Please see the Table of Contents for access to the PDF files.

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

Please click on the different underlined parts for access to the PDF files.

WHO Library Cataloguing-in-Publication Data

WHO multi-country study on women's health and domestic violence against women : initial results on prevalence, health outcomes and women's responses / authors: Claudia García-Moreno ... [et al.]

1. Domestic violence 2. Sex offenses 3. Women's health
4. Cross-cultural comparison 5. Multicenter studies
6. Epidemiologic studies I. García-Moreno,

ISBN 92 4 159358 X (NLM classification: WA 309)

Designed by: Grundy & Northedge Designers

Printed in Switzerland

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

Acknowledgements

The Study, and this comparative report summarizing the major findings of surveys conducted in 10 countries, was only possible because of the dedication, commitment and hard work of all of those involved, both internationally and in the countries concerned. In addition, the implementation of the Study was supported by many people in all of the participating institutions. The World Health Organization and the authors would like to thank all of those who contributed in different ways to making this Study happen, and apologize to anyone who may inadvertently remain unnamed.

The recommendation for undertaking this research emerged from the WHO Consultation on Violence against Women, held in 1996. The participants of that meeting, in particular the late Raquel Tiglao, an advocate for women's health and for services for abused women from the Philippines, Mmatshilo Motsei, and Jacquelyn Campbell, all pioneers in this work, inspired us to action.

The Study was undertaken as a key activity of the Department of Gender, Women and Health (GWH) of the World Health Organization, and developed and supported by the Core Research Team which is made up of: Charlotte Watts from the London School of Hygiene and Tropical Medicine, Mary Ellsberg and Lori Heise of the Program for Appropriate Technology in Health (PATH) in Washington, DC, and Henrica AFM Jansen and Claudia García-Moreno (Study Coordinator) from WHO.

First and foremost, we would like to acknowledge and thank the more than 24 000 women who participated in the Study, and who gave their time to answer our questions and share their life experiences with us.

We gratefully acknowledge the investigators and collaborating institutions in the countries, and the interviewers and other office and field staff in the countries, who all worked with immense dedication and commitment to ensure the successful implementation of the Study. Particular mention is made of the investigators:

in Bangladesh, Ruchira Tabassum Naved and Abbas Bhuiya (ICDDR,B: Centre for Health and Population Research, Dhaka), Safia Azim (Naripokkho, Dhaka) and Lars Ake Persson (Uppsala University, Sweden);

in Brazil, Lilia Blima Schraiber, Ana Flavia Lucas D'Oliveira and Ivan França-Junior (University of São Paulo, São Paulo), Carmen Simone Grilo Diniz (Feminist Collective for Health and Sexuality, São Paulo), Ana Paula Portella (SOS Corpo Genero e Cidadania, Recife), Ana Bernarda Ludermir (Federal University of Pernambuco, Recife);

in Ethiopia, Yemane Berhane, Negussie Deyessa, Yegomawork Goyasse, Atalay Alem, Derege Kebede and Alemayehu Negash (Addis Ababa University, Addis Ababa), Ulf Hogberg, Gunnar Kullgren and Maria Emmelin (Umeå University, Sweden), Mary Ellsberg (PATH, Washington, DC, USA);

in Japan, Mieko Yoshihama (University of Michigan, Ann Arbor, USA), Saori Kamano (National Institute of Population and Social

Security Research, Tokyo), Hiroko Akiyama (University of Tokyo, Tokyo), Fumi Hayashi (Toya Eiwa University, Tokyo), Tamie Kaino (Ochanomizu University, Tokyo), Tomoko Yunomae (Japan Accountability Caucus, Beijing, Tokyo);

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

in Peru, Ana Güezmes García (Centro de la Mujer Flora Tristan, Lima), Nancy Palomino Ramirez and Miguel Ramos Padilla (Universidad Peruana Cayetano Heredia, Lima);

in Samoa, Tina Tauasosi-Posiulai, Tima Levai-Peteru, Dorothy Counts and Chris McMurray (Secretariat of the Pacific Community);

in Serbia and Montenegro, Stanislava Otaševi and Silvia Koso (Autonomous Women's Center Against Sexual Violence, Belgrade), Viktorija Cucic (University of Belgrade, Belgrade);

in Thailand, Churnrurtai Kanchanachitra, Kritaya Archavanitkul and Wassana Im-em (Mahidol University, Bangkok), Usa Lerdsrisanthat (Foundation for Women, Bangkok);

in the United Republic of Tanzania, Jessie Mbwambo and Gideon Kwesigabo (Muhimbili College of Medical Sciences), Joe Lugalla (University of New Hampshire, Durham, USA), Sherbanu Kassim (Women's Research and Documentation Project, Dar es Salaam).

