Researching Violence Against Women

A PRACTICAL GUIDE
FOR RESEARCHERS AND ACTIVISTS

World Health Organization

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Please click inside the blue boxes below for access to the chapters within.

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Introduction

Twenty years ago, violence against women was not considered an issue worthy of international attention or concern. Victims of violence suffered in silence, with little public recognition of their plight. This began to change in the 1980s as women's groups organized locally and internationally to demand attention to the physical, psychological, and economic abuse of women. Gradually, violence against women has come to be recognized as a legitimate human rights issue and as a significant threat to women's health and well-being.

Now that international attention is focused on gender-based violence, methodologically rigorous research is needed to guide the formulation and implementation of effective interventions, policies, and prevention strategies. Until fairly recently, the majority of research on violence consisted of anecdotal accounts or exploratory studies performed on nonrepresentative samples of women, such as those attending services for battered women. While this research has played a critical role in bringing to light the issues of wife abuse, rape, trafficking, incest, and other manifestations of gender-based violence, it is less useful for understanding the dimensions or characteristics of abuse among the broader population.

This manual has been developed in response to the growing need to improve the quality, quantity, and comparability of international data on physical and sexual abuse. It outlines some of the methodological and ethical challenges of conducting research on violence against women and describes a range of innovative techniques that have been used to address these challenges. We hope that the manual will be useful for those interested in pursuing research on violence, especially in developing countries and other resource-poor settings.

The manual draws on the collective experiences and insights of many individuals, most notably the members of the International Research Network on Violence Against Women (IRNVAW), an ad hoc group of researchers and activists that meets periodically to share experiences regarding research on violence. The Network arose out of a two-day meeting on methodology and research ethics organized in June 1995 by the Center for Health and Gender Equity. To date the IRNVAW has sponsored four international meetings and several members have collaborated with the World Health Organization (WHO) in the design and implementation of a multi-country study on women's health and domestic violence. Many of the examples and insights included in this manual come from the pioneering work of IRNVAW members, as well as the WHO Multi-country Study on Women's Health and Domestic Violence, a household survey of women that has been conducted in

at least ten countries to date. We have also drawn extensively from our own research experiences, primarily in Nicaragua, Indonesia, and Ethiopia.

Readership

This manual is written for anyone interested in the application of social science and public health research methods to the study of gender-based violence. The manual assumes a certain level of familiarity with the logic of research and is not a substitute for training in research or research methodologies.

It is designed for **researchers** who want to know more about adapting traditional research techniques to the special case of investigating physical and sexual abuse. And it is designed for **activists, community workers, and service providers** who want to become conversant in methodological issues. One of the goals of this manual is to facilitate collaborations between researchers and community-based workers and activists by providing practitioners with an introduction to the tools and language of research, and by giving researchers greater insight into the specific issues that accompany research on violence.

Focus of the manual

For the sake of brevity, this manual focuses primarily on the issue of **violence against women by their intimate partners**. Gender-based violence assumes many forms, including rape, sexual assault and coercion, stalking, incest, sexual harassment, female genital mutilation, and trafficking in women. Although many of the insights presented herein will apply to these other types of violence, no single manual could exhaustively address all forms of abuse. Additionally, we concentrate on **applied research**, as opposed to research designed to advance theory or to address questions of primarily academic relevance.

The manual is directed particularly to those researchers interested in the intersection of **violence and health in developing countries**, given the clear impact that gender violence has on women's health status. However, much of the information presented in the manual is applicable to violence research as it relates to other issues, such as human rights, the well-being of families and children, and economic development. Similarly, the lessons for developing countries may be relevant to some violence research undertaken in industrialized countries, particularly among economically marginalized and/or politically disenfranchised populations.

Finally, the manual advances an ethic of research that is action-oriented, accountable to the antiviolence movement, and responsive to the needs of women living with violence. It strongly encourages collaboration between researchers and those working directly on violence as activists and/or practitioners. Recent experiences in countries as diverse as Canada, Zimbabwe, Indonesia, South Africa, Nicaragua, and Cambodia have shown that powerful synergies can be achieved from partnerships between researchers and advocates. Whereas researchers help to ensure that the endeavor is grounded in the principles of scientific inquiry, the involvement of advocates and service providers helps ensure that the right questions are asked in the right way, and that the knowledge generated is used for social change.

This document was based on the contributions of thousands of women from around the world who shared their stories and personal experiences in the hopes that their voices would contribute to diminishing the suffering of future generations of women from violence. The publication is dedicated to them.

1

PHOTO BY HAFM JANSEN

Violence Against Women as a Health and Development Issue*

Topics covered in this chapter:

Definitions of violence against women
Prevalence of intimate partner violence
The patterning of intimate partner violence
Prevalence and characteristics of sexual coercion and abuse
The effects of violence on women's health
Explaining gender-based violence
How do women respond to abuse?
Challenges for international research on gender-based violence

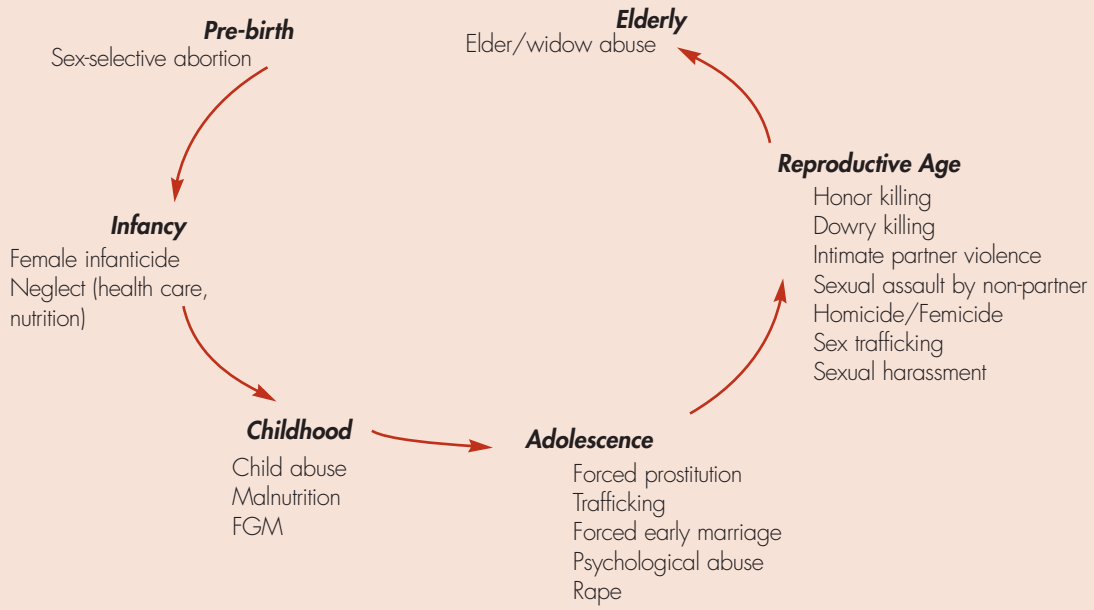
Violence against women is the most pervasive yet underrecognized human rights violation in the world. It is also a profound health problem that saps women's energy, compromises their physical and mental health, and erodes their self-esteem. In addition to causing injury, violence increases women's long-term risk of a number of other health problems, including chronic pain, physical disability, drug and alcohol abuse, and depression.[1, 2] Women with a history of physical or sexual abuse are also at increased risk for unintended pregnancy, sexually transmitted infections, and miscarriages.[3-5] Despite the high costs of violence against women, social institutions in almost every society in the world legitimize, obscure, and deny abuse. The same acts that would be punished if directed at an employer, a neighbor, or an acquaintance often go unchallenged when men direct them at women, especially within the family.

For over three decades, women's advocacy groups around the world have been working to draw more attention to the physical, psychological, and sexual abuse of women and to stimulate action. They have provided abused women with shelter, lobbied for legal reforms, and challenged the widespread attitudes and beliefs that support violence against women.[2]

Increasingly, these efforts are having

* Parts of this chapter are reprinted from Heise, Ellsberg and Gottemoeller, 1999[2] (available online at http://www.infoforhealth.org/pr/l11edsum.shtml).

FIGURE 1.1 THE LIFE CYCLE OF VIOLENCE AGAINST WOMEN



(Adapted from Watts and Zimmerman, 2002[6] and Shane and Ellsberg, 2002.[7])

results. Today, international institutions are speaking out against gender-based violence. Surveys and studies are collecting more information about the prevalence and nature of abuse. More organizations, service providers, and policy makers are recognizing that violence against women has serious adverse consequences for women's health and for society.

This chapter provides a brief overview of the issue of violence against women, including definitions, international prevalence, the documented health consequences of abuse, and evidence regarding causation and women's experiences of abuse. We include this information here for individuals who may be new to the topic and/or for those who are writing research proposals and may not have easy access to the international literature.

DEFINITIONS OF VIOLENCE AGAINST WOMEN

Although both men and women can be victims as well as perpetrators of violence, the characteristics of violence most commonly committed against women differ in critical respects from violence commonly committed against men. Men are more likely to be killed or injured in wars or youth- and gang-related violence than women, and they are more likely to be physically assaulted or killed on the street by a stranger. Men are also more likely to be the perpetrators of violence, regardless of the sex of the victim.[1] In contrast, women are more likely to be physically assaulted or murdered by someone they know, often a family member or intimate partner.[2] They are also at greater risk of being sexually assaulted or exploited, either in childhood, adolescence, or as adults. Women are vulnerable to different types of violence at different moments in their lives (see Figure 1.1).

There is still no universally agreed-upon terminology for referring to violence against women. Many of the most commonly used terms have different meanings in different regions, and are derived from diverse theoretical perspectives and disciplines.

One frequently used model for understanding intimate partner abuse and sexual abuse of girls is the "family violence" framework, which has been developed primarily from the fields of sociology and psychology.[8, 9] "Family violence" refers to all forms of abuse within the family regardless of the age or sex of the victim or the perpetrator. Although women are frequently victimized by a spouse, parent, or other family member, the concept of "family violence" does not encompass the many types of violence to which women are exposed outside the home, such as sexual assault and harassment in the workplace. Moreover, feminist researchers find the assumption of gender neutrality in the term "family violence" problematic because it fails to highlight that violence in the family is mostly perpetrated by men against women and children.

There is increasing international consensus that the abuse of women and girls, regardless of where it occurs, should be considered as "gender-based violence," as it largely stems from women's subordinate status in society with regard to men (Figure 1.2). The official United Nations definition of gender-based violence was first presented in 1993 when the General Assembly passed the Declaration on the Elimination of Violence against Women.[10] According to this definition, gender-based violence includes a host of harmful behaviors directed at women and girls because of their sex, including wife abuse, sexual assault, dowry-related murder, marital rape, selective malnourishment of female children, forced prostitution, female genital mutilation, and sexual abuse of female children (see Box 1.1 for the complete definition).[10]

Even when the abuse of women by male partners is conceptualized as gender-based violence, the terms used to describe this type of violence are not consistent. In many parts of the world, the term "domestic violence" refers to the abuse of women by current or former male intimate partners.[11, 12] However, in some regions, including Latin America, "domestic violence" refers to any violence that takes place in the home, including violence against children and the elderly.[13, 14] The term "battered women" emerged in the 1970s and is widely used in the United States and Europe to describe women who experience a pattern of systematic domination and physical assault by their male partners.[15] The terms "spouse abuse," "sexualized violence," "intimate partner violence," and "wife abuse" or "wife assault" are generally used interchangeably, although each term has weaknesses. "Spouse abuse" and "intimate partner violence" do not make explicit that the victims are generally women, whereas "wife abuse" and "wife assault" can be read to exclude common-law unions and dating violence.

