

**Article 10****Victims of Gender-based Violence<sup>1</sup>**

by Lori Heise, Mary Ellsberg,  
and Megan Gottemoeller

AROUND THE WORLD AT LEAST ONE WOMAN in every three has been beaten, coerced into sex, or otherwise abused in her lifetime. Most often the abuser is a member of her own family. Increasingly, gender-based violence is recognized as a major public health concern and a violation of human rights.

The effects of violence can be devastating to a woman's reproductive health as well as to other aspects of her physical and mental well being. In addition to causing injury, violence increases women's long-term risk of a number of other health problems, including chronic pain, physical disability, drug and alcohol abuse, and depression. Women with a history of physical or sexual abuse are also at increased risk for unintended pregnancy, sexually transmitted infections (STIs), and adverse pregnancy outcomes. Yet victims of violence who seek care from health professionals often have needs that providers do not recognize, do not ask about, and do not know how to address.

**What is Gender-based Violence?**

Violence against women and girls includes physical, sexual, psychological, and economic abuse. It is often known as "gender-based" violence because it evolves in part from women's subordinate status in society. Many cultures have beliefs, norms, and social institutions that legitimize and therefore perpetuate violence against women. The same acts that would be punished if directed at an employer, neighbor, or an acquaintance often go unchallenged when men direct them at women, especially within the family.

This article focuses principally on two types of violence: (1) abuse of women within marriage and other intimate relationships, and (2) coerced sex, whether it takes place in childhood, adolescence, or adulthood. This focus reflects the types of abuse most dominant in the lives of women and girls around the world.

*Manisha Gupte's story of dealing with violence shows the power of strategic thinking, determination and joining forces to successfully combat oppression of women. If only the work of her NGO, MASUM, could be multiplied ten thousand times, we could begin to combat the violence against women that is found everywhere in the world. The scope of violence, its grounding in gender discrimination and its negative public health outcomes are the topic of the article by Lori Heise and colleagues, which follows. They also include recommendations on how public health practitioners can best prevent violence against women and help those affected by it.*

<sup>1</sup> This article is condensed from Population Reports: Ending Violence against Women. Authors: Heise, Lori; Ellsberg, Mary and Megan Gottemoeller. "Ending Violence Against Women." Population Reports. Population Information Program, Center for Communication Programs, The Johns Hopkins University School of Public Health. Volume XXVII, Number 4. December 1999. Includes a special guide: "What Health Care Providers Can Do About Domestic Violence." Full text including references available: <http://www.jhuccp.org/pr/l1ledsum.stm>

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Other forms of abuse—such as trafficking in women, rape during war, female infanticide and female genital mutilation—are also important. They are not included in this article because they deserve separate consideration.

Violence against women is different from interpersonal violence in general. The nature and patterns of violence against men, for example, typically differ from those against women. Men are more likely than women to be victimized by a stranger or casual acquaintance. Women are more likely than men to be victimized by a family member or intimate partner. The fact that women are often emotionally involved with and financially dependent upon those who abuse them has profound implications for how women experience violence and how best to intervene.

**Intimate Partner Abuse.** Worldwide, one of the most common forms of violence against women is abuse by their husbands or other intimate male partners. Partner violence occurs in all countries and transcends social, economic, religious, and cultural groups. While research on intimate partner violence is in its early stages, there is growing agreement about its nature and the various factors that cause it (Jewkes 2002). Often referred to as “wife-beating,” “battering,” or “domestic violence,” intimate partner abuse is generally part of a pattern of abusive behavior and control, rather than an isolated act of physical aggression. It takes a variety of forms, including physical assault, psychological abuse, and controlling behaviors such as isolating a woman from her family and friends.

**Sexual Coercion.** Sexual coercion exists along a continuum, from forcible rape to non-physical forms of pressure that compel women and girls to engage in sexual activity against their will. The touchstone of coercion is that a woman lacks choice and faces severe physical or social consequences if she resists sexual advances.

Some forms of coercion—such as forced penetration (rape), sexual assault (forced sexual contact), and sexual molestation of children—are recognized as crimes by many legal systems. Other forms—such as intimidation, verbal pressure, or forced marriage—are culturally tolerated and at times even condoned. Still others involve collusion by organized crime or the military, such as trafficking in women and children, and rape in war. Most nonconsensual sex takes place among people who know each other—spouses, family members, courtship partners, or acquaintances. Sexual coercion can take place at any point in a woman’s life.

