

Résumé

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## **La violence perpétrée par un partenaire intime : une perspective de la santé mondiale**

**Sepali Guruge**

La violence perpétrée par un partenaire intime est une grave violation des droits de la personne et un problème de santé important à l'échelle mondiale. Les infirmières et les infirmiers, qui constituent la catégorie de professionnels de la santé comptant le plus d'effectifs dans le monde, sont bien placés pour s'attaquer à cette problématique. S'appuyant sur une documentation provenant de divers pays, cet article présente un résumé des documents traitant des conséquences sur la santé, des coûts, de la prévalence, des facteurs de risque, des perceptions et des manifestations de la violence perpétrée par un partenaire intime, et de la réactions des femmes à cette problématique. Puis, utilisant comme assise le programme de recherche de l'auteur sur la violence perpétrée par un partenaire intime, l'article met en lumière plusieurs implications à l'endroit de la profession infirmière : l'intersectionnalité; les échelles micro, meso et macro; la violence sociale; la violence que subit une femme au cours de sa vie; le contexte et le processus de migration. Pour terminer, l'article présente des recommandations à l'intention du personnel infirmier en matière de recherche et de pratique et propose des collaborations et un renforcement des capacités Nord-Sud dans le but de faire face à la nature complexe de ce fléau mondial.

Mots clés : santé à l'échelle mondiale, intersectionnalité, violence perpétrée par un partenaire intime, violence sociale, violence que subit une femme au cours de sa vie, processus de migration

# **Intimate Partner Violence: A Global Health Perspective**

**Sepali Guruge**

Intimate partner violence is a serious violation of human rights and a significant global health problem. As the largest health workforce worldwide, nurses are well positioned to address this health issue. Based on literature from various countries, this article presents a summary of the literature on health consequences, costs, prevalence, risk factors, perceptions, and manifestations of intimate partner violence, and women's responses to it. Next, building on the author's program of research on intimate partner violence, the article highlights a number of implications for nursing: intersectionality; micro, meso, and macro levels; social violence; violence throughout a woman's lifespan; and the migration context and process. Finally, the article presents research and practice recommendations for nurses and proposes North–South collaborations and capacity-building to address the complex nature of this global health problem.

**Keywords:** ecosystemic frameworks, global health, intersectionality, intimate partner violence, social violence, violence against women, violence throughout a woman's lifespan, violence throughout the migration process

## **Introduction**

Intimate partner violence (IPV) is defined as a pattern of physical, sexual, and/or emotional abuse by a current or former spouse or a non-marital partner in the context of coercive control (Tjaden & Thoennes, 2000). The overwhelming majority of victims of IPV worldwide are women. At a global level, IPV occurs in epidemic proportions (Heise et al., 1994). IPV has been consistently linked to a wide range of physical and mental health problems that may persist long after the abuse has ended (Campbell, 2002). Thus, women who have experienced IPV tend to use health services more frequently than women who have no history of IPV (Campbell, 2002). These health-care visits present an opportunity for nurses to provide care and support to women who have experienced IPV. However, due to the unprecedented population mobility from rural to urban settings and across international borders, nurses can no longer focus solely on their own locality. In the context of global health, they must take into account the diversity of women as well as the complex ways in which the social, economic, gender, geographic, ethnic, cultural, and political contexts of women's lives shape their experiences of, per-

ceptions about, and responses to IPV. Certain factors, experiences, and concerns transcend borders but others are unique to specific contexts. Drawing from my own program of research on IPV throughout the migration process (i.e., pre-migration, border crossing, and post-migration) and the literature, in this article I present a summary of the current knowledge about IPV and a number of implications and recommendations for nursing research and practice in this area.

