CHAPTER 4

Violence by intimate partners

Background

One of the most common forms of violence against women is that performed by a husband or an intimate male partner. This is in stark contrast to the situation for men, who in general are much more likely to be attacked by a stranger or acquaintance than by someone within their close circle of relationships (*1–5*). The fact that women are often emotionally involved with and economically dependent on those who victimize them has major implications for both the dynamics of abuse and the approaches to dealing with it.

Intimate partner violence occurs in all countries, irrespective of social, economic, religious or cultural group. Although women can be violent in relationships with men, and violence is also sometimes found in same-sex partnerships, the overwhelming burden of partner violence is borne by women at the hands of men (*6, 7*). For that reason, this chapter will deal with the question of violence by men against their female partners.

Women's organizations around the world have long drawn attention to violence against women, and to intimate partner violence in particular. Through their efforts, violence against women has now become an issue of international concern. Initially viewed largely as a human rights issue, partner violence is increasingly seen as an important public health problem.

The extent of the problem

Intimate partner violence refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Such behaviour includes:

- Acts of physical aggression – such as slapping, hitting, kicking and beating.
- Psychological abuse – such as intimidation, constant belittling and humiliating.
- Forced intercourse and other forms of sexual coercion.
- Various controlling behaviours – such as isolating a person from their family and friends, monitoring their movements, and restricting their access to information or assistance.

When abuse occurs repeatedly in the same relationship, the phenomenon is often referred to as ''battering''.

In 48 population-based surveys from around the world, between 10% and 69% of women reported being physically assaulted by an intimate male partner at some point in their lives (see Table 4.1). The percentage of women who had been assaulted by a partner in the previous 12 months varied from 3% or less among women in Australia, Canada and the United States to 27% of ever-partnered women (that is, women who have ever had an ongoing sexual partnership) in León, Nicaragua, 38% of currently married women in the Republic of Korea, and 52% of currently married Palestinian women in the West Bank and Gaza Strip. For many of these women, physical assault was not an isolated event but part of a continuing pattern of abusive behaviour.

Research suggests that physical violence in intimate relationships is often accompanied by psychological abuse, and in one-third to over one-half of cases by sexual abuse (*3, 8–10*). Among 613 women in Japan who had at any one time been abused, for example, 57% had suffered all three types of abuse – physical, psychological and sexual. Less than 10% of these women had experienced only physical abuse (*8*). Similarly, in Monterrey, Mexico, 52% of physically assaulted women had also been sexually abused by their partners (*11*). Figure 4.1 graphically illustrates the overlap between types of abuse among ever-partnered women in León, Nicaragua (*9*).

Most women who are targets of physical aggression generally experience multiple acts of aggression over time. In the León study, for instance, 60% of women abused during the previous year had been attacked more than once, and 20% had experienced severe violence more than six times. Among women reporting physical aggression, 70% reported severe abuse (*12*). The average number of physical assaults during the previous year among women currently suffering abuse, according to a survey in London, England, was seven (*13*), while in the United States, in a national study in 1996, it was three (*5*).

TABLE 4.1

Physical assault on women by an intimate male partner, selected population-based studies, 1982–1999

Country or area	Year of study	Coverage	Sample			Proportion of women physically assaulted by a partner (%)		
			Size	Study population[a]	Age (years)	During the previous 12 months	In current relationship	Ever
Africa								
Ethiopia	1995	Meskanena Woreda	673	II	⩾15	10[b]		45
Kenya	1984–1987	Kisii District	612	VI	⩾15		42	
Nigeria	1993	Not stated	1 000	I	—			31[c]
South Africa	1998	Eastern Cape	396	III	18–49	11		27
		Mpumalanga	419	III	18–49	12		28
		Northern Province	464	III	18–49	5		19
		National	10 190	III	15–49	6		13
Zimbabwe	1996	Midlands Province	966	I	⩾18			17[d]
Latin America and the Caribbean								
Antigua	1990	National	97	I	29–45			30[d]
Barbados	1990	National	264	I	20–45			30[c,e]
Bolivia	1998	Three districts	289	I	⩾20	17[c]		
Chile	1993	Santiago province	1 000	II	22–55		26/11[f]	
	1997	Santiago	310	II	15–49	23		
Colombia	1995	National	6 097	II	15–49		19	
Mexico	1996	Guadalajara	650	III	⩾15			27
		Monterrey	1 064	III	⩾15			17
Nicaragua	1995	León	360	III	15–49	27/20[f]		52/37[f]
	1997	Managua	378	III	15–49	33/28		69
	1998	National	8 507	III	15–49	12/8[f]		28/21[f]
Paraguay	1995–1996	National, except Chaco region	5 940	III	15–49			10
Peru	1997	Metro Lima (middle-income and low-income)	359	II	17–55	31		
Puerto Rico	1995–1996	National	4 755	III	15–49			13[g]
Uruguay	1997	Two regions	545	II[h]	22–55	10[e]		
North America								
Canada	1991–1992	Toronto	420	I	18–64			27[c]
	1993	National	12 300	I	⩾18	3[d,e]		29[d,e]
United States	1995–1996	National	8 000	I	⩾18	1.3[c]		22[c]
Asia and Western Pacific								
Australia	1996	National	6 300	I	—	3[d]	8[d]	
Bangladesh	1992	National (villages)	1 225	II	<50	19		47
	1993	Two rural regions	10 368	II	15–49		42	
Cambodia	1996	Six regions	1 374	III	—			16
India	1993–1994	Tamil Nadu	859	II	15–39		37	
	1993–1994	Uttar Pradesh	983	II	15–39		45	
	1995–1996	Uttar Pradesh, five districts	6 695	IV	15–65		30	
	1998–1999	National	89 199	III	15–49	11[i]		19[i]
	1999	Six states	9 938	III	15–49	14		40/26
Papua New Guinea	1982	National, rural villages	628	III[h]	—			67
	1984	Port Moresby	298	III[h]	—			56
Philippines	1993	National	8 481	V	15–49			10
	1998	Cagayan de Oro City and Bukidnon Province	1 660	II	15–49			26[j]
Republic of Korea	1989	National	707	II	⩾20	38/12[f]		
Thailand	1994	Bangkok	619	IV	—		20	

TABLE 4.1 *(continued)*

Country or area	Year of study	Coverage	Sample			Proportion of women physically assaulted by a partner (%)		
			Size	Study population[a]	Age (years)	During the previous 12 months	In current relationship	Ever
Europe								
Netherlands	1986	National	989	I	20–60			21/11[c,f]
Norway	1989	Trondheim	111	III	20–49			18
Republic of Moldova	1997	National	4 790	III	15–44	⩾7		⩾14
Switzerland	1994–1996	National	1 500	II	20–60	6[e]		21[e]
Turkey	1998	East and south-east Anatolia	599	I	14–75			58[c]
United Kingdom	1993	North London	430	I	⩾16	12[c]		30[c]
Eastern Mediterranean								
Egypt	1995–1996	National	7 121	III	15–49	16[j]		34[g]
Israel	1997	Arab population	1 826	II	19–67	32		
West Bank and Gaza Strip	1994	Palestinian population	2 410	II	17–65	52/37[f]		

Source: reproduced from reference *6* with the permission of the publisher.

[a] Study population: I = all women; II = currently married/partnered women; III = ever-married/partnered women; IV = married men reporting on own use of violence against spouse; V = women with a pregnancy outcome; VI = married women – half with pregnancy outcome, half without.

[b] In past 3 months.

[c] Sample group included women who had never been in a relationship and therefore were not at risk of partner violence.

[d] Although sample includes all women, rate of abuse is shown for ever-married/partnered women (number not given).

[e] Physical or sexual assault.

[f] Any physical abuse/severe physical abuse only.

[g] Rate of partner abuse among ever-married/partnered women recalculated from author's data.

[h] Non-random sampling techniques used.

[i] Includes assault by others.

[j] Perpetrator could be a family member or close friend.

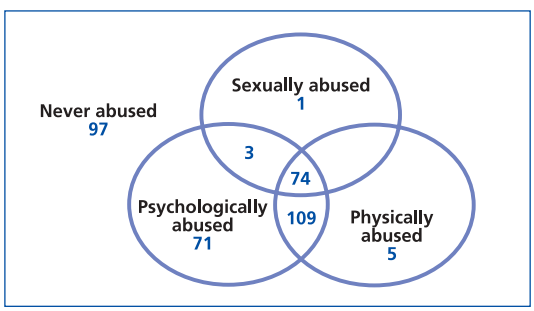
Various types of abuse generally coexist in the same relationship. However, prevalence studies of domestic violence are a new area of research and data on the various types of partner violence, other than physical abuse, are generally not yet available. The figures in Table 4.1, therefore, refer exclusively to physical assault. Even so, because of methodological differences, the data from these well-designed studies are not directly comparable. Reported estimates of abuse are highly sensitive to the particular definitions used, the manner in which questions are asked, the degree of privacy in interviews and the nature of the population being studied (*14*) (see Box 4.1). Differences between countries, therefore – especially fairly small differences – may well reflect methodological variations rather than real differences in prevalence rates.