WHO would also like to thank the members of the Steering Committee of the Study: Jacquelyn Campbell, Co-Chair (USA), Lucienne Gillioz (Switzerland), Rachel Jewkes (South Africa), Ivy Josiah (Malaysia), Olav Meirik, Co-Chair (Chile/Norway), Laura Rodrigues (United Kingdom/Brazil), Irma Saucedo (Mexico), Berit Schei (Norway) and Stig Wall (Sweden). In addition to their continued support to the Study, they reviewed and gave valuable input to several drafts of the report.

The Study would not have been possible without the support of numerous individuals within WHO: Tomris Türmen, David Evans, Nafsiah Mboi, Daniel Makuto, Eva Wallstam and Joy Phumaphi who, over the period of the Study, have overseen WHO's work on gender and women's health, under which this Study was developed and implemented. Particular thanks are due to colleagues in the Department of Reproductive Health and Research, in particular Paul Van Look, Timothy Farley and Jane Cottingham, for their continuous support since the Study's early days. Linda Morison of the London School of Hygiene and Tropical Medicine, Timothy Farley of WHO and Stig Wall of Umeå University provided advice on sampling and other statistical matters during the planning stages. Chandrika John, Eva Lustigova, Jenny Perrin, Lesley Robinson, Lindsay Simmons, Margaret Squadrani and Ludy Suryantoro provided administrative support to the Study.

This report also benefited from the contributions of a number of other people. In particular, Alexander Butchart, Etienne Krug and Alison Phinney, in the Department of Injuries and Violence Prevention, provided valuable comments on an earlier version of this report. Jose Bertolote in the Department of Mental Health, Jack Jones in School Health and Youth Health Promotion, and Paul Van Look also reviewed specific sections and provided useful comments. WHO acknowledges the following contributions to the production of the report: Andrew Wilson, for preparing the summary of the report; Angela Haden and Pat Butler, for editing the manuscript; Susan Kaplan and Ann Morgan, for proofreading; Barbara Campanini, for editing the references; Liza Furnival, for preparing the index; Tilly Northedge, for the layout and cover design; and Andrew Dicker, for formatting the report.

Finally, the Study would not have been possible without the generous financial support given to WHO by the Governments of the Netherlands, Norway, Sweden, Switzerland and the United Kingdom. The Rockefeller Foundation supported the implementation of the Study in Namibia and the United Republic of Tanzania, and provided the use of its meeting place in Bellagio in May 2004, where the initial preparations for this report with representatives of all the country research teams took place. This funding enabled WHO to develop the Study methods and materials, establish and work with the country research teams to implement the Study. WHO provided the funding for the implementation of the Study in 6 of the 8 initial countries: Brazil, Japan, Namibia, Peru, Thailand and the United Republic of Tanzania, with some of these countries receiving additional funds as detailed in Annex 3. In Bangladesh, the Study was funded by the Urban Primary Health Care project of the Government of Bangladesh; in Ethiopia by the Swedish Agency for Research Cooperation with Developing Countries (SAREC/Sida); in Samoa, by the United Nations Fund for Population Activities (UNFPA); and in Serbia and Montenegro, by Trocaire. We also acknowledge the contribution from the Global Coalition on Women and AIDS.

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 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?

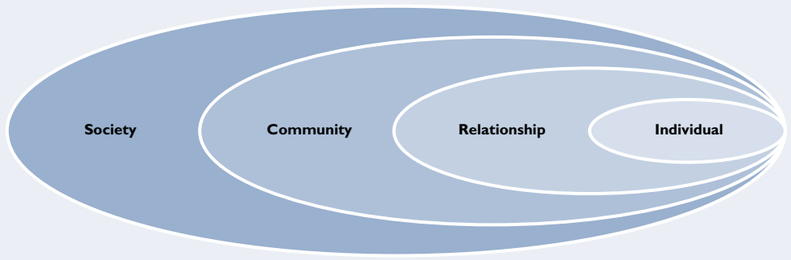
Increasingly, researchers and practitioners – as well as WHO – are using an "ecological framework" to understand the interplay of personal, situational, and sociocultural factors that combine to cause interpersonal violence (**9**, **27**). Introduced in the late 1970s, the ecological model was first 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).