### **Impact on Women’s Reproductive Health**

Physical and sexual abuse lie behind some of the most intractable reproductive health issues of our times—unwanted pregnancies, HIV and other STIs, and complications of

pregnancy. A growing number of studies document the ways in which violence by intimate partners and sexual coercion undermine women's sexual and reproductive autonomy and jeopardize their health.

Violence operates through multiple pathways to affect women's sexual and reproductive health. Physical violence can put women at direct risk of infections and unwanted pregnancies, if women are forced to have sex, for example, or fear using contraception or condoms because of their partners' reaction. A history of sexual abuse in childhood also can lead to unwanted pregnancies and STIs indirectly by increasing sexual risk-taking in adolescence and adulthood.

Violence has also been linked to many other serious health problems, both immediate and long-term. These include physical health problems, such as injury, chronic pain syndromes, and gastrointestinal disorders, and a range of mental health problems, including anxiety and depression. Although violence can have direct health consequences, it also increases women's risk of future ill health. Therefore, like tobacco or alcohol use, victimization can best be conceptualized as a risk factor for a variety of diseases and conditions as illustrated in Figure 1 (Heise et al. 1999).

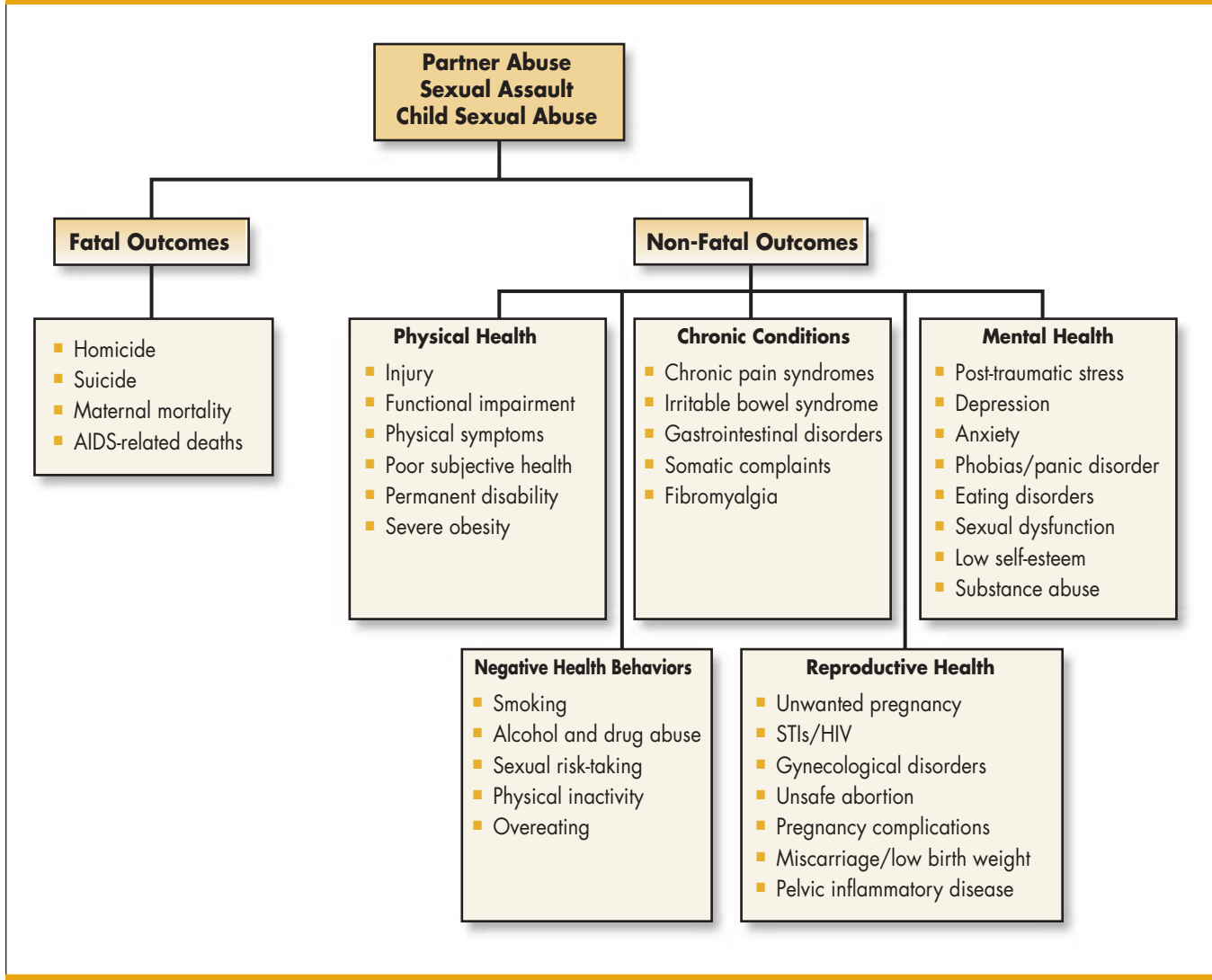
## **Obstacles to Reaching Victims of Abuse with Reproductive Health Services**

