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

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

References

1. **Hulme PA.** Retrospective measurement of childhood sexual abuse: a review of instruments. *Child Maltreatment*, 2004, 9:201–217.
2. **Beitchman JH et al.** A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect,* 1992, 16:101–118.
3. **Cheasty M, Clare AW, Collines C.** Relation between sexual abuse in childhood and adult depression: case-control study. *British Medical Journal*, 1998, 316:198–201.
4. **Boyer D, Fine D.** Sexual abuse as a factor in adolescent pregnancy. *Family Planning Perspectives*, 1992, 24:4–11.
5. **Gladstone GL et al.** Implications of childhood trauma for depressed women: an analysis of pathways from childhood sexual abuse to deliberate self harm and revictimization. *American Journal of Psychiatry,* 2004, 161:1417–1425.
6. **Spataro J et al.** Impact of child sexual abuse on mental health: prospective study in males and females. *British Journal of Psychiatry,* 2004, 184:416–421.
7. **Fergusson DM, Horwood LJ, Lynskey MT.** Childhood sexual abuse, adolescent sexual behaviours and sexual revictimization. *Child Abuse and Neglect,* 1997, 21:789–803.
8. **Coid J et al.** Relation between childhood sexual and physical abuse and risk of revictimization in women: a cross-sectional survey. *Lancet,* 2001, 358:450–454.
9. **Dunkle KL et al.** Prevalence and patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa. *American Journal of Epidemiology*, 2004, 160:230–239.
10. **Zierler S et al.** Adult survivors of childhood sexual abuse and subsequent risk of HIV infection. *American Journal of Public Health,* 1991, 81(s): 572–575.
11. **Butler JR, Burton LM.** Rethinking teenage childbearing: is sexual abuse a missing link? *Family Relations*, 1990, 39:73–80.
12. **Handwerker WP.** Gender power differences between parents and high-risk sexual behaviour by their children: AIDS/STD risk factors extend to a prior generation. *Journal of Women's Health*, 1993, 2:301–316.
13. **Olsson A et al.** Sexual abuse during childhood and adolescence among Nicaraguan men and women: population-based anonymous survey. *Child Abuse and Neglect*, 2000, 24:1579–1589.
14. **Stock JL et al.** Adolescent pregnancy and sexual risk-taking among sexually abused girls. *Family Planning Perspectives*, 1997, 29:200–203.
15. **Turner CF et al.** Adolescent sexual behavior, drug use and violence: increased reporting with computer survey technology. *Science*, 1998, 280:867–873.
16. **Aquilino WS.** Interview mode effects in surveys of drug and alcohol use: a field experiment. *Public Opinion Quarterly*, 1994, 58:210–240.
17. **Fu H et al.** Measuring the extent of abortion underreporting in the 1995 National Survey of Family Growth. *Family Planning Perspectives*, 1998, 30:128–133 and 138.
18. **Hewett PC, Mensch BS, Erulkar AS.** Consistency in the reporting of sexual behaviour by adolescent girls in Kenya: a comparison of interviewing methods. *Sexually Transmitted Infections,* 2004, 80(Suppl. II):S43–S48.
19. **Youri P, ed.** *Female adolescent health and sexuality in Kenyan secondary schools: a survey report*. Nairobi, African Medical Research Foundation, 1994.
20. **Glover EK et al.** Sexual health experiences of adolescents in three Ghanaian towns. *International Family Planning Perspectives*, 2003, 29:32–40.
21. **Phiri A, Erulkar A.** *Experiences of youth in urban Zimbabwe*. Harare, Zimbabwe National Family Planning Council, 2000.
22. **Koenig MA et al.** Coerced first intercourse and reproductive health among adolescent women in Rakai, Uganda. *International Family Planning Perspectives*, 2004, 30:156–163.
23. **Jewkes R, Sen P, Garcia Moreno C.** Sexual violence. In: Krug EG et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002.