For the purposes of this manual, we use the terms "violence against women" (VAW) and "gender-based violence" (GBV) interchangeably to refer to the full range of abuses recognized by the UN Declaration and other international agreements. We use

BOX 1.1 UNITED NATIONS DEFINITION OF VIOLENCE AGAINST WOMEN

The term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:

a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

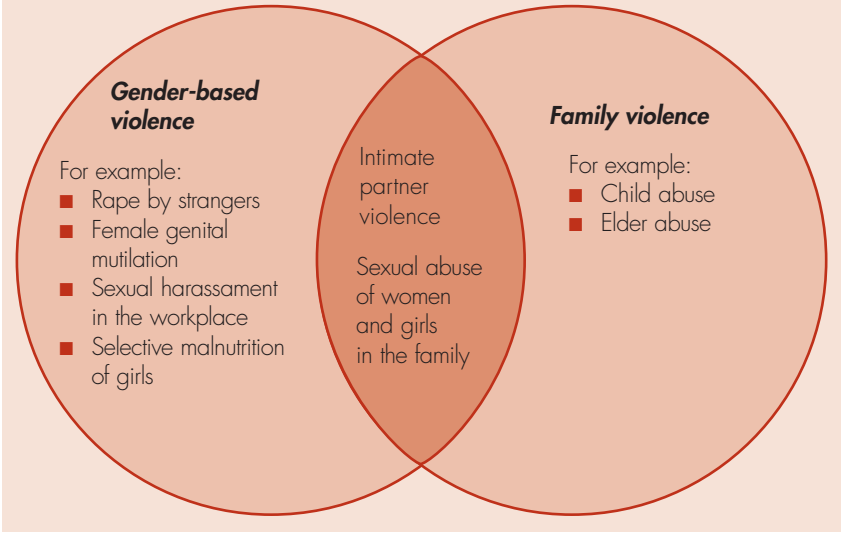
b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.

(From United Nations, 1993.[10])

FIGURE 1.2 THE OVERLAP BETWEEN GENDER-BASED VIOLENCE AND FAMILY/DOMESTIC VIOLENCE



the terms "intimate partner violence," "wife abuse" and "domestic violence" interchangeably to refer to the range of sexually, psychologically, and physically coercive acts used against adult and adolescent women by current or former male intimate partners.

PREVALENCE OF INTIMATE PARTNER VIOLENCE

International research consistently demonstrates that a woman is more likely to be assaulted, injured, raped, or killed by a current or former partner than by any other person. Table 1.1 presents findings from nearly 80 population-based studies carried out in more than 50 countries. These studies indicate that between 10 percent and 60 percent of women who have ever been married or partnered have experienced at least one incident of physical violence from a current or former intimate partner. Most studies estimate a lifetime prevalence of partner violence between 20 percent and 50 percent. Although women can also be violent, and abuse exists in some same-sex relationships, the vast majority of partner abuse is perpetrated by men against their female partners.

Researchers find considerable variation in the prevalence of partner violence from country to country, and among studies within a country. Unfortunately, lack of consistency in study methods, study design, and presentation of results makes it difficult to explore the causes and consequences of violence. As a result, it is often difficult to compare results even between studies performed in the same country.

Partly to address this shortcoming, the World Health Organization worked with collaborating institutions in 15 sites in ten countries between 1998 and 2004 to implement a multi-country study of domestic violence and women's health. The *WHO Multi-country Study on Women's Health and Domestic Violence Against Women*—also referred to here as the WHO VAW Study—was the first ever to produce truly comparable data on physical and sexual abuse across settings.[16] This research project sought to minimize differences related to methods by employing standardized questionnaires and procedures, as well as a common approach to interviewer training.

We will return to the WHO VAW Study many times throughout the manual to highlight some of the challenges posed by this project and how they were resolved.

THE PATTERNING OF INTIMATE PARTNER VIOLENCE

The WHO VAW Study also provided a rare opportunity to examine the "patterning" of violence across settings. Does physical violence occur together with other types of violence? Do violent acts tend to escalate over time? Are women most at risk from partners or from others in their lives?

The WHO VAW Study findings confirm that most women who suffer physical or sexual abuse by a partner generally experience multiple acts over time. Likewise, physical and sexual abuse tend to co-occur in

TABLE 1.1 PHYSICAL ASSAULTS ON WOMEN BY AN INTIMATE MALE PARTNER, SELECTED POPULATION-BASED STUDIES, 1982–2004

Country		Ref	Year of study	Coverage	Sample size	Study* population*	Age (years)	Proportion of women physically assaulted by a partner (%) last 12 mo	Ever
Africa									
Ethiopia	◆	17	2002	Meskanena Woreda	2261	III	15–49	29	49
Kenya		18	1984–87	Kisii District	612	V	>15		42[d]
	■	19	2003	National	3856	III	15–49	24	40
Namibia	◆	20	2002	Winhoek	1367	III	15–49	16	31
South Africa		21	1998	Eastern Cape	396	III	18–49	11	27
			1998	Mpumalanga	419	III	18–49	12	28
			1998	Northern Province	464	III	18–49	5	19
	■	22	1998	National	10,190	II	15–49	6	13
Tanzania	◆	20	2002	Dar es Salaam	1442	III	15–49	15	33
	◆	20	2002	Mbeya	1256	III	15–49	19	47
Uganda		23	1995–1996	Lira & Masaka	1660	II	20–44		41[d]
Zambia	■	24	2001–2002	National	3792	III	15–49	27	49
Zimbabwe		25	1996	Midlands Province	966	I	>18		17[b]
Latin America and the Caribbean									
Barbados		26	1990	National	264	I	20–45		30[a,c]
Brazil	◆	20	2001	Sao Paulo	940	III	15–49	8	27
	◆	20	2001	Pernambuco	1188	III	15–49	13	34
Chile		27	1993	Santiago Province	1000	II	22–55		26[d]
		28	1997	Santiago	310	II	15–49	23	
	●	29	2004[p]	Santa Rosa	422	IV	15–49	4	25
Colombia	■	30	1995	National	6097	II	15–49		19[d]
	■	31	2000	National	7602	III	15–49	3	44
Dominican Republic	■	24	2002	National	6807	III	15–49	11	22
Ecuador	▲	32	1995	National	11,657	II	15–49	12	
El Salvador	▲	33	2002	National	10,689	III	15–49	6	20[d]
Guatemala	▲	34	2002	National	6595[f]	VI	15–49	9	
Honduras	▲	35	2001	National	6827	VI	15–49	6	10
Haiti	■	24	2000	National	2347	III	15–49	21	29
Mexico		36	1996	Guadalajara	650	III	>15		27
		37	1996[p]	Monterrey	1064	III	>15		17
		38	2003	National	34,184	II	>15	9	
Nicaragua		39	1995	Leon	360	III	15–49	27	52
		40	1997	Managua	378	III	15–49	33	69
	■	41	1998	National	8507	III	15–49	13	30
Paraguay	▲	42	1995–1996	National	5940	III	15–49		10
	▲	43	2004	National	5070	III	15–44	7	19
Peru	■	24	2000	National	17,369	III	15–49	2	42

TABLE 1.1 PHYSICAL ASSAULTS ON WOMEN BY AN INTIMATE MALE PARTNER, SELECTED POPULATION-BASED STUDIES, 1982–2004

Country		Ref	Year of study	Coverage	Sample size	Study* population*	Age (years)	Proportion of women physically assaulted by a partner (%) last 12 mo	Ever
Latin America and the Caribbean (continued)									
Peru (continued)	◆	[20]	2001	Lima	1019	III	15–49	17	50
	◆	[20]	2001	Cusco	1497	III	15–49	25	62
Puerto Rico	▲	[44]	1995–1996	National	4755	III	15–49		13[e]
Uruguay		[45]	1997	National	545	II[k]	22–55	10[c]	
North America									
Canada		[46]	1993	National	12,300	I	>18	3[b,c]	29[b,c]
		[47]	1999	National	8356	III	>15	3	8[g]
United States		[48]	1995–1996	National	8000	I	>18	1[a]	22[a]
Asia and Western Pacific									
Australia	*	[49]	1996	National	6300	I		3[b]	8[b,d]
		[50]	2002–2003	National	6438	III	18–69	3	31
Bangladesh		[51]	1992	National (villages)	1225	II	<50	19	47
		[52]	1993	Two rural regions	10,368	II	15–49		42[d]
	◆	[20]	2003	Dhaka	1373	III	15–49	19	40
	◆	[20]	2003	Matlab	1329	III	15–49	16	42
Cambodia		[53]	1996	Six regions	1374	III	15–49		16
	■	[24]	2000	National	2403	III	15–49	15	18
China		[54]	1999–2000	National	1665	II	20–64		15
India	■	[24]	1998–1999	National	90,303	III	15–49	10	19
		[53]	1999	Six states	9938	III	15–49	14	40
	●	[29]	2004[p]	Lucknow	506	IV	15–49	25	35
	●	[29]	2004[p]	Trivandrum	700	IV	15–49	20	43
	●	[29]	2004[p]	Vellore	716	IV	15–49	16	31
Indonesia		[55]	2000	Central Java	765	IV	15–49	2	11
Japan	◆	[20]	2001	Yokohama	1276	III	18–49	3	13
New Zealand	◆	[56]	2002	Auckland	1309	III	18–64	5	30
	◆	[56]	2002	North Waikato	1360	III	18–64		34
Papua New Guinea		[57]	1982	National, rural villages	628	III[k]			67
Philippines	■	[58]	1993	National	8481	IV	15–49		10
		[59]	1998	Cagayan de Oro City & Bukidnon	1660	II	15–49		26
	●	[29]	2004[p]	Paco	1000	IV	15–49	6	21
Republic of Korea		[60]	1989	National	707	II	>20	38	
Samoa	◆	[20]	2000	National	1204	III	15–49	18	41
Thailand	◆	[20]	2002	Bangkok	1048	III	15–49	8	23
		[20]	2002	Nakonsawan	1024	III	15–49	13	34
Vietnam		[61]	2004	Ha Tay province	1090	III	15–60	14	25

