

“ I have experienced violence too.... I did not know where I could go for help. I now know where I can go. I was looking for such places. It is good to address these type of issues in a survey. I am happy now. ”

Woman interviewed in Japan

“ I would like to receive the results of this research. The opportunity to participate in it made me feel very important. ”

Woman interviewed in Brazil

“ I learned a lot from the beginning of the training, till the end of the survey. The survey opened wounds, but I had to learn to face it and cope with it. The respondents really needed and enjoyed this experience, because they could talk to somebody. My career path changed, since the beginning of the training because I could do something which can make a difference and mean something for my country. ”

Interviewer from Namibia

The WHO Multi-country Study on Women's Health and Domestic Violence against Women is a research initiative that has produced data on intimate-partner violence comparable across the 10 countries in this report: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania.¹ Carried out in adherence to strict ethical, safety and quality control procedures, the Study's use of a standardized and rigorous methodology has resulted in robust data, which permit comparison between survey sites in the same country, and between countries.² The WHO Study is also the first to provide data from developing countries on the association between violence and health outcomes at a population level.

¹ The study has now also been completed in New Zealand.

² The deviations from the standard protocol and questionnaire as implemented in Ethiopia, Japan, and Serbia and Montenegro, are specified in Annex I.

The following is a brief summary of the WHO Study findings and conclusions, along with an assessment of the strengths and limitations of the Study, and a discussion of future areas for research and analysis.

Prevalence and patterns of violence

Physical and sexual violence against women

The WHO Study shows clearly that physical and sexual violence against women is strikingly common. The aggregate figures on partner and non-partner violence indicate that, in every setting except Japan, more than a quarter of women in the study had been physically or sexually assaulted at least once since the age of 15 years. Indeed, at least half of all women in Bangladesh, Ethiopia province, Peru, Samoa, and the United Republic of Tanzania said that they had been physically or sexually assaulted since that age. In general, the vast majority of this violence was inflicted by a male intimate partner:

The only exception was Samoa, where violence from other people was slightly more prevalent.

This finding illustrates the extent to which, globally, women in non-conflict settings are at greatest risk of violence from their husband or intimate partner; rather than from strangers or others known to them. The results are consistent with similar studies from industrialized countries, and challenge commonly held perceptions that the home is a place of safety or refuge for women.

Physical and sexual violence by partners

Across the WHO Study sites, the extent of physical or sexual violence, or both, by an intimate partner; reported over a lifetime, varied widely, ranging from 15% in Japan city to 71% in Ethiopia province, with prevalence estimates in most countries ranging from 30% to 60%. Likewise, although in three sites less than 10% of women reported current violence by an intimate partner; i.e. violence in the year prior to being interviewed (Serbia and Montenegro city 3%, Japan city 4%, and Brazil city 9%), more than half reported current violence in Ethiopia province, and in most sites between 20% and 33% of women reported being abused by their partner in the past year. These findings illustrate the extent to which violence is a reality in partnered women's lives, with a large proportion of women having some experience of violence during their partnership, and many having recent experiences of abuse. Although the study findings make depressing reading, the wide variation found in prevalence rates also shows that violence is not inevitable. Even in settings where partner violence is widespread, many women live in violence-free relationships.

An important focus of the WHO Study was to document the similarities and differences in the levels of violence by partners across the study sites, and to use these data to

identify individual and community factors that may contribute to this variation. The levels of violence reported in different countries differed considerably; in addition, in countries where large cities and provincial settings were both studied, the overall levels of violence by an intimate partner were consistently higher in the provincial settings, which had more rural populations, than in the urban sites. Variations in the patterns of overlap between physical and sexual violence were also found: in most sites, physical partner violence was almost always accompanied by sexual violence, but in some settings (particularly in Bangladesh, Ethiopia province, and Thailand) a considerable proportion of women experienced solely sexual violence by an intimate partner.

At the individual level, a number of similarities in the patterns of violence by partners were found. Generally, in most sites, women who were separated or divorced and women who were living with a male partner without being married reported a higher lifetime prevalence of physical or sexual violence, or both, by an intimate partner than currently married women. Likewise, although older women do experience partner violence, in most sites a larger proportion of partnered 15–24-year-olds reported having experienced violence in the past year than older women. It was also found in most sites that women with a higher educational level reported a lower lifetime prevalence of partner violence than women who had not attended school or had primary education only.

The patterns observed at the individual level have been documented in other research studies, and reflect the fact that violence often starts early in partnerships, as well as the likelihood that separated women may have left violent relationships. However, the differences in the prevalence of partner violence between and within countries are not explained by differences in age, education, or patterns of partnership formation between study sites; they are likely to reflect true differences in the patterns of violence. The explanation for this variation will be a focus of further analysis to identify factors that may put women at increased risk or that may help to protect them from violence by an intimate partner.

Emotional abuse by intimate partners and controlling behaviours

The WHO Study definition of violence by an intimate partner included not only physical and sexual violence, but also emotional abuse. This report, however, has focused mainly on physical and sexual violence. While emotional abuse is recognized as an important element of partner

violence – and is often cited by women as the most hurtful form of abuse – there is little agreement on how to capture this adequately across cultures. For this reason the information on emotional abuse is considered exploratory at this stage. Further analysis is required to fully conceptualize measures of severity and frequency.

The Study found that in all sites controlling behaviour by an intimate partner was strongly associated with physical and sexual violence. In other words, male partners who inflicted physical or sexual violence, or both, were also more likely to have other forms of controlling behaviour, such as controlling a woman's access to health care, wanting to know where she is at all times, and being angry if she speaks with another man. This supports basic theories on partner violence, which highlight that power and control are motivations underlying men's violence towards their intimate partners, and that violent men use a range of strategies to exert power over and control women, including the use of different forms of violence.

Women's attitudes towards violence by an intimate partner

In addition to women's actual experience, the WHO Study investigated women's attitudes to partner violence, specifically the circumstances under which women believe it is acceptable for a man to hit or physically mistreat his wife, and their beliefs about whether and when a woman may refuse to have sex with her husband. There was wide variation in women's agreement with different reasons for acceptance of violence, and indeed with the idea that violence is ever justified. While over three quarters of women in the cities of Brazil, Japan, Namibia, and Serbia and Montenegro said no reason justified violence, less than one quarter thought so in the provincial settings of Bangladesh, Ethiopia, and Peru, and in Samoa. Acceptance of wife-beating was higher among women who had experienced abuse than among those who had not. Respondents were also asked whether they believed a woman had a right to refuse sex in a number of situations, including if: she is sick, she does not want to have sex, he is drunk, or he mistreats her. In all sites, less than 20% of women thought that women do not have the right to refuse sex under *any* of these circumstances, with the highest proportion (between 10% and 20%) being found in the provincial sites of Bangladesh, Ethiopia, Peru, and the United Republic of Tanzania, and in Samoa.

