

# Domestic Violence Against Women: Systematic Review of Prevalence Studies

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**Abstract** To systematically review the worldwide evidence on the prevalence of domestic violence against women, to evaluate the quality of studies, and to account for variation in prevalence between studies, using consistent definitions and explicit, rigorous methods. Systematic review of prevalence studies on domestic violence against women. Literature searches of 6 databases were undertaken for the period 1995 to 2006. Medline, Embase, Cinahl, ASSIA, ISI, and International Bibliography of the Social Sciences were searched, supplemented by hand searching of the reference lists from studies retrieved and specialized interdisciplinary journals on violence. A total of 134 studies in English on the prevalence of domestic violence against women, including women aged 18 to 65 years, but excluding women with specific disabilities or diseases, containing primary, empirical research data, were included in the systematic review. Studies were scored on eight pre-determined criteria and stratified according to the total quality score. The majority of the studies were conducted in North America (41%), followed by Europe (20%). 56% of studies were population-based, and 17% were carried out

either in primary or community health care settings. There was considerable heterogeneity both between and within geographical locations, health care settings, and study quality. The prevalence of lifetime domestic violence varies from 1.9% in Washington, US, to 70% in Hispanic Latinas in Southeast US. Only 12% scored a maximum of 8 on our quality criteria, with 27% studies scored 7, and 17% scored 6. The mean lifetime prevalence of all types of violence was found to be highest in studies conducted in psychiatric and obstetric/gynecology clinics. Results of this review emphasize that violence against women has reached epidemic proportions in many societies. Accurate measurement of the prevalence of domestic violence remains problematic and further culturally sensitive research is required to develop more effective preventive policies and programs.

**Keywords** Domestic violence · Women · Prevalence · Review

## Introduction

Violence against women includes all verbal, physical, and sexual assaults which violate a woman's physical body, sense of self and sense of trust, regardless of age, race, ethnicity, or country (Campbell 1995). Violence against women has been identified as a major public health and human rights issue (Joachim 2000), and has been estimated by the World Health Organization (WHO) to account for between 5–20% of healthy years of life lost in women aged 15 to 44 (WHO 1997).

Twenty years ago, violence against women was not considered an issue worthy of international attention or concern. This began to change in the 1980s, as women's groups were organized locally and internationally to

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demand attention to the physical, psychological, and economic abuse of women. Gradually, violence against women has come to be recognized as a legitimate human rights issue and a significant threat to women's health and well being (Ellsberg and Heise 2005). The process began in Europe and North America, but even in the United States, where this trend was most apparent, it took 20 years for rising awareness to lead to legislation and to potentially effective preventive measures. Only in the early 1990s were comprehensive laws enforced and effective resources allocated to deal with gender violence (Gelles 1997).

Worldwide, domestic violence is as serious a cause of death and incapacity among women aged 15–49 years as cancer, and a greater cause of ill health than traffic accidents and malaria combined (The World Bank 1993). In addition to causing injury, violence increases women's long-term risks of a number of other health problems, including chronic pain, physical disability, drug and alcohol abuse, and depression (Heise et al. 1999). Secondary to the biopsychosocial effects of battering are the high costs of such violence. Abused women have more than double the number of medical visits, an 8-fold greater mental health-care usage, and an increased hospitalization rate compared to non-abused women (Wisner et al. 1999). The WHO multi-country study on women's health and domestic violence has recently confirmed significant associations between lifetime experiences of partner violence and self reported poor health (Ellsberg et al. 2008).

Prevalence studies of violence against women report wide variations in levels of violence within and between health care settings. The reported lifetime prevalence of physical or sexual violence, or both, varied from 15% to 71% among the countries studied in the WHO multi-country study (Garcia-Moreno et al. 2006). Few studies have used standard methods to derive comparative prevalence figures. The World-Safe initiative represents a successful model that has been used in five countries (Brazil, Chile, Egypt, Philippines, and India) to study intimate partner violence against women and children (Sadowski et al. 2004). The WHO multi-country study uses another model, which has been applied in 10 different countries. While confirming that physical and sexual partner violence against women is widespread, the variation in prevalence within and between study settings emphasizes that this violence is not inevitable, and needs to be addressed.

Over the last 10 years, a number of prevalence surveys on intimate partner violence has been published from around the world. However, despite a number of initiatives, such as the European Network on Conflict, Gender, and Violence, the launching of a European Society of Criminology and efforts to develop an international survey on violence against women (Hagemann-White 2001), information from these studies has not been systematically collated and analyzed. The aim of

this systematic review is to systematically summarize the worldwide evidence on the prevalence of domestic violence against women, to evaluate the quality of studies, and to try to account for variation in prevalence rates between studies.

## Methods

### Literature Searches

Parallel literature searches of 6 databases (Medline, Embase, Cinahl, ASSIA, ISI, and International Bibliography of the Social sciences) were undertaken for the period 1995–2006. The reference lists from retrieved studies and specialized interdisciplinary journals in violence (Violence Against Women, Journal of Interpersonal Violence) were hand searched to look for further studies that might not have been retrieved by the database searches. Authors of unpublished studies, e.g., PhD theses, were contacted to obtain copies of their studies. We contacted experts in the field before and during the process to obtain feedback and advice with regard to methodology and analysis. All citations were exported into Reference Manager software (version 11). Searches included MeSH and text words terms, with combinations AND OR Boolean operator (Box 1).

#### Box 1: words used in the search

1. Domestic violence.	13. Frequency.
2. Spouse abuse.	14. Prevalenc\$.tw.
3. Battered women.	15. Incidenc\$.tw.
4. Partner abuse.	16. Proportion\$.tw.
5. Domestic violence.tw.	17. Frequenc\$.tw.
6. Spouse abuse.tw.	18. 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17.
7. Battered women.tw.	19. Women.
8. Partner abuse.tw.	20. Wom#n.tw.
9. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8.	21. 19 or 20.
10. Prevalence.	22. 9 and 18 and 21.
11. Incidence.	23. Limit 22 to "all adult (19 plus years)"
12. Proportion.	24. Limit 23 to female.

We included studies on the prevalence of domestic violence against women conducted between 1995 and 2006, published in English and including women aged between 18 and 65 years. We excluded studies on women with special disabilities or certain complicated diseases e.g., HIV, women in places of refuge, case reports, reviews, and non-English studies. We also excluded studies conducted on women aged >65 years and on violence against pregnant

women, where a large number of studies was found, which possibly merit a separate review.

Our searches identified 1,653 primary studies, which were reduced to 356 after screening the titles and abstracts to assess whether the contents were likely to be within the scope of the review. We also checked for duplicates between databases, accounting for 180 (10.9%) of the total studies. A further 176 studies were excluded because they were largely narratives about domestic violence cases, studies of risk factors rather than prevalence or were predominately review articles. A final total of 134 studies was selected for further analysis (see Fig. 1).