CHAPTER 7

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

Main findings

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

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

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

Women's self-reported health and physical symptoms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injuries caused by physical violence by an intimate partner

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental health

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

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

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

Figure 7.1 **Percentage of ever-partnered women reporting suicidal thoughts, according to their experience of physical or sexual violence, or both, by an intimate partner, by site**

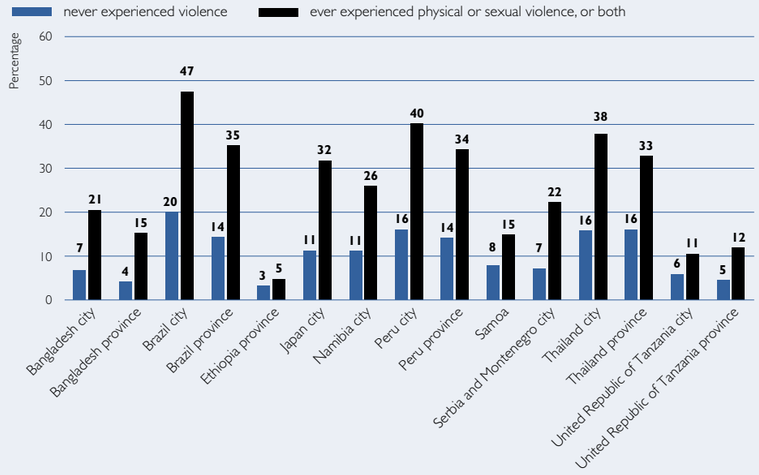
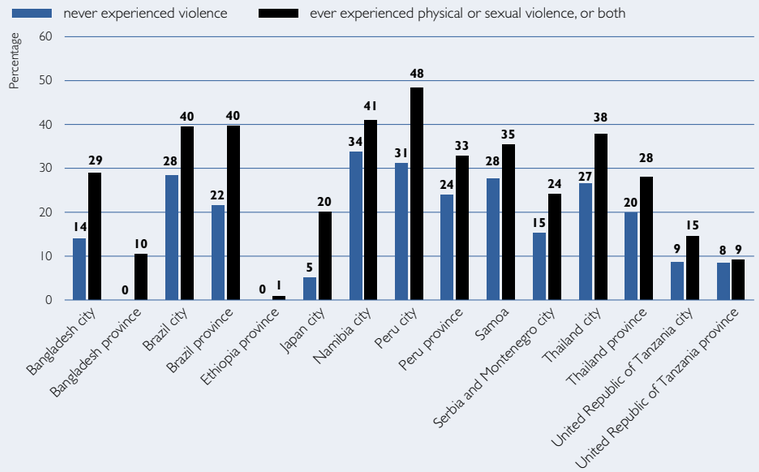


Figure 7.2 **Percentage of women who had attempted suicide among those who had ever contemplated suicide, according to their experience of physical or sexual violence, or both, by an intimate partner, by site**



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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

References

1. *A user's guide to the self-reporting questionnaire (SRQ)*. Geneva, World Health Organization, 1994 (WHO/MNH/PSF/94.8).
2. **Campbell JC.** Health consequences of intimate partner violence. *Lancet,* 2002, 359:1331–1336.
3. **Plichta SB, Falik M.** Prevalence of violence and its implications for women's health. *Women's Health Issues*, 2001, 11:244–258.
4. **Plichta SB, Abraham C.** Violence and gynecologic health in women < 50 years old. *American Journal of Obstetrics and Gynecology*, 1996, 174:903–907.
5. **Campbell J et al.** Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, 2002, 162:1157–1163.
6. **Fryers T, Melzer D, Jenkins R.** Social inequalities and the common mental disorders: a systematic review of the evidence. *Social Psychiatry and Psychiatric Epidemiology,* 2003, 38:229–237.
7. **McDonough P et al.** Income dynamics and adult mortality in the United States, 1972 through 1989. *American Journal of Public Health*, 1997, 87:1476–1483.
8. **Sorlie PD, Backlund E, Keller JB.** US mortality by economic, demographic, and social characteristics: the National Longitudinal Mortality Study. *American Journal of Public Health*, 1995, 85:949–956.
9. **Heise L, Ellsberg M, Gottemoeller M.** *Ending violence against women*. Baltimore, MD, Johns Hopkins University Press, 1999.
10. **Rand M, Strom K.** Violence-related injuries treated in hospital emergency departments. *Bureau of Justice Statistics, Special Report,* 1997:1–11.
11. **Fanslow J, Norton R, Spinola, C.** Indicators of assault-related injuries among women presenting to the emergency department. *Annals of Emergency Medicine*, 1998, 32:341–348.
12. **Kyriacou DN et al.** Risk factors for injury to women from domestic violence against women. *New England Journal of Medicine,* 1999, 341:1892–1898.
13. **Thompson M, Saltzman LE, Johnson H.** Risk factors for physical injury among women assaulted by current or former spouses. *Violence Against Women*, 2001, 7:886–899.
14. **Jewkes R, Levin J, Penn-Kekana L.** Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science and Medicine*, 2002, 55:1603–1617.
15. **Mock C et al.** The effect of recall on estimation of incidence rates for injury in Ghana. *International Journal of Epidemiology,* 1999, 28:750–755.
16. **Moshiro C et al.** Effect of recall on estimation of non-fatal injury rates: a community based study in Tanzania. *Injury Prevention*, 2005, 11:48–52.
17. **Fischbach RL, Herbert B.** Domestic violence and mental health: correlates and conundrums within and across cultures. *Social Science and Medicine*, 1997, 45:1161–1176.
18. **Muelleman RL, Lenaghan PA, Pakieser RA.** Nonbattering presentations to the ED of women in physically abusive relationships. *The American Journal of Emergency Medicine*, 1998, 16:128–131.
19. **Jewkes R, Sen P, Garcia-Moreno C.** Sexual violence. In: Krug EG et al., eds. *World report on violence and health.* Geneva, World Health Organization, 2002.
20. **Ellsberg M et al.** Domestic violence and emotional distress among Nicaraguan women: results from a population-based study. *The American Psychologist*, 1999, 54:30–36.
21. The health costs of violence. *Measuring the burden of disease caused by intimate partner violence. A summary of findings*. Carlton South, Australia, VicHealth, 2004.