TABLE 1.1 PHYSICAL ASSAULTS ON WOMEN BY AN INTIMATE MALE PARTNER, SELECTED POPULATION-BASED STUDIES, 1982–2004

Country		Ref	Year of study	Coverage	Sample size	Study* population*	Age (years)	Proportion of women physically assaulted by a partner (%) last 12 mo	Ever
Europe									
Albania	▲	62	2002	National	4049	III	15–44	5	8
Azerbaijan	▲	63	2001	National	5533	III	15–44	8	20
Finland	*	64	1997	National	4955	I	18–74		30
France	*	65	2002	National	5908	II	>18	3	9[i]
Georgia	▲	66	1999	National	5694	III	15–44	2	5
Germany	*	67	2003	National	10,264	III	16–85		23[b]
Lithuania	*	68	1999	National	1010	II	18–74		42[b,d,h]
Netherlands		69	1986	National	989	I	20–60		21[a]
Norway		70	1989	Trondheim	111	III	20–49		18
	*	71	2003	National	2143	III	20–56	6	27
Republic of Moldova	▲	72	1997	National	4790	III	15–44	8	15
Romania	▲	73	1999	National	5322	III	15–44	10	29
Russia	▲	74	2000	Three provinces	5482	III	15–44	7	22
Serbia/Montenegro	◆	20	2003	Belgrade	1189	III	15–49	3	23
Sweden	*	75	2000	National	5868	III	18–64	4[e]	18[e]
Switzerland		76	1994–1996	National	1500	II	20–60	6[c]	21[c]
	*	77	2003	National	1882	III	>18		10
Turkey		78	1998	E & SE Anatolia	599	I	14–75		58[a]
Ukraine	▲	79	1999	National	5596	III	15–44	7	19
United Kingdom		80	1993[p]	North London	430	I	>16	12[a]	30[a]
		81	2001	National	12,226	I	16–59	3	19[i]
Eastern Mediterranean									
Egypt	■	82	1995–1996	National	7123	III	15–49	13	34
	●	29	2004[p]	El–Sheik Zayed	631	IV	15–49	11	11
Israel		83	1997	Arab population	1826	II	19–67	32	
West Bank and Gaza Strip		84	1994	Palestinian population	2410	II	17–65	52	

Key ■ DHS survey data[24] ● INCLEN data[85] ▲ CDC study ◆ WHO study[20] * International Violence Against Women (IVAWS) Study

* Study population: I = all women; II = currently married/partnered women; III = ever–married/partnered women; IV = women with a pregnancy outcome; V = married women – half with pregnancy outcome, half without; VI women who had a partner within the last 12 months.

[a] Sample group included women who had never been in a relationship and therefore were not in exposed group.

[b] Although sample included all women, rate of abuse is shown for ever–married/partnered women (number not given).

[c] Physical or sexual assault.

[d] During current relationship.

[e] Rate of partner abuse among ever–married/partnered women recalculated from authors' data.

[f] Weighted for national representativity.

[g] Within the last five years.

[h] Includes threats.

[i] Since the age of 18.

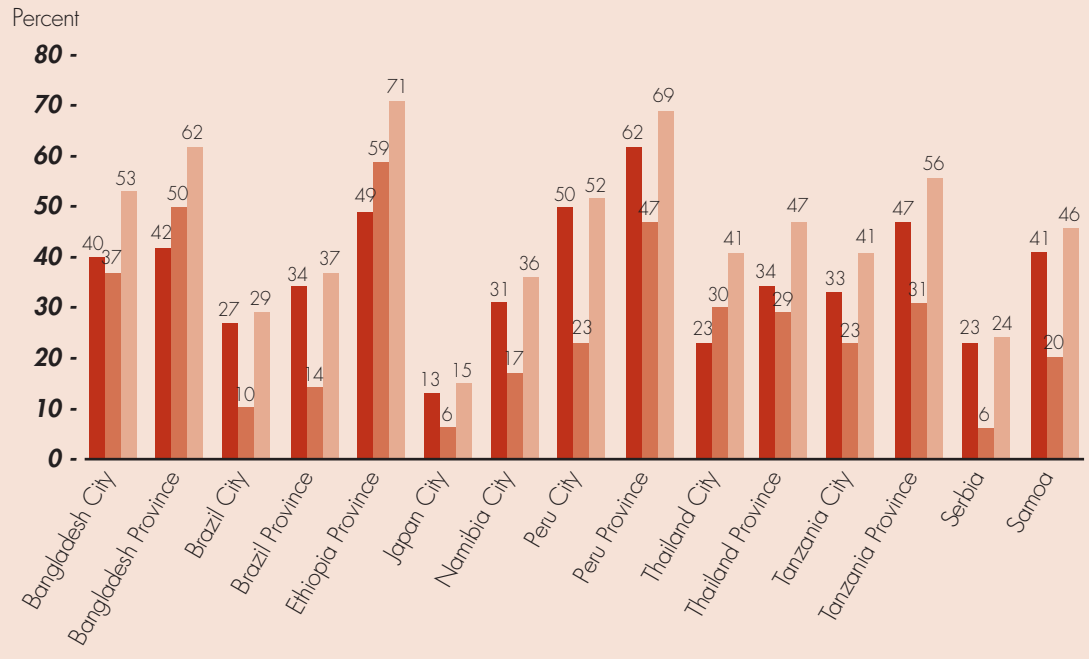
[j] Since the age of 16.

[k] Nonrandom sampling methods used.

[p] Publication date (field work dates not reported).

(Updated from Heise et al, 1999.[2])

FIGURE 1.3 PREVALENCE OF PHYSICAL VIOLENCE AND/OR SEXUAL PARTNER VIOLENCE IN TEN COUNTRIES



(From WHO, 2005.[20])

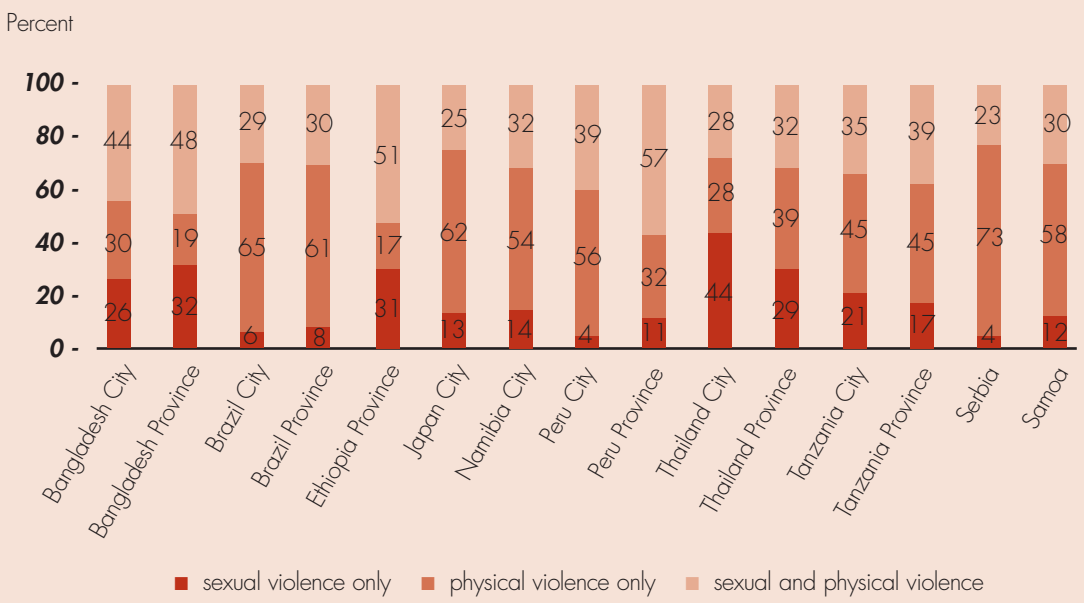
many relationships. Figure 1.3 summarizes the proportion of women who have experienced violence by an intimate partner among ever-partnered women aged 15 to 49 in the various sites included in the study. The first bar portrays the percentage of women in each setting who have experienced physical violence by a partner; the second bar portrays sexual violence by a partner; and the third bar represents the percentage of ever-partnered women who have experienced either physical and/or sexual violence by a partner in their lifetime.

Until recently, it was believed that few women exclusively experienced sexual violence by an intimate partner. Available studies from North and Central America had indicated that sexual violence was generally accompanied by physical abuse and by emotional violence and controlling behaviors.[2]

The findings from the WHO VAW Study suggest that, although this pattern is maintained in many countries, a few sites demonstrate a significant departure. In both the capital and province of Thailand, a substantial portion of women who experience partner violence, experience sexual violence only (Figure 1.4). In Bangkok, 44 percent of all cases of lifetime partner violence have experienced only sexual violence. The corresponding statistic in the Thai province is 29 percent of cases. A similarly high percentage of cases of violence in Bangladesh province (32 percent) and Ethiopia province (31 percent) involve sexual violence only.

These results speak to the importance of developing a broader international research base on violence against women. Insights derived exclusively from the North American literature may not reflect the reality of women's experiences in other settings.

FIGURE 1.4 INTIMATE PARTNER VIOLENCE ACCORDING TO TYPES OF VIOLENCE (AMONG EVER-ABUSED WOMEN)



(From WHO, 2005.[20])

PREVALENCE AND CHARACTERISTICS OF SEXUAL COERCION AND ABUSE

For many women and girls, sexual coercion and abuse are defining features of their lives. Forced sexual contact can take place at any time in a woman's life and includes a range of behaviors, from forcible rape to nonphysical forms of pressure that compel girls and women to engage in sex against their will. The touchstone of coercion is that a woman lacks choice and faces severe physical, social, or economic consequences if she resists sexual advances.

Studies indicate that the majority of nonconsensual sex takes place among individuals who know each other—spouses, family members, dating partners, or acquaintances.[86, 87] In fact, much nonconsensual sex takes place within consensual unions and includes a woman being compelled to have sex when she does not want it, or to engage in types of sexual activity that she finds degrading or humiliating.[1, 88, 89]

Much sexual coercion also takes place against children and adolescents in both industrial and developing countries. Between one-third and two-thirds of known sexual assault victims are age 15 or younger, according to justice system statistics and information from rape crisis centers in Chile, Peru, Malaysia, Mexico, Panama, Papua New Guinea, and the United States.[2]

Sexual exploitation of children is widespread in virtually all societies. Child sexual abuse refers to any sexual act that occurs between an adult or older adolescent and a child, and any nonconsensual sexual contact between a child and a peer. Laws generally consider the issue of consent to be irrelevant in cases of sexual contact by an adult with a child, defined variously as someone under 13, 14, 15, or 16 years of age.

Because of the taboo nature of the topic, it is difficult to collect reliable figures on the prevalence of sexual abuse in childhood. Nonetheless, the few representative sample surveys provide cause for concern.

A review of 25 studies worldwide indicates that 0 to 32 percent of women report that they experienced sexual abuse in childhood (see Table 1.2). Although both girls and boys can be victims of sexual abuse, most studies report that the prevalence of abuse among girls is at least 1.5 to 3 times higher than among boys.[90] Abuse among boys may be underreported compared with abuse among girls, however.