The association between the prevalence of partner violence and women's beliefs that such violence is normal or justified constitutes one of the salient findings of the WHO Study. The

fact that the association is particularly marked in rural and more traditional societies reinforces the hypothesis that the status of women within society is a key factor in the prevalence of violence against them, and that addressing this is a fundamental aspect of prevention efforts.

Non-partner violence

As indicated above, the Study also asked women about their experiences of physical and sexual violence since the age of 15 years by perpetrators other than their partner. There was a large variation in the levels of non-partner violence reported, ranging from 5% of women in Ethiopia province to 65% in Samoa. In many sites, more than a fifth of respondents reported being assaulted by a non-partner. With the exception of Peru, in countries where the study was conducted both in a city and a more rural province, higher levels of non-partner violence were reported in the city than in the province. The most commonly mentioned perpetrators of physical violence were the respondent's father; and other male or female family members. In some sites, teachers were also mentioned frequently. In contrast, family members were generally less likely to be reported to have been sexually violent towards women aged over 15 years, with strangers and boyfriends being more frequently mentioned.

Sexual abuse in childhood and forced first sex

Childhood sexual abuse (i.e. sexual abuse before 15 years of age) was a relatively common experience among girls in most of the sites, although there were wide variations in reported prevalence, which ranged from 1% (Bangladesh province) to 21% (Namibia city), with a general tendency for the levels of violence to be higher in city sites than in provincial sites. Girls are at greatest risk of sexual abuse by strangers and by male family members.

A substantial minority of women reported that their first sexual intercourse was by force, ranging from less than 1% to 30%. In all sites except Ethiopia province, the younger the girl at first sexual encounter, the more likely it was that sex was forced. In more than half of the sites, over 30% of women who reported first sex before the age of 15 years said that their first sexual experience was forced.

The wide variations in prevalence of forced first intercourse are likely to represent actual differences in levels of coercion, reflecting cultural differences in women's ability to control the circumstances of their first sexual experience. At the same time, the figures may also partly reflect different social attitudes

towards female sexuality and sex. In cultures such as those of Bangladesh and Ethiopia, which have strong social restrictions against women expressing a desire to have sex, women may have a higher tendency to report their first sexual experience as forced. The high levels of forced first sex in these countries are most likely the result of sexual initiation by a husband, rather than abuse by a boyfriend or stranger.

Association of violence with specific health outcomes

The WHO Study provides the first population-based data from a range of countries on the association between violence by an intimate partner and women's mental, physical and reproductive health. While the cross-sectional design does not allow for causal inferences, a powerful finding from the Study is the degree to which, across the many different study sites and populations, a current or previous experience of intimate-partner violence was significantly associated with a range of negative impacts on women's current physical, mental, sexual, and reproductive health. Even after adjusting for age, educational attainment and marital status, these associations usually remained significant. Future analysis will explore in greater depth the mechanisms by which violence affects women's health in different sites.

Physical health and injury

Having ever experienced physical or sexual violence, or both, by an intimate partner; whether moderate or severe, had significant associations with a range of physical symptoms (problems with walking, pain, memory, dizziness, and vaginal discharge) occurring in the 4 weeks preceding the interview. Women who reported violence were also significantly more likely than women who had never experienced violence to report that their general health was poor or very poor.

The association between physical or sexual violence, or both, and health status and symptoms was statistically significant in practically every site, even after controlling for age, education, and marital status. The variations between sites in the reporting of different symptoms are likely in part to reflect local idioms of distress.

Physical violence, particularly severe violence, was closely associated with injury. Although the majority of injured women reported minor injuries (bruises, abrasions, cuts, punctures, and bites), in some sites more serious injuries, such as those affecting eyes and ears, were relatively common.

Mental health

Women who had ever experienced physical or sexual violence, or both, by a partner were significantly more likely to have ever contemplated suicide than women who had never experienced abuse. Further, among all women who had ever contemplated suicide, women who had experienced violence were also significantly more likely to have attempted suicide.

Women who had ever experienced physical or sexual violence, or both, by a partner were significantly more likely to report recent symptoms of mental distress than women who had never experienced violence. The results illustrate that even past violence can be associated with recent negative mental health outcomes.

Violence during pregnancy, induced abortion and miscarriage

Among ever-pregnant women, the prevalence of physical violence by an intimate partner during a pregnancy ranged from 1% to 28%, with practically all violence being perpetrated by the father of the child. Between 23% and 49% of those abused reported being punched or kicked in the abdomen, with potentially serious consequences for the health of both the woman and the developing infant.

In most cases, the violence experienced in pregnancy was a continuation of the violence experienced previously. However, for a substantial proportion (between 13% and 52%), the violence started during the pregnancy. For the majority of women who were abused before and during a pregnancy, the violence stayed the same or was less severe. However, between 8% and 34% said that the violence got worse during the pregnancy.

In most sites, women who reported physical or sexual violence, or both, by a partner were significantly more likely to report having had at least one induced abortion or miscarriage than those who did not report violence, with the association being stronger for induced abortions than for miscarriages. These findings suggest that, across a broad range of settings, violence against women is an important factor affecting women's sexual and reproductive health.

Risk of HIV and other sexually transmitted infections

The WHO Study did not ask specific questions about HIV and other sexually transmitted infections, but explored the extent to which women knew whether or not their partner had had other sexual partners during their relationship,

and whether they had ever used a condom with their current or most recent partner.

Across all sites except Ethiopia province, a woman who reported that her current or most recent intimate partner had been physically or sexually violent towards her was significantly more likely to report that she knew that her partner was or had been sexually involved with other women while being with her. In most sites, the difference ranged from at least twice as likely to up to nine times as likely.

Women were also asked whether they had ever used a condom with their partner; whether they had requested use of a condom, and whether the request had been refused. The proportion of women who had ever used a condom with a current or most recent partner varied greatly across sites. No significant difference was found in use of condoms between abused and non-abused women, with the exception of Thailand and the United Republic of Tanzania, where women in a violent relationship were more likely to have used condoms. However, in a number of sites (cities in Peru, Namibia, and the United Republic of Tanzania) women in violent partnerships were more likely than non-abused women to have asked their partner to use condoms. Women in violent partnerships in these sites, as well as in Brazil city, Peru province, and Serbia and Montenegro, were significantly more likely than non-abused women to report that their partner had refused to use a condom.

These findings, as well as the high levels of child sexual abuse, are of concern in the transmission of HIV and other sexually transmitted infections, and underline the urgent need to address this hidden but widespread abuse against women. The degree to which partner infidelity may be associated with partner violence also requires serious consideration by HIV and AIDS policy-makers and programme managers, and highlights the need for a greater integration of issues of gender, power and coercion into HIV prevention and AIDS care and treatment programming.

