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PreNatal®
PREVENCIÓN DE DISCAPACIDADES

CONFERENCIA

VIOLENCIA FAMILIAR

INTERCAMBIO PROFESIONAL

Expositora : M.D. Janice Cohen

Cusco, 17 de Julio 2007
Arequipa, 31 de Julio 2007

Conference On Family Violence

International Professional Exchange

Presenters: Janice E. Cohen, M.D.
with Rachel Farrell and Nancy Janett Ochoa Luna

Cusco, July 17th, 2007

Arequipa, July 31st, 2007

Sponsored by
PreNatal, Arequipa & the US Peace Corps, Peru
The De Waal Foundation & the Pacific Institute for Health Innovation

Janice E. Cohen, M.D.

Extensive work in Public Health since 1976 with a recent focus on quality of life and long term outcomes for people with serious mental illness

2001-3 Chair, Mental Health Section, American Public Health Association

1977-81 Early work in women's health care – founder and Executive Director of a feminist health center, the Feminist Health Works in NYC, 1977-81, which provided family planning and gynecological care, self-help and educational programs to over 2000 families, professionals and organizations annually

Personal experience with domestic violence and its negative impact on mental, physical health and quality of life

Recently trained as Psychiatrist – Extensive work in public mental health clinics And psychiatric hospitals – now in private practice – currently work with many women and men with histories of physical, sexual and psychological abuse

Rachel Farrell, Community Health Volunteer
USA Peace Corps, Peru

Lambayeque, 2006 - 2007

Worked as a community public and mental health counselor and educator

Created community mental health offices in two local government health centers (Toribia Castro and San Martin)

Developed mental health campaigns and workshops with local schools and made community home visits

Helped to promote: “International Day of NO Violence Against Women”

Developed educational workshops on Domestic Violence for the parents of local schools

Worked with local Peruvian ‘Emergency Centers for Women Victims of Domestic Violence’ (MIMDES)

Arequipa, 2007

Working as a volunteer for NGO PreNatal, providing technical support

Conference Objectives

1. **Create a space for professional and cultural exchange** to discuss effective interventions for combating Domestic Violence.

2. **Unite women in the community** and help to connect them with local resources.

3. **Mobilize women in the community** to create changes to help them address the problem of Domestic Violence.

Freedom from Violence is the Most Basic Human Right

As a first step, we need to create among women a collective sense of entitlement to a life free of violence.

Human rights education - translating the discourse of human rights to make it meaningful to women at the grassroots level - is a critical mechanism in this process - to both prevent and combat violence against women.

Reproductive Health, Gender and Human Rights: A Dialogue: Edited by Elaine Murphy and Karin Ringheim, Women's Reproductive Health Initiative (WRHI) 1800 K Street NW, Suite 800, Washington, DC 20006 © 2001, PATH www.path.org

Domains Associated with Good Quality of Life

Physical and Psychological Health and Safety are Fundamental Prerequisites for All Others

Stable, safe, and decent housing

Family and social relationships

Employment/education/meaningful work

Financial independence and adequate income

Integration into one's community

Spiritual beliefs and religious practices

Talents and interests - leisure activities

Janice E. Cohen. Comprehensive Quality Management Systems: Improving Outcomes for People with Psychiatric Disabilities. (2003)

Women’s Rights ARE Human Rights

This notion is fundamental and revolutionary. In theory, women have never been overtly excluded from the concept of human rights.

Nevertheless, because women traditionally have been relegated to the private sphere and to a subordinate status in society, they have generally been excluded from recognized definitions and interpretations of human rights.

Most of the casualties of war are women & children.
Most of the world's refugees and displaced people are women & children.
Most of the world's poor are women and children.

Because of persistent discrimination against women and women's virtual invisibility, these human rights violations continue with no clear sign of abatement.

International Laws Against Domestic Violence

In 1945, the UN Charter afforded to women and men equal economic, social, cultural, political and civil rights.

The *Convention on the Elimination of All Form of Discrimination Against Women* (CEDAW), or the International Women's Human Rights Treaty, was adopted by the UN in 1979. CEDAW was the first document to comprehensively address women's rights within political, cultural, economic, social and family spheres.

In 1993, the World Conference on Human Rights, issued the *Declaration on the Elimination of Violence Against Women* (DEVAW), which set forth ways in which governments should act to prevent violence, and protect and defend women's rights. DEVAW holds states responsible to "prevent, investigate and, in accordance with national legislation, to punish acts of violence against women, whether perpetrated by the state or by private persons".

Peruvian Laws Against Domestic Violence

Peru was among the first countries in Latin America to adopt special legislation on domestic violence.

The Law for Protection from Family Violence was implemented in 1993 and subsequently strengthened in 1997.

Women's police stations and one-stop centers for victims of domestic violence were also established (Human Rights Watch, 2000).

Implementation of these laws is difficult, due to justice system bias and failure of state judges to enforce existing laws and punish perpetrators, unresponsive and ineffective police and inadequate medical examinations (Human Rights Watch, 2000).

Although a framework has been laid for the protection of women from violence, because of the ineffectiveness of laws and support agencies, women in Peru remain at high risk.

US Laws Against Domestic Violence

The Violence Against Women Act (VAWA) is a landmark piece of legislation, passed in 1994 and reauthorized in 2000.

It sought to improve criminal justice and community-based responses to domestic violence, dating violence, sexual assault and stalking in the United States.

The Violence Against Women Act (VAWA) Fostered:

Community-coordinated responses, that brought together for the first time, the criminal justice system, the social services system and private nonprofit organizations responding to domestic violence and sexual assault

Recognition and support for the efforts of domestic violence shelters, rape crisis centers, and other community organizations nationwide who are working everyday to end this violence

Federal prosecution of interstate domestic violence and sexual assault crimes

Federal guarantees of interstate enforcement of protection orders

Protections for battered immigrants, and

A new focus on underserved populations of domestic violence and sexual assault.

The Violence Against Women Act (VAWA)

Many reforms are attributed to its passage.

States passed more than 660 laws to combat domestic violence, dating violence, sexual assault and stalking. All states passed laws making stalking a crime and changed laws that treated date or spousal rape as a lesser crime than stranger rape.

More victims are reporting violence. Among victims of violence by an intimate partner, the percentage of women who reported the crime was greater in 1998 (59%) than in 1993 (48%).

The National Domestic Violence Hotline was established in 1996 and has answered over 1 million calls. The Hotline answers over 16,000 calls a month and provides access to translators in 139 languages.

Defining Domestic/Intimate Partner Violence

Domestic and Intimate Partner Violence (DV and IPV) are interchangeable terms describing the same type of violence.

DV and IPV refer to any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.

Domestic/Intimate Partner Violence is a form of Interpersonal Violence.