Further data reveal that coercion may be an element in many young girls' initiation into sexual life. An increasing number of studies have begun to document that a substantial number of young women's first sexual experiences are forced or unwanted, especially among younger adolescents. Table 1.3 summarizes data from a number of population-based surveys on the prevalence of forced first sex, including data emerging from the WHO VAW Study. A plethora of studies now confirm that the younger a girl is when she first has sex, the more likely she is to report her sexual debut as forced.[91]

Trafficking in women and girls for forced labor and sexual exploitation is another type of gender-based violence that has grown rapidly during the past decade, largely as a result of war, displacement, and economic and social inequities between and within countries. Although reliable statistics on the number of women and children who are trafficked are lacking, rough estimates suggest that from 700,000 to 2 million women and girls are trafficked across international borders every year.[6, 92, 93] These women face many risks, including physical violence and rape, both in their work and when trying to negotiate safer-sex practices.

Another aspect of gender-based violence that has been largely overlooked until recently is violence against women in situations of armed conflict. Recent reports have documented systematic rape in many conflicts, including the former Yugoslavia, Rwanda, Liberia, Sierra Leone, and Uganda.[94-96] These reports have highlighted the extent to which rape has been used as a deliberate strategy to "destabilize population, advance ethnic cleansing, express hatred for the enemy or supply combatants with sexual services."[96] In 2002, the International Criminal Tribunal in The Hague recognized the seriousness of sexual offences in war as a crime against humanity. International relief agencies are also calling attention to the precarious situation of women in refugee settings where rape, child sexual abuse, intimate partner violence, and other forms of sexual exploitation are widespread.

THE EFFECTS OF VIOLENCE ON WOMEN'S HEALTH

Gender-based violence is associated with serious health problems affecting both women and children, including injuries, gynecological disorders, mental health disorders, adverse pregnancy outcomes, and sexually transmitted infections (STIs) (Figure 1.5). Violence can have *direct* consequences for women's health, and it can increase women's risk of *future* ill health. Therefore, victimization, like tobacco or alcohol use, can best be conceptualized as a risk factor for a variety of diseases and conditions, rather than primarily as a health problem in and of itself.[2, 4]

Both population-based research and studies of emergency room visits in the United States indicate that physical abuse is an important cause of injury among women.[97] Documented injuries sustained from such physical abuse include contusions, concussions, lacerations, fractures, and gunshot wounds. Population-based studies indicate that 40 to 75 percent of women who are physically abused by a partner report injuries due to violence at some point in their life.[2]

Nevertheless, injury is not the most

TABLE 1.2 PREVALENCE OF CHILD SEXUAL ABUSE: SELECTED STUDIES, 1990–2003

Country & Year (Ref. No.)	*Study Method & Sample*	*Definition of Child Sexual Abuse*	*Prevalence*
Australia 1997 [98]	■ Retrospective study of 710 women	■ Sexual contact before the age of 12 with perpetrator 5+ years older; or unwanted sexual activity at ages 12-16	■ 20% of women report abuse
Bangladesh 2002 [20]	■ Population-based survey of women ages 15–49 (Dhaka 1602, Matlab 1527)	■ Unwanted sexual activity, contact and noncontact before the age of 15	■ In Dhaka 7% of women; in Matlab 1% of women report abuse
Barbados 1993 [99]	■ National random sample of 264 women	■ Sexual contact that is unwanted or with a biological relative; or before the age of 16 with perpetrator 5+ years older	■ 30% of women report abuse
Brazil 2002 [20]	■ Population-based survey of women ages 15–49 (Sao Paulo 1172, Pernambuco 1473)	■ Unwanted sexual activity, contact and noncontact before the age of 15	■ In Sao Paulo 8% of women; in Pernambuco 6% of women report abuse
Canada 1990 [100]	■ Population survey of 9953 men and women age 15+	■ Unwanted sexual activity, contact and noncontact, while growing up	■ 13% of women, 4% of men report abuse
Costa Rica 1992 [101]	■ Retrospective survey of university students	■ Unwanted sexual activity, contact and noncontact; no ages specified	■ 32% of women, 13% of men report abuse
Ethiopia 2002 [20]	■ Population-based survey of 3014 women ages 15–49	■ Unwanted sexual activity, contact and noncontact before the age of 15	■ 0.2% of women report abuse
Germany 1992 [102]	■ Multiple-screen questionnaire answered by 2,151 students in Würzburg and Leipzig	■ Distressing sexual activity, contact and noncontact, before the age of 14; or with perpetrator 5+ years older	■ In Würzburg 16% of girls, 6% boys; in Leipzig 10% of girls, 6% of boys report abuse
Japan 2002 [20]	■ Population-based survey of 1361 women ages 15–49	■ Unwanted sexual activity, contact and noncontact before the age of 15	■ 10% of women report abuse
Malaysia 1996 [103]	■ Retrospective self-administered questionnaire answered by 616 paramedical students	■ Vaginal or anal penetration, or unsolicited sexual contact, or witnessing exhibitionism before the age of 18	■ 8% of women, 2% of men report abuse
Namibia 2002 [20]	■ Population-based survey of 1492 women ages 15–49	■ Unwanted sexual activity, contact and noncontact before the age of 15	■ 5% of women report abuse
New Zealand 1997 [104]	■ Birth cohort of 520 girls, studied from birth to age 18	■ Unwanted sexual activity, contact and noncontact, before the age of 16	■ 14% of girls report contact abuse; 17% report any abuse
Nicaragua 1997 [105]	■ Anonymous self-administered questionnaire answered by 134 men and 202 women ages 25–44 drawn from population-based sample	■ Sexual contact, including attempted penetration, before the age of 13 with perpetrator 5+ years older; or nonconsensual activity over the age of 12	■ 26% of women, 20% of men report abuse
Norway (Oslo) 1996 [106]	■ Population-based sample of 465 adolescents, ages 13–19, followed for 6 years	■ Sexual contact, including "intercourse after pressure," occurring between a child before the age of 13 and an adult over the age of 17; or involving force	■ 17% of girls, 1% of boys report abuse

TABLE 1.2 PREVALENCE OF CHILD SEXUAL ABUSE: SELECTED STUDIES, 1990–2003

Country & Year (Ref. No.)	*Study Method & Sample*	*Definition of Child Sexual Abuse*	*Prevalence*
Peru 2002 [20]	■ Population-based survey of women ages 15–49 (Lima 1414, Cusco 1837)	■ Unwanted sexual activity, contact and noncontact before the age of 15.	■ In Lima 20% of women; in Cusco 8% of women report abuse
Samoa 2000 [20]	■ Population-based survey of 1640 women ages 15–49	■ Unwanted sexual activity, contact and noncontact before the age of 15.	■ 2% of women report abuse
Serbia & Montenegro 2003 [20]	■ Population-based survey of 1453 women ages 15–49	■ Unwanted sexual activity, contact and noncontact before the age of 15.	■ 2% of women report abuse
Spain 1995 [107]	■ Face-to-face interviews and self-administered questionnaires answered by 895 adults ages 18–60	■ Unwanted sexual activity, contact and noncontact before the age of 17.	■ 22% of women and 15% of men report abuse
Switzerland (Geneva) 1996 [108]	■ Self-administered questionnaire answered by 1193 9th grade students	■ Unwanted sexual activity, contact and noncontact.	■ 20% of girls, 3% of boys report contact abuse; 34% of girls, 11% of boys report any abuse
Switzerland (National) 1998 [109]	■ National survey of 3993 girls, ages 15–20, enrolled in schools or professional training programs	■ "Sexual victimization," defined as "when someone in your family, or someone else, touches you in a place you didn't want to be touched, or does something to you sexually which they shouldn't have done."	■ 19% of girls report abuse
Thailand 2002 [20]	■ Population-based survey of women ages 15–49 (Bangkok 1534, Nakhonsawan 1280)	■ Unwanted sexual activity, contact and noncontact before the age of 15.	■ In Bangkok 7.6% of women; in Nakhonsawan 4.7% of women report abuse
Tanzania 2002 [20]	■ Population-based survey of women ages 15–49 (Dar es Salaam 1816, Mbeya 1443)	■ Unwanted sexual activity, contact and noncontact before the age of 15.	■ In Dar es Salaam 4% of women; in Mbeya 4% of women report abuse
United States 1997 [110]	■ National 10-year longitudinal study of women's drinking that included questions about sexual abuse, answered by 1099 women	■ Unwanted sexual activity, contact and noncontact, before the age of 18; or before the age of 13 with perpetrator 5+ years older.	■ 21% of women report abuse
United States (Midwest) 1997 [111]	■ Self-administered questionnaire answered by 42,568 students in grades 7–12	■ "Sexual abuse," defined as "when someone in your family or another person does sexual things to you or makes you do sexual things to them that you don't want to do."	■ 12% of girls, 4% of boys report abuse
United States (Washington State) 1997 [112]	■ Multiple-choice survey of 3128 girls in grades 8,10 and 12	■ "Sexual abuse," defined as "when someone in your family or someone else touches you in a sexual way in a place you didn't want to be touched, or does something to you sexually which they shouldn't have done."	■ 23% of all girls; 18% of 8th graders, 24% of 10th graders, 28% of 12th graders report abuse

(Updated and adapted from Heise et al, 1999[2] and WHO, 2002.[1])

TABLE 1.3 PERCENTAGE OF MEN AND WOMEN REPORTING FORCED SEXUAL INITIATION: SELECTED POPULATION-BASED SURVEYS, 1993—2003

Country or Area	*Study Population*	*Year*	*Sample Size*	*Age Group (years)*	*Percentage reporting first sexual intercourse as forced*	
					Females	*Males*
Bangladesh	Dhaka	2002	1369	15–49	24	
Bangladesh	Matlab	2002	1326	15–49	30	
Brazil	Sao Paulo	2002	1051	15–49	3	
Brazil	Pernambuco	2002	1234	15–49	4	
Cameroon	Bamenda	1995	646	12–25	37	30
Caribbean	Nine countries	1997–1998	15,695	10–18	48	32
Ethiopia	Gurage	2002	2238	15–49	17	
Ghana	Three urban towns	1996	750	12–24	21	5
Japan	Yokohama	2002	1116	15–49	0	
Mozambique	Maputo	1999	1659	13–18	19	7
Namibia	Windhoek	2002	1357	15–49	2	
New Zealand	Dunedin	1993–1994	935	Birth cohort	7	0
Peru	Lima	1995	611	16–17	40	11
Peru	Lima	2002	1103	15–49	7	
Peru	Cusco	2002	1557	15–49	24	
Samoa	National	2002	1317	15–49	8	
Serbia & Montenegro	Belgrade	2002	1310	15–49	1	
South Africa	Transkei	1994–1995	1975	15–18	28	6
Tanzania	Dar es Salaam	2002	1556	15–49	14	
Tanzania	Mbeya	2002	1287	15–49	17	
Tanzania	Mwanza	1996	892	12–19	29	7
Thailand	Bangkok	2002	1051	15–49	4	
Thailand	Nakhonsawan	2002	1028	15–49	5	
United States	National	1995	2042	15–24	9	—