Women's responses and use of services

The WHO Study sought to learn more about the strategies that women use to end or cope with violence in their partnerships. There are many barriers to women accessing help from either formal or informal sources. As shown in the replies to questions on controlling behaviour, violent men often keep women isolated from potential sources of help, and women may fear that disclosure of their situation or seeking

medical treatment will lead to retaliation against themselves or their children. In most study sites except in Bangladesh, the majority of women who had ever been in a physically violent partnership had told someone about the violence. It is striking to note, however, that for significant numbers of respondents (ranging from a fifth in Brazil city to two thirds in Bangladesh city), the interview was the first time that they had ever spoken about their experiences of violence to anyone.

Even fewer women reported seeking help, due to reported barriers including feelings of shame and self-blame, and stigmatizing attitudes on the part of service providers, family, and community members. Nonetheless, women were not passive, adopting a range of strategies to cope with or end the violence, including leaving their home for one or more nights, leaving their partner, retaliating, and trying to find help. These patterns of help-seeking appeared to be strongly influenced by the severity of the violence that the women experienced. Women who had suffered severe physical violence were more likely than women who had experienced solely moderate physical violence to have spoken to someone about the violence, to have left their home for one or more nights, or to have sought help.

Importance of informal networks

The findings illustrate that women mainly seek help from informal sources, such as family, friends and neighbours, although the nature of these informal sources may vary by culture. The relative ease of talking to family and friends also varies by culture and site. Even if a woman did not seek help from her immediate social networks, in some cases friends, family, or neighbours tried to help without being asked.

Qualitative research suggests that, although some forms of intervention by friends and family members may be positive, there are also many examples where the people that women turn to are either ambivalent or negative. For example, family members may condone the man's violence, or seek strategies to address the violence that prioritize the well-being of the family unit over the woman's safety.

Availability of services

The limited use of formal services in all countries partly reflects the limited availability of services in many settings. Other issues may include: costs or other barriers to women travelling; the perception that services will not be sympathetic or able to help; and women's fear of the potential consequences to their own and their children's safety if they report violence to formal agencies.

Where services are available, they are often used by women experiencing violence. Nevertheless, this varies by site. Even where services exist, many women may not be aware of them. The frequency of responses such as "nobody will believe me" or "they will not be able to help" highlights the credibility gap of many services. These attitudes underline the need for a more substantive and appropriate response by a range of services, particularly health and police, which were the most commonly used services.

Strengths and limitations of the Study

The WHO Study findings on the association between violence by an intimate partner and health outcomes largely substantiate associations reported previously. However, although the findings are extremely consistent and robust, several limitations of the Study should be mentioned.

First, the cross-sectional design does not permit proof of causality between violence by an intimate partner and health problems or other outcomes. Nevertheless, the findings give an indication of the types of association, and the extent to which different associations are found in each of the participating countries and sites. Moreover, the data meet several other standards for causality, including the strength of the association, the consistency of the association, the plausibility of the effect, and a strong "dose-response" relationship between severity of violence and its apparent effect on health. Future analysis will explore the temporality of the effect (i.e. the extent to which exposure to violence can be shown to precede the negative health outcomes), as well as causal pathways.

Second, like any study based on self-reporting, there may be recall bias on some issues, as well as cultural biases in disclosure. The WHO Study nevertheless took a number of extra measures to ensure maximum comparability, particularly in the sites that were part of the first round of the Study (with the exception of Japan). Moreover, recall bias would tend to dilute any association between violence and health outcomes, rather than overestimate the relationship. While cultural biases that affect disclosure will always remain, the methodology used in the Study considerably enhanced frequency of disclosure and quality of data.

Third, the sample was restricted to a maximum of two sites per country. This was a

deliberate decision of the WHO Study team, as it allowed for more in-depth exploration of risk and protective factors while providing representative data. Sites were chosen carefully to be representative of a highly urbanized setting (the capital or another big city) and a province with a mix of rural and urban populations.

Fourth, it is possible that the decision to select only one woman per household could introduce bias by underrepresenting women from households with more than one woman. This possibility was tested by weighting the main prevalence outcomes to compensate for differences in number of eligible women per household. The results showed that the differences in selection probability did not significantly affect the outcomes in any of the study sites.

Finally, while some qualitative data are available to support the interpretation of the quantitative findings, these data are limited. Some issues would benefit from further exploration with qualitative studies.

Despite these limitations, the WHO Study's use of a comparable and robust methodology across countries substantially reduces one of the major difficulties that has plagued earlier work on violence against women. In particular, it reduced the role that differences in sample, operational definitions (of violence, eligible women, partnership status), questions used, denominators and methods might play in explaining differences in prevalence.

Special strengths of the Study methodology include the use of rigorous interviewer training, which has been shown to contribute to disclosure (I). The participatory method used in the development of the protocol and the questionnaire, the involvement of women's organizations in the research teams, and the emphasis on ethical and safety concerns also contributed to the quality of the data and to the effective implementation of the Study. The methodology and, in particular, the ethical and safety procedures are increasingly being recognized as the standard for research in this field.

Another important strength of the WHO Study was its link to the policy process. This was achieved through the involvement of members of the research team in policy-making bodies on violence or violence against women. The use in each country of steering committees involving key stakeholders, also ensured a wider ownership and interest in the study results at the country level.

Areas for further analysis

This first report provides descriptive information on some of the main elements addressed by the WHO Study. However, it represents only the first stage of analysis of an extensive database which has the potential to address a range of important questions regarding violence against women. These questions are of great relevance to public health, and exploring them will substantially improve our understanding of the nature, causes and consequences of violence, and the best ways to intervene against it. Some of these are described below.

Risk profiles for partner violence

The WHO Study collected information about the timing of physical or sexual violence by an intimate partner – when it first started, when it last occurred, its frequency in the previous year, and its frequency prior to the previous year. These data can be used to compare information about the timing of different forms of violence with the timing of the start and end of the relationship or marriage. This will enable analysis of the extent to which different forms of violence occur during relationships, or after separation, and to understand how women's risk of intimate-partner violence changes over the duration of a relationship. Such information can be used to inform the design and provision of prevention and support services.

Determinants of prevalence: risk and protective factors

Future analyses will explore in more depth the determinants and outcomes of partner violence. In particular, substantial in-depth analysis will be conducted to explore the extent to which different risk and protective factors, acting at the individual, household, and community levels, contribute to or reduce women's risk of violence. Although complex, this analysis is likely to provide important insights to help guide future prevention and other public health interventions.

Logistic regression and multilevel analysis will be used to take into account potential confounding factors at individual and community levels, and will serve to identify factors that are context-specific and those that span all or most contexts. For example, future work will include an analysis of how women's socioeconomic status (not just income, but also assets, and control over her income and assets) is related to violence by an intimate partner and to women's responses to the violence.

