research is broadly feminist in nature with roots in the women's liberation movement and the recognition of gender as a defining social structure. The movement, which emerged in the late 1960s in both the US and UK, has been largely underpinned by feminist theorising around gendered power dynamics within relationships and families (Mullender, 1996). These explanations provide both a measure of ideological coherence for organisations supporting survivors and the basis for an integrative feminist model of domestic violence (McPhail *et al.*, 2007).

Individuals and organisations working to end domestic violence in the UK and US, however, have never come to widespread agreement on either the terminology around or definition of the problem. The contested nature of these debates is reflected in the range of terms and definitions currently being used across the movement in the two sites. These differences reflect not only linguistic variations, but also differences in the way the issues are theorised and framed.

Early feminist discourses in both the UK and US used terms such as 'wife-beating' or 'battering' to describe both the physical abuse that many women live with and to indicate the gendered dynamic of this abuse. These politicised terms were successfully incorporated into the wider public vocabulary, where they remain in use in the US to describe a range of abusive behaviours, including emotional and psychological abuse. The National Coalition Against Domestic Violence (NCADV) in the US defines battering as 'a pattern of behavior [sic] used to establish power and control over another person with whom an intimate relationship is or has been shared through fear and intimidation, often including the threat or use of violence' (NCADV, 2005).

In the UK, the term 'battered woman' was also used to describe women who experienced abuse early on in the politicisation of domestic violence as a political issue, but has largely passed out of use because it does not adequately reflect the myriad ways that abuse can be inflicted. The Home Office uses the term domestic violence instead and defines it as 'any incident of threatening behaviour, violence or abuse between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality' (Home Office, 2005: 7).

Both the British and American definitions of domestic violence understand the dynamic as an imbalance of power and control between individuals in an intimate or formerly intimate relationship. While the Home Office definition is broad enough to include abusive dynamics within families, the NCADV definition is more restrictive, although the organisation does note that 'familial, elder and child abuse may be present in a violent home' (NCADV 2005). These parameters around intimacy and family membership are a key focus of this paper and the findings and discussion section will investigate how these definitions might be usefully extended to ensure that disabled survivors of abuse are included.

Researching politicisation and social movement activism

A qualitative approach guided the collection of data and is theoretically consistent with an analysis that focuses on the ways in which professionals and activists conceptualise and articulate the intersection of disability and domestic abuse. The collection of data relied on semi-structured interviews and focus groups with 29 participants in the UK and NC who were engaged in campaigning for greater awareness of the needs of disabled survivors of abuse, creating or providing services for this group of survivors, or involved in efforts to resource and implement these services. The participants thus were approached on the basis of professional experience or political activism around the intersection of abuse and disability. They were a diverse group of disabled and non-disabled women and included directors of national and state-level domestic violence organisations, disabled activists, training specialists and refuge workers who provide direct services to survivors of violence. Several participants, both disabled and non-disabled, linked their own experiences of domestic violence abuse to their work on this issue. Holding a range of positions within the voluntary and statutory sectors, they all had significant expertise of the dynamics of abuse and disability. These, then, can be seen as elite interviews (Skinner, 2004).

At the completion of the fieldwork period, I had carried out a total of 21 interviews and three group discussions. In England, I interviewed a total of 14 participants and these were evenly split between work in the domestic violence sphere and work in the disability sphere. This is an oversimplification, however, as some individuals were in positions where the two spheres overlapped, such as one participant who worked as a support worker for disabled women within a domestic violence organisation. With these 14 participants, I carried out 11 individual interviews and one group discussion with three disabled activists from a London-based organisation of women with learning disabilities. In North Carolina, I carried out interviews and group discussions with 15 individuals. Of these, six worked primarily in the domestic violence field, five were affiliated to disability organisations and four were policy-makers with the state.

The potential for individuals to have a significant impact on the politicisation of a social issue was a resonant theme throughout the interviews. Because the numbers of activists working on this issue are small in both North Carolina and England, I used snowballing techniques to locate and approach participants. Many of the participants knew one another and had worked together in efforts to bring this issue to the forefront of the political agenda. In several interviews, participants named particular individuals who have campaigned tirelessly around this issue, to illustrate the effect that one committed person can have. This happened during interviews in both North Carolina and England and with participants from both the disability and domestic violence spheres. In all cases,

the individuals identified as being exceptionally effective catalysts for the issue were disabled activists, many of whom had personal experience of abuse.

I was aware that, as key figures in the process of politicisation that I was exploring, participants would also be able to influence the research in a number of ways, including delaying its progress, taking control of the interview and the topics addressed and influencing the findings. There were, of course, inevitable delays in scheduling interviews and one participant delayed taking part until after she had collated current data on the work that her organisation was doing to address this form of need. This highlighted the political nature of the research and the potential for this project to compel some participants to take a stance on the issue. Most participants, however, did not exercise undue influence over the research process and in retrospect it seems that my concerns were, like Skinner's (2004), largely unfounded.

Findings and discussion

The research established that there are some difficulties between the domestic violence sector and the disability sector in agreeing on a definition of domestic violence. The two sectors are finding common ground around feminist understandings of domestic violence as occurring when one partner in an intimate relationship exercises an undue amount of power, but the nature of that intimacy is still currently being debated, as is the intimate nature of a caring relationship. There is also no real agreement on the gender dynamics involved in the abuse of people with disabilities. This section discusses these issues, intimacy, caring and gender, before moving on to consider specific ways in which the definition of domestic violence could be usefully expanded.

One encouraging finding from this research was around the growing awareness of the needs of disabled women experiencing abuse across both sectors, due in large part to the work being done by disability activists. Participants working within the domestic violence arena demonstrated a growing understanding of the needs of disabled women and used feminist understandings to frame the issue.

> For me, there is a distinction around the power, I suppose. It's still power and control but it's in a different context, I suppose. And there's a different level of power that caregivers have. The caregiver can be the intimate partner as well, so then, for me, it's clearly domestic violence. (UK disability activist)

> Unfortunately, it's usually a partner, that is, it's the primary carer ... when I queried it, there's just this imbalance of power in the relationship, particularly with disabled women when the primary caregiver is the abuser. (UK domestic violence support worker)

As the latter quote demonstrates, the recognition of familiar dynamics around power does not always signify that the participant sees the issue as having broken out of the parameters that common notions of intimacy suggest. This contested notion of intimacy has been clearly articulated by the disabled people's movement, both in the findings of this research and in policy documents from the Greater London Action on Disability (GLAD).

Participants from the disability sphere, unlike those from the domestic violence sphere, clearly defined the nature of the relationship between the primary caregiver

and the disabled person as an intimate one. Although some caregivers are spouses or sexual partners, perhaps more often they are not members of the family but paid staff, who are primarily women. In these cases, disabled women (and men) do share intimacy with the people who help them dress, bathe, toilet and complete other very personal tasks. Nonetheless, this is not what is normally meant when referring to an intimate relationship and particularly not in the domestic violence sphere, where intimacy implies a romantic and/or sexual relationship.

> It's difficult because domestic violence definitions that are out there are about a current or former partner that you are in an intimate relationship with. Now, the word there, 'current or former partner', gets in the way for me. Because, on some level around carer abuse, you don't get much more of an intimate relationship. (UK disability activist)

Participants working within the disability sphere consistently raised the point that disabled women's experience of domestic violence and abuse is likely to be significantly different from that of non-disabled women and were much more likely to discuss how disabled people are vulnerable to abuse from a more extensive range of people, primarily because they are likely to receive care from a number of people.

> You might have a lifetime friend who has moved in with you and they're supposed to be taking care of you. There's still that emotional relationship and it's not intimate in the way you think of sexual intimacy, but it's still intimate. And the pain is still the same. (NC domestic violence administrator)

The danger with defining domestic violence as occurring between sexually intimate (or formerly intimate) partners has also been unambiguously stated in the Greater London Action on Disability's (GLAD) response to the government's proposal on domestic violence, which takes issue with the way intimacy has traditionally been defined. This response suggests that the way domestic violence is currently defined, disabled women are likely to be excluded and their protection and safety is put at risk (GLAD, 2003). This document goes on to highlight the 'violence and abuse experienced by disabled people who have carers or personal assistants who work with them providing personal care, which can be from helping feed someone to intimate care e.g. toileting' (GLAD, 2003: 9).

In raising this aspect of abuse, participants working within the disability sphere were pushing at the boundary of how intimacy is defined in relation to domestic violence. In doing so, they are both resisting conventional definitions of domestic violence and putting forward an alternative interpretation of need that could potentially broaden current thinking around domestic violence service provision both in North Carolina and in England. This could open up access to groups of disabled people who are currently not able to contact domestic violence services, such as individuals living in residential care homes. Refuge-based services may not be appropriate for individuals who require intensive care and it seems likely that some form of outreach services for this group of survivors will need to be developed.

The recognition of disabled men's vulnerability to abuse is another issue that could result in an expanded concept of domestic violence. While the gendered nature of domestic abuse is well documented (Tjaden and Thoennes, 2000; Walby and Myhill,

2004; US Department of Justice, 2005; Home Office, 2007), there is a substantial gap in what we know about gender, disability and violence. All participants from the disability sphere were concerned about women's issues and saw themselves as working to improve the lives of women with disabilities, yet they also were very explicit in their recognition that disabled men are also at risk of abuse. Less clear is who is likely to perpetrate this abuse and how gender affects these dynamics. Additionally, they suggested that disabled men might have experiences of domestic violence and abuse that differ significantly from those of both non-disabled men and women.

> I don't think it is a gender issue when it comes to people with disabilities. The problems in group home settings are actually probably equal. If you're in a bad group home, you're in a bad group home. And you have just as much chance of being physically abused, I think, if you're a man or a woman. I don't think it really matters. (NC disability advocate)

There has been no large-scale research into experiences of abuse within group homes, but this debate can be informed by what we know about the dynamics of elder abuse, as older people and disabled people share many of the same vulnerabilities to abuse and may also share similar experiences of care. While evidence shows that older women are more at risk of experiencing physical abuse than older men (Penhale, 2003), there is also increasing evidence that older men are vulnerable to abuse (Krug *et al.*, 2002) and that female caregivers can be the perpetrators of this abuse (Whittaker, 2007). This is an area that is under-researched and further research is needed on both the gendered dynamics of elder abuse, particularly in residential care homes and other institutional settings, as well as the particular vulnerabilities of older men (Kosberg and Mangum, 2002).

Some participants in research, particularly those working in the domestic violence sector in NC, made explicit links to elder abuse. These participants suggested that caregiver abuse could fit within a broader framework of family violence, which includes not only intimate partner abuse, but also elder and child abuse. Thus, they suggested that the needs of disabled survivors could be taken up by refuge-based organisations or other service providers who see their remit as tackling issues of family violence and providing services to these groups of survivors.

> Sometimes, the way the violence community has categorized abuse and violence, caregiver abuse hasn't fitted anywhere. So, domestic violence, would that include caregiver? Typically caregiver violence has been an intimate partner. But some agencies are changing to call it 'family violence', you know, something in the home. Which would be the caregiver. Which might not be an intimate partner. It might be, it might not be. (NC disability activist)

> We have what I consider a broader definition of domestic violence because a lot of times people will say it's partner or spouse abuse but we've expanded that definition. That's why we're called the Family Violence Program instead of, like, domestic violence or spousal violence or whatever . . . I think you have to do this in terms of elder abuse especially, to be willing to expand that definition to see what their experiences are. (NC domestic violence support worker)

These participants suggested that, while the typical gender dynamic of domestic violence is more complex in cases of elder abuse, the services developed for survivors of

this form of interpersonal violence could be extended to disabled people experiencing caregiver violence. This would entail extending outreach work in residential homes or other institutions and, crucially, recognising that men and women who experience abuse may have different sets of needs.

