World Health Organization

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

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

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Contents

Contents *(continued)*

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 and informed 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

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About the authors

The authors make up the WHO Core Research Team for the Study, involved in the development of the study methodology, questionnaire and manuals, proving technical and scientific support to the countries in the study and responsible for cross-country analysis and reports on the results of the study.

Claudia García-Moreno is Coordinator in the WHO Department of Gender, Women and Health and is the Study Coordinator. She joined WHO in 1994 and initiated and developed its work on violence against women. She was responsible for overseeing the implementation of the Study, and, with Lori Heise, for developing the initial proposal for it.

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Lori Heise is Director of the Global Campaign for Microbicides at PATH and a research fellow in health policy at the London School of Hygiene and Tropical Medicine. She has worked for over two decades on intersecting issues of gender, power, sexuality and violence. She is a co-author of "*Researching violence against women: a practical guide for researchers and activists*".

World Health Organization

PATH
A catalyst for global health

Executive summary

This report of the WHO Multi-country Study on Women's Health and Domestic Violence against Women analyses data collected from over 24 000 women in 10 countries representing diverse cultural, geographical and urban/rural settings: Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania. The Study was designed to:

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

This report presents findings on objectives 1, 2, and 4. The third, analysis of risk and protective factors, will be addressed in a future report.

Organization of the Study

The Study consisted of standardized population-based household surveys. In five 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 with urban and rural populations. One 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. In this report, sites are referred to by country name followed by either "city" or "province"; where only the country name is used, it should be taken to refer to both sites.

Work was coordinated by WHO with a core research team of experts from the London School of Hygiene and Tropical Medicine (LSHTM), the Program for Appropriate Technology in Health (PATH), and WHO itself. A research team was established in each country, including representatives from research organizations and women's organizations providing services to abused women. The survey used female interviewers and supervisors trained using a standardized 3-week curriculum. Strict ethical and safety guidelines were adhered to in each country.

Violence against women by intimate partners

The results indicate that violence by a male intimate partner (also called "domestic violence") is widespread in all of the countries included in the Study. However, there was a great deal of variation from country to country, and from setting to setting. This indicates that this violence is not inevitable.

Physical violence by intimate partners

The proportion of ever-partnered women who had ever suffered physical violence by a male intimate partner ranged from 13% in Japan city to 61% in Peru province, with most sites falling between 23% and 49%. The prevalence of severe physical violence (a woman being hit with a fist, kicked, dragged, choked, burnt on purpose, threatened with a weapon, or having a weapon used against her) ranged from 4% in Japan city to 49% in Peru province. The vast majority of women physically abused by partners experienced acts of violence more than once.

Sexual violence by intimate partners

The range of lifetime prevalence of sexual violence by an intimate partner was between 6% (Japan city and Serbia and Montenegro city) and 59% (Ethiopia province), with most sites falling between 10% and 50%. While in most settings sexual violence was considerably less frequent than physical violence, sexual violence was more frequent in Bangladesh province, Ethiopia, province and Thailand city.

Physical and sexual violence by intimate partners

For ever-partnered women, the range of lifetime prevalence of physical or sexual violence, or both, by an intimate partner was 15% to 71%, with estimates in most sites ranging from 30% to 60%. Women in Japan city 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. Likewise, regarding current violence – as defined by one or more acts of physical or sexual violence in the year prior to being interviewed – the range was between 3% (Serbia and Montenegro city) and 54% (Ethiopia province), with most sites falling between 20% and 33%. These findings illustrate the extent to which violence is a reality in partnered women's lives, with a large proportion of women having some experience of violence during their partnership, and many having recent experiences of abuse.

Emotionally abusive acts and controlling behaviours

Emotionally abusive acts by a partner included: being insulted or made to feel bad about oneself; being humiliated in front of others; being intimidated or scared on purpose; or being threatened directly, or through a threat to someone the respondent cares about. Across all countries, between 20% and 75% of women had experienced one or more of these acts, most within the past 12 months. Data were also collected about partners' controlling behaviours, such as: routinely attempting to restrict a woman's contact with her family or friends, insisting on knowing where she is at all times, and controlling her access to health care. Significantly, the number of controlling behaviours by the partner was associated with the risk of physical or sexual violence, or both.

Women's attitudes towards violence

In addition to women's experience, the Study investigated women's attitudes to partner violence including: (a) the circumstances in which they believed it was acceptable for a man to hit or physically mistreat his wife, and (b) their beliefs about whether and when a woman may refuse to have sex with her husband. There was wide variation in women's acceptance of different reasons, and indeed of the idea that violence was ever justified. While over three quarters of women in the city sites of Brazil, Japan, Namibia, and Serbia and Montenegro said no reason justified violence, less than one quarter thought so in the provincial settings of Bangladesh, Ethiopia, and Peru. Acceptance of wife-beating was higher among women who had experienced abuse than among those who had not.

Respondents were also asked whether they believed a woman has a right to refuse to have

sex with her partner in a number of situations, including: if she is sick, if she does not want to have sex, if he is drunk, or if he mistreats her. In the provinces of Bangladesh, Ethiopia, Peru, and the United Republic of Tanzania, and in Samoa, between 10% and 20% of women felt that women did not have the right to refuse sex under *any* of these circumstances.

Non-partner physical and sexual violence

In addition to partner violence, the WHO Study also collected data on physical and sexual abuse by perpetrators – male and female – other than a current or former male partner.

Non-partner physical violence since age 15 years

Women's reports of experience of physical violence by a non-partner since the age of 15 varied widely. By far the highest level of non-partner physical violence was reported in Samoa (62%), whereas less than 10% of women in Ethiopia province, Japan city, Serbia and Montenegro city, and Thailand reported non-partner physical violence. Commonly mentioned perpetrators included fathers and other male or female family members. In some settings (Bangladesh, Namibia, Samoa, and the United Republic of Tanzania), teachers were also frequently mentioned.

Non-partner sexual violence since age 15 years

The highest levels of sexual violence by non-partners since age 15 years – between 10% and 12% – were reported in Peru, Samoa, and the United Republic of Tanzania city, while levels below 1% were reported in Bangladesh province and Ethiopia province. The perpetrators included strangers, boyfriends and, to a lesser extent, male family members (excluding fathers) or male friends of the family.

Comparing partner and non-partner violence since age 15 years

A common perception is that women are more at risk of violence from strangers than from partners or other men they know. The data show that this is far from the case. In the majority of settings, over 75% of women physically or sexually abused by any perpetrator since the age of 15 years reported abuse by a partner. In only two settings, Brazil city and Samoa, were at least 40% of women abused only by someone other than a partner.

Sexual abuse before age 15 years

Early sexual abuse is a highly sensitive issue that is difficult to explore in a survey. The Study therefore used a two-stage process allowing women to report both directly and anonymously (without having to reveal their response to the interviewer) 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 but one setting, anonymous reporting resulted in substantially more reports of sexual abuse, and large differences were recorded in Ethiopia province (0.2% using direct reporting versus 7% anonymously), Japan city (10% versus 14%), Namibia city (5% versus 21%), and the United Republic of Tanzania city (4% versus 11%). "Best estimates" based on the method that yielded the higher rate, indicate that prevalence of sexual abuse before 15 years of age varied from 1% (Bangladesh province) to 21% (Namibia city). The most frequently mentioned perpetrators were male family members other than a father or stepfather.

Forced first sex

In 10 of the 15 settings, over 5% of women reported their first sexual experience as forced, with more than 14% reporting forced first sex in Bangladesh, Ethiopia province, Peru province, and the United Republic of Tanzania. In all sites except Ethiopia province, the younger a woman at first experience of sex, the greater the likelihood that this was forced. 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. In some countries (notably Bangladesh and Ethiopia province), high levels of forced first sex are likely to be related to early sexual initiation in the context of early marriage, rather than being by perpetrators other than partners.

Violence by intimate partners and women's health

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

Injury resulting from physical violence

The prevalence of injury among women who had ever been physically abused by their partner ranged from 19% in Ethiopia province to 55% in Peru province and was associated with the severity of the violence. In Brazil, Peru province, Samoa, Serbia and Montenegro city, and Thailand, over 20% of ever-injured women reported that they had been injured many times. At least 20% of ever-injured women in Namibia, Peru province, Samoa, Thailand city, and the United Republic of Tanzania reported injuries to the eyes and ears.

Physical health

In the majority of settings, women who had ever experienced partner violence 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 walking and carrying out daily activities, pain, memory loss, dizziness, and vaginal discharge in the 4 weeks prior to the interview. An association between *recent ill-health* and *lifetime experience of violence* suggests that the physical effects of violence may last a long time after the actual violence has ended, or that violence over time may have a cumulative effect.

Mental health and suicide

In all settings, women who had ever experienced physical or sexual violence, or both, by an intimate partner reported significantly higher levels of emotional distress and were more likely to have thought of suicide, and to have attempted suicide, than women who had never experienced partner violence.

Reproductive health and violence during pregnancy

In the majority of settings, ever-pregnant women who had experienced partner physical or sexual violence, or both were significantly more likely to report having had at least one induced abortion than women who had never experienced partner violence. Similar patterns were found for miscarriage, but the strength of the association was less.

The proportion of ever-pregnant women physically abused during at least one pregnancy exceeded 5% in 11 of the 15 settings. Between one quarter and one half of women physically abused in pregnancy were kicked or punched in the abdomen. In all sites, over 90% were abused by the biological father of the child the woman was carrying. The majority of those beaten during pregnancy had experienced physical violence before, with between 8% and 34% reporting that the violence got worse during the pregnancy. However, from 13% (Ethiopia province) to about 50% (Brazil city and Serbia and Montenegro city) were beaten for the first time during pregnancy.

Risk of HIV and other sexually transmitted infections

The WHO Study explored the extent to which women knew whether or not their partner had had other sexual partners during their relationship. Across all sites except Ethiopia, a woman who reported that her intimate partner had been physically or sexually violent towards her was significantly more likely to report that she knew that her partner was or had been sexually involved with other women while being with her.

Women were also asked whether they had ever used a condom with their partner, whether they had requested use of condom, and whether the request had been refused. The proportion of women who had ever used a condom with a current or most recent partner varied greatly across sites. No significant difference was found in use of condoms between abused and non-abused women, with the exception of Thailand and the United Republic of Tanzania, where women in a violent relationship were more likely to have used condoms. However, in a number of sites (cities in Peru, Namibia, and the United Republic of Tanzania) women in violent partnerships were more likely than non-abused women to have asked their partner to use condoms. Women in violent partnerships in these sites, as well as in Brazil city, Peru province, and Serbia and Montenegro, were significantly more likely than non-abused women to report that their partner had refused to use a condom. These findings, as well as the high levels of child sexual abuse, are of concern in the transmission of HIV and other STIs, and underline the urgent need to address this hidden but widespread abuse against women.

Women's responses to physical violence by an intimate partner

Who women talk to

In all countries, the interviewer was the first person to whom many abused women had ever talked about their partner's physical violence. Two thirds of women who had been physically abused by their partner in Bangladesh, and about one half in Samoa and Thailand province, said they had not told anybody about the violence prior to the interview. In contrast, about 80% of physically abused women in Brazil and Namibia city had told someone, usually family or friends. But this means that even in these settings, two out of ten women had kept silent. Relatively few women in any setting had told staff of formal services or individuals in a position of authority about the violence.

Which agencies or authorities women turn to

Over half of physically abused women (between 55% and 95%) reported that they had never sought help from formal services (health services, legal advice, shelter) or from people in positions of authority (police, women's nongovernmental organizations (NGOs), local leaders, and religious leaders). Only in Namibia city and Peru had more than 20% of women contacted the police, and only in Namibia city and the United Republic of Tanzania city had more than 20% sought help from health care services.

Low use of formal services reflects in part their limited availability. However, even in countries relatively well supplied with resources for abused women, barriers such as fear, stigma and the threat of losing their children stopped many women from seeking help. In all settings, the most frequently given reasons for seeking help were related to the severity of the violence, its impact on the children, or encouragement from friends and family to seek help.

Leaving or staying with a violent partner

Between 19% and 51% of women who had been physically abused by their partner had ever left home for at least one night. Between 8% and 21% reported leaving 2–5 times. In most settings, women mainly reported going to their relatives, and to a lesser extent to friends or neighbours. Shelters were mentioned only in Brazil city and Namibia city (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, as well as culturally specific factors relating to the acceptability of women leaving or staying somewhere without their partner.

Areas for further analysis

This first report provides descriptive information on some of the main elements addressed by the WHO Study. However, it represents only the first stage of analysis of an extensive database which has the potential to address a range of important questions regarding violence against women. Questions that will be explored during the next stage of analysis include risk profiles for violence in terms of the timing and duration of the relationship with the violent partner; risk and protective factors for partner violence and whether they are context-specific or spanning all or most contexts; issues around definitions and prevalence of emotional abuse; more in-depth analysis of the relationship between violence and health and of patterns of women's responses to violence; and the impact of violence on other aspects of women's lives, including the effect on their children. These questions are of great relevance to public health, and exploring them will substantially improve our understanding of the nature, causes and consequences of violence, and the best ways to intervene against it.

Recommendations

In keeping with their responsibility for the well-being and safety of their citizens, national governments, in collaboration with NGOs, donors and international organizations, need to implement the following recommendations. These are based on the Study findings, and are grouped by theme.

Strengthening national commitment and action

1. Promote gender equality and women's human rights, in line with relevant international treaties and human rights mechanisms, including addressing women's access to property and assets, and expanding educational opportunities for girls and young women.
2. Establish, implement and monitor action plans to address violence against women, including violence by intimate partners.
3. Enlist social, political, religious, and other leaders in speaking out against violence against women.
4. Enhance capacity and establish systems for data collection to monitor violence against women, and the attitudes and beliefs that perpetuate the practice.

Promoting primary prevention

5. Develop, implement and monitor programmes aimed at primary prevention of intimate partner violence and sexual violence against women. These should include sustained public awareness activities aimed at changing the attitudes, beliefs and values that condone partner violence as normal and prevent it being challenged or talked about.
6. Give higher priority to combating sexual abuse of girls (and boys) in public health programmes, as well as in responses by other sectors such as the judiciary, education, and social services.

7. Integrate responses to violence against women into existing programmes for the prevention of HIV and AIDS, and for the promotion of adolescent health, including to promote the prevention of sexual violence as well as intimate-partner violence against women as an integral part of these programmes.
8. Make physical environments safer for women, through measures such as identifying places where violence often occurs, improving lighting, and increasing police and other vigilance.

Involving the education sector

9. Make schools safe for girls, by involving education systems in anti-violence efforts, including eradicating teacher violence, as well as engaging in broader anti-violence efforts.

Strengthening the health sector response

10. Develop a comprehensive health sector response to the various impacts of violence against women, and in particular address the barriers and stigma that prevent abused women from seeking help. This includes supporting mental health services to address violence against women as an important underlying factor in women's mental health problems.
11. Use reproductive health services as entry points for identifying and supporting women in abusive relationships, and for delivering referral or support services.

Supporting women living with violence

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

Sensitizing criminal justice systems

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

Supporting further research and collaboration and increasing donor support

14. Promote and support further research on the causes and consequences of violence against women and on effective prevention measures.
15. Increase support to programmes to reduce and respond to violence against women.

Introduction

“This survey should have been conducted 10 years ago. Now I have two daughters. I hope they will benefit from it.”

Woman interviewed in Bangladesh

“Thank you so much, I needed to talk to someone. I have never told anyone what I told you, but I would like that it happens more often that someone comes to talk. There should be more people who come to talk.”

Woman interviewed in Peru

CHAPTER 1

Introduction

Background to the Study

Until recently, most governments and policy-makers viewed violence against women as a relatively minor social problem affecting a limited number of women. The general view was that cases of violence could be appropriately addressed through the social welfare and justice systems. During the past decade, however, the combined efforts of grass-roots and international women's organizations, international experts, and committed governments have resulted in a profound transformation in public awareness regarding this issue (**1**). Violence against women, also known as gender-based violence, is now widely recognized as a serious human rights abuse, and increasingly also as an important public health problem that concerns all sectors of society (**2**, **3**).

Recognition of violence as a health and rights issue was underscored and strengthened by agreements and declarations at key international conferences during the 1990s, including the World Conference on Human Rights (Vienna, 1993) (**4**), the International Conference on Population and Development (Cairo, 1994) (**5**) and the Fourth World Conference on Women (Beijing, 1995) (**6**). Through these international agreements, governments have increasingly recognized the need to develop broad multisectoral approaches for the prevention of and response to violence against women, and have committed themselves to implement the institutional and legislative reforms necessary to achieve this goal. Despite this progress, many governments still do not acknowledge the problem of violence against women or take measures to prevent and address it. While the many health consequences of violence are also increasingly recognized, the involvement of the health sector in responding to the problem is still inadequate in many countries.

Why did WHO embark on a study of violence against women?

In 1995, the Beijing Platform for Action identified the lack of adequate information on the prevalence, nature, causes, and consequences of violence globally as a serious obstacle to the development of effective strategies to address violence. Governments were urged to invest in research to improve the relevant knowledge base on the prevalence, causes, nature, and consequences of violence against women (**6**, p.129a).

WHO's work on gender-based violence began in 1996 with the convening of an expert consultation on violence against women. The consultation brought together researchers, health care providers and women's health advocates from several countries (**7**). The participants agreed that there was a dearth of comparable data, particularly from developing countries, that many governments were reluctant to recognize violence against women as a problem, and that health was an important perspective from which to address this issue. The consultation recommended that WHO promote and support international research to explore the dimensions, health consequences and risk factors of violence against women. In the same year, the World Health Assembly declared the prevention of violence, including violence against women and children, to be a public health priority needing urgent action. In response, in 1997, WHO initiated the development of the Multi-country Study on Women's Health and Domestic Violence against Women (hereafter referred to as the WHO Study or the Study) (**8**).

More recently, WHO published the *World report on violence and health* (**9**), which included a global overview of available information – including prevalence data – on intimate partner and sexual violence and their impact on the health and well-being of women (Chapters 4 and 6). That report recognized the need for sound and reliable information on the

magnitude, the nature and the consequences of violence, as an essential foundation for the public health approach to violence, including violence against women. This Study both informed the WHO report and is an important contribution to meeting the need for information on violence, both nationally (in the countries that participated) and globally. The results of the Study will also feed into and inform WHO's Global Campaign on Violence Prevention, which was launched in 2002 (for more information, see http://www.who.int/violence_injury_prevention/violence/global_campaign/en/).

International research on prevalence of violence against women

The Declaration on the Elimination of Violence against Women adopted by the United Nations General Assembly in 1993 defined violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (**10**). It goes on to define the various forms that this violence can take. Although intimate-partner violence and sexual coercion are the most common and "universal" types of violence affecting women and girls, in many parts of the world violence takes on special characteristics according to cultural and historical conditions, and includes murders in the name of honour (so-called "honour killings"), trafficking of women and girls, female genital mutilation, and violence against women in situations of armed conflict.

International research conducted over the past decade has provided increasing evidence of the extent of violence against women, particularly that perpetrated by intimate male partners. The findings show that violence against women is a much more serious and common problem than previously suspected. A review of over 50 population-based studies performed in 35 countries prior to 1999 indicated that between 10% and 52% of women around the world report that they have been physically abused by an intimate partner at some point in their lives, and between 10% and 30% that they have experienced sexual violence by an intimate partner. Between 10% and 27% of women and girls reported having been sexually abused, either as children or as adults (**9**, **11**).

While these studies helped focus attention on the issue, they also raised many questions regarding the methods used to obtain estimates of violence in different countries. There were many differences in the way violence was defined, measured and presented. For example, some studies of partner violence include only physical violence, while others may also include sexual or emotional violence. Some studies measure lifetime experiences of violence, whereas others include only experiences in the current relationship, or in a defined period. Studies also differ in other important respects, such as the definition of the study population (for example, in terms of the age range and partnership status of the women), the forms of violence considered, the range of questions asked, and whether measures were taken to ensure privacy and confidentiality of interviews. Such factors have since been shown to greatly affect prevalence estimates by influencing a woman's willingness to disclose abuse (**12**, **13**). These methodological differences between studies have made it difficult to draw meaningful comparisons or to understand the similarities and differences in the extent, patterns, and factors associated with violence in different settings (**4**).

In response to the methodological and ethical challenges associated with research on prevalence of gender-based violence in developing countries, a group of researchers and advocates from around the world came together in the early 1990s to form the International Research Network on Violence against Women (IRNVAW). The purpose of the network was to create a forum for sharing insights and for addressing key challenges faced by investigators interested in gender-based violence, such as: how to ensure the safety of respondents and researchers throughout the research process, and how to define and measure violence in a way that allowed results to be compared across diverse cultural settings (**14**).

The design and implementation of the WHO Study incorporated the recommendations of IRNVAW. It also built on methodological work and research on violence by partners, carried out primarily in the United States using the Conflict Tactics Scale (**15**, **16**), as well as critiques of this methodology by other researchers (**17**). Since the initiation of the WHO Study, a number of other international research initiatives have also used population-based surveys to estimate the prevalence of different forms of violence against women across countries and cultures. These include: the World Surveys of Abuse in Family Environments (WorldSafe) supported by the International Clinical Epidemiology Network (INCLEN) (**18**), and the International Violence Against Women Survey (IVAWS) conducted by the European Institute for Crime Prevention and Control, affiliated with the United Nations (HEUNI), the United Nations Interregional Crime and Justice Research Institute (UNICRI) and Statistics Canada. These studies provide useful comparisons with aspects of the WHO Study and, taken together, are beginning to give a more comprehensive picture of violence against women around the world.

In addition, the Demographic and Health Surveys (DHS), supported by MACRO International and the United States Agency for International Development (USAID), and the International Reproductive Health Surveys (IRHS), supported by the United States Centers for Disease Control and Prevention (CDC), now contain a number of questions or a module on violence against women as part of broader household surveys on a range of health issues (**19**). These surveys offer the advantages of large sample size, efficiency of data collection, standardization of measurement instruments and the possibility of being generalized to the national population. It has been shown, however, that focused studies on violence against women tend to give higher prevalence estimates than larger health or other surveys which include only one or a small number of questions on violence (**13**). As a result, the DHS have moved away from single or limited questions to use of a full violence module in countries that wish to explore this issue. The module was developed on the basis of an early draft of the WHO Study protocol and so provides opportunities for expanding the database of comparable data. Furthermore, DHS now recommend the use of the WHO ethical and safety guidelines when applying the violence module. This is important, as the safety of respondents and interviewers is an important concern when questions about violence are included in the context of larger surveys on other issues.

The 1990s also saw rapid growth in the number of studies exploring the potential health consequences of violence, particularly in the United States and other industrialized countries. For years, clinicians and policy-makers had focused on injury as the primary health outcome of violence – if they considered health outcomes at all. Then, research began to draw attention to a range of other health-related conditions associated with intimate-partner violence and sexual abuse of women, such as chronic pain syndromes, drug and alcohol abuse, complications of pregnancy, increased risk of unwanted pregnancy and sexually transmitted infections, mental health problems, gynaecological problems, and decreased physical functioning (**20**–**23**). These studies suggested that, in addition to causing injury and other immediate sequelae, violence increased women's risk of *future* ill-health. Awareness of this is causing a significant shift in the way health professionals conceptualize violence. Rather than being seen as just a health problem in and of itself, violence can also be understood as a risk factor that – like smoking or unsafe sex – increases women's risk of a variety of diseases and conditions (**24**, **25**).

During the 1990s, researchers and practitioners also began exploring patterns of violence in different settings. Data increasingly suggested that the level of partner violence against women varied substantially, both between and within countries (**26**). This raised the question of what combination of factors could best explain the variation. What insights could be gained from this analysis that would advance violence theory and intervention?

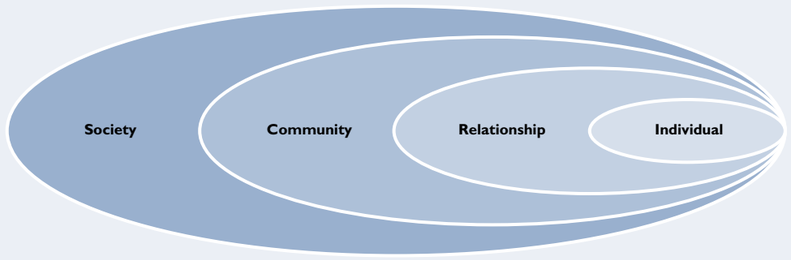
Increasingly, researchers and practitioners – as well as WHO – are using an "ecological framework" to understand the interplay of personal, situational, and sociocultural factors that combine to cause interpersonal violence (**9**, **27**). Introduced in the late 1970s, the ecological model was first applied to child abuse (**28**, **29**), and subsequently to youth violence (**30**, **31**). More recently, it has been used to understand intimate partner violence (**32**) and abuse of the elderly (**33**, **34**). In the ecological model, interpersonal violence results from the interaction of factors at different levels of the social environment.

The model can best be conceptualized as four nested circles (Figure 1.1). The innermost circle represents the biological and personal history that each individual brings to his or her behaviour in relationships. The second circle represents the immediate context in which violence takes place – frequently the family or other intimate or acquaintance relationship. The third circle represents the institutions and social structures, both formal and informal, in which relationships are embedded – neighbourhood, workplace, social networks, and peer groups. The fourth, outermost circle is the economic and social environment, including cultural norms.

The WHO Study incorporates an ecological model for understanding partner violence by including, at each level of the social ecology, variables hypothesized to increase or decrease a woman's risk of partner violence.

Analyses at national and international level comparing settings with high and low prevalence of partner violence provide an

Figure 1.1 Ecological model for understanding violence



Source: Reproduced from reference 9.

opportunity to identify potential individual, community and societal factors associated with its occurrence. Comparative analysis could be used to test whether there are identifiable risk factors within the immediate and larger community that could possibly be reduced through community activities.

To date, the lack of comparability among studies has made this type of analysis difficult, if not impossible. To explore potential risk and protective factors with any rigour requires a study that minimizes all methodologically induced variation among sites. Although there will always be sources of variation that cannot be fully controlled (such as cultural variation in women's willingness to disclose violence), the WHO Study included a variety of measures designed to maximize the comparability of data across sites (see Annex 1).

In future analyses, the data from this study will be used to explore individual, household, and community risk and protective factors in greater depth. Greater insights into the situations and contexts in which violence does and does not occur will be sought through multivariate and multilevel analysis of possible combinations of factors acting at different levels (**35**, **36**).

Clearly, if the potentially modifiable risk factors – and potentially protective factors – could be identified, this would have important implications for the development of preventive interventions both locally and internationally.

Study objectives

The WHO Multi-country Study on Women's Health and Domestic Violence against Women was designed to address some of the major gaps in the international literature on violence against women, especially related to intimate-partner violence in developing country settings and its impact on women's health. It attempted to overcome the obstacles to comparability encountered in previous studies by carrying out population-based surveys using a standardized questionnaire, with standardized training and procedures across sites.

The WHO Study's objectives were as follows:

- to obtain valid estimates of the prevalence and frequency of different forms of physical, sexual and emotional violence against women, with particular emphasis on violence perpetrated by intimate male partners;
- to assess the extent to which violence by intimate partners is associated with a range of health outcomes;
- to identify factors that may protect or put women at risk for intimate-partner violence;
- to document and compare the strategies and services that women use to deal with the violence they experience.

The study aimed to provide a strong evidence base for informing policy and action at the national and international level. Additional goals included: developing and testing new instruments for measuring violence cross-culturally; increasing national capacity and collaboration among researchers and women's organizations working on violence; and increasing sensitivity to violence among researchers, policy-makers and health care providers. To achieve these goals, WHO adopted an action-oriented model of research that encouraged the active engagement of women's organizations with expertise on violence against women. The model also gave priority to ensuring women's safety and well-being.

This first report describes the findings related to three of the four study objectives: to assess prevalence, determine health outcomes, and document women's coping strategies. Analysis of risk and protective factors for violence will be addressed in a future report. More in-depth multivariate and multilevel analysis of study outcomes will be explored in individual papers to be submitted for publication in the peer-reviewed scientific literature.

The original plan for the WHO Study included a survey of men. However this was not implemented (see Box 1.1).

Box 1.1 Studying men

The original plan for the WHO Study included interviews with a subpopulation of men about their experiences and perpetration of violence, including partner violence. This would have allowed researchers to compare men's and women's accounts of violence in intimate relationships and would have yielded data to investigate the extent to which men are physically or sexually abused by their female partners. On the advice of the Study Steering Committee, it was decided to include men only in the qualitative, formative component of the study and not in the quantitative survey.

This decision was taken for two reasons. First, it was considered unsafe to interview men and women in the same household, because this could have potentially put a woman at risk of future violence by alerting her partner to the nature of the questions. Second, to carry out an equivalent number of interviews in separate households was deemed too expensive.

Nevertheless, it is recognized that men's experiences of partner violence, as well as the reasons why men perpetrate violence against women, need to be explored in future research. Extreme caution should be used in any study of partner violence that seeks to compile prevalence data on men as well as women at the same time because of the potential safety implications.

Organization of the Study

The study was implemented by WHO through a core research team made up of international experts from WHO (including the study coordinator), the London School of Hygiene and Tropical Medicine, and the Program for Appropriate Technology in Health in Washington, DC (see Annex 2 for a list of participants in the core research team). This core research team had overall responsibility for designing the study, and supporting its implementation and analysis. WHO also established an expert steering committee that included internationally known epidemiologists, advocates and researchers on violence against women, from different regions of the world. This steering committee provided technical and scientific oversight to the study, and met periodically to review the progress and outputs of the study (see Annex 2 for a list of members of the steering committee).

Within each participating country, a collaborative research team was established to implement the study. This generally consisted of representatives of research organizations experienced in conducting survey research, a women's organization with experience of providing services to women experiencing violence and, in some places, government and national statistics offices (see Annex 3 for a list of country participants).

Each country research team also established an advisory group to support the implementation of the study and ensure the dissemination of the results. The membership of the groups differed between countries, but generally included key decision-makers, representatives of women's organizations and researchers. The study also aimed to ensure that representatives from relevant divisions within the ministry of health and other concerned ministries or bodies were included. Where possible, existing multisectoral committees on violence against women formed the core membership of the advisory group. Members of the country research teams met regularly with the advisory group to review progress and to discuss emerging issues.

Participating countries

Participating countries were identified, following discussions with the WHO regional offices, on the basis of the following criteria:

- presence of local women's groups working on violence against women that could use the data generated for advocacy and policy reform;
- absence of existing population-based data on violence against women;
- presence of strong potential partner organizations known to WHO;
- a political environment receptive to taking up the issue;
- absence of recent war-related conflict;
- representation of the different WHO regions.

The first countries selected were: Bangladesh, Brazil, Japan, Namibia, Peru, Samoa, Thailand, and the United Republic of Tanzania. A second group of countries later replicated the study: Ethiopia, New Zealand, and Serbia and Montenegro. Other countries, including Chile, China, Indonesia, and Viet Nam, have adapted or used parts of the study questionnaire.

This first report presents the findings from the countries that participated in the first round of the study, conducted between 2000 and 2003 – Bangladesh, Brazil, Japan, Namibia, Peru, Samoa, Thailand, and the United Republic of Tanzania – as well as from two countries that participated in the second round – Ethiopia and Serbia and Montenegro.[1] In combination, the results provide evidence of the extent of physical and sexual violence from 15 sites in 10 geographically, culturally and economically diverse countries (Figure 1.2).

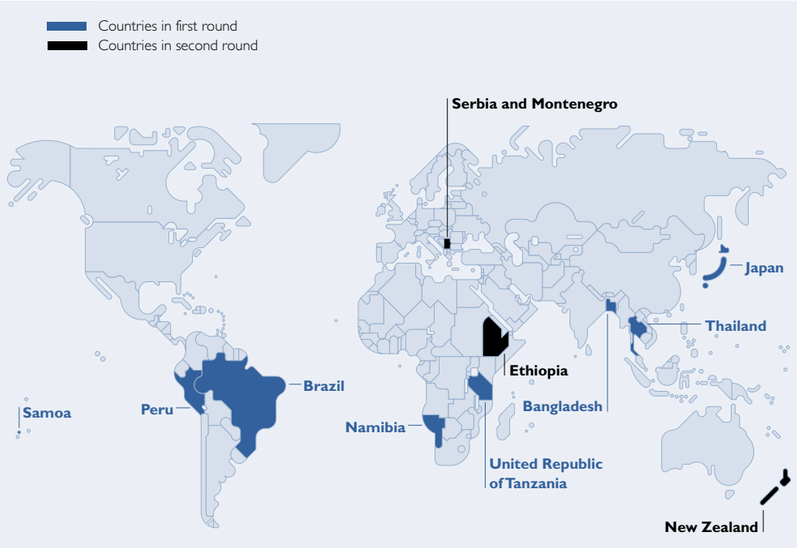
[1] The data set from New Zealand was not available when this report was being prepared. However, the first results from New Zealand have recently been published (**37**).

Box 1.2 Preliminary impact of the WHO Multi-country Study on Women's Health and Domestic Violence against Women

Even before the data were available, the WHO Study brought about several positive changes at different levels.

- The WHO Study contributed to increased awareness among researchers, interviewers and others involved in doing the research, as well as among the women interviewed. Most importantly, a pool of over 500 trained interviewers, researchers and other staff have been sensitized to the problem of violence against women and have acquired understanding and skills to investigate it. A large number of the female staff have reported making major changes in their personal or professional lives as a result of their involvement in the Study. Many of those involved in the Study, both men and women, continue to be actively engaged in working to address violence against women in their countries.
- The WHO Study contributed to the inclusion of violence by intimate partners in several policies and educational programmes of the partner universities and ministries of health. In Peru, for example, violence against women has been incorporated into the Masters course on reproductive health and sexuality in the Faculty of Public Health of the Cayetano Heredia University and has been discussed with local community leaders in the provincial site. In Brazil, medical and social science students were involved in the study, and violence against women has been included in postgraduate training at the University of São Paulo.
- The WHO Study prompted further research. For example: one of the researchers in Peru is now doing a study on men and violence against women; researchers in Brazil have done a study on women attending health centres in São Paulo, using the same instrument as in the WHO Study; researchers in Thailand and the United Republic of Tanzania report using the ethical and safety guidelines for research on other issues.
- At the grass-roots level, networks of service providers have been established or identified, and information on local organizations has been compiled and distributed widely.

Figure 1.2 Countries participating in the WHO Multi-country Study on Women's Health and Domestic Violence against Women



In each country, the findings from the national analysis have already been written up as a country report, and disseminated at the local and national level in a variety of ways. The dissemination activities were coordinated by the country research teams, and drew on the experience and resources made available by each country's advisory group and WHO. Where possible, the findings are being fed into advocacy and intervention activities concerned with violence against women – such as the 16 days of action against violence against women in Namibia, the development of the national plan of action for the elimination of violence against women and children in Thailand, and the development of the national policy and plan of action for violence prevention in Brazil. In addition, the study has already resulted in various important changes (Box 1.2). WHO country offices and relevant ministries, together with the researchers, are helping to disseminate the findings to different sectors, and to the donor community.

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Methods

“ The questions … challenge women’s experience, attitudes, opinions, and statements. By telling, at the end, I felt liberated. ”

Woman interviewed in Serbia and Montenegro

“ … I feel very good because I believe it will help many women knowing about these things, and even if this help will not reach me, I know it will reach many women. ”

Woman interviewed in Peru

CHAPTER 2

Definitions and questionnaire development

Definitions

One of the main challenges facing international researchers on violence against women is to develop clear operational definitions of different types of violence and tools for measuring violence that permit meaningful comparisons among diverse settings.

Researchers have used many criteria to define violence. A common method is to classify violence according to the type of act: for example, physical violence (e.g. slapping, hitting, kicking, and beating), sexual violence (e.g. forced intercourse and other forms of coerced sex), and emotional or psychological violence (e.g. intimidation and humiliation). Violence can also be defined by the relationship between the victim and perpetrator; for example, intimate partner violence, incest, sexual assault by a stranger, date rape or acquaintance rape.

In the *World report on violence and health* (**1**), WHO adopted a typology that categorizes violence in three broad categories, according to those committing the violent act:

- self-directed violence,
- interpersonal violence,
- collective violence.

These categories are each divided further to reflect specific types of violence (Figure 2.1).

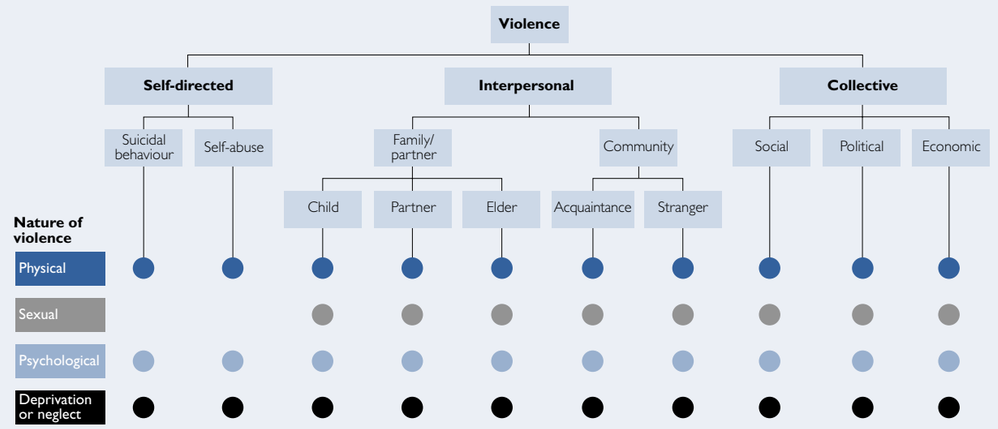
Measuring violence

The WHO Study focused primarily on “domestic violence”,[1] or violence by an intimate partner, experienced by women. Included in this were acts of physical, sexual and emotional abuse by a current or former intimate male partner, whether cohabiting or not.[2] In addition, it looked at controlling behaviours, including acts to constrain a woman’s mobility or her access to friends and relatives, extreme jealousy, etc. The Study also included physical and sexual violence against women, before and after 15 years of age, by perpetrators other than intimate partners. Definitions of each of these aspects of violence were operationalized in the study using a range of behaviour-specific questions related

[1] The term “intimate-partner violence” is now used in preference to the term “domestic violence”, which is not specific and could include child abuse, intimate partner violence and abuse of the elderly. This report uses intimate-partner or partner violence, except in the name of the Study, which was agreed before the appearance of the *World report on violence and health* (**1**).

[2] The Study focused on violence by *male* partners only, mainly because most intimate partners of women throughout the world are male. Indeed, in some countries it would not be culturally acceptable to ask about female–female relationships. In addition, the Study was intended as a contribution to the understanding of gender-based violence as an expression of gender inequality in relations between women and men.

Figure 2.1 A typology of violence



Source: Reproduced from reference 1.

to each type of violence (Annex 4). The study did not attempt to document an exhaustive list of acts of violence, but instead asked a limited number of questions about specific acts that commonly occur in violent partnerships. This approach has been used widely in studies of partner violence in the United States and elsewhere, and has been shown to encourage greater disclosure of violence than approaches that require respondents to identify themselves as abused or battered (**2**, **3**). Given that the conceptualization of violence differs between individuals and communities, a fairly conservative definition of violence was used. Thus the prevalence estimated in this manner is more likely to underestimate rather than overestimate the true prevalence of violence. The acts used to define each type of violence measured in the Study are summarized in Box 2.1.

Violence by intimate partners

While there is widespread agreement, and some standardization, regarding what acts are included as physical violence, this is less true for sexual violence. There is even less agreement on how to define and measure psychological or emotional abuse, especially in a cross-cultural perspective, because the acts that are perceived as abusive are likely to vary between countries and between socioeconomic and ethnic groups, and according to the overall level of violence in the group. Because of the complexity of defining and measuring emotional abuse in a way that is relevant and meaningful across cultures, the questions regarding emotional violence and controlling behaviour in the WHO Study questionnaire should be considered as a starting-point, rather than a comprehensive measure of all forms of emotional abuse.

The questions on physical partner violence were divided into those related to "moderate" violence, and those considered "severe" violence (Box 2.2). The distinction between moderate and severe violence is based on the likelihood of physical injury. For each act of physical, sexual, or emotional abuse that the respondent reported as having happened to her, she was asked whether it had happened ever or in the past 12 months, and with what frequency (once or twice, a few times, or many times) (Questions 704, 705, 706). The answers to these questions made it possible to assess the level of sexual or physical violence by current or former partners.

Box 2.1 Operational definitions of violence used in the WHO Multi-country Study on Women's Health and Domestic Violence against Women

Physical violence by an intimate partner
- Was slapped or had something thrown at her that could hurt her
- Was pushed or shoved
- Was hit with fist or something else that could hurt
- Was kicked, dragged or beaten up
- Was choked or burnt on purpose
- Perpetrator threatened to use or actually used a gun, knife or other weapon against her

Sexual violence by an intimate partner
- Was physically forced to have sexual intercourse when she did not want to
- Had sexual intercourse when she did not want to because she was afraid of what partner might do
- Was forced to do something sexual that she found degrading or humiliating

Emotional abuse by an intimate partner
- Was insulted or made to feel bad about herself
- Was belittled or humiliated in front of other people
- Perpetrator had done things to scare or intimidate her on purpose, e.g. by the way he looked at her, by yelling or smashing things
- Perpetrator had threatened to hurt someone she cared about

Controlling behaviours by an intimate partner
- He tried to keep her from seeing friends
- He tried to restrict contact with her family of birth
- He insisted on knowing where she was at all times
- He ignored her and treated her indifferently
- He got angry if she spoke with another man
- He was often suspicious that she was unfaithful
- He expected her to ask permission before seeking health care for herself

Physical violence in pregnancy
- Was slapped, hit or beaten while pregnant
- Was punched or kicked in the abdomen while pregnant

Physical violence since age 15 years by others (non-partners)
- Since age 15 years someone other than partner beat or physically mistreated her

Sexual violence since age 15 years by others (non-partners)
- Since age 15 years someone other than partner forced her to have sex or to perform a sexual act when she did not want to

Childhood sexual abuse (before age 15 years)
- Before age 15 years someone had touched her sexually or made her do something sexual that she did not want to

Box 2.2 Severity scale used for level of violence (see Question 705 of the WHO Study questionnaire)

"Moderate" violence: respondent answers "yes" to one or more of the following questions regarding her intimate partner (and does not answer "yes" to questions c–f below):
(a) [Has he] slapped you or thrown something at you that could hurt you?
(b) [Has he] pushed you or shoved you?

"Severe" violence: respondent answers "yes" to one or more of the following questions regarding her intimate partner:
(c) [Has he] hit you with his fist or with something else that could hurt you?
(d) [Has he] kicked you, dragged you or beaten you up?
(e) [Has he] choked or burnt you on purpose?
(f) [Has he] threatened to use or actually used a gun, knife or other weapon against you?

Psychometric analysis was performed on the violence questions used in the Study to ascertain the appropriateness of the behavioural items included in the different measures of physical, emotional and sexual violence. In general, there was good internal consistency among the items for each measure, indicating that the instrument provided a reliable and valid measure for each of the types of violence.

An exposure chart (Question 716) was used to collect information about the timing of the onset of physical or sexual violence by an intimate partner and when such violence last occurred. This was an important aspect of the data collection, which partly addressed the inherent limitations of the cross-sectional study design, as information about the timing of different forms of violence can be compared with details about the timing of the start and end of the relationship or marriage. This information allows for analysis of the extent to which different forms of violence occur prior to or during marriage or cohabitation, or after separation. The data can also be used to understand how women's risk of intimate-partner violence changes over the duration of the relationship.

Ever-partnered women

The definition of "ever-partnered women" is central to the study, because it defines the population that could potentially be at risk of partner violence (and hence becomes the denominator for prevalence figures). Although the study tried to maintain the highest possible level of standardization across countries, it was agreed that the same definition could not be used in all the countries, because the concept of "partner" is culturally or legally defined. In developing the country-specific definitions of "ever-partnered women", the study researchers were aware of the need to use a broad definition of partnership, since any woman who had been in a relationship with an intimate partner, whether or not they had been married, could have been exposed to the risk of violence. It was also recognized that the definition of ever-partnered women would need to be narrower in some contexts than others. For example, in Bangladesh it was considered inappropriate to ask unmarried women about non-marital partners; in any case, an unmarried woman in Bangladesh cohabiting with a partner would most likely have identified herself as being married and so be included in the study population. In general, the definition of "ever-partnered women" included women who were or had ever been married or in a common-law relationship. In countries where premarital sexual relationships are common, the definition covered dating relationships – defined as regular sexual partners, not living together. Former dating partners were not included, except in Japan, Namibia and Peru, where many women never live with regular sexual partners, even if they have children by them. Box 2.3 gives the definitions of "ever partnered" used in the countries taking part in the WHO Study.

Violence by non-partners

The survey also explored the extent to which women report experiencing violence by perpetrators other than a current or former male partner. It included questions on physically abusive behaviour by such perpetrators since the age of 15 years, in different contexts (at school or work, by a friend or neighbour or anyone else). Follow-up questions explored the frequency of violence for each perpetrator.

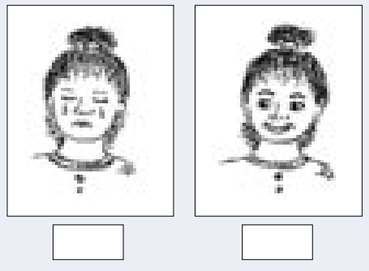
Box 2.3 Country-specific definitions of "ever-partnered women"

Bangladesh	Ever married
Brazil, Ethiopia, Serbia and Montenegro, Thailand, United Republic of Tanzania	Ever married, ever lived with a man, currently with a regular sexual partner
Japan, Namibia, Peru	Ever married, ever lived with a man, ever with a regular sexual partner
Samoa	Ever married, ever lived with a man

Likewise, the survey explored the extent to which the women had been sexually abused by others, including before age 15 years (child sexual abuse). As this is a highly sensitive issue, four methods were used to enhance disclosure of different forms of abuse. Respondents were asked whether, since the age of 15 years, any person other than their partner or husband had forced them to have sex or to perform a sexual act when they did not want to (Question 1002). Again, probing questions were used to explore the different contexts in which this might have occurred. For respondents who reported having experienced this type of abuse, information was collected about the perpetrator and the frequency. Second, respondents were asked whether, before the age of 15 years, anyone had ever touched them sexually or made them do something sexual that they did not want to do (Question 1003). Follow-on questions asked about the perpetrator, the ages of the respondent and the perpetrator at the time, and the frequency. Third, respondents were asked how old they were at their first sexual experience (Question 1004), and whether it had been something they had wanted to happen, something they had not wanted but that had happened anyway, or something that they had been forced into (Question 1005). Finally, at the end of each interview the respondent was offered an opportunity to indicate in a hidden manner whether anyone had ever touched her sexually or made her do something sexual against her will before the age of 15 years, without having to disclose her reply to the interviewer (Question 1201). For this question, respondents were handed a card that had a pictorial representation for yes and no and asked to record their response in private (Figure 2.2). In most sites, the respondent then folded the card and placed it in an envelope or a bag containing other cards before handing it back to the interviewer, thus keeping her answer secret from the interviewer. In Serbia and Montenegro and the United Republic of Tanzania, the sealed envelope with the card was attached to the questionnaire to allow the information to be linked to the individual woman at the time of data entry. The use of a card was intended to increase the likelihood of obtaining a more complete estimate of the prevalence of childhood sexual abuse.

Figure 2.2 Sample response card

Pictorial representation of response to Question 1201 concerning sexual abuse before 15 years of age: tearful face indicates "yes"; smiling face indicates "no"



Formative research

The WHO Study incorporated formative research, including research on definitional issues, in each of the country sites. The aim of this work was to gain insights that could be used in designing and translating the questionnaire, and in interpreting the survey findings. The research included: interviews with key informants; in-depth interviews with survivors of violence; and focus group discussions with women and men of different age groups.

Key informants

Informants included representatives from nongovernmental organizations focusing on areas such as violence against women, HIV/AIDS, women's health, women's rights and their awareness of those rights, or women's education and development.

In-depth interviews with survivors

In each country, in-depth semi-structured interviews were held with at least five women who were known to have been abused by their partners or former partners. Participants were recruited through different support services, by means of "snowball" techniques. These interviews were used to gain a better understanding of how women describe their experiences of domestic violence, the ways in which they have responded, and how such violence has influenced their lives. The structure of the interviews reflected the forms of information to be collected during the survey. The women's narratives helped inform the development and translation of the relevant modules within the core and country questionnaires. The information is also being used to help in interpreting the quantitative research findings, and to supplement the quantitative data obtained.

During the interviews, careful attention was given to the ethical and safety issues associated with the study (see Chapter 3). This included recognizing that the interviews might be distressing, and ensuring that adequate follow-up support was provided. Care was also taken to ensure that strict confidentiality was maintained, and that the respondent could not be identified in follow-up dissemination activities. Each interview aimed to end on a positive note, identifying the respondent's strengths and abilities. All tapes were erased once transcripts had been made.

Focus group discussions

Focus group discussions were held with women and men, young and old, in both urban and rural settings. The aim was again to explore local views and language about violence and obtain descriptions of different forms of violence. Focus group discussions were conducted using a script and short scenarios; participants were left to complete the story-line.

Box 2.4 Translation of the questionnaire

The working language for the development of the questionnaire was English. Before pre-testing in each country, the questionnaire was professionally translated into the relevant local languages. The formative research was used to guide the forms of language and expressions used, with the focus being on using words and expressions that were widely understood in the study sites. In settings where a number of languages were in use, questionnaires were developed in each language.

Previous research experience in South Africa and Zimbabwe found that professional back-translations were not a reliable way to check the accuracy of questions on violence and its consequences. For this reason, the translated questionnaire was first checked by local researchers involved in the study who compared the English and translated versions. Lengthy oral back-translation sessions with step-by-step discussion of each question were conducted with people not familiar with the questionnaire but fluent in the language and with people who understood the questionnaire and violence issues. The main purpose of this exercise was to identify differences in translations that could alter the meaning of questions and to establish cognitive understanding of the items in the questionnaire. Adjustments were made where needed. Once the translation had been finalized, the questions were again discussed during interviewer-training sessions on the basis of a question-by-question description of the questionnaire. Having interviewers from various cultural backgrounds aided in ascertaining whether wording used was culturally acceptable. During the training itself, further revisions to the translated questionnaires were made. Final minor modifications to fine-tune the translated questionnaire were usually made during the pilot survey in the field, in the third week of interviewer training.

Development of the questionnaire

The study questionnaire was the outcome of a long process of discussion and consultation. Following an extensive review of a range of pre-existing study instruments, and consultation with technical experts in specific areas (including violence against women, reproductive health, mental health, and tobacco and alcohol use), the core research team developed a first draft of the questionnaire. This was then reviewed by the expert steering committee and experts in relevant fields, and suggestions for revision were incorporated. The revised questionnaire was then reviewed by the country teams during an international meeting. Discussion focused on incorporating country priorities, and achieving a balance between exhaustively exploring specific issues and compiling less detailed information on a range of issues.

The questionnaire was then translated (see Box 2.4) and pretested in six countries (Bangladesh, Brazil, Namibia, Samoa, Thailand, and the United Republic of Tanzania). The experiences from these pretests were reviewed at the third meeting of the research teams, and used to make further revisions to the questionnaire.

Following a final pretest, the questionnaire for the Study was completed as version 9.9 (Annex 4), and was used in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Thailand, and the United Republic of Tanzania. An updated version of the questionnaire (version 10), which incorporates the experience in the first eight countries, was used in Serbia and Montenegro.

Questionnaire structure

The questionnaire consisted of an administration form, a household selection form a household questionnaire, a women's questionnaire, and a reference sheet. The women's questionnaire included an individual consent form and 12 sections designed to obtain details about the respondent and her community, her general and reproductive health, her financial autonomy, her children, her partner, her experiences of partner and non-partner violence, and the impact of violence on her life (see Box 2.5 for an outline of the questionnaire).

Maximizing disclosure

From the outset of the study it was recognized that violence is a highly sensitive issue, and that there was a danger that women would not

Box 2.5 WHO Multi-country Study on Women's Health and Domestic Violence against Women: topics covered by the women's questionnaire

Section 1:	Characteristics of the respondent and her community
Section 2:	General health
Section 3:	Reproductive health
Section 4:	Information regarding children
Section 5:	Characteristics of current or most recent partner
Section 6:	Attitudes towards gender roles
Section 7:	Experiences of partner violence
Section 8:	Injuries resulting from partner violence
Section 9:	Impact of partner violence and coping mechanisms used by women who experience partner violence
Section 10:	Non-partner violence
Section 11:	Financial autonomy
Section 12:	Anonymous reporting of childhood sexual abuse; respondent feedback

disclose their experiences of violence. For this reason, in designing the questionnaire, an attempt was made to ensure that women would feel able to disclose any experiences of violence. The questionnaire was structured so that early sections collected information on less sensitive issues, and that more sensitive issues, including the nature and extent of partner and non-partner violence, were explored later, once a rapport had been established between the interviewer and the respondent.

Partner violence often carries a stigma, and women may be blamed, or blame themselves, for the violence they experience. For this reason, all questions about violence and its consequences were phrased in a supportive and non-judgemental manner. The word "violence" itself was avoided throughout the questionnaire. In addition, careful attention was paid to the wording used to introduce the different questions on violence. These sections forewarned the respondent about the sensitivity of the forthcoming questions, assured her that the questions referred to events that many women experience, highlighted the confidentiality of her responses, and reminded her that she could choose not to answer any question or to stop the interview at any point. For example, the wording used to introduce the section on intimate-partner violence was:

"When two people marry or live together, they usually share both good and bad moments. I would now like to ask you some questions about your current and past relationships and how your husband/partner treats (treated) you. If anyone interrupts us I will change the topic of conversation. I would again like to assure you that your answers will be kept secret, and that you do not have to answer any questions that you do not want to. May I continue?"

This form of introduction also ensured that women were given a second opportunity (in addition to the informed consent) to decline to answer questions about violence.

Country adaptation and translation of the questionnaire

Once the questionnaire had been finalized, country teams were able to make minor adaptations. Country modifications generally involved either adding a limited number of questions to explore country-specific issues or modifying the response categories used to make them appropriate to the particular setting. To ensure that cross-country comparability was not jeopardized, all proposed changes were reviewed by the core research team. Relatively significant changes were made to the questionnaire only in Ethiopia, Japan, and Serbia and Montenegro (see Annex 1).

References

1. **Krug EG et al.** *World report on violence and health.* Geneva, World Health Organization, 2002.
2. **Straus MA, Gelles RJ.** Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. *Journal of Marriage and the Family,* 1986, 48:465–480.
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CHAPTER 3

Sample design, ethical and safety considerations, and response rates

This chapter contains basic information on sample design, the ethical and safety considerations in the study methodology, and the response rates in the study sites. Details on the following subjects are given in Annex 1 Methodology:

1. Ensuring comparability across sites and sampling strategies
2. Enhancing data quality
3. Interviewer selection and training
4. Respondents' satisfaction with the interview
5. Data processing and analysis
6. Characteristics of respondents
7. Representativeness of the sample.

Sample design

In each country, the quantitative component of the study consisted of a cross-sectional population-based household survey conducted in one or two sites (Box 3.1).

In Bangladesh, Brazil, Peru, Thailand, and the United Republic of Tanzania, surveys were conducted in two sites: one in the capital or a large city; and one in a province or region, usually with urban and rural populations. One rural setting was used in Ethiopia, and a single large city in Japan, Namibia, and Serbia and Montenegro. In Samoa the whole country was sampled. In this report, sites are referred to by country name followed by either "city" or "province"; where only the country name is used, it should be taken to refer to both sites.

The following criteria were used to help select an appropriate province:

- availability of, or the possibility of establishing, support services for women who, through the course of the survey, were identified as having experienced some form of violence and needing support;
- location broadly representative of the country as a whole, in terms of the range of communities, ethnic groups and religions;
- population not marginalized, and not perceived as being likely to have higher levels of partner violence than in the rest of the country.

In general, a woman was considered eligible for the study if she was aged between 15 and 49 years, and if she fulfilled one of the following three conditions:

- she normally lived in the household;
- she was a domestic servant who slept for five nights a week or more in the household;
- she was a visitor who had slept in the household for at least the past 4 weeks.

In Japan, where for legal reasons it was not feasible to interview women under 18 years of age, women aged 18–49 years were sampled.

The initial sample size calculations suggested that an obtained sample size of 1500 women in each site would give sufficient power to meet the study objectives (see Chapter 1). In order to make up for losses to the sample as a result of households without eligible women, refusals to participate, or incomplete interviews, the initial number of households to be visited was set approximately 20–30% higher than the target sample size in most sites. Appendix Table 1 shows details of the sample sizes obtained.

For most sites, a two-stage cluster sampling scheme was used to select households. In settings where the site (city or province) was very large, a multistage procedure was used in which districts (or analogous administrative units) were first selected, and then clusters were selected from within the chosen districts. Either explicit or implicit stratification by an appropriate socioeconomic indicator was used to ensure that the sample was representative of all socioeconomic groups. Depending on the sampling frame, between 22 and 200 clusters were selected from each of the sites participating in the study.

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Section 1:	Characteristics of the respondent and her community
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Box 3.1 WHO Multi-country Study on Women's Health and Domestic Violence against Women: survey sites

Country	Capital or large city	Provincial site
Bangladesh	**Dhaka:** country's capital, largest city and commercial centre, situated in the middle of the country in the delta region of the Ganges and Brahmaputra rivers. Population of over 10 million and growing rapidly; includes areas of extreme poverty. While overall literacy rate is still low, positive change has been noticed in recent years. Almost 90% Muslim.	**Matlab:** densely populated rural district, dominated by subsistence agriculture and widespread landlessness; site of demographic and health surveillance project operated by ICDDR,B: Centre for Health and Population Research.
Brazil	**São Paulo:** largest city in Brazil, with a population of 14 million (2000); dynamic commerce and trade. Base for major political parties and social movements.	**Zona da Mata de Pernambuco:** north-eastern province, largely rural, with small villages and towns. Sampling excluded major city of Recife. Mostly agricultural – emphasis is on sugar cane production – with a considerable service industry sector.
Ethiopia		**Butajira:** densely populated, largely rural district characterized by subsistence agriculture; majority Muslim. Principal town, Butajira, is 130 km south of the capital Addis Ababa; site of demographic and health surveillance project.
Japan	**Yokohama:** second largest city in Japan, highly urban, 3.3 million population. About 70% of women have post-secondary education.	
Namibia	**Windhoek:** capital and seat of Government; administrative, commercial and industrial centre. Population, 250 000 (2002 census). Melting pot of cultures: African, European and others. Official language, English; other commonly heard languages: Afrikaans, German, Oshiwambo, Otjiherero, Nama-Damara.	
Peru	**Lima:** Peru's capital and largest city, situated on the Pacific coast; estimated 7.5 million inhabitants (2000), nearly half of whom live in large periurban settlements, characterized by self-built or inadequate housing, with few green areas and insufficient basic services. Language, Spanish.	**Department of Cusco:** in the south-east region of the Peruvian Andes; historically the seat of great Inca civilizations. Cusco city, at 3350 m above sea level, is a centre for tourism. Most of the rest of the department consists of largely rural communities and isolated and remote settlements. Languages, Spanish and Quechua.
Samoa[a]	**Samoa:** fertile, volcanic islands half-way between Hawaii and Australia. Largely rural communities located mainly on the coast engaged in subsistence agriculture, although tourism is also important. Predominantly Polynesian and Christian.	
Serbia and Montenegro	**Belgrade:** capital city; economic, political and administrative centre. 1.7 million residents, mainly Serbs; 22 nationalities. One of the oldest towns in Europe, with extensive cultural tradition. Aerial bombing in 1999 caused substantial damage. After elections in 2000, major demonstrations led to democratic changes.	
Thailand	**Bangkok:** Thailand's capital and by far its largest city. Major metropolitan centre in the heart of the major commercial rice-growing region. 93% Buddhist.	**Nakhonsawan:** 70% rural province, 266 km north of Bangkok. Largely Buddhist.
United Republic of Tanzania	**Dar es Salaam:** Main seaport, largest city and seat of government. Population, 2.5 million (2002). It is a metropolitan city with a mixed population.	**Mbeya district:** in the south of the country. It is a mountainous, agricultural area with a population of 521 000 (2002). The region's rural population is largely indigenous.

[a] Whole country sampled.

Within each cluster, households were enumerated and mapped after careful definition of what a household was (for example, an address, a residence containing one family unit, a group who share the same stove). One of two methods was used to select the households within a cluster in a way that ensured that the sample was self-weighting with respect to the household:

- The cluster was selected with probability proportional to size and then a fixed number of households were systematically selected in each cluster.
- The cluster was selected randomly regardless of size and a fixed proportion of households were selected systematically in each cluster.

Box A1.1 in Annex 1 shows details of the sampling strategy employed in each site and how self-weighting at the level of the household was ensured.

In Japan and Ethiopia, a full listing of women in the study location was available, making it possible to directly sample eligible women, either in the whole study site (Ethiopia province) or in each selected cluster (Japan city), thus ensuring that the samples were self-weighted at the level of the individual woman.

In order to ensure the safety and confidentiality of interviews, only one woman per household was selected for interview. In all sites, except Ethiopia province and Japan city, the age and initials of all females in each selected household were recorded on a household selection form. From this list, the women eligible for interview were identified. The interviewer then randomly selected one woman to participate in the study. Where the selected woman was not available, the interviewer made an appointment to return to conduct the interview. At least two additional visits were made before the woman was considered lost to follow-up. In practice, particularly in urban areas, more than two repeat visits were often made. No replacements were made for interviews that could not be completed.

Ethical and safety considerations

The WHO Study drew upon IRNVAW experience, as well as the Council for International Organizations of Medical Science (CIOMS) *International guidelines for ethical review of epidemiological studies* (**1**). Discussions were held with the WHO Steering Committee for the Study and with key members of the Scientific and Ethical Review Group (SERG) of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development, and Research Training in Human Reproduction (HRP), to develop ethical guidelines on the conduct of domestic violence research (**2**). These ethical and safety guidelines (see Box 3.2) were adhered to in each country, and have since served to set standards for research on this and other sensitive issues in several of the research institutions involved in the WHO Study and elsewhere.

The WHO guidelines emphasize the importance of ensuring confidentiality and privacy, both as a means to protect the safety of respondents and field staff, and to improve the quality of the data. Researchers have a responsibility to ensure that the research does not lead to the participant suffering further harm and does not further traumatize the participant. Furthermore, interviewers must respect the respondent's decisions and choices.

Box 3.2 WHO ethical and safety guidelines

- The safety of respondents and the research team was taken to be paramount, and guided all project decisions.
- The Study aimed to ensure that the methods used built upon current research experience about how to minimize the underreporting of violence and abuse.
- Mechanisms were established to ensure the confidentiality of women's responses.
- All research team members were carefully selected and received specialized training and support.
- The Study design included actions aimed at minimizing any possible distress caused to the participants by the research.
- Fieldworkers were trained to refer women requesting or needing assistance to available local services and sources of support. Where few resources existed, the Study created short-term support mechanisms.
- In each country, WHO funds were committed to help ensure that the study findings were disseminated, and research teams were encouraged to use the findings to advance policy and the development of interventions.

Ethical permission for the study was obtained from WHO's own ethical review group (WHO Secretariat Committee for Research in Human Subjects), and from the local institution and, where necessary, national ethical review boards at each site.

All respondents were interviewed in private. Because of the low levels of literacy in many of the study populations and to protect confidentiality (no names were written on the questionnaire), consent to participate in the interview was in general given orally by participants, with the interviewer signing to confirm that the consent procedures had been completed. Participation was fully voluntary, and no payment or other incentive was offered to participants. In addition, before starting on particularly sensitive sections of the interview, women were again asked whether they wanted to proceed, and were reminded that they were free to terminate the interview or to skip any questions. If the interview was interrupted, the interviewers were trained either to terminate the interview, or to stop asking about violence and to move on to another, less sensitive topic until privacy could be ensured. (For more information on interviewer selection and training see Annex 1.)

The interview was scripted to end on a positive note, highlighting the respondent's strengths and the unacceptability of violence. At the end of the interview, irrespective of whether the respondent had disclosed violence or not, respondents were offered a card, leaflet or booklet giving contact details about available health, support and violence-related services, often coupled with information on other more general community services. In some places, cards with information about violence-related services were produced in a small format, in an attempt to ensure that women would be able to keep the information discreetly. Where necessary, and if the respondent requested immediate assistance, referrals were made to support services. In practice, however, requests for referral were generally low.

Response rates

In general, and particularly when compared with other surveys, the Study achieved a high response rate in each setting. Across the 15 different sites in 10 countries, 24 097 women completed interviews about their experiences of violence, with between 1172 and 1837 interviews per site, except for Ethiopia province, where 3016 women completed interviews.

Table 3.1 Household and individual sample obtained and response rates, by site

Site	Households		Individuals	
	No. of household interviews completed	Household response rate[a] (%)	No. of individual interviews completed	Individual response rate[b] (%)
Bangladesh city	1773	93.9	1603	95.9
Bangladesh province	1732	99.4	1527	95.8
Brazil city	1715	94.4	1172	89.9
Brazil province	1940	99.2	1473	95.7
Ethiopia province[c]	n.a.	n.a.	3016	97.8
Japan city[c]	n.a.	n.a.	1371	60.2
Namibia city	1925	98.0	1500	97.2
Peru city	1710	92.8	1414	91.8
Peru province	1955	98.9	1837	96.8
Samoa[d]	1646	(83–100)	1640	99.7
Serbia and Montenegro city	2769	59.8	1456	88.9
Thailand city	2131	91.3	1536	85.0
Thailand province	1836	98.9	1282	93.9
United Republic of Tanzania city	2042	98.9	1820	96.2
United Republic of Tanzania province	1950	99.6	1450	96.8

n.a., not available.