## **What Do We Know? A Summary of the Literature**

### ***Health Consequences of IPV***

Women living with IPV are often injured in the face, head, back, neck, thorax, breast, or abdomen (Muellman, Lenaghan, & Pakieser, 1996). Chronic physical health conditions linked with IPV include neck and back pain, arthritis, headaches and migraines, hypertension, peptic ulcers, and irritable bowel disease (Breiding, Black, & Ryan, 2008; Campbell & Lewandowski, 1997; Coker, Smith, Bethea, King, & McKeown, 2000; Lesserman & Dorssman, 2007; Letourneau, Holmes, & Chasedunn-Roark, 1999). Common mental health problems linked with IPV include depression, anxiety, post-traumatic stress disorder, substance use and dependence, and thoughts of suicide (Devries et al., 2011; Eby, Campbell, Sullivan, & Davidson, 1995; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Fischbach, & Herbert, 1997; Heise & Garcia-Moreno, 2002; Humphreys, Lee, Neylan, & Marmar, 1999; Ishida, Stupp, Melian, Serbanescu, & Goodwin, 2010; Plitcha, 2004; Roberts, Auinger, & Klein, 2005; Roberts, Klein, & Fisher, 2003; Varma, Chandra, & Thomas, 2007; Vizcarra et al., 2004). Reproductive health problems can include sexually transmitted disease, unwanted pregnancy, and chronic pelvic pain (Coker, 2007; Emenike, Lawolo, & Dalal, 2008; Letourneau et al., 1999; Silverman, Decker, Kapur, Gupta, & Raj, 2007; Stephenson, Koenig, & Ahmed, 2006). IPV during pregnancy is also associated with increased risk of miscarriage, premature delivery, malnutrition, and low birth weight (Ackerson & Subramanian, 2008; Campbell, Garcia-Moreno, & Sharps, 2004; El Kady, Gilbert, Xing, & Smith, 2005; Janssen et al., 2003). The type, length, and severity of IPV experienced over a woman's lifespan increase her risk for various and severe health problems (Scott-Storey, 2011).

### ***Costs of IPV***

IPV has a greater cumulative impact on morbidity and mortality than some more common public health problems (Garcia-Moreno & Watts, 2011). For example, in Mexico City IPV and rape have been estimated as the third most frequent cause of morbidity and mortality, accounting

for approximately 6% of all disability-adjusted life years lost (Ascensio, 1999). In Victoria, Australia, IPV accounts for approximately 8% of the overall disease burden among women of reproductive age — more than high blood pressure, smoking, or obesity (Vos et al., 2006). IPV also creates a financial burden for the family. Not all IPV-related services are freely available worldwide. For example, women in Ethiopia are expected to pay for a medical card in order to report IPV to the police (Guruge, Bender, et al., 2012). In some countries, out-of-pocket expenditure on IPV-related services can be as high as 75% of a household's average weekly income (International Center for Research on Women, 2009). In the United States, women who are unemployed, have no health insurance, and/or are undocumented often cannot access IPV-related services (Sokoloff, 2005).

IPV also generates huge costs for health-care systems. For example, in Uganda the cost of “domestic” violence in 2007 was estimated at US\$2.5 million (Economic Policy Research Center, 2009). Health Canada (2002) estimated that the direct medical cost of violence against women (including IPV) in 2002 in Canada was CDN\$1.1 billion. A study conducted in the United States estimated the related annual costs for medical and mental health services at US\$4.1 billion (National Center for Injury Prevention and Control, 2003). The extent of IPV-related social costs (such as poverty and homelessness) and economic costs (such as those related to social services, criminal justice, and loss of employment) has not been documented in most countries.

### ***Prevalence of IPV***

Studies from Australia, Canada, Israel, South Africa, and the United States report that 30–70% of all women murdered are killed by their husbands or boyfriends (Aldridge & Browne, 2003; Fox & Zawitz, 2006; World Health Organization [WHO], 2002b). At a global level, non-fatal (i.e., non-femicide) IPV rates are comparable to those for cancer, HIV/AIDS, and cardiovascular diseases (Heise et al., 1994). Based on 48 population-based surveys from developing and developed countries, the World Health Organization (WHO) (2002a) found that 10–70% of women reported being physically assaulted by a male partner at some point in their lives. However, country-to-country comparisons cannot be carried out based on these data due to differences in types of violence (e.g., physical/psychological), participant inclusion/exclusion criteria (all women, ever-partnered, etc.), sampling (convenience/random), sample sizes, geographical locations (rural/urban), time frames (e.g., lifetime, previous 12 months), and the wording of questions (Guruge, Tiwari, & Lucea, 2010). A WHO (2006) multi-country study that attempted to address some of these inconsistencies found that 15–71% of ever-partnered women had

experienced physical or sexual IPV, 1–28% of ever-pregnant women reported being abused during a pregnancy, and 20–60% of women had never before told anyone about experiencing IPV.