Activists from the domestic violence sphere in both sites also expressed concerns about other potential effects of expanding the definition of domestic violence and relation service provision. These concerns centred on fears that the movement could lose sight of its mission to provide services to survivors of gender-based violence if it were to expand to cover the abuse of vulnerable adults.

> I think the key contention is that it comes back to the fact that it's a challenge to redefining domestic violence ... I think that there is a difficulty in defining domestic violence so broadly that almost anything that anybody does to somebody else within the domestic setting that isn't very nice counts. And it's very problematic for a number of reasons, not least of which because it makes women who are experiencing what I would define as domestic violence almost invisible in their own issue. (UK domestic violence activist)

These participants felt that using a gender-neutral definition, therefore, could have the effect both of making the issue more ambiguous in the public sphere and of obscuring those women and children who have survived domestic violence. As an example of a fully politicised need, domestic violence has attained a level of widespread attention and state intervention, in large part due to tireless awareness-raising campaigns in both the UK and US. Some participants in the domestic violence sector felt that expanding the definition would undo this work and result in the issue becoming less politicised and less definable in the public sphere. This reluctance to expand current definitions and service provision was picked up on by some participants in the disability sphere.

> We think that it's clearly unlikely they are ever going to stretch that [current definition of domestic violence], but we feel that we can at least keep applying the pressure so that they understand that disabled women have different issues. (UK disability activist)

The current Home Office definition of domestic violence has been taken up by the two largest networks of refuges and domestic violence service providers in the UK, Refuge and Women's Aid Federation of England (WAFE). This definition, as discussed above, focuses on violence that occurs between intimate partners or family members and does not make space for oppression that occurs as a result of disability. The NCADV definition, while not specifically addressing caregiver abuse, does make clear links between violence against women and children and other forms of violence against marginalised groups in society. Although the organisation maintains that domestic violence 'results from the use of force or threat to achieve and maintain control over others in *intimate relationships*' (emphasis mine), it also recognises that domestic violence is 'intrinsically linked' to the 'unique experiences of oppression stemming from their specific historic, cultural and social experiences and realities' that people with disabilities (and other marginalised groups) can share (NCADV, 2005).

This expanded definition addresses some of the issues that this research raises and makes clear that domestic violence can take a range of forms that are specific to the experiences of a particular oppressed group. It may offer one possible way of

acknowledging the experiences of disabled survivors of caregiver abuse, while holding firmly to what we know about the power dynamics of domestic violence. As such, this definition represents a possible way forward in understanding caregiver abuse in relation to violence that is typically perpetuated against women, children and other vulnerable groups, including disabled men. It maintains the focus on domestic violence while making room for related experiences of oppression and abuse.

Another potential way forward in capturing the complexity of the dynamics involved in the abuse of disabled people has been put forward by Rioux *et al.* (1997), who have suggested a working definition that highlights the range of abuses that disabled people can experience:

> Acts of violence and abuse are defined as conscious and deliberate acts that cause or that threaten to cause harm. They are public or private acts that seriously violate the principle that disabled persons, like other persons, are to be equally valued and protected as citizens. They are acts that ignore or hold in contempt the voice of a person and that exploit a power imbalance, or that on other grounds are contrary to the free and informed consent of the person abuse. (Rioux *et al.*, 1997: 202)

This definition does several things: it put people with disabilities at the centre of the issue, highlights the power imbalance that gives rise to domestic abuse, defines the range of abuses that constitute interpersonal violence and specifically relates these dynamics to the experiences of disabled people. As a general definition of interpersonal violence, it does not specify the type of relationship that exists between the victim and the perpetrator. It thus makes room to address the complex dynamic of care as well as the potential for abuse to take forms outside of the dominant gendered dynamic in which men perpetrate violence against women.

Conclusion

This paper has explored struggles around defining domestic violence as it relates to people with disabilities, focusing on pockets of activism in the UK and North Carolina. It has highlighted two key axes around intimacy and gender and drawn out some tensions around these issues. The picture that emerges is one of a set of needs that are still very much in the process of politicisation, with existing debates around defining the parameters of the issue and few services and programmes on the ground as yet for survivors.

Agreeing on a single definition of domestic violence is likely to be a highly contested and complex task. Shifting to a disability-centred definition of this issue means re-working existing definitions of domestic violence to include caregivers, something that could be done by expanding on what constitutes an intimate relationship and could make room for the experiences of disabled people living within institutions and receiving residential care. Another tack might be around broadening the issue to 'family violence', which would include some cases of abuse where caregivers are family members and could include disabled men's experiences of abuse at the hands of family members, including female caregivers. Nonetheless, this approach is likely to exclude disabled people living in institutions or group care facilities, as well as those who are abused by professional carers. Whether or not re-worked concepts of intimacy and gender are incorporated into definitions of domestic violence will depend on how successful the

disability sphere is in establishing and defining this issue in the wider public and political spheres.

In order for these services to be developed and effectively implemented, several key questions must be addressed. Does domestic violence include abuse by caregivers, family members and paid professionals? Do commonly accepted notions of intimacy need to be re-thought in light of disabled people's experiences? How can disabled men's vulnerability to abuse be defined and addressed? Who is perpetrating the abuse of disabled people? These are questions that are currently being debated within the domestic violence and disability spheres in both England and North Carolina.

Answering these questions will take further research and, in the meantime, there is likely to be little agreement on a single definition of domestic violence. It seems more likely that different individuals, organisations and projects may answer the questions differently, resulting in a range of services. Some of these may be targeted towards, and inclusive of, disabled people experiencing caregiver abuse in institutional and residential settings and others may be designed specifically to meet the needs of disabled men, who are likely to have different issues around disclosure and naming their experiences. The lack of joined-up work on this issue is likely to result in a fragmented approach to service provision, but one that may well be adaptable and flexible enough to address a range of diverse needs.

References

Corker, M. (1998), 'Disability discourse in a postmodern world', in T. Shakespeare (ed.), *The Disability Reader*, London: Continuum.

Crow, L. (1996), 'Including all of our lives: reviewing the social model of disability', in C. Barnes and G. Mercer (eds.), *Exploring the Divide*, Leeds: The Disability Press.

Depoy, E., Gilson, S. and Cramer, E. (2003), 'Understanding the experiences of and advocating for the service and resource needs of abused, disabled women', in A. Hans and A. Pat (eds.), *Women, Disability and Identity*, London: Sage.

Drake, R. (1999), *Understanding Disability Policies*, Basingstoke: Macmillan.

Fawcett, B. (2000), *Feminist Perspectives on Disability*, Harlow: Prentice Hall.

Finkelstein, V. (1980), *Attitudes and Disabled People*, New York: World Rehabilitation Fund.

Fraser, N. (1989), *Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory*, Cambridge: Polity Press.

Greater London Action on Disability (2003), 'Response to safety and justice: the government's proposals on domestic violence', GLAD, London (unpublished).

Home Office (2005), *Domestic Violence: A National Report*, London: Home Office.

Home Office (2007), *Crime in England and Wales 2006/07*, Home Office Statistical Bulletin, London: Home Office.

Kosberg, J. and Mangum, W. (2002), 'The invisibility of older men in gerontology', *Journal of Elder Abuse and Neglect*, 22, 4, 27–42.

Krug, E., Dahlberg, L., Mercy, J., Zwi, A. and Lozano, R. (2002), *World Report on Violence and Health*, Geneva: World Health Organization.

McPhail, B., Busch, N., Kulkarni, S. and Rice, G. (2007), 'An integrative feminist model: the evolving feminist perspective on intimate partner violence', *Violence Against Women*, 13, 8, 817–41.

Morris, J. (1991), *Pride Against Prejudice: Transforming Attitudes to Disability*, London: The Women's Press.

Mullender, A. (1996), *Rethinking Domestic Violence: The Social Work and Probation Response*, London: Routledge.

Murray, N. (2003), 'Historical overview of disability policy', Paper presented at The University of Pittsburgh Institute of Politics, 3 May 2003, http://www.wheelchairnet.org/WCN_Living/Docs/Historicaloverview.html, 14 March 2005.

National Coalition Against Domestic Violence (2005), 'What is battering', http://www.ncadv.org/learn/TheProblem_100.html, 21 November 2008.

Penhale, B. (2003), 'Older women, domestic violence and elder abuse: a review of commonalities, difference and shared approaches', *Journal of Elder Abuse and Neglect*, 15, 3/4, 163–83.

Priestly, M. (1999), *Disability Politics and Community Care*, London: Jessica Kingsley.

Rioux, M., Crawford, C., Ticoll, M. and Bach, M. (1997), 'Uncovering the shape of violence: a research methodology rooted in the experience of people with disabilities', in C. Barnes and G. Mercer (eds.), *Doing Disability Research*, Leeds: The Disability Press.

Shakespeare, T. (2006), *Disability Rights and Wrongs*, London: Routledge.

Skinner, T. (2004), 'Researching people in power practice, analysis and action', in T. Skinner, M. Hester and E. Malos (eds.), *Researching Gender Violence*, Devon: Willan.

Stone, E. and Priestley, M. (1996), 'Parasites, pawns and partners: disability research and the role of non-disabled researchers', *British Journal of Sociology*, 47, 4, 699–716.

Tjaden, P. and Thoennes, N. (2000), *Extent, Nature and Consequences of Intimate Partner Violence: Research report*, Washington, DC: National Institute of Justice.

US Department of Justice (2005), *Family Violence Statistics*, Washington, DC: Bureau of Justice Statistics.

Walby, S. and Myhill, A. (2004), *Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey*, Home Office Research Study 276, London: Home Office.

Whittaker, T. (2007), 'Violence, gender and elder abuse: towards a feminist analysis and practice', in L. O'Toole, J. Schiffman, M. Kiter Edwards and M. Edwards (eds.), *Gender Violence: Interdisciplinary Perspectives*, London: New York University Press.

GLOSSARY

Violence against women

Gunilla Krantz, Claudia Garcia-Moreno

J Epidemiol Community Health 2005;**59**:818–821. doi: 10.1136/jech.2004.022756

Violence against women is now well recognised as a public health problem and human rights violation of worldwide significance. It is an important risk factor for women's ill health, with far reaching consequences for both their physical and mental health. This glossary aims to describe various forms of interpersonal violence that are directed towards women and girls. Terms and basic concepts used in research and policy on this public health problem will be explained.

Violence against women is now well recognised as a public health problem and human rights violation of worldwide significance. It is an important risk factor for women's ill health, with far reaching consequences for both their physical and mental health.[1] There is a need to understand better the magnitude and nature of the different forms of violence against women. Clear definitions are needed to be able to compare information across studies and to generate a knowledge base that will allow us to identify the various and overlapping ways in which violence against women occurs and what actions may serve to prevent it and respond to its consequences.

This glossary aims to describe various forms of interpersonal violence that are directed towards women and girls. Terms and basic concepts used in research and policy on this public health problem will be explained.

DEFINING VIOLENCE AGAINST WOMEN

The term violence against women encompasses a multitude of abuses directed at women and girls over the life span. The UN Declaration on the Elimination of Violence against Women (defines violence against women as: "....any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".[2] This statement defines violence as acts that cause, or have the potential to cause harm, and by introducing the term "gender based" emphasises that it is rooted in inequality between women and men.

