Executive Summary

This report presents findings from a national survey on violence against women and girls conducted by the Fiji Women's Crisis Centre (FWCC). The survey was undertaken in cooperation with the Fiji Islands Bureau of Statistics in 2011. It provides reliable data on the prevalence of physical, sexual, emotional and economic violence against women by husbands/intimate partners, and on physical and sexual assault of women and girls by others (non-partners), including rape, attempted rape and child sexual assault. It provides detailed information on the impacts of men's violence, including on women's physical, mental and reproductive health, women's work and ability to earn an income, their participation in organisations, and the short-term and long-term effects on children. It also provides data on women's attitudes to gender based violence and women's human rights, how women cope with violence, and the risk factors associated with gender based violence.

Methodology

FWCC replicated the survey approach developed by the World Health Organisation (WHO) for its *Multi-country Study on Women's Health and Domestic Violence Against Women* (Chapter 2 and Annex 2). The WHO questionnaire is a well-tested and validated instrument, based on extensive learning about ethical research on violence against women. The WHO methodology has been used in several other Pacific countries including Samoa, the Solomon Islands, Kiribati, Vanuatu and Tonga. Studies using the WHO approach are currently underway in several other countries including Nauru, the Federated States of Micronesia, Marshall Islands, Cook Islands, and Palau. The use of the WHO methodology has been recommended in order to enhance credibility, comparability and the sharing of experience and expertise in the region.

Technical assistance was provided by the Fiji Islands Bureau of Statistics (FBOS), including the design of the survey sample, training of interviewers and data processors, and monitoring of data processing. Random sampling techniques were used to select rural and urban enumeration areas in each Division, and to select households in each enumeration area. The sample was nationally representative and included enumeration areas from all provinces and major islands in each of Fiji's 4 Divisions. In each household, one woman was randomly selected to be interviewed, among all the women living in the household aged between 18 and 64.

The total number of households included in the sample was 3538. From these, 3389 household interviews were completed and 3193 interviews with individual women. This is a very high response rate. All members of the research team received 3 weeks training before the survey. WHO ethical and safety guidelines and quality control procedures were followed throughout the design and implementation of the study.

Summary of findings

Prevalence and nature of violence against women and girls

Violence by husbands and partners

Fiji's rates of violence against women and girls are among the very highest in the world: 64% of women who have ever been in an intimate relationship have experienced physical and/or sexual violence by a husband or intimate partner in their lifetime, and 24% are suffering from physical or sexual partner violence today. This includes 61% who were physically attacked and 34% who were sexually abused in their lifetime. Rates of emotional abuse are also high: 58% of ever-partnered women experienced emotional violence in their lifetime, and 29% in the previous 12 months before the survey. Overall, 72% of ever-partnered women experienced physical, sexual or emotional violence from their husband/partner in their lifetime, and many suffered from all 3 forms of abuse simultaneously (see Chapter 4).

In addition, 69% of women have been subjected to one or more forms of control by their husband or partner, and 28% were subjected to 4 or more types of control. For example, 39% of women (2 in 5) have to ask permission from their husbands before seeking health care for themselves and for 57% their husband or partner insists on knowing where they are at all times. Women living with intimate partner violence are also subjected to economic abuse: more than 1 in 4 ever-partnered women (28%) had husbands/partners who either took their savings or refused to give them money.

Some individuals, organisations and sections of the media continue to trivialise the problem and many people in Fiji believe that violence happens rarely, or that it is minor. These myths are exploded by the findings in this report, which describe a terrible reality for many women living with violence. This includes severe and repeated attacks akin to torture, coupled with humiliating emotional abuse and high levels of coercive control. The high proportion of women who have experienced very severe physical attacks is alarming: 44% or more than 2 in 5 ever-partnered women have been punched, kicked, dragged, beaten up, choked, burned, threatened with a weapon, or actually had a weapon used against them.

Fiji has an image of itself as a society that values family, children and community. Yet 15% of women have been beaten during pregnancy, and one-third of these were punched or kicked in the abdomen by their husband or partner. The global prevalence for physical and/or sexual intimate partner violence over a woman's lifetime is 30%, compared with 64% in Fiji.

The complex web of control, intimidation, humiliation and multiple forms of violence needs to be recognised by all service providers who aim to prevent violence and assist women living with violence. Coercive control by husbands and partners prevents women and girls from finding out about their legal and human rights and the services available to help them. It prevents them from reporting the violence to authorities and getting the help they need from health services and other agencies for their injuries and trauma. It also prevents women from telling their family and friends about the violence.

Physical and sexual violence against women and girls by non-partners

There are also high rates of non-partner violence against women and girls: overall, 31% were subjected to physical and/or sexual assault since the age of 15 by someone other than their husbands and partners. This includes 27% who were physically abused and 9% who were sexually abused. Among those who were sexually abused, 3.5% were raped and 6.8% were attempted rapes; some women have suffered from both rape and attempted rape since age 15. However the most prevalent form of sexual violence is child sexual abuse: 16% of all women were sexually abused when they were children under the age of 15 (see Chapter 5).

The majority of perpetrators of rape, attempted rape and child sexual assault were people known by their victims. The largest groups of perpetrators are male family members, boyfriends and male friends of the family. For those sexually abused over the age of 15, about 1 in 3 (30%-36%) were subjected to multiple attacks; for child sexual assault 2 in 5 (41%) were repeatedly abused. The majority of girls subjected to child sexual assault (95%) had one perpetrator, whereas 1 in 3 of those sexually abused over the age of 15 had more than one attacker (32% of those raped and 39% for attempted rapes). For physical assault over the age of 15, the major perpetrators were male family members and teachers, followed by female family members.

For 29% of women, their first sexual experience was either forced or coerced, including 5% who were forced and 24% who were coerced. All the findings on sexual assault are disturbing for their own sake, but also because sexual abuse and coercion are significant risk factors which increase the likelihood that a woman will also be subjected to intimate partner violence. Overall, 71% of women were subjected to physical and/or sexual violence by anyone in their lifetime – including partners and/or non-partners.

How women cope with the violence

Women show enormous resilience and strength in the face of repeated and serious violence and abuse. The findings demonstrate that they try to cope with the violence themselves before telling anyone about it. Only about half of the women living with violence (53%) have ever told anyone about it; when they do tell someone, they usually turn first to family members or friends. Forty percent (40%) of women who experienced violence have left home temporarily at least once due to the violence, but many have not disclosed the true reason for leaving. Only 24% have ever gone to an agency or formal authority for help, and the police and health services are usually the first agencies that women go to (see Chapter 10).

Given these findings, it is not surprising that almost 3 in 5 women (58%) believe that people outside the family should not intervene if a man mistreats his wife. These entrenched community attitudes are a serious disincentive to women disclosing violence and taking steps to deal with it (see Chapter 6).

When women do take the very difficult step of asking for help or leaving home, the evidence shows that the majority do so because the violence is extremely serious, they cannot endure any more, or because they are badly injured (see Chapter 10). Service-providers, traditional and church leaders, families and friends need to take note of these findings by not condoning, excusing or tolerating the violence. When women do ask for help or leave home, it means that the problem has reached crisis point. Requests for help need to be taken seriously; service-providers, families and friends need to respond appropriately to ensure that women's rights, health, access to resources and life are protected.

Health, social and economic impacts of violence against women and girls

The findings demonstrate costly impacts from Fiji's very high levels of violence against women and girls. These include:

- severe short-term and long-term impacts on the physical, reproductive and mental health of individual women (see Chapter 7);
- short-term and long-term impacts on children (see Chapter 8); and
- economic and social costs to families, communities and the nation (see Chapters 7-11).

Intimate partner violence against women imposes a high burden of injury on women and the economy: 43 women are injured, 1 is permanently disabled, and 10 lose consciousness every day in Fiji; 16 women are injured badly enough every day to need health care. However, the findings also show that women under-estimate the impacts of violence on their health and well-being (an important coping strategy for many women); only about 1 in 10 tell a health worker the true cause of their injury, and many do not get the health care they need.

With 30% of ever-partnered women injured due to domestic violence in their lifetime, and a significantly increased risk of emotional distress symptoms including suicidal thoughts and actions, domestic violence is undoubtedly one of the biggest risks to women's physical health and mental well-being in Fiji. Injuries and emotional distress have a severe impact on women's physical health, their ability to care for their families, earn an income, and engage in social and economic development. The findings also show that women living with domestic violence have higher rates of miscarriage and an increased likelihood of unwanted pregnancies, which also brings damaging health impacts and social and economic costs to the community.

Domestic violence has negative impacts on children's emotional well-being; it is associated with increased aggressive behaviour in some children, and increased timidity and social withdrawal in others. Children whose mothers are subjected to intimate partner violence are significantly more likely to fail or repeat at school. These impacts affect both boys and girls; they reduce their life opportunities and pre-dispose them to the risk of violence in their own intimate relationships in adult life, as either perpetrators or survivors. These findings have highlighted the fact that children need emotional support to address the range of emotional and behavioural problems that they experience due to violence perpetrated against their mothers. Most importantly, they need the violence to stop.