CHAPTER **8**

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

Main findings

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

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

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

Induced abortion and miscarriage

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

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

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

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

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

Use of antenatal and postnatal health services

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

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

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

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

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

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

Violence during pregnancy

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

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

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

§, percentage based on fewer than 20 respondents suppressed.

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

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

Parity

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

Risk of sexually transmitted infections, including HIV

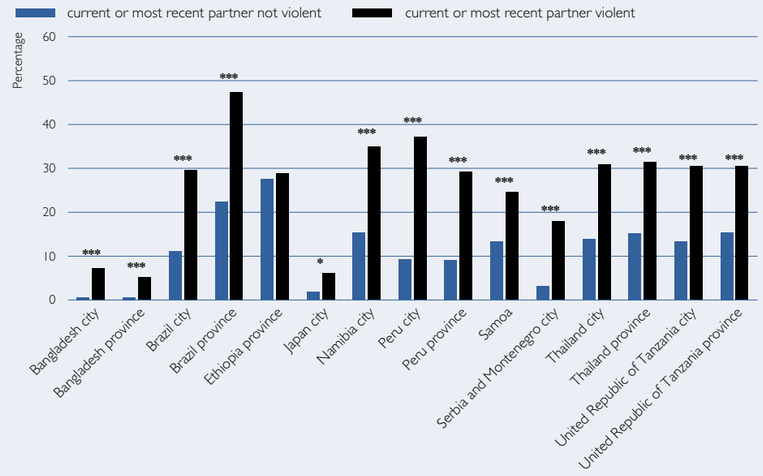
Because it was beyond the scope of the WHO Study to collect biological data on the prevalence of HIV and other sexually transmitted infections (STIs), it was not possible to explore directly whether there was a significant association between women's experiences of violence and these infections. In addition,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

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

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

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

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



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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

References

1. **Cleland J, Harlow S.** The value of the imperfect: the contribution of interview surveys to the study of gynaecological ill health. In: Jejeebhoy S, Koenig M, Elias C, eds., *Investigating reproductive tract infections and other gynaecological disorders. A multidisciplinary research approach.* Cambridge, Cambridge University Press, 2003:283–321.
2. **Evins G, Chescheir N.** Prevalence of domestic violence among women seeking abortion services. *Women's Health Issues,* 1996, 6:204–210.
3. **Glander SS et al.** The prevalence of domestic violence among women seeking abortion. *Obstetrics and Gynecology,* 1998, 91:1002–1006.
4. **Silberschmidt M, Rasch V.** Adolescent girls, illegal abortions and "sugar-daddies" in Dar es Salaam: vulnerable victims and active social agents. *Social Science and Medicine,* 2001, 52:1815–1826.
5. **Kishor S, Johnson K.** *Domestic violence in nine developing countries: a comparative study.* Calverton, MD, ORC MACRO International, 2004.
6. **Martin SL et al.** Physical abuse of women before, during, and after pregnancy. *Journal of the American Medical Association,* 2001, 285:1581–1584.
7. **Saltzman LE et al.** Physical abuse around the time of pregnancy: an examination of prevalence and risk factors in 16 states. *Maternal and Child Health Journal,* 2003, 7:31–43.
8. **Campbell J, Garcia-Moreno C, Sharps P.** Abuse during pregnancy in industrialized and developing countries. *Violence Against Women,* 2004, 10:770–789.
9. **Hakimi M et al.** *Silence for the sake of harmony: domestic violence and health in Central Java, Indonesia.* Yogyakarta, Indonesia, Gadja Mada University, PATH, Rifka Annisa, Umeå University, 2002.
10. **Peedicayil A et al.** Spousal physical violence against women during pregnancy. *British Journal of Obstetrics and Gynaecology*, 2004, 111:682–687.
11. **Ellsberg MC et al.** Wife abuse among women of childbearing age in Nicaragua. *American Journal of Public Health*, 1999, 89:241–244.