Quality Assessment

These studies was assessed using structured guidelines (Loney et al. 2000), and were scored on eight quality criteria as follows: (1) specification of the target population, (2) use of an adequate sampling method (e.g., random, cluster), (3) adequate sample size (>300 subjects), (4) adequate response rate (>66%), (5) valid, repeatable case definition, (6) measurement with valid instrument, (7) reporting of confidence intervals or standard errors, and (8) attempts to reduce observer bias. We recorded the date of the study, the prevalence (and/or incidence) estimates of domestic violence (including life-time and/or current estimates), and the type of violence reported. These variables

were coded from each study as categorical or continuous. After quality assessment was completed, studies were stratified according to the total score from 1–8.

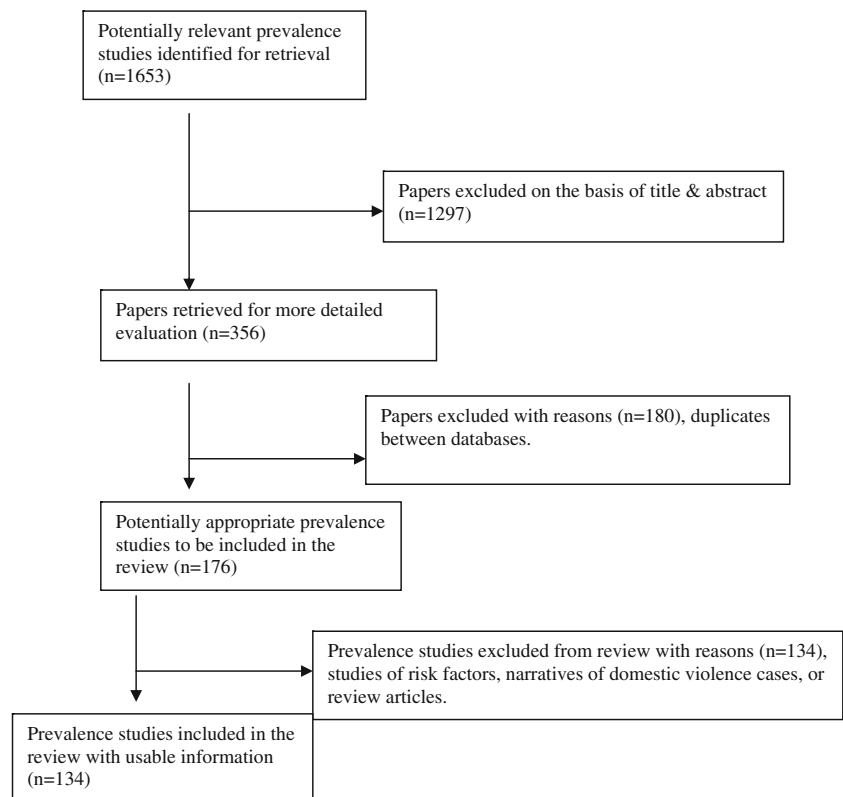
Data Synthesis

The study data were coded and analyzed using SPSS Version 11. Meta-analyses were conducted in STATA version 10. Continuous & categorical variables were expressed as frequencies and percentages, and are summarized statistically in tables and are presented in graphic form. Prevalence estimates in the figures represent the simple weighted *mean* prevalence for all the studies done in each continent.

A number of the studies we have included are described in more than one publication. In some cases, additional analysis conducted after completion of a study was reported in additional publications. In these cases, we used both reports to inform the data extraction. Conflict in quality scoring of the included studies was resolved by consensus between the authors (SA & RJ)

Forest plots were produced to give a graphical representation of the studies and to convey the extent of heterogeneity between prevalence estimates. Heterogeneity between prevalence estimates was tested using a chi-squared test. Sensitivity analyses were used to determine whether any heterogeneity found could be due to differing study methodologies, study quality or geographical differences.

Fig. 1 Flow chart summarising literature review



## Results

Most of the studies (41%) were conducted in North America, followed by 20% in Europe, 16% in Asia, 11% in Africa, and 5% in the Middle East (Table 1). Eighty three studies (56%) were population-based, twenty five (17%) were conducted in primary care, 12% in emergency care settings and others in obstetrics and gynaecology, paediatric, psychiatric and other hospital clinics. The sample size was over 300 in 84% of studies. Approximately 60% used a form of randomisation in their sampling (Table 2). In 41% of studies a measurement instrument was developed by the researchers using focus groups or by reference to other validated measuring instruments, although a few did not report about the instrument used. The most commonly used instrument was the Conflict Tactic Scale (16.9%), followed by the Abuse Assessment Screen (14%) and the WHO instrument (13%). The most frequently used method of collecting the data was face-to-face interviews (55%), followed by self-administered questionnaires (30%), and telephone interviews (13%).

Only eighteen studies (12%) scored a maximum of 8 on our quality criteria, with 33 (27%) studies scoring 7, 25 (17%) scoring 6 (Table 3).

**Table 1** Summary of frequencies of settings and continents

Frequency	%
<b>Geographical setting</b>	
60 studies in North America	40.5
29 studies in Europe	19.6
23 studies in Asia	15.5
16 studies in Africa	10.8
8 studies in Middle East	5.4
5 studies in Australia	3.4
4 studies in South America	2.7
<b>Healthcare setting</b>	
83 Population studies	56.1
25 studies primary care	16.9
18 studies in emergency care	12.2
8 studies in Obst/Gyn clinic	5.4
5 studies in hospital setting	3.4
3 studies in pediatric clinic	2
2 studies in psychiatric clinic	1.4
2 studies in college students	1.4
One study in surgical clinic	0.7
One study in HMO	0.7
<b>Methods</b>	
80 population cross-sectional studies	54.1
57 clinical cross-sectional studies	38.5
5 clinical cohort studies	3.4
4 population cohort studies	2.7

**Table 2** Summary of frequencies of sampling, methods, and instruments used

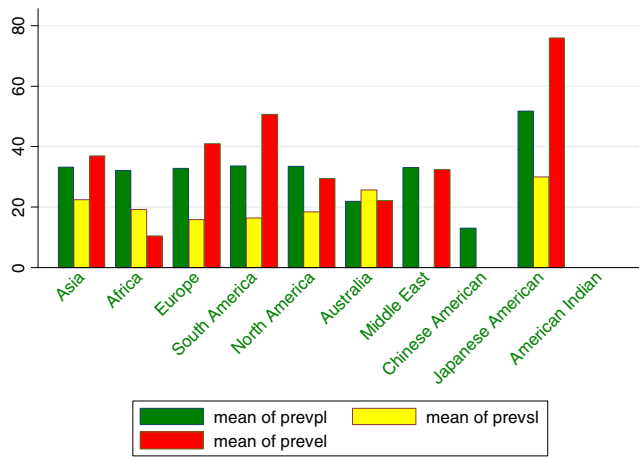
Frequency	%
<b>Sampling</b>	
124 studies >300 sample size	83.8
24 studies <300 sample size	16.2
88 studies used randomization	59.5
54 studies used other methods	36.5
<b>Instruments</b>	
60 studies used their own instrument	40.5
25 studies used CTS	16.9
21 studies used AAS	14.2
19 studies used WHO instrument	12.8
6 studies used PVS	4.1
4 studies used ISA	2.7
3 studies used NorAQ	2
2 studies used women's health questionnaire	1.4
One study used DVI	0.7
One study used SVAWS	0.7
One study used BRFSS	0.7
One study used WorldSAFE	0.7
<b>Contact with subjects</b>	
82 studies used face-to-face interview	55.4
44 studies used self-administered	29.7
19 studies used telephone interview	12.8

The mean lifetime prevalence for physical, sexual and emotional violence by country is shown in Fig. 2. The highest levels of physical violence were seen in Japanese immigrants to North America (about 47%), who also had high levels of emotional violence (about 78%) along with respondents studied in South America, Europe, and Asia (37–50%).

