

Domestic violence during pregnancy in Turkish and Moroccan communities

Migrant outreach workers give information

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This article describes a project implemented in midwifery practices in Amsterdam, in 2004. Turkish and Moroccan outreach workers were trained to offer information and education about domestic violence and to identify signs of domestic violence experienced by pregnant Turkish and Moroccan women. Domestic violence often starts in pregnancy. These pregnant women disclosed their experiences with domestic violence to the migrant outreach workers. The norms and values about domestic violence are influenced by different cultural perceptions about violent behaviour. Medical anthropologists are challenged to contribute to the development of new concepts in this field.

[domestic violence, pregnancy, ethnic minorities, Turkish and Moroccan outreach workers]

In the concluding remarks to her introductory article on the subjects of violence, health and human rights, Richters remarks: "What remained underexposed are 'the small wars and invisible genocides' ... daily enacted by ordinary citizens in the homes, workplaces and on the streets' (Richters 2004: 174). This article will focus on the "small wars enacted by ordinary citizens in their homes." We define this phenomenon as domestic violence. First, we will examine domestic violence in migrant groups. We will then focus in on domestic violence during pregnancy, an unexpected occurrence that can be observed all around the world.

This article describes a project in four midwifery practices in Amsterdam. Funded by the Department for the Co-ordination of Emancipation policy of the Ministry of Social Affairs and Labour, this project was carried out in 2004 by TNO Quality of Life. Turkish and Moroccan outreach workers were trained to give information and education about domestic violence as well as to identify signs of domestic violence experiences among pregnant Turkish and Moroccan women.

This article will also examine the medical anthropological perspective on domestic violence in pregnancy and the role healthcare providers can play. In her article, Richters invites social scientists to contribute to theory development in the field of

medical anthropology and violence. The issue of domestic violence during pregnancy is not only uncharted terrain in medical anthropology, but is also neglected in Dutch and Belgian medical practice (Buitendijk et al. 1998, Offerhaus & Buitendijk 2003). A thorough search of the medical literature on domestic violence in pregnancy resulted in a large amount of information. The lack of attention in medical anthropology towards the role of men on women's reproductive health was recently addressed by Dudgeon and Inhorn: "... the influence of men's intentions and practices on conception, pregnancy, and childbirth outcome have been little studied and are poorly understood within medical anthropology ..." (2004: 1386). We will examine the hypothesis that the negative effects of partner violence on childbirth are greatly influenced by the social and cultural norms and values of the society in which the couple was raised. Dutch society does not accept violence, and views it as a crime. Nevertheless, it occurs on the same scale it does in the Turkish and Moroccan communities. In those societies, however, many women accept violence as an inevitable fact of life.

This article will conclude with remarks aimed at contributing towards the discussion on medical anthropological concepts of domestic violence in pregnancy, specifically among ethnic minority groups.

Domestic violence among non-western migrant groups or ethnic minorities

There are many definitions of domestic violence that acknowledge that violence may be physical, sexual, psychological, emotional, verbal or financial (Bewley & Gibbs 2002). The definition commonly used, as it is in this article, is that domestic violence involves physical, sexual and psychological violence. Definitions of domestic violence are vague and cover many phenomena that are difficult to distinguish. Psychological violence comprises a wide set of behaviours that make it difficult to define when certain behaviour can be indicated as violent. The figures presented in most recent research on the prevalence of domestic violence in the entire Dutch population includes all these categories. According to these figures, 45% of men and women are victims of violence at some point during their lives, 25% have suffered from daily or weekly violence over a longer period (van Dijk et al. 1997). According to this study, men and women are equally victims of domestic violence. Men are mainly victims at a younger age, whereas women continue to be so throughout their lives.

In the study by van Dijk et al. (1997), non-western groups of foreign heritage were underrepresented. This is one of the reasons why the same research was repeated among the largest of these groups in the Netherlands: the Surinamese, Antillean/Aruban, Turkish and Moroccan communities (van Dijk & Oppenhuis 2002). The results reveal a much lower prevalence of domestic violence among these groups as compared to the native Dutch population: 24% versus 45%. This difference was attributed to underreporting in the migrant population due to an extreme sense of shame and the fear of jeopardizing family honour. These ethnic minorities showed clear differences in reporting experiences with domestic violence: Surinamese population (28%); Antillean/Aruban population (41%); Turkish population (21%) and Moroccan

population (14%). Another remarkable difference between the native Dutch population and these particular ethnic minorities is the intensity and frequency of the violence. There are indications that migrant groups only take note of violence when it is more frequent and severe. There is a clear proven relationship between the violence committed by men against women and violence against children. UNICEF estimates that 40 to 70 % of the men who use violence against their partner also abuse their children, while 50% of the women who suffer from violence by their partner maltreat their children (UNICEF 2003). Similarly, the children of women who were abused during pregnancy have a 40 to 60% chance of suffering from violence during their childhood (Baird 2002).