While health providers can play a crucial role in the issue, they are often slow to address violence against women. A complex interplay of professional, cultural, personal and institutional concerns shape the ability and willingness of health workers to address domestic violence, according to studies in Africa, Asia, Latin America, and the United States (U.S.). Some of the biggest barriers that block effective response are health care providers' lack of technical competence, cultural stereotypes and negative social attitudes, and institutional constraints (Garcia-Moreno 2002).

**Lack of technical competence and resources.** Health workers often do not ask women about their experience with violence because they feel unprepared to respond to the needs of victims. Some view domestic violence as a private issue and fear that clients would be upset or offended if asked about it. Others feel they do not have the time or resources to help them (Sugg and Inui 1992).

**Cultural stereotypes and negative social attitudes.** Health care providers typically share the same cultural values and societal attitudes toward abuse that are dominant in the society at large. Thus they may think that some women deserve abuse or that a wife's obligation is to be sexually available to her husband at all times. They also frequently assume that

**Figure 1 – Health Outcomes of Violence Against Women**



domestic violence and sexual assault occur only among poor women or among women of certain ethnic or religious backgrounds. Such attitudes stand in the way of sympathetic and caring responses to abused women who seek care (Kim and Motsei 2002).

**Institutional constraints.** Clinicians working with victims of violence often feel that their institutions and colleagues value their work less than other types of clinical intervention. Most programs designed to address abuse in health care settings have been the work of very committed individuals, but rarely have their initiatives become institutional policy. With the departure of these key leaders, many programs lose momentum, and some end. Legal liability or involvement is a major concern that keeps health workers from doing

more for victims of abuse. In some countries health workers often refuse to examine raped or otherwise abused women because they want to avoid having to testify in court. Other countries have passed laws mandating that health care providers report child abuse and, sometimes, abuse of adult women. With adult victims, however, such laws are generally counterproductive because they take control away from the abused woman, jeopardize her safety, and may make it less likely that she will seek health care for fear that her partner will be arrested as a result (Hyman et al. 1995).

Women's needs are often neglected because of bureaucratic gaps or inadequate coordination between the health and criminal justice systems. The lack of referral services and insufficient coordination between health workers and referral services often prevent women from receiving necessary medical care, including emergency contraception and STI screening.

**Women's reluctance to disclose violence.** Unless women are asked directly about violence, many do not volunteer information. For example, a survey in Nicaragua found that over one-third of women who had been abused by their partners had never told anyone. Shame was one of the main reasons that women in Nicaragua gave for not disclosing violence; and fear of reprisals was another (Ellsberg et al. 2000). Finally, in much of the world, women are unable to obtain health care without the knowledge or permission of their spouses or other male family members. Often, men will not allow their wives to visit a health center unescorted, especially if they are going to be treated for injuries due to violence. Women are especially unlikely to disclose abuse to a health care provider in front of their abuser.

### **Appropriate Provider Approaches to Victims of Abuse**

**Asking about abuse.** Once a woman decides to seek help from a health care institution, the response she receives is crucial. Many clinicians fear that asking patients about violence and sexual abuse will open a “Pandora's Box,” unleashing issues that they have neither the time nor the skills to deal with (Sugg and Inui 1992). When health workers fail to ask about violence, particularly when there are obvious signs of it, women are likely to assume that they are not interested. An indifferent or hostile reaction from health care providers reinforces a woman's feelings of isolation and self-blame, and makes it harder for her to mention the topic again. Meanwhile, for many women, facing indifference and hostility from health personnel is like being victimized again by the very system that is supposed to help.

