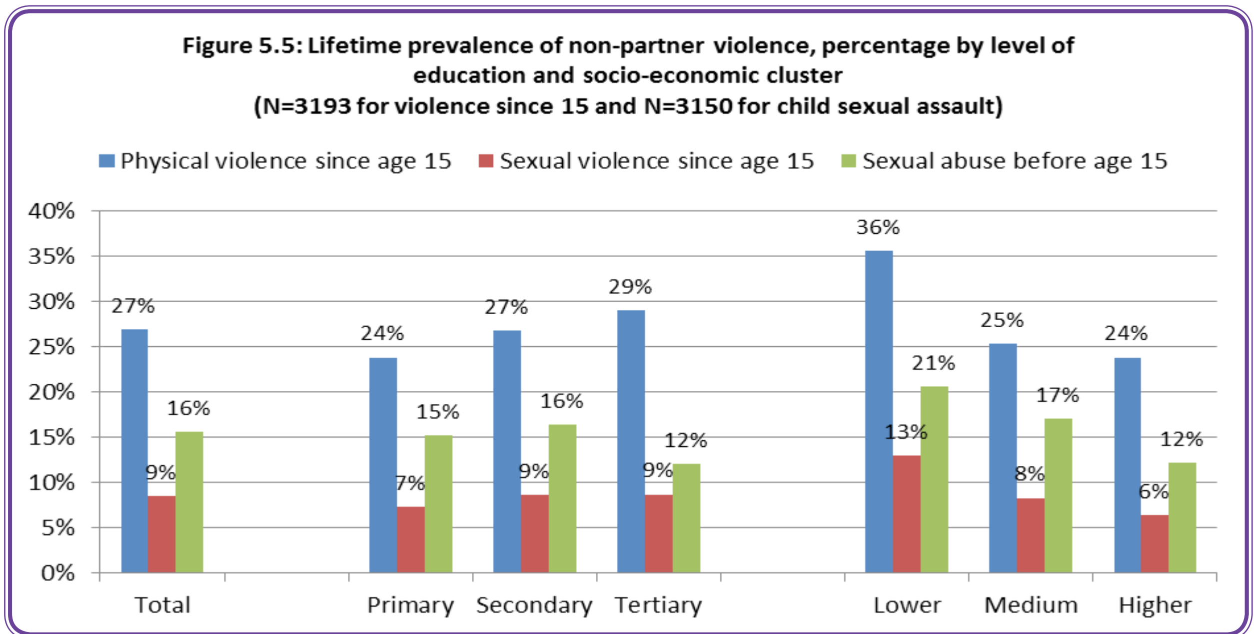


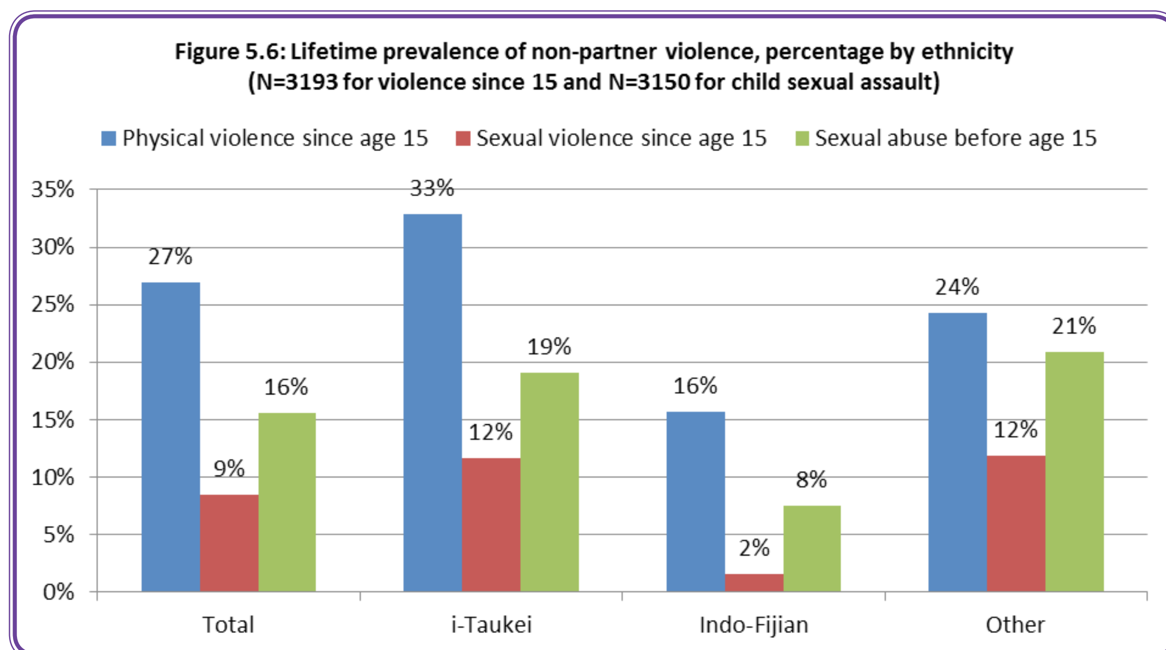
Source: Tables 5.1.1 and 5.2 of Annex 1.

Comparing rates of non-partner violence by socio-economic cluster shows that women from the lower socio-economic group were more likely to experience all 3 forms of non-partner violence. Nevertheless, women from the medium and higher socio-economic group experience all forms of violence at close to the national average: 1 in 4 experienced physical violence, 6%-8% experienced sexual abuse since age 15, and 12%-17% (more than 1 in 10) were subjected to child sexual abuse (Figure 5.5).

Prevalence by ethnicity and religion

Comparing prevalence of non-partner violence by ethnicity shows a similar pattern to violence perpetrated by husbands and partners (Chapter 4). Indo-Fijian women have a lower prevalence of physical and sexual abuse as adults by non-partners, compared with i-Taukei women and those from all other ethnic groups combined. One in 3 i-Taukei women (33%) have suffered from physical abuse, compared with 16% of Indo-Fijian women and 24% (1 in 4) from other ethnic groups. The prevalence of sexual violence since age 15 is about 1 in 10 for i-Taukei and other ethnic groups, compared with 2% (1 in 50) for Indo-Fijian women (Figure 5.6).

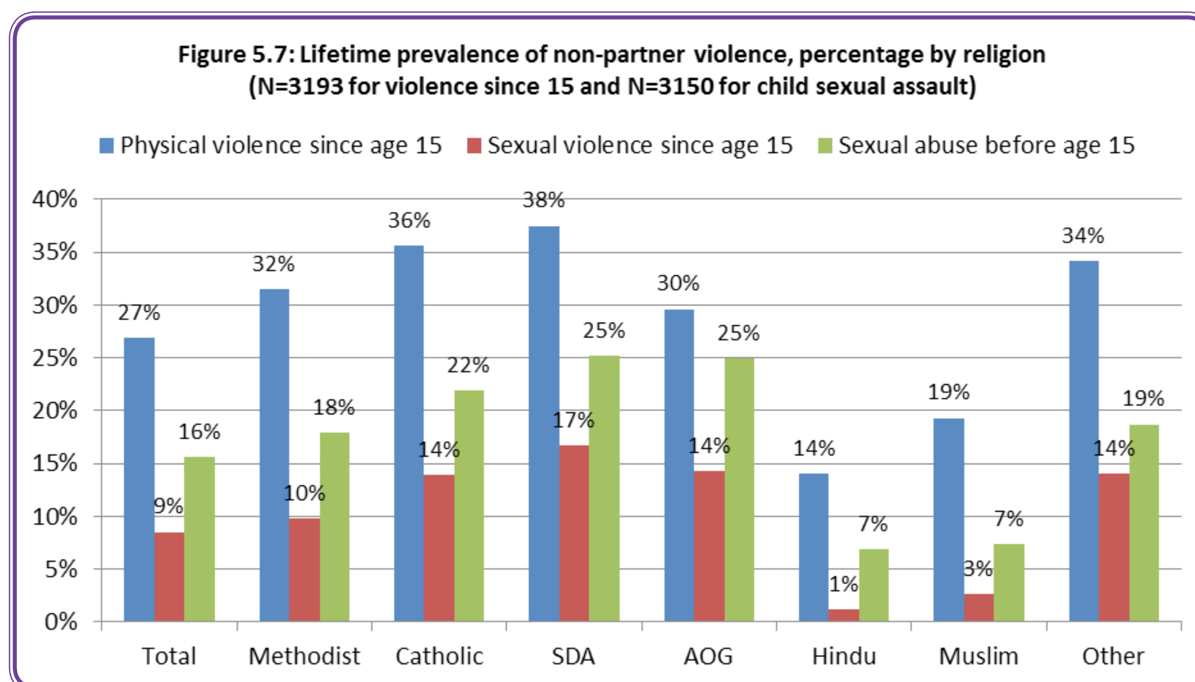
Although Indo-Fijian women reported a lower prevalence of child sexual assault, this is a significant problem in all communities. Almost one in 10 Indo-Fijian women (8%) were subjected to sexual assault as children under 15, compared with almost one in 5 i-Taukei women (19%) and just over 1 in 5 (21%) from other ethnic groups (Figure 5.6).



Source: Tables 5.1.1 and 5.2 of Annex 1.

There are higher levels of physical violence among Christian women over the age of 15 than among Hindu and Muslim women. About 1 in 3 Christian women have been physically assaulted since the age of 15, with prevalence ranging from 30% to 38% for different denominations, compared with 14% for Hindu and 19% for Muslim women (Figure 5.7).

There are similar patterns of prevalence for both sexual abuse since 15 years and child sexual abuse. However, child sexual assault affects for girls from all religious groups: prevalence ranges from 18% to 25% among Christian women, and is 7% among Hindu and Muslim women (Figure 5.7).



Source: Tables 5.1.1 and 5.2 of Annex 1.

Prevalence of all 3 forms of violence is somewhat higher than the national average for those categorised as having other religions (Figure 5.7). However, this is a very small group with only 76 respondents including 2 who identified as having no religion (Table 3.2 of Annex 1). Consequently the data is much less precise and no valid conclusions can be drawn from these differences.

5.3 Features of physical violence by non-partners

Table 5.2 shows the number of times that women were physically abused since age 15. It also shows the frequency of abuse among the 857 women who experienced some type of physical violence: of these, 31% said they were hit, beaten or kicked once or twice; 43% said this happened a few times; and 26% (about one in 4) said it happened many times (Table 5.2). Women from the Eastern Province and women aged 25-29 were more likely to say that they were hit many times (Table 5.1 of Annex 1).

Table 5.2: Frequency of physical abuse by non-partners since age 15 (percentage of all women [N=3193] compared with percentage of women who experienced physical violence [N=857])

Frequency of physical violence	Number	% of all women (N=3193)	% of women who experienced non-partner physical violence (N=857)
Once or twice	267	8%	31%
A few times	368	12%	43%
Many times	222	7%	26%
Ever non-partner physical violence since age 15	**857**	**27%**	**100%**

Source: Table 5.1.1 of Annex 1.

Women were asked who had mistreated them physically. Male family members were the majority of perpetrators including fathers (51%), other male family members (18%) and stepfathers (1%). Teachers were the next largest group of perpetrators (30%), followed by female family members (28%). Other perpetrators included male and female friends of the family and boyfriends (Table 5.3).

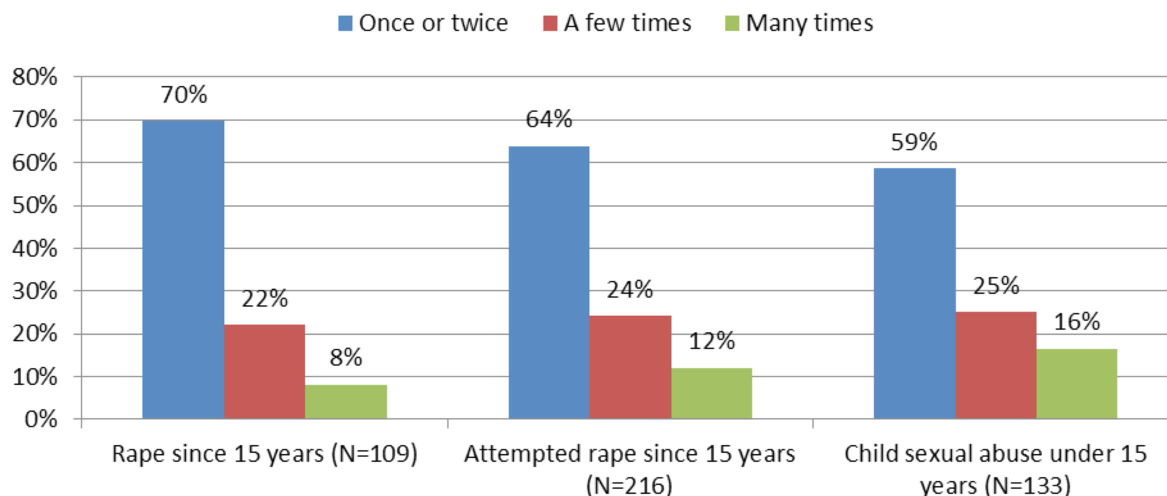
Table 5.3: Perpetrators of non-partner physical violence against women since age 15 (number and percentage of women who experienced non-partner physical violence, N = 860)

Perpetrators	Number	%
Father	437	51%
Teacher	261	30%
Female family member	238	28%
Other male family member	151	18%
Female friend of family	17	2%
Male friend of family	14	2%
Stepfather	12	1.4%
Boyfriend	12	1.4%
Stranger	6	0.7%
Someone at work	1	0.1%
Female partner	1	0.1%
Others	74	9%

Note: Numbers add to more than 860 and percentages to more than 100% because some respondents mentioned more than one perpetrator. Source: Table 5.3 of Annex 1.

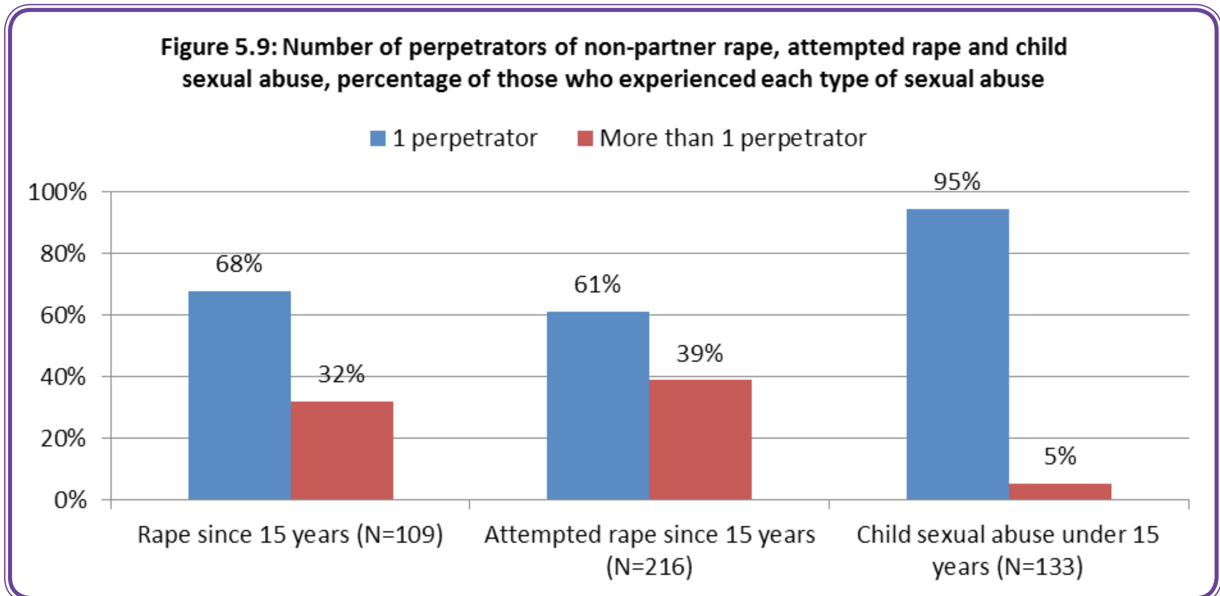
5.4 Features of sexual violence by non-partners

Attempted rape is about twice as prevalent as rape: 3.4% of women have been raped since they turned 15, compared with 6.8% where rape has been attempted. Overall, 8.5% of women have been subjected to both forms of sexual violence which indicates that some women have suffered from both rape and attempted rape (Table 5.2 of Annex 1). However, the most prevalent from of sexual violence is child sexual abuse, which has affected 16% of all women, almost double the rate subjected to sexual violence by non-partners as adults.