The term gender based violence has been defined as "acts or threats of acts intended to hurt or make women suffer physically, sexually or psychologically, and which affect women because they are women or affect women disproportionally".[3] Thus, gender based violence is often used interchangeably with violence against women. Both these definitions point at violence against women as a result of gender inequality. This inequality can be described as discrimination in opportunities and responsibilities and in access to and control of resources that is rooted in the socioculturally ascribed notion of masculinity as superior to femininity.

A FRAMEWORK FOR UNDERSTANDING VIOLENCE AGAINST WOMEN

A typology of violence presented in the world report on violence and health divides violence into three broad categories according to who commits the violent act: self directed violence, interpersonal violence, and collective violence.[4] It further captures the nature of the violent acts that can be physical, sexual, or psychological, including deprivation and neglect.

This typology gives a comprehensive overview of the violence present in society and is relevant for both women and men and for different age groups. Women experience all forms of violence, however, interpersonal violence—that is, violence inflicted by another person or by a small group of people on the woman is the most universal form of violence against women, as it takes place in all societies. It is in turn divided into two subcategories: family/intimate partner violence and community violence. Family/partner violence describes violence between family members (often taking place in the home), while community violence describes violence between people who are unrelated and who may or may not know each other, and it generally takes place outside the home.

This glossary will concentrate on various forms of interpersonal violence that strike young girls, adolescents, and women at reproductive age and beyond, showing also how the type of violence changes over the life course. The rationale behind this limitation is that family/partner violence is the kind of violence that strikes women most, while community violence is more common among men. Some culture specific forms of violence will also be described as they fall into this categorisation.

The nature of the violence

Violent acts—irrespective of whether they are self directed, interpersonal, or collective—are commonly categorised as physical, sexual, or psychological. Deprivation and neglect can be considered as forms of psychological abuse. However, these different forms often interact with each other, and form a complex pattern of behaviour where psychological violence is combined with physical and/or sexual abuse for some settings. Coker and colleagues found that women who experienced both physical and sexual

See end of article for authors' affiliations

Correspondence to: Dr G Krantz, Centre for Health Equity Studies, CHESS, Stockholm University/Karolinska Institute, SE-106 91 Stockholm, Sweden; gunilla.krantz@chess.su.se

Accepted for publication 25 August 2004

violence scored higher on scales measuring ill health than did women who experienced physical violence alone. They conclude that sexual violence might be a marker of more severe violence and perhaps also of violence escalation.[5]

Physical violence is exercised through physically aggressive acts such as kicking, biting, slapping, beating, or even strangling. Intentionally inflicted injuries are often disguised as accidents. At times, women are seriously injured and in some cases die as a result of their injuries.[6]

Findings from a number of recent studies from various parts of the world show that between 10% and 60% of the women had been hit or otherwise physically assaulted by an intimate male partner at some point in their lives[4] and between 3% and 52% of the women reported physical violence in the previous year.[7] The range in these figures illustrates not only possible real differences in prevalence rates among settings but also differences in research methods and in definitions of violence that make comparisons difficult. Furthermore, cultural differences affecting respondents' willingness to disclose intimate partner abuse also contribute to making the figures difficult to compare.

Psychological, mental, or emotional violence describe acts such as preventing a woman from seeing family and friends, ongoing belittlement or humiliation, economic restrictions, violence or threats against cherished objects and other forms of controlling behaviours. This form of violence is more difficult to define across cultures and countries as it can take different forms. In a study from Vietnam, emotional violence included acts such as a husband forcing his wife to have sex the day before she prepares to go to pray in the pagoda, thus forcing her to break the taboo of being clean and continent.[8] In studies from Africa, such acts as bringing girlfriends home, being locked out of the home, or refusing sex were more commonly identified as emotional violence.[9 10]

Sexual violence includes forced sex through the use of physical force, threats, and intimidation, forced participation in degrading sexual acts as well as acts such as the denial of the right to use contraceptives or to adopt measures to protect against sexually transmitted diseases.

Although much sexual violence occurs in the context of intimate partner violence it can also take place in many other settings. Sexual violence can be exercised by another family member, a dating partner, acquaintance or stranger, striking young girls and adolescents as well as grown up women. A woman can be sexually violated by one or several people as in gang rapes.

The terms rape, sexual assault, sexual abuse, and sexual violence are often used interchangeably. However, these terms may have very different meanings and implications in varying situations and locations.[11] The first two tend to be defined legally, with rape often being more narrowly defined than sexual assault. Legal definitions may vary from medical and social definitions and can also vary between countries.

INTERPERSONAL VIOLENCE

This section describes interpersonal violence directed at young girls, adolescents, and women of reproductive age, exercised by the husband/partner/former partner or other family members and follows the outlined and indicated structure in figure 1. Various types of violence will be described following the life course perspective—that is, starting with young girls, where some types of violence are culturally specific and others are universal.

Types of violence striking young girls and adolescents

Child abuse and neglect

Some children are abused and neglected by their parents and other care givers in all countries in the world. This kind of violence includes physical, sexual, and psychological abuse as well as neglect. The outcome might be fatal with the most common causes of death being head injuries, abdominal injuries, and intentional suffocation.[12] Non-fatal outcomes have been described as various forms of abuse and neglect that require medical care and intervention by social services.

Sex and age are important factors in determining the kind of violence exercised. Young children and boys are more at risk of physical abuse while older girls, having reached puberty and adolescence, risk sexual abuse, neglect, and being forced into prostitution.[13]

It has been suggested that women use physical punishment against their children more than men, but when the outcome is fatal men are more often the perpetrators. Men are also more likely to sexually abuse young girls.[14] Studies show that child abuse is related to parental stress, poor impulse control, and social isolation, as well as to factors such as poverty and lack of social capital.[15]

Incest is the term used to describe rape or sexual assault that is perpetuated by close blood relatives, and in most cases refers to when a father or brother exploit their young daughter or sister sexually. In the past 10–15 years, the awareness of child sexual abuse, including incest, has increased as girls and young women have been encouraged to reveal this kind of family violence. The phenomenon of mothers abusing their sons sexually also exists, although less common. This kind of violence exists in many countries and cultures, although up to now it has mainly been described in high income countries.

Gender based abuse of infants and female children

In some countries/regions of the world there is a social preference for boys, leading to the neglect of girls, in response to longstanding cultural traditions favouring males. This gives rise to, for example, sex selective abortions of females where the sex of the fetus is identified through the use of ultrasound technique, malnourishment of girls, or even infanticide—that is, the deliberate killing of female infants soon after birth. In countries where this is common (China, Taiwan, South Korea, India, Pakistan, and some sub-Saharan African countries), the female to male ratio is lower than expected, pointing to violation of the natural course of events.[16]

This was highlighted at the UN Conference on Women in Beijing in 1995 as a serious public health problem striking women, but also men. There was the fear that it would lead to women becoming a commodity to trade (trafficking), but also to an increase in prostitution and a risk of a considerable amount of men moving to other regions in search of a wife, resulting in a refugee problem, in many cases leading to poverty and bereavement.

Female genital mutilation

Female genital mutilation (FGM), is defined by WHO as the partial or total removal of the external genitalia or other injury to the female genital organs whether for cultural, religious, or other non-therapeutic reasons.[17] The terms female genital cutting (FGC) and female circumcision have also been used to describe this procedure. FGM is performed at different times in a girls' life depending on the setting. WHO estimates that between 100 to 140 million girls and women have undergone some type of FGM. Most of those affected live in 28 countries in Africa, although there are some in the Middle East and it also happens among immigrant communities in some countries in Western Europe.

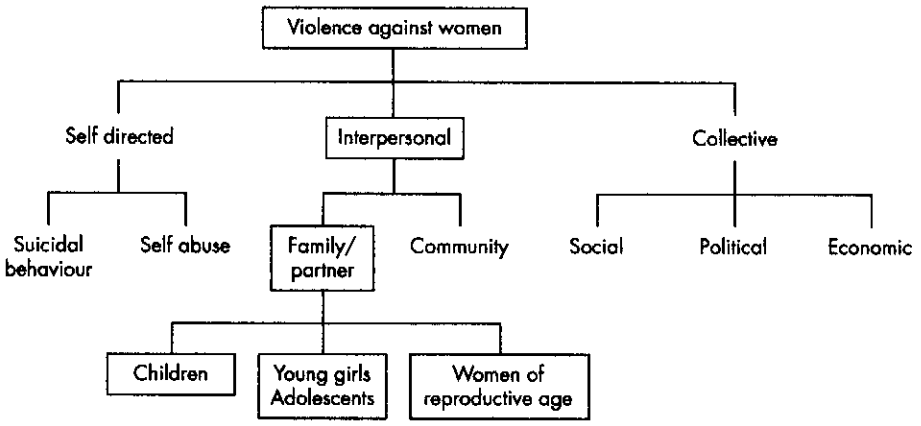


Figure 1 A typology of violence against women, modified after the world report on violence and health, WHO.[4]

Types of violence striking women of reproductive age and beyond

Intimate partner violence

One of the most common types of violence against women that exists in all societies and among rich as well as poor women is violence by an intimate male partner or former partner. The term intimate partner violence refers to the abuse taking place usually between husband and wife, or between other present or former cohabiting partners, and some also include boyfriends and girlfriends in this definition. Other terms that are often used to describe intimate partner violence include: domestic violence, battering, wife/spouse/partner abuse. Intimate partner violence is the preferred term as it is more descriptive in defining the type of relationship the subjects are involved in—however, it says nothing about the direction of this violence. Even though this is one of the most common forms of violence directed at women, the term intimate partner violence needs to be made specific by adding "against women" to exactly describe the phenomenon.

Intimate partner violence against women can be exercised either as physical, sexual, psychological violence, or any combination of these.[9] Studies from USA and Mexico, for example, estimate that 40%–52% of women experiencing physical violence by an intimate partner have also been sexually coerced by that partner.[18]

Wife battering has been used to describe a chronic syndrome characterised not by single episodes of violence but by repeated acts of physical, psychological, and emotional abuse used by men to control their female partners.[19] Some authors include battering as a separate category of partner abuse distinguished from physical assault by its longstanding, continuous nature, and battering has been defined as "a process whereby one member of an intimate relationship experiences psychological vulnerability, loss of power and control, and entrapment as a consequence of the other member's exercise of power through the patterned use of physical, sexual, psychological and/or moral force".[5]

Rape

There are many myths about rape—to have sex against one's will—which are based on stereotypes about what is appropriate sexual behaviour for men and women. For example, most people associate rape with a violent attack by a stranger, but rape is most often perpetrated by someone known to the victim. There is also an assumption that rape leaves obvious signs of injury, which is often not the case. Only around one third of rape victims sustain visible physical injuries.[11] Physical violence or pressure in the form of blackmail or threats might occur simultaneously with the rape, or is the violence carried out while the woman is asleep or under the influence of alcohol or other drugs, unable to defend herself. Rape is often not reported to the police and existing statistics greatly underestimate the magnitude of the problem.

Sexual coercion was defined by Heise *et al* as "the act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against her/his will."[20] This definition emphasises the many forms beyond the physical form in which another person can be made to have sex against their will.