The mean lifetime prevalence of physical violence was found to be highest (30–50%) in studies conducted in psychiatric and obstetric/gynecology clinics (Fig. 3). The highest rates of sexual violence were found in studies conducted in psychiatric, obstetric, and gynecology clinics (30–35%) and, for emotional violence, the highest rates

**Table 3** Summary of frequencies of quality score

Frequency	%
18 studies scored 8	12.2
33 studies scored 7	22.3
25 studies scored 6	16.9
34 studies scored 5	23
27 studies scored 4	18.2
8 studies scored 3	5.4
One study scored 2	0.7
2 studies scored 1	1.4



**Fig. 2** Mean of lifetime prevalence of physical, sexual, and emotional violence by continent or country. *Note:* prevpl=prevalence of life time physical violence, prevEL=prevalence of life time emotional violence, prevsl=prevalence of life time sexual violence

were found in accident and emergency and psychiatric departments (65–87%).

Forest plots of prevalence estimates and their confidence intervals indicate that there is a large amount of heterogeneity between studies. Heterogeneity was formally tested and confirmed by using the chi-squared test. This test showed strong evidence of heterogeneity ( $p < 0.001$ ). Sensitivity analyses found that even in studies that: used a standardized methodology (WHO), scored high in their quality criteria, were population-based (Fig. 3, 4, 5, and 6), and in studies that were done in the same continents (Dickers 2002), heterogeneity was a constant finding. Pooled estimates across geographical locations and settings were not calculated due to the extreme heterogeneity and the difficulty in interpreting them.

**Discussion**

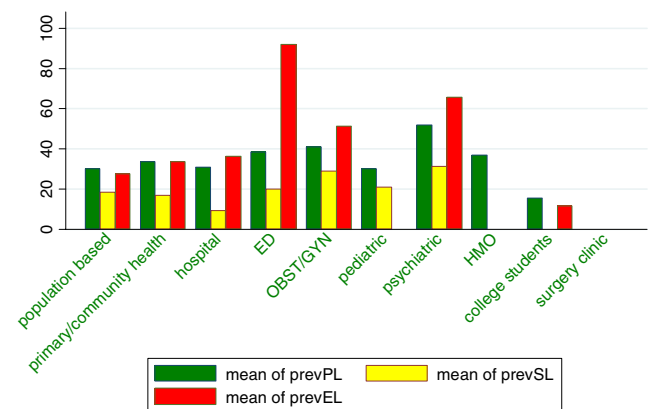
The results of this review emphasize that violence against women has reached epidemic proportions in many societies and suggests that no racial, ethnic, or socio-economic group is immune. However, we have also highlighted substantial differences in methodologies, sample sizes, sampling periods, study populations, and the types of violence studied. For all types of violence there was a consistent and a significant heterogeneity between studies, even in studies that appeared to use standardized methods (e.g., WHO multi-country study), population studies, and studies that scored high on our quality criteria. Age, ethnicity, and socioeconomic status were not consistently documented, making comparisons and evaluations of generalizability difficult. However, the WHO Multi-country study was an important attempt to collect internationally comparable statistics through the use of standardized survey methods.

Prevalence of violence has been assumed to be higher in clinical settings than in population samples (Campbell 2002), because it is assumed that health care utilization is higher among victims of abuse (Plichta 1992). For example, high prevalence rates have been measured in specific patient groups, for example at gynecology clinics in patients with severe premenstrual syndrome (PMS) or pelvic pain (Golding et al. 2000, Walling et al. 1994). This observation is consistent with the findings in our review, where the highest figures for violence were found in psychiatric, obstetrics and gynecology, and emergency clinic settings.

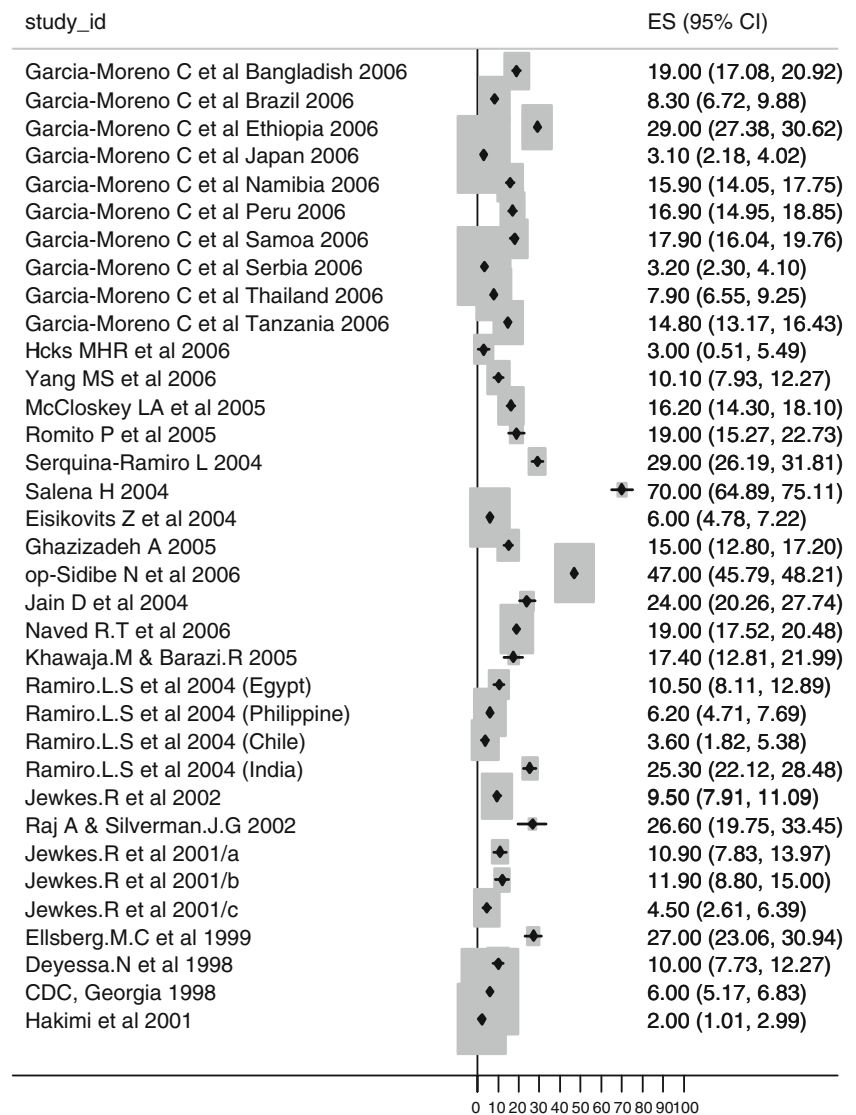
Our review highlights several important factors involved in the epidemiology of domestic violence against women.