[a] Household response rate is calculated as: the number of completed household interviews as a percentage of the total number of "true" households (i.e. all the houses in the sample minus those that were empty or destroyed).

[b] Individual response rate is calculated as: the number of completed interviews as a percentage of the number of households with eligible women and those where it could not be ascertained whether they contained eligible women or not.

[c] In Japan city and Ethiopia province, no household response rate was calculated because a direct sample of women (not of households) was used. Note also that the calculation of the individual response rate in Japan differs from that for the other sites because the denominator may include households where the interviewer was not able to establish whether or not the selected woman was actually living in that household. The calculated rate may therefore underestimate the real response rate.

[d] The household response rate for Samoa is not precisely known because the data set consists of completed household interviews (1646) only and it is not known how many houses in the original sample (1995) were empty or destroyed or how many households refused the interview. Nevertheless, the rate cannot be lower than 83%, and according to information on household and individual participation, it is likely that the real rate is much closer to 100%.

In 12 of the 13 sites that sampled households, between 91.3% and 99.6% of inhabited households completed the initial household interview. The only outlier was Serbia and Montenegro city, where the *household response rate* was around 60% (Table 3.1). Although this rate was low in comparison to the other sites, it was better than that usually obtained in surveys conducted in Serbia and Montenegro city sites (Strategic Marketing, survey company in Belgrade, personal communication, 2003). It is possible that the response rate may have been influenced by the assassination of the Serbian Prime Minister, which occurred as the fieldwork was starting. This exceptional event made many people mistrustful of interviewers and other strangers at their door. (See Appendix Table 1(a) for more details on the household response rate by site.)

The *individual response rate* was calculated as the number of completed women's questionnaires divided by the number of households in which either eligible women had been identified or it could not be ascertained whether they contained eligible women or not. While thus erring towards underestimation, the response rate at the individual level among eligible women was generally very high. In all but one of the sites, over 85% of selected women completed the interview. (See Appendix Table 1(b) for details on the individual response rate by site.) The exception was Japan city, where a direct sample of women was used and where the individual response rate was 60%. Although this rate is considerably lower than that in the other sites, it is better than the rates achieved by other population surveys in Japan (Central Research Services Inc., Tokyo, personal communication, 2000). In Ethiopia province, where a direct sample of women was also used, the individual response rate was 98%.

In countries where two sites were surveyed, both household and individual response rates were slightly lower in the city than in the province, except in Bangladesh where the individual response rates were almost identical. This tendency for cities to have lower response rates is likely to reflect the additional difficulties associated with conducting household surveys in urban areas, and the tendency for people in higher socioeconomic groups to be less willing to answer survey questions than people in poorer groups.

Because of the sampling strategy adopted to minimize risk, the age distribution of the sample obtained differed slightly from that of the overall population of eligible women. (For a detailed assessment of respondent characteristics, the representativeness of the sample, and potential biases, see Annex 1.) This is of concern, however, only if it affects the subsequent population prevalence figures obtained. Such an effect can be compensated for by weighting the prevalence by the number of eligible women in the households. This is discussed further in Box 4.1 in Chapter 4.

Overall, most respondents found participating in the study to be a positive experience. Indeed, in all countries, the overwhelming impression gathered by the interviewers 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 in private to a non-judgemental and empathetic person. The fact that so many women who had never discussed their experiences previously (see Chapter 9) chose to do so with the study interviewers underscores how the quality of interpersonal communication between interviewers and respondents may enhance or inhibit disclosure (**3**). For a more detailed analysis of respondent satisfaction with the interviews, see Annex 1.

As women are commonly stigmatized and blamed for the abuse they experience, there is unlikely to be overreporting of violence. In practice, the main potential form of bias is likely to reflect respondents' willingness to disclose their experiences of violence – which may differ between different age groups, between different geographical settings, and between different cultures and countries. The standardization of the study tools, the careful pretesting of the study questionnaire and intensive interviewer training will have helped minimize bias, maximize disclosure, and reduce the potential for intersite variability. (For further information on interviewer selection and training and other efforts to ensure comparability, please see Annex 1.) Nevertheless, remaining disclosure-related bias would be likely to lead to an underestimation of the levels of violence. Thus the prevalence figures presented in Chapters 4, 5, and 6 should be considered to be minimum estimates of the true prevalence of violence in each setting.

> "After having lived an experience like this study, we will never be the same. Not only because of what we heard, but also because of what we learned as recipients of many life stories, each one of them with different levels and degrees of violence."
>
> Interviewer from Peru

References

1. *International guidelines for ethical review of epidemiological studies*. Geneva, 1993. Council for International Organizations of Medical Science.
2. *Putting women first: ethical and safety recommendations for research on domestic violence against women*. Geneva, World Health Organization. 1999 (WHO/EIP/GPE/99.2).
3. **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.

Results

“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.”

Woman (27-year-old university graduate) interviewed in Thailand

“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

“He stopped the car and I didn’t know… I was very afraid, very, very afraid. And then he said, “you’re going to take your clothes off and you’re going to have sex with me”. Then I said, “no, I can’t, please, I am sick”. AIDS was not around at that time, but I told him I had a disease and he was going to get it. “Ok, do you prefer we do this with me holding the gun against your forehead or without it?” And then I said, “without it”.”

Woman, teacher, interviewed in Brazil (about the rape she suffered when her car was stolen by a criminal carrying a gun)

CHAPTER 4

Prevalence of violence by intimate partners

Main findings

- **For ever-partnered women, the range of lifetime prevalence of physical violence by an intimate partner was between 13% and 61%, with most sites falling between 23% and 49%. Between 4% and 49% of ever-partnered women reported severe physical violence.**
- **The range of lifetime prevalence of sexual violence by an intimate partner was between 6% and 59%, with most sites falling between 10% and 50%.**
- **The range of lifetime prevalence of physical or sexual violence, or both, by an intimate partner was between 15% and 71%. In most sites sexual violence was considerably less frequent than physical violence. Sexual violence was usually accompanied by physical violence, although in some settings a relatively large proportion of ever-abused women reported sexual violence only.**
- **Intimate partners who are physically or sexually violent also tend to have highly controlling behaviour.**

This chapter presents data on the prevalence of different forms of violence against women by a male partner or ex-partner. It also briefly discusses women's violence against their male partners. The data were all drawn from women's responses to the WHO Study questionnaire. Women’s experiences of violence and abuse were measured using a series of behaviour-specific questions that asked whether a current or former partner had ever perpetrated different physically, sexually or emotionally abusive acts against her. For each act that elicited an affirmative response, the respondent was asked whether she had experienced that act within the past 12 months and about the frequency with which it had occurred. Women were also asked a series of questions on whether their partners tried to control their daily activities.

The results on the extent of physical or sexual violence by current or former partners are presented by study site, according to the type and severity of violence, when the violence took place, and the extent of overlap of physical and sexual violence. Results are also given on women’s reported experience of different emotionally abusive acts, but these data should be considered as preliminary. The association between ever having experienced physical or sexual partner violence, and women's views on the acceptability of violence in different situations is also explored.

With the exception of information regarding women’s attitudes towards violence and coerced sex, all the data presented in this chapter pertain to women who report ever having had an intimate male partner, whether or not they currently have a partner. Although sexual abuse before the age of 15 years and coerced or forced first sex might also have been perpetrated by an intimate partner, these issues are addressed separately in Chapter 6.

Table 4.1 **Prevalence of physical and sexual violence against women by an intimate partner, by site**

Site	Physical violence		Sexual violence		Physical or sexual violence, or both		Total no. of ever-partnered women
	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	
Bangladesh city	39.7	19.0	37.4	20.2	53.4	30.2	1373
Bangladesh province	41.7	15.8	49.7	24.2	61.7	31.9	1329
Brazil city	27.2	8.3	10.1	2.8	28.9	9.3	940
Brazil province	33.8	12.9	14.3	5.6	36.9	14.8	1188
Ethiopia province	48.7	29.0	58.6	44.4	70.9	53.7	2261
Japan city	12.9	3.1	6.2	1.3	15.4	3.8	1276
Namibia city	30.6	15.9	16.5	9.1	35.9	19.5	1367
Peru city	48.6	16.9	22.5	7.1	51.2	19.2	1086
Peru province	61.0	24.8	46.7	22.9	69.0	34.2	1534
Samoa	40.5	17.9	19.5	11.5	46.1	22.4	1204
Serbia and Montenegro city	22.8	3.2	6.3	1.1	23.7	3.7	1189
Thailand city	22.9	7.9	29.9	17.1	41.1	21.3	1048
Thailand province	33.8	13.4	28.9	15.6	47.4	22.9	1024
United Republic of Tanzania city	32.9	14.8	23.0	12.8	41.3	21.5	1442
United Republic of Tanzania province	46.7	18.7	30.7	18.3	55.9	29.1	1256

[a] At least one act of physical or sexual violence during the 12 months prior to the interview.

Physical and sexual violence

Table 4.1 presents, for each site, prevalence rates for physical and sexual violence by male partners or ex-partners against women in their lifetime or currently. The lifetime prevalence of partner violence was defined as the proportion of ever-partnered women who reported having experienced one or more acts of physical or sexual violence by a current or former partner at any point in their lives. Current prevalence was the proportion of ever-partnered women reporting that at least one act of physical or sexual violence took place during the 12 months prior to the interview. The lifetime prevalence of physical violence by partners ranged from 13% (Japan city) to 61% (Peru province), with most sites falling between 23% and 49%. The range of reported lifetime prevalence of sexual violence by partners was between 6% (city sites in Japan, and Serbia and Montenegro) and 59% (Ethiopia province), with most sites falling between 10% and 50%. The proportion of women reporting either sexual or physical violence, or both, by a partner ranged from 15% (Japan city) to 71% (Ethiopia province), with most sites falling between 29% and 62%. Japan city consistently reported the lowest prevalence of all forms of violence, whereas the provinces of Bangladesh, Ethiopia, Peru, and the United Republic of Tanzania reported the highest figures. The prevalence rates were not significantly affected by the study design (see Box 4.1).

Figure 4.1 shows the lifetime prevalence of violence by an intimate partner, in the form of a bar graph. The first bar portrays the percentage of women in each setting who have experienced physical violence by a partner, ranked from highest prevalence (Peru province) to lowest (Japan city). The second bar presents the percentage of women reporting sexual violence by a partner. As Figure 4.1 demonstrates, the prevalence of sexual violence does not always correspond to that of physical violence. In Ethiopia province, Bangladesh province and Thailand city, women report more sexual violence than physical violence, whereas in all other sites, sexual violence is considerably less prevalent than physical violence.

Box 4.1 **Did the study design affect the results?**

In order to assess the degree of bias that might have been introduced by using the selection criterion of one woman per household, the prevalence estimates for violence were compared with the weighted estimates, taking into account the number of eligible women in each household. Appendix Table 2 shows, for each of the sites, the unweighted and weighted lifetime prevalence of physical violence, sexual violence, and physical and/or sexual violence, by an intimate partner for ever-partnered women. These estimates were not significantly different in any of the sites, and so, throughout this report, unweighted estimates are used.

The extent to which the precision of the results might have been affected by cluster sampling (design effect) was also explored. In Appendix Table 2, two sets of 95% confidence intervals are given for each estimate. The first confidence interval assumes a simple random sample; and the second takes into account the study design (cluster sampling). A comparison between these estimates shows that the corrected confidence interval is the same or only slightly wider than that obtained assuming a simple random sample, suggesting that there was minimal clustering of the different outcomes (physical violence, sexual violence, physical and/or sexual violence).

Figure 4.1 **Prevalence of lifetime physical violence and sexual violence by an intimate partner among ever-partnered women, by site**

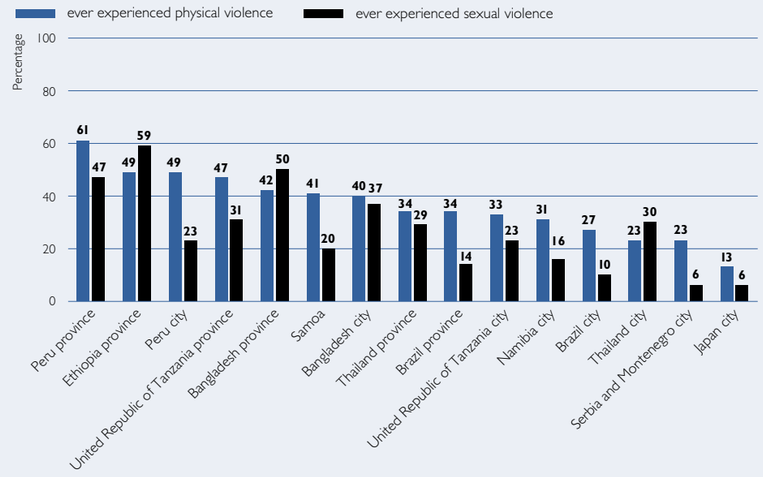
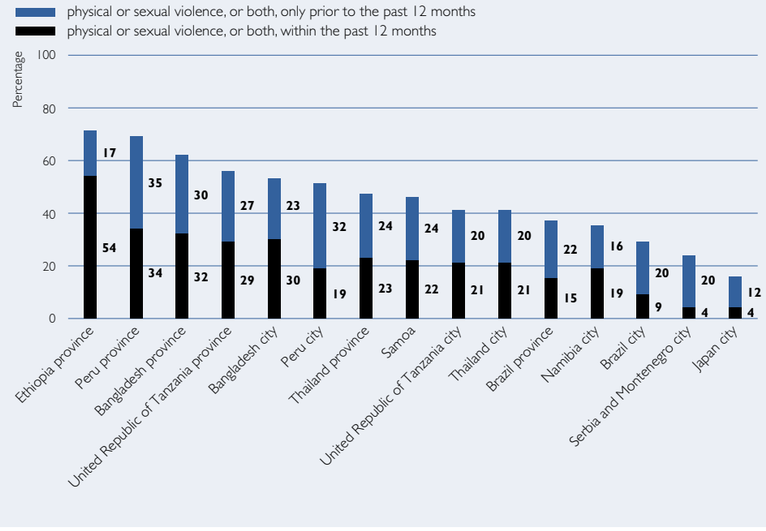


Figure 4.2 **Prevalence of physical or sexual violence, or both, by an intimate partner among ever-partnered women, according to when the violence took place, by site**



Differences were also found among the sites with regard to the proportion of ever-partnered women who reported violence within the previous 12 months (see Figure 4.2). For example, in Ethiopia province, 54% of women reported physical or sexual violence, or both, in the past year, compared with 17% who reported violence prior to the past year. In contrast, only 4% of women in Serbia and Montenegro city reported violence within the past year compared with 20% prior to the past year, and in Japan city the corresponding figures were 4% and 12%. One possible explanation for these differences could

be the duration of a relationship. In countries such as Ethiopia, where women have less possibility to leave a violent relationship (only 12% of ever-partnered women in the Ethiopian sample were separated, divorced or widowed), women are more likely to have experienced recent violence. The observation that across most sites, younger women experience more current violence (see Appendix Table 3) suggests that age distribution may also be a factor. This finding will be further explored in future analyses.

Acts of physical violence

Appendix Table 4 summarizes, by site, data on the types of physical acts that abused women experienced. It also gives the percentages of women who experienced each act during the 12 months prior to the interview. The most common act of violence reported by women was being slapped or having something thrown at them, the prevalence of which ranged from 9% in Japan city to 52% in Peru province. The percentage of women who were hit with a fist by a partner ranged from 2% in Japan city to 42% in Peru province, with most sites falling between 11% and 21%. In general, the percentage of women who experienced a particular act decreased as the severity of the act increased.

The acts mentioned in Appendix Table 4 are listed in order of severity, according to the likelihood of their causing physical injury. Women who were slapped, pushed or shoved are categorized as having been subjected to moderate violence, and those who had been hit with a fist, kicked, dragged or threatened with a weapon are categorized as having been subjected to severe violence (see Box 2.2 in Chapter 2).

Ranking acts of physical violence by severity is an exercise fraught with controversy. Critics of such schemes observe that a shove can, under certain circumstances, cause severe injury, even though it is categorized here as moderate violence. Nevertheless, the breakdown of acts by severity used in this report closely tracks other measures of severity, such as injury and mental health outcomes. Most injuries reported by women experiencing violence by an intimate partner occur in women who report physical acts categorized in this scheme as severe rather than moderate.

Using the classification in Box 2.2, the percentage of ever-partnered women in the population experiencing severe physical violence ranged from 4% of women in Japan city to 49% of women in Peru province. Significantly, in the majority of settings, the proportion of women who experienced only moderate physical violence was less than the proportion who experienced severe violence. This is clearly visible in Figure 4.3, which illustrates the percentage of ever-partnered women who have experienced moderate versus severe physical violence by an intimate partner.

Appendix Table 5 breaks down physical violence by severity and by when it occurred. In general, more women experienced acts of severe physical violence prior to the past 12 months than are currently experiencing severe acts. The opposite pattern was found in Ethiopia province and Samoa and in the cities of Bangladesh and Namibia, where current severe violence is more frequent than former severe violence.

Figure 4.3 Prevalence of physical violence by an intimate partner according to severity of violence among ever-partnered women, by site

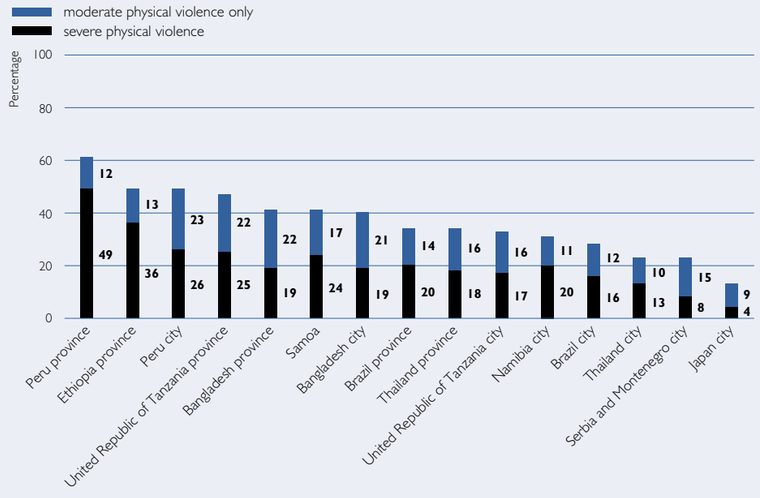


Table 4.2 Percentage of ever-partnered women who have experienced different acts of sexual violence by their intimate partners, by site

Site	Physically forced to have sexual intercourse		Had sex because afraid of what partner might do		Forced to do something degrading/humiliating		Experienced any of the 3 forms of sexual violence listed		Total no. of ever-partnered women
	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	
Bangladesh city	34.4	16.1	21.4	14.0	3.1	2.0	37.4	20.2	1373
Bangladesh province	45.7	18.4	31.7	18.3	3.8	1.7	49.7	24.2	1329
Brazil city	8.3	2.0	7.0	1.9	3.3	1.0	10.1	2.8	940
Brazil province	10.3	3.8	9.7	3.8	5.3	1.6	14.3	5.6	1188
Ethiopia province	46.0	32.6	57.6	42.5	0.4	0.3	58.6	44.4	2261
Japan city	4.9	1.2	3.1	0.7	1.3	0.2	6.2	1.3	1275
Namibia city	12.9	7.4	9.8	5.7	5.9	3.0	16.5	9.0	1367
Peru city	16.4	4.6	15.8	5.0	8.1	1.9	22.5	7.1	1087
Peru province	37.7	18.1	37.4	17.7	11.3	5.4	46.7	23.0	1534
Samoa	17.7	10.3	11.4	6.6	3.3	2.0	19.5	11.4	1204
Serbia and Montenegro city	3.5	0.2	4.0	0.9	1.5	0.1	6.3	1.1	1191
Thailand city	7.9	3.6	26.7	15.5	4.9	2.2	29.9	17.0	1048
Thailand province	7.5	3.5	26.1	14.0	4.1	2.0	28.9	15.6	1024
United Republic of Tanzania city	19.3	10.5	11.8	6.7	1.9	1.0	23.0	12.7	1442
United Republic of Tanzania province	27.1	16.2	17.5	10.0	2.0	1.4	30.7	18.3	1256

[a] At least one act of sexual violence during the 12 months prior to the interview.

Appendix Table 6 provides additional information about the frequency distribution of the different acts of physical violence that occurred within the 12 months prior to the interview. For all acts, the vast majority of women experienced the act not once, but a few or many times in the 12 months prior to the interview. These data demonstrate that far from being an isolated event, most acts of physical violence by an intimate partner are part of a pattern of continuing abuse.

Acts of sexual violence

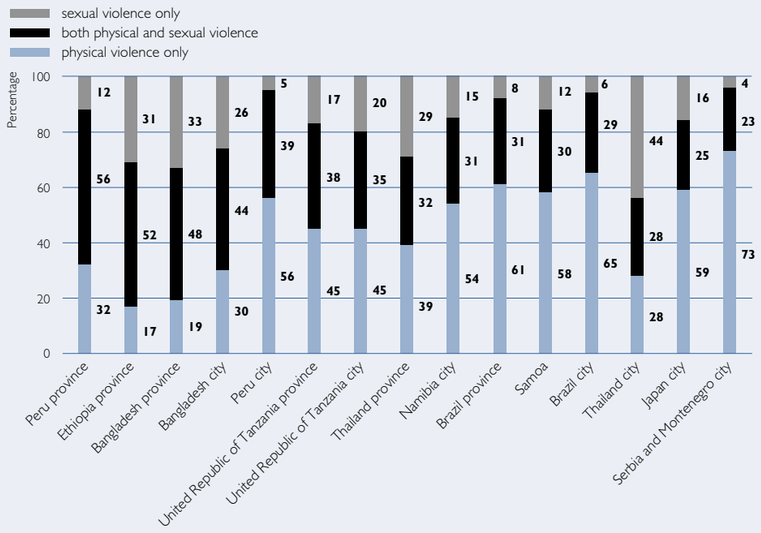
Table 4.2 shows the percentage of women who have experienced different forms of sexual abuse by an intimate partner during their lifetime and within the 12 months prior to being interviewed. The three different behaviours measured by the WHO Study were: being physically forced to have sexual intercourse against her will; having sexual intercourse because she was afraid of what her partner might do if she did not; or being forced to do something sexual that she thought was degrading or humiliating. Overall, the percentage of women who reported sexual abuse by a partner varied between 6% in Japan and Serbia and Montenegro cities and 59% in Ethiopia province, with the majority of settings falling between 10% and 50%. In all countries where two-site surveys were conducted, except Thailand, the percentage of women reporting sexual abuse was higher in the province than in the city site.

The proportion of women physically forced into intercourse varied from 4% in Serbia and Montenegro to 46% in Bangladesh and Ethiopia provinces – a greater than tenfold difference. One third of Ethiopian women surveyed said that they had been physically forced to have intercourse by a partner 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 women often face with protecting themselves from HIV infection (**1**, **2**).

In Ethiopia province and Thailand, a higher proportion of women reported having intercourse because they were afraid to refuse than reported being physically forced. For example, in Thailand city, 8% of women reported being physically forced to have sex by a partner compared with 27% who were coerced through fear. Elsewhere, the ratio of physical force to fear is more equal, or even reversed.

Of the three behaviours, being forced by their partners into sexual behaviours that they found degrading or humiliating was the least prevalent everywhere. The lifetime prevalence of this occurrence ranged from less than 1% of women in Ethiopia province to 11% of women in Peru province.

Figure 4.4 **Frequency distribution of types of violence by an intimate partner among ever-abused women, by site**



Overlap between physical and sexual violence

In the majority of the sites studied, there was a substantial overlap between physical and sexual violence by intimate partners (see Figure 4.4). In all sites, more than half of the women who reported partner violence reported either physical violence only or physical violence accompanied by sexual violence. In most sites between 30% and 56% of women who had ever experienced any violence, reported both physical and sexual violence, whereas in the cities in Brazil, Japan, Thailand, and Serbia and Montenegro, the overlap was less than 30%. In all settings except Thailand city, less than one third of ever-abused women reported only sexual violence by a partner (see Figure 4.4).

Thailand city was exceptional in that a substantial proportion of women (44%) who experienced violence by an intimate partner reported sexual violence only (Figure 4.4). The corresponding statistic in Thailand province is lower, but still a relatively high 29%. Similarly high proportions of sexual violence only were reported by abused women in Bangladesh province (33%) and Ethiopia province (31%). A study performed in Indonesia using the WHO methodology also produced similar findings (**3**).

Demographic factors associated with violence

A combination of two approaches was used to assess how the prevalence of violence might be affected by common sociodemographic variables, and the degree to which these might account for the variation in prevalence estimates across sites. Firstly, the prevalence of all forms of violence was stratified by site, age, partnership status, and educational attainment (see Appendix Table 3). Then, multivariate logistic regression was used to assess the impact of these same variables on the prevalence of each type of violence.

Patterns of current violence (i.e. in the 12 months immediately prior to the interview) by age group were broadly similar across sites. With the exception of Japan city and Ethiopia province, younger ever-partnered women, especially those aged 15–19 years, were at higher risk of experiencing current physical or sexual violence, or both, by an intimate partner. In general, the differences between the age groups were more pronounced in the cities than in the provinces. For example, in Bangladesh city, 48% of 15–19-year-old women had experienced physical or sexual violence, or both, by an intimate partner in the 12 months preceding the interview, compared with 10% of 45–49-year-olds. The corresponding figures for Bangladesh province are 41% (15–19-year-olds) and 26% (45–49-year-olds). It thus seems that violence starts early in relationships, which then may break up over time. It is also possible that older women in abusive relationships develop strategies that decrease the frequency of violence, or that they are less likely to report violence.

A pattern of increased risk for current violence among younger women has also been documented in Canada (**4**), the United States (**5**), and several developing countries (**6**). This pattern may reflect, in part, the fact that younger men tend to be more violent than older men, and that violence tends to start early in many relationships (**7**). Another explanation for the disparity in current violence between age groups may be that, in some settings, older women have greater status than young women, and therefore may be less vulnerable to violence. There may also be some confounding with cohabitation, given that the proportion of partnered women who are cohabiting (as opposed to being married) is higher among younger women than it is in older women.

The pattern of risk across different age groups is less consistent for lifetime experience of violence. The expected pattern is one of a higher prevalence of lifetime violence by an intimate partner among older women because they have been exposed to the risk of violence longer than younger women. However, this pattern rarely holds true in this study. There may be several explanatory factors for this finding. Older women may be less likely to remember or report violence, particularly incidents that took place many years previously (**8**). This may be a result of general recall problems or the desire to forget unpleasant events from early in a marriage that may or may not be continuing. Alternatively, the rates of violence may actually differ between the generations.

With regard to partnership status, women who were separated or divorced generally reported a higher lifetime prevalence of all forms of violence than currently married women. This was true in all sites, with the exception of Ethiopia and Bangladesh provinces, where the proportion of formerly married women is fairly low. The higher levels of violence among separated and divorced women suggest that violence may be an important cause of marital dissolution (**6**, **7**). Another possible explanation is that separated women are more willing to disclose experiences of violence because they have less fear of negative consequences of disclosure, or perhaps because they are more willing to recognize their ex-partner's behaviour as violent once they are no longer with him.

Women who were living with a partner but were not married reported a higher lifetime prevalence of violence by an intimate partner than did married women, although in general the prevalence of violence in this subgroup was slightly lower than that among divorced or separated women. It is difficult to interpret the higher risk of violence among women who are cohabiting (relative to married women), even though this is a finding common to several other studies in both industrialized and developing countries (**4**, **6**, **9**). It may be that marriage confers a status that offers some protection from violence or that violent men are less likely to get married, at least in some cultures. In addition, marriage is an expensive prospect in some localities, so the association between violence and marriage could be confounded by income levels, or specific cultural practices such as dowry and bride price.

A similar pattern is observed with respect to current violence by an intimate partner. Women who were living with a partner but were not married were more likely to have experienced violence during the 12 months prior to the interview than were married women. (The practice of living with a partner while unmarried is virtually non-existent in both Bangladesh and Ethiopia.)

In about half of the settings, the prevalence of current violence was higher among women who were separated or divorced than among those who were married. This held true in Brazil and the cities in Namibia, Peru, Serbia and Montenegro, and Thailand, suggesting that, in these settings at least, violence may persist even after separation. A similar pattern of ongoing and even escalating risk despite separation has been documented in the United States and in a number of other industrialized settings (**10**–**13**).

Lower educational level was associated with increased risk of violence in many sites. In both sites in Peru, Thailand, and the United Republic of Tanzania – as well as the city sites in Brazil and Namibia – the protective effect of education does not appear to start until women achieve the very highest levels of education (i.e. beyond secondary school). This finding is in line with other international studies, which report that education has a protective effect on women's risk of violence (**5**, **14**). It is not clear whether the association between violence and education is confounded by age or socioeconomic status; however, in multivariate analyses in other studies, higher educational attainment has been protective even after controlling for income and age. The protective effect may be related to the fact that women with

> "A woman I know was recently killed by her live-in partner. Now I am very fearful and hardly sleep at night. I keep watch because when my partner is drunk or has smoked marijuana, he sharpens his knife before going to bed. He regularly warns me that he will kill me if I leave him, or do not please him in any way."
> Woman interviewed in Namibia

Table 4.3 Percentage of ever-partnered women who have experienced different emotionally abusive acts by their intimate partners, by site

Site	Any act listed		Insults		Belittlement/ humiliation		Intimidation/ scaring		Threats of harm		At least 3 different acts	Total no. of ever-partnered women
	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	
Bangladesh city	44.4	29.0	36.1	22.5	28.6	18.3	21.4	14.6	5.1	3.4	15.3	1373
Bangladesh province	30.9	19.6	21.3	12.9	17.4	9.8	17.3	10.9	3.5	2.5	8.3	1329
Brazil city	41.9	18.7	32.9	13.6	19.4	6.6	21.9	9.2	16.6	6.3	15.5	940
Brazil province	48.8	24.2	35.5	17.0	25.9	11.9	27.9	12.9	23.4	9.4	21.1	1188
Ethiopia province	75.1	57.5	73.8	55.5	12.7	9.0	23.0	15.7	3.5	2.7	9.2	2261
Japan city	34.7	15.4	27.8	10.6	8.1	3.5	17.3	7.5	1.8	0.5	4.5	1278
Namibia city	33.8	19.4	29.8	16.3	14.8	8.7	11.2	6.8	8.9	4.9	8.4	1373
Peru city	57.8	30.7	52.7	26.3	20.5	9.9	24.7	12.9	14.2	6.5	15.7	1090
Peru province	68.5	43.0	62.7	38.1	31.3	18.5	32.6	18.7	24.2	14.5	26.4	1536
Samoa	19.6	12.3	14.8	9.5	7.1	3.7	10.2	5.8	6.1	3.7	5.6	1206
Serbia and Montenegro city	33.3	11.7	28.1	9.6	11.8	3.1	13.7	4.5	10.0	2.4	9.8	1194
Thailand city	36.8	19.3	21.7	11.8	16.8	7.9	22.2	11.5	9.0	4.9	10.0	1051
Thailand province	39.1	20.7	21.8	11.7	15.9	8.0	26.8	14.4	10.4	5.5	11.3	1027
United Republic of Tanzania city	45.0	25.3	37.8	20.3	15.7	7.7	22.2	12.3	12.4	6.5	12.6	1454
United Republic of Tanzania province	58.8	32.0	54.4	28.5	17.7	8.2	25.2	13.6	13.3	6.5	15.3	1258

[a] At least one emotionally abuse act during the 12 months prior to the interview.

more education tend to have partners who are also more educated. The association may also come about because more highly educated women have a greater range of choice in partners, have more freedom to choose whether to marry or not, and are able to negotiate greater autonomy and control of resources within the marriage. It is also possible that the apparent protective effect of more advanced education is actually an artefact of educated women being less likely to disclose abuse because of the associated stigma or social consequences. More in-depth analysis is needed to unravel the links between women's education, other socioeconomic characteristics of both the woman and her partner, and women's risk of violence.

Japan city was unique in that no associations were found between violence and age, education or partnership status. This may be attributed to the relative homogeneity of the women in the sample, where over two thirds of the women had higher education, and the majority were married and over 25 years of age (no women under 18 years old were included in the sample).

In order to assess the extent to which sociodemographic variables account for the variation among the sites, additional analyses were performed on the pooled data set using multivariate logistic regression techniques. The odds of experiencing physical or sexual violence, or both, were assessed across sites, controlling for age, partnership status and educational attainment. The results of the multivariate analysis confirmed the significant differences among sites, indicating that the variation in prevalence estimates is not primarily attributable to confounding by these sociodemographic variables. Future analysis will explore these issues in greater depth, and look for other potential risk and protective factors at an individual or community level that may help explain the variation found.

Acts of emotional abuse

In addition to asking about physical and sexual abuse by a partner, the WHO Study collected information on potentially emotionally abusive behaviour. The specific acts included were: 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); and being threatened with harm (either directly or in the form of a threat to hurt someone the respondent cared about).

Table 4.3 shows the percentage of ever-partnered women in each site who had experienced one or more of the emotionally abusive behaviours measured in the survey. Between 20% and 75% of women had experienced one or more of the emotionally abusive acts they were asked about, and between 12% and 58% of women had done so within the 12 months prior to the interview. In the provinces of Ethiopia and Peru, among the women who reported emotional abuse, a large proportion reported that at least one of these acts had occurred in the 12 months prior to the interview, more than in any other site. Generally, the acts most frequently mentioned by women were insults, belittling and intimidation. Threats of harm were less frequently mentioned, although almost one in four women in the provinces in Peru and Brazil reported threats by intimate partners in their lifetime.

Among the women who reported experiencing a particular act, two thirds or more had experienced it a few or many times (see Appendix Table 7). Additionally, a substantial proportion of women experienced several types of emotionally abusive act, with between 5% and 26% of ever-partnered women reporting having experienced three or more of the various acts listed in their lifetime (see Table 4.3).

During the formative research stage of the Study, efforts were made to identify acts that were recognized as emotionally abusive across cultural settings. However, the development of a valid measurement for emotional abuse was hampered by the relative scarcity of research on emotional abuse in comparison with studies on physical or sexual violence. Not only is the qualitative record of emotional abuse across cultures sparse, but methodological work to explore the best means to elicit and measure such experiences has hardly started. For this reason, the WHO Study reports women's disclosure of different emotionally abusive acts by site, and does not assume that the findings represent the overall prevalence of emotional violence. Furthermore, in this report, the association between experiences of emotional abuse and different health consequences is not explored. This should not be taken as an indication that the authors consider emotional abuse to be less significant in shaping women's health and well-being than physical or sexual violence. Indeed, qualitative research routinely reveals that women frequently consider emotionally abusive acts to be more devastating than acts of physical violence. The decision to present the data in this

> "My first husband never hit me, but while I was with him I have suffered so much psychological abuse that I cannot ever forget that. My current husband hits me but here mental suffering is less."
> Woman interviewed in Bangladesh

Table 4.4 Percentage of ever-partnered women reporting various controlling behaviours by their intimate partners, by site

Site	Percentage of women reporting that her partner:							Percentage of women who have experienced none, one or more acts of controlling behaviour:				Total no. of ever-partnered women
	Keeps her from seeing friends (%)	Restricts her contact with family (%)	Insists on knowing where she is at all times (%)	Ignores her, treats her indifferently (%)	Is suspicious that she is unfaithful (%)	Gets angry if she speaks with others (%)	Controls her access to health care (%)	none (%)	1 (%)	2 or 3 (%)	4 or more (%)	
Bangladesh city	10.4	8.7	14.8	15.9	7.3	18.9	34.5	49.3	24.5	17.3	8.9	1373
Bangladesh province	15.3	9.8	23.6	10.2	6.1	32.4	57.0	29.2	31.4	27.5	11.9	1329
Brazil city	25.7	13.1	38.3	12.0	12.4	37.7	5.1	43.3	18.6	23.8	14.3	940
Brazil province	24.3	13.8	33.9	17.8	14.1	38.7	18.8	40.3	21.0	20.5	18.2	1188
Ethiopia province	6.5	5.9	31.1	16.8	6.1	18.0	42.8	41.4	21.1	30.1	7.3	2261
Japan city	3.5	3.2	12.7	5.3	3.3	6.7	0.8	78.7	13.4	6.3	1.6	1287
Namibia city	18.9	8.3	38.5	11.8	17.3	31.1	6.9	48.9	17.7	19.5	13.9	1373
Peru city	28.6	15.5	44.3	16.7	14.4	44.0	14.0	30.9	25.3	25.7	18.1	1090
Peru province	27.9	23.2	54.4	32.6	28.6	43.0	41.7	23.2	16.3	30.7	29.8	1536
Samoa	30.9	13.0	67.9	5.3	18.6	20.8	36.0	24.7	24.0	32.7	18.7	1206
Serbia and Montenegro city	7.3	3.8	24.5	5.1	7.5	10.2	1.6	68.8	18.1	8.5	4.5	1194
Thailand city	18.0	3.7	29.6	18.5	22.2	26.4	9.6	41.8	24.5	23.5	10.3	1051
Thailand province	18.2	4.0	36.0	17.5	26.2	31.9	13.7	37.6	23.3	26.3	12.9	1027
United Republic of Tanzania city	23.0	10.5	70.7	10.5	18.1	58.2	67.7	10.5	17.6	46.9	25.0	1454
United Republic of Tanzania province	14.7	6.8	59.1	13.5	13.8	49.0	48.9	21.1	19.4	42.9	16.6	1258

way reflects recognition of the complexity of the issue, and that additional analysis will be required to ensure that the responses are appropriately aggregated and interpreted. Future work will explore whether emotional abuse alone is linked to various health outcomes and will examine the potential additive effects that emotional abuse may have on the consequences of physical or sexual violence by intimate partners.

Controlling behaviour

In addition to gathering data on emotionally abusive acts, the WHO Study also collected information on a range of controlling behaviours by a woman's intimate partner. Among the behaviours measured were whether the partner commonly attempts to restrict a woman's contact with her family or friends, whether he insists on knowing where she is at all times, whether he ignores her or treats her indifferently, whether he controls her access to health care (i.e. requires that she obtain his permission to seek health care) whether he constantly accuses her of being unfaithful, and whether he gets angry if she speaks with other men.

As shown in Table 4.4, the rate of women reporting one or more controlling behaviours by their intimate partner varied from a low of 21% in Japan city to almost 90% of ever-partnered women in the United Republic of Tanzania city. This suggests that male control over female behaviour is normative to different degrees in the various settings included in the Study.

The WHO Study findings suggest that the experience of physical or sexual violence, or both, tends to be accompanied by highly controlling behaviours by intimate partners. Appendix Table 8 further reveals that a woman who suffers violence by an intimate partner is significantly more likely to experience severe constraints on her physical and social mobility. For example, nearly 40% of women in Peru province who had ever suffered physical or sexual, violence, or both, by an intimate partner had experienced at least four of the controlling behaviours mentioned, compared with 7% of women who had never experienced violence. This pattern holds true for all of the sites.

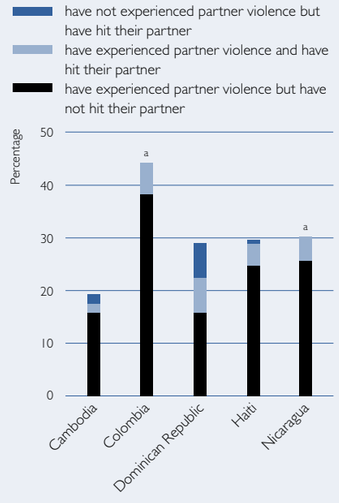
These results are consistent with previous findings from a wide range of countries, including Cambodia, Colombia, Dominican Republic, Haiti, Nicaragua, South Africa, and the United States (**6**, **15**, **16**), that men who are physically violent towards their wives also exhibit higher rates of controlling behaviours than men who are not. Indeed, many argue that "power and control" is a defining element of the broader phenomenon known as "battering" (**17**). Future analysis will explore whether it is more appropriate to conceptualize controlling behaviour as a risk factor for physical or sexual violence, or as a constituent element of the phenomenon being studied.

Women's violence against men

The Steering Committee of the WHO Study agreed that interviews with men should not be included, largely because of the logistic and safety implications of interviewing men and women in the same study. The Committee recognized the importance of getting accurate data on violence from men but considered that such an endeavour was worthy of its own study.

Nevertheless, in Samoa, in addition to the survey of women, a survey of men was conducted to (a) determine the extent of violence against men, (b) document its characteristics and causes, and (c) identify strategies to minimize partner violence against men and women. A total of 664 men were interviewed; 2% of them reported having experienced physical violence, and 3% sexual violence, while 45% reported having experienced emotional abuse.

Figure 4.5 **Percentage of ever-married women who have hit their partner under different circumstances of male violence**



[a] In Colombia and Nicaragua, the percentage of women who had hit their partners but had not experienced partner violence was not assessed.

Source: Adapted from reference 6, with the permission of the authors.

Apart from this small supplemental survey, however, the WHO Study did not directly address a question that is on the minds of many: what is the prevalence of violence perpetrated against men by their female partners? Behind this question is a much larger debate about the supposed gender symmetry or asymmetry of violence by intimate partners. Feminist researchers and advocates have long contended that, globally, physical and sexual violence in relationships are largely perpetrated by men against their female partners. More recently, a debate has erupted in the North American academic literature about whether this conclusion is accurate (**18**). An increasing number of researchers have argued that women are as aggressive as men in intimate partnerships and that therefore a focus on intimate-partner violence against women is misplaced. Most of the evidence fuelling the debate is drawn from

Table 4.5 **Percentage of physically abused women who report they have initiated physical violence against their partner, by site**

Site	Never (%)	Ever (%)	Once or twice (%)	Several times (%)	Many times (%)	Total no. of women reporting physical violence by partner
Bangladesh city	97.4	2.6	1.5	1.1	0.0	545
Bangladesh province	99.3	0.7	0.5	0.2	0.0	558
Brazil city	74.6	25.4	13.7	9.4	2.3	256
Brazil province	84.0	16.0	9.7	3.0	3.2	401
Ethiopia province	99.4	0.6	0.5	0.2	0.0	1101
Japan city	66.9	33.1	18.8	13.3	1.1	181
Namibia city	90.6	9.4	7.2	2.2	0.0	416
Peru city	75.3	24.7	15.9	8.0	0.8	527
Peru province	87.1	12.9	9.9	2.2	0.7	935
Samoa	95.5	4.5	3.3	0.2	1.0	488
Serbia and Montenegro city	88.4	11.6	8.2	3.4	0.0	267
Thailand city	71.7	28.3	10.1	8.4	9.7	237
Thailand province	76.5	23.5	8.1	5.2	10.2	344
United Republic of Tanzania city	91.5	8.5	5.1	1.9	1.5	469
United Republic of Tanzania province	97.9	2.1	0.7	0.9	0.5	580

Table 4.6 **Women's attitudes towards intimate-partner violence, by site**

	Percentage of women who agree that a man has good reason to beat his wife if:						Women who agree with:		
Site	Wife does not complete housework (%)	Wife disobeys her husband (%)	Wife refuses sex (%)	Wife asks about other women (%)	Husband suspects infidelity (%)	Wife is unfaithful (%)	One or more of the reasons mentioned (%)	None of the reasons mentioned (%)	Total no. of women
Bangladesh city	13.8	23.3	9.0	6.6	10.6	51.5	53.3	46.7	1603
Bangladesh province	25.1	38.7	23.3	14.9	24.6	77.6	79.3	20.7	1527
Brazil city	0.8	1.4	0.3	0.3	2.0	8.8	9.4	90.6	1172
Brazil province	4.5	10.9	4.7	2.9	14.1	29.1	33.7	66.3	1473
Ethiopia province	65.8	77.7	45.6	32.2	43.8	79.5	91.1	8.9	3016
Japan city	1.3	1.5	0.4	0.9	2.8	18.5	19.0	81.0	1371
Namibia city	9.7	12.5	3.5	4.3	6.1	9.2	20.5	79.5	1500
Peru city	4.9	7.5	1.7	2.3	13.5	29.7	33.7	66.3	1414
Peru province	43.6	46.2	25.8	26.7	37.9	71.3	78.4	21.6	1837
Samoa	12.1	19.6	7.4	10.1	26.0	69.8	73.3	26.7	1640
Serbia and Montenegro city	0.6	0.9	0.6	0.3	0.9	5.7	6.2	93.8	1456
Thailand city	2.0	7.8	2.8	1.8	5.6	42.9	44.7	55.3	1536
Thailand province	11.9	25.3	7.3	4.4	12.5	64.5	69.5	30.5	1282
United Republic of Tanzania city	24.1	45.6	31.1	13.8	22.9	51.5	62.5	37.5	1820
United Republic of Tanzania province	29.1	49.7	41.7	19.8	27.2	55.5	68.2	31.8	1450

Table 4.7 Ever-partnered women's attitudes towards intimate partner violence according to their experience of physical or sexual violence, or both, by an intimate partner, by site

Site	Experience of violence	Percentage of women who agree that a man has good reason to beat his wife if: Wife does not complete housework (%)	Wife disobeys her husband (%)	Wife refuses sex (%)	Wife asks about other women (%)	Husband suspects infidelity (%)	Wife is unfaithful (%)	Women who agree with at least one of the mentioned reasons (%)		Total no. of ever-partnered women
Bangladesh city	Never experienced violence	10.6	18.9	5.8	3.9	7.8	43.9	45.3		640
	Ever experienced violence	18.7	30.0	13.1	10.2	14.9	61.5	63.8	****	733
Bangladesh province	Never experienced violence	21.2	35.8	19.3	13.9	22.2	71.1	73.3		509
	Ever experienced violence	29.1	43.4	28.5	17.2	27.7	84.8	86.1	****	820
Brazil city	Never experienced violence	1.0	1.3	0.3	0.3	1.8	8.2	8.7		668
	Ever experienced violence	0.7	2.2	0.4	0.7	3.3	12.5	14.0	*	272
Brazil province	Never experienced violence	4.4	9.9	4.4	2.0	12.3	24.4	28.5		750
	Ever experienced violence	4.8	11.0	5.9	3.4	14.6	32.3	37.9	***	438
Ethiopia province	Never experienced violence	62.8	75.4	43.6	26.3	36.6	76.3	89.4		659
	Ever experienced violence	71.5	81.5	52.4	37.7	48.8	84.0	94.0	****	1602
Japan city	Never experienced violence	1.2	1.1	0.3	0.8	2.9	17.0	17.6		1080
	Ever experienced violence	2.0	3.1	1.5	1.0	2.6	26.5	27.6	***	196
Namibia city	Never experienced violence	10.1	10.9	3.3	4.2	6.0	8.1	18.4		876
	Ever experienced violence	10.2	16.1	3.9	4.7	6.1	10.6	24.2	*	491
Peru city	Never experienced violence	2.8	6.0	1.5	1.3	11.1	24.3	28.1		530
	Ever experienced violence	7.4	9.5	2.3	4.0	17.4	36.8	41.7	****	556
Peru province	Never experienced violence	41.5	42.9	21.3	23.8	36.6	68.6	75.4		475
	Ever experienced violence	47.4	52.4	31.0	31.3	42.2	77.2	83.9	****	1059
Samoa	Never experienced violence	9.2	16.5	6.6	7.1	21.4	64.9	69.3		649
	Ever experienced violence	13.5	22.0	9.4	9.7	27.0	72.1	75.9	*	555
Serbia and Montenegro city	Never experienced violence	0.3	0.9	0.2	0.1	0.3	3.9	4.5		907
	Ever experienced violence	1.4	1.4	1.4	0.4	1.4	7.8	8.5	*	282
Thailand city	Never experienced violence	2.1	8.4	3.4	1.8	5.3	45.4	47.5		617
	Ever experienced violence	2.3	12.5	4.4	2.3	7.2	51.5	53.4		431
Thailand province	Never experienced violence	10.2	23.4	7.6	3.0	10.6	66.0	69.8		539
	Ever experienced violence	16.3	32.2	9.1	4.5	16.9	66.6	73.8		485
United Republic of Tanzania city	Never experienced violence	21.7	42.3	29.9	13.5	21.4	48.8	59.0		846
	Ever experienced violence	29.4	51.0	39.1	15.4	27.3	58.7	69.8	****	596
United Republic of Tanzania province	Never experienced violence	23.3	41.7	37.7	17.1	26.4	48.9	61.9		554
	Ever experienced violence	33.1	55.5	48.6	22.5	29.8	61.9	74.4	****	702

Asterisks denote the significance level of the difference: * $P < 0.05$, ** $P < 0.01$, *** $P < 0.001$, **** $P < 0.0001$ (Pearson chi-square test).

research conducted in the United States, with a heavy emphasis on high school and college-age couples and dating partners (**19**, **20**). It is therefore unclear whether these findings would be applicable to other cultural contexts.

However, some indirect data are available which can be used to explore this issue. The WHO Study included a question to the women who reported physical abuse by an intimate partner about whether they had ever hit, or physically mistreated their partner when he was not already hitting or physically mistreating them (**6**). This question does not generate data specifically on the victimization of men, but it does address the core question of whether women frequently initiate violence against a male partner.

In the WHO Study, only a small proportion of women reported ever having initiated violence against a partner who was not already physically abusing them (see Table 4.5). Only in Thailand did more than 15% of physically abused women report initiating violence against their partner more than once or twice in their lifetime. In more traditional societies, including those in Bangladesh, Ethiopia, Namibia, Samoa, and the United Republic of Tanzania, woman-initiated violence was exceedingly rare; between 91% and 99% of abused women reported never having initiated violence against a partner.

These findings mirror those obtained from the Demographic and Health Surveys. Several Demographic and Health Surveys asked all ever-married women (not just abused women) about whether they had ever been violent towards a spouse (see Figure 4.5). In Cambodia, 4% of women acknowledged offensive violence; in the Dominican Republic the figure was 13%, and in Haiti it was 5%.

Since responses obtained from women may underestimate the true rates of female-initiated violence, it is reassuring to find an independent study that validates estimates obtained from surveys of women. A study done under the auspices of the Ministry of Women's Affairs and the Project against Domestic Violence in Cambodia asked Cambodian men directly about their experiences of violence by their wives; the result was that 3% of the men reported being abused. While the possibility of men also underreporting violence for fear of stigma and humiliation is recognized, this figure nevertheless compares favourably with the 4% of women who report engaging in offensive violence, according to the results of the Cambodian Demographic and Health Survey (**21**).

Further analysis of the Demographic and Health Survey figures according to women's experiences of violence found that women who had experienced physical violence by an intimate partner were much more likely to have initiated violence (for example, 15% of ever-abused women in Haiti compared with 1% of never-abused women reported offensive violence) (**6**).

Both the Demographic and Health Surveys and the WHO Study also enquired whether women who had been physically abused by a partner had ever fought back physically. In the WHO Study, 6–79% of physically abused women reported that they had fought back when confronted with male aggression. These results are presented in Chapter 9. Data from the Demographic and Health Surveys echo these findings, suggesting that violence in self-defence is relatively common among abused women, whereas woman-initiated aggression is relatively rare.

Women's attitudes towards violence

Qualitative research from various settings has suggested that rates of violence by an intimate partner may be higher in settings where the behaviour is normative, and where women and men believe that marriage grants men unconditional sexual access to their wives. The WHO Study thus included two sets of questions: one designed to determine the reasons under which for a man to hit or physically mistreat his wife is considered acceptable; and a second exploring whether and when a woman may refuse to have sex with her husband.

Table 4.6 shows the percentage of women in each site who believed that a man has a right to beat his wife under certain circumstances. The circumstances range from not completing housework adequately, to refusing sex, to disobeying her husband, to being unfaithful. The data demonstrate a wide variation between settings in the percentage of women who agree with each reason, as well as substantial variation within settings as to which reasons are seen as justifying abuse. For example, the percentage of women who agreed with one or more justifications for wife-beating varied from 6% in Serbia and Montenegro city to over 68% in the provinces of Bangladesh, Ethiopia, Peru, and in Samoa, Thailand, and the United Republic of Tanzania. With the exception of the United

Table 4.8 **Sexual autonomy: women's views on when it might be "acceptable" for a woman to refuse sex with her husband, by site**

Site	Percentage of women who agree that a woman has a right to refuse sex if: She does not want to (%)	He is drunk (%)	She is sick (%)	He mistreats her (%)	Percentage of women who agree with: All of the reasons listed (%)	None of the reasons listed (%)	Total no. of women
Bangladesh city	57.7	76.2	93.1	65.6	44.9	5.3	1603
Bangladesh province	45.6	69.5	82.3	55.4	35.8	11.3	1527
Brazil city	93.9	98.0	98.4	98.1	93.5	1.3	1172
Brazil province	76.1	89.3	95.2	92.3	71.6	2.9	1473
Ethiopia province	46.2	51.6	71.6	56.3	35.8	18.5	3016
Japan city	92.4	91.0	93.3	92.7	89.5	6.1	1371
Namibia city	82.1	85.3	88.4	87.7	74.6	5.7	1500
Peru city	92.4	92.0	98.6	96.4	85.5	0.5	1414
Peru province	48.6	62.4	80.4	72.2	39.5	12.0	1837
Samoa	28.0	54.3	72.4	68.8	20.4	12.6	1640
Serbia and Montenegro city	97.3	98.2	98.8	98.3	96.6	1.0	1456
Thailand city	85.6	88.2	97.9	92.3	75.1	0.5	1536
Thailand province	76.2	83.4	95.6	88.4	64.0	2.0	1282
United Republic of Tanzania city	37.8	62.7	87.5	76.6	29.0	7.1	1820
United Republic of Tanzania province	25.7	36.4	77.5	48.6	14.6	15.4	1450

Republic of Tanzania, rates of concordance with these beliefs were much lower in the city sites of the above-mentioned countries. In all sites except Namibia city, the reason that women most commonly agreed with as a justification for beating was that the wife was unfaithful. In 8 out of 15 sites, more than half the women agreed with this reason.

Table 4.7 compares the rate of acceptance of various justifications for violence between women who have and women who have not experienced physical or sexual violence, or both, by an intimate partner. In virtually all cases and for all reasons, the proportion of women agreeing with a particular justification was higher among women who had experienced partner violence than among those who had not. Table 4.7 also includes a summary measure that provides an overall indication of the proportion of women who agree that wife-beating is justified under certain conditions (i.e. at least one of the reasons mentioned). In all countries except Thailand, the overall acceptance that wife-beating is justified in some situations was significantly greater among women who had ever experienced physical or sexual partner violence, or both, than among women who had never experienced violence. This may indicate either that women learn to "accept" or rationalize violence in circumstances where they themselves are victims, or that women are at greater risk of violence in communities where a substantial proportion of individuals subscribe to the acceptability of violence. Future analysis will explore the effect of community-level norms related to the acceptability of wife-beating on a woman's odds of experiencing violence.

Table 4.8 examines a parallel set of beliefs regarding the circumstances under which wives have the right to refuse sex with their husband. In order to measure sexual autonomy, the WHO Study asked respondents whether they believed a woman has a right to refuse to have sex with her husband in a number of situations, including if she is sick, if she does not want to, if he is drunk, or if he mistreats her. As with wife-beating, women appear to make distinctions between what are acceptable reasons for refusing unwanted sexual demands from their husbands and what are not. In all sites, fewer women felt that a wife has the right to refuse to have sex because she does not want to than when her husband is drunk or abusive.

Table 4.8 also shows the proportion of women who agree that a wife can refuse sex under all of the circumstances mentioned or none of the circumstances mentioned. The proportion of women who believe in a woman's right to refuse sexual intercourse under all of the circumstances mentioned varies from 15% in the United Republic of Tanzania province to over 90% in Brazil city and in Serbia and Montenegro city. The most notable within-country difference was found in Peru, where 86% of women in the city believed that women could legitimately refuse sex under all of the circumstances mentioned, compared with only 40% of women in the province. The proportion of women who felt that women could not refuse sex under any of the circumstances mentioned varied enormously, from 19% in Ethiopia province and 15% in the United Republic of Tanzania province to less than 1% in Peru city and Thailand city.

Discussion

The WHO Study found that across the study sites between 15% and 71% of women reported physical or sexual violence, or both, by an intimate partner at some point in their lives. Most sites reported prevalence rates in the range 30–60%. Between 4% and 54% of women reported physical or sexual violence, or both, by a partner within the 12 months prior to the study, with most estimates falling between 15% and 30%. These results add to the existing body of research, primarily from industrialized countries, on the extent of physical and sexual violence against women (**4**–**7**, **14**, **21**, **22**) and confirm that violence by an intimate partner is a common experience for a large number of women in the world. The findings show, moreover, that a large proportion of the violence is severe, and occurs frequently. Physical violence was often accompanied by sexual violence, although, in a few sites (Bangladesh province, Ethiopia province, and Thailand city) a large proportion of abused women reported sexual violence only. Emotionally abusive and controlling behaviour by male partners was also common, particularly among women reporting physical or sexual violence, or both.

The WHO Study provides one of the first opportunities to examine cross-culturally the patterns of different forms of violence by intimate partners, and in particular, the extent to which men use physical or sexual violence against their partners. Prior to this study, available evidence from Latin America, and the USA (**7**, **14**, **23**) suggested that few women exclusively experienced sexual violence by an intimate partner, and that most women experienced either a combination of physical and sexual violence or physical violence alone. However, the findings from the WHO Study suggest that while this pattern is true for many countries, in a few sites there is a significant departure, with sexual violence being more prevalent than physical violence. One possible explanation for this is cultural differences in what are considered acceptable means for husbands to control or chastise their wives.

The widespread acceptability of circumstances where wife-beating is justified highlights the extent to which, in many settings, partner violence is conceptualized as a form of chastisement for female behaviour that transgresses certain expectations. Women appear to make distinctions regarding the circumstances under which wife-beating may or may not be "acceptable". In all sites, substantially more women accept wife-beating in the case of actual or suspected female infidelity than for any other reason. Wife-beating is also widely tolerated in circumstances where women "disobey" a husband or partner. Qualitative research suggests that individuals make complex judgements about the acceptability of violence by considering who does what to whom, and for what reason (**22**, **23**). In many settings, the same act can be deemed acceptable or unacceptable depending on whether it is considered for "just cause". Likewise, men may be granted social permission to hit their wives in settings where it would be unacceptable for a man to hit a colleague or neighbour.

However, exactly how attitudes towards wife-beating may influence women's experiences of violence at an individual level is not clear. It may be that the experience of violence "teaches" women that violence is acceptable. Alternatively, women who believe that women deserve abuse in certain circumstances may be less likely to challenge male authority and therefore be protected from abuse.

In many settings, women did feel that there were circumstances where a woman could refuse to have sex. However, the lack of sexual autonomy expressed by many women, particularly in the provincial study sites, has substantial implications for women in the era of HIV/AIDS.

One of the strengths of this Study is its use of uniform instruments and methodology, in particular in terms of sample design, training of fieldworkers, data quality control, and data analysis. This is the first time that such a rich body of comparable data has been available from such a culturally diverse group of countries. Great variation was found in the prevalence estimates among the settings, which leads to intriguing questions as to what factors at an individual and macro level have the greatest effect on determining overall levels of violence. Although some differences were found in the prevalence of violence according to women's education, age and marital status, in pooled multivariate analysis these factors alone did not account for the differences between sites. It appears that cultural norms play an important role, as women in the countries with the highest prevalence of violence (Bangladesh, Ethiopia, Peru) were also more likely to

> "That day he asked me for some money. He was about to leave for his drinking hours. He wanted some money I got from the sales of used paper. I refused. We quarrelled for a while. Then I was about to stand up. There came his leg at the back of my neck. I was beaten and bruised all over.... He never kicked me before. Usually it was just slapping or throwing something at me. I would get hurt if he got me. Once he threw a cutting board at me. I would have been dead, had I not ducked."
>
> Woman, 46 years old, interviewed in Thailand

endorse traditional views of violence and sexual autonomy. The variation in prevalence highlights the need for deeper analysis, using multilevel modelling to explore in greater depth the risk and protective factors for partner violence.

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CHAPTER 5

Prevalence of violence by perpetrators other than intimate partners since the age of 15 years

Main findings

- **Women's experience of physical violence by a non-partner since the age of 15 years varied widely. By far the highest level of non-partner violence was reported in Samoa (62%), whereas less than 10% of women in Ethiopia province, Japan city, Serbia and Montenegro city, and Thailand reported non-partner violence. Often more than one perpetrator was mentioned. In most sites the perpetrators were mainly family members. In several sites teachers accounted for an important proportion of the physical violence by non-partners.**
- **Reported levels of sexual violence by non-partners since the age of 15 years varied from less than 1% (in Ethiopia and Bangladesh provinces) to between 10% and 12% (in Peru, Samoa, and United Republic of Tanzania city). In most cases only one perpetrator was mentioned, usually either an acquaintance or a stranger.**
- **Between 19% and 76% of all women had experienced physical or sexual violence, or both, by partners or non-partners, since the age of 15 years. In almost all settings, the majority of violence against women had been perpetrated by their intimate partner.**

While the main focus of the WHO Study was on violence by intimate partners, the Study questionnaire also included questions about women's experiences of physical and sexual violence from other perpetrators (either male or female). These questions were put to all women, whether they had ever been partnered or not. This chapter presents the results on the extent of physical and sexual violence against women by perpetrators other than intimate partners (hitherto referred to as non-partner violence) from age 15 years onwards. The subject of sexual abuse before the age of 15 years (child sexual abuse) and forced first sex, whether by an intimate partner or another perpetrator, is covered in Chapter 6.

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

Respondents were asked whether, since the age of 15 years, anyone other than their intimate partner had ever beaten or physically mistreated them in any way. Additional probes were used to identify the perpetrators, and follow-on questions were asked about the frequency of this violence.

By far the highest level of non-partner physical violence was in Samoa (62%), with the next highest being in Peru (28% and 32% in the city and province, respectively), as shown in Table 5.1. Less than 10% of respondents reported non-partner physical violence in Ethiopia province, Japan city, Serbia and Montenegro city, and Thailand city and province. In most sites, the majority of non-partner physical violence was perpetrated by one

endorse traditional views of violence and sexual autonomy. The variation in prevalence highlights the need for deeper analysis, using multilevel modelling to explore in greater depth the risk and protective factors for partner violence.

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CHAPTER 5

Prevalence of violence by perpetrators other than intimate partners since the age of 15 years

Main findings

- **Women's experience of physical violence by a non-partner since the age of 15 years varied widely. By far the highest level of non-partner violence was reported in Samoa (62%), whereas less than 10% of women in Ethiopia province, Japan city, Serbia and Montenegro city, and Thailand reported non-partner violence. Often more than one perpetrator was mentioned. In most sites the perpetrators were mainly family members. In several sites teachers accounted for an important proportion of the physical violence by non-partners.**
- **Reported levels of sexual violence by non-partners since the age of 15 years varied from less than 1% (in Ethiopia and Bangladesh provinces) to between 10% and 12% (in Peru, Samoa, and United Republic of Tanzania city). In most cases only one perpetrator was mentioned, usually either an acquaintance or a stranger.**
- **Between 19% and 76% of all women had experienced physical or sexual violence, or both, by partners or non-partners, since the age of 15 years. In almost all settings, the majority of violence against women had been perpetrated by their intimate partner.**

While the main focus of the WHO Study was on violence by intimate partners, the Study questionnaire also included questions about women's experiences of physical and sexual violence from other perpetrators (either male or female). These questions were put to all women, whether they had ever been partnered or not. This chapter presents the results on the extent of physical and sexual violence against women by perpetrators other than intimate partners (hitherto referred to as non-partner violence) from age 15 years onwards. The subject of sexual abuse before the age of 15 years (child sexual abuse) and forced first sex, whether by an intimate partner or another perpetrator, is covered in Chapter 6.

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

Respondents were asked whether, since the age of 15 years, anyone other than their intimate partner had ever beaten or physically mistreated them in any way. Additional probes were used to identify the perpetrators, and follow-on questions were asked about the frequency of this violence.