Measuring partner violence

In surveys of partner violence, women are usually asked whether they have experienced any abuse from a list of specific acts of aggression, including being slapped or hit, kicked, beaten or threatened

FIGURE 4.1

Overlap between sexual, physical and psychological abuse experienced by women in León, Nicaragua (*N* = 360 ever-partnered women)



Source: reference *9*.

BOX 4.1

Making data on intimate partner violence more comparable

Various factors affect the quality and comparability of data on intimate partner violence, including:

— inconsistencies in the way violence and abuse are defined;
— variations in the selection criteria for study participants;
— differences resulting from the sources of data;
— the willingness of respondents to talk openly and honestly about experiences with violence.

Because of these factors, most prevalence figures on partner violence from different studies cannot be compared directly. For instance, not all studies separate different kinds of violence, so that it is not always possible to distinguish between acts of physical, sexual and psychological violence. Some studies examine only violent acts from the previous 12 months or 5 years, while others measure lifetime experiences.

There is also considerable variation in the study populations used for research. Many studies on partner violence include all women within a specific age range, while other studies interview only women who are currently married or who have been married. Both age and marital status are associated with a woman's risk of suffering partner abuse. The selection criteria for participants can therefore considerably affect estimates of the prevalence of abuse in a population.

Prevalence estimates are also likely to vary according to the source of data. Several national studies have produced estimates of the prevalence of partner violence — estimates that are generally lower than those obtained from smaller in-depth studies of women's experiences with violence. Smaller in-depth studies tend to concentrate more on the interaction between interviewers and respondents. These studies also tend to cover the subject matter in much greater detail than most national surveys. Prevalence estimates between the two types of studies may also vary because of some of the factors previously mentioned — including differences in the study populations and definitions of violence.

Improving disclosure

All studies on sensitive topics such as violence face the problem of how to achieve openness from people about intimate aspects of their lives. Success will depend partly on the way in which the questions are framed and delivered, as well as on how comfortable interviewees feel during the interview. The latter depends on such factors as the sex of the interviewer, the length of the interview, whether others are present, and how interested and non-judgemental the interviewer appears.

Various strategies can improve disclosure. These include:

- Giving the interviewee several opportunities during an interview in which to disclose violence.
- Using behaviourally specific questions, rather than subjective questions such as ''Have you ever been abused?''.
- Carefully selecting interviewers and training them to develop a good rapport with the interviewees.
- Providing support for interviewees, to help avoid retaliation by an abusive partner or family member.

The safety of both respondents and interviewers must always be taken into account in all strategies for improving research into violence.

The World Health Organization has recently published guidelines addressing ethical and safety issues in research into violence against women (*15*). Guidelines for defining and measuring partner violence and sexual assault are being developed to help improve the comparability of data. Some of these guidelines are currently available (*16*) (see also Resources).

with a weapon. Research has shown that behaviourally specific questions such as ''Have you ever been forced to have sexual intercourse against your will?'' produce greater rates of positive response than questions asking women whether they have been ''abused'' or ''raped'' (*17*). Such behaviourally specific questions also allow researchers to gauge the relative severity and frequency of the abuse suffered. Physical acts that are more severe than slapping, pushing or throwing an object at a person are generally defined in studies as ''severe violence'', though some observers object to defining severity solely according to the act (*18*).

A focus on acts alone can also hide the atmosphere of terror that sometimes permeates violent relationships. In a national survey of violence against women in Canada, for example, one-third of all women who had been physically assaulted by a partner said that they had feared for their lives at some time in the relationship (*19*). Although international studies have concentrated on physical violence because it is more easily conceptualized and measured, qualitative studies suggest that some women find the psychological abuse and degradation even more intolerable than the physical violence (*1, 20, 21*).

Partner violence and murder

Data from a wide range of countries suggest that partner violence accounts for a significant number of deaths by murder among women. Studies from Australia, Canada, Israel, South Africa and the United States of America show that 40–70% of female murder victims were killed by their husbands or boyfriends, frequently in the context of an ongoing abusive relationship (*22–25*). This contrasts starkly with the situation of male murder victims. In the United States, for example, only 4% of men murdered between 1976 and 1996 were killed by their wives, ex-wives or girlfriends (*26*). In Australia between 1989 and 1996, the figure was 8.6% (*27*).

Cultural factors and the availability of weapons define the profiles of murders of intimate partners in different countries. In the United States, more murders of women are committed by guns than by all other types of weapons combined (*28*). In India, guns are rare but beatings and death by fire are common. A frequent ploy is to douse a woman with kerosene and then to claim that she died in a ''kitchen accident''. Indian public health officials suspect that many actual murders of women are concealed in official statistics as ''accidental burns''. One study in the mid-1980s found that among women aged 15–44 years in Greater Bombay and other urban areas of Maharashtra state, one out of five deaths were ascribed to ''accidental burns'' (*29*).

Traditional notions of male honour

In many places, notions of male honour and female chastity put women at risk (see also Chapter 6). For example, in parts of the Eastern Mediterranean, a man's honour is often linked to the perceived sexual ''purity'' of the women in his family. If a woman is ''defiled'' sexually – either through rape or by engaging voluntarily in sex outside marriage – she is thought to disgrace the family honour. In some societies, the only way to cleanse the family honour is by killing the ''offending'' woman or girl. A study of female deaths by murder in Alexandria, Egypt, found that 47% of the women were killed by a relative after they had been raped (*30*).

The dynamics of partner violence

Recent research from industrialized countries suggests that the forms of partner violence that occur are not the same for all couples who experience violent conflict. There would seem to be at least two patterns (*31, 32*):

- A severe and escalating form of violence characterized by multiple forms of abuse, terrorization and threats, and increasingly possessive and controlling behaviour on the part of the abuser.
- A more moderate form of relationship violence, where continuing frustration and anger occasionally erupt into physical aggression.

Researchers hypothesize that community-based surveys are better-suited to detecting the second, more moderate form of violence – also called ''common couple violence'' – than the severe type of abuse known as battering. This may help explain

why community-based surveys of violence in industrialized countries frequently find substantial evidence of physical aggression by women, even though the vast majority of victims that come to the attention of service providers (in shelters, for instance) and the police or the courts are women. Although there is evidence from industrialized countries that women engage in common couple violence, there are few indications that women subject men to the same type of severe and escalating violence frequently seen in clinical samples of battered women (*32, 33*).

Similarly, research suggests that the consequences of partner violence differ between men and women, and so do the motivations for perpetrating it. Studies in Canada and the United States have shown that women are far more likely to be injured during assaults by intimate partners than are men, and that women suffer more severe forms of violence (*5, 34–36*). In Canada, female victims of partner violence are three times more likely to suffer injury, five times more likely to receive medical attention and five times more likely to fear for their lives than are male victims (*36*). Where violence by women occurs it is more likely to be in the form of self-defence (*32, 37, 38*).

In more traditional societies, wife beating is largely regarded as a consequence of a man's right to inflict physical punishment on his wife – something indicated by studies from countries as diverse as Bangladesh, Cambodia, India, Mexico, Nigeria, Pakistan, Papua New Guinea, the United

TABLE 4.2

Percentage of respondents who approve of using physical violence against a spouse, by rationale, selected studies, 1995–1999

Country or area	Year	Respondent	Rationale for physical abuse			
			She neglects children or house	She refuses him sex	He suspects her of adultery	She answers back or disobeys
Brazil (Salvador, Bahia)	1999	M	—	—	19[a]	—
		F	—	—	11[a]	—
Chile (Santiago)	1999	M	—	—	12[a]	—
		F	—	—	14[a]	—
Colombia (Cali)	1999	M	—	—	14[a]	—
		F	—	—	13[a]	—
Egypt	1996	Urban F	40	57	—	59
		Rural F	61	81	—	78
El Salvador (San Salvador)	1999	M	—	—	5[a]	—
		F	—	—	9[a]	—
Ghana[b]	1999	M	—	43	—	—
		F	—	33	—	—
India (Uttar Pradesh)	1996	M	—	—	—	10–50
New Zealand	1995	M	1	1	5[c]	1[d]
Nicaragua[e]	1999	Urban F	15	5	22	—
		Rural F	25	10	32	—
Singapore	1996	M	—	5	33[f]	4
Venezuela (Caracas)	1999	M	—	—	8[a]	—
		F	—	—	8[a]	—
West Bank and Gaza Strip[g]	1996	M[h]	—	28	71	57

Source: reproduced from reference *6* with the permission of the publisher.

M = male; F = female; — indicates question was not asked.

[a] "An unfaithful woman deserves to be beaten."

[b] Also, 51% of men and 43% of women agreed "a husband is justified in beating his wife if she uses family planning without his knowledge."

[c] "He catches her in bed with another man."

[d] "She won't do as she is told."

[e] Also, 11% of urban women and 23% of rural women agreed "a husband is justified in beating his wife if she goes out without his permission."

[f] "She is sexually involved with another man."

[g] Also, 23% of men agreed "wife-beating is justified if she does not respect her husband's relatives."