The way in which a woman is asked about violence makes an enormous difference to whether she will disclose her situation. If asked about violence in a nonjudgmental,

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empathic way, she is more likely to answer truthfully. Women are more inclined to discuss abuse if they perceive the clinician to be caring and easy to talk to, and if follow-up is offered (McCauley et al. 1998). Placing brochures or posters about domestic violence in a clinic or office can increase women's comfort in talking about abuse. Sometimes, medical staffs have found it helpful to wear buttons with the message "It's OK to talk to me about family violence and abuse." A U.S. medical association produced a poster to place in waiting rooms saying, "We may forget to ask, but we always want to know if you are experiencing violence at home."

Lack of confidentiality can be particularly devastating, as well as placing women at risk for further abuse. A woman in Zimbabwe complained, "I went to the hospital because my husband beat me when I got pregnant. What hurt me was that there was no confidentiality by the doctors and nurses treating me. Everyone in the ward got to know that I had been beaten by my husband" (Watts et al. 1997).

When there are obvious signs of abuse, such as unexplained injuries, health workers should ask, "Who did this to you?" If there are no signs, clinicians have found that the best way to ask about violence is to bring it up routinely as part of taking a clinical history. For example, the provider can say, "Because violence is so common these days, I ask all my patients whether they have ever been hurt by someone close to them." This phrasing can help to keep a woman from feeling that she has been singled out for questioning (Warshaw and Ganley 1998).

Several short screening questionnaires have been developed to help health care providers identify victims of abuse. At one prenatal clinic, detection of lifetime violence rose from 14 percent with routine inquiry during a social service interview to 41 percent using the five-question *Abuse Assessment Screen* (Norton et al. 1995). Another study found that asking three brief questions correctly identified the majority of abused women: "Have you been hit, kicked, punched or otherwise hurt by someone within the last year? If so, by whom?"; "Do you feel safe in your current relationship?"; and "Is there a partner from a previous relationship who is making you feel unsafe now?" (Feldhaus et al. 1997).

There is no international consensus on whether all women should be routinely screened for violence when they visit a health care facility. Each health service should decide upon a detection policy that best meets its clients' needs and local resources. Options other than universal screening include: (1) Asking when there are signs of abuse; (2) Screening strategically, based on special risks or opportunities, e.g., maternal and child health services, reproductive health services, mental health services, or emergency departments.

**Supporting women who disclose abuse.** Health workers often feel that there is little they can do when a woman discloses abuse. But what providers say and do can have an impor-

tant influence on a woman's course of action. The act of asking questions about violence can let women know that providers consider violence to be an important medical problem and not the client's fault. A Latin American woman said, "The doctor helped me feel better by saying that I didn't deserve this treatment, and he helped me make a plan to leave the house the next time my husband came home drunk" (Hartigan 1997).

Women in the U.S. also emphasize the power of validation, noting that it provided "relief," "comfort," "planted a seed," and "started the wheels turning" toward changing their perception of their own situation (Gerbert et al. 1999). Even if an abused woman does not disclose the violence on a first visit, asking about it shows that the clinician cares, and thus she may decide to talk about it later. While health workers ideally should coordinate their actions with community-based services, such as local women's groups, providers can take several useful actions immediately during the clinic visit: assess for immediate danger; provide appropriate care; document women's condition; develop a safety plan; inform women of their rights; and refer women to community resources (Warshaw and Ganley 1998).

