Domestic Violence:
A priority public health issue in the
Western Pacific Region
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FOREWORD

Different forms of violence, within and outside the family, exist in all countries and communities and involve all segments of society. However, while violence in the form of armed conflict is widely reported in the media and generally lasts for a limited period, domestic violence, most often perpetrated against women and children, is very common, pervasive and may last a whole lifetime, yet most domestic violence remains unreported in the popular media. Domestic violence has extremely serious health consequences. In the psychological sphere, these range from emotional trauma to permanent serious mental impairment and in the physical sphere from bruises, burns and broken bones to death. The consequences of sexual abuse include unwanted pregnancies and unsafe abortion, sexually transmitted diseases and HIV/AIDS, and suicide. International research shows that women are more likely to be killed, raped, injured or psychologically damaged by their partners (or former partners) than by any other person. Countries in the Region report prevalence rates for partner abuse of between 16% and 50% and this is likely to be an underestimation of the extent of the problem.

The health consequences of domestic violence are a major burden on the health sector as well on economic and social development. Domestic violence has devastating consequences for the individuals who are abused and represents a major affront to basic human rights. However, given the taboos that surround discussion of domestic violence in most countries and the lack of recognition of domestic abuse as a public health issue, our current knowledge about levels of domestic violence represents only the tip of the iceberg. We need to know more about prevalence rates and the health consequences of violence to develop effective intervention and prevention programmes. This monograph represents the beginning of that process.

In line with the Fiftieth World Health Assembly’s resolution on violence against women in 1996 and the concern expressed by Member States and nongovernmental organizations at the forty-eighth session of the Regional Committee for the Western Pacific in 1997, the Regional Office has expressed its commitment to supporting efforts to prevent such violence. In this process the Beijing Platform for Action (BPFA) and the regional policy document *New horizons in health* will be used as guides to direct illness prevention and health promotion action. The Regional Office will continue efforts to fulfil its mandate to improve the health status of women, especially with regard to domestic violence, in the countries of the Region.
Collection of gender-disaggregated data will go a long way towards gaining a clearer picture of the gender dimensions of domestic violence, especially since violence-induced mortality and morbidity is now included as one of the categories for which countries are asked to submit data for country profiles. Similarly, *New horizons in health* acknowledges the heterogeneity of people's experiences of health and illness and emphasizes the need to account for differences across the life span and across cultures and genders. The current monograph analyses the prevalence data and information on the health effects of domestic violence and argues for the urgent need to undertake further research.

Furthermore, mainstreaming of a gender perspective into the three themes of *New horizons in health*, preparation for life, protection of life and quality of life in later years, has already begun and gender-sensitive indicators for monitoring progress are being developed.

Despite these initiatives, much remains to be done. The emotional and psychological effects of domestic violence are not documented in morbidity data. Child abuse and the effects on children of witnessing domestic violence are seriously neglected areas of research.

This monograph documents some of the initiatives being taken in the countries of the Region to provide appropriate services for both victims and perpetrators of violence, to legislate against domestic violence and to develop violence prevention and health promotion programmes to make families and households safe and peaceful settings. The next step is to develop indicators to monitor the effectiveness of such initiatives over time. The WHO Regional Office for the Western Pacific welcomes the opportunity to work with countries and other sectors to create a violence-free society.

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We know that injury from violence of all kinds is a major contributor to the global burden of disease (Murray & Lopez, 1996). Domestic violence is a major component of this burden, which disproportionately falls on women across the entire life span. ‘At least one in five of the world’s female population has been physically or sexually abused by a man or men at some time in their life’ (WHO, 1997) and in ‘the United States domestic violence is the leading cause of injury among women of reproductive age’ (World Bank, 1993:50).

Is this experience mirrored in the countries of the Western Pacific Region? What are the short and long term health consequences of domestic violence?

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

INTRODUCTION

Violence not only causes physical injury, it also undermines the social, economic, psychological, spiritual and emotional well-being of the victim, the perpetrator and society as a whole. This is evident on a large scale in wars, where the populations of all countries involved (attacking and attacked) suffer long-term economic, political, social, psychological and emotional distress. It also applies at the community and individual levels in street brawls, schoolyard fights and domestic disputes. At all levels, the social, economic, psychological, physical and emotional harm to individuals constitutes a major health concern. As such, it requires responses from the health sector in collaboration with other sectors (such as social services, the courts, police and educational bodies) in developing prevention strategies as well as in dealing with the consequences of violence.
Domestic violence is a burden on numerous sectors of the social system and quietly, yet dramatically, affects the development of a nation ... batterers cost nations fortunes in law enforcement, health care, lost labour and general progress in development. These costs do not only affect the present generation; what begins as an assault by one person on another reverberates through the family and the community into the future' (Zimmerman, 1994:184).

Global Concern

In 1993, a World Bank Report singled out violence against women as a significant issue for the health sector. Violence against women was identified as a major contributor to the global burden of ill health in terms of ‘female morbidity and mortality, leading to psychological trauma and depression, injuries, sexually transmitted diseases, suicide and murder’ (World Bank, 1993:50). The World Bank Report 1993 (1993:50) estimated that rape and domestic violence cause 5% of the total burden of disease among 15-44 year old women in developing countries, (‘where the burden from maternal and communicable causes still overwhelms that from other conditions’) and rises to 19% in industrial countries where the ‘total disease burden is smaller’. The Report suggests that this burden for women affects their families in that ‘by damaging a woman’s physical, mental and emotional capacity to care for her family, domestic violence and rape also hurt the health of other family members, particularly young children’ (World Bank, 1993:50).

International Forums

Violence against men, women and children was internationally condemned in the early years of the United Nations in the articles of the Universal Declaration of Human Rights (1948). These basic human rights to ‘life, liberty and security’ were reinforced and refined in, among other conventions, the International Covenant on Economic, Social and Cultural Rights (1966), the International Covenant on Civil and Political Rights (1966), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) and the Convention on the Rights of the Child (1989).
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The gender dimensions of violence have emerged as a major issue in more recent international forums and conventions dealing with human rights, women’s health and population issues. Principles of gender justice formed the foundation of the Nairobi Forward-Looking Strategy (1975) and the Convention on the Elimination of Discrimination Against Women (1979). However, specific reference to gender-based violence was not made until 1992 when the Committee on the Elimination of Discrimination Against Women (CEDAW) (which monitors the implementation of the Convention on the Elimination of Discrimination Against Women (1979)) ‘formally included gender-based violence under gender-based discrimination’ (WHO, 1997). This was followed by the 1993 adoption by the United Nations of the Declaration on the Elimination of Violence Against Women, which identified violence as a major barrier to the achievement of women’s rights and fundamental freedoms.

Further endorsement of the central role of violence in compromising women’s rights and women’s health was provided by the programmes and platforms for action of the World Conference on Human Rights in Vienna in 1993, the International Conference on Population and Development (ICPD) in Cairo in 1994, the World Summit for Social Development in Copenhagen in 1995 and the Fourth World Conference on Women in Beijing in 1995.

All four international meetings provided consensual guidelines for signatory countries to develop treatment and prevention policies and services for gender-based violence. All forums proposed intersectoral action to provide the legal, social, cultural, economic and political environment for national action and international cooperation to eliminate violence. The ICPD Programme of Action (1994) recommended the development within countries of: Programmes for the prevention and treatment of sexual abuse and incest and other reproductive health services ...(It recommended that such) programmes should provide information to adolescents and make a conscious effort to strengthen positive social and cultural values. (para 7.47, ICPD, 1994)

The Beijing Platform for Action (BPFA) went further, devoting an entire section to violence against women. The Beijing PFA identified specific risks associated with violence and pointed to the direct links with health status and health service usage.
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Sexual and gender-based violence, including physical and psychological abuse, trafficking in women and girls, and other forms of abuse and sexual exploitation place girls and women at high risk of physical and mental trauma, disease and unwanted pregnancy. Such situations often deter women from using health and other services. (para 99 BPFA, 1995)

These international initiatives culminated in the adoption by the World Health Assembly of resolution WHA49.25 in 1996, declaring violence a public health priority issue (see Annex A). The 49th World Health Assembly noted ‘with great concern the dramatic worldwide increase in the incidence of intentional injuries affecting people of all ages and both sexes, but especially women and children’ (Annex A: WHA49.25, 1996).

Regional Concern

At the Regional level, in line with WHA49.25 (Annex A), violence against women has been raised as an urgent issue for immediate research and action. This monograph has been developed in response to calls from country delegates and nongovernmental organizations at the Forty-eighth session of the Western Pacific Regional Committee Meeting (RCM) in Sydney in September 1997 for the collection of reliable data on prevalence rates and an inventory of currently available services (including prevention initiatives) in the Region.

One of the Australian representatives to the 48th session of the RCM recommended ‘the development of a plan of action on violence and health in the light of statistics showing violence contributing to 3.8% of global cause of death and burden of disease in 1990 and projections which showed that it would account for 7.2% by 2020.’ The Australian representative suggested that ‘progress could be made within existing WHO resources, violence being directly related to a number of the existing WHO programme areas’. It was argued that ‘WHO should ... promote Region-wide acceptance of a plan of action on violence and health, and ensure that it was implemented as an integral component of countries’ policies and projects. In the same vein, ‘coordination with other UN agencies such as the Commission on Human Rights, the Commission on the Status of Women, The Commission for the Elimination of Discrimination Against Women and many others would ensure that scarce resources were used to complement rather than duplicate initiatives.’ (WPR/RC48/SR/6 Women, Health and Development, 1997:3-4)
One of the representatives from the Philippines reinforced Australia’s call for major initiatives on violence suggesting that ‘violence, including sexual abuse, is an emerging concern in the Philippines that needs to be addressed, with victims usually being the female members of the family. In response women’s desks have been established in a medical centre in Metro Manila and at some regional hospitals to assist victims’. A study on the determinants and consequences of violence against women is underway to provide guidelines in developing appropriate interventions (WPR/RC48/SR/6 Women, Health & Development, 1997:3-4).

A representative from Papua New Guinea argued that to overcome many problems associated with women and development, including domestic violence, the Ministry of Health in Papua New Guinea was introducing initiatives addressed to men to ‘try to change their attitudes to women’.

In response to these interventions, the Regional Director suggested a multi-pronged approach to the prevention of domestic violence. He agreed that WHO would work collaboratively with other international, regional and governmental and nongovernmental organizations to develop strategies to counter violence. He committed the Regional office to working with Papua New Guinea to ‘develop community-based activities in respect of the attitude of men towards women’. He also pointed to the WHO, WHD1998-1999 multi-country study to examine prevalence rates in several countries of the Region and to explore ‘the determinants and consequences of violence and how the problem might eventually be mitigated or eradicated.’ (WPR/RC48/SR/6 Women, Health and Development, 1997:3-4)

This monograph dovetails into the more detailed 1998-1999 multicountry research on violence in families initiated by the Women Health and Development Division of WHO, which will undertake a systematic study of prevalence rates in several countries in the Region, including the Philippines and Japan. The monograph also acts as a support document for a UNFPA-funded study examining prevalence rates of violence in seven Pacific Islands.

Calls from representatives to the Forty-eighth session of the RCM to put violence on the health agenda were matched by a convincing argument from representatives of the International Alliance of Women, a nongovernmental organization. They argued that,
given the success and widespread distribution of the Women’s Health series of monographs prepared by WHO, WPRO, a good starting point in putting violence on the regional health agenda would be to prepare a similar monograph on violence. The International Alliance of Women representatives suggested that ‘a monograph on the health effects of violence against women in the Western Pacific Region would be widely welcomed as an indication of the seriousness and pervasiveness of the issue and an extremely valuable tool in the challenge to ensure healthy societies free from violence’. They argued that, in spite of the great advances made in global recognition of the problem in the Declaration on All Forms of Violence Against Women (1993) and at the 49th World Health Assembly in 1996, reports from the field suggest that ‘the adverse effects of violence against women (still) constitute one of the major threats to women’s physical, mental and social well-being in all communities, to the extent that it could be considered a pandemic ...(and)...this could be considered one of the greatest unprotested scandals of the twentieth century’ (Giles & Wainer, 1997).

Although data on domestic violence is scant and uneven across countries, an attempt is made here to report on what data is available, to identify the gaps in data, and to report on initiatives that are being undertaken by governments and nongovernmental organizations in the Region to develop prevention and service delivery programmes. WHO, working in collaboration with national governments and nongovernmental organizations, has an advocacy, research and technical advisory role in this process.

Focus

While recognizing that violence against men, women and children occurs in all settings (from the most public to the most private), and comes in many forms (from torture and murder to sexual harassment, racial slurs, verbal abuse and economic and political repression), this monograph will concentrate on domestic violence as a health issue in the Western Pacific Region. It thus focuses on the link between violence against women and domestic violence.

Violence against women

The term ‘violence against women’ as used in the Beijing Platform for Action (section D) is based on the definition used in the Declaration on the Elimination of Violence Against Women adopted by the United Nations General Assembly in 1993. It refers to ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life’ (Beijing PFA,
This broad concept of ‘violence against women’ encompasses physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution as well as ‘violence perpetrated and condoned by the State’ (Beijing PFA, 1995: para 113). It also covers ‘violation of the human rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery and forced pregnancy’ (para 114) and ‘forced sterilisation and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection’ (para 115). For the purposes of the current study, public violence will not be the focus of interest. Rather, the monograph will concentrate on physical, sexual and psychological violence occurring in the domestic sphere including ‘battering, sexual abuse of female (and male) children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation’ in the household (Beijing PFA, 1995: 113).

The most common form of domestic violence is partner abuse. ‘Abuse against women by partners is not just criminal assault in the home, nor is it one isolated push or shove in a lifetime of a relationship, nor is it one episode of not being able to contact friends or family. Partner abuse is best understood as a chronic syndrome characterised, not by episodes of violence, but by the emotional and psychological abuse used by men to control their female partners’ (Hegarty & Roberts, 1998: 53).

**Domestic Violence**

Domestic violence was identified as a priority issue in the Beijing Platform for Action. It refers to violence emanating from the household and within relationships defined by familial or emotional (former or present) attachment. It is the most common form of violence against women and affects women across the life span, from sex-selective abortion of female fetuses to forced suicide and abuse of older women. Domestic violence is evident to some degree in every society in the world. Its priority as an issue of concern rests on the fact that ‘research consistently demonstrates that a woman is more likely to be injured, raped or killed by a current or former partner than by any other person’ (WHO, 1997; Council on Scientific Affairs, 1992) and the physical proximity and emotional intimacy of the household makes it the most likely site for psychological and emotional abuse. Zimmerman's (1994) qualitative study in Cambodia found that 43 out of 50 women interviewed reported being physically abused by their husbands, 24 reported physical abuse of their children by their husbands yet only 7 out of 50 reported their husbands abusing people outside of the household.
Data on rape and violence injury from a woman-friendly hospital in Cebu, Philippines, reveals that, of the 218 cases of rape treated in the hospital in 1997, 50% had been committed in the victim’s or the offender’s house, and fewer than 10% of rapes were committed by a person unknown to the victim. Similarly, in the case of violence injury, of the 363 cases treated in 1997, 266 took place in the victim’s own home and only 6% of perpetrators were not related or not in a relationship with the victim. Of the perpetrators, 76% were either a husband (current or ex), a live-in partner or a boyfriend. (Vicente Sotto Memorial Center, 1997).