[h] Palestinian population.

Republic of Tanzania and Zimbabwe (*39–47*). Cultural justifications for violence usually follow from traditional notions of the proper roles of men and women. In many settings women are expected to look after their homes and children, and show their husbands obedience and respect. If a man feels that his wife has failed in her role or overstepped her limits – even, for instance, by asking for household money or stressing the needs of the children – then violence may be his response. As the author of the study from Pakistan notes, ''Beating a wife to chastise or to discipline her is seen as culturally and religiously justified . . . Because men are perceived as the 'owners' of their wives, it is necessary to show them who is boss so that future transgressions are discouraged.''

A wide range of studies from both industrialized and developing countries have produced a remarkably consistent list of events that are said to trigger partner violence (*39–44*). These include:

- not obeying the man;
- arguing back;
- not having food ready on time;
- not caring adequately for the children or home;
- questioning the man about money or girlfriends;
- going somewhere without the man's permission;
- refusing the man sex;
- the man suspecting the woman of infidelity.

In many developing countries, women often agree with the idea that men have the right to discipline their wives, if necessary by force (see Table 4.2). In Egypt, over 80% of rural women share the view that beatings are justified in certain circumstances (*48*). Significantly, one of the reasons that women cite most often as just cause for beatings is refusing a man sex (*48–51*). Not surprisingly, denying sex is also one of the reasons women cite most often as a trigger for beatings (*40, 52–54*). This clearly has implications for the ability of women to protect themselves from unwanted pregnancy and sexually transmitted infections.

Societies often distinguish between ''just'' and ''unjust'' reasons for abuse and between ''acceptable'' and ''unacceptable'' levels of violence. In this way, certain individuals – usually husbands or older family members – are given the right to punish a woman physically, within limits, for certain transgressions. Only if a man oversteps these bounds – for example, by becoming too violent or for beating a woman without an accepted cause – will others intervene (*39, 43, 55, 56*).

This notion of ''just cause'' is found in much qualitative data on violence from the developing world. One indigenous woman in Mexico observed, ''I think that if the wife is guilty, the husband has the right to hit her . . . If I have done something wrong . . . nobody should defend me. But if I have not done something wrong, I have a right to be defended'' (*43*). Similar sentiments are found among focus group participants in north and south India. ''If it is a great mistake,'' noted one woman in Tamil Nadu, ''then the husband is justified in beating his wife. Why not? A cow will not be obedient without beatings'' (*47*).

Even where culture itself grants men substantial control over female behaviour, abusive men generally exceed the norm (*49, 57, 58*). Statistics from the Demographic and Health Survey in Nicaragua, for instance, show that among women who were physically abused, 32% had husbands scoring high on a scale of ''marital control'', compared with only 2% among women who were not physically abused. The scale included a range of behaviours on the part of the husband, including continually accusing the wife of being unfaithful and limiting her access to family and friends (*49*).

How do women respond to abuse?

Qualitative studies have confirmed that most abused women are not passive victims but rather adopt active strategies to maximize their safety and that of their children. Some women resist, others flee, while still others attempt to keep the peace by giving in to their husbands' demands (*3, 59–61*). What may seem to an outside observer to be a lack of positive response by the woman may in fact be a calculated assessment of what is needed to survive in the marriage and to protect herself and her children.

A woman's response to abuse is often limited by the options available to her (*60*). In-depth qualitative studies of women in the United States and Africa, Latin America, Asia and Europe show that various factors can keep women in abusive relationships. These commonly include: fear of retribution, a lack of alternative means of economic support, concern for the children, emotional dependence, a lack of support from family and friends, and an abiding hope that the man will change (*9, 40, 42, 62, 63*). In developing countries, women also cite the stigmatization associated with being unmarried as an additional barrier to leaving abusive relationships (*40, 56, 64*).

TABLE 4.3

Proportion of physically abused women who sought help from different sources, selected population-based studies

Country or area	Sample (*M*)	Proportion of physically abused women who:			
		Never told anyone (%)	Contacted police (%)	Told friends (%)	Told family (%)
Australia[a]	6 300	18	19	58	53
Bangladesh	10 368	68	—	—	30
Canada	12 300	22	26	45	44
Cambodia	1 374	34	1	33	22
Chile	1 000	30	16	14	32[b]/21[c]
Egypt	7 121	47	—	3	44
Ireland	679	—	20	50	37
Nicaragua	8 507	37	17	28	34
Republic of Moldova	4 790	—	6	30	31
United Kingdom	430	38	22	46	31

Source: reproduced from reference *6* with the permission of the publisher.

[a] Women who were physically assaulted in the past 12 months.

[b] Refers to the proportion of women who told their family.

[c] Refers to the proportion of women who told their partners' family.

Denial and the fear of being socially ostracized often prevent women from reaching out for help. Studies have shown that around 20–70% of abused women never told another person about the abuse until they were interviewed for the study (see Table 4.3). Those who do reach out do so mainly to family members and friends, rather than to institutions. Only a minority ever contact the police.

Despite the obstacles, many abused women eventually do leave violent partners, sometimes only after many years, once the children have grown up. In the study in León, Nicaragua, for example, 70% of the women eventually left their abusive partners (*65*). The median time that women spent in a violent relationship was around 6 years, although younger women were more likely to leave sooner (*9*). Studies suggest that there is a consistent set of factors leading women to separate from their abusive partners permanently. Usually this occurs when the violence becomes severe enough to trigger the realization that the partner is not going to change, or when the situation starts noticeably to affect the children. Women have also mentioned emotional and logistical support from family or friends as being pivotal in their decision to end the relationship (*61, 63, 66–68*).

According to research, leaving an abusive relationship is a process, not a "one-off" event. Most women leave and return several times before finally deciding to end the relationship. The process includes periods of denial, self-blame and suffering before women come to recognize the reality of the abuse and to identify with other women in similar situations. At this point, disengagement and recovery from the abusive relationship begin (*69*). Recognizing that this process exists can help people to be more understanding and less judgemental about women who return to abusive situations.

Unfortunately, leaving an abusive relationship does not of itself always guarantee safety. Violence can sometimes continue and may even escalate after a woman leaves her partner (*70*). In fact in Australia, Canada and the United States, a significant proportion of intimate partner homicides involving women occur around the time that a woman is trying to leave an abusive partner (*22, 27, 71, 72*).

What are the risk factors for intimate partner violence?

Researchers have only recently begun to look for individual and community factors that might affect the rate of partner violence. Although violence against women is found to exist in most places, it turns out that there are examples of pre-industrial

societies where partner violence is virtually absent (*73, 74*). These societies stand as testament to the fact that social relations can be organized in such a way as to minimize violence against women.

In many countries the prevalence of domestic violence varies substantially between neighbouring areas. These local differences are often greater than differences across national boundaries. For example, in the state of Uttar Pradesh, India, the percentage of men who admitted beating their wives varied from 18% in Naintal district to 45% in Banda district. The proportion that physically forced their wives to have sex varied from 14% to 36% among the districts (see Table 4.4). Such variations raise an interesting and compelling question: what is it about these settings that can account for the large differences in physical and sexual assault?

TABLE 4.4

Variations in men's attitudes and reported use of violence, selected districts in Uttar Pradesh, India, 1995–1996

District	Sample size (*N*)	Proportion of men who:			
		Admit to forcing wife to have sex (%)	Agree that if wife disobeys, she should be beaten (%)	Admit to hitting wife (%)	Hit wife in past year (%)
Aligarh	323	31	15	29	17
Banda	765	17	50	45	33
Gonda	369	36	27	31	20
Kanpur Nagar	256	14	11	22	10
Naintal	277	21	10	18	11

Source: reproduced from reference *6* with the permission of the publisher.

Recently, researchers have become more interested in exploring such questions, although the current research base is inadequate for the task. Our present understanding of factors affecting the prevalence of partner violence is based largely on studies conducted in North America, which may not necessarily be relevant to other settings. A number of population-based studies are available from developing countries, but their usefulness in investigating risk and protective factors is limited by their cross-sectional design and by the limited number of predictive factors that they explore. In general, the current research base is highly skewed towards investigating individual factors rather than community or societal factors that may affect the likelihood of abuse.

Indeed, while there is an emerging consensus that an interplay of personal, situational, social and cultural factors combine to cause abuse (*55, 75*), there is still only limited information on which factors are the most important. Table 4.5 summarizes the factors that have been put forward as being related to the risk of perpetrating violence against an intimate partner. This information should, however, be viewed as both incomplete and highly tentative. Several important factors may be missing because no studies have examined their significance, while other factors may prove simply to be correlates of partner aggression rather than true causal factors.

Individual factors

Black et al. recently reviewed the social science literature from North America on risk factors for physically assaulting an intimate partner (*76*). They reviewed only studies they considered to be methodologically sound and that employed either a representative community sample or a clinical sample with an appropriate control group. A number of demographic, personal history and personality factors emerged from this analysis, as consistently linked to a man's likelihood of physically assaulting an intimate partner. Among the demographic factors, young age and low income were consistently found to be factors linked to the likelihood of a man committing physical violence against a partner.