A range of economic and social costs of domestic violence have been highlighted by the survey findings. Direct costs to the health system are substantial, even though many women do not receive the health care they need for their injuries. High levels of control by men over women's mobility and access to employment reduces women's ability to earn income and provide for themselves and their families, and thus results in direct and indirect costs to families and communities. There are significant and ongoing lost opportunities for social and economic development due to men placing restrictions on women's participation in organisations and meetings, their disruptions to women's work, the long-term behavioural and educational impacts on children, and enormous costs due to lost productivity as a result of injury, disability and emotional distress.

Men's control over women's access to health care is pernicious and exacerbates health problems for both women and children. It increases the long-term costs of providing treatment, as opposed to early intervention in preventative health care.

Gender inequality: causes, attitudes and risk factors

The findings describe patterns of extreme gender inequality in Fiji: patterns of physical, sexual and emotional abuse coupled with coercive control, with men imposing power over women in a range of damaging ways, including by intimidation and threats. In addition, many women agree with statements that undermine or negate women's rights, and 43% agree with one or more "justifications" for a man to beat his wife. Sixty percent of women (60%) agree that "a good wife obeys her husband even if she disagrees", 55% believe that "it is important for a man to show his wife/partner who is the boss", 53% do not agree that woman has the right to choose her own friends, and 33% believe that a wife is obliged to provide sex, even if she doesn't feel like it (see Chapter 6).

The most common situations mentioned by women where violence occurs include jealousy by her husband, her disobedience, and his desire to show he is the boss, in addition to drunkenness. Women subjected to intimate partner violence are significantly more likely to agree with statements that negate women's human rights, and with a range of "justifications" for violence by husbands and partners. This is a common finding in other studies and indicates strongly that unequal gender norms and power relations are reinforced by women as well as men.

The high rates of both partner and non-partner abuse show that the use of violence as a form of punishment and discipline is accepted within many families and communities. Women themselves minimise the impact of the violence on their health and well-being; many even say that they have not sought help because the violence was "normal" (see Chapter 10). All these findings demonstrate that a tolerance for men's violence against women and unequal gender power relations remain entrenched in social norms, and in the belief systems of some women.

On the positive side, most women have a strong sense of sexual autonomy and 57% do not agree with any reasons for physical violence by a husband/partner. Overall, the more education a woman has, the more likely she is to agree with statements that support equal gender power relations and women's human rights. However there is an exception to this generalisation: tertiary educated women are less likely to agree that people outside the family should intervene if a man mistreats his wife, compared with secondary and primary school graduates (see Chapter 6). Moreover, these attitudes do not protect them from experiencing violence today (see Chapter 4).

Several findings also demonstrate clearly that men's violence against women is learned behaviour. Witnessing domestic violence and being subjected to violence as a child can lead to an acceptance and normalisation of violence, an acceptance of the view that men have an entitlement to exert power over women, and thus an acceptance of gender inequality by both women and men. Risk factors that increase women's likelihood of experiencing intimate partner violence are directly related to social norms that reinforce gender inequality in Fiji society, as well as to norms and practices that condone violence. Most factors in the background of husbands/partners are related to the social construction of masculinity, such as having multiple sexual relationships and fighting with other men; being regularly beaten as a child and frequent alcohol abuse are also key risk factors. The main risk factors in the women's background relate to acts of sexual abuse or coercion that she has already suffered, and a history of inter-generational violence (see Chapter 11).

Differences in prevalence and help-seeking behaviour

All forms of partner and non-partner violence against women are widespread in urban and rural areas, and in all Divisions of the country. However, prevalence is considerably higher in rural areas, including control over women's mobility. The lifetime prevalence of intimate partner violence in the Eastern Division of Fiji is one of the very highest recorded to date in the world.

All forms of partner and non-partner violence against women and girls are very high compared with global averages among all groups, regardless of ethnicity, religion, location, education levels and socio-economic cluster. Nevertheless, there is a consistent trend in the survey data for the prevalence of all forms of violence to be lower than the national average for Indo-Fijian women (but nevertheless considerably higher than global prevalence), and substantially higher for both i-Taukei women and those from all other ethnic groups combined. This is closely related to the higher prevalence in the Eastern Division, which has a much higher proportion of i-Taukei communities, compared with other Divisions. Seventy-two percent (72%) of i-Taukei women experienced physical and/or sexual violence by a husband or partner in their lifetime, compared with the national prevalence of 64%; 65% of i-Taukei women have experienced emotional violence compared with a national rate of 58%, and they have a higher prevalence of all forms of coercive control by husbands.

These same patterns and differences in prevalence are also found for violence during pregnancy, with 18% of i-Taukei having been attacked while pregnant compared with 11% for women from the Indo-Fijian community and a national rate of 15%. I-Taukei women have a higher prevalence of the most severe forms of physical violence (55% compared with a national rate of 44%); consequently, i-Taukei women and those from the Eastern Division also have much higher rates of injury.

There are also ethnic differences in help-seeking behaviour. Indo-Fijian women are more likely to seek help than i-Taukei women. Indo-Fijian women were more likely to ask for help from the police and courts, and to seek legal advice, social welfare services and assistance from FWCC or its Branches. In contrast, i-Taukei women were more likely to seek help from a hospital or health centre or a religious leader. I-Taukei women were less likely to tell immediate family members about the violence, and more likely to tell aunts, uncles and friends, compared with Indo-Fijian women who were more likely to tell immediate family members (such as parents and siblings).

Implications and recommendations

Men's violence against women is an enormous problem for Fiji with far-reaching and highly damaging impacts on individuals, families, communities and the whole nation. Entrenched social norms and mind-sets about women's roles and status need to be challenged and changed to prevent violence; changes in attitudes, behaviours and institutional practices are also essential to respond effectively to this widespread problem. Concerted action is needed by all stakeholders, and these actions need to be well-informed by an understanding of the problem, its scope and causes.

Although the survey findings reinforce the scale of the problem and the need for long-term commitments to address it, they also provide evidence that attitudes are changing. Due to long-term and persistent efforts by FWCC, as well as those of the women's movement in general and other organisations, there is now considerable support within the community in favour of women's rights and opposition to the use of violence. This provides a strong foundation for future work to consolidate attitudinal change and secure women's and girls' rights.

The findings from this survey have implications for all stakeholders engaged in efforts to eliminate violence in Fiji, and particularly those who provide services to women, girls and boys who have experienced violence in their families or other contexts. Although substantial progress has been made by FWCC and others to prevent and respond to men's violence against women, long-term and innovative efforts will be needed to reduce prevalence, particularly among those women who are currently most at risk.

While FWCC's strategies have been effective, the findings highlight the need for increased focus in key areas, and for ongoing efforts to promote women's human rights and gender equality and to reduce the tolerance of violence within the community. The recommendations listed below are based on: the evidence documented in this report; FWCC's experience in trialling, implementing and evaluating strategies over the past 28 years; and the deliberations and resolutions from the Sixth Pacific Regional Meeting on Violence Against Women and Girls in 2012.

Prevention

Being young is a key risk factor for violence. The findings show that violence begins very early in relationships, that younger women are more likely to experience intimate partner violence, and that younger men are more likely to perpetrate it. The missed potential of the formal education system at preventing violence and changing attitudes has been a consistent theme through several findings discussed in this report (see Chapters 4-6).

A family history of violence significantly increases the risk that girls will suffer from violence as adults; men are more likely to become perpetrators if they are beaten regularly during their childhood (see Chapter 11). This evidence underscores the importance of responding appropriately to violence whenever and wherever it occurs. Service delivery for women living with violence is usually categorised nowadays as an intervention focused on response rather than prevention.

The findings show clearly that helping women to take steps to stop the violence is imperative to prevent violence in future generations of young women and men. Preventing violence towards boys and girls at home and at school is also essential to prevent young men from learning and repeating these damaging behaviours. Rights-based and integrated approaches that encompass both prevention and response are essential to eliminate and circumvent violence before the behaviour is repeated by future generations.

There is strong evidence that men's power over women has to be challenged to increase the effectiveness of prevention efforts. The intense web of coercive control and the damaging impacts of emotional abuse also need to be acknowledged and addressed by stakeholders seeking to prevent violence against women and girls, in addition to physical and sexual violence.

Recommendations

1. *Prevention programs by all stakeholders must be evidence-based, and grounded in a sound understanding and gender analysis of the problem and dynamics of violence against women and girls.*
2. *Gender equality and awareness on violence against women and girls should be included in the education curriculum in schools and in teacher training programs.*
3. *Prevention programs should focus on the prevention of coercive control and emotional violence, as well as physical and sexual violence, in addition to actively promoting the rights of women and girls.*
4. *Innovative methods for reaching young women and men should be trialled to enhance the effectiveness of awareness-raising and behaviour change strategies, such as: building and mentoring a network of creative artists from various forms of performance art and social media; working through sports groups; and through social media.*

Targeting high-risk areas and groups

The different rates of prevalence between ethnic groups is one of the most challenging findings from the survey and suggests that different methods may be needed to reach out to different communities, to both prevent and respond to violence. High rates of all forms of violence in the Eastern Division require concerted action by all stakeholders (see Chapters 4-7). The central message that gender inequality and the low status of women are the fundamental causes of violence against women and girls cannot be compromised if prevention strategies are to be effective.