For the purpose of this article, we will focus on forms of violence perpetrated by men against the women with whom they are having, or have had, a sexual relationship. This is often called intimate partner violence (IPA). In other words, we will not devote any attention here to relationships between parents and children, or those between brothers and sisters and other family members or friends.

Domestic violence during pregnancy

Over the past 15 years, evidence has come to light that the domestic abuse of women may begin, or intensify, during pregnancy and that this abuse not only harms the women in question, but can also have various adverse effects on the pregnancy (Berenson et al. 1994). A vast number of studies have investigated this phenomenon (in the US, UK and Sweden). Coker et al. (2004) describe a total of 20 relevant studies addressing intimate partner violence during pregnancy and low birth weight, pre-term delivery or intrauterine growth retardation.

According to Gazmararian et al. (1996), the estimates on the prevalence of domestic violence during pregnancy range between 0.9% to 20.1% of pregnant women in the United States. Campbell (2002) estimates a worldwide occurrence of 3-13%. Prevalence estimates vary according to the population investigated, the time and method of screening, and inherent methodological problems (Coker et al. 2004, Bacchus et al. 2004a). Most researchers cite the known risk factors for violence during pregnancy as being maternal age, ethnicity, marital status, education, employment status, smoking, alcohol and drugs (Janssen et al. 2003). Women who experience domestic violence make significant use of health care resources. However, due to the reluctance of health professionals to enquire about domestic violence, it remains hidden. Women rarely disclose domestic violence spontaneously, without direct enquiry by the health professional. Lack of training, time constraints, and fear of offending the women are commonly cited as reasons for not enquiring about domestic violence (Mezey et al. 2003).

Of all cases of partner violence, 30% was initiated during a period in which the woman was pregnant. Some common factors that trigger violence in a relationship were identified by Dobash and Dobash (1992). These include problems involving finances, household work, sex, jealousy and possessiveness. While all these problems

were already present in the relationship, they intensified and were affected by the pregnancy. This clearly shows that the social situation during periods of extra tension becomes more apt to erupt. Men become confronted with their wives' shifting attention towards the unborn child as well as the hormonally-related changes in their sexual desire.

Research shows that women disclose their experiences with partner violence earlier when asked routinely and repeatedly about it. This is called screening on domestic violence (Mezey et al. 2003, Protheroe et al. 2004, Shadigan & Bauer 2004, Bacchus et al. 2004b). Bacchus reports an increase in prevalence when these routine enquiries are repeated on three occasions. Reported domestic violence during first consultations in pregnancy was 1.8%. At 34 weeks of gestation, the figure rises to 5.8%, but drops slightly to 5.0% at 10 days postpartum. The conclusion of this study was that routine enquiry regarding domestic violence could increase the rate of detection, and thus give women an opportunity to access help earlier on (Bacchus et al. 2004b).

These findings may offer sound reasons for introducing screening in midwifery practice. The reasons for introduction are twofold. First and foremost, it is important to detect violence during pregnancy because of the negative consequences it can have on the pregnancy, childbirth and health of the baby. Secondly, the intimate relationship between midwives and pregnant women creates an opportunity for the disclosure of any existing violence in their homes. Several experiences with screening by midwives are described in the literature. Midwives are trained in advance to detect signs of violence and to raise these issues with their clients. This leads to a greater awareness and understanding of domestic violence and increases the likelihood of identifying victims and supporting them (Protheroe et al. 2004). It is no easy task to introduce a screening process in midwifery practice. Mezey's study shows that, on the one hand, midwives felt that domestic violence was an important issue to address (Mezey et al. 2003). However, various practical and personal problems posed an obstacle, including time constraints, a lack of confidential time, safety issues and the midwives' own personal experiences with domestic violence.

In the Netherlands, a study carried out in 1999 by TNO and the LUMC, shows the percentage of partner violence during pregnancy to be 1%, which falls only slightly under the 1.8% Bacchus reported for the first screening. This low percentage was probably due to underreporting. Women were asked about domestic violence only during their first visit to the midwife (Offerhaus et al. 2001). Midwives are hesitant to *uncover* problems of violence in pregnancy. However, studies in Sweden and England reveal that women's attitudes to being asked about exposure to violence were positive. The majority of pregnant women found the questioning acceptable (Stenson et al. 2001, Webster et al. 2001, Bacchus et al. 2002, Edin & Högberg 2002). Aside from fear of offending the women, midwives are hesitant because they are concerned that they may be placing the woman at an increased risk of harm from her partner (Mezey et al. 2003).