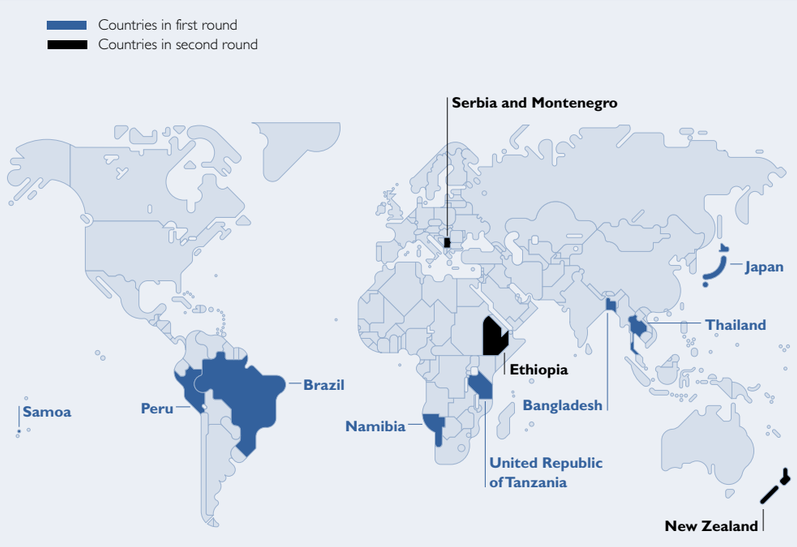
[1] The data set from New Zealand was not available when this report was being prepared. However, the first results from New Zealand have recently been published (**37**).

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.

References

1. **Heise L.** Violence against women: global organizing for change. In: Edleson JL, Eisikovits ZC, eds. *Future interventions with battered women and their families*. Thousand Oaks, CA, Sage Publications, 1996:7–33.
2. **Joachim J.** Shaping the human rights agenda: the case of violence against women. In: Meyer MK, Prugl E, eds. *Gender politics in global governance*. Lanham, MD, Rowman and Littlefield Publishers Inc., 2000:142–160.
3. **Mayhew S, Watts C.** Global rhetoric and individual realities: linking violence against women and reproductive health. In: **Lee K, Buse K, Fustukian S,** eds. *Health policy in a globalising world*. Cambridge, Cambridge University Press, 2002:159–180.
4. *Vienna Declaration and Programme of Action.* Adopted by the World Conference on Human Rights, Vienna, 14–25 June 1993. New York, NY, United Nations, 1993 (document A/CONF.157/23).
5. *International Conference on Population and Development (ICPD), Cairo, Egypt, 5–13 September 1994*. New York, NY, United Nations, 1994 (document A/CONF.171/13).
6. *The Fourth World Conference on Women, Beijing, China, 4–15 September 1995*. New York, NY, United Nations, 1995 (document A/CONF.177/20).
7. *Violence against women: WHO Consultation, Geneva, 5–7 February 1996*. Geneva, World Health Organization, 1996 (document FRH/WHD/96.27, available at: http://whqlibdoc.who.int/hq/1996/FRH_WHD_96.27.pdf, accessed 18 March 2005).
8. *WHO Multi-country Study on Women's Health and Domestic Violence against Women: study protocol.* Geneva, World Health Organization, 2004.
9. **Krug EG et al.** eds. *World report on violence and health*. Geneva, World Health Organization, 2002.
10. *Declaration on the elimination of violence against women.* New York, NY, United Nations, 1993 (United Nations General Assembly resolution, document A/RES/48/104).
11. **Heise L, Ellsberg M, Gottemoeller M.** *Ending violence against women*. Baltimore, MD, Johns Hopkins University Press, 1999.
12. **Koss MP.** Detecting the scope of rape: a review of prevalence research methods. *Journal of Interpersonal Violence*, 1993, 8:198–222.
13. **Ellsberg M et al.** Researching domestic violence against women: methodological and ethical considerations. *Studies in Family Planning*, 2001, 32:1–16.
14. *Measuring violence against women cross-culturally: notes from a meeting*. Takoma Park, MD, Health and Development Policy Project, 1995.
15. **Straus MA.** Measuring intrafamily conflict and violence: the Conflict Tactics Scale (CTS). *Journal of Marriage and the Family*, 1979, 41:75–88.
16. **Straus MA et al.** The revised Conflict Tactics Scale (CTS2). *Journal of Family Issues*, 1996, 17:283–316.
17. **Dobash RE, Dobash RD.** The myth of sexual symmetry in marital violence. *Social Problems*, 1992, 39:71–91.
18. **Hassan F et al.** Physical intimate partner violence in Chile, Egypt, India and the Philippines. *Injury Control and Safety Promotion*, 2004, 11:111–116.
19. **Kishor S, Johnson K.** *Domestic violence in nine developing countries: a comparative study*. Calverton, MD, MACRO International, 2004.
20. **Campbell J et al.** Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, 2002, 162:1157–1163.
21. **Gazmararian JA et al.** The relationship between pregnancy intendedness and physical violence in mothers of newborns. The PRAMS Working Group. *Obstetrics and Gynecology*, 1995, 85:1031–1038.
22. **Golding J.** Sexual assault history and women's reproductive and sexual health. *Psychology of Women Quarterly*, 1996, 20:101–121.
23. **Murphy CC et al.** Abuse: a risk factor for low birth weight? A systematic review and meta-analysis. *Canadian Medical Association Journal*, 2001, 164:1567–1572.
24. **Campbell JC.** Health consequences of intimate partner violence. *Lancet*, 2002, 359:1331–1336.
25. **Counts D, Brown JK, Campbell JC, eds.** *To have and to hit*, 2nd ed. Chicago, IL, University of Chicago Press, 1999.
26. **Levinson D.** *Violence in cross cultural perspective*. Newbury Park, CA, Sage Publications, 1989.
27. **Bronfenbrenner V.** *The ecology of human development: experiments by nature and design*. Cambridge, MA, Harvard University Press, 1979.
28. **Garbarino J, Crouter A.** Defining the community