By far the highest level of non-partner physical violence was in Samoa (62%), with the next highest being in Peru (28% and 32% in the city and province, respectively), as shown in Table 5.1. Less than 10% of respondents reported non-partner physical violence in Ethiopia province, Japan city, Serbia and Montenegro city, and Thailand city and province. In most sites, the majority of non-partner physical violence was perpetrated by one

Table 5.1 Prevalence of non-partner physical and sexual violence since the age of 15 years among all respondents, by site

Site	Physical violence n	Physical violence (%)	Sexual violence n	Sexual violence (%)	Physical or sexual violence, or both n	Physical or sexual violence, or both (%)	Total no. of respondents
Bangladesh city	279	17.4	122	7.6	352	22.0	1603
Bangladesh province	164	10.7	8	0.5	168	11.0	1527
Brazil city	245	20.9	80	6.8	287	24.5	1172
Brazil province	192	13.0	68	4.6	234	15.9	1472
Ethiopia province	149	4.9	9	0.3	154	5.1	3016
Japan city	64	4.7	48	3.5	102	7.5	1368
Namibia city	288	19.2	96	6.4	328	21.9	1498
Peru city	401	28.4	145	10.3	476	33.7	1414
Peru province	587	32.0	207	11.3	694	37.8	1837
Samoa	1016	62.0	174	10.6	1059	64.6	1640
Serbia and Montenegro city	139	9.6	56	3.9	173	11.9	1453
Thailand city	117	7.6	94	6.1	186	12.1	1534
Thailand province	121	9.5	33	2.6	144	11.3	1280
United Republic of Tanzania city	349	19.2	209	11.5	484	26.7	1816
United Republic of Tanzania province	230	15.9	135	9.4	319	22.1	1443

Table 5.2 Perpetrators of physical violence among women reporting physical violence by non-partners since the age of 15 years, by site

	Category of perpetrator								Number of perpetrators				Total no. of women reporting physical violence
	Family[a]		Acquaintance[b]		Stranger[c]		Not identified		1		2 or more		
Site	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	
Bangladesh city	235	84.2	50	17.9	1	0.4	3	1.1	224	80.3	55	19.7	279
Bangladesh province	117	71.3	49	29.9	0	0.0	13	7.9	121	73.8	43	26.2	164
Brazil city	185	75.5	49	20.0	21	8.6	19	7.8	196	80.0	49	20.0	245
Brazil province	144	75.0	16	8.3	12	6.3	28	14.6	169	88.0	23	12.0	192
Ethiopia province	108	72.5	24	16.1	3	2.0	21	14.1	139	93.3	10	6.7	149
Japan city	44	68.8	17	26.6	12	18.8	0	0.0	52	81.3	12	18.8	64
Namibia city	144	50.0	163	56.6	41	14.2	18	6.3	204	70.8	84	29.2	288
Peru city	339	84.5	50	12.5	24	6.0	41	10.2	313	78.1	88	21.9	401
Peru province	464	79.0	82	14.0	26	4.4	89	15.2	434	73.9	153	26.1	587
Samoa	939	92.4	317	31.2	16	1.6	6	0.6	510	50.2	506	49.8	1016
Serbia and Montenegro city	82	59.0	30	21.6	28	20.1	11	7.9	119	85.6	20	14.4	139
Thailand city	55	47.0	18	15.4	15	12.8	38	32.5	105	89.7	12	10.3	117
Thailand province	79	65.3	17	14.0	6	5.0	29	24.0	104	86.0	17	14.0	121
United Republic of Tanzania city	106	30.4	243	69.6	15	4.3	61	17.5	271	77.7	78	22.3	349
United Republic of Tanzania province	78	33.9	135	58.7	12	5.2	57	24.8	176	76.5	54	23.5	230

Note: This table summarizes the data in Appendix Table 9.
[a] Father, stepfather, male family member, female family member.
[b] Teacher, male friend of family, female friend of family, boyfriend, someone at work, religious leader.
[c] Police/soldier, stranger.

person (see Table 5.2). However, in Bangladesh province, Namibia city, Peru, Samoa, and the United Republic of Tanzania, more than a fifth of respondents who had experienced non-partner physical violence reported that two or more perpetrators had assaulted them. Among women who reported being physically assaulted by someone other than their partner, in all sites, except in the United Republic of Tanzania and Thailand city, the perpetrators were mainly family members. As shown in Appendix Table 9, commonly mentioned perpetrators included the respondent's father (the proportion of physically abused women reporting that their father was the perpetrator ranged from 12% in Bangladesh province to 58% in Samoa), other male family members (from 7% in Samoa to 28% in Bangladesh province and Peru city), and female family members (from 5% in Ethiopia province to 63% in Samoa). In both the United Republic of Tanzania province and city more than 50% reported being assaulted by teachers. Teachers were also mentioned as perpetrators by between 15% and 30% of physically assaulted women in Bangladesh, Namibia city, and Samoa. Boyfriends were mentioned by more than 10% in the cities in Brazil, Japan, Namibia, and Serbia and Montenegro, and strangers were mentioned by more than 10% of women reporting non-partner physical violence in the cities in Japan, Namibia, Serbia and Montenegro, and Thailand.

Table 5.3 Perpetrators of sexual violence among women reporting sexual violence by non-partners, since the age of 15 years, by site

	Category of perpetrator								Number of perpetrators				Total no. of women reporting sexual violence
	Family[a]		Acquaintance[b]		Stranger[c]		Not identified		1		2 or more		
Site	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	
Bangladesh city	10	8.2	19	15.6	96	78.7	5	4.1	115	94.3	7	5.7	122
Bangladesh province	4	§	3	§	1	§	0	§	8	§	0	§	8
Brazil city	11	13.8	39	48.8	23	28.8	12	15.0	73	91.3	7	8.8	80
Brazil province	9	13.2	37	54.4	12	17.6	11	16.2	67	98.5	1	1.5	68
Ethiopia province	1	§	5	§	0	§	3	§	9	§	0	§	9
Japan city	1	2.1	22	45.8	29	60.4	1	2.1	42	87.5	6	12.5	48
Namibia city	6	6.3	64	66.7	23	24.0	5	5.2	94	97.9	2	2.1	96
Peru city	22	15.2	58	40.0	43	29.7	35	24.1	128	88.3	17	11.7	145
Peru province	20	9.7	98	47.3	54	26.1	50	24.2	191	92.3	16	7.7	207
Samoa	18	10.3	102	58.6	42	24.1	13	7.5	173	99.4	1	0.6	174
Serbia and Montenegro city	2	3.6	23	41.1	24	42.9	10	17.9	53	94.6	3	5.4	56
Thailand city	2	2.1	30	31.9	44	46.8	23	24.5	89	94.7	5	5.3	94
Thailand province	4	12.1	12	36.4	6	18.2	13	39.4	31	93.9	2	6.1	33
United Republic of Tanzania city	24	11.5	102	48.8	52	24.9	46	22.0	193	92.3	16	7.7	209
United Republic of Tanzania province	6	4.4	61	45.2	35	25.9	37	27.4	129	95.6	6	4.4	135

Note: This table summarizes the data in Appendix Table 10.
§ Percentage based on fewer than 20 respondents suppressed.
[a] Father, stepfather, male family member, female family member.
[b] Teacher, male friend of family, female friend of family, boyfriend, someone at work, religious leader.
[c] Police/soldier, stranger.

Generally, the most frequently mentioned perpetrators were acquaintances or strangers (Table 5.3). In most cases, only one perpetrator was mentioned, except in the cities of Japan and Peru where more than 10% of women reported two or more perpetrators. Appendix Table 10 shows the detailed breakdown by type of perpetrator.

Overall prevalence of non-partner violence since the age of 15 years

The overall prevalence of physical or sexual violence, or both, by a non-partner since the age of 15 years (obtained by combining reports of physical and sexual violence) varies widely between sites, ranging from 5% in Ethiopia province to 65% in Samoa, with more than a fifth of respondents reporting being physically or sexually abused by a non-partner in Bangladesh city, Brazil city, Namibia city, Peru, Samoa, and the United Republic of Tanzania. In countries where the study was conducted both in a city and a province, higher levels of non-partner violence were reported in the city than in the province, except in Peru. It is interesting to note that despite the high levels of reported partner violence in Ethiopia province, only 5% of women reported being physically or sexually abused by someone other than a partner.

Sexual violence by non-partners since the age of 15 years

Respondents were also asked whether, since the age of 15 years, they had ever been forced to have sex or to perform a sexual act when they did not want to, by anyone other than an intimate partner. Between 0.3% and 12% of respondents reported being forced to have sex or to perform a sexual act that they did not want to by non-partners since the age of 15 years. The highest levels (between 10% and 12%) were reported in Peru, Samoa, and the United Republic of Tanzania city (Table 5.1). Very low levels of non-partner sexual violence were reported in Ethiopia province (0.3%) and Bangladesh province (0.5%). The remaining sites reported levels of between 3% and 9%.

> "Since I got married I was sexually harassed and abused by my brothers-in-law in many ways. Even if I am not to blame for this, my husband severely abuses me because of this. Once he almost killed me by driving a knife into my throat and injuring me deeply."
> Woman interviewed in Bangladesh (When at the end of the interview she was offered referral to counselling services she simply said that her husband wouldn't allow her to go.)

Table 5.4 Prevalence of partner and non-partner physical or sexual violence, or both, since age 15 years, by site

Site	Non-partner physical or sexual violence, or both		Total no. of respondents	Partner physical or sexual violence, or both[a]		Total no. of ever-partnered women	Partner or non-partner physical or sexual violence, or both		Total no. of respondents
	n	(%)		n	(%)		n	(%)	
Bangladesh city	352	22.0	1603	733	53.4	1373	938	58.5	1603
Bangladesh province	168	11.0	1527	820	61.7	1329	914	59.9	1527
Brazil city	287	24.5	1172	272	28.9	940	453	38.7	1172
Brazil province	234	15.9	1472	438	36.9	1188	571	38.8	1473
Ethiopia province	154	5.1	3016	1602	70.9	2261	1687	55.9	3016
Japan city	102	7.5	1365	196	15.4	1276	253	18.5	1370
Namibia city	328	21.9	1498	491	35.9	1368	637	42.5	1499
Peru city	476	33.7	1413	556	51.2	1086	805	56.9	1414
Peru province	694	37.8	1837	1059	69.0	1534	1301	70.8	1837
Samoa	1059	64.6	1640	555	46.1	1204	1243	75.8	1640
Serbia and Montenegro city	173	11.9	1453	282	23.7	1189	380	26.2	1453
Thailand city	186	12.1	1534	431	41.1	1048	537	35.0	1535
Thailand province	144	11.3	1280	485	47.4	1024	561	43.8	1281
United Republic of Tanzania city	484	26.7	1816	596	41.3	1443	907	49.9	1816
United Republic of Tanzania province	319	22.1	1443	702	55.9	1256	869	60.2	1443

[a] May include some partner violence before the age of 15 years.

Non-partner violence compared with partner violence

A common perception is that women are most at risk of violence from people they hardly know or do not know at all, rather than from people they know well, in particular their intimate partners. To explore this issue further, a measure of the overall prevalence of physical or sexual violence, or both, since the age of 15 years, regardless of the perpetrator, was compiled for all respondents in the study, whether they had ever been partnered or not, for each site. The aggregate figures indicate that between 19% and 76% of women in the study sites had been physically or sexually abused since the age of 15 years. The levels of violence were between 26% and 60% in most sites. The figures were highest in Bangladesh, Ethiopia province, Peru, Samoa, and the United Republic of Tanzania province, where more than half the women reported physical or sexual violence, or both, by someone, whether a partner or non-partner, since the age of 15 years (Table 5.4).

The data can be used to compare the relative proportions of women experiencing violence by partners and by non-partners. Among women who had reported physical or sexual violence, or both, since the age of 15 years, in all sites except Samoa, at least 60% had been abused by a partner, with the proportion approaching 80% or above in most sites. Furthermore, in all sites except Brazil city, the United Republic of Tanzania city, and Samoa, less than one third of women abused since the age of 15 years had been abused only by someone other than an intimate partner (Figure 5.1).

Discussion

Between a fifth and three quarters of all women surveyed had experienced physical or sexual violence, or both, by partners or non-partners, since the age of 15 years. In almost all settings, the majority of violence against women had been perpetrated by their intimate partner, rather than by other persons.

Despite women being more at risk of violence from their intimate partners than from others, the Study nevertheless confirms that in many settings violence by others is relatively common, with between 11% and 38% of women reporting non-partner violence in most sites. Less than 8% of respondents in Ethiopia province and Japan city reported non-partner violence since the age of 15 years, whereas in Samoa the prevalence of non-partner violence was as high as 65%. These findings on the levels of non-partner violence since the age of 15 years are similar to those emerging from other population-based studies of violence in the developing world, including the Demographic and Health Surveys (DHS) conducted by ORC Macro. A summary of violence-related results from recent DHS surveys (**1**) noted that between 21% and 57% of women interviewed reported experiencing violence by anyone (partners and non-partners) since the age of 15 years. The lowest lifetime prevalence estimates were found in India (21%), Cambodia (23%) and the Dominican Republic (24%), and the highest in Colombia (41%), Peru (47%), and Zambia (57%).

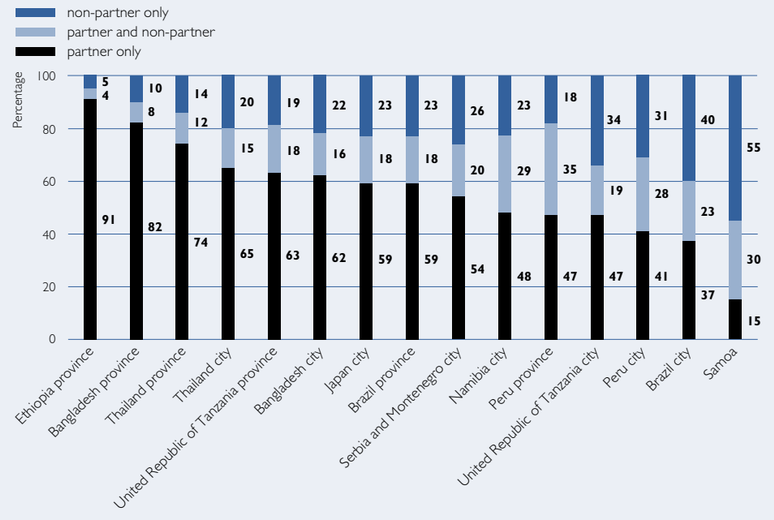
As many aspects of the WHO Study methodology were standardized across countries (except in Japan), the differences in the patterns of non-partner physical and sexual violence observed are likely to reflect true variations in the patterns of physical and sexual violence within and between countries – although some differences may also arise from culturally specific differences in women's willingness to disclose information about their experiences of violence, especially sexual violence. For example, the extremely low levels of sexual violence by non-partners reported in Bangladesh and Ethiopia provinces (< 0.5%) may be a function of the great stigma associated with sexual violence in these rural settings. Another explanation may be that the early age of marriage in these societies offers protection from the risk of sexual violence by others, through the guardianship of the husband or the husband's family.

Despite this, there are many similarities among the country findings. A common pattern is the extent to which physical or sexual violence since the age of 15 years is perpetrated by intimate partners, rather than by other men. It is also interesting to note that across all sites, the non-partner perpetrators of physical violence are different from the non-partner perpetrators of sexual violence. In all sites except Namibia city and the United Republic of Tanzania, most non-partner perpetrators of physical violence against women since the age of 15 years were family members, whereas in all sites most perpetrators of non-partner sexual violence were non-family members – including non-cohabiting boyfriends and strangers.

The varying patterns of perpetration of non-partner violence in the different sites are likely to reflect many different cultural and contextual factors, including the forms of social mobility that women in different settings may have. For example, women in Bangladesh were most at risk of physical violence, mainly from family members, while women in many of the other sites were also at risk of sexual violence from a variety of perpetrators, mainly boyfriends and strangers. The opportunity for rural women in Bangladesh to be sexually abused by boyfriends or others outside the home is probably limited by the stronger social strictures against courtship or free movement of women without a male chaperon. This highlights the need to study and understand local patterns of violence against women.

Anti-violence activists and service providers have long maintained that women are more at risk of violence from an intimate partner than from any other type of perpetrator. The WHO Study demonstrates empirically that this observation is true across a wide range of settings. The fact that intimate partners are the primary source of women's risk of violence makes the epidemiology and the consequences of violence distinctly different for women and

Figure 5.1 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



men. Men are most at risk from strangers or acquaintances rather than intimates (**2**, **3**). This differing profile has important implications for how best to focus anti-violence programmes aimed at women and men. Traditional criminal justice may be less well suited for dealing with violence against women because of the emotional and economic ties between victim and perpetrator. Likewise, people must realize that it is not generally true that the greatest risk to women comes from strangers approaching them on the street or breaking into their homes, but from people known to them.

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CHAPTER 6

Prevalence of sexual abuse in childhood and forced first sexual experience

Main findings

- **The prevalence of sexual abuse before the age of 15 years varied from 1% (Bangladesh province) to 21% (Namibia city). In most cases only one perpetrator was mentioned, usually a male family member other than a father or stepfather.**
- **In 10 of the 15 settings, over 5% of women reported their first sexual experience as forced, with more than 14% reporting forced first sex in Bangladesh, Ethiopia province, Peru province, and the United Republic of Tanzania. In contrast, less than 1% of women in Japan city and Serbia and Montenegro city described their first sexual experience as forced. In all sites except Ethiopia province, the younger a woman's age at first sex, the greater the likelihood that her sexual initiation was forced.**

In addition to physical or sexual violence in adulthood (over 15 years of age) by an individual other than a current or former male partner, the study also explored the extent to which women had experienced sexual abuse before the age of 15 years (childhood sexual abuse) and whether their first sex was wanted, coerced or forced. After asking about potential instances and perpetrators of physical or sexual abuse by a non-partner since the age of 15 years, the questionnaire asked about unwanted sexual experiences prior to the age of 15 years, who the perpetrators were and the frequency of this abuse (see Annex 4). In addition, respondents were asked the age at which they first had sexual intercourse and the degree to which this sexual experience was voluntary.

Sexual abuse before 15 years

Early sexual abuse is a highly sensitive issue that is difficult to explore in survey situations (**1**). Because of this, two different approaches were used. First, respondents were asked whether anyone in their family had ever touched them sexually, or made them do something sexual that they did not want to, before the age of 15 years. The interviewers proceeded to enquire about other possible perpetrators of sexual abuse prior to the age of 15 years: a relative; someone at work or school; a friend or neighbour; or someone else. If the respondent had been sexually abused during childhood, additional information was collected about the event: her age when it first happened; the perpetrator's age, and whether the event happened once or twice, a few times or many times.

In addition, at the end of each interview, in all countries except Bangladesh[1] respondents were asked again about sexual abuse prior to the age of 15 years. The question wording was the same, but in this case respondents did not have to reveal their answer directly to the interviewer. Instead they were asked to record their response on a card that had a pictorial representation for "yes" (a sad face) and "no" (a happy face). In most sites, the respondent folded her card or sealed it in an envelope and placed it in a bigger envelope or bag containing other cards, thus enabling her to keep her response secret and preventing the interviewers or researchers from being able to link the response with the individual woman. In Serbia and Montenegro and the United Republic

[1] Field-testing in Bangladesh revealed that the anonymous way of reporting sexual abuse (by means of marking a card showing two pictures of faces) did not work in this setting, as women felt intimidated by having to put anything down on paper and thought they needed to have a husband's permission for this. Therefore, the Bangladesh study did not include an anonymous reporting question.

Table 6.1 Percentage of respondents reporting sexual abuse before the age of 15 years, by site

Site	Face-to-face report n	Face-to-face report (%)	Face-to-face report Total no. of respondents	Anonymous report n	Anonymous report (%)	Anonymous report Total no. of completed cards	Best estimate[a] (%)
Bangladesh city[b]	119	7.4	1602	n.a.	n.a.	n.a.	7.4
Bangladesh province[b]	16	1.0	1527	n.a.	n.a.	n.a.	1.0
Brazil city	92	7.8	1172	136	11.6	1172	11.6
Brazil province	85	5.8	1473	128	8.7	1473	8.7
Ethiopia province	7	0.2	3014	211	7.0	3014	7.0
Japan city	131	9.6	1361	188	13.8	1361	13.8
Namibia city	73	4.9	1492	318	21.3	1492	21.3
Peru city	276	19.5	1414	264	18.7	1413	19.5
Peru province	145	7.9	1837	328	18.1	1814	18.1
Samoa[c]	30	1.8	1640	n.a.	n.a.	n.a.	1.8
Serbia and Montenegro city	28	1.9	1453	52	3.6	1453	4.2
Thailand city	117	7.6	1534	137	8.9	1543	8.9
Thailand province	60	4.7	1280	63	4.9	1280	4.9
United Republic of Tanzania city	79	4.4	1816	195	10.7	1816	12.2
United Republic of Tanzania province	60	4.2	1443	124	8.5	1451	9.5

n.a., not available.
[a] In those sites where anonymous reporting was not linked to the individual questionnaire, the best estimate is the highest prevalence given by either of the two methods; in the sites where anonymous reports could be linked to the questionnaires, abuse as reported by either method is included.
[b] In Bangladesh, the anonymous reporting method (by marking a pictorial card) was not used.
[c] Data were not provided on the results of the anonymous reporting on abuse.

of Tanzania, however, the sealed envelopes were stapled to the questionnaire to allow the information to be linked to the individual record at the time of data entry.

As shown in Table 6.1, the directly reported levels of sexual abuse before the age of 15 years ranged from 1% or less in Ethiopia and Bangladesh provinces to 20% in Peru city, with the next highest level being in Japan city (10%). In most sites, however, the reported prevalence was higher when measured using the anonymous method of reporting – increasing from 0.2% to 7% in Ethiopia province, from 5% to 21% in Namibia city, and from 4% to 11% in the city site of the United Republic of Tanzania. In only one site (Peru city) did the anonymous method produce a slightly, but not significantly, lower prevalence (20% as against 19%).

Initially, the anonymous reports of sexual abuse before 15 years of age were not linked to the individual questionnaires, and so any differences in the patterns of disclosure between the face-to-face reporting and anonymous disclosure could not be explored. In order to investigate how anonymous disclosure related to face-to-face disclosure, the method was later changed slightly. In the two countries that implemented the study at a later stage – Serbia and Montenegro and the United Republic of Tanzania – the envelopes containing the face cards were stapled to the questionnaire, so that during data entry the anonymous reports could be linked to the respondent's identity number, thus allowing the two responses to be compared. The linked reports demonstrated that, at the individual level, anonymous reporting did not always encourage the most reporting: some women reported childhood sexual abuse during the interview but did not disclose it anonymously, and some did the opposite. Because of this, the combined prevalence (obtained if a positive response to either question is used to define a case of child sexual abuse) is higher in the United Republic of Tanzania and in Serbia and Montenegro than one based on either of the two methods used separately. In the United Republic of Tanzania, the combined prevalence was 12% in the city site and 10% in the provincial site. For Serbia and Montenegro city the combined prevalence was 4%. In the remaining sites, where it was not possible to combine the results, the best estimate of the prevalence of child sexual abuse was taken to be the higher of the two reported prevalences (which in most cases was that of the anonymous report).

Respondents who reported to the interviewer that they had been sexually abused before the age of 15 years were asked who the perpetrator was. Table 6.2 groups perpetrators into four categories: family; acquaintance; stranger; and not identified. Appendix Table 11 provides a more detailed breakdown of the responses by specific type of perpetrator. The most commonly reported perpetrators were family members; and among these, male family members other than fathers and stepfathers were by far the most common, followed at a considerable distance by stepfathers, then fathers and female family members. In most countries strangers were an important category and in the cities in Bangladesh, Japan, Serbia and Montenegro, and Thailand were more frequently mentioned than any other category. In Brazil province, Namibia, Samoa, and the United Republic of Tanzania, where acquaintances were commonly reported perpetrators, male friends of the family and boyfriends dominated this category. Table 6.2 also shows that, in all sites, over 90% of women reported only one perpetrator, except for Peru city where 15% of women reported two or more perpetrators.

Table 6.2 Perpetrators of childhood sexual abuse among women reporting sexual abuse before the age of 15 years, by site

Site	Category of perpetrator: Family[a] n	Family[a] (%)	Acquaintance[b] n	Acquaintance[b] (%)	Stranger[c] n	Stranger[c] (%)	Not identified n	Not identified (%)	Number of perpetrators: 1 n	1 (%)	2 n	2 (%)	Total no. of women reporting sexual abuse before age 15 years
Bangladesh city	13	10.9	17	14.3	83	69.7	7	5.9	117	98.3	2	1.7	119
Bangladesh province	8	§	3	§	3	§	2	§	16	§	0	§	16
Brazil city	61	66.3	13	14.1	8	8.7	13	14.1	87	94.6	5	5.4	92
Brazil province	46	54.1	26	30.6	11	12.9	10	11.8	78	91.8	7	8.2	85
Ethiopia province	1	§	6	§	0	§	0	§	7	§	0	§	7
Japan city	12	9.2	27	20.6	91	69.5	7	5.3	124	94.7	7	5.3	131
Namibia city	34	46.6	25	34.2	12	16.4	3	4.1	69	94.5	4	5.5	73
Peru city	148	53.6	46	16.7	69	25.0	53	19.2	234	84.8	42	15.2	276
Peru province	60	41.4	29	20.0	33	22.8	35	24.1	134	92.4	11	7.6	145
Samoa	7	23.3	10	33.3	10	33.3	5	16.7	28	93.3	2	6.7	30
Serbia and Montenegro city	8	28.6	7	25.0	11	39.3	3	10.7	27	96.4	1	3.6	28
Thailand city	9	7.7	14	12.0	68	58.1	29	24.8	113	96.6	4	3.4	117
Thailand province	13	21.7	7	11.7	18	30.0	23	38.3	59	98.3	1	1.7	60
United Republic of Tanzania city	22	27.8	23	29.1	11	13.9	26	32.9	76	96.2	3	3.8	79
United Republic of Tanzania province	11	18.3	25	41.7	11	18.3	17	28.3	57	95.0	3	5.0	60

Note: This table summarizes the data in Appendix Table 11.
§ percentage based on fewer than 20 respondents suppressed.
[a] Father, stepfather, male family member, female family member.
[b] Teacher, male friend of family, female friend of family, boyfriend, someone at work, religious leader.
[c] Police/soldier, stranger.

Forced first sex

Respondents who reported ever having had sex were asked at what age they had their first sexual intercourse. To explore the degree to which this first intercourse was fully voluntary, respondents were asked whether they would describe their first experience of sexual intercourse as something that they had wanted to happen, that they had not really wanted to happen but that had happened anyway (coerced), or that they had been forced to do. Only the results for forced first sex are presented here. Table 6.3 shows that between less than 1% and 30% of respondents who had had sexual experience reported that their first sexual experience was forced, irrespective of the age at which first sex occurred. The highest proportions were reported by women in Bangladesh city and province, Ethiopia province, Peru province and in both sites of the United Republic of Tanzania, where more than 14% reported that their first sexual encounter was forced. In contrast, less than 1% of women in both Japan, and Serbia and Montenegro cities described their first sexual experience as forced.

Age at the time of first experience of sexual intercourse differs widely by site. In the cities in Japan, Thailand, and Serbia and Montenegro very few women reported first having had sex under the age of 15 years, while in Bangladesh and Ethiopia province a high proportion of women had their first sexual experience before the age of 15 years (which is probably a consequence of the young age of women at marriage in these sites). In all sites except Ethiopia province, the younger a woman at the time of her first sexual experience, the greater the likelihood that her sexual initiation was forced (see Figure 6.1). Indeed, in 8 out of 12 sites,[2] more than 30% of women who reported having had their first sexual experience before the age of 15 years described that sexual experience as forced. In Ethiopia province where forced sexual initiation was commonly reported, the proportion of women reporting forced first sex was consistently between 15% and 20% regardless of the age of first experience of sexual intercourse.

> "The memory of forced sex on the wedding night is still very painful."
> Woman interviewed in Bangladesh

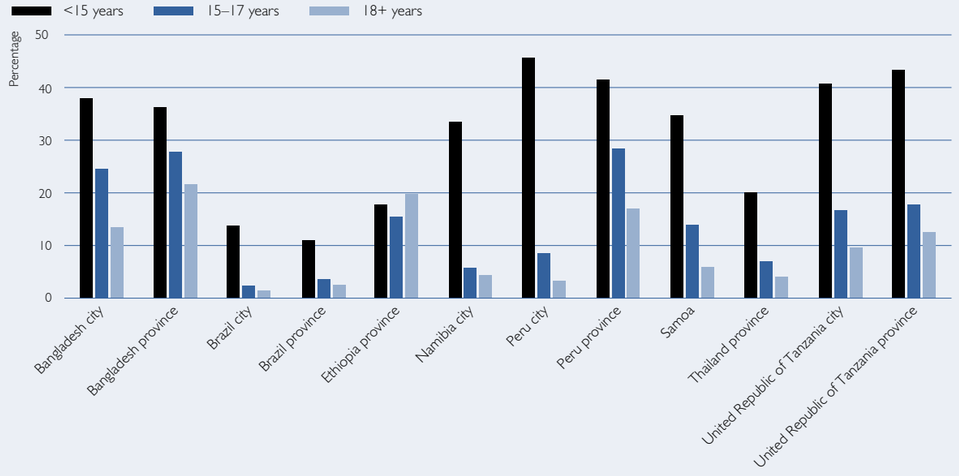
[2] Japan city, Thailand city, and Serbia and Montenegro city are excluded because of the low number of individuals experiencing first sexual intercourse before age 15 years.

Table 6.3 Percentage of women reporting forced first experience of sexual intercourse among sexually experienced women, by site and by age at the time of first sexual experience

	First sex before age 15 years			First sex at age 15–17 years			First sex at age 18+ years			All ages		
	Women reporting first sex forced		Total no. of women reporting first sex before 15 years	Women reporting first sex forced		Total no. of women reporting first sex at 15–17 years	Women reporting first sex forced		Total no. of women reporting first sex at 18+ years old	Women reporting first sex forced		Total no. of women who have ever had sex
Site	n	(%)		n	(%)		n	(%)		n	(%)	
Bangladesh city	156	37.7	414	103	24.3	424	71	13.4	530	330	24.1	1369[a]
Bangladesh province	208	36.0	578	130	27.6	471	59	21.4	276	397	29.9	1326
Brazil city	12	13.6	88	8	2.3	348	9	1.5	613	29	2.8	1051
Brazil province	23	11.0	210	15	3.5	429	15	2.5	592	53	4.3	1234[a]
Ethiopia province	59	17.6	335	214	15.3	1401	98	19.6	501	371	16.6	2238
Japan city	3	§	9	1	0.7	140	0	0.0	967	4	0.4	1116
Namibia city	20	33.3	60	25	5.7	436	37	4.3	858	82	6.0	1357[a]
Peru city	29	45.3	64	27	8.5	318	24	3.3	719	80	7.3	1103
Peru province	56	41.2	136	175	28.2	621	134	16.8	799	368	23.6	1560
Samoa	10	34.5	29	38	13.8	275	59	5.8	1010	107	8.1	1317
Serbia and Montenegro city	0	§	7	5	1.7	296	4	0.4	987	9	0.7	1310
Thailand city	3	§	18	15	8.3	180	20	2.3	853	38	3.6	1051
Thailand province	7	20.0	35	16	6.9	233	31	4.1	758	55	5.3	1029
United Republic of Tanzania city	38	40.4	94	106	16.6	638	78	9.5	818	223	14.3	1557
United Republic of Tanzania province	31	43.1	72	108	17.6	614	74	12.4	595	213	16.6	1287

§, Percentage based on fewer than 20 respondents suppressed.
[a] Total includes a few women whose age at first sexual experience is unknown.

Figure 6.1 Percentage of women reporting forced first experience of sexual intercourse among sexually experienced women, by site and by age at the time of first sexual experience[a]



[a] Japan city, Serbia and Montenegro city, and Thailand city are not represented because of the very low percentages reporting first sex before age 15 years.

Discussion

These findings highlight firstly the magnitude of sexual abuse among young girls and adolescents in both the developing and industrialized world, and secondly the extent to which the first sexual experience of women is forced. For a substantial proportion of young women who participated in the surveys, particularly in developing countries, their first experience of sexual intercourse was not a wanted event, but rather a product of coercion or force, and this is more likely to be the case, the younger the reported age of that first sexual encounter.

The high levels of sexual abuse before the age of 15 years – up to 20% – are of great concern. Such abuse is a severe violation 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. A growing body of research – much of it from the industrialized world – has reported significant associations between child sexual abuse and a host of unhealthy outcomes, including behavioural and psychological problems, sexual dysfunction, relationship problems, low self-esteem, depression, thoughts of suicide, deliberate self-harm, alcohol and substance abuse, and sexual risk-taking (**2**–**6**). Women who are sexually abused in childhood are also at greater risk of being physically or sexually abused as adults (**2**, **7**–**9**).

Sexual abuse in childhood has also been linked to a range of negative reproductive health outcomes, such as unwanted pregnancy and sexually transmitted infections, including HIV (**2**, **4**, **10**, **11**). Research suggests that early sexual trauma may set off a cascade of behavioural responses that translate into increased sexual risk-taking by girls during adolescence. Studies in Barbados, New Zealand, Nicaragua, and the United States confirm that, on average, victims of sexual abuse start having voluntary sex significantly earlier than non-victims (**7**, **12**–**14**). Such studies also link sexual abuse to other risky behaviours, including having sex with many partners, using drugs and abusing alcohol, not using contraception and trading sex for money or drugs.

Future analyses of the WHO data will explore whether the associations found in the literature hold true in the WHO study sites. Specifically, future papers will explore whether early sexual abuse is a risk factor for increased risk of violence in adulthood, unwanted or mistimed pregnancies, suicide ideation, and a high lifetime number of sexual partners.

The differences observed in the WHO Study between the prevalence of childhood sexual abuse disclosed in face-to-face interviews versus anonymous methods is consistent with other studies that have found that respondents often find it easier to disclose highly stigmatized behaviours using anonymous formats. Studies of sensitive topics such as sexual behaviour (**15**, **16**), induced abortion (**17**), sexual abuse (**13**), and coerced sex (**18**) have consistently found a higher reporting of risky behaviours using anonymous or computerized methods than with interviewer-based methods of data collection. Interestingly these other studies also found discrepancies similar to those noted previously in this chapter in the linked data from Serbia and Montenegro, and the United Republic of Tanzania. These discrepancies reflect the fact that women may have different reasons for disclosing differently using different methods; some may feel more comfortable disclosing sexual abuse face-to-face rather than anonymously (as so clearly shown by the women in Bangladesh who would not write anything without their husband's or mother-in-law's permission).

With respect to forced first intercourse, the wide variation in reported prevalence may, in part, reflect different social attitudes towards female sexuality and sexual behaviour. In countries such as Bangladesh and Ethiopia, with strong social restrictions on women expressing a desire to have sex, women may have a greater tendency to report their first sexual experience as forced. These high levels of forced first intercourse are likely to be predominantly sexual initiation by a husband – especially because women marry young – rather than abuse by another family member, a boyfriend or a stranger. Alternatively, the variation may represent actual differences in levels of forced first sex, reflecting cultural differences in women's ability to control the circumstances of their first sexual experience. Future analysis will explore this issue further, by looking, for instance, at the percentages of women who report that their first sexual experience was coerced without being forced (i.e. "they did not want to have sex, but it happened anyway").

One of the earliest surveys to reveal the extent of coercion among youth in developing countries was conducted in 1993 and involved 10 000 female secondary school students in Kenya. According to that survey, 24% of sexually experienced females reported that they had been forced into their first encounter (**19**). More recently, in Ghana and Zimbabawe, 25% of females aged 15–24 years reported that their first experience of sexual intercourse was forced; the detailed figures for Zimbabwe were 12% in an urban area and 33% in a rural setting (**20**, **21**). Among 575 sexually experienced 15–19-year-old women in the Rakai District of rural Uganda, 14% reported that their sexual initiation had been coerced or forced. Women who reported coerced or forced first intercourse were significantly less likely than those who did not to be currently using modern contraception and to have used a condom at their last intercourse; furthermore, they were more likely to report their current or most recent pregnancy as unintended, and also more likely to report one or more genital tract symptoms (**22**).

The WHO Study also documented a strong association between early sexual initiation and forced sex. Indeed, a number of studies have found that the younger a girl is when she first

has sex, the more likely it is that the encounter was forced (**23**). For example, in the Rakai study mentioned above, whereas 26% of young women who first had sex when they were younger than 14 years of age described the event as coerced, this proportion fell to 10% among those whose sexual debut was at age 16 years or older (**22**). Even greater differences were documented in some of the WHO study sites.

The causes and consequences of child sexual abuse need to be addressed, and given higher priority in public health programmes. Similarly, issues of coercion, in particular forced sex, and consent need to be integrated into adolescent sexual and reproductive health programmes and HIV prevention initiatives.

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CHAPTER 7

Associations between violence by intimate partners and women's physical and mental health

Main findings

- **The prevalence of injury among women who had ever been physically abused by their partner ranged from 19% in Ethiopia province to 55% in Peru province. In 7 of the 15 sites, over 20% of ever-injured women reported that they had been injured many times.**
- **In the majority of settings, women who had ever experienced physical or sexual partner violence, or both, were significantly more likely to report poor or very poor health than were women who had never experienced partner violence. They were also more likely to have had problems walking and carrying out daily activities, pain, memory loss, dizziness and vaginal discharge in the 4 weeks prior to the interview.**
- **In all settings, women who had ever experienced physical or sexual partner violence, or both, reported significantly higher levels of emotional distress and were more likely to have thought of suicide or to have attempted suicide, than were women who had never experienced partner violence.**

> "... I don't feel well and I just cry. There are times that I want to be dead, I even thought of killing myself or poisoning myself and my kids, because I think if I have suffered that much, how much would my kids suffer if I am no longer there..."
>
> Woman interviewed in Peru

This chapter summarizes the findings of the WHO Study on the association between a woman's lifetime experience of physical or sexual violence, or both, by an intimate partner and selected indicators of physical and mental health. Although in a cross-sectional survey it is not possible to demonstrate causality between violence and health problems or other outcomes, the findings give an indication of the forms of association, and the extent to which different associations are found in each of the participating countries. Findings on injuries caused directly by physical violence by an intimate partner are also presented in this chapter.

Women's self-reported health and physical symptoms

All women, regardless of partnership status, were asked whether they considered their general health to be excellent, good, fair, poor or very poor. They were subsequently asked whether they had experienced a number of physical symptoms during the 4 weeks prior to the interview, including problems with walking, pain, memory loss, dizziness, and vaginal discharge. The proportions of ever-partnered women reporting physical health problems, according to their experience of physical or sexual violence, or both, by an intimate partner at some point in their lives, are presented in Table 7.1.

In most sites, women who reported violence by an intimate partner were significantly more likely than women who had not experienced violence to report that their general health was poor or very poor. Significant bivariate associations were also repeatedly found between lifetime experiences of violence by an intimate partner and specific symptoms of ill-health (Table 7.1).

Multivariate logistic regression modelling was performed to explore associations between violence by an intimate partner and health problems, adjusting for potential confounding variables. Crude and adjusted odds ratios (with 95% confidence intervals) were calculated for the odds of health problems in ever-partnered

has sex, the more likely it is that the encounter was forced (**23**). For example, in the Rakai study mentioned above, whereas 26% of young women who first had sex when they were younger than 14 years of age described the event as coerced, this proportion fell to 10% among those whose sexual debut was at age 16 years or older (**22**). Even greater differences were documented in some of the WHO study sites.

The causes and consequences of child sexual abuse need to be addressed, and given higher priority in public health programmes. Similarly, issues of coercion, in particular forced sex, and consent need to be integrated into adolescent sexual and reproductive health programmes and HIV prevention initiatives.

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CHAPTER 7

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Main findings

- **The prevalence of injury among women who had ever been physically abused by their partner ranged from 19% in Ethiopia province to 55% in Peru province. In 7 of the 15 sites, over 20% of ever-injured women reported that they had been injured many times.**
- **In the majority of settings, women who had ever experienced physical or sexual partner violence, or both, were significantly more likely to report poor or very poor health than were women who had never experienced partner violence. They were also more likely to have had problems walking and carrying out daily activities, pain, memory loss, dizziness and vaginal discharge in the 4 weeks prior to the interview.**
- **In all settings, women who had ever experienced physical or sexual partner violence, or both, reported significantly higher levels of emotional distress and were more likely to have thought of suicide or to have attempted suicide, than were women who had never experienced partner violence.**

> "... I don't feel well and I just cry. There are times that I want to be dead, I even thought of killing myself or poisoning myself and my kids, because I think if I have suffered that much, how much would my kids suffer if I am no longer there..."
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This chapter summarizes the findings of the WHO Study on the association between a woman's lifetime experience of physical or sexual violence, or both, by an intimate partner and selected indicators of physical and mental health. Although in a cross-sectional survey it is not possible to demonstrate causality between violence and health problems or other outcomes, the findings give an indication of the forms of association, and the extent to which different associations are found in each of the participating countries. Findings on injuries caused directly by physical violence by an intimate partner are also presented in this chapter.

Women's self-reported health and physical symptoms

All women, regardless of partnership status, were asked whether they considered their general health to be excellent, good, fair, poor or very poor. They were subsequently asked whether they had experienced a number of physical symptoms during the 4 weeks prior to the interview, including problems with walking, pain, memory loss, dizziness, and vaginal discharge. The proportions of ever-partnered women reporting physical health problems, according to their experience of physical or sexual violence, or both, by an intimate partner at some point in their lives, are presented in Table 7.1.

In most sites, women who reported violence by an intimate partner were significantly more likely than women who had not experienced violence to report that their general health was poor or very poor. Significant bivariate associations were also repeatedly found between lifetime experiences of violence by an intimate partner and specific symptoms of ill-health (Table 7.1).

Multivariate logistic regression modelling was performed to explore associations between violence by an intimate partner and health problems, adjusting for potential confounding variables. Crude and adjusted odds ratios (with 95% confidence intervals) were calculated for the odds of health problems in ever-partnered

Table 7.1 **Percentage of ever-partnered women reporting selected symptoms of ill-health, according to their experience of physical or sexual violence, or both, by an intimate partner, by site[a]**

Site	Experience of violence	Self-reported health is poor or very poor (%)		Problems with walking (%)		Problems with carrying out daily activities (%)		Pain (%)		Problems with memory (%)		Dizziness (%)		Vaginal discharge (%)		Total no. of ever-partnered women
Bangladesh city	Never experienced violence	12.5		17.8		15.8		25.8		12.5		43.6		22.3		640
	Ever experienced violence	19.4	***	24.1	**	22.2	**	35.7	****	20.2	****	63.8	****	43.7	****	733
Bangladesh province	Never experienced violence	16.3		21.2		22.8		27.9		11.8		59.3		38.7		509
	Ever experienced violence	21.1	*	29.1	***	29.4	**	38.9	****	17.4	**	73.0	****	50.9	****	820
Brazil city	Never experienced violence	3.7		8.8		10.2		30.4		9.0		23.3		24.9		668
	Ever experienced violence	8.5	**	12.1		16.9	**	46.0	****	18.8	****	36.8	****	29.8		272
Brazil province	Never experienced violence	14.4		12.9		14.0		25.7		8.0		28.9		19.7		750
	Ever experienced violence	28.1	****	19.2	**	24.7	****	40.0	****	16.7	****	43.4	****	30.4	****	438
Ethiopia province[b]	Never experienced violence	1.8		0.3		0.1		20.1		0.3		3.3		2.3		657
	Ever experienced violence	3.5	*	0.5		0.2		21.1		0.9		3.6		4.2	*	1589
Japan city	Never experienced violence	3.0		3.7		8.9		8.3		6.7		14.2		4.5		1080
	Ever experienced violence	5.6		5.1		14.8	*	12.2		14.3	****	22.4	**	6.6		196
Namibia city	Never experienced violence	2.9		4.9		4.2		8.2		4.8		15.9		10.4		876
	Ever experienced violence	6.3	**	11.4	****	9.8	****	14.9	****	11.4	****	29.1	****	15.9	**	491
Peru city	Never experienced violence	4.5		7.4		14.2		28.7		11.1		23.2		36.8		530
	Ever experienced violence	9.2	**	17.1	****	22.7	****	42.8	****	17.7	**	34.2	****	51.1	****	556
Peru province	Never experienced violence	10.9		12.8		12.0		31.4		16.4		34.7		36.4		475
	Ever experienced violence	18.8	****	23.0	****	24.7	****	40.4	***	26.6	****	47.2	****	49.5	****	1059
Samoa	Never experienced violence	1.8		6.5		5.5		22.2		4.5		43.5		1.5		649
	Ever experienced violence	1.3		7.4		7.0		29.2	**	4.9		55.1	****	4.1	**	555
Serbia and Montenegro city	Never experienced violence	3.6		10.5		7.9		25.9		6.1		25.4		12.1		907
	Ever experienced violence	8.5	***	17.4	**	14.2	**	36.8	****	13.2	****	29.9		20.6	****	281
Thailand city	Never experienced violence	12.5		11.5		12.6		17.2		19.1		44.4		5.7		617
	Ever experienced violence	19.7	***	20.0	****	16.5		24.8	**	31.6	****	53.5	**	11.9	****	431
Thailand province	Never experienced violence	17.8		10.8		13.9		18.8		21.5		56.7		8.0		539
	Ever experienced violence	27.0	****	16.1	*	21.2	**	27.5	***	30.3	***	69.5	****	17.1	****	485
United Republic of Tanzania city	Never experienced violence	1.9		12.2		9.7		19.2		14.4		16.4		7.1		846
	Ever experienced violence	2.3		21.5	****	15.8	***	29.4	****	25.0	****	23.2	***	11.1	**	596
United Republic of Tanzania province	Never experienced violence	3.4		13.4		12.7		21.5		11.6		15.7		7.4		554
	Ever experienced violence	6.1	*	14.4		15.4		28.0	**	14.6		26.2	****	13.2	***	702

Asterisks denote significance levels: *, $P < 0.05$, **, $P < 0.01$, ***, $P < 0.001$, ****, $P < 0.0001$ (Pearson chi-square test).

[a] Percentages are given for women reporting that their general health is poor or very poor or reporting symptoms of ill-health within the 4 weeks prior to the interview (2 lowest items on 5-point Likert scale).

[b] In Ethiopia self-reported general health was measured in the same way as in all other sites, whereas the other health indicators were measured using equivalent questions in the Composite International Diagnostic Interview (CIDI).

Table 7.2 **Logistic regression models for the associations between selected health conditions and experience of intimate partner violence among ever-partnered women[a]**

Health condition	COR	95% CI	AOR	95% CI
Self-reported health status: poor or very poor	1.9	1.7–2.1	1.6	1.5–1.8
Problems with walking	2.0	1.8–2.1	1.6	1.5–1.8
Problems with carrying out daily activities	1.9	1.8–2.1	1.6	1.5–1.8
Pain	1.8	1.7–2.0	1.6	1.5–1.7
Problems with memory	2.0	1.9–2.2	1.8	1.6–2.0
Dizziness	2.0	1.9–2.2	1.7	1.6–1.8
Vaginal discharge	2.3	2.1–2.5	1.8	1.7–2.0

COR, crude odds ratio; AOR, adjusted odds ratio (adjusted for site, age group, current marital status and educational level); CI, confidence interval.

[a] Odds ratios and 95% confidence intervals are given for the odds of health problems in ever-partnered women who have ever experienced physical or sexual violence, or both, by an intimate partner, relative to the odds of health problems in women who have not experienced violence (except for general health, all conditions related to occurrences in the past 4 weeks). These all-sites odds ratios are calculated using multivariate logistic regression techniques on a pooled data set, including all 15 sites for self-reported health status, and all sites except Ethiopia for all other health conditions.

women who have experienced violence by an intimate partner, relative to the odds of health problems in women who have not experienced violence by an intimate partner. The logistic regression analyses were performed on a pooled data set (including all 15 sites) of all respondents, adjusting for site, age, educational attainment and marital status, as well as for each site separately, again adjusting for age, education and marital status. The pooled crude and adjusted odds ratios are presented in Table 7.2, and the crude and adjusted odds ratios for each health problem, by site, are presented in Appendix Table 12.

According to the pooled multivariate analysis, women with lifetime experiences of physical or sexual violence, or both, by an intimate partner were significantly more likely to report poor or very poor health (AOR, 1.6; 95% CI, 1.5–1.8), and that within the past 4 weeks they had experienced problems with walking or carrying out daily activities, pain, memory loss, dizziness and vaginal discharge (Table 7.2). For the individual sites, there was evidence of an association between violence and poor health in all but one instance, and the association was significant in most sites. The associations for some of the specific health problems were not significant in Ethiopia province, Japan city, Samoa, and the United Republic of Tanzania province (Appendix Table 12). This lack of significance was related to low reporting of symptoms of ill-health, which reduces the power of the analysis. For example, in the four countries mentioned, women's reporting of poor health overall was extremely low (3% or less among women who had not suffered violence) compared with other sites, such as Thailand province, where 18% of non-abused and 27% of abused women reported poor health (Table 7.1).

Injuries caused by physical violence by an intimate partner

Women who reported physical violence by an intimate partner were asked whether their partner's acts had resulted in injuries.[1] Follow-on questions asked about frequency, types of injuries and whether health services were needed and used. Table 7.3 shows, by site, the number of women who had ever suffered physical violence by an intimate partner and, among them, the percentage who reported that they had been injured as a consequence of an assault by an intimate partner. The prevalence of injury among ever-abused women ranged from 19% in Ethiopia province to 55% in Peru province, with most sites between 27% and 46%. The frequency with which women experienced injury as a consequence of violence (once or twice, 3–5 times, and more than 5 times) also varied among sites. In Bangladesh city, Brazil, Namibia city, Peru, Samoa, Serbia and Montenegro city, and Thailand, over 15% of ever injured women reported that it had happened more than five times, whereas in Bangladesh province, Ethiopia province, Japan city, and the United Republic of Tanzania, the reported frequency of injuries was much lower. In Ethiopia province, only 1% of ever-injured women reported being injured more than five times.

Although the majority of ever-injured women reported minor injuries (bruises, abrasions, cuts, punctures, and bites), in some sites more serious injuries were relatively common (Table 7.4). In Namibia city, among ever-injured women, 44%

[1] In the questionnaire this was specified as follows: "By injury, I mean any form of physical harm, including cuts, sprains, burns, broken bones or broken teeth, or other things like this".

Table 7.3 Severity and frequency of injuries among women ever injured by an intimate partner, by site[a]

Site	Among women ever physically abused by an intimate partner: Ever injured n	Ever injured (%)	Among women ever injured: Frequency of injuries: 1 or 2 times (%)	3–5 times (%)	>5 times (%)	If ever unconscious: < 1 hour (%)	> 1 hour (%)	Never (%)	Ever needed health care for injuries (%)
Bangladesh city	146	26.7	58.2	25.3	16.4	34.9	15.1	50.0	68.5
Bangladesh province	138	24.8	55.1	33.3	11.6	29.0	29.0	42.0	80.4
Brazil city	102	39.8	52.0	23.5	24.5	9.8	4.9	85.3	39.2
Brazil province	150	37.4	58.7	19.3	22.0	14.0	5.3	80.7	38.0
Ethiopia province	210	19.1	86.2	12.4	1.4	11.9	14.8	73.3	33.3
Japan city	41	26.6	65.0	27.5	7.5	2.4	4.9	92.3	53.7
Namibia city	127	30.5	45.7	34.6	19.7	15.0	7.9	77.2	66.1
Peru city	242	45.9	56.2	25.6	18.2	14.5	4.5	81.0	30.6
Peru province	519	55.4	40.0	36.5	23.5	42.6	9.4	48.0	58.0
Samoa	144	29.4	54.2	21.5	24.3	27.8	5.6	66.7	35.4
Serbia and Montenegro city	81	29.9	37.0	27.2	35.8	18.5	0.0	81.5	38.3
Thailand city	120	50.6	45.8	23.3	30.8	8.3	1.7	90.0	30.8
Thailand province	151	43.9	62.9	15.2	21.9	5.3	2.6	92.1	22.5
United Republic of Tanzania city	137	29.0	72.3	21.2	6.6	8.0	7.3	84.7	61.3
United Republic of Tanzania province	173	29.5	67.4	23.8	8.7	10.4	12.7	76.9	57.8

[a] This information was collected only from women who reported physical violence by an intimate partner.

Table 7.4 Percentage of different types of injuries among women ever injured by an intimate partner, by site[a]

Site	Cuts, punctures, bites (%)	Abrasions, bruises (%)	Sprains, dislocations (%)	Burns (%)	Deep cuts (%)	Ear, eye injuries (%)	Fractures (%)	Broken teeth (%)	Other injuries (%)	Total no. of women ever injured by an intimate partner
Bangladesh city	44.5	63.0	15.1	2.1	11.0	13.7	5.5	1.4	5.5	146
Bangladesh province	30.4	68.8	8.0	0.0	10.1	7.2	5.1	0.7	17.4	138
Brazil city	23.5	50.0	20.6	4.9	5.9	2.0	8.8	3.9	39.2	102
Brazil province	38.0	52.0	9.3	4.0	6.7	8.7	4.0	4.0	22.0	150
Ethiopia province	10.0	38.6	22.4	1.0	1.4	9.5	18.1	5.7	14.3	210
Japan city	14.6	87.8	7.3	0.0	0.0	12.2	7.3	2.4	2.4	41
Namibia city	42.5	51.2	11.0	5.5	17.3	44.1	18.9	8.7	10.2	127
Peru city	13.2	83.1	9.5	0.8	6.6	12.0	5.8	4.5	17.8	242
Peru province	16.8	93.6	12.7	1.5	12.5	30.3	10.4	8.5	15.6	519
Samoa	29.2	73.6	1.4	0.0	11.1	29.9	4.9	n.a.	n.a.	144
Serbia and Montenegro city	18.8	85.2	8.6	0.0	6.2	9.9	12.3	8.6	1.2	81
Thailand city	10.0	89.2	31.7	0.8	2.5	20.0	8.3	3.3	18.3	120
Thailand province	9.3	76.2	33.8	1.3	4.6	10.6	6.0	2.6	18.5	151
United Republic of Tanzania city	16.8	62.0	18.2	5.8	7.3	19.7	4.4	2.9	19.0	137
United Republic of Tanzania province	17.9	74.0	26.6	2.3	7.5	20.2	4.6	4.6	16.2	173

n.a., data not available.
[a] This information was collected only from women who reported physical violence by an intimate partner.

reported injuries to the eyes and ears, 19% suffered fractures, and 9% suffered broken teeth as a result of physical violence by a partner. In both sites in Bangladesh and in Peru province, at least 50% of ever-injured women reported that they had "lost consciousness" because of a violent incident (Table 7.3). Further qualitative research is needed to fully understand these findings, since the term "loss of consciousness" may have different meanings in different cultural contexts and languages.

Of those who had ever been injured by an intimate partner, between 23% (in Thailand province) and 80% (in Bangladesh province) reported having needed health care for an injury (whether health care was actually received or not) (Table 7.3). The highest proportions were recorded for Bangladesh, Japan city, Namibia city, Peru province, and the United Republic of Tanzania, where over 50% of ever-injured women reported having needed health care for an injury.

Table 7.5 Mean SRQ scores[a] for emotional distress among ever-partnered women, according to their experience of physical or sexual violence, or both, by an intimate partner, by site

Site	Experience of violence	Mean SRQ score		Total no. of ever-partnered women
Bangladesh city	Never experienced violence	5.4		640
	Ever experienced violence	7.9	****	733
Bangladesh province	Never experienced violence	5.2		509
	Ever experienced violence	7.4	****	820
Brazil city	Never experienced violence	4.6		668
	Ever experienced violence	7.4	****	272
Brazil province	Never experienced violence	5.2		750
	Ever experienced violence	8.4	****	438
Ethiopia province	Never experienced violence	2.3		659
	Ever experienced violence	2.7	****	1602
Japan city	Never experienced violence	1.5		1080
	Ever experienced violence	2.6	****	196
Namibia city	Never experienced violence	3.3		876
	Ever experienced violence	5.3	****	491
Peru city	Never experienced violence	5.1		530
	Ever experienced violence	8.1	****	556
Peru province	Never experienced violence	7.0		475
	Ever experienced violence	9.8	****	1059
Samoa	Never experienced violence	2.7		649
	Ever experienced violence	3.6	****	555
Serbia and Montenegro city	Never experienced violence	2.6		907
	Ever experienced violence	4.4	****	282
Thailand city	Never experienced violence	4.4		617
	Ever experienced violence	6.9	****	431
Thailand province	Never experienced violence	5.5		539
	Ever experienced violence	7.9	****	485
United Republic of Tanzania city	Never experienced violence	2.5		846
	Ever experienced violence	4.7	****	596
United Republic of Tanzania province	Never experienced violence	2.5		554
	Ever experienced violence	4.0	****	702

Asterisks denote significance levels: * $P < 0.05$, ** $P < 0.01$, *** $P < 0.001$, **** $P < 0.0001$ (negative binomial regression analysis).
[a] Based on a WHO screening tool for emotional distress: a self-reporting questionnaire of 20 questions (SRQ-20).

Mental health

Mental health was assessed using a self-reporting questionnaire of 20 questions (SRQ-20), developed by WHO as a screening tool for emotional distress. This instrument was integrated into the health section of the questionnaire. The SRQ-20 has been validated in a wide range of settings (**1**). It asks respondents whether, within the 4 weeks prior to the interview, they had experienced a series of symptoms that are associated with emotional distress, such as crying, inability to enjoy life, tiredness, and thoughts of ending life. The number of items that women respond to affirmatively are added up for a possible maximum score of 20. In practice, when the tool is used for screening, country-specific cut-off points that are indicative of emotional distress are developed. For the WHO Study, because the instrument had not previously been validated in the study countries, and because the mean scores varied widely among the sites, a single cut-off score was not used for identifying emotional distress. Instead, in each site, mean scores for women who had experienced intimate-partner violence were compared with those for non-abused women (Table 7.5). In all of the sites, the mean score for women who experienced abuse was significantly higher than that for non-abused women.

Women were also asked about suicidal thoughts and attempts at any point in their lives. Figure 7.1 shows the percentage of women who reported having thought about taking their lives, according to their experience of violence by an intimate partner, whereas Figure 7.2 gives the percentage of the women with suicidal thoughts who reported having attempted to take their lives at some point, again according to their experience of violence.

> "I would become a bit disoriented. I would lose a sense of direction, not knowing where I was going. I would miss my bus stop. Or sometime I got off the bus before my stop. I had to take another bus.... My thoughts wandered. I lost my memory. My daughter told me to stay calm and cool. I couldn't.… My brain is gone."
>
> Woman, 38 years old, interviewed in Thailand

Figure 7.1 **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**

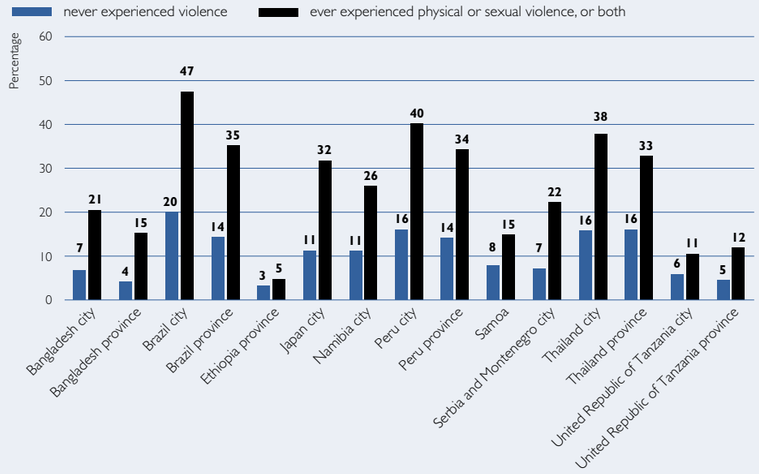
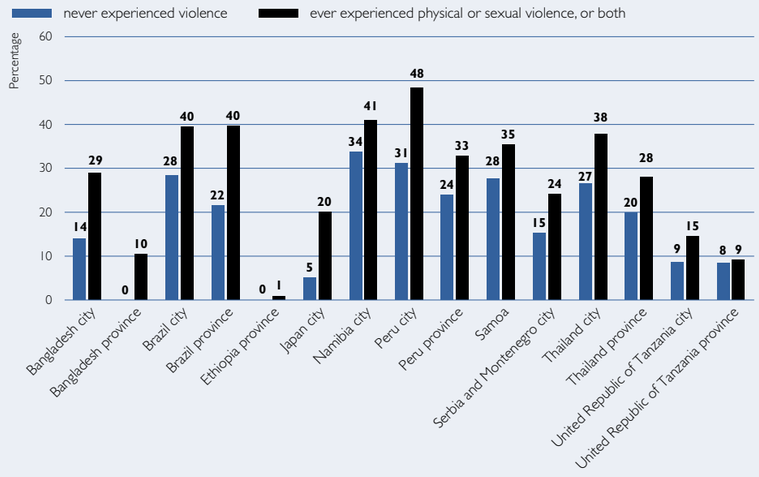


Figure 7.2 **Percentage of women who had attempted suicide among those who had ever contemplated suicide, according to their experience of physical or sexual violence, or both, by an intimate partner, by site**



Appendix Table 13 presents the results of multivariate logistic regression analysis on the association between suicidal thoughts or acts, and experiences of violence by an intimate partner. The pooled multivariate analysis, adjusting for site, age, education, and marital status, showed that women who had experienced physical or sexual violence, or both, were significantly more likely to have thought of ending their lives (AOR, 2.9; 95%, CI, 2.7–3.2), and to have attempted on one or more occasions to end their lives (AOR, 3.8; 95% CI, 3.3–4.5). Evidence of association was also found in all the individual sites. The associations were significant in most sites, with the exception of Ethiopia province in the case of suicidal thoughts, and in Bangladesh province, Ethiopia province, and the United Republic of Tanzania province in the case of suicidal acts, largely because of the relatively rare occurrence of the events, which limits the power of the analysis.

Discussion

Prior research on women's health and theoretical reasoning suggests that health problems are primarily outcomes of abuse rather than precursors (**2**), although the analyses do not allow for causal inference. The findings of the WHO Study regarding the association between health outcomes and violence by an intimate partner are consistent with findings from studies around the world, which so far have been done mainly in industrialized countries. The WHO Study shows that a current or previous experience of physical or sexual violence, or both, by an intimate partner is associated with a wide range of physical and mental health problems among women. These associations do not appear to be explained by differences in age, level of education, or marital status in any of the sites. These findings suggest that violence is not only a significant health problem by virtue of its direct impacts such as injury and mortality, but also that it contributes to the overall burden of disease through its *indirect* impacts on a number of health outcomes.

The association between violence by an intimate partner and selected physical symptoms of illness is supported by findings elsewhere (**3**–**5**). Studies primarily conducted in Europe and the United States have found that women who have experienced violence are more likely to suffer a broad range of functional disorders, including chronic pain, irritable bowel syndrome, and gynaecological disorders. It is particularly noteworthy that the WHO Study found an association between *recent* experiences of ill-health and *lifetime* experiences of partner violence. This suggests that the impact of violence may last long after the actual violence has ended.

Although it is a subjective measure, self-reported ill-health has been shown to be predictive of morbidity in countries where this has been tested (**6**–**8**). Differences in levels of reported ill-health among sites are to be expected, and are undoubtedly influenced by cultural variations in perceptions of health and ill-health. Nevertheless, as the intent was to compare the effect of violence on women's perceived health and well-being within each site individually, the findings should not be affected by cultural variations in perceptions of ill-health.

The findings regarding injury are consistent with data from Canada, New Zealand, the United Kingdom, and the United States that have established intimate partner violence as a common cause of injury to women (**9**–**12**). According to studies in the United States, 43–52% of women who have ever been exposed to intimate partner violence say they have been injured as a result (**13**). In South Africa, between 35% and 60% of abused women from three different provinces reported injuries resulting from domestic violence (**14**). In the Canadian National Survey on Violence against Women, 76% of women who said they were injured reported minor injuries and 24% reported severe injuries (fractures, broken bones, miscarriages, or internal injuries) (**13**).

The data are subject to recall bias, particularly when women are asked about situations that may have taken place long ago. For example, studies performed in Ghana and the United Republic of Tanzania have found that using recall periods of 1 year or more significantly reduced the reported incidence of non-fatal injuries, as compared with periods of 3 months or less (**15**, **16**). The decline in reporting rates was particularly pronounced for minor injuries, whereas the length of the recall period did not significantly affect the reporting of severe injuries. It is therefore likely that the rates of reported injury in this study are significantly lower than the actual rate, particularly for minor injuries.

Several studies have found that the prevalence and the type of injury are often associated with the severity of the violence, an association that was also found in the WHO Study; 86% of injuries were reported by women who had experienced severe forms of physical violence by an intimate partner.

Finally, the findings with regard to mental health outcomes are consistent with results from many studies in both developing and industrialized countries, linking suicidal ideation and behaviour with intimate partner violence (**17**, **18**). Since data about women who had actually committed suicide were not available, the strength of the association between violence and suicidal behaviour reported here is likely to be an underestimate. More broadly, mental health problems, such as depression and anxiety disorders in women, are widely recognized as important sequelae of intimate partner violence around the world (**9**, **19**–**21**), but it should be mentioned that they can also be predictors and risk factors for becoming a victim or perpetrator of intimate partner violence.

Because of the cross-sectional design of the WHO Study, there is a need to be cautious in inferring causality. It can be argued that women who have experienced violence are more likely to recall situations of ill-health, leading to an overestimation of the associations between violence and health problems. However, when considering lifetime experiences of violence and a recent history of ill-health, recall bias would tend to underestimate the prevalence of violence, thereby diluting potential associations.

> "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

The findings of the WHO Study are consistent with results from recent studies performed elsewhere and suggest that the impact of violence on women's physical and mental health that has been documented primarily in industrialized countries is similar or even greater in developing countries (**2**, **5**).

The extent to which the findings of the WHO Study are generally consistent across sites both within and between countries is striking. This suggests that, irrespective of where a woman may live, her cultural or racial background, or the degree to which violence may be tolerated or accepted in her society or by herself, a current or previous experience of physical or sexual violence, or both, by an intimate partner is associated with increased odds of poor physical and mental health. The high prevalence of partner violence and its associations with poor health, and the implied costs of this, both in terms of health expenditures and human suffering, highlight the urgent need to address this problem.

Further analysis of these data will explore these associations in greater depth, by comparing different exposures to violence, for example, by type of partner violence (physical, sexual and emotional violence), time frame (current or past), potential confounding factors, such as alcohol use or unemployment, violence by non-partners, and potential interactions with other individual, household and community characteristics. Associations between health outcomes and violence by non-partners will also be explored. This in-depth analysis will seek insights into the complex relationship between violence and health outcomes, in order to help inform the development of relevant health policies and health service responses.

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CHAPTER **8**

Associations between violence by intimate partners and women's sexual and reproductive health

Main findings

- **In the majority of settings, ever-pregnant women who had ever experienced physical or sexual partner violence, or both, were significantly more likely to report induced abortions and miscarriages than were women who had never experienced partner violence.**
- **The proportion of ever-pregnant women who were physically abused during at least one pregnancy exceeded 5% in 11 of the 15 settings, with the majority of sites falling between 4% and 12%. Across the sites between one quarter and one half of women who were physically abused in pregnancy were punched or kicked in the abdomen. In all sites, over 90% were abused by the biological father of the child they were carrying.**
- **In all sites except Ethiopia province, women who reported physical or sexual violence, or both, by their current or most recent partner were significantly more likely to report that their partner had multiple sexual partners, than were women whose current or most recent partner had never been violent.**
- **In most sites, women whose current or most recent partner was violent were more likely to have asked their partner to use a condom, and to report that their partner had ever refused to use a condom, than were women in non-violent relationships.**

This chapter summarizes the findings of the WHO Study on the association between a woman's lifetime experience of physical or sexual violence, or both, by an intimate partner and selected indicators of her sexual and reproductive health.