Many women do not seek help because they lack access to services. Entrenched belief systems that reinforce gender inequality, condone violence and extol the "virtues" of obedience and punishment are also significant barriers to women seeking help, and to the effectiveness of prevention efforts. When women do seek help, many turn first to law and justice sector agencies including the police; all stakeholders and relatives need to heed the evidence in this report that women only ask for help when the violence and its consequences are very severe indeed.

There is strong evidence that focusing on one risk factor alone (such as alcohol abuse) will not end violence against women. Most research on men's violence against women in other settings concurs with the evidence in Fiji that intimate partner violence is largely driven by factors related to gender inequality including a sense of sexual entitlement among some men, childhood experiences, and behaviours linked to harmful expressions and interpretations of masculinity (see Chapter 11).

This study was not designed to investigate whether there is an increased risk of violence faced by women and girls living with a disability, although there is considerable international evidence that this is the case. However, it has demonstrated clearly that intimate partner violence increases disability among women due to a range of serious injuries (see Chapter 7).

Recommendations

Differences between ethnic groups in help-seeking behaviour, prevalence and severity of violence against women and girls need to be acknowledged by all service-providers in their prevention and response efforts.

5. *Differences between ethnic groups in help-seeking behaviour, prevalence and severity of violence against women and girls need to be acknowledged by all service-providers in their prevention and efforts.*
6. *More attention needs to be given to targeting isolated and vulnerable communities where this research has shown women and girls to be at the greatest risk, including the Eastern Division.*
7. *Traditional leaders need to demonstrate strong commitment and active involvement in community based initiatives and mobilisation to end violence against women and girls.*
8. *Faith based organisations should be actively involved in the prevention of violence against women and girls through their missionary work as well as through their welfare and support programs.*
9. *Community based initiatives and mobilisation should focus on providing knowledge, skills and practical strategies to family and community members and friends who witness violence against women and girls, and assist them to respond appropriately when women turn to them for help or disclose violence for the first time.*
10. *All service providers should be trained to respond appropriately to cases of violence against women and girls using a gender equality and rights based approach, including police, judiciary staff and officers, traditional leaders, faith based organisations and welfare agencies.*
11. *Perpetrator programs should be based on a sound understanding of the causes and dynamics of violence against women; they should focus on behavioural change and holding offenders accountable, and be adequately monitored and evaluated from a rights based perspective.*
12. *Prevention and service delivery programs should take into account the links between violence and disability, and be responsive to the needs and rights of women and girls with disabilities and other vulnerable groups.*
13. *Quality standards should be developed for both prevention and service delivery programs that address violence against women; standards should articulate a rights based and gender equality approach, and be grounded in evidence regarding the scope, nature, dynamics and impacts of violence against women and girls.*
14. *The Fiji Police Force should systematically and consistently implement its No Drop Policy for all offences against women and girls; police and other law and justice sector agencies should be adequately resourced and skilled to respond expeditiously and sensitively.*
15. *Donors that support prevention and response programs should assess proposals from a rights based and gender equality perspective, and ensure that funded programs and organisations adhere to quality standards.*

Improving health sector responses

The high rates of injury and the damaging range of physical, mental and reproductive health problems associated with violence against women calls for informed, skilled and sensitive responses from health sector workers (see Chapter 7). The significant burden of injury, disability and emotional distress needs to be acknowledged in health policies and strategies, including in mental health policy and strategy. Health professionals are seeing women every day whose injuries or health problems are directly or indirectly due to the violence in their lives; in many cases, health workers are also the first people to be asked for help.

Recommendations

16. *Protocols need to be established within the health sector for dealing with cases of violence against women against children.*
17. *All health workers should be trained to ensure sensitive and appropriate responses when victims/survivors access health services, to ensure protection of their rights, confidentiality and their health.*
18. *Health services in rural and maritime areas should be equipped to provide appropriate prevention and response services to women and girls.*
19. *Physical, reproductive and mental health prevention strategies need to take into account the serious impacts of violence against women including men's control over women's access to health care, by reinforcing women's rights to decision-making about their own health, access to health care, and sexual and reproductive rights.*

Economic empowerment

Employment and ownership of assets do not protect women from violence. Nonetheless, without employment and assets, women have no means to support themselves and their children, and therefore no escape route from violent relationships. Women in Fiji have very limited access to employment and own few assets; women living with violence need to earn income, since their husbands/partners are significantly more likely to refuse to provide money for household expenses, and to take women's money without permission. On the other hand, women who are earning money and contributing more to the household than their husbands are significantly more likely to experience partner violence (see Chapter 9). Programs aimed at increasing women's employment and the productivity of small and medium enterprises have the potential to empower women and advance social and economic development. However for this to occur, gender inequalities need to be explicitly addressed. For women who are beginning to earn an income for the first time, economic empowerment programs could help prevent partner violence – if they work with women to enable them to claim their rights, and work with men to increase their understanding of women's rights, and the benefits to the whole family and community when women's productivity is increased.

Recommendations

20. *Economic empowerment programs should be based on an understanding of how gender inequality and gender based violence impacts on women's lives and their alibility to earn and control income and assets; they should support women to claim their rights to earn and control income and assets, by working with both women and men.*
21. *Targeted activities are needed to support women who have made the difficult decision to leave a violent relationship, to ensure they have access to long-term housing and secure income-generating opportunities.*

Chapter 1:
Introduction

This report presents the methodology and findings from the Fiji Survey on "Women's Health and Life Experiences". The survey was conducted by the Fiji Women's Crisis Centre in cooperation with the Fiji Islands Bureau of Statistics (FBOS) in 2011. This is the third national study undertaken by FWCC on the prevalence of and attitudes to violence against women in Fiji.

1.1 The Fiji Women's Crisis Centre (FWCC)

The Fiji Women's Crisis Centre (FWCC) is an autonomous, multi-racial non-government organisation which was established in 1984. FWCC's goal is to eliminate violence against women in Fiji and throughout the Pacific region. To achieve this aim, FWCC has an integrated and comprehensive program designed to both prevent and respond to violence, by reducing individual and institutional tolerance of violence against women, and increasing the availability of appropriate services for survivors. FWCC has it main centre in Suva in Fiji's Central Division, 3 Branches in Ba, Nadi and Rakiraki on Viti Levu in the Western Division, and 1 Branch in Labasa on Vanua Levu in the Northern Division. FWCC plans to open a fifth branch in Savusavu in the southern part of Vanua Levu within the next 2 years, along with two shelters for women in the Western and Northern Divisions and a shelter for girls in Suva. FWCC also manages a Regional Training Institute for the Pacific based in Suva.

FWCC addresses the problem of violence against women using a human rights and development framework. This focus on human rights includes a gender and social analysis of the problem and permeates all aspects of FWCC's work, recognising that the root causes of violence against women are unequal gender power relations, and lack of knowledge and belief in human rights. Hence, the promotion of gender equality and an understanding of human rights are foundational strategies for all FWCC's work. Several reinforcing strategies are used in FWCC's program including the following:

1. *Empowering women to be more aware of their rights and to bring about positive changes in their lives.*
   This is achieved through the provision of crisis counselling, advocacy, legal and other support services to women, including the provision of temporary accommodation where needed. Providing counselling and support services is a core strategy in FWCC's efforts to eliminate violence against women, because all other aspects of FWCC's work draw on this lived experience of women and children survivors. FWCC's Counsellor Advocates provide psycho-social support and non-judgemental counselling aimed at enabling women to make their own decisions, and assisting women to claim their rights from other service-providers.
2. *Increasing awareness, understanding and skills to prevent and respond to violence against women.*
   This includes community education and mobilisation, media, campaigning, training and other prevention activities targeted at key agencies, educational and religious institutions and community groups. FWCC aims to create awareness, discussion and debate on violence and women's human rights, which in turn leads to changes in knowledge, belief systems and skills, which ultimately can lead to behavioural and practice changes in individuals, organisations and institutions. FWCC's activities to select, train, monitor and support men to become effective male advocates for women's human rights has been a key part of this work, along with targeted training provided to a range of service providers in the law and justice, education, health and civil society sectors.
3. *Influencing key agencies to improve policy, legislation and services.*
   This is done at a number of levels through the monitoring of service provision, the implementation of the law, and the portrayal of women in the media. FWCC collaborates with other agencies and stakeholders in Fiji and across the Pacific region to advocate for policy and legislative change, effective and evidence-based prevention strategies, and improved service delivery. FWCC's research activities are an integral part of its efforts to influence other agencies, in Fiji and across the Pacific region.