Migrant outreach workers in four midwifery practices

The project

The project at the focus of this paper was carried out in four midwifery practices in Amsterdam from late April to early December 2004. The objectives of the project were threefold. First, it sought to test the possibility of raising the issue of domestic violence during pregnancy with Turkish and Moroccan women, though preferably not in the presence of their partners. Its second objective was to determine the effectiveness of deploying migrant outreach workers in giving information and enquiring about domestic violence among fellow migrant groups. And finally, the project's ultimate aim was to develop a method for introducing the subject of domestic violence in midwifery practice.

Midwifery practices in the Netherlands' larger cities deal with 60% of the pregnant women in the country's migrant population, a population that consists of over a hundred nationalities. According to the study by Van Dijk and Oppenhuis (2002), the prevalence of domestic violence in the Turkish and Moroccan communities was low, a finding probably due to underreporting. In the four midwifery practices, only one case of severe domestic violence was reported or discovered per year before the project started (source: verbal information from midwives). Eight migrant outreach workers, four Moroccan and four Turkish, were trained by Transact and TNO during a specially tailored two-day training programme. This programme provided information and education about general subjects regarding pregnancy and about domestic violence, focusing on how to open the subject for discussion and how to recognize the signs of violence. The programme also conveyed two vital messages: 1) violence is not tolerable in Dutch society, and 2) violence creates health risks for the pregnancy. The information about maintaining a healthy lifestyle during pregnancy focused in on the importance of not smoking, eating healthily, engaging in physical activities and avoiding domestic violence. The outreach workers were also taught to inform women of the risks of an adverse outcome in their pregnancy if they are subjected to repeated and severe violence. During the first meeting with pregnant women, they concentrated mainly on providing information. During the second conversation, they elaborated further on personal details. If necessary after a second consultation, they scheduled a third meeting. Some semi-open questions were listed for the first and the second consultations as a communication tool and a means of observation. In addition to those questions, the outreach workers filled out a checklist for the midwives, listing the subjects they had addressed during their meetings with the pregnant woman. The outreach workers were taught not to make notes in front of pregnant women, but to report on the conversation after the women left.

An important task for the outreach workers was to refer women with severe problems to specialized professionals, in coordination with the midwife responsible.

Results

The outreach workers held 132 consultations with pregnant Turkish and Moroccan women. The number of first and second consultations differed per practice. Every practice had one Turkish and one Moroccan outreach worker. Table 1 shows the number of consultations per practice and per outreach worker.

Table 1 *Number of consultations*

consultation practice	Turkish		Moroccan		total		%
	1st	2nd	1st	2nd	1st	2nd	
	n	n	n	n	n	n	% of 1st
1.	18	12	29	19	47	31	66%
2.	15	9	17	3	32	12	38%
3.	14	2	23	7	37	9	24%
4.	6	3	10	5	16	8	50%
total	53	26	79	34	132	60	45%

In practice 1, the outreach workers succeeded in scheduling a second consultation with 31 of the 47 pregnant women with whom they had a first consultation (66%). In practice 3, this figure only came to 24%. In practice 2, the outreach workers had 32 first and 12 second consultations (38%). The figures for practice 4 were 16 first and 8 second consultations (50%). Clearly, there were considerable differences between practices and between outreach workers.

The outcomes of the conversations between the migrant outreach workers and pregnant women showed great differences. This was measured in different parameters. One of these was the number of consultations in which they raised the issue of domestic violence. During training, all of the migrant outreach workers stressed the extreme secrecy with which their communities treat the subject of violence and the difficulty of opening it up for discussion. The results reflected that difficulty. Five migrant outreach workers succeeded in talking about the issue in every consultation, but three clearly felt reluctant to introduce the subject. One individual never did; one only did so 3 times in 15 meetings and another only in half of the consultations. Another success parameter for the migrant workers was the presence of husbands. Because women can only talk openly about partner violence when their partner is not present, the outreach workers were instructed to try to talk alone with the women. One outreach worker was more successful than the others in convincing husbands to stay away during the conversation. Men were present during 23% of the consultations (n=30). One outreach worker succeeded in conducting 18 consultations with the husband present on only one occasion. Another outreach worker managed to conduct 12 of 16 consultations without the husband's presence. In 17% (n=22) of the consultations, another family member was present, usually a sister- or mother-in-law, when the husband was not present. In those cases, the outreach workers noticed reluctance on the part of the pregnant women to answer questions. In summary, in 59% of the cases (n=78), the outreach workers succeeded in conducting a

consultation alone with the woman. They gave information about maintaining a healthy lifestyle during pregnancy. Aside from offering nutritional advice, they stressed the importance of getting fresh air and exercising. An essential part of that information included the issue of domestic violence. The message was that violence is not acceptable: it should not be tolerated personally, and poses a threat to the unborn child.