- 1) Surveys may not measure the actual number of women who have been abused, but rather, the number of women who are willing to disclose abuse. As with all self-reported disclosure, it is possible that results are biased by either over-reporting or under-reporting. In most studies, however, little evidence of over-reporting has been found (Koss 1993).
- 2) The *meaning* of violence varies from culture to culture, and sometimes within the same culture (Krauss 2006). Women from Asian cultures are brought up in a belief system that stresses the greater need of the family over the needs of individual members (Rydstrom 2003). Although women in the poorest of nations are probably most inclined to believe that men are justified in beating their wives, in all settings, in developed and developing countries, abused women tend to hold more beliefs which justify violence against them (Fagan and Browne 1994).

Fagan and Browne point out that, in classifying respondents as victims, a particular interpretation is placed on these responses, which may ignore important differences in the interpretation of ‘assault’ and of behaviors which



**Fig. 3** Mean of lifetime prevalence of physical, sexual, and emotional violence by setting. *Note:* prevPL=prevalence of life time physical violence, prevEL=prevalence of life time emotional violence, prevSL=prevalence of life time sexual violence

**Fig. 4** Forest plot of current physical violence studies

constitute violence. However, not all women who suffer abuse identify with the socially constructed image of a ‘battered woman (Mahoney 1991). It is not only important to learn whether respondents have experienced any of the particular behaviors that we define as violent or abusive, but also to understand to what degree they share these labels with us. Many important social, political, and economic factors affect women’s lives, other than the cultural practices that receive so much attention in relation to violence. These include poverty, inequalities, new articulations of patriarchies in specific regions, and the legacies of colonialism and racism (Sokoloff and Pratt 2005).

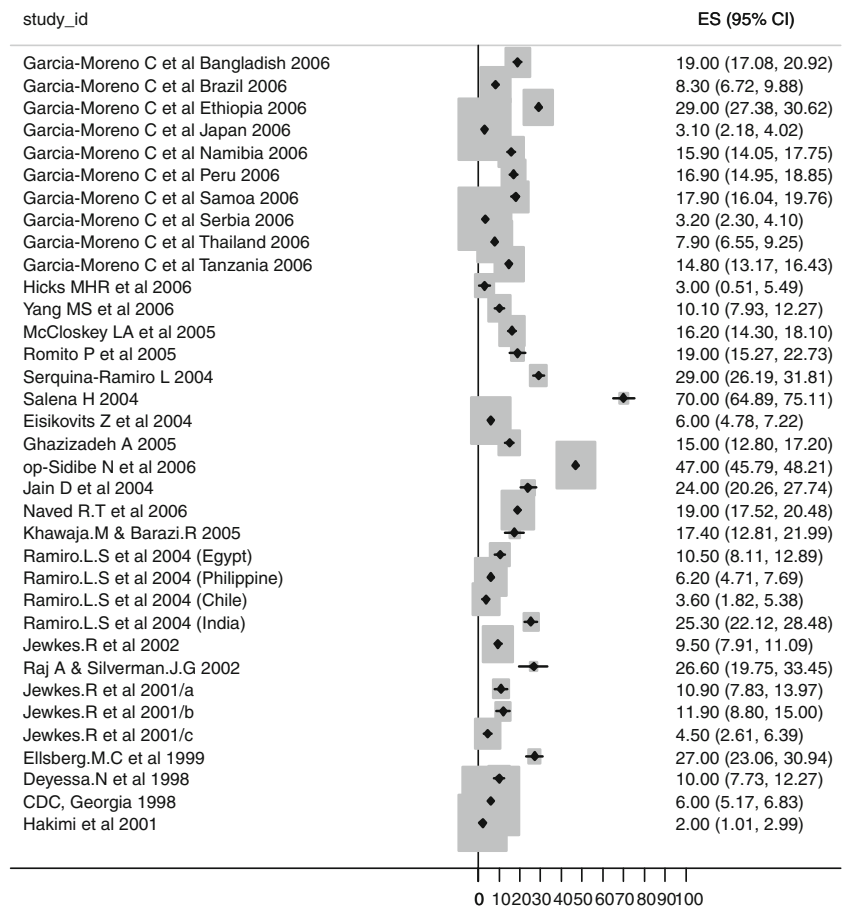
In Arab and Islamic countries, domestic violence is not yet considered a major concern, despite its increasing frequency and serious consequences. Domestic violence may be seen as a private matter and a potentially justifiable response to misbehavior on the part of the wife. Selective excerpts from religious tracts have been inappropriately

used to endorse violence against women, although abuse is more likely to be a result of culture than of religion (Douki et al. 2003). However, issues of power and gender (Caetano et al. 2000), rather than ethnicity and race (Anderson 1997), may be more important in creating and maintaining male dominance and the imbalance of power between husbands and wives (Harris et al. 2005).

Indeed, definitions of race and ethnicity are themselves problematic in research of this kind. Diverse ethnic groups are often collapsed into a single category, such as Asians, or the patterns of a single group such as Mexican Americans are over generalized to all Hispanics (Campbell et al. 1997). Because of this, data on partner violence among minority populations are often incomplete, precluding meaningful generalizations.

3) The *measurement* of domestic violence, and the accuracy of its reporting, are both fraught with problems, and much further work is need in this area. The choice of

**Fig. 5** Forest plot of prevalences of current physical violence from population studies



measures and the methodology used to establish the prevalence of domestic violence have significant impacts on the prevalence rates there are reported (Waltermaurer 2005). In our study, face-to-face interview methods yielded more disclosures of violence than self-reported or telephone interviews, in accordance with previous research indicating that the use of multiple and open-ended questions increases accurate reporting (Hamby et al. 1996). Written screening alone probably underestimates the prevalence of intimate partner violence (McFarlane et al. 1991).

Our results indicate that prevalence of all types of violence has increased over time, despite the provision of legal services for victims of violence. International law, particularly the Convention on the Elimination of All Forms of Discrimination against Women (Merry 2003) is a law without sanctions, so that its implementation can easily be avoided, and traditional interpersonal relationships within societies can continue to provide conditions which perpetuate the use of violence (Khawaja and Barazi 2005; Michalski 2004).