Definitions and prevalence of emotional abuse

Because of the complexity of defining and measuring emotional abuse in a way that is relevant and meaningful across cultures, the questions regarding emotional violence and controlling behaviour in the WHO Study questionnaire should be considered as a starting point, rather than a comprehensive measure of all forms of emotional abuse. Prevalence of emotional abuse, therefore, was not included in this report as this dimension requires further analysis. Future work on the emotional dimension of intimate-partner violence will include an analysis of its overlap with the other two dimensions – physical and sexual – as well as with controlling behaviours. The data from this Study will enable identification across countries of other aspects of emotional abuse such as jealousy, humiliation or isolation.

In-depth analysis of relationship between violence and health

Another critical element for further research will be a more in-depth analysis of the association between several of the main health outcomes and different types of exposure to partner violence, adjusting for the frequency and severity of previous victimization during childhood and a wider range of potential confounding factors. The relationship between emotional abuse and different health outcomes will also be explored.

Future analysis of the WHO Study data will also explore whether the associations found between sexual abuse of girls below the age of 15 years and other outcomes in the literature hold true in the study sites, including whether early sexual abuse is associated with increased risk of re-victimization in adulthood, earlier sexual debut, early marriage, unwanted or mistimed pregnancies, suicide ideation, and number of lifetime sexual partners.

Patterns of women's responses

The literature has established that it may take many years for a woman to recognize, question, and eventually leave a violent relationship. Seeking help, retaliating, and leaving are some of the steps in this process, and a first descriptive analysis of these is presented in this report. A next step for analysis would be to look at patterns of women's responses according to severity of violence, and to explore other determinants of leaving and of help-seeking from formal services.

Other consequences of violence against women

Further analysis will be done on the impact of violence on aspects of women's lives – other than the health indicators presented in this report. Examples include women's ability to work outside the home and to control their assets. In addition, the WHO Study has collected information on how often and with what consequences children witness violence by their mother's intimate partner. Such information will be of relevance to interventions for children who witness violence in their homes.

A basis for action

The WHO Study findings confirm the pervasiveness and magnitude of violence against women in a wide range of cultural and geographical contexts, and provide information on the nature of the problem. This is an essential first step in addressing any public health problem. The uniqueness of the Study will become even more evident when the multilevel analysis of risk and protective factors is complete. This will provide valuable insight into the role of different factors in determining prevalence and help identify what is universal, and what is cultural and context-specific.

For researchers, the WHO Study is important because it provides population-based data from developing countries, links different types of violence to a broad range of health outcomes, and uses standard measures for violence and health outcomes across cultural settings. Its coverage of physical, sexual and emotional violence by an intimate partner, as well as measures of previous victimization, allow for a more in-depth understanding of what determines the health outcomes.

Most importantly, the Study provides participating countries with vital information on which to base public health interventions. By and large, these countries had little or no reliable data on the extent of the problem before the WHO Study began. With this information now available, the need for action is clear. The following chapter provides a number of practical recommendations to guide this action.

References

1. Jansen HAFM et al. Interviewer training in the WHO Multi-country Study on Women's Health and Domestic Violence. *Violence Against Women*, 2004, 10:831–849.

The results of the WHO Multi-country Study on Women's Health and Domestic Violence against Women highlight the need for urgent action by a wide range of actors, from local health authorities and community leaders to national governments and international donors.

As the Study clearly demonstrates, violence against women is widespread and deeply ingrained, and has serious impacts on women's health and well-being. Its continued existence is morally indefensible; its cost to individuals, to health systems, and to society in general is enormous. Yet no other major problem of public health has – until relatively recently – been so widely ignored and so little understood.

The wide variations in prevalence and patterns of violence from country to country, and even more important, from setting to setting within countries, indicate that there is nothing “natural” or inevitable about it. Attitudes can and must change; the status of women can and must be improved; men and women can and must be convinced that partner violence is not an acceptable part of human relationships.

The following recommendations are drawn primarily from the findings of the Study, but are also informed by research and lessons learned from experience in many countries. In particular they reinforce the findings and recommendations presented in WHO's *World report on violence and health* (1), specially the detailed recommendations in Chapters 4 (Violence by intimate partners) and 6 (Sexual violence). See Box 11.1 for a list of selected WHO materials on violence and health.

The recommendations are grouped into the following categories:

- Strengthening national commitment and action
- Promoting primary prevention
- Involving the education sector
- Strengthening the health sector response
- Supporting women living with violence
- Sensitizing criminal justice systems
- Supporting research and collaboration

Addressing and preventing violence against women requires action at many levels and by many actors and sectors. However, it is important that states take responsibility for the safety and well-being of their citizens. In this regard, national governments, in collaboration with NGOs, international organizations and donors, need to give priority to implementing the following recommendations:

Strengthening national commitment and action

Recommendation 1.

Promote gender equality and women's human rights, and compliance with international agreements

Violence against women is an extreme manifestation of gender inequality that needs to be addressed urgently, as such violence in turn perpetuates this inequality. The unequal status of women is also associated in a variety of ways with domestic violence and with women's responses to that violence. Improving women's legal and socioeconomic status is likely to be, in the long term, a key intervention in reducing women's vulnerability to violence.

In line with the Millennium Development Goal 3 of promoting gender equality and empowering women, it is crucial that governments increase their efforts to raise the status of women, both in terms of awareness of their rights, and

through concrete measures in fields such as employment, education, political participation, and legal rights. These rights include those related to owning and disposing of property and assets, access to divorce, and child custody following separation.

The association of more education with less violence supports the view that education is in itself protective. Therefore, programming arising from the United Nations Millennium Development Goals and “Education for All” objectives, particularly those aimed at improving women's access to education and, in particular, keeping girls enrolled through secondary education, should be strongly supported as part of overall anti-violence efforts.

National efforts to challenge the widespread tolerance and acceptance of many forms of violence against women are also important. One of the salient findings of the Study is the association between the prevalence of intimate-partner violence and women's belief that such violence is “normal” or “justified”. The association is particularly marked in rural and more traditional societies, suggesting that attitudes and assumptions about the status of women, deeply ingrained in culture as well as law, are key factors contributing to high levels of violence, and therefore need to be addressed.

Considerable progress would be realized if governments complied with human rights treaties and other international consensus documents that they have already ratified. Since the 1950s, most national governments have signed and ratified a number of important international documents that condemn violence against women and promote their human rights. These include the Universal Declaration of Human Rights (1948), the Convention on the Elimination of All Forms of Discrimination against Women (1979), and the United Nations Declaration on the Elimination of Violence against Women (1993). Most countries have endorsed international commitments on development and women's human rights and health in documents such as the 1994 Programme of Action of the International Conference on Population and Development (ICPD) (2), the 1995 Declaration and Platform for Action of the Fourth World Conference on Women (1995 – the “Beijing Declaration”) (3), and the 2000 Millennium Development Goals (4). These agreements were reiterated at the 5- and 10-year anniversaries of the respective conferences.

