WHO's landmark study documents the horrifying extent of violence against women by their intimate partners. It also clearly shows that violence against women demands a public health response, because the impact of such violence goes far beyond the immediate harm caused, affecting all aspects of women's future health.

This summary outlines the initial results of the study based on evidence collected from over 24 000 women by carefully trained teams of interviewers. It presents the findings from 15 sites in 10 countries representing diverse cultural settings: Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania.

Focusing on the prevalence of violence by intimate partners, and the associations between such violence and women's physical, mental, sexual and reproductive health, the report also deals with non-partner violence, sexual abuse during childhood and forced first sexual experience.

Who do women turn to and whom do they tell about the violence in their lives? Although some women leave home and some fight back, the shocking answer in too many cases is nobody.

The report culminates in 15 recommendations to strengthen national commitment and action on violence against women by promoting primary prevention, harnessing education systems, strengthening health sector responses, supporting women living with violence, sensitizing criminal justice systems, and undertaking research and enhancing collaboration.

ISBN 92 4 159351 2

Summary report

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

## Initial results on prevalence, health outcomes and women's responses

World Health Organization

> **“After knowing I was pregnant, he changed. No more sweet and kind words from him... He would hit me and throw things at me. He meant to kill me. Once he lifted a table and threw it at me... I survived. Later that night, we fought. He used a broom to hit me several times. I was bruised all over. I was in such a great pain never experienced before...”**
>
> Woman interviewed in Thailand

> **“So I take a blanket and I spend the night with my children out in the cold because he is hitting me too much and I have to take the kids to stop him hitting them too. I would go up the mountain, and sleep there all night. I’ve done that more than ten times...”**
>
> Woman interviewed in Peru

The World Health Organization was established in 1948 as a specialized agency of the United Nations serving as the directing and coordinating authority for international health matters and public health. One of WHO’s constitutional functions is to provide objective and reliable information and advice in the field of human health, a responsibility that it fulfils in part through its extensive programme of publications.

The Organization seeks through its publications to support national health strategies and address the most pressing public health concerns of populations around the world. To respond to the needs of Member States at all levels of development, WHO publishes practical manuals, handbooks and training material for specific categories of health workers; internationally applicable guidelines and standards; reviews and analyses of health policies, programmes and research; and state-of-the-art consensus reports that offer technical advice and recommendations for decision-makers. These books are closely tied to the Organization’s priority activities, encompassing disease prevention and control, the development of equitable health systems based on primary health care, and health promotion for individuals and communities. Progress towards better health for all also demands the global dissemination and exchange of information that draws on the knowledge and experience of all WHO’s Member countries and the collaboration of world leaders in public health and the biomedical sciences.

To ensure the widest possible availability of authoritative information and guidance on health matters, WHO secures the broad international distribution of its publications and encourages their translation and adaptation. By helping to promote and protect health and prevent and control disease throughout the world, WHO’s books contribute to achieving the Organization’s principal objective – the attainment by all people of the highest possible level of health.

World Health Organization

Summary report

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

Initial results on prevalence, health outcomes and women's responses

**WHO Library Cataloguing-in-Publication Data**

WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses.

1. Domestic violence 2. Sex offenses 3. Women's health 4. Cross-cultural comparison 5. Multicenter studies 6. Epidemiologic studies I.World Health Organization.

ISBN 92 4 159351 2 (NLM classification: WA 309)

Suggested citation: *WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization, 2005.



Designed by: Grundy & Northedge Designers

Printed in Switzerland

# Contents

# Core Research Team, Steering Committee, and Country Research Teams

## Core Research Team

Claudia García-Moreno (Study Coordinator), World Health Organization, Geneva, Switzerland
Henrica A.F.M. (Henriette) Jansen, World Health Organization, Geneva, Switzerland
Charlotte Watts, London School of Hygiene and Tropical Medicine (LSHTM), London, England
Mary Ellsberg, Program for Appropriate Technology in Health (PATH), Washington, DC, USA
Lori Heise, PATH, Washington, DC, USA

## Steering Committee

Jacquelyn Campbell, Johns Hopkins University, Baltimore, MD, USA (co-Chair)
Lucienne Gillioz, Bureau d'Égalité, Geneva, Switzerland
Rachel Jewkes, Medical Research Council, Pretoria, South Africa
Ivy Josiah, Women's Aid Organisation, Selangor, Malaysia
Olav Meirik, Instituto Chileno de Medicina Reproductiva (ICMER), Santiago, Chile (co-Chair)
Laura Rodrigues, London School of Hygiene and Tropical Medicine, London, England
Irma Saucedo Gonzalez, El Colegio de Mexico, Mexico City, Mexico
Berit Schei, Norwegian University of Science and Technology, Trondheim, Norway
Stig Wall, Umeå University, Sweden

## Country Research Teams

### Bangladesh

Ruchira Tabassum Naved, ICCDR,B, Dhaka
Safia Azim, Naripokkho, Dhaka
Abbas Bhuiya, ICCDR,B, Dhaka
Lars Ake Persson, Uppsala University, Sweden

### Brazil

Lilia Blima Schraiber, Faculty of Medicine, University of São Paulo, São Paulo
Ana Flavia Lucas D'Oliveira, Faculty of Medicine, University of São Paulo, São Paulo
Ivan França Junior, School of Public Health, University of São Paulo, São Paulo
Carmen Simone Grilo Diniz, Feminist Collective for Sexuality and Health, São Paulo
Ana Paula Portella, SOS Corpo, Genero e Cidadania, Pernambuco
Ana Bernarda Ludermir, Medical School, Federal University of Pernambuco

### Ethiopia

Yemane Berhane, Addis Ababa University, Addis Ababa
Ulf Hogberg, Umeå University, Sweden
Gunnar Kullgren, Umeå University, Sweden
Negussie Deyessa, Addis Ababa University, Addis Ababa
Maria Emmelin, Umeå University, Sweden
Mary Ellsberg, PATH, Washington, DC, USA
Yegomawork Gossaye, Umeå University/Addis Ababa University, Addis Ababa

Atalay Alem, Addis Ababa University, Addis Ababa
Derege Kebede, Addis Ababa University, Addis Ababa
Alemayehu Negash, Umeå University/Addis Ababa University, Addis Ababa

**Japan**
Mieko Yoshihama, University of Michigan, Ann Arbor, MI, USA
Saori Kamano, National Institute of Population and Social Security Research, Tokyo
Hiroko Akiyama, University of Tokyo, Tokyo
Fumi Hayashi, Toyo Eiwa University, Tokyo
Tamie Kaino, Ochanomizu University, Tokyo
Tomoko Yunomae, Japan Accountability Caucus, Beijing, Tokyo

**Namibia**
Eveline January, Ministry of Health and Social Services, Windhoek
Hetty Rose-Junius, Ministry of Health and Social Services, Windhoek
Johan Van Wyk, Ministry of Health and Social Services; Windhoek
Alvis Weerasinghe, National Planning Commission, Windhoek

**Peru**
Ana Güezmes García, Centro de la Mujer Peruana Flora Tristán, Lima
Nancy Palomino Ramírez, Universidad Peruana Cayetano Heredia, Lima
Miguel Ramos Padilla, Universidad Peruana Cayetano Heredia, Lima

**Samoa**
Tina Tauasosi-Posiulai, Secretariat of the Pacific Community
Tima Levai-Peteru, Secretariat of the Pacific Community
Dorothy Counts, Secretariat of the Pacific Community
Chris McMurray, Secretariat of the Pacific Community

**Serbia and Montenegro**
Stanislava Otaševic, Autonomous Women's Center Against Sexual Violence, Belgrade
Silvia Koso, Autonomous Women's Center Against Sexual Violence, Belgrade
Viktorija Cucic, Medical School, University of Belgrade, Belgrade

**Thailand**
Churnrurtai Kanchanachitra, Mahidol University, Bangkok
Kritaya Archavanitkul, Mahidol University, Bangkok
Wassana Im-em, Mahidol University, Bangkok
Usa Lerdsrisanthat, Foundation for Women, Bangkok

**United Republic of Tanzania**
Jessie Mbwambo, Muhimbili University College of Health Sciences, Dar es Salaam
Gideon Kwesigabo, Muhimbili University College of Health Sciences, Dar es Salaam
Joe Lugalla, University of New Hampshire, Durham, NH, USA
Sherbanu Kassim, Women Research and Documentation Project, Dar es Salaam

# Preface

Violence against women by an intimate partner is a major contributor to the ill-health of women. This study analyses data from 10 countries and sheds new light on the prevalence of violence against women in countries where few data were previously available. It also uncovers the forms and patterns of this violence across different countries and cultures, documenting the consequences of violence for women's health. This information has important implications for prevention, care and mitigation.

The health sector can play a vital role in preventing violence against women, helping to identify abuse early, providing victims with the necessary treatment, and referring women to appropriate care. Health services must be places where women feel safe, are treated with respect, are not stigmatized, and where they can receive quality, informed support. A comprehensive health sector response to the problem is needed, in particular addressing the reluctance of abused women to seek help.

The high rates documented by the Study of sexual abuse experienced by girls and women are of great concern, especially in light of the HIV epidemic. Greater public awareness of this problem is needed and a strong public health response that focuses on preventing such violence from occurring in the first place.

The research specialists and the representatives of women's organizations who carried out the interviews and dealt so sensitively with the respondents deserve our warmest thanks. Most of all, I thank the 24 000 women who shared this important information about their lives, despite the many difficulties involved in talking about it. The fact that so many of them spoke about their own experience of violence for the first time during this study is both an indictment of the state of gender relations in our societies, and a spur for action. They, and the countries that carried out this groundbreaking research have made a vital contribution.

This study will help national authorities to design policies and programmes that begin to deal with the problem. It will contribute to our understanding of violence against women and the need to prevent it. Challenging the social norms that condone and therefore perpetuate violence against women is a responsibility for us all. Supported by WHO, the health sector must now take a proactive role in responding to the needs of the many women living in violent relationships. Much greater investment is urgently needed in programmes to reduce violence against women and to support action on the study's findings and recommendations.

We must bring the issue of domestic violence out into the open, examine it as we would the causes of any other preventable health problem, and apply the best remedies available.

**LEE Jong-Wook**
Director-General, World Health Organization

# Foreword

Violence against women is a universal phenomenon that persists in all countries of the world, and the perpetrators of that violence are often well known to their victims. Domestic violence, in particular, continues to be frighteningly common and to be accepted as "normal" within too many societies. Since the World Conference on Human Rights, held in Vienna in 1993, and the Declaration on the Elimination of Violence against Women in the same year, civil society and governments have acknowledged that violence against women is a public policy and human rights concern. While work in this area has resulted in the establishment of international standards, the task of documenting the magnitude of violence against women and producing reliable, comparative data to guide policy and monitor implementation has been exceedingly difficult. The WHO Multi-country Study on Women's Health and Domestic Violence against Women is a response to this difficulty.

The Study challenges 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. According to the Study, it is particularly difficult to respond effectively to this violence because many women accept such violence as "normal". Nonetheless, international human rights law is clear: states have a duty to exercise due diligence to prevent, prosecute and punish violence against women.

Looking at violence against women from a public health perspective offers a way of capturing the many dimensions of the phenomenon in order to develop multisectoral responses. Often the health system is the first point of contact with women who are victims of violence. Data provided by this Study will contribute to raising awareness among health policy-makers and care providers of the seriousness of the problem and how it affects the health of women. Ideally, the findings will inform a more effective response from government, including the health, justice and social service sectors, as a step towards fulfilling the state's obligation to eliminate violence against women under international human rights laws.

Violence against women has a far deeper impact than the immediate harm caused. It has devastating consequences for the women who experience it, and a traumatic effect on those who witness it, particularly children. It shames states that fail to prevent it and societies that tolerate it. Violence against women is a violation of basic human rights that must be eliminated through political will, and by legal and civil action in all sectors of society.

This report of the WHO Multi-country Study on Women's Health and Domestic Violence against Women, along with the recommendations it contains, is an invaluable contribution to the struggle to eliminate violence against women.

**Yakın Ertürk**

Special Rapporteur on violence against women, its causes and consequences

# Foreword

Each culture has its sayings and songs about the importance of home, and the comfort and security to be found there. Yet for many women, home is a place of pain and humiliation.

As this report clearly shows, violence against women by their male partners is common, wide-spread and far-reaching in its impact. For too long hidden behind closed doors and avoided in public discourse, such violence can no longer be denied as part of everyday life for millions of women.

The research findings presented in this report reinforce the key messages of WHO's *World Report on Violence and Health* in 2002, challenging notions that acts of violence are simply matters of family privacy, individual choice, or inevitable facts of life. The data collected by WHO and researchers in 10 countries confirm our understanding that violence against women is an important social problem. Violence against women is also an important risk factor for women's ill-health, and should receive greater attention.

Experience, primarily in industrialized countries, has shown that public health approaches to violence can make a difference. The health sector has unique potential to deal with violence against women, particularly through reproductive health services, which most women will access at some point in their lives. The Study indicates, however, that this potential is far from being realized. This is partly because stigma and fear make many women reluctant to disclose their suffering. But it is also because few doctors, nurses or other health personnel have the awareness and the training to identify violence as the underlying cause of women's health problems, or can provide help, particularly in settings where other services for follow-up care or protection are not available. The health sector can certainly not do this alone, but it should increasingly fulfil its potential to take a proactive role in violence prevention.

Violence against women is both a consequence and a cause of gender inequality. Primary prevention programmes that address gender inequality and tackle the many root causes of violence, changes in legislation, and the provision of services for women living with violence are all essential. The Millennium Development Goal regarding girls' education, gender equality and the empowerment of women reflects the international community's recognition that health, development, and gender equality issues are closely interconnected.

WHO regards the prevention of violence in general – and violence against women in particular – a high priority. It offers technical expertise to countries wishing to work against violence, and urges international donors to support such work. It continues to emphasize the importance of action-oriented, ethically based research, such as this Study, to increase our understanding of the problem and what to do about it. It also strongly urges the health sector to take a more proactive role in responding to the needs of the many women living in violent relationships.

**Joy Phumaphi**
Assistant Director-General, Family and Community Health, WHO

# 1 Overview

The WHO Multi-country Study on Women's Health and Domestic Violence against Women is a landmark research project, both in its scope and in how it was carried out. For the results presented in this report, specially trained teams collected data from over 24 000 women from 15 sites in 10 countries representing diverse cultural settings: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania. The use of a standardized and robust methodology has substantially reduced many of the difficulties that affected earlier work on violence against women, and produced results that permit comparison and analyses across settings.