Source: Tables 5.1.2, 5.1.3 and 5.1.4 of Annex 1.

It is disturbing – but not unexpected – that more than 2 in 5 women (41%) who suffered from child sexual assault were abused more than once, and 16% reported that they were sexually abused many times. These figures may under-estimate the intensity and frequency of child sexual assault, since women who disclosed child sexual assault using the anonymous face card at the end of the survey were not asked questions about the frequency of the abuse or the identity of perpetrators. Thirty percent (30%) of women who were raped suffered from multiple attacks, and 8% were raped many times. Similarly, 36% of women who were subjected to other forms of sexual assault such as attempted rape were also abused more than once, and 12% many times (Figure 5.8).



Source: Tables 5.3 of Annex 1.

Among those women who have been raped, almost 1 in 3 women (32%) have been raped by more than one perpetrator. For those women who reported attempted rape, about 2 in 5 (39%) had more than one perpetrator. In contrast, most survivors of child sexual assault (95%) reported that there was one perpetrator, and the remaining 5% had more than one perpetrator (Figure 5.9).

Table 5.4: Perpetrators of non-partner rape, attempted rape and child sexual abuse (percentage of women who experienced non-partner sexual violence, N=190 for rape since 15 years, N=216 for attempted rape since 15 years, and N=133 for child sexual abuse under 15)

Perpetrators	Rape (% of perpetrators)	Attempted rape (% of perpetrators)	Child sexual abuse (% of perpetrators)
Other male family member (not father)	21.1%	28.2%	45.1%
Boyfriend	22.0%	13.0%	4.5%
Male friend of family	14.7%	15.3%	12.8%
Stranger	8.3%	14.8%	15.0%
Stepfather	5.5%	2.8%	6.8%
Female family member	5.5%	2.8%	3.8%
Father	2.8%	0.5%	0.8%
Someone at work	1.8%	1.4%	1.5%
Female friend of family	0.9%	1.9%	0.8%
Teacher	0.9%	0.9%	0.8%
Police/soldier	0	0.9%	0
Priest/religious leader	0	0.5%	0
Others	21.1%	24.5%	14%

Note: Percentages add to more than 100% because some respondents mentioned more than one perpetrator. Percentages for survivors of child sexual assault are only for those women who admitted to being abused during the interview; they do not include those who marked the anonymous face card at the end of the interview. Source: Table 5.3 of Annex 1.

Male family members (excluding fathers and step-fathers) were the largest group of perpetrators of rape and attempted rape (21% and 28% respectively), followed by boyfriends (22% and 13%) and male friends of the family (15% for both rape and attempted rape). Eight percent (8%) of rapes were perpetrated by strangers and 15% of attempted rapes. Stepfathers and female family members were perpetrators in 6% of rapes and 3% of attempted rapes, followed by fathers (3% of rapes and 0.5% of attempted rapes). Other perpetrators were someone at work (2% for rape and 1.4% for attempted rape), female friends of the family and teachers. No women admitted to being raped by police, soldiers or religious leaders, but a few women reported attempted rapes by these people. Twenty-one percent (21%) of rapes and 25% of attempted rapes were perpetrated by others who were not identified as being in any of the above categories (Table 5.4).

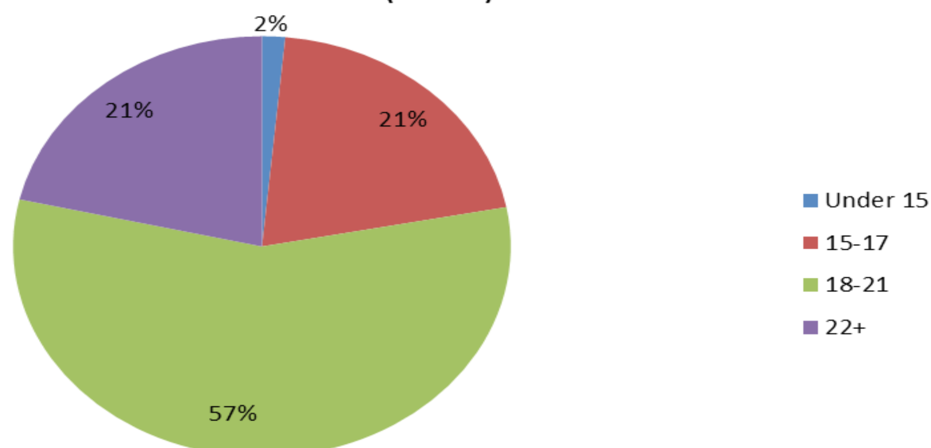
The profile of perpetrators for child sexual assault is somewhat different, although other male family members (excluding fathers and step-fathers) are by far the largest group of perpetrators, at 45%. Strangers were identified as the next biggest single category of perpetrators (15%), followed by male friends of the family (13%), stepfathers (7%), boyfriends (5%), and female family members (4%). Other perpetrators mentioned were someone at work (2%), and fathers, female friends of the family and teachers (all 0.8%). Other unidentified perpetrators were mentioned by 14% of women (Table 5.4).

If we aggregate the figures for all male family members, including fathers, stepfathers and other male family members, the following picture emerges. Male family members were perpetrators of physical violence in 65% of cases (with fathers as the majority). This compares with 29% of rapes, 32% of attempted rapes and 53% of child sexual assaults, but other male family members were the main perpetrators, rather than fathers and step-fathers. If we aggregate further to include all perpetrators who would be known to the women and girls who suffered sexual abuse, including male family members, friends and associates, 69% of women were raped by men who they knew; 63% of attempted rapes and 72% of child sexual assaults were by people known to the victim (Table 5.3 of Annex 1).

5.5 Women's first sexual experience

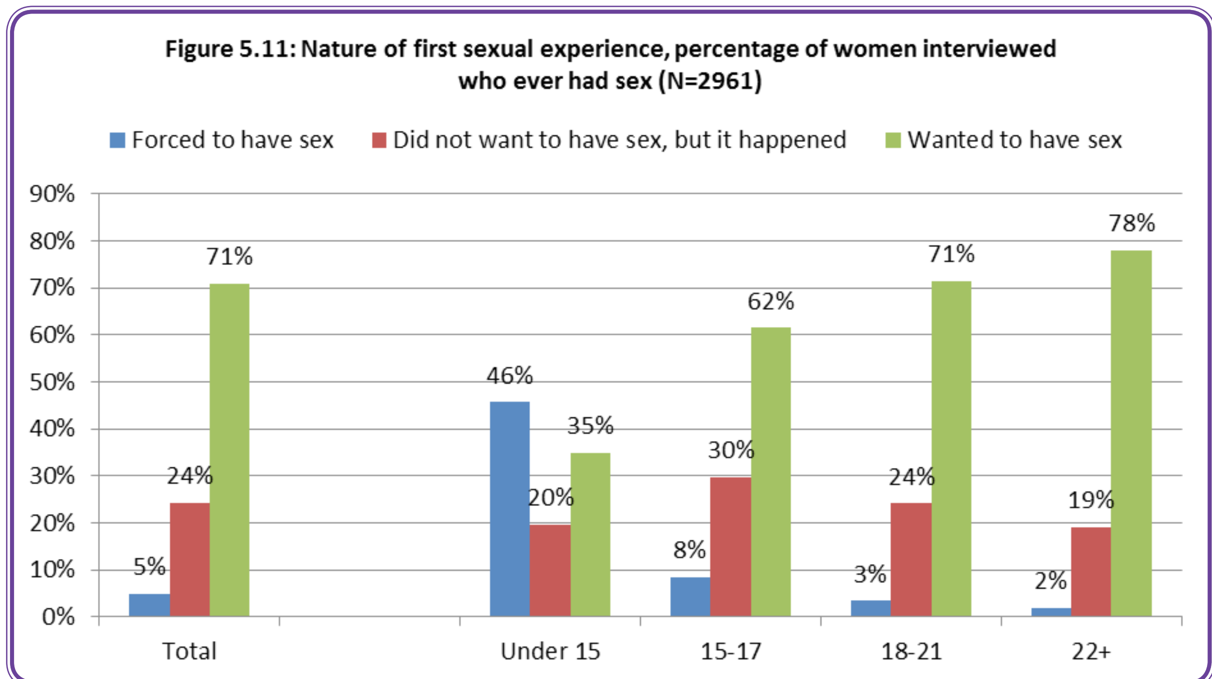
During the survey women were asked how old they were when they first had sex. They were also asked whether they wanted to have sex the first time, whether they didn't want to but it happened anyway, or whether they were forced to have sex. Among the 3193 women who participated in the survey, 5% said they had never had sex and 1% refused to answer this question (Table 5.5a of Annex 1). Among the 2992 who ever had sex, 2% were under 15 years of age when this happened, 21% were aged between 15 and 17, 57% were aged 18-21, and the remaining 21% were 22 or more (Figure 5.10).

Figure 5.10: Age of first sexual experience, percentage of women interviewed who ever had sex (N=2992)



Source: Table 5.5b of Annex 1.

Overall, 5% of women were forced to have sex the first time. Younger women were more likely to be forced, and older women were more likely to want to have sex the first time. For those who first had sex when they were under 15, 46% said it was forced and another 20% said it was coerced, with the remaining 35% saying that they wanted to have sex the first time. For women who first had sex when they were aged 15-17, about 3 in 5 (62%) wanted to do so, and the remainder (38%) were either forced or coerced. Coercion is common regardless of the age of first sex: 30% of 15-17 year olds (almost 1 in 3), 24% of 18-21 year olds (about 1 in 4), and 19% of those aged over 22 (1 in 5) were coerced during their first sexual experience (Figure 5.11).



Source: Table 5.6b of Annex 1.

5.6 Discussion of findings

5.6.1 High tolerance for violence

The combined prevalence of non-partner and intimate partner violence in Fiji (71%) is double the global estimate of 35.6%.[19] Fiji's prevalence of non-partner sexual violence since aged 15 (8.5%) is also higher than the global estimate of 7.2% (WHO 2013: 18-20). This finding and the others discussed in this chapter point to a high tolerance for violence in Fiji, and the need to focus on promoting women's and girls' human right to live without any form of violence.

With male and female family members and teachers as the main perpetrators of physical violence, the use of violence as a form of discipline and conflict resolution is normalised. The rates of non-partner physical violence found in this study are worrying for their own sake, because most violence can cause short-term or permanent injury, and because the use of violence against adults escalates anger and resentment, rather than resolves conflict. A common justification for corporal punishment is the saying: "spare the rod, save the child" (UNICEF 2009: 16). However, by normalising violence within the family young women and men learn that physical abuse is acceptable by those who have the most power in relationships, and learn to tolerate it.

19 The global estimate includes non-partner sexual violence and physical and/or sexual intimate partner violence (WHO 2013: 20); the prevalence for Fiji includes both physical and/or sexual non-partner violence as well as physical and/or sexual intimate partner violence.

The findings on the levels of non-partner violence by age, location, and level of education are particularly disturbing. As noted above, all forms of non-partner violence are extraordinarily high for women in the Eastern Province, and for young women aged 18-29. The prevalence of physical violence tends to increase as women progress from primary school through to tertiary education, and teachers make up the second-largest group of perpetrators, after fathers. These findings concur with those of the UNICEF study on child protection in Fiji, where children identified “teachers hitting children” as the number one factor that made children feel unsafe in schools (UNICEF 2009: 13). All these findings suggest that the education system reinforces physical violence. This is alarming, particularly when one considers the enormous potential of the education system to promote women’s and girls’ rights, and for teachers to be powerful role models of non-violence.

As with the findings on intimate partner violence discussed in Chapter 4, ethnic differences in rates of non-partner violence are troubling and point to the need for long-term dialogue and education about the consequences of violence, and research on the factors that may promote or reinforce it. During a workshop with FWCC staff, the higher prevalence of physical violence for i-Taukei women compared with those from Indo-Fijian and other backgrounds were explained partly by the tendency for young Indo-Fijian women to have their mobility more tightly controlled than those from other communities[20]; because their mobility is restricted, young Indo-Fijian women may be less likely to transgress traditional gender roles, and thus less likely to be physically abused by family members for doing so.

Although the findings indicate that there is a higher tolerance for violence in general among i-Taukei communities, it is important to emphasise that all forms of violence are a serious problem in all ethnic communities, religions and socio-economic groups.

5.6.2 Myths about the risks of sexual violence to women and girls

A common myth is that women are most at risk of sexual violence from people they hardly know or do not know at all. On the contrary, the findings show that the vast majority of perpetrators are well-known to their victims, and most are male relatives or family friends. The fact that boyfriends made up 22% of those who committed rape, 13% of those who attempted rape and 5% of those who perpetrated child sexual assault provides further evidence that violence by partners begins very early in some relationships, and confirms findings from Chapter 4 on intimate partner violence. Similar findings on perpetrators have been found in other country studies (SPC 2009: 79; SPC 2010: 101; VWC 2011: 106-107; WHO 2005: 46-48).

Some sections of the community may argue that sexual assault is a new or emerging problem, that it has increased due to the erosion of traditional and religious values, exposure to outside influences or changes in the way women dress, or that it is more prevalent in urban areas. The findings from the survey directly challenge all these false ideas. Comparing the prevalence of sexual abuse by age demonstrates very clearly that both the sexual assault of women over 15 and child sexual abuse are persistent problems that have affected women and girls over many decades. For example, between 13% and 17% of women aged 35 to 64 were subjected to child sexual abuse, compared with a national prevalence of 16%.

The data on the frequency of sexual assault of women over 15 show that a significant group of women – about 1 in 3 – are subjected to rape and attempted rape several times, and that about 1 in 10 are subjected to rape and attempted rape many times in their lives. This suggests that women who have been sexually assaulted at least once can become extremely vulnerable to repeated attacks.

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20 A UNICEF report on child protection in Fiji also noted that Indo-Fijian and Chinese children are likely to be more closely supervised than i-Taukei children (UNICEF 2009:16).