context for parent–child relations: the correlates of child maltreatment. *Child Development*, 1978, 49:604–616.

29. **Belsky J.** Child maltreatment: an ecological integration. *American Psychologist* 1980;35:320–335.
30. **Tolan PH, Guerra NG.** *What works in reducing adolescent violence: an empirical review of the field*. Boulder, CO, University of Colorado, Center for the Study and Prevention of Violence, 1994.
31. **Chaulk R, King PA.** *Violence in families: assessing prevention and treatment programs*. Washington, DC, National Academy Press, 1998.
32. **Heise L.** Violence against women: an integrated, ecological framework. *Violence Against Women*, 1998, 4:262–290.
33. **Schiamberg LB, Gans D.** An ecological framework for contextual risk factors in elder abuse by adult children. *Journal of Elder Abuse and Neglect*, 1999, 11:79–103.
34. **Carp RM.** *Elder abuse in the family: an interdisciplinary model for research*. New York, NY, Springer, 2000.
35. **O'Campo P et al.** Violence by male partners against women during the childbearing year: a contextual analysis. *American Journal of Public Health*, 1995, 85:1092–1097.
36. **Koenig MA et al.** Women's status and domestic violence in rural Bangladesh: individual- and community-level effects. *Demography*, 2003, 40:269–288.
37. **Fanslow J, Robinson E.** Violence against women in New Zealand: prevalence and health consequences. *New Zealand Medical Journal*, 2004, 117:1173–1184.

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).

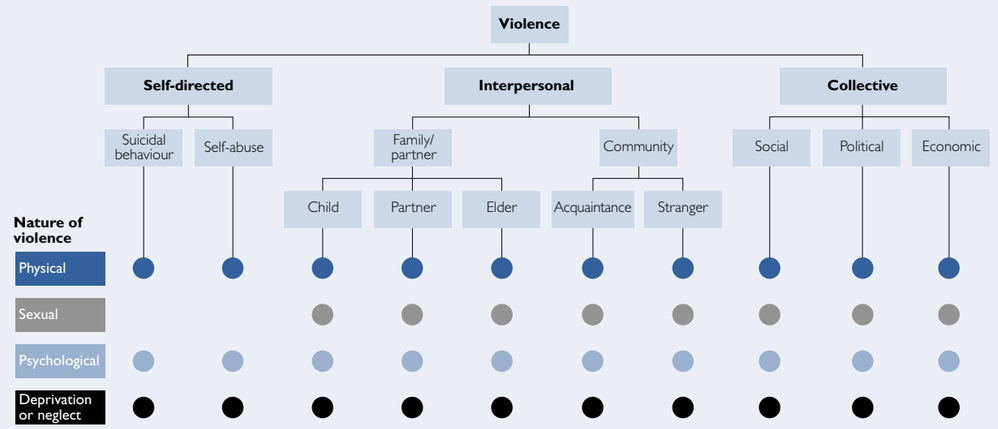
Measuring violence

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.

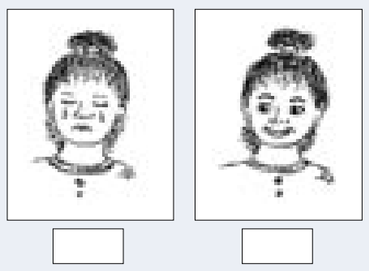
Box 2.3 Country-specific definitions of "ever-partnered women"

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.
3. **Straus MA et al.** The revised Conflict Tactics Scales (CTS2). *Journal of Family Issues,* 1996, 17:283–316.

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.