While some governments have made strides in harmonizing their legislation with these commitments and in instituting policies and programmes to promote them, many others have

made little or no progress. Frequently the greatest obstacle is political inertia or outright opposition. It is important, therefore, that institutions, nongovernmental organizations, and civil society organizations – both domestic and international – that advocate for gender equality and human rights, or that monitor national progress towards international commitments, strengthen their efforts to bring about the necessary changes in national laws, policies and programming.

Recommendation 2.

Establish, implement and monitor multisectoral action plans to address violence against women.

National governments are ultimately responsible for the safety and health of their citizens, and it is therefore crucial that governments commit themselves to reducing violence against women, which is a major and preventable public health problem. Violence by an intimate partner was found to be the most prevalent form of violence against women in virtually all of the countries studied, and is likely to be the main form of violence in other non-conflict settings thereby requiring special attention in plans of action to address violence. The Study findings also illustrate the degree to which intimate-partner violence puts women at increased risk of poor physical, sexual, reproductive, and mental health. In both industrialized and developing countries, the prevention of violence against women should rank high on national public health, social, and legal agendas.

National action first requires that governments publicly acknowledge that the problem exists. It is hoped that this Study, in combination with the accumulating evidence on the issue from other research, provides ample grounds for this recognition. Second, governments must make a commitment to act, and plan and implement national programmes both to avert future violence and to respond to it when it occurs. This will require that governments, where necessary supported by international agencies, invest significant resources in programmes to address violence against women.

Countries that are devising national action plans for violence prevention – a key recommendation in the *World report on violence and health* (1) – should give high priority within them to preventing violence against women and particularly intimate-partner violence.

In most countries around the world, there are women's organizations that work to challenge violence against women and to provide support to women experiencing abuse. In some places,

“Countries should take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and children.” (ICPD Programme of Action, paragraph 4.9).

Governments need to “...work actively to ratify and/or implement international human rights norms and instruments as they relate to violence against women, ..., formulate and implement plans of action to eliminate violence against women, ..., allocate adequate resources within the government budget and mobilize community resources for activities related to the elimination of violence against women....” (Beijing Platform for Action, paragraphs 124 e, j, and p).

there are also men's organizations working to combat violence against women. In many countries, however, the issue is not on the national agenda in a significant way. National efforts often focus initially on legal and judicial reform; less attention has been paid to violence as a risk factor for ill-health, and the potential role of the health sector. For violence to get on to the national policy and health sector agendas, it is important that the problem is brought out of the shadows, the evidence discussed openly, and commitments made to deal actively with violence against women – and particularly intimate-partner violence and sexual abuse of children – as a national priority.

Recognizing violence against women as a public health problem does not mean that the health sector can be expected to deal with it alone. As experience with other complex public health problems has shown, multisectoral action is required, with the health sector playing an important role. Reducing violence against women will take concerted and coordinated action by a range of different sectors (e.g. health and social services, religious organizations, the judiciary and police, trade unions and businesses, and the media), each wielding their comparative advantages and expertise. Not all sectors will be equally able or amenable to addressing the problem, so it is important that a formal mechanism is created and provided with sufficient resources to coordinate multisectoral efforts. The form this takes (a national committee, a task force, a focal point within a key ministry, or other) will vary, but experience suggests that identification with the highest level of political office is crucial.

Recommendation 3.

Enlist social, political, religious, and other leaders in speaking out against violence against women.

In many settings, violence against women is trivialized, and some forms of violence are seen as an acceptable or inevitable component of social relationships. People – particularly men – in positions of authority and influence (e.g. political, religious, and traditional leaders) can play an important role in raising awareness about the problem of violence against women, challenging commonly held misconceptions and norms, and shaping the discussion in ways that promote positive change. In many places, women politicians may be the natural champions of anti-violence efforts, while in others, male religious, political, or business and labour authorities may play leading roles. However, the fact that violence

against women is widespread and deeply ingrained suggests that coordinated action by coalitions or alliances of figures from different sectors may be a more effective approach than identifying the issue with a single figure or sector.

Recommendation 4.

Enhance capacity for data collection to monitor violence against women, and the attitudes and beliefs that perpetuate it.

Surveillance is a critical element of a public health approach as it allows trends to be monitored and the impact of interventions to be assessed. Responsibility for such surveillance should be explicitly given to an institution, agency, or government unit in order to ensure the use of a standardized methodology and the establishment of mechanisms to guarantee that data will be disseminated and used properly.

Discussions are being held internationally about how best to monitor violence against women, using both regular surveys and routine data collection in different service points (5). In this regard, the WHO questionnaire and the ethical and safety guidelines developed for the Study, and the WHO/PATH manual on researching violence against women (6), are useful tools. The *Injury surveillance guidelines*, jointly developed by WHO and CDC, are also useful tools for collecting systematic data on injuries, including those relating to intimate-partner violence (7). It is of prime importance for national statistics offices and relevant ministries (such as ministries of health and justice) to take this issue on board. Organizations that provide services for abused women should also increase their capacity for routine data collection and surveillance of violence against women, and for monitoring the attitudes and beliefs that perpetuate the practice. Priority must be given to building capacity, and to ensure that data are collected in a way that respects confidentiality and does not jeopardize women's safety (5).

Promoting primary prevention

Recommendation 5.

Develop, implement and evaluate programmes aimed at primary prevention of intimate-partner violence and sexual violence.

Preventing partner violence requires changing the gender-related attitudes, beliefs, and values of both women and men, at a societal as well

as at an individual level. Prevention efforts should therefore include multimedia and other public awareness activities to challenge women's subordination, and to counter the attitudes, beliefs and values – particularly among men – that condone male partner violence against women as normal and prevent it being challenged or talked about.

As the Study results indicate, there is great variation between and within countries in attitudes, beliefs, and values related to partner violence. For this reason, the specific media and key messages chosen will vary from place to place, and should be based on research and consultation. In formulating key messages for campaigns aimed at changing social norms, an important objective is to eliminate the barriers that prevent women talking about the problem and using available support services. This means not only increasing the accessibility of such services, but also reducing the stigma, shame, and denial around partner violence. These messages can also play a role in strengthening informal support networks by encouraging family and community members to reach out to and support women living with violence.

Special efforts should be made to reach men. Media strategies that encourage men who are not violent to speak out against violence and challenge its acceptability will help counter notions that all men condone violence. They also serve to provide alternative role models of masculine behaviour to those commonly portrayed by the media.