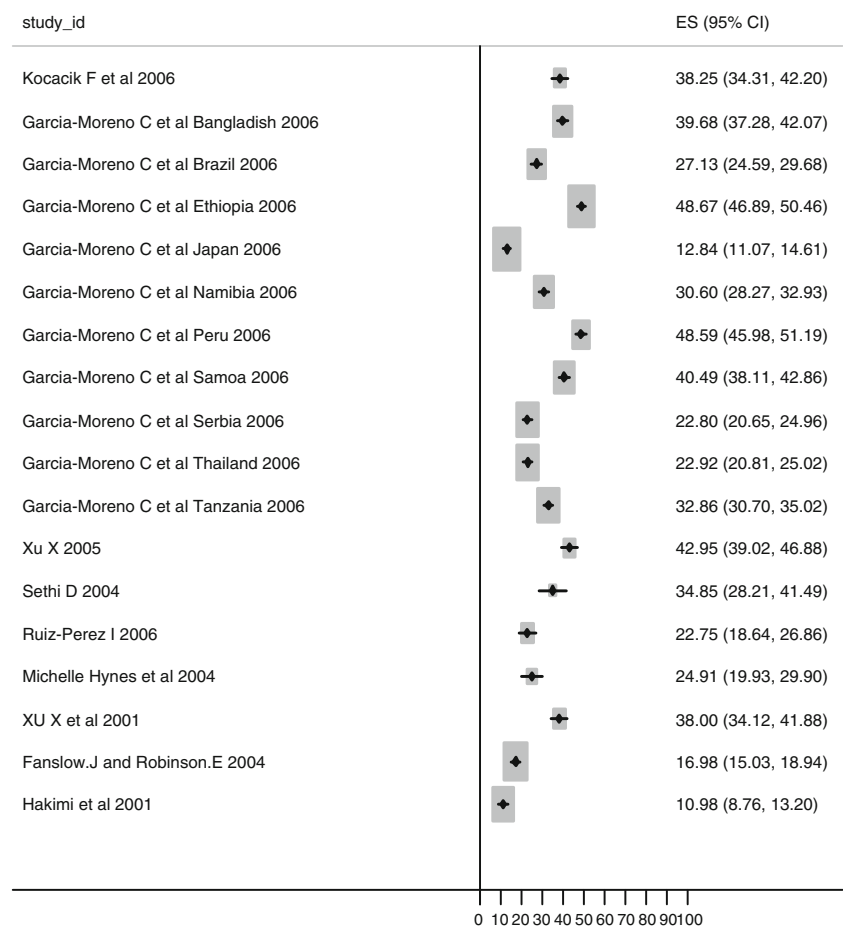
While we have attempted to follow a rigorous protocol in the conduct of this review, it is still subject to a number

of limitations. It may be prone to indexing bias, publication bias and reporting bias. Our ability to assess quality of the studies that we identified was limited by the methodological information provided in the published articles, some of which was incomplete.

**Conclusion**

The high prevalence rates of violence experienced by women suggests that doctors practicing in all areas of medicine need to recognize and explore the potential relevance of violence issues when considering women’s reasons for presenting with ill health. Sensitization to the problem of domestic violence should be incorporated not only in medical training, but into governmental, legal, and judicial organizations. Inconsistencies in methodology identified in the study emphasize the importance of developing clearer definitions so that findings can be compared across settings, to allow more accurate comparasions of prevalence rates over time, and between different population groups. Future research should seek to recognize cultural differences in family functioning without necessarily viewing such differences as ‘deviant’ or ‘pathological’, and should recog-

**Fig. 6** Forest plot of high quality studies on life time prevalence of physical violence



nize the complex nature of differences between and within ethnic groups. More concentrated and culturally sensitive research can lead to a clearer understanding of the scope and causes of violence against women, which in turn may lead to more effective preventive and intervention efforts.

#### *What is already known on this topic:*

- Domestic violence is increasingly recognized as a global health issue.
- In the past decade a number of prevalence surveys on intimate partner violence have been performed.
- Widely different estimates of the prevalence of domestic violence have been reported in different settings, suggesting a need to standardize the methodology used in such research.

#### *What this study adds:*

- Violence against women has reached epidemic proportions in most societies.
- This review identified major differences in methodology, instruments, sample size, period covered, the population surveyed and types and forms of violence studied.
- In all types of violence our meta-analysis indicated significant heterogeneity between studies, even in studies employing standardized methods.
- To accurately estimate the prevalence of violence in different settings, researchers need to develop clear and consistent definitions to allow comparisons between settings.

- prevalence of lifetime domestic violence varies from 1.9% in Washington, US, to 70% in Hispanic Latinas in Southeast US.

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**Contributorship** Samia Alhabib had the original idea for the study which was refined by Roger Jones. Data collection, critical appraisal of studies and general data analysis were undertaken by Samia Alhabib. Meta-analysis and sensitivity analysis were undertaken by Ula Nur. Samia Alhabib and Roger Jones drafted and finalized the manuscript.

**Potential Conflict of Interest** None declared.

**Ethics Approval** Not required.

**Funding** None



Appendix

Summary Table of the include studies:

Study ID	Population	% & Violence type	sampling	Sample size	Response	Case definition	instrument	CI	↓Bias	Score
Hakim et al. 2001, population study	Indonesia (Java)	P (LT: 11%, C: 2%), S (LT: 22%, C: 13%), E (LT: 34%, C: 16%)	? Random	765	94%	Yes	WHO interview	Yes	Yes	7
Hynes et al. 2004, population study	East Timor	Current, P: 24.8% (19.9–29.8), E: 30.5% (22.2–38.8), S: 15.7% (8.6–22.8)	Random	288	74%	Yes	WHO interview	Yes	Yes	7
Haj-Yahia et al. 2000, population study	Palestine	Annual incidence; E: 52%, P: 52%, S: 37.6%, E: 45%	Random	2,800, 1,500	86.7%, 88.9%	Yes	CTS & ISA, Self-administered	No	No	6
Nikki et al. 2000, community clinic	Latin	Current overall prevalence; 19%	Non-random	1,001	?	Yes	?AAS, interview	No	No	4
Naved et al. 2006, population study	Bangladesh	LT prevalence P: 39.7% (Urban), 41.7% (Rural), current P: 19% (Urban), 15.8% (Rural)	Random	2,702	96%	Yes	CTS, interview	No	Yes	7
Mousavi et al. 2005, population study	Iran	LT overall: 36.8%, Incidence: 29.3%, P: 27.2%, E: 32.4%	Random	386	87.5%	No	Others, interview	No	Yes	5
Fawole et al. 2005, population study	Nigeria	P: Current 31.3%	Random	431	?	No	Others, self-administered	No	Yes	4
Khawaja and Barazi 2005, population study	Jordan	LT P: 42.5%, C: 17.4%	Random	262 (women)	95%	Yes	Others, interview	No	No	4
Seedat et al. 2005, population study	U.S	LT P: 16%	Random	637	71%	No	Others, telephone interview	No	Yes	5
Anar and Gemaro 2005, college students	U.S	P: C: 48%	Non-random	863	?	Yes	AAS, self-Reported	No	No	4
Koziol-McLain et al. 2004, ED	New Zealand	P: C: 21.3%, LT: 44.3%	Random	174	60%	Yes	interview	Yes	Yes	6
Fanslow and Robinson 2004, population study	New Zealand	LT P (Auckland): 15%, 17% (North Waikato) S: 9% in Auckland, 12% in North Waikato.	Random	2,855	66.9%	Yes	WHO interview	Yes	Yes	8
Ramiro et al. 2004, population study	Egypt, India, Philippine, Chile	LT; (P) (Egypt); 11.1%, India=34.6%, Philippines = 21.2%, Chile= 24.9%	Random	422 (Chile), 631 (Egypt), L: 506, T: 700, V: 716, 1,000 (Philippines), Brazil=813 (Philippine)	96.1%(Chile), 93.5%(Egypt), 88%(India), 100% (Philippine)	Yes	Developed by researchers using focus group, interview	Yes	Yes	7
Swahnberg K et al. 2004, Gyn. clinic	Sweden	C; E; Chile= 15.2%, Egypt=10.8%, India=16.2%, Philippines=4.8%	non-random	2,439	81%	Yes	NorAQ	No	Yes	6
Koenig et al. 2004, population study	Uganda	LT E: 16.8, P: 32.1%, S: 15.9%, LT coercive sex: 24%	? random	4,279	93%	Yes	Interview, other methods	No	Yes	5
? Swahnberg J M et al. 2003, population study	Sweden, validation study of NorAQ	LT P: 36.4%, S: 16.9%, E: 21.4%	random	1,168	61%	Yes	NorAQ	Yes	Yes	7
Grande et al. 2003, population study	South Australia	LT P: 16%, E: 19%	random	women=2,884	73.1%	Yes	Others, telephone survey	Yes	Yes	8
Hurwell et al. 2003, population study	American Indian	C P: 5%, E: 18%, LT for both: 12%	random	women=588	94%	Yes	Others, telephone survey	No	Yes	6
Murty et al. 2003, population study	Iowa	C P: 2.9%, E: 46.7%	random	689	67.1%	Yes	CTS, interview	No	Yes	7
? Bensley et al. 2003, population study	Washington	C P: 1.9%, E: 5.1%	random	3,527	57%	Yes	BRFSS	Yes	Yes	7
Maziak and Asfar 2003, primary care.	Syria	C P: 23%	random	411	97%	Yes	Others, interview	No	Yes	6
El-Bassel et al. 2003, ED	New York, American Latin	C P: 15%, S: 6%, LT P: 43%, S: 20%	Non-random	143	Not reported	No	Others, interview	No	No	1
Llika et al. 2002, primary care center	Nigeria	C overall: 40%, P: 15.8%, E: 20.1%	random	300	100%	Yes	Others, interview	No	No	5
Okengbo et al. 2002, population study	Nigeria	LT P: 78.7, %; S: 21.3%, Mutilation; 52.7%	Random	308	Not reported	Yes	Others, interview	No	No	4
Basile 2002, population study	U.S	LT S: 34%	Random	602	50%	Yes	Others, telephone survey	No	No	4
? Coker et al. 2002, population study	U.S	LT P: 13.3%, S: 4.3%, E: 12.1%	Random	6,790	72.1%	Yes	CTS, telephone survey	Yes	No	7
Jewkes et al. 2002, population study	South Africa	LT P: 24.6%, Current: 9.5%	Random	1,306	90.3%	Yes	Others, interview	Yes	Yes	7