## **Appropriate Health Service Responses to Violence: Lessons Learned**

Globally, health systems and providers have only recently begun to tackle the challenge of responding to physical and sexual abuse (Garcia-Moreno 2002). Most violence interventions in health care settings—with the exception of a handful in the U.S.—have not been formally evaluated, and pilot interventions in resource-poor settings are just beginning. Nonetheless, some tentative lessons have emerged:

1. **Do more than train.** While training health care providers is important, training alone is seldom enough to change providers' behavior toward victims of domestic violence. Although training can improve providers' knowledge and practice in the short term, the impact of training generally erodes unless a variety of other measures are also taken that support and sustain new approaches.
2. **Adopt a systems approach.** Achieving lasting change requires transforming the health system itself as well as changing the behavior of individual providers. When managers, administrators, and the health care system itself encourage and reward new, caring behavior towards victims of abuse, providers will feel better able to recognize and address violence.
3. **Make procedural changes in client care.** Often, making such procedural changes as adding prompts for providers on medical charts (e.g., stickers asking about abuse, or a stamp that prompts providers to screen) or including appropriate questions on intake

forms and interview schedules can encourage attention to domestic violence.

4. **Confront underlying attitudes and beliefs.** Most training programs for health care workers have focused on the clinical management of victims. This approach yields limited results, however, because providers themselves generally share the same biases, prejudices, and fears regarding abuse as the society at large. As programs have gained experience, it has become clear that providers must examine their own attitudes and beliefs about gender, power, abuse, and sexuality before they can develop new professional knowledge and skills about dealing with victims.
5. **Redefine success.** Health workers often feel reluctant to address cases of domestic violence because it is a problem that cannot easily be cured or even addressed. In response, some training projects have tried to help the providers reframe their role from “fixing” the problem and dispensing advice to providing support. Revising expectations in this way has helped providers overcome feelings of resentment and impotence in addressing domestic violence. Reframing the provider’s role also helps promote women’s self-determination. Counseling concerning abuse, like contraceptive counseling, should be nondirective and respect women’s choices.
6. **Provide opportunities to model new behavior.** Two major barriers to asking clients about abuse are providers’ belief that violence is uncommon among their clients and providers’ fear of how the clients will respond. Opportunities to practice new behavior can help overcome both barriers.
7. **Be strategic about where you start.** Changing health systems is difficult. Thus the best practice is usually to start where success is most likely. Often this strategy means choosing to undertake pilot interventions first in settings where there is substantial internal and external support for change. Internally, it is important to gain the commitment and support of top managers early. Externally, it is best to undertake pilot interventions where support and referral services for abuse victims already exist.
8. **Plan for staff turnover.** In most health systems, particularly in developing countries, staff members routinely rotate in and out of clinics and other health centers. Thus policies on violence must be institutionalized, and training will be needed for new staff members on a continuing basis.
9. **Follow up.** Programs should provide continuing support to individuals and institutions attempting to reform their response to domestic violence. Projects that have attempted to spark change by using a “train the trainer model”—inviting providers to attend a centralized training and then expecting them to duplicate the training in their home setting—have generally found that such schemes do not work well without substantial continuity and support.

## **Successful Interventions**

In developing countries a number of reproductive health programs have taken the lead in addressing violence against women. The efforts of these programs are making it easier for other programs to tackle the complex issues of gender-based violence.

**South Africa: Addressing violence as part of “life skills” workshops.** The Planned Parenthood Association of South Africa (PPASA), together with EngenderHealth’s Men as Partners Program, has developed a program that integrates participatory activities on gender, sexual power, and intimate relationships into PPASA’s “life skills” workshops. The program began after a survey of 2,000 South African men found that 58 percent believed that the concept of rape did not apply to a husband forcing his wife to have sex, 48 percent thought the way a woman dressed caused her to be raped, and 22 percent approved of a man hitting his partner (compared with 5% who approved of a woman hitting her partner) (Reproductive Health Research Unit 1998).

**Latin America: Integrating violence issues into other reproductive health care.** The International Planned Parenthood Federation (IPPF) Western Hemisphere Region is currently working with affiliates in the Dominican Republic, Peru, and Venezuela to integrate attention to gender-based violence into other sexual and reproductive health programming. For example, in Venezuela PLAFAM has trained service providers, redesigned patient routing forms, and created new case registration forms (Asociacion de Planificacion Familiar 1999).

**Peru: Women listening to women’s voices.** ReproSalud, an innovative reproductive health program of the Peruvian women’s organization Manuela Ramos, helps rural women organize to address reproductive health issues that they identify as most important. Of the 51 communities that had held “diagnosticos” as of March 1998, 12 communities had identified domestic violence as one of their three most important problems (Koumpounis 1999).