Other strengths of the study include the multinational participatory method used to develop the research protocol and questionnaire, the involvement of women's organizations in the research teams, the attention to addressing ethical and safety considerations, and the emphasis on careful selection and training of interviewers and on capacity building of all members of the research teams. Another important feature was the Study's link with policy processes, achieved through the cooperation of members of the research team with policy-making bodies on violence, and the involvement of consultative committees that included key stakeholders at the country level.

## Background

Until recently, most governments and policy-makers viewed violence against women as a relatively minor social problem, particularly "domestic" violence by a husband or other intimate partner.[1] Since the 1990s, however, the efforts of women's organizations, experts and committed governments have resulted in a profound transformation in public awareness about this problem. Such violence is now widely recognized as a serious human rights and public health problem that concerns all sectors of society (**1**).

International research has signalled that violence against women is a much more serious and widespread problem than previously suspected. A review of studies from 35 countries carried out prior to 1999 indicated that between 10% and 52% of women reported being physically abused by an intimate partner at some point in their lives, and between 10% and 30% reported they had experienced sexual violence by an intimate partner. Between 10% and 27% of women and girls reported having been sexually abused, either as children or adults (**2**, **3**). Data from developing countries was, however, generally lacking.

Furthermore, as the volume of evidence grew, it became clear that levels of violence varied substantially between settings, both among and within countries. This raised many questions, not only regarding the factors underlying these differences but also about the methods used to investigate violence in different countries. The many differences in the way violence was defined and measured in different studies made it difficult to make meaningful comparisons between studies or make reliable estimates in different settings (**3**). As well as research on the prevalence of violence, increasing attention was paid to its health consequences, with most of the evidence for this coming from studies in North America (**4**–**6**).

In 1995, the United Nations Fourth World Conference on Women identified violence against women as one of the critical areas of concern needing action. The relevant chapter of its Platform for Action (**7**) states that:

"*The absence of adequate sex-disaggregated data on statistics and the incidence of violence make the elaboration of programmes and monitoring of changes difficult.*" (paragraph 120).

Moreover, it recommends, among other things, the promotion of "*research and data collection on the prevalence of different forms of violence against women, especially domestic violence, and research into the causes, the nature and the consequences of violence against women....*" (paragraph 129a).

[1] The term "domestic violence" is now being replaced by "intimate-partner violence".

WHO thereafter convened an expert consultation of violence against women in 1996, bringing together researchers, health care providers and women's health advocates from several countries. The participants recommended that WHO support international research to explore the dimensions, health consequences and risk factors of violence against women. In 1997, WHO initiated the Multi-country Study on Women's Health and Domestic Violence against Women (hereafter referred to as the WHO Study).

## Objectives

The WHO Study was designed to address some of the major gaps in international research on violence against women. Specifically, the study aims were to:

1. **estimate the prevalence of violence against women, with particular emphasis on physical, sexual and emotional violence by male intimate partners;**
2. **assess the extent to which intimate-partner violence is associated with a range of health outcomes;**
3. **identify factors that may either protect or put women at risk of partner violence;**
4. **document and compare the strategies and services that women use to deal with violence by an intimate partner.**

This first report on the results of the WHO Study presents initial findings on objectives 1, 2 and 4: prevalence, health outcomes, and coping strategies. Analysis of risk and protective factors for violence will be addressed in a future report.

The WHO Study also aimed to develop new ways of measuring violence cross-culturally, and to increase national capacity and collaboration among researchers and women's organizations working on violence. It also had an advocacy goal of increasing sensitivity to violence among researchers, policy-makers, and health care providers. The involvement of women's health advocates in the research process, has been critical to ensuring that the Study's safety standards were maintained, that respondents received follow up services if they needed them, and that the study findings are used for advocacy and policy change. In the participating countries the Study helped develop a network of people committed to working to address violence against women.

The original plan for the WHO Study included a survey of men. However, it was not possible to implement this (see Box 1.1).

**Box 1.1 Studying men**

The WHO Study was originally planned to include interviews with men as well as women. This would have allowed comparison between men's and women's accounts of violence, and made it possible to investigate the extent to which men are physically or sexually abused by their partners. However, it was concluded that interviewing men and women in the same household might put the women at risk of future abuse. The alternative – doing the equivalent number of interviews in separate households with a separate team of male interviewers – was beyond the financial resources of the study. Men's experience of partner violence is nevertheless an important issue that needs exploration in future research. It is equally important to understand the beliefs, attitudes, and characteristics of perpetrators of violence against women.

## Organization

The Study was coordinated by WHO with a core research team of international experts from the London School of Hygiene and Tropical Medicine, the Program for Appropriate Technology in Health and WHO. WHO also established an expert steering committee of researchers and advocates from different regions of the world to provide technical and scientific oversight.

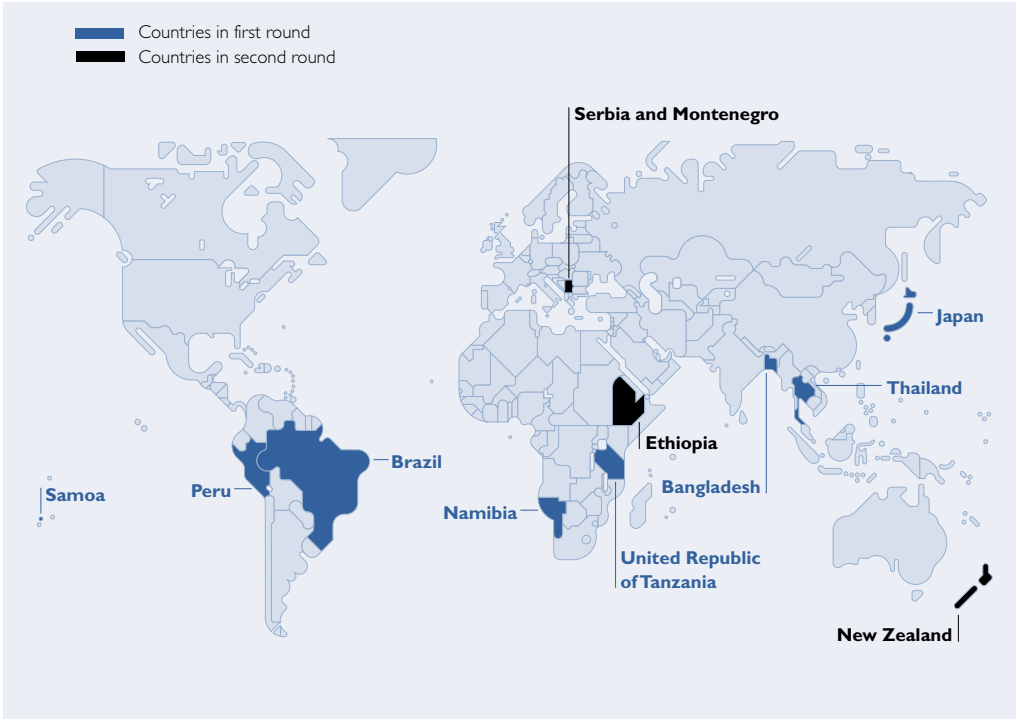
Within each participating country, a collaborative research team was established to implement the WHO Study. This generally consisted of representatives from research organizations experienced in survey work, and a women's organization providing services to abused women. Each country research team also established a consultative committee to support the study and ensure the dissemination of the results. To ensure that comparability between countries was maintained, and that the same issues and concepts were explored and analysed in the same way in each country, members of the core research team visited each country at key points, for example during interviewer training and pilot-testing.

### Choice of countries and settings

Participating countries were chosen according to specified criteria, including the presence of local anti-violence groups able to use the data for advocacy and policy reform, absence of existing data, and a political environment receptive to tackling the issue.

In each country, the Study consisted of a cross-sectional, population-based household survey conducted in one or two settings. In

**Figure 1** **Countries participating in the WHO Multi-country Study on Women's Health and Domestic Violence against Women**




half of the countries (Bangladesh, Brazil, Peru, Thailand, and the United Republic of Tanzania), surveys were conducted in (a) the capital or a large city and (b) one province or region, usually containing both urban and rural populations (see also Box 1.2). A single rural setting was used in Ethiopia, and a single large city was used in Japan, Namibia, and Serbia and Montenegro. In Samoa, the whole country was sampled. Figure 1 shows the countries participating in the WHO Study.

### Definitions and measurement tools

One of the main challenges facing international research on violence against women is to develop clear definitions of different types of violence, that permit meaningful comparisons among diverse settings. Given that the way people think about violence differs between individuals and communities, the Study used conservative definitions of violence.[2] The results are therefore more likely to underestimate than overestimate the true prevalence of violence.

The Study questionnaire resulted from a long process of discussion and consultation. The first draft of the core questionnaire was developed by the core research team, and was reviewed first by the expert steering committee and other experts, and then by the country teams. The questionnaire was then translated and pretested in six countries (Bangladesh, Brazil, Namibia, Samoa, Thailand, and the United Republic of Tanzania) and retested in the remaining participating countries.

The use of a single methodology across countries[3] greatly reduced the difficulties that have plagued earlier research, particularly the degree to which differences in sampling, definitions, questions used, and so on, account for differences in results. While cultural biases that affect disclosure will always remain, the methodological consistency of the WHO Study ensured that the variations found in prevalence between and within countries represent, for the most part, real differences.

Since the initiation of the WHO Study, other international research initiatives have also used population-based surveys to estimate the prevalence of violence against women across countries and cultures.[4] These studies provide useful comparisons with the WHO Study and, taken together, now begin to give a more comprehensive picture of violence against women around the world.

### Interviewer selection and training

Women's willingness to disclose violence is known to be influenced by characteristics of the interviewers such as sex, age, marital status, attitudes, and interpersonal skills (**8**). The WHO Study used female interviewers and supervisors who were selected according to criteria such as emotional maturity, ability to engage with people of different backgrounds in an empathetic and non-judgemental manner, and skills in dealing with sensitive issues. All were trained using a standardized three-week curriculum designed especially for the WHO Study (**9**).

[2] The operational definitions for the different forms of violence are given in Chapter 2 of this report.

[3] In Japan, important modifications were made to the methodology.

[4] These include the World Surveys of Abuse in Family Environments (WorldSafe) and the International Violence Against Women Survey (IVAWS). In addition, the Demographic and Health Surveys (DHS) and the CDC-supported International Reproductive Health Surveys (IRHS) increasingly contain questions on violence against women as part of larger household surveys on a range of health issues.

**"I learned a lot, from the beginning of the training till the end of the survey... The respondents really needed and enjoyed this experience, because they could talk to somebody. My career path [has] changed since the beginning of the training because I could do something which can make a difference and mean something for my country."**

Interviewer in Namibia

### Ethical and safety guidelines

The WHO Study developed a set of ethical guidelines for its work, entitled *Putting women first: ethical and safety recommendations for research on domestic violence against women* (**10**). These guidelines were adhered to in each country. Ethical permission for the study was obtained from WHO's own ethical review group, from each of the local institutions' ethical review boards and, in countries where it was required, from national review boards and ministries of health. In all countries, the overwhelming impression was that women were not only willing to talk about their experiences of violence, but were often deeply grateful for the opportunity to tell their stories to a non-judgemental, empathetic person (**9**).

### National dissemination and follow-up

In each country, the national results were used to produce a country report. These country reports have been disseminated at the local and national level in coordination with the country research teams, advisory groups, WHO country offices, and relevant ministries. The findings are being used in ongoing advocacy and in shaping policies, laws and programmes.

### For future analysis

This report presents a summary of the initial results of the WHO Study, and reflects only a small part of the overall analysis. The database has the potential to address other important questions of relevance to public health. For example, the study investigated a number of factors that may put women at risk of partner violence, or conversely protect her. It further addressed the broader consequences of partner violence against women, including how violence affects an individual's ability to provide for her family, maintain a job, keep her income, stay in contact with her relatives, and be an active member of groups or associations. The study also explored a range of consequences for women's children, and the extent to which children have witnessed physical violence against their mother. Among other questions, women were asked about the birth weight of their most recent live birth in the past 5 years, their children's attendance at school, behavioural problems, and whether any children had run away from home.

More in-depth analysis of these and other research questions will be explored in future reports and in papers to be published in the peer-reviewed literature.

**"On the one hand it made me feel good, because it was something that I had never told anyone before. Now I've told someone."**

Woman interviewed in Brazil

**Box 1.2 A note about terminology**

Certain conventions about terminology have been adopted in this summary report to reduce redundancy and make it more readable. The principal one is to permit a description of respondents as "having experienced violence" or "having sought help" when in fact the data are based on self-reporting rather than observation. Second, the term "abuse" is used frequently as a synonym for violence; thus, "ever-abused" means ever having experienced violence (or, bearing in mind the previous point, having *reported* ever experiencing violence). Third, in countries where research was conducted in two settings, "urban" is used to describe the capital or other large city setting and "provincial" to describe the second setting, which may have been rural or a mixture of both rural and urban. Finally, when both settings in one country produced similar results, the country name only may be used; for example, the statement "family size was larger in Bangladesh and provincial Peru", means that family size was larger in both settings in Bangladesh but only the provincial setting in Peru. In the figures the terms "city" and "province" are used.

# 2 Violence against women by intimate partners

The main focus of the WHO Study was violence against women by male intimate partners. This included physical and sexual violence, emotional abuse and controlling behaviours by current partners or ex-partners, and covered both the current situation of the women interviewed and their lifetime experience. This report concentrates mainly on women's reports of physical and sexual violence, particularly when assessing the associations with health consequences, because of the difficulty of quantifying emotional abuse consistently across cultures.

The results indicate that violence by a male intimate partner (also called "domestic violence") is widespread in all of the countries covered by the Study. However, there was a great deal of variation from country to country, and from setting to setting within the same country. Whereas there was variation by age, by marital status and by educational status, these sociodemographic factors did not account for the differences found between settings. The wide variation in prevalence rates signals that this violence is not inevitable.