12. **Larrain S, Rodriguez T.** The origins and control of domestic violence against women. In: Gomez E, ed. *Gender, women and health.* Washington, DC, Pan American Health Organization, 1993:184–191.
13. **Martin SL et al.** Domestic violence in northern India. *American Journal of Epidemiology,* 1999, 150:417–426.
14. **Ellsberg M et al.** Candies in hell: women's experiences of violence in Nicaragua. *Social Science and Medicine,* 2000, 51:1595–1610.
15. **Pallitto CC, O'Campo P.** The relationship between intimate partner violence and unintended pregnancy: analysis of a national sample from Colombia. *International Family Planning Perspectives,* 2004, 30:165–173.
16. **Dunkle KL et al.** Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet,* 2004, 363:1415–1421.
17. **Martin SL et al.** Sexual behaviors and reproductive health outcomes: associations with wife abuse in India. *Journal of the American Medical Association,* 1999, 282:1967–1972.
18. **Wingood GM, DiClemente RJ.** Child sexual abuse, HIV sexual risk, and gender relations of African American women. *American Journal of Preventive Medicine,* 1997, 13:380–384.
19. **Heise L, Ellsberg M, Gottemoeller M.** *Ending violence against women.* Baltimore, MD, Johns Hopkins University Press, 1999.

CHAPTER 9

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

Main findings

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

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

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

Who women tell about violence and who helps

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

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

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

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

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

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

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

Agencies or authorities to which women turn

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

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

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

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

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

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

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

Figure 9.1 Percentage of ever physically abused women who had told no one, someone, or a service or authority about their experience of intimate-partner violence, by site

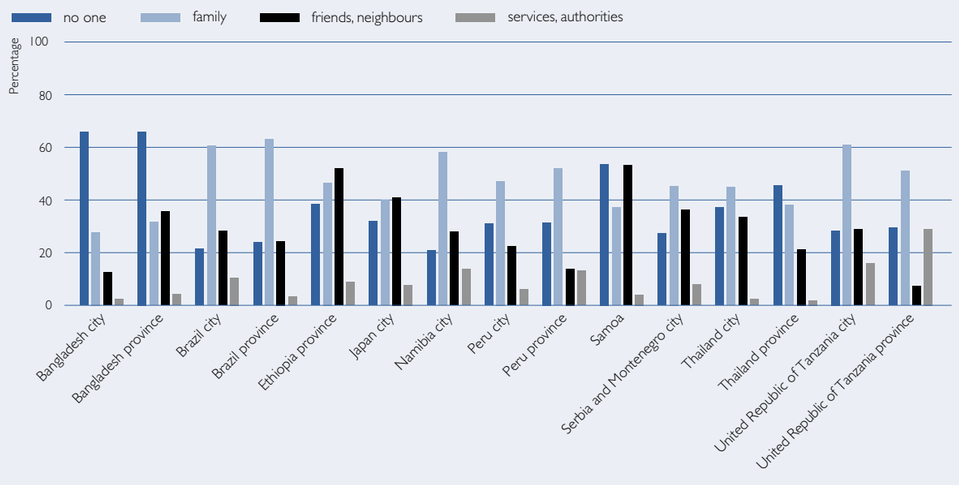


Figure 9.2 Percentage of ever physically abused women who had told someone about their experience of intimate-partner violence, by severity of violence, and by site