Some studies have found a relationship between physical assault and composite measures of socio-economic status and educational level, although the data are not fully consistent. The Health and Development Study in Dunedin, New Zealand – one of the few longitudinal, birth cohort studies to explore partner violence – found that family poverty in childhood and adolescence, low academic achievement and aggressive delinquency at the age of 15 years all strongly predicted physical abuse of partners by men at the age of 21 years

TABLE 4.5
Factors associated with a man's risk for abusing his partner

Individual factors	Relationship factors	Community factors	Societal factors
• Young age • Heavy drinking • Depression • Personality disorders • Low academic achievement • Low income • Witnessing or experiencing violence as a child	• Marital conflict • Marital instability • Male dominance in the family • Economic stress • Poor family functioning	• Weak community sanctions against domestic violence • Poverty • Low social capital	• Traditional gender norms • Social norms supportive of violence

(*77*). This study was one of the few that evaluated whether the same risk factors predict aggression by both women and men against a partner.

History of violence in family

Among personal history factors, violence in the family of origin has emerged as an especially powerful risk factor for partner aggression by men. Studies in Brazil, Cambodia, Canada, Chile, Colombia, Costa Rica, El Salvador, Indonesia, Nicaragua, Spain, the United States and Venezuela all found that rates of abuse were higher among women whose husbands had either themselves been beaten as children or had witnessed their mothers being beaten (*12, 57, 76, 78–81*). Although men who physically abuse their wives frequently have violence in their background, not all boys who witness or suffer abuse grow up to become abusive themselves (*82*). An important theoretical question here is: what distinguishes those men who are able to form healthy, non-violent relationships despite childhood adversity from those who become abusive?

Alcohol use by men

Another risk marker for partner violence that appears especially consistent across different settings is alcohol use by men (*81, 83–85*). In the meta-analysis by Black et al. mentioned earlier, every study that examined alcohol use or excessive drinking as a risk factor for partner violence found a significant association, with correlation coefficients ranging from $r = 0.21$ to $r = 0.57$. Population-based surveys from Brazil, Cambodia, Canada, Chile, Colombia, Costa Rica, El Salvador, India, Indonesia, Nicaragua, South Africa, Spain and Venezuela also found a relationship between a woman's risk of suffering violence and her partner's drinking habits (*9, 19, 79–81, 86, 87*).

There is, however, a considerable debate about the nature of the relationship between alcohol use and violence and whether it is truly causal. Many researchers believe that alcohol operates as a situational factor, increasing the likelihood of violence by reducing inhibitions, clouding judgement and impairing an individual's ability to interpret cues (*88*). Excessive drinking may also increase partner violence by providing ready fodder for arguments between couples. Others argue that the link between violence and alcohol is culturally dependent, and exists only in settings where the collective expectation is that drinking causes or excuses certain behaviours (*89, 90*). In South Africa, for example, men speak of using alcohol in a premeditated way to gain the courage to give their partners the beatings they feel are socially expected of them (*91*).

Despite conflicting opinions about the causal role played by alcohol abuse, the evidence is that women who live with heavy drinkers run a far greater risk of physical partner violence, and that men who have been drinking inflict more serious violence at the time of an assault (*57*). According to the survey of violence against women in Canada, for example, women who lived with heavy drinkers were five times more likely to be assaulted by their partners than those who lived with non-drinkers (*19*).

Personality disorders

A number of studies have attempted to identify whether certain personality factors or disorders are

consistently related to partner violence. Studies from Canada and the United States show that men who assault their wives are more likely to be emotionally dependent, insecure and low in self-esteem, and are more likely to find it difficult to control their impulses (*33*). They are also more likely than their non-violent peers to exhibit greater anger and hostility, to be depressed and to score high on certain scales of personality disorder, including antisocial, aggressive and borderline personality disorders (*76*). Although rates of psychopathology generally appear higher among men who abuse their wives, not all physically abusive men show such psychological disorders. The proportion of partner assaults linked to psychopathology is likely to be relatively low in settings where partner violence is common.

Relationship factors

At an interpersonal level, the most consistent marker to emerge for partner violence is marital conflict or discord in the relationship. Marital conflict is moderately to strongly related to partner assault by men in every study reviewed by Black et al. (*76*). Such conflict has also been found to be predictive of partner violence in a population-based study of women and men in South Africa (*87*) and a representative sample of married men in Bangkok, Thailand (*92*). In the study in Thailand, verbal marital conflict remained significantly related to physical assault of the wife, even after controlling for socioeconomic status, the husband's stress level and other aspects related to the marriage, such as companionship and stability (*92*).

Community factors

A high socioeconomic status has generally been found to offer some protection against the risk of physical violence against an intimate partner, although exceptions do exist (*39*). Studies from a wide range of settings show that, while physical violence against partners cuts across all socio-economic groups, women living in poverty are disproportionately affected (*12, 19, 49, 78, 79, 81, 92–96*).

It is as yet unclear why poverty increases the risk of violence – whether it is because of low income in itself or because of other factors that accompany poverty, such as overcrowding or hopelessness. For some men, living in poverty is likely to generate stress, frustration and a sense of inadequacy for having failed to live up to their culturally expected role of providers. It may also work by providing ready material for marital disagreements or by making it more difficult for women to leave violent or otherwise unsatisfactory relationships. Whatever the precise mechanisms, it is probable that poverty acts as a ''marker'' for a variety of social conditions that combine to increase the risk faced by women (*55*).

How a community responds to partner violence may affect the overall levels of abuse in that community. In a comparative study of 16 societies with either high or low rates of partner violence, Counts, Brown & Campbell found that societies with the lowest levels of partner violence were those that had community sanctions against partner violence and those where abused women had access to sanctuary, either in the form of shelters or family support (*73*). The community sanctions, or prohibitions, could take the form either of formal legal sanctions or the moral pressure for neighbours to intervene if a woman was beaten. This ''sanctions and sanctuary'' framework suggests the hypothesis that intimate partner violence will be highest in societies where the status of women is in a state of transition. Where women have a very low status, violence is not ''needed'' to enforce male authority. On the other hand, where women have a high status, they will probably have achieved sufficient power collectively to change traditional gender roles. Partner violence is thus usually highest at the point where women begin to assume non-traditional roles or enter the workforce.

Several other community factors have been suggested as possibly affecting the overall incidence of partner violence, but few of these have been tested empirically. An ongoing multi-country study sponsored by the World Health Organization in eight countries (Bangladesh, Brazil, Japan, Namibia, Peru, Samoa, Thailand and the United Republic of Tanzania) is collecting data on a number of community-

level factors to examine their possible relationship to partner violence. These factors include:

- Rates of other violent crime.
- Social capital (see Chapter 2).
- Social norms to do with family privacy.
- Community norms related to male authority over women.

The study will shed light on the relative contributions of individual and community-level factors to rates of partner violence.

Societal factors

Research studies across cultures have come up with a number of societal and cultural factors that might give rise to higher levels of violence. Levinson, for example, used statistical analysis of coded ethnographic data from 90 societies to examine the cultural patterns of wife beating – exploring the factors that consistently distinguish societies where wife beating is common from those where the practice is rare or absent (*74*). Levinson's analysis suggests that wife beating occurs more often in societies in which men have economic and decision-making power in the household, where women do not have easy access to divorce, and where adults routinely resort to violence to resolve their conflicts. The second strongest predictor in this study of the frequency of wife beating was the absence of all-women workgroups. Levinson advances the hypothesis that the presence of female workgroups offers protection from wife beating because they provide women with a stable source of social support as well as economic independence from their husbands and families.

Various researchers have proposed a number of additional factors that might contribute to higher rates of partner violence. It has been argued, for example, that partner violence is more common in places where war or other conflicts or social upheavals are taking place or have recently taken place. Where violence has become commonplace and individuals have easy access to weapons, social relations – including the roles of men and women – are frequently disrupted. During these times of economic and social disruption, women are often more independent and take on greater economic responsibility, whereas men may be less able to fulfil their culturally expected roles as protectors and providers. Such factors may well increase partner violence, but evidence for this remains largely anecdotal.

Others have suggested that structural inequalities between men and women, rigid gender roles and notions of manhood linked to dominance, male honour and aggression, all serve to increase the risk of partner violence (*55*). Again, although these hypotheses seem reasonable, they remain to be proved by firm evidence.

The consequences of intimate partner violence

The consequences of abuse are profound, extending beyond the health and happiness of individuals to affect the well-being of entire communities. Living in a violent relationship affects a woman's sense of self-esteem and her ability to participate in the world. Studies have shown that abused women are routinely restricted in the way they can gain access to information and services, take part in public life, and receive emotional support from friends and relatives. Not surprisingly, such women are often unable properly to look after themselves and their children or to pursue jobs and careers.

Impact on health

A growing body of research evidence is revealing that sharing her life with an abusive partner can have a profound impact on a woman's health. Violence has been linked to a host of different health outcomes, both immediate and long-term. Table 4.6 draws on the scientific literature to summarize the consequences that have been associated with intimate partner violence. Although violence can have direct health consequences, such as injury, being a victim of violence also increases a woman's risk of future ill health. As with the consequences of tobacco and alcohol use, being a victim of violence can be regarded as a risk factor for a variety of diseases and conditions.