Information was collected about the number of pregnancies and live births, and whether the respondent had ever had a miscarriage, a stillbirth, or an induced abortion (see Annex 4). Women were also asked about their use of contraception, and whether they had used condoms to prevent disease. Women who reported a pregnancy were asked about physical violence during pregnancy. The Study also asked women about their partner, for example, whether she suspected that he was unfaithful to her, and whether he had ever refused to use a condom. Although in a cross-sectional survey it is not possible to demonstrate causality between violence and health problems or other outcomes, the findings give an indication of the forms of association, and the extent to which different associations are found in each of the participating countries.

Induced abortion and miscarriage

In all sites except Samoa (where only 0.2% of ever-pregnant women reported induced abortions), women who had experienced physical or sexual violence, or both, by an intimate partner reported more induced abortions than women who had not experienced partner violence. The difference was statistically significant at a bivariate level in

Table 8.1 Percentage of ever-pregnant women reporting having had an induced abortion or miscarriage (spontaneous abortion), according to their experience of physical or sexual violence, or both, by an intimate partner, by site

Site	Experience of violence	Ever had induced abortion (%)		Ever had miscarriage (spontaneous abortion) (%)		Total no. of ever-pregnant women
Bangladesh city	Never experienced violence	9.9		16.6		585
	Ever experienced violence	19.0	****	15.8		695
Bangladesh province	Never experienced violence	1.7		10.6		482
	Ever experienced violence	3.2		12.1		791
Brazil city	Never experienced violence	8.5		22.2		541
	Ever experienced violence	19.2	****	29.2	*	250
Brazil province	Never experienced violence	2.9		21.8		680
	Ever experienced violence	6.7	**	29.2	**	415
Ethiopia province	Never experienced violence	0.3		13.4		626
	Ever experienced violence	2.0	**	16.2		1556
Japan city	Never experienced violence	12.4		21.1		750
	Ever experienced violence	27.5	****	22.8		149
Namibia city	Never experienced violence	0.4		13.0		721
	Ever experienced violence	1.2		16.0		430
Peru city	Never experienced violence	4.1		23.7		443
	Ever experienced violence	14.5	****	32.9	**	516
Peru province	Never experienced violence	2.7		14.5		441
	Ever experienced violence	8.3	****	25.4	****	1027
Samoa	Never experienced violence	0.2		7.7		613
	Ever experienced violence	0.2		15.0	****	533
Serbia and Montenegro city	Never experienced violence	45.9		19.5		660
	Ever experienced violence	65.0	****	20.7		246
Thailand city	Never experienced violence	4.5		17.4		530
	Ever experienced violence	12.5	****	17.6		376
Thailand province	Never experienced violence	2.0		16.3		492
	Ever experienced violence	7.6	****	20.7		463
United Republic of Tanzania city	Never experienced violence	5.5		19.3		725
	Ever experienced violence	9.8	**	23.3		560
United Republic of Tanzania province	Never experienced violence	4.1		13.3		517
	Ever experienced violence	7.2	*	15.9		679

Asterisks denote significance levels: *, $P < 0.05$, **, $P < 0.01$, ***, $P < 0.001$, ****, $P < 0.0001$ (Pearson chi-square test).

all sites except Bangladesh province, Namibia city, and Samoa (Table 8.1). The results of pooled multivariate analysis among ever-pregnant women showed that abused women were more than twice as likely to have had an induced abortion (AOR, 2.4; 95% CI, 2.1–2.7, adjusting for site, age, educational level, and marital status). The association was statistically significant in all sites except Bangladesh province, Brazil province, Namibia city, and Samoa, where very few abortions were reported (Appendix Table 14). Similar patterns were found for miscarriage, in both the bivariate (Table 8.1) and the multivariate analysis, but the strength of the association was less. According to the results of pooled logistic regression analysis, women who reported having experienced violence were more likely to report having had a miscarriage (AOR, 1.4; 95% CI, 1.3–1.5), although the association was statistically significant in only 8 of the 15 sites.

Use of antenatal and postnatal health services

Women who reported having had a live birth in the past 5 years were asked whether they had attended an antenatal care service for their last pregnancy. In all sites except Ethiopia province, the majority of women reported having received some form of antenatal service (Table 8.2). In three sites (Bangladesh city, Ethiopia province, and the United Republic of Tanzania province), the proportion reporting not having attended an antenatal service was significantly higher among those women who reported that their partner had been physically and/or sexually violent towards them than among other women.

Women were also asked whether they had attended a postnatal service in the 6 weeks

Table 8.2 Use of antenatal and postnatal care services for most recent live birth, according to experience of physical or sexual violence, or both, by an intimate partner, by site

Site	Experience of violence	No antenatal care (%)		No postnatal care (%)		Total no. of women with live birth in past 5 years
Bangladesh city	Never experienced violence	10.4		50.7		270
	Ever experienced violence	17.9	**	67.4	****	364
Bangladesh province	Never experienced violence	33.1		83.7		245
	Ever experienced violence	34.7		81.9		426
Brazil city	Never experienced violence	0.9		24.9		217
	Ever experienced violence	3.3		40.0	**	90
Brazil province	Never experienced violence	8.0		60.6		289
	Ever experienced violence	12.7		66.9		166
Ethiopia province	Never experienced violence	65.5		98.1		420
	Ever experienced violence	71.2	*	98.5		1205
Japan city	Never experienced violence	0.0		3.6		302
	Ever experienced violence	0.0		7.4		54
Namibia city	Never experienced violence	3.9		20.3		408
	Ever experienced violence	4.4		19.6		203
Peru city	Never experienced violence	2.1		9.5		190
	Ever experienced violence	5.7		23.7	****	229
Peru province	Never experienced violence	5.5		39.2		293
	Ever experienced violence	7.1		38.7		634
Samoa	Never experienced violence	5.5		52.3		415
	Ever experienced violence	3.4		57.6		377
Serbia and Montenegro city	Never experienced violence	n.a.		n.a.		n.a.
	Ever experienced violence	n.a.		n.a.		n.a.
Thailand city	Never experienced violence	2.0		16.9		196
	Ever experienced violence	1.4		27.3	*	139
Thailand province	Never experienced violence	2.5		33.1		160
	Ever experienced violence	5.2		44.0		135
United Republic of Tanzania city	Never experienced violence	1.8		51.8		392
	Ever experienced violence	3.1		56.6		292
United Republic of Tanzania province	Never experienced violence	3.8		57.5		368
	Ever experienced violence	7.6	*	69.6	**	460

Asterisks denote significance levels: *, $P < 0.05$, **, $P < 0.01$, ***, $P < 0.001$, ****, $P < 0.0001$ (Pearson chi-square test).
n.a., not available.

following delivery. As shown in Table 8.2, there was a large variation in the levels of contact with postnatal services between countries, with less variation between sites within the same country. For example, only 4% of non-abused women and 7% of abused women in Japan city had not received postnatal care, while in Ethiopia province, the corresponding figures are 98% and 99%. In Bangladesh, Brazil, Peru, and Thailand cities, and the United Republic of Tanzania province, women who reported that their partner was violent were significantly less likely to report a postnatal visit than women who had not experienced partner violence. This suggests that in a number of settings, violence by an intimate partner does interfere with access to antenatal and postnatal care, although the effect varies by setting.

Violence during pregnancy

Table 8.3 shows the prevalence and characteristics of physical violence during pregnancy. The proportion of ever-pregnant women who reported experiencing physical violence during at least one pregnancy varied considerably, from 1% in Japan city to 28% in Peru province, with the majority of sites falling between 4% and 12%. It is interesting to note that not all of the countries with very high overall levels of physical violence (for example, Ethiopia) had correspondingly high levels of physical violence during pregnancy. This may indicate that in some settings violence during pregnancy is less accepted, even if violence against women is common. This variation by site in the relative protection afforded by pregnancy is reflected in the finding that the percentage of

Table 8.3 Physical violence by an intimate partner during pregnancy, by site

	Ever-pregnant women		Ever physically abused, ever-pregnant women		Women ever beaten during a pregnancy					Women beaten during pregnancy by the same person as before the pregnancy	
Site	Ever beaten during a pregnancy (%)	Total no. of ever-pregnant women	Ever beaten during a pregnancy (%)	Total no. of physically abused ever-pregnant women	Punched or kicked in abdomen (%)	Beaten in most recent pregnancy by father of child (%)	Living with person who beat them while pregnant (%)	Beaten by same person as before the pregnancy (%)	Total no. of women ever beaten in pregnancy	Reported beating got worse during pregnancy (%)	Total no. of women beaten by the same person before the pregnancy
Bangladesh city	10.2	1280	24.9	526	36.6	99.2	96.9	83.2	131	11.9	109
Bangladesh province	12.4	1273	29.2	541	24.7	99.4	100.0	86.0	157	8.1	135
Brazil city	8.0	791	26.8	235	28.6	96.8	92.1	50.8	63	34.4	32
Brazil province	11.1	1095	31.8	381	37.5	97.5	92.6	57.0	121	26.1	69
Ethiopia province	7.5	2179	15.1	1079	28.0	98.2	83.5	86.6	164	14.8	142
Japan city	1.2	888	7.8	129	§	§	§	§	10	§	2
Namibia city	6.4	1149	17.8	370	49.3	89.2	79.7	73.0	74	20.4	54
Peru city	14.8	958	28.8	493	32.4	97.9	88.0	63.4	142	31.1	90
Peru province	27.6	1469	44.0	918	52.5	97.8	96.5	83.4	404	9.8	337
Samoa	9.9	1150	23.8	475	26.3	95.6	98.2	71.9	114	11.0	82
Serbia and Montenegro city	3.4	906	13.2	234	44.8	100.0	100.0	48.4	31	§	15
Thailand city	4.2	908	17.5	217	31.6	94.7	94.7	63.2	38	8.3	24
Thailand province	3.8	955	10.6	331	36.1	94.4	97.2	58.3	36	23.8	21
United Republic of Tanzania city	6.9	1283	19.1	451	37.9	93.7	86.1	64.6	79	15.7	51
United Republic of Tanzania province	12.3	1193	25.8	570	23.1	100.0	97.9	57.1	140	20.0	80

§, percentage based on fewer than 20 respondents suppressed.

physically abused women (who had ever been pregnant) who reported violence during pregnancy also varied fairly widely by country. In all the sites, less than half of the women said they had been abused during pregnancy. The lowest proportions were seen in Japan city (8%), Serbia and Montenegro city (13%), and Thailand province (11%) and the highest in Brazil province (32%) and Peru province (44%).

In most cases, women who were physically abused during pregnancy also reported that they had been beaten prior to getting pregnant. However, between 13% (Ethiopia province) and approximately 50% (Brazil city, and Serbia and Montenegro city) of all women abused in pregnancy said they were beaten for the first time during a pregnancy. The majority of women who suffered 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. In 8–34% of cases, however, the violence got worse during pregnancy. Among women who reported violence during a pregnancy, between one quarter and one half were severely abused (kicked or punched in the abdomen). Overwhelmingly, in all sites the violence was committed by the man responsible for the pregnancy (more than 90% of cases), and the woman was living with him at the time (over 80% of cases)(see Table 8.3).

Parity

Table 8.4 presents data on the number of live births reported by women, according to their experience of violence by an intimate partner. Overall parity varied a great deal between sites and countries, with no women in Japan city reporting 5 or more children, compared with over 50% of Ethiopian women. In all sites except Thailand city and Japan city, women who experienced violence were significantly more likely to have more children than non-abused women.

Risk of sexually transmitted infections, including HIV

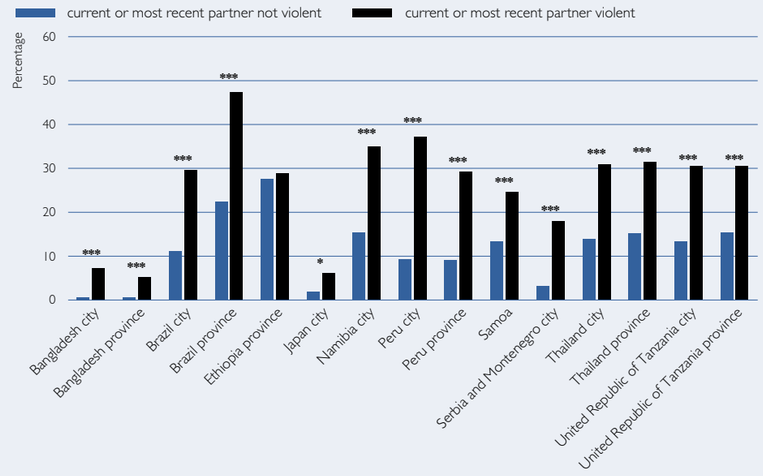
Because it was beyond the scope of the WHO Study to collect biological data on the prevalence of HIV and other sexually transmitted infections (STIs), it was not possible to explore directly whether there was a significant association between women's experiences of violence and these infections. In addition, it has been suggested that women's self-reported STI symptoms are not a reliable indicator of prevalence of STIs (**1**). For this reason, the WHO Study concentrated on exploring the relationship between partner violence and two indirect indicators of risk of HIV or STI infection namely the extent to which the woman knows that her partner has had other sexual partners while being with her, and whether the respondent had ever used a condom with her current or most recent partner.

Ever-partnered women were asked whether their current or most recent partner had had a relationship with any other women while being with her. Respondents had the option to respond affirmatively, to report that their partner might have had other sexual partners, or to report that they knew he had not. Figure 8.1 shows the proportion of women who reported that their partner had had another sexual relationship while they had been together, according to whether this partner had ever been violent towards them.[1]

The proportion of women reporting that their partner had had other sexual partners varied widely between settings. However, in all sites except Ethiopia province, women with violent partners were significantly more likely to report that they knew that their partner had had other sexual partners while with them than women whose partners were not violent – with

[1] All analyses on the associations between aspects of the current or most recent partner and the experience of partner violence included only women who were ever married or had ever lived with a partner.

Figure 8.1 Percentage of ever-married or cohabiting women reporting that their current or most recent partner had been unfaithful according to their experience of physical or sexual violence, or both, by that intimate partner, by site



Asterisks denote significance levels: *, $P < 0.05$, ***, $P < 0.0001$ (Pearson chi-square test).

Table 8.4 Number of live births reported by ever-partnered women according to their experience of physical or sexual violence, or both, by an intimate partner, by site

Site	Experience of violence	Number of live births: 0 (%)	1–2 (%)	3–4 (%)	≥5 (%)		Total no. of ever-partnered women
Bangladesh city	Never experienced violence	13.0	56.3	23.3	7.5		640
	Ever experienced violence	9.8	51.4	29.2	9.5	*	733
Bangladesh province	Never experienced violence	8.4	37.1	32.8	21.6		509
	Ever experienced violence	5.0	29.3	39.8	26.0	****	820
Brazil city	Never experienced violence	25.1	56.3	16.0	2.5		668
	Ever experienced violence	12.9	50.0	33.5	3.7	****	272
Brazil province	Never experienced violence	13.5	48.3	25.7	12.5		750
	Ever experienced violence	7.1	41.3	31.5	20.1	****	438
Ethiopia province	Never experienced violence	6.4	19.0	21.1	53.6		659
	Ever experienced violence	4.0	15.6	22.7	57.7	*	1602
Japan city	Never experienced violence	33.5	55.2	11.0	0.0		1080
	Ever experienced violence	28.6	54.6	16.3	0.0		196
Namibia city	Never experienced violence	20.8	46.1	21.7	11.4		876
	Ever experienced violence	16.5	42.0	27.3	14.3	*	491
Peru city	Never experienced violence	22.8	49.2	23.0	4.9		530
	Ever experienced violence	12.8	44.2	30.6	12.4	****	556
Peru province	Never experienced violence	11.6	39.8	20.6	28.0		475
	Ever experienced violence	4.8	31.8	25.3	38.1	****	1059
Samoa	Never experienced violence	8.9	32.4	28.5	30.2		649
	Ever experienced violence	5.6	24.1	31.2	39.1	****	555
Serbia and Montenegro city	Never experienced violence	32.7	59.8	7.3	0.2		907
	Ever experienced violence	23.8	67.4	8.5	0.4	*	282
Thailand city	Never experienced violence	18.0	64.8	16.7	0.5		617
	Ever experienced violence	16.2	65.7	17.4	0.7		431
Thailand province	Never experienced violence	12.4	67.3	19.3	0.9		539
	Ever experienced violence	6.4	66.6	23.7	3.3	****	485
United Republic of Tanzania city	Never experienced violence	21.0	39.4	22.5	17.1		846
	Ever experienced violence	13.3	44.0	26.2	16.6	***	596
United Republic of Tanzania province	Never experienced violence	10.6	37.7	29.2	22.4		554
	Ever experienced violence	6.1	33.6	31.9	28.3	**	702

Asterisks denote significance levels: *, $P < 0.05$, **, $P < 0.01$, ***, $P < 0.001$, ****, $P < 0.0001$ (Pearson chi-square test).

the proportion being threefold greater in several sites (Figure 8.1).

Ever-partnered women were asked whether they had ever used a condom to prevent disease with their current or most recent partner; if they had ever asked their partner to use a condom, and if their partner had ever refused a request to use a condom.

The majority of women surveyed had never used a condom with their partner. The proportion of women reporting ever having used a condom with their partner varied from less than 1% in Ethiopia province to 30% or higher in the cities in Brazil, Namibia, and Serbia and Montenegro. Table 8.5 presents women's responses to questions on whether they had ever used condoms with their current or most recent partner, whether they had ever asked their partner to use a condom, and whether he had ever refused, according to whether or not he had ever been physically or sexually violent towards them.

In the individual sites, there were no significant differences in the extent to which women reported having ever used a condom with their current or most recent partner, except in both sites in Thailand and both sites in the United Republic of Tanzania, where women in violent partnerships were significantly more likely than other women to report that they had ever used a condom with their partner. In all sites except Bangladesh province, women in violent relationships were more likely to have asked their partner to use a condom than women whose current or most recent partner was not violent. However, the difference was significant only in the city sites in Namibia, Peru, and the United Republic of Tanzania. The greatest differences were found in the proportion of women reporting that their partner had ever refused to use a condom to prevent disease, with women in violent partnerships in Brazil city, Namibia city, Peru, Serbia and Montenegro, and the United Republic of Tanzania being more likely than other women to report that their partner had refused to use a condom. Where there was no significant difference, this may be attributable, at least in part, to the low levels of condom use reported.

Discussion

The WHO Study found significant associations between physical and sexual violence and several indicators of women's sexual and reproductive health, including induced abortions, miscarriages, parity, and some STI and HIV risk behaviour. The association between violence and induced abortion has also been found among women in Canada and the United States (**2**, **3**), as well as among young women in the United Republic of Tanzania (**4**). More broadly, a highly significant association between partner violence and having had a miscarriage, abortion, or stillbirth has been found in Cambodia, the Dominican Republic, and Haiti (**5**).

The WHO Study found an overall prevalence of violence during pregnancy that was higher than figures reported in the United States, where most estimates lie between 4% and 8% (**6**, **7**). However, in a recent review of violence during pregnancy in developing countries, as well as in studies in Indonesia and India (**8**–**10**), a similarly wide range of 1–32% was reported, with the lowest prevalence rates reported in Indonesia and China (1% and 7%, respectively), and the highest in Egypt (32%) and India (28% and 18% in different studies) (**8**, **10**). Several of the studies in the review had a similar design to the WHO Study, and were based on retrospective data collected from women who had been pregnant but were not necessarily pregnant at the time of the study. Asking ever-pregnant women retrospectively about their experience of violence might either inflate or deflate estimates of prevalence. Inaccurate recall about whether already occurring violence took place in pregnancy or not could lead to an inflated figure. Alternatively underreporting can arise as a result of the stigma women may feel about disclosing violence during pregnancy. One of the reviews (**8**), however, found that reports of the prevalence of violence during a current pregnancy were very similar to reports of violence during any previous pregnancy in the countries where both kinds of study were performed (China 4.3% as against 3.5%; India 21% as against 28%).

These findings suggest that, in some societies, pregnancy is a time of relative protection from physical violence, whereas in others, abuse in pregnancy is common. More research is needed to study the patterns of violence by an intimate partner before, during and after pregnancy, and to understand how these issues are affected by cultural norms.

Associations have also been found between parity and violence by an intimate partner in studies in Cambodia, Chile, Colombia, Egypt, India, Nicaragua, and Peru (**5**, **11**–**13**). Because of the cross-sectional design of the WHO Study, it is difficult to determine the directionality of the relationship, although other international studies have suggested that high parity is a consequence, rather than a risk factor for violence. For example, a study in Nicaragua found that in 80% of cases violence began in the first 4 years of marriage, often before the couple had their first child (**14**). A recent analysis of Demographic and Health Survey data in Colombia, which found an increased risk of unintended pregnancy among abused women, suggested that "abused women living in an environment of fear and male dominance lacked the ability to control their fertility" (**15**).

Another important finding of the Study is that, across a broad range of settings, men who are violent towards their partners are also more likely to have multiple sexual partners. In many ways this association between partner violence and partner infidelity is not surprising, as the same notions of masculinity that condone male infidelity also tend to support male violence or control. This association may result in women being at increased risk of HIV or STI. Because violent men are more likely to be unfaithful, they may have a greater chance of becoming infected with HIV and other STIs, potentially putting women in violent relationships at increased risk of infection. This conclusion is supported by a study in South Africa, which found that abusive men are more likely than non-abusive men to be HIV-infected (**16**). A similar study in India found that abusive men were significantly more likely to have engaged in extramarital sex and to have STI symptoms than non-abusive men (**17**).

The mixed findings on condom use reflect those of other studies, which on the whole also found little association between condom use and partner violence in developing countries. Where an association was found, reported levels of condom use were higher in violent partnerships. These findings contrast with those reported by some studies in industrialized countries that have found inverse associations between violence and condom use. For example, one study reported

> "I was pregnant and he would always get home drunk…. My daughter was sick and I complained that he hadn't brought the medicine. He beat me very much…. I tried to escape, jumped a very high wall, and knocked on my neighbour's door. I don't know how I didn't miscarry."
> Woman interviewed in Brazil

Table 8.5 Reported condom use and negotiation among ever-married and cohabiting women according to their experience of violence by a current or most recent intimate partner, by site

Site	Experience of violence	Ever used a condom with current or most recent partner			Total no. of women ever-married or lived with partner	Ever asked current or most recent partner to use condom[a]			Total no. of respondents[a]	Current or most recent partner ever refused to use a condom[b]			Total no. of respondents[b]
		n	(%)			n	(%)			n	(%)		
Bangladesh city	Current or most recent partner not violent	15	2.3		643	106	16.5		643	4	0.6		643
	Current or most recent partner violent	11	1.5		721	138	19.1		721	3	0.4		721
Bangladesh province	Current or most recent partner not violent	17	3.3		512	55	10.7		512	6	1.2		512
	Current or most recent partner violent	20	2.5		808	82	10.1		808	15	1.9		808
Brazil city	Current or most recent partner not violent	197	32.4		608	155	37.7		411	31	20.0		155
	Current or most recent partner violent	77	39.3		196	56	47.1		119	20	35.7	*	56
Brazil province	Current or most recent partner not violent	227	28.0		810	106	18.2		583	49	46.2		106
	Current or most recent partner violent	95	31.5		302	47	22.7		207	29	61.7		47
Ethiopia province	Current or most recent partner not violent	5	0.7		705	1	0.1		700	0	§		1
	Current or most recent partner violent	7	0.5		1472	4	0.3		1465	1	§		4
Namibia city	Current or most recent partner not violent	300	47.4		633	45	13.5		333	19	42.2		45
	Current or most recent partner violent	109	49.3		221	31	27.7	***	112	27	87.1	****	31
Peru city	Current or most recent partner not violent	118	25.7		460	178	38.7		460	40	8.7		460
	Current or most recent partner violent	127	30.2		421	210	49.9	***	421	92	21.9	****	420
Peru province	Current or most recent partner not violent	59	12.3		480	77	16.0		480	21	4.4		480
	Current or most recent partner violent	104	10.7		970	178	18.4		970	70	7.2	*	970
Serbia and Montenegro city	Current or most recent partner not violent	474	60.4		785	331	41.6		795	22	2.8		795
	Current or most recent partner violent	86	54.8		157	70	44.6		157	21	13.4	****	157
Thailand city	Current or most recent partner not violent	124	19.5		637	26	5.1		511	13	46.4		28
	Current or most recent partner violent	106	27.2	**	389	22	7.7		284	14	63.6		22
Thailand province	Current or most recent partner not violent	60	10.4		577	30	5.8		516	12	40.0		30
	Current or most recent partner violent	74	17.2	**	430	25	7.0		356	14	56.0		25
United Republic of Tanzania city	Current or most recent partner not violent	117	14.3		820	160	19.5		820	52	6.3		820
	Current or most recent partner violent	73	18.6	*	392	118	30.9	****	382	55	14.0	****	392
United Republic of Tanzania province	Current or most recent partner not violent	49	8.3		589	84	14.3		589	25	4.2		589
	Current or most recent partner violent	81	13.8	**	589	104	17.7		589	47	8.0	**	589

Note: Japan city and Samoa are not represented because the questions on condom use were not asked in these sites.
§, percentage based on fewer than 20 respondents suppressed.
Asterisks denote significance levels: *, $P < 0.05$, **, $P < 0.01$, ***, $P < 0.001$, ****, $P < 0.0001$ (Pearson chi-square test).
[a] In most countries only those women who had never used a condom with their partner were asked this particular question, except in Bangladesh, Peru, Serbia and Montenegro, and the United Republic of Tanzania where this question was asked of all respondents.
[b] In most countries only those women who had ever asked their partner to use a condom were asked this particular question, except in Bangladesh, Peru, Serbia and Montenegro, and the United Republic of Tanzania where this question was asked of all respondents.

that African-American women with abusive primary partners were more likely than non-abused women to report never having used condoms, and receiving verbal or physical abuse when requesting condom use (**18**).

The findings of the WHO Study are also in contrast to various qualitative studies from developing countries in which women have mentioned violence or fear of violence as a barrier to condom use (**19**). One explanation may be that measures of condom use employed in the WHO Study were not sensitive enough to be able to detect an association between condom use and violence. It is possible that violence may operate differently among different groups of women. Some women with violent partners may redouble their efforts to use condoms because they correctly perceive that violent partners pose a greater risk of infection through increased exposure to STIs and HIV, whereas others may be less able to use condoms than women with non-violent partners because they are afraid. Thus, at a population level, these competing trends could potentially weaken or even cancel each other out.

Although the questions on condom use were asked in the context of protecting against disease transmission, they cannot be considered completely separate from its use as a contraceptive. Women may have one or both motives for wanting to use condoms. In view of this dual use, it is noteworthy that the association between violence and men's refusal to use condoms concurs with other multi-country research that has explored the association between women's experiences of violence and contraceptive use, which shows that women who had experienced intimate partner violence were more likely to have tried to use contraception, but also more likely to have discontinued its use (**19**). The WHO Study also collected information on contraceptive use in general, which will be analysed at a later stage.

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CHAPTER 9

Women's coping strategies and responses to physical violence by intimate partners

Main findings

- **Two thirds of women who had been physically abused by their partner in Bangladesh and about one half in Samoa and Thailand province had not told anybody about the violence prior to the interview. In contrast, about 80% of physically abused women in Brazil and Namibia city had told someone, usually family or friends.**
- **Between 55% and 95% of women who had been physically abused by their partner had never sought help from formal services or from individuals in a position of authority (e.g. village leaders). Only in Peru and Namibia had more than 20% of women contacted the police, and only in Namibia city and the United Republic of Tanzania city had more than 20% sought help from health services.**
- **Between 19% and 51% of women who had been physically abused by their partner had ever left for at least one night. Women who had left home usually stayed with relatives and to a lesser extent with friends or neighbours.**
- **Women were more likely to have sought help or left home if they had experienced severe physical violence.**

Until recently, the majority of research on women's responses to violence by an intimate partner involved women attending different support services, such as refuges, shelters or counselling services (**1, 2**). While research involving survivors of violence by an intimate partner who have access to such services can provide rich information about women's needs and experiences, it does not provide insights into the strategies used more generally by women to cope with, or respond to, the violence in their lives. At a population level, little is known about women's responses to violence – including the help that women receive from informal networks such as families and friends, and more formal governmental and nongovernmental agencies.

In the WHO Study, to explore these issues further, respondents who reported that their intimate partner was physically violent were asked a series of questions about whom they had talked to about their partner's behaviour, where they had sought help, who had helped them, and whether they had ever fought back or left their partner because of his violence. If a woman had been abused by more than one partner, she was asked about the most recent partner who was violent towards her.

Who women tell about violence and who helps

Women were asked whether they had told anyone about their partner's violent behaviour in a question to which multiple answers could be given (see Appendix Table 15). A large proportion of women, ranging from 21% (Namibia city) to 66% (Bangladesh city and province) reported not having told anyone about their partner's violence. This suggests that in many cases the interviewer was the first person that they had ever talked to about the violence.

> No. I prefer to be alone, quietly, sometimes sobbing, it depends on him. At work I have a close friend. I told her sometimes. She would nod and encourage me to stay in the relationship. For the kids, she said. He is not that bad. No one is perfect. My friend is already married. Some of my friends share my fate.
>
> Woman, 25 years old, interviewed in Thailand

Figure 9.1 shows, among women who had ever experienced physical violence by an intimate partner, the percentage who had either not spoken to anyone, or who had spoken to their family or their partner's family members, friends or neighbours, and/or to other services or people in positions of authority. Across the study sites, between 28% and 63% of women reported talking to family members.

In many sites, women also told friends or neighbours about the violence. Typically between 18% and 56% of women experiencing violence reported having spoken to friends except in Bangladesh, Ethiopia province, Samoa, and the United Republic of Tanzania, where the percentages were below 14%. In almost all sites, few women reported talking to formal services or people in positions of authority. Religious leaders, health personnel, police, counsellors, and women's nongovernmental organizations were seldom mentioned. An exception to this was United Republic of Tanzania province, where 25% of respondents reported telling local leaders about their partner's violence.

In all sites, women who had experienced severe physical violence were more likely to report that they had talked to someone than women who had experienced moderate violence (Figure 9.2).

Women who had been physically abused were also asked about whether anyone had tried to help them (Appendix Table 16). Between 34% (in Brazil) and 59% (in Bangladesh city) of women reported that no one had tried to help them.

Women's reports of who had tried to help them contrast with their reports about whom they had told. Although respondents were likely to talk to parents, siblings, and friends, they were less likely to report that these people had tried to help them. In the United Republic of Tanzania province, although a quarter of women had talked about the violence with local leaders, only 7% mentioned that local leaders had tried to help. There were also examples where people whom the women had not told nevertheless tried to help. For example, in Bangladesh only a few women reported telling their partner's family and neighbours about the violence, but a greater percentage reported that these people had tried to help.

Agencies or authorities to which women turn

Respondents were asked whether they had ever gone to formal services or people in positions of authority for help, including police, health services, legal advice, shelter, women's nongovernmental organizations, local leaders, and religious leaders. Appendix Table 17 shows the percentages of women who had sought support from the different types of agency or authority. Help-seeking patterns differed substantially between countries, with the lowest contact with agencies and authorities being found in Bangladesh, Japan city, Samoa, and Thailand province. In all sites, the majority (between 55% and 95%) of physically abused women reported that they had never gone to any of these types of agency.

Only in Brazil city, Namibia city, Peru, and the United Republic of Tanzania city, did more than 15% of women report seeking help from the police. In Namibia city and the United Republic of Tanzania city, more than 20% of women went to health care facilities, and between 10% and 17% in Brazil, Peru province, Serbia and Montenegro city, and the United Republic of Tanzania province sought support from health services. In the remaining eight sites, less than 10% of women reported seeking support from health services.

In all sites, more women who had experienced physical violence by an intimate partner had talked to someone about their partner's violence than had sought help from a service provider or agency, with the absolute differences ranging from 16% in Ethiopia province to 63% in Japan city (Figure 9.3). In some sites, women reported seeking help from other people in positions of authority – in Ethiopia province and the United Republic of Tanzania between 15% and 31% of women who had experienced physical violence reported that they had sought support from local leaders. In Brazil city, 15% of women who had experienced physical violence had sought help from religious leaders.

The differences in women's help-seeking behaviour probably reflect a combination of factors, including women's willingness to seek support from agencies, the effect of different potential barriers to accessing services, and the relative availability of services in different settings, as well as their responsiveness. For example, in Namibia where relatively high levels of contact with police and health services were reported, the Ministry of Health and Social Welfare supports women and child protection units, which provide legal advice, health care and counselling in the same facility. Likewise, in the Latin American countries participating in the Study, there are female-run police stations. Although the effectiveness of these services may vary, particularly in rural areas, police statistics indicate that reporting of violence increases greatly as the number of services increases.

Women's help-seeking behaviour was also strongly related to the severity of violence in all sites, with women who had experienced severe violence seeking support more frequently from an agency or authority than women who had experienced moderate physical violence (Figure 9.4). In all sites the most frequently given reasons for seeking help were related either to the severity or impact of the violence (she could not endure more; she was badly injured; he threatened or tried to kill her; he threatened or hit the children; or she saw that the children were suffering), or to external encouragement from friends and family to seek help (Appendix Table 18 and Box 9.1).

Women who had *not* gone for help to any of the services mentioned were asked why this was the case. The most common responses were either that the woman considered the violence normal or not serious – this response was given by between 29% (Peru province) and 86% (Samoa) of women who had not sought help – or that she feared the consequences, either for her own safety, or that she would lose her children, or that she would bring shame to her family. In Ethiopia province, 53% of these women said that fear kept them from seeking help. Other reasons included beliefs about the inadequacy of the likely response, in particular, that she would not be believed or that it would not help (Appendix Table 19 and Box 9.1).

> I went to the police, the police said just ordinary husband–wife matters, "you would be okay soon." The police had their lessons. They no longer wanted to get involved. The police didn't take my complaint and told me to go home.
>
> Woman, 27 years old, interviewed in Thailand

Figure 9.1 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

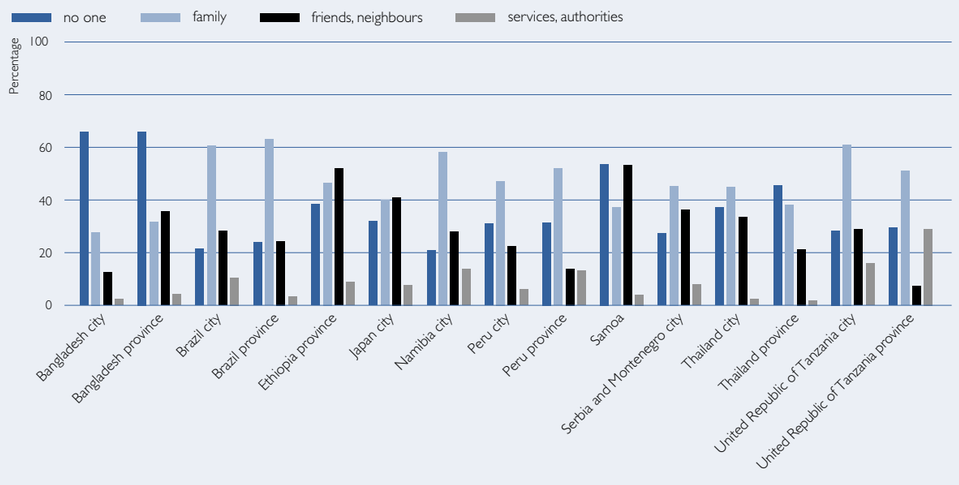


Figure 9.2 Percentage of ever physically abused women who had told someone about their experience of intimate-partner violence, by severity of violence, and by site

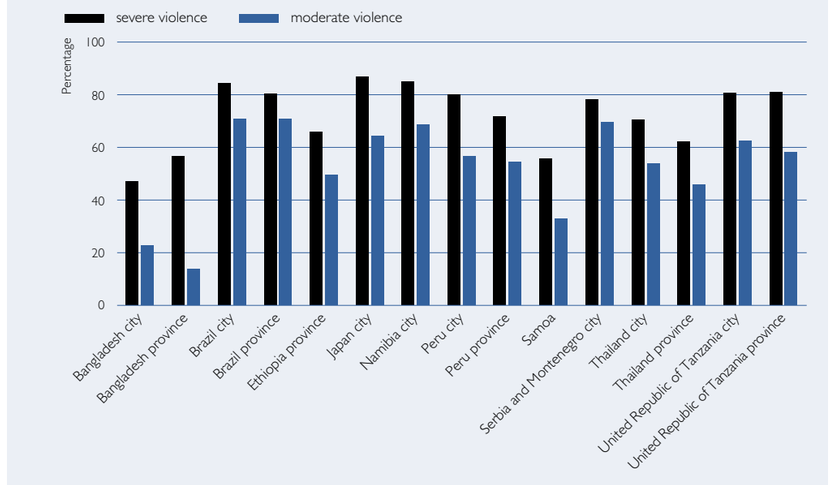


Figure 9.3 Percentage of ever physically abused women who had told someone about their experience of intimate-partner violence compared with the percentage of ever physically abused women who had sought help, by site

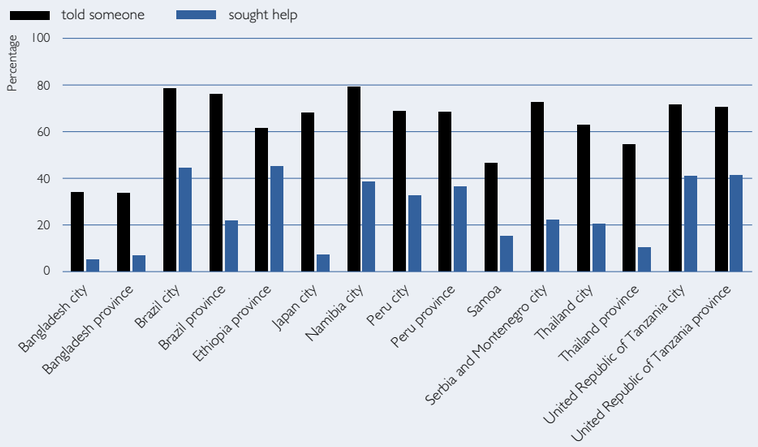
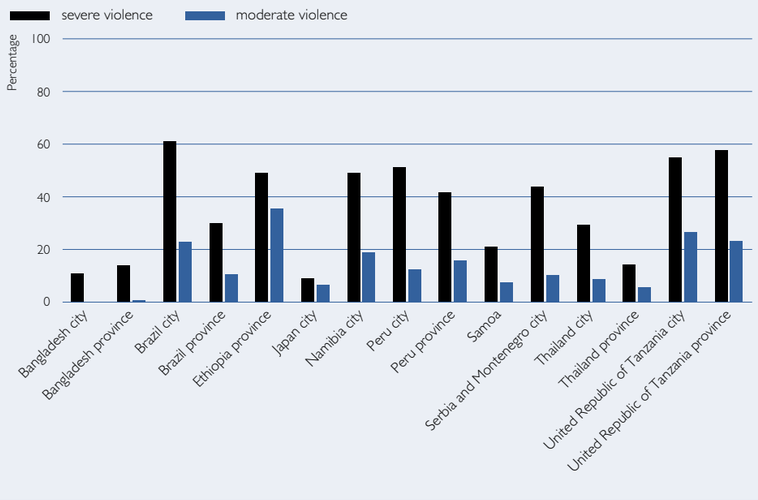


Figure 9.4 Percentage of ever physically abused women who sought help from at least one agency or authority, by severity of intimate-partner violence, and by site



Women were also asked from whom they would have liked to receive more help. In general women found this question difficult to answer. In all sites except Japan city, more than one third of women (and more than 80% in Bangladesh, Ethiopia province, Peru city, and Samoa) did not mention any specific agency or provider. Where women did respond, the majority said that they would like to have more support from family members.

Fighting back

Respondents were asked whether they had ever fought back physically against their partner's physical violence (Table 9.1). Across the sites, between 6% and 79% of women had ever fought back against their partners, with the lowest levels being reported in Ethiopia and Bangladesh provinces. In Brazil, Japan city, Peru, Serbia and Montenegro city, and Thailand, more than 50% of women who had ever experienced physical violence reported having fought back. The proportion reporting using violence in retaliation was consistently higher among women experiencing severe physical violence (ranging from 6% in Ethiopia province to more than 80% in the city sites of Brazil and Peru), than in women experiencing moderate violence (Table 9.1).

Box 9.1 Reasons for seeking or not seeking help among physically abused women

Most commonly mentioned reasons for seeking help

- She could not endure more
- She was badly injured
- Partner had threatened or hit her children
- She had been encouraged by friends or family

Most commonly mentioned reasons for not seeking help

- The violence was normal or not serious
- She was afraid of the consequences/threats/more violence
- She was embarrassed or afraid of being blamed or not believed
- She was afraid of bringing shame on her family

Women who leave

Women who reported physical violence by an intimate partner were also asked if they had ever left home because of the violence, even if only overnight. Between 49% (Brazil province) and 81% (Bangladesh province) of women reported never leaving (Figure 9.5). Between 8% and 21% of women who had ever experienced physical violence reported leaving 2–5 times, and 6% or less of women reported leaving 6 or more times. Again there is a strong relationship with the severity of violence, with between one third and two thirds of all women who reported severe violence having left at least once, whereas among women who experienced moderate violence 30% or fewer left for at least one night (Figure 9.6).

Women who had left were asked about their reasons for leaving (Appendix Table 20). In all sites, between 43% and 90% of women reported that they had left because they could not endure more. Otherwise, although the specific reasons for leaving differed somewhat between sites, a large proportion intimated that the violence had become severe. For example, in Namibia city, Peru province, and the United Republic of Tanzania province, more than 20% reported leaving because they were badly injured; in Peru province more than 20% reported being thrown out of the home; and in Brazil province, Namibia city, and Peru more than 10% reported that their partner had threatened or tried to kill them.

As shown in Appendix Table 21, the majority of women who left sought refuge with relatives (ranging from 50% in Japan city to more than 80% in Bangladesh, Ethiopia province, Peru city, and Samoa). To a lesser extent, women stayed with friends or neighbours. In Bangladesh province, Namibia city, and the United Republic

Table 9.1 Percentage of ever physically abused women who ever fought back, by severity of intimate partner violence,[a] by site

	Any physical violence by partner					Moderate violence		Severe violence	
		Frequency of fighting back							
Site	Ever fought back (%)	Once or twice (%)	Several times (%)	Many times (%)	No. of women reporting physical violence	Ever fought back (%)	No. of women reporting moderate violence	Ever fought back (%)	No. of women reporting severe violence
Bangladesh city	13.0	7.5	4.4	1.1	545	8.0	288	18.7	257
Bangladesh province	5.7	3.6	1.4	0.7	557	1.7	296	10.5	258
Brazil city	78.9	31.6	13.3	34.0	256	72.7	110	83.6	146
Brazil province	63.0	24.8	13.5	24.8	400	59.9	162	65.4	237
Ethiopia province	5.6	5.2	0.2	0.0	1101	4.7	299	5.9	800
Japan city	53.3	19.7	22.4	11.2	152	43.1	109	79.1	43
Namibia city	34.0	20.5	7.5	6.0	415	19.0	142	42.2	270
Peru city	74.2	44.2	19.5	10.4	527	65.6	250	81.9	277
Peru province	63.5	36.5	21.3	5.8	935	57.1	184	65.2	750
Samoa	22.3	15.0	3.3	4.1	488	16.9	201	26.1	287
Serbia and Montenegro city	51.1	23.3	13.0	14.8	270	41.7	175	68.4	95
Thailand city	70.5	38.4	9.7	22.4	237	67.6	105	72.7	132
Thailand province	58.6	31.5	9.9	17.2	343	48.1	160	67.8	183
United Republic of Tanzania city	36.3	15.9	10.0	10.4	471	29.6	233	42.8	236
United Republic of Tanzania province	16.0	9.5	3.6	2.9	582	10.3	273	21.2	306

[a] Women are considered to have suffered severe violence if they have experienced at least one of the following acts: being hit with a fist or something else, kicked, dragged, beaten up, choked, burnt on purpose, threatened with or had a weapon used against them. Severe violence may also include moderate acts. Women are considered to have suffered moderate violence if they have only been slapped, pushed, shoved or had something thrown at them. Moderate violence excludes any of the acts categorized as severe violence.

Figure 9.5 **Frequency of leaving (for at least one night) because of intimate partner violence among ever physically abused women, by site**

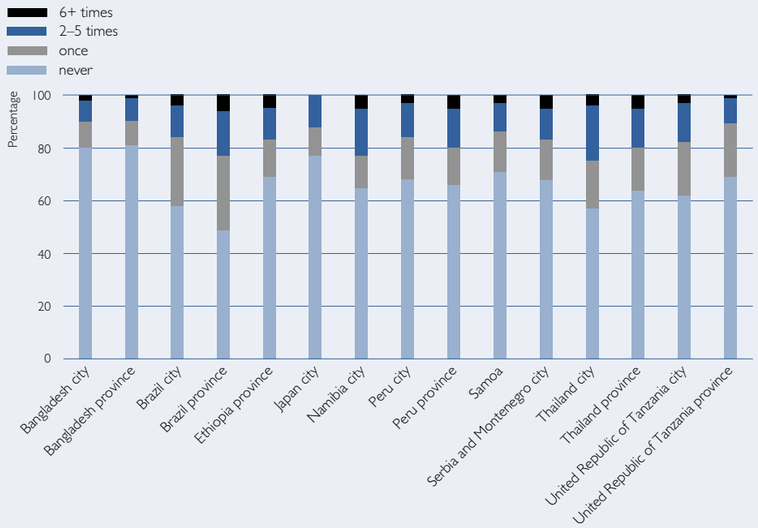
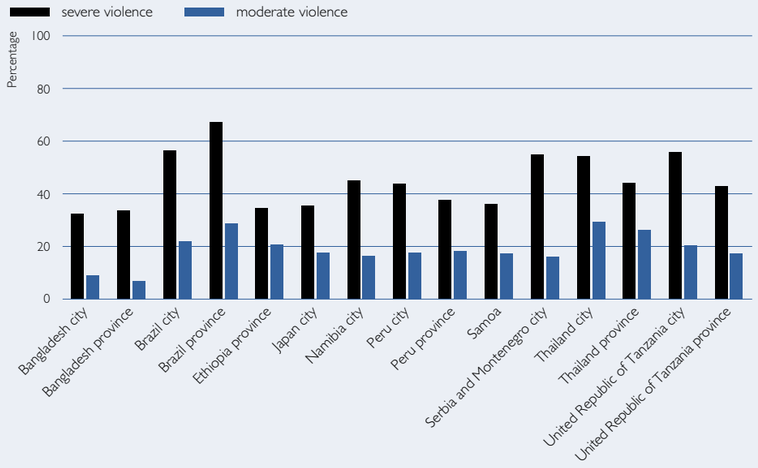


Figure 9.6 **Percentage of ever physically abused women who ever left for at least one night because of their experience of intimate partner violence, by severity of violence, and by site**



of Tanzania province, between 10% and 16% reported staying with their partner's family. In Japan city and to a lesser extent in Brazil city, Thailand city, and the United Republic of Tanzania province, a small percentage of women also mentioned staying in hotels or lodgings. Shelters were mentioned only in Brazil city and Namibia city (less than 1%).

Women who returned were asked about their reasons for returning (Appendix Table 22). Commonly mentioned reasons for returning included that the woman could not leave the children, for the sake of her family, because she loved her partner, because he asked her to come back, because she forgave him or thought he would change, or because the family said she should return. Women who never left gave similar reasons for not leaving – staying because of the children, shame and emotional attachments, as well as indicating that they did not know where to go (Appendix Table 23).

Discussion

The findings from the WHO Study underscore the immense difficulties that women suffering intimate partner violence face in seeking and obtaining help. The Study found that a substantial proportion of women in violent relationships do not tell others about the violence they are experiencing or seek help. Indeed, for many women interviewed, the WHO Study was the first instance in which they had told anyone about their partner's violence towards them. Other studies have indicated that women living in violent relationships often experience feelings of extreme isolation, hopelessness and powerlessness that make it particularly difficult for them to seek help. As shown in Chapter 4 of this report, violent partners often keep women isolated from potential sources of help, and women may fear that disclosure of their situation will lead to retaliation against themselves or their children. Feelings of shame and self-blame, and stigmatizing attitudes on the part of service providers, family and community members were also commonly cited in studies as barriers to seeking help (**3**).

The results of the WHO Study also highlight the extent to which immediate social networks (family, friends, and neighbours), rather than more formal services, provide the first point of contact for women in violent relationships. This finding is similar to the results of research in the United States and other countries (**4**, **5**). Care must nevertheless be taken when interpreting these findings, as it is not clear whether this contact helped in any way. Qualitative research suggests that, although some forms of intervention by friends and family members may be positive, there are also many examples where the people that women turn to are either ambivalent or negative. For example, some family members may condone the man's violence, or seek strategies to address the violence that prioritize the well-being of the family unit over the woman's safety. Nevertheless, several studies have highlighted the importance of social support in mediating the effects of violence. Women who report that they have support from family and friends are consistently found to suffer fewer negative effects on their mental health, and are able to cope more successfully with violence (**6**, **7**).

Data from other studies also suggest that, overall, in both industrialized and developing countries, levels of contact with formal agencies are low. For example, a study performed in León, Nicaragua, found that 80% of abused women had never sought help from anyone, only 14% had ever reported the violence to the police, and only 2% had ever talked about their situation with a health provider (**8**). The Canadian Violence against Women Survey found that only 26% of abused women reported the violence to the police. The women who went to the police were more likely to have been injured, to have children who had witnessed the violence, and to be afraid for their lives than women who did not report violence (**9**).

The findings on where and when women seek help concur with the experience of women's organizations in both developing and industrialized countries, which commonly report that their clients seek their help once the violence has become severe, or their life or their children's lives have been threatened. The extent to which women feel that violence is "normal" or "not serious" is not consistent with the evidence presented in Chapter 7 concerning the health outcomes associated with violence by an intimate partner. This suggests either that many of the help-seeking behaviours relate to the perceived normality of the violence, or that women may not recognize the seriousness or impact of the violence on their own health and well-being.

Despite the many barriers to women disclosing violence, the results reveal that women in violent relationships do actively seek ways to reduce or end the violence in their lives. Where women do seek help, they primarily turn to informal sources of support, particularly family and friends, rather than to formal sources. In addition, family members or others may try to help even if women do not talk to them about the violence. Some women reported fighting back in response to their partner's violence, and many had left their homes for at least one night, sometimes many times. Research in other countries indicates that many of these actions are steps along the way to successful disengagement from violent relationships. For example, the Nicaraguan study mentioned earlier found that nearly 70% of abused women eventually did leave violent relationships. However, they first tried many other strategies to minimize or cope with the violence. Women who sought help or left the house temporarily were more likely to leave a violent relationship, whereas women who defended themselves were more likely to stay (**7**, **8**). The severity of the violence, and whether the children were harmed by it, were the most important factors determining what strategy a woman would use.

In addition to the factors mentioned above, the generally low use of formal services reported reflects in part the limited availability of services in many sites. Other constraints may include costs or other barriers to travel, perceptions that services will not be sympathetic or able to help,

and fear of the potential consequences to their own and their children's safety. These reasons are often mentioned, even in countries such as the United States, where there is a relatively high availability of services.

The findings illustrate the many factors affecting whether or not women leave violent relationships, and the degree to which – from concern for her family, emotional attachments, and a lack of alternatives – women may remain in a violent relationship until the violence becomes severe. Even when women do try to leave, they may be prompted by family and emotional concerns to return many times.

Many studies on how women cope with violence, mostly performed in the United States, suggest that leaving a violent relationship is a process, rather than a one-time event (**10**–**13**). The process of entrapment in, and recovery from, an abusive relationship has been described as a four-phase process: binding, enduring, disengaging, and recovering. A woman passes progressively through these phases as the meaning she ascribes to her abusive experience, her interactions with her partner, and herself change (**14**). The way that a woman responds to a specific act of violence is influenced by the phase she is in at that moment. A similar process is described by Brown, who applies the Transtheoretical Model of Behaviour Change[2] to gain an understanding of how abused women pass through different stages of recognition of violence before they are able to take action to overcome it (**15**).

These theoretical perspectives provide useful insights, at least in the United States, for understanding how women perceive and cope with violence. The WHO findings underscore, however, that not all change needs to come from the survivors themselves. There are a number of institutional and cultural barriers that keep women from gaining access to help. This context to a large degree shapes women's available options (**16**). Therefore, strengthening community and social services to support abused women is a crucial step in encouraging women to seek help before the abuse becomes life-threatening.

Given that women are often most likely to disclose to informal networks, and to turn to them for help, the findings also suggest that an important intervention would be to reduce the social stigma surrounding violence, and to strengthen informal networks of friends, relatives and neighbours that women turn to for support.

Further analysis of these data will explore the patterns of disclosure, help-seeking, retaliation, and leaving in different settings, as well as factors influencing women's response to violence.

[2] The Transtheoretical Model of Behaviour Change is a theoretical model of behaviour change, which has been the basis for developing effective interventions to promote health behaviour change. The model describes how people modify a problem behaviour or acquire a positive behaviour. The central organizing construct of the model is the Stages of Change. It is a model that focuses on the decision-making of the individual, involving emotions, cognitions, and behaviour and a reliance on self-report..

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Conclusions and recommendations

“I have experienced violence too…. I did not know where I could go for help. I now know where I can go. I was looking for such places. It is good to address these type of issues in a survey. I am happy now.”

Woman interviewed in Japan

“I would like to receive the results of this research. The opportunity to participate in it made me feel very important.”

Woman interviewed in Brazil

“I learned a lot from the beginning of the training, till the end of the survey. The survey opened wounds, but I had to learn to face it and cope with it. The respondents really needed and enjoyed this experience, because they could talk to somebody. My career path changed, since the beginning of the training because I could do something which can make a difference and mean something for my country.”

Interviewer from Namibia

CHAPTER 10

Summary of findings, conclusions and areas for further research

The WHO Multi-country Study on Women's Health and Domestic Violence against Women is a research initiative that has produced data on intimate-partner violence comparable across the 10 countries in this report: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania.[1] Carried out in adherence to strict ethical, safety and quality control procedures, the Study's use of a standardized and rigorous methodology has resulted in robust data, which permit comparison between survey sites in the same country, and between countries.[2] The WHO Study is also the first to provide data from developing countries on the association between violence and health outcomes at a population level.

The following is a brief summary of the WHO Study findings and conclusions, along with an assessment of the strengths and limitations of the Study, and a discussion of future areas for research and analysis.

[1] The study has now also been completed in New Zealand.

[2] The deviations from the standard protocol and questionnaire as implemented in Ethiopia, Japan, and Serbia and Montenegro, are specified in Annex 1.

Prevalence and patterns of violence

Physical and sexual violence against women

The WHO Study shows clearly that physical and sexual violence against women is strikingly common. The aggregate figures on partner and non-partner violence indicate that, in every setting except Japan, more than a quarter of women in the study had been physically or sexually assaulted at least once since the age of 15 years. Indeed, at least half of all women in Bangladesh, Ethiopia province, Peru, Samoa, and the United Republic of Tanzania said that they had been physically or sexually assaulted since that age. In general, the vast majority of this violence was inflicted by a male intimate partner. The only exception was Samoa, where violence from other people was slightly more prevalent.

This finding illustrates the extent to which, globally, women in non-conflict settings are at greatest risk of violence from their husband or intimate partner, rather than from strangers or others known to them. The results are consistent with similar studies from industrialized countries, and challenge commonly held perceptions that the home is a place of safety or refuge for women.

Physical and sexual violence by partners

Across the WHO Study sites, the extent of physical or sexual violence, or both, by an intimate partner, reported over a lifetime, varied widely, ranging from 15% in Japan city to 71% in Ethiopia province, with prevalence estimates in most countries ranging from 30% to 60%. Likewise, although in three sites less than 10% of women reported current violence by an intimate partner, i.e. violence in the year prior to being interviewed (Serbia and Montenegro city 3%, Japan city 4%, and Brazil city 9%), more than half reported current violence in Ethiopia province, and in most sites between 20% and 33% of women reported being abused by their partner in the past year. These findings illustrate the extent to which violence is a reality in partnered women's lives, with a large proportion of women having some experience of violence during their partnership, and many having recent experiences of abuse. Although the study findings make depressing reading, the wide variation found in prevalence rates also shows that violence is not inevitable. Even in settings where partner violence is widespread, many women live in violence-free relationships.

An important focus of the WHO Study was to document the similarities and differences in the levels of violence by partners across the study sites, and to use these data to

identify individual and community factors that may contribute to this variation. The levels of violence reported in different countries differed considerably; in addition, in countries where large cities and provincial settings were both studied, the overall levels of violence by an intimate partner were consistently higher in the provincial settings, which had more rural populations, than in the urban sites. Variations in the patterns of overlap between physical and sexual violence were also found: in most sites, physical partner violence was almost always accompanied by sexual violence, but in some settings (particularly in Bangladesh, Ethiopia province, and Thailand) a considerable proportion of women experienced solely sexual violence by an intimate partner.

At the individual level, a number of similarities in the patterns of violence by partners were found. Generally, in most sites, women who were separated or divorced and women who were living with a male partner without being married reported a higher lifetime prevalence of physical or sexual violence, or both, by an intimate partner than currently married women. Likewise, although older women do experience partner violence, in most sites a larger proportion of partnered 15–24-year-olds reported having experienced violence in the past year than older women. It was also found in most sites that women with a higher educational level reported a lower lifetime prevalence of partner violence than women who had not attended school or had primary education only.

The patterns observed at the individual level have been documented in other research studies, and reflect the fact that violence often starts early in partnerships, as well as the likelihood that separated women may have left violent relationships. However, the differences in the prevalence of partner violence between and within countries are not explained by differences in age, education, or patterns of partnership formation between study sites; they are likely to reflect true differences in the patterns of violence. The explanation for this variation will be a focus of further analysis to identify factors that may put women at increased risk or that may help to protect them from violence by an intimate partner.

Emotional abuse by intimate partners and controlling behaviours

The WHO Study definition of violence by an intimate partner included not only physical and sexual violence, but also emotional abuse. This report, however, has focused mainly on physical and sexual violence. While emotional abuse is recognized as an important element of partner violence – and is often cited by women as the most hurtful form of abuse – there is little agreement on how to capture this adequately across cultures. For this reason the information on emotional abuse is considered exploratory at this stage. Further analysis is required to fully conceptualize measures of severity and frequency.

The Study found that in all sites controlling behaviour by an intimate partner was strongly associated with physical and sexual violence. In other words, male partners who inflicted physical or sexual violence, or both, were also more likely to have other forms of controlling behaviour, such as controlling a woman's access to health care, wanting to know where she is at all times, and being angry if she speaks with another man. This supports basic theories on partner violence, which highlight that power and control are motivations underlying men's violence towards their intimate partners, and that violent men use a range of strategies to exert power over and control women, including the use of different forms of violence.

Women's attitudes towards violence by an intimate partner

In addition to women's actual experience, the WHO Study investigated women's attitudes to partner violence, specifically the circumstances under which women believe it is acceptable for a man to hit or physically mistreat his wife, and their beliefs about whether and when a woman may refuse to have sex with her husband. There was wide variation in women's agreement with different reasons for acceptance of violence, and indeed with the idea that violence is ever justified. While over three quarters of women in the cities of Brazil, Japan, Namibia, and Serbia and Montenegro said no reason justified violence, less than one quarter thought so in the provincial settings of Bangladesh, Ethiopia, and Peru, and in Samoa. Acceptance of wife-beating was higher among women who had experienced abuse than among those who had not. Respondents were also asked whether they believed a woman had a right to refuse sex in a number of situations, including if: she is sick, she does not want to have sex, he is drunk, or he mistreats her. In all sites, less than 20% of women thought that women do not have the right to refuse sex under *any* of these circumstances, with the highest proportion (between 10% and 20%) being found in the provincial sites of Bangladesh, Ethiopia, Peru, and the United Republic of Tanzania, and in Samoa.

The association between the prevalence of partner violence and women's beliefs that such violence is normal or justified constitutes one of the salient findings of the WHO Study. The fact that the association is particularly marked in rural and more traditional societies reinforces the hypothesis that the status of women within society is a key factor in the prevalence of violence against them, and that addressing this is a fundamental aspect of prevention efforts.

Non-partner violence

As indicated above, the Study also asked women about their experiences of physical and sexual violence since the age of 15 years by perpetrators other than their partner. There was a large variation in the levels of non-partner violence reported, ranging from 5% of women in Ethiopia province to 65% in Samoa. In many sites, more than a fifth of respondents reported being assaulted by a non-partner. With the exception of Peru, in countries where the study was conducted both in a city and a more rural province, higher levels of non-partner violence were reported in the city than in the province. The most commonly mentioned perpetrators of physical violence were the respondent's father, and other male or female family members. In some sites, teachers were also mentioned frequently. In contrast, family members were generally less likely to be reported to have been sexually violent towards women aged over 15 years, with strangers and boyfriends being more frequently mentioned.

Sexual abuse in childhood and forced first sex

Childhood sexual abuse (i.e. sexual abuse before 15 years of age) was a relatively common experience among girls in most of the sites, although there were wide variations in reported prevalence, which ranged from 1% (Bangladesh province) to 21% (Namibia city), with a general tendency for the levels of violence to be higher in city sites than in provincial sites. Girls are at greatest risk of sexual abuse by strangers and by male family members.

A substantial minority of women reported that their first sexual intercourse was by force, ranging from less than 1% to 30%. In all sites except Ethiopia province, the younger the girl at first sexual encounter, the more likely it was that sex was forced. In more than half of the sites, over 30% of women who reported first sex before the age of 15 years said that their first sexual experience was forced.

The wide variations in prevalence of forced first intercourse are likely to represent actual differences in levels of coercion, reflecting cultural differences in women's ability to control the circumstances of their first sexual experience. At the same time, the figures may also partly reflect different social attitudes towards female sexuality and sex. In cultures such as those of Bangladesh and Ethiopia, which have strong social restrictions against women expressing a desire to have sex, women may have a higher tendency to report their first sexual experience as forced. The high levels of forced first sex in these countries are most likely the result of sexual initiation by a husband, rather than abuse by a boyfriend or stranger.

Association of violence with specific health outcomes

The WHO Study provides the first population-based data from a range of countries on the association between violence by an intimate partner and women's mental, physical and reproductive health. While the cross-sectional design does not allow for causal inferences, a powerful finding from the Study is the degree to which, across the many different study sites and populations, a current or previous experience of intimate-partner violence was significantly associated with a range of negative impacts on women's current physical, mental, sexual, and reproductive health. Even after adjusting for age, educational attainment and marital status, these associations usually remained significant. Future analysis will explore in greater depth the mechanisms by which violence affects women's health in different sites.

Physical health and injury

Having ever experienced physical or sexual violence, or both, by an intimate partner, whether moderate or severe, had significant associations with a range of physical symptoms (problems with walking, pain, memory, dizziness, and vaginal discharge) occurring in the 4 weeks preceding the interview. Women who reported violence were also significantly more likely than women who had never experienced violence to report that their general health was poor or very poor.

The association between physical or sexual violence, or both, and health status and symptoms was statistically significant in practically every site, even after controlling for age, education, and marital status. The variations between sites in the reporting of different symptoms are likely in part to reflect local idioms of distress.

Physical violence, particularly severe violence, was closely associated with injury. Although the majority of injured women reported minor injuries (bruises, abrasions, cuts, punctures, and bites), in some sites more serious injuries, such as those affecting eyes and ears, were relatively common.

Mental health

Women who had ever experienced physical or sexual violence, or both, by a partner were significantly more likely to have ever contemplated suicide than women who had never experienced abuse. Further, among all women who had ever contemplated suicide, women who had experienced violence were also significantly more likely to have attempted suicide.

Women who had ever experienced physical or sexual violence, or both, by a partner were significantly more likely to report recent symptoms of mental distress than women who had never experienced violence. The results illustrate that even past violence can be associated with recent negative mental health outcomes.

Violence during pregnancy, induced abortion and miscarriage

Among ever-pregnant women, the prevalence of physical violence by an intimate partner during a pregnancy ranged from 1% to 28%, with practically all violence being perpetrated by the father of the child. Between 23% and 49% of those abused reported being punched or kicked in the abdomen, with potentially serious consequences for the health of both the woman and the developing infant.

In most cases, the violence experienced in pregnancy was a continuation of the violence experienced previously. However, for a substantial proportion (between 13% and 52%), the violence started during the pregnancy. For the majority of women who were abused before and during a pregnancy, the violence stayed the same or was less severe. However, between 8% and 34% said that the violence got worse during the pregnancy.

In most sites, women who reported physical or sexual violence, or both, by a partner were significantly more likely to report having had at least one induced abortion or miscarriage than those who did not report violence, with the association being stronger for induced abortions than for miscarriages. These findings suggest that, across a broad range of settings, violence against women is an important factor affecting women's sexual and reproductive health.

Risk of HIV and other sexually transmitted infections

The WHO Study did not ask specific questions about HIV and other sexually transmitted infections, but explored the extent to which women knew whether or not their partner had had other sexual partners during their relationship, and whether they had ever used a condom with their current or most recent partner.

Across all sites except Ethiopia province, a woman who reported that her current or most recent intimate partner had been physically or sexually violent towards her was significantly more likely to report that she knew that her partner was or had been sexually involved with other women while being with her. In most sites, the difference ranged from at least twice as likely to up to nine times as likely.

Women were also asked whether they had ever used a condom with their partner, whether they had requested use of a condom, and whether the request had been refused. The proportion of women who had ever used a condom with a current or most recent partner varied greatly across sites. No significant difference was found in use of condoms between abused and non-abused women, with the exception of Thailand and the United Republic of Tanzania, where women in a violent relationship were more likely to have used condoms. However, in a number of sites (cities in Peru, Namibia, and the United Republic of Tanzania) women in violent partnerships were more likely than non-abused women to have asked their partner to use condoms. Women in violent partnerships in these sites, as well as in Brazil city, Peru province, and Serbia and Montenegro, were significantly more likely than non-abused women to report that their partner had refused to use a condom.