The greater the degree of privacy in the household, the more likely it is that acts of violence will remain hidden. Where there is overlap between the private and public spheres, as in the case of homeless people, the violent act is more likely to attract attention.

As discussed below, it is acknowledged that men are also victims of domestic violence but the prevalence rates of domestic violence against males remains low (Archer, 1994).
GENDER DIMENSIONS OF VIOLENCE

Broom (1998:46) argues that 'the experience of violent assault is highly variable and contains important gender dimensions'.

Males are undoubtedly the main perpetrators of violent acts, but they are not the main victims of all kinds of violence (Fletcher, 1995).

The most visible kinds of violence — such as mugging, street assault, and fights in public places — usually involve males as both aggressor and victim. But sexual assault and domestic violence are overwhelmingly crimes against women, and they constitute a serious threat to the health of many women ... and women appear to be at particularly high risk when they are pregnant. (Broom, 1998:45)

Certainly, women can be perpetrators of violence. As the literature points out, violence is not an exclusively male domain (Brott, 1993; Archer, 1994; Miller and Sharif, 1995; Fitzroy, 1997). Debates continue in the domestic violence literature on the extent of 'husband battering' and the problems of underreporting given that 'confessing to being knocked around by another man is a piece of cake compared to admitting being victimised by a woman' (Brott, 1993). However, the underreporting works both ways. Women also fear the consequences of reporting violence and declare an unwillingness to subject themselves to the shame of being identified as a 'battered woman' (Abdullah, 1995; Arrifin, 1997). Currently available statistics show that only 2-3% of reported sexual assaults are perpetrated by women (Fitzroy, 1997:53), with the victims often being other women, and research studies report that between 9-14% of all violence is perpetrated by women (Archer, 1994; Polk, 1994). Archer (1994:4-6) suggests that these figures are also inflated by researchers confusing acts of 'aggression' (defined by the behaviour) with acts of 'violence' (defined by outcome) and by ignoring the context of the violence, such as violent acts perpetrated in self-defence. Even if the figures are close to the real situation, they serve to dispel the 'myth of sexual symmetry in marital
violence’ (Dobash et al, 1992); there is marked gender asymmetry in domestic violence prevalence in all countries for which data is available.

The gender dimension of violence refers not only to incidence and prevalence rates. Establishing the ‘burden of disease’ on the basis of injuries sustained (eg. a broken nose) does not take account of the context in which that injury occurred, which significantly affects how it is experienced.

A particular injury, such as concussion or laceration, may be physically the same, regardless of how one was injured. But the personal meaning and social consequences will be very different depending on whether the injury was sustained in a car accident, a mugging by a stranger, a pub fight with a drinking companion, or an attack by one’s intimate partner. The first three sources of injury are likely to be singular or rare event, to be publicly acknowledged, and to receive immediate assistance. By contrast, ‘wife bashing’ is apt to be repeated and escalating, shrouded in shame and secrecy, and often concealed from health care workers....while any injury can leave emotional scars, the psychological impact of being attacked by a loved and trusted partner is particularly devastating and personally debilitating. (Broom, 1998:45)

Betrayal in the form of child abuse by parents or other relatives attracts public attention, including headline news, when there is substantial physical injury or death. However, in the more common cases of repeated sexual, physical, and psychological abuse where the victims are not hospitalized, the problem remains hidden from public view.

**Causes: need for a multi-level model**

The causes of domestic violence are multiple and complex. A ‘complete understanding of gender abuse may require acknowledging factors operating on multiple levels’ (Heisse, 1997). Feminist perspectives, proclaiming patriarchy as the overarching cause of domestic violence, have dominated the field in recent years and have substantially advanced our understandings of domestic violence. While ‘theories based on stress, social learning, personality disorders or alcohol abuse may suggest why individual men
become violent, they do not explain why women are so persistently the target and feminist analysis fills the gap in understanding this phenomenon (Heisse, 1997). However, feminist explanations of violence have tended to ignore or underplay other factors contributing to abuse (Fitzroy, 1997; Heisse, 1997).

The feminist emphasis on male dominance and gender hierarchy (to the exclusion of other social and individual factors) fails to explain why some men beat and rape women when others do not, even though all men are exposed to cultural messages that posit male superiority and grant men as a class the right to control female behavior (Heisse, 1997:2)

‘Theory must be able to account for both why individual men become violent and why women as a class are so often their target’ (Heisse, 1997). Heisse (1997:3) argues for the adoption of an ‘ecological approach to abuse’ which ‘conceptualizes violence as a multifaceted phenomenon grounded in an interplay between personal, situational and sociocultural factors’.

On the basis of research conducted in North America, Heisse (1997) proposes a framework for understanding violence against women which takes account of personal history (at the individual level), microsystems (at the family level), exosystems (at the community and societal level) and macrosystems (at the cultural and belief system level). In developing prevention programmes all levels must be addressed.

Personal history includes factors such as:
- Witnessing marital violence as a child
- Being abused oneself as a child
- Absent or rejecting father

Microsystem influences include:
- Male dominance in the family
- Male control of wealth in the family
- Use of alcohol
- Marital/verbal conflict
Exosystem factors include:

- Low socioeconomic status/unemployment
- Isolation of woman and family
- Delinquent peer associations

Macrosystem factors include:

- Male entitlement/ownership of women
- Masculinity linked to aggression and dominance
- Rigid gender roles
- Acceptance of interpersonal violence and physical chastisement (Heisse, 1997:3)

Public awareness campaigns often address only one level. For example, in response to fears about increased levels of child abuse in Sarawak, after several child abuse cases had received media attention, the Sarawak Tribune published a feature article entitled “How do I protect my child from abuse?” The solutions offered were all individually oriented and included support, security and confrontation. The key tips offered to parents were:

- teach children to say no to those they know as well as to strangers;
- tell children to trust their instincts;
- offer comfort and support if they have had a bad experience; and
- reassure the victim that they have done nothing wrong. (Source: Sarawak Tribune, March 25 1998, Outlook page 3)

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

One macrosystem factor, social construction of femininity and masculinity, and one microsystem factor, use of alcohol, are used to illustrate how a broader aetiological framework can inform prevention strategies.
Causes: social construction of femininity and masculinity

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

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

However, much of the disparity relates to how men and women are socialized into their gender roles in different societies throughout the world. In societies with a patriarchal power structure, ‘definitions of femininity (dependence, fearfulness) amount to a cultural disarmament that may be quite as effective as the physical kind’ (Connell, 1995:83). Domestic violence then becomes a playing out of definitions and shared understandings of femininity and masculinity which are deeply embedded in the culture and in the psyches of both men and women within that culture. Thus ‘domestic violence cases often find abused women, physically able to look after themselves, who have accepted the abusers’ definitions of themselves as incompetent and helpless’ (Connell, 1995:83).

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

Factors such as cultural norms also significantly temper the experience of violence and different culturally ‘acceptable’ responses exist for men and women in all cultures.

In the rare instance in which a man is attacked by a female partner, other elements of shame and denial may enter the equation because of the implicit insult to masculine power and strength. (Broom, 1998:45-6)

Domestic violence against men, when it does reach the public arena, is regarded as deviant and, as such, commands an enormous amount of publicity. For example, the
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Bobbit case in the United States of America, where a woman retaliated for her husband’s violent abuse by cutting off his penis, was widely reported in the international press. More minor cases of spouse abuse perpetrated by women are often reported in local and national newspapers. For example, “Husband hit for having extra marital affair” (Sarawak Tribune, 23 March 1998:6) tells of a woman who injured her husband by hitting him with an axe for which he was ‘given several stitches on the head’.

However, until recently, domestic violence against women has been regarded as ‘normal’ and generated little media attention. Certainly an injury to a woman, inflicted during a domestic dispute, which required a few stitches would hardly be regarded as newsworthy.

‘Husbands who batter wives typically feel that they are exercising a right, maintaining good order in the family and punishing their wives’ delinquency -especially wives’ failure to keep their proper place’ (Connell, 1995:213). Consequently, ‘the abuse of women is effectively condoned in almost every society of the world’ (WHO, 1997); violence is often perceived by both men and women as an ‘acceptable’ or ‘normal’ way of expressing anger in both developing and industrialized societies. For example in Australia in recent years a judge dismissed a case against a man for sexually abusing his wife on the basis that ‘it is normal within a marital situation for a husband to beat his wife up a bit’ since ‘sometimes when a woman says “no” she really means “yes”’.

The situation is no different in countries like Hong Kong, where ‘Chinese traditional family life implies a strong wish to keep problems within the family, without recourse to outsiders such as social workers, police or the law. It is a patriarchal society, recognising the man as the head of the household and the subordinate status of women and children ... (which is reflected in the fact that)... polygamy was legal in Hong Kong until 1971’ (Dr Judith Mackay quoted in Harmony House Annual Report, 1995). However, despite its illegality, polygamy is still practised in Hong Kong. It was not until April 1998 that a Hong Kong judge ‘closed the legal chapter on concubines by ruling that the Chinese practice of taking "secondary wives" was abolished by a 1931 law change’ (New Sunday Times, Hong Kong, 26 April 1998).

Despite its ‘normal’ status within many societies as a form of behaviour, domestic violence is still not an acceptable topic of conversation. Cultural taboos remain about naming the behaviour. Particular instances of abuse are hidden from public view and a consensus is sometimes reached within the household to keep the abuse a family secret. This public ‘silence’ stops both victims and perpetrators from seeking help.

Recent publicity in the mass media in Malaysia has attempted to reverse this situation and address some of the macrosystem factors that maintain silence and legitimacy around domestic violence. For example, a full-page spread feature article in the New
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*Strait Times* (Malaysia), (Life and Times, March 16, 1998, page 1), entitled “A victory for empowerment”, told the story of a Muslim woman who challenged interpretations of syariah law on ‘nusyuz’ (disobedience). She had been subjected to continuous abuse from her husband over many years and had left her husband. This had led to a charge of ‘nusyuz’ and a court case where she represented herself and won her case. Section 129 of the Selangor Islamic law 1984 states that any woman who wilfully disobeys any order lawfully given by her husband according to Hukum Syara commits an offence and shall be punished. If a husband is able to prove ‘nusyuz’ on the part of his wife, she is not entitled to maintenance under the law but there is no provision for ‘nusyuz’ committed by the husband. This case and its outcome sets a precedent for further challenges to interpretations of Islamic Law which condone violence against women and which enshrine masculinity with superior status.

‘This is the woman who would prostrate to kiss her husband’s hands and feet to pacify him so that he would not continue hitting her’ (*New Straits Times* (Malaysia), (Life and Times, March 16, 1998, page 1).

**Causes: alcohol**

Cultural acceptance of alcohol as a social drug, despite its known affects in increasing violence (especially domestic violence) (Archer, 1994), adds another dimension to the difficulties of disentangling violence from its cultural roots and developing prevention campaigns. Archer (1994:165-6) suggests that alcohol abuse works in complex ways to exacerbate domestic violence and that often this involves complicity from the victim of violence. Intoxication reduces the ‘accuracy of social judgement’ leading to ‘behaviour that is likely to attract complaints’, especially from an intimate partner, and reduces inhibitions leading to “out of character” behaviour which is often excused by the perpetrator and the victim of the violence (“it wasn’t really me/him, it was the drink”). Archer (1994:166) extends this argument to suggest that ‘some individuals become intoxicated in order to carry out the violent act’. However, Heisse (1997:9) argues that alcohol operates largely as ‘a situational factor, increasing the likelihood of violence, by removing inhibitions, clouding judgement, and impairing an individuals ability to interpret cues’, although the effects of alcohol may also be indirect given that alcohol abuse ‘provides a ready topic for arguments among couples’.

Overall, it has been shown that ‘abusive men with alcohol problems tend to be violent more frequently and inflict more serious injuries on their partners than do men without alcohol problems’. Consequently, ‘treating an underlying alcohol problem potentially can help reduce the incidence and severity of assaults, but it seldom “solves” the violence’ (Heisse, 1997:9).
Cultural relativity versus universal principles

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

Some issues are negotiable and can take account of cultural sensitivities and customs, others, especially those which compromise the health and well-being of particular groups in society, are not negotiable. Domestic violence fits the latter category because of its devastating short-term and long-term physical, psychological, emotional, economic and social effects on the victims of such violence, in this case predominantly women and children. It also has short- and long-term affects on the perpetrator and on society as a whole. Acknowledgement of a global consensus to override specific cultural traditions of violence is shown in the Declaration on the Elimination of Violence Against Women adopted by the United Nations in 1993 and the World Health Assembly's resolution WHA49.25 in 1996, declaring violence a public health priority issue (Annex A). All countries in the Western Pacific Region are signatories to these declarations and resolutions, so have effectively decided to override cultural customs with universal principles. The urgent task is to translate such commitments into policies, laws, services and grass-root activities.
PREVALENCE

Every country in the Region reports difficulty in gathering accurate data on domestic violence. This difficulty relates to several factors, including the problem of definition (Hegarty & Roberts, 1998), the sensitivity of the topic and cultural taboos surrounding discussion of it, the ‘normalcy’ of domestic violence in many countries, and the lack of public authority recognition, until recently, of violence as a public health issue worthy of investigation. Consequently, very little data is available for most countries in the Western Pacific Region. Cambodia, the Philippines, Australia and Malaysia are the exceptions where comprehensive data has been gathered by governments, nongovernmental organizations and/or United Nations-funded research studies. However, even in these countries, the information represents only the tip of the domestic violence iceberg and data on abuse of children in the household is particularly scant.

Australia

In a comparative review of studies of the prevalence of domestic violence, 12-month prevalence estimates of partner abuse of women in Australia varied from 2.1% (Ferrante et al, 1996) to 28% (Mazza et al, 1996) and lifetime prevalence rates for physical abuse of women by partners was as high as 22.5% (McLennan, 1996), 23% (Webster et al, 1994) and 25% (Bates et al, 1995) ‘depending mainly on the definition of domestic violence used in each study’ (Hegarty & Roberts, 1998).

Where data is available on males as victims of domestic violence, 12-month prevalence rates for males as victims range from 0.2% [2.1 for women] in a random-digit dialling community survey of 1511 men and 1550 women (Ferrante et al, 1996) to 2.9% [7.1 for women] in a survey of consecutive patients at an emergency department with 475 men and 522 women (de Vries Robbe, 1996). Lifetime prevalence rates for males as victims ranged from 8.5 % [19.3 % for women] in the de Vries Robbe (1996) study to 8.8% [23.6 % for women] in a similar study with consecutive patients at an emergency department (Roberts et al, 1995). Thus the female prevalence rates were up to 10 times higher than for males for 12-month prevalence rates and two to three times as high as those for males where the same definitions of abuse were used.

The researchers undertaking the survey suggest that 'lack of a precise definition result in varying operationalised definitions of partner abuse from all types of violence in relationships (including a single minor violent incident) through to only those violent
incidents that are classified as a crime’ (Hegarty & Roberts, 1998). Despite these definitional difficulties, studies examining both 12-month prevalence rates and lifetime prevalence rates suggest that domestic violence is a major public health issue in Australia.