**The Philippines: Organizing against violence.** The Davao City Coordinating Council on Violence Against Women has carried out activities to reduce violence at all levels of society. These activities range from puppet shows that encourage community dialogue about gender-based violence to citywide training for police, health workers, and government officials. In 1997, the Davao City Council passed the Women’s Development Code, a landmark ordinance that promotes and protects the rights of women and includes extensive provisions on gender-based violence, including comprehensive counseling, medical and legal support for victims, and women’s desks in all Davao City police departments (Development of People’s Foundation 1997).

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**Tanzania: Organizing to protect refugee women.** The International Rescue Committee (IRC) has launched a project on sexual abuse and gender-based violence among the Burundian refugee women housed in camps in the Kibondo district of Tanzania. The project has used participatory research and peer outreach workers to organize the camp communities to deal with gender-based violence. The project provides counseling, 24-hour a day medical services, and access to emergency contraception at four drop-in centers (Nduna 1998).

**Liberia: Training traditional birth attendants.** In 1993, Mother Patern College of Health Sciences in Monrovia, Liberia, joined with Women's Rights International, a U.S.-based nongovernmental organization (NGO), to address the aftermath of rape during Liberia's seven-year civil war. The project's Liberian staff developed a participatory program to educate traditional birth attendants on the consequences of gender-based violence. The program uses exercises such as "Kaymah's Trouble," a story of a woman raped during the war, to help traditional birth attendants expand their roles as community leaders to address violence against women (Women's Rights International 1998).

**Nicaragua: Researching the reproductive health consequences of violence.** Since its 1991 inception, the research collaboration between Umeå University, Sweden, and the School of Medicine in León, Nicaragua has yielded some of the richest data available anywhere on the reproductive health consequences of violence against women. Working closely with the Nicaraguan Women's Network Against Violence, researchers integrated questions on violence into a series of studies exploring infant mortality, adolescent pregnancy, HIV risk, and low birth weight. These pioneering studies have produced a wealth of information (Ellsberg et al. 2000) .

### **Implications and Recommendations: High-Priority First Steps**

Reproductive health professionals often feel that the issue of violence against women is too complex and too overwhelming to tackle. But fundamental change can—and often must—begin incrementally. A graduated response to violence could begin with the following steps:

#### **Priorities for Donors**

Research into vaginal microbicides. Changing the power balance between women and men in sexual relationships will take time—time that women at risk of HIV and other STIs today do not have. Thus a high-priority investment by donors must be research into vaginal microbicides—substances, similar to today's spermicides, that women could use to protect themselves from infection—if necessary, without the knowledge or cooperation of

their sex partners. Scientists predict that a first-generation microbicide could be developed within five years given sufficient investment. Presently, research in this area is inadequate. Women's and AIDS groups have organized the Global Campaign for HIV/STI Prevention Alternatives for Women to demand more investment in microbicide development.

Pilot projects. More must be learned about how to integrate concern for gender-based abuse into other reproductive health programs. Immediate support is needed for pilot projects with strong evaluation components to discover what works best in different settings, particularly where resources are few.

### **Priorities for Program Planners**

Integration into ongoing training. The most effective way to improve training about abuse for reproductive health care providers is to integrate it into current training, especially when training addresses quality of care, counseling, and male involvement. At a minimum, all training for providers can add sensitization exercises about gender, sexuality, and abuse.

Make new norms a program objective. Measurable indicators of reproductive health program success can include, for example, changes in the percentage of women and men who agree that a married woman has a right to refuse sex. The Demographic and Health Surveys (DHS) now include such questions. With new norms as a program objective, managers will focus attention on how best to encourage changes in public attitudes about women's autonomy and men's behavior.

### **Priorities for Providers**

Discuss with women clients how much they can control sexual encounters. This is a crucial consideration in choice of a family planning method. Providers can point to methods that a woman can use without her partner's knowledge or if she cannot anticipate sex. Also, providers can emphasize that sex—including sex within marriage—should be wanted by both parties, not forced by the man.

Do not require spousal approval for contraceptive use. Many providers require a woman to have her husband's consent to obtain contraception, even when policies do not. Such requirements undermine women's autonomy and put them at risk of violence. In Ethiopia, when family planning clinics stopped requiring spousal consent, women's attendance soon rose 26 percent.