Studies show that women who have experienced physical or sexual abuse in childhood or

TABLE 4.6
Health consequences of intimate partner violence

Physical
Abdominal/thoracic injuries
Bruises and welts
Chronic pain syndromes
Disability
Fibromyalgia
Fractures
Gastrointestinal disorders
Irritable bowel syndrome
Lacerations and abrasions
Ocular damage
Reduced physical functioning
Sexual and reproductive
Gynaecological disorders
Infertility
Pelvic inflammatory disease
Pregnancy complications/miscarriage
Sexual dysfunction
Sexually transmitted diseases, including HIV/AIDS
Unsafe abortion
Unwanted pregnancy
Psychological and behavioural
Alcohol and drug abuse
Depression and anxiety
Eating and sleep disorders
Feelings of shame and guilt
Phobias and panic disorder
Physical inactivity
Poor self-esteem
Post-traumatic stress disorder
Psychosomatic disorders
Smoking
Suicidal behaviour and self-harm
Unsafe sexual behaviour
Fatal health consequences
AIDS-related mortality
Maternal mortality
Homicide
Suicide

adulthood experience ill-health more frequently than other women – with regard to physical functioning, psychological well-being and the adoption of further risk behaviours, including smoking, physical inactivity, and alcohol and drug abuse (*85, 97–103*). A history of being the target of violence puts women at increased risk of:

— depression;
— suicide attempts;
— chronic pain syndromes;
— psychosomatic disorders;
— physical injury;
— gastrointestinal disorders;
— irritable bowel syndrome;
— a variety of reproductive health consequences (see below).

In general, the following are conclusions emerging from current research about the health consequences of abuse:

- The influence of abuse can persist long after the abuse itself has stopped (*103, 104*).
- The more severe the abuse, the greater its impact on a woman's physical and mental health (*98*).
- The impact over time of different types of abuse and of multiple episodes of abuse appears to be cumulative (*85, 99, 100, 103, 105*).

Reproductive health

Women who live with violent partners have a difficult time protecting themselves from unwanted pregnancy or disease. Violence can lead directly to unwanted pregnancy or sexually transmitted infections, including HIV infection, through coerced sex, or else indirectly by interfering with a woman's ability to use contraceptives, including condoms (*6, 106*). Studies consistently show that domestic violence is more common in families with many children (*5, 47, 49, 50, 78, 93, 107*). Researchers have therefore long assumed that the stress of having many children increases the risk of violence, but recent data from Nicaragua, in fact, suggests that the relationship may be the opposite. In Nicaragua, the onset of violence largely precedes having many children (80% of violence beginning within the first 4 years of marriage), suggesting that violence may be a risk factor for having many children (*9*).

Violence also occurs during pregnancy, with consequences not only for the woman but also for the developing fetus. Population-based studies from Canada, Chile, Egypt and Nicaragua have found that 6–15% of ever-partnered women have been physically or sexually abused during pregnancy, usually by their partners (*9, 48, 49, 57, 78*). In the United States, estimates of abuse during pregnancy range from 3% to 11% among adult

women and up to 38% among low-income, teenage mothers (*108–112*).

Violence during pregnancy has been associated with (*6, 110, 113–117*):

— miscarriage;
— late entry into prenatal care;
— stillbirth;
— premature labour and birth;
— fetal injury;
— low birth weight, a major cause of infant death in the developing world.

Intimate partner violence accounts for a substantial but largely unrecognized proportion of maternal mortality. A recent study among 400 villages and seven hospitals in Pune, India, found that 16% of all deaths during pregnancy were the result of partner violence (*118*). The study also showed that some 70% of maternal deaths in this region generally went unrecorded and that 41% of recorded deaths were misclassified. Being killed by a partner has also been identified as an important cause of maternal deaths in Bangladesh (*119*) and in the United States (*120, 121*).

Partner violence also has many links with the growing AIDS epidemic. In six countries in Africa, for instance, fear of ostracism and consequent violence in the home was an important reason for pregnant women refusing an HIV test, or else not returning for their results (*122*). Similarly, in a recent study of HIV transmission between heterosexuals in rural Uganda, women who reported being forced to have sex against their will in the previous year had an eightfold increased risk of becoming infected with HIV (*123*).

Physical health

Obviously, violence can lead to injuries, ranging from cuts and bruises to permanent disability and death. Population-based studies suggest that 40–72% of all women who have been physically abused by a partner are injured at some point in their life (*5, 9, 19, 62, 79, 124*). In Canada, 43% of women injured in this way received medical care and 50% of those injured had to take time off from work (*19*).

Injury, however, is not the most common physical outcome of partner abuse. More common are ''functional disorders'' – a host of ailments that frequently have no identifiable medical cause, such as irritable bowel syndrome, fibromyalgia, gastrointestinal disorders and various chronic pain syndromes. Studies consistently link such disorders with a history of physical or sexual abuse (*98, 125–127*). Women who have been abused also experience reduced physical functioning, more physical symptoms and a greater number of days in bed than non-abused women (*97, 98, 101, 124, 125, 128*).

Mental health

Women who are abused by their partners suffer more depression, anxiety and phobias than non-abused women, according to studies in Australia, Nicaragua, Pakistan and the United States (*129–132*). Research similarly suggests that women abused by their partners are at heightened risk for suicide and suicide attempts (*25, 49, 133–136*).

Use of health services

Given the long-term impact of violence on women's health, women who have suffered abuse are more likely to be long-term users of health services, thereby increasing health care costs. Studies in Nicaragua, the United States and Zimbabwe indicate that women who have experienced physical or sexual assault, either in childhood or adulthood, use health services more frequently than their non-abused peers (*98, 100, 137–140*). On average, abuse victims experience more operative surgery, visits by doctors, hospital stays, visits to pharmacies and mental health consultations over their lifetime than non-victims, even after controlling for potential confounding factors.

Economic impact of violence

In addition to its human costs, violence places an enormous economic burden on societies in terms of lost productivity and increased use of social services. Among women in a survey in Nagpur, India, for example, 13% had to forgo paid work because of abuse, missing an average of 7 workdays per inci-

dent, and 11% had been unable to perform household chores because of an incident of violence (*141*).

Although partner violence does not consistently affect a woman's overall probability of being employed, it does appear to influence a woman's earnings and her ability to keep a job (*139, 142, 143*). A study in Chicago, IL, United States, found that women with a history of partner violence were more likely to have experienced spells of unemployment, to have had a high turnover of jobs, and to have suffered more physical and mental health problems that could affect job performance. They also had lower personal incomes and were significantly more likely to receive welfare assistance than women who did not report a history of partner violence (*143*). Similarly, in a study in Managua, Nicaragua, abused women earned 46% less than women who did not report suffering abuse, even after controlling for other factors that could affect earnings (*139*).

Impact on children

Children are often present during domestic altercations. In a study in Ireland (*62*), 64% of abused women said that their children routinely witnessed the violence, as did 50% of abused women in Monterrey, Mexico (*11*).

Children who witness marital violence are at a higher risk for a whole range of emotional and behavioural problems, including anxiety, depression, poor school performance, low self-esteem, disobedience, nightmares and physical health complaints (*9, 144–146*). Indeed, studies from North America indicate that children who witness violence between their parents frequently exhibit many of the same behavioural and psychological disturbances as children who are themselves abused (*145, 147*).

Recent evidence suggests that violence may also directly or indirectly affect child mortality (*148, 149*). Researchers in León, Nicaragua, found that after controlling for other possible confounding factors, the children of women who were physically and sexually abused by a partner were six times more likely to die before the age of 5 years than children of women who had not been abused. Partner abuse accounted for as much as one-third of deaths among children in this region (*149*). Another study in the Indian states of Tamil Nadu and Uttar Pradesh found that women who had been beaten were significantly more likely than non-abused women to have experienced an infant death or pregnancy loss (abortion, miscarriage or stillbirth), even after controlling for well-established predictors of child mortality such as the woman's age, level of education and the number of previous pregnancies that had resulted in a live birth (*148*).

What can be done to prevent intimate partner violence?

The majority of work carried out to date on partner violence has been spearheaded by women's organizations, with occasional funding and assistance from governments. Where governments have become involved – as in Australia, Latin America, North America and parts of Europe – it has generally been in response to demands by civil society for constructive action. The first wave of activity has generally involved elements of legal reform, police training and the establishment of specialized services for victims. Scores of countries have now passed laws on domestic violence, although many officials are either still unaware of the new laws or unwilling to implement them. Those within the system (in the police or the legal system, for instance) frequently share the same prejudices that predominate in society as a whole. Experience has repeatedly shown that without sustained efforts to change institutional culture and practice, most legal and policy reforms have little effect.