During the first consultation, information about domestic violence was given to 73% (n=96) of the pregnant women. The reasons why outreach workers were reluctant to talk about violence were attributed to the presence of the husband or others. In total, the outreach workers observed a regular occurrence of violence during the actual pregnancy in 17 cases; this constitutes 18% of the group with whom violence was discussed (n=96), and 13% of the entire group (n=132). Four of these women reported physical violence, 13 suffered from psychological violence. The occurrence of sexual violence was never observed or mentioned. Two women reported incidental violence before pregnancy, which was not repeated in the current pregnancy. Based on our definition, we did not include these women in that group of 17. With one exception, all of these cases of violence were detected during the first consultation.

The outreach workers reported a suspicion of violence in 13 first consultations (10%). These women were very silent, did not face the outreach worker and avoided their questions. Seven of these women did not return for a second consultation. A second consultation did take place with the remaining six, and in all of these cases, the suspicions disappeared. In four cases, suspicions arose during the second consultation. In four of the 17 cases of violence, the husband was present during the consultation.

Psychological violence mainly involved complete isolation and deprivation from contact, even with neighbours. The husbands in these cases prohibited their wives from leaving the house alone. Four women indicated that their mothers-in-law contributed to this feeling of deprivation. The problems reported with mothers-in-law are considered domestic violence because the partner plays an important role in tolerating these situations.

Some of the pregnant women complained to the outreach workers of many severe social problems, such as financial pressures, housing problems, and partners who left them alone for weeks with no money. Compared to all these social problems, some women considered physical violence a minor problem. Many were raised in a community that accepts the subordination of women to men and where the moderate slapping of women is not uncommon. The definition of domestic violence was very difficult to apply in view of the fact that some forms of violence are accepted among Turkish and Moroccan women due to their different cultural interpretations.

In a group meeting with the outreach workers, shortly before the end of the project, we noticed that they presented many observations that were not documented. Their verbal reports during meetings were extensive and vivid, but their written reports were short. Most outreach workers had difficulty expressing themselves on paper about what the pregnant women disclosed to them. Although they were allowed to report in Arabic or Turkish, they never made use of that option.

Until now, the verbal reports of outreach workers has been the only information available on these women's perceptions of and experiences with raising the issue of

domestic violence. Most outreach workers had the impression that women were pleased with the opportunity to talk about their problems in their own language. An evaluation is being implemented to verify the accuracy of that impression. Women who participated during their pregnancy will be asked about their perceptions of and experiences with receiving information about domestic violence and being questioned by outreach workers about the subject.

Women who disclosed severe physical violence were referred – with their consent – to the appropriate institutions in collaboration with their midwife. After referral to counselling services, the outreach workers called the women to check whether they actually went for help.

The medical anthropological perspective

Domestic violence in pregnancy poses a serious threat; it can result in low birth weight, pre-term delivery and even stillbirth. Women throughout Dutch society – including those of native and non-native Dutch heritage – suffer from domestic violence. However the outreach workers' conversations with Turkish and Moroccan pregnant women revealed that these women tend to accept violence as an inevitable fact of life. Their social environment fosters this view, as many grew up watching their mothers experience the same.

Thus, the personal understanding of these women regarding their experiences with partner violence is strongly related to the society in which they were raised. Although Universal Human Rights suggest that there is worldwide agreement on what we understand as a human right, reality is more complicated. Richters refers to this complexity: "The question is whether a certain form of violence in a particular society can be considered 'normal' or acceptable because of prevailing cultural values and norms, while other societies view the same behaviour as being a clear and gross violation of human rights" (Richters 2004: 164).