Public health experience shows that general public awareness campaigns may have little effect by themselves, and must be accompanied by focused outreach and structural change. More targeted efforts should be carried out in health settings, in schools, at workplaces and places of worship, and within different professions and sectors. More awareness will also serve to strengthen advocacy efforts, and to shape budgets and policies on violence against women.

As well as mass communication strategies, other options should be explored including community-based approaches (e.g. legal literacy programmes, HIV/AIDS community mobilization, local media initiatives) and activities to target specific risk factors for violence, such as alcohol use. In particular, communities need to be encouraged to talk about partner violence and its implications, and to challenge its acceptability. Local religious congregations, cultural groups and economic associations (such as associations of market women) may provide the basis for support activities and for advocacy with government

authorities.¹ Overall there is a need to strengthen the primary prevention efforts to complement the current emphasis on victim services.

Recommendation 6.

Prioritize the prevention of child sexual abuse.

The high levels of sexual abuse experienced by girls documented by the Study are of great concern. Such acts are severe violations of a young girl's basic rights and bodily integrity, and may have profound health consequences for her, both immediately and in the long term. Efforts to combat sexual abuse of girls (and boys) therefore, should have higher priority in public health planning and programming, as well as in responses by other sectors such as the judiciary, education and social services.

Greater public awareness of child sexual abuse is necessary; yet promoting such awareness may be extremely difficult because of the sensitivity of the subject. Advocacy by leaders and other respected figures could make a big difference. As with HIV and other stigmatized issues, leadership at the highest level can help "break the silence" and create social space for discussion of the problem within families and communities (see recommendation 3).

As part of a coordinated response, the health and education sectors need to develop the capacity to identify and deal with child sexual abuse. Health workers need training to recognize the behavioural and clinical symptoms of such abuse, and protocols should be developed on what to do if they suspect a child is being abused. Training and resources are also necessary for health care systems to provide physical and psychological care to girls (and boys) who have experienced sexual abuse.

Similarly, teachers and other education professionals need training to recognize the symptoms, as well as protocols and policies for referral to medical or social services. Schools should also provide preventive programmes and counselling wherever possible.

Recommendation 7.

Integrate responses to violence against women into existing programmes such as for the prevention of HIV and AIDS and for the promotion of adolescent health.

The Study findings illustrate the high levels of sexual violence against women and girls and support other research which suggests that violence contributes to women's vulnerability to HIV infection. Current emphasis on HIV prevention, and initiatives such as the Global

¹ WHO's Global Campaign for Violence Prevention aims to raise awareness about the problem of violence, highlight the crucial role that public health can play in addressing its causes and consequences; and encourage action at every level of society. For more information please see http://www.who.int/violence_injury_prevention/violence/en/

²The Global Coalition on Women and AIDS is a worldwide network working together to catalyse changes to make the AIDS response work better for women (see <http://womenandaids.unaids.org>).

Coalition on Women and AIDS,² provide opportunities to strengthen efforts to combat violence against women. This should be seen as a component of effective HIV and AIDS prevention programmes. HIV prevention programmes should therefore include activities to raise awareness and promote the prevention of sexual violence as well as intimate-partner violence. Programmes that aim to improve communication about sex and to promote abstinence, fewer partners and condom use, in particular, need to recognize the extent to which sexual activity is forced or coerced, and explicitly address issues of genuine, freely-given consent and coercion. The unacceptability of violence against women should be integrated and addressed within HIV prevention efforts at all levels, from national AIDS committees to local community groups, and in HIV-related media and educational activities. Strategies to respond to women who are experiencing or who fear violence and who are attending HIV counselling and testing services, and women-oriented health programmes, such as prevention of mother-to-child transmission of HIV and other sexually transmitted infections, or family planning, need to be developed. Other sexual and reproductive health programmes, as well as those focused on promoting adolescent health also need to address intimate-partner violence and issues of coercion and forced sex.

Recommendation 8.

Make physical environments safer for women.

The Study finding that violence by strangers is generally more prevalent in cities than in rural settings suggests that measures to make the urban environment safer for women can contribute to primary prevention of this violence. It is also important to identify such measures in rural areas where women may be at risk of violence as they carry out household survival tasks such as fetching water and firewood for cooking. Such measures should be implemented systematically, first by identifying places where violence against women often occurs and then by analysing why it occurs there.

Depending on the risk factors identified and the available resources, safety can be enhanced through a variety of concrete measures. These include improving lighting and, in urban areas, increasing police and other vigilance, particularly in areas where alcohol or other drugs are consumed, and opening up “blind spots” where an assault could take place without anyone being able to see or hear it happening.

Involving the education sector

Recommendation 9.

Make schools safe for girls.

The finding that young women and girls experience significant levels of violence indicates that primary and secondary school systems should be heavily involved in making schools safe, including eradicating teacher violence, as well as engaging in broader anti-violence efforts.

Schools must be places of safety for girls and young women. The Study's finding on the extent of violence by teachers revealed variations among the participating countries. However there is room for improvement in action to eradicate physical and sexual violence by teachers against students, in virtually all countries and schools. In some cases an effective response to violence by teachers requires fundamental changes within the education sector; to change traditional patterns of behaviour; condemn abuse and establish a culture in which violence is not condoned or tolerated, and perpetrators of violence are punished. International initiatives, such as the Focusing Resources on Effective School Health (FRESH) initiated by UNESCO, UNICEF, WHO, the World Bank, Education International, Education Development Center, and the Partnership for Child Development can provide frameworks for action to meet this objective.

For example, schools using the FRESH framework would influence violence through their policies, environment and curricula. School policies can prohibit the use of violence as a form of punishment. They can also prohibit physical violence and harassment by and between teachers and students. Enforcement of such policies should be monitored. Skills-based education, such as life skills supported by WHO, UNICEF and UNESCO is an effective way to enable students and staff to reduce potential conflicts, and to get involved in community actions to reduce violence and promote non-violent behaviour. School health programmes, such as HIV prevention programmes and reproductive health programmes (particularly those targeting sexually transmitted infections and unwanted pregnancies among adolescents) should address issues of gender, power, and consent. They should enable boys and girls to develop relationship and conflict resolution skills, and to identify strategies to reduce the occurrence of violence.

To be effective, programmes should begin early, involve both girls and boys (although probably using different information and key messages, and with a balance of single-sex

and mixed-sex discussions), and apply age-appropriate learning experiences throughout children's school careers. Such programmes must also be supported by relevant school policies, a supportive school environment, and school health services or referrals to care for and counsel victims and witnesses of violent incidents and harassment.

Strengthening the health sector response

Recommendation 10.

Develop a comprehensive health sector response to the various impacts of violence against women.

Developing a comprehensive health sector response to the various impacts of violence against women is of critical importance and action by specific health care services is also needed. In particular, it is important to address the demonstrated reluctance of abused women to seek help.