The proportion of ever-partnered women who had ever experienced physical or sexual violence, or both, by an intimate partner in their lifetime, ranged from 15% to 71%, with most sites falling between 29% and 62%. Women in Japan were the least likely to have ever experienced physical or sexual violence, or both, by an intimate partner, while the greatest amount of violence was reported by women living in provincial (for the most part rural) settings in Bangladesh, Ethiopia, Peru, and the United Republic of Tanzania. Yet even in Japan, about 15% of ever-partnered women reported experiencing physical or sexual violence, or both, at some time in their lives. For partner violence in the past year, the figures ranged from 4% in Japan and Serbia and Montenegro to 54% in Ethiopia.

### How was physical and sexual violence measured?

Prevalence estimates of physical and sexual violence were obtained by asking direct, clearly worded questions about the respondent's experience of specific acts. For physical violence, women were asked whether a current or former partner had ever:

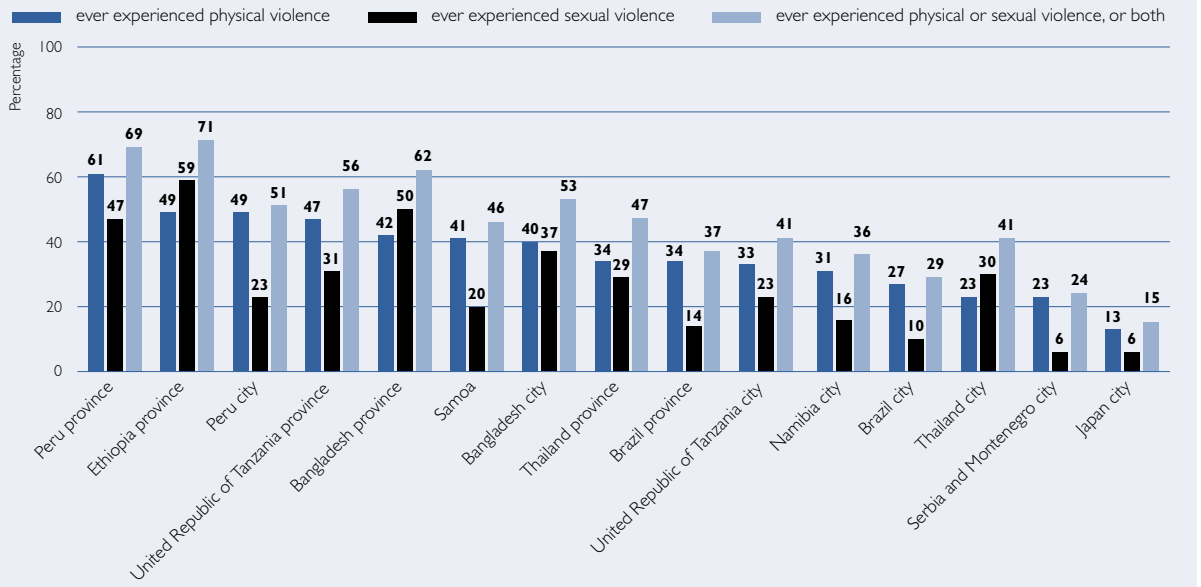
- slapped her, or thrown something at her that could hurt her;
- pushed or shoved her;
- hit her with a fist or something else that could hurt;
- kicked, dragged or beaten her up;
- choked or burnt her on purpose;
- threatened her with, or actually used a gun, knife or other weapon against her.

Sexual violence was defined by the following three behaviours:

- being physically forced to have sexual intercourse against her will;
- having sexual intercourse because she was afraid of what her partner might do;
- being forced to do something sexual she found degrading or humiliating.

Information was also collected about the frequency and the timing of the violence, allowing analysis of the extent to which different forms of violence occurred in the 12 months prior to the interview versus in the woman's lifetime. In combination with information on the timing of the relationship, it is possible to assess the extent to which different forms of violence occurred prior to marriage or cohabitation, during marriage or cohabitation, or after separation. It can also shed light on how women's risk of violence changed over the duration of their relationship.

**Figure 2** **Prevalence of lifetime physical violence and sexual violence by an intimate partner, among ever-partnered women, by site**




## Physical and sexual violence

### Wide variations in prevalence

The wide variations between settings can be seen in Figure 2, which shows the percentage of ever-partnered women in each setting who had ever (i.e. over their lifetime) experienced physical or sexual violence by a male partner. The proportion of women who had ever suffered physical violence by a male partner ranged from 13% in Japan to 61% in provincial Peru. Japan also had the lowest level of sexual violence at 6%, with the highest figure of 59% being reported in Ethiopia.

While sexual violence was considerably less frequent than physical violence in most settings, it was more frequent in provincial Bangladesh, Ethiopia, and urban Thailand. In countries where large cities and provincial settings were both studied, the overall levels of partner violence were consistently higher in the provincial settings, which had more rural populations, than in the urban sites.

### Acts, severity, and frequency of physical violence

The most common act of violence experienced by women was being slapped by their partner, from 9% in Japan to 52% in provincial Peru. This was followed by being struck with a fist, for which these two settings again represented the extremes (2% and 42%, respectively). In most places, between 11% and 21% of women reported being hit by a partner with his fist.

The severity of a physically violent act was ranked according to its likelihood of causing physical injuries. Being slapped, pushed or shoved were defined as *moderate* physical violence. Being hit with a fist, kicked, dragged, threatened with a weapon, or having a weapon used against her were defined as *severe* physical violence.[1] According to this definition, the percentage of ever-partnered women experiencing severe physical violence ranged from 4% of women in Japan to 49% in provincial Peru, with most countries falling between 13% and 26%. As Figure 3 also shows, if women have ever experienced partner violence, it is highly likely that at some time an act of severe violence will occur. In only three countries – Bangladesh, Japan, and Serbia and Montenegro – had a greater proportion of women experienced only moderate violence than had experienced severe violence.

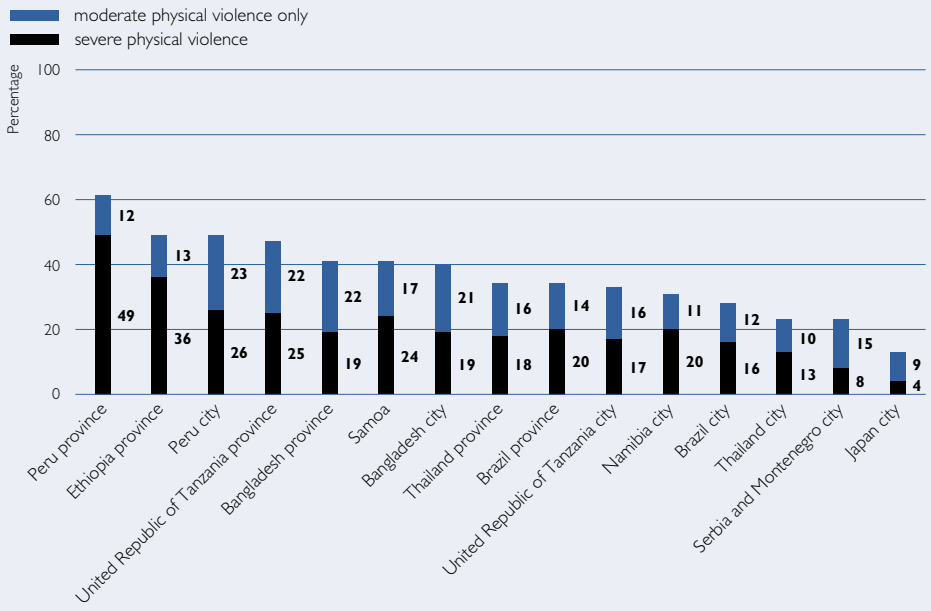
In general, more women reported severe physical violence having occurred over a year ago than in the past 12 months. The exceptions were urban Bangladesh, Ethiopia, Namibia, and Samoa where more women reported severe violence in the past 12 months. It is possible that this reflects the lack of support options in

**"The beating was getting more and more severe... In the beginning it was confined to the house. Gradually, he stopped caring. He slapped me in front of others and continued to threaten me... Every time he beat me it was as if he was trying to test my endurance, to see how much I could take."**

27-year-old university graduate from Thailand

[1] Ranking such acts by severity is controversial. Clearly, under certain circumstances a shove can cause severe injury, even though it is categorized as "moderate" violence. For the most part, however, this ranking conforms with other measures of severity, such as injury.

**Figure 3** **Prevalence of physical violence by an intimate partner according to severity of violence, among ever-partnered women, by site**




these settings, limiting abused women's ability to escape their relationship, even when they are subjected to severe physical violence.

Far from being an isolated event, most acts of physical violence by an intimate partner reflect a pattern of continuing abuse. The vast majority of women who had ever been physically abused by partners experienced acts of violence more than once, and sometimes frequently. With the exception of the most severe types of physical violence – choking, burning, and the threatened or actual use of a weapon – in each site, over half of women who had experienced a violent act in the past 12 months had experienced that act more than once.

### Sexual violence

Overall, the percentage of women who reported sexual abuse by a partner ranged from 6% in Japan and Serbia and Montenegro to 59% in Ethiopia, with the majority of settings falling between 10% and 50%. The proportion of women physically forced into intercourse ranged from 4% in Serbia and Montenegro to 46% in provincial Bangladesh and Ethiopia. Nearly one third of Ethiopian women reported being physically forced by a partner to have sex against their will within the past 12 months. This high rate of forced sex is particularly alarming in the light of the AIDS epidemic and the difficulty that many women have in protecting themselves from HIV infection.

In most settings, about half of sexual violence was a result of physical force rather than fear. In Ethiopia and Thailand, however, a larger proportion of women reported having sex because they were afraid of something their partner might do. In all settings, some women reported being forced by partners into sexual behaviours that they found degrading or humiliating. Less than 2% of women in Ethiopia, Japan, Serbia and Montenegro, and urban United Republic of Tanzania reported this, compared to 11% of women in provincial Peru.

### Overlap between physical and sexual violence

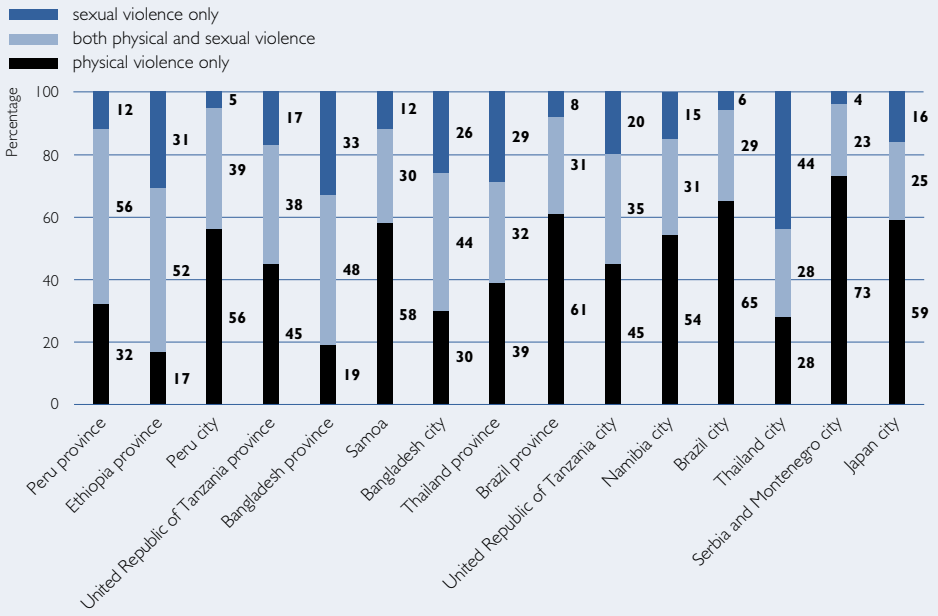
The WHO Study provides one of the first cross-cultural examinations of patterns of partner violence. As illustrated in Figure 4, the most common pattern is that women experience physical violence only, or both physical and sexual violence. In most sites between 30% and 56% of women who had experienced *any* violence by an intimate partner reported *both* physical and sexual violence. Only in the urban settings in Brazil and Thailand, and in Japan and Serbia and Montenegro was the overlap between physical and sexual violence less than 30%.

This pattern does not hold true in all settings, however. In both urban and provincial Thailand, and in provincial Bangladesh and Ethiopia, a substantial proportion of women experienced sexual violence only.

## Factors that protect women or put them at risk

An important aim of the WHO Study was to investigate personal, family and social factors that might protect a woman from violence, or might

**Figure 4** **Frequency distribution of types of violence by an intimate partner among ever-abused women, by site**




put her at greater risk. Taking an "ecological" approach, the interviews covered a variety of factors at different levels and within different contexts of a woman's life (**2, 11, 12**):

- *Individual* factors included the woman's level of education, financial autonomy, previous victimization, level of empowerment and social support, and whether there was a history of violence in her family as she was growing up.
- *Partner* factors included the male partner's level of communication with her, use of alcohol and drugs, employment status, whether he had witnessed violence between his parents as a child, and whether he was physically aggressive towards other men.
- Factors related to the *immediate social context* included the degree of economic inequality between men and women, levels of female mobility and autonomy, attitudes towards gender roles and violence against women, the extent to which extended family, neighbours, and friends intervene in domestic violence incidents, levels of male-male aggression and crime, and some measure of social capital.

Future analysis will explore whether and how these factors interact to increase or decrease a woman's risk of partner violence. The current descriptive analysis examines only how the sociodemographic factors age, partnership status and education, affect reported prevalence of abuse.

### Age

Younger women, especially those aged 15 to 19 years, were at higher risk of "current" (within the past 12 months) physical or sexual violence, or both, by a partner in all settings except Japan and Ethiopia. For example, in urban Bangladesh, 48% of 15–19-year-old women reported physical or sexual violence, or both, by a partner within the past 12 months, versus 10% of 45–49-year-olds. In urban Peru, the difference was 41% among 15–19-year-olds versus 8% of 45–49-year-olds. This pattern may reflect in part that younger men tend to be more violent than older men, and that violence tends to start early in many relationships. In some settings more younger women may be living together with their partners versus being married which, as described below, is associated with higher levels of violence. Also in some settings, older women have greater status than young women, and may therefore be less vulnerable to violence.

