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

Claudia García-Moreno
Henrica A.F.M. Jansen
Mary Ellsberg
Lori Heise
Charlotte Watts

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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.

Henrica AFM (Henriette) Jansen is Epidemiologist to the WHO Multi-country Study on Women's Health and Domestic Violence against Women in the WHO Department of Gender, Women and Health. She was the lead person for the final versions of the questionnaire and data entry and processing programs, and managed data collection and analysis.

Charlotte Watts is a Senior Lecturer in Epidemiology and Health Policy in the Health Policy Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine and a Technical Adviser to the WHO Multi-country Study on Women's Health and Domestic Violence against Women. She developed the initial protocol and questionnaire for the Study.

Mary Carroll Ellsberg is Senior Adviser for Gender, Violence and Human Rights at PATH in Washington, DC, USA. She is an epidemiologist and has also participated in research on violence against women in Nicaragua, Indonesia and Ethiopia. She is the lead author of "*Researching violence against women: a practical guide for researchers and activists*", which synthesizes the experience from the WHO Study and other research on violence against women.

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

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%), 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.