(From World Health Organization, 2002[1], 2005.[20])

common physical health outcome of gender-based abuse. More common are "functional disorders"—ailments that frequently have no identifiable cause, such as irritable bowel syndrome; gastrointestinal disorders; and various chronic pain syndromes, including chronic pelvic pain. Studies consistently link such disorders with a history of physical or sexual abuse. Women who have been abused also tend to experience poorer physical functioning, more physical symptoms, and more days in bed than do women who have not been abused.[113-116]

For many women, the psychological consequences of abuse are even more serious than its physical effects. The experience of abuse often erodes women's self-esteem and puts them at greater risk of a variety of mental health problems, including depression, anxiety, phobias, post-traumatic stress disorder, and alcohol and drug abuse.[2]

Violence and sexual abuse also lie behind some of the most intractable

reproductive health issues of our times—unwanted pregnancies, HIV and other STIs, and complications of pregnancy. Physical violence and sexual abuse can put women at risk of infection and unwanted pregnancies *directly*, if women are forced to have sex, for example, or if they fear using contraception or condoms because of their partner's reaction. A history of sexual abuse in childhood also can lead to unwanted pregnancies and STIs *indirectly* by increasing sexual risk-taking in adolescence and adulthood. There is a growing body of research indicating that violence may increase women's susceptibility to HIV infection.[117-120] Studies carried out in Tanzania and South Africa found that seropositive women were more likely than their seronegative peers to report physical partner abuse. The results indicate that women with violent or controlling male partners are at increased risk of HIV infection. There is little information as yet to indicate how violence increases women's risk for HIV. Dunkle and colleagues suggest that abusive men are more likely to have HIV and impose risky sexual practices on their partners. There are also indications that disclosure of HIV status may put women at risk for violence.[118]

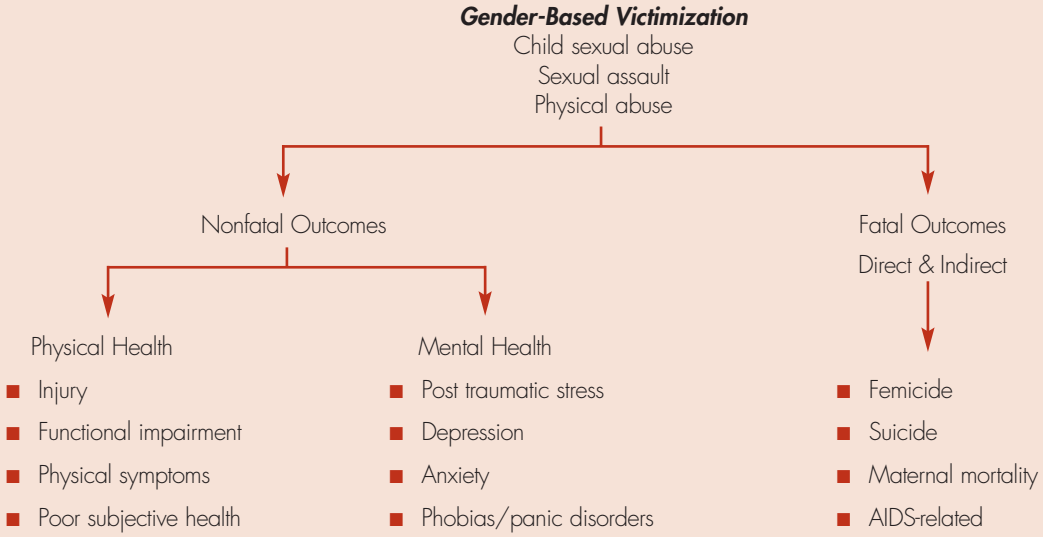
Violence can also be a risk factor during pregnancy. Studies from around the world demonstrate that violence during pregnancy is not a rare phenomenon. Within the United States, for example, between 1 percent and 20 percent of currently pregnant women report physical violence, with the majority of findings between 4 percent and 8 percent.[5] The differences are due partly to differences in the way women were asked about violence.[3, 5, 121, 122] A recent review found that the prevalence of abuse during pregnancy is 3 to 11 percent in industrialized countries outside of North America and between 4 and 32 percent in developing countries, including studies from China, Egypt, Ethiopia, Mexico, India, Nicaragua, Pakistan, Saudi Arabia, and South Africa.[3]

Violence during pregnancy can have serious health consequences for women and their children.[2] Documented effects include delayed prenatal care, inadequate weight gain, increased smoking and substance abuse, STIs, vaginal and cervical infections, kidney infections, miscarriages and abortions, premature labor, fetal distress, and bleeding during pregnancy.[4]

Recent research has focused on the relationship between violence in pregnancy and low birth weight, a leading cause of infant deaths in the developing world. Although research is still emerging, findings of six different studies performed in the United States, Mexico, and Nicaragua suggest that violence during pregnancy contributes to low birth weight, pre-term delivery, and to fetal growth retardation, at least in some settings.[121, 123] A recent meta analysis of existing studies confirms that intimate partner violence during pregnancy is indeed associated with a significant, albeit small, reduction in birth weight.[124]

In its most extreme form, violence kills women. Worldwide, an estimated 40 to more than 70 percent of homicides of women are perpetrated by intimate partners, frequently in the context of an abusive relationship.[125] By contrast, only a small percentage of men who are murdered are killed by their female partners, and in many such cases, the women are defending themselves or retaliating against abusive men.[126] A study of female homicide in South Africa found that intimate femicide (female murder by an intimate partner) accounted for 41 percent of all female homicides. This study estimated that a woman is killed by her intimate partner in South Africa every six hours.[127] Violence is also a significant risk factor for suicide. Studies in numerous countries have found that women who have suffered domestic

FIGURE 1.5 HEALTH OUTCOMES OF VIOLENCE AGAINST WOMEN



Physical Health

- Injury
- Functional impairment
- Physical symptoms
- Poor subjective health
- Permanent disability

Mental Health

- Post traumatic stress
- Depression
- Anxiety
- Phobias/panic disorders
- Eating disorders
- Sexual dysfunction
- Low self-esteem
- Mental distress
- Substance abuse disorders

Fatal Outcomes

- Femicide
- Suicide
- Maternal mortality
- AIDS-related

Injurious Health Behaviors

- Smoking
- Alcohol and drug use
- Sexual risk-taking
- Physical inactivity
- Overeating

Functional Disorders

- Chronic pain syndromes
- Irritable bowel syndrome
- Gastrointestinal disorders
- Somatic complaints
- Fibromyalgia

Reproductive Health

- Unwanted pregnancy
- STIs/HIV
- Gynecological disorders
- Unsafe abortion
- Pregnancy complications
- Miscarriage/low birth weight
- Pelvic inflammatory disease

(From Heise et al, 1999.[2])

violence or sexual assault are much more likely to have had suicidal thoughts, or to have attempted to kill themselves.[19]

EXPLAINING GENDER-BASED VIOLENCE

Violence against women is widespread, but it is not universal. Anthropologists have documented small-scale societies—such as the Wape of Papua New Guinea—where domestic violence is virtually absent.[128, 129] This reality stands as testament to the fact that social relations can be organized to minimize abuse.

Why is violence more widespread in some places than in others? Increasingly, researchers are using an "ecological framework" to understand the interplay of personal, situational, and socio-cultural factors that combine to cause abuse.[21, 130-133] In this framework, violence against women results from the interaction of factors at different levels of the social environment (Figure 1.6).

The framework can best be visualized as four concentric circles. The innermost circle represents the biological and personal history that each individual brings to his or her behavior in relationships. The second circle represents the immediate context in which abuse takes place: frequently the family or other intimate or acquaintance relationship. The third circle represents the institutions and social structures, both formal and informal, in which relationships are embedded, such as neighborhoods, the workplace, social networks, and peer groups. The fourth, outermost circle is the economic and social environment, including cultural norms.

A wide range of studies shows that several factors at each of these levels increase the likelihood that a man will abuse his partner:

- **At the individual level**, the male was abused as a child or witnessed marital violence in the home, had an absent or rejecting father, or frequently uses alcohol. A recent review of nationally representative surveys in nine countries found that for women, low educational attainment, being under 25 years of age, having witnessed her father's violence against her mother, living in an urban area, and low socio-economic status were consistently associated with an increased risk of abuse.[24]

- **At the level of the family and relationship**, the male controls wealth and decision making within the family and marital conflict is frequent.

- **At the community level**, women are isolated with reduced mobility and lack of social support. Male peer groups condone and legitimize men's violence.

- **At the societal level**, gender roles are rigidly defined and enforced and the concept of masculinity is linked to toughness, male honor, or dominance. The prevailing culture tolerates physical punishment of women and children, accepts violence as a means to settle interpersonal disputes, and perpetuates the notion that men "own" women.

The ecological framework combines individual level risk factors with family, community, and society level factors identified through cross cultural studies, and helps explain why some societies and some individuals are more violent than others, and why women, especially wives, are so much more likely to be the victims of violence within the family. Other factors combine to protect some women. For example, women who have authority and power outside the family tend to experience lower levels of abuse in intimate partnerships. Likewise, when family members and friends intervene promptly, they

appear to reduce the likelihood of domestic violence. In contrast, wives are more frequently abused in cultures where family affairs are considered "private" and outside public scrutiny.

Justifications for violence frequently evolve from gender norms, that is, social norms about the proper roles and responsibilities of men and women. Many cultures hold that a man has the right to control his wife's behavior and that women who challenge that right—even by asking for household money or by expressing the needs of the children—may be punished. In countries as different as Bangladesh, Cambodia, India, Mexico, Nigeria, Pakistan, Papua New Guinea, Nicaragua, Tanzania, and Zimbabwe, studies find that violence is frequently viewed as physical chastisement—the husband's right to "correct" an erring wife.[2] As one husband said in a focus group discussion in Tamil Nadu, India, "If it is a great mistake, then the husband is justified in beating his wife. Why not? A cow will not be obedient without beatings."[134]

Worldwide, studies identify a consistent list of events that are said to "trigger" violence.[130] These include: not obeying the husband, talking back, not having food ready on time, failing to care adequately for the children or home, questioning him about money or girlfriends, going somewhere without his permission, refusing him sex, or expressing suspicions of infidelity. All of these represent transgressions of dominant gender norms in many societies.

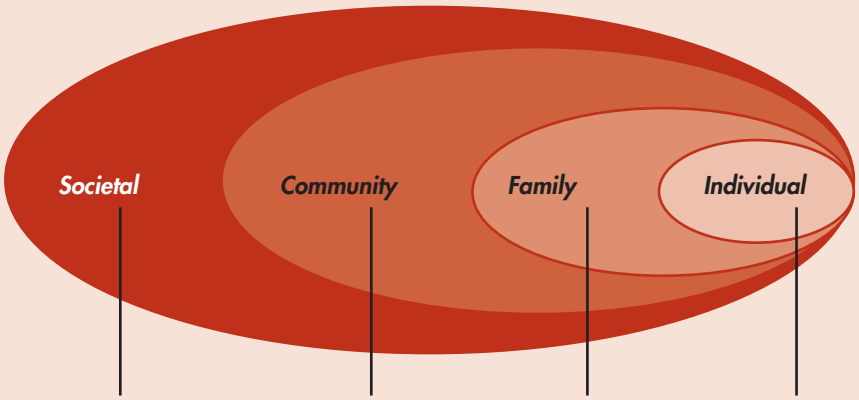
Although the ecological framework has gained broad acceptance for conceptualizing violence, there have been few attempts to explore how individual and community level risk factors relate to each other and ultimately influence women's vulnerability to violence. One study performed in the United States found that the socio-economic status of the neighborhood had a greater impact on the risk of violence than individual household income levels.[135] A study in Bangladesh found that some aspects of women's status could either increase or decrease a woman's risk of being beaten, depending on the socio-cultural conditions of the community she lives in. In one site, characterized by more conservative norms regarding women's roles and status, women with greater personal autonomy and those who participated for a short time in savings and credit groups experienced more violence than women with less autonomy. Community-level measures of women's status had no effect on the risk of violence.