5.6.3 Perpetrators of child sexual assault

Sexual abuse of women over 15 and child sexual assault perpetrated by female family members or friends, although minor compared with that committed by male family members and friends, accords with evidence from other studies of a growing problem of children being exploited for commercial sex work by both female and male relatives. For example, a study by the International Labour Organization (ILO) on child labour in Fiji found 109 children engaged in prostitution, with some starting sex work as early as 10 years old.

The ILO study found that children's vulnerability to commercial sex work increased if they live with extended families, suffer from parental neglect, live in violent households, or have been victims of either physical or sexual abuse; more than half of the child sex workers interviewed during the ILO survey were living at home with parents or guardians (ILO 2010: 12, 15).

The survey found that few child sexual assaults were committed by fathers (0.8%) and step-fathers (6.8%), and that 15% were by strangers. This finding is not supported by FWCC's counselling experience, where fathers make up 13% of perpetrators of child sexual abuse, step-fathers 10%, grandfathers and step-grandfathers 4%, teachers 5% and strangers only 6%. However, the perpetrator profile among FWCC clients does support the other findings of the survey – most perpetrators are well-known to the victim, and are men who have opportunity and access to children due to positions of trust or power. Male relatives make up 59% of total perpetrators of FWCC clients compared with 53% from the survey, and 93% of perpetrators were well-known to the victim (Table 5.5).

Table 5.5: Perpetrators of child sexual abuse among FWCC clients, 2001-2011 (number and percentage of women who experienced child sexual abuse)

Perpetrators	Number	%
Male family member: uncles, cousins, step-brothers, brothers-in- law	109	32%
Father	43	13%
Male friends: family friend, school friends, acquaintances	37	11%
Neighbour, landlord	36	11%
Stepfather	34	10%
Boyfriend, de facto, partner	25	7%
Stranger	22	6%
Teacher	18	5%
Grandfather, step-grandfather	14	4%
Priest/religious leader	3	1%
Not disclosed	1	0.3%

Note: Percentages add to more than 100% because some clients identified more than one perpetrator. Source: FWCC client statistics.

These differences in perpetrator profiles are explained by the fact that most survivors (90%) did not disclose child sexual assault during the interview; they did so by marking the anonymous face card at the end of the interview. Hence, they were not asked questions about the frequency of the abuse or the perpetrators. FWCC has found that it can take several counselling sessions before a survivor admits the identity of the perpetrator, particularly when it is the father.

The high prevalence of child sexual abuse found during the survey (16%), and the fact that so many women chose not to disclose it during the interview, highlights the shame that accompanies it throughout one's life, and the huge under-reporting of this problem.

Chapter 6:

Women's Attitudes To Gender Power Relations & Violence Against Women

Summary of main findings

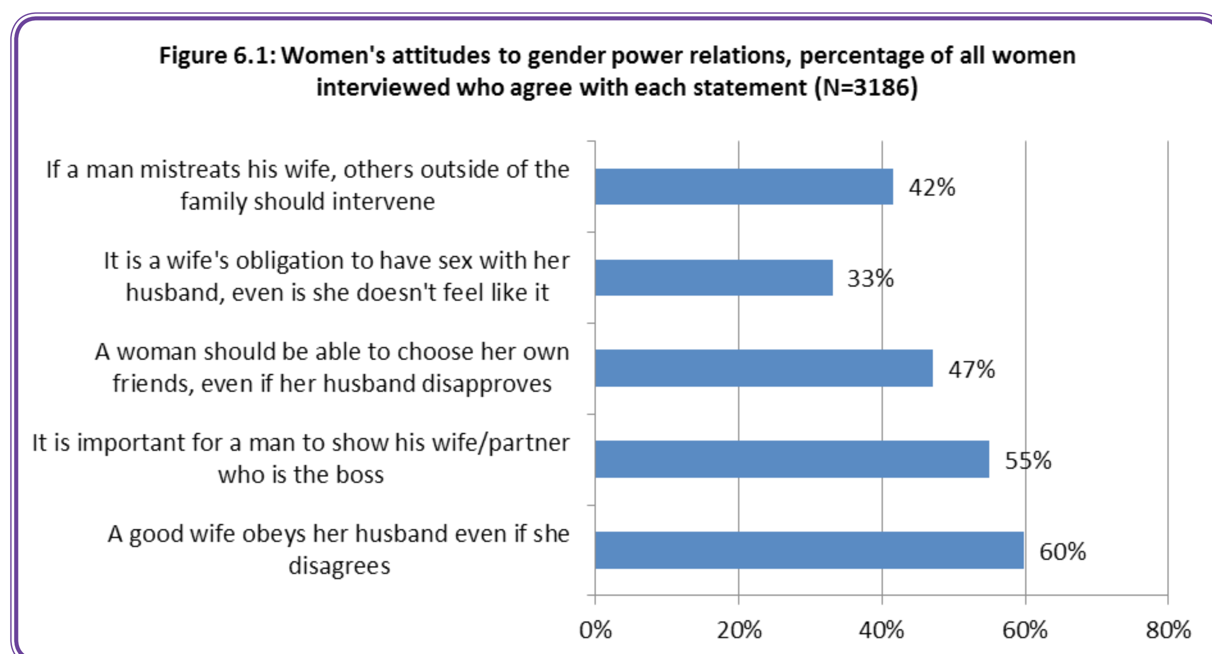
- Although many women agree with statements that undermine women's rights and gender equality, others point to the potential for attitudinal changes on gender relations.
- Two in 5 women (43%) agree with at least one justification for a man to beat his wife; 57% do not agree with any reasons for physical violence by a husband/partner.
- Most women have a strong sense of sexual autonomy and more than 3 in 4 (77%) believe that a woman has the right to refuse sex with her husband if she doesn't feel like it.
- The situations that women most often identify as being factors in violent physical assaults by her husband/partner include his jealousy (30%), her disobedience (29%), and his drunkenness (29%).

This chapter presents findings on women's attitudes to gender power relations and violence against women in intimate partner relationships. Women were asked whether they agreed or disagreed with a series of statements. The first series focused on gender power relations between husbands and wives; the second explored women's views on whether a man has "a good reason to hit his wife/partner" in specific situations; and the third asked about situations where a married woman can refuse to have sex with her husband (see section 6 of the questionnaire in Annex 2). All questions were asked of all 3193 respondents, including ever-partnered and never-partnered women; 7 women did not answer this series of questions and have been omitted from the analysis, giving a total of 3186 respondents.

Findings are also presented on women's views regarding particular situations where physical violence by their husband/partner tends to occur (see section 9 of the questionnaire in Annex 2). This question was put to 1853 ever-partnered women who had ever been physically assaulted by their husband/partner.

6.1 Women's attitudes to gender power relations

6.1.1 Overview of women's attitudes to gender power relations

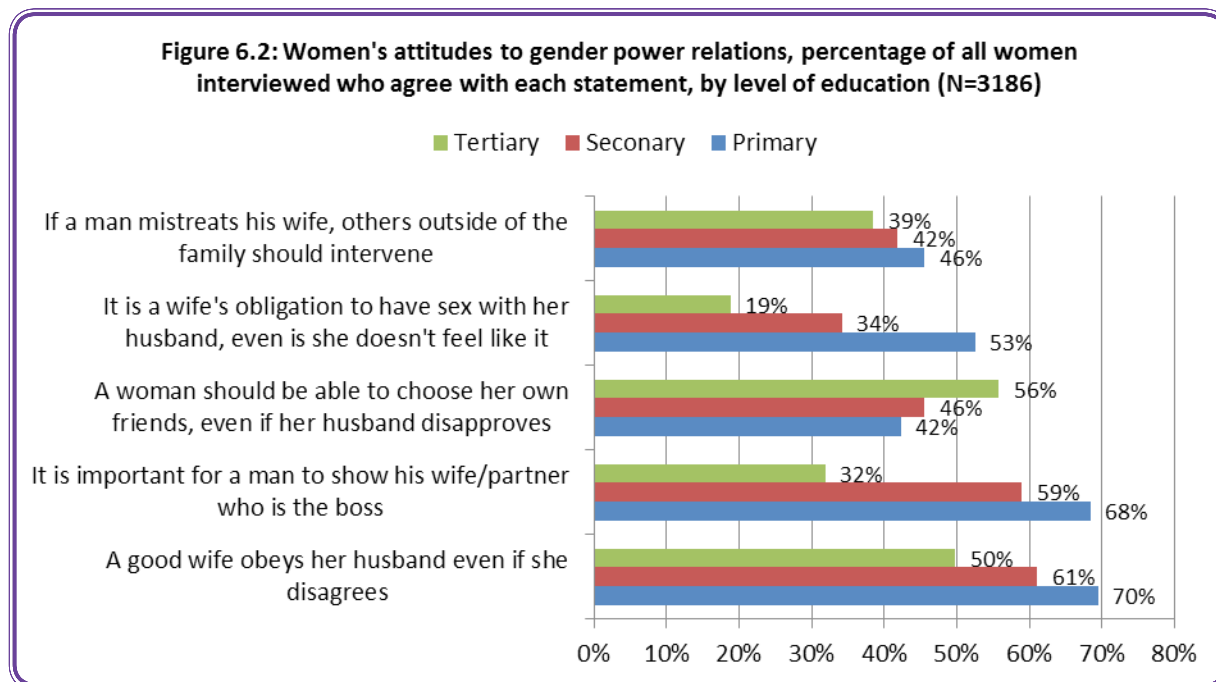


Source: Table 6.1 of Annex 1.

Overall, a majority of women believe that a good wife should obey her husband, even if she disagrees with him (60%), and that it is important for a man to show his wife/partner who is the boss (55%). Less than half (47%) agree that a woman should be able to choose her own friends, even if her husband disapproves. Agreement with these statements shows that there is a widespread belief in traditional views of gender roles and unequal gender power relations. In contrast, only 1 in 3 (33%) agrees that a wife is obligated to have sex with her husband if she doesn't feel like it, which indicates a sense of sexual autonomy among the majority of women. While it is encouraging that 2 in 5 (42%) agree that others outside the family should intervene if a man mistreats his wife, almost 3 in 5 disagree – and this demonstrates the scale of the task ahead to address and eliminate violence against women (Figure 6.1).

6.1.2 Differences in women's attitudes to gender power relations

There are some noteworthy variations in attitudes among different groups of women, which provide insight into the differences in prevalence noted in Chapters 4 and 5. On the whole, there are few differences in opinion by location, although women in the Eastern Division are substantially more likely to agree with the view that a man should show he is the boss (62% compared with the national rate of 52%). There are also some differences by age on this statement, with less young women aged 18-34 agreeing (44-51%) compared with older women aged 50-64 (64-68%). Similarly, younger women aged 18-29 are somewhat more likely to believe that women should be able to choose their own friends, and less likely to agree that a wife is obliged to have sex with her husband (Table 6.1 of Annex 1). These differences in views suggest that attitudes may be changing, and that younger women may be more likely to challenge traditional gender relations than older women.



Source: Table 6.1 of Annex 1.

Differences in attitudes according to level of education are the most striking, although it is worth remembering that education does not protect women from experiencing violence in the first place, despite attitudinal differences (see Chapter 4). Overall, women educated to tertiary level are far more likely to hold views that support women's human rights and gender equality. Nevertheless, half of tertiary educated women believe that a good wife should obey her husband, and 1 in 3 believe that he should show he is the boss (Figure 6.2).

The view that people outside the family should not intervene if a man mistreats his wife becomes more entrenched as the level of education increases: less women educated to tertiary level (39%) believe that others should intervene, compared with those educated to secondary (42%) and primary (46%) level (Figure 6.2).

There are also some interesting differences in attitudes associated with ethnicity. Indo-Fijian women are substantially more likely to agree that a good wife should obey her husband (67%), compared with 57% of i-Taukei women and 53% of those from other ethnic groups combined. Indo-Fijian women are also more likely to agree that a wife is obliged to have sex with her husband (42%), compared with 29% of i-Taukei women and 30% from other ethnic groups.

These views suggest that Indo-Fijian women may be somewhat less likely to challenge their husbands on issues relating to traditional gender roles and expectations than women from i-Taukei communities. On the other hand, i-Taukei women are far more likely to agree that a man should show his wife that he is the boss (61%), compared with 46% of Indo-Fijian women and 38% from other ethnic groups. Most of these differences are also reflected in different views between the major religions of Christianity, Hinduism and Islam (Table 6.1 of Annex 1).

6.1.3 Association between women's attitudes and their experience of violence

Three of the attitudes on gender relations show a statistically significant association with women's experience of physical and/or sexual violence by her husband/partner. Women who agreed that it is important for a man to show that he is the boss were significantly more likely to have experienced violence in their lifetime. They were also significantly more likely to have been subjected to "severe" versus "moderate" physical violence, and to have experienced both physical and sexual violence.[21] In contrast, women's views on the importance of obedience to her husband and her obligations to have sex are not significantly associated with violence (Table 6.1). While all these attitudes are expressions of unequal gender relations, the belief that a man should show that he is the boss provides a licence for men to express this in various ways, including by the use of violence.

Table 6.1: Women's attitudes to gender relations, according to their experience of physical or sexual violence from their husbands/partners (number and % of ever-partnered women who have and have not experienced intimate partner violence)

Percentage who agree with the following statement:	% who agree who never experienced violence	% who agree who experienced physical and/or sexual violence	P value
A good wife obeys her husband even if she disagrees	59%	61%	0.56
It is important for a man to show his wife/ partner who is the boss	51%	59%	<0.001
A woman should be able to choose her own friend even if her husband disagrees	43%	49%	0.002
It's a wife's obligation to have sex with her husband, even if she doesn't feel like it	32%	35%	0.12
If a man mistreats his wife, others outside of the family should intervene	38%	44%	0.001

Note: A P value of 0.001 means that there is a 0.1% possibility that the association is due to chance or error. Source: Table 6.1 of Annex 1.

Women who believe that a woman should be able to choose her own friends are also more likely to be living with violence. In addition, women who have experienced violence in their lifetime are significantly more likely to believe that others outside the family should intervene if a woman mistreats his wife (Table 6.1).