az-Olavarrrieta et al. 2002. Hospital study	Mexico	P and/or S; C; 9%, LT; 26.3%	Non-random	1,780	71.9%	Yes	Self-administered,, AAS	No	No	5
Coker et al. 2002., family practice	South Carolina	LT P; 41.8%, S; 21.4%, E; 12.1%	?	1,152	73%	Yes	Interview, ISA- to measure the severity of physical + AAS, PVS, self-administered	No	Yes	6
Melnick et al. 2002., surgical trauma clinic	U.S	C P; 18%	Not-reported	127	Not-reported	Yes	Others, interview	Yes	Yes	5
Romito and Gerin 2002, ER +Community center	Italy	C P and/or S; 10.2%	Non-random	510	76%	Yes	Others, interview	No	Yes	5
Raj and Silverman 2002., population study	South Asian women in Boston	C P; 26.6%, S; 15%, LTP;30.4%, S; 18.8%	Snowball?	160	Not-reported	Yes	CTS, self-administered	No	No	3
Brokaw et al. 2002, ED	New Mexico	LT P; 47.3%	Random	421	67.1%	No	Others, interview	No	Yes	5
Krishnan et al. 2001., ED	U.S	LT P; 72%, S; 20%, E; 92%	Non-random	87	70%	No	Others, interview	No	No	2
Grynbaum et al. 2001., primary care	Israel	C P; 21.7%, Incidence; 10%	Non-random	133	95.7%	No	PVS, self-administered	No	No	3
Barnes et al. 2001., University students	African American	LT P; 15.6%, E; 11.7%	random	179	47%	Yes	ISA, self-administered	No	No	4
Weinbaum et al. 2001., population study	California	C P; 6%	random	3,408	70%	Yes	CTS, telephone survey	Yes	No	7
Parkinson et al. 2001, Paediatric clinic	Massachusetts	C P; 2.5%, LT; 16.5%	Non-random	553	71.2%	No	Others, self-administered	Yes	No	4
Coid et al. 2001., primary care	London	LT P; 41%, S; 9%	Non-random	1,207	55%	Yes	Others, self-administered	No	No	3
Subramaniam and Sivayogan 2001, community health center	Sri Lanka	LT P; 30%, C; 22%	random	417	55%	Yes	Others, interview	No	Yes	5
Jewkes et al. 2001., population study	South Africa	1) Eastern Cape ( <i>n</i> =396); LT P; 26.8%, C P; 10.9%, LT S; 4.5%, C E; 51.4%. 2) Mpumalanga: ( <i>n</i> =419), LT P; 28.4%, C; 11.9%, LT S; 7.2%, C E; 50%. 3) Northern Province: ( <i>n</i> =464); LT P; 19.1%, C; 4.5%, C E; 39.6% LT P; 19.1%, S; 20.4%	random	1,306	90.3%	Yes	Others, interview	Yes	Yes	7
Plichta and Falik 2001., population study	U.S	LT P; 19.1%, S; 20.4%	?	1,821	?	Yes	CTS	Yes	No	5
Bauer et al. 2000., primary care	California	1) C P; 10%, S; 3%, E; 10%, 2) LT P; 45%, S; 17%, E; 34%	random	734	74%	Yes	AAS, telephone survey	No	No	6
Harwell and Spence 2000., population study	Montana	C P; 3%	random	1,017	90%	Yes	Others, telephone interview	Yes	Yes	7
Coker et al. 2000., population study	south Carolina	LT P; 10.6%, S; 7.8%, E; 7.4%	random	women=314	69.4%	Yes	ASS, telephone survey	Yes	Yes	8
Caetano et al. 2000., population study	U.S couples	C P black; 23%, Hispanic; 17%, whites; 12%	random	White=555, Black=358, Hispanic=527	85%	Yes	CTS, interview	No	No	6
? CDC 2000., population study.	South Carolina	LT P; 10.6%, E; 7.4%, S; 7.8%	random	313 women	69.4%	Yes	AAS, telephone survey	Yes	No	7
? CDC 2000., population study.	Washington	LT P; 23.6%	random	2,012 women	61.4%	Yes	CTS, telephone survey	Yes	No	6
Coker et al. 2000., family practice	South Carolina	LT P; 40%, E; 13.6%, C P; 8.9%, E; 7.5%	Non-random	1,152	73%	Yes	Interview, ISA to measure current abuse, WEB to assess battering, AAS to measure life-time abuse	No	Yes	6
Coker et al. 2000., family practice	Columbia	LT P; 32%, S; 17.3%, E; 12.5%, C P; 18.9%, S; 14.4%,	?	1,401	89%	Yes	Interview, ISA; for current S & P, WEBS; for battering, AAS; for life-time	No	No	5
Ernst et al. 2000., ED	U.S	C P; 5%, LT; 38.6%	? Random	57	78%	Yes	Self-reported, ISA	No	Yes	5
Ellsberg et al. 1999., population study	Nicaragua	LT P; 40%, C; 27%	?	488	100%	Yes	CTS, Interview	Yes	Yes	7
Tollstrup et al. 1999., population study	Mexico	C P; 6.7%, E; 13.5	Random	2,415	75	Yes	CTS, telephone survey	No	Yes	7
Deyessa et al. 1998., population study	Ethiopia	LT P; 45% ( <i>n</i> =303), C; 10%	Random	673	?	Yes	Others, interview	No	Yes	5
Karsliner et al. 1998., community clinic	Minnesota	LT P; 37%, C P; 6.6%, E; 21.1%, S; 2.1%,	Non-random	1,693	82.4%	Yes	Others, self-administered	No	Yes	5
? CDC 1998., population study	Georgia	C P; 6%, LT; 30%	Random	3,130	78%	Yes	Others, telephone survey	Yes	No	6
Pakieser et al. 1998., ED	Texas	LT P; 37%, C; 10%.	Non-random	4,448	40%	Yes	Others, self-administered	No	No	No