Dowry related violence

Dowry is the payment to be made to the groom's family to marry away a daughter, and it takes different forms in different cultures. However, the size of the dowry is a common reason for disputes between the families, with the groom's family demanding more than the bride's family can offer, resulting in harassment of brides and also dowry related deaths, particularly in certain parts of India and other southern Asian countries.[21] This violence is exercised not only

Key points

- Violence against women is an important public health problem, and an obvious violation of women's human rights.
- Clear definitions are needed to be able to compare information across studies and to generate a knowledge base that will allow us to identify the various and overlapping ways in which violence against women occurs.

Policy implications

- To fight intimate partner violence, preventive strategies that challenge present gender stereotypes are required.
- Health care staff, district and community leaders are key persons in building knowledge, shaping opinions, and showing the way forward and therefore shoulder a responsibility to address the subject of violence against women.
- Documentation and evaluation are key elements in building such knowledge and clear definitions are an important element to achieve this.

by the husband but also by the husbands' close relatives (mother, brothers, sisters).

Acid throwing

In some Asian countries such as Bangladesh, India, and Pakistan, the disfiguring of women by throwing acid or burning them are forms of violence rooted in gender inequality, but the immediate reason for this is often disputes concerning marriage and dowry.[22] While this is not one of the most prevalent forms of violence against women, its consequences are dire for those women subjected to it.

"Honour" killings

This is the murder of a woman, usually by a brother, father, or other male family member, because she has allegedly brought shame to her family. This phenomenon is rooted in the notion of male honour and female chastity that prevails in many countries in the Eastern Mediterranean region. It means a man's honour is linked to the perceived sexual purity of the women in his family. If a woman engages in sex outside marriage or even if she is raped, she is thought to disgrace the family honour. In some societies, the only way to cleanse the family honour is by killing the woman/girl.[4] This kind of violence against women and girls is exercised also in western European countries within immigrant families. It is generally referred to as "honour" killings—a rather misleading term as the connection with honour is difficult to understand in most cultures. The term "murder in the name of honour" has been suggested.

Elder abuse

Mistreatment of older people, taking place in the home or at care institutions, is being referred to as elder abuse and has been defined as: "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person".[23] Elder abuse was first identified in developed countries, where most of the existing research has been conducted but reports from developing countries have shown that it is a universal phenomenon. This kind of mistreatment takes the form of physical, psychological, or sexual abuse as well as financial or material abuse or as pure neglect—that is, the failure to fulfil a care giving obligation.

CONCLUSIONS

Violence against women is a serious violation of women's human rights and of direct concern to the public health sector because of the significant contributions that public health workers could do if properly trained, as they are placed close to the victims, and possibly well acquainted with the community and its inhabitants. Thus, local health services and communities could play a central part in raising awareness among the public to prevent this violence. To openly debate this subject is a way to reduce society's tolerance towards violence against women.

There is still limited knowledge about what interventions are most effective for the prevention of gender based violence, however documentation and evaluation are key elements in building this knowledge and clear definitions are an important element in this.

Authors' affiliations

G Krantz, Centre for Health Equity Studies, CHESS, Stockholm University/Karolinska Institute, Stockholm, Sweden
C Garcia-Moreno, Department of Gender, Women and Health, World Health Organisation, Geneva, Switzerland

REFERENCES

1 **Campbell JC.** Health consequences of intimate partner violence. *Lancet* 2002;**359**:1331–6.
2 **United Nations General Assembly (UNGA).** Declaration on the elimination of violence against women. Proceedings of the 85th plenary meeting, Geneva, 20 Dec, 1993.
3 **Richters JMA.** *Women, culture and violence; a development, health and human rights issue.* Leiden: Women and Autonomy Centre (VENA), 1994.
4 **WHO.** *WHO report on violence and health.* Geneva: World Health Organisation, 2002.
5 **Coker AL,** Smith PH, McKeown RE, *et al.* Frequency and correlates of intimate partner violence by type: physical, sexual, and psychological battering. *Am J Public Health* 2000;**90**:553–9.
6 **Ellsberg M,** Pena R, Herrera A, *et al.* Wife abuse among women of childbearing age in Nicaragua. *Am J Public Health* 1999;**89**:241–4.
7 **Heise L,** Ellsberg M, Gottemoeller M. A global overview of gender-based violence. *Int J Gynecol Obstet* 2002;**78**(suppl 1):5–14.
8 **Krantz G,** Phuong TV, Larsson V, *et al.* Intimate partner violence: forms, consequences and preparedness to act, as perceived by health care staff and district and community leaders in a rural district in northern Vietnam. *Public Health,* (in press).
9 **Jewkes R.** Intimate partner violence: causes and prevention. *Lancet* 2002;**359**:1423–9.
10 **Watts C,** Zimmerman C. Violence against women: global scope and magnitude. *Lancet* 2002;**359**:1232–7.
11 **WHO.** *Guidelines for medico-legal care for victims of sexual violence.* Geneva: The World Health Organisation, 2003.
12 **Kirschner RH,** Wilson H. Pathology of fatal child abuse. In: Reece RM, Ludwig S, eds. *Child abuse: medical diagnosis and management.* Philadelphia, PA: Lippincott Williams and Wilkins, 2001:47–80.
13 **Finkelhor D.** The international epidemiology of child sexual abuse. *Child Abuse Negl* 1994;**18**:409–17.
14 **Straus MA.** Identification of child maltreatment with the parent-child conflict tactics scale: development and psychometric data for a national sample of American parents. *Child Abuse Negl* 1998;**22**:249–70.
15 **Gillham B.** Unemployment rates, single parent density, and indices of child poverty: their relationship to different categories of child abuse and neglect. *Child Abuse Negl* 1998;**22**:79–90.
16 **Miller BD.** Female-selective abortion in Asia: patterns, policies, and debates. *American Anthropology* 2001;**103**:1083–95.
17 **WHO.** *Violence against women: a priority health issue.* Geneva: World Health Organisation, 1997.
18 **Campbell JC,** Soeken KL. Forced sex and intimate partner violence: effects on women's risk and women's health. *Violence against women* 1999;**5**:1017–35.
19 **Hegarty K,** Roberts G. How common is domestic violence against women? The definition of partner abuse in prevalence studies. *Aust N Z J Public Health* 1998;**22**:49–54.
20 **Heise L,** Moore K, Toubia N. *Sexual coercion and women's reproductive health: a focus on research.* New York: Population Council, 1995.
21 **Gangrade KD.** Social development and the girl child. *Soc Change* 1995;**25**:70–83.
22 **WHO.** Facts about injuries. http://www.who.int/violence_injury_prevention/index.html.
23 **Anon.** What is elder abuse? *Action on Elder Abuse Bulletin* 1995;**11**:May–Jun.

The world report on violence and health

Etienne G Krug, James A Mercy, Linda L Dahlberg, Anthony B Zwi

In 1996, the World Health Assembly declared violence a major public health issue. To follow up on this resolution, on Oct 3 this year, WHO released the first *World Report on Violence and Health*. The report analyses different types of violence including child abuse and neglect, youth violence, intimate partner violence, sexual violence, elder abuse, self-directed violence, and collective violence. For all these types of violence, the report explores the magnitude of the health and social effects, the risk and protective factors, and the types of prevention efforts that have been initiated. The launch of the report will be followed by a 1-year Global Campaign on Violence Prevention, focusing on implementation of the recommendations. This article summarises some of the main points of the world report.

About 4400 people die every day because of intentional acts of self-directed, interpersonal, or collective violence. Many thousands more are injured or suffer other non-fatal health consequences as a result of being the victim or witness to acts of violence. Additionally, tens of thousands of lives are destroyed, families shattered, and huge costs are incurred in treating victims, supporting families, repairing infrastructure, prosecuting perpetrators, or as a result of lost productivity and investment.

This week, WHO sounds the alarm by releasing the first *World Report on Violence and Health*[1] and launching a Global Campaign on Violence Prevention. The report analyses a broad spectrum of violence including child abuse and neglect by care givers, youth violence, intimate partner violence, sexual violence, elder abuse, self-directed violence and collective violence. For all these types of violence, the report explores the magnitude and effect in different cultural, social, and economic contexts and describes the types of prevention efforts that have been initiated. WHO intends to attract greater attention and draw in resources for violence prevention and to stimulate action at local, national, and international levels.

History of violence as a public health issue

In many countries, violence prevention is still a new or emerging field in public health. The public health community has started only recently to realise the contributions it can make to reducing violence and mitigating its consequences. In 1949, Gordon called for injury prevention efforts to be based on the understanding of causes, in a similar way to prevention efforts for communicable and other diseases.[2] In 1962, Gomez, referring to the WHO definition of health, stated that it is obvious that violence does not contribute to "extending life" or to a "complete state of well-being". He defined violence as an issue that public health experts needed to address and stated that it should not be the primary domain of lawyers, military personnel, or politicians.[3]

The attention devoted to violence prevention by public health experts has increased substantially since the 1970s; the number of publications on violence listed in Medline has risen by 550% (from 2711 in the 1970s to more than 8000 in the 1990s). During the same period, the total number of articles listed in Medline less than doubled. In addition to undertaking scientific research, several countries developed other activities related to violence, mainly in the area of data collection and services for victims. The number of civil society organisations and activities directed at responding to gender-based violence against women also rose steeply. Efforts to put violence on the global public health agenda culminated in 1996 with the adoption of a resolution by the World Health Assembly, the annual gathering of all ministers of health.[4] This resolution declared violence a major global public health issue and called for increased action.

Why should the public health sector be involved in violence prevention?

The public health sector is directly concerned with violence not only because of its huge effect on health and health services, but also because of the significant contributions that can and should be made by public health workers in reducing its consequences. Public health can benefit efforts in this area with its focus on prevention, scientific approach, potential to coordinate multi-disciplinary and multisectoral efforts, and role in assuring the availability of services for victims.

Public health complements existing approaches to violence, which are mainly reactive, by focusing on changing the behavioural, social, and environmental factors that give rise to violence.[5] This vision is grounded in traditions and concepts of public health that have been successfully applied to reducing other public health problems such as smallpox, motor vehicle injuries, and poliomyelitis. There is growing evidence for, and commitment to, the idea that violence prevention works. Public health also has a strong emphasis on using scientific evidence when making policies. If we are to be successful in preventing violence, prevention policies and programmes must be firmly grounded in science, as in other successful public health efforts.