4. *Providing accessible services through FWCC's Branches to prevent and respond to violence against women in rural areas.*
   Branches provide counselling and community education including outreach to villages, settlements and isolated areas. They replicate the work of FWCC at the national level and engage in collaborative efforts with local community groups, traditional leaders, local government authorities and service-providers to take prevention messages to remote areas, in addition to enabling easier access and improved services for women and children experiencing violence.
5. *Providing a regional program of training, networking and institutional support and mentoring.*
   FWCC is the Secretariat of the Pacific Women's Network Against Violence Against Women – a vibrant and active network of committed and effective individuals, civil society organisations and government agencies – that has been working to prevent and respond to violence against women in the Pacific region for over 20 years. The Sixth Regional Meeting of the Network was held in November 2012 to review prevention and response activities and plan future strategies. FWCC runs the 4-week Regional Training Program twice a year, which provides a foundation for individuals and agencies working on violence against women in Fiji and the region. Attachment training programs are provided at FWCC, along with tailored in-country programs on specific topics and approaches, such as counselling skills, male advocacy for women's human rights, gender training, and how to run effective programs to address gender based violence. FWCC's work to raise awareness of the impact of militarisation, conflict and political instability on women's human rights is fundamental to achieving its aims, because respect for the rule of law and human rights is a pre-condition for ending violence against women.

The FWCC receives core funding from the Australian Government's aid program for its national and regional activities, including for the implementation of this research. The New Zealand Aid Programme provides funding for FWCC's 4 Branches. FWCC has widespread community support and receives small donations from several other organisations and community members.

1.2 Violence against women

Violence against women and girls is widely condemned as a fundamental violation of human rights, and is recognised as a significant public health problem, causing enormous social harm and costs to national economies (AusAID 2008; UN 2006; UN Millennium Project 2005; World Bank 2011; WHO 2013). In recognition of the scale and impact of the problem, the 2013 session of the United Nations (UN) Commission of the Status of Women (CSW) was dedicated to addressing the problem of violence against women and girls (UN CSW 2013).

The Commission reaffirmed the definition of violence against women outlined in the UN Declaration of Violence Against Women (UN 1993, see Box 1.1), and recognised that domestic violence remains the most prevalent form that affects women and girls of all social strata across the world. It noted that women and girls who face multiple forms of discrimination are exposed to increased risk of violence, including women with disabilities (UN CSW 2013: 2, 10).

UN Commission on the Status of Women:
"The Commission affirms that violence against women and girls ***is rooted in historical and structural inequality in power relations between women and men,*** *and persists in every country in the world as a pervasive violation of the enjoyment of human rights. Gender-based violence is a form of discrimination that seriously violates and impairs or nullifies the enjoyment by women and girls of all human rights and fundamental freedoms. Violence against women and girls is* ***characterized by the use and abuse of power and control in public and private spheres, and is intrinsically linked with gender stereotypes that underlie and perpetuate such violence,*** *as well as other factors that can increase women's and girls' vulnerability to such violence." (UN CSW 2013: 2, emphasis added.)*

Box 1.1: United Nations Declaration on the Elimination Violence Against Women (DEVAW)[1]

Violence against women is defined as any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including the threat of violence, coercion, or arbitrary deprivations of liberty. Violence against women includes:

a. physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, and violence related to exploitation;

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

c. physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs.

The Declaration says that violence against women:

- violates women's human rights and fundamental freedoms (including the rights to life, equality, liberty and security, equal protection under the law, physical and mental health, just and favourable conditions of work, and the right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment;
- results from historically unequal power relations between men and women;
- is a social mechanism that forces women into a subordinate position compared to men;
- is pervasive in the family and society, and cuts across lines of income, class and culture; and
- limits women's opportunities to achieve legal, social, political and economic equality.

The Declaration says that Governments should:

- condemn violence against women;
- not refer to any custom, tradition, religion or any other consideration to avoid eliminating violence against women;
- adopt without delay appropriate policies and measures to eliminate violence against women;
- prevent, investigate and punish acts of violence against women;
- promote the protection of women through legal, political, administrative and cultural measures and inform women of their rights;
- ensure that women are not victimised through gender-insensitive laws and enforcement practices; and
- recognise the important role of the women's movement and non-government organisations in raising awareness, and in speaking out and acting on the problem of violence against women.

The Commission outlined a comprehensive agenda for action to address the problem, which aligns with FWCC's approach over the last 3 decades. This includes the following (UN CSW 2013: 5-17):

a) strengthening the implementation of legal and policy frameworks and accountability;
b) addressing structural and underlying causes and risk factors to prevent violence against women and girls across all sectors;
c) strengthening multi-sectoral services, programs and responses to violence against women and girls; and
d) improving the evidence base on prevalence, underlying causes, risk factors, costs and best practices.

1 The text in this box is drawn from UN General Assembly 1993, and from a poster prepared for "Beneath Paradise: Documentation by Women in Pacific NGOs" by Juliet Hunt for the International Women's Development Agency, in cooperation with the Pacific Network Against Violence Against Women, 1994.

1.3 Legal, policy and institutional context of violence against women in Fiji

1.3.1 Policy context

Fiji ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1995 and is signatory to several other key international and regional instruments which uphold the rights of women and oppose violence against women and girls. These include the following (Fiji Ministry of Women 2013; and UNFPA 2008):

- the Convention on the Rights of the Child;
- the Jakarta Declaration for the Advancement of Women in Asia and the Pacific;
- the Commonwealth Plan of Action for Gender Equality 2005–2015 arising from the 7th meeting of Commonwealth Ministers responsible for Women's Affairs; and
- the Revised Pacific Platform for Action on gender equality and the advancement of women, arising from the 2nd conference of Pacific Ministers responsible for women, and the 9th Triennial Conference on Pacific Women (SPC 2005).

The Fiji Islands Ministry of Women's (MOW) website refers to the National Women's Plan of Action (1999–2008) as the guiding document for work undertaken by the Ministry to address women's needs, interests and aspirations across economic, social, legal and political spheres. Five major areas of concern were covered in the National Plan of Action including: mainstreaming women's and gender concerns; women and the law; micro enterprise development; balancing gender in decision making; and violence against women and children (Fiji MOW 2013). Fiji's report on progress towards achieving the Millennium Development Goals (MDGs) refers to a new Women's Plan of Action 2010–2019 which also has 5 strategic objectives (Fiji Ministry of National Planning 2010: 26):

1. Formal Sector Employment and Livelihood
2. Equal Participation in Decision Making
3. Elimination of Violence Against Women and Children
4. Access to Services, including health and HIV and AIDS, education and other basic services (water and sanitation, housing and transport)
5. Women and the Law

Five task forces composed of representatives of key government departments and civil society organisations were set up to implement the 1999-2008 Plan of Action in each area, with varying degrees of success. The task forces on women and the law and violence against women were judged as being the most effective at formulating clear objectives for action and implementing activities, due in large part to the efforts of FWCC and its sister organisation the Fiji Women's Rights Movement (FWRM) (ADB 2006: 11).

The task forces were disbanded after several years. However, after the release of some of the preliminary findings from this research in January 2013, two were re-established by the Ministry of Women. The national elimination of violence against women (EVAW) task force met regularly in 2013 and FWCC has conducted training for Ministry of Women staff and Task Force. The EVAW task force plans to assist with formalising a gender policy for the Government, assessing Government initiatives on EVAW, evaluating access to EVAW services, and drawing up a National Plan of Action on EVAW. An Inter-Agency Task Force on Women and the Law was also re-established (FWCC 2013).

The Ministry of Women's "Violence Free Community" initiative is focused on communities declaring themselves to have "zero tolerance" for violence against women (Fiji MOW 2013). This ongoing program begins by setting up and training "gate-keeper committees" in each village or community, made up of church, traditional, women and youth leaders. According to the Minister for Women, one role of these committees is to "mediate between the community and the police department so that the couple can undergo counselling (and) reconciliation", given that the Domestic Violence Decree requires prosecution. The committees also monitor sexual abuse of women and children in the community and provide support to those affected by violence (ABC Radio Australia 2012).

Policies in the health sector generally give little attention to the problem of violence against women and children and its impact. For example, there is no mention of violence against women in the *Ministry of Health Strategic Plan 2011–2015*, the *Non-Communicable Diseases Prevention and Control National Strategic Plan 2010–2014,* or the *Draft Suicide Prevention Policy and Implementation Action Plan*[2] (Fiji MOH no date [a] and [b]; and Fiji MOH 2008). However, the Ministry of Health's *Child Health Policy and Strategy 2012–2015* acknowledges that children need to grow up in a home and community environment that are free from violence, abuse, exploitation and neglect (Fiji MOH no date [c]: 12). Furthermore, the Ministry of Education has a Child Protection Policy with zero tolerance for child abuse, and includes mandatory reporting obligations (Fiji Ministry of Education 2012).