Interpersonal Violence is violence that occurs largely between family members and intimate partners, and which usually, although not exclusively, takes place in the home.

Interpersonal Violence also includes other forms of violence such as Child Abuse and Abuse of the Elderly.

Types of Intimate Partner Violence

Acts of physical aggression – such as slapping, hitting, kicking and beating

Psychological abuse – such as intimidation, constant belittling and humiliating

Forced intercourse and other forms of sexual coercion.

Various controlling behaviors – such as isolating a person from her family and friends, monitoring her movements, and/or restricting her access to information or assistance

When abuse occurs repeatedly in the same relationship, it is often referred to as ‘‘battering’’

The WHO Multi-country Study on Women's Health and Domestic Violence against Women

1) Sponsored by the World Health Organization from 2000 and 2003

2) Collected data from over 24 000 women in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania (11 countries)

3) Challenged the perception that home is a safe haven for women by showing that women are more at risk of experiencing violence in intimate relationships than anywhere else

4) Found that it is particularly difficult to respond effectively to this violence because many women accept such violence as "normal"

5) Asserted international and country human rights laws, which state that nations have a duty to exercise due diligence to prevent, prosecute and punish violence against women

Lifetime Prevalence of Domestic Violence in Peru

The WHO Multi-country Study found:

- 51% of ever-partnered women in Lima and
- 69% of ever-partnered women in Cusco
- Experienced physical or sexual violence by a partner.

Another study of women living in metropolitan Lima found:

- 85% suffered psychological violence
- 31% suffered physical abuse
- 49% suffered sexual abuse

1) WHO Multi-country Study on Women's Health and Domestic Violence against Women. 2) Gonzales de Olarte & Gavilano Llosa, (1999) in *Individual, Family, and Community Risk Markers for Domestic Violence in Peru*, Dallan F. Flake, *Brigham Young University*.

Lifetime Prevalence of Domestic Violence in Peru

Table 2

Prevalence of domestic violence in Peru (2000): Women aged 15-49 currently married or living with a partner

Domestic violence	Prevalence (%)
Ever experienced physical violence by partner	39.8
By age groups (years)	
15-19	28.36
20-24	32.52
25-29	39.49
30-34	41.79
35-39	42.24
40-44	41.92
45-49	43.65
By educational level	
No education	42.04
Primary school	42.80
High school	41.21
Tertiary, College or more	28.93
Frequency of Husband getting drunk	
Never	24.59
Sometimes	41.08
Frequently	76.84
Punished or hurt by father as a child	67.72

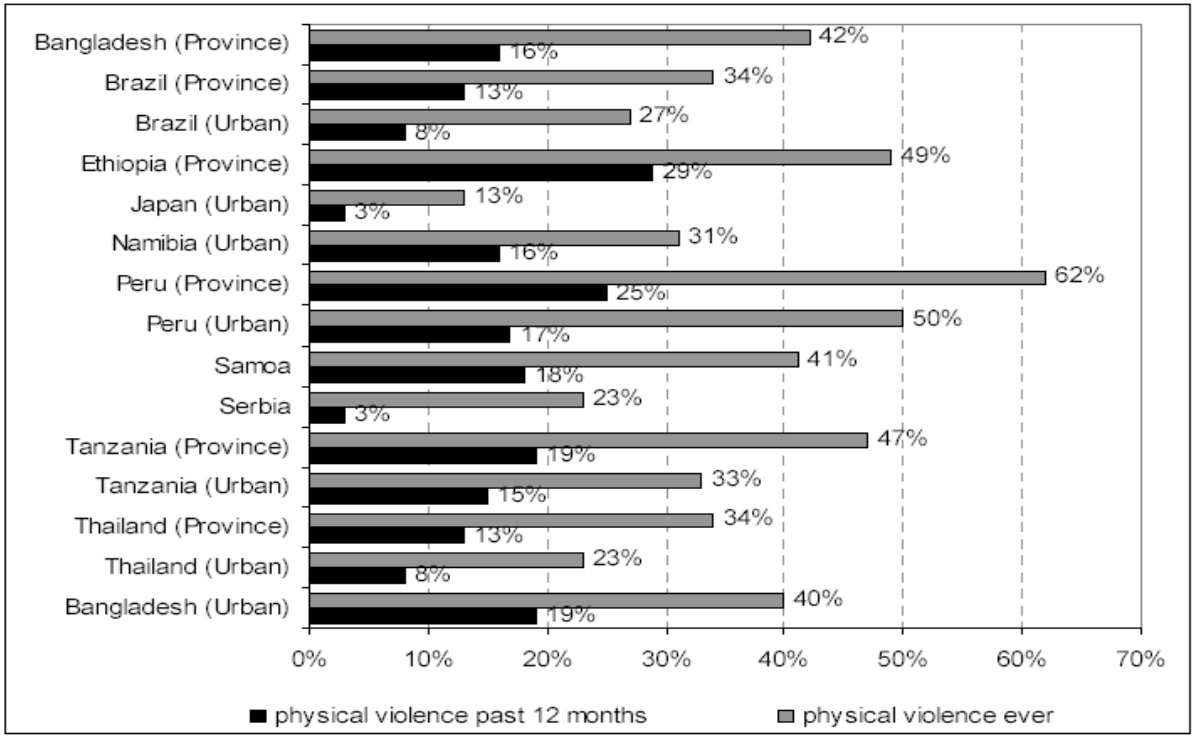
Source: DHS, Peru 2000.

The Impact of Intimate Partner Violence against Women in Peru: Estimates using Matching Techniques. Andrew Morrison, Maria Beatriz Orlando, Georgina Pizzolitto, March 2007/Lead Economist, Senior Economist and Consultant at the World Bank.

Recent Evidence Suggests that Provincial/Rural Peruvian Women have Among the Highest Lifetime Prevalence of Domestic Violence in the World

Figure 1

Percentage of women who reported physical violence by an intimate partner in past 12 months and over lifetime



Source: Unpublished data from the WHO Multi-country study on Women's Health and Domestic Violence Against Women. The final published comparative report is forthcoming. Cited with permission.

The Impact of Intimate Partner Violence against Women in Peru: Estimates using Matching Techniques. Andrew Morrison, Maria Beatriz Orlando, Georgina Pizzolitto, March 2007/Lead Economist, Senior Economist and Consultant at the World Bank.