The Egyptian Demographic Health Survey (El-Zanaty 1996) reflects the fact that women in the Egyptian society regard domestic violence as normal and as justifiable for a husband. Although culturally, Turkish, Moroccan and Egyptian women differ in many respects, their common Islamic background gives them a similar gender perspective, a perspective influenced by the same religious sources. This makes the Egyptian example interesting. In 1995, the status of women was included for the first time in the EDHS (n=7121). Most married women (86%) agreed that husbands were sometimes justified in beating their wives. They were most likely to agree that a man is justified in beating his wife if she refuses him sex (70%), or if she answers him back (69%), and least likely to agree if she burns the food (27%). Agreement with beating did not vary with the age of the respondent, only with level of education and area of residence. Nonetheless, even in urban areas, at least three out of four women felt husbands were justified in beating their wives under one or more of the conditions cited (El-Zanaty 1996).

The underreporting in Van Dijk and Oppenhuis' study (2002) was attributed to cultural concerns about shame and upholding family honour. This is definitely an impor-

tant factor in underreporting. However, in communities where beating is accepted as a husband's right and seen as normal, many women will not mention it because they do not view it as violence. This could be another reason for underreporting aside from feelings of shame. In addition, the report suggests that the four migrant groups in the study do often not report incidental violence and only mention severe problems.

In the project discussed here, the outreach workers did not ask questions about personal experiences with domestic violence until after they had provided information about the unacceptability of violence. This was done in order to make the women aware of the unacceptability of violence by their partners. Only after that, were questioned about their personal experiences. Certain conditions are necessary in questioning women about violent experiences. Women must feel that they are in a safe environment and have a relationship of trust with their healthcare provider. In addition, their partner should not be present, nor should any relatives or friends who might inform their partners.

The fact that sexual violence was never mentioned by the pregnant women, or by the outreach workers, points to another culturally sensitive fact. In many societies, women tend to respond to the sexual desires of men as dictated by their gender role. In a situation where the wife is supposed to respond to the sexual desires of her partner irrespective of her own feelings, sexual violence is non-existent. This phenomenon is often observed among ethnic minorities and is justified by religious arguments. It should also be noted, however, that even the Netherlands Emancipation Monitor for 2004 (a publication of the Ministry of Social Affairs and Labour) found that more men than women agreed with the statement that men in long-term or marital relationships are *entitled* to receive sex from their partner when they desire it (Portegijs et al. 2005).

Medical anthropologists face the challenge of developing a way to deal with domestic violence that takes account of different interpretations of human rights, where they have an effect on the health of women, specifically, on the health of pregnant women.

Concluding remarks

It is difficult in midwifery practice to ask routinely and repeatedly about domestic violence during pregnancy. This applies to women of in the native Dutch population and even more so to those of foreign origin. In this project, we found a way to come into contact with Turkish and Moroccan women and talk with them about domestic violence through Turkish and Moroccan outreach workers. The project was successful in opening the subject of violence to discussion during antenatal clinic visits and in disclosing cases of domestic partner violence. Domestic violence was reported more often to the outreach workers, than it was to the midwives before the project started. Prior to this project, the participating midwifery practices saw only one severe case reported per year. The deployment of the migrant outreach workers brought about a significant increase: from four cases in one year to 17 cases in 7 months. With one exception, all these cases were detected during the first consultation, which raises questions about the necessity of repeated screening in these groups.

The follow-up after the first contact was fairly low. It is still unclear why many second conversations did not take place, especially in cases where the outreach workers suspected – or observed signs of – violence.

This project also confronted us with the complicated definition of domestic violence. According to our definition, a woman whose husband leaves her alone with four children and no money or news of when to expect him back, is a victim of psychological violence. However, this may not be reported as such – either by pregnant women, or by migrant outreach workers. In light of this, efforts to get women to report such violence must take this kind of situation into account.

As found in our study and acknowledged by other researchers, the definition of physical violence is not straightforward. Whether a woman will report violence will depend in part on what she perceives as normal. For example, if a woman is used to accepting beatings by her partner, as illustrated in the Egyptian survey, she will not change her attitude after one conversation with an outreach worker who tells her the opposite. Moreover, outreach workers themselves have their own interpretation of domestic violence, which is influenced by their (common) cultural background. Therefore, we need to inform women of what is acceptable in our society to help them understand that the violence they experience is not acceptable. This is what the outreach workers were taught to tell pregnant women. The intervention showed that the characters and personalities of outreach workers, and probably also their own personal history with violence, influence their ability to persuade others of that view.

A great deal of conceptualization remains in the difficult task of defining domestic violence, and more specifically, intimate partner violence. In the case of allochthonous groups ethnic minorities, the interpretation of domestic violence is influenced by the cultural norms and values of two societies: that of their “new” country and their “old” or “home” country. Medical anthropology can make an important contribution to this discussion where psychological and physical health elements are involved, such as in pregnancy.

Notes

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