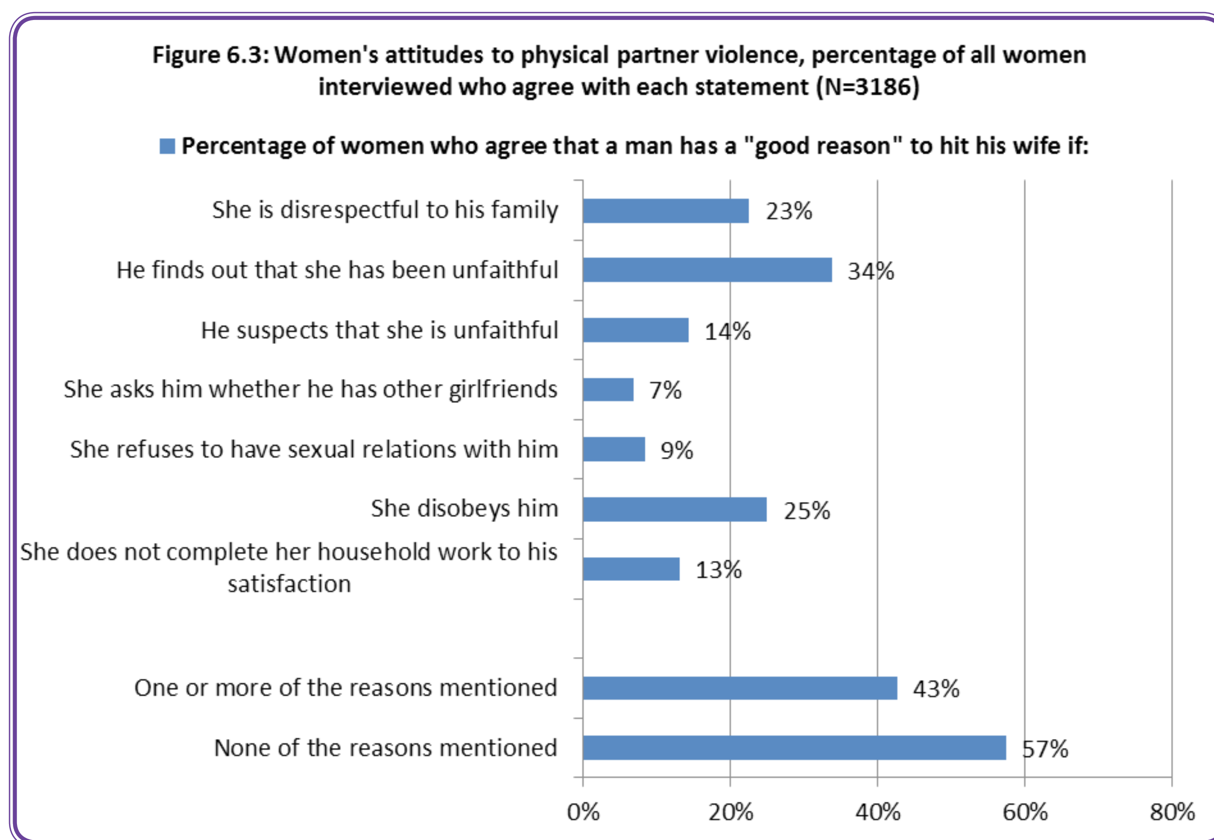
21 Among those women who agreed that a man should show he is the boss, 61% had been subjected to "severe" physical violence (hitting with a fist or something else, kicking, dragging, beating up, choking, burning or using a weapon) compared with 54% subjected to "moderate" violence (slapping, throwing something, pushing or shoving), and 62% who had experienced both physical and sexual violence. P values for these associations were less than 0.001.

6.2 Women's attitudes to physical violence by husbands/partners

6.2.1 Overview of women's attitudes to physical intimate partner violence

Overall, 57% of women do not agree that there are any "good reasons" for a man to hit his wife; conversely, more than 2 in 5 women (43%) agreed with one or more reasons for him to do so. Unfaithfulness (34%), disobeying the husband (25%) and disrespect for the husband's family (23%) were the main reasons that women thought justified physical violence.

Fourteen percent (14%) also thought a man is justified in hitting his wife even if he only suspects she is unfaithful, and 13% thought it justified if she does not complete household work to his satisfaction. Less than 1 in 10 women (9%) agreed that refusal to have sex is a "good reason", and 7% thought asking him whether he has other girlfriends was a "good reason" (Figure 6.3).



Source: Table 6.2 of Annex 1.

6.2.2 Differences in women's attitudes to physical intimate partner violence

Some of the patterns discussed in Chapter 4 regarding the prevalence of intimate partner violence are also evident in women's attitudes to physical abuse. For example, women from the Eastern Division (60%) are substantially more likely to agree with one or more of the justifications for violence than those from urban areas (37%) and from the Central and Western Divisions (40%). Indo-Fijian women are generally somewhat less likely to agree with each statement. Nevertheless 34% of Indo-Fijian women (1 in 3) agree with at least one justification for physical violence compared with 48% of i-Taukei women and 27% from other ethnic groups. This is also reflected in opinions by religion, with Christian women likely to agree with at least one justification, compared with Hindu (32%) and Muslim (40%) women (Table 6.2 in Annex 1).

However, other patterns observed in Chapter 4 are not repeated. For example, opinions on these matters tend to fluctuate with age: although women aged 25-39 are less likely to agree with one or more statements, those aged 18-24 are more likely to do so (Table 6.2 in Annex 1).

Consistent with the attitudes on gender relations discussed above, women educated to tertiary level are somewhat less likely to agree with any justification for physical violence. One in 3 tertiary-educated women (32%) believe that violence is justified for one or more reasons, compared with 44% of those educated to primary level and 45% of those with secondary education (Table 6.2 of Annex 1).

6.2.3 Association between women's attitudes to physical violence and their experience of violence

Not surprisingly, there is a highly significant association between believing that a man is justified in using physical violence, regardless of the reason, and women's experience of violence by a husband or intimate partner. Thirty-five percent (35%) of women (about 1 in 3) who have never experienced violence agreed with one or more reasons for using physical violence against a wife/partner. This compares with 48% (almost half) for those who have lived in a violent relationship. Conversely, about half of those living in a violent relationship believe that there is no justification for violence.

Table 6.2: Women's attitudes to physical intimate partner violence, according to their experience of physical or sexual violence from their husbands/partners (number and % of ever-partnered women who have and have not experienced intimate partner violence)

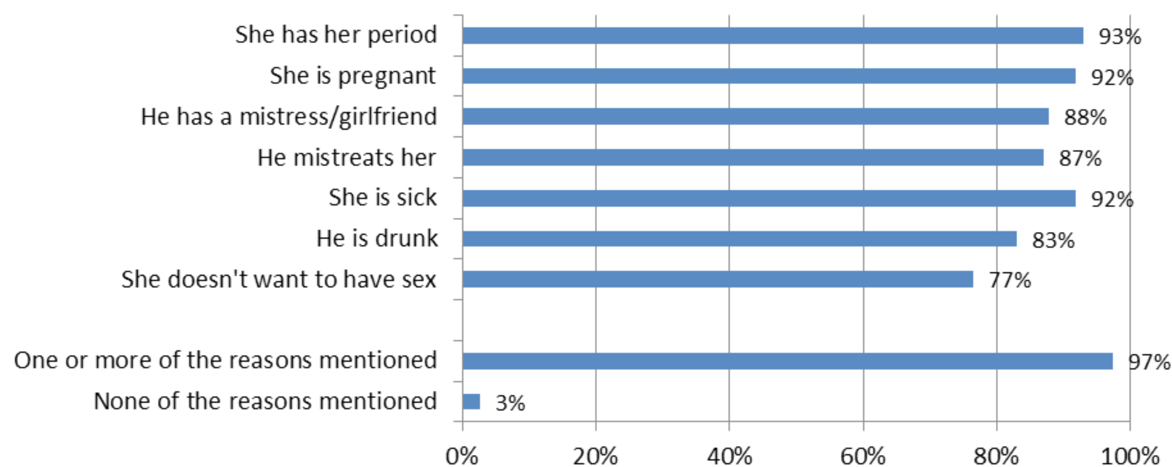
Percentage who agree that a man has a "good reason" to hit his wife if:	% who agree who never experienced violence	% who agree who experienced physical and/or sexual violence	P value
She does not complete her household work to his satisfaction	10%	15%	<0.001
She disobeys him	19%	29%	<0.001
She refuses to have sexual relations with him	6%	10%	<0.001
She asks him whether he has other girlfriends	5%	8%	<0.001
He suspects that she is unfaithful	10%	17%	<0.001
He finds out that she has been unfaithful	26%	39%	<0.001
She is disrespectful to his family	18%	25%	<0.001
Agrees with one or more of the reasons mentioned	35%	48%	<0.001
Agrees with none of the reasons mentioned	65%	52%	<0.001

Note: A P value of <0.001 means that there is less than 0.1% possibility that the association is due to chance or error (that is less than 1 possibility in 1,000). Source: Table 6.2 of Annex 1.

6.3 Women's attitudes to sexual autonomy

With 97% of women agreeing with one or more reasons for refusing sex with their husbands, it is clear that most women have a sense of sexual autonomy. However, it is worth noting that 23% of women (almost 1 in 4) do not agree that a woman can refuse sex with her husband simply because she doesn't want to have sex with him or doesn't feel like it (Figure 6.4). This suggests that a substantial number of women believe that they must have a good reason to refuse sex within marriage. This reinforces the finding discussed above (section 6.1), that 33% of women feel obligated to have sex with their husband, even if they don't feel like it.

Not withstanding the fact that 3 in 4 women have a strong sense of sexual autonomy, more than 1 in 10 do not believe she can refuse if he mistreats her (13%) or is having an affair (12%), and almost 2 in 10 do not believe that she should refuse if he is drunk (17%). Almost 1 in 10 (8%) believe she has no right to refuse even if she is sick (Figure 6.4).



Source: Table 6.3 of Annex 1.

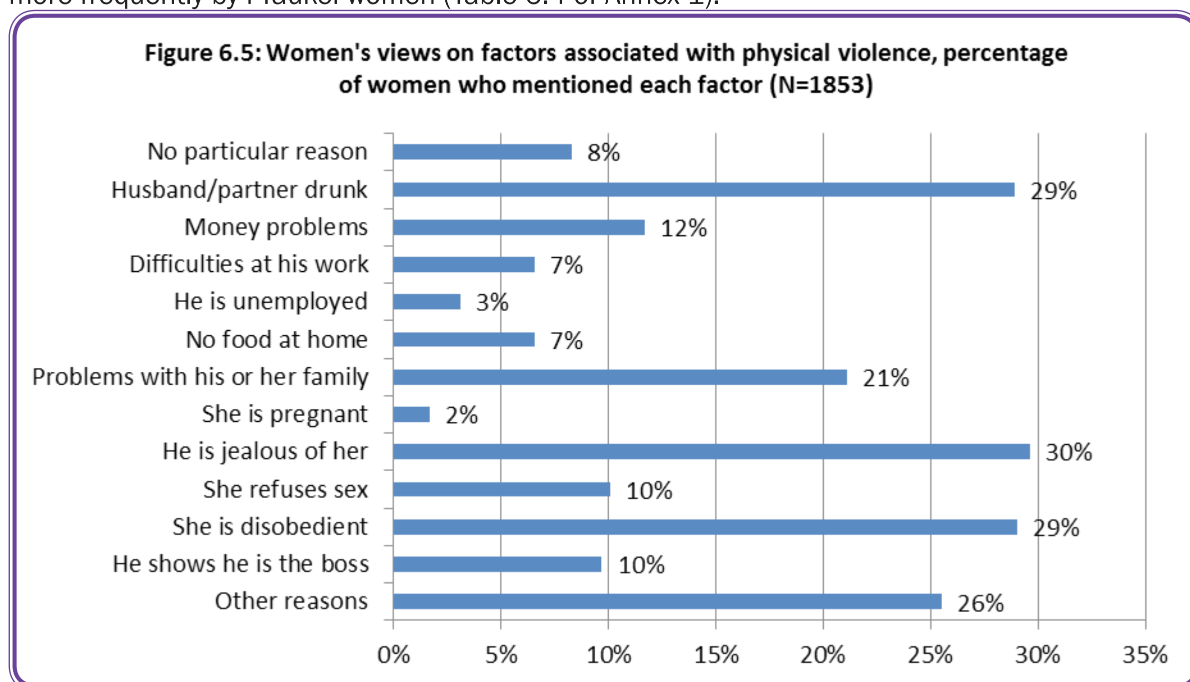
It is noteworthy that there are no substantial differences in attitudes on sexual autonomy by location, age, education or ethnicity (Table 6.3 in Annex 1). This is in contrast to the patterns discussed above for attitudes to other aspects of gender relations and physical violence, and to the patterns observed in the prevalence of intimate partner violence and non-partner violence discussed in Chapters 4 and 5.

Moreover, there are no statistically significant differences in attitudes to sexual autonomy between women who have experienced physical and/or sexual violence in their lifetime, and those who have not. For example, 78% of women who have not experienced violence believe that a married woman can refuse sex if she wants to, compared with 75% of those who have lived in violent relationships (Table 6.3 in Annex 1).

6.4 Women's views about situations when physical violence occurs

Women who had experienced physical violence in their lifetime were asked what type of situations or factors were associated with their husband's/partner's behaviour. On average, each woman gave 2 responses. It is important to emphasise that a situation or factor associated with violence is <u>not</u> the same as the cause of men's violence against women. The most frequently mentioned factors were the husband/partner feeling jealous of his wife (30%), disobedience by the wife (29%), the husband/partner being drunk (29%), and problems with his or her family (21%). Other factors mentioned included: money problems (12%), her refusal to have sex (10%), his wanting to show that he is the boss (10%), difficulties at his work (7%), no food at home (7%), his unemployment status (3%), and her being pregnant (2%). Eight percent (8%) of women mentioned that there was no particular reason, and 26% also mentioned a variety of other reasons (Figure 6.5).

Women in urban areas more frequently mentioned that there was no particular reason for the violence (14%) or that his drunkenness was a factor (36%). In rural areas and particularly in the Eastern Division, more women mentioned his jealousy (43% in the Eastern Division and 32% in rural areas), her disobedience (40% in the Eastern Division and 35% in rural areas), and him showing that he is the boss (17% in the Eastern Division and 12% in rural areas). Family problems were mentioned more frequently than the national average by Indo-Fijian women; jealousy and disobedience were mentioned more frequently by i-Taukei women (Table 6.4 of Annex 1).



Note: Percentages total more than 100% because women could identify more than one factor. Source: Table 6.4 of Annex 1.

6.5 Discussion of findings

The high levels of agreement with many statements that are opposed to women's rights highlights the enormous task ahead for all stakeholders working to eliminate violence. With 3 in 5 women believing that a "good wife" should obey her husband, obedience is a key feature in gender relations for the majority of women in Fiji. Disobedience is seen by 1 in 4 women as a "good reason" for a man to hit his wife. The notion that one adult should be obedient to another in an intimate relationship is demeaning and disempowering, and demonstrates the low status of women in Fiji. One does not expect obedience from people with equal status and power in relationships based on mutual respect. Disobedience also emerged as the major justification for domestic violence in FWCC's 1999 survey, along with adultery and flirting, being cheeky or talking back to the husband, and laziness (FWCC 2001: 33).

Overall, the responses to questions on sexual relations indicate that many women have a strong sense of sexual autonomy. According to FWCC staff, these findings point to attitudinal changes on marital rape in recent years due to long-term campaigns on this issue. Nevertheless, about 1 in 3 women believe that it is a wife's obligation to have sex, that there must be a good reason for her to refuse (not just that she doesn't want to, or doesn't feel like it), and about 1 in 10 still believe that refusing sex is a good reason for man to hit his wife.

The expectation that women should be subservient to men is demonstrated by the fact that more than half of the women who responded to the survey agreed that it is important for a man to show his wife that he is the boss. This attitude legitimises men's violence and controlling behaviours as a way of maintaining their higher status, and is reflected in many common sayings that condition girls and

women to believe that violence is an expression of love. For example, violence may be accompanied by assertions that it is "only to teach her", or that it is "for her own good". If a woman has lost her teeth due to repeated physical assaults, people may comment that her husband "loves her too much".

It is telling that 1 in 3 women identified jealousy as the most important factor associated with physical violence: in other words, men will resort to violence when women are perceived as being more successful than their husbands, or when men believe they have been displaced from their position of higher status and privilege in the household. In these cases, women's actions or achievements challenge men's perceptions of themselves as leaders and decision-makers; men's use of violence is a way of exerting their power and control over women, to keep women in their subordinate place.