These findings, as well as the high levels of child sexual abuse, are of concern in the transmission of HIV and other sexually transmitted infections, and underline the urgent need to address this hidden but widespread abuse against women. The degree to which partner infidelity may be associated with partner violence also requires serious consideration by HIV and AIDS policy-makers and programme managers, and highlights the need for a greater integration of issues of gender, power and coercion into HIV prevention and AIDS care and treatment programming.

Women's responses and use of services

The WHO Study sought to learn more about the strategies that women use to end or cope with violence in their partnerships. There are many barriers to women accessing help from either formal or informal sources. As shown in the replies to questions on controlling behaviour, violent men often keep women isolated from potential sources of help, and women may fear that disclosure of their situation or seeking medical treatment will lead to retaliation against themselves or their children. In most study sites except in Bangladesh, the majority of women who had ever been in a physically violent partnership had told someone about the violence. It is striking to note, however, that for significant numbers of respondents (ranging from a fifth in Brazil city to two thirds in Bangladesh city), the interview was the first time that they had ever spoken about their experiences of violence to anyone.

Even fewer women reported seeking help, due to reported barriers including feelings of shame and self-blame, and stigmatizing attitudes on the part of service providers, family, and community members. Nonetheless, women were not passive, adopting a range of strategies to cope with or end the violence, including leaving their home for one or more nights, leaving their partner, retaliating, and trying to find help. These patterns of help-seeking appeared to be strongly influenced by the severity of the violence that the women experienced. Women who had suffered severe physical violence were more likely than women who had experienced solely moderate physical violence to have spoken to someone about the violence, to have left their home for one or more nights, or to have sought help.

Importance of informal networks

The findings illustrate that women mainly seek help from informal sources, such as family, friends and neighbours, although the nature of these informal sources may vary by culture. The relative ease of talking to family and friends also varies by culture and site. Even if a woman did not seek help from her immediate social networks, in some cases friends, family, or neighbours tried to help without being asked.

Qualitative research suggests that, although some forms of intervention by friends and family members may be positive, there are also many examples where the people that women turn to are either ambivalent or negative. For example, family members may condone the man's violence, or seek strategies to address the violence that prioritize the well-being of the family unit over the woman's safety.

Availability of services

The limited use of formal services in all countries partly reflects the limited availability of services in many settings. Other issues may include: costs or other barriers to women travelling; the perception that services will not be sympathetic or able to help; and women's fear of the potential consequences to their own and their children's safety if they report violence to formal agencies.

Where services are available, they are often used by women experiencing violence. Nevertheless, this varies by site. Even where services exist, many women may not be aware of them. The frequency of responses such as "nobody will believe me" or "they will not be able to help" highlights the credibility gap of many services. These attitudes underline the need for a more substantive and appropriate response by a range of services, particularly health and police, which were the most commonly used services.

Strengths and limitations of the Study

The WHO Study findings on the association between violence by an intimate partner and health outcomes largely substantiate associations reported previously. However, although the findings are extremely consistent and robust, several limitations of the Study should be mentioned.

First, the cross-sectional design does not permit proof of causality between violence by an intimate partner and health problems or other outcomes. Nevertheless, the findings give an indication of the types of association, and the extent to which different associations are found in each of the participating countries and sites. Moreover, the data meet several other standards for causality, including the strength of the association, the consistency of the association, the plausibility of the effect, and a strong "dose–response" relationship between severity of violence and its apparent effect on health. Future analysis will explore the temporality of the effect (i.e. the extent to which exposure to violence can be shown to precede the negative health outcomes), as well as causal pathways.

Second, like any study based on self-reporting, there may be recall bias on some issues, as well as cultural biases in disclosure. The WHO Study nevertheless took a number of extra measures to ensure maximum comparability, particularly in the sites that were part of the first round of the Study (with the exception of Japan). Moreover, recall bias would tend to dilute any association between violence and health outcomes, rather than overestimate the relationship. While cultural biases that affect disclosure will always remain, the methodology used in the Study considerably enhanced frequency of disclosure and quality of data.

Third, the sample was restricted to a maximum of two sites per country. This was a

deliberate decision of the WHO Study team, as it allowed for more in-depth exploration of risk and protective factors while providing representative data. Sites were chosen carefully to be representative of a highly urbanized setting (the capital or another big city) and a province with a mix of rural and urban populations.

Fourth, it is possible that the decision to select only one woman per household could introduce bias by underrepresenting women from households with more than one woman. This possibility was tested by weighting the main prevalence outcomes to compensate for differences in number of eligible women per household. The results showed that the differences in selection probability did not significantly affect the outcomes in any of the study sites.

Finally, while some qualitative data are available to support the interpretation of the quantitative findings, these data are limited. Some issues would benefit from further exploration with qualitative studies.

Despite these limitations, the WHO Study's use of a comparable and robust methodology across countries substantially reduces one of the major difficulties that has plagued earlier work on violence against women. In particular, it reduced the role that differences in sample, operational definitions (of violence, eligible women, partnership status), questions used, denominators and methods might play in explaining differences in prevalence.

Special strengths of the Study methodology include the use of rigorous interviewer training, which has been shown to contribute to disclosure (**1**). The participatory method used in the development of the protocol and the questionnaire, the involvement of women's organizations in the research teams, and the emphasis on ethical and safety concerns also contributed to the quality of the data and to the effective implementation of the Study. The methodology and, in particular, the ethical and safety procedures are increasingly being recognized as the standard for research in this field.

Another important strength of the WHO Study was its link to the policy process. This was achieved through the involvement of members of the research team in policy-making bodies on violence or violence against women. The use in each country of steering committees involving key stakeholders, also ensured a wider ownership and interest in the study results at the country level.

Areas for further analysis

This first report provides descriptive information on some of the main elements addressed by the WHO Study. However, it represents only the first stage of analysis of an extensive database which has the potential to address a range of important questions regarding violence against women. These questions are of great relevance to public health, and exploring them will substantially improve our understanding of the nature, causes and consequences of violence, and the best ways to intervene against it. Some of these are described below.

Risk profiles for partner violence

The WHO Study collected information about the timing of physical or sexual violence by an intimate partner – when it first started, when it last occurred, its frequency in the previous year, and its frequency prior to the previous year. These data can be used to compare information about the timing of different forms of violence with the timing of the start and end of the relationship or marriage. This will enable analysis of the extent to which different forms of violence occur during relationships, or after separation, and to understand how women's risk of intimate-partner violence changes over the duration of a relationship. Such information can be used to inform the design and provision of prevention and support services.

Determinants of prevalence: risk and protective factors

Future analyses will explore in more depth the determinants and outcomes of partner violence. In particular, substantial in-depth analysis will be conducted to explore the extent to which different risk and protective factors, acting at the individual, household, and community levels, contribute to or reduce women's risk of violence. Although complex, this analysis is likely to provide important insights to help guide future prevention and other public health interventions.

Logistic regression and multilevel analysis will be used to take into account potential confounding factors at individual and community levels, and will serve to identify factors that are context-specific and those that span all or most contexts. For example, future work will include an analysis of how women's socioeconomic status (not just income, but also assets, and control over her income and assets) is related to violence by an intimate partner and to women's responses to the violence.

Definitions and prevalence of emotional abuse

Because of the complexity of defining and measuring emotional abuse in a way that is relevant and meaningful across cultures, the questions regarding emotional violence and controlling behaviour in the WHO Study questionnaire should be considered as a starting point, rather than a comprehensive measure of all forms of emotional abuse. Prevalence of emotional abuse, therefore, was not included in this report as this dimension requires further analysis. Future work on the emotional dimension of intimate-partner violence will include an analysis of its overlap with the other two dimensions – physical and sexual – as well as with controlling behaviours. The data from this Study will enable identification across countries of other aspects of emotional abuse such as jealousy, humiliation or isolation.

In-depth analysis of relationship between violence and health

Another critical element for further research will be a more in-depth analysis of the association between several of the main health outcomes and different types of exposure to partner violence, adjusting for the frequency and severity of previous victimization during childhood and a wider range of potential confounding factors. The relationship between emotional abuse and different health outcomes will also be explored.

Future analysis of the WHO Study data will also explore whether the associations found between sexual abuse of girls below the age of 15 years and other outcomes in the literature hold true in the study sites, including whether early sexual abuse is associated with increased risk of re-victimization in adulthood, earlier sexual debut, early marriage, unwanted or mistimed pregnancies, suicide ideation, and number of lifetime sexual partners.

Patterns of women's responses

The literature has established that it may take many years for a woman to recognize, question, and eventually leave a violent relationship. Seeking help, retaliating, and leaving are some of the steps in this process, and a first descriptive analysis of these is presented in this report. A next step for analysis would be to look at patterns of women's responses according to severity of violence, and to explore other determinants of leaving and of help-seeking from formal services.

Other consequences of violence against women

Further analysis will be done on the impact of violence on aspects of women's lives – other than the health indicators presented in this report. Examples include women's ability to work outside the home and to control their assets. In addition, the WHO Study has collected information on how often and with what consequences children witness violence by their mother's intimate partner. Such information will be of relevance to interventions for children who witness violence in their homes.

A basis for action

The WHO Study findings confirm the pervasiveness and magnitude of violence against women in a wide range of cultural and geographical contexts, and provide information on the nature of the problem. This is an essential first step in addressing any public health problem. The uniqueness of the Study will become even more evident when the multilevel analysis of risk and protective factors is complete. This will provide valuable insight into the role of different factors in determining prevalence and help identify what is universal, and what is cultural and context-specific.

For researchers, the WHO Study is important because it provides population-based data from developing countries, links different types of violence to a broad range of health outcomes, and uses standard measures for violence and health outcomes across cultural settings. Its coverage of physical, sexual and emotional violence by an intimate partner, as well as measures of previous victimization, allow for a more in-depth understanding of what determines the health outcomes.

Most importantly, the Study provides participating countries with vital information on which to base public health interventions. By and large, these countries had little or no reliable data on the extent of the problem before the WHO Study began. With this information now available, the need for action is clear. The following chapter provides a number of practical recommendations to guide this action.

References

1. **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.

CHAPTER 11

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* (**1**), specially the detailed recommendations in Chapters 4 (Violence by intimate partners) and 6 (Sexual violence). See Box 11.1 for a list of selected WHO materials on violence and health.

The recommendations are grouped into the following categories:

- Strengthening national committment 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, national governments, in collaboration with NGOs, 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, and compliance with international agreements

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.

In line with the Millennium Development Goal 3 of promoting gender equality and empowering women, it is crucial that governments increase their efforts to raise the status of women, both in terms of awareness of their rights, and through concrete measures in fields such as employment, education, political participation, and legal rights. These rights include those related to owning and disposing of property and assets, access to divorce, and child custody following separation.

The association of more education with less violence supports the view that education is in itself protective. Therefore, programming arising from the United Nations Millennium Development Goals and "Education for All" objectives, particularly those aimed at improving women's access to education and, in particular, keeping girls enrolled through secondary education, should be strongly supported as part of overall anti-violence efforts.

National efforts to challenge the widespread tolerance and acceptance of many forms of violence against women are also important. One of the salient findings of the Study is the association between the prevalence of intimate-partner violence and women's belief that such violence is "normal" or "justified". The association is particularly marked in rural and more traditional societies, suggesting that attitudes and assumptions about the status of women, deeply ingrained in culture as well as law, are key factors contributing to high levels of violence, and therefore need to be addressed.

Considerable progress would be realized if governments complied with human rights treaties and other international consensus documents that they have already ratified. Since the 1950s, most national governments have signed and ratified a number of important international documents that condemn violence against women and promote their human rights. These include the Universal Declaration of Human Rights (1948), the Convention on the Elimination of All Forms of Discrimination against Women (1979), and the United Nations Declaration on the Elimination of Violence against Women (1993). Most countries have endorsed international commitments on development and women's human rights and health in documents such as the 1994 Programme of Action of the International Conference on Population and Development (ICPD) (**2**), the 1995 Declaration and Platform for Action of the Fourth World Conference on Women (1995 – the "Beijing Declaration") (**3**), and the 2000 Millennium Development Goals (**4**). These agreements were reiterated at the 5- and 10-year anniversaries of the respective conferences.

While some governments have made strides in harmonizing their legislation with these commitments and in instituting policies and programmes to promote them, many others have made little or no progress. Frequently the greatest obstacle is political inertia or outright opposition. It is important, therefore, that institutions, nongovernmental organizations, and civil society organizations – both domestic and international – that advocate for gender equality and human rights, or that monitor national progress towards international commitments, strengthen their efforts to bring about the necessary changes in national laws, policies and programming.

> ***"Countries should take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and children."*** (ICPD Programme of Action, paragraph 4.9).

Recommendation 2.

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

National governments are ultimately responsible for the safety and health of their citizens, and it is therefore crucial that governments commit themselves to reducing violence against women, which is a major and preventable public health problem. Violence by an intimate partner was found to be the most prevalent form of violence against women in virtually all of the countries studied, and is likely to be the main form of violence in other non-conflict settings thereby requiring special attention in plans of action to address violence. The Study findings also illustrate the degree to which intimate-partner violence puts women at increased risk of poor physical, sexual, reproductive, and mental health. In both industrialized and developing countries, the prevention of violence against women should rank high on national public health, social, and legal agendas.

National action first requires that governments publicly acknowledge that the problem exists. It is hoped that this Study, in combination with the accumulating evidence on the issue from other research, provides ample grounds for this recognition. Second, governments must make a commitment to act, and plan and implement national programmes both to avert future violence and to respond to it when it occurs. This will require that governments, where necessary supported by international agencies, invest significant resources in programmes to address violence against women.

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.

In most countries around the world, there are women's organizations that work to challenge violence against women and to provide support to women experiencing abuse. In some places,

> *Governments need to "…work actively to ratify and/or implement international human rights norms and instruments as they relate to violence against women, …, formulate and implement plans of action to eliminate violence against women,…allocate adequate resources within the government budget and mobilize community resources for activities related to the elimination of violence against women...."* (Beijing Platform for Action, paragraphs 124 e, j, and p).

there are also men's organizations working to combat violence against women. In many countries, however, the issue is not on the national agenda in a significant way. National efforts often focus initially on legal and judicial reform; less attention has been paid to violence as a risk factor for ill-health, and the potential role of the health sector. For violence to get on to the national policy and health sector agendas, it is important that the problem is brought out of the shadows, the evidence discussed openly, and commitments made to deal actively with violence against women – and particularly intimate-partner violence and sexual abuse of children – as a national priority.

Recognizing violence against women as a public health problem does not mean that the health sector can be expected to deal with it alone. As experience with other complex public health problems has shown, multisectoral action is required, with the health sector playing an important role. 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), each wielding their comparative advantages and expertise. Not all sectors will be equally able or amenable to addressing the problem, so it is important that a formal mechanism is created and provided with sufficient resources to coordinate multisectoral efforts. The form this takes (a national committee, a task force, a focal point within a key ministry, or other) will vary, but experience suggests that identification with the highest level of political office is crucial.

Recommendation 3.

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

In many settings, violence against women is trivialized, and some forms of violence are seen as an acceptable or inevitable component of social relationships. 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. In many places, women politicians may be the natural champions of anti-violence efforts, while in others, male religious, political, or business and labour authorities may play leading roles. However, the fact that violence against women is widespread and deeply ingrained suggests that 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 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.

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 (**5**). In this regard, the WHO questionnaire and the ethical and safety guidelines developed for the Study, and the WHO/PATH manual on researching violence against women (**6**), are useful tools. The *Injury surveillance guidelines,* jointly developed by WHO and CDC, are also useful tools for collecting systematic data on injuries, including those relating to intimate-partner violence (**7**). It is of prime importance for national statistics offices and relevant ministries (such as ministries of health and justice) to take this issue on board. Organizations that provide services for abused women should also increase their capacity for routine data collection and surveillance of violence against women, and for monitoring the attitudes and beliefs that perpetuate the practice. Priority must be given to building capacity, and to ensure that data are collected in a way that respects confidentiality and does not jeopardize women's safety (**5**).

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 therefore 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 male partner violence against women as normal and prevent it being challenged or talked about.

As the Study results indicate, there is great variation between and within countries in attitudes, beliefs, and values related to partner violence. For this reason, the specific media and key messages chosen will vary from place to place, and should be based on research and consultation. In formulating key messages for campaigns aimed at changing social norms, an important objective is to eliminate the barriers that prevent women talking about the problem and using available support services. This means not only increasing the accessibility of such services, but also reducing the stigma, shame, and denial around partner violence. These messages can also play a role in 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 that encourage men who are not violent to speak out against violence and challenge its acceptability will help counter notions that all men condone violence. They also serve to provide alternative role models of masculine behaviour to those commonly portrayed by the media.

Public health experience shows that general public awareness campaigns may have little effect by themselves, and must be accompanied by focused outreach and structural change. More targeted efforts should be carried out in health settings, in schools, at workplaces and places of worship, and within different professions and sectors. More awareness will also serve to strengthen advocacy efforts, and to shape budgets and policies on violence against women.

As well as mass communication strategies, other options 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. In particular, communities need to be encouraged to talk about partner violence and its implications, and to challenge its acceptability. Local religious congregations, cultural groups and economic associations (such as associations of market women) may provide the basis for support activities and for advocacy with government authorities.[1] Overall there is a need to strengthen the primary prevention efforts to complement the current emphasis on victim services.

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.

Greater public awareness of child sexual abuse is necessary; yet promoting such awareness may be extremely difficult because of the sensitivity of the subject. Advocacy by leaders and other respected figures could make a big difference. As with HIV and other stigmatized issues, leadership at the highest level can help "break the silence" and create social space for discussion of the problem within families and communities (see recommendation 3).

As part of a coordinated response, the health and education sectors need to develop the capacity to identify and deal with child sexual abuse. Health workers need training to recognize the behavioural and clinical symptoms of such abuse, and protocols should be developed on what to do if they suspect a child is being abused. Training and resources are also necessary for health care systems to provide physical and psychological care to girls (and boys) who have experienced sexual abuse.

Similarly, teachers and other education professionals need training to recognize the symptoms, 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 into existing programmes such as 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. Current emphasis on HIV prevention, and initiatives such as the Global

[1] 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/

[2]The Global Coalition on Women and AIDS is a worldwide network working together to catalyse changes to make the AIDS response work better for women (see http://womenandaids.unaids.org).

Coalition on Women and AIDS,[2] provide opportunities to strengthen efforts to combat violence against women. This should be seen as a component of effective HIV and AIDS prevention programmes. HIV prevention programmes should therefore include activities to raise awareness and promote the prevention of sexual violence as well as intimate-partner violence. Programmes that aim to improve communication about sex and to promote abstinence, fewer partners and condom use, in particular, need to recognize the extent to which sexual activity is forced or coerced, and explicitly address issues of genuine, freely-given consent and coercion. The unacceptability of violence against women should be integrated and addressed within HIV prevention efforts at all levels, from national AIDS committees to local community groups, and in HIV-related media and educational activities. Strategies to respond to women who are experiencing or who fear violence and who are attending HIV counselling and testing services, and women-oriented health programmes, such as prevention of mother-to-child transmission of HIV and other sexually transmitted infections, or family planning, need to be developed. Other sexual and reproductive health programmes, as well as those focused on 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.

The Study finding that violence by strangers is generally more prevalent in cities than in rural settings suggests that measures to make the urban environment safer for women can contribute to primary prevention of this violence. It is also important to identify such measures in rural areas where women may be at risk of violence as they carry out household survival tasks such as fetching water and firewood for cooking. Such measures should be implemented systematically, first by identifying places where violence against women often occurs and then by analysing why it occurs there.

Depending on the risk factors identified and the available resources, safety can be enhanced through a variety of concrete measures. These include improving lighting and, in urban areas, 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.

The finding that young women and girls experience significant levels of violence indicates that 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.

Schools must be places of safety for girls and young women. The Study's finding on the extent of violence by teachers revealed variations among the participating countries. However there is room for improvement in action to eradicate physical and sexual violence by teachers against students, in virtually all countries and schools. In some cases an effective response to violence by teachers requires fundamental changes within the education sector, to change traditional patterns of behaviour, condemn abuse and establish a culture in which violence is not condoned or tolerated, and perpetrators of violence are punished. International initiatives, such as the Focusing Resources on Effective School Health (FRESH) initiated by UNESCO, UNICEF, WHO, the World Bank, Education International, Education Development Center, and the Partnership for Child Development can provide frameworks for action to meet this objective.

For example, schools using the FRESH framework would influence violence through their policies, environment and curricula. School policies can prohibit the use of violence as a form of punishment. They can also prohibit physical violence and harassment by and between teachers and students. Enforcement of such policies should be monitored. Skills-based education, such as life skills supported by WHO, UNICEF and UNESCO 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 consent. They should enable boys and girls to develop relationship and conflict resolution skills, and to identify strategies to reduce the occurrence of violence.

To be effective, programmes should begin early, involve both girls and boys (although probably using different information and key messages, and with a balance of single-sex and mixed-sex discussions), and apply age-appropriate learning experiences throughout children's school careers. 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.

Developing a comprehensive health sector response to the various impacts of violence against women is of critical importance and action by specific health care services is also needed. In particular, it is important to address the demonstrated reluctance of abused women to seek help.

The Study clearly shows that, in all countries, violence against women is significantly associated with a range of poor health outcomes. It is not only a significant risk factor through its direct impact on health (namely, injury and mortality), but contributes to the overall burden of disease through its impact on women's reproductive, sexual, physical, and mental health. This has serious implications for the health sector, as many health providers see and treat (knowingly or not) millions of women living in violent relationships.

The health sector – not just public health but all providers of health services – needs to develop a comprehensive response to the problem. At the planning level, this will require health officials to identify the sector's particular strengths in the wider multisectoral response. In some places, the health sector may take the lead role in advocating for prevention; in others it may leave that role to other sectors while concentrating on establishing or enhancing services for women who have experienced violence. 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/AIDS-related services).

The Study findings clearly demonstrate the strong association between a woman's experience of violence and mental distress, including her risk of suicide. 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 with 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 will need to coordinate and work with other sectors, particularly the police, social services and the voluntary sector. This should not be done on an ad hoc basis, but will require the creation of formal referral procedures and protocols.

The Study amply shows that most abused women are reluctant to seek help from health providers, and tend to do so only if the violence is severe. This suggests that, 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) confidentiality and their security will be ensured. The Study findings highlight the extent to which the attitudes of health staff are likely to influence whether women feel comfortable about disclosing violence or not. Training is a critical element in improving the health service response to violence against women. It 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 the potential of reproductive health services as entry points for identifying women in abusive relationships, and for delivering referral and support services.

The widespread availability and use of reproductive health services (including antenatal care, family planning services, 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. This conclusion is reinforced by Study results showing that (a) severe physical violence during pregnancy is not uncommon, threatening both the mother and the unborn child, and (b) there are significant associations between physical and sexual violence by partners, and miscarriage and induced abortion, as well as with high parity and HIV risk. Providers of reproductive health services therefore may

be more likely than other health providers to see abused women. Moreover, 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 care providers should be sensitized and trained to recognize and respond to violence particularly during and after pregnancy. 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, as a minimum staff should be aware of the problem and should provide information about legal and counselling options as well as supportive messages emphasizing that such violence is wrong, that women are not to blame for it and that it is a widespread problem. 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.

Whatever care is offered, reproductive health services should be places of safety and confidentiality for women.

Supporting women living with violence

Recommendation 12.

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

Only a minority of women in the Study sought help and support from formal support 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, many women had little 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. Such models should build 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. If the involvement of these people can be secured, efforts should be made to train and orient them and their 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 (e.g. the fact that a woman may need support over a long period of time before she is able to make a definitive change to her situation).

The Study findings show that, in all settings, abused women are most likely to seek help from informal networks of friends, relatives and neighbours. This suggests the value of strengthening these informal networks 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.

The Study showed that, as with health services, many women in violent partnerships do not seek help from courts for the violence. This suggests that 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 of the perpetrator (e.g. suggesting that the woman is somehow at fault), or by disbelieving or denigrating complainants (e.g. by suggesting that women were in fact consenting to forced sex). Ideally there should be support for women bringing complaints: keeping them informed of the progress of cases, the requirements of their participation, that their safety as witnesses is protected, and that there is a comprehensive approach to assist them generally. Furthermore, those convicted need to be appropriately punished.

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, for example, orders a man to stay away from a partner who has experienced violence, is necessary to ensure that women's safety is paramount. The potential for intimidation by a male partner must be addressed, and sentencing should be adapted to the specific circumstances in which the woman lives and her own wishes. 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.

While the prevalence and patterns of violence are becoming better known in some places – in part through this Study – in others few data are available. More research on the magnitude of the problem of violence against women, and its costs, in given countries or settings is therefore urgently needed in order to provide a basis for advocacy and action. At the same time, because violence against women is clearly related to culturally rooted attitudes and beliefs, more research needs to 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, and should be supported.

To date, little research has been done on the male attitudes and beliefs that contribute to partner violence. This needs to be remedied 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 aimed at informing 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. In this regard, the WHO *Handbook for the documentation of interpersonal violence prevention programmes* (**8**) 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 into 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. In addition, there is substantial scope for integrating prevention and responses to violence against women into existing health and development programmes, including HIV prevention, adolescent health, and sexual and reproductive health initiatives.

Donors and international organizations need to support the efforts of academic institutions,

research bodies and governments to carry out research on this issue and foster increased collaboration across countries and regions. This increased collaboration and information exchange on successful and promising interventions between the different sectors, countries, and regions will help to build a stronger body of knowledge to inform action in this area.

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 living in violent situations or who have suffered any form of violence.

Box 11.1 Selected WHO materials related to violence and health

- Krug EG et al., eds. *World report on violence and health.* Geneva, World Health Organization, 2002 (http://whqlibdoc.who.int/hq/2002/924154561 5.pdf, accessed 2 September 2005).
- *Addressing violence against women and achieving the Millenium Development Goals.* Geneva, World Health Organization, 2005.
- *Clinical management of survivors of rape: a guide to the development of protocols for use in refugee and internally displaced person situations.* Geneva, World Health Organization/Office of the United Nations High Commissioner for Refugees, 2002 (WHO/RHR/02.08; http://whqlibdoc.who.int/hq/2002/WHO_RHR_02.08.pdf, accessed 2 September 2005).
- Ellsberg MC, Heise L. *Researching violence against women: a practical guide for researchers and activists.* Washington, DC, PATH/Geneva, World Health Organization, in press.
- *Guidelines for medico-legal care of victims of sexual violence.* Geneva, World Health Organization, 2003 (http://whqlibdoc.who.int/publications/2004/924154628X.pdf, accessed 2 September 2005).
- *Intimate partner violence and HIV/AIDS.* Geneva, World Health Organization, 2004 (Critical Intersections Information Bulletin Series, No. 1; http://whqlibdoc.who.int/unaids/2004/a85591.pdf, accessed 2 September 2005).
- *Preventing violence: a guide to implementing the recommendations of the World report on violence and health.* Geneva, World Health Organization, 2004 (http://whqlibdoc.who.int/publications/2004/9241592079.pdf, accessed 2 September 2005).
- *Putting women first: ethical and safety guidelines for research on domestic violence against women.* Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.1; http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.1.pdf, accessed 2 September 2005).
- Sethi D et al. *Handbook for the documentation of interpersonal violence prevention programmes.* Geneva, World Health Organization, 2004 (http://whqlibdoc.who.int/publications/2004/9241546395.pdf, accessed 2 September 2005).
- *Violence against women and HIV/AIDS: setting the research agenda.* Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.08; http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.08.pdf, accessed 2 September 2005).

For further information, please visit the web sites of the following WHO departments:

- Gender, Women and Health (http://www.who.int/gender/)
- Injuries and Violence Prevention (http://www.who.int/violence_injury_prevention/).

References

1. **Krug EG et al.,** eds. *World report on violence and health.* Geneva, World Health Organization, 2002. See, in particular, Chapter 4, Heise L, Garcia-Moreno C. Violence by intimate partners; and Chapter 6, Jewkes R, Sen P, Garcia-Moreno C. Sexual violence.
2. *International Conference on Population and Development, Cairo, Egypt, 5–13 September 1994.* New York, NY, United Nations, 1994 (document A/CONF.171/13).
3. *Fourth World Conference on Women, Beijing, China, 4–15 September 1995.* New York, NY, United Nations, 1995 (document A/CONF.177/20).
4. *United Nations Millennium Declaration.* General Assembly Resolution, 55th session, document A/RES/55/2, Chapter III, number 11, September 2000.
5. *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.* New York, Division for the Advancement of Women, 2005 (www.un.org/womenwatch/daw/egm/vaw-stat-2005).
6. **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.
7. **Holder Y et al.,** eds. *Injury surveillance guidelines.* Atlanta, GA, Centers for Disease Control and Prevention, and Geneva, World Health Organization, 2001.
8. **WHO.** *Handbook for the documentation of interpersonal violence prevention programmes.* Geneva, World Health Organization, 2004.

Annexes

“I am glad to narrate here that during the training I have gained various skills and experience which enriched my in-depth understanding. I feel I am wearing spectacles that are making me see and understand women’s rights.”

Interviewer from Tanzania

“I am so pleased that you have talked to me. I feel relieved more than anything since I have told you about my situation.”

Woman interviewed in Ethiopia

“My participation in the survey helped me to know myself better and to understand what it was happening to me. I realized that the person, whom I trusted the most and because of whom I left behind my “old way” of life, abused me. At first I didn’t want to believe it. The contents of the training showed me that slaps and kicks are not love. Something serious was happening to me.”

Interviewer from Serbia and Montenegro

ANNEX 1

Methodology

Subjects covered in this section:

- Ensuring comparability across sites and sampling strategies
- Enhancing data quality
- Interviewer selection and training
- Respondents’ satisfaction with interview
- Data processing and analysis
- Characteristics of respondents
- Representativeness of the sample

Ensuring comparability across sites and sampling strategies

One of the major objectives – and the greatest challenge – of the WHO Study was to maintain cross-setting comparability, by ensuring that the same issues and concepts were explored and analysed in the same way in each participating country.

The following steps were taken to ensure that, during each phase of the Study, joint ownership and cross-site comparability were maintained:

- The core research team took central responsibility for the study design, and coordinated and documented revisions to the questionnaire and study procedures.
- Annual meetings were held with the country research teams to finalize the questionnaire, survey methods and initial analysis, to share experiences and lessons learned, and to troubleshoot and provide technical support.
- Sampling strategies – aimed at ensuring that the sample was self-weighting with respect to the household – were reviewed by a member of the core research team (see Box A1.1).
- Core research team members visited each country during the inception phase, interviewer training, pilot-testing phases and, in some instances, data cleaning phases of the Study.
- A standardized question-by-question description of the questionnaire was used to inform the questionnaire translation, and during the interviewer training.
- All questionnaires were back-translated, and pretested in each language.
- Detailed training manuals for facilitators, supervisors, interviewers and data processors ensured the standardization of the training, quality of supervision, and implementation of the study procedures.
- Standard quality-control measures were implemented during fieldwork in all countries, including checking the questionnaire on site, regular debriefings and support to the interviewers.
- Standardized data entry systems and database structures were used in all countries, and core syntaxes were developed for data analysis.

Enhancing data quality

Various mechanisms were used in each country to ensure and monitor the quality of the survey implementation. These mechanisms included:

- use of a detailed standardized training package (see Box A1.2 for list of materials);
- clear explanations of the requirements and conditions of employment to each interviewer and supervisor, with the option to dismiss staff who were not performing adequately or who had negative attitudes towards the topic of the Study;
- compilation of details of eligible members of each household during the survey, so that possible sampling biases could be explored by comparing the sample interviewed with the distribution of eligible respondents;
- close supervision of each interviewer during fieldwork, including having the supervisor observe the beginning of a proportion of the interviews;

Box A1.1 Sampling strategies adopted in the various sites in the WHO Multi-country Study on Women's Health and Domestic Violence against Women

Country/site	Sampling frame	First (and second) sampling stage	Selection of households: second (or third) stage
Bangladesh – Dhaka municipality	Enumeration areas (EAs, *mohollas*) as defined by census bureau (1991). Average 100 households per EA.	40 EAs randomly selected, adding preceding and subsequent EA to index EA to get average 300 households per cluster.	Every sixth household selected in cluster, starting from randomly selected point in cluster probability proportionate to size (PPS): total 2105 households (40% oversampling).
Bangladesh – Matlab	142 villages (10 973 households) in 5 areas. Average 300 households (range 17–1860) per village.	42 clusters (villages) randomly selected.	Appr. 20% of households randomly selected in every village (PPS) from up-to-date list (ICDDR,B database): total 1946 households (30% oversampling).
Brazil – São Paulo	Probability matrix of 263 clusters prepared by Federal Bureau of Statistics (1995 data). Range 100–750 households per cluster.	72 clusters systematically selected (PPS) from an ordered list based on literacy rate of heads of households.	30 households randomly selected from list of households in each cluster: total 2163 households (40% oversampling).
Brazil – Pernambuco	All 42 villages and towns in the rural area of the State of Pernambuco.	15 villages/towns systematically selected (PPS) from an ordered list by geographic density, urbanization rate and literacy of head of household. In each selected village/town 8 clusters randomly selected.	18 households systematically selected in each cluster: total 2136 households (40% oversampling).
Ethiopia – Butajira Rural Health Program (BRHP)	Study sites of BRHP in Meskan and Mareko district (one of the 11 districts in Gurage Zone; 257 500 population). The district consists of *kebele*. The 10 study *kebele* (9 rural and 1 semi-urban) are used by BRHP for surveillance.	The 10 study *kebele* stratified into urban and rural.	Simple random sample from list of eligible women in the 10 study *kebeles*, adapted to select only one woman per household (designed to include 15% from urban and 85% from rural *kebeles*); total 3200 women.
Japan – Yokohama	All 24 954 survey units in 18 districts in whole city of Yokohama (population 3 420 700). Average 50 households per survey unit.	127 clusters (survey units) randomly selected with probability equal to proportion of women aged 18–49 years per district, systematically selected from geographically ordered list.	On average 19 (range 17–20) women (18–49 years old) systematically selected in each survey unit from list of female residents; total 2400 women (60% oversampling).
Namibia – Windhoek	All 503 enumeration areas in whole city (appr. 200 000 inhabitants). Average 120 households per EA (cluster).	143 clusters systematically selected (PPS) from a list, ordered geographically and according to socioeconomic status.	15 households randomly selected in each cluster from a list; total 2025 households (35% oversampling).
Peru – Lima	Appr. 12 000 clusters in the whole city, determined by National Statistical Institute (INEI). Average 100 households per cluster.	166 clusters systematically selected with PPS from list ordered according to socioeconomic status.	12 households per cluster systematically selected from list of households; total 1992 households (30% oversampling).

Box A1.1 Sampling strategies adopted in the various sites in the WHO Multi-country Study on Women's Health and Domestic Violence against Women *(continued)*

Country/site	Sampling frame	First (and second) sampling stage	Selection of households: second (or third) stage
Peru – Department of Cusco	All clusters in each of the two strata: Cusco town and rest of department of Cusco (excluding one inaccessible district, Echarata); each proportionally represented. Average 100–200 households per cluster.	Cusco town: 46 clusters selected with PPS. Rest of the department: 3 provinces selected with PPS from list ordered on proportion of urbanization. In each province 22 clusters selected with PPS.	Cusco town: 12 households selected systematically from list of households per cluster (total 552 households). Rest of the department: for urban clusters 23 households selected from list of households per cluster. In rural clusters a *centro poblado* randomly selected and 23 households visited from a random starting point (total 1518 households). In whole department total 2070 households (40% oversampling).
Samoa	All villages in the country divided into 355 blocks of appr. 60 households each (based on listing of the Department of Statistics).	133 clusters (blocks) randomly selected (simple random sample).	15 households systematically selected from listing of heads of household per cluster; total 1995 households (30% oversampling).
Serbia and Montenegro	Appr. 2000 continuous urban electorate blocks in Belgrade (11 municipalities, 1.3 million people). Average 200 households (range 20–50) per block.	203 clusters (blocks) selected with PPS from geographically ordered list.	In each cluster one address was randomly selected from a list after which every fourth door in a predetermined direction was knocked on until 10 households with eligible women were identified.
Thailand – Bangkok	14 030 census blocks.	80 clusters (census blocks) selected with PPS.	35 households systematically selected per cluster; total 2800 households (85% oversampling).
Thailand – Nakhonsawan	15 districts, with total 1601 census blocks. Average 150 households per block.	3 of 15 districts selected with PPS; in these districts 60 clusters (census blocks) selected with PPS after rural/urban stratification.	35 households systematically selected per cluster from list of households ordered by size; total 2100 households (40% oversampling).
United Republic of Tanzania – Dar es Salaam	City of Dar es Salaam (3 000 000 inhabitants) consisting of 3 districts, subdivided in 10 divisions, 73 wards (5000–100 000 population), streets/ villages (5000–40 000 population), and *wajumbe* (10–50 households).	22 wards (clusters) selected with PPS from list of wards, ordered by district and division. In each ward 2 streets selected randomly. In the 2 selected streets combined, 20 *wajumbe* systematically selected from a list of all *wajumbe* (total 440 *wajumbe*).	In each of the *wajumbe,* 5 households randomly selected from a list of heads of households prepared in the field (100 households per ward); total 2200 households (50% oversampling).
United Republic of Tanzania – Mbeya	Two districts (Mbeya Urban and Rural) (appr. 517 000 population) of total 6 districts in the province. These 2 districts consist of 5 divisions, 53 wards and below these 36 streets (Mbeya Urban) and 16 villages (Mbeya Rural). Villages consist of *vitongoji* (30–100 households each).	22 wards (clusters) selected with PPS from list of 53 wards ordered by district and division. Mbeya Urban: in each ward, 2 streets selected and, within these, 20 *wajumbe* as above. Mbeya Rural: in each ward 2 villages selected and within these 20 *vitongoji*.	In each of the *wajumbe* and *vitongoji,* 5 households randomly selected from a list of heads of households prepared in the field (100 households per ward): total 2200 households (50% oversampling).

- random checks of some households by the supervisor, without warning, during which respondents were interviewed by the supervisor using a brief questionnaire to verify that the respondent had been selected in accordance with the established procedure and to assess the respondent's perceptions of the initial interview;
- continuous monitoring of each interviewer and each team, using performance indicators such as response rate, number of completed interviews, and rate of identification of physical violence;
- having a questionnaire editor in each team review each completed questionnaire to identify inconsistencies and skipped questions, thus enabling any gaps or errors to be identified and corrected before the team moved on to another cluster;
- a second level of questionnaire editing upon arrival of the questionnaire in the central office, carried out by "office editors";
- extensive checking of validity, consistency and range, conducted at the time of data entry by the check program incorporated in the data entry system (EpiInfo6), and double entry of all data followed by validation of double entry (EpiData) and correction of computer-identified errors.

Box A1.2 WHO materials for those interested in doing research on violence against women

WHO can provide a wide range of documents and other materials that it has developed for the Study; some of this material is available on CD ROM or from our web site at www.who.int/gender

- Study protocol (available in English and Spanish)
- Ethical and safety guidelines for doing research on violence against women (available in English, French and Spanish)
- Study questionnaire (available in a number of languages)
- Manual with question-by-question explanation of the questionnaire
- Guidelines for facilitators and slide show, in particular for training on gender and violence issues
- Manuals for interviewers, supervisors and field editors
- Example of a "dummy questionnaire" (to change subject when interviewer is interrupted)
- Example of quality control questionnaire (for supervisors)
- Manual for data processor
- Data entry program (EpiInfo6 and EpiData) with interactive consistency and error checking
- Code book with all variables and values and their labels
- Data analysis recode and syntax files for standardized analysis in SPSS
- Ellsberg M, Heise L. *Researching violence against women: a practical guide for researchers and activists.* PATH/WHO, 2005

Interviewer selection and training

International research indicates that women's willingness to disclose violence is influenced by a variety of interviewer characteristics, including sex, age, marital status, attitudes, and interpersonal skills (**1**–**3**). The WHO Study used female interviewers and supervisors, and accorded paramount importance to their careful selection and appropriate training. Unfortunately, for logistic reasons it was not possible to provide comprehensive training to the interviewers in Japan and to some of the interviewers who joined the study late in Serbia and Montenegro (Box A1.3).

The criteria for selecting interviewers included ability to engage with people of different backgrounds in an empathetic and non-judgemental manner, emotional maturity, skills at building rapport, and ability to deal with sensitive issues. Standards regarding age and background of interviewers were determined by setting. Given the complexity of the questionnaire, the interviewers were required to have above primary-level education. In all countries, more potential interviewers and supervisors were recruited for training than the Study required. This enabled the country research team to maintain some flexibility, and have the option not to hire all of the interviewers. The final selection of interviewers was made during or after the training.

The previous experiences of the members of the WHO core research team and of the International Research Network on Violence Against Women (IRNVAW) had highlighted the need for interviewers working on domestic violence to receive additional training and support over and above that normally provided to survey research staff. For this reason, the WHO core research team developed a standardized 3-week training course for interviewers, for use in all settings (see Box A1.4). The course materials included a timetable and outline for training and a set of accompanying manuals: a training facilitator's manual; a manual with a question-by-question explanation of the questionnaire; and specific procedural manuals

Box A1.3 Changes in protocol or questionnaire in Japan, Ethiopia, and Serbia and Montenegro

Japan

In Japan, the study team made a number of accommodations to address specific concerns about privacy and to conform to Japanese research conventions.

Use of a professional survey company. Surveys in Japan are traditionally implemented by professional survey firms rather than independent researchers. In keeping with this norm, the Japanese team contracted with a well known Japanese survey firm, the *Chuo Chousa Sha* (Central Research Services) to assist in sampling and to conduct the interviews.

Abbreviated training for interviewers. The team used 25 professional female interviewers – each with more than 10 years of experience – selected from *Chuo Chousa Sha's* pool of experienced fieldworkers. Interviewers received one day of training, which covered: background of the study and violence issues; importance of confidentiality; and safety and ethical issues. The training included an explanation of all the study materials, as well as role plays. A Japanese training manual, covering the subjects dealt with during the training and including a list of support services, was given to all interviewers.

Questionnaire layout. The Japanese questionnaire followed a different numbering system and layout, as required by the survey company conducting the study (the corresponding WHO question number was given in brackets).

Partial use of self-administered questions and response booklet. Securing privacy was exceptionally difficult because of the crowded housing conditions in Yokohama. In fact, most of the pilot interviews had to be conducted in the respondents' doorway. In order to adhere to the spirit of the WHO protocol, which emphasized absolute privacy, the team augmented the face-to-face interview with a self-administered pencil-and-paper format for questions containing subject matter or words that they did not want overheard by the respondent's household members or passers-by.[1,2] Thus, for certain questions, the interviewer handed to the respondent a self-administered questionnaire, for immediate completion. For other questions, the interviewer showed the respondent a booklet in which the applicable questions or response categories were printed, which allowed the interviewer to ask the respondent "What about this?" while pointing to a question.

Data processing. As the data entry and coding systems were different in Japan, the database had to be recoded to be compatible with the standard database structure used in the other countries.

Ethiopia

Questionnaire. The study in Ethiopia also used the Amharic version of the Composite International Diagnostic Interview (CIDI Version 2.1, sections C, D, E, and K) to ask about mental symptoms, and the International Classification of Disease (ICD-10) algorithms to screen for specific mental illnesses. The CIDI questionnaire had previously been validated and used extensively by the mental health group in Butajira. A combined domestic violence and mental health questionnaire was finally used in the field for data collection. The main adaptations were that questions 202 to 208, 211 and 212 of the WHO Study questionnaire were deleted, while the CIDI questions were asked at the end of section 2. For the comparative analysis, several CIDI variables for general health and suicide were recoded into the equivalent WHO variables to enable cross-country comparison.

Serbia and Montenegro

Training of interviewers. In Serbia and Montenegro, an original cadre of 13 interviewers was recruited and received the full training course recommended by WHO. Midway through the fieldwork, the Serbian team recruited an additional group of professional interviewers from a survey firm because the study was falling behind schedule. These 21 professional interviewers received only one day of training rather than the 2.5 weeks received by the original 13 interviewers.

Questionnaire. Because of limited resources, sections 4 (children) and 10 (financial autonomy) were omitted from the questionnaire used in Serbia and Montenegro.[3]

1 These included questions about experience of violence by intimate partners and about the woman's children or spouse, and her experience with or opinions about sex.
2 The respondents in the pretests also voiced their strong preference for the self-administration method, which is commonly used in Japan, where the literacy rate is high.
3 Serbia and Montenegro is the only country in this report that used version 10 of the questionnaire, which asked questions on injuries and coping not only for physical violence but also for sexual violence by an intimate partner. The analysis presented here, however, deals only with physical violence, to allow cross-country comparison.

for interviewers, supervisors, field editors, and data processors.

The training was conducted in each country by the country research team, assisted – in all countries except Japan – by a member of the WHO core research team. Certain sessions, as needed, were conducted by local or national psychologists, representatives of advocacy groups, and census experts.

Box A1.4 WHO Multi-country Study on Women's Health and Domestic Violence against Women: goals of interviewer training

The goals of training were to enable interviewers to:

- be sensitive to gender issues at a personal as well as a community level;
- develop a basic understanding of gender-based violence, its characteristics, causes, and impact on the health of women and children;
- understand the goals of the WHO Study;
- learn skills for interviewing, taking into account safety and ethical guidelines for research on domestic violence;
- become familiar with the questionnaire, protocol, and field procedures of the Study.

Interviewers were trained to reinforce the respondent's own coping strategies and to remind her that the information she had shared was important and would help other women.

"I would tell a woman who lived with violence that she should have faith and courage to keep going on, to fight for her children if she had any, and if not, to have the courage to face things..." (interviewer from Peru).

Training and support continued through regular meetings and debriefings during the fieldwork. In addition to technical meetings to evaluate progress with data collection and other logistic aspects of the survey, emotional debriefing sessions were held to provide interviewers with an opportunity to discuss their own feelings about the interviews. The sessions were conducted by the country research teams and, in some cases, by professional counsellors, in recognition of the range and complexity of feelings that can arise when conducting fieldwork on this issue.

"Sometimes I had a big problem not to hug the woman who was crying during the interview. It was not so easy to overcome and to stay calm in the presence of those women who have suffered for years without any help from outside" (interviewer from Serbia and Montenegro).

In most countries, opportunities for individual counselling were also provided if needed. Given the potentially distressing nature of research on violence, and the memories that it may awaken among field staff, the country teams found these sessions to be essential for maintaining the morale and emotional well-being of staff during fieldwork.

A final evaluation was held in most sites at the conclusion of fieldwork. Many interviewers felt that the training and field experiences had opened their eyes to the realities of women's lives and the types of violence that women face, and had been a transforming experience. As a result, many have gone on to become involved in anti-violence work.

"I grew a lot emotionally. I am much more secure and mature as a person. It gives me a sense of pride to have been part of the study. I feel we can give the Government hard facts and statistics to create better services for women" (interviewer from Namibia).

"After having lived an experience like this study, we will never be the same, not only because of what we heard but also because of what we learned as recipients of many life stories, each one of them with different levels and degrees of violence" (interviewer from Peru).

"I feel that through this training I am now wearing spectacles that are making me see and understand women's rights" (interviewer from United Republic of Tanzania).

The critical importance placed on the careful selection and intensive training of interviewers contributed substantially to the reliability of the findings by enhancing disclosure as well as minimizing risks to respondents and interviewers (**1**). This conclusion is supported by the experience in Serbia and Montenegro, where 21 additional professional interviewers joined the fieldwork halfway through. Because of time constraints, these 21 interviewers received only one day of orientation rather than the full 2.5-week training programme. It was found that interviewers who followed the full training programme achieved significantly higher response rates, more disclosure of violence, shorter interview duration, and higher respondent satisfaction than those who had less training (**1**). This experience suggests that failure to provide special training and support to interviewers could undermine the safety of interviewers and respondents, and compromise data quality.

Respondents' satisfaction with interview

It is commonly perceived that women do not want to be asked about their experiences of violence. To explore this issue, towards the end of the interview all respondents were asked the following question: "I have asked you about many difficult things. How has talking about these things made you feel?" (Question 1203). The answers were written down verbatim and coded by the interviewers in one of the following three categories: good/better; same; bad/worse (Table A1.1).

In general, even respondents who had disclosed physical or sexual violence, or both, by an intimate partner found participating in the Study to be a positive experience: except in the city sites of Japan and Serbia and Montenegro, the majority (60–97%) of women who had experienced physical or sexual violence, or both, by a partner reported that they felt good/better at the end of the interview. In Japan and Serbia and Montenegro, these percentages were much lower (6% and 38%, respectively), although not much different from those of respondents not reporting violence in these sites.

Very few respondents reported feeling bad/worse after being interviewed: between 0% and 8% of women reporting partner violence and between 0% and 3% of women with no history of partner violence. When this sentiment was felt, the reason was usually because the woman had found it difficult to revisit or to talk about painful events.

Table A1.1 Impact of the interview on respondents, by whether respondent had reported physical or sexual violence, or both, by an intimate partner, by site

		Percentage distribution according to feeling at end of interview			
Site	**Experience of violence**	Good/better (%)	Same (%)	Bad/worse (%)	
Bangladesh city	Never experienced violence	95.6	3.8	0.6	
	Ever experienced violence	97.0	2.5	0.5	
Bangladesh province	Never experienced violence	96.3	2.6	1.2	
	Ever experienced violence	95.6	3.7	0.7	
Brazil city	Never experienced violence	75.7	22.8	1.5	
	Ever experienced violence	73.5	20.6	5.9	***
Brazil province	Never experienced violence	90.3	8.7	1.1	
	Ever experienced violence	91.3	8.0	0.7	
Ethiopia province	Never experienced violence	95.6	2.4	2.0	
	Ever experienced violence	98.0	1.6	4.0	***
Japan city	Never experienced violence	3.3	94.2	2.5	
	Ever experienced violence	6.1	90.8	3.1	
Namibia city	Never experienced violence	85.6	13.4	1.0	
	Ever experienced violence	85.5	10.0	4.5	***
Peru city	Never experienced violence	73.8	23.0	3.2	
	Ever experienced violence	82.1	10.1	7.8	***
Peru province	Never experienced violence	81.9	15.0	3.2	
	Ever experienced violence	80.4	11.2	8.4	***
Samoa	Never experienced violence	98.9	1.1	0.0	
	Ever experienced violence	98.6	1.4	0.0	
Serbia and Montenegro city	Never experienced violence	41.5	57.7	0.8	
	Ever experienced violence	38.4	55.9	5.7	***
Thailand city	Never experienced violence	42.5	56.8	0.6	
	Ever experienced violence	59.8	39.8	0.5	***
Thailand province	Never experienced violence	51.8	48.2	0.0	
	Ever experienced violence	60.8	38.6	0.6	***
United Republic of Tanzania city	Never experienced violence	73.4	25.5	1.1	
	Ever experienced violence	75.3	23.2	1.5	
United Republic of Tanzania province	Never experienced violence	94.0	5.4	0.5	
	Ever experienced violence	94.9	4.6	0.6	

Asterisks denote the significance level of the difference: * $P < 0.05$, ** $P < 0.01$, *** $P < 0.001$, **** $P < 0.0001$ (Pearson chi-square test).

"I was reminded of my experience of being sexually mistreated in the past, which I had forgotten about" (woman interviewed in Japan).

"I felt comfortable although the questions are painful. I did my best to survive the experience of violence. Women should support and protect each other. Problems of family violence should be discussed much more in our society" (woman interviewed in Serbia and Montenegro).

In about half of the sites, women reporting partner violence had similar levels of satisfaction with the interview to those of women who did not report violence. Where they differed, the patterns were not consistent. In Peru city and Thailand, women who had experienced partner violence were more likely to report feeling better after the interview than those who did not report violence, whereas in Brazil city, Namibia city, Peru province, and Serbia and Montenegro city, women who reported violence were more likely to report feeling worse. In Ethiopia province the results were mixed (**1**).

Data processing and analysis

The data processing and data entry procedures were rigorously standardized across countries. They were developed centrally and supervised in each country by a member of the core research team.

Although some of the questions or answer options differed between countries, a standardized approach to coding was adopted. The data entry program was adapted for use in each country, and every single country adaptation was centrally documented and monitored in a master code book. This helped ensure that the data in each country were essentially entered in the same way, and that decisions about coding were implemented universally.

Each site was responsible for the entry, cleaning and preliminary analysis of the data. The core research team provided assistance where necessary.

At country level, the data were analysed using SPSS. The core research team developed recode and analysis syntax files centrally to ensure that the initial analysis was done in a standardized way. Univariate exploratory and descriptive analyses of the women's questionnaire were performed separately for the city site and the province within each country. The dependent and independent variables were described, and were used to obtain crude prevalence estimates. In Brazil and Japan, additional analysis was done using Stata.

The clean databases were centrally aggregated in one large database that was used for the analyses presented in this report. All analyses for this report were done using SPSS, except for the analyses of the effect of survey design on prevalence of violence, and of the associations between violence and mental health scores, which were done using Stata.

Characteristics of respondents

The age, partnership status and educational characteristics of all respondents who completed the interview and of all ever-partnered respondents (the main focus of this study), are shown by site in Tables A1.2–A1.4.

Age

As would be expected from the demographic profile of each site, there were generally fewer respondents in the older age groups than in the middle age groups (Table A1.2). In Ethiopia province, where life expectancy is relatively low, almost one in four respondents were in the youngest age group (15–19 years). In contrast, in the cities in Japan and in Serbia and Montenegro, as well as in Thailand province, there were as many or more women in the older groups than in the younger groups. In the cities in Japan and in Serbia and Montenegro, this is a result of high life expectancy and low fertility. In Thailand province, it is probably attributable to the migration of young women from the rural areas to work in urban areas.

Important differences in age distribution are seen in the ever-partnered women as compared to all respondents; the youngest age group is in many cases the smallest, as a large proportion of women aged 15–19 years have not yet been partnered. In Samoa and Thailand city, the group of 20–24-year-olds among the partnered women is also relatively small, because many in this age group are not yet partnered. Where women tend to get partners relatively young, such as in Bangladesh and the United Republic of Tanzania, the age distribution of partnered women more closely resembles that of all women, in particular from age 20 years onwards.

Partnership status

Taking into account that the definition of ever-partnered differs among sites (see Chapter 2),

Table A1.2 Age distribution of respondents

(a) All respondents

Site	Age group (years) 15–19 (%)	20–24 (%)	25–29 (%)	30–34 (%)	35–39 (%)	40–44 (%)	45–49 (%)	Total no. of respondents
Bangladesh city	15.9	20.8	22.0	17.5	10.4	8.2	5.1	1602
Bangladesh province	16.1	17.3	18.6	17.3	13.8	9.8	7.1	1527
Brazil city	13.4	14.8	17.2	14.6	16.3	13.5	10.2	1172
Brazil province	17.1	16.0	20.0	14.6	13.9	10.7	7.6	1472
Ethiopia province	23.3	14.2	15.1	16.9	11.7	12.1	6.8	3016
Japan city	3.2[a]	10.4	15.0	19.6	19.1	15.9	16.8[b]	1371
Namibia city	10.7	17.9	20.1	18.1	15.8	10.5	7.0	1500
Peru city	16.8	16.3	15.8	17.5	13.2	10.5	10.0	1414
Peru province	13.9	15.9	18.1	16.7	15.6	10.0	9.9	1837
Samoa	14.2	17.4	19.0	15.5	16.0	10.4	7.5	1640
Serbia and Montenegro city	8.5	16.7	15.6	14.0	14.0	14.9	16.3	1453
Thailand city	12.3	14.3	14.4	19.7	15.2	14.2	9.8	1535
Thailand province	11.9	10.9	11.6	14.7	18.5	15.9	16.5	1281
United Republic of Tanzania city	19.7	21.3	20.3	13.2	10.5	8.9	6.2	1811
United Republic of Tanzania province	17.1	20.1	23.6	14.6	11.4	8.3	5.0	1441

[a] 18–19 years.
[b] Includes 10 women who had turned 50 years of age between the time of selection and the time of interview.

(b) All ever-partnered respondents

Site	Age group (years) 15–19 (%)	20–24 (%)	25–29 (%)	30–34 (%)	35–39 (%)	40–44 (%)	45–49 (%)	Total no. of ever-partnered women
Bangladesh city	8.6	19.7	23.9	20.3	12.1	9.5	6.0	1372
Bangladesh province	8.2	16.0	20.8	19.8	15.8	11.3	8.2	1329
Brazil city	6.2	13.8	18.4	15.1	18.9	15.7	11.8	940
Brazil province	7.5	15.0	21.6	17.1	16.8	13.0	9.1	1187
Ethiopia province	4.1	13.6	19.1	22.6	15.6	16.1	9.0	2261
Japan city	2.2[a]	9.0	14.3	20.5	19.8	16.6	17.6[b]	1287
Namibia city	5.9	17.5	21.1	19.4	17.2	11.3	7.6	1373
Peru city	5.2	13.9	17.2	21.2	16.2	13.2	13.0	1090
Peru province	4.4	13.9	20.4	19.3	18.4	11.9	11.7	1536
Samoa	2.1	13.0	20.7	19.7	20.7	13.8	10.0	1206
Serbia and Montenegro city	2.9	13.9	14.6	15.5	16.3	17.3	19.4	1194
Thailand city	2.7	9.2	15.0	24.6	18.6	17.4	12.5	1051
Thailand province	2.8	8.3	13.0	17.0	21.7	18.1	19.1	1027
United Republic of Tanzania city	8.8	20.9	23.0	15.9	12.8	11.0	7.6	1450
United Republic of Tanzania province	8.6	20.8	25.9	16.5	13.0	9.5	5.6	1257

[a] 18–19 years.
[b] Includes 10 women who had turned 50 years of age between the time of selection and the time of interview.

Table A1.3 shows that Thailand city has the highest proportion of never-partnered women (32%), followed by Samoa (27%), and Ethiopia province (25%). The sites with the lowest proportion of never-partnered women were the city sites in Japan, Namibia, and Serbia and Montenegro.

In most sites, a greater proportion of ever-partnered women were currently married than had any other partnership status (cohabiting or previously partnered), except in Brazil province where an equal proportion were currently living with a man without being married and in Namibia city where an equal proportion reported having a regular sexual partner, living apart. In Bangladesh, it was not culturally appropriate to ask about cohabitation; any couple living as such would have reported being married. In Japan city only 1% of ever-partnered women reported cohabiting (without being married), and in Ethiopia province no one reported cohabiting. The proportion of ever-partnered women currently dating (i.e. regular partner, living apart) varied from 1% in Ethiopia province to 32% in Namibia city. In Bangladesh and Samoa, women with regular

Table A1.3 Current partnership status of respondents

(a) All respondents

Site	Never partnered (%)	Currently married (%)	Living with man, not married (%)	Regular partner, living apart (%)	Currently no partner, divorced or separated (%)	Currently no partner, widowed (%)	Total no. of respondents
Bangladesh city	14.3	80.0	n.a.	n.a.	2.6	3.1	1603
Bangladesh province	13.0	82.9	n.a.	n.a.	1.3	2.8	1527
Brazil city	19.8	41.8	16.3	13.1	7.8	1.1	1172
Brazil province	19.3	33.5	32.5	6.3	6.4	1.9	1473
Ethiopia province	25.0	65.6	0.0	0.5	3.2	5.6	3016
Japan city	6.1	69.2	0.9	11.2	12.6[a]	0.0	1371
Namibia city	8.5	28.3	19.2	29.5	12.7[a]	1.8	1500
Peru city	22.9	34.0	21.6	9.2	11.3[a]	0.9	1413
Peru province	16.4	42.0	29.8	2.3	7.3[a]	2.2	1837
Samoa	26.5	53.2	14.9	n.a.	4.5	1.0	1640
Serbia and Montenegro city	9.2	52.0	4.8	17.6	15.3	1.0	1451
Thailand city	31.5	51.8	7.6	2.5	5.7	0.8	1535
Thailand province	19.9	64.6	7.3	1.4	4.4	2.3	1282
United Republic of Tanzania city	19.9	45.6	13.9	14.5	3.8	2.3	1815
United Republic of Tanzania province	12.8	48.1	24.2	5.3	4.2	5.3	1441

n.a., not available. For cultural reasons, this option was not included in answer to the question.
[a] Includes women who had a past regular sexual partner without living together.

(b) All ever-partnered respondents

Site	Currently married (%)	Living with man, not married (%)	Regular partner, living apart (%)	Currently no partner, divorced or separated (%)	Currently no partner, widowed (%)	Total no. of ever-partnered women
Bangladesh city	93.4	n.a.	n.a.	3.0	3.6	1373
Bangladesh province	95.3	n.a.	n.a.	1.5	3.2	1329
Brazil city	52.1	20.3	16.4	9.8	1.4	940
Brazil province	41.6	40.3	7.8	7.9	2.4	1188
Ethiopia province	87.5	0.0	0.6	4.3	7.5	2261
Japan city	73.7	0.9	11.9	13.4[a]	0.0	1287
Namibia city	31.0	21.0	32.3	13.8[a]	2.0	1373
Peru city	44.2	28.0	11.9	14.7[a]	1.2	1089
Peru province	50.3	35.6	2.7	8.8[a]	2.6	1536
Samoa	72.3	20.3	n.a.	6.1	1.3	1206
Serbia and Montenegro city	63.2	5.9	21.4	8.2	1.3	1194
Thailand city	75.6	11.1	3.7	8.3	1.2	1051
Thailand province	80.6	9.2	1.8	5.6	2.9	1027
United Republic of Tanzania city	57.0	17.3	18.1	4.7	2.8	1453
United Republic of Tanzania province	55.2	27.8	6.1	4.9	6.1	1256

n.a., not available. For cultural reasons, this option was not included in answer to the question.
[a] Includes women who had a past regular sexual partner without living together.

partners living apart (dating) were, according to the partnership definition for these sites, not considered ever-partnered.

The proportion of formerly partnered, currently divorced, or separated women was usually less than 10% of the ever-partnered, although it was higher in Japan city, Namibia city, and Peru city. In the city sites in Namibia and Peru, women had often had multiple consecutive partners, with whom they had never lived, and who were the fathers of their children.

Education

As would be expected, there were large variations in the educational levels within and between countries (see Table A1.4). In the site in Ethiopia, three quarters of respondents had not attended school. In Bangladesh province, 37% of respondents had not attended school, while in Bangladesh city the proportion was half this size: 18%. A similar difference was seen between the two sites in the United Republic of Tanzania (the

Table A1.4 Educational level of respondents

(a) All respondents

Site	No education (%)	Primary education (%)	Secondary education (%)	Higher education (%)	Total no. of respondents
Bangladesh city	17.9	18.2	47.3	16.6	1599
Bangladesh province	36.7	29.7	32.1	1.5	1517
Brazil city	2.0	42.6	34.4	21.0	1172
Brazil province	8.1	65.2	22.3	4.4	1473
Ethiopia province	76.3	20.2	2.3	1.2	2841
Japan city	0.0	0.0	37.1	62.9	1370
Namibia city	3.9	17.3	62.0	16.7	1499
Peru city	0.6	11.5	45.0	42.8	1414
Peru province	10.7	44.7	28.1	16.4	1837
Samoa	0.4	11.7	80.9	7.0	1640
Serbia and Montenegro city	0.0	2.8	45.9	51.3	1453
Thailand city	1.6	33.3	32.7	32.4	1535
Thailand province	3.8	59.5	23.4	13.3	1280
United Republic of Tanzania city	12.0	62.6	22.7	2.7	1816
United Republic of Tanzania province	22.0	68.9	8.9	0.2	1443

(b) All ever-partnered respondents

Site	No education (%)	Primary education (%)	Secondary education (%)	Higher education (%)	Total no. of ever-partnered women
Bangladesh city	20.1	19.5	45.1	15.3	1369
Bangladesh province	40.9	31.8	25.9	1.4	1319
Brazil city	2.6	46.3	31.1	20.0	941
Brazil province	9.8	65.2	20.5	4.5	1188
Ethiopia province	84.8	12.9	1.4	0.9	2093
Japan city	0.0	0.0	38.8	61.2	1145
Namibia city	4.1	18.0	59.7	18.1	1264
Peru city	0.9	14.2	41.6	43.3	1022
Peru province	12.9	50.4	22.1	14.6	1499
Samoa	0.4	14.1	79.9	5.6	1206
Serbia and Montenegro city	0.0	1.8	46.1	52.1	1194
Thailand city	2.0	42.4	31.6	24.0	1051
Thailand province	4.5	68.9	15.7	10.9	1025
United Republic of Tanzania city	13.1	63.7	20.2	3.1	1453
United Republic of Tanzania province	24.3	67.9	7.6	0.2	1257

proportion who had never attended school was 22% in the province and 12% in the city). In Peru province, 11% had not attended school, whereas in Peru city less than 1% had not attended school.

In contrast, in the cities in Japan and Serbia and Montenegro, all respondents had received at least secondary-level schooling, with more than half of them having had higher education. Bangladesh city is interesting in that it has both a high level of illiteracy and an equal proportion of women who had higher education. Overall, the distribution of educational level among ever-partnered women was very similar to that for all respondents, for all sites.