### Partnership status

In all but two settings, women who had been separated or divorced reported much more partner violence during their lifetime than currently married women (the exceptions were provincial Bangladesh and Ethiopia, where the proportion of divorced or separated women is relatively low in the general population). There was also more partner violence among women who were cohabiting (living with a man) rather than married. In almost half of the settings, there was more violence in the past 12 months

**“One day he returned home very late. I asked him “You are so late ... where did you go?” He answered, “I went to the red light zone. Do you have any problems with that?” I started shouting at him and he instantly landed a blow on my right eye. I screamed and he grabbed my hair and dragged me from one room to another while constantly kicking and punching me. He did not calm down at that ... He undid his belt and then hit me as much and as long as he wanted. Only those who have been hit with a belt know what it is like.”**

University-educated woman married to a doctor in Bangladesh

among women who were separated or divorced, implying in some cases that violence may persist even after separation.

### Education

The WHO Study found that higher education was associated with less violence in many settings. In some settings (urban Brazil, Namibia, Peru, Thailand, and the United Republic of Tanzania), the protective effect of education appears to start only when women's education goes beyond secondary school. Previous research also suggests that education for women has a protective effect, even when controlling for income and age (**13, 14**). It may be that women with higher education have a greater range of choice in partners and more ability to choose to marry or not, and are able to negotiate greater autonomy and control of resources within the marriage.

## Acts of emotional abuse

Qualitative research consistently finds that women frequently consider emotionally abusive acts to be more devastating than physical violence. The specific acts of emotional abuse by a partner in the WHO Study included the following:

- being insulted or made to feel bad about oneself;
- being humiliated or belittled in front of others;
- being intimidated or scared on purpose (for example by a partner yelling and smashing things);
- being threatened with harm (directly or indirectly in the form of a threat to hurt someone the respondent cared about).

Across all countries, between 20% and 75% of women had experienced one or more of these acts, most within the past 12 months. Those most frequently mentioned were insults, belittling, and intimidation. Threats of harm were less frequent, although almost one in four women in provincial Brazil and provincial Peru reported being threatened. Among women reporting each type of act, two thirds or more had experienced the behaviour more than once.

Because of the complexity of defining and measuring emotional abuse in a way that is relevant and meaningful across cultures, the results of the WHO Study's investigation of emotional violence and controlling behaviour should be considered a starting-point, rather than a comprehensive measure of all forms of emotional abuse. Future analysis, however, will explore the connection between emotional abuse and health outcomes; both emotional abuse by itself, and in addition to physical or sexual violence by partners.

**“Emotional abuse is worse. You can become insane when you are constantly humiliated and told that you are worthless, that you are nothing.”**

Woman interviewed in Serbia and Montenegro

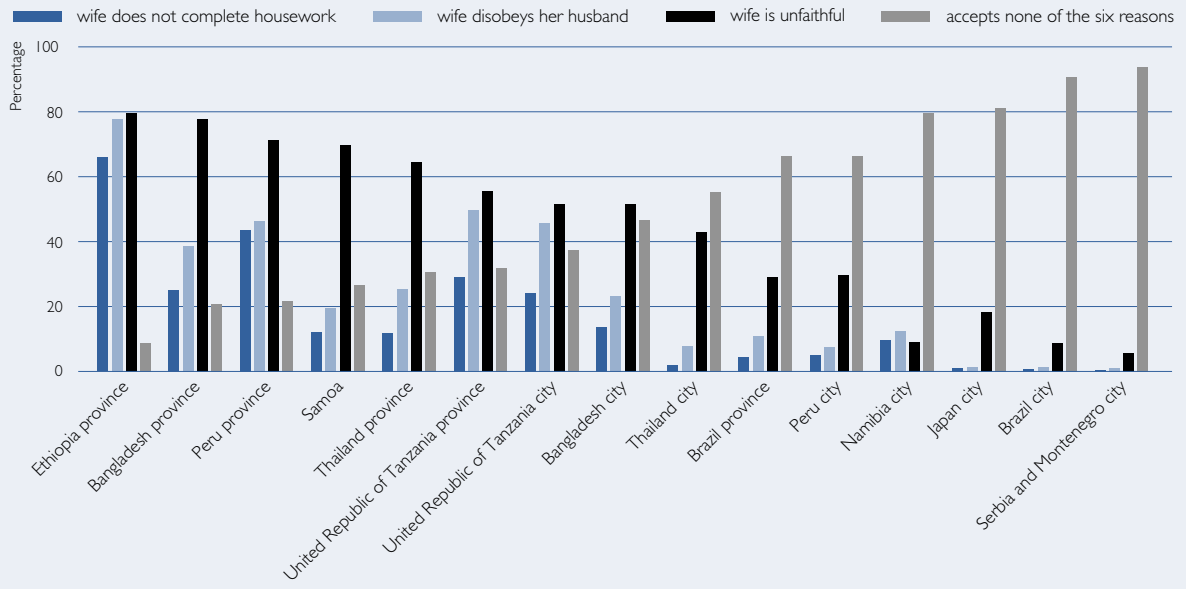
## Controlling behaviour

Men who physically abuse their partners also exhibit higher rates of controlling behaviour than men who do not (**3,15**). The WHO Study defined controlling behaviour by a woman's partner as including:

- keeping her from seeing friends;
- restricting contact with her family of birth;
- insisting on knowing where she is at all times;
- ignoring or treating her indifferently;
- getting angry if she speaks with other men;
- often accusing her of being unfaithful;
- controlling her access to health care.

The proportion of women reporting one or more of these behaviours by their partner varied from a low of 21% in Japan to almost 90% in urban United Republic of Tanzania. This suggests a great variation in the degree to which such behaviour is acceptable (normative) in different cultures.

**Figure 5** **Percentage of women agreeing with certain reasons that justify wife-beating, by site**




Significantly, the WHO Study data reveal that, in all sites, the experience of physical or sexual violence, or both, tends to be accompanied by more controlling behaviour by an intimate partner.

## Women's attitudes towards violence

In addition to women's experience of violent acts, the WHO Study investigated two important aspects of women's attitudes to partner violence:

- the circumstances under which women believe that a man is justified in beating his wife (wife-beating is probably the most common expression for physical violence by a male partner); and
- women's beliefs about whether and when a woman may refuse to have sex with her husband.

First, women were presented with six different situations and were asked, for each of these, whether she agreed or not that the specific reason justified wife-beating. The reasons most commonly given included not completing housework adequately, refusing to have sex, disobeying her husband, and being unfaithful. As can be seen in Figure 5, there was wide variation in women's acceptance of different reasons, and indeed with the idea that violence was ever justified. The most marked variation was between the urban, industrialized settings and the rural and traditional ones.

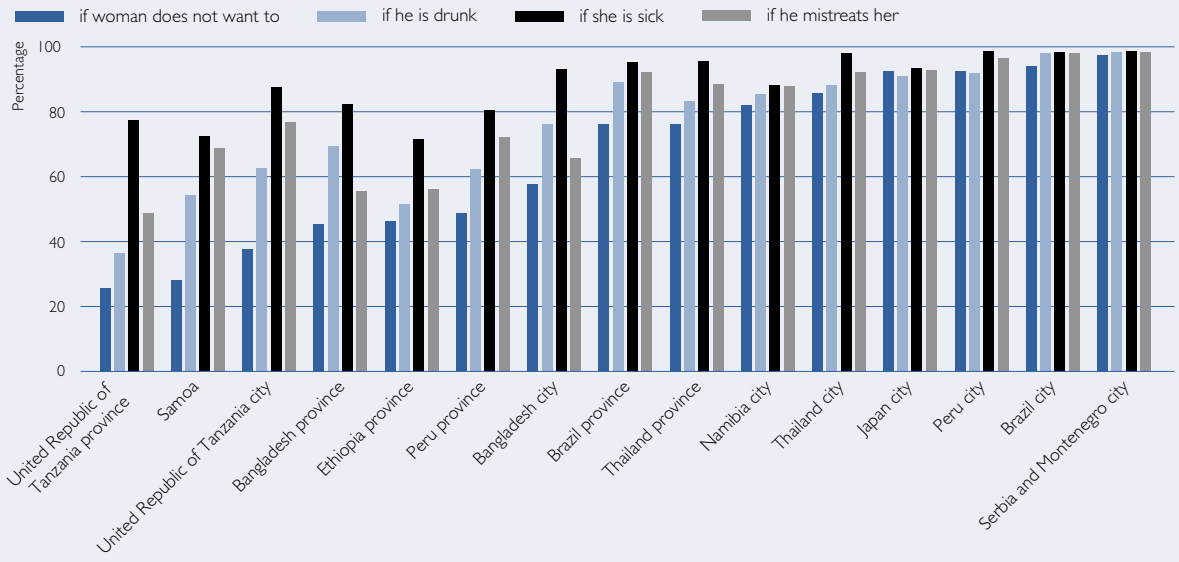
> **"My husband slaps me, has sex with me against my will and I have to conform. Before being interviewed I didn't really think about this. I thought this is only natural. This is the way a husband behaves."**
>
> Woman interviewed in Bangladesh

While over three quarters of women in the urban settings of Brazil, Japan, Namibia, and Serbia and Montenegro said that no reason justified violence, at most only a quarter thought so in the provincial settings of Bangladesh, Ethiopia, Peru, and Samoa. In all settings, the reason most widely accepted as a justification for violence was female infidelity, but the range was wide: from 80% in Ethiopia to 6% in Serbia and Montenegro. Disobeying a husband was the next most accepted reason.

In virtually all cases and for all reasons, acceptance of wife-beating was higher among women who had experienced abuse than among those who had not. This may indicate that women learn to "accept" violence in circumstances where they themselves are victims, or that women who see violence as "normal" are more likely to enter or remain in violent relationships. Future analyses will explore whether community levels of violence are higher in settings where violence against women is widely accepted.

Respondents were also asked whether they believed a woman has a right to refuse sex with her husband in a number of situations, including if

**Figure 6** **Percentage of women believing that a wife has a right to refuse to have sex with her husband under certain circumstances, by site**




she is sick, if she does not want to have sex, if the husband is drunk, and if the husband is mistreating her (Figure 6). As with physical violence, women appeared to make distinctions between the acceptability of different reasons to refuse sex. Fewer women felt sex could be refused based on a woman's preference (she doesn't want it) than if she was ill or the partner was drunk or abusive. In the provincial sites of Bangladesh, Peru, and the United Republic of Tanzania, and in Ethiopia and Samoa, between 10% and 20% of women felt that women did not have the right to refuse to have sex under *any* of these circumstances.

**"He got this gun, I don't know from who... And he would tell the girls: "I'm going to kill your mother... The day will break and your mother will be dead right here..." I would sleep in a locked bedroom and with a dog inside the room with me. My dog. So he would not kill me."**

Woman interviewed in Brazil

# 3 Violence against women by non-partners

In addition to partner violence, the WHO Study also collected data on physical and sexual abuse by men and women other than a current or former partner. This chapter explores:

- non-partner sexual and physical violence since the age of 15 years
- child sexual abuse before the age of 15 years
- forced first sex.

## Physical and sexual violence by non-partners since the age of 15 years

Women's reports of the experience of physical or sexual violence, or both, by a non-partner since the age of 15 years varied widely. The combined prevalence of physical and sexual violence by a non-partner after the age of 15 years ranged from 5% in Ethiopia to 65% in Samoa. Higher levels of non-partner violence were reported in the urban settings than in the provincial settings in all countries except Peru. Interestingly, despite high levels of partner violence in Ethiopia, less than 5% of women in these settings reported being physically or sexually abused by someone other than a partner.

### Physical violence since the age of 15 years

By far the highest level of physical violence by someone other than a partner was reported in Samoa at 62%, with the next highest prevalence being in Peru (28% in the urban setting and 32% in the provincial setting). Even in the settings with the lowest levels, Ethiopia and Japan, the figure was around 5%. In most settings, the violence was generally inflicted by one person, but in provincial Bangladesh, Namibia, Peru, Samoa, and the United Republic of Tanzania more than a fifth of respondents who had experienced non-partner physical violence reported two or more perpetrators. Commonly mentioned perpetrators for physical abuse by non-partners since the age of 15 years included fathers and other male or female family members, but in some settings (Bangladesh, Namibia, Samoa and the United Republic of Tanzania) teachers were also frequently mentioned.

### Sexual violence since the age of 15 years

Respondents were asked whether, since the age of 15 years, they had been forced by a non-partner to have sex or to perform a sexual act when they did not want to. The highest levels – between 10% and 12% – were reported in Peru, Samoa, and urban United Republic of Tanzania, while levels below 1% were reported in provincial Bangladesh and Ethiopia. The perpetrators included strangers, boyfriends, and male family members (not including fathers) or male friends of the family.

### Comparing partner and non-partner violence

A common perception is that women are more at risk of violence from strangers than from partners or other men they know. These data show that this is far from the case (Figure 7). Whereas between 4% (Ethiopia) and 35% (provincial Peru) of women reporting violence by any perpetrator since the age of 15 years have been abused by both partners and non-partners, in Ethiopia almost all violence is by partners, while in Samoa non-partner violence constitutes the largest part of the violence experienced by women. In the majority of settings, over 75% of women physically or sexually abused since the age of 15 years reported abuse by a partner. In only two settings, urban Brazil and Samoa, were at least 40% of women abused only by someone other than a partner.

## Sexual abuse before the age of 15 years

Since early sexual abuse is a highly sensitive issue that is difficult to explore in a survey, two different approaches were used to ask about it. Women were first asked directly whether anyone had ever touched them sexually, or made them do something sexual that they did not want to

before the age of 15 years. In all countries except Bangladesh, the same question was asked again at the end of the interview, but the women were invited to mark their response on a card with a pictorial representation for "yes" and "no" (a smiling and a crying face of a girl). They then folded this card or sealed it in an envelope, thus keeping their response concealed from the interviewer.

As shown in Figure 8, in all but one setting (urban Peru) anonymous reporting resulted in more reports of sexual abuse before the age of 15 years. For example, Ethiopia had the lowest level of directly reported sexual abuse at less than 1%, but this rose to 7% in the anonymous responses. Large increases between direct and anonymous responses were also seen in Japan (10% to 14%), Namibia (5% to 21%), and urban United Republic of Tanzania (4% to 11%). Women in Bangladesh were not comfortable marking a piece of paper without their husband's permission, and so only direct figures were produced (7% in the urban and 1% in the provincial setting). The most frequently mentioned perpetrators were male family members other than a father or stepfather.