COUNTRY COMPARISONS

TABLE 4.1

Physical assault on women by an intimate male partner, selected population-based studies, 1982–1999

Country or area	Year of study	Coverage	Sample			Proportion of women physically assaulted by a partner (%)		
			Size	Study population[a]	Age (years)	During the previous 12 months	In current relationship	Ever
Africa								
Ethiopia	1995	Meskanena Woreda	673	II	⩾15	10[b]		45
Kenya	1984–1987	Kisii District	612	VI	⩾15		42	
Nigeria	1993	Not stated	1 000	I	—			31[c]
South Africa	1998	Eastern Cape	396	III	18–49	11		27
		Mpumalanga	419	III	18–49	12		28
		Northern Province	464	III	18–49	5		19
		National	10 190	III	15–49	6		13
Zimbabwe	1996	Midlands Province	966	I	⩾18			17[d]
Latin America and the Caribbean								
Antigua	1990	National	97	I	29–45			30[d]
Barbados	1990	National	264	I	20–45			30[c,e]
Bolivia	1998	Three districts	289	I	⩾20	17[c]		
Chile	1993	Santiago province	1 000	II	22–55		26/11[f]	
	1997	Santiago	310	II	15–49	23		
Colombia	1995	National	6 097	II	15–49		19	
Mexico	1996	Guadalajara	650	III	⩾15			27
		Monterrey	1 064	III	⩾15			17
Nicaragua	1995	León	360	III	15–49	27/20[f]		52/37[f]
	1997	Managua	378	III	15–49	33/28		69
	1998	National	8 507	III	15–49	12/8[f]		28/21[f]
Paraguay	1995–1996	National, except Chaco region	5 940	III	15–49			10
Peru	1997	Metro Lima (middle-income and low-income)	359	II	17–55	31		
Puerto Rico	1995–1996	National	4 755	III	15–49			13[g]
Uruguay	1997	Two regions	545	II[h]	22–55	10[e]		
North America								
Canada	1991–1992	Toronto	420	I	18–64			27[c]
	1993	National	12 300	I	⩾18	3[d,e]		29[d,e]
United States	1995–1996	National	8 000	I	⩾18	1.3[c]		22[c]
Asia and Western Pacific								
Australia	1996	National	6 300	I	—	3[d]	8[d]	
Bangladesh	1992	National (villages)	1 225	II	<50	19		47
	1993	Two rural regions	10 368	II	15–49		42	
Cambodia	1996	Six regions	1 374	III	—			16
India	1993–1994	Tamil Nadu	859	II	15–39		37	
	1993–1994	Uttar Pradesh	983	II	15–39		45	
	1995–1996	Uttar Pradesh, five districts	6 695	IV	15–65		30	
	1998–1999	National	89 199	III	15–49	11[i]		19[i]
	1999	Six states	9 938	III	15–49	14		40/26
Papua New Guinea	1982	National, rural villages	628	III[h]	—			67
	1984	Port Moresby	298	III[h]	—			56
Philippines	1993	National	8 481	V	15–49			10
	1998	Cagayan de Oro City and Bukidnon Province	1 660	II	15–49			26[j]
Republic of Korea	1989	National	707	II	⩾20	38/12[f]		
Thailand	1994	Bangkok	619	IV	—		20	

Country Comparisons

TABLE 4.1 *(continued)*

Country or area	Year of study	Coverage	Sample			Proportion of women physically assaulted by a partner (%)		
			Size	Study population[a]	Age (years)	During the previous 12 months	In current relationship	Ever
Europe								
Netherlands	1986	National	989	I	20–60			21/11[c,f]
Norway	1989	Trondheim	111	III	20–49			18
Republic of Moldova	1997	National	4 790	III	15–44	⩾7		⩾14
Switzerland	1994–1996	National	1 500	II	20–60	6[e]		21[e]
Turkey	1998	East and south-east Anatolia	599	I	14–75			58[c]
United Kingdom	1993	North London	430	I	⩾16	12[c]		30[c]
Eastern Mediterranean								
Egypt	1995–1996	National	7 121	III	15–49	16[j]		34[g]
Israel	1997	Arab population	1 826	II	19–67	32		
West Bank and Gaza Strip	1994	Palestinian population	2 410	II	17–65	52/37[f]		

Source: reproduced from reference *6* with the permission of the publisher.

[a] Study population: I = all women; II = currently married/partnered women; III = ever-married/partnered women; IV = married men reporting on own use of violence against spouse; V = women with a pregnancy outcome; VI = married women — half with pregnancy outcome, half without.

[b] In past 3 months.

[c] Sample group included women who had never been in a relationship and therefore were not at risk of partner violence.

[d] Although sample includes all women, rate of abuse is shown for ever-married/partnered women (number not given).

[e] Physical or sexual assault.

[f] Any physical abuse/severe physical abuse only.

[g] Rate of partner abuse among ever-married/partnered women recalculated from author's data.

[h] Non-random sampling techniques used.

[i] Includes assault by others.

[j] Perpetrator could be a family member or close friend.

Lifetime Prevalence of Domestic Violence in the US

Lifetime occurrence is 9% for severe violence and 8% to 22% for total violence.

When minor as well as severe acts of physical violence toward women in the general female population are included, prevalence appears to be between 10% and 15% and somewhat higher for some subgroups.

31% of American women report experiencing physical or sexual abuse by a husband or boyfriend.

25% of American women reported being raped and/or physically assaulted by a current or former spouse, cohabiting partner or date.

1. Prevalence of Domestic Violence in the United States *Susan Wilt, DrPH, MS; Sarah Olson, PhD, MA.* JAMWA Vol.51, No.3, May - July 1996
2. "Domestic Violence is a Serious, Widespread Social Problem in America: The Facts", Family Violence Prevention Fund, www.endabuse.org

Fatal Intimate Partner Violence in the USA

A significant proportion of all female homicide victims are killed by their intimate partners.

In 2000, intimate partner homicides accounted for 33.5 percent of all murders of American women.

On average, more than three women are murdered by their husbands or boyfriends in the US every day.

”Domestic Violence is a Serious, Widespread Social Problem in America: The Facts”, Family Violence Prevention Fund, www.endabuse.org

Physical Violence by a Partner During Pregnancy in the USA

As many as 324,000 women each year experience intimate partner violence during their pregnancy.

Injury related deaths account for 33% of all maternal mortality cases, while medical reasons make us the rest.

Pregnant and recently pregnant women are more likely to be victims of homicide than die of any other cause.

Homicide is the leading cause of death overall for pregnant women during their pregnancy.

1. Prevalence of Domestic Violence in the United States *Susan Wilt, DrPH, MS; Sarah Olson, PhD, MA.* JAMWA Vol.51, No.3, May - July 1996
2. "Domestic Violence is a Serious, Widespread Social Problem in America: The Facts", Family Violence Prevention Fund, www.endabuse.org

Physical Violence by a Partner During Pregnancy in Peru

15% of ever-pregnant women in Lima and 28% in ever-pregnant women in Cusco experienced physical violence during at least one pregnancy.

Of these, 33% in Lima and over 50% in Cusco were punched or kicked in the abdomen. In virtually all cases the perpetrator was the unborn child's father.