Representativeness of the sample

Sampling bias

Two approaches were taken to evaluate whether the women interviewed (the respondents) were representative of the population of women aged 15–49 years in the study location. First, for each site, the median age and age distribution of the women who completed the interview were compared with those of all eligible women in the households selected (derived from the details collected using the household selection form, which requested a list of female members of the household). This comparison is shown in Table A1.5 a,b. Second, where possible the median

age and age distribution of all eligible women in the household were compared with other population data on the overall age distribution of women in the same area, as shown in Table A1.5 c. For each site, the median age and the age distribution of women in these three groups (respondents, eligible women, and total female population) were compared. Figure A1.1 a–o gives for each site a detailed breakdown by age group for these three groups and Figure A1.2 presents the comparison of median ages for these groups by site. These comparisons show that the age distribution of eligible women in the households more closely matches the age distribution of the female population according to official sources, than the age distribution of respondents. In all sites, the median age of the respondents was slightly greater (by 1 or 2 years) than that of all eligible women, with the youngest age group (15–19 years) being slightly underrepresented, and women in the middle age groups (25–40 years), being slightly over-represented. This may result from the sampling strategy used in the study, where, for safety reasons, only one woman per household was interviewed. As a result of this strategy, women in households with fewer eligible women were likely to be overrepresented because of their higher probability of being selected. This in turn is likely to have affected the age distribution of respondents, as households with women in the middle age groups were likely to have on average fewer eligible women in the same household (daughters still too young and mother too old), while in households with an adolescent woman it was more likely there were also others who were eligible (her siblings, her mother).

The extent to which the sample design (effect of cluster sampling and of differences in probability of selection of individuals) affects the measurement of partner violence is explored in Box 4.1 in Chapter 4.

Participation bias

As well as possible bias created by the sampling strategy in terms of who is selected and who not (as discussed above), bias can also be created by the refusal of a proportion of the selected women to participate. This is of particular importance in a study of violence against women, since women who are living in a situation of violence might be more reluctant to participate in a study. It may also be possible that a woman who has a violent partner is less easily found, for example if she has temporarily left the house. For this reason the Study used an extended operational definition of household, which included as eligible women not only women who ordinarily lived in the household, but also women visitors who had stayed in the household for at least the 4 weeks preceding the interview (although they did not regularly live in the household), and domestic workers who slept at least 5 nights a week in the household. Furthermore, interviewers were trained to use a number of strategies to keep refusals to a minimum, such as multiple return visits to households if a chosen respondent was not found at home.

If there was an effect of participation bias, it can be expected to be low, since in all sites except Japan the individual response rate was high. However, it is possible to determine whether participation bias is related to age distribution. To do this in each site the median age of respondents was compared with the median age of women who were selected but who refused to participate, or who did not complete the interview (Figure A1.3 and Table A1.6). No systematic bias in either direction was found across sites in terms of median age. While the effect of this on violence cannot be assessed, because of the stigma attached to violence, as well as the potential absence of abused women, any participation bias is likely to result in an underestimation of the prevalence of partner and non-partner violence (**2**, **3**).

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Table A1.5 Age distribution of respondents, eligible women and female population, by site

(a) Age distribution of all respondents who completed the interview

	Age group (years)															
	15–19		20–24		25–29		30–34		35–39		40–44		45–49		Total no. of respondents	Age (years)	
Site	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)		Median	Mean
Bangladesh city	255	15.9	334	20.8	352	22.0	281	17.5	167	10.4	131	8.2	82	5.1	1602	27	28.5
Bangladesh province	246	16.1	264	17.3	284	18.6	264	17.3	210	13.8	150	9.8	109	7.1	1527	29	29.6
Brazil city	157	13.4	174	14.8	201	17.2	171	14.6	191	16.3	158	13.5	120	10.2	1172	31	31.4
Brazil province	252	17.1	236	16.0	294	20.0	215	14.6	205	13.9	158	10.7	112	7.6	1472	29	29.7
Ethiopia province	703	23.3	427	14.2	455	15.1	511	16.9	352	11.7	364	12.1	204	6.8	3016	28	28.7
Japan city	44[a]	3.2	142	10.4	205	15.0	269	19.6	262	19.1	218	15.9	231[b]	16.8	1371	35	34.8
Namibia city	160	10.7	268	17.9	302	20.1	271	18.1	237	15.8	157	10.5	105	7.0	1500	30	30.5
Peru city	237	16.8	230	16.3	224	15.8	247	17.5	186	13.2	148	10.5	142	10.0	1414	30	30.2
Peru province	255	13.9	293	15.9	332	18.1	306	16.7	287	15.6	183	10.0	181	9.9	1837	30	30.6
Samoa	233	14.2	285	17.4	312	19.0	254	15.5	262	16.0	171	10.4	123	7.5	1640	29	30.1
Serbia and Montenegro city	123	8.5	242	16.7	226	15.6	204	14.0	204	14.0	217	14.9	237	16.3	1453	32	32.9
Thailand city	189	12.3	220	14.3	221	14.4	302	19.7	234	15.2	218	14.2	151	9.8	1535	32	31.6
Thailand province	153	11.9	140	10.9	148	11.6	188	14.7	237	18.5	204	15.9	211	16.5	1281	35	33.5
United Republic of Tanzania city	356	19.7	385	21.3	367	20.3	239	13.2	190	10.5	161	8.9	113	6.2	1811	27	28.2
United Republic of Tanzania province	247	17.1	289	20.1	340	23.6	210	14.6	164	11.4	119	8.3	72	5.0	1441	27	28.3
Total	**3566**	**14.8**	**3929**	**16.3**	**4263**	**17.7**	**3932**	**16.3**	**3388**	**14.1**	**2757**	**11.5**	**1962**	**8.2**	**24072**	**30**	**30.4**

[a] 18–19 years.
[b] Includes 10 women who had turned 50 years of age between the time of selection and the time of interview.

Table A1.5 Age distribution of respondents, eligible women and female population, by site *(continued)*

(b) Age distribution of all eligible women in households in the sample

	Age group (years)														Total no. of eligible women	Age (years)	
	15–19		20–24		25–29		30–34		35–39		40–44		45–49				
Site	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)		Median	Mean
Bangladesh city	611	22.6	544	20.1	489	18.1	389	14.4	274	10.1	227	8.4	168	6.2	2702	26	27.7
Bangladesh province	543	23.0	434	18.4	363	15.3	327	13.8	269	11.4	242	10.2	187	7.9	2365	27	28.5
Brazil city	311	16.9	289	15.7	281	15.3	243	13.2	265	14.4	248	13.5	204	11.1	1841	30	30.8
Brazil province	464	21.5	365	16.9	350	16.2	274	12.7	274	12.7	230	10.7	200	9.3	2157	28	29.3
Ethiopia province[a]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Japan city[a]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Namibia city	395	14.4	540	19.7	569	20.8	426	15.6	376	13.7	247	9.0	185	6.8	2738	28	29.4
Peru city	559	19.6	561	19.6	447	15.7	397	13.9	320	11.2	286	10.0	285	10.0	2855	28	29.3
Peru province	573	21.2	469	17.3	407	15.0	361	13.3	366	13.5	272	10.0	261	9.6	2709	28	29.3
Samoa	672	20.6	614	18.8	562	17.2	455	14.0	406	12.5	316	9.7	236	7.2	3261	28	28.7
Serbia and Montenegro city	272	12.3	431	19.4	330	14.9	253	11.4	247	11.1	305	13.7	382	17.2	2220	31	32.0
Thailand city	427	13.8	507	16.4	453	14.6	561	18.1	441	14.2	402	13.0	309	10.0	3100	30	30.9
Thailand province	302	15.7	239	12.4	220	11.5	256	13.3	327	17.0	291	15.2	285	14.8	1920	33	32.3
United Republic of Tanzania city	972	26.2	817	22.0	644	17.3	419	11.3	335	9.0	314	8.4	216	5.8	3717	25	27.0
United Republic of Tanzania province	488	22.8	424	19.8	413	19.3	275	12.8	223	10.4	175	8.2	145	6.8	2143	26	27.8
Total	**6589**	**19.5**	**6234**	**18.5**	**5528**	**16.4**	**4636**	**13.7**	**4123**	**12.2**	**3555**	**10.5**	**3063**	**9.1**	**33728**	**28**	**29.3**

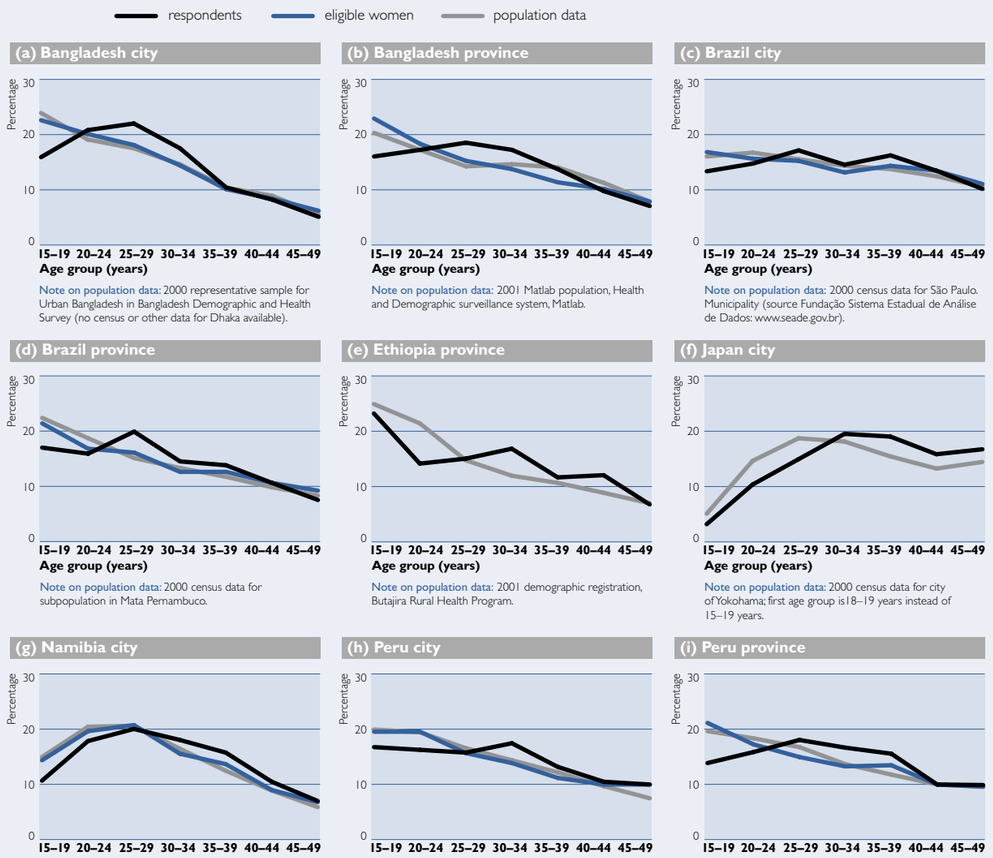
n.a., not available.
[a] In Japan and Ethiopia the women were sampled directly; thus no information is available on household composition.

(c) Age distribution of female population, according to official statistics

	Age group (years)														Total no. of women	Age (years)	
	15–19		20–24		25–29		30–34		35–39		40–44		45–49				
Site	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)		Median	Mean
Bangladesh city[a]	648	23.9	517	19.1	474	17.5	396	14.6	280	10.4	242	8.9	150	5.5	2707	27.0	27.9
Bangladesh province[b]	11682	20.4	9867	17.3	8166	14.3	8393	14.7	8053	14.1	6465	11.3	4537	7.9	57162	29.3	29.5
Brazil city[c]	505821	16.1	527291	16.8	487908	15.6	453688	14.5	433351	13.8	391778	12.5	332814	10.6	3132651	30.5	30.7
Brazil province[d]	71355	22.5	59651	18.8	48065	15.2	42477	13.4	37528	11.8	31296	9.9	26509	8.4	316881	27.9	28.8
Ethiopia province[e]	2861	25.0	2465	21.5	1697	14.8	1378	12.0	1231	10.7	1025	8.9	808	7.0	11465	26.2	27.9
Japan city[f]	39384	5.1	114000	14.7	145790	18.8	141259	18.2	120601	15.5	103377	13.3	112519	14.5	776930	33.2	33.2
Namibia city[g]	10942	15.0	14964	20.5	15138	20.7	12017	16.5	9136	12.5	6483	8.9	4290	5.9	72970	28.5	29.1
Peru city[h]	374320	20.0	364589	19.5	310423	16.6	268492	14.4	228565	12.2	181272	9.7	139362	7.5	1867023	28.1	28.9
Peru province[i]	6284	19.7	5880	18.4	5349	16.8	4385	13.7	3782	11.8	3177	10.0	3059	9.6	31916	28.8	29.4
Samoa[j]	6732	19.9	6287	18.6	5713	16.9	5007	14.8	4227	12.5	3295	9.7	2543	7.5	33804	28.7	29.0
Serbia and Montenegro city[k]	49658	12.3	56153	13.9	57939	14.4	54409	13.5	53416	13.3	58900	14.6	72318	18.0	402793	33.5	32.9
Thailand city[l]	279087	12.4	403044	18.0	390070	17.4	358456	16.0	318451	14.2	279401	12.5	214206	9.6	2242715	30.7	30.9
Thailand province[m]	42425	13.9	38642	12.6	40775	13.3	48871	16.0	50699	16.6	45982	15.0	38274	12.5	305668	33.2	32.2
United Republic of Tanzania city[n]	160266	21.6	182156	24.5	150635	20.3	102376	13.8	67723	9.1	47330	6.4	32077	4.3	742563	26.0	27.0
United Republic of Tanzania province[o]	33420	24.0	30964	22.3	24880	17.9	17906	12.9	13383	9.6	10499	7.5	8024	5.8	139076	26.0	27.4
Total	**1594885**	**15.7**	**181647**	**17.9**	**1693022**	**16.7**	**1519510**	**15.0**	**1350426**	**13.3**	**1170521**	**11.5**	**991490**	**9.8**	**1013632**	**29.8**	**30.3**

[a] 2000 representative sample for Urban Bangladesh in Bangladesh Demographic and Health Survey (no census or other data for Dhaka available).
[b] 2001 Matlab population, Health and Demographic surveillance system, Matlab.
[c] 2000 census data for São Paulo Municipality (source Fundação Sistema Estadual de Análise de Dados: www.seade.gov.br).
[d] 2000 census data for subpopulation in Mata Pernambuco.
[e] 2001 Demographic registration, Butajira Rural Health Program.
[f] 2000 census data for city of Yokohama; first age group is 18–19 years instead of 15–19 years.
[g] 2001 census data for Windhoek city.
[h] 1993 census data for Metropolitan Lima.
[i] 1993 census data for Cusco City, Anta, Canas and Espinar (the selected provinces).
[j] 2001census data for Samoa.
[k] 2002 census data for Belgrade.
[l] 2000 census data for Bangkok.
[m] 2000 census data for Nakhonsawan.
[n] 2002 census data for the three selected districts of Dar es Salaam.
[o] 2002 census data for the two selected districts: Mbeya urban and Mbeya rural.

Figure A1.1 Age distribution of respondents, of all eligible women in households in the sample, and of the female population aged 15–49 years, by site



Note on population data: 2000 representative sample for Urban Bangladesh in Bangladesh Demographic and Health Survey (no census or other data for Dhaka available).

Note on population data: 2001 Matlab population, Health and Demographic surveillance system, Matlab.

Note on population data: 2000 census data for São Paulo. Municipality (source Fundação Sistema Estadual de Análise de Dados: www.seade.gov.br).

Note on population data: 2000 census data for subpopulation in Mata Pernambuco.

Note on population data: 2001 demographic registration, Butajira Rural Health Program.

Note on population data: 2000 census data for city of Yokohama; first age group is 18–19 years instead of 15–19 years.

Note on population data: 2001 census data for Windhoek city.

Note on population data: 1993 census data for Metropolitan Lima.

Note on population data: 1993 census data for Cusco City, Anta, Canas and Espinar (the selected provinces).

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Note on population data: 2002 census data for Belgrade.

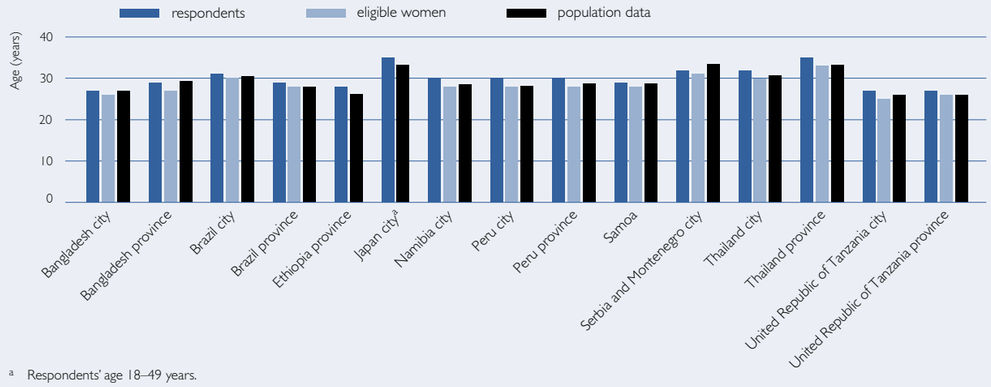
Note on population data: 2000 census data for Bangkok.

Note on population data: 2000 census data for Nakhonsawan.

Note on population data: 2002 census data for the three selected districts of Dar es Salaam.

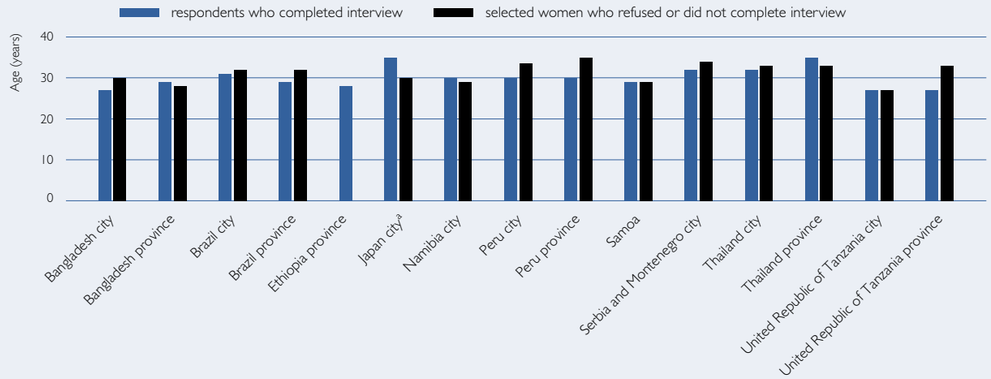
Note on population data: 2002 census data for the two selected districts: Mbeya urban and Mbeya rural.

Figure A1.2 Median age of respondents, of all eligible women in households in the sample, and of the female population aged 15–49 years, by site



[a] Respondents' age 18–49 years.

Figure A1.3 Median age of respondents who completed the questionnaire and of eligible women who were selected but who refused to participate, were absent or did not complete the interview, by site



[a] Respondents' age 18–49 years.

Table A1.6 Median age of respondents who completed the questionnaire and of women who were selected but refused to participate, were absent or did not complete the interview, by site

	Women who completed interview[a]		Women who did not complete interview	
Site	Number	Median age (years)	Number	Median age (years)
Bangladesh city	1602	27	67	30
Bangladesh province	1525	29	65	28
Brazil city	1171	31	145	32
Brazil province	1472	29	67	32
Ethiopia province	3016	28	n.a.	n.a.
Japan city	1371	35	1029	30
Namibia city	1498	30	29	29
Peru city	1411	30	138	33.5
Peru province	1836	30	69	35
Samoa	1637	29	5	29
Serbia and Montenegro city	1453	32	213	34
Thailand city	1535	32	264	33
Thailand province	1282	35	83	33
United Republic of Tanzania city	1812	27	84	27
United Republic of Tanzania province	1442	27	118	33

n.a., not available.

[a] Numbers differ slightly from those in Table A1.2(b) because data were taken from household selection forms rather than individual interview forms. Where the age of the selected woman was given incorrectly or was missing that individual was omitted from this analysis.

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ANNEX 4 Questionnaire

WHO Multi-country Study on Women's Health and Life Events

QUESTIONNAIRE (Version 9.9) [1]

[1] Version 9.9 was used in all countries in this report except in Serbia and Montenegro where version 10 was used. Version 10 incorporates a number of improvements based on extensive experience with and feedback on Version 9. It also contains a few new questions which enable measurement of associations between partner violence and HIV/AIDS risk.

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

Survey on women's health and life events in STUDY LOCATION

ADMINISTRATION FORM
HOUSEHOLD SELECTION FORM
HOUSEHOLD QUESTIONNAIRE

Study conducted by NAME OF INSTITUTION(S)

Confidential upon completion

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

ADMINISTRATION FORM

IDENTIFICATION

COUNTRY CODE (*provided*)	____
LOCATION (CAPITAL = 1, PROVINCE = 2)	[ ]
WARD/VILLAGE	[ ][ ][ ]
CLUSTER NUMBER	[ ][ ][ ]
HOUSEHOLD NUMBER	[ ][ ]
NAME OF HOUSEHOLD HEAD	

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY [ ][ ] MONTH [ ][ ] YEAR [ ][ ][ ][ ]
INTERVIEWER'S NAME	_____	_____	_____	INTERVIEWER [ ][ ]
RESULT***	_____	_____	_____	RESULT [ ][ ]
NEXT VISIT: DATE	_____	_____		TOTAL NUMBER OF VISITS [ ]
TIME	_____	_____		
LOCATION	_____	_____		
QUESTIONNAIRES COMPLETED? [ ] 1. None completed ⇒	*** RESULT CODES Refused (specify): _____ _____...11 Dwelling vacant or address not a dwelling12 Dwelling destroyed.....13 Dwelling not found, not accessible.....14 Entire hh absent for extended period .....15 No hh member at home at time of visit ....**16** Hh respondent postponed interview.....**17**	 ⇒ **Need to return** ⇒ **Need to return**		TOTAL IN HOUSEHOLD (HH FORM, Q1) [ ][ ] TOTAL ELIGIBLE WOMEN (HH FORM, Q3, total with YES) [ ][ ] LINE NUMBER OF SELECTED FEMALE RESPONDENT (HH FORM, Q3) [ ][ ]
[ ] 2. Household questionnaire only ⇒	Selected woman refused (specify): ____ _____...21 No eligible woman in household .....22 Selected woman not at home .....**23** Selected woman postponed interview .....**24** Selected woman incapacitated.....25	 ⇒ **Need to return** ⇒ **Need to return**		
[ ] 3. Women's questionnaire partly ⇒	Does not want to continue (specify) : ___ _____...31 Rest of interview postponed to next visit .**32**	 ⇒ **Need to return**		
[ ] 4. Women's questionnaire completed ⇒	41			

LANGUAGE OF QUESTIONNAIRE (*code provided)*	[ ][ ]
LANGUAGE INTERVIEW CONDUCTED IN *(codes provided)*	[ ][ ]
QUALITY CONTROL INTERVIEW CONDUCTED (1 = yes, 2 = no)	[ ]

FIELD SUPERVISOR	QUESTIONNAIRE CHECKED BY	OFFICE EDITOR	ENTERED BY
NAME [ ][ ]	NAME [ ][ ]	NAME [ ][ ]	ENTRY 1: _____
DAY [ ][ ]	DAY [ ][ ]		
MONTH [ ][ ]	MONTH [ ][ ]		ENTRY 2: _____
YEAR [ ][ ][ ][ ]	YEAR [ ][ ][ ][ ]		

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

HOUSEHOLD SELECTION FORM

Hello, my name is _____ . I am calling on behalf of CENTRE FOR SURVEY RESEARCH. We are conducting a survey in STUDY LOCATION to learn about women's health and life experiences.

1	Please can you tell me how many people live here, and share food? PROBE: Does this include children (including infants) living here? Does it include any other people who may not be members of your family, such as domestic servants, lodgers or friends who live here and share food? MAKE SURE THESE PEOPLE ARE INCLUDED IN THE TOTAL	TOTAL NUMBER OF PEOPLE IN HOUSEHOLD [ ][ ]
2	Is the head of the household male or female?	MALE ..... 1 FEMALE ..... 2 BOTH 3

	FEMALE HOUSEHOLD MEMBERS	RELATIONSHIP TO HEAD OF HH	RESIDENCE	AGE	ELIGIBLE
3 LINE NUM-BER	Today we would like to talk to one woman from your household. To enable me to identify whom I should talk to, would you please give me the first names of all girls or women who usually live in your household (and share food).	What is the relationship of NAME to the head of the household.* (USE CODES BELOW)	Does NAME usually live here? CHECK SPECIAL CASES. SEE (A) BELOW. YES NO	How old is NAME? (YEARS, more or less)	SEE CRITERIA BELOW (A+B) YES NO
1			1 2		1 2
2			1 2		1 2
3			1 2		1 2
4			1 2		1 2
5			1 2		1 2
6			1 2		1 2
7			1 2		1 2
8			1 2		1 2
9			1 2		1 2
10			1 2		1 2

CODES

01 HEAD	06 MOTHER	12 DOMESTIC SERVANT
02 WIFE (PARTNER)	07 MOTHER-IN-LAW	13 LODGER
03 DAUGHTER	08 SISTER	14 FRIEND
04 DAUGHTER-IN-LAW	09 SISTER-IN-LAW	98 OTHER NOT RELATIVE:
05 GRANDDAUGHTER	10 OTHER RELATIVE	_____
	11 ADOPTED/FOSTER/STEP DAUGHTER	

(A) SPECIAL CASES TO BE CONSIDERED MEMBER OF HOUSEHOLD:

- DOMESTIC SERVANTS IF THEY SLEEP 5 NIGHTS A WEEK OR MORE IN THE HOUSEHOLD.
- VISITORS IF THEY HAVE SLEPT IN THE HOUSEHOLD FOR THE PAST 4 WEEKS.

(B) ELIGIBLE: ANY WOMAN BETWEEN 15 AND 49 YEARS LIVING IN HOUSEHOLD.

RANDOMLY SELECT ONE ELIGIBLE WOMAN FOR INTERVIEW.
TO DO THIS, WRITE THE LINE NUMBERS OF ELIGIBLE WOMEN ON PIECES OF PAPER, AND PUT IN A BAG.
ASK A HOUSEHOLD MEMBER TO PICK OUT A NUMBER – SO SELECTING THE PERSON TO BE INTERVIEWED.

PUT CIRCLE AROUND LINE NUMBER OF WOMAN SELECTED. ASK IF YOU CAN TALK WITH THE SELECTED WOMAN. IF SHE IS NOT AT HOME, AGREE ON DATE FOR RETURN VISIT.
CONTINUE WITH HOUSEHOLD QUESTIONNAIRE.

* If both (male and female) are the head, refer to the male.

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

ADMINISTERED TO ANY RESPONSIBLE ADULT IN HOUSEHOLD

HOUSEHOLD QUESTIONNAIRE

	QUESTIONS & FILTERS	CODING CATEGORIES	
	QUESTIONS 1–6: COUNTRY-SPECIFIC SOCIOECONOMIC INDICATORS		
1	If you don't mind, I would like to ask you a few questions about your household. What is the main source of drinking-water for your household?	TAP/PIPED WATER IN RESIDENCE .....1 OUTSIDE TAP (PIPED WATER).....2 PUBLIC TAP .....3 WELL-WATER, WITHIN RESIDENCE .....4 OUTSIDE/PUBLIC WELL .....5 SPRING WATER .....6 RIVER/STREAM/POND/LAKE/DAM .....8 RAINWATER.....9 TANKER/TRUCK/WATER VENDOR .....10 OTHER: _____ ..96	
2	What kind of toilet facility does your household have?	OWN FLUSH TOILET .....1 SHARED FLUSH TOILET .....2 VENTILATED IMPROVED PIT LATRINE.....3 TRADITIONAL PIT TOILET/LATRINE .....4 RIVER/CANAL.....5 NO FACILITY/BUSH/FIELD .....6 OTHER: _____ 8	
3	What are the main materials used in the roof? RECORD OBSERVATION	ROOF FROM NATURAL MATERIALS .....1 RUDIMENTARY ROOF.....2 TILED OR CONCRETE ROOF.....3 CORRUGATED IRON .....4 OTHER: _____ 8	
4	Does your household have: a) Electricity b) A radio c) A television d) A telephone e) A refrigerator	YES NO a) ELECTRICITY 1 2 b) RADIO 1 2 c) TELEVISION 1 2 d) TELEPHONE 1 2 e) REFRIGERATOR 1 2	
5	Does any member of your household own: a) A bicycle? b) A motorcycle? c) A car?	YES NO a) BICYCLE 1 2 b) MOTORCYCLE 1 2 c) CAR 1 2	
6	Do people in your household own any land?	YES.....1 NO .....2 DON'T KNOW 8	
7	How many rooms in your household are used for sleeping?	NUMBER OF ROOMS .....[ ][ ]	
8	Are you concerned about the levels of crime in your neighbourhood (like robberies or assaults)? Would you say that you are not at all concerned, a little concerned, or very concerned?	NOT CONCERNED.....1 A LITTLE CONCERNED .....2 VERY CONCERNED.....3	
9	In the past 4 weeks, has someone from this household been the victim of a crime in this neighbourhood, such as a robbery or assault?	YES.....1 NO 2	
10	NOTE SEX OF RESPONDENT	MALE.....1 FEMALE 2	

Thank you very much for your assistance.

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

Survey on women's health and life events in STUDY LOCATION

WOMEN'S QUESTIONNAIRE

Study conducted by NAME OF INSTITUTION(S)

Confidential upon completion

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

INDIVIDUAL CONSENT FORM

Hello, my name is *. I work for *. We are conducting a survey in STUDY LOCATION to learn about women's health and life experiences. You have been chosen by chance (as in a lottery/raffle) to participate in the study.

I want to assure you that all of your answers will be kept strictly secret. I will not keep a record of your name or address. You have the right to stop the interview at any time, or to skip any questions that you don't want to answer. There are no right or wrong answers. Some of the topics may be difficult to discuss, but many women have found it useful to have the opportunity to talk.

Your participation is completely voluntary but your experiences could be very helpful to other women in COUNTRY.

Do you have any questions?

(The interview takes approximately * minutes to complete.) Do you agree to be interviewed?

NOTE WHETHER RESPONDENT AGREES TO INTERVIEW OR NOT

[ ] DOES NOT AGREE TO BE INTERVIEWED → THANK PARTICIPANT FOR HER TIME AND END

[ ] AGREES TO BE INTERVIEWED

↓

Is now a good time to talk?
It's very important that we talk in private. Is this a good place to hold the interview, or is there somewhere else that you would like to go?

TO BE COMPLETED BY INTERVIEWER

I certify that I have read the above consent procedure to the participant.

Signed:

_____

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

DATE INTERVIEW: day [ ][ ] **month** [ ][ ] **year** [ ][ ][ ][ ]

100. RECORD THE TIME	Hour [ ] [ ] (24 h) Minutes [ ] [ ]	

SECTION 1 RESPONDENT AND HER COMMUNITY

	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
	If you don't mind, I would like to start by asking you a little about <COMMUNITY NAME>. *INSERT NAME OF COMMUNITY/VILLAGE/NEIGHBOURHOOD ABOVE AND IN QUESTIONS BELOW.* *IF NO NAME, SAY IN THIS COMMUNITY/VILLAGE/AREA AS APPROPRIATE.*		
101	Do neighbours in COMMUNITY NAME generally tend to know each other well?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
102	If there were a streetfight in COMMUNITY NAME would people generally do something to stop it?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
103	If someone in COMMUNITY NAME decided to undertake a community project *(INSERT LOCALLY RELEVANT EXAMPLES)* would most people be willing to contribute time, labour or money?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
104	In this neighbourhood do most people generally trust one another in matters of lending and borrowing things?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
105	If someone in your family suddenly fell ill or had an accident, would your neighbours offer to help?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
106	I would now like to ask you some questions about yourself. What is your date of birth (day, month and year that you were born)?	DAY ..... [ ][ ] MONTH ..... [ ][ ] YEAR ..... [ ][ ][ ][ ] DON'T KNOW YEAR 9998	
107	How old were you on your last birthday? (MORE OR LESS)	AGE (YEARS) ..... [ ][ ]	
108	How long have you been living continuously in COMMUNITY NAME?	NUMBER OF YEARS ..... [ ][ ] LESS THAN 1 YEAR ..... 00 LIVED ALL HER LIFE ..... 95 VISITOR (AT LEAST 4 WEEKS IN HOUSEHOLD) 96	
109	Can you read and write?	YES ..... 1 NO 2	
110	Have you ever attended school?	YES ..... 1 NO 2	⇒ **112**
111	What is the highest level of education that you achieved? MARK HIGHEST LEVEL. *CONVERT YEARS IN SCHOOL, LOCALLY-SPECIFIC CODING*	PRIMARY _____ year ..... 1 SECONDARY _____ year ..... 2 HIGHER _____ year ..... 3 NUMBER OF YEARS SCHOOLING .. [ ][ ]	
112	Where did you grow up? PROBE: Before age 12 where did you live longest?	THIS COMMUNITY/TOWN ..... 1 ANOTHER RURAL AREA/VILLAGE ..... 2 ANOTHER TOWN/CITY ..... 3 ANOTHER COUNTRY 4	
113	Do any of your family of birth live close enough by that you can easily see/visit them?	YES ..... 1 NO 2	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

114	How often do you see or talk to a member of your family of birth? Would you say at least once a week, once a month, once a year, or never?	AT LEAST ONCE A WEEK ..... 1 AT LEAST ONCE A MONTH ..... 2 AT LEAST ONCE A YEAR ..... 3 NEVER (HARDLY EVER) 4	
115	When you need help or have a problem, can you usually count on family members for support?	YES ..... 1 NO 2	

116a

Do you regularly attend a group or organization? IF YES: What kind of group or association? IF NO, PROMPT: Organizations like women's or community groups, religious groups or political associations. MARK ALL MENTIONED PROBE IF NECESSARY TO IDENTIFY TYPE OF GROUP *ADD COUNTRY-SPECIFIC CODES*	NONE ..... A CIVIC/POLITICAL/UNION ..... B SOCIAL WORK/CHARITABLE ... C SPORTS/ARTS/CRAFTS ..... D ECONOMIC/SAVINGS CLUB .... E WOMEN'S ORGANIZATION ..... F RELIGIOUS ORGANIZATION .... G OTHER:_____ _____ X	⇒ **IF NONE GO TO 118**

116b. How often do you attend? (ASK ONLY FOR EACH MARKED IN 116a)

At least once a week	At least once a month	At least once a year	Never (hardly ever)
1	2	3	4
1	2	3	4
1	2	3	4
1	2	3	4
1	2	3	4
1	2	3	4
1	2	3	4

117	Are any of these groups attended by women only? (REFER TO THE ATTENDED GROUPS ONLY)	YES ..... 1 NO 2	
118	Have you ever been prevented from attending a meeting or participating in an organization? IF YES, ASK Who prevented you? MARK ALL THAT APPLY *LOCALLY-SPECIFIC CODES CAN BE ADDED*	NOT PREVENTED ..... A PARTNER/HUSBAND ..... B PARENTS ..... C PARENTS-IN-LAW/PARENTS OF PARTNER ..... D OTHER:_____ .X	
119	Are you currently married or do you have a male partner? IF RESPONDENT HAS A MALE PARTNER ASK Do you and your partner live together? *OPTION 4 (TEXT IN ITALICS) IS OPTIONAL. SHOULD BE INCLUDED IN COUNTRIES WHERE IT IS NOT UNCOMMON THAT WOMEN HAVE UNIONS WITH PARTNERS WITHOUT LIVING TOGETHER*	CURRENTLY MARRIED ..... 1 LIVING WITH MAN, NOT MARRIED ..... **3** *CURRENTLY HAVING A REGULAR PARTNER (SEXUAL RELATIONSHIP), LIVING APART* ..... 4 NOT CURRENTLY MARRIED OR LIVING WITH A MAN *(NOT INVOLVED IN A SEXUAL RELATIONSHIP)* 5	⇒ **123** ⇒ **123** ⇒ **123**
120	Have you ever been married or lived with a male partner?	YES ..... 1 NO 2	⇒ **S2**
121	Did the last partnership end in divorce or separation, or were you widowed? *COUNTRY-SPECIFIC CODES CAN BE ADDED*	DIVORCED ..... 1 SEPARATED/BROKEN UP ..... 2 WIDOWED 3	⇒ **123**

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

122	Was the divorce/separation initiated by you, by your husband/partner, or did you both decide that you should separate?	RESPONDENT ..... 1 HUSBAND/PARTNER ..... 2 BOTH (RESPONDENT AND PARTNER) ..... 3 OTHER: _____ 6	
123	How many times have you been married, or lived with a man? (INCLUDE CURRENT PARTNER IF LIVING TOGETHER)	NUMBER OF TIMES MARRIED ..... [ ][ ] ..... IF "00"	⇒ **S2**
124	The next few questions are about your current or most recent partnership. Do/did you live with your husband/partner's parents or any of his relatives?	YES ..... 1 NO 2	
125	IF CURRENTLY WITH PARTNER: Do you currently live with your parents or any of your relatives? IF NOT CURRENTLY WITH PARTNER: Were you living with your parents or relatives during your last relationship?	YES ..... 1 NO 2	
	COUNTRY WITH POLYGAMY [ ] *(LOCALLY-SPECIFIC CODING)* ⇓	*COUNTRY WITHOUT POLYGAMY [ ]* ⇒	⇒ **129**
126	Does/did your husband/partner have any other wives while being married (having a relationship) with you?	YES ..... 1 NO ..... 2 DON'T KNOW 8	⇒ **129** ⇒ **129**
127	How many wives does/did he have (including yourself)?	NUMBER OF WIVES ..... [ ][ ] DON'T KNOW 98	⇒ **129**
128	Are/were you the first, second..... wife? *ADAPT WORDING LOCALLY, CHECK THAT THIS REFERS TO THE OTHER WIVES HE HAD AT SAME TIME WHILE BEING WITH RESPONDENT*	NUMBER/POSITION ..... [ ][ ]	
129	Did you have any kind of marriage ceremony to formalize the union? What type of ceremony did you have? MARK ALL THAT APPLY *COUNTRY-SPECIFIC RESPONSE CATEGORIES*	NONE ..... A CIVIL MARRIAGE ..... B RELIGIOUS MARRIAGE ..... C CUSTOMARY MARRIAGE ..... D OTHER: _____ X	⇒ **S.2**
130	In what year was the (first) ceremony performed? (THIS REFERS TO CURRENT/LAST RELATIONSHIP)	YEAR ..... [ ][ ][ ][ ] DON'T KNOW 9998	
131	Did you yourself choose your current/most recent husband, did someone else choose him for you, or did he choose you? IF SHE DID NOT CHOOSE HERSELF, PROBE: Who chose your current/most recent husband for you?	BOTH CHOSE ..... 1 RESPONDENT CHOSE ..... 2 RESPONDENT'S FAMILY CHOSE ..... 3 PARTNER CHOSE ..... 4 PARTNER'S FAMILY CHOSE ..... 5 OTHER: _____ ... 6	⇒ **133*** ⇒ **133***
132	Before the marriage with your current /most recent husband, were you asked whether you wanted to marry him or not?	YES ..... 1 NO 2	
*	*COUNTRY WITH DOWRY/BRIDE PRICE [ ]* ⇓	*COUNTRY WITHOUT DOWRY/ BRIDE PRICE ..... [ ]* ⇒	⇒ **S.2**
133	Did your marriage involve dowry/bride price payment?	YES/DOWRY ..... 1 YES/BRIDE PRICE ..... 2 NO ..... 3 DON'T KNOW 8	 ⇒ **S.2** ⇒ **S.2**
134	Has all of the dowry/bride price been paid for, or does some part still remain to be paid?	ALL PAID ..... 1 PARTIALLY PAID ..... 2 NONE PAID 3	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

135	Overall, do you think that the amount of dowry/bride price payment has had a positive impact on how you are treated by your husband and his family, a negative impact, or no particular impact?	POSITIVE IMPACT ..... 1 NEGATIVE IMPACT ..... 2 NO IMPACT 3	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

SECTION 2 GENERAL HEALTH

BEFORE STARTING WITH SECTION 2:
REVIEW RESPONSES IN SECTION 1 AND MARK MARITAL STATUS ON REFERENCE SHEET, BOX A.

201	I would now like to ask a few questions about your health and use of health services. In general, would you describe your overall health as excellent, good, fair, poor or very poor?	EXCELLENT ..... 1 GOOD ..... 2 FAIR ..... 3 POOR ..... 4 VERY POOR 5	
202	Now I would like to ask you about your health in the <u>past 4 weeks</u>. How would you describe your ability to walk around? Would you say that you have no problems, very few problems, some problems, many problems or that you are unable to walk at all?	NO PROBLEMS ..... 1 VERY FEW PROBLEMS ..... 2 SOME PROBLEMS ..... 3 MANY PROBLEMS ..... 4 UNABLE TO WALK AT ALL 5	
203	In the <u>past 4 weeks</u> did you have problems with performing usual activities, such as work, study, household, family or social activities? Would you say no problems, very few problems, some problems, many problems or unable to perform usual activities?	NO PROBLEMS ..... 1 VERY FEW PROBLEMS ..... 2 SOME PROBLEMS ..... 3 MANY PROBLEMS ..... 4 UNABLE TO PERFORM USUAL ACTIVITIES 5	
204	In the <u>past 4 weeks</u> have you been in pain or discomfort? Would you say not at all, slight pain or discomfort, moderate, severe or extreme pain or discomfort?	NO PAIN OR DISCOMFORT ..... 1 SLIGHT PAIN OR DISCOMFORT ..... 2 MODERATE PAIN OR DISCOMFORT ..... 3 SEVERE PAIN OR DISCOMFORT ..... 4 EXTREME PAIN OR DISCOMFORT 5	
205	In the <u>past 4 weeks</u> have you had problems with your memory or concentration? Would you say no problems, very few problems, some problems, many problems or extreme memory or concentration problems?	NO PROBLEMS ..... 1 VERY FEW PROBLEMS ..... 2 SOME PROBLEMS ..... 3 MANY PROBLEMS ..... 4 EXTREME MEMORY PROBLEMS 5	

206	In the <u>past 4 weeks</u> have you had:		YES	NO
	a) Dizziness	a) DIZZINESS	1	2
	b) Vaginal discharge	b) VAGINAL DISCHARGE	1	2

207	In the <u>past 4 weeks</u>, have you taken medication:		NO	ONCE OR TWICE	A FEW TIMES	MANY TIMES
	a) To help you calm down or sleep?	a) FOR SLEEP	1	2	3	4
	b) To relieve pain?	b) FOR PAIN	1	2	3	4
	c) To help you not feel sad or depressed?	c) FOR SADNESS	1	2	3	4
	FOR EACH, IF YES PROBE: How often? Once or twice, a few times or many times? *(CAN USE COUNTRY-SPECIFIC NAMES OF COMMON MEDICATION)*					

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

208	In the <u>past 4 weeks</u>, did you consult a doctor or other professional or traditional health worker because you yourself were sick? IF YES: Whom did you consult? PROBE: Did you also see anyone else?	NO ONE CONSULTED ..... A DOCTOR ..... B NURSE (AUXILIARY) ..... C MIDWIFE ..... D COUNSELLOR ..... E PHARMACIST ..... F TRADITIONAL HEALER ..... G TRADITIONAL BIRTH ATTENDANT ..... H OTHER: _____ ..X	

209	The next questions are related to other common problems that may have bothered you in the <u>past 4 weeks</u>. If you had the problem in the past 4 weeks, answer yes. If you have not had the problem in the past 4 weeks, answer no.		YES	NO	
	a) Do you often have headaches?	a) HEADACHES	1	2	
	b) Is your appetite poor?	b) APPETITE	1	2	
	c) Do you sleep badly?	c) SLEEP BADLY	1	2	
	d) Are you easily frightened?	d) FRIGHTENED	1	2	
	e) Do your hands shake?	e) HANDS SHAKE	1	2	
	f) Do you feel nervous, tense or worried?	f) NERVOUS	1	2	
	g) Is your digestion poor?	g) DIGESTION	1	2	
	h) Do you have trouble thinking clearly?	h) THINKING	1	2	
	i) Do you feel unhappy?	i) UNHAPPY	1	2	
	j) Do you cry more than usual?	j) CRY MORE	1	2	
	k) Do you find it difficult to enjoy your daily activities?	k) NOT ENJOY	1	2	
	l) Do you find it difficult to make decisions?	l) DECISIONS	1	2	
	m) Is your daily work suffering?	m) WORK SUFFERS	1	2	
	n) Are you unable to play a useful part in life?	n) USEFUL PART	1	2	
	o) Have you lost interest in things?	o) LOST INTEREST	1	2	
	p) Do you feel that you are a worthless person?	p) WORTHLESS	1	2	
	q) Has the thought of ending your life been on your mind?	q) ENDING LIFE	1	2	
	r) Do you feel tired all the time?	r) FEEL TIRED	1	2	
	s) Do you have uncomfortable feelings in your stomach?	s) STOMACH	1	2	
	t) Are you easily tired?	t) EASILY TIRED	1	2	

210	Just now we talked about problems that may have bothered you in the past 4 weeks. I would like to ask you now if, in your life, have you <u>ever</u> thought about ending your life?	YES ..... 1 NO 2	**⇒ 212**
211	Have you <u>ever</u> tried to take your life?	YES ..... 1 NO 2	
212	In the <u>past 12 months</u>, have you had an operation (other than a caesarean section)?	YES ..... 1 NO 2	
213	In the <u>past 12 months</u>, did you have to spend any nights in a hospital because you were sick (other than to give birth)? IF YES: How many nights in the past 12 months?	NIGHTS IN HOSPITAL ..... [ ][ ] NONE 00	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

214	Do you <u>now</u> smoke..... 1. Daily? 2. Occasionally? 3. Not at all? *IN COUNTRIES WHERE WOMEN SMOKE*	DAILY 1 OCCASIONALLY ..... 2 NOT AT ALL..... 3	⇒ **216** ⇒ **216**
215	Have you <u>ever</u> smoked in your life? Did you ever smoke..... 1. Daily? (smoking at least once a day) 2. Occasionally? (at least 100 cigarettes, but never daily) 3. Not at all? (not at all, or less than 100 cigarettes in your lifetime) *IN COUNTRIES WHERE WOMEN SMOKE*	DAILY..... 1 OCCASIONALLY ..... 2 NOT AT ALL..... 3	
216	How often do you drink alcohol? Would you say: 1. Every day or nearly every day 2. Once or twice a week 3. 1–3 times a month 4. Occasionally, less than once a month 5. Never *IN COUNTRIES WHERE LIKELY TO GET RELIABLE RESPONSES*	EVERY DAY OR NEARLY EVERY DAY ..... 1 ONCE OR TWICE A WEEK..... 2 1–3 TIMES IN A MONTH ..... 3 LESS THAN ONCE A MONTH ..... 4 NEVER 5	 ⇒ **S.3**
217	On the days that you drank in the <u>past 4 weeks</u>, about how many alcoholic drinks did you usually have a day? *IN COUNTRIES WHERE LIKELY TO GET RELIABLE RESPONSES*	USUAL NUMBER OF DRINKS ..... [ ][ ] NO ALCOHOLIC DRINKS IN PAST 4 WEEKS ...00	
218	In the <u>past 12 months</u>, have you experienced any of the following problems, related to your drinking? a) money problems b) health problems c) conflict with family or friends d) problems with authorities (bar owner/police, etc) x) other, specify *IN COUNTRIES WHERE LIKELY TO GET RELIABLE RESPONSES*	YES NO a) MONEY PROBLEMS 1 2 b) HEALTH PROBLEMS 1 2 c) CONFLICT WITH FAMILY OR FRIENDS 1 2 d) PROBLEMS WITH AUTHORITIES 1 2 x) OTHER: _____ 1 2	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

SECTION 3 REPRODUCTIVE HEALTH

301	Now I would like to ask about all of the births that you have had during your life. Have you ever given birth? How many times? (THIS REFERS TO LIVE BIRTHS)	NUMBER OF BIRTHS..... [ ][ ] I F 1 OR MORE .... ⇒ NONE 00	 ⇒ **303**
302	Have you ever been pregnant?	YES .....1 NO.....2 MAYBE/NOT SURE 3	⇒ **304** ⇒ **310** ⇒ **310**
303	How many children do you have, who are alive now? RECORD NUMBER	CHILDREN .....[ ][ ] NONE 00	
304	Have you ever given birth to a boy or a girl who was born alive, but later died? This could be any age. IF NO, PROBE: Any baby who cried or showed signs of life but survived for only a few hours or days?	YES .....1 NO.....2	⇒ **306**
305	a) How many sons have died? a) How many daughters have died? (THIS IS ABOUT ALL AGES)	a) SONS DEAD .....[ ][ ] b) DAUGHTERS DEAD.....[ ][ ] IF NONE ENTER '00'	
306	Do (did) all your children have the same biological father, or more than one father?	ONE FATHER.....1 MORE THAN ONE FATHER .....2 DON'T KNOW, NO ANSWER 8	
307	How many of your children receive financial support from their father(s)? Would you say none, some or all?	NONE .....1 SOME .....2 ALL .....3 N/A 7	
308	How many times have you been pregnant – include pregnancies that did not end in a live birth? PROBE: How many pregnancies were with twins, triplets?	a) **TOTAL** NO. OF PREGNANCIES.....[ ][ ] b) PREGNANCIES WITH TWINS .....[ ] c) PREGNANCIES WITH TRIPLETS..... [ ]	
309	Have you ever had a pregnancy that miscarried, or ended in a stillbirth? PROBE: How many times did you miscarry, how many times did you have a stillbirth, and how many times did you abort? *PROBE MAY NEED TO BE LOCALLY ADAPTED*	a) MISCARRIAGES .....[ ][ ] b) STILLBIRTHS .....[ ][ ] c) ABORTIONS.....[ ][ ] IF NONE ENTER '00'	
310	Are you pregnant now?	YES .....1 NO.....2 MAYBE.....3	⇒ **A** ⇒ **B** ⇒ **B**

VERIFY THAT ANSWERS FOR BOTH LINES ADD UP TO THE SAME FIGURE. IF NOT, PROBE AGAIN AND CORRECT.	**A. [301] ____ + [309 a+b+c] _____ + 1 = [308a] _____+ [308b] ____ + [2x308c] ____ = ___ B. [301] ____ + [309 a+b+c] _____ = [308a] _____+ [308b] ____ + [2x308c] ____ = ___**	
311	Have you <u>ever</u> used anything, or tried in any way to delay or avoid getting pregnant?	YES .....1 NO.....2 NEVER HAD INTERCOURSE 3	 ⇒ **315** ⇒ **S.5**
312	Are you <u>currently</u> doing something, or using any method, to avoid getting pregnant?	YES .....1 NO.....2	 ⇒ **315**

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

313	What (main) method are you currently using? IF MORE THAN ONE, ONLY MARK MAIN METHOD	PILL/TABLETS .....1 INJECTABLES .....2 IMPLANTS (NORPLANT) .....3 IUD .....4 DIAPHRAGM/FOAM/JELLY .....5 CALENDAR/MUCUS METHOD .....6 FEMALE STERILIZATION .....7 CONDOMS .....8 MALE STERILIZATION .....9 WITHDRAWAL .....10 HERBS .....11 OTHER: _____ ..96	 ⇒ **315** ⇒ **315** ⇒ **315**
314	Does your current husband/partner know that you are using a method of family planning?	YES .....1 NO .....2 N/A: NO CURRENT PARTNER 8	
315	Has/did your current/most recent husband/partner ever refused to use a method or tried to stop you from using a method to avoid getting pregnant?	YES .....1 NO 2	 ⇒ **317**
316	In what ways did he let you know that he disapproved of using methods to avoid getting pregnant? MARK ALL THAT APPLY	TOLD ME HE DID NOT APPROVE .....A SHOUTED/GOT ANGRY .....B THREATENED TO BEAT ME .....C THREATENED TO LEAVE/THROW ME OUT OF HOME .....D BEAT ME/PHYSICALLY ASSAULTED .....E TOOK OR DESTROYED METHOD .....F OTHER _____ .X	
317	Have you ever used a condom with your current /most recent partner to prevent disease?	YES .....1 NO 2	⇒ **S.4**
318	Have you ever asked your current/most recent partner to use a condom?	YES .....1 NO 2	 ⇒ **S.4**
319	Has/did your current/most recent husband/partner ever refuse to use a condom to prevent disease?	YES .....1 NO 2	 ⇒ **S.4**
320	In what ways did he let you know that he disapproved of using a condom? MARK ALL THAT APPLY	TOLD ME HE DID NOT APPROVE .....A SHOUTED/GOT ANGRY .....B THREATENED TO BEAT ME .....C THREATENED TO LEAVE/THROW ME OUT OF HOME .....D BEAT ME/PHYSICALLY ASSAULTED .....E TOOK OR DESTROYED METHOD .....F ACCUSED ME OF BEING UNFAITHFUL/ NOT A GOOD WOMAN .....G LAUGHED AT ME/NOT TAKE SERIOUS ..H SAID IT IS NOT NECESSARY .....I OTHER _____ .X	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

SECTION 4 CHILDREN

BEFORE STARTING WITH SECTION 4:
REVIEW RESPONSES AND MARK REPRODUCTIVE HISTORY ON REFERENCE SHEET, BOX B.

CHECK: **(Ref. sheet, box B, point 2)**	**ANY LIVE BIRTHS [ ]** ⇓	**NO LIVE BIRTHS [ ] ⇒**	**⇒ S.5**
401	I would like to ask about the last time that you gave birth (regardless of whether the child is still alive or not). What is the date of birth of this child?	DAY .....[ ][ ] MONTH .....[ ][ ] YEAR .....[ ][ ][ ][ ]	
402	What name was given to your last born child? Is (NAME) a boy or a girl?	NAME: _____ BOY .....1 GIRL 2	
403	Is your last born child (NAME) still alive?	YES .....1 NO 2	 ⇒ **405**
404	How old was (NAME) at his/her last birthday? RECORD AGE IN COMPLETED YEARS CHECK AGE WITH BIRTH DATE	AGE IN YEARS .....[ ][ ] IF NOT YET COMPLETED 1 YEAR 00	⇒ **406** ⇒ **406**
405	How old was (NAME) when he/she died?	YEARS .....[ ][ ] MONTHS (IF LESS THAN 1 YEAR) .....[ ][ ] DAYS (IF LESS THAN 1 MONTH) .....[ ][ ]	
406	CHECK IF DATE OF BIRTH OF LAST CHILD (IN Q401) IS MORE OR LESS THAN 5 YEARS AGO	5 OR MORE YEARS AGO ..... 1 LESS THAN 5 YEARS AGO 2	⇒ **417**
407	I would like to ask you about your last pregnancy. At the time you became pregnant with this child (NAME), did you want to become pregnant then, did you want to wait until later, did you want no (more) children, or did you not mind either way?	BECOME PREGNANT THEN .....1 WAIT UNTIL LATER .....2 NOT WANT CHILDREN .....3 NOT MIND EITHER WAY 4	
408	At the time you became pregnant with this child (NAME), did your husband/partner want you to become pregnant then, did he want to wait until later, did he want no (more) children at all, or did he not mind either way?	BECOME PREGNANT THEN .....1 WAIT UNTIL LATER .....2 NOT WANT CHILDREN .....3 NOT MIND EITHER WAY .....4 DON'T KNOW 8	
409	When you were pregnant with this child (NAME), did you see anyone for an antenatal check? IF YES: Whom did you see? Anyone else? MARK ALL THAT APPLY	NO ONE .....A DOCTOR .....B OBSTETRICIAN/GYNAECOLOGIST .....C NURSE/MIDWIFE .....D AUXILIARY NURSE .....E TRADITIONAL BIRTH ATTENDANT .....F OTHER: _____ _____ X	
410	Did your husband/partner stop you, encourage you, or have no interest in whether you received antenatal care for your pregnancy?	STOP .....1 ENCOURAGE .....2 NO INTEREST 3	
411	When you were pregnant with this child, did your husband/ partner have preference for a son, a daughter or did it not matter to him whether it was a boy or a girl?	SON .....1 DAUGHTER .....2 DID NOT MATTER 3	
412	During this pregnancy, did you consume any alcoholic drinks?	YES .....1 NO .....2 DON'T KNOW/DON'T REMEMBER 8	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

413	During this pregnancy, did you smoke any cigarettes or use tobacco?	YES .....1 NO .....2 DON'T KNOW/DON'T REMEMBER 8	
414	Were you given a (postnatal) check-up at any time during the 6 weeks after delivery?	YES .....1 NO.....2 DON'T KNOW.....8	
415	Was this child (NAME) weighed at birth?	YES .....1 NO.....2 DON'T KNOW.....8	⇒ 417 ⇒ 417
416	How much did he/she weigh? RECORD FROM HEALTH CARD WHERE POSSIBLE	KG FROM CARD [ ].[ ].....1 KG FROM RECALL [ ].[ ].....2 DON'T KNOW/DON'T REMEMBER 8	
417	Do you have any children with ages 5-12 years? How many? (INCLUDING 12-YEAR-OLD CHILDREN)	NUMBER ..... [ ][ ] NONE.....00	⇒ S.5
418	a) How many are boys? b) How many are girls?	a) BOYS.....[ ] b) GIRLS.....[ ]	
419	How many of these children currently live with you? PROBE: a) How many boys? b) How many girls?	a) BOYS.....[ ] b) GIRLS.....[ ] IF "0" FOR BOTH SEXES ==== **GO TO** ⇒	⇒ S.5
420	Do any of these children (ages 5-12 years): a) Have frequent nightmares? b) Suck their thumbs or fingers? c) Often wet their bed? d) Are any of these children very timid or withdrawn? e) Are any of them aggressive with you or other children?	YES NO a) NIGHTMARES 1 2 b) SUCK THUMB 1 2 c) WET BED 1 2 d) TIMID 1 2 e) AGGRESSIVE 1 2	
421	Of these children (ages 5-12 years), how many of your boys and how many of your girls have ever run away from home?	a) NUMBER OF BOYS RUN AWAY .....[ ] b) NUMBER OF GIRLS RUN AWAY .....[ ] IF NONE ENTER "0"	
422	Of these children (ages 5-12 years), how many of your boys and how many of your girls are studying/in school?	a) BOYS.....[ ] b) GIRLS.....[ ] IF "0" FOR BOTH SEXES ==== **GO TO** ⇒	⇒ S.5
423	Have any of these children had to repeat (failed) a year at school? MAKE SURE ONLY CHILDREN AGED 5-12 YEARS.	YES.....1 NO.....2 DON'T KNOW.....8	
424	Have any of these children stopped school for a while or dropped out of school? MAKE SURE ONLY CHILDREN AGED 5-12 YEARS.	YES.....1 NO.....2 DON'T KNOW.....8	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

SECTION 5 CURRENT OR MOST RECENT PARTNER

CHECK (Ref. sheet, box A)	CURRENTLY MARRIED/ LIVING WITH A MAN/ *WITH PARTNER* (Option 1) [ ] (*Option 5*) ⇓	FORMERLY MARRIED/ LIVING WITH A MAN (Option 2) [ ] ⇓	NEVER MARRIED/LIVED WITH A MAN (Option 4) [ ] ⇒	⇒ S.6

501	I would now like you to tell me a little about your current/ most recent husband/partner. How old was your husband/ partner on his last birthday? PROBE: MORE OR LESS	AGE (YEARS) .....[ ][ ]	
502	In what year was he born?	YEAR.....[ ][ ][ ][ ] DON'T KNOW 9998	
503	Can he read and write?	YES..... 1 NO 2	
504	Did he ever attend school?	YES..... 1 NO 2	⇒ 506
505	What is the highest level of education that he achieved? MARK HIGHEST LEVEL. *CONVERT YEARS IN SCHOOL, LOCALLY-SPECIFIC CODING*	PRIMARY _____ year ..... 1 SECONDARY _____ year ..... 2 HIGHER _____ year..... 3 DON'T KNOW ..... 8 NUMBER OF YEARS SCHOOLING...[ ][ ]	
506	IF CURRENTLY WITH PARTNER: Is he currently working, looking for work or unemployed, retired or studying? IF NOT CURRENTLY WITH PARTNER: Towards the end of your relationship was he working, looking for work or unemployed, retired or studying?	WORKING ..... 1 LOOKING FOR WORK/UNEMPLOYED.... 2 RETIRED ..... 3 STUDENT 4	⇒ 508 ⇒ 508 ⇒ 509
507	When did his last job finish? Was it in the past 4 weeks, between 4 weeks and 12 months ago, or before that? (FOR MOST RECENT HUSBAND/PARTNER: in the last 4 weeks or in the last 12 months of your relationship?)	IN THE PAST 4 WEEKS 1 4 WKS–12 MONTHS AGO ..... 2 MORE THAN 12 MONTHS AGO..... 3 NEVER HAD A JOB..... 4	 ⇒ 509
508	What kind of work does/did he normally do? SPECIFY KIND OF WORK *CAN ADD COUNTRY-SPECIFIC CODES*	PROFESSIONAL: _____ . 1 SEMI-SKILLED: _____ . 2 UNSKILLED/MANUAL: _____ . 3 MILITARY/POLICE: _____ .. 4 OTHER: _____ . 8	
509	How often does/did your husband/partner drink alcohol? 1. Every day or nearly every day 2. Once or twice a week 3. 1–3 times a month 4. Occasionally, less than once a month 5. Never	EVERY DAY OR NEARLY EVERY DAY .. 1 ONCE OR TWICE A WEEK ..... 2 1–3 TIMES IN A MONTH ..... 3 LESS THAN ONCE A MONTH..... 4 NEVER ..... 5 DON'T KNOW 8	 ⇒ 512
510	In the past 12 months (In your last relationship), how often have you seen (did you see) your husband/partner drunk? Would you say most days, weekly, once a month, less than once a month, or never?	MOST DAYS ..... 1 WEEKLY ..... 2 ONCE A MONTH..... 3 LESS THAN ONCE A MONTH..... 4 NEVER 5	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

511	In the <u>past 12 months</u> (during the <u>last 12 months</u> of your relationship), have you experienced any of the following problems, related to your husband/partner's drinking? a) Money problems b) Family problems x) Any other problems, specify.	YES NO a) MONEY PROBLEMS 1 2 b) FAMILY PROBLEMS 1 2 x) OTHER: _____ 1 2	
512	How often does/did your husband/partner use drugs? 1. Every day or nearly every day 2. Once or twice a week 3. 1–3 times a month 4. Occasionally, less than once a month 5. Never *IN COUNTRIES WHERE APPROPRIATE TO ASK ABOUT DRUG USE*	EVERY DAY OR NEARLY EVERY DAY .. 1 ONCE OR TWICE A WEEK ..... 2 1–3 TIMES IN A MONTH ..... 3 LESS THAN ONCE A MONTH ..... 4 NEVER ..... 5 DON'T KNOW 8	
513	<u>Since you have known him</u>, has he ever been involved in a physical fight with another man?	YES ..... 1 NO ..... 2 DON'T KNOW 8	⇒ **515** ⇒ **515**
514	In the <u>past 12 months</u> (in the <u>last 12 months</u> of the relationship), has this happened never, once or twice, a few times or many times?	NEVER ..... 1 ONCE OR TWICE ..... 2 A FEW (3–5) TIMES ..... 3 MANY (MORE THAN 5) TIMES ..... 4 DON'T KNOW 8	
515	Has your <u>current/most recent</u> husband/partner had a relationship with any other women while being with you?	YES ..... 1 NO ..... 2 MAY HAVE ..... 3 DON'T KNOW 8	⇒ **S.6** ⇒ **S.6**
516	Has your <u>current/most recent</u> husband/partner had children with any other woman while being with you?	YES ..... 1 NO ..... 2 MAY HAVE ..... 3 DON'T KNOW 8	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

SECTION 6 ATTITUDES TOWARDS GENDER ROLES

	In this community and elsewhere, people have different ideas about families and what is acceptable behaviour for men and women in the home. I am going to read you a list of statements, and I would like you to tell me whether you generally agree or disagree with the statement. There are no right or wrong answers.		
601	A good wife obeys her husband even if she disagrees	AGREE ..... 1 DISAGREE ..... 2 DON'T KNOW 8	
602	Family problems should only be discussed with people in the family	AGREE ..... 1 DISAGREE ..... 2 DON'T KNOW 8	
603	It is important for a man to show his wife/partner who is the boss	AGREE ..... 1 DISAGREE ..... 2 DON'T KNOW 8	
604	A woman should be able to choose her own friends even if her husband disapproves	AGREE ..... 1 DISAGREE ..... 2 DON'T KNOW 8	
605	It's a wife's obligation to have sex with her husband even if she doesn't feel like it	AGREE ..... 1 DISAGREE ..... 2 DON'T KNOW 8	
606	If a man mistreats his wife, others outside of the family should intervene	AGREE ..... 1 DISAGREE ..... 2 DON'T KNOW 8	
607	In your opinion, does a man have a good reason to hit his wife if: a) She does not complete her household work to his satisfaction b) She disobeys him c) She refuses to have sexual relations with him d) She asks him whether he has other girlfriends e) He suspects that she is unfaithful f) He finds out that she has been unfaithful	YES NO DK a) HOUSEHOLD 1 2 8 b) DISOBEYS 1 2 8 c) NO SEX 1 2 8 d) GIRLFRIENDS 1 2 8 e) SUSPECTS 1 2 8 f) UNFAITHFUL 1 2 8	
608	In your opinion, can a married woman refuse to have sex with her husband if: a) She doesn't want to b) He is drunk c) She is sick d) He mistreats her	YES NO DK a) NOT WANT 1 2 8 b) DRUNK 1 2 8 c) SICK 1 2 8 d) MISTREAT 1 2 8	

ID ____ [ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ]

SECTION 7 RESPONDENT AND HER PARTNER

CHECK (Ref. sheet, box A)	EVER MARRIED/LIVING WITH A MAN/*WITH PARTNER* (Options 1, 2) [ ] *(Option 5)* ⇓	NEVER MARRIED/LIVED WITH A MAN/ SINGLE (Option 4) [ ] ⇒	⇒ S.10

When two people marry or live together, they usually share both good and bad moments. I would now like to ask you some questions about your current and past relationships and how your husband/partner treats (treated) you. If anyone interrupts us I will change the topic of conversation. I would again like to assure you that your answers will be kept secret, and that you do not have to answer any questions that you do not want to. May I continue?