**Figure 7** **Frequency distribution of partner and non-partner physical or sexual violence, or both, among women reporting such abuse since the age of 15 years, by site**

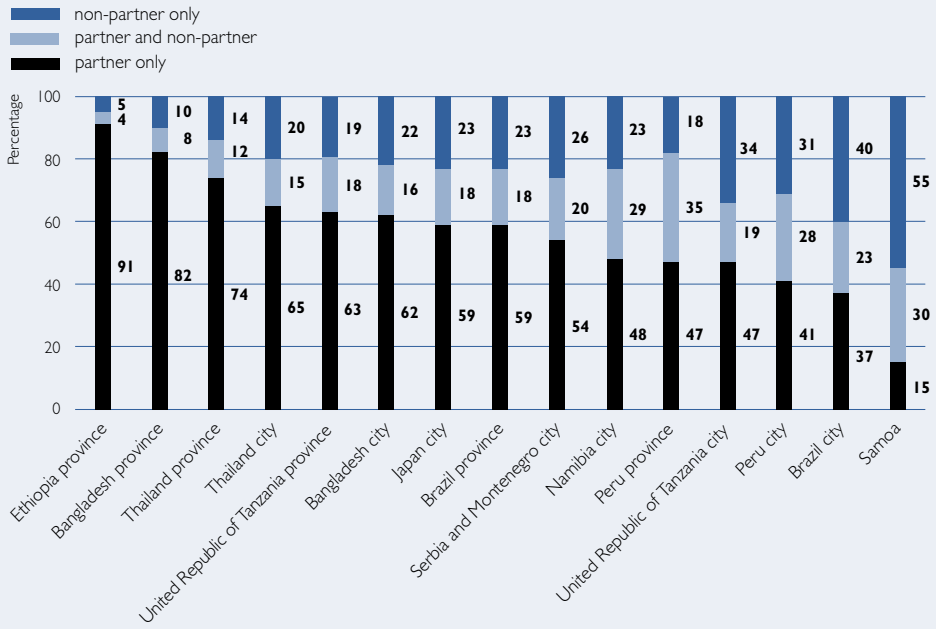
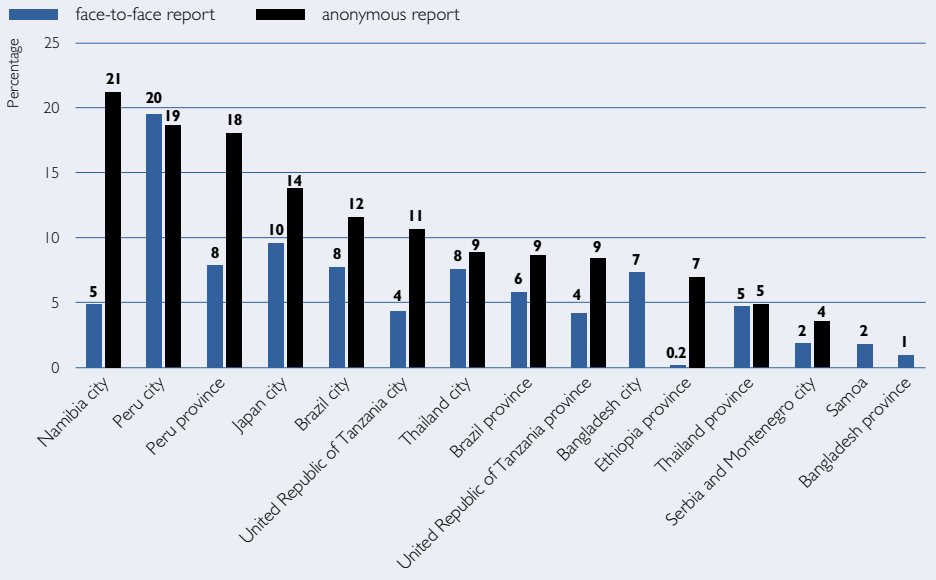



**Figure 8** **Sexual abuse before age 15 years: face-to-face versus anonymous report among all women, by site**




Note: No data from anonymous report available for Bangladesh and Samoa.

## Forced first sex

Respondents were asked whether their first experience of sexual intercourse was (a) forced (b) not wanted but not forced, or (c) by choice, and the age at which this experience had happened. In 10 of the 15 settings, over 5% of women who had ever had sex reported their first sexual experience as forced, as shown in Figure 9. The figure was 14% or more in Bangladesh, Ethiopia, provincial Peru, and the United Republic of Tanzania. The wide variation may in part reflect social attitudes towards female sexuality (for example, in cultures which frown on women expressing a desire to have sex, women may have a higher tendency to report their first sexual experience as forced) or real cultural differences in women's ability to control the circumstances of their first experience of sexual intercourse.

In all settings except Ethiopia, the younger a woman at the time of her first experience of sexual intercourse, the greater the likelihood that her sexual initiation was forced. Figure 10 shows that in more than half the settings, over 30% of women who reported first sex before the age of 15 years described that sexual experience as forced. This is consistent with other studies, which have documented a strong association between early sexual initiation and coercion (**16**). In some countries (notably Bangladesh and Ethiopia) high levels of forced first sex are likely to be related to early sexual initiation in the context of early marriage, rather than to violence by acquaintances or strangers.

**Figure 9** **Percentage of women reporting that their first experience of sexual intercourse was forced, among sexually experienced women, by site**

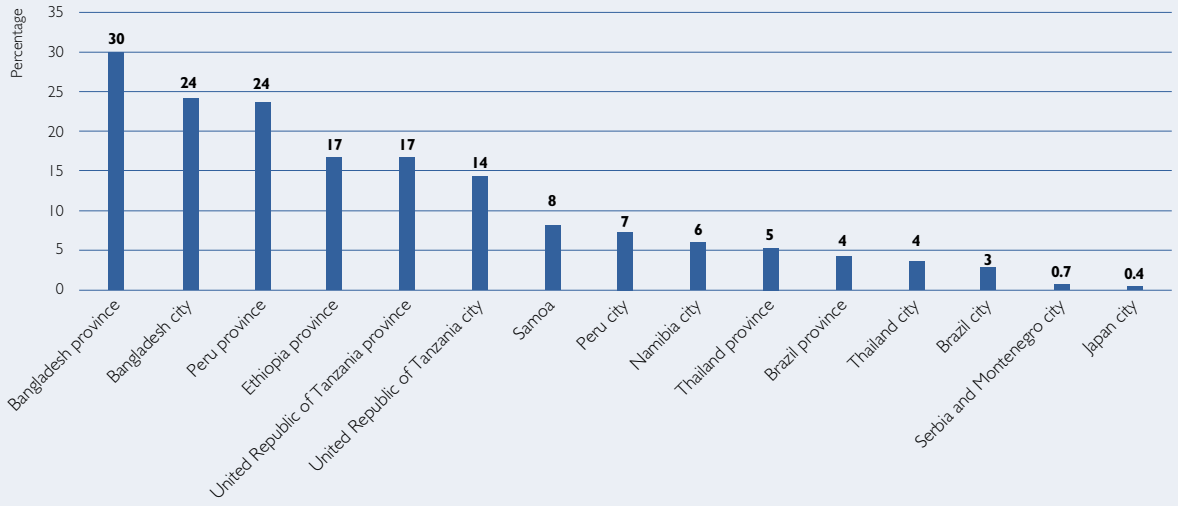
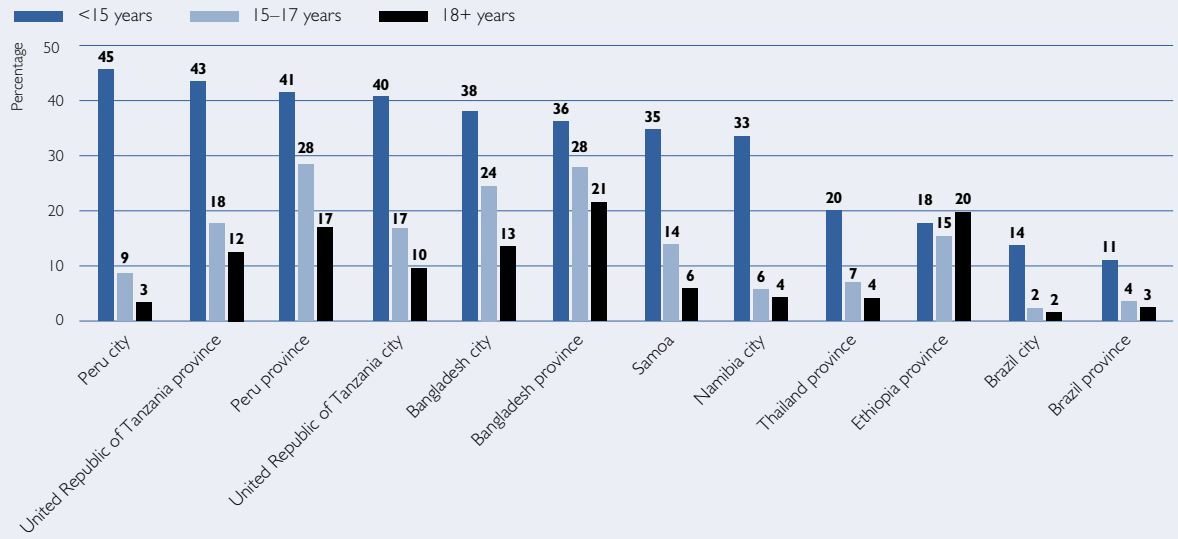



**Figure 10** **Percentage of women reporting that their first experience of sexual intercourse was forced, among sexually experienced women, by age of women at the time of first sexual experience, and by site**




Note: Japan city, Serbia and Montenegro city, and Thailand city are not represented because of the low percentages reporting first sex before the age of 15 years.

# 4 Partner violence and women's health

The role of partner violence in women's injury and ill-health has become a major concern in public health. The WHO Study collected a variety of data about each respondent's current physical and mental health, and about illness and use of health services in the month prior to the interview. Women who reported having experienced physical violence by an intimate partner were asked about the forms and frequency of different injuries, and the health care they received, if any.

Information was also collected about women's reproductive history, such as the number of pregnancies, stillbirths, spontaneous and induced abortions, live births, and children currently alive. Details about the most recent live birth in the past 5 years were also documented.

Although a cross-sectional survey cannot establish whether violence *causes* particular health problems (with the exception, obviously, of injuries), the results of the WHO Study strongly support other research which has found strong *associations* between violence and both physical and mental symptoms of ill-health.

## Injury resulting from physical violence

Respondents were asked if they had experienced injury as a result of physical violence by an intimate partner (a) once or twice, (b) three to five times, (c) more than five times. The prevalence of injury among ever-abused women ranged from 19% in Ethiopia to 55% in provincial Peru. Injuries were associated with severe physical violence. In Brazil, provincial Peru, Samoa, Serbia and Montenegro, and Thailand over 20% of ever-injured women reported that they had been injured more than five times.

Although the majority of injuries were classed as minor (bruises, abrasions, cuts, punctures, and bites), in some settings, more serious injuries (broken bones, injuries to ears and eyes) were relatively common. At least 20% of ever-injured women in Namibia, provincial Peru, Samoa, urban Thailand, and the United Republic of Tanzania reported injuries to the eyes and ears. In Bangladesh, Ethiopia, provincial Peru, and Samoa, over a quarter of ever-injured women reported that they had lost consciousness as a result of partner violence.

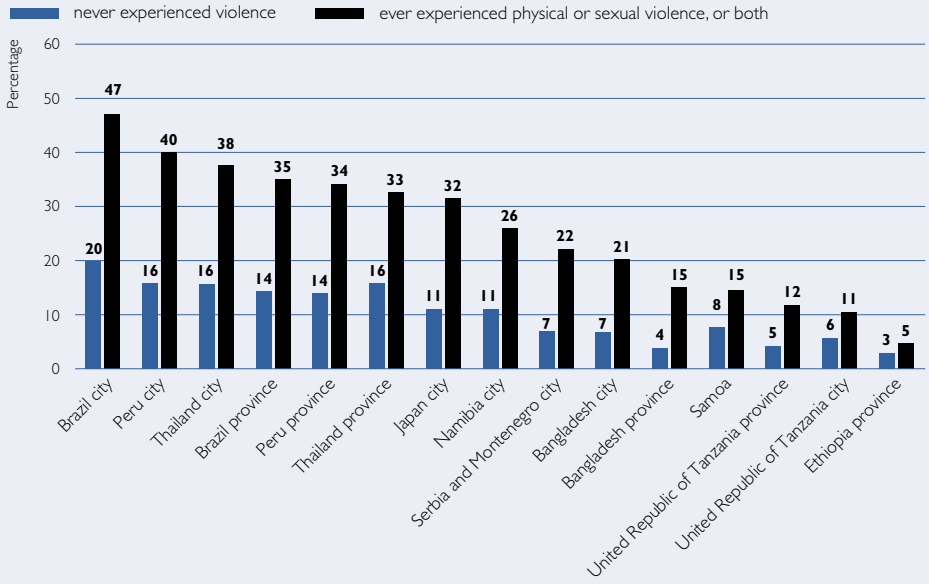
## Intimate-partner violence and physical health

Although it is a subjective measure, self-reported health is considered to be predictive of illness in a population-based survey (**17,18**). The WHO Study asked respondents whether they considered their general health to be excellent, good, fair, poor, or very poor. Respondents were further asked for each item on a list of health problems whether they had experienced the problem during the 4 weeks prior to the interview and how serious it was.

In the majority of settings (except Japan, Samoa, and urban United Republic of Tanzania), women who had ever experienced physical or sexual partner violence, or both, were significantly more likely to report poor or very poor health than women who had never experienced partner violence. Ever-abused women were also more likely to have had problems with: walking and carrying out daily activities, pain, memory loss, dizziness, and vaginal discharge in the 4 weeks prior to the interview. It is particularly noteworthy that *recent experiences of ill-health* were associated with *lifetime experiences of violence*. This suggests that the physical effects of violence may last long after the actual violence has ended, or that cumulative abuse affects health most strongly.

In the settings where no significant association between violence and ill-health was found, the findings may have been affected by low reporting of symptoms of ill-health. For example, less than 3% of non-abused women in Ethiopia, Japan, Namibia, Samoa, and the urban site in the United Republic of Tanzania reported poor health. Differences among settings were undoubtedly also influenced by cultural variations in how health and ill-health are perceived.

**Figure 11** **Percentage of ever-partnered women reporting suicidal thoughts, according to their experience of physical or sexual violence, or both, by an intimate partner, by site**




Note: The differences in rates between abused and non-abused women are statistically significant in all sites, except in Ethiopia.