### ***Risk Factors for IPV***

IPV is shaped by a set of interacting factors at the individual, micro (family), meso (community) and macro (societal) levels. *Individual-level* factors include age differences between partners, marital status, and the abuser's mental health status and use/abuse of alcohol (Heise, 1998). A history of childhood abuse and witnessing parental IPV have emerged as risk factors in studies conducted in Brazil, Cambodia, Canada, Chile, Colombia, Costa Rica, El Salvador, Indonesia, Nicaragua, Spain, the United States, and Venezuela (WHO, 2002a, 2002b). At the *family level*, changing family dynamics and gender roles (e.g., women working outside the home or postponing marriage and children, or men being away from home for long periods due to work) are known to strain family relations and contribute to IPV (Garcia-Moreno, 2000; Jewkes, Penn-Kekana, Levin, Ratsaka, & Schrieber, 2001; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Raj & Silverman, 2002), particularly if these changes challenge "traditional" gender norms (Guruge, Tiwari, et al., 2010). At the *community level*, reduced access to social safety nets, increased geographical isolation, or higher rates of other types of violence, for example, may increase a woman's risk for IPV (Abraham, 2002; Guruge, 2007; Heise, 1998; Maclean & Sicchia, 2004). Literature from a range of countries indicates that poverty acts as a "marker" for a variety of individual and social conditions (e.g., overcrowding, hopelessness, frustration, sense of inadequacy, and stress); together, these can increase a woman's risk for IPV (Guruge, Tiwari, et al., 2010). *Societal-level* factors may include armed conflict or political instability; rigid gender roles; a sense of male entitlement, authority, and ownership over women; religious approval of chastisement of women; and a cultural ethos that condones violence as a means of settling interpersonal disputes (Brownridge & Halli, 2002; Heise, 1998).

### ***Perceptions and Manifestations of IPV***

IPV is socially constructed and is therefore shaped by cultural, religious, socio-economic, educational, and political factors (Guruge, Tiwari, et al., 2010). Thus, differently situated women may disagree about (1) what constitutes IPV, (2) what leads to IPV, (3) acceptable/unacceptable levels of violence, (4) women's roles in perpetrating IPV, and (5) how to deal with individuals who commit IPV (Vickers, 2002). For example, a WHO multi-country study (WHO, 2006) revealed that an overwhelming per-

centage of women from some study sites agreed that it was “acceptable” for a husband to beat his wife under certain circumstances. The type of IPV is also shaped by context: In the post-migration context, IPV may involve not allowing women to access language training, taking away their immigration documents, and threatening deportation (Agnew, 1998; Guruge, 2010; Raj & Silverman, 2002). For women living in rural settings, IPV may take the form of partner-enforced isolation, such as being denied transportation or a telephone (Bosch, & Schumm, 2004; Hornosty & Doherty, 2002). “Mail-order brides” may be subjected to forms of IPV that incorporate racial, ethno-cultural, and religious domination (Glodava & Onizuko, 1994; Langevin & Belleau, 2000).

### ***Women’s Responses to IPV***

Women’s responses to IPV are individually and socially shaped and depend on available supports and services within a couple’s community and society, as well as the pressure and control they assert on the couple (Guruge & Humphreys, 2009). Family members, neighbours, and co-workers often have a strong influence on the couple (Guruge & Humphreys, 2009). In collectivist communities where family ties, harmony, and order are given priority, women are taught to subordinate their own interests to those of their family (Abraham, 2002), so a woman may feel pressured to keep her family together. In contrast, in some low-to-middle-income countries in South Asia and Africa the abuser may be physically punished or shunned by other women and/or men in the family or the community (Guruge, 2007; Guruge, Ford-Gilboe, et al., 2012; Vickers, 2002). Worldwide, many women are reluctant to seek help for IPV due to shame or fear of being stigmatized and/or having their children taken away or being pressured to leave their husbands (WHO, 2006). Societal response (i.e., supports, resources, and services) can also influence women’s responses. For example, only one shelter is currently available to abused women in all of Sri Lanka, a country with approximately 9 million girls and women and an estimated IPV rate of 60–80% (Guruge, Ford-Gilboe, et al., 2012). In some areas in Hilo, Hawaii, the distance from the police station and the extended time needed for police to reach women following 911 calls deter women from calling the police (Guruge & Morrison, 2012). In Canada, immigrant women’s interest and/or willingness to seek help is often negatively shaped by Canadian immigration policies, which prioritize men as primary applicants and pose threats of deportation for abusive husbands and/or other family members (Guruge, 2007; Guruge, Kanthasamy, et al., 2010; Guruge, Khanou, & Gastaldo, 2010).

## **Implications for Nursing**

Based on my program of research, this section identifies a number of interrelated implications for nurse educators, researchers and policy-makers, and nurses in various practice settings.