Author(s)	Study Design	Country	Sample Size	Prevalence	Method	Response Rate	Self-administered	Yes	No
Sachs et al., ED	Magdol et al. 1997, population study	California	480 women	LT P: 14.7%, C: 3.9%	Non-random	66.2%	Others, self-administered	Yes	No
Magdol et al. 1997, population study		New Zealand		C P: 27.1%, E: 83.8%					
Schet et al. 2006, population study		Australia	356	LT P/E/S: 27.5%	Random	90%	CTS, interview	No	No
Yuan et al. 2006, population study		Native American	793	LT P: 45% S: 14%	Random	98%	Others, interview	No	No
Avdibegovic et al. 2006, psychiatric clinic		Bosnia and Herzegovina	283	LT P: 75.9%, P & S: 43.5%, E: 85.6%	Random	89.5%	DVI, interview	No	No
Kocacik et al. 2006, population study		Turkey	583	LTE: 53.8%, P 38.3%, S: 7.9%	random	100%	WHO, interview	No	No
WHO. Garcia-Moreno et al. 2006, population study		Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa (National), Serbia, Thailand, Tanzania,	24,097	Bangladesh: LT (P: 39.7%, S: 37.4%), C (P: 19%, S: 20.2%) Japan=7 2-Brazil: LT (P: 27.2%, S: 10.2%), C (P: 8.3%, S: 2.8%) 3. Ethiopia: LT (P: 48.7%, S: 58.6%), C (P: 29%, S: 44.4%) 4. Japan: LT (P: 12.9%, S: 6.2%), C (P: 3.1%, S: 1.3%) 5. Namibia: LT (P: 30.6%, S: 16.5%), C (P: 15.9%, S: 9.1%) 6. Peru: LT (P: 48.6%, S: 22.5%), C (P: 16.9%, S: 7.1%) 7. Samoa: LT (P: 40.5%, S: 19.5%), C (P: 17.9%, S: 11.5%) 8. Serbia: LT (P: 22.8%, S: 6.3%), C (P: 3.2%, S: 1.1%) 9. Thailand: LT (P: 22.9%, S: 29.9%), C (P: 7.9%, S: 17.1%)	random	Japan (60.2%), other countries range: 85–97.8%	Interview, built on CTS	Yes	Yes
10. Tanzania: LT (P: 32.9%, S: 23%), C (P: 14.8%, S: 12.8%)									
Hicks et al. 2006, population study		Chinese American	323	LT P: 13%, C: 3%	random	56%	CTS, interview	Yes	Yes
Yang et al. 2006, population study		Taiwanese aboriginal tribes	876	LT prevalence P: 15%, C: 10.1%, S: 4%	random	84.7%	ASS, interview	Yes	No
Thompson et al. 2006, population study		Washington	3,568	LT prevalence (P: 44%, S: 30.3%, E: 35.1%)	random	56.4%	WEB, telephone survey	No	No
Ruiz-Perez et al. 2006, general practice		Spain	1,402	LT prevalence; P: 14.3%, E: 30.8%, S: 8.9%	Random	88.35%	WHO, self-administrated	No	No
Ergin et al. 2005, primary care		Turkey (Bursa)	1,427	LT P: 34.1%, E: 15.8%, economic: 8.2%, all-type violence: 29.5%	Not reported	71%	AAS, interview	No	Yes
McCloskey et al. 2005, population study		Mohsi (Tanzania sub-Saharan Africa)	1,444	LT P: 19.7%, S: 3.4%, C: P: 16.2%, S: 1.4%	Random	71%	One item from CTS, and 2 items from AAS, one item from SES, interview	Yes	No
Bengtsson-Tops 2005, psychiatric clinic		Sweden	1,382	Overall prevalence: 26% LT P: 28%, S: 19%, Economic: 16%; E: 46% C: P: 6%, S: 3%, Economic: 6%, E: 22%	Non-Random	79%	Others, interview	No	No
Kyu and Kana 2005, population study		Myanmar (South-East Asia),	286	C: P: 27%, E: 69%	Random	82%	CTS, self-administered	No	No
Burazeri et al. 2005, population study		Albania	1,196	C: P: 37%	Random	87%	Others, interview	Yes	No
Mayda and Akkas 2004, population study		Turkey	116	LT P: 41.4%, E: 25.98%, S: 8.6%, E: 77.6%	Non-Random	100%	Others, interview	No	Yes
McFarlane et al. 2005, primary care		U.S	7,443	C P&S: 8.9% in White, 6% in African American, 5.3% in Hispanic.	Non random	Not reported	Others?	No	No
Romito et al. 2005, family practice		Italy	444	Overall P, S, E, LT: 27.4%, C: 19.9%	Non random	78.6%	Others, self-administered	No	No
Newman et al. 2005, paediatric ED		Chicago	461	C P & S: 11%	Non random	Not reported	AAS, self-administered	No	No
Hegarty and Bush 2002, general practice		Australia	2,338	LT, P: 23.3%, E: 33.9%, S: 10.6%	random	78.5%	AAS, self-administered	Yes	No