The public health importance of domestic violence in Australia is reinforced by the Australian Bureau of Statistics Women’s Safety Survey which provided the ‘first comprehensive national data on the extent and nature of violence against women’ (domestic and other forms of violence) and serves as a benchmark to measure changed levels of violence against women (Office of the Status of Women, 1998). The Women’s Safety Survey interviewed women across Australia and found a 7.1% 12-month prevalence rate with younger women being more at risk than older women. Nineteen per cent of women aged 18-24 years had experienced an incidence of violence in the previous 12 months as against 6.8% of women aged 35-44 years and 1.2% of women aged over 55 years (similar cohort differences were found for physical abuse in the longitudinal study of women’s health). Thirty per cent of women had experienced at least one incident of violence since the age of 15 years, 8% of married women reported an incidence of violence during their current relationship and 42% of women who had been in a previous relationship reported an incidence of violence by a previous partner. Forty-six per cent of women who had experienced violence by a previous partner, and 38% of those experiencing violence from a current partner, said they had children who witnessed the violence. Over 700 000 women were pregnant at some time during a relationship with a previous partner who had been violent and 42% of these women experienced violence during pregnancy (Office of the Status of Women, 1998). The Women’s Safety Survey found that women were ‘four times more likely to be assaulted by a man than a woman’ (OSW, 1998).

‘The National Homicide Monitoring Program shows that men are nine times more likely than women to be the perpetrators of homicide, while one out of three homicide victims are women. Forty five % of all female victims of homicide were killed either directly or indirectly as a result of a dispute between intimate partners. This compares with 10% of male victims. Half of these disputes were precipitated by a domestic argument, while a further one third can be attributed to sexual jealousy’ (Office of the Status of Women, 1998).

Research conducted by the Australian Council for Women (1994) confirms that violence is an important health issue for Australian women. ‘Of 100 000 cards sent to women asking them to nominate one issue which concerned them, violence was the single largest concern for 17% of the respondents’ (Gott, 1995).

The longitudinal study on women's health in Australia (Women's Health Australia, 1997) has preliminary baseline data on prevalence of domestic violence from three national
cohort of women with approximately 15,000 women in each cohort. All three cohorts of women were asked the question: *Have you ever been in a violent relationship with a partner/spouse?* For the youngest cohort (18-22 years) 10.37% in urban areas, 13.89% in rural areas, and 18.23% in remote areas answered yes. For the middle group (45-49 years) 14.9% of urban dwellers, 16.8% of rural dwellers and 18.8% of remote area dwellers answered yes. For the older age group (70-74 years) 7.1% of urban dwellers, 5.8% of rural dwellers and 8% of remote area dwellers answered yes. However a different pattern emerges in answer to the question: *Has anyone close to you tried to hurt or harm you recently?* 10.8% (urban), 11.5% (rural) and 10.68% (remote area) of the younger group answered yes, 6.2% (urban), 5.9% (rural) and 5.1% (remote area) of the middle group answered yes, 2.3% (urban), 2.1% (rural) and 1.0% (remote area) of the older group answered yes. This pattern is repeated in the affirmative responses to a question about being 'pushed, grabbed, shoved, kicked or hit' (younger age group 15.6% - urban, 16.01% - rural, 19.41% - remote; middle age group 4.1% - urban, 3.5% - rural, 3.7% - remote, older age group 1.4% - urban, 1.2% - rural, 1% - remote) and about 'being forced to take part in unwanted sexual activity' (younger age group 3.53% - urban, 3.97% - rural, 3.81% - remote; middle age group 1.8% - urban, 1.8% - rural, 2% - remote, older age group 0.6% - urban, 0.7% - rural, 0.7% - remote). Thus either women are less willing to report recent violence as they get older or there is a drop off in acts of violence against women as they get older.

Female genital mutilation (FGM) is practised among some immigrant populations in Australia (World Bank, 1993:50). There are no official statistics available on the prevalence of either female genital mutilation or male circumcision in Australia, but estimates have been made on the basis of numbers of immigrants from countries which routinely practice FGM and prevalence rates of FGM in those countries. 'It is estimated that over 88,000 women and girls are now living in Australia from countries that traditionally practice female genital mutilation (FGM) although prevalence rates and types of FGM practised vary considerably.' 'Australia has migration from some countries where prevalence rates for FGM are said to be from 70% to 90%, e.g. Egypt, Ethiopia, Sudan and Somalia. Based on WHO advice, 60% to 70% of women from these communities could be expected to practice some type of FGM in Australia' (Office of the Status of Women, 1998). Despite the banning of FGM in six states and territories of Australia, on an individual basis, health practitioners are faced with a dilemma in terms of harm minimization. Is it better to comply with the demands for female genital mutilation from parents and carry out the procedure in a minimalist form under sterile conditions or refuse to comply and run the risk of a radical form of mutilation being undertaken by an unqualified person under non-sterile conditions?
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Cambodia

Zimmerman's (1994) exploratory qualitative study of domestic violence in Cambodia did not collect statistics on prevalence rates for the whole population but quantitative data was collected for the sample of 50 interviewees and ‘not once’ did the researchers ‘encounter a village without reports of domestic violence’. ‘In each village visited, at least some, and often many, women were regularly beaten by their husbands’ (Zimmerman, 1994:v).

Of the 50 participants in the study, 43 reported having been punched or slapped by their husbands, 32 had been kicked and 34 attacked with rods, poles or sticks. In the case of marital rape, 14 reported that they were threatened or coerced into having sex with their husbands and 11 reported being physically forced to have intercourse. 31 women reported being physically abused during pregnancy.

In terms of psychological abuse, 34 of the women reported that their husbands had threatened to kill them, 21 needed permission to leave the house and 5 were forbidden to have contact with any other men. Twenty-four women reported that their husbands hurt their children and only seven reported that their husbands abused people outside of the family. The researchers concluded that, in the villages where they conducted the research, ‘in abusive relationships wives are usually the sole targets of their husband’s aggression’ (Zimmerman, 1994:114).

Nelson and Zimmerman’s (1996) larger study of violence in Cambodia found that, in a nationally representative sample of men and women (1,374 women and 1,286 men), 16% of women reported being physically abused by a spouse, 8% reported being injured and 73.9% of those interviewed personally know of at least one family in which there was wife abuse (Nelson & Zimmerman, 1996). More than 10% of Cambodian men reported that ‘they physically abuse their spouses’.

Women least at risk of spousal abuse are those who live in an extended family. ‘Women living in the same home with their parents suffer from spousal abuse at half the rate (8.3%) as that for all women (16%)’. 7.8% of all men and 8.8% of all women reported witnessing physical violence between their parents but the percentage is much higher among abusive men (29.5%) and abused women (23.7%). ‘Nearly 10% of all women report that their spouses become abusive after drinking. Nearly 50% reporting abuse said their husbands hit them after consuming alcohol, and among women reporting injury, the number rises to 65.7%’ (Nelson & Zimmerman, 1996). Thirty-four per cent of abused women seek no help. The 66% who do seek help tend to contact neighbours (32%), parents (11.8%) or another relative (10.7%). ‘After neighbours, the next highest category for injured women was “no one”’. ‘Almost 25% of women who report having
been hit by their spouses do not believe that they are physically abused by their husbands' yet 'almost 100% of Cambodians surveyed (both men and women) believe that all forms of physically violent behaviour are wrong. Although this is often at variance with what occurs in practice, men and women, almost without exception, are aware of what constitutes "good" and "bad" behaviour' (Nelson & Zimmerman, 1996).

In relation to child abuse, Nelson & Zimmerman (1996) found that '67.5% of all respondents believe that they should hit their children as a disciplinary measure. More women (71.6%) than men (57.3%) report that children should be hit. Injured women are far more likely to believe that children should be hit (92.4%). While only 7.6% of all women interviewed state that after quarrelling or fighting with each other, their spouses hit their children, 27.6% of abused women and 35.8% of injured women report that after a fight their husbands hit their children’ (Nelson & Zimmerman, 1996). Statistics are not available on the percentage of women who hit their children.

**Fiji**

'The Government of Fiji is concerned about the increasing incidence of violence in the country and the complex of factors that contribute to this situation. While the collection, compilation and publication of statistics on violence against women have much room for improvement, the several special efforts made so far clearly indicate a significant increase in violence committed against women and children since the last quarter of the 1980s. The available data also do not give an adequate picture of violence of all forms taking place in the household setting, since domestic violence is undifferentiated from other forms of assault. Further, domestic violence is not fully reported to the authorities owing either to fear or pressure from family members to have the matter settled amicably. ..The police statistics on rape, defilement and incest...show that there has been an increase in cases of defilement in respect of the under-16 age group and a decrease in the number of rape cases reported over the years form 1987 to 1993’ (ESCAP, 1997f: 34).

**Hong Kong, China**

Official statistics on domestic violence in Hong Kong are only just starting to be systematically collected from a variety of sources including police records, social service records, health services records and women's shelters. However, some statistics are available from 1985 onwards. Harmony House, a women's refuge in Hong Kong, reports that in the ten years after its opening in 1985 it provided 'a safe haven for 1 352 women
and their 1,515 children fleeing from domestic violence in their homes. The Harmony House 24-hour hotline received 14,266 calls in the same ten-year period.

Figures from Harmony House suggest a profile of victims of violence which offer clues to prevention strategies. In 1996-1997, 164 women and 233 children were provided with refuge in the Harmony House shelter. Most families stayed for one to two months. After leaving the shelter, 45% decided to separate or divorce and less than 30% returned to their partners. The women were mainly housewives, aged 31-40 years with lower secondary education who lived in public housing. Most people who came to the shelter had lived in Hong Kong for less than seven years and most came to Hong Kong as part of a family reunion arrangement. At admission, women come with bruises to the eyes and arms and fractured legs. They are mainly victims of physical and psychological abuse rather than sexual abuse and for most of them the abuse started one to three years into their marriage. They usually tolerated the abuse for five to nine years before seeking help. Mothers reported that over 50% of the children admitted to Harmony House had also been abused by their fathers. Faced with the threat of violence, most women (60.5%) sought assistance from police and 47.5% from doctors for medical treatment. (Harmony House Annual Report, 1996-1997). Women and children also use the many other services offered by Harmony House. In 1996-1997 the Harmony House Hotline received 4,041 calls, 1,414 women were counselled, 150 joined therapeutic groups, 602 attended Women House Meetings, and 158 participated in Women’s Training Corner which aims to build skills and confidence for battered women. Services for children such as individual counselling, therapeutic groups (91 attendees), Children House Meetings (555 attendees) and Tutorial classes (1,571 attendees) were also well supported, as were services for families such as library and playroom activities and recreational and festival programmes.

The Working Group on Battered Spouses (consisting of representatives from the police, the judiciary, the legal profession (including legal aid), the education department, social services, health organizations, medical practitioners, information services responsible for public education, and nongovernmental organizations) using police records, social service records, health services records, legal records and women’s shelters records, put out statistics for April to December 1997. The Working Group recognizes that these figures seriously underestimate the real levels of domestic violence in the community given that most cases are not reported to any authorities. Of those cases that were reported from April to December 1997, of a total of 1,019 cases of domestic violence, 834 cases of physical abuse were recorded (82%), 111 cases of physical and psychological abuse (11%), 40 case of physical, sexual and psychological abuse (4%), 16 cases of psychological abuse (2%), and 16 cases of physical and sexual abuse (2%). No cases of sexual abuse alone (i.e. without psychological or physical abuse) were recorded. Forty-one cases (4%) of the victims of domestic violence were male, 96% (978 cases) were female. The highest risk age groups for both men and women was
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30-39 years. For the majority of victims, their first point of contact was the Hong Kong Police Force (31%), 21% first reported to the Social Welfare Department, 19% first reported to nongovernmental organizations (including women's shelters), 15% first reported to hospital authorities and 14% first reported to the Legal Aid Department. Victims came from all districts of Hong Kong. Seventy-one per cent of abusers were husbands of the victims, 3% were wives, 3% were cohabitees, 2% boyfriends, 2% ex-husbands. Most abusers were aged 45 years or above, and numbers of abusers rose dramatically in the 30 years and above cohorts.

Child abuse cases are recorded by the Child Protection Registry set up by the Social Welfare Department in 1986. The Registry reported 311 newly registered child abuse cases in 1996 (compared with 224 new cases in 1995), which is an increase of 39% on the previous year. Of these cases, 77% were 'genuine' or 'proven' cases, the other 23% were 'suspected' child abuse cases. Forty per cent of the registered cases in 1996 were sexual abuse cases, 39% physical abuse cases, 11% were multiple abuse, 7% gross neglect and 3% psychological abuse. Of the abuse victims, 61% were girls, mainly involving sexual abuse, most of the boy victims suffered physical abuse. The largest percentage of victims were aged 3-5 years (21%) followed by 9-11 years (20%) and 12-14 years (19%). The majority of children aged 12-17 years were sexually abused, and those under 12 years were predominantly physically abused (except for girls where sexual abuse was the predominant form of abuse from age 3 years onwards). Male sexual abuse peaked in the 9-11 age group, whereas for girls sexual abuse peaked in the 3-5 and 12-17 age groups. Most children (64%) were living with both parents, only 7% were living with childminders, in foster homes, institutions or boarding schools.

There were significant gender differences in the abuse patterns of perpetrators. Perpetrators of abuse against children were 63% male. Sexual abuse was the major form of abuse perpetrated by males (61% of male abusers) followed by physical abuse (25%) and multiple abuse (9%). Of the 37% of female abusers, 60% physically abused, 19% multiply abused, 9% abused by gross neglect, 7% psychologically abused and 5% sexually abused. Both male and female abusers were typically 32-41 years old and married. Most had achieved only primary education (37%), although those who had received no education at all made up only 4% of abusers. Three per cent of abusers had a university education or above, 58% of abusers were parents of the abused, 10% were step parents and 15% were unrelated. Unrelated persons were largely sexual abusers. Parents were responsible largely for physical abuse (52% of parental abuse cases), multiple abuse (16%) and sexual abuse (15%).

Similar patterns emerged in the analysis of the 690 active child abuse cases (cases actively handled by service units of the Social Welfare Department and nongovernmental organizations) recorded by the Child Protection Registry at the end of December 1996. However, the distribution of abusers by sex had changed to 59% of
abusers being male and 41% female, with 67% of the female abusers being involved in physical abuse cases. The percentage of parent abusers in the 'active cases' rose to 72% with stepparents constituting 8% of all child abusers.

Prevalence rates gathered by individual departments or the Regional Child Abuse Investigation Unit are much smaller, as they deal with the more serious cases where criminal investigations and legal proceedings are undertaken. For example, the statistics on domestic violence gathered by the Police Department in 1997 revealed 491 wife battering cases, 100 husband battering cases, 141 other domestic violence cases. Of all domestic violence cases in 1997, 156 resulted in prosecutions and 252 Domestic Incident Notices were recorded. However, the pattern over time reflects changes in the definition of domestic violence.

Statistics from the Child Protection Policy Unit of the Police Department report an increase in wife battering cases from 198 in 1993 and 1994, to 269 in 1995, 487 in 1996 and 212 up until June 1997. Figures for 1993 to 1995 cover offenses of 'Wounding and Serious Assault' only. From 1996 onwards, offenses of 'Common Assault, Criminal Intimidation, Criminal Damage and Unlawful Detention' are also covered. Despite this definitional change, the number of people convicted by the Court decreased from 44 and 46 in 1993 and 1994 to 40 in 1995 and 36 in 1996, and the penalties remained the same (largely a fine of HK$ 1 000 - 4 000) or decreased. The number of imprisonments went down to only three in 1996 (from seven in 1993, eight in 1994 and eight in 1995) and the period of sentence reduced to less than three months in two cases and six to nine months for the other case in 1996.