**"I suffered for a long time and swallowed all my pain. That's why I am constantly visiting doctors and using medicines. No one should do this."**

Woman interviewed in Serbia and Montenegro

## Intimate-partner violence and mental health

Around the world, mental health problems, emotional distress, and suicidal behaviour are common among women who have suffered partner violence (**2**). In the WHO Study emotional distress was identified through symptoms such as crying easily, inability to enjoy life, fatigue, and thoughts of suicide in the 4 weeks prior to the interview. In all settings, ever-partnered women who had ever experienced physical or sexual violence, or both, by an intimate partner reported significantly higher levels of emotional distress than non-abused women.

Likewise, in all settings, ever-partnered women who had been abused by their partners were much more likely to have ever thought of suicide (Figure 11), and to have attempted it than non-abused women. This is consistent with other research in developing and industrialized nations. Since the Study did not collect information about actual suicides, the association between violence and suicidal behaviour is likely to be underestimated.

**"I tried drinking Genola. It's a washing liquid.... I went to the hospital for that and they helped me out. I see these faces, his family's faces all staring at me, giving me the evil eye. Like they thought I should do it. I should die."**

Woman interviewed in Samoa

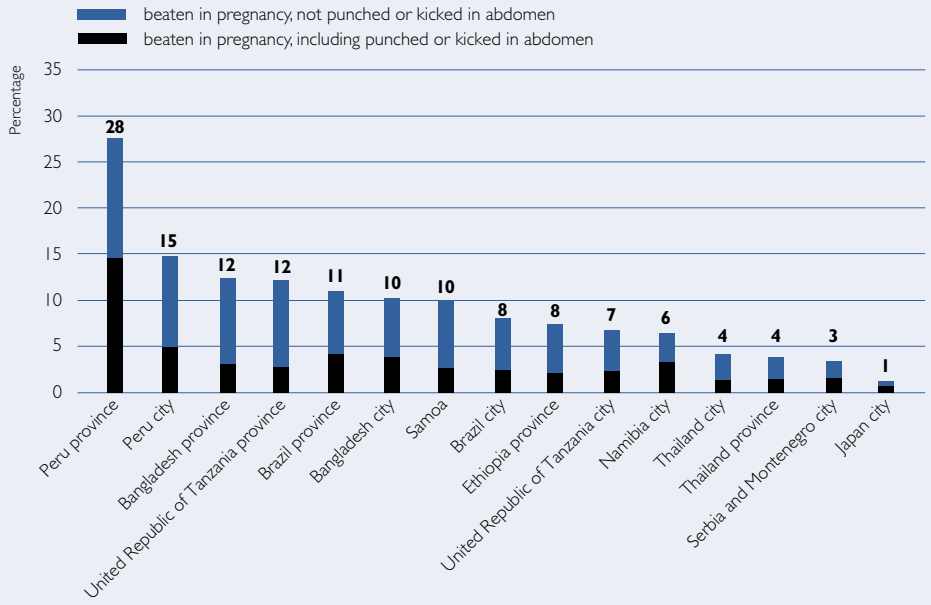
## Intimate-partner violence and reproductive health

### Violence during pregnancy

The proportion of ever-pregnant women physically abused during at least one pregnancy exceeded 5% in 11 of the 15 settings. The lowest figure was 1% in Japan, and the highest was 28% in provincial Peru. Between a quarter and half of the women who were physically abused during pregnancy were kicked or punched in the abdomen (Figure 12). In all settings but one, between 11% and 44% of ever-abused ever-pregnant women reported being assaulted during pregnancy; in the exception, Japan, the figure was 8%. In all sites, over 90% were abused by the biological father of the child the woman was carrying, most of whom were living with the woman at the time.

While the majority of those beaten during pregnancy had experienced physical violence before, between 13% (Ethiopia) and approximately 50% (urban Brazil and Serbia and Montenegro) said they were beaten for the first time during pregnancy.

**Figure 12** **Percentage of ever-pregnant women who were ever beaten in at least one pregnancy, by site**




The majority of women who experienced violence both before and during a pregnancy in all sites reported that, during the last pregnancy in which they were abused, the violence was the same or somewhat less severe or frequent than before the pregnancy. The results support findings from both developing and industrialized countries that pregnancy can be a time of protection from violence, but this is not consistent across all cultures (**19**).

> **"He hit me in the belly and made me miscarry two babies – identical or fraternal twins, I don't know. I went to the Loayza hospital with heavy bleeding and they cleaned me up."**
>
> Woman interviewed in urban Peru

### Miscarriages and induced abortions

In the majority of settings, ever-pregnant women who had experienced physical or sexual partner violence, or both, reported more induced abortions. However, the difference was not statistically significant in provincial Bangladesh, Namibia, and Samoa, where very few abortions were reported at all. Abused women were also more likely to report having had a miscarriage than women who had never experienced partner violence.

### Use of antenatal and postnatal health services

In most settings there was no difference in the use of antenatal services by abused and non-abused women who had had a live birth in the 5 years preceding the interview. However, in urban Bangladesh, Ethiopia, and provincial United Republic of Tanzania, women who were ever physically or sexually abused by their partner were significantly less likely to have attended an antenatal service for the most recent live birth. There was more variation in the levels of contact with postnatal services between countries. In the urban sites in Bangladesh, Brazil, Peru, and Thailand, and in the provincial site in the United Republic of Tanzania, women who reported partner violence were significantly less likely to have received postnatal care for their most recent live birth than women who did not report partner violence.

# 5 Coping and responding to intimate-partner violence

Many of the studies on women's responses to partner violence have been carried out on women using support services such as shelters or counselling services. At a population level, however, little is known about women's responses to violence, or about the help they receive from informal networks (families, friends, and so on) and formal health or social services. The WHO Study therefore made this an important focus of its research.

## Who women tell about violence

In all countries, the interviewer was frequently the first person that abused women had *ever* talked to about their partner's physical violence. As can be seen in Figure 13, two thirds of women who had been physically abused by their partner in Bangladesh, and about half in Samoa and provincial Thailand, had not told anybody about the violence prior to the interview. In contrast, about 80% of physically abused women in Brazil and Namibia had told someone, usually family or friends. But even in these settings, two out of 10 women had kept silent about their experience.

Relatively few physically abused women in any setting had told staff of formal services or people in positions of authority such as religious or traditional leaders, health personnel, police, counsellors, and staff of women's nongovernmental organizations about the violence. In all settings, women who had experienced severe physical violence were more likely to talk to someone than those who had experienced moderate physical violence.

## Who tries to help

Although many respondents reported having told family and friends about their partner's violence, they were less likely to report that these people had tried to help. In fact, across all settings between 34% and 59% of physically abused women reported that no one had tried to assist them. In the provincial site in the United Republic of Tanzania, for instance, although a quarter of women had talked with local leaders, only 7% said these leaders had tried to help. It is not clear whether this contact improved the situation. In some cases, for example, family members may condone the man's violence, or suggest arrangements that prioritize the needs or well-being of the family over the woman's safety.

## Which agencies or authorities women turn to

Research in many countries has shown that informal networks such as family, friends, and neighbours usually provide the first point of contact for abused women, rather than more formal services (**20**). This finding is supported by the results of the WHO Study, which asked respondents about their use of different formal services (health services, legal advice, shelters) or whether they had contacted people in positions of authority (police, women's nongovernmental organizations, local leaders, religious leaders). Figure 14 shows that even when women told someone about the physical abuse, in each site a much smaller proportion of women sought help. Indeed, the majority of physically abused women (between 55% and 95%) reported that they had never gone to any of these agencies.

The finding that more women had talked informally to someone than had sought formal help may in part reflect that an individual's response to violence may take time to develop. In some cases, it may take years before a woman starts to challenge or question the violence in her life, and even longer before she seeks help (**21**).

The lowest levels of contact with different agencies and authorities to seek help were

**Figure 13** **Percentage of ever physically abused women who had told no one, someone, or a service or authority about their experience of intimate-partner violence, by site**

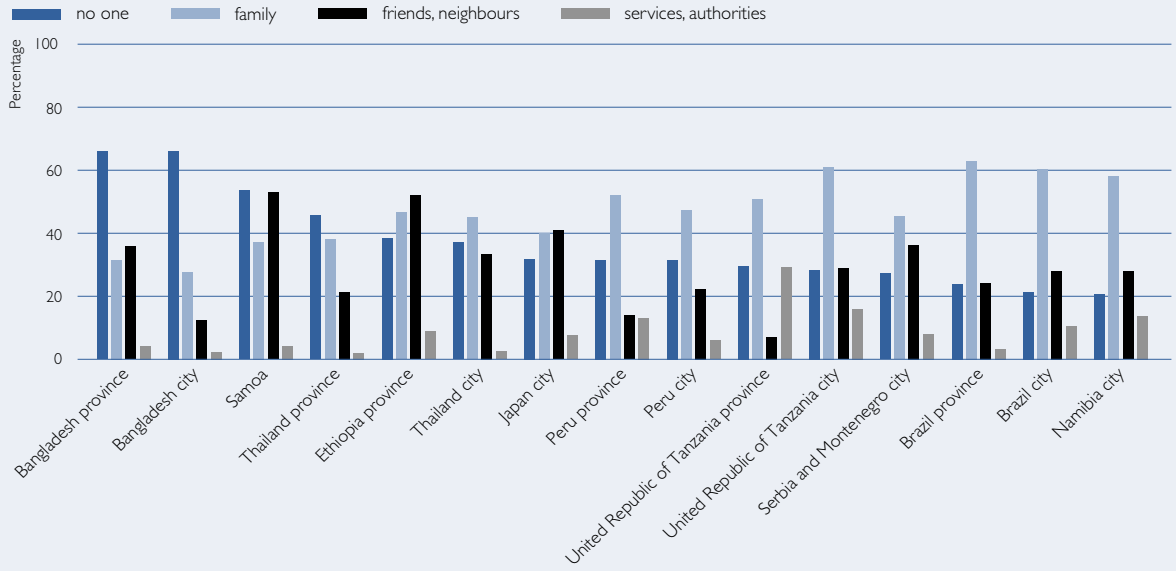
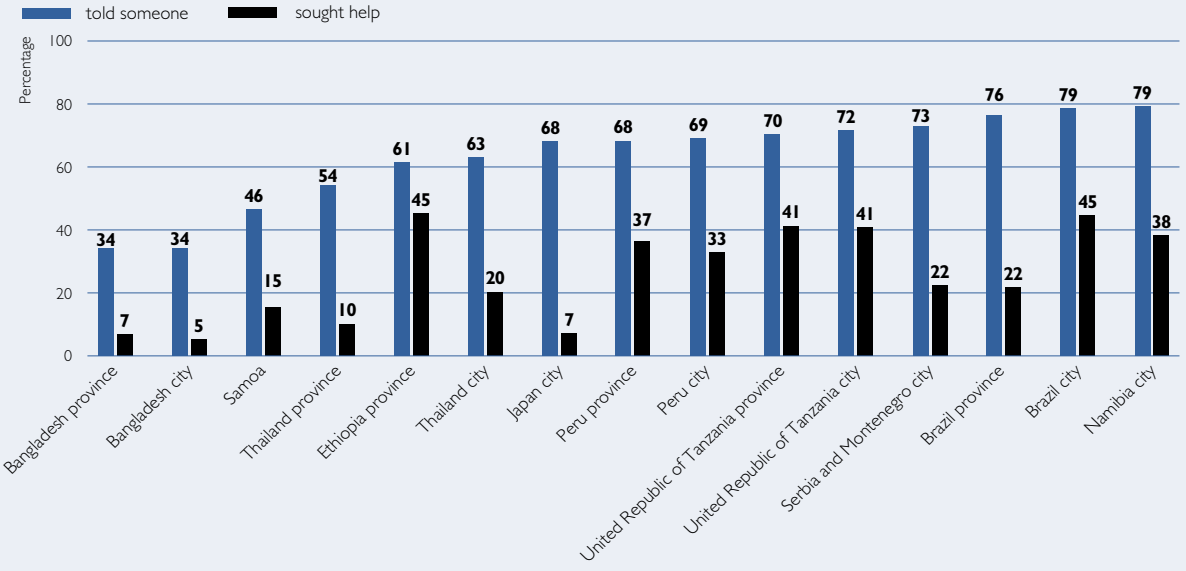



**Figure 14** **Percentage of ever physically abused women who had told someone about their experience of intimate-partner violence, compared with the percentage of ever physically abused women who had sought help, by site**



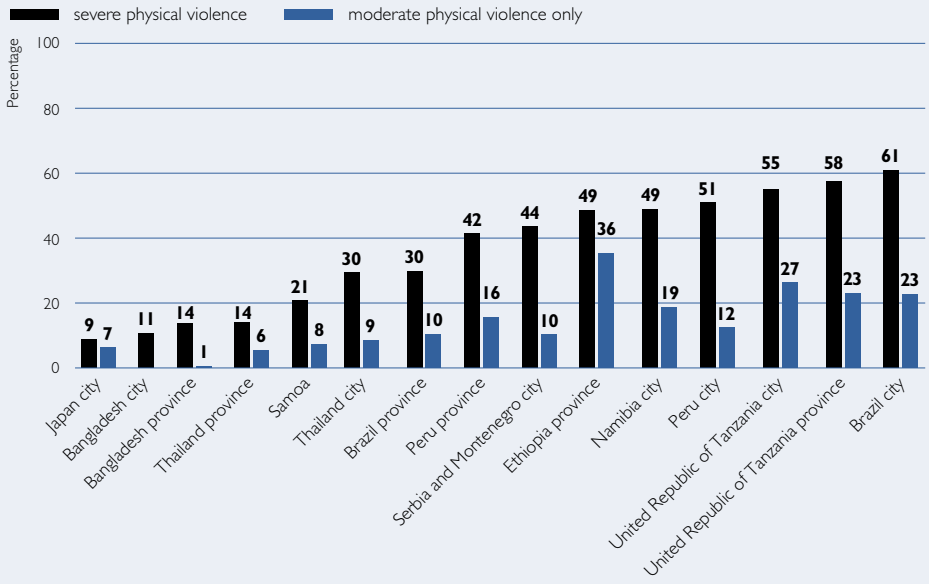

found in Bangladesh, Japan, Samoa, and provincial Thailand. Only in Namibia and Peru had more than 20% of physically abused women contacted the police, and only in Namibia and urban United Republic of Tanzania had more than 20% sought help from health care services. In eight of the settings, less than 10% of physically abused women reported seeking help for abuse from health services. In Ethiopia and provincial United Republic of Tanzania, 15% and 31% of physically abused women, respectively, sought support from local leaders, while in urban Brazil, 15% of women sought help from religious leaders.