1.3.2 Legal framework and implementation of the law

Several pieces of legislation and decrees have been introduced aimed at reinforcing women's rights and addressing violence against women in Fiji. The *Family Law Act* (2003) established a Family Court and covers marriage, divorce, maintenance, and custody. The law includes provisions for no-fault divorce, recognition of the role of both partners in the marriage, and the protection of the interests of children (FWRM, RRRT and UNDP 2007). Partners in the marriage can also apply for injunctions for their personal protection. Two other important reforms put in place before the 2006 coup were the abolishment of the law of corroboration in sexual offences though case law[3], and the setting of a precedent in case law recognising marital rape as a serious crime (FWCC 2013). The Fiji Police Force has had a no-drop policy for domestic violence offences since 1995. This means that the victim/survivor cannot withdraw or drop a complaint after it has been made with the police, who are required to follow up on all cases.

Five decrees relating to violence against women and children have been introduced by the Interim Administration in Fiji since the 2006 coup. The *Domestic Violence Decree* (2009), *Criminal Procedure Decree* (2009), and the *Crimes Decree* (2009) were based on draft legislation that FWCC had a significant input into over several years prior to the December 2006 coup. The *Child Welfare Decree* (2010) provides for mandatory reporting of physical and sexual abuse of children. The *Family Law Amendment Decree* (2012) extends the coverage of the Family Law Act to de facto couples.

These decrees have improved the legal framework for criminalising and prosecuting cases of sexual and domestic violence. The *Domestic Violence Decree* provides expanded authority to police to investigate and prosecute cases of domestic violence and provides for victims/survivors to obtain a Domestic Violence Restraining Order (DVRO). The *Crimes Decree* improved and expanded on the previous *Penal Code* in relation to sexual assault and other crimes of violence against women, including by expanding the legal definition of rape. It also includes offences of trafficking in women and children and puts in place harsher penalties (12–25 years imprisonment) for such offences (SPC 2010a: 63; and Ellsberg et al 2011).

2 A final National Suicide Prevention Policy and Implementation Action Plan was not available at the time of writing.
3 Balelala v State [2004] Fiji Court of Appeal (FJCA) 49.

Despite these changes to law, Fiji has not adopted a comprehensive or integrated approach to legislative reform in the area of violence against women; nor has any other country in the Pacific region. The SPC describes the approach to law reform in this area as piecemeal, because the changes do not address the full range of gender-based violence or the underlying systemic discrimination against women (SPC 2010a: 67). Moreover, decrees have been introduced without dialogue with civil society or public consultation; while some training has been provided for police and other law and justice sector officials on the new decrees, this has not been comprehensive. These factors reduce the likelihood that they will be fully understood or implemented (Ellsberg et al 2011).

FWCC's experience with clients points to significant problems with the implementation of all aspects of the law. There is a lot of pressure on women to reconcile with their husbands/partners following incidents of domestic violence, rather than seek access to justice. This pressure can come from traditional, community and religious leaders, the Police, the Family Court and other Courts – even in cases of the most extreme forms of violence and where the woman has made the very difficult decision to leave temporarily or permanently to protect her safety and end the violence. A large part of the FWCC Counsellor Advocate role is following up on lack of action by the Police, delays by the Courts, and actions taken by service-providers that undermine women's and children's rights and their access to justice. Re-victimisation of women remains a serious issue in Fiji; while many women will choose to reconcile with their husbands/partners, forcing reconciliation often results in further violence and blame of survivors.

Some of the specific issues with implementation of the law include lack of knowledge of laws including the Domestic Violence Decree, and manipulation of the law to undermine women's rights. The Decree was framed in a "gender neutral" way to enable both men and women equal rights under the law to seek DVROs. While many women are taking advantage of the law to gain protection, the framing of the law in this manner has enabled police, perpetrators and others to use DVROs to punish vulnerable women who report violence. Examples include informing perpetrators when their wives have lodged an application for a DVRO, and encouraging perpetrators to lodge DVROs against victims; issuing DVROs to husbands in cases where this is not warranted and contrary to the law; and discouraging women from reporting domestic violence. Lengthy delays in the serving of DVROs (over several weeks or months), has frequently resulted in women suffering from further serious abuse and injuries. Blaming women for both domestic violence and sexual assault perpetrated against their children is not uncommon. An emerging issue is a tendency for men to access legal aid before their wives (due to their knowledge about available services and funds to travel to legal aid centres); in these cases, legal aid officers can only provide assistance to one party in a dispute and this prevents women from being able to access legal aid.[4]

There are signs of a positive trend towards increased sentencing for sexual crimes of violence against children and a recognition in society generally that these are very serious crimes. However, the duration of sentencing still varies according to the presiding magistrate or judge, even for sexual crimes committed against children.[5] Unfortunately some members of the judiciary express discriminatory and blaming attitudes during hearings of cases of violence against women.

4 FWCC client files.

5 For example: Mary Rauto "10 years for rape" Fiji Times, 24 January 2012 (rape of an 8 year-old girl – State v Ratuva [2012] Fiji High Court 31); Repeka Nasiko "Eight-year sentence for riverside rape" Fiji Times, 18 March 2012 (rape of a 9 year-old girl – State v Nado [2012] Fiji High Court 953); Torika Tokalau "13 years for rape" Fiji Times, 9 April 2013 (rape of 12 year-old girl – State v Navunidakua [2013] Fiji High Court 155); and DPP v Veresa [2013] Fiji Magistrates Court 73 (where a brother was sentenced to weekend detention of the rape of his sister; the sentence was later increased to 17 years and 8 months prison on appeal to the High Court – DPP v Veresa [2013] Fiji High Court 361).

Delays in having cases heard and final judgements delivered are excessive: preliminary research undertaken by FWCC indicates that some cases reported in 2000/2001 were only finalised in 2013, and many cases reported after 2001 have not yet been heard. Moreover, many offenders do not spend their full term in prison due to reductions in sentences because of good behaviour while in prison, and the practice of providing automatic remissions in sentences from time to time.[6]

1.3.3 Institutional and social context

Cultural and religious fundamentalism promotes and reinforces conservative ideas and myths about women and their rights. Many traditional and conservative leaders are reinforcing traditional roles of women as caregivers and homemakers. These types of views were reinforced during the period of political upheaval and conflict following the 2006 coup and are still widespread today. For example, Fiji's 2010 report on the MDGs notes that one of the biggest impediments to addressing women's very low participation in politics, higher levels of the civil service and employment in non-traditional sectors is "customary notions about women's 'true' position in the society" and other social, political, economic and legal barriers (Fiji Ministry of National Planning 2010: 34).

When women assert their rights, this is often blamed for family breakdowns, sexual abuse and domestic violence. In the context of political and ethnic conflict and military rule, issues concerning women and their rights are often seen as secondary to those of national security and poverty by many opinion makers. In this context, women's organisations such as FWCC and other civil society organisations have had to work much harder to highlight human rights issues in general, including those of violence against women (UNFPA 2008: 7-8). In addition, issues relating to women's human rights and violence against women are often trivialised in the mainstream media in Fiji, particularly in radio shows where myths about domestic violence and rape continue to be aired.

Although entrenched attitudes opposing women's rights remains an ongoing problem, compared with 20-30 years ago there is now considerably more support for addressing the problem of violence against women and promoting women's rights among a range of organisations, institutions, communities and individuals with influence and authority. This is largely due to the long-term and persistent efforts of FWCC and other civil society organisations, such as the Fiji Women's Rights Movement.

For example, several Churches have taken up the issue of violence against women in recent years including the Anglican, Catholic, Presbyterian and Methodist Churches, and the Pacific Council of Churches. The Ministry of Education through the National Advisory Council on Substance Abuse has undertaken a program in schools on violence against women and girls, targeting senior students; they have also taken on the "Thursdays in black" campaign (which acknowledges women affected by sexual violence), and drafted a curriculum on gender equality for the subject of Family Life Education with FWCC input.

6 FWCC staff workshop, July 2013.

Many other government agencies, civil society organisations and sporting groups now organise and run their own campaigns during the 16 Days of Activism on Gender Violence in November/December, whereas in years gone by these activities were led by FWCC. Notwithstanding the challenges of mainstream media coverage noted above, there are also more people leading and engaging in debate on violence against women and human rights, particularly through social media but also in mainstream media through letters to the editor. On the whole there are more well-informed local commentators on violence against women.

A National Network was formed at FWCC's initiative in December 2009 which includes a range of service providers. Participants resolved to work towards the establishment of counselling and support services to ensure that women in isolated communities can access services. The National Network committed to building the capacity of influential leaders in communities to enable them to support victims; they also resolved to involve people at community level in outreach awareness programs to strengthen prevention. All FWCC's Branches attend regular inter-agency committees where various stakeholders focus on improving the effectiveness of interventions targeted at preventing violence against women and girls, and responding to it.

By using their influence and authority to promote gender equality in their personal and work lives, FWCC's trained male advocates have helped to bring about some of these changes in communities and organisations. They have helped to prevent violence from occurring, assisted women and girls living with violence to claim their rights and end the violence, and with FWCC's support have taken anti-violence and women's rights messages into their communities and workplaces.