A qualitative research project was undertaken by FWCC in 2006; it explored community perceptions of women's rights and the consequences when women do assert their rights. Conclusions from the 2006 study help to contextualise those from the current survey. The overwhelming view expressed by study participants in 2006 (both male and female) was that if a woman is beaten by her husband, she must have "done something wrong" and thus deserved it. The study found that there was a backlash against women who did assert their rights; the prevailing attitude was that such women were "socially deviant, arrogant, power greedy and a source of gossip within the community" (FWCC 2006: 7-8). While it was seen as acceptable for women to publicly voice opinions or criticisms that the whole community agreed with, she would be ridiculed and judged as behaving inappropriately if this involved a challenge to male roles or leadership (FWCC 2006: 7, 46, 58).

The 2006 study found a high degree of confusion about women's rights and how these may impact on traditional roles. There was a prevalent view that if women asserted their rights, this would be at the expense of their household responsibilities and social and cultural obligations, and thus would be harmful to the whole community. Promoting women's rights was perceived as being in direct conflict with cultural and religious norms, which insist that women should submit to their husbands. Asserting women's rights was seen as a foreign way to behave, in addition to being impractical and promoting discord and disharmony (FWCC 2006: 7, 26, 42). Thus, when women choose their own friends or challenge their husbands/partners on this issue, or when they fail to behave as required by traditional norms, the findings from the current study indicate that they are "punished" for doing so (Figures 6.1 and 6.3).

The fact that more than 2 in 5 women still believe that a man has "good reason" to hit his wife in any circumstances shows that a tolerance for men's violence against women and unequal gender power relations are entrenched in some women's belief systems; this is particularly the case in the Eastern Division. Another challenging finding is that only about 2 in 5 women believe that people outside of the family should intervene if a man mistreats his wife. Both attitudes will require clear and persistent government and community leadership to be countered. For this to be done effectively, stakeholders need to be clear about the implications of taking a rights-based approach to addressing men's violence against women; this requires challenging attitudes that legitimise men's use violence and control, and that women should be subservient and obedient. Given the highly significant association between women's experience of violence and women's belief that violence is justified if women "misbehave", men's power over women has to be confronted head on, to increase the effectiveness of primary and secondary prevention efforts.

Although the discussion above highlights entrenched belief systems that reinforce gender inequality, there are also very positive signs that some attitudes are beginning to change. For example, it is positive that almost 3 in 5 women thought that physical violence could not be justified, and that younger women were less likely to agree with some statements that reinforce unequal gender relations (such as that men should show they are the boss, and that wives are obliged to have sex).It is also encouraging that women educated to tertiary level were substantially less likely to agree with statements that undermine women's rights and justify violence, even though these attitudes by themselves do not protect them from violence. On the contrary, there is some evidence – when we compare findings on attitudes with those on prevalence in Chapter 4 – that challenging traditional norms and beliefs may make women more vulnerable to violence, particularly in the short-term and in the early days of a relationship when power relations are being established. This is also supported by FWCC's 2006 study, which found that men tend to become more abusive, aggressive and violent when women challenge men's domination and control (FWCC 2006: 62).

Although there is no quantitative evidence that women are now any more likely to seek help outside the family, FWCC has anecdotal evidence from counselling that this is the case, particularly when one compares the current situation with that described in FWCC's 2006 study on community perceptions. This found that domestic violence was overwhelmingly seen as private matter, with little awareness of the need for family or community members to provide support to women living with violence (FWCC 2006: 63-64). FWCC Counsellors report that in the past, most women spent many years in a violent relationship before telling anyone, taking the difficult step of seeking help outside the family or taking the decision to leave. In recent years, FWCC has seen an increase in younger clients; Counsellors now report that mothers, other relatives, friends, and neighbours are increasingly referring women for assistance to stop the violence, rather than advising them to put up with the violence or become more submissive to prevent it.

However, the fact that tertiary educated women are <u>less</u> likely to agree that people outside the family should intervene is a worrying finding and points again to missed opportunities for promoting an understanding of women's human rights and violence against women through the education system. This finding may be explained by the extreme humiliation and shame associated with having a problem of domestic violence publicly known or discussed, given that women are often still blamed for the problem rather than men (FWCC 2006: 63-64). All these findings underline how critically important it is for relatives, community members and service-providers to respond appropriately when women do make the very difficult decision to seek help to deal with violence – by reinforcing women's rights, holding men accountable for their behaviour rather than blaming the victim, prioritising the safety of women and children, and supporting women to leave if they decide to do so.

There is anecdotal evidence that positive attitudinal changes have indeed occurred, and that this change is due to a combination of factors – including the persistent work that FWCC has done over many years in raising awareness of women's rights and understanding of the nature of men's violence against women, in addition to the efforts of the women's movement in Fiji more generally. A variety of community leaders and organisations have progressively taken up the issue of violence of against women due to FWCC's input and support, and FWCC's male advocacy program has been successful at spreading prevention messages into new places that were previously resistant and opposed to FWCC and its work. Social and economic changes have also played a part, by providing women with more opportunities for education, training and employment, which help to raise the status of women. Overall, the findings on attitudes provide important insights into women's views of gender equality and human rights, including opportunities for consolidating attitudinal change, and key areas of focus for further work to strengthen prevention.

Chapter 7:

Impacts Of Violence Against Women On Physical, Mental And Reproductive Health, Including During Pregnancy

Summary of main findings

Physical health

- Almost half (47%) of the women who experienced physical and/or sexual partner violence in their lifetime have been injured; and more than 1 in 10 (13%) have lost consciousness.

- Among those ever injured, 3 in 5 (60%) have been injured more than once and 2% (1 in 50) now have a permanent disability.

- Among those who needed health care due to their injuries, less than 2 in 3 actually received health care; among these, 1 in 3 did not tell the health worker the real reason for the injury.

- Women living with physical and/or sexual violence have much poorer health and are hospitalised more often.

Mental health

- Women living with physical, sexual or emotional violence have more symptoms of emotional distress and are significantly more likely to think about and attempt suicide than those who have not experienced intimate partner violence.

Pregnancy and reproductive health

- **15% of ever-pregnant women were beaten during pregnancy, and one-third of these were punched or kicked in the abdomen while pregnant by their husband/partner.**

- Women living with physical and/or sexual violence are more likely to have unwanted pregnancies; their husbands/partners are also more likely to have prevented them from using contraception.

- Women beaten during pregnancy are more likely to have had a miscarriage

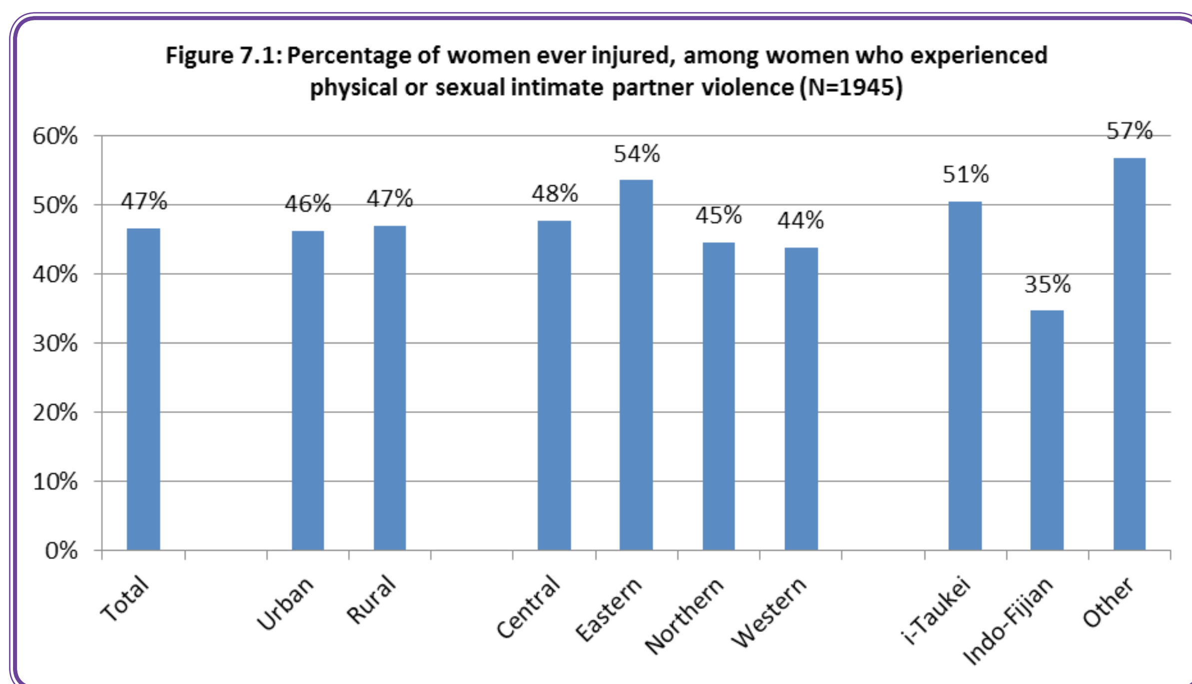
This chapter presents findings on the impact of physical and sexual partner violence on women's physical health, including the frequency and type of injuries women experienced, and their use of medication and health services. It also discusses the impacts of physical, sexual and emotional violence on women's mental health, and their likelihood of thinking about or attempting suicide. Findings are presented on the prevalence of violence against women during pregnancy and the association between intimate partner violence and reproductive health outcomes. Women's use of contraception is discussed, and how this is affected by intimate partner violence.

The survey posed most questions on women's physical, mental and reproductive health before women were asked to disclose whether they had experienced violence by a husband/partner. This approach minimises bias in women's responses and provides robust evidence on the impact of violence on women's health. Other questions focused on women's views of the specific impacts of partner violence (section 7.1.1).

7.1 Impacts of partner violence on physical health

7.1.1 Injuries caused by partner violence

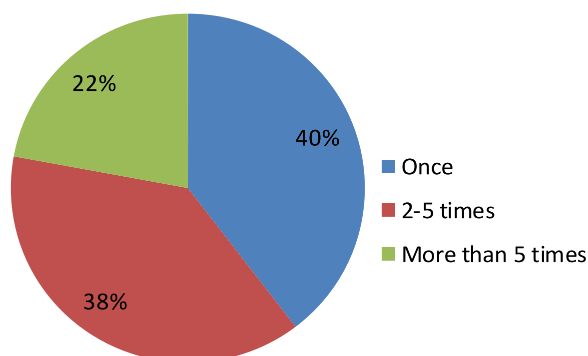
Of the 1945 women who experienced physical and/or sexual violence by their husbands/partners, 909 were injured as a result of the violence; this is almost half (47%) of the women who are living with violence (Figure 7.1). If we consider the whole sample of 3035 ever-partnered women who participated in the survey, about 1 in 3 (30%) have been injured.



Source: Table 7.1 of Annex 1.

There is little difference in the rates of injury between rural and urban areas. However, women in the Eastern Division are more likely to have suffered from injuries (54%), as are i-Taukei women (51%) and those from other ethnic groups (57%), compared with 35% for Indo-Fijian women (Figure 7.1). It is reasonable to conclude that these higher rates of injury are due to higher prevalence of the most severe forms of physical violence within these groups, including assaults with fists and weapons, kicking, dragging and being beaten up (see section 4.3 and Table 4.3 in Annex 1). Conversely, young women aged 18-24 were somewhat less likely to experience the most severe forms of violence, and they also have lower rates of injury (38%) compared with the national average of 47% (Table 7.1 of Annex 1).

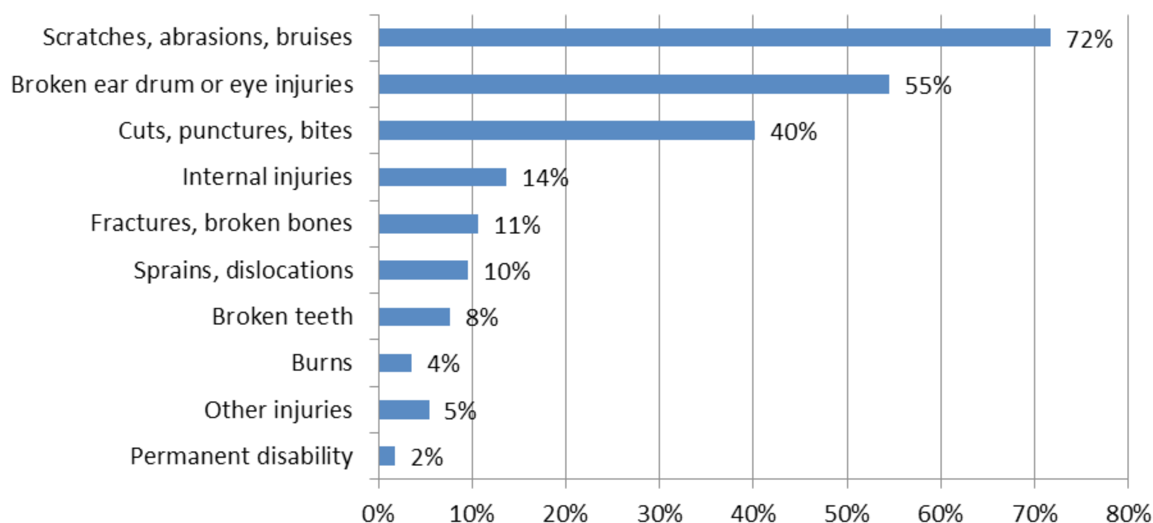
Figure 7.2: Frequency of injuries, percentage of women ever injured due to physical or sexual violence (N=909)



Among the 909 women who were injured in their lifetime, 2 in 5 (40%) were injured once, about 2 in 5 (38%) were injured 2 to 5 times, and the remaining 1 in 5 (22%) were injured more than 5 times (Figure 7.2). Sadly (but not surprisingly), the women most likely to be injured are those who have suffered from both physical and sexual violence: 61% of these women have suffered injuries, compared with 2% who experienced only sexual violence, and 37% who were only subjected to physical violence by their husbands and intimate partners (Table 7.1 of Annex 1).

Among the women injured, scratches, abrasions and bruises make up the largest category of injuries (72%); followed by broken ear drums and eye injuries (55%) and cuts, punctures and bites (40%). More than 1 in 10 had internal injuries; fractured and broken bones and sprains and dislocations also affected about 1 in 10 of those injured, along with broken teeth. Four percent (1 in 25 or 4%) of those injured were burned; 2% (1 in 50) now have a permanent disability as a result of their injuries (Figure 7.3).