The statistics for husband battering cases jumped dramatically from 42 in 1993 and 1994, 48 in 1995 to 231 in 1996, largely as a result of definitional changes. The number of convictions increased slightly and, in contrast to the situation for wife battering, the sentences and fines increased.

Police Department statistics for child sexual and physical abuse also increased, but not as dramatically as for wife and husband battering, and the number of people convicted by the courts fluctuated. In 1993 there were 742 child sexual abuse cases (with 210 convictions) and 277 child physical abuse cases (with 51 convictions). By 1994 the numbers had risen to 835 child sexual abuse cases (282 convictions) and 339 physical abuse cases (81 convictions). Child sexual abuse cases decreased to 825 (280 convictions) in 1995 and 809 (223 convictions) in 1996. Physical abuse cases to 381 in both 1995 and 1996 and convictions rose to 84 in 1995 but dropped to 65 in 1996. Penalties for child sexual and physical abuse did not increase over the three years.
Republic of Korea

Prevalence rates for domestic physical abuse in Republic of Korea vary widely according to the sample size and questions asked. Kim and Cho (1992) in a stratified random sample of the Republic of Korea population found that '38% of wives reported being physically abused by their spouse in the last year' (WHO, 1997), and Heise et al (1994) report that in a random sample of the entire country in 1988, 37.5% of wives had been battered. However, a 1991 study of domestic violence in Korea found that 'more than two thirds of women are regularly beaten by their husbands' (Skrobanek, 1993) and Wha-soon (1994) reports that 61% of married women surveyed had been assaulted by their husbands.

Figures for rape are more constant. In a 1992 study, 21.8% of the women surveyed said they had been raped (Heise et al, 1994) and in 'Seoul 17 % of women report being victims of attempted or actual rape' (World Bank, 1993:50).

A Korean Gallup Research System poll (1989) reports that 57.5% of men said they had beaten their wives (Korean Women’s Association United, 1993).

Malaysia

In Malaysia in 1989, ‘1.8 million women or 39% of women above the age of 15 years are estimated to have been physically beaten by their husbands or boyfriends’ (Abdullah et al, 1995:5) based on responses to a nationally representative survey which asked “In the past year, how many women do you personally know who have been physically beaten by their husbands or boyfriends?”. ‘Nine per cent of the adult population knew at least one such person’. Projected to the entire adult population of Peninsular Malaysia, ‘this means 847 000 adults knew at least one woman who had been beaten. ...48% of the women known were a close friend or a close relative, such as sister or mother’. No statistics are available for the Borneo states of Malaysia.

All socioeconomic classes and all ethnic groups in both rural and urban areas in Peninsular Malaysia ‘knew women who had been beaten’ although the Indian population (22%) was over-represented ‘compared to 9% of Chinese adults and 8% of Malays’ (Abdullah et al,1995:5)

These statistics are very different to those collected by agencies such as the police, social welfare, health authorities and Muslim legal agencies, all of whom have their own national figures on domestic violence. These agencies see only the tip of the domestic violence iceberg and often the data gathering procedures are not systematic. ‘Only 22%
of the public stated that a woman who has been physically abused by her husband or boyfriend should make a police report’ (Survey Research Malaysia, 1990, quoted in Abdullah et al, 1995:6).

However, more systematic data is now being recorded for a study of the epidemiology and incidence of domestic violence in the Klang Valley which shows a sharp increase in reported cases of battered women and rape victims between 1993 and 1996. The number of cases of battered women presenting to the Kuala Lumpur Hospital nearly doubled from 372 in 1993 to 710 in 1996. Rape cases increased from 154 (1993) to 280 (1996). This increase is attributed to better detection through the provision of a One Stop Crisis Centre at the Kuala Lumpur Hospital, in 1993, which supports survivors of domestic violence (Asaari, 1998).

The demographic composition of battered women presenting to the Kuala Lumpur Hospital is varied, with all social strata and a variety of ethnic groups being represented. The ethnic origin of battered women in 1996 was Malay 44.4%, Chinese 29.6%, Indian 18.5% and other 7.4%, which follows the percentage of each ethnic group in the total population, except for under-representation from the Chinese community (Asaari, 1998).

Most domestic violence survivors were pushed or slapped (48.6%), 20% were attacked with weapons, 17.1% kicked and the majority of the rest suffered throttling, burning and bites. Severe injuries immediately following battering included recurrent traumatic abortions, fractured limbs, burns, stab wounds, head injuries and psychological trauma. Other long-term social, economic and emotional sequelae included broken marriages, psychological effects on children, imitative violence in adult life after witnessing and/or experiencing violence in childhood, economic loss and emotional suffering (Asaari, 1998).

Child abuse is still not adequately monitored to gain national or systematic figures. The practice of female genital mutilation is reported among minorities in Malaysia. (World Bank, 1993:50) but no figures are provided on the prevalence of this practice.

**Papua New Guinea**

The level of domestic violence in Papua New Guinea is anecdotally described as very high (United Nations, 1997b; Papua New Guinea Department of Health, 1993:4; National Statistical Office, 1997) for both women and children. This has been related to poverty, the low status of women in many Papua New Guinea tribes, the high level of polygamy, the high fertility rate, lack of education and lack of access to social and health support services. Violence has become an issue of concern with the Governments'
emphasize on meeting its commitments as a signatory to the Convention on the Rights of the Child (United Nations, 1997b; Papua New Guinea Department of Health, 1993). However, geographical isolation is a major problem in gaining reliable data and in instituting health promotion programmes. ‘Communication with the 85% of the population who live in rural areas is difficult and expensive’ (United Nations, 1997b). In one survey conducted in urban Papua New Guinea ‘18 % of all urban wives surveyed had sought hospital treatment for injuries inflicted by their husbands’ (World Bank, 1993:50).

**Philippines**

Despite the difficulties in gathering systematic and accurate data on domestic violence, service-use data obtained from the Department of Social Welfare and Development (DSWD) and various women’s nongovernmental organizations suggest that ‘wife abuse/battering ranks the highest among all types of domestic violence’ in the Philippines. ‘At least six out of ten Filipino women suffered unjust and cruel treatment by their partners’ and in ‘1992, DSWD handled the cases of 6655 disadvantaged women of whom 3853 or 58% had been abused or battered’. However, this figure is a small proportion of total domestic violence cases.

Women’s nongovernmental organizations disclosed the following findings:

The Women’s Crisis Center, which offers counselling and shelter to battered women, reports getting an average of 100 calls from abused women each week. Based on its random survey of three urban poor communities in Metro Manila in 1991, 11 out of 12 experienced battering at least once in their married life. As a result of their baseline survey, HASIK (Harnessing Self-reliant Initiatives for Knowledge, Inc.), another nongovernmental organization working with the urban poor, reports that up to 60% of women in the neighbourhood are regularly battered by their partners. The Cordillera Women’s Education and Research center (CWERC) also reported that 50% of women living in three Baguio mining communities were victims of domestic violence based on its 1990 survey. The majority of women victims are from ages 19 to 50 and have been beaten from 2 to 25 years. Of the battered women, around 18% are professionals, 15% are skilled workers and 25% unemployed or unskilled workers. A significant number are married to policemen or military officials.

Most cases come from middle class or poor families. (This conclusion may not be valid considering the source of the statistics presented being women’s shelters, police reports, public hospitals, and the fact that women belonging to the upper class are less likely to use any of the above mentioned). The same reports showed that batterings were usually induced by several factors such as partner’s jealousy, vices and extra-marital affairs,
woman’s failure to come up to partner’s standards or just a simple disagreement on household matters’ (ESCAP, 1997a:26-7).

Samoa

Given the lack of data on direct indicators of domestic violence, suicide attempts have been used as a de facto indicator of family violence (ESCAP, 1997c: 21). ‘Reliable and comprehensive information and data on domestic violence are not available, since most cases of domestic violence, whether against males or females, are for various reasons not reported to the authorities. However, an idea of the stress undergone by men and women could be obtained from the records on suicide attempts and resultant deaths maintained by the Apia National Hospital for the period 1988-1992’ (ESCAP, 1997c: 21). However, the statistics tell us nothing about the reason for suicide. The greater number of suicides and attempted suicides among males (66 out of a total of 101 suicide deaths and 117 out of a total of 184 suicide attempts) may suggest that males who are exceptionally stressed perpetrate violence on themselves rather than on their partners. But the numbers are small and there is no additional data to confirm this conclusion.

Singapore

No systematic collection of domestic violence prevalence rates has been undertaken in Singapore, but the number of applications to the police for personal protection orders (PPOs) is used as an indicator of levels of domestic violence. In 1992, 521 PPOs were issued. One thousand and seventy six cases of spousal violence were dealt with by the police in just six months from January to June 1994 and, in the same six-month period in 1995 the number had risen to 1244. In 1996, 1300 PPOs were issued (AWARE, March 1998) and in 1997 there were 2019 applications for court orders for protection against violent family members. There were also 200 reported maid abuse cases (of 100000 foreign maids in Singapore) in 1997 (Straits Times, April 25, 1998:59). Under amendments to the Women’s Charter which came into effect on 1 May 1997, family members other than spouses can apply for PPOs. An average of nine applications per day were received from May 1997. Approximately half of those were from children, parents-in-law, aunts, uncles and grandparents. Two hundred abusive husbands were also ordered by the courts to receive mandatory counselling under the amendments to the Women’s Charter (1997) (AWARE, March 1998).

Official statistics on child abuse (Ministry of Community Development) suggest no significant increase in child abuse cases in Singapore since 1988. In 1992, there were 138 reported cases of child abuse compared to 217 cases in 1988. Of the 138 cases in
1992, only 22% were found to have evidence of abuse. The number of sexual offenses committed against children decreased from 416 in 1990 to 379 in 1992.

**Solomon Islands**

'There is very little documentary evidence in regard to the incidence of domestic violence in Solomon Islands. Police records on assault do not specify cases of domestic violence. Police prefer not to be involved and generally advise women to settle the matter within the family or through custom. Despite the lack of recorded data and information, it is generally believed, particularly by women’s groups, that domestic violence, especially wife beating, is a serious problem and poses a threat to the emotional and physical health of many women. “Domestic problem” is one of the most commonly cited reasons for absenteeism from work. Several factors have been identified as contributing to increasing domestic violence: inequality between men and women which gives men the power and privilege to beat their wives, the increase in the availability and consumption of alcohol, and increasing urbanisation and the gradual breakdown of the family support system. The psychological stress induced in husbands on account of the assumption by women of a non-traditional role in the formal sector workforce is also said to contribute to domestic violence. There is also a gross under-reporting of cases of sexual violence against women; only 35 cases of rape were reported in 1990. While 34 of these 35 cases were accepted as breaches of criminal law, there were no convictions for rape. Identification and articulation of the problems of violence against women need to be accorded priority in any schemes designed for enhancing women’s rights and privileges’ (ESCAP, 1997c:33).

**Viet Nam**

There are no national statistics on domestic violence in Viet Nam so researchers in the field rely on anecdotal information, small-scale quantitative surveys and qualitative data to gauge the scale of the problem in the country. Another technique that is used to gain some indication of the extent of domestic violence is to compare small-scale opportunistic research data with equivalent data from other countries. For example: 'While working on a STD (sexually transmitted diseases) and AIDS (acquired immunodeficiency syndrome) prevention programme in 1995, a worker from Care International (Australia) asked the participants at a seminar ...a question related to domestic violence: Did they know of any women being violated by her husband during the previous twelve months. The response was that 25% to 40% of them did (know of such a person). This rough indicator is very high compared with (answers to) the same
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(question) in other countries where researchers have already shown that domestic violence is a serious social problem'. For example in Malaysia, the equivalent indicator revealed a 9% positive response yet a ‘national representative random survey of adults above 15 years of age’ undertaken in 1989, showed that ‘39% of women over 15 years old are estimated to have been physically beaten by their husbands or boyfriends’. It is concluded that ‘this comparison indicates that domestic violence in Viet Nam could be a serious problem’ (Nguyen, 1998).

Another indirect indicator of domestic violence is the divorce rate. The Women’s Union’s 1995 report reveals that in Ho Chi Minh city between 1986 and 1994, ‘there were 14 747 applications for divorce with violence being cited as the main reason’ (Nguyen, 1998). A judiciary report on divorce across the whole of Viet Nam claims that ‘of the 17 834 divorces in Viet Nam in 1978, 15 570 cases were due to violence and violence-related causes (or nearly 87.5% of the total divorces) (Le, 1998).
HEALTH CONSEQUENCES

The health consequences of domestic violence (physical, sexual and psychological) range from death to loss of confidence and low self esteem.

- Fatal outcomes
  - Suicide
  - Homicide
  - Maternal mortality
  - HIV/AIDS
  - Nonfatal outcomes

Physical health outcomes include:

- injury (lacerations, fractures, internal organ injury, loss of limbs),
- unwanted pregnancy
- gynaecological problems
- sexually transmitted diseases including AIDS
- miscarriage
- pelvic inflammatory disease
- chronic pelvic pain, headaches
- permanent disabilities
- asthma
- irritable bowel syndrome
- self-injurious behaviour (smoking, drug use and dependence, unprotected and indiscriminate sex)
Mental health outcomes include:

- depression
- fear
- anxiety
- loss of confidence
- low self esteem
- sexual dysfunction
- eating problems
- obsessive-compulsive disorder
- post traumatic stress disorder
- pharmaceutical drug dependence (Adapted from WHO, 1996b:11)

These physical and mental health outcomes have social and emotional sequelae for the individual, the family, the community and society at large. Over both the short term and long term, women’s physical injuries and mental disquiet will either interrupt, or end, their educational and career paths, leading to poverty and economic dependence. Family life will be disrupted having a significant effect on children, including poverty (if divorce or separation occurs) and a loss of faith and trust in the institution of the family. These sequelae not only affect the quality of life of individuals and communities, but also have long-term effects on social order and cohesion.

**Physical injury**

Data from around the world suggests that domestic violence knows no national, class, age or religious boundaries. Data on physical injury from domestic violence, from a woman-friendly hospital in Cebu, Philippines, reveals that in 1997, of the 363 cases which were treated in the hospital, 4 were children under the age of 5, 7 were between 5 and 10 years, 12 between the ages of 10 and 15 years, 25 were between 16 and 20 years, 65 between 21 and 25 years, 85 between 26 and 30 years, 67 between 31 and 35 years, 57 between 36 and 40 years, 19 between 41 and 45 years, and 7 each between 46 and 50 years, 51 and 55 years and 56 to and above (Vincente Sotto Memorial Center, 1997). All occupational groups (from unemployed to professional) and all levels of educational attainment (no schooling to postgraduate) were represented among the victims of physical abuse.
In both developing and industrialized countries where data has been gathered, it is estimated that between 'one fifth and more than half of women surveyed say they have been beaten by their partners' (World Bank, 1993:50). The physical consequences include homicide, serious injuries to women (including during pregnancy), injuries to children, injuries to men (including injuries inflicted on men by women in self defence), unwanted pregnancy and the sequelae of unsafe abortions, sexually transmitted diseases including HIV/AIDS and vulnerability to other diseases (WHO, 1997). Results from a qualitative study on domestic violence in Cambodia (Zimmerman, 1984) suggest that the most common physical injuries resulting from domestic violence are bruises and lacerations followed by unconsciousness, severe illness or extreme weight loss, sexually transmitted diseases, broken bones, miscarriage, sprains, burns, lost teeth, deafness, homicide and suicide. Less apparent injuries reported by the Cambodian sample of 50 women included swelling, sprained and dysfunctional limbs, unwanted pregnancy, scars and disfigurement, deformities, chronic headaches and dizziness, hearing and sight impairment, internal organ damage or trauma and gynaecological problems.