Dal Grande et al. 2003, population study	Australia	LT P; 16%, E; 19%.	random	6,004	73.1%	Yes	Others, telephone interview	Yes	7
Xu X et al. 2005, gynecology clinic	China (Fuzhou)	Overall LT P, S, E; 43%, C; 26%	random	685	89%	Yes	WHO Q, interview	Yes	7
Parish et al. 2004, population study	China	LT P; 34%	random	1,665 women	76%	No	Others, interview	No	4
John et al. 2004, gynecology clinic	North England	LT P; 21%, C; 4%	Non random	920	90%	Yes	AAS, self-administered	No	5
Romito et al. 2004, primary care	Italy	C P; 5.2%, S; 5.2%, E; 19%	Non random	542	8.6%	Yes	Others, Self-administered	Yes	5
Serquina-Ramiro et al. 2004, population study	Manila	LT P; 47.2%, C; 29%	Random	1,000	90%	Yes	WorldSAFE, interview	No	7
Rivera-Rivera et al. 2004, population study	Mexico	LT P; 35.8%	random	1,641	93.5%	Yes	CTS, interview	Yes	8
Keeling and Birch 2004, Hospital	Warral, UK	LT P; 34.9%, C; 14%	Non random	294	99.3%	No	AAS, self administered	Yes	4
Cox et al. 2004, ED	Northern Canada	Overall life-time P & E; 51%, C; 26%, Incidence: 18%	random	1,223	80%	Yes	Others, interview	Yes	8
Kramer et al. 2004, primary care	U.S	LT P; 49.5%, S; 26.5, E; 72%. C P; 11.7%, S; 4.2%, E; 27.9%.	Non random	1,268	9% in each cell	Yes	AAS, self administered	Yes	6
Sethi et al. 2004, ER	UK	Life-time P; 34.8%, C; 6.1%	Non random	228	86.8%	Yes	WHO Q, interview	Yes	5
Peralta and Fleming 2003, family medicine	Madison, Wisconsin	C P; 10.3%, E; 43.5%	Non random	399	Not reported	Yes	CTS, self reported	No	4
Ruiz-Perez et al. 2006, primary care	Spain	LT of any violence; 22.8%	Non random	449	89.08%	Yes	WHO Q, self administered	No	5
Lown et al. 2006, population study	California	C P; 27.4%, S; 6.7%	Non random	1,786	85%	Yes	CTS, interview	Yes	7
Ghazizadeh et al. 2005, population study	Iran	LT P; 38%, C; 15%	random	1,040	97%	No	Others, interview	No	5
Faramarzi et al. 2005, obstetric/gynecology clinic	Iran	C P; 15%, S; 42.4%, E; 81.5%	Non random	2,400	Not clear	Yes	AAS, interview	No	5
Ahmed and Elmradi 2005, medical center	Sudan	C P & E; 41.6%	Non random	492	86.8%	Yes	Others, self-administered	No	4
Evans-Campbell et al. 2006, population study	New York	LT P; 40%	random	112 women	83%	No	Others, interview	No	4
op-Sidibe et al. 2006, population study	Egypt	LT P; 34.3%, C; 47%	random	6,566	99%	Yes	Others, interview	No	5
Apler et al. 2005, primary care	Turkey	LT P; 58.7%, C P; 41.1% <sup>0%</sup> , E; 33.6%	Non random	506	Not reported	Yes	AAS, interview	No	4
Coid et al. 2003, general practice	Hackney, east London	LT S; 24%	Non random	1,206	54%	Yes	Others, self administered	Yes	4
Siegel et al. 2003, pediatric setting	U.S	Incidence; 6%, LT P; 22%, C; 16%	Non random	435	Not reported	No	Others, self administered	No	3
Boyle and Todd 2003, ED	Cambridge	LT P; 21.3%, C; 6.1%, incidence: 1.2%	random	307	84.8%	Yes	Others, interview	Yes	5
Shaikh et al. 2003, obstetric/gynecology clinic	Pakistan	LT P; 55.9%, E; 75.9%, S; 46.9%	Non random	307	70.4%	Yes	Others, interview	No	3
Richardson et al. 2002, general practice	East London	LT P; 41%, C; 17%, E; 74%	Non random	2,192	64%	Yes	Others, self administered	Yes	6
Bradley et al. 2002, general practice	Ireland	LT P; 39%, E; 54%	Non random	2,615	72%	Yes	Others, self administered	Yes	5
Mazza et al. 2001, population study	Australia	Overall LT prevalence; 28.5%, E; 17%, S; 40.8%, C P; 7.9%, LT; 38%	Non random	395	90%	Yes	CTS, self-administered	Yes	6
Zachary et al. 2001, ED	New York	LT P; 14%, E; overall; 40%, S; 9.3%	Non random	795	76.8%	Yes	CTS, interview	No	6
Az-Olavarieta et al. 2001, hospital study	Mexico	LT P; 37.6%, E; 32.8%, C P; 15.5%, E; 19.1%	Non random	1,255	83%	Yes	Others, elf-administered	Yes	5
Augenbraun et al. 2001, hospital study	Brooklyn, NY	C P; 10.7%	Non random	375	96%	Yes	Others, elf-administered	No	5
Lown and Vega 2001, population study	Fresno County, California	C P; 6%, S; 3%, E; 12.5%	Random	1,155	90%	Yes	AAS, self-administered	Yes	8
Hedin et al. 2000, gynecology clinic	Sweden	LT P; S; E; 36.9%, C; 4%	Non random	207	64%	Yes	SVAW, self-administered	No	3
Jones et al. 1999, HMO survey	Washington DC	LT P; 52%, S; 21%, LT P; 34%	Non random	10, 599	14%	Yes	AAS, self-administered	No	4
Duffy et al. 1999, pediatric ED	New England city	LT P; 34%	Non random	150	Not reported	No	AAS, interview	No	4
Fikree and Bhatti 1999, primary care	Pakistan, Karachi	LT P/E; 36.9%, C P/S; 14.4%	Non random	4,641	74%	Yes	Others, interview	No	1
Deanwater et al. 1998, ED	Pennsylvania & California	LT non P; 22%, P; 33%, C non-P; 15%, current P; 19%	random	283 women	94%	Yes	AAS, self-administered	Yes	7
Ernst et al. 1997, ED	New Orleans		random	283 women	94%	Yes	ISA, self-administered	No	5

Author(s)	Year	Country	Study Design	Sample Size	Response Rate	Measurement	Outcome	Follow-up
Feldhaus et al.	1997	Colorado	ED	322	76%	PVS, interview	No	Yes
Salena et al.	2004	southeast US	population study	309	Not reported	Others, self-administered	No	Yes
Biroscak et al.	2006	Michigan	ED	2,926	82%	Others, chart review	Yes	No
Salam et al.	2006	Bangladesh	population study	496	73%	Others, interview	No	Yes
Hofner et al.	2005	Switzerland	ED	1,894	77.2%	PVS, interview	No	No
Eisikovits et al.	2004	Israel	population study	2,092	70%	CTS, self-administered	No	Yes
Rinfret-Raynor et al.	2004	Canada (Quebec)	population study	2,120	76.6%	SVS, CTS, telephone survey	No	Yes
Krishnan et al.	2005	South India	population study	397	88	Others, interview	Yes	No
Kozziol-McLain et al.	1999	Colorado	population study (PHD)	409	82%	PVS, followed by CTS, telephone survey	Yes	Yes
Jain et al.	2004	India	population study	500	79%	Others, interview	No	Yes
Csoboth et al.	2003	Hungarian	population study	3,615	94%	Others, self-administered	No	No
Wijma et al.	2003	5 Nordic countries	gynecology clinic	4,729	77	NorAQ, self-administered	No	No
Medina et al.	2003	Spain	population study	2,015	71.3%	CTS, interview	Yes	Yes
Smith et al.	2002	U.S	population study	268	45%	AAS, self-administered	No	No
Yoshihama et al.	2001	Japan	population study	211	52%	CTS, interview	No	Yes
X Xu et al.	2001	China	obstetric/gynecology clinic, PHD	600	885	WHO, interview	No	No
Toilestrup et al.	1999	Mexico	population study	2,418	75%	CTS, telephone survey	No	Yes

\*Readers can e-mail the correspondent author to have the full citation of the needed references

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