The opposite was true in the less conservative setting where women had better overall status. In this site, individual measures of autonomy and participation in credit schemes had no impact on the risk of violence, whereas living in a community where more women participated in credit groups and where women had a higher status overall had a protective effect. These findings suggest that the same condition (mobility or participating in a credit group) may have completely different effects on a woman's risk of violence, according to whether the activity is seen as acceptable by community norms. These findings underscore the complexity of these issues and the dangers in applying knowledge gained from one site to another without understanding of the broader cultural context.[136]

HOW DO WOMEN RESPOND TO ABUSE?

Most abused women are not passive victims, but use active strategies to maximize their safety and that of their children. Some women resist, others flee, and still others attempt to keep the peace by capitulating to their husband's demands. What may seem to an observer to be lack of response to living with violence may in fact be a woman's strategic assessment of

FIGURE 1.6. AN ECOLOGICAL FRAMEWORK FOR EXPLAINING GENDER-BASED VIOLENCE



- Societal
  - Norms and laws granting men control over female behavior
  - Violence accepted for resolving conflict
  - Masculinity linked to dominance, honor or agression
- Community
  - Isolation of women and family
  - Delinquent peer groups
  - Low socio - economic status
- Family
  - Marital conflict
  - Male control of wealth and decision making in the family
  - Poverty
  - Unemployment
- Individual
  - Being male
  - Witnessing marital conflict as a child
  - Absent or rejecting father
  - Being abused as a child
  - Alcohol use

(From Heise, 1998.[130])

what it takes to survive and to protect herself and her children.

A woman's response to abuse is often limited by the options available to her. Women consistently cite similar reasons for remaining in abusive relationships: fear of retribution, lack of other means of economic support, concern for the children, emotional dependence, lack of support from family and friends, and an abiding hope that "he will change." In some countries, women say that the social unacceptability of being single or divorced poses an additional barrier that keeps them from leaving destructive marriages.[2]

At the same time, denial and fear of social stigma often prevent women from reaching out for help. In numerous surveys, for example, from 22 to almost 70 percent of abused women say that until the interview they never told anyone about their abuse. Those who reach out do so primarily to family members and friends. Few have ever contacted the police.[1, 20]

Despite the obstacles, many women eventually do leave violent partners—even if after many years. In a study in León, Nicaragua, for example, 70 percent of abused women eventually left their abusers. The median time that women spent in a violent relationship was six years. Younger women were likely to leave sooner than older women.[137]

Studies suggest a consistent set of factors that propel a woman to leave an abusive relationship: The violence gets more severe and triggers a realization that her partner is not going to change, or the violence begins to take a toll on the children. Women also cite emotional and logistical support from family or friends as pivotal in their decision to leave.[2]

Leaving an abusive relationship is a multistage process. The process often includes periods of denial, self-blame, and endurance before women recognize the abuse as a pattern and identify with other women in the same situation, thereby beginning to

disengage and recover. Most women leave and return several times before they finally leave once and for all.[138] Leaving does not necessarily guarantee a woman's safety, however, because violence may continue even after a woman leaves. In fact, a woman's risk of being murdered by her abuser is often greatest immediately after separation.[139]

CHALLENGES FOR INTERNATIONAL RESEARCH ON GENDER-BASED VIOLENCE

Nearly 30 years of groundbreaking research in the field of gender-based violence has greatly expanded international awareness of the dimensions and dynamics of violence. However, there are still many gaps in our current state of knowledge. Researchers interested in gender-based violence from a public health perspective face a number of important challenges.

- **The scarcity of population-based data limits our understanding of how violence affects different groups of women.** Until very recently, the majority of research was been carried out with nonrepresentative samples of women, often those who have attended shelters or other services for victims. Although these studies are useful for understanding the dynamics of abuse, they do not tell us how many women overall are affected, nor provide information about individuals who do not seek services. According to most estimates, these women greatly outnumber those who seek help.

- **Most international prevalence figures on violence are not comparable.** This is due mainly to inconsistencies in the way that violence is conceptualized and measured. Researchers need to develop consensus around violence research methods that allow us to make meaningful comparisons between studies. Methodological consistency refers not only to defining violence using similar criteria, but also the use of measures to minimize underreporting of violence, such as ensuring privacy during the interview and providing interviewers with special training on violence.[139]

- **Research on violence may put women at risk.** Many researchers point out that research on violence involves a number of inherent risks to both respondents and interviewers.[140] The World Health Organization has developed a set of guidelines to minimize the risk of harm to researchers and participants.[141] However, these guidelines are just now being incorporated more widely into international research practice.

- **More public health research is needed to understand how violence affects the health of women and children in different settings.** Studies of battered women consistently demonstrate the negative impact of abuse on women's psychological status and reproductive health, and emerging epidemiological studies indicate that violence towards mothers may even affect infant birth weight and survival. However, more research is needed to determine what proportion of women's overall mental and physical health problems is associated with violence and to investigate the mechanisms through which violence affects health.

- **More cross-cultural research is needed to reveal how societal norms and institutions promote or discourage violent behavior.** Most researchers agree that cultural norms can greatly affect the extent and characteristics of

violence, as well as the way that specific acts are interpreted in different societies. Nonetheless, there have been few systematic attempts to compare these issues in different settings. Most theories about the dynamics of abuse have been based on the experiences of US and European women, and it is unclear how relevant these are to women from other cultures.

- **Research evaluating different approaches to violence prevention is scarce.** Although there has been an enormous increase in both community and clinic-based programs to prevent violence and to support abused women and girls, few programs have been systematically documented or evaluated. For example, many activists and professional associations in the United States currently encourage health providers to ask each woman at every visit whether she has been abused. However, there is little information about what happens to women after disclosing violence, or whether asking women is an effective tool for enhancing women's safety. In particular, we need to develop criteria for assessing whether practices that are effective in one setting are likely to be relevant or feasible in another, very different setting.

The greatest challenge facing researchers in the field of violence is to learn from past mistakes, to identify "best practices," and to find out what makes them successful so that we can channel resources and efforts where they are most likely to make a difference.

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Ethical Considerations for Researching Violence Against Women*

Topics covered in this chapter:

Respect for persons at all stages of the research process
Minimizing harm to respondents and research staff
Maximizing benefits to participants and communities (beneficence)
Justice: Balancing risks and benefits of research on violence against women

[The experience] that most affected me was with a girl my age, maybe 22 years old...She told me all about how her husband beat her while she was washing clothes in the back patio. Her mother-in-law would spy on her and tell her son things so that he would punish her. She was very afraid, and her voice trembled as she spoke, but she really wanted to tell me about her tragedy. She kept looking over to where her mother-in-law was watching us. She asked me for help and I told her about the Women's Police Station. When her mother-in-law got up to go to the latrine, I quickly gave her a copy of the pamphlet and she hid it. She thanked me when I left and I ended up crying in the street because I couldn't stand to see such a young girl being so mistreated... Nicaraguan interviewer. (Ellsberg et al, 2001.[19])

In many ways, researching violence against women is similar to researching other sensitive topics. There are issues of confidentiality, problems of disclosure, and the need to ensure adequate and informed consent. As the previous quote from an interviewer illustrates, however, there are aspects of gender-based violence research that transcend those in other areas because of the potentially threatening and traumatic nature of the subject matter. In the case of violence, the safety and even the lives of women respondents and interviewers may be at risk.[1]

In 1991, the Council for International Organization of Medical Sciences (CIOMS)

* This chapter was adapted from Ellsberg and Heise, 2002.[1]

presented a set of International Guidelines for Ethical Review of Epidemiological Studies.[3] These guidelines apply the basic ethical principles of biomedical research involving human subjects to the field of epidemiology: respect for persons, non-maleficence (minimizing harm), beneficence (maximizing benefits), and justice. In 1999, the World Health Organization (WHO) published guidelines for addressing ethical and safety issues in gender-based violence research.[4] The guidelines were based on the experiences of the International Research Network on Violence Against Women (IRNVAW) and were designed to inform the *WHO Multi-country Study on Women's Health and Domestic Violence Against Women.* (See Box 2.1 for a description of the main points.) The authors argue that these ethical guidelines are critical, not only to protecting the safety of respondents and researchers, but also to ensuring data quality.

This chapter examines each of the basic principles mentioned in the CIOMS guidelines in turn and explores the challenges of applying them to the special case of conducting research on domestic and sexual violence.

BOX 2.1 ETHICAL AND SAFETY RECOMMENDATIONS FOR DOMESTIC VIOLENCE RESEARCH

- The safety of respondents and the research team is paramount and should infuse all project decisions.
- Prevalence studies need to be methodologically sound and to build upon current research experience about how to minimize the underreporting of abuse.
- Protecting confidentiality is essential to ensure both women's safety and data quality.
- All research team members should be carefully selected and receive specialized training and ongoing support.
- The study design must include a number of actions aimed at reducing any possible distress caused to the participants by the research.
- Fieldworkers should be trained to refer women requesting assistance to available sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.
- Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.
- Violence questions should be incorporated into surveys designed for other purposes only when ethical and methodological requirements can be met.

(From WHO, 1999.[4])

RESPECT FOR PERSONS AT ALL STAGES OF THE RESEARCH PROCESS

Informed consent for respondents

The principle of respect for persons incorporates two fundamental ethical principles: respect for autonomy and protection of vulnerable persons. These are commonly addressed by individual informed consent procedures that ensure that respondents understand the purpose of the research and that their participation is voluntary.

There is still no consensus on whether the informed consent process for VAW studies should explicitly acknowledge that the study will include questions on violence or whether it is sufficient to warn participants that sensitive topics will be raised. The WHO VAW study used an oral consent process that referred to the survey as a study on women's health and life experiences.[5] Women were advised that, "Some of the topics discussed may be personal and difficult to talk about, but many women have found it useful to have the opportunity to talk." Women were told that they could end the interview at any time or skip any question they did not want to answer. (See Box 2.3 for an example of the informed consent form used in the WHO VAW study.) A more detailed explanation of the nature of the questions on violence was provided directly before the violence questions, and respondents were asked whether they wanted to continue and were again reminded of their option not to answer. It is a good idea to prepare a list of responses for questions that a woman might ask about the study, such as how she was selected for the study, what will the study be used for, and how her responses will be kept secret.