Figure 7.3: Types of injuries experienced by women in their lifetime, percentage mentioned by women who were ever injured (N=909)



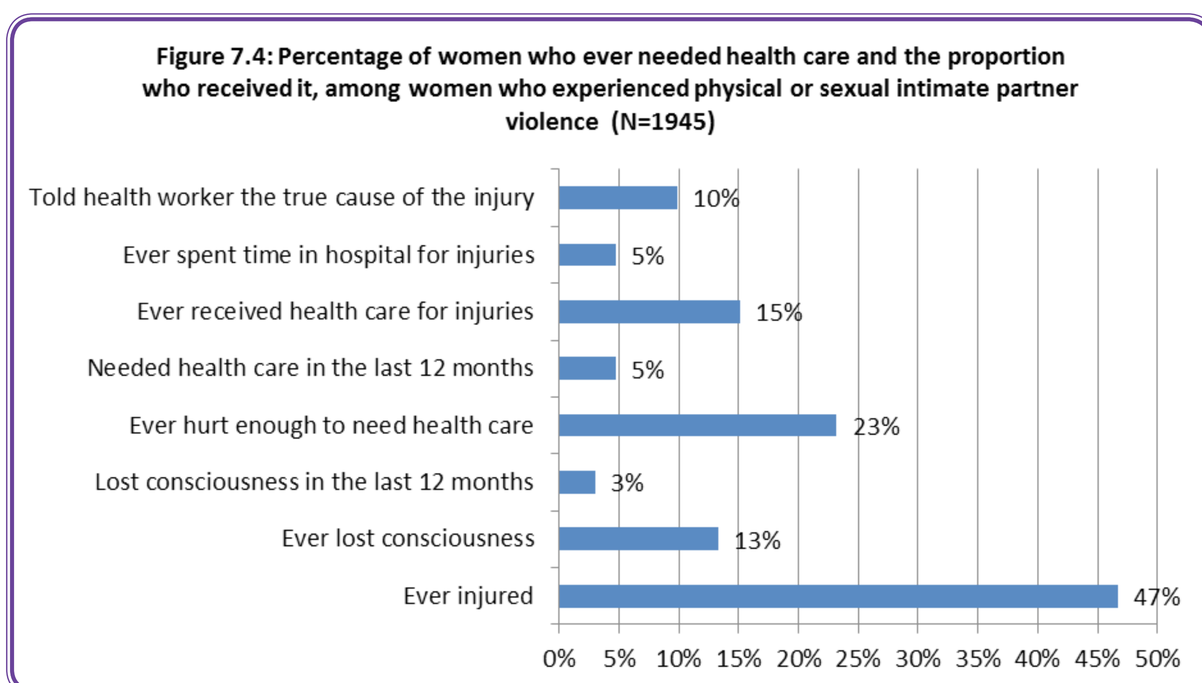
Note: Percentages total more than 100% because women identified more than one type of injury. Source: Table 7.2 of Annex 1.

More than 1 in 10 of the 1945 women living with violence lost consciousness at some time in their life (13%) and 3% in the 12 months before the survey was conducted. One in 4 (23%) were hurt badly enough to need health care, and 1 in 20 in the last 12 months. Although 450 women needed health care due to their injuries, only 293 ever received it; in other words, one-third of those who needed health care did not get it. Of the 293 women who did receive health care, only 193 (about two-thirds) told a health worker about the true causes of her injury; this means that of all the women injured due to intimate partner violence, only about 1 in 10 tell a health worker the truth about the cause of the injury (Figure 7.4 and Table 7.2 of Annex 1).

Women were also asked about injuries inflicted during the 12 months prior to the survey. These figures paint a shocking picture for the individual women concerned (Table 7.2 of Annex 1):

- 252 women were injured and 5 were injured so badly that they were permanently disabled.
- 172 women had eardrums broken or eye injuries, 30 had a bone fractured or broken.
- 59 women lost consciousness and 30 suffered internal injuries.
- 91 of the women who participated in the survey needed health care for their injuries.

Despite the evidence above of extensive and serious injuries, women themselves tended to downplay the impact of violence on their well-being. For example, although 47% of women had been injured in their lifetime, 58% said that the violence had no effect at all on their physical or mental health. About a quarter (26%) said that the violence had affected them a little, and 17% said it had affected them a lot – even though 23% said they had been hurt badly enough to need health care (Table 7.3 of Annex 1 and Figure 7.4).



Source: Table 7.2 of Annex 1.

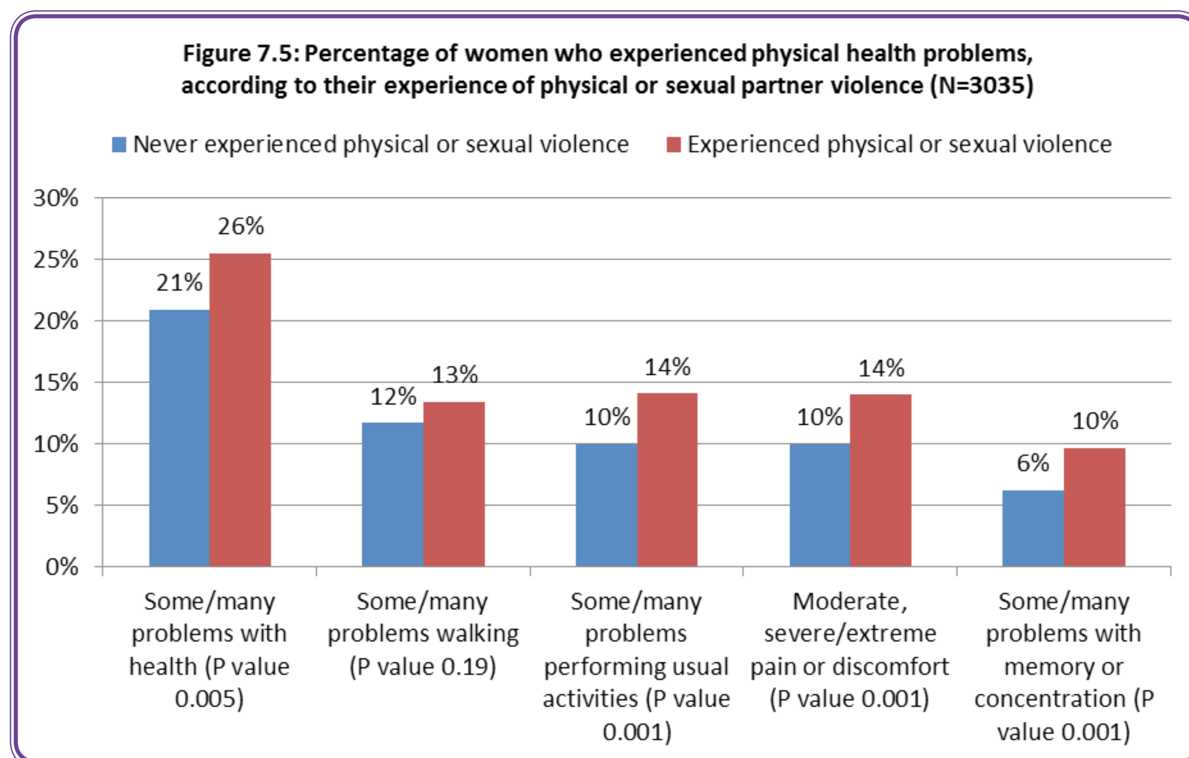
7.1.2 Other impacts on physical health

A range of other physical health issues were explored before women were asked about intimate partner violence, including the prevalence of asthma, diabetes, high blood pressure, and physical disabilities. Women who experienced intimate partner violence were significantly more likely to have asthma: 4.2% of women who had not experienced violence had asthma, compared with 6.5% among those who were living with violence (the P value for this association was 0.011). Women in urban areas who had experienced partner violence were more likely to suffer from high blood pressure: 19.8% compared 15.2% who had not experienced violence (with a P value of 0.028). Although there were more women with physical disabilities who suffered from violence (2.7% compared with 1.7% who had not experienced violence), the association was not statistically significant, with a P value of 0.08. Nor was there any association between diabetes and violence (Table 7.4a of Annex 1).

Women were also asked about their overall health before they were asked about their experience of intimate partner violence. There were highly significant associations between most of the health issues explored and women's experience of violence (Figure 7.5):

- women living with violence were more likely to have poorer health (26% had poor health, compared with 21% who had not experienced violence);
- they had greater difficulties with performing their daily activities and were more likely to be suffering from pain (14% compared with 10% who had not experienced violence); and
- they were more likely to have problems with memory and concentration (10% compared with 6%).

These associations were found to be more significant in urban areas than rural areas; rural women tended to provide a more positive assessment of their health than their urban sisters, although they were more likely to be suffering from pain (Figure 7.5 and Table 7.4a of Annex 1). However, this does not mean that rural women have better health overall. FWCC's interpretation is that rural women tend to downplay their health issues and problems even more than urban women, and they also have less access to health services, and thus less access to information about their general health. This interpretation is supported by the findings on women's own assessment of the impact of violence on their well-being: 60% of rural women said there was no impact compared with 55% of urban women; and 14% of rural women said that intimate partner violence had a big impact on their physical and mental health compared with 21% of urban women, despite the fact that they both suffered from similar rates of injury (Table 7.3 of Annex 1).



Note: P values less than 0.05 indicate that the association with intimate partner violence is statistically significant. Source: Table 7.4a of Annex 1.

7.1.3 Use of health services and medication

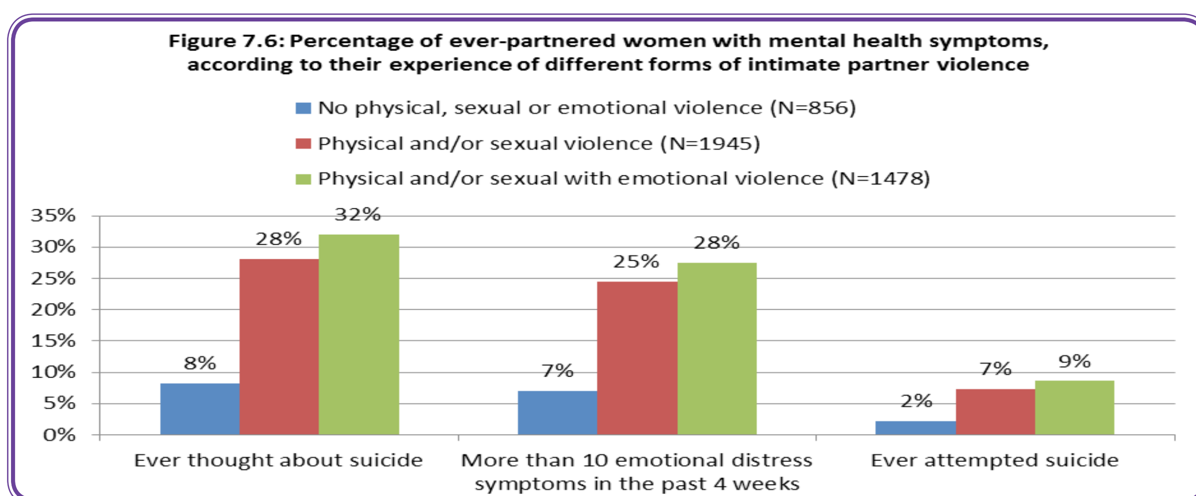
Even though many women who had been injured by their husbands/partners did not always get the health care they needed (see Figure 7.4), women living with violence were nevertheless significantly more likely to need to consult a doctor or other health worker, spend a night in hospital, and take medication for pain (Table 7.5 of Annex 1):

- One in 3 women living with violence (33%) needed to consult a doctor or health worker in the 4 weeks before the survey, compared with 25% who had not experienced violence and 31% of all respondents (P value less than 0.001).
- Half of the women (50%) living with violence needed to take medicine for pain in the 4 weeks before the survey, compared with 44% who had not experienced violence and 48% of all respondents (P value less than 0.001).
- Almost 1 in 10 women (9%) living with violence needed to spend at least one night in hospital in the 12 months before the survey, compared with 5% among those who had not experienced violence and 8% of all respondents (P value less than 0.001).

7.2 Impacts of partner violence on mental health

Mental health status was assessed using 20 questions developed by the WHO as a screening tool for emotional distress. These were included in the health section at the beginning of the questionnaire before women were asked to disclose their experience of violence (see section 2 of Annex 2). The use of these 20 questions has been validated as a robust method for assessing mental health status in a wide range of settings. Respondents were asked whether, within the 4 weeks prior to the interview, they experienced a range of symptoms that are associated with emotional distress, such as crying, inability to enjoy life, tiredness, and thoughts of ending life.[22] The number of symptoms that women experience can be aggregated to provide an overall score of emotional distress, where 0 represents the lowest level of emotional distress and 20 represents the highest level.

Women living with intimate partner violence are significantly more likely to experience more than 10 symptoms of emotional distress. The findings also indicate that the mental health impact of partner violence increases for those women who experience all three forms of violence: emotional, physical and or sexual violence. Seven percent (7%) of women with no physical, sexual or emotional partner violence had more than 10 symptoms of emotional distress in the 4 weeks before the survey, compared with 25% of those who experience physical and/or sexual violence, and 28% of those who also experienced emotional abuse (Figure 7.6).



Note: Symptoms of emotional distress used the WHO SRQ-20 (self reporting questionnaire with 20 questions (see section 2 of Annex 2). Source: Tables 7.4a and 7.4b in Annex 1).

22 The tool used is the Self Reporting Questionnaire (SRQ-20) (WHO 2005: 59 and WHO 1994).

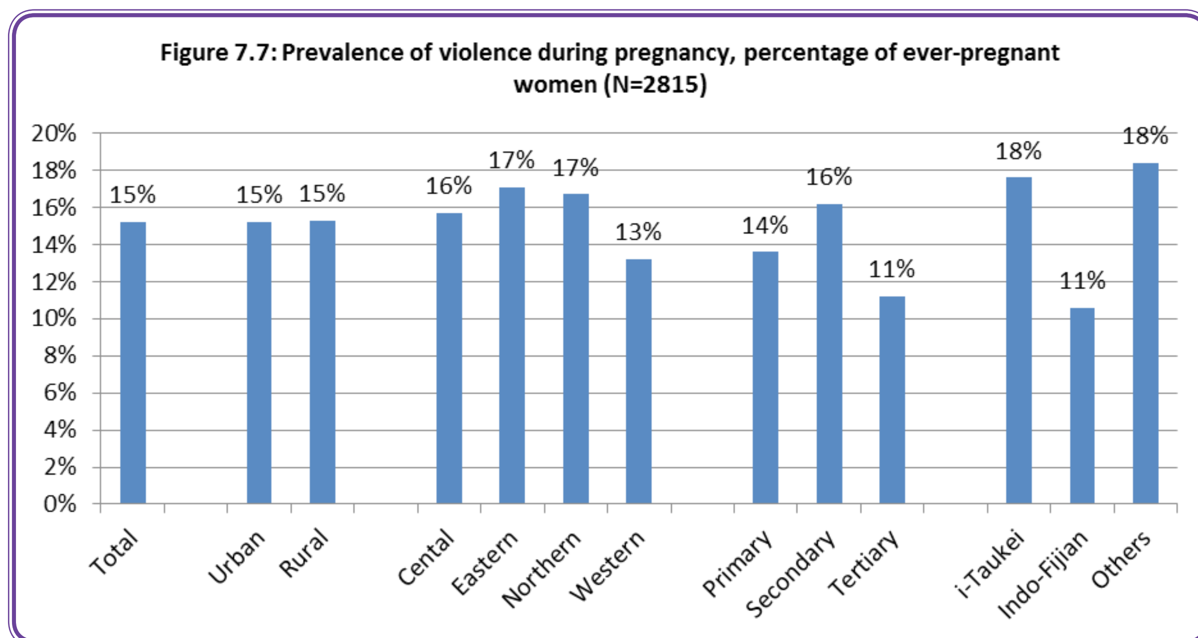
Eight percent (8%) of women with no physical, sexual or emotional violence had ever thought about suicide. This compares with 28% of those living with physical and/or sexual violence, and 32% of those who are also subjected to emotional abuse. Similarly, 2% of women with no intimate partner violence had ever attempted suicide, compared with 7% for those who experienced physical and/or sexual violence and 9% for those who also experienced emotional abuse (Figure 7.6). The P values for associations between mental distress, suicidal thoughts and actions, and the experience of partner violence indicate a high level of statistical significance for these findings (Tables 7.4a and 7.4b in Annex 1).