### ***Attention to Intersectionality***

To clarify the nature of IPV in the global context, research, practice, and policy must focus on diversity within and between groups, shared experiences within and across groups, and the intersections of multiple sites of privilege and oppression. “As Yuval-Davis (1997) argues, ‘not all women are oppressed and/or subjugated in the same way or to the same extent,’ and violence against women and its impact are not borne equally by all groups of women” (Hankivsky & Varcoe, 2007, p. 485). The intersectionality perspective helps to capture the complexity of multiple dimensions of social identity (such as gender, race, class, and immigration status), how these intersect to influence health and well-being, how they come together in distinct ways to affect health outcomes for individuals and groups (Guruge & Khanlou, 2004), and why certain individuals and groups are disproportionately more vulnerable to IPV. It also helps to clarify “the broader issues such as racism, sexism, ageism, and classism as well as various institutional and structural elements that continue to create inequalities” between/among different groups of women and men (Guruge & Khanlou, 2004, p. 42). In other words, the intersectionality perspective enables the consideration of shared meanings within groups and shifting identities and realities, while incorporating diversity within and between groups, without contributing to existing power inequities. From this perspective, the production of, experiences of, and responses to IPV are seen as being influenced profoundly by the intersections of multiple sites of oppression and privilege that women experience within the family, the community and society, and the world.

### ***Attention to Micro, Meso, and Macro Levels***

As noted earlier, risk factors for and women’s responses to IPV can be explored on micro, meso, and macro levels; strategies to address and prevent IPV can also be organized along these levels. Thus, an ecosystemic framework can help clarify how individuals are situated within and influenced by family, community, and society. Ecosystemic frameworks can promote critical inquiry into the determinants of IPV by locating them within complex socio-economic, historical, political, and institutional structures and dynamics that often impede changes at system levels (Guruge & Khanlou, 2004). Use of an ecosystemic framework can help nurses reconsider their frames of reference for practice and ensure that

nurses move beyond the individual (and individual blame) to examine how factors at the micro, meso, and macro level affect women's responses to IPV. For example, a woman's response to IPV is shaped by micro-level factors, including financial stresses, isolation of the couple, and loss of family support; meso-level factors, including available education, employment, and settlement opportunities; and macro-level factors, including the policies and practices of various institutions such as departments of education, health, labour, justice, and immigration (Guruge & Gastaldo, 2008).

### ***Attention to Social Violence***

To understand the nature of IPV in the global context, nurses must consider how urbanization, globalization, cultural imperialism, ethnocentrism, and marginalization create various forms of overt and/or subtle forms of social violence: the growing gap between the rich and poor within the same country, among ethno-racial groups, and between countries; cheap (often female) labour resulting from global factories, economic instability, and financial crises; and increased use of alcohol and illicit drugs and increased trading of legal and illegal arms, fuelling new or existing conflicts (Barrientos & Barrientos, 2002; Guruge & Gastaldo, 2008; International Labour Organization, 2002; Standing, 1999). These processes and situations (re)create inequities that determine who has access to information, resources, and support and that disproportionately and adversely affect the health of children, women, and the poor (Chatterjee & Jeganathan, 2000; Giles, de Alwis, Klein, & Silva, 2003; Giles & Hyndman, 2004). Furthermore, local cultures are being flooded by Western (mainly American) culture (Maclean & Sicchia, 2004), eroding long-established local cultural and religious values and practices and contributing to family fragmentation and loss of social networks and support (Guruge & Gastaldo, 2008). These processes, which began under colonialism, have continued as neocolonial relations with new players, new rules, and a new pace of change generate more subtle ways of maintaining economic, political, and cultural imperialism and domination (Guruge & Gastaldo, 2008). Over the years, globalization has enforced gender inequalities in a number of ways: Women are often employed in poorly regulated informal sectors with little or no disability, pension, or maternity benefits; earn lower wages than men for the same job; face doubled and tripled work burdens with unpaid work and caregiving in the home and community; and are exposed to hazardous working conditions, including workplace harassment (Bennett & Tomossy, 2006; Bonder et al., 2004; Kawadi & Wamala, 2006; Lee, 2003; Maclean & Sicchia, 2004; Maki, 1993; Mehra & Gammage, 1999; Standing, 1999). These processes and conditions increase women's vulnerability to vio-



lence and limit their ability to respond to IPV in a manner that is appropriate for them. They have a disproportionately greater influence among women in the South.<sup>1</sup>