BOX 2.2 ADAPTING ETHICAL GUIDELINES TO LOCAL SETTINGS

Researchers involved in the *WHO Multi-country Study on Women's Health and Domestic Violence Against Women* debated at length the value of mentioning violence directly in the initial consent process versus adding a second-order consent process immediately before the questions on abuse. Some researchers argued that it was important to alert women up front as to the true nature of the questions whereas others felt it was preferable to postpone introducing the notion of violence until immediately prior to the actual abuse-related questions. This would allow some rapport to develop, but still give a woman an opportunity to opt out of the violence-related questions.

The consent process was well received by respondents in all countries except Japan. During pilot testing, several Japanese respondents expressed a sense of betrayal because they had not been informed that the interview contained questions about violence.[6] As a result, the Japan team modified its consent language to explicitly acknowledge violence up front. This is an excellent example of how ethical principles and actual experience can combine to guide practice.

BOX 2.3 INDIVIDUAL CONSENT FORM

Used in the *WHO Multi-country Study on Women's Health and Domestic Violence Against Women*

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

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

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

Do you have any questions?

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

NOTE WHETHER RESPONDENT AGREES TO INTERVIEW.

[ ] DOES NOT AGREE TO BE INTERVIEWED

THANK PARTICIPANT FOR HER TIME AND END INTERACTION.

[ ] AGREES TO BE INTERVIEWED.

Is now a good time to talk?

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

TO BE COMPLETED BY INTERVIEWER

I CERTIFY THAT I HAVE READ THE ABOVE CONSENT PROCEDURE TO THE PARTICIPANT.

SIGNED: _____

(From WHO, 2004.[5])

Mandatory reporting of abuse

Some countries have laws that require certain kinds of professionals to report cases of suspected abuse to authorities or social service agencies. Such laws raise difficult issues for researchers because they throw into conflict several key ethical principles: respect for confidentiality, the need to protect vulnerable populations, and respect for autonomy. In the case of adult women, there is consensus among most researchers that the principles of autonomy and confidentiality should prevail and that researchers should do everything within their power to avoid usurping a woman's right to make autonomous decisions about her life. (Of course if a woman seeks support in reporting her abuse, researchers should oblige.)

The dilemma of whether to comply with legal reporting requirements is particularly problematic when dealing with child abuse. There is no consensus internationally about how to handle cases of child abuse because children are generally considered more vulnerable and less able to act on their own behalf. The dilemma is particularly acute in settings where there are no effective services to assist troubled families, or where reporting is likely to trigger a cascade of events that might put the child at even greater risk (such as being removed from his/her home and placed in an institution). The WHO VAW study specifically excluded questions about child abuse, but required teams to develop local protocols

for handling cases of child abuse that interviewers might nonetheless come to know about. The guiding principle of these protocols was to act in "the best interests of the child," a standard that each team operationalized locally, based on advice from key agencies about prevailing conditions.

Community agreement

In many countries, it is also important to obtain community support for research, as well as individual consent. (Community consent, however, should never replace individual consent.) This is often sought by meeting with community leaders to explain the overall objectives of the research. For safety reasons, when obtaining community support for VAW research, it is important to frame the study in general terms—such as a study on women's health or life experiences rather than mention violence or abuse directly. If it becomes well known in the community that women are being questioned about violence, men may prohibit their partners from participating or may retaliate against them for their participation. In addition to potentially jeopardizing the safety of respondents, this could also undermine the study objectives and data accuracy.

MINIMIZING HARM TO RESPONDENTS AND RESEARCH STAFF

Ensuring participant safety

The primary ethical concern related to researching VAW is the potential for inflicting harm to respondents through their participation in the study. A respondent may suffer physical harm if a partner finds out that she has been talking to others about her relationship with him. Because many violent partners control the actions of their spouses closely, even the act of speaking to another person without his permission may trigger a beating.

No systematic studies have been performed to determine how often women suffer negative consequences from participating in research on violence. However, several VAW researchers have recorded chilling examples of experiences where women have been placed at risk as a result of inadequate attention to safety issues.[8] For example, researchers from Chiapas, Mexico, describe how, when they first began researching domestic violence, they were not fully aware of the risks involved. They included a small set of questions on domestic violence within a larger study on reproductive health without taking any special precautions regarding safety of respondents. They were shocked to learn later that three respondents were beaten by their partners because they had participated in the survey.[9]

The WHO guidelines provide a number of suggestions about how to minimize risks to respondents, including:

- Interviewing only one woman per household (to avoid alerting other women who may communicate the nature of the study back to potential abusers).
- Not informing the wider community that the survey includes questions on violence.
- Not conducting any research on violence with men in the same clusters where women have been interviewed.[4]

Protecting privacy and confidentiality

His mother and sisters kept passing by, and would peek in the doorway to see what we were talking about, so we would have to speak really softly…and the girl said to me, "Ay, don't ask me anything in front of them." (Nicaraguan interviewer) [2]

Protecting privacy is important in its own right and is also an essential element in ensuring women's safety. In addition to

interviewing only one woman per household, the WHO recommendations advise researchers to conduct violence-related interviews in complete privacy, with the exception of children under the age of two. In cases where privacy cannot be ensured, interviewers should be encouraged to reschedule the interview for a different time or place. Achieving this level of privacy is difficult and may require more resources than might be needed for research on less sensitive topics.

Researchers have developed a variety of creative methods for ensuring privacy. Interviewers in Zimbabwe and Nicaragua often held interviews outside or accompanied women to the river as they washed clothes. Many studies have successfully used "dummy" questionnaires, containing unthreatening questions on issues such as breastfeeding or reproductive health. Respondents are forewarned that if someone enters the room, the interviewer will change the topic of conversation by switching to a dummy questionnaire. Other members of the research team such as supervisors and even drivers can also play a role in distracting household members who are intent on listening to the interview. In one instance in Zimbabwe, fieldworkers entered into lengthy negotiations to purchase a chicken from the husband of a respondent so that she could be interviewed in private.[10] Other researchers have carried candy and coloring books to keep children busy during interviews.

BOX 2.4 SUGGESTIONS FOR MINIMIZING HARM TO WOMEN PARTICIPATING IN RESEARCH

- Interview only one woman per household.
- Don't inform the wider community that the survey includes questions on violence.
- Don't interview men about violence in the same households or clusters where women have been asked about violence.
- Interviews should be conducted in complete privacy.
- Dummy questionnaires may be used if others enter the room during the interview.
- Candy and games may be used to distract children during interviews.
- Use of self-response questionnaires for some portions of the interview may be useful for literate populations.
- Train interviewers to recognize and deal with a respondent's distress during the interview.
- End the interview on a positive note that emphasizes a woman's strengths.

PHOTO BY HAFM JANSEN

Interview in Thailand

Indeed, the Japanese team for the WHO VAW study found it so difficult to achieve privacy in Japan's crowded apartments that they had to depart from the protocol and use self-response booklets for especially sensitive questions. In this highly literate population, women were able to read and record their answers without the questions having to be read aloud.[6]

Ensuring privacy may be even more problematic in telephone surveys. Interviewers for the VAW survey in Canada were trained to detect whether anyone else was in the room or listening on another line, and to ask whether they should call back at another time. They provided respondents with a toll free number to call back if they wanted to verify

PHOTO BY HAFM JANSEN

Respondent in Tanzania tells children to go play before starting her interview

that the interview was legitimate, or in case they needed to hang up quickly. About 1,000 out of a sample of 12,000 women called back, and 15 percent of the calls were to finish interrupted interviews.[11]

Minimizing participant distress

Interviews on sensitive topics can provoke powerful emotional responses in some participants. The interview may cause a woman to relive painful and frightening events, and this in itself can be distressing if she does not have a supportive social environment.[12] Interviewers therefore need to be trained to be aware of the effects that the questions may have on informants and how best to respond, based on a woman's level of distress.

Most women who become emotional during an interview actively choose to proceed, after being given a moment to collect themselves. Interviewer training should include practice sessions on how to identify and respond appropriately to symptoms of distress as well as how to terminate an interview if the impact of the questions becomes too negative.

Interviewer training should also include explicit exercises to help field staff examine their own attitudes and beliefs around rape and other forms of violence. Interviewers frequently share many of the same stereotypes and biases about victims that are dominant in the society at large. Left unchallenged, these beliefs can lead to victim-blaming and other destructive attitudes that can undermine both the respondent's self esteem and the interviewer's ability to obtain quality data.

Referrals for care and support

At a minimum, the WHO guidelines suggest that researchers have an ethical obligation to provide a respondent with information or services that can help her situation. In areas where specific violence-related services are available, research teams have developed detailed directories that interviewers can use to make referrals. In Canada's VAW survey, for example, the computer program used by telephone interviewers had a pop-up screen that listed resources near the respondent, based on her mail code. In Zimbabwe, Brazil, Peru, and South Africa, researchers developed small pamphlets for respondents that listed resources for victims along with a host of other health and social service agencies.[10] All women were offered the pamphlet after being asked if it would be safe for them to receive it (cases have been reported where women have been beaten when a partner found informational material addressing violence). In Zimbabwe, interviewers carried a referral directory and wrote out addresses on physician referral pads so that the referral would not attract suspicion if discovered. Ideally, contact should be made in advance with the services so that they are prepared to receive referrals from the study.

In settings where resources are scarce or nonexistent, researchers have developed interim support measures. For example, a study on violence against women performed in rural Indonesia brought in a

counselor to the field once a week to meet with respondents.[13] In Ethiopia, the study hired mental health nurses to work in the closest health center for the duration of the fieldwork.[14] The number of women who actually make use of such services is often quite low, but subsequent interviews with women indicate that they appreciate knowing that services are available if needed.[11] In Peru and in Bangladesh, the WHO VAW team has used the study as an opportunity to train local health promoters in basic counseling and support skills. In this way, the team will leave behind a permanent resource for the community.

Bearing witness to violence

The image of these stories affects you, to see how these women suffer, and especially the feeling that no one supports them. These are experiences that you never forget… (Nicaraguan interviewer)[2]

Although preventing harm to respondents is of primary importance, researchers also have an ethical obligation to minimize possible risks to field staff and researchers. Sources of risk include threats to physical safety either as a result of having to travel in dangerous neighborhoods or from unplanned encounters with abusive individuals who object to the study. Some strategies to reduce the first source of risk include removing extremely dangerous neighborhoods from the sampling frame before drawing the sample (for example those controlled by narco-traffickers); outfitting teams with cell phones; and having male drivers accompany female interviewers into dangerous areas.

PHOTO BY HAFM JANSEN

Interview in Bangladesh

Abusive partners have also been known to threaten interviewers with physical harm. In a South African study, for example, a man came home from a bar in the middle of his partner's interview and pulled a gun on the fieldworker, demanding to see the questionnaire. Because of prior training, the interviewer had the presence of mind to give the man an English version of the questionnaire, which he was unable to read.[10] "Dummy" questionnaires would also have been helpful in this situation.