Ever-pregnant women who had experienced partner violence were significantly more likely to have had induced abortions and miscarriages than non-abused women.

1. The WHO Multi-country Study on Women's Health and Domestic Violence against Women.

Domestic Violence and Youth in Peru

Non-partner physical and sexual violence since age 15

28% of all respondents in Lima and 32% in Cusco reported physical violence by someone other than a partner since age 15 years. The main perpetrators were fathers, and female and male relatives.

10% of women had experienced sexual violence by a non-partner since age 15 years. While boyfriends were the most frequently mentioned perpetrators (about 30% of cases in both sites), strangers were almost as frequently mentioned in Lima (28%) and in Cusco (26%).

Domestic Violence and Youth in Peru

Sexual abuse of girls < 15 years of age

In both Cusco and Lima, 20% of women reported being sexually abused as a child. The main perpetrators were male relatives (other than the father or stepfather), followed by strangers.

Forced first sex

For these women, who had their first experience of sexual intercourse before the age of 15, sexual intercourse was forced for more than 40% of them in both Cusco and Lima.

Percentages differed between sites when first sex was at a later age. Among women having first sex at 18 years or older, it was forced for 3% in Lima and 17% in Cusco.

Domestic Violence and Youth in the USA

Approximately 20% of female high school students reported being physically abused and/or sexually abused by a dating partner.

40% of girls age 14-17 reported knowing someone their age who had been hit or beaten by a boyfriend.

In a national survey of more than 6,000 American families, 50% of men who frequently assaulted their wives also frequently abused their children.

1. Prevalence of Domestic Violence in the United States *Susan Wilt, DrPH, MS; Sarah Olson, PhD, MA.* JAMWA Vol.51, No.3, May - July 1996
2. "Domestic Violence is a Serious, Widespread Social Problem in America: The Facts", Family Violence Prevention Fund, www.endabuse.org

Domestic Violence and Youth/Forced First Sex

TABLE 6.3

Percentage of adolescents reporting forced sexual initiation, selected population-based surveys, 1993–1999

Country or area	Study population	Year	Sample		Percentage reporting first sexual intercourse as forced (%)	
			Size[a]	Age group (years)	Females	Males
Cameroon	Bamenda	1995	646	12–25	37.3	29.9
Caribbean	Nine countries[b]	1997–1998	15 695	10–18	47.6[c]	31.9[c]
Ghana	Three urban towns	1996	750	12–24	21.0	5.0
Mozambique	Maputo	1999	1 659	13–18	18.8	6.7
New Zealand	Dunedin	1993–1994	935	Birth cohort[d]	7.0	0.2
Peru	Lima	1995	611	16–17	40.0	11.0
South Africa	Transkei	1994–1995	1 975	15–18	28.4	6.4
United Republic of Tanzania	Mwanza	1996	892	12–19	29.1	6.9
United States	National	1995	2 042	15–24	9.1	–

Source: references *5*, *6* and *54–60*.

[a] Total number of adolescents in the study. Rates are based on those who have had sexual intercourse.

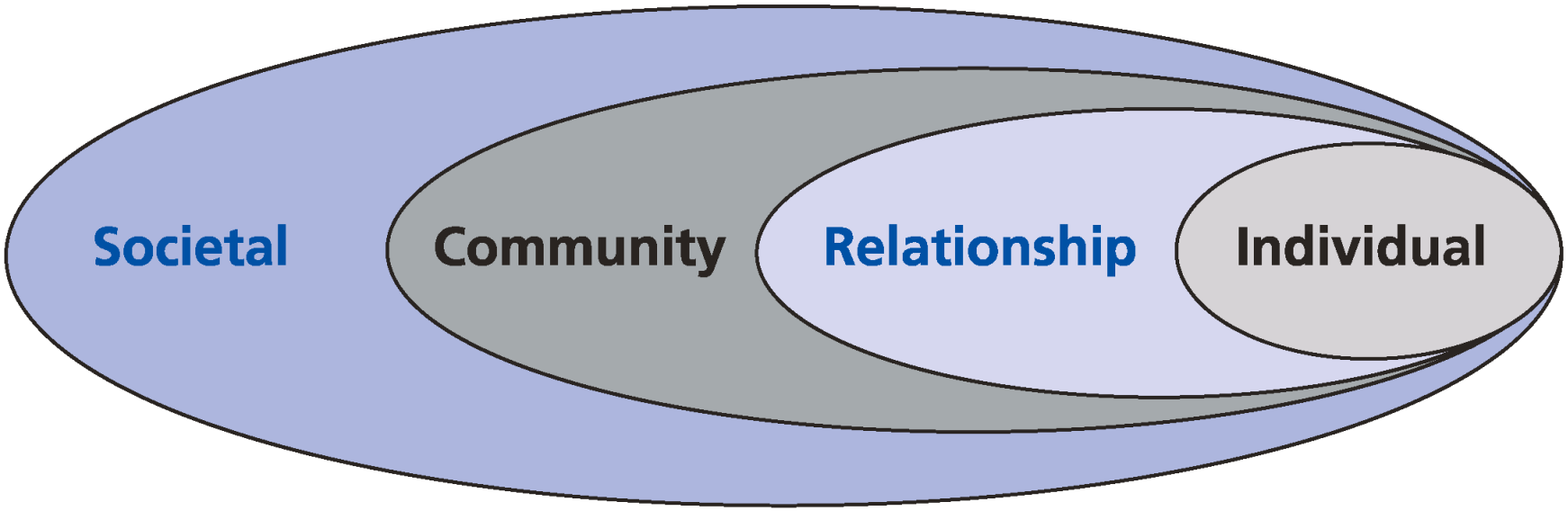
[b] Antigua, Bahamas, Barbados, British Virgin Islands, Dominica, Grenada, Guyana, Jamaica and Saint Lucia.

[c] Percentage of adolescents responding that their first intercourse was forced or "somewhat" forced.

[d] Longitudinal study of a cohort born in 1972–1973. Subjects were questioned at 18 years of age and again at 21 years of age about their current and previous sexual behaviour.

In the ecological framework, social and cultural norms, such as those that assert men's inherent superiority over women, combine with individual level factors, such as whether a man was abused himself as a child, to determine the likelihood of abuse.

Ecological model for understanding violence



The more risk factors present, the greater the likelihood that violence will occur.

RISK FACTORS: Individual Influences

Educational attainment by woman generally reduces risk. In some settings, including Peru, the protective effect of education appears to start only when women's education goes beyond secondary school (high school).

Early marriage or cohabitation increases risk.

Childhood exposure to family violence by one or more partners increases risk.

Older women are at higher risk of lifetime violence (appears to be cumulative).

Women's increased age at marriage or first intercourse reduces risk.