Despite over 20 years of activism in the field of violence against women, remarkably few interventions have been rigorously evaluated. Indeed, the recent review of programmes to prevent family violence in the United States by the National Research Council found only 34 studies that attempted to evaluate interventions related to partner abuse. Of those, 19 focused on law enforcement, reflecting the strong preference among government officials towards using the criminal justice system to deal with violence (*150*). Research on interventions in developing countries is even more limited. Only a

handful of studies exist that attempt critically to examine current interventions. Among these are a review of programmes on violence against women in four states of India. In addition, the United Nations Development Fund for Women has reviewed seven projects across five regions funded by the United Nations Violence Against Women Trust Fund, with the aim of disseminating the lessons learnt from these projects (*151*).

Support for victims

In the developed world, women's crisis centres and battered women's shelters have been the cornerstone of programmes for victims of domestic violence. In 1995, there were approximately 1800 such programmes in the United States, 1200 of which provided emergency shelter in addition to emotional, legal and material support to women and their children (*152*). Such centres generally provide support groups and individual counselling, job training, programmes for children, assistance in dealing with social services and with legal matters, and referrals for treatment for drug and alcohol abuse. Most shelters and crisis centres in Europe and the United States were originally set up by women activists, though many are now run by professionals and receive government funding.

Since the early 1980s, shelters and crisis centres for women have also sprung up in many developing countries. Most countries have at least a few nongovernmental organizations offering specialized services for victims of abuse and campaigning on their behalf. Some countries have hundreds of such organizations. However, maintaining shelters is expensive, and many developing countries have avoided this model, instead setting up telephone hotlines or non-residential crisis centres that provide some of the same services as residential ones.

Where running a formal shelter is not possible, women have often found other ways to deal with emergencies related to domestic abuse. One approach is to set up an informal network of ''safe homes'', where women in distress can seek temporary shelter in the homes of neighbours. Some communities have designated their local place of worship – a temple or church, for instance – as a sanctuary where women can stay with their children overnight to escape drunken or violent partners.

Legal remedies and judicial reforms

Criminalizing abuse

The 1980s and 1990s saw a wave of legal reforms relating to physical and sexual abuse by an intimate partner (*153, 154*). In the past 10 years, for example, 24 countries in Latin America and the Caribbean have passed specific legislation on domestic violence (*154*). The most common reforms involve criminalizing physical, sexual and psychological abuse by intimate partners, either through new laws on domestic violence or by amending existing penal codes.

The intended message behind such legislation is that partner violence is a crime and will not be tolerated in society. Bringing it into the open is also a way to dispel the idea that violence is a private, family matter. Aside from introducing new laws or extending existing ones, there have been experiments in some developed countries to back up legislation by introducing special domestic violence courts, training police and court officials and prosecution lawyers, and providing special advisers to help women deal with the criminal justice system. Although rigorous evaluation of these measures has so far been sparse, the recent review of family violence interventions by the United States National Academy of Sciences concludes: ''Anecdotal evidence suggests that specialized units and comprehensive reforms in police departments, prosecutors' offices and specialized courts have improved the experience of abused children and women'' (*150*).

Similar experiments are under way elsewhere. In India, for example, state governments have established legal aid cells, family courts, *lok adalat* (people's courts) and *mahilla lok adalat* (women's courts). A recent evaluation notes that these bodies are primarily conciliatory mechanisms, relying exclusively on mediation and counselling to promote family reconciliation. It has, however, been suggested that these institutions are less than satisfactory even as conciliatory mechanisms, and

that the mediators tend to place the well-being of women below the state's interest in keeping families together (*155*).

Laws and policies on arrest

After support services for victims, efforts to reform police practice are the next most common form of intervention against domestic violence. Early on, the focus was on training the police, but when training alone proved largely ineffective in changing police behaviour, efforts shifted to seeking laws requiring mandatory arrest for domestic violence and policies that forced police officers to take a more active stand.

Support for arrest as a means of reducing domestic violence was boosted by a 1984 research experiment in Minneapolis, MN, United States, that suggested that arrest halved the risk of future assaults over a 6-month period, compared with the strategies of separating couples or advising them to seek help (*156*). These results were widely publicized and led to a dramatic shift in police policies toward domestic violence throughout the United States.

Efforts to duplicate the Minneapolis findings in five other areas of the United States, however, failed to confirm the deterrent value of arrest. These new studies found that, on average, arrest was no more effective in reducing violence than other police responses such as issuing warnings or citations, providing counselling to the couples or separating them (*157, 158*). Detailed analysis of these studies also produced some other interesting findings. When the perpetrator of the violence was married, employed or both, arrest reduced repeat assaults, but for unemployed and unattached men, arrest actually led to increased abuse in some cities. The impact of arrest also varied by community. Men living in communities with low unemployment were deterred by arrest regardless of their individual employment status; suspects living in areas of high unemployment, however, were more violent following an arrest than they were after simply receiving a warning (*159*). These findings have led some to question the wisdom of mandatory arrest laws in areas of concentrated poverty (*160*).

Alternative sanctions

As alternatives to arrest, some communities are experimenting with other methods of deterring violent behaviour. One civil law approach is to issue court orders that prohibit a man from contacting or abusing his partner, mandate that he leave the home, order him to pay maintenance or child support, or require him to seek counselling or treatment for substance abuse.

Researchers have found that although victims generally find protection orders useful, the evidence for their effectiveness in deterring violence is mixed (*161, 162*). In a study in the cities of Denver and Boulder, CO, United States, Harrell & Smith (*163*) found that protection orders were effective for at least a year in preventing a reoccurrence of domestic violence, compared with similar situations where there was no protection order. However, studies have shown that arrests for violation of a protection order are rare, which tends to undermine their effectiveness in preventing violence (*164*). Other research shows that protection orders can enhance a woman's self-esteem but have little effect on men with serious criminal records (*165, 166*).

Elsewhere, communities have explored techniques such as public shaming, picketing an abuser's home or workplace, or requiring community service as a punishment for abusive behaviour. Activists in India frequently stage *dharna*, a form of public shaming and protest, in front of the homes or workplaces of abusive men (*155*).

All-women police stations

Some countries have experimented with all-women police stations, an innovation that started in Brazil and has now spread throughout Latin America and parts of Asia (*167, 168*). Although commendable in theory, evaluations show that this initiative has to date experienced many problems (*155, 168–172*). While the presence of a police station staffed entirely by women does increase the number of abused women coming forward, frequently the services that abused women require – such as legal advice and counselling – are not available at the stations. Furthermore, the assumption that female

police officers will be more sympathetic to victims has not always proved true, and in some places, the creation of specialized police cells for crimes against women has made it easier for other police units to dismiss women's complaints. A review of all-women police stations in India observes that ''women victims are forced to travel great distances to register their complaints with all-women police stations and cannot be assured of speedy neighbourhood police protection.'' To be viable, the strategy must be accompanied by sensitivity-training for police officers, incentives to encourage such work and the provision of a wider range of services (*155, 168, 170*).

Treatment for abusers

Treatment programmes for perpetrators of partner violence are an innovation that has spread from the United States to Australia, Canada, Europe and a number of developing countries (*173–175*). Most of the programmes use a group format to discuss gender roles and teach skills, including how to cope with stress and anger, take responsibility for one's actions and show feelings for others.

In recent years, there have been efforts to evaluate these programmes, although they have been hindered by methodological difficulties that continue to pose problems in interpreting the results. Research from the United States suggests that the majority of men (53–85%) who complete treatment programmes remain physically non-violent for up to 2 years, with lower rates for longer follow-up periods (*176, 177*). These success rates, however, should be seen in the light of the high drop-out rate that such programmes encounter; overall, between one-third and one-half of all men who enrol in these programmes fail to complete them (*176*) and many who are referred to programmes never formally enrol (*178*). An evaluation of the United Kingdom's flagship Violence Prevention Programme, for example, showed that 65% of men did not show up for the first session, 33% attended fewer than six sessions, and only 33% went on to the second stage (*179*).

A recent evaluation of programmes in four cities in the United States found that most abused women felt ''better off'' and ''safe'' after their partners had entered treatment (*177*). Nevertheless, this study found that after 30 months, nearly half the men had used violence once, and 23% of the men had been repeatedly violent and continued to inflict serious injuries, while 21% of the men were neither physically nor verbally abusive. A total of 60% of couples had split up and 24% were no longer in contact.

According to a recent international review by researchers at the University of North London, England (*179*), evaluations collectively suggest that treatment programmes work best if they:

- continue for longer rather than shorter periods;
- change men's attitudes enough for them to discuss their behaviour;
- sustain participation in the programme;
- work in tandem with a criminal justice system that acts strictly when there are breaches of the conditions of the programme.

In Pittsburgh, PA, United States, for example, the non-attendance rate dropped from 36% to 6% between 1994 and 1997 when the justice system began issuing arrest warrants for men who failed to appear at the programme's initial interview session (*179*).

Health service interventions

In recent years attention has turned towards reforming the response of health care providers to victims of abuse. Most women come into contact with the health system at some point in their lives – when they seek contraception, for instance, or give birth or seek care for their children. This makes the health care setting an important place where women undergoing abuse can be identified, provided with support and referred if necessary to specialized services. Unfortunately, studies show that in most countries, doctors and nurses rarely enquire of women whether they are being abused, or even check for obvious signs of violence (*180–186*).