The most common risk for fieldworkers, however, is the emotional toll of listening to women's repeated stories of despair, physical pain, and degradation. It is hard to overestimate the emotional impact that research on violence may have on field-

BOX 2.5 PROTECTING RESPONDENT SAFETY IN CAMBODIA

Researchers in a study performed in Cambodia found a young woman who was held prisoner in her own home by her husband. When the research team arrived to interview her, they found the woman locked in her house, with only a peephole where a chain was threaded through a crudely cut hole in the door. The woman conducted the interview through the peephole. During the interview, the husband appeared and was suspicious about their activity. The team gave him a false explanation for their visit and then left the home.

The next day, the team sought help from the Ministry of Women's Affairs, which co-sponsored the study. Secretariat staff informed the researchers that the woman's husband had stormed into their office the preceding afternoon, dragging his wife by the arm. He demanded to know who had been at his door. He told the Secretariat personnel that if they couldn't confirm her explanation, then his wife would suffer. They readily confirmed her story. She was safe for the moment, but the researchers realized that it would be too dangerous to ever approach this woman again.

The team made several overtures with different government officials and the police to help get the woman freed, but everyone was afraid to intervene because the woman's husband had an important position. Researchers described the frustration that the team felt at not being able to free the woman and the guilt they felt at having put the woman in greater danger.

(From Zimmerman, 1995.[8])

workers and researchers. As the narrative from a Nicaraguan fieldworker presented at the beginning of this chapter illustrates, a study on violence often becomes an intensely personal and emotional journey for which many researchers are not prepared. Particularly when field staff have had personal experiences of abuse, the experience can be overwhelming. Judith Herman, in her work on psychological trauma in survivors of political and domestic violence, describes this as a common experience for those who study violence:

To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature. To study psychological trauma means bearing witness to horrible events.[15]

Including discussions of violence in interviewer training is crucial for reducing distress during fieldwork. During fieldwork, another important measure is to provide interviewers and research staff with regular opportunities for emotional debriefing, or when necessary, individual counseling. Researchers have used a variety of creative strategies for protecting the emotional health of their staff. In Peru, for example, the WHO multi-country team employed a professional counselor to lead weekly support sessions that incorporated guided imagery and relaxation techniques. Experience has repeatedly demonstrated that emotional support for fieldworkers is essential. Not only does it help interviewers withstand the demands of the fieldwork, but it also improves their ability to gather quality data.

Transcripts of debriefing sessions with interviewers who participated in studies without adequate support illustrate this point:

…When I heard stories about women being beaten and tied up, I would leave there feeling desperate… I would be a wreck, and my supervisor would tell me "get a hold of yourself, you cry for every little thing." But how could I control myself? I couldn't stand it… I would try, but sometimes it was impossible, and I would burst into tears during the next interview… (Nicaraguan interviewer) [2]

Other interviewers commented that they felt extremely drained and distracted by the interviews where women reported violence. One woman reported that she had stopped working for the study because she could not bear to listen to women's stories of abuse. [2]

Experience has shown that trauma-related stress is not confined to field staff who are directly involved with respondents. Field supervisors, transcribers, drivers, and even data entry personnel may be affected. In one study in Belize, a transcriber broke down after hours of listening to in-depth qualitative interviews with survivors of abuse.[16]

It is particularly important to provide opportunities during training for interviewers to address their own experiences of abuse. Given the high prevalence of gender-based violence globally, it is likely that a substantial proportion of interviewers will have experienced gender-based violence themselves at some point. These experiences need to be taken into consideration. Most people learn to cope with painful past experiences, and usually do not dwell on them in their everyday lives. However, when trainees are confronted with the subject matter the information may awaken disturbing images and or emotions. For many trainees, simply acknowledging the fact that these reactions are normal and providing timely opportunities to discuss them will be sufficient to help them complete the training and participate successfully in fieldwork. In those rare cases where feelings become too overwhelming, trainees should be supported in their decision to withdraw from the study.

MAXIMIZING BENEFITS TO PARTICIPANTS AND COMMUNITIES (BENEFICENCE)

The principle of beneficence refers to the ethical obligation to maximize possible benefits to study participants and the group of individuals to which they belong. This principle gives rise to norms requiring that the risks of research be reasonable in light of the expected benefits, that the research design be sound, and that the investigators be competent both to conduct the research and to ensure the well-being of participants.

The interview as an intervention

Asking women to reveal stories of trauma can be a transforming experience for both researchers and respondents. Indeed, there is ample evidence that most women welcome the opportunity to tell their stories if they are asked in a sympathetic, nonjudgmental way. In our experience, women rarely refuse to answer questions on violence.

Many women who disclose violence in surveys have never told anyone about their situations.[17] Many studies find that participants find the experience to be so helpful that they ask fieldworkers to "interview" a friend or relative who has a story to tell. As Herman notes, "remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims."[15]

Even the act of telling her story can offer a woman some small way of transforming her personal ordeal into a way to help others. Indeed, researchers sensitive to this issue encourage interviewers and field staff to take hope and satisfaction from their participation in the process of giving a voice to women's suffering.

A qualitative study of survivors of abuse who had visited a women's crisis center in Nicaragua found that a central part of women's process of recovery and personal as well as collective empowerment came not only from increased knowledge of their rights, but also from the opportunity to share their experiences and to help other women in similar situations.[18] In this sense, asking women about experiences of violence may be seen as an intervention in itself. At the very least, asking conveys the message that violence is a topic worthy of study, and not a shameful or unimportant issue.

In this same vein, many fieldworkers in the León, Nicaragua, research described the experience of listening to women's stories, as well as the opportunity to tell their own stories in the debriefing sessions, as a profoundly healing experience. One interviewer who had never before discussed her experiences said,

[when I joined this study] I felt that I had finally found someone I could tell everything to, someone with whom I could share my burden, because it's horrible to feel so alone. Now I feel that a weight has been taken off me…I feel relieved…[19]

Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims. (Herman, 1992.[15])

The interview is also an opportunity to provide women with information on gender-based violence. Many studies have issued small cards that can be easily hidden in a shoe or inside a blouse with information about local resources for abused women and messages such as, "If you are being abused, there are ways out" or "Violence is never justified." Such messages may enable women to see experiences in a new light or to identify violence in others close to them.

Researchers also stress the importance of ending the interview on a note that emphasizes women's strengths and tries to minimize distress, particularly as a respondent may have revealed information that

made her feel vulnerable.[20] A number of studies have carefully scripted such endings to ensure that the interview finishes with clear statements that explicitly acknowledge the abuse, highlight the unacceptability of the violence, and emphasise the respondent's strengths in enduring and/or ending the violence. The WHO study ends each interview with the words, *"From what you have told me, I can tell that you have had some very difficult times in your life. No one has the right to treat someone else in that way. However, from what you have told me I can also see that you are strong and have survived through some difficult circumstances."*[7]

One indication of how women have viewed the interview process can be obtained by assessing respondents' satisfaction with the interview. At the end of the WHO interview, respondents were asked the following question: "I have asked about many difficult things. How has talking about these things made you feel?" The answers were written down verbatim and coded by the interviewer into the following three categories: good/better, bad/worse, and same/no difference. The majority (between 60 and 95 percent in seven sites) of women who had experienced physical or sexual partner violence reported that they felt good/better at the end of the interview. In most countries, the range was similar between women who had or had not experienced partner violence. Very few women reported feeling worse after being interviewed. Between 0.5 and 8.4 percent of women reporting partner violence ever (highest in Peru) and between zero and 3.2 percent of women with no history of partner violence felt worse.[17]

Looking for households in Samoa

PHOTO BY HAFM JANSEN

Assuring scientific soundness

The CIOMS guidelines note: "A study that is scientifically unsound is unethical in that it exposes subjects to risk or inconvenience while achieving no benefit in knowledge."[3] This principle is particularly important in the area of gender-based violence where women are asked to disclose difficult and painful experiences and where the act of research itself may put women at further risk of abuse. Thus the WHO guidelines note that violence researchers have an ethical responsibility to ensure the soundness of their work by selecting a large enough sample size to permit conclusions to be drawn, and by building upon current knowledge about how to minimize underreporting of violence. (See Chapter 7 for more discussion of sampling techniques.) Underreporting of violence will dilute associations between potential risk factors and health outcomes, leading to falsely negative results. Underestimating the dimensions of violence may also prevent violence intervention programs from receiving the priority they deserve in the allocation of resources.

Research demonstrates that disclosure rates of violence are highly influenced by the design and wording of questions, the training of interviewers, and the implementation of the study.[2] In Chapter 6, we discuss this issue in much greater depth and outline the variety of measures that have been developed to enhance disclosure of violence.

Using study results for social change

It is important to feed research findings into ongoing advocacy, policy making, and intervention activities. Too often critical research findings never reach the attention of the policy makers and advocates best positioned to use them. The enormous personal, social, and health-related costs of violence against women place a moral obligation on researchers and donors to try to ensure that study findings are applied in the real world. It is also important that the study community receives early feedback on the results of the research in which it has participated. Chapter 14 addresses this issue in more detail and describes several successful examples of how research findings have been used to contribute to changing laws and policies on domestic violence.

One way to improve the relevance of research projects is, from the outset, to involve organizations that carry out advocacy and direct support for survivors of violence, either as full partners in the research or as members of an advisory committee. Such committees can play an important role in helping guide the study design, advise on the wording of questions, assist with interviewer training, and give guidance on possible forms of analysis and the interpretation of results. These groups also have a central role to play in publicizing and applying the project's findings.

JUSTICE: BALANCING RISKS AND BENEFITS OF RESEARCH ON VIOLENCE AGAINST WOMEN

Research, like any endeavor that touches people's lives, involves inherent risks. The principle of distributive justice demands that the class of individuals bearing the burden of research should receive an appropriate benefit, and those who stand to benefit most should bear a fair proportion of the risks and burdens of the study.

In the case of gender-based violence research, the risks are potentially large, but so too are the risks of ignorance, silence, and inaction. Researchers and ethical review boards must constantly balance this reality. Lisa Fontes cites the case of a colleague from India who wanted to study wives who were hospitalized after having been burned by their husbands in disputes over dowry. She ultimately decided not to conduct the research for fear that the research would put women at further risk. As Fontes observes, "Her decision eliminated the research-related risk to the participants, but also eliminated the potential benefit of reducing the terrible isolation and vulnerability of these victims."[21]

Women would ask me what this survey was for, and how it would help them. I would tell them that we won't see the solution tomorrow or the next year. Our daughters and granddaughters will see the fruits of this work, maybe things will be better by then. Nicaraguan fieldworker. (From Ellsberg, et al, 2000.[19])

It is possible to conduct research on violence with full respect for ethical and safety considerations if proper care and resources are devoted to this end. We must remember that women living with violence are already at risk. Researchers cannot eliminate this reality, just as they cannot fully eliminate the possibility that further harm will be caused by their study. The obligation of researchers is to carefully weigh the risks and benefits of any study and to take every measure possible to limit possible harm and to maximize possible benefit. At the very least, we must ensure that when women take risks to share their stories, we honor that risk by using the findings for social change.

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