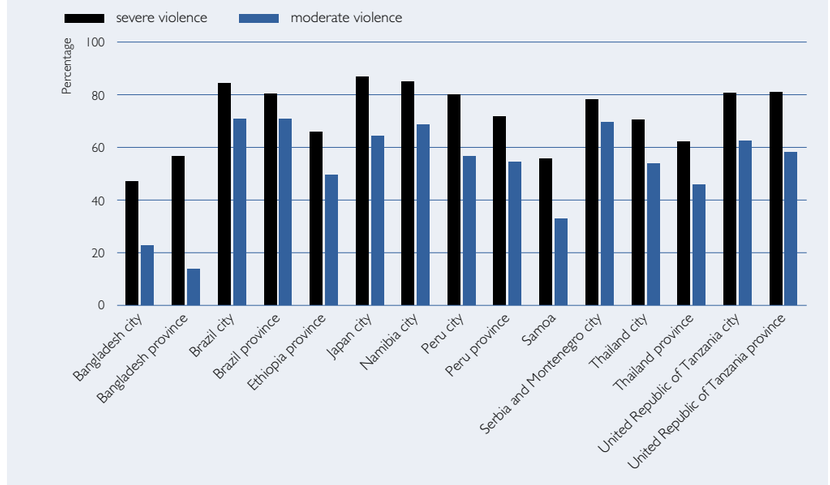


Figure 9.3 Percentage of ever physically abused women who had told someone about their experience of intimate-partner violence compared with the percentage of ever physically abused women who had sought help, by site

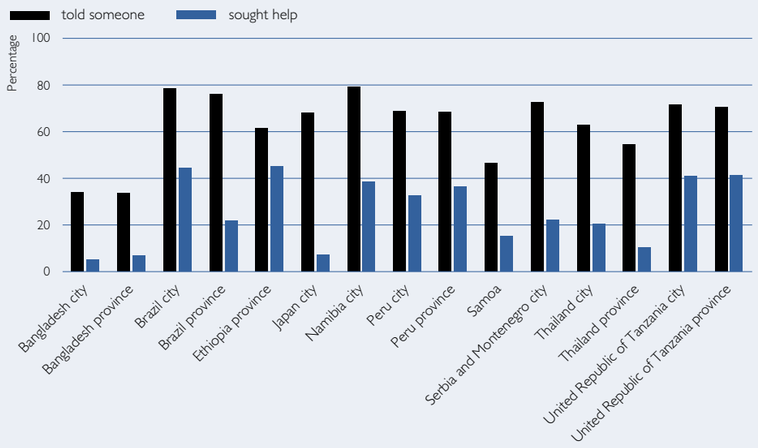
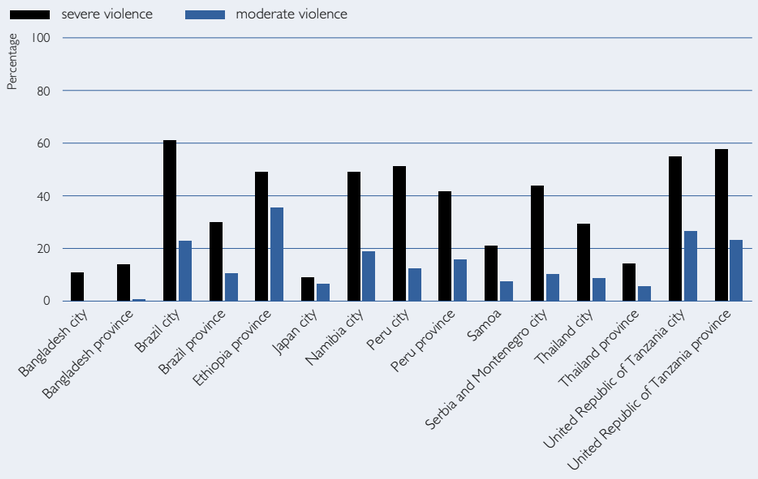


Figure 9.4 Percentage of ever physically abused women who sought help from at least one agency or authority, by severity of intimate-partner violence, and by site