The physical health consequences of domestic violence are often obscure, indirect and emerge over the long term. For example women who are subjected to violent attacks during childhood often present with menstrual problems and irritable bowel syndrome in later life (WHO, 1997).

Other effects are more direct. For instance, 'research has shown that battered women run twice the risk of miscarriage and four times the risk of having a baby that is below average weight. In some places violence also accounts for a sizeable portion of maternal deaths'. For example 'in Matlab Thana, Bangladesh, intentional injury during pregnancy —motivated by dowry disputes or shame over rape or a pregnancy outside wedlock — caused 6 % of all maternal deaths between 1976 and 1986' (World Bank, 1993:50).

More recently, WHO (1997) reports that 'between 16% and 52% of women suffer physical violence from their male partners, and at least one in five women suffer rape or attempted rape in their lifetimes'. A study by Shiroma (1996) in Mexico revealed that '16% of women ever married or partnered report physical abuse since the age of 15' (WHO, 1997) but in most other countries 20-40% of women report such abuse and in some districts of India, Kenya and Uganda the figure rises to over 40%. The highest reported levels of violence were in Nicaragua (Ellsberg et al, 1996) where, in a representative sample of ever-married women aged 14 to 49 from Leon, '52% report being physically abused by a partner at least once' (WHO, 1997). Even these alarming figures are likely to be significantly underestimated given that violence within families continues to be a taboo subject in both industrialized and industrializing countries.

Some women may believe that they deserve the beatings because of some wrong action on their part. Other women refrain from speaking about the abuse because they fear that
their partner will further harm them in reprisal for revealing "family secrets", or they may be ashamed of their situation. (WHO, 1997)

Similarly, the tendency by law enforcement agencies to regard domestic violence as a 'private affair', and thus to not see intervention as part of their brief, means that there is no public record of most instances of abuse unless the victim is killed or hospitalized with serious injuries. This serves to reinforce and legitimize continued assaults.

Where laws and bills have been introduced to de-legitimize domestic violence, as in the Philippines, in House Bill 4228 and Senate Bill 1042, prescribing a special law on rape, Senate Bill 408, providing for a 'heavier penalty for habitual wife beating as well as temporary protection to the wife' and Senate Bill 635, giving equal rights to wives and husbands, they may not be enforced by the police and the courts. A paper on domestic violence in Viet Nam, presented to a Regional Meeting on Domestic Violence in March 1998, warns that no amount of legislative and national policy reform on domestic violence will be effective unless infrastructure mechanisms are in place to inform women of their rights under such laws and to ensure that enforcement agencies adhere to both the letter and the spirit of the law (Nguyen, 1998).

Sexual violence and rape

If physical violence is underreported, other forms of domestic violence such as sexual violence and rape, and psychological and emotional violence, remain even further hidden in the domestic sphere.

Alarming figures emerge from around the world on prevalence rates for rape and other sexual abuse. Again these acts of violence cut across age, national, race and class boundaries. Data on rape, from a woman-friendly hospital in Cebu, Philippines, reveals that in 1997 rape cases covered the age range 0-50 years. Of the 218 cases of rape that were treated in the hospital, 33 were children under the age of 5, 31 were between 5 and 10 years, 63 between the ages of 10 and 15 years, 62 were between 16 and 20 years, 18 between 21 and 25 years, 6 between 26 and 30 years, 3 between 31 and 35 years and 2 between 46 and 50 years (Vincente Sotto Memorial Center, 1997). The victims came from a variety of educational and occupational backgrounds.

In the United States of America, rape has been shown to be a better 'predictor of how many times women sought medical help and of the severity of their health problems than was a woman's age or unhealthy habits'. (World Bank, 1993:50). There are also other sequelae from rape including 'physical injury, ... emotional trauma, ... pregnancy and sexually transmitted diseases including AIDS.' For example a rape crisis centre in
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Bangkok 'reports that 10% of its clients contract sexually transmitted diseases as a result of rape and 15 to 18% become pregnant' and 'in countries where abortion is restricted or illegal, rape victims often resort to unsafe abortions, greatly increasing the danger of infertility or even death' (World Bank, 1993:50). Research in the Philippines on reproductive tract infections (Ramos-Jimenez, 1998) reveals that rape is a major cause of all such infections.

Sexual violence also has long-term and indirect effects, including vulnerability to other diseases (WHO, 1997). For example, a United States study 'has shown that patients with irritable bowel syndrome, compared with those with the less serious inflammatory bowel disease, were more likely to have suffered severe sexual trauma, severe childhood sexual abuse or some other form of sexual victimisation' (Walker, 1993 reported in WHO, 1997). Teenage pregnancy from rape has long-term consequences since 'it is well documented that child bearing during early and mid adolescence, before girls are biologically and psychologically mature is associated with adverse health outcomes for both the mother and child' (WHO, 1997).

There appears to be a close relationship between physical abuse and rape. 'Surveys in a number of countries show that from 10% to 15% of women report being forced to have sex by their intimate partner'. But 'among women who are physically assaulted in their relationship, the figures are higher' (WHO, 1997).

Psychological and emotional violence

Psychological and emotional violence covers 'repeated verbal abuse, harassment, confinement and deprivation of physical, financial and personal resources' (WHO, 1997).

Quantifying psychological abuse is extremely difficult and very few studies have been conducted to establish prevalence rates of this type of violence. Both physical violence and psychological violence have emotional and psychological sequelae.

In terms of psychological burden of disease, battered women in the United States of America are ‘four to five times more likely to require psychiatric treatment as non battered women and are five times as likely to attempt suicide’ (World Bank, 1993:50). Qualitative studies that have been undertaken conclude that it is just as damaging to one’s health to be continuously psychologically abused as it is to be physically abused. Undermining an individual’s sense of self can have serious mental and physical health consequences and has been identified as a major reason for suicide (World Bank, 1993; WHO, 1997). ‘For some women, the incessant insults and tyrannies which constitute
emotional abuse may be more painful than the physical attacks because they effectively undermine women’s security and self-confidence’ (WHO, 1997). This often leads to serious mental health problems and in some cases risky behaviour. ‘For example, the reduced self-esteem of women who have been abused in childhood may result in their making little effort to avoid situations where their health or safety are in jeopardy’ (WHO, 1997) especially with regard to indiscriminate and unsafe sexual activity. The effects on children of witnessing violence in the family are similar to those on children abused themselves. They are more likely to either perpetrate or accept violence in their adult lives (WHO, 1997).

Zimmerman (1984:94) reports that the psychological effects of both physical and psychological domestic violence in a Cambodian sample of women closely resemble the symptoms of post traumatic stress disorder experienced by Cambodian refugees after the Khmer Rouge period. These include:

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

The Cambodian women experienced depression, anxiety, post traumatic stress disorder, weight loss, lethargy, memory loss, disorientation, inability to concentrate, mental illness and suicide attempts. The most common emotional response among the Cambodian women was shame and humiliation. The women said they felt ashamed, scared, helpless, angry and guilty.

‘Beatings, cursing, loudly proclaimed accusations, regular acts of terror and continuous disregard for feelings and needs caused battered women shame and humiliation among their peers. Husbands’ lovers or ‘second wives’ add to the shame and loss of self-respect’ (Zimmerman, 1984:91)

Despite all of these physical, psychological and emotional consequences of domestic violence, the Cambodian women stay with their abusive husbands largely ‘for the children’s sake’. Economic factors including ‘nowhere to go’, hopes of partners changing their behaviour, loving their husbands despite their violence, shame and fear were other major reasons they gave for not leaving (Zimmerman, 1994:95-103).
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Children

On all dimensions of domestic violence, there is a dearth of data worldwide and surveys only reveal the tip of the domestic violence iceberg. Even less data exists on the prevalence rates of violence against children. Sexual, physical and psychological abuse are all difficult to measure. In most countries of the Region, children are still not considered legal witnesses so children's evidence needs to be corroborated by an adult witness' account. Parents tend not to abuse their children in front of witnesses. Hong Kong has recently changed the law to allow children under 7 years legitimate witness status and infrastructural supports are being put in place to prevent child witness intimidation.

The fine line between disciplining a child and physical and psychological abuse is also problematic. The changes to the Singapore Women's Charter support women's rights to freedom from abuse but disciplining children under the age of 21 years is excluded from the terms of reference of the Charter. Statistics from Hong Kong (Child Protection Unit, 1998) suggest that mothers physically abuse their children, in the name of discipline, as much as fathers. In Cambodia, a recent study on domestic violence (Nelson & Zimmerman, 1996) shows that women approve of hitting their children to discipline them more than men do. The gender dimensions of child abuse need to be researched much more thoroughly before any conclusions are reached.

Violence has been shown to be intergenerational, where male and female children of abused mothers tend to repeat the patterns of abuse and acceptance of being abused in their adult lives (WHO, 1997). Similarly, children who witness abuse of their mothers experience the same emotional and psychological effects as their mothers (Davis & Carlson, 1987).

One Massachusetts study showed that children growing up in abusive homes are 24 times more likely to commit sexual assault crimes, 74% more likely to commit crimes against another person and 50% more likely to abuse drugs or alcohol. In Oregon, 68% of juvenile offenders were from violent homes (Buel, 1990). Another study found that 63% of males between the ages of 11 and 20 who are in prison for homicide in the United States killed their mother's batterer .... 'these men are taking on the role of protecting their mothers when they perceive that the police, courts, family and community are failing to do so (Nicholson, 1990)' (Zimmerman, 1984:112).
Genital Mutilation

Other forms of violence against children such as female genital mutilation also produce a high burden of disease and infirmity for women. The World Bank estimated that in 1993 ‘85 million to 114 million women in the world... (had) experienced genital mutilation’. By 1995 the World Health Organization estimated that the number of women genitally mutilated had risen to 130 million (WHO, 1996). The number may have increased substantially over the last few years given that the practice continues in many developing and developed countries, despite being outlawed in many countries. A relatively mild form of genital mutilation is routinely carried out on Muslim girls in Malaysia (World Bank, 1993). Genital mutilation is still practiced among immigrant groups from Africa, the Middle East and Malaysia in Australia (World Bank, 1993) and sometimes this is done by medical practitioners in the name of harm minimization given that if they refuse they know that it will be carried out under unsterilized conditions in the community. More radical forms of genital mutilation have life threatening short- and long-term health consequences, especially in relation to childbirth. Despite the direct and indirect health consequences, ‘in those societies where it is practised, it is believed that FGM is necessary to ensure the self-respect of the girl and her family and increase her marriage opportunities’ (WHO, 1997).

Circumcision of male infants also constitutes an act of mutilation and thus domestically generated violence. Although there are minor health arguments to support the practice in terms of hygiene in some regions, the complications in terms of wound infection after circumcision and the human rights violation of parents deciding to have part of the infant’s anatomy removed without the infant being in a position to consent, far outweigh the minor hygiene inconvenience of leaving the foreskin intact (Milos & Macris, 1992). Although 80% of the world’s male population remains uncircumcised and the percentage is increasing in United States (http://circumcision.org/info.htm, 1997), the practice persists for religious, social and ‘health’ reasons in many countries of the Region.

The global economic and social costs of domestic violence are enormous. Direct costs in added health care services, courts, police, legal procedures and community supports are augmented by indirect costs associated with loss of productivity and employment opportunities resulting from death, serious physical injury and psychological damage.
Domestic violence and rape have ‘complex economic, cultural, and legal roots’ and thus defy simple public policy solutions. ‘Prevention will require a coordinated response on many fronts’ including, ‘in the short to medium term, training health workers to recognise abuse, expanding treatment and counselling services, and enacting and enforcing laws against battering and rape. In the long term much depends on changing cultural beliefs and attitudes towards violence against women’ (World Bank, 1993:50-51), providing the infrastructure to implement laws and educating all individuals about national and international laws and their rights within those laws. International conventions provide a possible vehicle to mobilize such change through international consensus which guides the national policies of signatory countries. International conventions, which are initiated and drafted by national policy makers and nongovernmental organizations working together, can also provide a focal point to direct the activities of nongovernmental organizations and community groups working to prevent violence. However, the key to successful implementation of international conventions rests with specific country initiatives which take account of the unique economic, social, political, religious and cultural circumstances of each country.

Country initiatives

Several countries in the Region have developed creative intersectoral responses to the increasingly evident endemic domestic violence in their populations. These responses include legislative change, increased research (into prevalence, contributing factors and indicators), sensitive health policies and services, increased public awareness and education campaigns, improved social services including services for perpetrators and fiscal and funding measures. Government departments, professional groups (lawyers, judges, politicians, doctors, nurses, police, journalists), nongovernmental organizations and community groups (especially women’s groups) have all contributed to these initiatives.

Australia

Policy and laws: Violence against women was one of the seven priority health issues in the National Women’s Health Policy of 1989. The policy promoted preventive and supportive strategies which take account of the factors which ‘underlie women’s vulnerability to physical and sexual violence.’ These included economic support for
survivors and their children, community education programmes and interventions directed towards perpetrators. The policy recognized that ‘security from violence is a major concern for older women’. The priority placed on violence against women in the National Women's Health Policy has been reinforced more recently with the National Domestic Violence Summit in November 1996 where all Heads of Government agreed to work together in Partnerships Against Domestic Violence to test new approaches to prevention with a budget of A$25 million. Heads of Government also agreed to participate in a Commonwealth/State task force to carry the initiative forward. The Summit released Model Domestic Violence Laws to ensure continuity of protection for victims across the country. The agenda for the National Summit on Domestic Violence was established by a National Domestic Violence Forum consisting of 130 government and nongovernment experts in domestic violence. Nongovernmental organizations represented included women's services workers, peak bodies, researchers, the judiciary and medical practitioners (Office of the Status of Women, 1998).

Business Against Domestic Violence invites private enterprise to participate as a partner in violence prevention, and was launched by the Prime Minister in November 1997. Corporate Australia is being encouraged to contribute top-level leadership, develop policies linking the workplace to services addressing domestic violence and/or donate to public benevolence projects. Tax deductibility has been granted for donations to the Trust. Several large corporations have taken up the challenge and provided donations, leadership and research funding (Office of the Status of Women, 1998).

'The Family Law Reform Act 1995 effects a fundamental refocussing of the Family Law Act 1975 away from parental rights and towards parental responsibility and the best interests of children. The Reform Act highlights the importance of the protection of children and parents from exposure to family violence. It ensures that decisions about children take into account family violence issues and gives appropriate recognition to the interrelationship between Family Court orders and protection orders under State and Territory legislation. The Family Court has adopted a Family Violence Policy aimed at heightening staff awareness of the issue and offering the victims of violence the opportunity of separate conciliation or mediation when they are in fear or where the result of past violence includes a significant power imbalance' (Office of the Status of Women, 1998).
Research: In line with the emphasis on domestic violence as a priority issue in the Women’s Health Policy and at the National Domestic Violence Summit, several organizations and research projects are starting to collect national data. The Australian Bureau of Statistics Women’s Safety Survey is a major initiative to develop baseline data on domestic violence that will inform policy and services. The longitudinal study on women’s health, Women Health Australia, is gathering national data on domestic violence as part of its national research project with three cohorts of women (preliminary data on prevalence rates is presented in the section on Prevalence). CASA House in Melbourne is developing a national database for rape crisis and sexual assault services. It is also developing national standards of practice for rape crisis and sexual assault services. Research is also underway into the operation of Division 11 of the Family Law Act which concerns inconsistencies between state and territory family violence orders and Family Law contact orders.