The Study clearly shows that, in all countries, violence against women is significantly associated with a range of poor health outcomes. It is not only a significant risk factor through its direct impact on health (namely, injury and mortality), but contributes to the overall burden of disease through its impact on women's reproductive, sexual, physical, and mental health. This has serious implications for the health sector; as many health providers see and treat (knowingly or not) millions of women living in violent relationships.

The health sector – not just public health but all providers of health services – needs to develop a comprehensive response to the problem. At the planning level, this will require health officials to identify the sector's particular strengths in the wider multisectoral response. In some places, the health sector may take the lead role in advocating for prevention; in others it may leave that role to other sectors while concentrating on establishing or enhancing services for women who have experienced violence. At the service level, responses to violence against women should be integrated into all areas of care (e.g. emergency services, reproductive health services such as antenatal care, family planning, and post-abortion care, mental health services, and HIV/AIDS-related services).

The Study findings clearly demonstrate the strong association between a woman's experience of violence and mental distress, including her risk of suicide. It is necessary to improve access to non-stigmatizing mental health

services for women that adequately recognize the associations between violence and mental health, in particular with depression and suicide ideation. These services need to contribute to empowering women in situations of violence, and to avoid over-medicalizing the problem.

Health providers who see and care for abused women will need to coordinate and work with other sectors, particularly the police, social services and the voluntary sector. This should not be done on an ad hoc basis, but will require the creation of formal referral procedures and protocols.

The Study amply shows that most abused women are reluctant to seek help from health providers, and tend to do so only if the violence is severe. This suggests that, in addition to more general awareness-raising, the health sector needs to find ways to ensure that: (a) women who have experienced violence are not stigmatized or blamed when they seek help from health institutions, (b) women will receive appropriate medical attention and other assistance, and (c) confidentiality and their security will be ensured. The Study findings highlight the extent to which the attitudes of health staff are likely to influence whether women feel comfortable about disclosing violence or not. Training is a critical element in improving the health service response to violence against women. It should aim, among other things, to ensure that providers are appropriately sensitized to issues of abuse, treat women with respect, maintain confidentiality, and do not reinforce women's feelings of stigma or self-blame, as well as being able to provide appropriate care and referral as needed.

Recommendation 11.

Use the potential of reproductive health services as entry points for identifying women in abusive relationships, and for delivering referral and support services.

The widespread availability and use of reproductive health services (including antenatal care, family planning services, and services dealing with sexually transmitted infections) in most countries give these services a potential advantage for identifying women in abusive relationships and offering them referrals or support services. This conclusion is reinforced by Study results showing that (a) severe physical violence during pregnancy is not uncommon, threatening both the mother and the unborn child, and (b) there are significant associations between physical and sexual violence by partners, and miscarriage and induced abortion, as well as with high parity and HIV risk. Providers of reproductive health services therefore may

be more likely than other health providers to see abused women. Moreover, unless providers are aware of and willing to address violence and coercion, they will be unable to promote women's sexual and reproductive health effectively.

Reproductive health care providers should be sensitized and trained to recognize and respond to violence particularly during and after pregnancy. Protocols and referral systems need to be put in place to ensure that appropriate care, follow up and support services are available. In settings where resources are limited and referral is not possible, as a minimum staff should be aware of the problem and should provide information about legal and counselling options as well as supportive messages emphasizing that such violence is wrong, that women are not to blame for it and that it is a widespread problem. In places where antenatal services involve male partners in parenting classes and similar activities, adding an anti-violence component to such activities may be an avenue for attempting to change male attitudes and prevent violence.

Whatever care is offered, reproductive health services should be places of safety and confidentiality for women.

Supporting women living with violence

Recommendation 12.

Strengthen formal and informal support systems for women living with violence.

Only a minority of women in the Study sought help and support from formal support services or institutions (e.g. social workers, counsellors, shelters). This reflects many factors, one of the most important being simply the lack of such services, particularly in rural areas. In addition, many women had little confidence that existing services and authorities would listen with sensitivity or impartiality, or could make any difference to their situation. This highlights the need for better and more accessible support services where women can safely disclose their experience of violence.

While formal services offered by health or justice-related institutions should be expanded or improved, other models of service provision should also be explored. Such models should build on the existing sources of informal support to which women often turn. They could include sensitizing religious leaders and other respected local persons to the problem, and encouraging them to become involved in providing support, and even temporary refuge for abused women. If the involvement of these people can be secured, efforts should

be made to train and orient them and their organizations, on the issues involved, including the gendered and stigmatized nature of the problem, procedural matters such as confidentiality, and the complexities of responding to partner violence (e.g. the fact that a woman may need support over a long period of time before she is able to make a definitive change to her situation).

The Study findings show that, in all settings, abused women are most likely to seek help from informal networks of friends, relatives and neighbours. This suggests the value of strengthening these informal networks so that when women do reach out to friends and family, they are better able to respond in a sympathetic and supportive manner. Media activities highlighting the extent of violence and promoting the role of friends, neighbours and relatives, as well as interventions to reduce the social stigma around violence, may all help to reinforce constructive responses.

Sensitizing criminal justice systems

Recommendation 13.

Sensitize legal and justice systems to the particular needs of women victims of violence.

The Study showed that, as with health services, many women in violent partnerships do not seek help from courts for the violence. This suggests that all those in the criminal justice systems (police, investigators, medico-legal staff, lawyers, judges, etc.) should be trained and sensitized to consider and address the particular needs and priorities of abused women, particularly those faced with violence by a partner or ex-partner. Those investigating allegations of violence against women should be trained in using medico-legal evidence gathering techniques, particularly in allegations of rape and sexual assault, in a non-judgemental and respectful manner. Gathering this evidence should be part of a comprehensive package of care, including counselling and relevant treatment.

Criminal justice systems as a whole need to be assessed comprehensively to ensure that women seeking justice and protection are treated appropriately and professionally. Those administering the criminal justice system, especially police, should not undermine women complainants by taking the side of the perpetrator (e.g. suggesting that the woman is somehow at fault), or by disbelieving or denigrating complainants (e.g. by suggesting that women were in fact consenting to forced sex). Ideally there should be support for women bringing complaints:

keeping them informed of the progress of cases, the requirements of their participation, that their safety as witnesses is protected, and that there is a comprehensive approach to assist them generally. Furthermore, those convicted need to be appropriately punished.

Laws on assault often assume that perpetrator and victim do not know each other; a pattern that applies less often when considering violence against women. Women may retain bonds of affection towards a partner despite his violence, and imprisoning the partner may jeopardize the livelihood of the woman and her children. A coordinated approach between the criminal justice system and appropriate civil law protection, for example, orders a man to stay away from a partner who has experienced violence, is necessary to ensure that women's safety is paramount. The potential for intimidation by a male partner must be addressed, and sentencing should be adapted to the specific circumstances in which the woman lives and her own wishes. Flexible sentencing or alternative sanctions should be explored, where possible, to deter further violence.