701 In general, do (did) you and your (current or most recent) husband/partner discuss the following topics together:

		YES	NO
a) Things that have happened to him in the day	a) HIS DAY	1	2
b) Things that happen to you during the day	b) YOUR DAY	1	2
c) Your worries or feelings	c) YOUR WORRIES	1	2
d) His worries or feelings	d) HIS WORRIES	1	2

702 In your relationship with your (current or most recent) husband/partner, how often would you say that you quarrelled? Would you say rarely, sometimes or often?

RARELY 1
SOMETIMES.....2
OFTEN 3

703 I am now going to ask you about some situations that are true for many women. Thinking about your (current or most recent) husband/partner, would you say it is generally true that he:

		YES	NO
a) Tries to keep you from seeing your friends	a) SEEING FRIENDS	1	2
b) Tries to restrict contact with your family of birth	b) CONTACT FAMILY	1	2
c) Insists on knowing where you are at all times	c) WANTS TO KNOW	1	2
d) Ignores you and treats you indifferently	d) IGNORES YOU	1	2
e) Gets angry if you speak with another man	e) GETS ANGRY	1	2
f) Is often suspicious that you are unfaithful	f) SUSPICIOUS	1	2
g) Expects you to ask his permission before seeking health care for yourself	g) HEALTH CENTRE	1	2

704 The next questions are about things that happen to many women, and that your current partner, or any other partner may have done to you.
I want you to tell me if your current husband/partner, or any other partner, has ever done the following things to you.

	A) (**If YES continue with B. If NO skip to next item**)		B) Has this happened in the past 12 months? (**If YES ask C only. If NO ask D only**)		C) In the past 12 months would you say that this has happened once, a few times or many times? (**After answering C, skip D**)			D) Before the past 12 months would you say that this has happened once, a few times or many times?		
	YES	NO	YES	NO	One	Few	Many	One	Few	Many
a) Insulted you or made you feel bad about yourself?	1	2	1	2	1	2	3	1	2	3
b) Belittled or humiliated you in front of other people?	1	2	1	2	1	2	3	1	2	3
c) Did things to scare or intimidate you on purpose (e.g. by the way he looked at you, by yelling and smashing things)?	1	2	1	2	1	2	3	1	2	3
d) Threatened to hurt you or someone you care about?	1	2	1	2	1	2	3	1	2	3

ID ____ [ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ]

705 Has he or any other partner ever...

	A) (**If YES continue with B. If NO skip to next item**)		B) Has this happened in the past 12 months? (**If YES ask C only. If NO ask D only**)		C) In the past 12 months would you say that this has happened once, a few times or many times? (**After answering C, skip D**)			D) Before the past 12 months would you say that this has happened once, a few times or many times?		
	YES	NO	YES	NO	One	Few	Many	One	Few	Many
a) Slapped you or thrown something at you that could hurt you?	1	2	1	2	1	2	3	1	2	3
b) Pushed you or shoved you?	1	2	1	2	1	2	3	1	2	3
c) Hit you with his fist or with something else that could hurt you?	1	2	1	2	1	2	3	1	2	3
d) Kicked you, dragged you or beaten you up?	1	2	1	2	1	2	3	1	2	3
e) Choked or burnt you on purpose?	1	2	1	2	1	2	3	1	2	3
f) Threatened to use or actually used a gun, knife or other weapon against you?	1	2	1	2	1	2	3	1	2	3

706 Has he or any other partner ever...

	A) (**If YES continue with B. If NO skip to next item**)		B) Has this happened in the past 12 months? (**If YES ask C only. If NO ask D only**)		C) In the past 12 months would you say that this has happened once, a few times or many times? (**after answering C, skip D**)			D) Before the past 12 months would you say that this has happened once, a few times or many times?		
	YES	NO	YES	NO	One	Few	Many	One	Few	Many
a) Physically forced you to have sexual intercourse when you did not want to?	1	2	1	2	1	2	3	1	2	3
b) Did you ever have sexual intercourse you did not want because you were afraid of what he might do?	1	2	1	2	1	2	3	1	2	3
c) Did he ever force you to do something sexual that you found degrading or humiliating?	1	2	1	2	1	2	3	1	2	3

707 VERIFY WHETHER ANSWERED YES TO ANY QUESTION ON PHYSICAL VIOLENCE, **SEE QUESTION 705**

YES, PHYSICAL VIOLENCE 1
NO PHYSICAL VIOLENCE 2

MARK IN BOX C

708 VERIFY WHETHER ANSWERED YES TO ANY QUESTION ON SEXUAL VIOLENCE, **SEE QUESTION 706**

YES, SEXUAL VIOLENCE 1
NO SEXUAL VIOLENCE 2

MARK IN BOX C

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

CHECK (Ref. sheet, box B, option 1)	**EVER BEEN PREGNANT** [ ] ⇓ **NUMBER OF PREGNANCIES (option 5)** [ ][ ] ⇓ **CURRENTLY PREGNANT? (option 4) YES....1** ⇓ **NO....2**	**NEVER PREGNANT** [ ] ⇒	**⇒ 716***
709	You said that you have been pregnant TOTAL times. Was there ever a time when you were beaten or physically assaulted by (any of) your partner(s) while you were pregnant?	YES .....1 NO.....2	**⇒ 716***
710	IF RESPONDENT WAS PREGNANT ONCE, ENTER 1 AND GO TO 711 IF RESPONDENT WAS PREGNANT MORE THAN ONCE: Did this happen in one pregnancy, or more than one pregnancy? In how many pregnancies were you beaten?	NUMBER OF PREGNANCIES BEATEN ..[ ][ ]	
711	Were you ever punched or kicked in the abdomen while you were pregnant?	YES .....1 NO.....2	
IF VIOLENCE REPORTED IN MORE THAN ONE PREGNANCY, THE FOLLOWING QUESTIONS REFER TO THE LAST/MOST RECENT PREGNANCY IN WHICH VIOLENCE REPORTED			
712	During the most recent pregnancy in which you were beaten, was the person who beat you the father of the child?	YES .....1 NO .....2 DON'T KNOW 8	
713	Were you living with this person when it happened?	YES .....1 NO .....2 DON'T KNOW 8	
714	Had the same person beaten you before you were pregnant?	YES .....1 NO 2	**⇒ 716***
715	Compared to before you were pregnant, did the violence get less, stay about the same, or get worse while you were pregnant?	GOT LESS .....1 STAYED ABOUT THE SAME .....2 GOT WORSE .....3 DON'T KNOW 8	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

*** CHECK Ref. sheet box A.**	**Option 1: CURRENTLY MARRIED AND/OR LIVING WITH MAN: YES [ ] NO [ ]** **Option 6: NUMBER OF TIMES MARRIED/LIVED TOGETHER WITH A MAN? [ ][ ] *(If 00 ⇒ S 8)***				
CHECK Ref. sheet box C.	**WOMAN HAS NOT EXPERIENCED PHYSICAL OR SEXUAL VIOLENCE ("NO" TO BOTH Options 1 and 2)** [ ] **ASK ONLY COLUMNS a AND b ⇓**	**WOMAN EXPERIENCED VIOLENCE ("YES" TO Option 1 AND/OR Option 2)** **ASK COLUMNS a TO e [ ]** **(FOR ALL PARTNERS) ⇓**			
716	IF MORE THAN ONE PARTNERSHIP, ASK: You told me you have been married or lived with a man TOTAL times. Could you now please tell me a little about your husband/partner(s)? (Starting with your current or most recent partner):				
	a) When did you start living together? IF CURRENTLY MARRIED OR LIVING TOGETHER START WITH 1. IF NOT, START WITH 2.	b) When did the relationship end?	c) Did he physically or sexually mistreat you? IF NO, SKIP TO NEXT PARTNER, IF YES, CONTINUE	d) When was the first incident?	e) When was the last incident?
1.	[ ][ ] MONTH [ ][ ][ ][ ] YEAR		YES .....1 ⇒ NO .....2 ⇓	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	[ ][ ] MONTH [ ][ ][ ][ ] YEAR
2.	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	YES .....1 ⇒ NO .....2 ⇓	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	[ ][ ] MONTH [ ][ ][ ][ ] YEAR
3.	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	YES .....1 ⇒ NO .....2 ⇓	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	[ ][ ] MONTH [ ][ ][ ][ ] YEAR
4.	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	YES .....1 ⇒ NO .....2 ⇓	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	[ ][ ] MONTH [ ][ ][ ][ ] YEAR
5.	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	YES .....1 ⇒ NO 2	[ ][ ] MONTH [ ][ ][ ][ ] YEAR	[ ][ ] MONTH [ ][ ][ ][ ] YEAR

CHECK WHETHER ALL PARTNERS INCLUDED.

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

SECTION 8 INJURIES

CHECK Ref. sheet box C	WOMAN EXPERIENCED PHYSICAL VIOLENCE ("YES" TO Option 1) [ ] ⇓	WOMAN HAS NOT EXPERIENCED PHYSICAL VIOLENCE ("NO" TO Option 1) [ ] ⇒	⇒ S.10

I would now like to learn more about the injuries that you experienced from (any of) your partner's violence. By injury, I mean any form of physical harm, including cuts, sprains, burns, broken bones or broken teeth, or other things like this.

801	Have you ever been injured as a result of violence/abuse by (one of) your (current or former) husband(s)/partner(s)	YES ..... 1 NO 2	⇒ S.9
802 a	In your life, how many times were you injured by (any of) your husband(s)/partner(s)? Would you say once or twice, several times or many times?	ONCE/TWICE ..... 1 SEVERAL (3–5) TIMES ..... 2 MANY (MORE THAN 5) TIMES 3	
802 b	Has this happened in the past 12 months?	YES ..... 1 NO 2	
803 a	What type of injury did you have? MARK ALL PROBE: Any other injury?	CUTS, PUNCTURES, BITES ..... A SCRATCH, ABRASION, BRUISES ..... B SPRAINS, DISLOCATIONS ..... C BURNS ..... D PENETRATING INJURY, DEEP CUTS, GASHES ..... E BROKEN EARDRUM, EYE INJURIES ..... F FRACTURES, BROKEN BONES ..... G BROKEN TEETH ..... H OTHER: _____ X	b) ONLY ASK FOR RESPONSES MARKED IN 803a: Has this happened in the past 12 months? YES NO 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2
804 a	Did you ever lose consciousness? IF YES For how long? More or less than 1 hour?	YES, LESS THAN 1 HOUR ..... 1 YES, MORE THAN 1 HOUR ..... 2 NO 3	⇒ 805
804 b	Has this happened in the past 12 months?	YES ..... 1 NO 2	
805	Were you ever hurt badly enough that you needed health care? IF YES: How many times?	TIMES NEEDED HEALTH CARE ..... [ ][ ] YES, BUT DON'T KNOW ..... 98 NOT NEEDED 00	⇒ S.9
806	Did you ever receive health care for your injury? IF YES All of the time, or sometimes?	YES SOMETIMES ..... 1 YES ALWAYS ..... 2 NO 3	⇒ S.9
807	For your injury, did you have to spend any nights in a hospital? IF YES: How many nights?	NUMBER OF NIGHTS IN HOSPITAL . [ ][ ] IF NONE ENTER "00"	
808	Did you tell a health worker the real cause of your injury?	YES ..... 1 NO 2	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

SECTION 9 IMPACT AND COPING

I would now like to ask you some questions about what usually happened when your partner was violent. IF REPORTED VIOLENCE BY MORE THAN ONE PARTNER: I would like you to answer these questions for the most recent (last) partner who used violence

901	Are there any particular situations that tend to lead to violence? PROBE: Any other situation? MARK ALL MENTIONED	NO PARTICULAR REASON ..... A WHEN MAN DRUNK ..... B MONEY PROBLEMS ..... C DIFFICULTIES AT HIS WORK ..... D WHEN HE IS UNEMPLOYED ..... E NO FOOD AT HOME ..... F PROBLEMS WITH HIS OR HER FAMILY ..... G SHE IS PREGNANT ..... H HE IS JEALOUS OF HER ..... I SHE REFUSES SEX ..... J SHE IS DISOBEDIENT ..... K OTHER _____ X	

CHECK: (Ref. sheet, box B, point 3)	CHILDREN LIVING [ ] ⇓	NO CHILDREN ALIVE [ ] ⇒	⇒ 903

902	For any of these incidents of physical violence, were your children present or did they overhear you being beaten? IF YES: How often? Would you say once or twice, several times or most of the time?	NEVER ..... 1 ONCE OR TWICE ..... 2 SEVERAL TIMES ..... 3 MANY TIMES/MOST OF THE TIME ..... 4 DON'T KNOW 8	
903	During or after a violent incident, does (did) he ever force you to have sex? PROBE: Make you have sex with him against your will? IF YES: How often? Would you say once or twice, several times or most of the time?	NEVER ..... 1 ONCE OR TWICE ..... 2 SEVERAL TIMES ..... 3 MANY TIMES/MOST OF THE TIME 4	
904	During the times that you were hit, did you ever fight back physically (or to defend yourself)? IF YES: How often? Would you say once or twice, several times or most of the time?	NEVER ..... 1 ONCE OR TWICE ..... 2 SEVERAL TIMES ..... 3 MANY TIMES/MOST OF THE TIME 4	
905	Have you ever hit or physically mistreated your husband/partner when he was not hitting or physically mistreating you? IF YES: How often? Would you say once or twice, several times or many times?	NEVER ..... 1 ONCE OR TWICE ..... 2 SEVERAL TIMES ..... 3 MANY TIMES 4	
906	Would you say that your husband/partner's violence towards you has affected your physical or mental health? PROBE: Has it affected your health a little, or a lot?	NO EFFECT ..... 1 A LITTLE ..... 2 A LOT 3	
907	In what way, if any, has the violence disrupted your work or other income-generating activities? MARK ALL THAT APPLY *CATEGORIES TO BE DEVELOPED LOCALLY*	N/A (NO WORK FOR MONEY) ..... A WORK NOT DISRUPTED ..... B PARTNER INTERRUPTED WORK ..... C UNABLE TO CONCENTRATE ..... D UNABLE TO WORK/SICK LEAVE ..... E LOST CONFIDENCE IN OWN ABILITY ..... F OTHER: _____ X	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

908	Who have you told about the physical violence? MARK ALL MENTIONED PROBE: Anyone else?	NO ONE ..... A FRIENDS ..... B PARENTS ..... C BROTHER OR SISTER ..... D UNCLE OR AUNT ..... E HUSBAND/PARTNER'S FAMILY ..... F CHILDREN ..... G NEIGHBOURS ..... H POLICE ..... I DOCTOR/HEALTH WORKER ..... J PRIEST ..... K COUNSELLOR ..... L NGO/WOMEN'S ORGANIZATION ..... M LOCAL LEADER ..... N OTHER _____ X	
909	Did anyone ever try to help you? IF YES, Who helped you? MARK ALL MENTIONED PROBE: Anyone else?	NO ONE ..... A FRIENDS ..... B PARENTS ..... C BROTHER OR SISTER ..... D UNCLE OR AUNT ..... E HUSBAND/PARTNER'S FAMILY ..... F CHILDREN ..... G NEIGHBOURS ..... H POLICE ..... I DOCTOR/HEALTH WORKER ..... J PRIEST ..... K COUNSELLOR ..... L NGO/WOMEN'S ORGANIZATION ..... M LOCAL LEADER ..... N OTHER _____ X	
910	Did you ever go to any of the following for help? READ EACH ONE a) Police b) Hospital or health centre c) Social services d) Legal advice centre e) Court f) Shelter g) Local leader h) Women's organization (Use name) j) Priest/Religious leader x) Anywhere else? Where? *LOCALLY-SPECIFIC OPTIONS CAN BE ADDED*	YES NO a) POLICE 1 2 b) HOSPITAL/HEALTH CENTRE 1 2 c) SOCIAL SERVICES 1 2 d) LEGAL ADVICE CENTRE 1 2 e) COURT 1 2 f) SHELTER 1 2 g) LOCAL LEADER 1 2 h) WOMEN'S ORGANIZATION: 1 2 _____ j) PRIEST/RELIGIOUS LEADER 1 2 x) ELSEWHERE:_____ 1 2 _____	
CHECK Question 910	**MARK WHEN WOMAN ANSWERED YES ON ANY QUESTION (AT LEAST ONE "1" CIRCLED)** [ ]⇓	**MARK WHEN ALL ANSWERS NO (ONLY "2" CIRCLED)** [ ]	**⇒ 912**

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

911	What were the reasons that made you go for help? **MARK ALL MENTIONED AND GO TO 913**	ENCOURAGED BY FRIENDS/FAMILY ..... A COULD NOT ENDURE MORE ..... B BADLY INJURED/AFRAID HE WOULD KILL HER ..... C HE THREATENED OR TRIED TO KILL HER ..... D HE THREATENED OR HIT CHILDREN ..... E SAW THAT CHILDREN SUFFERING ..... F THROWN OUT OF THE HOME ..... G AFRAID SHE WOULD KILL HIM ..... H OTHER _____ _____ X	**FOR ALL OPTIONS GO TO 913**
912	Why did you not go to any of these? MARK ALL MENTIONED	DON'T KNOW/NO ANSWER ..... A FEAR OF THREATS/CONSEQUENCES/MORE VIOLENCE ..... B VIOLENCE NORMAL/NOT SERIOUS ..... C EMBARRASSED/ASHAMED/AFRAID WOULD NOT BE BELIEVED OR WOULD BE BLAMED ..... D BELIEVED NOT HELP/KNOW OTHER WOMEN NOT HELPED ..... E AFRAID WOULD END RELATIONSHIP ..... F AFRAID WOULD LOSE CHILDREN ..... G BRING BAD NAME TO FAMILY ..... H OTHER _____ _____ ..X	
913	Is there anyone that you would like to receive (more) help from? Who? MARK ALL MENTIONED *CAN ADD COUNTRY-SPECIFIC OPTIONS*	NO ONE MENTIONED ..... A FAMILY ..... B HER MOTHER ..... C HIS MOTHER ..... D HEALTH CENTRE ..... E POLICE ..... F PRIEST/RELIGIOUS LEADER ..... G OTHER: _____ .. X	
914	Did you ever leave, even if only overnight, because of the violence? IF YES: How many times?	NUMBER OF TIMES LEFT ..... [ ][ ] NEVER 00	**⇒ 919**
915	What were the reasons why you left the last time? MARK ALL MENTIONED	NO PARTICULAR INCIDENT ..... A ENCOURAGED BY FRIENDS/FAMILY ..... B COULD NOT ENDURE MORE ..... C BADLY INJURED/AFRAID HE WOULD KILL HER ..... D HE THREATENED OR TRIED TO KILL HER ..... E HE THREATENED OR HIT CHILDREN ..... F SAW THAT CHILDREN SUFFERING ..... G THROWN OUT OF THE HOME ..... H AFRAID SHE WOULD KILL HIM ..... I ENCOURAGED BY ORGANIZATION: _____ ..... J OTHER _____ ... X	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

916	Where did you go the last time? MARK ONE	HER RELATIVES.....1 HIS RELATIVES.....2 HER FRIENDS/NEIGHBOURS .....3 HOTEL/LODGINGS .....4 STREET .....5 CHURCH/TEMPLE.....6 SHELTER.....7 OTHER _____.....8	
917	How long did you stay away the last time? RECORD NUMBER OF DAYS OR MONTHS	NUMBER OF DAYS (IF LESS THAN 1 MONTH) ..... [ ][ ] 1 NUMBER OF MONTHS (IF 1 MONTH OR MORE)..... [ ][ ] 2 LEFT PARTNER/DID NOT RETURN/NOT WITH PARTNER 3	⇒ **S.10**
918	Why did you return? MARK ALL MENTIONED AND GO TO SECTION 10	DIDN'T WANT TO LEAVE CHILDREN ..... A SANCTITY OF MARRIAGE ..... B FOR SAKE OF FAMILY/CHILDREN ..... C COULDN'T SUPPORT CHILDREN ..... D LOVED HIM.....E HE ASKED HER TO GO BACK .....F FAMILY SAID TO RETURN ..... G FORGAVE HIM ..... H THOUGHT HE WOULD CHANGE.....I THREATENED HER/CHILDREN..... J COULD NOT STAY THERE (WHERE SHE WENT)..... K OTHER _____ X	**FOR ALL OPTIONS GO TO Section 10**
919	What were the reasons that made you stay? MARK ALL MENTIONED	DIDN'T WANT TO LEAVE CHILDREN ..... A SANCTITY OF MARRIAGE ..... B DIDN'T WANT TO BRING SHAME ON FAMILY ..... C COULDN'T SUPPORT CHILDREN ..... D LOVED HIM.....E DIDN'T WANT TO BE SINGLE.....F FAMILY SAID TO STAY ..... G FORGAVE HIM ..... H THOUGHT HE WOULD CHANGE.....I THREATENED HER/CHILDREN ..... J NOWHERE TO GO..... K OTHER _____ X	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

SECTION 10 OTHER EXPERIENCES

In their lives, many women experience different forms of violence from relatives, other people that they know, and/or from strangers. If you don't mind, I would like to briefly ask you about some of these situations. Everything that you say will be kept private. May I continue?

100 la	Since the age of 15 years, has anyone (FOR WOMEN WITH CURRENT OR PAST PARTNER: other than your partner/husband) ever beaten or physically mistreated you in any way? IF YES: Who did this to you? PROBE: How about a relative? How about someone at school or work? How about a friend or neighbour? A stranger or anyone else?	NO ONE.....A	⇒ **1002**		
			b) ASK ONLY FOR THOSE MARKED. How many times did this happen? Once or twice, a few times, or many times?		
			Once or twice	A few times	Many times
		FATHER.....B	1	2	3
		STEPFATHER.....C	1	2	3
		OTHER MALE FAMILY MEMBER .....D	1	2	3
		FEMALE FAMILY MEMBER: _____ E	1	2	3
		TEACHER.....F	1	2	3
		POLICE/SOLDIER.....G	1	2	3
		MALE FRIEND OF FAMILY .....H	1	2	3
		FEMALE FRIEND OF FAMILY I	1	2	3
		BOYFRIEND.....J	1	2	3
		STRANGER .....K	1	2	3
		SOMEONE AT WORK.....L	1	2	3
		PRIEST/RELIGIOUS LEADER .....M	1	2	3
		OTHER _____..X	1	2	3
1002a	Since the age of 15 years, has anyone (FOR WOMEN WITH CURRENT OR PAST PARTNER: other than your partner/husband) ever forced you to have sex or to perform a sexual act when you did not want to? IF YES: Who did this to you? PROBE: How about a relative? How about someone at school or work? How about a friend or neighbour? A stranger or anyone else?	NO ONE.....A	⇒ **1003**		
			b) ASK ONLY FOR THOSE MARKED. How many times did this happen? Once or twice, a few times, or many times		
			Once or twice	A few times	Many times
		FATHER.....B	1	2	3
		STEPFATHER.....C	1	2	3
		OTHER MALE FAMILY MEMBER .....D	1	2	3
		FEMALE FAMILY MEMBER: _____ E	1	2	3
		TEACHER.....F	1	2	3
		POLICE/SOLDIER.....G	1	2	3
		MALE FRIEND OF FAMILY .....H	1	2	3
		FEMALE FRIEND OF FAMILY I	1	2	3
		BOYFRIEND.....J	1	2	3
		STRANGER .....K	1	2	3
		SOMEONE AT WORK.....L	1	2	3
		PRIEST/RELIGIOUS LEADER .....M	1	2	3
		OTHER _____..X	1	2	3

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

1003a	Before the age of 15 years, do you remember if anyone in your family ever touched you sexually, or made you do something sexual that you didn't want to? IF YES: Who did this to you? IF YES OR NO CONTINUE: How about someone at school? How about a friend or neighbour? Has anyone else done this to you? IF YES: Who did this to you?	NO ONE ..... A	⇒ **1004**					
			ASK ONLY FOR THOSE MARKED IN 1003a					
			b) How old were you when it happened with this person for the first time? (more or less)	c) How old was this person? PROBE: roughly (more or less).	d) How many times did this happen?			
					Once/ twice	Few times	Many times	
		FATHER ..... B	[ ][ ]	[ ][ ]	1	2	3	
		STEPFATHER C	[ ][ ]	[ ][ ]	1	2	3	
		OTHER MALE FAMILY MEMBER ..... D	[ ][ ]	[ ][ ]	1	2	3	
		FEMALE FAMILY MEMBER: _____ E	[ ][ ]	[ ][ ]	1	2	3	
		TEACHER ..... F	[ ][ ]	[ ][ ]	1	2	3	
		POLICE/ SOLDIER ..... G	[ ][ ]	[ ][ ]	1	2	3	
		MALE FRIEND OF FAMILY ..... H	[ ][ ]	[ ][ ]	1	2	3	
		FEMALE FRIEND OF FAMILY I	[ ][ ]	[ ][ ]	1	2	3	
		BOYFRIEND ..... J	[ ][ ]	[ ][ ]	1	2	3	
		STRANGER ..... K	[ ][ ]	[ ][ ]	1	2	3	
		SOMEONE AT WORK L	[ ][ ]	[ ][ ]	1	2	3	
		PRIEST/RELIGIOUS LEADER ..... M	[ ][ ]	[ ][ ]	1	2	3	
		OTHER _____ . X	[ ][ ]	[ ][ ]	1	2	3	
				DK = 98				

1004	How old were you when you first had sex?	AGE YEARS (MORE OR LESS) ..... [ ][ ] NOT HAD SEX 95	⇒ **1006**
1005	How would you describe the first time that you had sex? Would you say that you wanted to have sex, you did not want to have sex but it happened anyway, or were you forced to have sex?	WANTED TO HAVE SEX ..... 1 NOT WANT BUT HAD SEX ..... 2 FORCED TO HAVE SEX 3	
1006	When you were a child, was your mother hit by your father (or her husband or boyfriend)?	YES ..... 1 NO ..... 2 PARENTS DID NOT LIVE TOGETHER ..... 3 DON'T KNOW 8	 ⇒ **1008*** ⇒ **1008*** ⇒ **1008***
1007	As a child, did you see or hear this violence?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
* **CHECK (Ref. sheet, box A)**	**EVER MARRIED/LIVING WITH A MAN/*WITH PARTNER*** **(Options 1, 2)** [ ] ⇓ ***(Option 5)***	**NEVER MARRIED/LIVED WITH A MAN/ SINGLE** **(Option 4)** [ ] ⇒	⇒ **1011**
1008	As far as you know, was your (most recent) partner's mother beaten by her husband?	YES ..... 1 NO ..... 2 PARENTS DID NOT LIVE TOGETHER ..... 3 DON'T KNOW 8	 ⇒ **1010** ⇒ **1010** ⇒ **1010**
1009	Did your (most recent) husband/partner see or hear this violence?	YES ..... 1 NO ..... 2 DON'T KNOW 8	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

1010	As far as you know, was your (most recent) husband/partner himself beaten regularly by someone in his family?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1011	How many sisters do you have, born to the same mother, age 15–49 years?	SISTERS 15–49 YEARS OLD ..... [ ][ ] NO SISTERS 15–49 YEARS OLD 00	 ⇒ **S.11**
1012	How many of these sisters have ever been married or lived with a partner?	SISTERS EVER WITH PARTNER ..... [ ][ ] NONE 00	 ⇒ **S.11**
1013	Have any of these sisters ever been beaten or physically mistreated by their husband or some other male partner? IF YES, PROBE: How many sisters?	SISTERS BEATEN ..... [ ][ ] NONE ..... 00 DON'T KNOW 98	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

SECTION 11 FINANCIAL AUTONOMY

Now I would like to ask you some questions about things that you own and your earnings. We need this information to understand the financial position of women nowadays.

1101	Please tell me if you own any of the following, either by yourself or with someone else: a) Land b) Your house c) A company or business d) Large animals (cows, horses, etc.) e) Small animals (chickens, pigs, goats, etc.) f) Produce or crops from certain fields or trees g) Large household items (TV, bed, cooker, car) h) Jewellery, gold or other valuables x) Other property, specify FOR EACH, PROBE: Do you own this on your own, or do you own it with others?		YES Own by self	YES Own with others	NO Don't own	
		a) LAND	1	2	3	
		b) HOUSE	1	2	3	
		c) COMPANY	1	2	3	
		d) LARGE ANIMALS	1	2	3	
		e) SMALL ANIMALS	1	2	3	
		f) PRODUCE	1	2	3	
		g) HOUSEHOLD ITEMS	1	2	3	
		h) JEWELLERY	1	2	3	
		x) OTHER PROPERTY: _____	1	2	3	

1102	a) Do you earn money? IF YES: What exactly do you do to earn money? ASK ALL. SPECIFY: b) Job c) Selling things, trading d) Doing seasonal work x) Any other activity, specify	NO.....A b) JOB: _____ .. c) SELLING/TRADING: _____ .. d) SEASONAL WORK: _____ .. x) OTHER: _____ ..	⇒ *CHECK YES NO 1 2 1 2 1 2 1 2		

*** CHECK (Ref. sheet, box A)**	**CURRENTLY MARRIED/LIVING WITH A MAN (Options 1) [ ] ⇓**	**NOT CURRENTLY MARRIED/LIVING WITH A MAN (Options 2, 4) [ ] ⇒** *(Option 5)*	**⇒ S.12**
CHECK 1102	**1. OPTIONS b) c) d) or x) MARKED [ ] ⇓**	**2. OPTION a) MARKED [ ] ⇒**	**⇒ 1105**

1103	Are you able to spend the money you earn how you want yourself, or do you have to give all or part of the money to your husband/partner?	SELF/OWN CHOICE ..... 1 GIVE PART TO HUSBAND/PARTNER ..... 2 GIVE ALL TO HUSBAND/PARTNER 3	
1104	Would you say that the money that you bring into the family is more than what your husband/partner contributes, less than what he contributes, or about the same as he contributes?	MORE THAN HUSBAND/PARTNER ..... 1 LESS THAN HUSBAND/PARTNER ..... 2 ABOUT THE SAME ..... 3 DO NOT KNOW..... 8	
1105	Have you ever given up/refused a job for money because your husband/partner did not want you to work?	YES..... 1 NO..... 2	
1106	Has your husband/partner ever taken your earnings or savings from you against your will? IF YES: Has he done this once or twice, several times or many times?	NEVER ..... 1 ONCE OR TWICE ..... 2 SEVERAL TIMES..... 3 MANY TIMES/ALL OF THE TIME ..... 4 N/A (DOES NOT HAVE SAVINGS/EARNINGS) 7	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

1107	Does your husband/partner ever refuse to give you money for household expenses, even when he has money for other things? IF YES: Has he done this once or twice, several times or many times?	NEVER ..... 1 ONCE OR TWICE ..... 2 SEVERAL TIMES..... 3 MANY TIMES/ALL OF THE TIME ..... 4 N/A (PARTNER DOES NOT EARN MONEY) 7	
1108	In case of emergency, do you think that you alone could raise enough money to house and feed your family for 4 weeks? -This could be for example by selling things that you own, or by borrowing money from people you know, or from a bank or moneylender?	YES..... 1 NO..... 2	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

SECTION 12 COMPLETION OF INTERVIEW			
1201	I would now like to give you a card. On this card are two pictures. No other information is written on the card. The first picture is of a sad face, the second is of a happy face. No matter what you have already told me, I would like you to put a mark next to the sad picture if someone has ever touched you sexually, or made you do something sexual that you didn't want to, before you were 15 years old. Please put a mark next to the happy face if this has never happened to you. Once you have marked the card, please fold it over and put it in this bag, along with many other women's responses. This will ensure that I do not know your answer. GIVE RESPONDENT CARD AND PEN. DO NOT LOOK AT RESPONSE. ONCE CARD IS FOLDED, ASK RESPONDENT TO PUT IT INTO A BAG THAT ALSO CONTAINS OTHER COMPLETED CARDS. DO NOT RECORD DETAILS OF QUESTIONNAIRE IDENTIFICATION ON CARD.	CARD COMPLETED ......1 CARD NOT COMPLETED 2	
1202	We have now finished the interview. Do you have any comments, or is there anything else you would like to add? ______________________________		
1203	I have asked you about many difficult things. How has talking about these things made you feel?	GOOD/BETTER .... 1 BAD/WORSE................. 2 SAME/NO DIFFERENCE.. 3	
1204	Finally, do you agree that we may contact you again (within the next month) if we need to ask a few more questions for clarification? COUNTRIES TO SPECIFY TIME PERIOD DEPENDING ON WHEN THEY PLAN TO DO QUALITY CONTROL VISITS	YES.............................. 1 NO................................ 2	

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

FINISH ONE – IF RESPONDENT HAS DISCLOSED PROBLEMS/VIOLENCE

I would like to thank you very much for helping us. I appreciate the time that you have taken. I realize that these questions may have been difficult for you to answer, but it is only by hearing from women themselves that we can really understand about their health and experiences of violence.

From what you have told us, I can tell that you have had some very difficult times in your life. No one has the right to treat someone else in that way. However, from what you have told me I can see that you are strong, and have survived through some difficult circumstances.

Here is a list of organizations that provide support, legal advice and counselling services to women in STUDY LOCATION. Please do contact them if you would like to talk over your situation with anyone. Their services are free, and they will keep anything that you say private. You can go whenever you feel ready to, either soon or later on.

FINISH TWO – IF RESPONDENT HAS NOT DISCLOSED PROBLEMS/VIOLENCE

I would like to thank you very much for helping us. I appreciate the time that you have taken. I realize that these questions may have been difficult for you to answer, but it is only by hearing from women themselves that we can really understand about women's health and experiences in life.

In case you ever hear of another woman who needs help, here is a list of organizations that provide support, legal advice and counselling services to women in STUDY LOCATION. Please do contact them if you or any of your friends or relatives need help. Their services are free, and they will keep anything that anyone says to them private.

1205	Record time of end of interview:	Hour [ ][ ] (24 h) Minutes [ ][ ]

INTERVIEWER COMMENTS TO BE COMPLETED AFTER INTERVIEW

____

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

REFERENCE SHEET

Box A. MARITAL STATUS

Mark only ONE of the following for marital status of respondent:

1. [ ] Currently married and/or living with man (Question 119: any one of the options 1 or 3)
2. [ ] Previously married/lived with man (Question 120, option 1)
3.
4. [ ] Single – not previously married/lived with man *(no sexual relationship)* (Question 120, option 2)
5. *[ ] Currently with regular sexual partner (dating relationship) (Question 119, option 4)*
   [THIS OPTION IS AVAILABLE IN SOME COUNTRIES ONLY]

6. Number of times married/lived together with man (Question 123): [ ][ ]

Box B. REPRODUCTIVE HISTORY

Check and complete ALL that applies for reproductive history of respondent:

1. Respondent has been pregnant at least once (Question 308, 1 or more)	[ ] Yes	[ ] No
2. Respondent had at least one live birth (Question 301, 1 or more birth)	[ ] Yes	[ ] No
3. Respondent has children who are alive (Question 303, 1 or more children)	[ ] Yes	[ ] No
4. Respondent is currently pregnant (Question 310, option 1)	[ ] Yes	[ ] No
5. Number of pregnancies reported (Question 308):	[ ][ ]	

Box C. VIOLENCE AND INJURIES

Check and complete ALL that applies for respondent:

1. Respondent has been victim of physical violence (Question 707)	[ ] Yes	[ ] No
2. Respondent has been victim of sexual violence (Question 708)	[ ] Yes	[ ] No

Statistical appendix

ID ____ [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

REFERENCE SHEET

Box A. MARITAL STATUS

Mark only ONE of the following for marital status of respondent:

1. [ ] Currently married and/or living with man (Question 119: any one of the options 1 or 3)
2. [ ] Previously married/lived with man (Question 120, option 1)
3.
4. [ ] Single – not previously married/lived with man *(no sexual relationship)* (Question 120, option 2)
5. *[ ] Currently with regular sexual partner (dating relationship) (Question 119, option 4)*
   [THIS OPTION IS AVAILABLE IN SOME COUNTRIES ONLY]

6. Number of times married/lived together with man (Question 123): [ ][ ]

Box B. REPRODUCTIVE HISTORY

Check and complete ALL that applies for reproductive history of respondent:

1. Respondent has been pregnant at least once (Question 308, 1 or more)	[ ] Yes	[ ] No
2. Respondent had at least one live birth (Question 301, 1 or more birth)	[ ] Yes	[ ] No
3. Respondent has children who are alive (Question 303, 1 or more children)	[ ] Yes	[ ] No
4. Respondent is currently pregnant (Question 310, option 1)	[ ] Yes	[ ] No
5. Number of pregnancies reported (Question 308):	[ ][ ]	

Box C. VIOLENCE AND INJURIES

Check and complete ALL that applies for respondent:

1. Respondent has been victim of physical violence (Question 707)	[ ] Yes	[ ] No
2. Respondent has been victim of sexual violence (Question 708)	[ ] Yes	[ ] No

Statistical appendix

Statistical appendix

Discrepancies in totals between tables in this report may arise because missing, refused and "don't know" answers are ignored in most analyses.

Appendix Table 1 Household and individual sample obtained and response rates, by site

(a) Results of household interviews

	Results for all houses visited							Results for "true" households				
	Household interview completed		Household interview refused		House empty/ destroyed[a]		Total no. of houses visited	No. of household interviews completed	Household response rate[b]	No. of household interviews refused	Household refusal rate	Total no. of "true" households
Site	n	(%)	n	(%)	n	(%)		n	(%)	n	(%)	
Bangladesh city	1773	84.2	115	5.5	217	10.3	2105	1773	93.9	115	6.1	1888
Bangladesh province	1732	89.0	11	0.6	203	10.4	1946	1732	99.4	11	0.6	1743
Brazil city	1715	79.3	101	4.7	347	16.0	2163	1715	94.4	101	5.6	1816
Brazil province	1940	90.8	16	0.7	180	8.4	2136	1940	99.2	16	0.8	1956
Ethiopia province[c]	3173	99.2	0	0.0	27	0.8	3200	n.a.	n.a.	n.a.	n.a.	n.a.
Japan city[c]	2279	95.0	0	0.0	121	5.0	2400	n.a.	n.a.	n.a.	n.a.	n.a.
Namibia city	1925	95.1	39	1.9	61	3.0	2025	1925	98.0	39	2.0	1964
Peru city	1710	88.6	133	6.9	86	4.5	1929	1710	92.8	133	7.2	1843
Peru province	1955	97.2	22	1.1	35	1.7	2012	1955	98.9	22	1.1	1977
Samoa[d]	1646	82.5	n.a.	n.a.	n.a.	n.a.	1995	1646	(83–100)	n.a.	n.a.	(1646–1995)
Serbia and Montenegro city	2769	45.8	1862	30.8	1414	23.4	6045	2769	59.8	1862	40.2	4631
Thailand city	2131	76.1	203	7.3	465	16.6	2799	2131	91.3	203	8.7	2334
Thailand province	1836	87.5	20	1.0	243	11.6	2099	1836	98.9	20	1.1	1856
United Republic of Tanzania city	2042	92.8	22	1.0	136	6.2	2200	2042	98.9	22	1.1	2064
United Republic of Tanzania province	1950	88.8	7	0.3	240	10.9	2197	1950	99.6	7	0.4	1957

n.a.,not available.
[a] Includes households speaking a non-local language: 1 in Japan, 4 in Serbia and Montenegro, 6 in United Republic of Tanzania city, and 64 in United Republic of Tanzania province.
[b] Household response rate is calculated as the number of completed household interviews as a percentage of total "true" households (i.e. all the houses in the sample minus those that were empty or destroyed).
[c] Sample based on direct selection of women; therefore the household response rate cannot be determined in a comparable way.
[d] The household response rate for Samoa is not precisely known, because the data set consists of completed household interviews (1646) only, and does not contain information on all the houses in the original sample (1995).

(b) Results of individual interviews

	Results for all eligible households											Results for "true" individuals (eligible women)				
	Individual interview completed		Individual interview refused		Individual absent/postponed/ incapacitated		No eligible woman in household		Individual interview partially completed		Total no. of eligible house-holds (with completed household interview)	No. of individual interviews completed	Individual response rate[a]	No. of individuals refused/absent/ interview not completed	Individual refusal rate	Total no. of households with eligible selected women
Site	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)		n	(%)	n	(%)	
Bangladesh city	1603	90.4	18	1.0	30	1.7	102	5.8	20	1.1	1773	1603	95.9	68	4.1	1671
Bangladesh province	1527	88.2	2	0.1	57	3.3	138	8.0	8	0.5	1732	1527	95.8	67	4.2	1594
Brazil city	1172	68.3	63	3.7	58	3.4	412	24.0	10	0.6	1715	1172	89.9	131	10.1	1303
Brazil province	1473	75.9	20	1.0	42	2.2	401	20.7	4	0.2	1940	1473	95.7	66	4.3	1539
Ethiopia province[b]	3016	95.1	17	0.5	50	1.6	90[c]	2.8	0	0.0	3173	3016	97.8	67	2.2	3083
Japan city[b]	1371	60.2	591[d]	25.9	317	13.9	0	0.0	0	0.0	2279	1371	60.2	908	39.8	2279
Namibia city	1500	77.9	13	0.7	27	1.4	382	19.8	3	0.2	1925	1500	97.2	43	2.8	1543
Peru city	1414	82.7	100	5.8	13	0.8	169	9.9	14	0.8	1710	1414	91.8	127	8.2	1541
Peru province	1837	94.0	19	1.0	10	0.5	58	3.0	31	1.6	1955	1837	96.8	60	3.2	1897
Samoa	1640	99.6	0	0.0	2	0.1	1	0.1	3	0.2	1646	1640	99.7	5	0.3	1645
Serbia and Montenegro city	1456	52.6	98	3.5	82	3.0	1131	40.8	2	0.1	2769	1456	88.9	182	11.1	1638
Thailand city	1536	72.1	123	5.8	138	6.5	324	15.2	10	0.5	2131	1536	85.0	271	15.0	1807
Thailand province	1282	69.8	17	0.9	59	3.2	470	25.6	8	0.4	1836	1282	93.9	84	6.1	1366
United Republic of Tanzania city	1820	89.1	20	1.0	45	2.2	150	7.3	7	0.3	2042	1820	96.2	72	3.8	1892
United Republic of Tanzania province	1450	74.4	6	0.3	38	1.9	452	23.2	4	0.2	1950	1450	96.8	48	3.2	1498

[a] Individual response rate is calculated as: number of completed interviews as a percentage of the number of households with eligible women and those where it could not be ascertained whether they contained eligible women or not.
[b] Sample based on direct selection of women; therefore the response rates are not strictly comparable with those of the other sites, as they may include refusals at the household level.
[c] 90 women in Ethiopia were not eligible: 41 because they were the wrong age, 40 because an eligible woman had already been selected in the same household, and 9 women had died.
[d] Of the 591 refusals in Japan, 420 eligible women refused personally and in 171 cases another household member refused on the eligible woman's behalf.

Appendix Table 2 Lifetime prevalence of violence against women by an intimate partner among ever-partnered women, by site

(a) Physical violence

Site	Unweighted prevalence (%)	Prevalence weighted for number of eligible women in household (%)	95% confidence interval assuming simple random sample	95% confidence interval corrected for cluster sampling	Total no. of ever-partnered women	No. of clusters
Bangladesh city	39.7	36.9	37.1–42.3	35.3–44.0	1373	39
Bangladesh province	41.7	40.2	39.0–44.3	37.7–45.6	1329	42
Brazil city	27.2	26.1	24.4–30.1	23.9–30.6	940	72
Brazil province	33.8	34.0	31.1–36.4	30.8–36.7	1188	118
Ethiopia province	48.7	n.a.[a]	46.6–50.8	46.6–50.8[b]	2261	[b]
Japan city	12.9	n.a.[a]	11.0–14.7	11.1–14.7	1277	127
Namibia city	30.6	30.7	28.2–33.1	27.6–33.7	1369	143
Peru city	48.6	49.3	45.6–51.6	45.2–52.0	1086	166
Peru province	61.0	60.8	58.6–63.5	57.5–64.4	1535	110
Samoa	40.5	37.9	37.8–43.3	37.3–43.8	1204	133
Serbia and Montenegro city	22.8	23.1	20.4–25.2	19.9–25.6	1191	179
Thailand city	22.9	20.7	20.4–25.4	19.8–25.9	1049	80
Thailand province	33.8	34.1	30.9–36.7	30.0–37.6	1024	60
United Republic of Tanzania city	32.9	31.2	30.4–35.3	30.4–35.3	1442	22
United Republic of Tanzania province	46.7	45.2	43.9–49.4	42.7–50.6	1256	22

(b) Sexual violence

Site	Unweighted prevalence (%)	Prevalence weighted for number of eligible women in household (%)	95% confidence interval assuming simple random sample	95% confidence interval corrected for cluster sampling	Total no. of ever-partnered women	No. of clusters
Bangladesh city	37.4	36.3	34.8–39.9	32.3–42.4	1373	39
Bangladesh province	49.7	50.4	47.0–52.4	46.3–53.2	1329	42
Brazil city	10.1	9.7	8.2–12.0	8.0–12.2	940	72
Brazil province	14.3	14.9	12.3–16.3	12.2–16.4	1188	118
Ethiopia province	58.6	n.a.[a]	56.5–60.6	56.5–60.6[b]	2261	[b]
Japan city	6.2	n.a.[a]	4.9–7.5	4.7–7.7	1275	127
Namibia city	16.5	17.9	14.5–18.4	14.2–18.7	1367	143
Peru city	22.5	22.8	20.1–25.0	20.0–25.1	1087	166
Peru province	46.7	47.0	44.2–49.2	44.1–49.3	1534	110
Samoa	19.5	19.6	17.3–21.8	17.1–22.0	1204	133
Serbia and Montenegro city	6.3	6.6	4.9–7.7	4.8–7.8	1191	179
Thailand city	29.9	29.8	27.1–32.6	27.1–32.6	1048	80
Thailand province	28.9	29.9	26.1–31.7	26.0–31.9	1024	60
United Republic of Tanzania city	23.0	22.4	20.8–25.1	20.7–25.2	1442	22
United Republic of Tanzania province	30.7	30.9	28.2–33.3	27.9–33.6	1256	22

Appendix Table 2 *continued*

(c) Physical or sexual violence, or both

Site	Unweighted prevalence (%)	Prevalence weighted for number of eligible women in household (%)	95% confidence interval assuming simple random sample	95% confidence interval corrected for cluster sampling	Total no. of ever-partnered women	No. of clusters
Bangladesh city	53.4	51.6	50.7–56.0	49.3–57.4	1373	39
Bangladesh province	61.7	61.5	59.1–64.3	58.6–64.8	1329	42
Brazil city	28.9	28.2	26.0–31.8	25.5–32.4	940	72
Brazil province	36.9	37.2	34.1–39.6	33.9–39.8	1188	118
Ethiopia province	70.9	n.a.[a]	69.0–72.7	69.0–72.7[b]	2261	[b]
Japan city	15.4	n.a.[a]	13.3–17.3	13.4–17.4	1276	127
Namibia city	35.9	36.7	33.4–38.5	32.7–39.1	1367	143
Peru city	51.2	51.7	48.2–54.2	47.8–54.6	1086	166
Peru province	69.0	69.1	66.7–71.4	66.2–71.9	1534	110
Samoa	46.1	44.3	43.3–48.9	42.8–49.4	1204	133
Serbia and Montenegro city	23.7	23.9	21.3–26.1	20.7–26.7	1189	179
Thailand city	41.1	40.0	38.1–44.1	37.9–44.3	1048	80
Thailand province	47.4	48.2	44.3–50.4	43.6–51.1	1024	60
United Republic of Tanzania city	41.3	39.6	38.8–43.9	38.7–44.0	1442	22
United Republic of Tanzania province	55.9	54.6	53.1–58.6	52.3–59.4	1256	22

n.a., not available.
[a] In Ethiopia and Japan, the women were directly sampled, with each individual having the same probability of being selected.
[b] In Ethiopia cluster sampling was not applied: a simple random sample of women was selected.

Appendix Table 3 Prevalence of violence against women by an intimate partner among ever-partnered women, by age group, marital status, educational level, and site

(a) Bangladesh city

Demographic characteristics	Physical violence		Sexual violence		Physical or sexual violence, or both		Total no. of ever-partnered women
	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	
Age group (years)							
15–19	44.9	36.4	42.4	30.5	58.5	47.5	118
20–24	40.0	23.7	40.4	24.4	55.9	36.7	270
25–29	47.0	25.9	38.1	22.0	57.3	36.3	328
30–34	39.6	15.5	39.2	21.2	55.0	28.4	278
35–39	34.3	9.0	30.7	12.7	49.4	19.3	166
40–44	32.3	6.9	38.5	13.1	47.7	16.2	130
45–49	25.6	2.4	23.2	7.3	34.1	9.8	82
Current partnership status							
Currently married	39.0	19.7	36.6	21.0	52.3	31.4	1283
Currently no partner, divorced/separated	73.2	17.1	65.9	12.2	90.2	19.5	41
Currently no partner, widowed	30.6	2.0	32.7	4.1	51.0	6.1	49
Educational level							
No education	61.5	27.3	48.4	19.3	70.2	33.8	275
Primary education	54.3	26.2	44.2	24.3	66.3	37.8	267
Secondary education	30.6	16.0	34.3	20.4	47.2	28.8	618
Higher education	18.7	8.1	22.0	15.3	32.1	19.6	209
All women	39.7	19.0	37.4	20.2	53.4	30.2	1373

(b) Bangladesh province

Demographic characteristics	Physical violence		Sexual violence		Physical or sexual violence, or both		Total no. of ever-partnered women
	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	
Age group (years)							
15–19	25.7	19.3	48.6	32.1	53.2	41.3	109
20–24	34.0	18.9	47.6	27.4	53.3	34.0	212
25–29	48.6	18.5	54.3	31.2	68.1	40.2	276
30–34	45.6	17.9	50.2	22.8	66.5	32.7	263
35–39	44.8	12.9	47.1	21.0	62.9	25.7	210
40–44	39.3	9.3	45.3	12.0	57.3	18.7	150
45–49	43.1	9.2	53.2	19.3	62.4	25.7	109
Current partnership status							
Currently married	41.9	16.5	49.8	25.3	62.0	33.3	1266
Currently no partner, divorced/separated	40.0	5.0	55.0	10.0	60.0	10.0	20
Currently no partner, widowed	37.2	0.0	46.5	0.0	53.5	0.0	43
Educational level							
No education	49.3	19.8	49.3	24.3	64.6	33.7	540
Primary education	44.9	15.8	52.7	21.2	64.7	29.6	419
Secondary education	27.8	10.5	48.0	27.8	55.3	32.5	342
Higher education	§	§	§	§	§	§	18
All women	41.7	15.8	49.7	24.2	61.7	31.9	1329

Appendix Table 3 *continued*

(c) Brazil city

Demographic characteristics	Physical violence		Sexual violence		Physical or sexual violence, or both		Total no. of ever-partnered women
	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	
Age group (years)							
15–19	24.1	19.0	6.9	3.4	24.1	19.0	58
20–24	21.5	12.3	4.6	0.8	22.3	12.3	130
25–29	28.3	8.7	12.1	4.0	29.5	9.8	173
30–34	26.8	9.2	10.6	2.8	29.6	10.6	142
35–39	28.7	5.6	11.2	3.4	29.8	6.7	178
40–44	24.3	2.7	10.1	2.0	27.7	4.1	148
45–49	36.0	8.1	12.6	2.7	37.8	9.0	111
Current partnership status							
Currently married	20.0	6.5	6.1	2.0	21.4	7.8	490
Living with man, not married	34.6	12.6	12.0	4.7	35.1	13.1	191
Regular partner, living apart	21.4	8.4	7.8	0.6	22.7	9.1	154
Currently no partner, divorced/separated	58.7	9.8	29.3	6.5	63.0	10.9	92
Currently no partner, widowed	§	§	§	§	§	§	13
Educational level							
No education	33.3	8.3	4.2	4.2	33.3	8.3	24
Primary education	32.6	9.6	14.0	4.1	35.8	11.0	436
Secondary education	25.0	8.6	8.9	2.4	25.7	9.6	292
Higher education	17.6	4.8	3.7	0.0	17.6	4.8	188
All women	27.2	8.3	10.1	2.8	28.9	9.3	940

(d) Brazil province

Demographic characteristics	Physical violence		Sexual violence		Physical or sexual violence, or both		Total no. of ever-partnered women
	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	
Age group (years)							
15–19	27.0	20.2	11.2	7.9	27.0	20.2	89
20–24	36.0	21.3	13.5	8.4	38.8	24.7	178
25–29	30.5	13.3	10.2	4.3	32.8	14.5	256
30–34	31.5	11.3	13.8	3.4	35.5	12.3	203
35–39	40.7	8.5	18.6	7.5	45.2	12.6	199
40–44	37.7	11.7	22.1	5.2	42.2	13.6	154
45–49	29.6	4.6	10.2	2.8	31.5	5.6	108
Current partnership status							
Currently married	21.1	7.9	8.3	3.8	24.3	10.3	494
Living with man, not married	41.1	16.7	16.9	6.3	44.3	18.6	479
Regular partner, living apart	39.8	17.2	21.5	6.5	43.0	17.2	93
Currently no partner, divorced/separated	56.4	18.1	25.5	10.6	58.5	20.2	94
Currently no partner, widowed	35.7	3.6	14.3	3.6	39.3	3.6	28
Educational level							
No education	44.8	12.1	26.7	6.9	50.0	14.7	116
Primary education	36.8	14.1	14.8	6.6	39.2	16.1	775
Secondary education	22.2	10.7	9.1	2.5	26.7	11.9	243
Higher education	18.5	7.4	3.7	1.9	20.4	9.3	54
All women	33.8	12.9	14.3	5.6	36.9	14.8	1188

Appendix Table 3 *continued*

(e) Ethiopia province

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
15–19	22.8	20.7	56.5	46.7	59.8	50.0	92
20–24	42.0	32.9	53.1	47.6	67.4	59.6	307
25–29	49.5	34.7	66.4	54.2	75.9	63.9	432
30–34	56.9	34.5	63.1	51.8	77.1	62.4	510
35–39	50.0	27.8	57.7	42.6	70.5	52.0	352
40–44	49.7	22.5	55.2	33.8	67.6	41.5	364
45–49	44.1	14.7	47.1	21.6	61.3	27.9	204
Current partnership status							
Currently married	49.7	32.0	59.5	49.2	71.9	59.4	1979
Living with man, not married	§	§	§	§	§	§	1
Regular partner, living apart	§	§	§	§	§	§	14
Currently no partner, divorced/separated	50.5	10.3	59.8	16.5	73.2	19.6	97
Currently no partner, widowed	37.6	6.5	47.1	7.6	58.2	10.0	170
Educational level							
No education	48.3	28.6	58.1	44.0	70.2	52.6	1775
Primary education	51.7	33.9	59.8	47.6	73.1	59.8	271
Secondary education	26.7	16.7	56.7	40.0	56.7	43.3	30
Higher education	§	§	§	§	§	§	18
All women	48.7	29.0	58.6	44.4	70.9	53.7	2261

(f) Japan city

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
18–19	3.6	0.0	3.6	3.6	7.1	3.6	28
20–24	10.4	1.7	7.0	1.7	13.0	2.6	115
25–29	12.2	5.0	6.1	1.7	13.8	6.1	181
30–34	13.8	2.7	5.7	0.8	16.5	3.1	261
35–39	16.5	5.5	5.5	1.6	18.1	5.9	254
40–44	11.8	2.4	4.7	0.9	14.2	2.8	212
45–49	11.9	1.3	8.9	1.3	15.6	2.2	225
Current partnership status							
Currently married	12.5	3.3	4.7	1.0	14.2	3.7	946
Living with man, not married	§	§	§	§	§	§	12
Regular partner, living apart	13.1	2.6	5.9	0.7	14.4	2.6	153
Currently no partner, divorced/separated	14.5	1.8	15.8	4.2	22.4	4.8	165
Educational level							
Secondary education	13.3	2.5	5.9	1.5	15.2	3.6	473
Higher education	12.7	3.5	6.4	1.2	15.4	4.0	803
All women	12.9	3.1	6.2	1.3	15.4	3.8	1276

Appendix Table 3 *continued*

(g) Namibia city

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
15–19	31.3	20.0	21.3	16.3	42.5	27.5	80
20–24	30.0	22.5	17.9	10.4	35.8	25.8	240
25–29	27.0	11.4	14.5	6.6	32.5	14.9	289
30–34	29.3	14.7	14.3	8.7	34.3	18.5	265
35–39	31.8	16.5	18.3	11.1	35.7	20.0	235
40–44	31.2	13.0	14.3	5.2	36.4	14.9	154
45–49	41.3	16.3	19.2	9.6	44.2	19.2	104
Current partnership status							
Currently married	21.9	11.5	12.8	7.3	25.8	13.7	423
Living with man, not married	39.2	22.6	16.0	8.7	42.0	25.3	288
Regular partner, living apart	27.6	15.2	19.2	11.5	36.2	21.3	442
Currently no partner, divorced/separated	44.1	18.6	19.7	8.5	48.9	20.2	188
Currently no partner, widowed	30.8	7.7	11.5	3.8	34.6	11.5	26
Educational level							
No education	36.8	22.8	5.3	5.3	36.8	22.8	57
Primary education	36.3	18.4	15.9	10.2	39.6	21.6	245
Secondary education	30.8	17.5	19.0	10.3	37.7	22.0	823
Higher education	22.8	6.6	11.2	4.6	26.1	7.9	241
All women	30.6	15.9	16.5	9.1	35.9	19.5	1367

(h) Peru city

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
15–19	46.4	33.9	23.2	19.6	53.6	41.1	56
20–24	46.7	25.7	18.4	8.6	50.0	27.6	152
25–29	52.4	20.9	24.6	8.0	55.1	22.5	187
30–34	46.7	17.5	19.2	7.4	49.3	19.7	229
35–39	51.1	8.0	24.3	4.0	51.1	9.7	176
40–44	52.1	18.8	23.6	4.9	54.2	19.4	144
45–49	43.0	4.2	26.1	4.9	46.5	7.7	142
Current partnership status							
Currently married	41.3	11.0	17.1	5.0	43.5	13.5	480
Living with man, not married	63.2	25.3	25.6	7.2	64.1	26.0	304
Regular partner, living apart	44.2	20.2	21.7	10.9	45.7	22.5	129
Currently no partner, divorced/separated	47.8	17.6	34.6	10.7	55.3	22.0	159
Currently no partner, widowed	§	§	§	§	§	§	13
Educational level							
No education	§	§	§	§	§	§	9
Primary education	58.6	12.5	28.3	5.9	61.2	15.8	152
Secondary education	57.7	23.5	29.1	9.8	60.6	26.2	447
Higher education	36.8	12.6	14.6	5.0	39.1	14.0	478
All women	48.6	16.9	22.5	7.1	51.2	19.2	1086

Appendix Table 3 *continued*

(i) Peru province

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
15–19	41.2	30.9	35.3	27.9	60.3	48.5	68
20–24	56.5	32.7	42.1	27.1	67.8	43.9	214
25–29	58.1	26.5	40.9	24.0	63.9	35.5	313
30–34	60.3	23.7	48.5	24.4	69.5	33.6	295
35–39	63.6	25.8	50.9	24.4	71.7	34.6	283
40–44	64.5	19.1	48.9	15.9	70.9	25.8	182
45–49	72.1	15.6	54.7	16.8	76.0	23.5	179
Current partnership status							
Currently married	57.3	19.6	45.3	22.1	65.7	29.6	770
Living with man, not married	63.4	35.1	43.7	28.2	70.6	45.2	547
Regular partner, living apart	40.5	16.7	40.5	21.4	57.1	35.7	42
Currently no partner, divorced/separated	74.1	22.2	64.4	14.1	83.0	25.2	135
Currently no partner, widowed	75.0	0.0	60.0	0.0	77.5	0.0	40
Educational level							
No education	67.2	25.5	56.5	27.2	73.3	37.2	191
Primary education	60.1	23.4	52.0	26.4	70.5	34.8	762
Secondary education	65.0	28.9	41.4	19.8	71.4	35.9	343
Higher education	52.9	22.7	29.4	13.0	57.6	27.3	238
All women	61.0	24.8	46.7	22.9	69.0	34.2	1534

(j) Samoa

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
15–19	36.0	28.0	28.0	20.0	52.0	36.0	25
20–24	41.7	27.6	19.9	12.8	46.8	33.3	156
25–29	34.9	22.5	18.5	13.3	39.8	26.1	249
30–34	42.4	16.8	16.4	10.5	45.8	20.6	238
35–39	42.8	16.4	22.0	13.6	48.4	21.6	250
40–44	39.8	7.8	18.7	6.6	48.8	12.0	166
45–49	44.2	13.3	21.7	8.3	49.2	17.5	120
Current partnership status							
Currently married	39.9	16.1	17.9	10.3	44.3	20.1	872
Living with man, not married	42.9	25.7	21.6	14.7	50.6	32.2	245
Currently no partner, divorced/separated	38.9	16.7	31.9	15.3	51.4	20.8	72
Currently no partner, widowed	§	§	§	§	§	§	15
Educational level							
No education	§	§	§	§	§	§	5
Primary education	45.9	17.1	21.2	12.4	53.5	23.5	170
Secondary education	40.1	18.6	19.8	11.6	45.4	22.7	961
Higher education	32.4	10.3	11.8	8.8	35.3	16.2	68
All women	40.5	17.9	19.5	11.5	46.1	22.4	1204

Appendix Table 3 *continued*

(k) Serbia and Montenegro city

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
15–19	20.0	14.3	5.7	2.9	20.0	14.3	35
20–24	18.9	6.1	3.6	0.6	18.9	6.1	164
25–29	16.7	2.3	4.6	0.0	18.5	2.3	173
30–34	24.9	3.2	9.7	1.6	25.9	4.3	185
35–39	22.6	2.6	6.2	1.0	23.7	3.1	194
40–44	24.6	1.4	4.3	1.9	26.1	2.4	207
45–49	27.3	2.2	8.6	0.9	27.7	2.6	231
Current partnership status							
Currently married	19.0	1.7	3.9	1.2	20.2	2.5	752
Living with man, not married	27.1	10.0	8.6	1.4	28.6	10.0	70
Regular partner, living apart	20.1	2.8	6.7	0.0	20.5	2.8	254
Currently no partner, divorced/separated	55.1	11.2	20.4	3.1	55.1	11.2	98
Currently no partner, widowed	§	§	§	§	§	§	15
Educational level							
Primary education	28.6	0.0	4.8	0.0	33.3	0.0	21
Secondary education	27.1	4.4	7.8	1.5	27.7	4.9	549
Higher education	18.7	2.3	5.0	0.8	19.9	2.7	619
All women	22.8	3.2	6.3	1.1	23.7	3.7	1189

(l) Thailand city

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
15–19	29.6	25.9	29.6	29.6	48.1	44.4	27
20–24	23.7	12.4	34.0	22.7	44.3	29.9	97
25–29	24.2	10.8	35.7	21.0	46.5	27.4	157
30–34	23.9	7.7	30.9	18.1	42.1	21.6	259
35–39	22.1	5.6	28.4	17.5	41.2	19.6	194
40–44	20.2	7.7	26.8	14.2	36.6	19.1	183
45–49	22.1	1.5	24.4	6.9	35.1	7.6	131
Current partnership status							
Currently married	19.2	7.4	28.1	16.6	37.8	21.0	794
Living with man, not married	33.6	14.7	35.3	27.6	48.3	34.5	116
Regular partner, living apart	13.2	2.6	39.5	26.3	42.1	26.3	38
Currently no partner, divorced/separated	47.1	6.9	35.6	5.7	63.2	6.9	87
Currently no partner, widowed	§	§	§	§	§	§	13
Educational level							
No education	28.6	14.3	38.1	33.3	38.1	33.3	21
Primary education	29.1	9.4	28.8	15.5	43.6	19.8	445
Secondary education	23.6	8.8	30.8	17.8	42.9	23.9	331
Higher education	10.4	3.6	29.9	17.5	34.7	19.5	251
All women	22.9	7.9	29.9	17.1	41.1	21.3	1048

Appendix Table 3 *continued*

(m) Thailand province

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
15–19	39.3	32.1	28.6	25.0	50.0	39.3	28
20–24	36.9	22.6	34.5	21.4	52.4	31.0	84
25–29	31.6	11.3	27.8	17.3	45.9	22.6	133
30–34	30.3	14.9	24.0	12.6	39.4	21.1	175
35–39	37.2	14.8	31.8	16.6	54.3	26.5	223
40–44	33.3	6.5	29.0	13.4	47.8	17.7	186
45–49	32.8	11.8	28.2	14.4	44.6	20.0	195
Current partnership status							
Currently married	30.7	11.8	27.4	15.9	44.7	22.3	828
Living with man, not married	52.1	24.5	28.7	19.1	62.8	36.2	94
Regular partner, living apart	§	§	§	§	§	§	15
Currently no partner, divorced/separated	52.6	19.3	47.4	14.0	64.9	19.3	57
Currently no partner, widowed	23.3	3.3	30.0	0.0	36.7	3.3	30
Educational level							
No education	43.5	19.6	30.4	17.4	52.2	28.3	46
Primary education	37.3	14.2	30.9	16.5	50.9	24.3	705
Secondary education	27.3	11.8	24.8	14.3	42.2	21.1	161
Higher education	16.4	7.3	20.9	10.9	30.0	14.5	110
All women	33.8	13.4	28.9	15.6	47.4	22.9	1024

(n) United Republic of Tanzania city

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
15–19	21.8	16.1	16.1	11.3	29.8	22.6	124
20–24	29.0	21.9	22.6	16.8	39.4	30.3	297
25–29	36.4	19.0	26.2	15.4	45.5	25.6	332
30–34	37.4	13.9	26.1	12.6	44.3	20.0	230
35–39	36.0	10.2	23.7	12.9	46.2	19.4	186
40–44	32.1	6.9	21.4	8.8	39.6	13.2	159
45–49	30.9	2.7	17.3	2.7	34.5	3.6	110
Current partnership status							
Currently married	28.9	12.2	20.5	12.4	36.7	19.1	828
Living with man, not married	46.0	25.4	25.0	14.3	53.6	31.3	252
Regular partner, living apart	29.1	15.5	23.5	13.9	39.4	23.5	251
Currently no partner, divorced/separated	47.8	11.6	40.6	14.5	58.0	18.8	69
Currently no partner, widowed	31.7	2.4	26.8	2.4	43.9	2.4	41
Educational level							
No education	27.4	11.1	12.6	6.3	33.7	14.2	190
Primary education	36.3	16.6	26.2	15.1	45.0	24.1	921
Secondary education	27.3	12.6	21.3	10.8	36.7	19.9	286
Higher education	22.2	6.7	11.1	6.7	28.9	8.9	45
All women	32.9	14.8	23.0	12.8	41.3	21.5	1442

Appendix Table 3 *continued*

(o) United Republic of Tanzania

Demographic characteristics	Physical violence: Ever (%)	Physical violence: Current[a] (%)	Sexual violence: Ever (%)	Sexual violence: Current[a] (%)	Physical or sexual violence, or both: Ever (%)	Physical or sexual violence, or both: Current[a] (%)	Total no. of ever-partnered women
Age group (years)							
15–19	29.2	25.5	31.1	23.6	44.3	36.8	106
20–24	39.3	22.5	30.5	20.2	48.9	32.1	262
25–29	46.6	20.9	33.7	22.1	58.0	34.0	326
30–34	52.9	19.2	28.8	16.8	62.0	28.8	208
35–39	52.1	14.1	30.1	14.1	56.4	21.5	163
40–44	51.3	7.6	27.7	12.6	58.8	17.6	119
45–49	60.6	12.7	29.6	9.9	64.8	21.1	71
Current partnership status							
Currently married	44.3	18.5	30.2	18.6	53.2	29.0	693
Living with man, not married	53.0	24.9	31.8	23.2	62.2	38.1	349
Regular partner, living apart	28.4	10.8	31.1	18.9	43.2	24.3	74
Currently no partner, divorced/separated	65.6	19.7	39.3	9.8	77.0	21.3	61
Currently no partner, widowed	42.9	0.0	24.7	0.0	48.1	0.0	77
Educational level							
No education	55.9	19.9	30.1	17.3	63.4	30.7	306
Primary education	44.5	18.8	31.0	18.4	53.9	28.8	852
Secondary education	37.5	14.6	31.3	20.8	51.0	27.1	96
Higher education	§	§	§	§	§	§	2
All women	46.7	18.7	30.7	18.3	55.9	29.1	1256

§. Percentage based on fewer than 20 respondents suppressed.
[a] At least one act of physical or sexual violence during the 12 months preceding the interview.