### ***Attention to Experiences of Violence Throughout a Woman's Lifespan***

IPV must be understood within the context of other forms of violence against women throughout their lifespan. For example, more than 8,000 dowry-related deaths were reported in India in 2007 (United Nations, 2012); more than 15,000 women annually are sold into sexual slavery in China (Hankivsky & Varcoe, 2007); 50% of all women in Canada have experienced at least one episode of physical or sexual violence (Statistics Canada, 1993); in the United States, 83% of girls between 12 and 16 years of age experience some form of sexual harassment in public schools (United Nations, 2012); globally, an estimated 150 million girls under the age of 18 experienced some form of sexual violence in 2002 alone (United Nations, 2012); and each year, approximately 2 million girls between the ages of 5 and 15 are trafficked, sold, or coerced into prostitution (Lederer, 1996). In some countries (e.g., Ethiopia), IPV is shaped by early/underage marriage, female genital cutting, rape, sexual assault, abduction, and trafficking (Guruge, Bender, et al., 2012). In one of my recent (pilot) studies in Canada (Guruge, Roche, & Catallo, 2012), immigrant women from Iran and Sri Lanka reported experiencing multiple forms of violence: childhood abuse, witnessing violence as a child, sexual or physical assault before the age of 15, sexual or physical assault after the age of 15 by someone other than an intimate partner, and IPV. With the recent focus on the world's increasing aging population, the extent of the abuse and neglect of older women by family members is also being exposed. Thus, IPV cannot be addressed in isolation.

### ***Global to Local: Attention to the Migration Context and Process***

Women make up approximately half of all international migrants (DeLaet, 1999) and approximately half of all asylum-seekers, refugees, and immigrants to Canada (Citizenship and Immigration Canada, 2010). Emerging evidence suggests that the complex processes of migration and (re)settlement, which may include shifts in power dynamics, may leave women vulnerable to IPV (Guruge, Refaie-Shirpak, et al., 2010). In the

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<sup>1</sup> The South or the global South refers to "developing" or low-to-middle-income countries. The North-South as such is based on a socio-economic and political division rather than necessarily a geographical one. The global South includes 85% of the world's population and only 3% of its wealth. However, this situation is changing; as nations become wealthy or "developed" they may become part of the North even if they are located in the Southern Hemisphere ([http://en.wikipedia.org/wiki/North-South\\_divide](http://en.wikipedia.org/wiki/North-South_divide); <http://www.slideshare.net/pvanleeuwen/kegley-chapter-5>).

post-migration and (re)settlement context, social and economic barriers such as social isolation, poor access to employment and fair wages for women (and their husbands), linguistic barriers, difficulty accessing safe housing, social and geographical adjustments, welfare surveillance, and systemic racism embedded within health and social services contribute to stress, marital conflict, and IPV (Guruge & Gastaldo, 2008). As nurses provide care for women dealing with IPV, they must go beyond each woman's present experience in the post-migration context and consider her experiences during the pre-migration and border-crossing contexts. For example, my previous work (Guruge, 2007; Guruge, Roche, et al., 2012) revealed that women experience various forms of threat, abuse, and violence at the hands of authorities such as police and asylum/immigration officials. Pre-migration conflict and forced migration can have various physical, mental, economic, and social consequences. Some of these are associated with poverty and deprivation; others are associated with more extreme difficulties such as war-related injuries, torture, and sexual violence (Gushulak & MacPherson, 2011; Kirmayer et al., 2011). Pre-migration experiences during civil unrest and war often result in increased violence against women (United Nations, 2012). Women who are displaced, who travel alone, who use "illegal" means of migration, or who are trafficked are often subjected to detention, rape, and various other forms of trauma during border crossing (Guruge & Gastaldo, 2008). Thus, nurses must focus on how pre-migration, border-crossing, and post-migration processes and contexts act together to shape women's vulnerabilities and resiliencies with regard to IPV.

### **Where to From Here?**

Drawing from my own research and current global knowledge about IPV, I have developed some recommendations for nursing research and practice; these are intended to serve as a starting point.

#### ***Research***

Despite the substantial contributions made by health science research to the field of IPV, many gaps remain. Most research has focused either on IPV as an isolated entity or on the combination of childhood abuse and IPV. Researchers need to consider women's exposure to many other forms of violence throughout their lifespans, including social violence, the compounding effects of violence on women's physical and mental health, and the kinds of care, support, and services that women may require. Research is urgently needed to further understand women's exposure to and experiences of pre-migration, border-crossing, and post-migration violence. Such research could provide important insights to

guide the provision of care, support, and services to immigrant and refugee women living in the global North.