More than one union reduces risk.

Living in rural region versus urban area increases risk.

1. WHO Multi-country Study on Women's Health and Domestic Violence against Women.
2. *Individual, Family, and Community Risk Markers for Domestic Violence in Peru*. DALLAN F. FLAKE, *Brigham Young University*

RISK FACTORS: Family Influences

Cohabitation versus being married increases risk.

Large family size increases risk.

Low socioeconomic status increases risk.

Partner alcohol consumption increases risk 9 times.

Husband-wife status: equal status between partners in employment, education and decision-making power reduces risk.

1. WHO Multi-country Study on Women's Health and Domestic Violence against Women.
2. *Individual, Family, and Community Risk Markers for Domestic Violence in Peru*. DALLAN F. FLAKE, *Brigham Young University*

RISK FACTORS: Community & Societal Influences

Community

Living in region with a high rate of poverty increases risk.

Societal

Excessive political and social violence increases risk (Messing, 1999).

Between 1980 and 1990, Peru's homicide rate soared from 2.4 to 11.5 murders per 100,000 people (World Bank, 1997).

1. WHO Multi-country Study on Women's Health and Domestic Violence against Women.
2. *Individual, Family, and Community Risk Markers for Domestic Violence in Peru*. DALLAN F. FLAKE, *Brigham Young University*

RISK FACTORS: Other Societal Influences

Rigid gender scripts also influence the prevalence of domestic violence in Peru. Gender-based norms reinforce male dominance over females.

The term M*achismo* is used to describe Latino masculinity and refers to the cultural expectation that males must show they are masculine, strong, sexually Aggressive, and able to consume large amounts of alcohol. (Giraldo,1972)

Marianismo refers to the cultural expectation that women embrace the veneration of the Virgin Mary in that they are capable of enduring any suffering inflicted on them by males. (Stevens, 1973)

Latina women are to expected to be submissive, dependent, and sexually faithful to their husbands. They are also expected to take care of household needs and dedicate themselves entirely to their husbands and children.

In such cultures, where men are afforded more status and power than women, abuse is particularly prominent. (Firestone, Harris, & Vega, 2000)

Health Consequences of Abuse

Domestic Violence is a risk factor for many negative health outcomes.

In addition to causing immediate physical injury and mental anguish, violence increases women's risk of future ill health, most significantly premature death.

A wide range of studies shows that women who have experienced physical or sexual violence, whether in childhood or adulthood, are at greater risk of subsequent health problems.

Compared to non-abused women, women who have been victimized have:

1) Reduced physical functioning,
2) More physical symptoms,
3) Worse subjective health,
4) More life-time diagnoses of health problems and
5) Higher health care utilization.

The impact of abuse persists long after the abuse has stopped. The more severe the abuse, the greater the number of symptoms and the more severe the effect on women's physical and mental health.

Leserman et al,1996.

Fatal and Non-Fatal Outcomes of Abuse

The following table outlines the fatal and nonfatal outcomes, including physical and mental health problems, and behavioral and reproductive health consequences of three types of abuse.

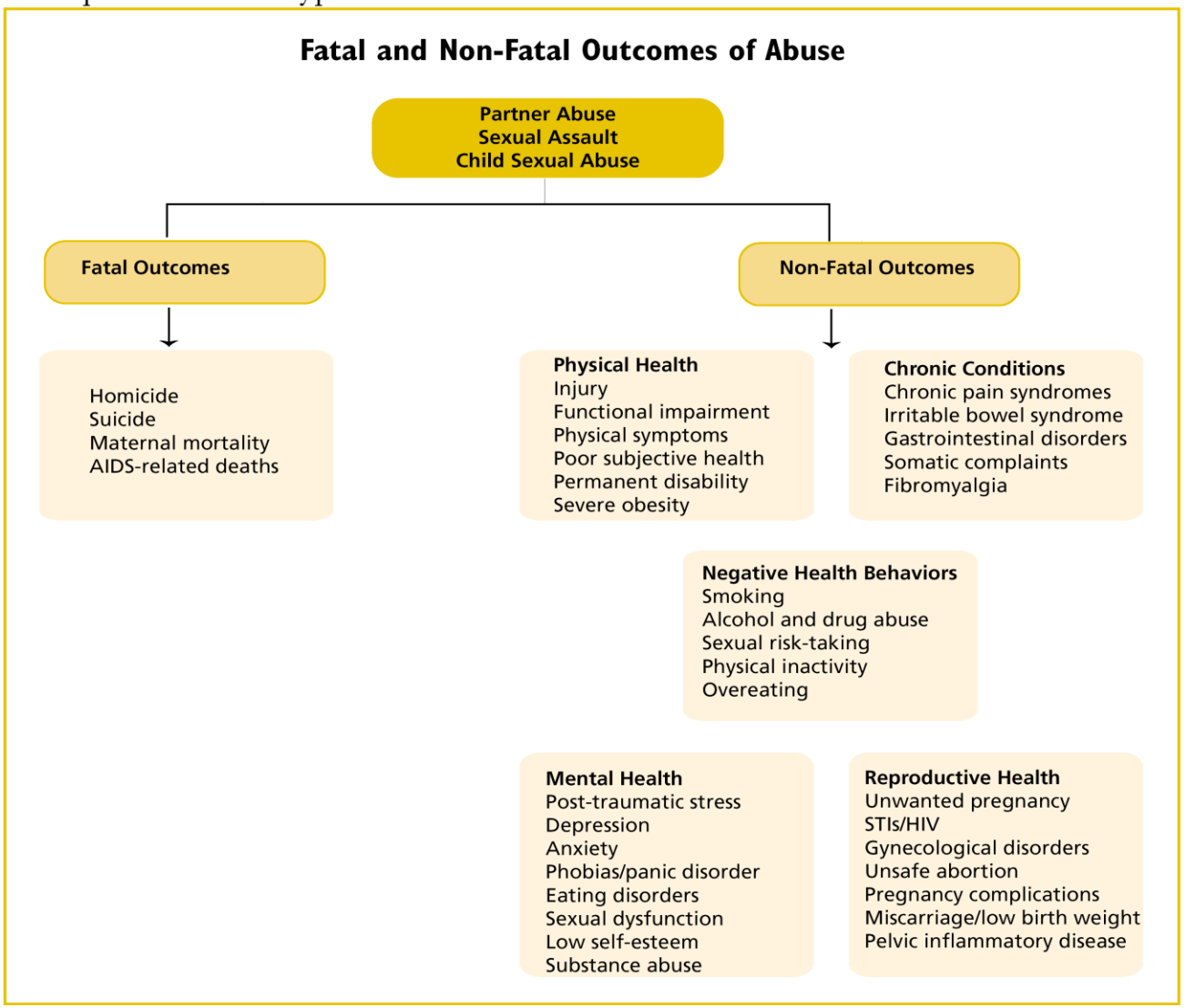


Figure 8–3

Impact of Domestic Violence on Child Health

Violence has a significant impact on child mortality and may undermine child survival as well.