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## **Resources**

### **Reproductive Health Outlook (RHO).**

<http://www.rho.org>

Provides links to numerous Websites of organizations addressing violence against women.

RHO includes sections on gender and on men and reproductive health.

### **End Violence against Women: Information and Resources.**

<http://www.endvaw.org>

This Website provides a wealth of documents, reports, and training and communication materials developed by groups around the world.

### **Abuse Against Women.**

<http://www.alternatives.com/libs/womabuse.htm>

Small database of text documents focusing on abuse, sex abuse, workplace harassment, and rape. Mostly North American context but includes some developing country content too.

### **Feminist Majority Foundation.**

<http://www.feminist.com/violence.htm>

Collects resources on domestic violence, rape and violence against women, child sexual abuse, female genital mutilation and sexual harassment. Mainly focuses on the U.S.

### **International Center for Human Rights and Democratization Development.**

<http://ichrrd.ca/PublicationsE/biblioWomen.html>

Comprehensive list of places where women are in conflict situations.

### **Mining company.**

<http://women3rdworld.miningco.com>

An excellent Website containing news, organizations, resources and articles on a variety of issues faced by women in developing countries, including violence against women.

### **UNIFEM.**

<http://www.unifem.undp.org/csw98.htm> and [www.unifem.undp.org/trust.htm](http://www.unifem.undp.org/trust.htm)

Information about international resolutions concerning violence against women. UNIFEM's work and resources available.

### **South Asian Women Network.**

<http://www.umiacs.umd.edu/users/sawweb/sawnet/violence>

Information about domestic violence in South Asia and organizations that offer help. Links to similar worldwide resources.

### **Women's Net.**

<http://www.igc.org/igc/womensnet>

Information about violence against women worldwide.

### **Women's Net South Africa.**

<http://womensnet.org.za/pvaw/vaw.htm>

Lists campaigns and organizations and outlines in the understanding of violence against women in South Africa. Internet links to African and International organizations.

### **Q Web Sweden.**

<http://www.qweb.kvinnoforum.se/qabout.htm>

A global communication network for exchange of experience and ideas on women's health and gender issues. Includes their anti-trafficking project, and provides an extensive resource base on violence and abuse.

## **Organizations Working on Violence Against Women:**

### **Africa**

#### **Comité National de Lutte Contre les Violences Faites aux Femmes**

C/O RADI BP 12085  
Dakar, Senegal  
Phone: + 221 (824) 60 48  
Fax: + 221 (825) 75 36

#### **Groupe de Recherche Femmes et Lois au Sénégal (Grefels)**

BP 5339, Dakar Senegal  
Phone: + 221 (825) 65 33

#### **Musasa Project**

PO Box A 205, Avondale  
Harare, Zimbabwe

#### **Sisters Collective**

PO Box 60100  
Katutura, 9000 Namibia

#### **National Network on Violence against Women**

Mmabatho Ramagoshi  
National Office  
PO Box 72957  
Lynwood Ridge 0040  
Pretoria, South Africa  
Phone: + 27 (12) 348 1233

### **Asia**

#### **Association of Women for Action and Research**

Block 5, Dover Crescent # 01-22  
Singapore 130005  
Phone: + 65 (779) 7137  
Fax: + 65 (777) 0318

#### **British Council Division in Calcutta**

5 Shakespeare Saran  
Calcutta 700 071, India  
Phone: +91 (33) 2855370 / 2825378 / 2823445

#### **Forum against Oppression of Women**

120 Safalya Building  
1st floor, Currey Road  
N.M. Joshi Marg  
Bombay 400012, India

#### **Global Alliance against Trafficking in Women**

The International Co-ordination Office

PO Box 1281  
Bangrak Post Office  
Bangkok 10500 Thailand  
Phone: (662) 864-1427  
Fax: (662) 864-1637

#### **War against Rape**

102 Pearl Crest 18-C  
4th Commercial Lane  
Zamzama Boulevard, D.H.A. Phase V  
Karachi 75500 Pakistan  
Phone: +92 (21) 57 3008

#### **Women's Aid Organization**

Pertubuhan Wanita  
PO Box 493 Jalan Sultan, 46790  
Petaling Jaya, Selangor Darul Ehsan, Malaysia