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

Fighting back

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

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

Most commonly mentioned reasons for seeking help

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

Most commonly mentioned reasons for not seeking help

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

Women who leave

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

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

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

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

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

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

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

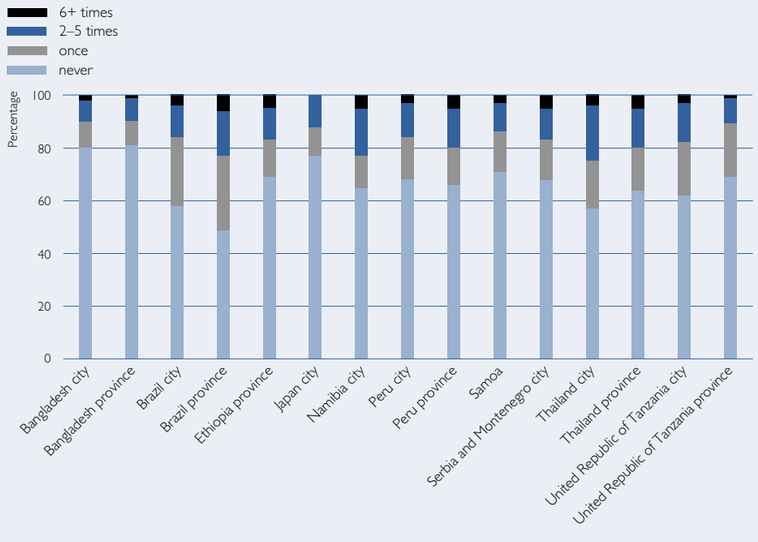
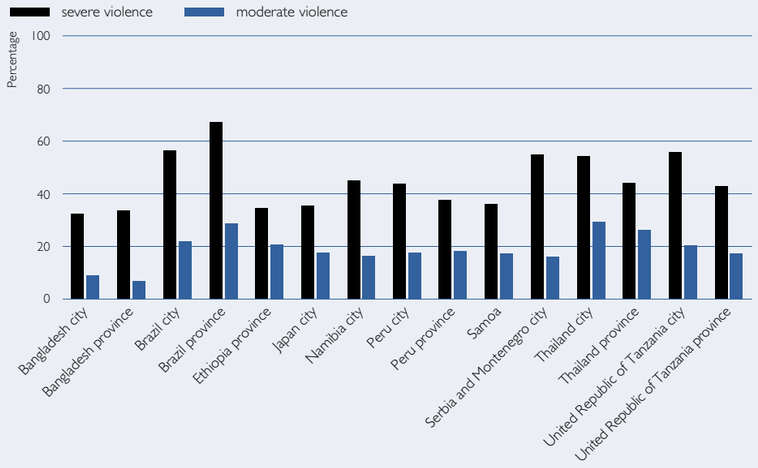


Figure 9.6 **Percentage of ever physically abused women who ever left for at least one night because of their experience of intimate partner violence, by severity of violence, and by site**



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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

References

1. **Jacobson NS et al.** Psychological factors in the longitudinal course of battering. When do the couples split up? When does the abuse decrease? *Violence and Victims,* 1996, 11:371–392.
2. **Strube M.** The decision to leave an abusive relationship: empirical evidence and theoretical issues. *Psychological Bulletin*, 1988, 104:236–250.
3. **Kishor S.** Measuring violence against women: experiences from the Demographic and Health Surveys. In: *Second Annual Meeting of the International Research Network on Violence against Women*. Washington, DC, Center for Health and Gender Equity, 1996, 23–25.
4. **Rose L, Campbell J, Kub J.** The role of social support and family relationships in women's responses to battering. *Health Care for Women International*, 2000, 21:27–29.
5. **Counts D, Brown JK, Campbell JC.** *To have and to hit*, 2nd ed. Chicago, IL, University of Chicago Press, 1999.
6. **Coker AL et al.** Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health Gender-based Medicine,* 2002, 11:465–476.
7. **Ellsberg M et al.** Candies in hell: women's experiences of violence in Nicaragua. *Social Science and Medicine*, 2000, 51:1595–1610.
8. **Ellsberg MC et al.** Women's strategic responses to violence in Nicaragua. *Journal of Epidemiology and Community Health*, 2001, 55:547–555.
9. **Johnson H.** *Dangerous domains: violence against women in Canada*. Ontario, Thomson International, 1996.
10. **Kirkwood C.** *Leaving abusive relationships.* London, Sage Publications, 1992.
11. **Moss VA et al.** The experience of terminating an abusive relationship from an Anglo and African American perspective: a qualitative descriptive study. *Issues in Mental Health Nursing*, 1997, 18:433–454.
12. **Campbell J et al.** Voices of strength and resistance: a contextual and longitudinal analysis of women's responses to battering. *Journal of Interpersonal Violence*, 1998, 13:743–762.
13. **Campbell J, Soeken K.** Women's responses to battering over time: an analysis of change. *Journal of Interpersonal Violence*, 1999, 14:21–40.
14. **Landenburger K.** A process of entrapment in and recovery from an abusive relationship. *Issues in Mental Health Nursing*, 1989, 10:209–227.
15. **Brown J.** Working toward freedom from violence. *Violence Against Women*, 1997, 3:5–26.
16. **Dutton MA.** Battered women's strategic response to violence: the role of context. In: Edelson JL, Eisikovits ZC, eds. *Future interventions with battered women and their families*. London, Sage Publications, 1996.

Conclusions and recommendations