Most importantly, the feasibility of establishing a national clearing house for dissemination of information on domestic violence, is being explored by the Office of the Status of Women.

Research is also being undertaken with women with special needs, including women who do not use domestic violence services or police when they are abused. Phone-ins, targeted interviews and group discussions are ascertaining why some women avoid notification services.

Services: The National Association of Services Against Sexual Violence was incorporated in 1997 and it has the development of national standards of practice as a priority in its strategic plan. Services and information are being developed for women with specific needs such as rural and remote area women, women with disabilities, Aboriginal women, migrant women, non-English speaking women and refugees.

The Office of the Status of Women, recognizing the particular needs of women in rural and remote areas, has developed a national domestic violence rural kit which equips women with a range of information about domestic violence, the range of services available, how to access services and the relevant legal procedures. Nongovernmental organizations such as the Country Women’s association are being funded to assist with distribution of the kit (Office of the Status of Women, 1998). A Rural and Remote Domestic Violence Initiative, funded by the federal government, has been operating since 1994. The purpose of the Initiative was to test information and referral services in rural and remote locations of Australia for women and children experiencing domestic violence. The Department of Health and Family Services has developed two further projects to test innovative models of service delivery working with families as victims of domestic violence and also adolescent boys who are victims of domestic violence (Office of the Status of Women, 1998).
Commonwealth funding has been provided for a domestic violence resource manual entitled *Atunypa Wiru Minyma Uwankaraku -Good Protection for All Women Resource Manual* for Aboriginal women in remote communities in the Northern Territory, Western Australia and South Australia. It was developed by the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council and provides bi-lingual information on current domestic violence laws in these states, information about the police and courts and guidelines for reporting domestic violence and receiving assistance (Office of the Status of Women, 1998).

The Commonwealth and State Governments are funding the translation of pamphlets on domestic violence into a range of community languages for each State and Territory. The Department of Immigration and Multicultural Affairs is clarifying privacy and other legal issues surrounding access to, and disclosure of, a person's domestic violence history to third parties involved in the migration process with a view to ensuring more fully informed migration decision-making (Office of the Status of Women, 1998). Updated material (video and printed), in a variety of languages, is being developed to help prospective immigrants to Australia make an informed decision about marriage and migration to Australia. The videos and booklets provide information about basic rights of women in Australia (including the unacceptibility of domestic violence) and support services available for migrants, especially those aimed at assisting women in situations of domestic violence. A specific set of information has also been produced for Filipino women given that domestic violence continues to be a significant issue for Filipinas in Australia. Refugee women have also been identified by the Department of Immigration and Multicultural Affairs as at risk for domestic violence given the breakdown of traditional support mechanisms and additional counselling, accommodation and support services have been put in place (Office of the Status of Women, 1998).

A national forum of key experts on the issue of violence against women with disabilities was held in February 1998, funded by the Office of the Status of Women, to establish prevention and therapeutic services to cover the specific needs of women with disabilities.

Services are also being developed to help perpetrators of violence stop their violent behaviour. For example, the Office of the Status of Women has made a grant to the Victorian Network for the Prevention of Male Family Violence Inc (V-Net) to produce and print an updated version of a self-help book for men who use violence, *Mirrors, Windows and Doors*. The Darebin Men’s Health Project sponsored by Vic Health, is running a programme to help men overcome their abusive behaviour using an ‘action learning process’(Martin, 1997). The underlying causes of male violence and other issues are being addressed and each participant has a mentor. It is anticipated that the project will develop a framework and a written curriculum for agencies across Victoria to use when working with men's issues. ‘A lot of men feel trapped in the sense that they
believe there's only one way to be a man... They simply don't realise that there are other options’ (Martin, 1997:15).

Initiatives are also being taken to assist in the prevention of child abuse. In the 1996/97 budget, the Federal Government committed A$4.3 million over two years to deliver parenting education programs to support parents in raising children. The Community Welfare Department is being called on to develop and deliver appropriate best practice parent education programmes. ‘Providing parents with the information necessary to deal with some of the pressures of day-to-day life is expected to lead to a reduction in child abuse’ (Office of the Status of Women, 1998).

The Department of Employment, Education, Training and Youth Affairs (DEETYA) has responsibility for two domestic violence prevention projects for young people involving domestic violence prevention workshops (50 workshops across Australia with 13 500 young people) and a survey of young people's attitudes to and experience of domestic violence (5 000 young people aged 12-20 years).

In its 1995-96 budget, the Federal Government allocated over A$3 million to a National Education Program on Female Genital Mutilation (FGM). The Program aims to prevent FGM in Australia primarily through funding the States and Territories to provide culturally appropriate education and community support, targeting communities at risk of the practice, as well as health and related professionals. It also aims to assist women and girls who have already undergone FGM.

The Royal Australian College of Obstetricians and Gynaecologists has developed a booklet, Female Genital Mutilation, Information for Australian Health Professionals, and will develop curriculum material for medical practitioners and health professionals. Six States and Territories have introduced specific legislation banning female genital mutilation, although in some States legislation will not be implemented until the education programme is fully underway. A chapter on female genital mutilation has been included in the Model Criminal Code (Office of the Status of Women, 1998).

**Brunei Darussalam**

**Services and Prevention — Government:** A body called the Action Team for Child Abuse and Domestic Violence of Brunei Darussalam has been established to follow up on cases of domestic violence and child abuse that are presented to hospitals and social workers. The Action Team was established in 1990 in response to increased cases of child abuse and recognition of the need for a multidisciplinary approach to the problem. The terms of reference for the Action Team are to: ‘(a) co-ordinate the various agencies and encourage cooperation, communication and exchange of information between
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agencies, (b) define the tasks and responsibilities of each discipline to avoid duplication of work during investigation, and (c) reduce the stress on victims and their families'. The Action Team for Child Abuse and Domestic Violence also has long-term preventive objectives to 'reduce and eventually eradicate incidences of child abuse and to create programmes to upgrade awareness in society of the problems of family violence' (Rahmah, 1993). Participating parties in the Action Team include the ministries of Culture, Youth and Sports, Health, Religious Affairs, Law and Internal Affairs.

The mass media, and weekly talks during weekly Friday prayers, are two of the channels used to disseminate information about creating the conditions for harmony in the family. This process is enhanced by the Malay Islamic Monarchy Philosophy which is taught in schools from the primary to tertiary levels and emphasises harmony and unity in the family as well as in the nation. Pre-marital counselling (which is compulsory for all Muslim couples) and continuing counselling for problems in marriage, as well as financial support to enhance family recreational activity during annual leave, are other approaches to improving the quality of family life. (Rahmah, 1993)

Services and Prevention — NGO: The Women's Group in Brunei Darussalam has also been active in putting domestic violence on the public agenda, including developing an a violence prevention campaign in 1991 called the ‘Happy Family’. Regular seminars and workshops on child abuse are also organized by groups such as the Women Graduates Association of Brunei Darussalam. (Rahmah, 1993)

Cambodia

Policy and law: Zimmerman (1994:196) argued that an ‘effective way to ensure that the issue of domestic violence is given the priority it warrants is to establish a private agency dedicated solely to addressing domestic violence. Such an agency or ‘Project Against Domestic Violence’ could work with government and private organizations to help formulate policies and legislation to combat domestic violence and monitor the implementation of law and public policy’ (Zimmerman, 1994:196). In response to the recommendations contained in a 1994 qualitative research study on domestic violence in Cambodia (Zimmerman, 1994), a Project Against Domestic Violence, Cambodia (PADV) has been established. PADV is a local nongovernmental organization ‘raising awareness, educating service providers, and influencing private and public sector policies’ (Zimmerman, 1994: Update).

The 1994 research also acted as the catalyst for Cambodia's Secretariat of State for Women's Affairs to host a Regional Conference on Intra-Familial Violence sponsored by UNICEF. The 16 representatives from the Region at that forum 'drafted the UN “Phnom Penh Declaration Against Intra-Familial Violence” and the “Far East and the Pacific
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Regional Plan of Action to Eliminate and Prevent Intra-Familial Violence Against Women and Children” (Zimmerman, 1994: Update). Cambodia also developed its own ‘National Declaration and Plan of Action Against Domestic Violence’ in response to the revelations of the 1984 study. These major steps forward in addressing domestic violence in Cambodia were presented at the 1995 Fourth World Conference on Women in Beijing.

Research and services: A further major development has been the expansion of the 1984 small scale study to a PADV and Secretariat of State for Women’s Affairs joint ‘national statistical survey on the prevalence of, practices of, and attitudes towards, domestic violence in Cambodia’ (Nelson & Zimmerman, 1996).

Continuous monitoring of progress in combating domestic violence is underway and informs government and civil sectors in the development of prevention activities. For example the findings of a research project on Law and Domestic Violence (1996) ‘will be used to design effective and accessible programmes for legal aid, judicial training and training of law enforcement personnel, as well as help to inform legislators of the need for law and revisions of laws to address domestic violence’ (Samen, 1997). The research and monitoring programme also serves to ‘create links between the organizations to build a referral network of services which can help victims’ and ‘to stimulate awareness of domestic violence’, keeping ‘the issue in the public eye’ (Samen, 1997).

The education programme has been offering training to service providers since 1996. The PADV-run programme emphasises that domestic violence is not just a family problem, but rather a public health and human rights issue. Included in the list of trainees are the staff of the Ministry of Women’s Affairs. Nongovernmental organizations such as PADV also have specific programmes to increase public awareness of domestic violence and to promote nonviolent forms of interaction in the family.

Hong Kong, China

Policy and Law: The Domestic Violence Ordinance 1990, updated 1995, chapter 189, provides the legal framework for ‘protection of persons from domestic violence’ in Hong Kong. In 1996, the official definition of domestic violence, for legal and policing purposes and data gathering, was extended from Wounding and Serious Assault, to include the offences of Common Assault, Criminal Intimidation, Criminal Damage and Unlawful Detention. Nongovernmental organizations dealing with domestic violence are calling for further changes to laws dealing with perpetrators to include mandatory counselling.
Guidelines for effective service provision and prevention strategies for domestic violence in Hong Kong are emerging from intersectoral collaboration between the police, the judiciary, the legal profession (including legal aid), the education department, social services, health organizations, medical practitioners, information services responsible for public education, and nongovernmental organizations. A working party (The Battered Spouses Working Group) was established in 1995 with representatives from each of these sectors to devise policies and guidelines and to act as a review forum for new initiatives. A similar multidisciplinary group has been brought together to form a Technical Group on Child Abuse.

Legal policy on child abuse changed dramatically in 1995 when a law was passed to include children under seven years of age as competent witnesses in legal cases. This legal change necessitated procedural changes to protect child witnesses. A multidisciplinary working group was set up to improve court procedures, including examining the use of video evidence to avoid appearance in court and the provision of a child support person in court. To deal with the massive increase in child abuse cases, especially sexual abuse cases, coming to court as a result of this legal change, the Child Protection Unit of the Police Force was established in late 1995.

Services: The Hong Kong Police Department is addressing domestic violence as a serious issue for health and social order. Its Child Protection Unit has extended its brief to include domestic violence. They are involved in prevention strategies as well as minimizing the trauma to domestic violence victims. The Hong Kong Police have prepared a Victims of Domestic Violence Advice Card which is given to all victims of domestic violence incidents which are reported to the police. The Advice Card (written collaboratively with the judiciary, legal advisers, the social welfare department and a nongovernmental organization, the Federation of Women's Centres) gives information on the police role in domestic violence, police powers, district court injunctions, legal aid, social welfare services, housing and shelters for women and children, and the Federation of Women's Centres' legal advice clinic.

Three shelters for women and children subjected to domestic violence operate in Hong Kong. One is Government-run (by the Social Welfare Department), the other two are run by nongovernmental organizations (Harmony House and Serene Court). Harmony House "is a retreat for women, with or without children, who are in immediate danger of violence. Its first task is to provide safety for these women and to give them necessary support. The goals of the organization are: (1) to help battered women to find self-confidence and self reliance; (2) to help them find the necessary resources they need to live a life free from the threat of violence and to offer them choices; and (3) to assist them to regain their human dignity" (Harmony House, Annual Report 1996-7). Services related to the refuge include a hotline service, individual counselling, therapeutic groups, house meetings and Training Corners for both women and children.
and children's schooling while at the Centre. Both women and children are provided with skills enhancement, empowerment and self-esteem building training. In line with their goals to go beyond just shelter, Harmony House has a Family Ideal Community Education Project that provides services and training to prevent violence and promote 'harmonious relationships in families in Hong Kong'. Harmony House is involved in professional training for groups such as the police, nurses and social services officers and in more general training of students (such as the Human Rights Ambassadors volunteer programme), church groups and public awareness campaigns. It provides a resource centre for researchers in the field of domestic violence, students, journalists and social service organizations.

**Training:** Government organizations and nongovernmental organizations are involved in training programmes for personnel dealing with domestic violence. The Child Protection Unit of the Hong Kong Police Department has in-house training for its police personnel as well as providing training for other professional groups. Harmony House provides training for professional groups (social workers, nurses, police, lawyers, journalists) as well as for community groups and the media. The nongovernmental organization shelters also provide self-esteem and skills training for the victims of domestic violence.

**Malaysia**

**Policy, laws:** In 1985, nongovernmental organizations were actively involved in drafting a Domestic Violence Act which was passed in 1994 (Domestic Violence Act 521 of the Laws of Malaysia), but no implemented until 1996. The Act defines domestic violence in terms of physical injury, threat of physical injury, sexual abuse, confinement and detention and damage or destruction of property. To count as domestic violence, the abused must be related by birth, adoption or marriage (or ex-marriage or de facto marriage) to the perpetrator or be a child or incapacitated adult living in the same household. The Act is designed to be read in conjunction with Penal Code F.M.S. Cap. 45 and allows for interim protection orders, protections orders, compensation and, in some cases, mandatory counselling and/or a conciliation process.

Evaluation of the effectiveness of the Act by Women's Aid Organization (WAO) suggests that, after 18 months, the situation of domestic violence victims in Malaysia has not changed significantly (WAO, Monitoring the Domestic Violence Act 1994, unpublished report, Dec 1997). Both institutional and attitudinal barriers remain to improving the situation for women who are survivors of domestic violence which need to be addressed through appropriate training of the judiciary, police, social welfare officers, social workers and health professionals.
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The Asia Pacific Women, Law and Development Forum (APWLD) which is based in Malaysia 'has a task force on Violence Against Women covering law reform, new Asia Pacific Women's watch on violence against women; and is involved in the development of a handbook on feminist counselling for training and services' (Abdullah, 1997).

Services: In 1993, in response to increasing incidences of domestic violence, a test management strategy for victims of domestic violence was initiated in the Klang Valley. The department of emergency services in the Kuala Lumpur Hospital developed a One Stop Center to create a network for inter-agency management of domestic violence. The success of the test project was reflected in the Ministry of Health adopting the One Stop Center as the national model for the management of domestic violence survivors in all major hospital's emergency departments in Malaysia. The One Stop multidisciplinary crisis centre model is used for survivors of batterings, child abuse, rape and all other forms of domestic violence (Asaari, 1998).