Appendix Table 4 Percentage of ever-partnered women who have experienced different acts of physical violence by an intimate partner, by site

Site	Slapped or threw something		Pushed or shoved		Hit with fist or something else		Kicked or dragged		Choked or burnt		Threatened with or used weapon		Total no. of ever-partnered women
	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	Ever (%)	Current[a] (%)	
Bangladesh city	38.5	17.2	22.7	12.2	15.5	7.9	13.8	6.4	5.7	3.3	1.9	0.8	1373
Bangladesh province	39.6	14.1	25.2	10.7	15.1	6.5	14.7	5.9	5.9	2.8	4.0	2.0	1329
Brazil city	19.5	3.9	22.6	7.3	11.1	2.0	7.1	1.5	3.1	0.6	6.9	1.3	940
Brazil province	24.5	9.1	25.7	10.2	13.4	4.9	9.6	3.1	2.8	0.8	12.4	3.5	1188
Ethiopia province	41.3	23.3	24.4	15.3	16.7	9.3	29.2	14.7	1.7	1.1	1.6	0.7	2261
Japan city	9.2	1.4	8.6	2.7	2.2	0.2	2.7	0.4	0.2	0.0	0.5	0.1	1277
Namibia city	24.1	11.9	17.3	9.5	16.2	7.8	10.6	5.7	4.0	2.3	6.9	3.3	1369
Peru city	39.0	11.8	36.1	11.9	21.4	6.2	15.5	4.5	4.9	1.1	4.8	0.7	1086
Peru province	52.2	19.3	44.8	16.7	42.4	15.5	39.8	14.9	12.5	4.5	10.0	3.0	1535
Samoa	37.0	15.0	9.6	5.1	20.8	10.0	11.5	6.1	1.2	0.7	4.5	2.8	1204
Serbia and Montenegro city	17.8	2.4	15.9	2.4	5.9	0.9	5.4	0.8	1.4	0.2	2.9	0.5	1191
Thailand city	15.3	4.8	16.0	5.8	8.3	3.0	7.7	2.5	4.1	1.2	4.5	1.9	1049
Thailand province	22.9	9.7	19.5	8.0	9.4	4.2	10.0	4.1	5.1	2.8	6.5	3.2	1024
United Republic of Tanzania city	29.1	12.3	16.2	6.8	12.8	5.2	10.1	4.3	3.2	1.3	4.0	1.5	1442
United Republic of Tanzania province	41.8	14.7	23.9	9.8	19.5	7.2	14.7	5.8	5.4	2.2	5.7	1.6	1256

[a] At least one act of physical violence during the 12 months preceding the interview.

Appendix Table 5 Severity[a] and timing[b] of physical violence against ever-partnered women by an intimate partner, by site

Site	Lifetime prevalence of violence			Current violence		Former violence		Total no. of ever-partnered women
	All physical (%)	Moderate (%)	Severe (%)	Moderate (%)	Severe (%)	Moderate (%)	Severe (%)	
Bangladesh city	39.7	21.0	18.7	8.7	10.3	12.2	8.4	1373
Bangladesh province	41.7	22.3	19.4	6.5	9.3	15.8	10.1	1329
Brazil city	27.2	11.7	15.5	5.0	3.3	6.7	12.2	940
Brazil province	33.8	13.7	20.0	5.4	7.5	8.3	12.5	1188
Ethiopia province	48.7	13.3	35.4	7.4	21.6	5.9	13.8	2261
Japan city	12.9	9.2	3.8	2.4	0.7	6.7	3.1	1277
Namibia city	30.6	10.5	19.9	5.3	10.6	5.3	9.3	1369
Peru city	48.6	23.1	25.5	7.4	9.6	15.7	15.9	1086
Peru province	61.0	12.0	49.0	3.8	21.0	8.2	28.0	1535
Samoa	40.5	16.7	23.8	5.6	12.3	11.0	11.5	1204
Serbia and Montenegro city	22.8	14.7	8.1	1.6	1.6	13.1	6.5	1191
Thailand city	22.9	10.3	12.6	2.8	5.1	7.5	7.4	1049
Thailand province	33.8	15.8	18.0	5.1	8.3	10.7	9.7	1024
United Republic of Tanzania city	32.9	16.3	16.5	6.4	8.3	9.9	8.3	1442
United Republic of Tanzania province	46.7	21.8	24.7	8.0	10.7	13.8	14.0	1256

[a] Women are considered to have suffered severe violence if they have experienced at least one of the following acts: being hit with a fist or something else, kicked, dragged, beaten up, choked, burnt on purpose, threatened with a weapon or had a weapon used against them. Severe violence may also include moderate acts. Women are considered to have suffered moderate violence if they have only been slapped, pushed, shoved or had something thrown at them. Moderate violence excludes any of the acts categorized as severe violence.

[b] Current violence refers to violence which took place during the 12 months preceding the interview. Former violence refers to violence experienced prior to the 12 months preceding the interview. If violence took place both during the past 12 months and prior to the past 12 months, it is categorized as current violence.

Appendix Table 6 Different acts of physical violence against women by an intimate partner in the 12 months preceding the interview: prevalence of each act among ever-partnered women, and the frequency distribution of number of times women experienced that particular act, by site

	Slapped or threw something in the past 12 months		Frequency of act among those slapped			Pushed or shoved in the past 12 months		Frequency of act among those pushed or shoved			Hit with a fist or something else in past 12 months		Frequency of act among those hit with fist or something else			Kicked or dragged in past 12 months		Frequency of act among those dragged or kicked			Choked or burnt in past 12 months		Frequency of act among those choked or burnt			Threatened or had weapon used against them in past 12 months		Frequency of act among those threatened or had weapon used against them			Total no. of ever-partnered women
Site	n	(%)	Once (%)	A few times (%)	Many times (%)	n	(%)	Once (%)	A few times (%)	Many times (%)	n	(%)	Once (%)	A few times (%)	Many times (%)	n	(%)	Once (%)	A few times (%)	Many times (%)	n	(%)	Once (%)	A few times (%)	Many times (%)	n	(%)	Once (%)	A few times (%)	Many times (%)	
Bangladesh city	236	17.2	19.9	45.8	34.3	167	12.2	8.4	48.5	43.1	109	7.9	11.0	48.6	40.4	88	6.4	14.8	42.0	43.2	45	3.3	28.9	26.7	44.4	11	0.8	§	§	§	1373
Bangladesh province	187	14.1	22.5	41.7	35.8	142	10.7	19.7	43.0	37.3	87	6.5	13.8	52.9	33.3	79	5.9	17.7	44.3	38.0	37	2.8	35.1	32.4	32.4	26	2.0	30.8	50.0	19.2	1329
Brazil city	37	3.9	40.5	37.8	21.6	69	7.3	43.5	43.5	13.0	19	2.0	§	§	§	14	1.5	§	§	§	6	0.6	§	§	§	12	1.3	§	§	§	940
Brazil province	108	9.1	35.2	33.3	31.5	121	10.2	33.9	41.3	24.8	58	4.9	34.5	36.2	29.3	37	3.1	24.3	45.9	29.7	9	0.8	§	§	§	42	3.5	33.3	28.6	38.1	1188
Ethiopia province	526	23.3	28.3	44.7	27.0	347	15.3	31.7	44.7	23.6	211	9.3	26.1	44.5	29.4	333	14.7	35.1	36.3	28.5	26	1.1	38.5	46.2	15.4	16	0.7	§	§	§	2261
Japan city	18	1.4	§	§	§	34	2.7	41.2	55.9	2.9	3	0.2	§	§	§	5	0.4	§	§	§	2	0.0	§	§	§	1	0.1	§	§	§	1277
Namibia city	162	11.9	32.1	43.8	24.1	130	9.5	23.1	46.9	30.0	106	7.8	24.5	41.5	34.0	78	5.7	28.2	35.9	35.9	31	2.3	19.4	41.9	38.7	45	3.3	51.1	17.8	31.1	1369
Peru city	128	11.8	35.2	53.1	11.7	129	11.9	34.4	49.2	16.4	68	6.2	40.3	43.3	16.4	49	4.5	40.8	42.9	16.3	12	1.1	§	§	§	8	0.7	§	§	§	1086
Peru province	296	19.3	18.6	56.1	25.3	256	16.7	18.4	52.9	28.6	238	15.5	17.2	56.3	26.5	229	14.9	18.8	53.3	27.9	69	4.5	34.8	39.1	26.1	46	3.0	28.3	32.6	39.1	1535
Samoa	180	15.0	36.1	36.1	27.8	62	5.1	25.8	35.5	38.7	120	10.0	32.5	30.8	36.7	73	6.1	30.1	30.1	39.7	9	0.7	§	§	§	34	2.8	35.3	17.6	47.1	1204
Serbia and Montenegro city	29	2.4	31.0	41.4	27.6	29	2.4	44.8	31.0	24.1	11	0.9	§	§	§	10	0.8	§	§	§	2	0.2	§	§	§	6	0.5	§	§	§	1191
Thailand city	50	4.8	36.0	30.0	34.0	61	5.8	44.3	41.0	14.8	31	3.0	29.0	41.9	29.0	26	2.5	30.8	46.2	23.1	13	1.2	§	§	§	20	1.9	40.0	40.0	20.0	1049
Thailand province	99	9.7	38.4	42.4	19.2	82	8.0	30.5	34.1	35.4	43	4.2	18.6	48.8	32.6	42	4.1	16.7	45.2	38.1	29	2.8	37.9	24.1	37.9	33	3.2	30.3	36.4	33.3	1024
United Republic of Tanzania city	177	12.3	43.6	39.7	16.8	98	6.8	33.3	43.4	23.2	75	5.2	36.0	41.3	22.7	62	4.3	42.9	34.9	22.2	18	1.3	§	§	§	22	1.5	63.6	18.2	18.2	1442
United Republic of Tanzania province	184	14.7	32.6	43.5	23.9	122	9.8	27.9	40.2	32.0	90	7.2	38.5	36.3	25.3	72	5.8	36.1	31.9	31.9	27	2.2	44.4	25.9	29.6	20	1.6	40.0	25.0	35.0	1256

§. Percentage based on fewer than 20 respondents suppressed.

Appendix Table 7 Different acts of emotionally abusive behaviour towards women by an intimate partner in the 12 months preceding the interview: prevalence of each act among ever-partnered women and the frequency distribution of number of times women experienced that particular act, by site

	Insulted in the past 12 months		Frequency of act among those insulted			Humiliated or belittled in the past 12 months		Frequency of act among those humiliated or belittled			Scared or intimidated in the past 12 months		Frequency of act among those scared or intimidated			Threatened with harm in the past 12 months		Frequency of act among those threatened with harm			Total no. of ever-partnered women
Site	n	(%)	Once (%)	A few times (%)	Many times (%)	n	(%)	Once (%)	A few times (%)	Many times (%)	n	(%)	Once (%)	A few times (%)	Many times (%)	n	(%)	Once (%)	A few times (%)	Many times (%)	
Bangladesh city	309	22.5	6.5	54.4	39.2	251	18.3	4.4	49.8	45.8	200	14.6	6.0	48.0	46.0	47	3.4	14.9	40.4	44.7	1373
Bangladesh province	171	12.9	5.3	58.5	36.3	130	9.8	6.9	59.2	33.8	145	10.9	9.0	60.7	30.3	33	2.5	15.2	48.5	36.4	1329
Brazil city	128	13.6	15.6	49.2	35.2	62	6.6	21.0	38.7	40.3	87	9.2	28.7	35.6	35.6	59	6.3	28.8	49.2	22.0	940
Brazil province	202	17.0	15.8	44.1	40.1	141	11.9	19.9	41.1	39.0	153	12.9	18.3	47.1	34.6	112	9.4	20.5	40.2	39.3	1188
Ethiopia province	1255	55.5	17.9	48.8	33.2	203	9.0	19.7	39.9	40.4	354	15.7	19.8	49.7	30.5	61	2.7	29.5	39.3	31.1	2261
Japan city	136	10.6	34.6	53.7	11.8	45	3.5	35.6	48.9	15.6	96	7.5	40.6	49.0	10.4	7	0.5	§	§	§	1278
Namibia city	218	16.3	21.9	49.8	28.3	117	8.7	19.5	48.3	32.2	91	6.8	18.7	42.9	38.5	67	4.9	25.4	35.8	38.8	1373
Peru city	285	26.3	16.5	54.4	29.1	108	9.9	20.4	40.7	38.9	140	12.9	15.7	55.7	28.6	71	6.5	22.5	52.1	25.4	1090
Peru province	584	38.1	7.0	61.0	32.0	284	18.5	10.2	56.3	33.5	287	18.7	11.8	59.9	28.2	222	14.5	17.6	51.4	31.1	1536
Samoa	114	9.5	36.0	29.8	34.2	45	3.7	17.8	33.3	48.9	70	5.8	25.7	30.0	44.3	45	3.7	26.7	22.2	51.1	1206
Serbia and Montenegro city	113	9.6	21.9	60.5	17.5	36	3.1	18.9	51.4	29.7	52	4.5	20.8	56.6	22.6	28	2.4	21.4	46.4	32.1	1194
Thailand city	124	11.8	11.4	44.7	43.9	82	7.9	17.1	46.3	36.6	120	11.5	16.7	48.3	35.0	51	4.9	23.5	45.1	31.4	1051
Thailand province	119	11.7	19.3	42.0	38.7	81	8.0	16.0	46.9	37.0	146	14.4	21.2	45.2	33.6	56	5.5	16.1	44.6	39.3	1027
United Republic of Tanzania city	286	20.3	23.1	53.5	23.4	109	7.7	19.3	49.5	31.2	174	12.3	24.1	50.6	25.3	93	6.5	36.6	34.4	29.0	1454
United Republic of Tanzania province	357	28.5	18.8	51.5	29.7	102	8.2	17.6	45.1	37.3	170	13.6	15.3	56.5	28.2	80	6.5	28.8	50.0	21.3	1258

§. Percentage based on fewer than 20 respondents suppressed.

Appendix Table 8 Controlling behaviours by an intimate partner: frequency distribution of the number of acts of controlling behaviour reported by ever-partnered women, according to their experience of physical or sexual violence, or both, by site

Site	Experience of violence	No. of acts of controlling behaviour: None (%)	1 (%)	2 or 3 (%)	4 or more (%)		Total no. of ever-partnered women
Bangladesh city	Never experienced violence	65.6	23.9	9.2	1.3		640
	Ever experienced violence	35.1	25.1	24.3	15.6	****	733
Bangladesh province	Never experienced violence	37.1	34.8	21.4	6.7		509
	Ever experienced violence	24.3	29.3	31.3	15.1	****	820
Brazil city	Never experienced violence	51.5	19.0	22.9	6.6		668
	Ever experienced violence	23.2	17.6	26.1	33.1	****	272
Brazil province	Never experienced violence	50.9	22.0	19.2	7.9		750
	Ever experienced violence	22.1	19.4	22.6	35.8	****	438
Ethiopia province	Never experienced violence	51.6	19.4	26.1	2.9		659
	Ever experienced violence	37.2	21.8	31.8	9.2	****	1602
Japan city	Never experienced violence	82.5	12.2	4.7	0.6		1080
	Ever experienced violence	56.6	20.4	15.3	7.7	****	196
Namibia city	Never experienced violence	59.0	19.3	15.3	6.4		876
	Ever experienced violence	30.3	14.9	27.3	27.5	****	491
Peru city	Never experienced violence	44.0	29.4	20.9	5.7		530
	Ever experienced violence	18.2	21.6	30.2	30.0	****	556
Peru province	Never experienced violence	36.8	25.3	30.7	7.2		475
	Ever experienced violence	16.9	12.4	30.8	39.9	****	1059
Samoa	Never experienced violence	31.4	27.3	31.0	10.3		649
	Ever experienced violence	16.6	20.2	34.8	28.5	****	555
Serbia and Montenegro city	Never experienced violence	76.3	15.5	6.6	1.5		907
	Ever experienced violence	45.0	25.9	14.9	14.2	****	282
Thailand city	Never experienced violence	53.3	26.1	15.9	4.7		617
	Ever experienced violence	25.1	22.0	34.6	18.3	****	431
Thailand province	Never experienced violence	47.7	25.4	21.9	5.0		539
	Ever experienced violence	26.0	21.0	31.3	21.6	****	485
United Republic of Tanzania city	Never experienced violence	13.0	22.5	47.9	16.7		846
	Ever experienced violence	5.2	11.1	46.5	37.2	****	596
United Republic of Tanzania province	Never experienced violence	29.1	23.8	41.0	6.1		554
	Ever experienced violence	14.5	16.0	44.6	24.9	****	702

Asterisks denote significance levels: *, $P < 0.05$; **, $P < 0.01$; ***, $P < 0.001$; ****, $P < 0.0001$ (Pearson chi-square test.)

Appendix Table 9 Perpetrators of physical violence among women reporting physical violence by non-partners since the age of 15 years, by site

Site	Father (%)	Stepfather (%)	Male family member (%)	Female family member (%)	Teacher (%)	Police/ soldier (%)	Male friend of family (%)	Female friend of family (%)	Boyfriend (%)	Stranger (%)	Someone at work (%)	Religious leader (%)	Mother-in-law[a] (%)	Sister-in-law[a] (%)	Co-wife[a] (%)	Not identified[b] (%)	Total no. of women reporting physical violence
Bangladesh city	24.7	1.4	26.5	45.5	15.4	0.0	1.8	0.0	0.0	0.4	1.1	0.0	2.5	1.8	0.4	1.1	279
Bangladesh province	12.2	0.0	28.0	37.8	26.2	0.0	2.4	1.2	0.0	0.0	0.0	0.6	9.1	6.1	0.0	7.9	164
Brazil city	27.8	4.5	20.0	33.1	0.4	0.4	2.4	2.9	15.5	8.2	0.4	0.0	n.a.	n.a.	n.a.	7.8	245
Brazil province	25.5	4.7	17.7	36.5	0.0	0.0	1.6	2.1	4.2	6.3	0.5	0.0	n.a.	n.a.	n.a.	14.6	192
Ethiopia province	55.7	0.7	14.8	5.4	4.7	0.0	2.0	3.4	2.7	2.0	3.4	0.0	n.a.	n.a.	n.a.	14.1	149
Japan city	51.6	4.7	14.1	6.3	7.8	0.0	1.6	0.0	10.9	18.8	7.8	0.0	n.a.	n.a.	n.a.	0.0	64
Namibia city	18.8	4.2	12.8	19.4	26.0	4.2	5.6[c]	5.2	27.8	10.1	0.3	0.0	n.a.	n.a.	n.a.	6.3	288
Peru city	38.4	1.7	27.9	28.9	1.7	0.0	0.7	1.2	8.0	6.0	1.0	0.0	n.a.	n.a.	n.a.	10.2	401
Peru province	40.5	3.7	22.1	31.7	5.1	0.3	1.4	4.1	2.7	4.1	1.4	0.0	n.a.	n.a.	n.a.	15.2	587
Samoa	57.8	0.9	7.3	62.5	30.0	0.0	0.2	0.7	0.3	1.6	0.0	0.8	n.a.	n.a.	n.a.	0.6	1016
Serbia and Montenegro city	36.0	1.4	8.6	22.3	0.7	1.4	0.7	0.0	20.1	18.7	0.7	0.0	n.a.	n.a.	n.a.	7.9	139
Thailand city	17.9	0.9	16.2	18.8	4.3	0.0	0.9	2.6	4.3	12.8	3.4	0.0	n.a.	n.a.	n.a.	32.5	117
Thailand province	21.5	1.7	23.1	27.3	8.3	0.8	0.8	1.7	0.8	4.1	2.5	0.0	n.a.	n.a.	n.a.	24.0	121
United Republic of Tanzania city	14.9	0.3	10.3	7.7	59.9	0.3	0.6	2.9	6.9	4.0	0.6	0.3	n.a.	n.a.	n.a.	17.5	349
United Republic of Tanzania province	16.1	0.0	14.3	5.7	51.7	0.0	1.3	2.2	4.3	5.2	0.0	0.4	n.a.	n.a.	n.a.	24.8	230

n.a.,not available.

[a] Only in Bangladesh were in-laws and co-wives separate pre-coded response categories in the questionnaire.

[b] If a woman experienced violence by more than one perpetrator in the same category, the second perpetrator is usually coded in this category.

[c] In Namibia neighbours were recorded as a separate category but are included here under male friends of family.

Appendix Table 10 Perpetrators of sexual violence among women reporting sexual violence by non-partners since the age of 15 years, by site

Site	Father (%)	Stepfather (%)	Male family member (%)	Female family member (%)	Teacher (%)	Police/soldier (%)	Male friend of family (%)	Female friend of family (%)	Boyfriend (%)	Stranger (%)	Someone at work (%)	Religious leader (%)	Not identified[a] (%)	Total no. of women reporting sexual violence
Bangladesh city	0.0	0.0	8.2	0.0	0.0	0.0	5.7	0.0	4.9	78.7	4.9	0.0	4.1	122
Bangladesh province	§	§	§	§	§	§	§	§	§	§	§	§	§	8
Brazil city	0.0	6.3	7.5	0.0	1.3	0.0	10.0	0.0	32.5	28.8	7.5	0.0	15.0	80
Brazil province	1.5	2.9	8.8	0.0	0.0	0.0	14.7	1.5	32.4	17.6	4.4	1.5	16.2	68
Ethiopia province	§	§	§	§	§	§	§	§	§	§	§	§	§	9
Japan city	0.0	0.0	2.1	0.0	4.2	0.0	6.3	0.0	22.9	60.4	16.7	0.0	2.1	48
Namibia city	0.0	1.0	5.2	0.0	2.1	0.0	9.4[b]	0.0	55.2	24.0	0.0	0.0	5.2	96
Peru city	1.4	2.1	11.7	0.7	0.7	1.4	8.3	0.0	31.7	28.3	1.4	0.0	24.1	145
Peru province	0.0	1.0	7.7	1.0	2.9	0.0	8.7	0.0	30.9	26.1	5.3	0.0	24.2	207
Samoa	1.1	0.0	8.0	1.1	4.0	0.6	6.3	0.0	46.0	23.6	2.3	0.0	7.5	174
Serbia and Montenegro city	1.8	0.0	1.8	0.0	1.8	0.0	3.6	0.0	32.1	42.9	3.6	0.0	17.9	56
Thailand city	0.0	0.0	2.1	0.0	0.0	2.1	9.6	0.0	17.0	44.7	6.4	0.0	24.5	94
Thailand province	0.0	3.0	9.1	0.0	6.1	3.0	3.0	0.0	21.2	15.2	6.1	0.0	39.4	33
United Republic of Tanzania city	0.0	0.0	11.0	0.5	2.4	2.4	6.7	1.4	40.2	22.5	0.5	0.0	22.0	209
United Republic of Tanzania province	0.7	1.5	2.2	0.0	4.4	3.0	8.9	1.5	28.9	23.7	3.0	0.0	27.4	135

§, Percentage based on fewer than 20 respondents suppressed.
[a] If a woman experienced violence by more than one perpetrator in the same category, the second perpetrator is usually coded in this category.
[b] In Namibia neighbours were recorded as a separate category but are included here under male friend of family.

Appendix Table 11 Perpetrators of childhood sexual abuse among women reporting sexual abuse before the age of 15 years, by site

Site	Father (%)	Stepfather (%)	Male family member (%)	Female family member (%)	Teacher (%)	Police/soldier (%)	Male friend of family (%)	Female friend of family (%)	Boyfriend (%)	Stranger (%)	Someone at work (%)	Religious leader (%)	Not identified[a] (%)	Total no. of women reporting sexual abuse before age 15 years
Bangladesh city	0.0	0.0	10.9	0.0	2.5	0.0	10.9	0.0	0.8	69.7	0.8	0.0	5.9	119
Bangladesh province	§	§	§	§	§	§	§	§	§	§	§	§	§	16
Brazil city	7.6	8.7	50.0	2.2	0.0	0.0	7.6	2.2	2.2	8.7	1.1	1.1	14.1	92
Brazil province	1.2	9.4	41.2	3.5	0.0	0.0	18.8	2.4	7.1	12.9	2.4	0.0	11.8	85
Ethiopia province	§	§	§	§	§	§	§	§	§	§	§	§	§	7
Japan city	0.8	2.3	6.1	0.8	5.3	0.8	6.9	0.0	8.4	68.7	0.0	0.0	5.3	131
Namibia city	5.5	4.1	32.9	5.5	2.7	0.0	19.2[b]	2.7	12.3	16.4	0.0	0.0	4.1	73
Peru city	3.6	6.5	43.5	2.5	2.2	0.4	12.7	0.0	1.4	24.6	0.0	0.7	19.2	276
Peru province	1.4	3.4	36.6	0.0	0.0	0.0	11.0	0.7	8.3	22.8	0.0	0.0	24.1	145
Samoa	0.0	3.3	16.7	3.3	3.3	0.0	6.7	0.0	23.3	33.3	0.0	0.0	16.7	30
Serbia and Montenegro city	3.6	3.6	21.4	0.0	0.0	0.0	10.7	3.6	10.7	39.3	0.0	0.0	10.7	28
Thailand city	0.0	0.9	6.8	0.0	1.7	0.0	8.5	0.9	0.9	58.1	0.9	0.0	24.8	117
Thailand province	0.0	5.0	15.0	1.7	1.7	0.0	6.7	0.0	1.7	30.0	1.7	0.0	38.3	60
United Republic of Tanzania city	0.0	0.0	22.8	5.1	6.3	0.0	8.9	2.5	11.4	13.9	0.0	0.0	32.9	79
United Republic of Tanzania province	1.7	0.0	13.3	3.3	3.3	0.0	13.3	0.0	23.3	18.3	1.7	0.0	28.3	60

§, Percentage based on fewer than 20 respondents suppressed.
[a] If a woman experienced violence by more than one perpetrator in the same category, the second perpetrator is usually coded in this category.
[b] In Namibia neighbours were recorded as a separate category but are included here under male friends of family.

Appendix Table 12 Logistic regression models for the associations between selected health conditions and experience of intimate partner violence among ever-partnered women, by site[a]

	Poor/very poor health				Problems with walking				Problems with daily activities			
Site	COR	95% CI	AOR	95% CI	COR	95% CI	AOR	95% CI	COR	95% CI	AOR	95% CI
Bangladesh city	1.7	1.2–2.2	1.4	1.0–1.9	1.5	1.1–1.9	1.4	1.0–1.8	1.5	1.2–2.0	1.5	1.1–1.9
Bangladesh province	1.4	1.0–1.8	1.3	1.0–1.7	1.5	1.1–1.9	1.4	1.1–1.8	1.4	1.1–1.8	1.3	1.0–1.7
Brazil city	2.4	1.3–4.3	2.0	1.1–3.7	1.4	0.9–2.2	1.3	0.8–2.1	1.8	1.2–2.7	1.8	1.1–2.7
Brazil province	2.3	1.7–3.1	1.8	1.3–2.4	1.6	1.2–2.2	1.5	1.1–2.1	2.0	1.5–2.7	1.8	1.3–2.4
Ethiopia province	2.0	1.0–3.9	2.0	1.0–3.9	1.5	0.3–7.2	1.4	0.3–7.0	n.a.	n.a.	n.a.	n.a.
Japan city	1.9	1.0–3.9	1.9	0.9–4.0	1.4	0.7–2.8	1.4	0.7–2.8	1.8	1.1–2.8	1.7	1.1–2.7
Namibia city	2.3	1.3–3.9	2.1	1.2–3.6	2.5	1.7–3.8	2.6	1.7–3.9	2.4	1.5–3.7	2.6	1.6–4.0
Peru city	2.1	1.3–3.5	1.9	1.1–3.2	2.6	1.7–3.8	2.7	1.8–4.0	1.8	1.3–2.4	1.9	1.3–2.6
Peru province	1.9	1.4–2.6	1.6	1.2–2.3	2.0	1.5–2.7	2.0	1.5–2.7	2.4	1.8–3.3	2.4	1.8–3.3
Samoa	0.7	0.3–1.7	0.6	0.2–1.6	1.2	0.7–1.8	1.1	0.7–1.8	1.3	0.8–2.1	1.3	0.8–2.0
Serbia and Montenegro city	2.5	1.4–4.3	2.0	1.1–3.6	1.8	1.2–2.6	1.5	1.0–2.2	1.9	1.3–2.9	1.7	1.1–2.6
Thailand city	1.7	1.2–2.4	1.6	1.2–2.3	1.9	1.4–2.7	1.9	1.3–2.7	1.4	1.0–1.9	1.3	0.9–1.9
Thailand province	1.7	1.3–2.3	1.6	1.2–2.2	1.6	1.1–2.3	1.5	1.1–2.3	1.7	1.2–2.4	1.7	1.2–2.4
United Republic of Tanzania city	1.3	0.6–2.6	1.2	0.6–2.6	2.0	1.5–2.7	2.0	1.5–2.7	1.7	1.3–2.4	1.8	1.3–2.5
United Republic of Tanzania province	1.8	1.1–3.2	1.6	0.9–2.9	1.1	0.8–1.5	1.0	0.7–1.4	1.3	0.9–1.7	1.1	0.8–1.6

	Pain				Problems with memory				Dizziness				Vaginal discharge			
Site	COR	95% CI	AOR	95% CI	COR	95% CI	AOR	95% CI	COR	95% CI	AOR	95% CI	COR	95% CI	AOR	95% CI
Bangladesh city	1.6	1.3–2.0	1.6	1.2–2.0	1.8	1.3–2.4	1.8	1.3–2.5	2.3	1.8–2.8	1.9	1.5–2.4	2.7	2.1–3.4	2.0	1.6–2.6
Bangladesh province	1.6	1.3–2.0	1.5	1.2–1.9	1.6	1.1–2.2	1.5	1.1–2.1	1.8	1.4–2.3	1.7	1.3–2.4	1.6	1.3–2.0	1.6	1.3–2.0
Brazil city	2.0	1.5–2.6	1.9	1.4–2.6	2.3	1.6–3.5	2.3	1.5–3.6	1.9	1.4–2.6	2.2	1.6–3.0	1.3	0.9–1.8	1.5	1.1–2.1
Brazil province	1.9	1.5–2.5	1.8	1.4–2.3	2.3	1.6–3.3	2.1	1.4–3.1	1.9	1.5–2.4	1.7	1.3–2.2	1.8	1.4–2.3	1.9	1.5–2.6
Ethiopia province	1.1	0.8–1.3	1.1	0.9–1.4	2.8	0.6–12.3	2.8	0.6–12.4	1.1	0.6–1.8	1.1	0.6–1.8	2.0	1.1–3.7	2.0	1.1–3.6
Japan city	1.5	1.0–2.5	1.5	0.9–2.4	2.3	1.5–3.7	2.3	1.5–3.8	1.8	1.2–2.6	1.8	1.2–2.6	1.5	0.8–2.9	1.6	0.9–3.1
Namibia city	2.0	1.4–2.8	2.0	1.4–2.9	2.6	1.7–4.0	2.4	1.6–3.7	2.2	1.7–2.9	2.1	1.6–2.8	1.6	1.2–2.3	1.6	1.1–2.2
Peru city	1.9	1.4–2.4	1.9	1.5–2.5	1.7	1.2–2.4	1.8	1.2–2.5	1.7	1.3–2.2	1.6	1.2–2.1	1.8	1.4–2.3	1.7	1.3–2.2
Peru province	1.5	1.2–1.9	1.5	1.2–1.9	1.9	1.4–2.4	1.7	1.3–2.3	1.7	1.3–2.1	1.6	1.3–2.0	1.7	1.4–2.1	1.8	1.4–2.2
Samoa	1.5	1.1–1.9	1.4	1.1–1.9	1.1	0.6–1.9	1.0	0.6–1.8	1.6	1.3–2.0	1.6	1.2–2.0	2.8	1.3–5.9	2.6	1.2–5.5
Serbia and Montenegro city	1.7	1.3–2.2	1.6	1.2–2.1	2.4	1.5–3.7	2.0	1.3–3.2	1.3	0.9–1.7	1.2	0.9–1.6	1.9	1.3–2.7	2.2	1.5–3.2
Thailand city	1.6	1.2–2.2	1.5	1.1–2.0	2.0	1.5–2.6	2.0	1.5–2.6	1.4	1.1–1.8	1.4	1.1–1.8	2.2	1.4–3.5	2.2	1.4–3.5
Thailand province	1.6	1.2–2.2	1.6	1.2–2.1	1.6	1.2–2.1	1.6	1.2–2.1	1.7	1.3–2.3	1.6	1.2–2.1	2.4	1.7–3.6	2.5	1.6–3.7
United Republic of Tanzania city	1.7	1.4–2.2	1.8	1.4–2.3	2.0	1.5–2.6	1.9	1.5–2.5	1.6	1.2–2.0	1.6	1.2–2.1	1.6	1.1–2.4	1.6	1.1–2.3
United Republic of Tanzania province	1.4	1.1–1.9	1.3	1.0–1.7	1.3	0.9–1.8	1.3	0.9–1.8	1.9	1.4–2.5	1.9	1.4–2.5	1.9	1.3–2.8	1.9	1.3–2.8

COR, crude odds ratio; AOR, adjusted odds ratio (adjusted for age, current marital status and educational level); CI, confidence interval; n.a., data not available.

[a] Odds ratios and 95% confidence intervals are given for the odds of health problems in ever-partnered women who have ever experienced physical or sexual violence, or both, by an intimate partner, relative to the odds of health problems in ever-partnered women who have not experienced violence (except for general health, all conditions where asked for the past 4 weeks).

Appendix Table 13 Logistic regression models for the associations between suicidal thoughts and suicidal acts, and experience of intimate partner violence among ever-partnered women, by site

	Suicidal thoughts[a]				Suicidal acts[b]			
Site	COR	95% CI	AOR	95% CI	COR	95% CI	AOR	95% CI
All sites	2.4	2.2–2.6	2.9	2.7–3.2	3.5	3.0–4.1	3.8	3.3–4.5
Bangladesh city	3.5	2.5–5.0	3.5	2.4–5.1	6.6	2.8–15.6	6.3	2.6–15.5
Bangladesh province	4.2	2.6–6.7	4.0	2.5–6.5	§	§	§	§
Brazil city	3.6	2.7–4.9	3.3	2.4–4.6	3.8	2.5–6.0	3.5	2.1–5.6
Brazil province	3.3	2.5–4.3	3.0	2.2–3.9	5.1	3.1–8.4	4.3	2.5–7.1
Ethiopia province	1.6	0.9–2.6	1.6	0.9–2.6	5.1	0.7–39.6	4.8	0.6–37.2
Japan city	3.7	2.6–5.2	3.5	2.4–5.1	11.7	4.3–31.5	11.4	4.1–31.3
Namibia city	2.8	2.1–3.7	2.8	2.1–3.8	3.4	2.1–5.5	3.4	2.1–5.5
Peru city	3.2	2.4–4.2	3.4	2.5–4.6	4.7	3.0–7.2	4.6	2.9–7.2
Peru province	3.1	2.3–4.1	3.3	2.4–4.5	3.7	2.2–6.2	3.7	2.2–6.4
Samoa	2.0	1.4–2.9	2.0	1.4–3.0	2.5	1.3–4.8	2.6	1.3–5.0
Serbia and Montenegro city	3.8	2.6–5.5	3.4	2.3–5.1	4.7	2.1–10.7	3.1	1.3–7.6
Thailand city	3.2	2.4–4.3	3.1	2.3–4.2	3.8	2.3–6.1	3.4	2.1–5.6
Thailand province	2.6	1.9–3.4	2.4	1.8–3.3	3.0	1.7–5.3	2.8	1.5–5.0
United Republic of Tanzania city	1.9	1.3–2.8	1.9	1.3–2.9	3.2	1.0–10.5	4.0	1.2–13.8
United Republic of Tanzania province	2.9	1.8–4.6	2.7	1.7–4.4	2.8	0.6–13.4	2.2	0.4–11.1

§, insufficient cases

COR, crude odds ratio; AOR, adjusted odds ratio, adjusted for age, current marital status and educational level. The all-sites odds ratios –based on a pooled data set including all 15 sites– are adjusted for age, current marital status, educational level and site. CI, confidence interval.

[a] Odds ratios and 95% confidence intervals are given for the odds of suicidal thoughts in ever-partnered women who have ever experienced physical or sexual violence, or both, by an intimate partner, relative to the odds of suicidal thoughts in ever-partnered women who have not experienced violence.

[b] Odds ratios and 95% confidence intervals are given for the odds of suicidal acts in ever-partnered women who have ever experienced physical or sexual violence, or both, by an intimate partner, relative to the odds of suicidal acts in ever-partnered women who have not experienced violence.

Appendix Table 14 Logistic regression models for the associations between induced abortions and miscarriages, and experience of intimate partner violence among ever-pregnant women, by site[a]

	Induced abortion				Miscarriage			
Site	COR	95% CI	AOR	95% CI	COR	95% CI	AOR	95% CI
All sites	1.3	1.2–1.4	2.4	2.1–2.7	1.2	1.1–1.3	1.4	1.3–1.5
Bangladesh city	2.1	1.5–2.9	2.5	1.8–3.6	0.9	0.7–1.3	1.0	0.8–1.4
Bangladesh province	1.9	0.9–4.3	2.1	0.9–4.8	1.2	0.8–1.7	1.1	0.8–1.6
Brazil city	2.6	1.7–4.0	2.6	1.6–4.2	1.5	1.0–2.0	1.5	1.0–2.2
Brazil province	2.4	1.3–4.3	1.7	0.9–3.3	1.5	1.1–2.0	1.3	1.0–1.8
Ethiopia province	6.1	1.5–25.8	6.2	1.4–26.9	1.2	0.9–1.6	1.2	0.9–1.6
Japan city	2.7	1.8–4.1	2.3	1.5–3.7	1.1	0.7–1.7	1.2	0.8–1.8
Namibia city	2.8	0.7–11.8	2.5	0.6–11.4	1.3	0.9–1.8	1.5	1.1–2.1
Peru city	4.0	2.4–6.8	4.0	2.3–7.0	1.6	1.2–2.1	1.7	1.3–2.3
Peru province	3.2	1.7–6.0	3.3	1.7–6.2	2.0	1.5–2.7	2.2	1.6–3.0
Samoa	1.2	0.1–18.4	1.5	0.1–26.8	2.1	1.5–3.1	2.1	1.5–3.2
Serbia and Montenegro city	2.2	1.6–3.0	2.0	1.4–2.7	1.1	0.8–1.6	1.2	0.8–1.8
Thailand city	3.0	1.8–5.0	2.9	1.7–4.9	1.0	0.7–1.4	1.0	0.7–1.5
Thailand province	3.9	1.9–8.1	3.1	1.5–6.7	1.4	1.0–1.9	1.4	1.0–2.0
United Republic of Tanzania city	1.9	1.2–2.9	1.7	1.1–2.6	1.3	1.0–1.7	1.4	1.0–1.8
United Republic of Tanzania province	1.8	1.1–3.1	2.0	1.2–3.5	1.2	0.9–1.7	1.2	0.8–1.6

COR, crude odds ratio; AOR, adjusted odds ratio, adjusted for age, current marital status and educational level. The all-sites odds ratios –based on a pooled data set including all 15 sites– are adjusted for age, current marital status, educational level and site. CI, confidence interval.

[a] Odds ratios and 95% confidence intervals are given for the odds of induced abortions and miscarriages in ever-pregnant women who have ever experienced physical or sexual violence, or both, by an intimate partner, relative to the odds of these problems in ever-pregnant women who have not experienced violence.

Appendix Table 15 Percentage of ever physically abused women who told no one, someone and/or a service about their experience of intimate-partner violence, by site

Site	No one (%)	Friends (%)	Parents (%)	Brother or sister (%)	Uncle or aunt (%)	Partner's family (%)	Children (%)	Neighbours (%)	Police (%)	Doctor/ health worker (%)	Priest (%)	Counsellor (%)	NGO/ women's org. (%)	Local leader (%)	Other (%)	Total no. of women ever physically abused by a partner
Bangladesh city	65.9	2.6	17.8	15.8	2.8	7.2	0.7	10.3	0.6	1.3	0.0	0.0	0.2	0.9	0.7	545
Bangladesh province	66.2	0.9	18.6	14.1	4.0	15.9	1.8	11.6	0.5	1.3	0.0	0.0	0.0	3.2	1.3	554
Brazil city	21.5	30.5	32.8	32.8	3.5	18.4	2.0	7.4	4.7	3.1	2.0	3.1	0.0	0.0	6.3	256
Brazil province	23.9	18.5	42.9	21.4	4.7	19.2	0.7	11.7	1.0	1.7	0.5	0.5	0.0	0.0	5.2	401
Ethiopia province	38.6	6.4	31.2	7.7	2.4	14.3	2.0	19.3	1.1	1.3	0.2	0.1	0.4	7.4	2.7	1101
Japan city	32.0	56.2	29.4	13.1	3.9	15.7	3.3	2.0	1.3	3.9	1.3	3.3	0.7	0.0	2.0	153
Namibia city	20.8	32.5	34.6	25.8	6.7	12.4	5.0	8.1	9.8	3.6	1.4	1.0	1.2	0.0	2.9	419
Peru city	31.1	25.9	26.1	23.7	4.9	11.6	1.7	2.5	3.0	2.1	1.7	0.4	0.2	0.0	10.4	528
Peru province	31.6	17.8	33.2	24.5	6.5	13.2	2.6	8.0	8.2	6.0	0.6	0.0	0.7	2.2	10.0	936
Samoa	53.7	11.5	25.0	7.2	1.8	9.8	0.2	4.5	1.2	1.8	1.2	0.0	0.0	0.8	0.2	488
Serbia and Montenegro city	27.3	52.8	27.7[a]	25.8	1.8	6.3	1.8	4.4	4.8	3.7	0.7	3.0	0.4	0.0	1.8	271
Thailand city	37.1	32.9	25.0	30.4	6.7	5.4	3.3	5.8	1.3	1.7	0.4	0.0	0.0	0.0	2.1	240
Thailand province	45.7	26.9	20.8	21.4	5.2	4.3	2.9	11.3	0.3	1.4	0.0	0.0	0.0	0.3	2.0	346
United Republic of Tanzania city	28.5	13.5	34.8	19.2	6.3	29.3	1.7	12.7	6.3	4.6	3.2	0.4	0.0	8.4	5.9	474
United Republic of Tanzania province	29.7	7.2	27.3	9.4	1.5	29.4	1.4	25.4	3.4	3.6	2.9	0.3	0.0	24.9	3.9	586

NGO, nongovernmental organization.
[a] In Serbia and Montenegro city, the figure for parents is a combination of the results for mother (27.3%) and father (12.2%).

Appendix Table 16 Percentage of ever physically abused women who received offers of help from no one, someone and/or a service in relation to their experience of intimate-partner violence, by site

Site	No one (%)	Friends (%)	Parents (%)	Brother or sister (%)	Uncle or aunt (%)	Partner's family (%)	Children (%)	Neighbours (%)	Police (%)	Doctor/health worker (%)	Priest (%)	Counsellor (%)	NGO/ women's org. (%)	Local leader (%)	Other (%)	Total no. of women ever physically abused by a partner
Bangladesh city	58.9	1.5	12.3	8.6	2.0	13.2	1.1	18.2	0.4	0.7	0.0	0.0	0.0	0.7	0.4	545
Bangladesh province	51.3	0.0	12.5	6.9	3.1	28.5	3.6	15.2	0.0	0.4	0.0	0.0	0.0	2.3	1.3	554
Brazil city	33.6	18.0	23.4	24.6	2.7	14.5	2.0	6.3	1.6	0.8	1.2	2.3	0.0	0.0	5.1	256
Brazil province	34.4	12.0	28.9	15.5	3.2	16.5	1.2	8.7	0.7	0.7	0.2	0.2	0.0	0.0	5.0	401
Ethiopia province	41.4	4.0	24.3	5.3	1.3	11.4	1.3	18.7	0.8	1.4	0.1	0.0	0.4	8.0	1.9	1101
Japan city	45.8	36.1	20.8	6.3	2.1	7.6	2.8	2.8	0.7	0.7	0.7	2.1	0.7	0.0	1.4	144
Namibia city	37.7	19.8	21.0	15.5	5.0	6.7	2.4	6.9	7.4	3.1	1.2	0.7	1.2	0.0	1.9	419
Peru city	40.7	16.9	17.6	17.6	5.9	8.9	0.9	4.2	0.9	0.8	1.7	0.0	0.2	0.0	4.7	528
Peru province	41.0	11.1	21.5	19.0	5.3	9.7	2.5	6.6	4.5	2.9	0.7	0.1	0.9	1.7	8.2	936
Samoa	48.6	9.2	18.9	7.4	2.3	16.4	1.8	5.9	0.6	0.8	1.0	0.0	0.0	0.8	1.0	488
Serbia and Montenegro city	50.6	25.1	18.8[a]	14.4	1.5	3.3	1.5	1.8	2.2	1.8	0.4	1.8	0.4	0.0	0.7	271
Thailand city	43.8	12.9	14.6	13.3	2.9	17.1	7.9	7.5	1.3	0.0	0.0	0.0	0.0	0.0	3.8	240
Thailand province	41.6	7.2	14.5	17.3	5.5	13.3	9.5	9.8	0.3	0.0	0.0	0.0	0.0	0.6	2.6	346
United Republic of Tanzania city	49.8	7.2	5.9	6.5	2.1	10.1	2.3	22.2	0.8	0.8	0.4	0.0	0.0	1.9	6.5	474
United Republic of Tanzania province	51.9	1.7	3.9	2.7	0.9	12.5	2.0	25.9	0.3	0.2	1.0	0.0	0.0	7.2	4.9	586

NGO, nongovernmental organization.
[a] In Serbia and Montenegro city, the figure for parents is a combination of the results for mother (18.1%) and father (8.1%).

Appendix Table 17 Percentage of ever physically abused women who had ever sought support from various agencies and persons in authority in relation to their experience of intimate-partner violence, by site

Site	Police (%)	Hospital/ health centre (%)	Social services (%)	Legal advice centre (%)	Court (%)	Shelter (%)	Local leader (%)	Women's org. (%)	Religious leader (%)	Women's police dept (%)	Elsewhere (%)	Gone to at least one place for help (%)	Total no. of women ever physically abused by a partner
Bangladesh city	1.5	0.2	0.4	0.7	0.4	0.0	2.4	0.9	0.4	0.0	0.9	5.1	545
Bangladesh province	0.7	0.2	0.0	0.0	0.9	0.0	5.6	0.2	0.7	0.0	0.7	6.9	554
Brazil city	17.6	13.7	5.9	14.8	12.1	2.0	2.0	0.8	15.2	13.7	3.1	44.5	256
Brazil province	10.0	11.0	0.2	3.2	3.2	0.2	0.0	0.5	5.2	0.5	0.5	21.9	401
Ethiopia province	2.3	4.4	0.2	0.4	1.3	0.0	14.6	0.8	0.5	0.0	32.7	45.2	1099
Japan city	3.3	2.0	0.7	1.3	2.0	0.7	0.7	0.7	2.6	0.0	0.7	7.2	152
Namibia city	20.9	21.8	7.5	5.6	5.8	1.9	1.5	1.9	6.1	0.0	3.4	38.3	418
Peru city	24.5	8.4	0.0	5.3	6.1	0.2	0.0	1.2	7.0	5.1	1.9	32.8	527
Peru province	25.0	16.8	0.0	5.0	12.4	1.9	3.4	2.2	2.5	3.0	1.7	36.5	936
Samoa	4.7	7.2	0.0	0.6	1.2	0.0	5.3	1.2	2.5	0.0	0.6	15.4	488
Serbia and Montenegro city	12.3	10.0	8.9	6.4	5.6	0.0	0.0	2.2	1.1	0.0	0.4	22.1	271
Thailand city	10.5	5.9	0.8	1.3	1.3	0.4	0.8	0.0	4.6	0.0	1.7	20.3	237
Thailand province	5.2	3.8	0.9	0.3	0.3	0.0	0.3	0.0	2.0	0.0	0.9	10.2	343
United Republic of Tanzania city	15.3	20.5	2.4	2.6	4.3	1.5	17.2	1.1	5.3	0.0	10.1	40.8	473
United Republic of Tanzania province	6.5	13.7	0.9	2.2	3.8	0.2	30.9	0.3	5.1	0.0	5.0	41.2	585

Appendix Table 18 Reasons cited for seeking help, among ever physically abused women who had sought help from at least one agency in relation to their experience of intimate-partner violence, by site

Site	Encouraged by friends/family (%)	Could not endure more (%)	Badly injured (%)	Threatened or tried to kill her (%)	Threatened or hit children (%)	Children suffering (%)	Thrown out of home (%)	Afraid she would kill him (%)	Other reason to go for help (%)	Total no. of physically abused women who reported seeking help from at least one agency
Bangladesh city	17.9	78.6	21.4	10.7	32.1	3.6	10.7	0.0	10.7	28
Bangladesh province	15.8	84.2	31.6	2.6	36.8	5.3	18.4	0.0	7.9	38
Brazil city	10.5	49.1	14.9	8.8	3.5	10.5	1.8	1.8	33.3	114
Brazil province	20.5	36.4	33.0	4.5	3.4	2.3	2.3	1.1	19.3	88
Ethiopia province	3.6	66.8	22.7	9.5	2.0	5.6	5.2	0.4	7.0	497
Japan city	§	§	§	§	§	§	§	§	§	11
Namibia city	33.1	47.5	36.3	14.4	6.9	10.0	6.3	3.8	7.5	160
Peru city	11.6	54.9	13.9	7.5	4.0	6.9	1.7	2.3	45.7	173
Peru province	20.2	67.5	28.9	8.2	12.9	19.3	16.7	2.0	16.1	342
Samoa	5.3	65.3	26.7	6.7	1.3	6.7	1.3	1.3	8.0	75
Serbia and Montenegro city	16.7	63.3	30.0	8.3	5.0	11.7	0.0	0.0	15.0	60
Thailand city	8.3	43.8	31.3	8.3	4.2	4.2	0.0	2.1	47.9	48
Thailand province	8.6	31.4	25.7	2.9	5.7	5.7	0.0	0.0	51.4	35
United Republic of Tanzania city	5.7	58.5	23.8	9.3	3.1	6.7	7.8	2.6	30.1	193
United Republic of Tanzania province	4.6	58.9	24.5	10.0	5.0	5.0	14.5	1.7	29.5	241

§, Percentage based on fewer than 20 respondents suppressed.

Appendix Table 19 Reasons cited for not seeking help, among ever physically abused women who had not sought help from any agency in relation to their experience of intimate-partner violence, by site

Site	Don't know/ no answer (%)	Fear of the consequences/ threats/violence (%)	Violence normal/ not serious (%)	Embarrassed/afraid to be blamed or not believed (%)	Believed it would not help (%)	Afraid would end relationship (%)	Afraid would lose children (%)	Bring bad name to family (%)	Other reason (%)	Total no. of women who reported not seeking help from any agency
Bangladesh city	1.9	7.4	62.9	31.3	11.6	6.6	6.6	26.9	4.3	517
Bangladesh province	1.9	12.2	56.4	42.6	10.9	7.8	5.6	36.4	3.1	516
Brazil city	6.3	12.7	40.8	8.5	5.6	3.5	2.1	0.7	33.8	142
Brazil province	3.2	18.5	51.1	9.3	2.9	7.7	1.0	1.6	21.1	313
Ethiopia province	2.8	53.0	37.4	4.0	4.3	2.7	10.6	3.2	6.3	602
Japan city	10.7	8.6	82.9	7.9	2.9	1.4	1.4	3.6	21.4	153
Namibia city	22.1	8.1	50.0	2.3	2.7	9.7	4.7	1.9	14.3	258
Peru city	5.1	6.2	31.7	15.0	2.8	3.1	2.5	6.2	53.3	353
Peru province	5.6	26.8	28.8	28.3	3.0	8.6	6.6	10.3	25.4	594
Samoa	2.2	2.9	85.7	0.0	0.2	3.1	1.9	4.8	2.7	413
Serbia and Montenegro city	9.5	3.3	68.7	4.3	1.4	4.3	1.9	6.2	10.4	211
Thailand city	7.4	1.1	55.6	4.2	3.2	0.5	1.6	2.6	36.0	189
Thailand province	6.2	3.2	59.7	8.1	2.9	0.3	1.3	5.5	28.6	308
United Republic of Tanzania city	5.7	7.5	56.1	6.4	2.5	5.7	1.4	4.3	33.9	280
United Republic of Tanzania province	6.1	7.6	47.7	12.8	2.0	10.8	2.0	6.4	35.5	344

Appendix Table 20 Reasons cited for leaving temporarily, among ever physically abused women who had left at least once because of intimate-partner violence, by site

Site	No particular incident (%)	Encouraged by friends (%)	Could not endure more (%)	Badly injured (%)	Threatened to kill her (%)	Threatened/hit children (%)	Children suffering (%)	Thrown out of home (%)	Afraid she would kill him (%)	Encouraged by organization (%)	Other reason (%)	Total no. of women who reported having left at least once
Bangladesh city	1.8	5.5	89.0	9.2	0.9	0.9	0.9	10.1	0.0	0.0	11.9	109
Bangladesh province	1.9	2.8	89.7	15.0	2.8	3.7	4.7	12.1	0.9	0.0	4.7	107
Brazil city	2.8	5.7	48.1	11.3	8.5	3.8	7.5	2.8	1.9	0.0	45.3	106
Brazil province	2.9	4.9	57.1	12.2	12.2	3.4	1.5	7.3	1.5	0.0	17.1	205
Ethiopia province	12.2	5.1	59.8	14.3	6.0	3.0	8.3	10.7	1.2	0.0	11.6	336
Japan city	14.8	7.4	74.1	3.7	3.7	0.0	0.0	3.7	0.0	0.0	0.0	27
Namibia city	4.3	28.4	54.3	25.0	12.9	5.2	12.1	5.2	10.3	0.9	12.9	116
Peru city	2.8	2.8	60.1	11.9	18.2	4.9	11.2	9.1	0.0	0.0	37.8	143
Peru province	0.7	5.6	71.1	21.6	19.7	10.5	14.8	24.9	2.6	0.0	15.1	305
Samoa	1.4	3.6	73.4	16.5	4.3	4.3	2.2	3.6	0.0	0.0	12.2	139
Serbia and Montenegro city	14.3	9.5	63.5	11.1	7.9	4.8	4.8	3.2	0.0	0.0	7.9	63
Thailand city	9.8	2.0	55.9	4.9	5.9	2.0	1.0	4.9	2.0	0.0	42.2	102
Thailand province	13.9	1.6	43.4	6.6	2.5	0.0	2.5	8.2	0.8	0.0	46.7	122
United Republic of Tanzania city	2.3	1.8	61.4	13.5	8.8	1.8	2.3	12.9	3.5	0.0	25.1	171
United Republic of Tanzania province	1.7	6.8	66.7	20.9	6.8	3.4	1.7	17.5	0.0	0.6	26.0	177

Appendix Table 21 Persons with whom and places where women stayed the last time, among physically abused women who had left at least once because of intimate-partner violence, by site

Site	Her relatives (%)	His relatives (%)	Friends/neighbours (%)	Hotel/lodgings (%)	Street (%)	Church/temple (%)	Shelter (%)	Other (%)	Total no. of women who reported having left at least once
Bangladesh city	89.0	2.8	4.6	0.9	0.9	0.0	0.0	1.8	109
Bangladesh province	87.9	10.3	1.9	0.0	0.0	0.0	0.0	0.0	107
Brazil city	54.7	4.7	17.0	3.8	0.0	0.9	0.9	17.9	106
Brazil province	70.6	4.4	11.8	0.5	1.0	0.5	0.0	11.3	204
Ethiopia province[a]	89.6	3.6	2.1	0.0	0.0	0.0	0.0	0.0	336
Japan city	50.0	3.8	23.1	11.5	3.8	0.0	0.0	7.7	26
Namibia city	59.5	13.8	17.2	1.7	0.0	0.0	0.9	6.9	116
Peru city	84.5	0.7	8.5	0.0	0.7	0.0	0.0	5.6	142
Peru province	73.4	4.3	11.2	0.3	2.6	0.0	0.0	8.2	304
Samoa	84.2	2.9	10.1	0.0	0.0	0.7	0.0	2.2	139
Serbia and Montenegro city	74.6	4.8	14.3	1.6	0.0	0.0	0.0	3.2	63
Thailand city	60.8	5.9	23.5	4.9	0.0	0.0	0.0	4.9	102
Thailand province	72.1	4.1	14.8	2.5	0.0	0.0	0.0	6.6	122
United Republic of Tanzania city	74.9	7.6	4.7	0.6	0.0	0.0	0.0	12.3	171
United Republic of Tanzania province	59.3	15.8	4.0	4.0	0.0	0.6	0.0	16.4	177

[a] In Ethiopia province 16 women (4.8%) did not mention where they stayed.

Appendix Table 22 Reasons cited for returning after leaving temporarily, among physically abused women who had left and returned at least once because of intimate-partner violence, by site

Site	Couldn't leave children (%)	Sanctity of marriage (%)	For sake of family (%)	Couldn't support children (%)	She loved him (%)	He asked her to go back (%)	Family said to return (%)	She forgave him (%)	She thought he would change (%)	He threatened her/children (%)	She could no longer stay where she was (%)	Violence normal (%)	Her status/ dignity (%)	Family status/ honor (%)	Other reason (%)	Total no. of women who reported having left and returned at least once
Bangladesh city	28.3	18.5	33.7	4.3	7.6	52.2	26.1	4.3	6.5	0.0	4.3	n.a.	4.3	12.0	2.2	92
Bangladesh province	45.1	26.5	57.8	10.8	7.8	44.1	33.3	9.8	8.8	1.0	3.9	n.a.	9.8	15.7	2.9	102
Brazil city	13.0	3.7	22.2	11.1	35.2	27.8	14.8	14.8	24.1	5.6	18.5	n.a.	n.a.	n.a.	16.7	54
Brazil province	24.3	1.9	17.8	7.5	18.7	37.4	10.3	9.3	10.3	4.7	8.4	n.a.	n.a.	n.a.	17.8	107
Ethiopia province	44.6	28.2	21.8	12.3	2.5	10.1	19.3	6.0	3.2	0.0	1.6	n.a.	n.a.	n.a.	8.2	316
Japan city	20.8	8.3	29.2	4.2	20.8	25.0	8.3	12.5	29.2	0.0	4.2	n.a.	n.a.	n.a.	8.3	24
Namibia city	17.3	10.7	10.7	9.3	33.3	48.0	6.7	32.0	13.3	0.0	8.0	n.a.	n.a.	n.a.	12.0	75
Peru city	30.3	2.5	30.3	6.6	13.9	41.8	9.8	27.0	23.8	0.8	12.3	n.a.	n.a.	n.a.	26.2	122
Peru province	47.8	5.2	18.2	8.2	8.6	41.2	11.0	33.0	18.2	3.8	15.1	n.a.	n.a.	n.a.	22.7	291
Samoa	52.4	14.3	5.6	0.8	12.7	38.1	4.0	14.3	0.8	0.8	0.8	n.a.	n.a.	n.a.	5.6	126
Serbia and Montenegro city	34.1	4.9	19.5	12.2	14.6	31.7	4.9	17.1	14.6	4.9	14.6	4.9	n.a.	n.a.	9.8	41
Thailand city	29.6	3.7	27.2	1.2	14.8	39.5	6.2	14.8	7.4	2.5	0.0	n.a.	n.a.	n.a.	28.4	81
Thailand province	31.3	5.4	19.6	0.0	20.5	33.9	7.1	25.0	3.6	0.0	0.9	n.a.	n.a.	n.a.	28.6	112
United Republic of Tanzania city	19.5	16.9	11.0	2.5	7.6	42.4	22.9	39.0	13.6	0.8	3.4	n.a.	n.a.	n.a.	16.1	118
United Republic of Tanzania province	24.2	10.5	15.3	2.4	8.1	33.1	21.8	50.0	12.1	0.0	5.6	n.a.	n.a.	n.a.	18.5	124

n.a., not available (the answer option was not precoded in the questionnaire).

Appendix Table 23 **Reasons cited for staying among ever physically abused women who had never left temporarily because of intimate partner violence, by site**

Site	Couldn't leave children (%)	Sanctity of marriage (%)	For sake of family (%)	Couldn't support children (%)	She loved him (%)	She didn't want to be single (%)	Family said to return (%)	She forgave him (%)	She thought he would change (%)	He threatened her/children (%)	She had nowhere to go (%)	Violence normal (%)	Her status/ dignity (%)	Family status/ honor (%)	Other reason (%)	Total no. of women who reported never having left
Bangladesh city	41.7	60.3	7.6	9.9	24.5	21.6	0.7	16.5	7.1	0.0	12.2	n.a.	24.8	28.9	2.3	436
Bangladesh province	43.8	55.0	9.4	8.5	20.1	21.3	1.8	15.7	4.3	0.0	10.3	n.a.	16.8	36.2	4.0	447
Brazil city	24.7	4.0	4.7	11.3	22.7	4.0	0.7	24.0	14.0	3.3	9.3	n.a.	n.a.	n.a.	38.7	150
Brazil province	29.0	1.0	4.1	10.9	23.8	7.3	2.6	17.1	5.2	1.0	9.8	n.a.	n.a.	n.a.	42.0	193
Ethiopia province	58.2	38.5	4.7	5.9	3.6	2.5	1.5	3.0	8.6	0.5	0.3	n.a.	n.a.	n.a.	5.7	758
Japan city	33.7	4.3	5.4	5.4	12.0	4.3	2.2	26.1	16.3	1.1	17.4	n.a.	n.a.	n.a.	19.6	92
Namibia city	16.6	7.8	4.1	4.6	36.9	4.1	2.8	16.6	14.3	1.4	8.3	n.a.	n.a.	n.a.	24.0	217
Peru city	42.3	3.0	5.6	3.9	8.9	2.6	1.6	10.8	6.2	1.0	15.4	n.a.	n.a.	n.a.	57.0	305
Peru province	52.7	8.6	12.3	6.1	11.0	5.4	2.7	16.0	9.1	2.4	19.4	n.a.	n.a.	n.a.	34.5	592
Samoa	63.6	26.4	9.5	0.6	44.1	1.4	1.1	17.5	2.3	0.0	0.6	n.a.	n.a.	n.a.	2.9	349
Serbia and Montenegro city	20.8	6.9	5.4	2.3	17.7	0.8	0.8	10.8	9.2	0.0	5.4	46.2	n.a.	n.a.	11.5	130
Thailand city	46.3	8.2	2.2	1.5	41.8	3.0	0.0	11.9	1.5	0.0	7.5	n.a.	n.a.	n.a.	40.3	134
Thailand province	50.5	9.5	5.5	1.8	40.0	2.3	2.3	9.5	9.5	1.4	4.5	n.a.	n.a.	n.a.	34.1	220
United Republic of Tanzania city	17.6	22.7	17.2	5.1	16.5	5.9	6.2	43.6	11.0	1.5	4.4	n.a.	n.a.	n.a.	31.5	273
United Republic of Tanzania province	22.8	22.0	14.3	4.3	12.5	2.8	6.0	47.0	10.8	0.3	5.3	n.a.	n.a.	n.a.	29.3	400

n.a., not available (the answer option was not precoded in the questionnaire).

Index