In León, Nicaragua, researchers found a six-fold greater risk of under-5 mortality and an almost eight-fold greater risk of infant mortality for women who had experienced physical and sexual abuse by a partner. In terms of population-attributable risk, one-third of child deaths in this region were attributed to physical or sexual abuse of the mother by an intimate partner.

Similar findings emerged from studies conducted in India and Zimbabwe.

Nicaragua's 1999 Demographic and Health Survey found a link between partner abuse and infant and under-5 mortality. The rates of diarrhea and malnutrition were somewhat higher and the rates of immunization somewhat lower among children of women who experienced partner violence.

1. Asling-Monemi et al., 2000. 2. Rosales et al., 1999.

Impact of Domestic Violence on Children in Peru

In general, children's educational outcomes seem to be affected by physical violence against their mothers, with the exception of Peru where children of women victims are more likely to attend school and less likely to be behind in school.

There is evidence from Peru that women who suffer physical violence are 18.7% more likely to use violence to discipline their children. this leads to an intergenerational transmission of violence, since children who are victims of violence are likely to reproduce violence later in their lives.

1) WHO Multi-country Study on Women's Health and Domestic Violence against Women.

Why Women Seek Or Do Not Seek Help

Low use of formal services by women who are abused reflects in part the limited availability of services in many places.

However, even in countries relatively well supplied with resources for abused women, barriers such as fear, stigma, and the threat of losing their children stop many women from seeking help.

Only in Namibia and Peru had more than 20% of physically abused women contacted the police.

Only in Namibia and urban Tanzania had more than 20% of physically abused women sought help from health care services.

WHO Multi-country Study on Women's Health and Domestic Violence against Women.

Why Women Seek Or Do Not Seek Help

In all settings, women who had experienced severe physical violence were more likely to seek support from an agency or authority than those who had experienced moderate violence.

The most frequently given reasons FOR SEEKING HELP were related to:

1) The severity of the violence (e.g. the woman could not endure more or she was badly injured),
2) The impact of violence on the children, and
3) Encouragement from friends and/or family to seek help.

The most frequently given reasons FOR NOT SEEKING HELP were:

1) They considered the violence normal or not serious enough (from 29% of women who reported not seeking help in provincial Peru to 86% in Samoa),
2) The consequences, such as further violence, losing their children, or bringing shame to their family, and
3) They felt that they would not be believed or that it would not help.

Why Women Remain Or Return

There were wide variation between settings in the reasons women gave for returning home to a partner who had abused them.

1) She could not leave her children.
2) “For the sake of the family”
3) She loved her partner.
4) Her partner asked her to come back.
5) She forgave her partner or thought he would change.
6) Her family said she should return.
7) She did not know where to go.

1) WHO Multi-country Study on Women’s Health and Domestic Violence against Women.

Prototypical Scenario of Domestic Violence in Perú

This is the story of many Peruvian women

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- Ronaldo, a 21 yr man from the slums of the city of Arequipa, has seasonal jobs, usually works half the year in construction, and when those jobs let up, helps out in his uncle's mechanic shop.
- Ronaldo met his wife Nandy at the age of 16, and soon after got her pregnant, forcing them to get married, which was the culturally appropriate thing to do.
- Both only made it to their second year of high school, and are barely proficient in reading and writing.
- The following year, the couple welcomed their first daughter, Sabrina.

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- Money begins to become tight, and so does space seeing as the couple is sharing a small bedroom in Ronaldo´s parents' house.
- They don't have the option of staying with Nandy´s family because they live in the high sierra of Cusco.
- On top of that, Nandy´s mother was killed by her father in a domestic dispute in which her father kicked her mother's stomach while she was pregnant. For that reason, Nandy has resolved to never see her father again.
- Ronaldo begins to become irritable with the baby and with Nandy. After work, he drinks with his friends, leaving Nandy with the baby.
- Nandy complains that he is wasting all his money on booze, and he retaliates by saying that he is the one that works, and that she should either get a job or stop complaining.

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- One night, Ronaldo comes home late and wakes up Nandy, demanding sex. She objects, saying that he is drunk, and their daughter is right there on the bed, but he tells her to shut up, and do what a wife is supposed to do. He slaps her across the face and practically rapes her.

- This is when the violence only gets worse. The next couple weeks, Nandy is distant with Ronaldo. She can't stand his drinking, and is embarrassed when people around her tell her that their daughter Sabrina looks malnourished. She is too ashamed to say that there is no food, because Ronaldo spends it all on alcohol.

- Three weeks later, Nandy gets a stroke of luck and is offered a job working in her aunt's corner store. Although it isn't much, she is guaranteed to make at least S.120 a month, or the equivalent of $40 dollars. She is content, because now she can buy milk for her daughter Sabrina.

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- The next month, a neighbor approaches Nandy and says she has seen Ronaldo embracing another woman. She tells Nandy to beware, because it looked as if he is having an affair.
- Nandy is furious and confronts Ronaldo about his possible affair. Ronaldo explodes, saying that their neighbor is a gossiping bitch, and that she is stupid if she believes any of her lies.
- Nandy begins to challenge him, and their argument escalates until Ronaldo slaps Nandy square across the face.
- She begins to plead, and tells him he is an animal for hitting her in front of their daughter. He storms out of the house and doesn't return that night.
- Nandy begins to realize that things will not change. She also feels trapped because her family is far away and she doesn't feel comfortable confiding in her in-laws. In fact, they seem to condone their son's behavior.

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- More bad news comes when Nandy finds out she is pregnant for the second time. Nandy feels even more despair. She considers not even telling Ronaldo and aborting her pregnancy.

- She is scared of an abortion however, because if anyone were to find out, she would be ostracized and possibly sent to jail.

- She decides against an abortion, and tells Ronaldo the news. He reacts with fury by telling her she is irresponsible and doesn't know how to properly utilize the "rhythm method" they have been using for the past year.

- Nandy tells him that it took the both of them to conceive of this pregnancy, and Ronaldo screams and kicks her in the stomach. Nandy falls to the ground, shielding her stomach, but Ronaldo continues to deliver kicks to her womb. He again storms out of the house and doesn't return that night.