1.4 The status of women in Fiji

Fiji's report on the MDGs provides the most recent assessment of women's status in Fiji across a range of indicators. The report concludes that Fiji has succeeded in achieving gender equality in primary and secondary school enrolments and completion rates, and has made good progress in reducing maternal mortality (Fiji Ministry of National Planning 2010: viii, 26-36). Maternal mortality was 26 per 100,000 live births in 2011, but the adolescent fertility rate (for girls aged 15-19) was 43 per 100,000 live births in 2011; this is high compared with a rate of 20 for the East Asian and Pacific region (World Bank 2013).

According to the World Bank's Gender Equality Data and Statistics, women made up 30% of employment in the non-agricultural sector in Fiji in 2005 (World Bank 2013). Women's overall participation in the labour force has increased since 1990, when 29% of women were engaged in formal sector employment, to 39% in 2007. This compares with 84% of men engaged in formal sector employment in 1990 and 79% in 2007. Overall, labour force participation rates have remained stagnant for both women and men over the last decade or more. This underscores the considerable increase in poverty rates in Fiji from 25% in 1990 to around 40% in 2008, which is attributed to economic and political challenges in expanding the pool of jobs in Fiji's MDG report. Moreover, the Ministry of National Planning notes that much of the work engaged in by women has low health and safety standards, particularly in the garment industry. Although women are increasingly engaged in self-employment, they nevertheless make up only 20% of the registered micro and small businesses in Fiji (Fiji Ministry of National Planning 2010: viii, 30-31).

Fiji's MDG report acknowledges that cultural and traditional attitudes towards women's roles in social and economic development limit their participation in formal employment. The highest levels of employment by women are found in the civil service, where they made up 47% of employees in 2007. However, the vast majority of these civil servants are nurses, teachers, dental assistants and administrative officers, and the gender wage gap is very high, with men dominating in decision making and higher paid positions. Gender stereotyping and wage gaps are also evident in private sector employment: sectors with the highest representation of women employees in 2007 were hotel, retail and restaurant businesses, and community, social, and personal services, which employed 41% women and 59% men. Women made up 33% of employees in the manufacturing sector, and 34% in finance and real estate. The MDG report notes that women with disabilities are more likely to be engaged in self-employment and that they are "almost invisible" in formal sector employment (Fiji Ministry of National Planning 2010: 31-33).

Women make up 22% of paid employees in agriculture, forestry and fisheries (Fiji Ministry of National Planning 2010: 31), but no data is available on their level of unpaid contribution to work in these sectors. However, the Asia-Pacific Human Development Report cites recent research that puts the value of unpaid household work at almost FJD480 million (US $237 million), "a figure greater than the income from sugar or tourism, the country's two largest industries" (UNDP 2010: 63).

In 2005, 9% of seats were held by women in the national parliament (World Bank 2013); this compares with no women at all in the national parliament in 1990 (Fiji Ministry of National Planning 2010: 30), but remains very low by international standards. Overall, the equal opportunities and achievements of girls in primary and secondary education have not translated into equal treatment in the workforce, politics or decision-making in social and economic life in Fiji.

Chapter 2:
Research Objectives & Methodology

This chapter describes key features of the research methodology, including research objectives and questions, an overview of what is covered in the survey questionnaire, the design of the survey sample, and how fieldworkers were trained and supported to ensure valid and reliable findings. Ethical and safety issues and the strengths and limitations of the research design are also discussed.

2.1 Overview of research method and objectives

The aim of the study was to provide updated data on the prevalence of violence against women in Fiji, attitudes to violence, its impacts on women and children, and women's coping strategies. FWCC conducted its first survey on the incidence, prevalence and nature of domestic violence and sexual assault in 1999 (FWCC 2001), and followed this up with a qualitative study on community perceptions of women's rights in 2006 (FWCC 2006). For the current research, FWCC replicated the survey method developed by the World Health Organisation (WHO) for its Multi-country Study on Women's Health and Domestic Violence against Women (WHO 2005).

Although the WHO methodology does not provide directly comparable findings with FWCC's earlier studies, it is a well-tested and validated methodology, based on extensive experience and learning about research on violence against women. The WHO methodology has been used in several other Pacific countries including Samoa (SPC 2003), the Solomon Islands (SPC 2009), Kiribati (SPC 2010), Vanuatu (VWC 2011) and Tonga (Ma`a Fafine mo e Famili 2012). Studies using the WHO approach are currently underway in several other Pacific countries including the Republic of Nauru, Federated States of Micronesia, Republic of the Marshall Islands, Cook Islands, and Republic of Palau (UNFPA 2013). The use of the WHO methodology has been recommended in order to enhance credibility, comparability and the sharing of experience and expertise in the region (Jansen 2010: 16; and AusAID 2008: 29).

Most of the Pacific studies mentioned above combined the WHO questionnaire instrument with qualitative research, although this was not the case for the Vanuatu study (VWC 2011: 31). A qualitative component was not used in FWCC's study because qualitative documentation was available from FWCC's previous research activities (FWCC 2001 and FWCC 2006); in addition, rich information including extensive case studies has been gathered through FWCC's work over many years, including from annual program monitoring and evaluation workshops.

Samoa was the only country in the WHO multi-country study that surveyed men as well as women (SPC 2003). This was rejected by the WHO for other study sites due to the substantial additional resources required (WHO 2007: 22). For ethical and safety reasons, a different sampling framework is needed to interview men, an additional survey instrument, and a different group of (male) interviewers (Jansen 2010:16). Both men and women were included in FWCC's 2 previous national research studies (FWCC 2001 and FWCC 2006). For all these reasons a decision was made to focus the current study solely on women.

FWCC's research used the study protocol developed by WHO (WHO 2007) which included the following research questions.

Prevalence and incidence

1. What is the prevalence of physical abuse of women since the age of 15 years, and what is the frequency of abuse reported by these women?
2. What is the prevalence and frequency that women report being forced to have sex against their will? At what age(s) did this occur, and who are the main perpetrators?
3. What is the prevalence and frequency that women are physically, sexually or emotionally abused by a current or former intimate partner?
4. To what extent does physical violence occur during pregnancy?

Effects of violence against women

5. To what extent is intimate-partner violence against women witnessed by children within the household?
6. To what extent is a history of intimate partner violence associated with different indicators of women's physical, mental and reproductive ill-health and the use of health services?
7. What are the consequences of domestic violence for different aspects of women's life? To what extent does violence affect women's ability to work, provide for their families, and interact with the community?
8. What are the consequences of domestic violence against women for their children? Does it affect children's behaviour, or their progress at school?

Attitudes, risks and protective factors

9. What factors in a woman's family and individual life are associated with intimate partner violence against women, such as her attitudes to gender equality and violence against women, access to and control of resources, membership of groups, witnessing violence against her mother during childhood, contact with family members, alcohol use, or access to different kinds of support? To what extent are other family members aware of the abuse?
10. What individual factors are associated with men being violent towards their wives/partners, such as witnessing violence against his mother during childhood, being physically abused as a child, his employment status, male violence towards other men, or alcohol use?

Coping strategies

11. What strategies do women use to minimise or end violence? To what extent do women retaliate against the perpetrator, leave the relationship, and seek help from family members, friends, or different support agencies? Are there groups from whom they would like to receive more help?
12. What are the implications of the research findings for preventative and supportive interventions?

2.2 The survey questionnaire

2.2.1 Overview of the survey instrument

The WHO questionnaire instrument (version 10) was the outcome of an extensive process of international consultation, trialling and validation (WHO 2007: 25-26), and only minor adaptations were made by FWCC for the Fiji context. The questionnaire included the following sections: an administration form; a household selection form; a household questionnaire; and the women's questionnaire. The household selection form was used to randomly select one individual woman aged 18 to 64 from each household. Each woman selected was interviewed using the women's questionnaire. The women's questionnaire included the following sections (see Annex 2):

- **Individual consent form:** introduces the survey and its focus on women's health and life experiences, assures the respondent that her answers will be confidential, and requires the interviewer to certify that the woman consents to be interviewed.
- **Section 1, respondent and her community:** includes questions on the respondent's contact with family and local organisations, and characteristics of the respondent including her relationship status.
- **Section 2, general health:** includes questions on the respondent's physical and mental health including during the previous month such as the use of medication and health services, frequency of smoking and drinking, suicidal thoughts and actions.
- **Section 3, reproductive health:** includes questions on the respondent's history of pregnancy, miscarriage, contraceptive use, and her husband's/partner's responses to family planning.
- **Section 4, children:** includes questions on the number of children, the most recent pregnancy and the behaviour of children and their schooling.