Violence prevention activities typically involve partnerships across sectors of society, scientific

Lancet 2002; **360:** 1083–88

Injuries and Violence Prevention Department, Non Communicable Diseases and Mental Health, WHO, Geneva, Switzerland (E G Krug MD); **Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA, USA** (J A Mercy PhD, L L Dahlberg PhD); **and School of Public Health and Community Medicine, University of New South Wales, Sydney, NSW, Australia** (Prof A B Zwi PhD)

Correspondence to: Dr E G Krug, Injuries and Violence Prevention Department, WHO, Av Appia 20, 1211 Geneva, Switzerland (e-mail: kruge@who.int)

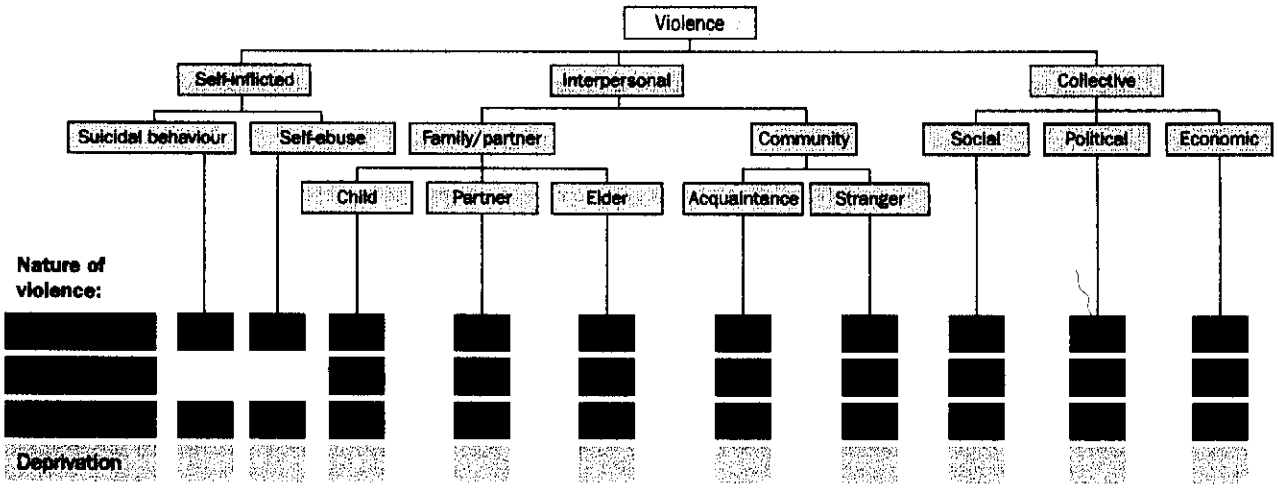


Figure 1: **Types of violence**

disciplines, and organisations. The central role of communities in preventing violence has also become a common theme. Public health has a long-standing commitment to supporting and aiding communities to solve their own health problems. Public health also plays an important part in assuring that necessary health services are available in communities.[6] This role can be extended to health services to reduce the severity and duration of the physical or psychological injuries and disabilities of people injured in violent incidents. Clearly, for example, emergency response and trauma systems are a critical health-services component of comprehensive approaches to violence prevention and management.

The report and what it will achieve

Overview

The report is a result of 3 years of work by more than 160 experts from more than 70 countries and regional consultations held in Africa, the Americas, Asia, Europe, and the Middle East. Much of the available information regarding violence and health at the global level has been compiled in one document. It is the first time that WHO has taken such a clear and visible stand in favour of violence prevention. With endorsements of political leaders such as Nelson Mandela, Kofi Annan, and Oscar Arias the report will be a powerful tool for mobilising decision-makers around the world. The Director General of WHO has clearly committed the organisation to playing an important part in violence prevention: "While public health does not offer all the answers to this complex problem, we are determined to play our role in the prevention of violence worldwide. This report will contribute to shaping the global response to violence and to making the world a healthier and safer place for all."

Definition and types of violence

The report uses the definition of violence developed by a WHO working group in 1996: "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."[7] This particular definition encompasses all types of violence and covers the wide range of acts of commission and omission that constitute violence and outcomes beyond deaths and injuries.

In the report, violence is divided into three broad categories: self-inflicted, interpersonal, and collective (figure 1). Each category is subdivided to reflect specific types of violence, settings of violence, and nature of violent acts (physical, sexual, psychological, and deprivation or neglect). Although analysis of specific types of violence is worthwhile, it is also important to understand their links. For example, victims of child abuse have an above average chance of becoming involved in aggressive and violent behaviour as adolescents and adults,[8-10] and sexual abuse during childhood or ado-

Rights were not granted to include this image in electronic media. Please refer to the printed journal.

Sébastien Godefroy

A battered woman in an establishment for women in difficulty

lescence has been linked to suicidal behaviour.[11] Many risk factors, such as alcohol abuse, the availability of firearms, or socioeconomic inequalities are also common in most types of violence. These links are important because they show the potential for prevention of several types of violence by interventions to address a few key risk factors. They also support the need for greater collaboration between groups working on the prevention of different types of violence.

Magnitude

Global and national data are very scarce. However, it is estimated that 1·6 million people died from violence in 2000,[12] which corresponds to 28·8 per 100 000 population. Almost half these deaths were suicides, nearly a third were homicides, and a fifth were war related. Rates vary considerably between and within countries.

Without reliable data, global estimates for the different types of abuse are difficult to make. However, the widespread nature of violence is clear: in 48 population-based studies from around the world, between 10% and 69% of women reported having been physically assaulted by an intimate partner during their lifetime;[13] about 20% of women and 5–10% of men reported having been sexually abused as children;[14,15] and the results of the few population-based studies on abuse of elderly people show that between 4% and 6% are abused in some way in their homes.[16–20]

Much research has shown that the health consequences of violence are far broader than death and injuries. Victims of violence are at risk of psychological and behavioural problems, including depression, alcohol abuse, anxiety, and suicidal behaviour, and reproductive health problems, such as sexually transmitted diseases, unwanted pregnancies, and sexual dysfunction.[13,21–23]

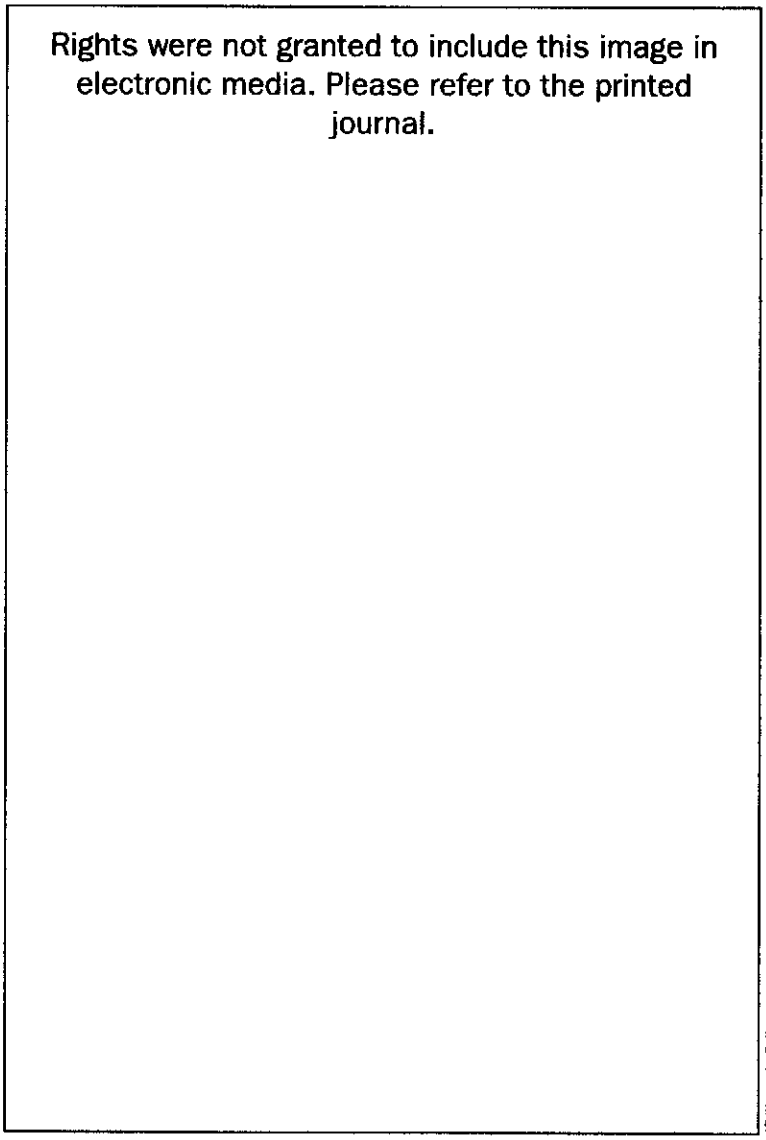
Causes

Violence cannot be attributed to a single factor. Its causes are complex and occur at different levels. To represent this complexity, the report uses an ecological model with four levels.[24–30] The first level identifies biological and personal factors that influence how individuals behave and increase their likelihood of becoming a victim or perpetrator of violence: demographic characteristics (age, education, income), personality disorders, substance abuse, and a history of experiencing, witnessing, or engaging in violent behaviour.

The second level focuses on close relationships, such as those with family and friends. In youth violence, for example, having friends who engage in or encourage violence can increase a young person's risk of being a victim or perpetrator of violence.[31,32] For intimate partner violence, the most consistent marker at this level of the model is marital conflict or discord in the relationship. In elder abuse, important factors are stress due to the nature of the past relationship between the abused person and the care giver or because of overcrowded living conditions.

The third level explores the community context—ie, schools, workplaces, and neighbourhoods. Risk at this level may be affected by factors such as the existence of a local drug trade, the absence of social networks, and poverty. All these factors have been shown to be important in several types of violence.

Finally, the fourth level looks at the broad societal factors that help to create a climate in which violence is encouraged or inhibited: the responsiveness of the criminal justice system, social and cultural norms regarding gender roles or parent-child relationships, income inequality, the strength of the social welfare system, the social acceptability of violence, the availability of firearms, the exposure to violence in mass media, and political instability.



AP/Kamenko Pajic

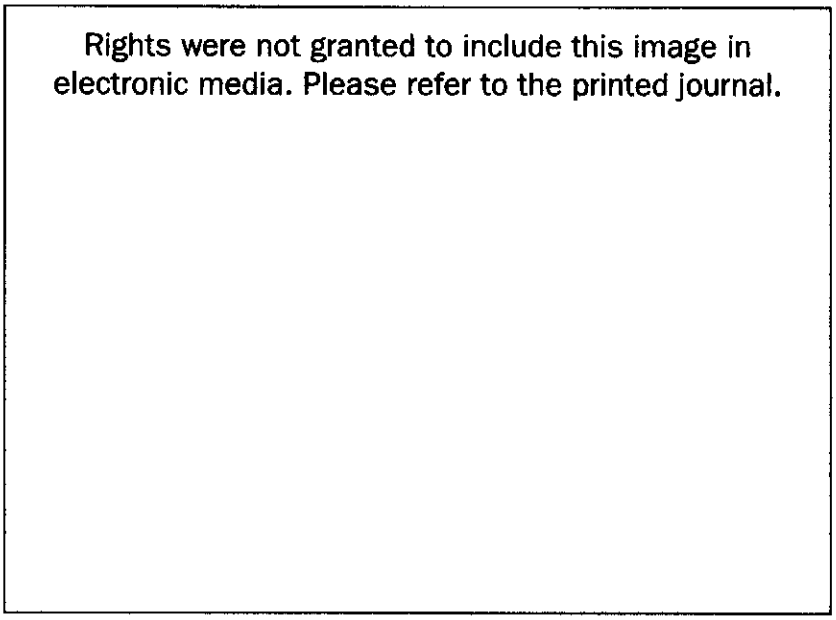
Million Mom March for gun control in Washington DC, USA

Lessons learned about prevention

The ecological model can also be used as a framework for violence prevention. To prevent violence it is necessary to act across several different levels at the same time. Programmes focusing on individuals tend to encourage positive attitudes and behaviour in children and young people and can change the behaviour of individuals who have already become violent. Relationship approaches are used to influence interactions inside families and negative influences from peers. Community-based efforts can stimulate community action or focus on the care and

support of victims. Finally, societal approaches focus on economic conditions, cultural norms, and broad social influences such as mass media.

Our understanding of the nature and prevention of the major types of violence suggests some common directions. First, families play a fundamental part in influencing the propensity for violent behaviour. Families can exert both protective and risk-inducing influences on the likelihood



Panos Pictures

Graffiti against violence, Calcutta, India

that their children will engage in interpersonal violence and suicidal behaviour as they grow older. The creation of environments that enhance the ability of families to protect their children from violence will be a key activity. Efforts to provide parents with information they can use to raise their children more effectively in difficult environments seems another promising direction.