Supporting research and collaboration

Recommendation 14.

Support research on the causes, consequences, and costs of violence against women and on effective prevention measures.

While the prevalence and patterns of violence are becoming better known in some places – in part through this Study – in others few data are available. More research on the magnitude of the problem of violence against women, and its costs, in given countries or settings is therefore urgently needed in order to provide a basis for advocacy and action. At the same time, because violence against women is clearly related to culturally rooted attitudes and beliefs, more research needs to be carried out on the causes of violence against women in different cultures and in different circumstances. Such research should aim to deepen understanding of both the risk and protective factors related to violence, focusing particularly on identifying key factors that are potentially amenable to intervention. Ensuring the further analysis of the existing database established by this Study will contribute greatly to understanding the determinants of the different patterns of violence both within and between countries and sites, and should be supported.

To date, little research has been done on

the male attitudes and beliefs that contribute to partner violence. This needs to be remedied if a comprehensive understanding of the problem is to be achieved. Longitudinal research is also needed on the evolution of violent behaviour by intimate partners over time, examining whether and how it differs from the development of other violent behaviours.

Research aimed at informing the design and delivery of interventions where these do not exist needs to be accompanied by evaluation research on the short- and long-term effects of programmes to prevent and respond to partner violence – including school-based programmes, legal and policy changes, services for victims of violence, programmes that target perpetrators of violence, and campaigns to change social norms. In this regard, the WHO *Handbook for the documentation of interpersonal violence prevention programmes* (8) provides useful guidance for the systematic collection, from diverse settings, of information on programmes for the prevention of interpersonal violence. Ultimately, the aim is to identify successful and promising interventions, and publicize the results to promote the scaling up of such efforts.

Recommendation 15.

Increase support to programmes to reduce and respond to violence against women.

While many of the measures called for in these recommendations are relatively inexpensive, resource-poor countries are struggling to maintain their public health systems and social services. New activities and programmes targeting violence against women will have to compete for funding with a variety of urgent priorities for national governments. Even if political commitment is present, it may be difficult to translate this commitment into action without additional funding. International donors, development agencies, and nongovernmental organizations should therefore be prepared to provide financial and technical support for concrete, well-designed proposals by national governments and development counterparts (in particular, women's organizations) that aim to prevent violence against women, provide services to women who have been abused, or reduce gender inequality. In addition, there is substantial scope for integrating prevention and responses to violence against women into existing health and development programmes, including HIV prevention, adolescent health, and sexual and reproductive health initiatives.

Donors and international organizations need to support the efforts of academic institutions,

research bodies and governments to carry out research on this issue and foster increased collaboration across countries and regions. This increased collaboration and information exchange on successful and promising interventions between the different sectors, countries, and regions will help to build a stronger body of

knowledge to inform action in this area.

The ultimate challenge is to prevent and eventually eliminate all forms of violence, including violence against women. The immediate task is to support and offer choices to those living in violent situations or who have suffered any form of violence.

Box 11.1 Selected WHO materials related to violence and health

- Krug EG et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002 (<http://whqlibdoc.who.int/hq/2002/9241545615.pdf>, accessed 2 September 2005).
- *Addressing violence against women and achieving the Millenium Development Goals*. Geneva, World Health Organization, 2005.
- *Clinical management of survivors of rape: a guide to the development of protocols for use in refugee and internally displaced person situations*. Geneva, World Health Organization/Office of the United Nations High Commissioner for Refugees, 2002 (WHO/RHR/02.08; http://whqlibdoc.who.int/hq/2002/WHO_RHR_02.08.pdf, accessed 2 September 2005).
- Ellsberg MC, Heise L. *Researching violence against women: a practical guide for researchers and activists*. Washington, DC, PATH/Geneva, World Health Organization, in press.
- *Guidelines for medico-legal care of victims of sexual violence*. Geneva, World Health Organization, 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>, accessed 2 September 2005).
- *Intimate partner violence and HIV/AIDS*. Geneva, World Health Organization, 2004 (Critical Intersections Information Bulletin Series, No. 1; <http://whqlibdoc.who.int/unaid/2004/a85591.pdf>, accessed 2 September 2005).
- *Preventing violence: a guide to implementing the recommendations of the World report on violence and health*. Geneva, World Health Organization, 2004 (<http://whqlibdoc.who.int/publications/2004/9241592079.pdf>, accessed 2 September 2005).
- *Putting women first: ethical and safety guidelines for research on domestic violence against women*. Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.1; http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.1.pdf, accessed 2 September 2005).
- Sethi D et al. *Handbook for the documentation of interpersonal violence prevention programmes*. Geneva, World Health Organization, 2004 (<http://whqlibdoc.who.int/publications/2004/9241546395.pdf>, accessed 2 September 2005).
- *Violence against women and HIV/AIDS: setting the research agenda*. Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.08; http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.08.pdf, accessed 2 September 2005).

For further information, please visit the web sites of the following WHO departments:

- Gender, Women and Health (<http://www.who.int/gender/>)
- Injuries and Violence Prevention (http://www.who.int/violence_injury_prevention/).

References

1. Krug EG et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002. See, in particular; Chapter 4, Heise L, Garcia-Moreno C. Violence by intimate partners; and Chapter 6, Jewkes R, Sen P, Garcia-Moreno C. Sexual violence.

2. *International Conference on Population and Development, Cairo, Egypt, 5–13 September 1994*. New York, NY, United Nations, 1994 (document A/CONF.171/13).

3. *Fourth World Conference on Women, Beijing, China, 4–15 September 1995*. New York, NY, United Nations, 1995 (document A/CONF.177/20).

4. *United Nations Millennium Declaration*. General Assembly Resolution, 55th session, document A/RES/55/2, Chapter III, number 11, September 2000.

5. *Violence against women: a statistical overview, challenges and gaps in data collection and methodology and approaches for overcoming them*. Expert group meeting, DAW, ECE and WHO. Geneva, 11–14 April, 2005. New York, Division for the Advancement of Women, 2005 (www.un.org/womenwatch/daw/egm/vaw-stat-2005).

6. Ellsberg MC, Heise L. *Researching violence against women: a practical guide for researchers and activists*. Washington, DC and Geneva, PATH/World Health Organization, in press.

7. Holder Y et al., eds. *Injury surveillance guidelines*. Atlanta, GA, Centers for Disease Control and Prevention, and Geneva, World Health Organization, 2001.

8. WHO. *Handbook for the documentation of interpersonal violence prevention programmes*. Geneva, World Health Organization, 2004.

Annexes