7.3 Prevalence of partner violence during pregnancy and other impacts of partner violence on reproductive health

7.3.1 Prevalence and features of violence during pregnancy

Among 2815 women who had ever been pregnant, 15% had been hit or beaten while pregnant. There was little variation in the prevalence of violence by location, with the Western Division having the lowest (13%) and Eastern Division (17%) the highest. Tertiary-educated women had the lowest prevalence at 11%, compared with 16% for those educated to secondary level and 14% for those educated to primary level (Figure 7.7 and Table 4.5 of Annex 1).

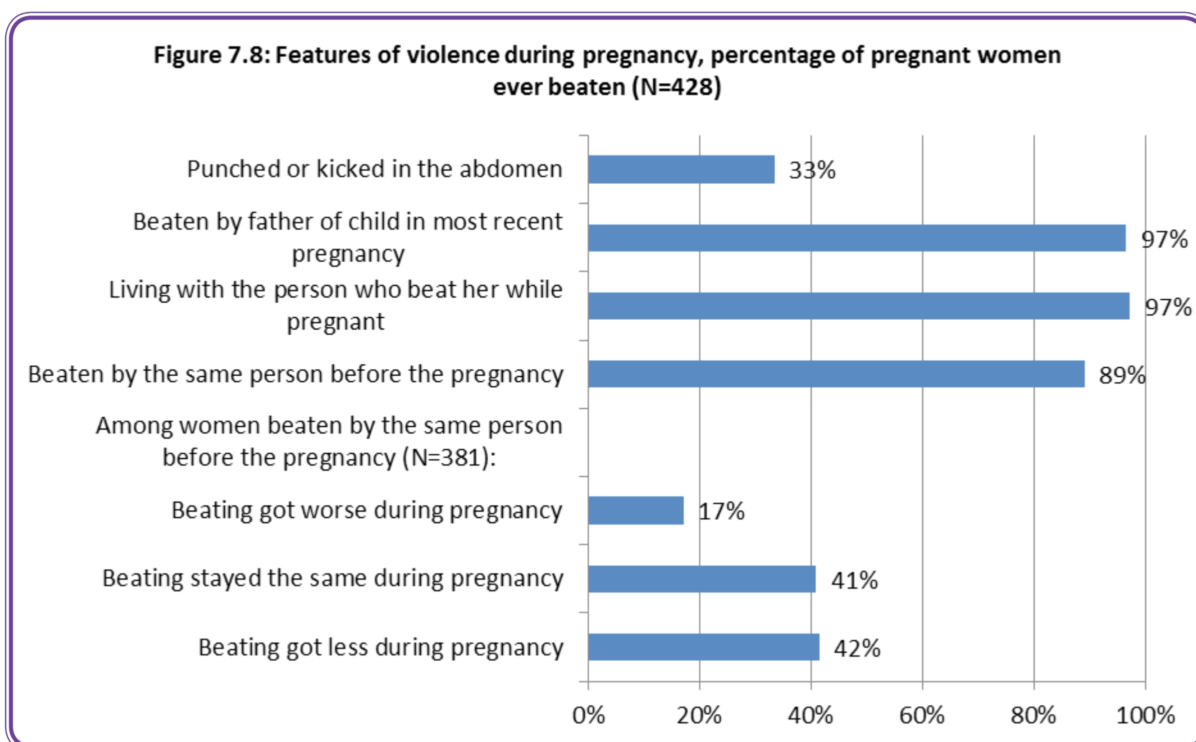
Differences in prevalence by ethnicity were the most marked and followed the patterns noted in Chapters 4 and 5 for other forms of partner and non-partner violence: 11% of Indo-Fijian women were hit or beaten during pregnancy, compared with 18% of i-Taukei women and 18% of those from other ethnic groups combined. There were also some differences in prevalence by age: 20% of women aged 18-29 were hit during pregnancy, compared with around 16% for those aged 30-49, and 10% for those aged over 50 (Figure 7.7 and Table 4.5 of Annex 1). These variations suggest that violence towards women in pregnancy may have increased in recent years. However, comparisons of prevalence by age demonstrate that this has been a persistent problem over many generations.



Source: Table 4.5 of Annex 1.

Among the 428 women who were hit or beaten during pregnancy, 33% were punched or kicked in the abdomen. This is a shocking finding and represents 5% of all women ever-pregnant in Fiji (1 in every 20). The vast majority of women (97%) were hit, slapped or beaten by the father of the child, and they were living with the perpetrator at the time of the attack (Figure 7.8).

The majority of women (89%) were also beaten by the same person before the pregnancy. Sadly, pregnancy did not protect the majority of these women (3 in 5) from violence: for 41% the violence stayed the same as before the pregnancy and for 17% it became more frequent or more severe. For 41% (2 in 5), the violence got less during the pregnancy (Figure 7.8).



Source: Table 4.6 of Annex 1.

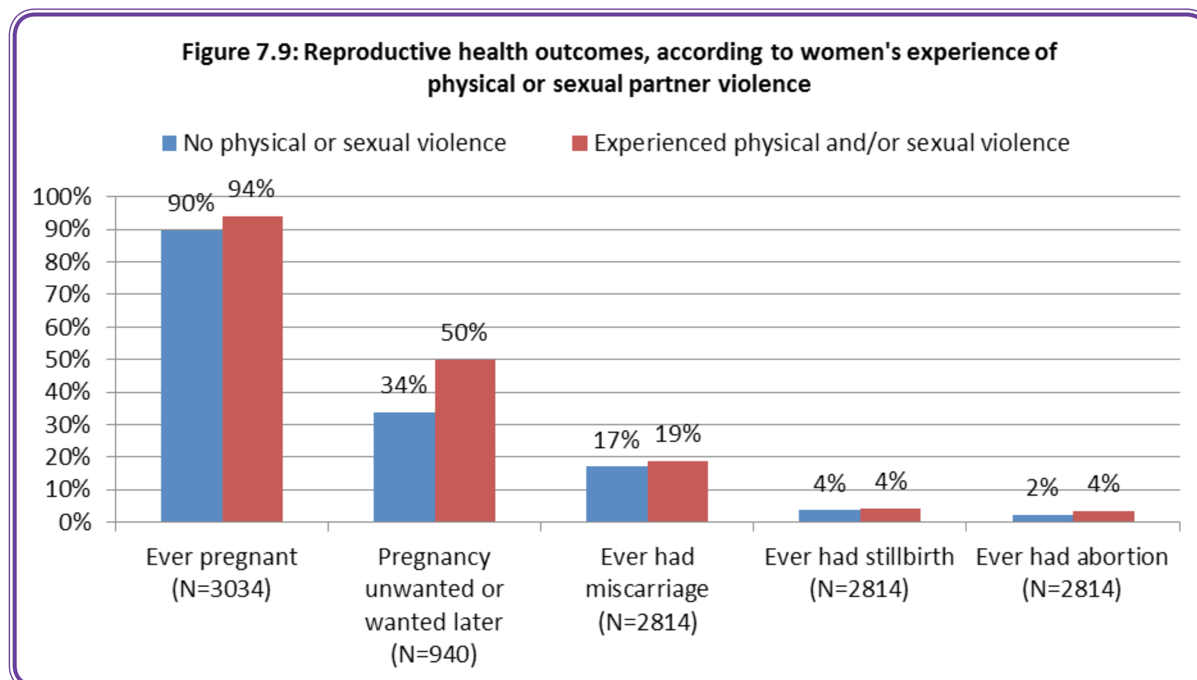
7.3.2 Impacts of partner violence on reproductive health behaviours and outcomes

Questions on reproductive health behaviours and outcomes were posed before women were asked about their experience of intimate partner violence. Women who experienced physical and/or sexual partner violence were significantly more likely to have an unwanted pregnancy, or one that they would have preferred to have later: this occurred for 50% of women living with violence compared with 34% of those who had never experienced partner violence. Four percent (4%) of women living with violence have had an abortion, compared with 2% of those who had not experienced violence. Both these associations were statistically significant, with P values of less than 0.001 and 0.05 respectively (Figure 7.9 and Table 7.6 of Annex 1).

Although women living with violence were slightly more likely to have miscarriages or stillbirths, these associations with intimate partner violence were not statistically significant. However, women who were physically assaulted during pregnancy were significantly more likely to miscarry: 22% of these women had miscarriages, compared with 18% of those who had not been hit, kicked or beaten during pregnancy, and this association was statistically significant (P value of 0.017) (Tables 7.6a and 7.6b of Annex 1).

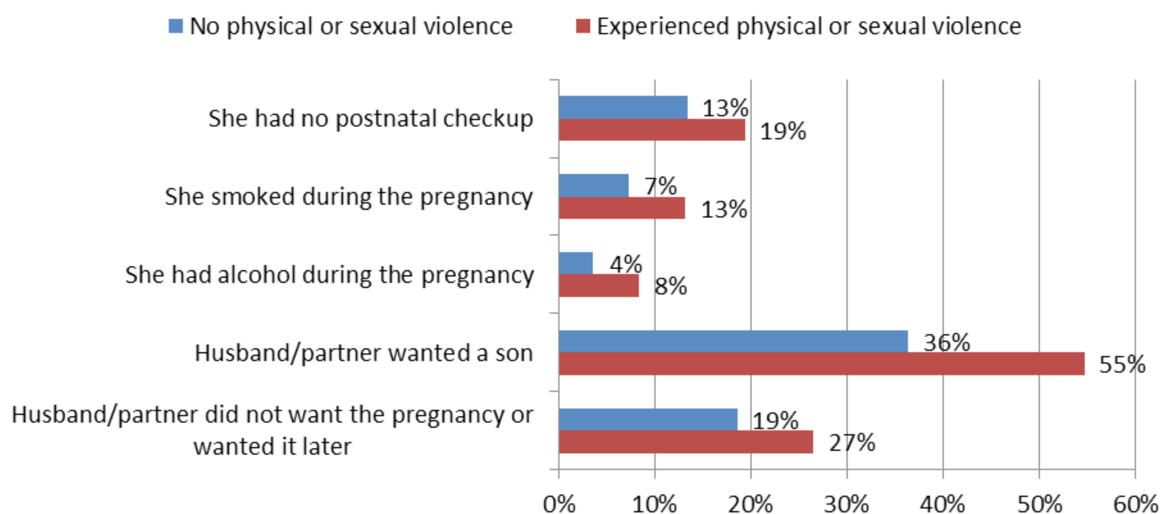
Being exposed to physical or sexual violence by a husband or intimate partner had several other impacts on women's behaviour while pregnant which were statistically significant (Figure 7.10):

- Nineteen percent (19%) of women living with partner violence did not have a post-natal check-up, compared with 13% who had not experienced violence (P value of 0.031).
- Almost twice as many women living with partner violence smoked during pregnancy (13.2%), compared with 7% of those who had not experienced violence (P value of 0.009).
- Similarly, twice as many women living with partner violence drank alcohol during pregnancy (8.3%), compared with 3.6% who had not experienced violence (P value of 0.011).



Note: P values indicate statistically significant associations for "ever pregnant" (<0.001), "pregnancy unwanted or wanted later" (<0.001), and "ever had an abortion" (<0.05). Source: Table 7.6a of Annex 1.

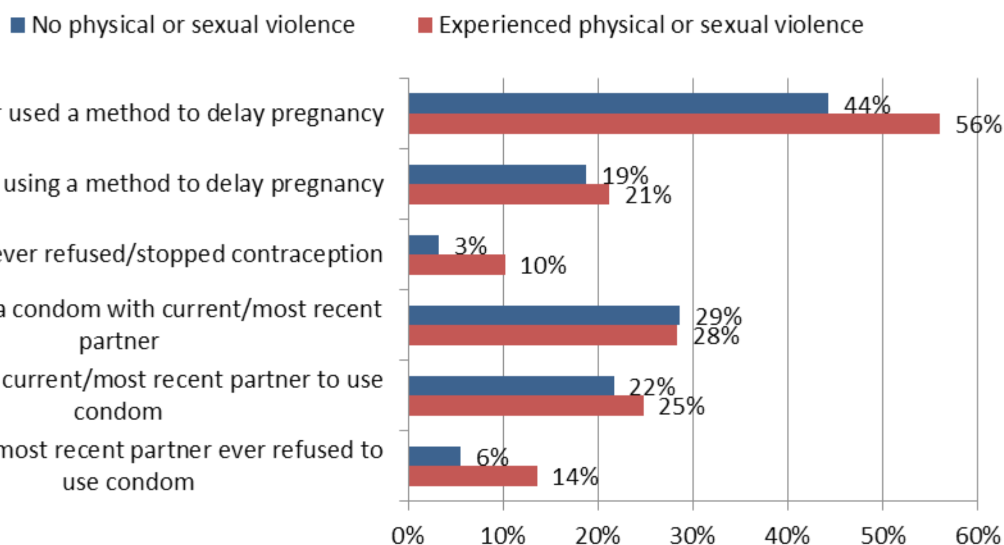
Women were asked whether their husband/partner had a preference for a son or a daughter during their last pregnancy, and whether the pregnancy was wanted by their husband/partner. For the women living with violence, husbands/partners wanted a son in 55% of cases, compared with 36% for those women who had not experienced violence. The husbands/partners of women living with violence were also far more likely not to want the pregnancy, or to want it later: more than 1 in 4 felt this way (27%) compared with 19% (less than 1 in 5) for those who had not experienced violence. Both these associations with intimate partner violence were statistically significant, with P values of less than 0.001 and 0.009 respectively (Figure 7.10 and Table 7.7 of Annex 1.



Note: All associations between the experience of intimate partner violence and the above were statistically significant. Source: Table 7.7 of Annex 1.

Associations between intimate partner violence and women's use of contraception were also highly significant. The questionnaire explored the use of contraception in general, and the use of condoms in particular (both before the questions on experience of partner violence). On the one hand, women living with violence were far more likely to have ever used a method to prevent or delay pregnancy (56% compared with 44% of those not living with violence, with a P value of less than 0.001); they were also more likely to be currently using such a method (21% compared with 19%, although this difference was not statistically significant with a P value of 0.12). On the other hand, women living in violent relationships were also significantly more likely to have had their husband/partner prevent them from using contraception; this affected 10% of women living with violence compared with only 3% of those not living with violence, with a highly significant P value of less than 0.001 (Figure 7.11 and Table 7.8 of Annex 1).

There was a similar pattern for the findings on the use of condoms: 25% of women in violent relationships had ever asked their current or most recent partner to use a condom, compared with 22% of those who had not experienced violence (statistically significant with a P value of 0.055). At the same time, the husbands/partners of women in violent relationships were much more likely to have refused to use a condom: 14% had refused, compared with only 6% of men who had not been violent (statistically significant with a P value of less than 0.001). In addition, women with violent husbands/partners were significantly less likely to tell their husbands/partners that they were using contraception (91% compared with 96%), and they were also less likely to have used a condom during the last time they had sex (22% compared with 29%) (Figure 7.11 and Table 7.8 of Annex 1).