Existing interventions have focused on sensitizing health care providers, encouraging routine screening for abuse and drawing up protocols for

the proper management of abuse. A growing number of countries – including Brazil, Ireland, Malaysia, Mexico, Nicaragua, the Philippines and South Africa – have begun pilot projects training health workers to identify and respond to abuse (*187–189*). Several countries in Latin America have also incorporated guidelines to address domestic violence in their health sector policies (*190*).

Research suggests that making procedural changes in patient care – such as stamping a reminder for the provider on the patient's chart or incorporating questions on abuse in the standard intake forms – have the greatest effect on the behaviour of health care providers (*191, 192*).

Confronting deep-rooted beliefs and attitudes is also important. In South Africa, the Agisanang Domestic Abuse Prevention and Training Project and its partner, the Health Systems Development Unit of the University of Witwatersrand, have developed a reproductive health and gender course for nurses that has a strong domestic violence component. In these courses, popular sayings, wedding songs and role-plays are used in an exercise to dissect commonly held notions on violence and the expected roles of men and women. Following the exercise, there is a discussion on the responsibility of nurses as health professionals. Analysis of a survey completed after one of these courses found that participants no longer believed that beating a woman was justified and that most accepted that a woman could be raped by her husband.

Active screening for abuse – questioning patients about their possible histories of suffering violence by intimate partners – is generally considered good practice in this field. However, while studies repeatedly show that women welcome being queried about violence in a non-judgemental way (*181, 182, 193*), little systematic evaluation has been carried out on whether screening for abuse can improve the safety of women or their health-seeking behaviour – and if it does, under what conditions (*194*).

Community-based efforts

Outreach work

Outreach work has been a major part of the response to partner violence from nongovernmental organizations. Outreach workers – who are often peer educators – visit victims of violence in their homes and communities. Nongovernmental organizations frequently recruit and train peer workers from the ranks of former clients, themselves earlier victims of partner violence.

Both governmental and nongovernmental projects have been known to employ ''advocates'' – individuals who provide abused women with information and advice, particularly with help in negotiating the intricacies of the legal system and of family welfare and other benefits. These people focus on the rights and entitlements of victims of violence and carry out their work from institutions as diverse as police stations, legal prosecutors' offices and hospitals.

Several outreach schemes have been evaluated. The Domestic Violence Matters project in Islington, London, England, placed civilian advocates in local police stations, with the task of contacting all victims of partner violence within 24 hours of their calling the police. Another initiative in London, the Domestic Violence Intervention project in Hammersmith and Fulham, combined an education programme for violent men with appropriate interventions for their partners. A recent review of these programmes found that the Islington project had reduced the number of repeated calls to the police and – by inference – had reduced the reoccurrence of domestic violence. At the same time, it had increased the use by women of new services, including shelters, legal advice and support groups. The second project had managed to reach greater numbers of women from ethnic minority groups and professional women than other services for victims of domestic violence (*195*).

Coordinated community interventions

Coordinating councils or interagency forums are an increasingly popular means of monitoring and improving responses towards intimate partner violence at the community level (*166*). Their aim is to:

— exchange information;

— identify and address problems in the provision of services;

— promote good practice through training and drawing up guidelines;
— track cases and carry out institutional audits to assess the practice of various agencies;
— promote community awareness and prevention work.

Adapted from the original pilot programmes in California, Massachusetts and Minnesota in the United States, this type of intervention has spread widely throughout the rest of the United States, Canada, the United Kingdom and parts of Latin America.

The Pan American Health Organization (PAHO), for instance, has set up pilot projects in 16 Latin American countries to test this approach in both urban and rural settings. In rural settings, the coordinating councils include individuals such as the local priest, the mayor, community health promoters, magistrates and representatives of women's groups. The PAHO project began with a qualitative research study – known as *La Ruta Crítica* – to examine what happens to women in rural communities when they seek help, and the results are summarized in Box 4.2.

These types of community interventions have seldom been evaluated. One study found a statistically significant increase in the proportion of police calls that resulted in arrests, as well as in the proportion of arrests that resulted in prosecution, after the implementation of a community intervention project (*196*). The study also found a significant increase in the proportion of men sent for mandatory counselling in each of the communities, though it is unclear what impact, if any, these actions had on rates of abuse.

Qualitative evaluations have noted that many of these interventions focus primarily on coordinating refuges and the criminal justice system, at the expense of wider involvement of religious communities, schools, the health system, or other social service agencies. A recent review of interagency forums in the United Kingdom concluded that while coordinating councils can improve the quality of services offered to women and children, interagency work can act as a smokescreen, concealing the fact that little actually changes. The review suggested that organizations should identify firm criteria for self-evaluation that cover user satisfaction and real changes in policies and practices (*197*).

Prevention campaigns

Women's organizations have long used communication campaigns, small-scale media and other events in an attempt to raise awareness of partner violence and change behaviour. There is evidence that such campaigns reach a large number of people, although only a few campaigns have been evaluated for their effectiveness in changing attitudes or behaviour. During the 1990s, for instance, a network of women's groups in Nicaragua mounted an annual mass media campaign to raise awareness of the impact of violence on women (*198*). Using slogans such as "*Quiero vivir sin violencia*" (I want to live free of violence), the campaigns mobilized communities against abuse. Similarly, the United Nations Development Fund for Women, together with several other United Nations agencies, has been sponsoring a series of regional campaigns against gender violence around the slogan, "A life free of violence: it's our right" (*199*). One communication project that has been evaluated is the multimedia health project known as *Soul City*, in South Africa – a project that combines prime-time television and radio dramas with other educational activities. One component is specifically devoted to domestic violence (see Box 9.1 in Chapter 9). The evaluation found increased knowledge and awareness of domestic violence, changed attitudes and norms, and greater willingness on the part of the project's audience to take appropriate action.

School programmes

Despite a growing number of initiatives aimed at young people on preventing violence, only a small number specifically address the problem of violence in intimate relationships. There is considerable scope, though, to integrate material that explores relationships, gender roles and coercion and control into existing programmes for reducing school violence, bullying, delinquency and other problem behaviours, as well as into reproductive and sexual health programmes.

BOX 4.2

La Ruta Crítica: a study of responses to domestic violence

In 1995, the Pan American Health Organization launched a community study in 10 countries in Latin America (Belize, Bolivia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama and Peru). Its purpose was to record the process that a woman who has suffered domestic violence goes through after making a decision to end her silence and seek assistance. The Spanish name for this process was *La Ruta Crítica* — the critical path — referring to the unfolding series of decisions and actions taken by the woman as she comes to terms with the violent situation and the responses she encounters from others in her search for help. Each action and decision by the woman along the path affects the actions of others, including service providers and members of the community, and what they do, in turn, has an influence on the next step the woman takes.

The questions investigated by the study were therefore concerned with the consequences of a woman deciding to seek help, the sources she approached for assistance, her motivations, and the attitudes and responses, both of institutional service providers and individuals. The qualitative study involved over 500 in-depth interviews with women who had been abused and more than 1000 interviews with service providers, as well as some 50 focus group sessions.

Women who had been victims of violence identified several factors that can act as triggers for action. These included an increase in the severity or frequency of the violence, causing a recognition that the abuser was not going to change. One important factor motivating action was the realization that the life of the woman or those of her children were in danger. As with the factors that precipitated action, the factors inhibiting a woman from seeking help were multiple and interconnected.

The study found that economic considerations seemed to carry more weight than emotional ones. Many women, for instance, expressed concern about their ability to support themselves and their children. The women interviewed also frequently expressed feelings of guilt, self-blame or being abnormal. Corruption and stereotyping by gender in the judicial system and among the police were also mentioned. The greatest inhibiting factor, though, was fear — that the consequences of telling someone or of leaving would be worse than staying in the relationship.

From the *Ruta Crítica* study, it is clear that there are many factors, both internal and external, that have a bearing on an abused woman's decision to take action to stop the violence. The process is often a long one — many years in some cases — involving several attempts at seeking help from a number of sources. Rarely is there just a single event that precipitates action. The evidence indicates that, despite facing formidable obstacles, abused women are often resourceful in seeking help and in finding ways of mitigating the violence inflicted on them.

The programmes for young people that do explicitly address abuse within intimate relationships tend to be independent initiatives sponsored by bodies working to end violence against women (see Box 4.3). Only a handful of these programmes have been evaluated, including one in Canada (*200*) and two in the United States (*201, 202*). Using experimental designs, these evaluations found positive changes in knowledge and attitudes toward relationship violence (see also *203*). One of the programmes in the United States demonstrated a reduction in the perpetration of violence at 1 month. Although its effect on behaviour had vanished after 1 year, its effects on norms of violence within an intimate relationship, on skills for resolving conflict and on knowledge were all maintained (*201*).

Principles of good practice

A growing body of wisdom on partner violence, accumulated over many years by large numbers of service providers, advocates and researchers, suggests a set of principles to help guide ''good

BOX 4.3

Promoting non-violence: some examples of primary prevention programmes

The following are a few of the many examples from around the world of innovative programmes to prevent violence between intimate partners.