- **Section 5, current or most recent husband/partner:** includes questions on his age, education level, employment, frequency of drinking and drug use, involvement in physical fights with other men, and whether he had relationships with other women, or children with other women, while he was in a relationship with the respondent.
- **Section 6, attitudes:** includes questions on attitudes to gender relations, situations where a man may have "good reason" for physical violence against his wife, and attitudes to women's sexual autonomy.
- **Section 7, respondent and her partner:** includes a request for permission to continue the questionnaire, questions on the respondent's communication patterns with her husband/partner, her experiences of controlling behaviours by her partner, and emotional, physical and sexual violence, including violence during pregnancy.
- **Section 8, injuries:** includes questions on the frequency, type and severity of injuries resulting from physical violence by a husband/partner, and the use of health services for these injuries; this section was only asked of women who disclosed physical or sexual violence in section 7.
- **Section 9, impact and coping:** includes questions on the situations or factors associated with violence by husbands/partners, whether children witnessed the violence, the association between physical violence and rape, whether women retaliated and the impact of this, her view of the impact of the violence on her physical and mental health and work, and any actions she took to tell anyone about the violence or seek help (including leaving home), and the reasons for doing so or not doing so; this section was only asked of women who disclosed physical or sexual violence in section 7.
- **Section 10, other experiences:** includes questions on women's experiences of physical and sexual violence by people other than husbands/partners since the age of 15, child sexual assault, her first sexual experience, whether there was a history of violence towards mothers in her or her husband's/partner's family, and whether her husband/partner was beaten regularly as a child by someone in his family.
- **Section 11, financial autonomy:** includes questions on the respondent's ownership of assets, control over her own income, and capacity to support herself and her family in an emergency.
- **Section 12, completion of interview:** includes an opportunity for anonymous reporting of child sexual abuse using a face card (Box 2.2), and a question on how she felt after the interview.

Adaptations made by FWCC to the WHO generic questionnaire included: a question on non-partner physical abuse was reworded to include the same acts as for partner abuse; a question on non-partner sexual violence since age 15 was added to investigate other forms of sexual abuse including attempted rape; and several other minor changes were made for the Fiji context. The questionnaire was translated into i-Taukei and Hindi, and the wording and translation was improved and finalised during training of interviewers and the pilot fieldwork (Jansen 2011a: 3, 8).

2.2.2 Operational definitions used in the survey

Eligible and ever-partnered women

Women eligible to participate in the survey were those aged between 18 and 64 years who lived in the household. This included visitors if they slept in the household for the past 4 weeks, or domestic workers ("house help") if they slept 5 nights a week or more in the house. Only 1 eligible woman was interviewed per household; in households with more than 1 eligible woman, the respondent was selected randomly. In households with no eligible women, only the household questionnaire was completed and no individual woman's interview was done.

Ever-partnered women are those who could potentially be at risk of experiencing violence by a husband or partner; hence the number of ever-partnered women in the sample is used as the denominator for calculating prevalence figures. This was defined as women and girls who were ever in an intimate sexual relationship with a man.

This includes women who were ever legally married, those who ever lived with a male partner including in a de facto relationship, those who ever had a regular intimate male partner but never lived with him, and those who ever had an intimate relationship with a man they were dating or were engaged to.

Violence against women
The survey focused on physical, sexual and emotional violence by husbands or intimate partners, coercive and controlling behaviours by husbands/partners, physical and sexual violence perpetrated by people other than husbands/partners since the age of 15, and child sexual abuse before the age of 15. The specific acts used to define each of these types of violence are summarised in Box 2.1.

Box 2.1: Operational definitions of violence against women and girls used in the survey

Physical violence by a husband/partner
- Slapped or had something thrown at her that could hurt her
- Pushed or shoved, or had her hair pulled
- Hit with a fist or something else that could hurt her
- Kicked, dragged, or beaten up
- Choked or burnt on purpose
- Threatened to use or actually used a gun, cane knife or other weapon against her

Sexual violence by a husband/partner
- Physically forced to have sexual intercourse when she did not want to
- Had sexual intercourse when she did not want to because she was afraid of what her husband/partner might do
- Forced to do something sexual by her partner that she found degrading or humiliating

Emotional abuse by a husband/partner
- Insulted or made to feel bad about herself
- Belittled or humiliated her in front of other people
- He did things to scare or intimidate her on purpose (e.g. by the way he looked at her, or by yelling or smashing things)
- He threatened to hurt her or someone she cared about

Controlling behaviours by a husband/partner
- Tries to keep her from seeing her friends
- Tries to restrict contact with her family of birth
- Insists on knowing where she is at all times
- Ignores her or treats her indifferently
- Gets angry if she speaks with another man
- Is often suspicious that she is unfaithful
- Expects her to ask his permission before seeking health care for herself

Physical violence during pregnancy
- Slapped, hit or beaten while pregnant
- Punched or kicked in the stomach while pregnant

Physical violence by non-partners (over 15 years)
- Hit, beaten, kicked, had something thrown at her, pushed, choked or burnt on purpose, threatened to use or actually used a gun, knife or other weapon against her

Sexual violence by non-partners (over 15 years)
- Forced to have sex or to perform a sexual act that she did not want to
- Attempted to force her to have sex, touched her sexually, or did anything else sexually that she did not want

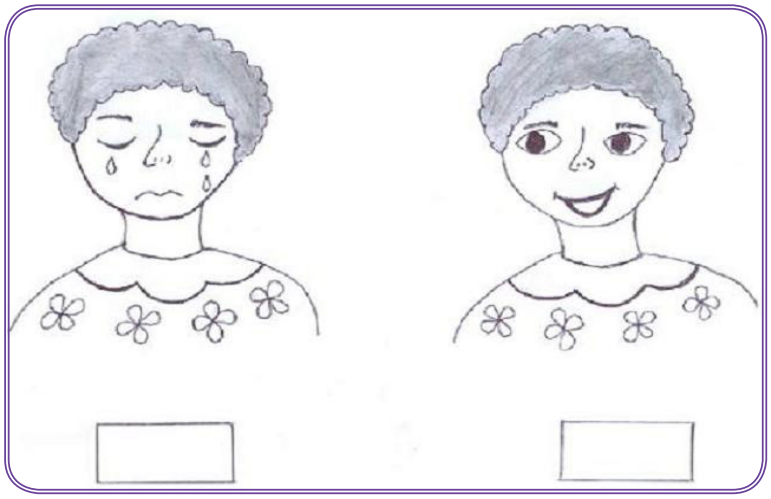
Sexual violence before the age of 15
- Ever touched sexually or made to do something sexual that she did not want to

For each act of physical, sexual or emotional abuse by a husband/partner, the respondent was asked whether it occurred in the previous 12 months, or before the previous 12 months. Respondents were also asked how frequently the violent and abusive acts had occurred: once, a few (2-5) times or many (more than 5) times.

2.2.3 Child sexual abuse

This is a difficult topic to explore in a questionnaire because of the highly sensitive nature of childhood sexual abuse and the shame and trauma associated with it, which results in considerable under-reporting of the problem. Three different ways of exploring this topic were used. First, in section 10 (see Annex 2, question 1003a), respondents were asked whether anyone ever touched them sexually, or made them do something sexual that they did not want to before the age of 15 years. Then respondents were asked their age when they first had sex, and whether their first sexual experience was forced, coerced, or by choice (questions 1004-1005). Finally, at the end of each interview, each respondent was handed a card with 2 pictures of a sad and happy face (Box 2.2) which allowed them to report on this topic anonymously (question 1201). The respondent was asked to mark the sad face if someone ever touched her sexually or made her do something sexual against her will before the age of 15 years; and to mark the happy face if this did not happen to her. Respondents were asked to seal this card in an envelope before handing it back to the interviewer, enabling her to keep her response secret.

Box 2.2: Face card used for reporting of child sexual assault



The WHO found that that this combination of methods helps ensure that a more complete estimate of the prevalence of childhood sexual abuse is obtained. In the WHO multi-country study, anonymous reporting did not always encourage the most reporting: some women disclosed childhood sexual abuse during the interview but did not mark the card in this way, and some did the opposite. Because of this, the combined prevalence – obtained if a positive response was given to either the interview question or the face card – is used as the most accurate estimate (WHO 2005: 50; WHO 2007: 29-30).

2.3 Design of the survey sample

A multi-stage sampling strategy was prepared by a consultant from the Fiji Islands Bureau of Statistics (FBOS). A target sample of 3,000 households was chosen. This was inflated by 25% to allow for possible non-response, due to the highly sensitive nature of the survey content, giving a total target sample of 3750. In the first stage, the 2008-2009 sampling frame of the Household Income and Expenditure Study was used, which was based on 1,602 enumeration areas identified from 2007 population census data. A representative sample was selected from 8 strata covering urban and rural areas in Fiji's 4 Divisions (Central, Eastern, Northern and Western).

In these 8 strata, 357 enumeration areas were systematically selected using a probability proportional to size (PPS) sampling technique.[7] Some adjustments were made to this selection, taking into account geographical features and transportation difficulties; to ensure geographical and ethnic representation, proper sampling measures were taken to replace these areas (Jansen 2011a: 9; and FBOS 2011).

In the second stage of sampling, 10 households were randomly selected from each enumeration area. This represented 22.3% of all enumeration areas and 2.1% of all households in Fiji. Two urban enumeration areas were omitted from the sample, to avoid full coverage of households and over-representation of the only urban centre in one province; this was essential for ethical and safety reasons to promote the confidentiality of the survey content. The sample included 355 enumeration areas with a target of 3553 households (Table 2.1) (Jansen 2011a: 9; and FBOS 2011). Final adjustments resulted in a total sample of 3538 households visited (see Chapter 3 and Table 3.1 of Annex 1). Enumeration areas from all provinces and major islands were included in the final sample.