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- Nandy is devastated, and the entire night, does not stop crying. Ronaldo doesn't come home for two days, and his parents begin to ask Nandy what she has done to drive Ronaldo away.
- Meanwhile, Nandy has sharp pains, and thinks she will lose her baby. She panics, and with the little money and courage she has, she goes to her local MINSA health center.
- The obstetrician that attends to her notices the bruises all over Nandy´s stomach and questions her about domestic violence. Nandy begins to deny any allegations, but soon after breaks down crying and tells the obstetrician everything.
- The obstetrician tells her that if she doesn't leave her husband, she will have a miscarriage because of too much stress. Nandy agrees, but doesn't see how this would be possible. She convinces herself that her only option is to stay with Ronaldo and try to keep her family together.

Prototypical Scenario of Domestic Violence in Perú

- One week later, Nandy begins to have sharp pains and starts bleeding, and at once realizes that she is miscarrying.
- Ronaldo comes home several hours later to see his wife in pain, losing their second child. He actually consoles her and takes her to the doctor the next day. It turns out as well that the affair Ronaldo was having has ended, and things have seemed to calm down.
- Both decide to work things out and Ronaldo promises to stop drinking and stop running around with other women. He says he realizes the importance of his marriage and the life of their one daughter Sabrina, and decides to become an Evangelic.
- Nandy sees a change in him, but isn´t sure how long it will last. All she can do is hope.

Formal Pathway of Domestic Violence Cases in Peru

All cases are handled through the “Emergency Centers for where all services are free of charge, but there are only available in major towns and cities.

- Services provided:
  - Psychological counseling
  - Legal counseling with the support of
    - Local police stations
    - DEMUNA (District attorney)
    - Fiscalia de familia (Family attorney)
    - Juzgado de familia (Family court)
  - Social Services

Formal Pathway of Domestic Violence Cases in the US

Pathway may involve Criminal vs. Civil Charges

Criminal charges involve filing an initial police report.

Assigning legal representation: Criminal cases are assigned a district attorney free of charge. Civil cases must hire a private attorney at the DV victim's expense.

Pre-trial pitfalls may include gathering of evidence and other causes of delay.

The trial

Sentencing: The remedy with criminal charges is a jail sentence whereas the remedy with civil charges is money.

The majority of Domestic Violence cases are State Law Claims, and only a very few make it to the Federal Courts.

The statute of limitations with a DV case is normally 2 years, meaning that if the victim does not bring his or her case to court within that time period, he or she will lose it.

Informal Pathway of Domestic Violence in Peru

Based on the case study – “Nandy”

The victim tries to seek help from her family and in-laws, but does not receive the support that she needs.

The victim cannot completely depend financially on her husband, so she begins to work a menial job to buy the basic goods that her child needs.

The victim sees an obstetrician at local health center in order to inquire about the pregnancy.

The victim decides to stay with her husband after his affair ends and he promises to become an Evangelist.

Developmental/Psychological Dynamics in Domestic Violence

Girls (and children as a group), who are totally dependent and emotionally attached to their parents, and who witness repeated abuse by a male partner/father against their mother or are abused themselves by a parent or family member, often develop a belief that the abuse is their fault.

Because children perceive parents as omnipotent and interpret violence as punishment, they typically think that they must have done something wrong to deserve such abuse. Dependence on the abuser is often reinforced, as the abuser is typically a person on whom the child is totally dependent for love, approval, and their survival in this world.

The normal, healthy impulse is to defend or protect oneself against harm:
- verbally by getting angry or yelling and asking that someone stop
- physically, by either putting up a barrier with a part of the body or fighting back
- fleeing/removing oneself entirely from perpetrator.

Healthy, normal responses are often not realistic alternatives for children or adults in domestic violence situations. Victims may believe that the violence is a reasonable, justified response to a perpetrator’s anger, anger caused by something bad or wrong that the child or woman did.

Developmental/Psychological Dynamics in Domestic Violence

Shame and anger, instead of being directed towards the perpetrator, are typically internalized by the victim, who may blame herself for having done something wrong to precipitate the violence, for being a person who deserves to be punished, or alternately allowing herself or her child to continue to be abused.

Defending or protecting oneself or one's child actively or reactively may be perceived to be (or in fact be) more dangerous – if the outcome is further violence and retaliation, possible loss of existing supports and protections provided by one's family, or being sent away or abandoned entirely by one's community.

Negative beliefs that are automatic and subconscious may be adaptive, particularly when abuse is severe and chronic, when few organized supports and alternatives exist, and where cultural norms and existing institutions reinforce violence against women.

Nevertheless, "qualitative research consistently finds that women frequently consider emotionally abusive acts to be more devastating than physical violence."

(WHO Report on Health and Violence)

Integrating Many Approaches and Models as a Mental Health Professional

1) The Mental Health Recovery Model is person-centered and is based on principles of empowerment and self-help. It has many parallels with the Women's Self-Help Model and the Psycho/Social/Vocational/Spiritual Rehabilitation Model.

2) Insight-oriented cognitive behavioral psychotherapy examines the past, primarily to understand how past experiences impact peoples' thoughts and behaviors in the present. Clients may guide the therapy into examining and analyzing past trauma and experiences, but the focus remains on altering the impact, which negative thinking has on how people feel and behave in the present, and teaching people how to develop and substitute more positive ways of thinking and acting.

3) Integrated care means looking at the total person and all aspects of their lives. It also involves interacting with a client's family members, employer, teachers, social service agencies, or other individuals who may be important in the client's life. It involves multiple roles beyond physician such case manager, mentor, facilitator and advocate. It does not adhere to, or consider effective and appropriate, strict therapist/patient boundaries, as dictated by analytical psychotherapy models.

4) Goals involve giving people the skills and supports they need to achieve the personal and life goals that they define for themselves in ways that they determine are most appropriate for them.

Help-seeking Behaviors of Domestic Violence Victims in the US

Domestic violence has an enormous impact on the health care system. 75% of women who are DV victims are first identified in medical settings and account for the following:

22%-35% of injured women seen in emergency departments,

25% of women seeking emergency psychiatric services,

23% of women seeking prenatal care,

58% of women over 30 years of age who have been raped, and

45%-59% of mothers of abused children.

Catherine A. Gillespie: Domestic Violence: What Clinicians Should Know: The Internet Journal of Academic Physician Assistants. 2004; Volume 4, Number 1.

Help-seeking Behaviors of Victims of Domestic Violence in Peru

33% of women in Lima and Cusco told no one about physical violence inflicted by their partner (66% did).

Only about 33% of women who had experienced physical violence by a partner sought help from a service provider, mainly the police (25%) or health service (8% in Lima, 17% in Cusco).

Over 25% of women who did not seek help said it was because the violence was normal" or not serious, while 15% in Lima and 28% in Cusco reported not seeking help because they felt shame or thought they would not be believed.

Principles and Tools of Domestic Violence Screening in the US

- Numerous screening tools have been developed to assist health care providers increase the identification of victims of domestic violence. Of these proposed strategies for communicating about domestic violence, the most important tools begin with the patient provider relationship and communication process.