In Calabar, Nigeria, the Girl's Power Initiative is aimed at young girls. The girls meet weekly over a period of 3 years to discuss frankly a range of issues related to sexuality, women's health and rights, relationships and domestic violence. Specific topics in the programme, designed to build self-esteem and teach skills for self-protection, have included societal attitudes that put women at risk of rape, and distinguishing between love and infatuation.

Education Wife Assault in Toronto, Canada, works with immigrant and refugee women, helping them develop violence prevention campaigns that are culturally appropriate for their communities by means of special ''skill shops''. Education Wife Assault provides technical assistance, enabling women to conduct their own campaigns. At the same time, it also offers emotional support to the women organizers to help them overcome the discrimination often directed at women campaigning against domestic violence because they are seen as threatening their community's cohesiveness.

In Mexico, the nongovernmental organization Instituto Mexicano de Investigación de Familia y Población has created a workshop for adolescents to help prevent violence in dating and within relationships between friends. Entitled ''Faces and Masks of Violence'', the project uses participatory techniques to help young people explore expectations and feelings about love, desire and sex, and to understand how traditional gender roles can inhibit behaviour, both in men and women.

In Trinidad and Tobago, the nongovernmental organization SERVOL (Service Volunteered for All) conducts workshops over 14 weeks for adolescents to assist them in developing healthy relationships and learning parenting skills. The project helps these young people understand how their own parenting contributed towards shaping what they are and teaches them how not to repeat the mistakes their parents and other relatives may have made in bringing up their families. As a result, the students discover how to recognize and handle their emotions, and become more sensitive to how early physical and psychological traumas can lead to destructive behaviour later in life.

practice'' in this field. These principles include the following:

- Actions to address violence should take place at both national and local level.
- The involvement of women in the development and implementation of projects and the safety of women should guide all decisions relating to interventions.
- Efforts to reform the response of institutions – including the police, health care workers and the judiciary – should extend beyond training to changing institutional cultures.
- Interventions should cover and be coordinated between a range of different sectors.

Action at all levels

An important lesson to emerge from efforts to prevent violence is that actions should take place at both national and local levels. At the national level, priorities include improving the status of women, establishing appropriate norms, policies and laws on abuse, and creating a social environment that is conducive to non-violent relationships.

Many countries, industrialized as well as developing, have found it useful to set up a formal mechanism for developing and implementing national plans of action. Such plans should include clear objectives, lines of responsibility and time schedules, and be backed by adequate resources.

Experience nevertheless suggests that national efforts alone are insufficient to transform the landscape of intimate violence. Even in those industrialized countries where national movements against partner violence have existed for more than 25 years, the options for help available to a woman who has suffered abuse, and the reactions she is likely to meet from institutions such as the police, still vary greatly according to the particular locality. Where there have been efforts in the community to prevent violence, and where there are established groups to conduct training and monitor the activities of formal institutions, victims of abuse fare considerably better than where these are lacking (*204*).

Women's involvement

Interventions should be designed to work with women – who are usually the best judges of their situation – and to respect their decisions. Recent reviews of a range of domestic violence programmes in the Indian states of Gujarat, Karnataka, Madhya Pradesh and Maharashtra, for instance, have consistently shown that the success or failure of projects was determined largely by the attitudes of organizers towards intimate partner violence and their priorities for including the interests of women during the planning and implementation of interventions (*205*).

Women's safety should also be carefully considered when planning and implementing interventions. Those that make women's safety and autonomy a priority have generally proved more successful than those that do not. For example, concern has been raised about laws requiring health care workers to report suspected cases of abuse to the police. These types of interventions take control away from women and have usually proved counterproductive. They may well put a woman's safety at risk and make it less likely that she will come forward for care (*206–208*). Such laws also transform health workers into arms of the judicial system and work against the emotional protection that the environment of the clinic is meant to provide (*150*).

Changing institutional cultures

Little enduring change is usually achieved by short-term efforts to sensitize institutional actors, unless there are also real efforts to engage the whole institution. The nature of the organization's leadership, the way in which performances are evaluated and rewarded, and the embedded cultural biases and beliefs are all of prime importance in this respect (*209, 210*). In the case of reforming health care practice, training alone has seldom been sufficient to change institutional behaviour toward victims of violence (*211, 212*). Although training can improve knowledge and practice in the short term, its impact generally wears off quickly unless accompanied by institutional changes in policies and performance (*211, 213*).

A multisectoral approach

Various sectors such as the police, health services, judiciary and social support services should work together in tackling the problem of intimate partner violence. Historically, the tendency of programmes has been to concentrate on a single sector, which has been shown by experience very often to produce poor results (*155*).

Recommendations

The evidence available shows violence against women by intimate partners to be a serious and widespread problem in all parts of the world. There is also a growing documentation of the damaging impact of violence on the physical and mental health of women and their overall well-being. The following are the main recommendations for action:

- Governments and other donors should be encouraged to invest much more in research on violence by intimate partners over the next decade.
- Programmes should place greater emphasis on enabling families, circles of friends and community groups, including religious communities, to deal with the problem of partner violence.
- Programmes on partner violence should be integrated with other programmes, such as those tackling youth violence, teenage pregnancies, substance abuse and other forms of family violence.

- Programmes should focus more on the primary prevention of intimate partner violence.

Research on intimate partner violence

The lack of a clear theoretical understanding of the causes of intimate partner violence and its relationship to other forms of interpersonal violence has frustrated efforts to build an effective global response. Studies to advance the understanding of violence are needed on a variety of fronts, including:

- Studies that examine the prevalence, consequences and risk and protective factors of violence by intimate partners in different cultural settings, using standardized methodologies.
- Longitudinal research on the trajectory of violent behaviour by intimate partners over time, examining whether and how it differs from the development of other violent behaviours.
- Studies that explore the impact of violence over the course of a person's life, investigating the relative impact of different types of violence on health and well-being, and whether the effects are cumulative.
- Studies that examine the life history of adults who are in healthy, non-violent relationships despite past experiences that are known to increase the risk of partner violence.

In addition, much more research is needed on interventions, both for the purpose of lobbying policy-makers for more investment as well as to improve the design and implementation of programmes. In the next decade, priority should be given to the following:

- Documentation of the various strategies and interventions around the world for combating intimate partner violence.
- Studies assessing the economic costs of intimate partner violence.
- Evaluation of the short-term and long-term effects of programmes to prevent and respond to partner violence – including school education programmes, legal and policy changes, services for victims of violence, programmes that target perpetrators of violence, and campaigns to change social attitudes and behaviour.

Strengthening informal sources of support

Many women do not seek assistance from the official services or systems that are available to them. Expanding the informal sources of support through neighbourhood networks and networks of friends, religious and other community groups, and workplaces is therefore vital (*6, 61, 183, 214*). How these informal groups and individuals respond will determine whether a victim of partner violence takes action or else retreats into isolation and self-blame (*214*).

There is plenty of room for programmes that can create constructive responses on the part of family and friends. An innovative programme in Iztacalco, Mexico, for instance, used community events, small-scale media (such as posters, pamphlets and audio cassettes) and workshops to help victims of violence discuss the abuse they had undergone and to demonstrate to friends and other family members how best to deal with such situations (*215*).

Making common cause with other social programmes

There is a considerable overlap between the factors that increase the risk of various problem behaviours (*216*). There also appears to be a significant continuity between aggressive behaviour in childhood and a range of problem behaviours in youth and early adulthood (see Chapter 2). The insights gained from research on these types of violence overlap as well. There is an evident need to intervene early with high-risk families and to provide support and other services before dysfunctional patterns of behaviour within the family set in, preparing the stage for abusive behaviour in adolescence or adulthood.

Unfortunately, there is at present little coordination between programmes or research agendas on youth violence, child abuse, substance abuse and partner violence, despite the fact that all these problems regularly coexist in families. If true progress is to be made, attention must be paid to the development of aggressive behaviour patterns – patterns that often begin in childhood. Integrated

prevention responses that address the links between different types of violence have the potential to reduce some of these forms of violence.

Investing in primary prevention

The importance of primary prevention of violence by intimate partners is often overshadowed by the importance of the large number of programmes that, understandably, seek to deal with the immediate and numerous consequences of violence.

Both policy-makers and activists in this field must give greater priority to the admittedly immense task of creating a social environment that allows and promotes equitable and non-violent personal relationships. The foundation for such an environment must be the new generation of children, who should come of age with better skills than their parents generally had for managing their relationships and resolving the conflicts within them, with greater opportunities for their future, and with more appropriate notions on how men and women can relate to each other and share power.

Conclusion

Violence by intimate partners is an important public health problem. Resolving it requires the involvement of many sectors working together at community, national and international levels. At each level, responses must include empowering women and girls, reaching out to men, providing for the needs of victims and increasing the penalties for abusers. It is vital that responses should involve children and young people, and focus on changing community and societal norms. The progress made in each of these areas will be the key to achieving global reductions in violence against intimate partners.

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