Note: P values indicate statistically significant associations for items 1, 3 and 6 (<0.001), and item 5 (0.055). Source: Table 7.8 of Annex 1.

As noted above, a proportion of husbands and partners had disapproved, refused or tried to prevent their wives from using contraception, and showed their disapproval in various ways. The majority told their wives/partners that they did not approve: 86% of men did so for contraception, and 82% for the use of condoms. Of the 265 women whose husbands refused to use condoms, 17% said that using a condom was not necessary, 13% shouted or got angry, 5% accused her of being unfaithful or not being a good woman, 4% laughed at her or did not take her seriously, 4.3% either physically assaulted her or threatened to do so, and 2.5% destroyed the condoms. Similarly, of the 206 women whose husbands had tried to prevent women from using other forms of contraception, 15% shouted or got angry, 6% either assaulted her, or threatened to do so or throw her out of the home, and 3% destroyed the contraception (Table 7.9 of Annex 1).[1]

7.4 Discussion of findings

7.4.1 Physical and mental health impacts

The findings illustrate enormous pain and suffering by individual women living with violence as well as enormous costs to the economy, families and communities. They also provide further evidence to challenge some common myths:

- The physical health impacts of domestic violence are widespread and serious. Many women are experiencing a range of injuries that impact directly on their physical health, and on their ability to carry out their daily activities of caring for the family and earning income.
- The mental health impacts of all forms of violence by husbands/partners are also extremely serious, including emotional abuse.
- Women do not exaggerate the impacts of domestic violence. On the contrary, the findings show that many women under-estimate the impact on their health and emotional well-being, and this appears to be an important coping mechanism for women living with violence.

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1 Percentages add to more than 100% for husband's/partners' ways of showing they disapproved of contraception and condoms, because women could give multiple responses to these questions.

Survey findings on the percentage and type of injuries inflicted during the 12 months prior to the survey can be applied to the total population of ever-partnered women in Fiji to provide a minimum estimate of the annual, weekly and daily impact of intimate partner violence. This paints a shocking picture for the women affected, and a huge cost to the health system and economy (Box 7.1).

Box 7.1: Estimates of the impact of intimate partner violence in Fiji each year

According to Fiji's 2007 Census there were 189,385 women in Fiji aged 18-64 who were ever in an intimate relationship with a man. Using the data from this survey, it is possible to estimate the number of women affected by partner violence each year, each week and each day:

- 15,725 women will suffer from injuries each year – this is an average of 302 women every week or 43 women injured every day due to violence by their husband/partner. However, only about 1 in 10 of these women will tell a health worker the true cause of their injury.
- 312 women will become permanently disabled – 6 every week or almost 1 every day.
- 3,682 women will be physically assaulted so severely that they lose consciousness – 71 each week or 10 every day.
- 5,678 women will need health care for their injuries – 109 each week or about 16 each day; but many of these women will not get the health care they need.
- 10,733 women will have eardrums broken or eye injuries – 206 per week or about 29 every day.
- 1,872 women will have a bone fractured or broken – 36 each week, or 5 each day.
- 1,872 women will suffer from internal injuries – 36 every week or 5 each day.
- 1,622 women will have sprains or dislocations – 31 each week or 4 each day.
- 437 women will suffer from burns – 8 each week or 1 each day.
- 936 women will have their teeth broken – 18 each week or 3 every day.

Note: Estimates are calculated as follows: the percentage of women who said they were injured in the previous 12 months before the survey (Table 7.2 of Annex 1) is applied to the number of ever-partnered women in Fiji, based on 2007 Census data (Table 3.3 of Annex 1). These are minimum estimates because they use 2007 Census data, and because the survey counted the number of women with each type of injury (whereas some injuries may happen multiple times). Source: Table 7.10 of Annex 10.

The rates of injury in Fiji due to intimate partner violence are among the highest in the world. Of 15 sites included in the WHO multi-country study and 5 other studies that used the WHO methodology, Fiji's rate of injury is exceeded in only 3 cases: Kiribati, provincial Peru and urban Thailand (Fulu 2007: 60; Jansen et. al. 2009: 72; SPC 2009: 105; SPC 2010: 123; VWC 2011: 109; WHO 2005: 58).

With 30% of ever-partnered women injured in their lifetime, intimate partner violence is undoubtedly one of the biggest risks to women's physical health and well-being in Fiji. For example the prevalence of diabetes is estimated to be 16-18% of the total population, raised blood glucose affects 16% of Fiji's women, raised blood pressure affects 30% of women and hypertension 19% (AusAID 2010: 57; MOHa: 14; MOHb: 10; WHO 2013a: 2). According to the WHO, the rates of injury reported in the survey are likely to be significantly lower than the actual rate, due to evidence that women are less likely to recall or mention minor injuries (WHO 2005: 61). This view is supported in the current survey by the finding that women in Fiji tend to downplay the impact of violence on their health, an attitude which is reinforced by women's low status and the view that women's health is not important (see the discussion on women's health in section 4.7.2 in Chapter 4).

The highly significant association between women's experience of physical or sexual partner violence and their use of medication for pain and health services including hospitalisation is of great concern. Health workers throughout the country are treating women who are living with violence every week – for their injuries, and ongoing general health problems due to violence. However in many cases the health workers may not be aware of the cause of the health problems suffered by their patients, since many women do not tell health workers about the violence.

The attitudes and responses of health workers including the way they communicate with women patients is recognised as a key gender issue affecting women's use of health services. Many factors can make it difficult for a woman to disclose physical and sexual violence: whether the health worker is male or female, long waiting times, lack of privacy in the physical environment of health centres, lack of confidence that health staff will respect confidentiality, and lack of empathy from the health worker. In addition, many clients have told FWCC staff that her husband/partner will take her to the hospital or health centre for injuries caused by his violence; in most cases the doctor or health worker does not ask her husband to leave, and her husband does most of the talking. It is impossible for women to disclose the true cause of her injuries in these circumstances.

The strong association between mental health problems and all forms of violence is alarming, including symptoms of emotional distress such as depression, anxiety, suicidal thoughts and attempted suicides. The proportion of women who have more than 11 symptoms of emotional distress paints a devastating picture of life for women who are being subjected to domestic violence. An Australian study undertaken of the burden of disease caused by intimate partner violence found that it had the greatest impact on the health of women aged 15 to 45, compared with any other risk factors such as obesity, high cholesterol, high blood pressure and illicit drug use. The same study found that 60% of the increased burden of disease due to intimate partner violence was associated with mental health impacts (VicHealth 2004: 25-27; see also Box 7.2).

The WHO multi-country study on the prevalence of violence against women also concluded that mental health problems such as anxiety and depression are widely recognised as consequences of intimate partner violence around the world, rather than pre-conditions or precursors that may exist before the violence begins (WHO 2005: 61). It is clear that having these symptoms would have a negative impact on a woman's ability to work at her full capacity, and thus on overall national social and economic development. The fact that so many symptoms of emotional distress were experienced by women in the 4 weeks prior to the survey also indicates that the mental health impacts of physical, sexual and emotional violence last long after the violent incident may have occurred.

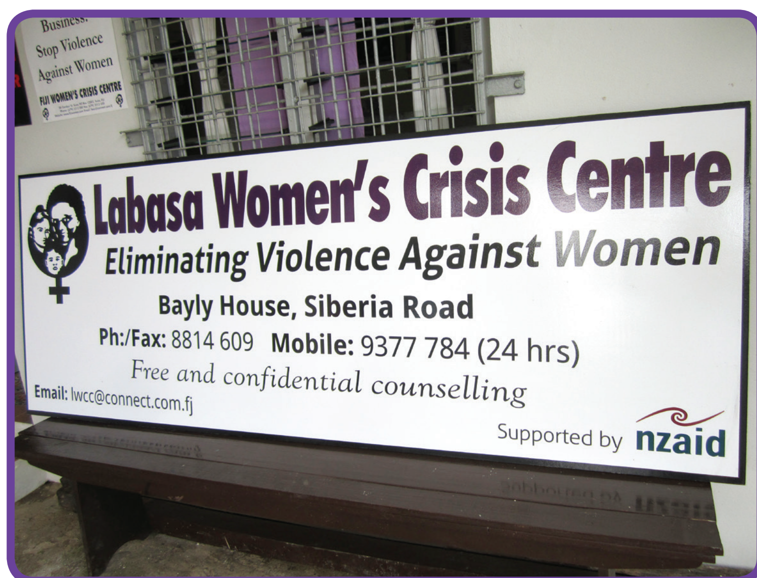
Many other studies have identified the devastating consequences of intimate partner violence on mental health. A meta-review undertaken by WHO found that 16 studies had identified statistically significant associations between unipolar depressive disorders and intimate partner violence, and that women living with violence were twice as likely to experience depression; 31 studies identified an association between alcohol abuse by women and partner violence; and 3 found a substantially increased risk of suicide (WHO 2013: 29). Since it is not possible to know how many women from the total sample of households in the Fiji survey have actually committed suicide, the strong association between violence and suicidal behaviour may be underestimated.

There has been recent acknowledgement of suicide as an increasing problem in Fiji. The Ministry of Health (MOH) draft National Suicide Prevention Policy notes that the rates of both suicide and attempted suicide among Indo-Fijian women (and young women) are very high compared with global data, as is the overall suicide rate, and that available data under-estimates the extent of the problem (MOH 2008). In a summary of health issues in the Western Pacific region, the WHO noted that global

trends show a higher male to female suicide rate (approximately 3 to 1), but suicides in Fiji go against this trend and show a more equal gender ratio. The WHO also noted that depressive disorders account for nearly 42% of the disability from neuropsychiatric disorders among women compared to 29% among men in the Western Pacific region (WHO 2009; WHO 2013b: 22).

Women in Fiji face a double burden of stigma if they try to get help to deal with the emotional distress associated with living in a violent relationship: there is shame, humiliation and blame attached to domestic violence, in addition to the stigma associated with disclosing psychological and emotional distress. The WHO noted that "authoritarian" attitudes of some health workers can make the disclosure of emotional distress even more difficult (WHO 2009).

There is recognition by the Fiji Government and some donors of the need to invest in suicide prevention and mental health, which has been labelled an "iceberg disease" because much of the problem remains hidden (AusAID 2010: 15; MOHa: 17; MOH 2008; WHO 2013b). Although some program documents acknowledge the contribution of intimate partner violence to suicide risk (AusAID 2012a), overall there is little explicit recognition of the impact of domestic violence to suicide risk and mental health problems in policy, planning or health reporting (for example MOHa; MOHb; MOH 2008; MOH 2011; WHO 2013b).[2] Nor is there acknowledgement of the complex interplay between domestic violence and other risk factors and health outcomes. On the positive side, the MOH draft National Suicide Prevention Policy does identify the need for a gender analysis of legislation and policies that may impact on suicide prevention (MOH 2008). In addition to reliable sex-disaggregated data on depression and suicide, further research is needed on the ways that intimate partner violence contributes to physical, mental and reproductive health problems, and how these issues can be addressed in community based suicide prevention and health promotion efforts (Box 7.2).



Although this study shows that violence against women results in disability, it has not been possible to determine whether disabled women experience physical or sexual violence at higher rates than other women; nor is it possible to draw conclusions about the impact of violence on the health of disabled women and girls. However, research from other countries indicates that violence against women with disabilities far exceeds that of non-disabled women, with a broader range of types of violence and perpetrators (International Network of Women with Disabilities 2010: 6-7). Dedicated research is needed on the prevalence of partner and non-partner violence against disabled women and girls in Fiji, and its impacts on their health.

2 The WHO (2013b) notes that a draft National Mental Health policy has been developed, but this is not yet available for review.

This study has not explored the relationship between non-partner violence and physical and mental health outcomes for women. However, this is also worthy of future research, keeping in mind that non-partner violence is also significant risk factor for women experiencing violence from their husbands or intimate partners (see Chapter 11). The WHO's meta-review on health impacts of violence against women found some similar health impacts for both non-partner and intimate partner violence including depression, anxiety and alcohol abuse (WHO 2013: 27-30).

Box 7.2: Health impacts of intimate partner violence documented in other studies

<table>
<tr><td colspan="6">INTIMATE PARTNER VIOLENCE
↓</td></tr>
<tr><td>PHYSICAL TRAUMA
↓</td><td colspan="3">PSYCHOLOGICAL TRAUMA AND STRESS
↓</td><td colspan="2">FEAR AND CONTROL
↙↗ ↓ ↓</td></tr>
<tr><td rowspan="2">INJURY
• Musculo-skeletal ↘
• Soft tissue
• Genital trauma
• Ear and eye
• Teeth
→
↘
↓
↓</td><td colspan="3">MENTAL HEALTH PROBLEMS
• Post traumatic stress disorder
• Anxiety
• Depression
• Eating disorders
• Self-harming behaviours
• Suicidality
• Sleep problems
↓ ↓ ↓</td><td>Limited sexual and reproductive control
• Lack of contraception
• Unsafe sex
↓ ↘</td><td>HEALTH SEEKING BEHAVIOUR
• Lack of autonomy
• Difficulties seeking care and other services (e.g. stigma, shame and lack of services in remote areas)
↙</td></tr>
<tr><td>Non - communicable Diseases
• Cardiovascular
• Hypertention
↓</td><td>Somatoform
• Irritable bowel
• Chronic pelvic pain
• Other chronic pain
↓</td><td>Substance Abuse
Alcohol, tobacco, other drugs
↓</td><td>Perinatal and maternal health
• Low birth weight
• Prematurity
• Miscarriage
• Other pregnancy complications
↓</td><td>Sexual and reproductive health
• Unwanted pregnancy
• abortion
• HIV, STIs, UTIs
• Gynaecological problems
↓</td></tr>
<tr><td colspan="6">DISABILITY AND DEATH
HOMICIDE – SUICIDE – LIFE-THREATENING STIs – DEATH DUE TO ILLNESS AND COMPLICATIONS WITH CHILDBIRTH</td></tr>
</table>

Sources: Adapted from WHO 2013: 8 and VicHealth 2004: 21.
UTIs: urinary tract infections; STIs: sexually transmitted infections; HIV: human immunodeficiency virus; Somatoform: involving the physical expression of psychological symptoms (VicHealth 2004: 21).

7.4.2 Reproductive health impacts

The findings on prevalence of physical violence during pregnancy are shocking and show that this has been a persistent problem over many generations. For many women, pregnancy is not a time when they are protected from violence: for almost 3 in 5 women, the violence either stayed the same during the pregnancy, or increased in frequency or intensity. The prevalence of physical assault during pregnancy – and the high rate of targeted attacks to the abdomen – is among the highest in the world. In the Pacific region Fiji's prevalence of 15% of ever-pregnant women is only exceeded by Kiribati which has a prevalence of 23% (SPC 2009: 115: SPC 2010: 135; VWC 2011: 125; WHO 2005: 66-67). These findings challenge widespread perceptions that family and children are highly valued in Fiji. They also demonstrate that intimate partner violence increases the likelihood of unwanted pregnancies and children, miscarriage and abortion. Similar impacts have emerged from other studies globally (see Box 7.2).