Childhood exposure to violence in the form of physical, sexual, or emotional abuse, neglect, or even witnessing violence in the home has a significant effect on the wellbeing of children. Childhood exposure to violence is a risk factor for a range of risk behaviours and disorders (eg, smoking, obesity, high-risk sexual behaviour, and depression) that are, in turn, causally related to other major public health problems such as cancer, heart disease, sexually transmitted disease, and suicide.[33] Early interventions to reduce childhood exposure to violence are key factors to reduce the far-reaching consequences of violence and its expression by children as they grow into adolescents and adults.

Social norms and values can have a powerful role in justifying the victimisation of women and children. Suicidal behaviour and even war are also more easily justified in certain cultural contexts. Much attention has to be paid to the varied social and cultural traditions that exist across the world. The notion that violence towards women, children, or other human beings can be justified needs to be reconsidered given the enormous health and social costs that violence exacts from victims and societies. Promotion of norms and values in which violence is depicted as illegitimate and irresponsible could be very important in creating social contexts that are intolerant of violence and are considerate to its victims.

Economic conditions are both causes and effects of violence. Poor people bear a disproportionate share of the public health burden of violence in almost every society. Income inequality, in particular, is associated with national homicide rates.[34] Interpersonal violence and war impede economic development by increasing the costs of health and security-related services, reducing productivity and property values, disrupting human services, and undermining governance. The threat of violence can destabilise the economies of nations and regions by compromising the establishment and viability of businesses. Consequently, we cannot separate economic policies and programmes from violence prevention. Comprehensive approaches to violence prevention should include efforts to promote positive economic development, especially in ways that seek to reduce inequities.

The WHO report shows that early childhood interventions, such as home visits, reduce maltreatment of children and are among the most promising interventions for long-term reduction in violence among young people. Parenting and family therapy programmes also have positive, long-term effects on violent and delinquent behaviour and are cost effective. Programmes that emphasise life-skills and social competency are promising approaches to address interpersonal violence, and treatment for mental disorders and behavioural therapy programmes can reduce suicidal behaviour. Other measures, such as reducing access to tools for suicide and homicide, have reduced rates of these incidents in some settings. The report also shows, however, that few programmes have been rigorously assessed. There is also an imbalance in focus—community and societal strategies have been underemphasised by comparison with programmes addressing individual and relationship factors.

Proposed way ahead

National plans of action need to be developed in collaboration with all relevant agencies to ensure that governmental and non-governmental agencies agree priorities and objectives, define one another's responsibilities, and work together on achieving these goals. Plans should include review and reform of legislation and policy, building data collection and research capacity, strengthening services for victims, and developing and assessing prevention responses. To ensure that the plan moves beyond words to action, a specific organisation must be mandated to monitor and report periodically on progress.

Our understanding of the magnitude and causes of violence needs to be improved. Data for the human, social, and financial costs of violence are important for understanding the issue, setting priorities, and advocating for increased prevention efforts. However, the quantity and quality of data are poor all over the world. Furthermore, data are often not comparable across countries and regions because of differences in definition, data collection methods, and classification systems. Greater efforts are needed to collect data in a standard way and ensure its wide dissemination. Although progress has been made in understanding the factors that cause violence and those that contribute to its prevention, much more research is needed, especially into broader social and cultural factors, including those related to globalisation.

One of the main areas the report draws attention to is investment in primary prevention: early intervention to prevent children developing into perpetrators of violence. Several primary prevention interventions show promise. Violence prevention efforts need to be integrated into social and educational policies and thereby reduce gender and social inequalities, which are major risk factors for most types of violence. Inequalities can be addressed only by an array of interventions including legal reforms, strengthening of social protection services, education, and advocacy.

One area where the public health sector has an important responsibility is in assuring the availability of services for victims of violence. Emergency and long-term care services need to be improved so that they provide a comprehensive response for victims of violence. Common taboos often prevent recognition of, and services for, sexual violence, self-inflicted violence, and abuse of children, women, or elderly people. Furthermore, efforts should be made to provide a response that integrates the medical, legal, and social services that victims might need.

Many agencies are working towards addressing violence at the international or national level. However, few mechanisms exist to promote collaboration between agencies and specialties. WHO held a meeting to increase collaboration across UN agencies, which led to the publication of *The Guide to UN Resources and Activities for the Prevention of Interpersonal Violence*.[35] In the Americas, the Inter-American Coalition on Violence Prevention (http//www.iacpv.org) builds on the strengths of six agencies to develop multisectoral violence prevention: Centers for Disease Control and Prevention (CDC); Inter-American Development Bank; Organization of American States; Pan-American Health Organization; United Nations Education, Scientific, and Cultural Organization; and the World Bank. The coalition's main objectives are to raise awareness among decision makers, opinion makers, and civic leaders about the social and economic costs of violence; to promote the need to transcend traditional crime-fighting approaches based on control, and to promote those emphasising prevention; and to establish coordination procedures between multilateral organisations to enhance the success of interventions at national and local levels.

Adherence to international treaties and human rights mechanisms needs to be promoted and strengthened. Various international instruments of direct relevance for violence prevention have been signed in the past few decades. Countries could intensify efforts to ratify these instruments and adapt their national legislation accordingly. Finally, practical international responses to the global drugs and arms trade need to be sought. Because of their large and global effects, even small successes in this area might change the lives of many people.

What challenges does the movement to prevent violence face?

The movement to prevent violence faces many challenges. First and foremost, we need to convince policy makers, ministers of health, and the public that violence prevention programmes and policies can be cost effective compared with alternatives such as incarceration. Although more scientific evidence is needed in many areas, good evidence is already available for some types of violence. For example, in an economic analysis of several violence prevention strategies compared with incarceration in California, incentives for high school graduation and parental training were more cost effective than a repeat offender minimum sentence incarceration approach such as the three strikes law.[36]

Another major challenge is to convince national and local public health institutions that violence prevention is a legitimate and important part of their mission. Ministers of health can be important actors and facilitators for violence prevention. At present, violence prevention is not generally viewed as a public health priority, much less a legitimate public health activity in most ministries of health. However, this attitude is slowly changing. For example, the ministry of health in Mozambique has supported the creation of a national violence prevention plan, and schools of public health are increasingly offering courses in violence epidemiology and integrating violence prevention topics into their curricula.

A significant challenge is the creation of a sense of ownership and responsibility for addressing the problem of violence at the community level. Empowerment of communities is essential, because many of the most important solutions will have to be implemented locally. The value of community ownership and a sustained commitment to violence prevention has been shown powerfully in Bogota, Colombia, where three successive mayors have supported and continued to implement a multifaceted set of violence prevention policies and programmes, including restrictions on the sale of alcohol and firearm carrying on weekends and special occasions, community mobilisation, and infrastructure development. Homicide rates in Bogota have fallen substantially, and this decline is associated, in part, with the intermittent city-wide ban on carrying firearms.[37]

Global leadership will be needed to help stimulate and provide technical assistance to violence prevention efforts across the world. Without the creation of international organisations with a capacity for such leadership, development and implementation of effective violence prevention policies and programmes will proceed slowly and with difficulty. Moreover, such leadership can improve the ability of nations to learn from one another.

To prevent violence we must be able to measure and monitor it. Development of surveillance systems to collect basic information systematically and continuously on the magnitude and character of injuries and deaths from violence is a challenge in all parts of the world. Fortunately, many efforts are underway to develop such systems. For example, earlier this year, WHO and CDC published *Injury Surveillance Guidelines*. Standards for the classification of injury data are also being developed: the international classification of external causes of injury (http://www.iceci.org) is intended to help researchers and prevention practitioners to understand more precisely the characteristics of the injuries they are studying, answer questions on the circumstances of injuries, and provide more detailed information about specific injury categories such as assaults and suicide attempts. These standards have been used to develop an emergency department injury surveillance system in Jamaica.[38] Information from this system is being used to guide violence prevention activities.

Conclusion

With the publication of the *World Report on Violence and Health*, the international community now has a compilation of some of the best available knowledge on the prevention of violence and the role of the public health sector. The report should serve as catalyst for debate and action. During the 1-year campaign that starts this week, WHO and its partners will bring this debate to countries

around the world to ensure the wide use of the report and the implementation of its recommendations into policies and action.

Conflict of interest statement
The authors of this article co-edited the WHO report.

References

1 Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva: World Health Organization, 2002.

2 Gordon JE. The epidemiology of accidents. *Am J Public Health* 1949; 504–15.

3 Abad Gomez, H. Violence requires epidemiological studies. *Tribuna Medica* 1962; **2**: 1–12.

4 World Health Assembly. Prevention of violence: public health priority (WHA 49,25). Geneva: World Health Organization, 1996.

5 Mercy JA, Rosenberg ML, Powell KE, Broome CV, Roper WL. Public health policy for preventing violence. *Health Aff (Millwood)* 1993; Winter **12**: 7–29.

6 Committee for the Study of the Future of Public Health, Division of Health Care Services, Institute of Medicine. The future of public health. Washington: National Academy Press, 1988.

7 WHO global consultation on violence and health. Violence: a public health priority (WHO/EHA/SPI.POA.2). Geneva: World Health Organisation, 1996.

8 Farrington DP. The family backgrounds of aggressive youths. In: Hersov LA, Berger M, Shaffer D (eds). Aggression and antisocial behavior in childhood and adolescence. Oxford: Pergamon Press, 1978: 73–93.

9 McCord J. A forty year perspective on the effects of child abuse and neglect. *Child Abuse Negl* 1983; **7**: 265–70.

10 Widom CS. Child abuse, neglect, and violent criminal behavior. *Criminology* 1989; **27**: 251–72.

11 Paolucci EO, Genuis ML, Violato C. A meta-analysis of the published researchon the effects of child sexual abuse. *J Psychol* 2001; **135**: 17–36.

12 Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. Statistical annex: world report on violence and health. Geneva: World Health Organization, 2002.

13 Heise LL, Ellsberg M, Gottemoeller M. Ending violence against women (population reports, series L, no 11). Baltimore: Johns Hopkins University School of Public Health, Center for Communications Programs, 1999.

14 Finkelhor D. The international epidemiology of child sexual abuse. *Child Abuse Negl* 1994; **18**: 409–17.

15 Finkelhor D. Current information on the scope and nature of child sexual abuse. *Future Child* 1994; **4**: 31–53.

16 Pillemer K, Finkelhor D. Prevalence of elder abuse: a random sample survey. *Gerontologist* 1988; **28**: 51–57.

17 Podnieks E. National survey on abuse of the elderly in Canada. *J Elder Abuse Negl* 1992; **4**: 5–58.

18 Kivelä SL et al. Abuse in old age: epidemiological data from Finland. *J Elder Abuse Negl* 1992; **4**: 1–18.

19 Ogg J, Bennett GCJ. Elder abuse in Britain. *BMJ* 1992; **305**: 998–99.

20 Comijs HC, Pot AM, Smit JH, Bouter LM, Jonker C. Elder abuse in the community: prevalence and consequences. *J Am Geriatr Soc* 1998; **46**: 885–88.

21 Fergusson DM, Horwood MT, Lynskey LJ. Childhood sexual abuse and psychiatric disorder in young adulthood: II psychiatric outcomes of childhood sexual abuse. *J Am Acad Child Adolesc Psychiatry* 1996; **35**: 1365–74.