There are three shelters dedicated to abused women and their children in Malaysia, all run by nongovernmental organizations and all in Peninsular Malaysia. The first was opened by Women's Aid Organization in 1982. The WAO Refuge Centre offers shelter for battered women and their children and acts as a focus for WAO advocacy and other activities related to family, women and domestic violence. The WAO also offers face-to-face counselling for women who choose not to use shelters, and a crisis telephone counselling service. Follow-up and ancilliary services are also provided in the Anak Angkat Programme: 'A child sponsorship programme for children of ex-residents' and a child care centre for children of ex-residents (WAO Annual Review, 1995).

Research: The Asia-Pacific Resource and Research Centre for Women (ARROW) is a nongovernmental organization that acts as a resource and research centre for women's health issues, including domestic violence. The organization runs a document service, produces kits for use in public awareness campaigns and professional training, publishes three newsletters per year, including special issues on violence against women, and runs workshops and dialogues on domestic violence for the Asia-Pacific region. The Centre aims to assist in the development of research projects, databases and services which are gender-sensitive and which implement the recommendations of the ICPD Cairo 1994 and the Beijing Platform for Action (BPFA) 1995. It also monitors country activities in line with ICPD and BPFA. In June 1998, ARROW organized the Southeast Asian Regional Policy Dialogue on Women's Health: Monitoring the Implementation of the Beijing Platform for Action including the recommendations on violence against women.
Philippines

Services and prevention programmes: Nongovernmental organizations are very active in developing programmes to combat domestic violence. The Coalition Against Trafficking in Women, the Gabriela Commission on Violence Against Women, Pilipina, the Women's Legal Bureau, the Cordillera Task Force on Violence Against Women, the Asia-Pacific Women's Action Network, WomenHealth Philippines, the Women’s Crisis Centre, ISIS, HASIK and the National Family Violence Prevention Group are just a few of the organizations involved in developing services and prevention programmes for violence against women. These include establishing women’s desks in police stations and hospitals.

Combat-VAW, which operates in urban poor communities in Quezon City is coordinated by “two nongovernmental organizations, HASIK and the Women’s Legal Bureau (WLB).” It aims “to address violence against women by providing education, training and support services in selected urban depressed areas in the Quezon City”. The goals of Combat-VAW are:

(a) to create conditions in the community that will facilitate attitudinal changes towards violence directed against women

(b) to empower women by providing them basic skills and knowledge that will enable them to fight for their rights and to actively respond to situations of violence; and

(c) to develop a group of women and men as community educators and advocates.

These aims are obtained through education and training, support services, research and documentation within community organising” (Ramos-Jiminez, 1996b:11).

Research, Education and Training: The Task Force on Social Science and Reproductive Health Social Development Research Center at De La Salle University in Manila has violence against women as one of its research priority areas and is currently involved in mainstreaming education on the health consequences of violence into the medical and nursing curriculum of universities and training schools in the Philippines (Ramos-Jiminez, 1996a, 1996b). The police, social workers and the judiciary are being trained in the health and social consequences of domestic violence by the Women’s Crisis Centre at East Avenue Medical Centre, Quezon City.

The Philippines is one of the countries to be included in the multi-country study on violence against women in the family, coordinated by the Women, Health and Development division of WHO in Geneva.
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Legislative changes: Major legislative changes have been introduced to deal with violence at a national governmental level in the Philippines. The National Prosecution Services (NAPROSS) of the Department of Justice introduced the Republic Act 7192 Compliance Report which legislates domestic violence as a crime and assesses and updates the existing legal system’s responsiveness to violence against women. NAPROSS favours legislative action (in dialogue with policymakers and support groups) on a variety of child abuse, prostitution and trafficking in women issues.

A number of bills have been introduced in Congress to deal with rape, domestic violence, pornography, trafficking in women and prostitution. Most notably, in 1997 bills were passed which have wide-ranging implications for dealing with rape. In House Bill 4228 and Senate Bill 1042, prescribing a special law on rape, the definition of rape has been changed from a criminal act against ‘chastity’ to a criminal act against ‘the person’ which broadens the interpretation of the law to include rape in marriage. The bills also institutionalize measures for recovery of rape victims and effective prosecution of offenders.

On domestic violence, Senate Bill 408 provides for a ‘heavier penalty for habitual wife beating as well as temporary protection to the wife’. Senate Bill 635 accords equal rights to wives and husbands.

Singapore

Policy and Law: The Women's Charter (Chapter 353 of the Statutes of the Republic of Singapore) sets the policy and legal framework for granting family members rights against domestic violence. The amendments to the Women's Charter (1997) greatly enhance the rights of women and abusive husbands can now be ordered by the courts to receive mandatory counselling. The definition of domestic violence was extended to include psychological and emotional violence and restraint. Under the 1997 amendments, ‘family violence’ means the commission of the following acts:

(a) wilfully or knowingly placing, or attempting to place, a family member in fear of hurt;

(b) causing hurt to a family member by such act which is known or ought to have been known would result in hurt;

(c) wrongfully confining or restraining a family member against his (sic) will; or

(d) causing continual harassment with intent to cause or knowing that it is likely to cause anguish to a family member.
but does not include any force lawfully used in self-defense, or by way of correction towards a child below 21 years of age.' (Women’s Charter, Part VII 64)

The 1997 amendments to the Women’s Charter extended the number of people who could take out protection orders against perpetrators.

In April 1998, the Singaporean Government legislated for enhanced penalties against employers who abused their maids. Nominated MP Claire Chiang suggested that the enhanced penalties should be extended to all perpetrators of domestic violence but this extension was rejected.

The Children and Young Persons Act provides the legal framework for action to protect children and to ‘allow intervention by relevant authorities if a child is found to be abused or ill-treated’.

**Services, Co-ordination and Training:** The Society Against Family Violence (SAFV) has been operating since 1991. It is affiliated with the National Council of Social Services and the Singaporean Council of Women’s Organizations (SCWO) and acts as a ‘network committed to a lifestyle of transformation towards non-violence both at the community and individual levels, through the family. The mission of SAFV is to provide support services that prevent and/or reduce the frequency of violence in Singaporean families’. It acts as a clearing house to coordinate existing services and resources and provides training for members of the Singapore Police Force as well as organizing seminars and a support group for field workers.

The Family Resource and Training Centre (FRTC) provides continuing education for social workers and other welfare personnel in Singapore. Since 1994 they have coordinated workshops for front-line staff in the field of domestic violence. These workshops are subsidized by the Ministry of Community Development.

The Association of Women for Action and Research (AWARE) is a nongovernmental organization that offers a hotline service for victims of domestic violence. It also performs an advocacy role for women especially in bringing about legislative and political change in line with the recommendations of the Beijing Platform for Action (1995). It undertakes its own research on domestic violence and publishes a journal called *Awareness* which regularly contains articles on domestic violence.

**Viet Nam**

**Policy and Laws:** The 1986 Marital and Marriage Law provides a legal framework for organizations such as the Women’s Union to monitor progress on curbing domestic
violence. The Women's Union Report 1995 argues that the Law should be followed to the letter since 'it is not good enough to grant a divorce to a battered woman'. The Report recommends that 'the violent acts should be dealt with by criminal proceedings separately' (Nguyen, 1998).

'In May 1996, the Counselling Centre on family, marriage and relationships organised a meeting attended by the mass organizations, the police and politicians of the city to raise awareness of the needs of survivors of domestic violence for appropriate safe places after episodes of violence in the home. Despite some resistance by local authorities to implement the letter and spirit of legislation on domestic violence, and to be proactive in preventing domestic violence and providing support at the time of attacks, awareness has been raised that domestic violence is a major health and social problem for both men and women in Viet Nam. It is suggested that the next steps to eliminate domestic violence include support services for men to deal with stress. (Nguyen, 1998)
CONCLUSIONS

As the above analysis details, domestic violence is a major public health issue in the Western Pacific Region. The economic, health and social costs to the Region, to countries and to individuals are enormous. However, given the lack of data from many countries, it is not possible to quantify these costs. Problems remain in gaining reliable and accurate data on prevalence rates. Several countries in the Region have taken steps to minimize the anomalies and inconsistencies in data collection. In some cases, this information has been translated into collaborative and intersectoral strategies to combat domestic violence (Cambodia, Australia, Hong Kong, the Philippines) which can serve as models for other countries to consider.

One of the problems in establishing prevalence rates in the countries of the Western Pacific Region is the lack of a clearly defined definition of what constitutes domestic violence. There are other problems associated with the shame of domestic violence, such as an unwillingness to discuss the issue, which skew prevalence data towards highly conservative estimates, but resolving the definitional problem would go a long way towards getting better information from which to develop policy. Hegarty & Roberts (1998: 53) stress 'the need to consider the effect of the operationalised definition of abuse used (in the measurement of domestic violence) on the rate found'.

Lack of research results in there being 'a disturbing tendency for commonsense beliefs about the origins of domestic violence to inform policy initiatives and be reproduced by them. This in part results from the inherent difficulty of undertaking research in this complex field' (Ripper, 1998). Researchers, policymakers and health service providers must not be daunted by such difficulties, effective public policy on domestic violence will only emerge if the research is done. The initiatives being undertaken in Cambodia are a case in point. The establishment of a joint government/nongovernmental organization Project Against Domestic Violence, Cambodia, which acts as a focus for new initiatives, was developed as the result of a qualitative study of 50 Cambodian women (Zimmerman, 1984).

'Domestic violence calls upon justice, law enforcement, health, education and other public agencies, as well as nongovernmental organizations and other private organizations and individuals. Remedies will include legislation, legal representation, counselling, health care, refuge, child care and public information and education' (Zimmerman, 1994: 196). For example, in Cambodia the appropriate agencies include government ministries (justice, health, interior, social action, education, information), Secretariat of State for Women's Affairs (SSWA), health care providers (hospitals,
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family planning programs and clinics, midwives, medical schools, pharmacies) local and international nongovernmental organizations and donors, Project Against Domestic Violence (PADV), and the media (Zimmerman, 1984: 196-7).

Cultural mores, religious practices, economic and political conditions may set the precedence for condoning domestic violence, but ultimately committing an act of violence is a choice that the individual makes out of a range of options to exercise power, resolve conflict with a family member or partner, to deal with sexual needs or to discipline a child. The challenge for international organizations in collaboration with governments and nongovernmental organizations is to create an economic, political, religious and social infrastructure that makes nonviolent choices easy choices in conflict resolution or meeting needs in the domestic sphere. The extent to which such measures are translating into practice and improving health outcomes and quality of life needs to be monitored using appropriate indicators. Mortality and morbidity measures may tell us nothing of the quality of life and social and emotional health of individuals who are regularly abused in the home. A three-level approach to service provision and violence prevention, in line with countries' commitments to international conventions on human rights, is being adopted in some countries in the Region. It comprises (i) legislative and legal measures, reinforced with (ii) economic, housing, child care, education and training, and other structural support, and (iii) services for the individual to build self-esteem and respect for self and others. Outcome indicators that cover both objective conditions (which militate against domestic violence) and the subjective experience of life quality need to be developed for all three levels.

Role for WHO

Policy

WHO should:

- cooperate with government ministries and agencies (justice, police, health, social services, education, information), nongovernmental organizations, United Nations organizations, community groups and the media to collaborate to implement the recommendations of section D: Violence Against Women, of the Beijing Platform for Action (1995), in particular paragraphs 128, 129, 130 (see Annex B). This can start with WHO initiating and participating in policy dialogues and workshops between the parties mentioned above; and

- provide leadership and guidance to Member States of the Western Pacific Region in developing public health programmes to prevent domestic violence in line with the recommendations of WHA49.25 (see Annex A). Available research and best
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practice can inform this process but national and intranational differences and sensitivities (where they do not undermine human rights) need to be taken into account.

Research and data collection

WHO can:

• collaborate with countries in disaggregating violence statistics by cause and by source (police, courts, hospitals, clinics, social services, neighbours, family members);

• extend the current WHO policy of gender disaggregating all data to develop gender-specific and gender-sensitive health and quality of life indicators to gauge the effects of domestic violence on the populations of countries in the Western Pacific Region;

• develop clear regional (and global) definitions of what is being referred to in ‘domestic violence’ such that accurate estimates can be made of prevalence rates. Differences in prevalence rates across countries and across studies may be purely definitional and methodological rather than ‘real’;

• work with countries to apply indirect indicators if direct data is not available, e.g. level of family support, level of alcohol consumption, suicide rates, divorce rates, customs relating to status of women and level of economic independence of women, to gauge problems with gender relations which may perpetuate domestic violence. Such data must be complemented with qualitative data and explanations of the relationship between the indirect indicator and domestic violence; and

• collaborate with countries to develop research projects on causes of domestic violence (as has been done in Cambodia): inflexible gender roles, secrecy about domestic violence, alcohol abuse, starting by putting violence on the public health agenda in the Western Pacific Region through awareness campaigns which encourage both victims and perpetrators to ‘come out of the closet’ and seek help.
'Accurate and comparable data on violence are needed at the community, national and international levels to strengthen advocacy efforts, help policy makers understand the problem and guide the design of interventions' (WHO, 1997).

'To obtain a better estimate of the prevalence of domestic violence, we need to obtain, through survey research, figures that reflect the fact that partner abuse against women is a complex behavioural phenomenon, in which severity, frequency, meaning and intention are all important features of any physical, emotional and sexual act against a partner. Which relationships are included in the prevalence rate should be clear ...' (Hegarty & Roberts, 1998:53).

Monitoring and evaluation

WHO can:

- collaborate with countries and other agencies to monitor and evaluate the effects of interventions for domestic violence (services and prevention strategies) and cooperate in the development of mechanisms for monitoring violence against children.