- The elements of trust, compassion, support, and confidentiality must be present within the communication process for the victim to share her most personal feelings. A women must perceive these elements, as the cycle of abuse often leaves a woman feeling disempowered and lacking credibility.

- These screening tools are recommended for use on a routine basis and an affirmative response to any of the questions should be considered a positive result. Unlike other types of patient screening tools the effectiveness of the tool also relies on the basis of the patient – provider relationship. Providers must establish an empathetic and trusting relationship with the patient for screening to be effective. The interpersonal nature of the questioning has as more to do with the disclosure and the comfort of the patient than the actual questions themselves.

Catherine A. Gillespie: Domestic Violence: What Clinicians Should Know: The Internet Journal of Academic Physician Assistants. 2004; Volume 4, Number 1

Principles for Screening For Domestic Violence - RADAR

- The Center for Disease Control and Prevention (CDC) has adopted the RADAR system, a training device to encourage providers to incorporate screening into practice. This is an acronym developed to assist in the important issues of screening for domestic violence

- R – Routinely screen every patient, make screening a part of every day practice from prenatal, postnatal, routine gynecological visits, and annual health screenings.
- A – Ask questions directly, kindly, and nonjudgmental.
- D – Document findings in the patient's chart using the patients own words, with details and use body maps and photographs as necessary.
- A – Assess the patient's safety and see if the patient has a safety plan.
- R – Review options of dealing with domestic violence with the patient and provide referrals.

Screening For DV: The Abuse Assessment Screen

- **The Abuse Assessment Screen (AAS)** is a four question screening tool designed by the CDC to encourage use and to improve the capacity to identify, prevent, and reduce intimate partner violence. This was initially created for use in pregnant women, but can be modified with omitting the question in direct reference to pregnancy. The questions are as follows:

1) **Within the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone? (If yes, by whom? Number of times? Nature of Injury?).**

2) **Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? (If yes, by whom? Number of times? Nature of Injury?)**

3) **Within the last year, has anyone made you do something sexual that you didn't want to do? (If yes, who?).**

4) **Are you afraid of your partner or anyone else?**

Screening For Domestic Violence: **HITS**: Hurt/Insult/Threaten/Scream

HITS is a screening tool that is designed for outpatient clinical settings and consists of four questions based on the acronym for Hurt, Insult, Threaten and Scream.

The questions are as follows:

How often does your partner:

1) Physically Hurt you?
2) Insult you?
3) Threaten you with harm?
4) Scream or curse at you?

Screening For Domestic Violence
Partner Violence Screen (PVS)

PVS was developed for use in emergency room situations. This is a short list of questions that allows for an opening to the evaluation of domestic violence.

The questions are as follows:

1) Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?

2) Do you feel safe in your current relationship?

3) Is there a partner from a previous relationship who is making you feel unsafe now?

Development of Protocols

1) Avoid responses that further endanger the victim - balance standardized responses with individual responses that recognize potential consequences for the victim of confronting the abuser, seek and validate the victim. Consider:
2) How is the victim input solicited and her autonomy supported?
3) How is victim safety maximized?
4) How does the practice balance standardization with individual needs?
5) Link with others - all responses must be built on cooperation that ensures consistency.
6) How does the practice build on cooperative relationships that respect the group?
7) How does the practice build communication linkages that ensure consistent responses by all?
8) Involve victims in monitoring changes - someone from outside should monitor changes in order to identify unintended consequences.
9) How will this be monitored by victims?
10) How will their feedback be obtained and communicated back to promote change?

Questions/Discussion of Nandy's Case

What are some of the risk factors involved? Individual/Family/Community/Societal

How typical is this scenario in your experience, professionally? personally?

What cultural beliefs are reflected in Nandy's behavior and choices?

What psychological/developmental issues may be relevant?

Is Nandy's fear of going to jail for having an abortion realistic? Is it against her religious beliefs? (Does she believe that it is a sin?)

What else might the obstetrician might have said or done when Nandy came to the clinic? (assume that he didn't give her further advice or refer her for other counseling).

What interventions/supports for Nandy, Sabrina, Ronaldo or Ronaldo's family along the way might have been useful had they been available and had Nandy and/or other members of her family been willing to accept them?

What might have been the outcome had Nandy pursued the formal pathway?

What do you think about Nandy's decision to stay with Ronaldo?

How positively or negatively do you feel about Nandy's future? Sabrina's future?

What can you do within your community to address DV?

Screen women for DV

Target resources in places where women are most likely to seek help

Understand factors which influence women's decisions and ability to leave violent partners

Help women consider their reasons for, as well as the potential outcomes they may face both in staying and leaving violent partners – help women with planning and problem solving

Identify and develop various resources that might provide women and girls with greater choices and supports including those that might reduce risk such as:

- Educational, financial and vocational opportunities
- Birth control and family planning services
- Delayed marriage/cohabitation
- Women's support groups and organizations
- Public education on women's rights and the consequences of DV

What can you do within your community to address DV?

Investigate which resources are most needed within the community. And then work to develop them.

Ask women directly what services and resources they feel would help them most such as:

- Improved access to medical and reproductive health care for woman and their children,
- Mental health counseling and treatment
- Safe houses and shelters
- Strategies to limit partner access to alcohol
- Anti-violence education through schools, churches, worksites, and the media.

Investigate ways to transform/utilize available resources and government mandates into meaningful resources and programs that effectively address the problem, including training and promoting women as front-line staff and leaders.

Advocate as a unified voice for changes to institutions and agencies that may be neglecting their responsibility and duty to protect women from violence.

Final Thoughts

Remember that many of the laws, programs and infrastructures that now exist to address domestic violence in the US grew out of work started over 30 years ago by a small number of women in the Women's Movement.

Remember that there is no one correct path for every woman - that goals of safety, survival AND quality of life, **as defined by each woman herself**, should guide any intervention or assistance provided.

Remember that it may take many times before a women leaves and that neither the woman leaving nor the perpetrator receiving punishment or treatment will ensure the women's safety.

Remember and always reinforce:

– that it is never the victim's fault

– that there is nothing a woman or child could ever do to justify being abused by a partner, and

– that every woman has a fundamental right to a life free from violence.

Program Evaluation

Would you be interesting in attending another workshop or program on this topic?

Were there any activities/projects mentioned that you might like to do as follow-up on, such as reading or implementing some of the recommendations from one of the studies or reports, doing some educational work in the community, or starting a women's support group?

Were there any new things that your learned that you didn't know? Were any of these things particularly useful or helpful?

Are there any issues or topics that you would have liked to have heard more about?

Did the presentation help you better identify the needs of women affected by domestic violence?

Did it give you any information that might help you to better address problems of domestic violence in the future?

Did this workshop change any of your attitudes or beliefs about domestic violence?