22 Davidson JR, Hughes DC, George LK, Blazer DG. The association of sexual assault and attempted suicide within the community. *Arch Gen Psychiatry*, 1996, **53**: 550–55.

23 Wiederman MW, Sansone RA, Sansone LA. History of trauma and attempted suicide among women in a primary care setting. *Violence Vict* 1998; **13**: 3–9.

24 Garbarino J, Crouter A. Defining the community context for parent-child relations: the correlates of child maltreatment. *Child Dev* 1978; **49**: 604–16.

25 Bronfenbrenner V. The ecology of human development: experiments by nature and design. Cambridge: Harvard University Press, 1979.

26 Garbarino J. Adolescent development: an ecological perspective. Columbus: Charles E Merrill, 1985.

27 Tolan P, Guerra N. What works in reducing adolescent violence: an empirical review of the field. Boulder: University of Colorado, Center for the Study and Prevention of Violence, 1994.

28 Heise LL. Violence against women: an integrated ecological framework. *Violence Against Women* 1998; **4**: 262–90.

29 Schiamberg LB, Gans D. An ecological framework for contextual risk factors in elder abuse by adult children. *J Elder Abuse Negl* 1999; **11**: 79–103.

30 Carp RM. Elder abuse in the family: an interdisciplinary model for research. New York: Springer, 2000.

31 Thornberry TP, Huizina D, Loeber R. The prevention of serious delinquency and violence: implications from the program of research on the causes and correlates of delinquency. In: Howell JC, Krisberg B, Hawkins JD, Wilson JJ, eds. Sourcebook on serious, violent and chronic juvenile offenders. Thousand Oaks: Sage, 1995: 213–37.

32 Lipsey MW, Derzon JH. Predictors of serious delinquency in adolescence and early adulthood: a synthesis of longitudinal research. In: Loeber R, Farrington DP, eds. Serious and violent juvenile offenders: risk factors and successful interventions. Thousand Oaks: Sage, 1998: 86–105.

33 Felitti VJ, Anda RF, Nordenberg D, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *Am J Prev Med* 1998; **14**: 245–58.

34 Fajnzylber P, Lederman D, Loayza N. Inequality and violent crime. Washington: Regional Studies Program, Office of the Chief Economist for Latin America and the Caribbean, World Bank, 1999.

35 Guide to United Nations resources and activities for the prevention of interpersonal violence (WHO/NMH/VIP/02.05). Geneva: World Health Organization, 2002.

36 Greenwood PW, Model KE, Rydell CP, Chiesa J. Diverting children from a life of crime: measuring costs and benefits. Santa Monica: RAND, 1996.

37 Villaveces A, Cummings P, Espitia VE, Koepsell TD, McKnight B, Kellermann AL. Effect of a ban on carrying firearms on homicide rates in 2 Colombian Cities. *JAMA* 2000; **283**: 1205–09.

38 Ward E, Durant T, Thompson M, Gordon G, Mitchell W, Ashley D, and the VRISS working group. Implementing a hospital-based violence-related injury surveillance system—a background to the Jamaican experience. *J Injury Control Safety Promotion* (in press).

Contacts

Fleming College

D.S.O Counsellor
Audrey Healy
Ph: 705-749-5530 705-749-5530
Email: ahealy@flemingc.ca

Student Association
www.flemingsac.ca
705-324-1983 705-324-1983

Services and Sustainability Coordinator
Jessica Spooner
705-743-4460 x223

Trent University

Student Counselling Services
Stewart H
705-748-1386 705-748-1386
Counselling@trentu.ca

Vice President Student Issues
John Paul Nyereka
vpissues@trentcsa.ca

Manage Disability Services Office
Eunice Land-Lucas
705-748-1011 x6192
elundlucas@trentu.ca

TRENT RECOMMENDATION

To have a table set up on campus to provide information

This was suggested by John Paul. There are tables all over the campus in areas of high student traffic which can be booked. At these tables flyers, pamphlets, and verbal information can be provided to students as they walk by to class. It was suggested that some sort of incentive be used to draw in the attention of the busy students such as hot chocolate or prizes. It was said that when incentives were used the tables were more successful.

TRENT RECOMMENDATION

The Arthur

This was suggested by John Paul. Contact the editor of The Arthur, Trent's newspaper, and place advertisements in there. Ads in the paper can be either promotion for focus groups or rallies or information that should get out to the public. This is a great way to reach out to the activist population of Trent and staff as well. The newspaper after publishing would available all over campus, in all colleges, and the athletic building. Have papers distributed in the athletic building is a great way to start to reach out to the community as well as students.

TRENT RECOMMENDATION

Posters/Pamphlets/Flyers

Posters are a great way to grab the attention of students to get across simple and drastic points. It was recommended by everyone that posters be posted around campus. Posters should be eye catching and to the point. If they contain lengthy saying they may not get read by students who are quickly passing by. It was suggested by one of the students who responded to our email that pamphlets be available and/or handed out talking about types of violence, types of disabilities and healthy relationships geared towards BOTH men and women. These pamphlets could be given out at the table stations as well as put in the DSO, counselling services, Trent Central Student Association so they can be picked up by students. Flyers with information as well as services that can be accessed both in the community and on campus can both be posted around campus as posters or can be handed out at tables or can be placed in the cafeterias on the tables (students will be able to read them as they eat).

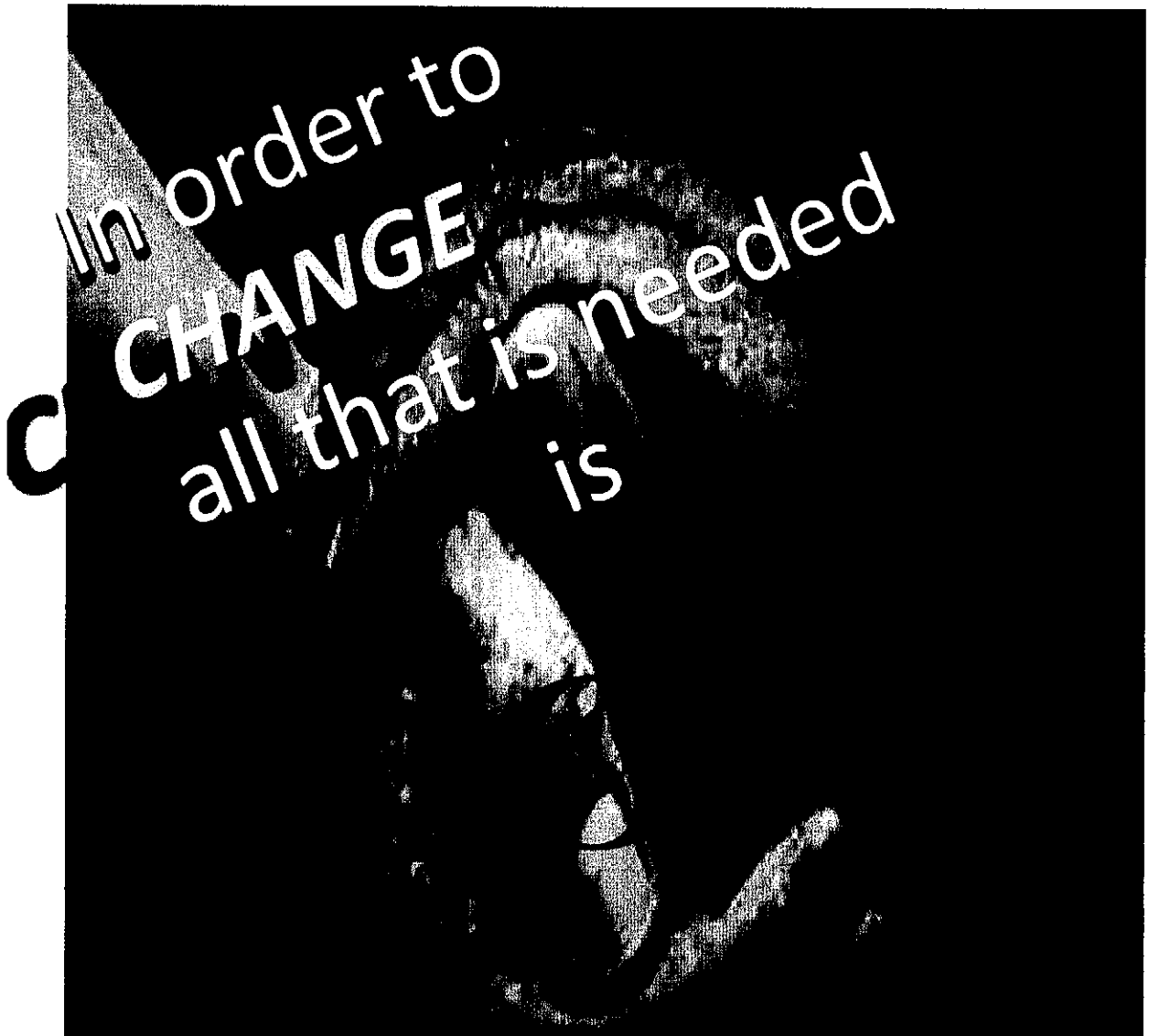
TRENT RECOMMENDATION

Focus group or awareness rally inviting the entire student population of Trent University

We feel that this would be an effective way to raise awareness on the Trent campus due to the large number of student activists as well as the sense of community found among the students. There are many large lecture halls for which this could be hosted as well as many outdoor places for times of nice weather. In support of this recommendation this suggestion was also put forth by recommended by both Eunice of the Trent DSO and John Paul of TCSA. John Paul and the TCSA had hosted a Rally about racism and drew in 60 – 80 students. This would be a great way to get information from the students as well as get the word out there to stop violence amongst women with disabilities.