Services and programmes

WHO should:

- continue to work collaboratively with countries (ministries and nongovernmental organizations) to enhance services (such as self-help initiatives, women's shelters and empowerment training for battered women as well as training of health and other professionals) and develop prevention programmes (e.g. with Papua New Guinea as committed by the Regional Director at WHO, WPRO, Regional Committee Meeting 1997).
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ANNEX A

WHA49.25 Prevention of violence: a public health priority

The Forty-ninth World Health Assembly,

Noting with great concern the dramatic worldwide increase in the incidence of intentional injuries affecting people of all ages and both sexes, but especially women and children;

Endorsing the call made in the Declaration of the World Summit for Social Development for the introduction and implementation of specific policies and programmes of public health and social services to prevent violence in society and mitigate its effect;

Endorsing the recommendations made at the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995) urgently to tackle the problem of violence against women and girls and to understand its health consequences;

Recalling the United Nations Declaration on the elimination of violence against women;

Noting the call made by the scientific community in the Melbourne Declaration adopted at the third international conference on injury prevention and control (1996) for increased international cooperation in ensuring the safety of the citizens of the world;

Recognizing the serious immediate and future long-term implications for health and psychological and social development that violence represents for individuals, families, communities and countries;

Recognizing the growing consequences of violence for health care services everywhere and its detrimental effect on scarce health care resources for countries and communities;

Recognizing that health workers are frequently among the first to see victims of violence, having a unique technical capacity and benefiting from a special position in the community to help those at risk;

Recognizing that WHO, the major agency for coordination of international work in public health, has the responsibility to provide leadership and guidance to Member
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States in developing public health programmes to prevent self-inflicted violence and violence against others,

1. DECLARES that violence is a leading worldwide public health problem;

2. URGES Member States to assess the problem of violence on their own territory and to communicate to WHO their information about this problem and their approach to it;

3. REQUESTS the Director-General, within available resources, to initiate public health activities to address the problem of violence that will:

   (1) characterize different types of violence, define their magnitude and assess the causes and the public health consequences of violence using also a "gender perspective" in the analysis;

   (2) assess the types and effectiveness of measures and programmes to prevent violence and mitigate its effect, with particular attention to community-based initiatives;

   (3) promote activities to tackle this problem at both international and country level including steps to:

      (a) improve the recognition, reporting and management of the consequences of violence;

      (b) promote greater intersectoral involvement in the prevention and management of violence;

      (c) promote research on violence as a priority for public health research;

      (d) prepare and disseminate recommendations for violence prevention programmes in nations, States and communities all over the world;

   (4) ensure the coordinated and active participation of appropriate WHO technical programmes;

   (5) strengthen the Organization’s collaboration with governments, local authorities and other organizations of the United Nations system in the planning, implementation and monitoring of programmes of violence prevention and mitigation;
4. FURTHER REQUESTS the Director-General to present a report to the ninety-ninth session of the Executive Board describing the progress made so far and to present a plan of action for progress towards a science-based public health approach to violence prevention. (Sixth plenary meeting, 25 May 1996 - Committee B, fourth report).
ANNEX B:


Section D: Violence Against Women

112. Violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms. The long-standing failure to protect and promote those rights and freedoms in the case of violence against women is a matter of concern to all States and should be addressed. Knowledge about its causes and consequences, as well as its incidence and measures to combat it, have been greatly expanded since the Nairobi Conference. In all societies, to a greater or lesser degree, women and girls are subjected to physical, sexual and psychological abuse that cuts across lines of income, class and culture. The low social and economic status of women can be both a cause and a consequence of violence against women.

113. The term “violence against women” means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.
114. Other acts of violence against women include violation of the human rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery and forced pregnancy.

115. Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.

116. Some groups of women, such as women belonging to minority groups, indigenous women, refugee women, women migrants, including women migrant workers, women in poverty living in rural or remote communities, destitute women, women in institutions or in detention, female children, women with disabilities, elderly women, displaced women, repatriated women, women living in poverty and women in situations of armed conflict, foreign occupation, wars of aggression, civil wars, terrorism, including hostage-taking, are also particularly vulnerable to violence.

117. Acts or threats of violence, whether occurring within the home or in the community, or perpetrated or condoned by the State, instil fear and insecurity in women's lives and are obstacles to the achievement of equality and for development and peace. The fear of violence, including harassment, is a permanent constraint on the mobility of women and limits their access to resources and basic activities. High social, health and economic costs to the individual and society are associated with violence against women. Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men. In many cases, violence against women and girls occurs in the family or within the home, where violence is often tolerated. The neglect, physical and sexual abuse, and rape of girl children and women by family members and other members of the household, as well as incidences of spousal and non-spousal abuse, often go unreported and are thus difficult to detect. Even when such violence is reported, there is often a failure to protect victims or punish perpetrators.

118. Violence against women is a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of women's full advancement. Violence against women throughout the life cycle derives essentially from cultural patterns, in particular the harmful effects of certain traditional or customary practices and all acts of extremism linked to race, sex, language or religion that perpetuate the lower status accorded to women in the family, the workplace, the community and society. Violence against women is exacerbated by social pressures, notably the shame of denouncing certain acts that have been perpetrated against women; women's lack of access to legal information, aid or protection; the lack of laws that effectively prohibit violence against women; failure to reform existing laws; inadequate
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efforts on the part of public authorities to promote awareness of and enforce existing laws; and the absence of educational and other means to address the causes and consequences of violence. Images in the media of violence against women, in particular those that depict rape or sexual slavery as well as the use of women and girls as sex objects, including pornography, are factors contributing to the continued prevalence of such violence, adversely influencing the community at large, in particular children and young people.

119. Developing a holistic and multidisciplinary approach to the challenging task of promoting families, communities and States that are free of violence against women is necessary and achievable. Equality, partnership between women and men and respect for human dignity must permeate all stages of the socialization process. Educational systems should promote self-respect, mutual respect, and cooperation between women and men.

120. The absence of adequate gender-disaggregated data and statistics on the incidence of violence makes the elaboration of programmes and monitoring of changes difficult. Lack of inadequate documentation and research on domestic violence, sexual harassment and violence against women and girls in private and in public, including the workplace, impede efforts to design specific intervention strategies. Experience in a number of countries shows that women and men can be mobilized to overcome violence in all its forms and that effective public measures can be taken to address both the causes and the consequences of violence. Men’s groups mobilizing against gender violence are necessary allies for change.

121. Women may be vulnerable to violence perpetrated by persons in positions of authority in both conflict and non-conflict situations. Training of all officials in humanitarian and human rights law and the punishment of perpetrators of violent acts against women would help to ensure that such violence does not take place at the hands of public officials in whom women should be able to place trust, including police and prison officials and security forces.

122. The effective suppression of trafficking in women and girls for the sex trade is a matter of pressing international concern. Implementation of the 1949 Conventions for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others, 20/ as well as other relevant instruments, needs to be reviewed and strengthened. The use of women in international prostitution and trafficking networks has become a major focus of international organized crime. The Special Rapporteur of the Commission on Human Rights on violence against women, who has explored these acts as an additional cause of the violation of the human rights and fundamental freedoms of women and girls, is invited to address, within her mandate and as a matter of urgency, the issue of international trafficking for the purposes of the sex trade, as well as the
issues of forced prostitution, rape, sexual abuse and sex tourism. Women and girls who are victims of this international trade are at an increased risk of further violence, as well as unwanted pregnancy and sexually transmitted infection, including infection with HIV/AIDS.

123. In addressing violence against women, Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes so that before decisions are taken an analysis may be made of their effects on women and men, respectively.

Strategic objective D.1. Take integrated measures to prevent and eliminate violence against women

Actions to be taken

124. By Governments:

(a) Condemn violence against women and refrain from invoking any custom, tradition or religious consideration to avoid their obligations with respect to its elimination as set out in the Declaration on the Elimination of Violence against Women;

(b) Refrain from engaging in violence against women and exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons;

(c) Enact and/or reinforce penal, civil, labour and administrative sanctions in domestic legislation to punish and redress the wrongs done to women and girls who are subjected to any form of violence, whether in the home, the workplace, the community or society;

(d) Adopt and/or implement and periodically review and analyse legislation to ensure its effectiveness in eliminating violence against women, emphasizing the prevention of violence and the prosecution of offenders; take measures to ensure the protection of women subjected to violence, access to just and effective remedies, including compensation and indemnification and healing of victims, and rehabilitation of perpetrators;
(c) Work actively to ratify and/or implement international human rights norms and instruments as they relate to violence against women, including those contained in the Universal Declaration of Human Rights, 21/ the International Covenant on Civil and Political Rights, 13/ the International Covenant on Economic, Social and Cultural Rights, 13/ and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; 22/

(f) Implement the Convention on the Elimination of All Forms of Discrimination against Women, taking into account general recommendation 19, adopted by the Committee on the Elimination of Discrimination against Women at its eleventh session; 23/

(g) Promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes related to violence against women; actively encourage, support and implement measures and programmes aimed at increasing the knowledge and understanding of the causes, consequences and mechanisms of violence against women among those responsible for implementing these policies, such as law enforcement officers, police personnel and judicial, medical and social workers, as well as those who deal with minority, migration and refugee issues, and develop strategies to ensure that the revictimization of women victims of violence does not occur because of gender-insensitive laws or judicial or enforcement practices;

(h) Provide women who are subjected to violence with access to the mechanisms of justice and, as provided for by national legislation, to just and effective remedies for the harm they have suffered and inform women of their rights in seeking redress through such mechanisms;

(i) Enact and enforce legislation against the perpetrators of practices and acts of violence against women, such as female genital mutilation, female infanticide, prenatal sex selection and dowry-related violence, and give vigorous support to the efforts of non-governmental and community organizations to eliminate such practices;

(j) Formulate and implement, at all appropriate levels, plans of action to eliminate violence against women;
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(k) Adopt all appropriate measures, especially in the field of education, to modify the social and cultural patterns of conduct of men and women, and to eliminate prejudices, customary practices and all other practices based on the idea of the inferiority or superiority of either of the sexes and on stereotyped roles for men and women;

(l) Create or strengthen institutional mechanisms so that women and girls can report acts of violence against them in a safe and confidential environment, free from the fear of penalties or retaliation, and file charges;

(m) Ensure that women with disabilities have access to information and services in the field of violence against women;

(n) Create, improve or develop appropriate, and fund the training programmes for judicial, legal, medical, social, educational and police and immigrant personnel, in order to avoid the abuse of power leading to violence against women and sensitize such personnel to the nature of gender-based acts and threats of violence so that fair treatment of female victims can be assured;

(o) Adopt laws, where necessary, and reinforce existing laws that punish police, security forces or any other agents of the State who engage in acts of violence against women in the course of the performance of their duties; review existing legislation and take effective measures against the perpetrators of such violence;

(p) Allocate adequate resources within the government budget and mobilize community resources for activities related to the elimination of violence against women, including resources for the implementation of plans of action at all appropriate levels;

(q) Include in reports submitted in accordance with the provisions of relevant United Nations human rights instruments, information pertaining to violence against women and measures taken to implement the Declaration on the Elimination of Violence against Women;

(r) Cooperate with and assist the Special Rapporteur of the Commission on Human Rights on violence against women in the performance of her mandate and furnish all information requested; cooperate also with other competent mechanisms, such as the Special Rapporteur of the Commission on Human Rights on Torture and the Special Rapporteur of the Commission on Human Rights on summary, extrajudicial and arbitrary executions, in relation to violence against women;
(s) Recommend that the Commission on Human Rights renew the mandate of the Special Rapporteur on violence against women when her term ends in 1997 and, if warranted, to update and strengthen it.

125. By Governments, including local governments, community organizations, non-governmental organizations, educational institutions, the public and private sectors, particularly enterprises, and the mass media, as appropriate:

(a) Provide well-funded shelters and relief support for girls and women subjected to violence, as well as medical, psychological and other counselling services and free or low-cost legal aid, where it is needed, as well as appropriate assistance to enable them to find a means of subsistence;

(b) Establish linguistically and culturally accessible services for migrant women and girls, including women migrant workers, who are victims of gender-based violence;

(c) Recognize the vulnerability to violence and other forms of abuse of women migrants, including women migrant workers, whose legal status in the host country depends on employers who may exploit their situation;

(d) Support initiatives of women's organizations and non-governmental organizations all over the world to raise awareness on the issue of violence against women and to contribute to its elimination;

(e) Organize, support and fund community-based education and training campaigns to raise awareness about violence against women as a violation of women's enjoyment of their human rights and mobilize local communities to use appropriate gender-sensitive traditional and innovative methods of conflict resolution;

(f) Recognize, support and promote the fundamental role of intermediate institutions, such as primary health-care centres, family planning centres, existing school health services, mother and baby protection services, centres for migrant families and so forth in the field of information and education related to abuse;
Organize and fund information campaigns and education and training programmes in order to sensitize girls and boys and women and men to the personal and social detrimental effects of violence in the family, community and society; teach them how to communicate without violence and promote training for victims and potential victims so that they can protect themselves and others against such violence;

Disseminate information on the assistance available to women and families who are victims of violence;

Provide, fund and encourage counselling and rehabilitation programmes for the perpetrators of violence and promote research to further efforts concerning such counselling and rehabilitation so as to prevent the recurrence of such violence;

Raise awareness of the responsibility of the media in promoting non-stereotyped images of women and men, as well as in eliminating patterns of media presentation that generate violence, and encourage those responsible for media content to establish professional guidelines and codes of conduct; also raise awareness of the important role of the media in informing and educating people about the causes and effects of violence against women and in stimulating public debate on the topic.

By Governments, employers, trade unions, community and youth organizations and non-governmental organizations, as appropriate:

(a) Develop programmes and procedures to eliminate sexual harassment and other forms of violence against women in all educational institutions, workplaces and elsewhere;

(b) Develop programmes and procedures to educate and raise awareness of acts of violence against women that constitute a crime and a violation of the human rights of women;

(c) Develop counselling, healing and support programmes for girls, adolescents and young women who have been or are involved in abusive relationships, particularly those who live in homes or institutions where abuse occurs;
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(d) Take special measures to eliminate violence against women, particularly those in vulnerable situations, such as young women, refugee, displaced and internally displaced women, women with disabilities and women migrant workers, including enforcing any existing legislation and developing, as appropriate, new legislation for women migrant workers in both sending and receiving countries.

127. By the Secretary-General of the United Nations:

Provide the Special Rapporteur of the Commission on Human Rights on violence against women with all necessary assistance, in particular the staff and resources required to perform all mandated functions, especially in carrying out and following up on missions undertaken either separately or jointly with other special rapporteurs and working groups, and adequate assistance for periodic consultations with the Committee on the Elimination of Discrimination against Women and all treaty bodies.

128. By Governments, international organizations and non-governmental organizations:

Encourage the dissemination and implementation of the UNHCR Guidelines on the Protection of Refugee Women and the UNHCR Guidelines on the Prevention of and Response to Sexual Violence against Refugees.

Strategic objective D.2. Study the causes and consequences of violence against women and the effectiveness of preventive measures

Actions to be taken

129. By Governments, regional organizations, the United Nations, other international organizations, research institutions, women’s and youth organizations and non-governmental organizations, as appropriate:

(a) Promote research, collect data and compile statistics, especially concerning domestic violence relating to the prevalence of different forms of violence against women, and encourage research into the causes, nature, seriousness and consequences of violence against women and the effectiveness of measures implemented to prevent and redress violence against women;
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(b) Disseminate findings of research and studies widely;

(c) Support and initiate research on the impact of violence, such as rape, on women and girl children, and make the resulting information and statistics available to the public;

(d) Encourage the media to examine the impact of gender role stereotypes, including those perpetuated by commercial advertisements which foster gender-based violence and inequalities, and how they are transmitted during the life cycle, and take measures to eliminate these negative images with a view to promoting a violence-free society.

Strategic objective D.3. Eliminate trafficking in women and assist victims of violence due to prostitution and trafficking

Actions to be taken

130. By Governments of countries of origin, transit and destination, regional and international organizations, as appropriate:

(a) Consider the ratification and enforcement of international conventions on trafficking in persons and on slavery;

(b) Take appropriate measures to address the root factors, including external factors, that encourage trafficking in women and girls for prostitution and other forms of commercialized sex, forced marriages and forced labour in order to eliminate trafficking in women, including by strengthening existing legislation with a view to providing better protection of the rights of women and girls and to punishing the perpetrators, through both criminal and civil measures;

(c) Step up cooperation and concerted action by all relevant law enforcement authorities and institutions with a view to dismantling national, regional and international networks in trafficking;

(d) Allocate resources to provide comprehensive programmes designed to heal and rehabilitate into society victims of trafficking, including thorough job training, legal assistance and confidential health care, and take measures to cooperate with non-governmental organizations to provide for the social, medical and psychological care of the victims of trafficking;
(e) Develop educational and training programmes and policies and consider enacting legislation aimed at preventing sex tourism and trafficking, giving special emphasis to the protection of young women and children.