Table 2.1: Selection of sample enumeration areas and households

Enumeration Areas	Central Division	Eastern Division	Northern Division	Western Division	Total
Urban EA	98	2	16	48	**164**
Rural EA	48	29	44	70	**191**
Total EAs	**146**	**31**	**60**	**118**	**355**
Households					
Urban	982	20	160	480	**1642**
Rural	481	290	440	700	**1911**
Total Households	**1463**	**310**	**600**	**1180**	**3553**

Sources: Jansen 2011a: 9; and FBOS 2011. Note: 3538 households were visited in the final sample (Table 3.1 of Annex 1).

In the third stage of sampling, one woman aged 18-64 years was randomly selected to be interviewed from each household. The WHO multi-country study interviewed women aged 15-49, due the WHO's special interest in reproductive health. FWCC chose a minimum age of 18 for legal reasons, since women over 18 do not need parental consent to participate in a survey. Interviewing women up to 64 years of age enabled FWCC to explore the experiences of older women (Jansen 2011a: 9).

2.4 Fieldwork, data processing and quality control

2.4.1 Interviewer selection, training, pilot and fieldwork

Lessons learned on conducting population-based surveys on violence against women show that the selection and training of interviewers can have an impact on whether respondents are comfortable to talk about their experiences of violence. Supervision in the field, monitoring and ongoing support are also essential to achieve valid findings (Ellsberg and Heise 2005; and Jansen 2010: 21-22). WHO guidelines highlighted the following important skills for interviewers: ability to interact with all types of people; emotional maturity; skill at building rapport; and experience in dealing with sensitive issues (WHO 2007: 38).

7 This sampling technique ensures that households in larger enumeration areas have the same probability of getting into the sample as those from smaller enumeration areas. It is commonly used to generate a representative and random sample when sampling units vary in size.

Thirty-four members of the FWCC research team were trained over 3 weeks in October 2010 including 19 nominated by the FBOS and 15 who were staff of FWCC and its Branches. Trainees included 33 women and 1 man (who was engaged to provide logistical support and not as an interviewer). The training was led by FWCC's research consultant, with some sessions provided by FWCC and FBOS staff (Jansen 2011a: 7).

WHO's standard training curriculum was used. This covered the following topics: gender sensitisation (2 days), interviewing techniques, a detailed question-by-question explanation and discussion of the questionnaire, and roleplays in small groups. In the first week all participants were provided with the questionnaire, an interviewer's manual, and question-by-question manual in English. Fijian and Hindi questionnaires were provided to those trainees who spoke these languages. Supervisors were provided with a supervisor manual in English during the third week of the training. The third week concentrated on field practice with two days field piloting. The training and pilot provided an opportunity to thoroughly review and fine-tune the questionnaire. The questionnaire was not translated into Rotuman; however interviews in Rotuman were extensively practiced by 3 interviewers whose mother tongue was Rotuman (Jansen 2011a: 7).

FWCC formed 8 teams, each with 3 interviewers and 1 editor/supervisor. For the pilot, each team visited separate enumeration areas in or close to Suva that were not included in the sample design, covering all social strata and types of living conditions. Each interviewer practiced 2 full interviews per day. Interviews were done in all languages. Each pilot day was followed by a day of debriefing where interviewers discussed their experiences and proposed strategies and lessons learned. The pilot study demonstrated that the field procedures worked well and that respondents were cooperative and happy to tell their story (Jansen 2011a: 10). Fieldwork was undertaken from mid November 2010 with a break for the holiday season and was completed in August 2011. The fieldwork began in enumeration areas in Suva (Jansen 2011a: 12).

2.4.2 Quality control

The WHO methodology included several standardised procedures and formats for quality control during fieldwork (WHO 2007: 40-41). These included the following in the Fiji study (Jansen 2011a: 12-13):

- Close supervision of each interviewer during fieldwork. For example, supervisors were instructed to observe the beginning of a proportion of the interviews.
- Random checks of one household per enumeration area by the supervisor, during which respondents were interviewed by the supervisor using a brief questionnaire to verify that the respondent had been selected in accordance with the established procedures and to assess the respondent's perceptions of the interview.
- Continuous monitoring of each interviewer by field supervisors using a standard monitoring format that included performance indicators such as response rate, the number of completed interviews, and the rate of identification of physical violence.
- Review of all completed questionnaires by the editor/supervisor in each team to identify inconsistencies and skipped questions, thus enabling gaps or errors to be noted and corrected before the team moved on to another enumeration area.
- Questionnaires were edited by FWCC before data entry.
- Close contact with field teams by FWCC staff at all times during the fieldwork, to identify and resolve issues and provide support.

2.4.3 Data entry, tabulation and analysis

Quality control mechanisms were also applied during data entry. Data entry screens (one for each section of the questionnaire) were set up by FBOS on CSPro software so that automatic consistency checks were incorporated into the data entry system. FBOS trained data processors and provided ongoing technical assistance including supervision and monitoring of data entry (Jansen 2011a: 13). All questionnaires were entered twice by the data processors to verify that data was entered correctly. FWCC's research consultant assisted with cleaning the data files before tabulating the findings and undertaking statistical analysis.

A workshop was held in Suva with FWCC and Branch staff in September 2012 to discuss and analyse the findings. This was an additional opportunity to check the accuracy of tables and charts included in this report. The interpretations, analysis and recommendations in the following chapters are based on the discussion at this workshop.

2.5 Ethical and safety considerations

WHO's guidelines on ethical and safety considerations guided the development and implementation of the research (WHO 2007: 36-37). Some of the specific measures used were the following (Jansen 2011a: 11-12):

- **Safe name for the survey:** For women experiencing violence, the mere act of participating in a survey may provoke violence, or place the respondent or interviewer at risk. The name of the study used throughout implementation was: "Survey of Women's Health and Life Experiences". This enabled respondents to explain the survey to others safely, and was used by fieldwork teams to describe the survey to the community and to other members of the household. Interviewers and supervisors carried an official letter explaining the survey. Fieldwork teams advised provincial administrators, the police post or local officials as appropriate as they entered each enumeration area.
- **Informed consent:** Interviewers introduced themselves by saying that they were part of a team working for FWCC and the Fiji Bureau of Statistics. Although there was a risk that FWCC would be associated with domestic violence, fieldworkers did not mislead communities or respondents on this point. Fieldwork teams were confident that could address any myths or concerns by explaining FWCC's work in positive terms, and by focusing on the benefits to families of FWCC's work. The teams found that communities, households and individual women were overwhelmingly welcoming to FWCC.
- **Confidentiality agreement:** On the second day of the training all staff signed a confidentiality agreement as part of their work contract.
- **Support for interviewers:** Trained counsellors from FWCC were available to provide support and counselling to interviewers where needed, in recognition of the traumatic nature of the subject matter, with interviewers hearing disclosures of violence each day.
- **Support for respondents:** Interviewers informed their team supervisors of the following cases: respondents with suicidal thoughts in previous 4 weeks; respondents who specifically asked for help; cases where the household or the woman refused to complete the interview; and cases where current child abuse was reported. Protocols were in place to refer women who requested assistance to the FWCC or its Branches for counselling, immediate or follow-up assistance as needed.
- **Information about services:** A pocket-size leaflet with information on FWCC services was given to each respondent at the end of the interview, together with several health leaflets; this strategy was designed to protect women, in case the leaflets were discovered by perpetrators of violence.

2.6 Strengths and limitations of the research design

By using the WHO methodology, FWCC followed international best practice in the research design and implementation. Consequently, the findings are robust and reliable with the most accurate estimates possible of prevalence of violence against women. However, with this type of research design, it is not possible to "prove" that violence causes the various health problems and other impacts described in the following chapters. Nevertheless, it is possible to identify statistically significant associations between violence and the various impacts described, to do so with full confidence, and to apply FWCC's many years of experience in interpreting these findings. One important strength of the research design was the nationally representative sample that provides reliable estimates of prevalence for each of Fiji's 4 Divisions and for urban and rural areas.

Any survey based on self-reporting has some possibility of bias associated with respondents' memory of events and incidents. However, lessons learned from research on violence against women indicate that recall bias tends to result in under-estimates of the prevalence of violence, rather than over-estimates (WHO 2005: 23). The findings presented in Chapter 7 on health impacts and Chapter 10 on women's coping strategies reinforce this international experience.

The decision to select only 1 woman per household introduces bias because it means that women living in households with more than 1 woman are under-represented. The WHO multi-country study tested the degree of this bias by weighting the main prevalence outcomes to compensate for differences in the number of eligible women per household; the same testing was done for the Fiji study (see Chapter 3). In all cases the results showed no significant differences in prevalence rates; consequently the chapters below use the international standard for calculating rates of prevalence recommended by WHO (WHO 2005: 28).