Most health research in the area of IPV focuses on screening for and assessment of IPV, management of its health consequences, and identification of risk factors. Researchers have begun to focus on health interventions to improve care for women living with IPV and/or its aftermath; however, these interventions are often reactive and tend to focus on the individual. Attention to prevention interventions, especially ones that are theory- and community-based, collaborative, and multidisciplinary, is urgently needed. Given the multi-level nature of IPV risk factors, prevention interventions should incorporate multi-level strategies. Such work can be guided by ecosystemic approaches. Additionally, incorporating intersectionality approaches might yield more effective prevention strategies for differently situated groups of women in the North and the South. Mixed-method studies (involving both qualitative and quantitative methods) may be required to clarify the range and depth of issues that have already been identified. Interventions to prevent violence have yielded promising results in Brazil, South Africa, Nicaragua, Uganda, and Tanzania (Foshee et al., 2004; Guedes, 2004). Such knowledge could benefit countries in the global North. Studies incorporating multiple sites within and across countries are also more likely to provide additional insights about commonalities/similarities and diversities/differences within and between groups and across settings and countries and the context-specific nature of prevention strategies. Findings from this kind of research will likely become a priority for health-care administrators and policy-makers.

Forging North–South and South–South links will be crucial to ensure effective research collaboration and capacity-building across international boundaries. By sharing and pooling experiences, expertise, data, methods, and resources, researchers can gain new perspectives about existing practices, programs, and initiatives and generate multidisciplinary interventions that can be applied across multiple populations simultaneously. Such links will require a greater investment by major research funding bodies such as the Canadian Institutes of Health Research to promote health science research on IPV in low-income countries, enhance local capacity, build strong research institutions, and support more equitable collaborations between researchers in the North and the South.

### ***Practice***

Addressing IPV in the context of other forms of violence throughout a woman's lifespan can provide important insights about more effective

care and support for women affected by IPV. Nurses need to move beyond focusing on the individual “victim” and “perpetrator” and the micro–macro dichotomy and seek to understand the continuous and reciprocal interaction between micro, meso, and macro levels of society and what takes place at home (Guruge, 2007). Additionally, nurses must move beyond the current focus on screening and identifying IPV victims and on encouraging every woman to leave her abuser, as some women may not consider this to be an option, or may prefer not to leave, depending on their individual/family/community/country situation. Thus, innovative approaches and solutions are needed to provide care for women living with IPV.

Nurses play a vital role in various settings worldwide; they provide immediate care, safety, and support for women and their children affected by IPV through identification, documentation, risk assessment, safety planning, reporting, and care and referral. Without diminishing this contribution, I propose that nurses can further their role as advocates within and beyond the health-care system, providing structural solutions. They may advocate for affordable and increased public housing, shelters, and long-term transitional housing for women and children, linguistically and culturally appropriate services, coordinated services offered under one roof, reducing piecemeal approaches to services, addressing service eligibility criteria (such as proof of citizenship), and finding ways for women to update their employment skills and obtain quality and affordable child care and employment (Guruge & Gastaldo, 2008; Guruge & Humphreys, 2009).

Nurses’ roles in health promotion and primary prevention of violence must include early education about healthy relationships, promoting public awareness about the effects of violence against women and children, life-skills development, safety and support programs for women, engaging men in violence-prevention programs, and developing capacity-building and community-based programs to enable women’s decision-making (Guruge, 2012; Guruge & Gastaldo, 2008). These programs may include job counselling, literacy and language training, and resources to address child-care, transportation, and financial needs (Guruge, 2012; Guruge & Gastaldo, 2008). These strategies will require the incorporation of components from within and beyond the health sector, as well as collaboration between and among women and men, their families, their communities, and service providers and policy-makers within and across borders. Working across sectors and borders, nurses can also facilitate/coordinate global campaigns and petitions to gain political commitment to address this important global health issue.

## Conclusions

Efforts to eradicate IPV must address the inequalities that shape the lives of women in their home countries and beyond. This will require understanding differences among women and between groups of women, questioning generalized notions of gender relations, and critically examining the processes that sustain a multitude of inequalities. Women will be freed from oppression in general, and IPV in particular, only when the North and the South work together to address the economic, political, and social circumstances of women in the South and their various counterparts in the North, because IPV is connected to and shaped by social violence, which fuels and sustains violence against women. By taking this kind of approach, nurses can play a leading role in improving the health of women worldwide.

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