### 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 (Figure 15). The most frequently given reasons for seeking help were related to the severity of the violence (e.g. she could not endure more or she was badly injured), its impact on her children, or encouragement from friends and family to seek help.

The respondents' most common reason for not seeking help was either that they considered the violence normal or not serious (from 29% of women who reported not seeking help in provincial Peru to 86% in Samoa), or that they

**Figure 15** **Percentage of ever physically abused women who sought help from at least one agency or authority, by severity of intimate-partner violence, and by site**




feared consequences such as further violence, losing their children, or bringing shame to their family. Some felt they would not be believed, or that it would not help.

This low use of formal services also 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 (**22**).

## Do women fight back?

The proportion of physically abused women reporting that they fought back against their partners varied greatly between settings, from 6% in provincial Bangladesh to 79% in urban Brazil. In eight of the 15 settings (Japan, Serbia and Montenegro, and both the urban and provincial sites in Brazil, Peru, and Thailand) more than half of the physically abused women reported having fought back. In all settings, the likelihood of doing so was higher among women who had experienced severe physical violence than those who had experienced moderate physical violence.

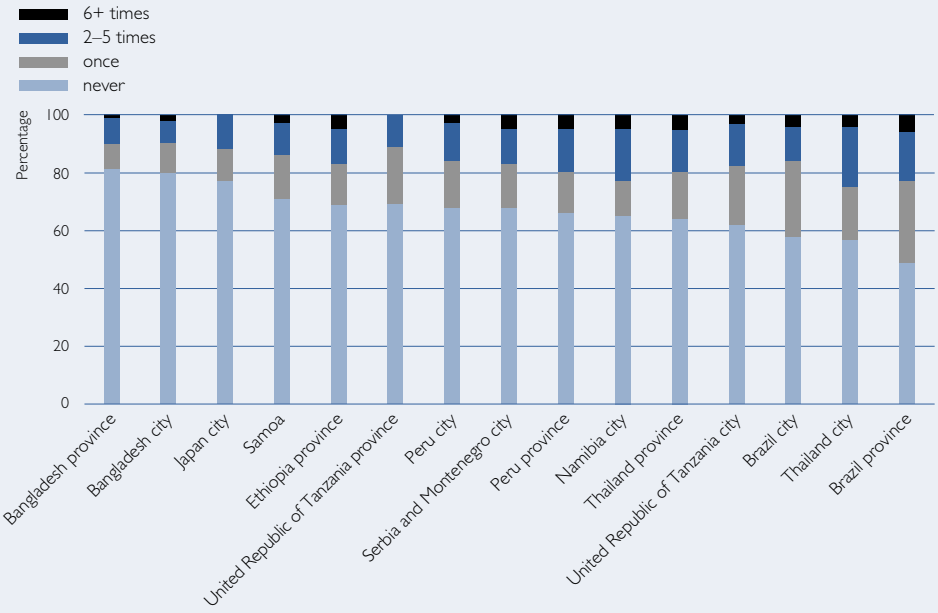
As explained earlier, the WHO Study did not directly address the question of violence perpetrated against men by their female partners. However, all physically abused women were asked if they had initiated violence against a partner when he was not already physically abusing her. Only in Thailand did more than 15% of ever physically abused women report initiating violence against their partner more than twice in their lifetime. The proportion was especially low in more traditional societies. In provincial Bangladesh and Ethiopia, less than 1% of physically abused women reported ever initiating violence against a partner. These findings mirror results from the Demographic and Health Surveys in other countries (**23**).

## Leaving or staying with a violent partner

As shown in Figure 16, between 19% and 51% of women who had been physically abused by their partner had ever left overnight for at least one night. Between 8% and 21% reported leaving 2–5 times. Again there is a strong relationship between leaving and the severity of physical violence. The severity of the violence was, indeed, the main reason given for leaving (the woman could not endure more, she was badly injured, or her partner had threatened or tried to kill her).

In most settings, women who left home mainly reported going to their relatives, and to a lesser extent to friends or neighbours. However, in Namibia, and in the provincial sites in Bangladesh and the United Republic of Tanzania, between 10% and 16% of women who had left at least once reported staying with their partner's family the last time they left. Shelters were mentioned only in urban Brazil and Namibia and in these sites only very few times (by less than 1% of women who left). Again, these patterns are likely to reflect both the availability of places of safety for women and their children, and culturally specific factors relating to the acceptability of women leaving, or staying anywhere without their partner.

**Figure 16** **Number of times women left (for at least one night) because of intimate-partner violence among ever physically abused women, by site**




In all settings a large proportion (between 43% and 90%) of women who had left reported as reasons for leaving that they "could not endure more" or because the violence had become very severe. For example, in Namibia and the provincial settings in Peru and the United Republic of Tanzania, more than 20% left because they were badly injured. In provincial Brazil, Namibia, and both settings in Peru, over 10% reported that their partner had threatened to kill them.

**"So I take a blanket and I spend the night with my children out in the cold because he is hitting me too much and I have to take the kids to stop him hitting them too. I would go up the mountain, and sleep there all night. I've done that more than ten times."**

Woman interviewed in provincial Peru

**Why do women return?**

There was wide variation between settings in the reasons women gave for returning home to a partner who had abused them. Women frequently reported returning home because they could not leave the children, or "for the sake of the family". Other reasons were that the woman loved her partner, that he asked her to come back, that she forgave him or thought he would change, or because the family said she should return. Women who never left gave similar reasons, as well as indicating that they did not know where to go.

**"I did not know where I could go for help. Now I know where I can go. I was looking for such places. It is good to address these types of issues in a survey."**

Woman interviewed in Japan

# 6 Recommendations

The results of the WHO Multi-country Study on Women's Health and Domestic Violence against Women highlight the need for urgent action by a wide range of actors, from local health authorities and community leaders to national governments and international donors.

As the Study clearly demonstrates, violence against women is widespread and deeply ingrained, and has serious impacts on women's health and well-being. Its continued existence is morally indefensible; its cost to individuals, to health systems, and to society in general is enormous. Yet no other major problem of public health has – until relatively recently – been so widely ignored and so little understood.

The wide variations in prevalence and patterns of violence from country to country, and, even more important, from setting to setting within countries, indicate that there is nothing "natural" or inevitable about it. Attitudes can and must change; the status of women can and must be improved; men and women can and must be convinced that partner violence is not an acceptable part of human relationships.

The following recommendations are drawn primarily from the findings of the Study, but are also informed by research and lessons learned from experience in many countries. In particular, they reinforce the findings and recommendations presented in WHO's *World report on violence and health* (**2**), particularly the detailed recommendations in Chapter 4 on violence by intimate partners and Chapter 6 on sexual violence. They are grouped into the following categories:

- Strengthening national commitment and action
- Promoting primary prevention
- Involving the education sector
- Strengthening the health sector response
- Supporting women living with violence
- Sensitizing criminal justice systems
- Supporting research and collaboration

Addressing and preventing violence against women requires action at many levels and by many actors and sectors. However, it is important that states take responsibility for the safety and well-being of their citizens. In this regard, governments, in collaboration with nongovernmental organizations, international organizations and donors, need to give priority to implementing the following recommendations.

## Strengthening national commitment and action

### Recommendation 1

**Promote gender equality and women's human rights.**

Violence against women is an extreme manifestation of gender inequality that needs to be addressed urgently, as such violence in turn perpetuates this inequality. The unequal status of women is also associated in a variety of ways with domestic violence and with women's responses to that violence. Improving women's legal and socioeconomic status is likely to be, in the long term, a key intervention in reducing women's vulnerability to violence. This includes: awareness of their rights, and measures to ensure women's rights related to owning and disposing of property and assets, access to divorce and child custody following separation. Women's access to education – in particular keeping girls enrolled through secondary education – and to safe and gainful employment should also be strongly supported as part of overall anti-violence efforts. National efforts to challenge the widespread tolerance and acceptance of violence against women are also important.

Considerable progress would be realized if governments complied with human rights treaties and international agreements that they have already ratified, such the Convention on the Elimination of All Forms of Discrimination against Women (1979), the United Nations Declaration

on the Elimination of Violence against Women (1993), the 1994 Programme of Action of the International Conference on Population and Development (ICPD) (**24**), the 1995 Declaration and Platform for Action of the Fourth World Conference on Women (the "Beijing Declaration") (**7**), and the 2000 Millennium Declaration and Development Goals (**25**).

Governments should strive to harmonize their legislation with these commitments and bring about the necessary changes in national laws, policies and programming. Advocacy for gender equality and human rights, and monitoring of national progress towards international commitments, need to be strengthened.

### Recommendation 2

**Establish, implement and monitor multisectoral action plans to address violence against women.**

Governments must commit themselves to reducing violence against women, which is a major and preventable public health problem. The prevention of violence against women should rank high on national public health, social, and legal agendas.

Governments should publicly acknowledge that the problem exists, make a commitment to act, plan and implement national programmes both to avert future violence and to respond to it when it occurs, and invest significant resources in programmes to address violence against women, particularly partner violence and sexual abuse of girls.

Countries that are devising national action plans for violence prevention – a key recommendation in the *World report on violence and health* (**1**) – should give high priority within them to preventing violence against women and particularly intimate-partner violence.

Reducing violence against women will take concerted and coordinated action by a range of different sectors (e.g. health and social services, religious organizations, the judiciary and police, trade unions and businesses, and the media). It is important that a formal mechanism is created and provided with sufficient resources to coordinate multisectoral efforts, and should ideally be identified with the highest level of political office.

### Recommendation 3

**Enlist social, political, religious, and other leaders in speaking out against violence against women.**

People – particularly men – in positions of authority and influence (e.g. political, religious, and traditional leaders) can play an important role in raising awareness about the problem of violence against women, challenging commonly held misconceptions and norms, and shaping the discussion in ways that promote positive change. Coordinated action by coalitions or alliances of figures from different sectors may be a more effective approach than identifying the issue with a single figure or sector.

### Recommendation 4

**Enhance capacity and establish systems for data collection to monitor violence against women, and the attitudes and beliefs that perpetuate it.**

Surveillance is a critical element of a public health approach as it allows trends to be monitored and the impact of interventions to be assessed. Responsibility for such surveillance should be explicitly given to an institution, agency or government unit, in order to ensure the use of a standardized methodology and the establishment of mechanisms to guarantee that data will be disseminated and used properly. Building capacity in surveillance, including the use of surveys is an important element in this.

Discussions are being held internationally about how best to monitor violence against women, using both regular surveys and routine data collection in different service points. In this regard, the WHO questionnaire, the ethical and safety guidelines developed for the Study (**10**), and the forthcoming PATH/WHO *Manual on research methodologies for studying violence against women* (**26**) provide useful tools. The *Injury surveillance guidelines* developed by WHO and CDC, also provide practical advice on collecting systematic data on injuries, according to international standards (**27**).[1] National statistics offices and relevant ministries, particularly health and justice, as well as organizations providing services for women, should ensure that data are collected in a way that respects confidentiality and does not jeopardize women's safety (**28**).

[1] The *Injury surveillance guidelines* are available online at http://www.who.int/violence_injury_prevention/publications/surveillance/surveillance_guidelines/en/ or through WHO.

## Promoting primary prevention

### Recommendation 5

**Develop, implement and evaluate programmes aimed at primary prevention of intimate-partner violence and sexual violence.**

Preventing partner violence requires changing the gender-related attitudes, beliefs, and values of both women and men, at a societal as well as

at an individual level. Prevention efforts should include multimedia and other public awareness activities to challenge women's subordination, and to counter the attitudes, beliefs and values – particularly among men – that condone partner violence as normal.

The specific media and key messages should be based on research and consultation. An important objective is to eliminate the barriers that prevent women talking about the problem and using available support services. This involves reducing the stigma, shame and denial around partner violence against women, and strengthening informal support networks by encouraging family and community members to reach out to and support women living with violence.

Special efforts should be made to reach men. Media strategies can encourage men who are not violent to speak out against violence and challenge its acceptability. This will help counter notions that all men condone violence and provide alternative role models of masculine behaviour to those usually portrayed by the media.

Targeted efforts should be carried out in health settings, in schools, at workplaces, and within different professions and sectors. Other communication strategies should be explored including community-based approaches (e.g. legal literacy programmes, HIV/AIDS community mobilization, local media initiatives) and activities to target specific risk factors for violence such as alcohol use. Communities need to be encouraged to talk about partner violence and to challenge its acceptability. Overall, there is a need to strengthen primary prevention efforts.[2]

[2] WHO's Global Campaign for Violence Prevention aims to raise awareness about the problem of violence, highlight the crucial role that public health can play in addressing its causes and consequences, and encourage action at every level of society. For more information please see http://www.who.int/violence_injury_prevention/violence/en/

## Recommendation 6

**Prioritize the prevention of child sexual abuse.**

The high levels of sexual abuse experienced by girls documented by the Study are of great concern. Such acts are severe violations of a young girl's basic rights and bodily integrity, and may have profound health consequences for her, both immediately and in the long term. Efforts to combat sexual abuse of girls (and boys) therefore, should have higher priority in public health planning and programming, as well as in responses by other sectors such as the judiciary, education, and social services.

Advocacy by leaders and other respected figures could make a big difference, because it can help "break the silence" and create social space for discussion of the problem within families and communities.

The health and educational sectors need to develop the capacity to identify and deal with child sexual abuse. This will require protocols, training, and resources for health workers.

Similarly, teachers and other education professionals need training to recognize child abuse, as well as protocols and policies for referral to medical or social services. Schools should also provide preventive programmes and counselling wherever possible.

## Recommendation 7

**Integrate responses to violence against women in existing programmes for the prevention of HIV and AIDS, and for the promotion of adolescent health.**

The Study findings illustrate the high levels of sexual violence against women and girls, and support other research which suggests that violence contributes to women's vulnerability to HIV infection. Preventing violence against women will contribute to improving the effectiveness of HIV/AIDS programmes. HIV prevention programmes should therefore include activities to raise awareness and promote the prevention of sexual violence as well as intimate-partner violence, recognize the extent to which sexual activity is forced or coerced, and explicitly address issues of consent and coercion. Strategies are needed to respond to women who are experiencing or who fear violence and who are attending HIV services, family planning or other sexual and reproductive health services. Sexual and reproductive health programmes, as well as those promoting adolescent health also need to address intimate-partner violence, and issues of coercion and forced sex.