FLEMING RECOMMENDATIONS

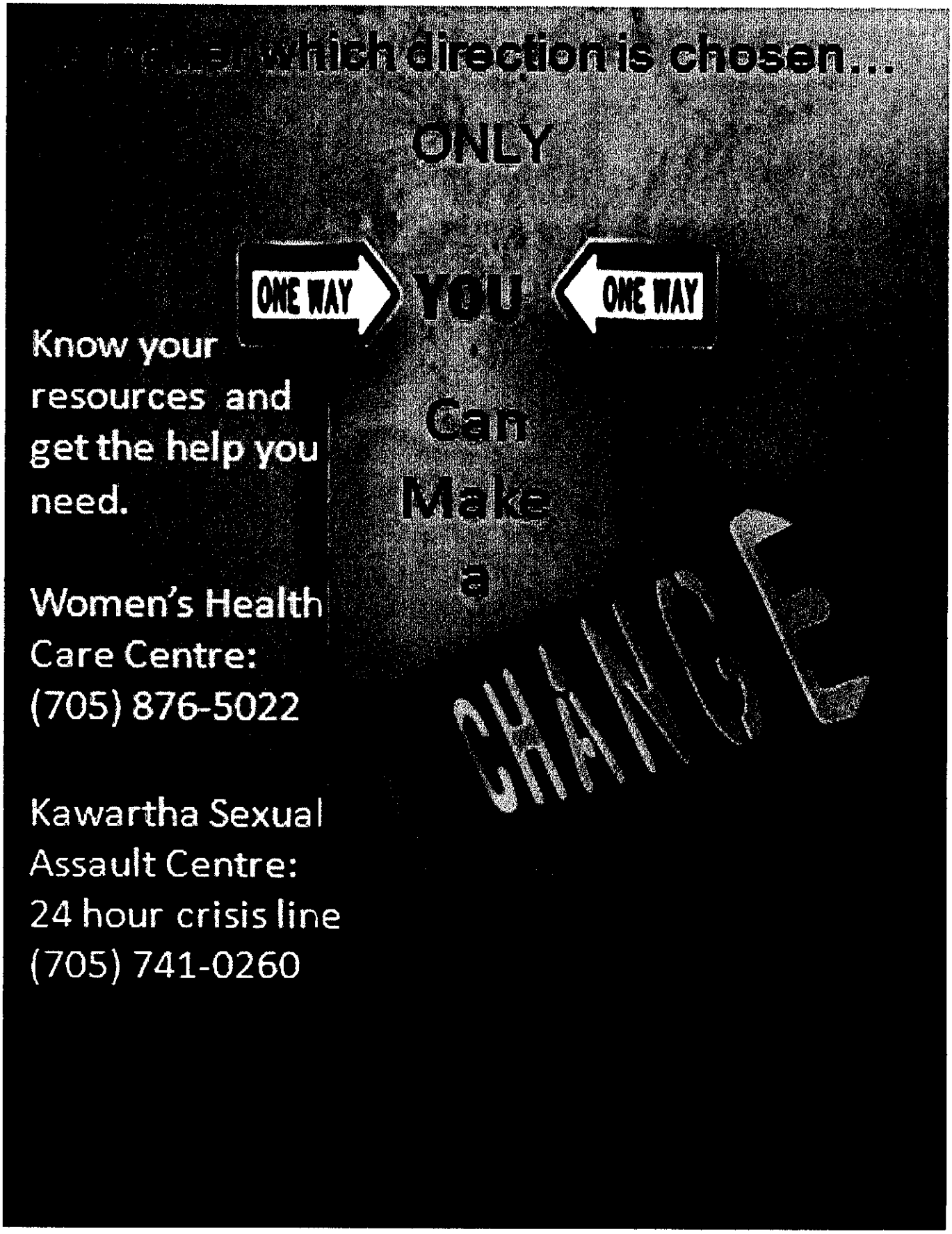
At Fleming College, the Disability Services Office and Student Administrative Council offered a number of ways to raise awareness. The first, regarding the focus group, was to hold it in the community, rather than at the school, to promote attendance. This particular group is less likely to attend a focus group on campus because of privacy issues. The second, related to the greater school community, was to use posters throughout campus with resources in the community that can be accessed. Another recommendation was to use the newly purchased televisions throughout campus to raise awareness of violence affecting women with disabilities and set up information tables in the campus pub. Another suggestion was delivery of fact sheets, brochures and other sources of information to the campus' residencies and e-mail distribution to all students related to the violence against women with disabilities. The Student Administrative Council also suggested announcements at the beginning of class made by members of the student council.



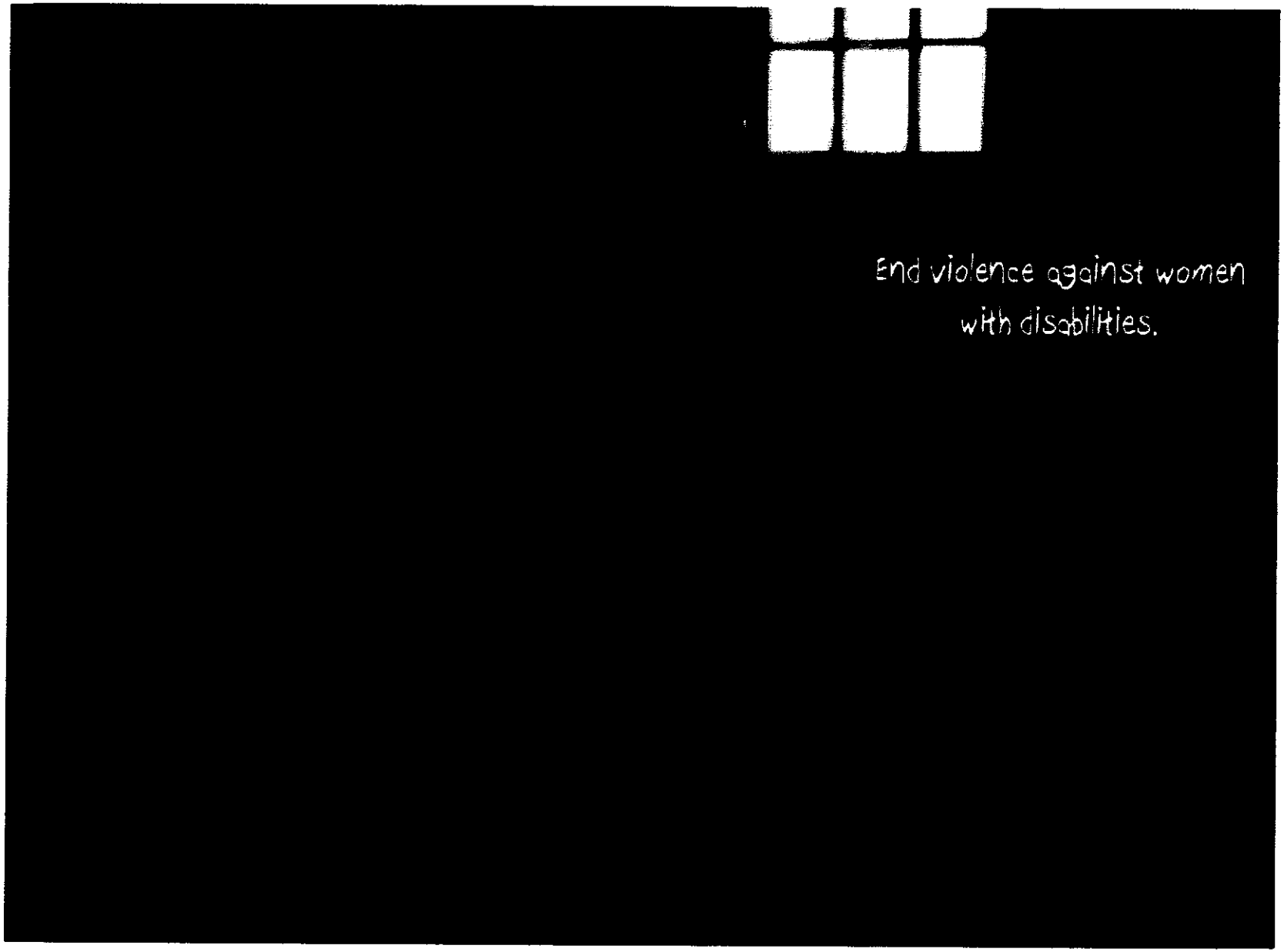
Know your community resources.
Get the Help you Need!

Women's Health Care Centre:
(705) 876-5022

Kawartha Sexual Assault Centre: 24 – hour crisis line
(705) 741-0260


Which direction is chosen...
ONLY
ONE WAY
YOU
ONE WAY
Can
Make
a
CHANGE
Know your resources and get the help you need.
Women's Health Care Centre:
(705) 876-5022
Kawartha Sexual Assault Centre:
24 hour crisis line
(705) 741-0260

Arthroplasty

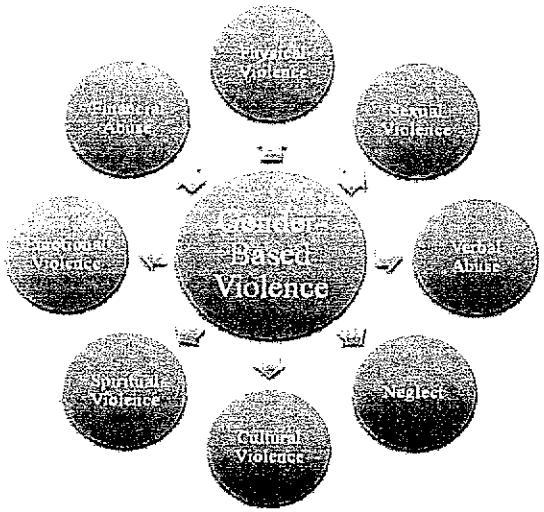

End violence against women
with disabilities.

Need somewhere to turn to?
You are not alone...
..To help end violence against women

What is Violence?

Intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. (Krantz & Garcia-Moreno, 2005)

Types Of Violence



What Is Disability?

A condition or function judged to be significantly impaired relative to the usual standard of an individual or group. (Disabled World, 2010)

Resources In Peterborough And Peterborough County

Kawartha Sexual Assault Center
411 Water Street, Suite 102
Peterborough, Ontario
K9H 3L9
Business Line (705) 748- 5901
Crisis Line: (705) 741-0260
Fax: (705) 741- 0405

Women's Health Care Centre
1 Hospital Drive
Peterborough
Ontario, Canada
K9J 7C6
Phone: (705) 876-5117

YWCA Peterborough, Victoria & Haliburton
216 Simcoe Street
Peterborough, ON K9H 2H7
Tel: 705-743-3526
TTY: 705-743-4015
Fax: 705-745-4654
Email: info@ywcapeterborough.org

YWCA Women's Centre of Haliburton County
11 Bobcaygeon Road
Minden, ON K0M 2K0
Office: 705-286-1942
Support: 705-286-6442
Fax: 705-286-4341
Email: ywcahal@bellnet.ca

Women, Violence, And Disability

THE LINK BETWEEN VIOLENCE AND DISABILITY

- Being physically less capable of defending themselves;
- Difficulty in reporting maltreatment due to the lack of accessible forms of communication;
- Inaccessibility of information and counselling services due to barriers in the physical environment and due to the lack of accessible forms of communication;
- Lower self-esteem due to not being seen as a woman but only as a person with a disability, or even worse – only as her disability;
- A greater amount of dependence on other people for care;
- Fear of reporting the abuse, as it might result in the breaking of bonds and loss of the care they may require;
- Being more exposed to violence as a result of living in institutions, residences and hospitals;
- Less credibility when reporting violence in institutions;
- Less risk of discovery as perceived by the perpetrator;
- Failure of others to believe some survivors;

DID YOU KNOW?

FACTS

- Women with disabilities are abused at a much higher rate than women without disabilities.
- In Canada there are approximately 1,900,000 women aged 15 and over who have disabilities. It is estimated that approximately 40% of these women with disabilities will be assaulted, sexually assaulted or abused throughout their lifetime.
- Depending on whether they reside within an institutional or community setting, women with disabilities are 1.5 to 10 times more likely to be victimized than women who are not disabled.

MYTHS

MYTH: "Women with disabilities are not sexually attractive to most men and therefore, they are very rarely victims of sexual assault."

REALITY: Ninety percent of women with disabilities are raped, assaulted or abused at some time in their lives. Sexual violence, like other types of violence and abuse, is about control and fear and has nothing to do with traditional definitions of sexual attractiveness.

MYTH: "Girls and women with disabilities are most often abused by strangers. No one who commits their live to caring for someone with a disability would turn around and abuse them."

REALITY: Women with disabilities are most often abused by someone they know; often someone in a position of authority and trust, such as a care giver.

MYTH: "The police are always prepared to help women who have been assaulted, especially if she is a woman with disabilities."

REALITY: Oftentimes, women with disabilities are often considered to be 'not good witnesses' and not capable of testifying or giving evidence by the police and the courts, particularly if they have difficulty or require assistance in communicating; and when they do report abuse, they are often not believed.

MYTH: "Girls with intellectual disabilities are so overprotected by their parents that they are less likely to be raped than other girls their age."

REALITY: Of girls with intellectual disabilities, it is estimated that 40% to 70% will be sexually abused before the age of 18.