#### **Gabriela Commission on Violence against Women**

20-B Florina Street  
Rosas District  
Quezon City, Philippines

### **Europe**

#### **Association Européenne Contre les Violences Faites aux Femmes au Travail (AVFT)**

71 rue St. Jacques  
75005 Paris, France

#### **Association Animus**

PO Box 97  
Sofia, Bulgaria

#### **British Council, Gender Team**

UK Partnerships, Bridgewater House  
58 Whitworth Street,  
Manchester M 16BB, UK

#### **Center for Women War Victims**

Dirduceva 6  
4100 Zagreb  
Phone: + 385 (41) 434 189  
Fax: + 385 (41) 433 416

#### **WOMANKIND World-Wide**

3 Albion Place  
Galena Rod  
Hammersmith, London W 60LT, UK  
Phone: + 44 (181) 563 8607  
Email: womankind@gn.apc.org

**Women Living Under Muslim Law (WLML)**

Boite Postale  
34790 Grabels (Montpellier),  
France  
[www.wluml.org/](http://www.wluml.org/)

**Women's Aid Federation of England**

PO Box 391  
Bristol BS997WS, UK  
Phone: + 44 (117) 944 4411  
Fax: + 44 (117) 942 1703  
Email: [wafe@wafe.co.uk](mailto:wafe@wafe.co.uk)  
Email: [centenza\\_zg@zamir-zg.ztn.apc.org](mailto:centenza_zg@zamir-zg.ztn.apc.org)

**Latin America**

**Belize Women against Violence Movement**

PO Box 1190  
Belize City, Belize

**Caribbean Association for Feminist Research and Action**

PO Box 441, Tunapuna Post Office  
Trinidad and Togo, West Indies

**Colectivo de Lucha Contra la Violencia hacia las Mujeres**

Santa Ma. La Ribera 107-8  
Col. Santa Ma. La. Ribera  
06400 Mexico City, Mexico  
Email: [cafrainfo@wow.net](mailto:cafrainfo@wow.net)

**North America**

**Canada, Status of Women**

350 Albert Street  
Ottawa, Ontario  
K1A 1A3, Canada  
[www.swc-cfc.gc.ca/direct.html](http://www.swc-cfc.gc.ca/direct.html)

**Center for Health and Gender Equity**

3960 Carroll Avenue, Suit 910  
Takoma Park, MD 20912  
Phone: + 1 (301) 270-1182  
Fax: + 1 (301) 270-2052  
Email: [www.genderhealth.org](http://www.genderhealth.org)

**Center for Women's Global Leadership**

Douglas College  
Rutgers University  
27 Clifton Avenue  
New Brunswick, NJ 08903 USA

Phone: + 1 (732) 932-8782  
Fax: + 1 (732) 932-1180  
Email: [cwgl@igc.apc.org](mailto:cwgl@igc.apc.org)

**International League for Human Rights**

432 Park Avenue South  
New York, NY 10016, USA  
Phone: + 1 (212) 684-1221  
Fax: + 1 (212) 684-1696

**Program for Appropriate Technology in Health (PATH)**

1455 NW Leary Way  
Seattle, WA 98107  
Tel: (206) 285-3500  
Fax: (206) 285.6619  
Email: [info@path.org](mailto:info@path.org)

**RAINBO**

915 Broadway, Suite 1109  
New York, NY 10010-7108  
USA  
Fax: + 1 (212) 477-4154

**The Global Fund for Women**

425 Sherman Avenue, Suite 300  
Palo Alto, California 94306-1823  
USA  
Phone: + 1 (650) 853-8305  
Fax: + 1 (650) 328-0384  
Email: [gfw@globalfundforwomen.org](mailto:gfw@globalfundforwomen.org)

**The Women's Human Rights Program**

Amnesty International  
322 8th Avenue  
New York, NY 10001  
USA  
Email: [whrprogram@aiusa.org](mailto:whrprogram@aiusa.org)  
[www.amnestyusa.org/](http://www.amnestyusa.org/)

**World Council of Muslim Women Foundation**

Contact: Dr. Fahlman  
PO Box 128, Seba Beach  
Alberta T0E 2B0, Canada  
Fax: + 1 (403) 439-5088  
Email: [wcinwf@connect.ab.ca](mailto:wcinwf@connect.ab.ca)