## Recommendation 8

**Make physical environments safer for women.**

Measures to make urban and rural environments safer for women can contribute to primary prevention. Such measures should be implemented systematically, by identifying places where violence against women often occurs and analysing why it occurs there. Depending on the risk factors identified and the available resources, safety can be enhanced through, for example, improving lighting, increasing police and other vigilance, particularly in areas where alcohol or other drugs are consumed, and opening up "blind spots" where an assault could take place without anyone being able to see or hear it happening.

## Involving the education sector

### Recommendation 9

**Make schools safe for girls.**

Primary and secondary school systems should be heavily involved in making schools safe, including eradicating teacher violence, as well as engaging in broader anti-violence efforts.

There is room for improvement in action to eradicate physical and sexual violence by teachers against students in virtually all countries and all schools. In some cases, this requires fundamental changes within the education sector, and in school policies, environments and curricula. School policies should prohibit the use of violence as a form of punishment, and violence and harassment by and between teachers and students. Enforcement of such policies should be monitored.

Skills-based education is an effective way to enable students and staff to reduce potential conflicts, and to get involved in community actions to reduce violence and promote non-violent behaviour. School health programmes, such as HIV prevention programmes and reproductive health programmes (particularly those targeting sexually transmitted infections and unwanted pregnancies among adolescents) should address issues of gender, power, and freely given consent.

To be effective, programmes should begin early, involve both girls and boys (although probably with different information and key messages, and with a balance of single-sex and mixed-sex discussions), and apply age-appropriate learning. Such programmes must also be supported by relevant school policies, a supportive school environment, and school health services or referrals to care for and counsel victims and witnesses of violent incidents and harassment.

## Strengthening the health sector response

### Recommendation 10

**Develop a comprehensive health sector response to the various impacts of violence against women.**

Many health providers see and treat (knowingly or not) millions of women living in violent relationships. Developing a comprehensive health sector response to the various impacts of violence against women is therefore vital, and action by specific health care services is also needed. At the planning level, this will require health officials to identify the sector's particular role within the wider multisectoral response, in advocating for prevention, and in providing services for women who have experienced violence. In particular, it is important to address the demonstrated reluctance of abused women to seek help. At the service level, responses to violence against women should be integrated into all areas of care (e.g. emergency services, reproductive health services such as antenatal care, family planning, and post-abortion care, mental health services, and HIV and AIDS-related services). It is necessary to improve access to non-stigmatizing mental health services for women that adequately recognize the associations between violence and mental health, in particular depression and suicide ideation. These services need to contribute to empowering women in situations of violence, and to avoid over-medicalizing the problem.

Health providers who see and care for abused women need to coordinate and work with other sectors, particularly the police and social services. This will require the creation of formal referral procedures and protocols.

In addition to more general awareness-raising, the health sector needs to find ways to ensure that: (a) women who have experienced violence are not stigmatized or blamed when they seek help from health institutions, (b) women will receive appropriate medical attention and other assistance, and (c) their confidentiality and security will be ensured. Training should aim, among other things, to ensure that providers are appropriately sensitized to issues of abuse, treat women with respect, maintain confidentiality and do not reinforce women's feelings of stigma or self-blame, as well as being able to provide appropriate care and referral as needed.

### Recommendation 11

**Use reproductive health services as entry points for identifying and supporting women in abusive relationships, and for delivering referral or support services.**

The availability and widespread use of reproductive health services (including antenatal care, family planning services, post-abortion care and services dealing with sexually transmitted infections) in most countries give these services a potential advantage for identifying women in abusive relationships and offering them referrals or support services. However, unless providers are aware of and willing to address violence and coercion, they will be unable to promote women's sexual and reproductive health effectively.

Reproductive health providers should be sensitized and trained to recognize and respond to violence, particularly during and after pregnancy. Recognizing that identification is not enough, protocols and referral systems need to be put in place to ensure that appropriate care, follow-up and support services are available. In settings where resources are limited and referral is not possible, health staff should at least be aware of the problem and should provide information about legal and counselling options, as well as supportive messages that emphasize that such violence is wrong, and that it is a widespread problem. Ensuring confidentiality and women's safety should be paramount. In places where antenatal services involve male partners in parenting classes and similar activities, adding an anti-violence component to such activities may be an avenue for attempting to change male attitudes and prevent violence.

## Supporting women living with violence

### Recommendation 12

**Strengthen formal and informal support systems for women living with violence.**

The Study found that few women sought help and support from formal services or institutions (e.g. social workers, counsellors, shelters). This reflects many factors, one of the most important being simply the lack of such services, particularly in rural areas. In addition, women lacked confidence that existing services and authorities would listen with sensitivity or impartiality, or could make any difference to their situation. This highlights the need for better and more accessible support services where women can safely disclose their experience of violence.

While formal services offered by health or justice-related institutions should be expanded or improved, other models of service provision should also be explored, building on the existing sources of informal support to which women often turn. They could include sensitizing religious leaders and other respected local persons to the problem, and encouraging them to become involved in providing support, and even temporary refuge, for abused women. Training and orientation of such organizations on the issues involved, including the gendered and stigmatized nature of the problem, procedural matters such as confidentiality, and the complexities of responding to partner violence would be required.

Since abused women are most likely to seek help from informal networks of friends, relatives and neighbours, strengthening these networks is important so that when women do reach out to friends and family, they are better able to respond in a sympathetic and supportive manner. Media activities highlighting the extent of violence and promoting the role of friends, neighbours, and relatives, as well as interventions to reduce the social stigma around violence may all help to reinforce constructive responses.

## Sensitizing criminal justice systems

### Recommendation 13

**Sensitize legal and justice systems to the particular needs of women victims of violence.**

All those in the criminal justice systems (police, investigators, medico-legal staff, lawyers, judges, etc.) should be trained and sensitized to consider and address the particular needs and priorities of abused women, particularly those faced with violence by a partner or ex-partner. Those investigating allegations of violence against women should be trained in using medico-legal evidence gathering techniques, particularly in allegations of rape and sexual assault, in a non-judgemental and respectful manner. Gathering this evidence should be part of a comprehensive package of care, including counselling and relevant treatment.

Criminal justice systems as a whole need to be assessed comprehensively to ensure that women seeking justice and protection are treated appropriately and professionally. Those administering the criminal justice system, especially police, should not undermine women complainants by taking the side or the perpetrator, or by disbelieving or denigrating complainants. Ideally there should be support for women bringing complaints.

Laws on assault often assume that perpetrator and victim do not know each other, a pattern that applies less often when considering violence against women. Women may retain bonds of affection towards a partner despite his violence, and imprisoning the partner may jeopardize the livelihood of the woman and her children. A coordinated approach between the criminal justice system and appropriate civil law protection, is necessary to ensure that

women's safety is paramount. Furthermore, those convicted need to be appropriately punished. Flexible sentencing or alternative sanctions should be explored, where possible, to deter further violence.

## Supporting research and collaboration

### Recommendation 14

**Support research on the causes, consequences, and costs of violence against women and on effective prevention measures.**

In some places few data on violence against women are available. More research on the magnitude and nature of the problem of violence against women, and its costs, in given countries or settings is therefore urgently needed to provide a stronger basis for advocacy and action. More research needs be carried out on the causes of violence against women in different cultures and in different circumstances. Such research should aim to deepen understanding of both the risk and protective factors related to violence, focusing particularly on identifying key factors that are potentially amenable to intervention. Ensuring the further analysis of the existing database established by this Study will contribute greatly to understanding the determinants of the different patterns of violence, both within and between countries and sites.

Research on the male attitudes and beliefs that contribute to partner violence is needed if a comprehensive understanding of the problem is to be achieved. Longitudinal research is also needed on the evolution of violent behaviour by intimate partners over time, examining whether and how it differs from the development of other violent behaviours.

Research to inform the design and delivery of interventions where these do not exist needs to be accompanied by evaluation research on the short- and long-term effects of programmes to prevent and respond to partner violence – including school-based programmes, legal and policy changes, services for victims of violence, programmes that target perpetrators of violence, and campaigns to change social norms. *The WHO Handbook for the documentation of interpersonal violence prevention programmes* (**29**) provides useful guidance for the systematic collection, from diverse settings, of information on programmes for the prevention of interpersonal violence. Ultimately, the aim is to identify successful and promising interventions, and publicize the results to promote the scaling up of such efforts.

### Recommendation 15

**Increase support to programmes to reduce and respond to violence against women.**

While many of the measures called for in these recommendations are relatively inexpensive, resource-poor countries are struggling to maintain their public health systems and social services. New activities and programmes targeting violence against women will have to compete for funding with a variety of urgent priorities for national governments. Even if political commitment is present, it may be difficult to translate this commitment to action without additional funding. International donors, development agencies, and nongovernmental organizations should therefore be prepared to provide financial and technical support for concrete, well-designed proposals by national governments and development counterparts (in particular, women's organizations) that aim to prevent violence against women, provide services to women who have been abused, or reduce gender inequality.

Donors and international organizations need to support efforts to carry out research on this issue, and foster increased collaboration across countries and regions.

The ultimate challenge is to prevent and eventually eliminate all forms of violence, including violence against women. The immediate task is to support and offer choices to those women living in violent situations or who have suffered any form of violence.

## References


1. *Violence against women: WHO Consultation, Geneva, 5–7 February 1996*. Geneva, World Health Organization, 1996 (document FRH/WHD/96.27, available at http://whqlibdoc.who.int/hq/1996/FRH_WHD_96.27.pdf, accessed 18 March 2005).
2. **Krug EG et al., eds.** *World report on violence and health.* Geneva, World Health Organization, 2002.
3. **Heise L, Ellsberg M, Gottemoeller M.** *Ending violence against women.* Baltimore, MD, Johns Hopkins University Press, 1999.
4. **Campbell J et al.** Intimate partner violence and physical health consequences. *Archives of Internal Medicine,* 2002, 162:1157–1163.
5. **Gazmararian JA et al.** The relationship between pregnancy intendedness and physical violence in mothers of newborns. The PRAMS Working Group. *Obstetrics and Gynecology,* 1995, 85:1031–1038.
6. **Golding J.** Sexual assault history and women's reproductive and sexual health. *Psychology of Women Quarterly,* 1996, 20:101–121.
7. *Fourth World Conference on Women, Beijing, China, 4–15 September 1995.* New York, NY, United Nations, 1995 (document A/CONF.177/20).
8. **Koss M.** Detecting the scope of rape. A review of prevalence research methods. *Journal of Interpersonal Violence,* 1993, 8: 93–103.
9. **Jansen HAFM et al.** Interviewer training in the WHO Multi-country Study on Women's Health and Domestic Violence. *Violence Against Women,* 2004, 10:831–849.
10. **Watts C et al.** *Putting women first: ethical and safety recommendations for research on domestic violence against women.* Geneva, World Health Organization, 2001 (document WHO/EIP/GPE/01.1, available at http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.1.pdf, accessed 18 March 2005).
11. **Heise L.** Violence against women: an integrated, ecological framework. *Violence Against Women,* 1998, 4:262–290.
12. **Belsky J.** Child maltreatment: an ecological integration. *The American Psychologist,* 1980, 35:320–335.
13. **Jones A et al.** Annual and lifetime prevalence of partner abuse in a sample of female HMO enrollees. *Women's Health Issues,* 1999, 9:295–305.
14. **Tjaden P, Thoennes N.** *Extent, nature and consequences of intimate partner violence: findings from the National Violence Against Women Survey.* Washington, DC, National Institute of Justice, Centers for Disease Control and Prevention, 2000.
15. **Johnson M.** Conflict and control: images of symmetry and asymmetry in domestic violence. In: Booth A, Crouter A, Clements M, eds. *Couples in conflict.* Hillsdale, NJ, Lawrence Erlbaum, 2000.
16. **Jewkes R, Sen P, Garcia-Moreno C.** Sexual violence. In: Krug EG et al., eds. *World report on violence and health.* Geneva, World Health Organization, 2002.
17. **McDonough P et al.** Income dynamics and adult mortality in the United States, 1972 through 1989. *American Journal of Public Health,* 1997, 87:1476–1483.
18. **Sorlie PD, Backlund E, Keller JB.** US mortality by economic, demographic, and social characteristics: the National Longitudinal Mortality Study. *American Journal of Public Health,* 1995, 85:949–956.
19. **Campbell J, Garcia-Moreno C, Sharps P.** Abuse during pregnancy in industrialized and developing countries. *Violence Against Women,* 2004, 10:770–789.
20. **Rose L, Campbell J, Kub J.** The role of social support and family relationships in women's responses to battering. *Health Care for Women International,* 2000, 21:27–29.
21. **Landenburger K.** A process of entrapment in and recovery from an abusive relationship. *Issues in Mental Health Nursing,* 1989, 10:209–227.
22. **Dutton MA.** Battered women's strategic response to violence: the role of context. In: Edelson JL, Eiskovits ZC, eds. *Future interventions with battered women and their families.* London, Sage Publications, 1996.
23. **Kishor S, Johnson K.** Profiling domestic violence: a multi-country study. Calverton, MD, ORC MACRO, Measure DHS+, 2004.
24. International Conference on Population and Development, Cairo, Egypt, 5–13 September 1994. New York, NY, United Nations, 1994 (document A/CONF.171/13).
25. *United Nations Millennium Declaration* General Assembly Resolution, 55th session, document A/RES/55/2, Chapter III, number 11, September 2000.
26. **Ellsberg MC, Heise L.** Researching violence against women: a practical guide for researchers and activists. Washington, DC and Geneva, PATH/World Health Organization, In press.
27. **Holder Y et al., eds.** *Injury surveillance guidelines.* Atlanta, GA, Centers for Disease Control and Prevention, and Geneva, World Health Organization, 2001.
28. **Division for the Advancement of Women,** *Violence against women: a statistical overview, challenges and gaps in data collection and methodology and approaches for overcoming them.* Expert group meeting, DAW, ECE and WHO. Geneva, 11–14 April, 2005 (www.un.org/womenwatch/daw/egm/vaw-stat-2005).
29. **WHO.** Handbook for the documentation of interpersonal violence prevention programmes. Geneva, World Health Organization, 2004.