Juxtaposing Beliefs and Reality: Prevalence Rates of Intimate Partner Violence and Attitudes to Violence and Gender Roles Reported by New Zealand Women

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Abstract

This study documents the prevalence of intimate partner violence (IPV) for four ethnic groups and explores ethnic-specific differences and similarities in women's attitudes. Data are from a cross-sectional survey of 2,674 ever-partnered women aged 18 to 64 years. High rates of IPV among all ethnic groups reinforce the need to retain and expand current prevention and intervention efforts. Violence was not regarded as normative for any ethnic group. All women, but Pacific and Asian women in particular, would benefit from interventions that reinforce women's acceptance of seeking and utilizing outside intervention in cases of partner maltreatment.

Keywords attitudes to violence, ethnicity, gender roles, New Zealand, prevalence

Introduction

Internationally, intimate partner violence (IPV) has become recognized as a serious public health issue (Chalk & King, 1998; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002), with research documenting the widespread prevalence of the problem within the population as well as the long-term physical, reproductive, and mental health consequences that are associated with experiences of violence (Ellsberg, Jansen, Garcia-Moreno, Heise, & Watts, 2008; Fanslow & Robinson, 2004; Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005).

From a public health perspective, identification of high-risk groups within a population is of value, as it highlights those who may require more intensive and sustained prevention and intervention efforts. Many previous studies have reported disproportionately high rates of violence for indigenous and minority groups, compared with White or European ethnic groups (Field & Caetano, 2004; Malcoe, Duran, & Montgomery, 2004; Wahab & Olson, 2004). One of the purposes of this article is to explore if there are differences in occurrence of IPV by ethnic group in New Zealand, using data from the New Zealand Violence Against Women Study (NZ VAW Study).

In addition, within this study, we explore women's attitudes toward a range of issues that are closely linked with violence. In their review, Flood & Pease (2009) document how attitudes toward violence against women are "inextricably intertwined"(p. 128) with attitudes toward gender and sexuality. They state,

> Perceptions of the legitimacy of men's violence to intimate partners are constituted through agreement with the notions that men should be dominant in households and intimate relationships and have the right to enforce their

> dominance through physical chastisement, [that] men have uncontrollable sexual urges, women are deceptive and malicious, and marriage is a guarantee of sexual consent. (Flood & Pease, 2009, p.128)

Women's attitudes can be used as indicators of wider societal views about these issues. Cross-national research on attitudes to violence has shown that in many countries, women hold attitudes that are supportive of violence, with women from developing countries and from provincial regions more likely to report agreement with circumstances justifying violence (Garcia-Moreno et al., 2005). We sought to explore attitudes held by New Zealand women on these issues, to add to the base of knowledge in this area.

In addition to contributing to knowledge about between-country variation, we are interested in exploring within-country variation in attitudes expressed by women of different ethnic groups in New Zealand. Information on women's attitudes to gender roles, sexual autonomy, perceived acceptability of violence, and attitudes about outside intervention in family problems may offer us insights into different cultural understandings about acceptance of violence and the roles of women and men, which could inform prevention and intervention messages.

Women's attitudes may also influence changes between lifetime and 12-month rates within ethnic groups. Although women's attitudes to violence do not influence their likelihood of experiencing violence (Anderson et al., 2004, as cited in Flood & Pease, 2009), their attitudes can influence (a) the degree to which women may blame themselves for being assaulted, (b) their likelihood of reporting to the police or other authorities, and (c) their likelihood of experiencing long-term negative psychological effects (Flood & Pease, 2009). Thus, while women's attitudes to

violence and gender roles are unlikely to have a bearing on their initial experience of violence (signalled by the lifetime rate), their attitudes about the normative nature of this behavior are likely to influence their help-seeking behavior, and the degree to which they seek to extricate themselves from the violent situation. To explore these issues further, we look at the relationship between women's attitudes and changes between lifetime and 12-month rates within ethnic groups. Finally, we will be investigating possible interaction effects between ethnicity, experience of violence, and attitudes.

Method

Study Population

The study population was women aged 18 to64 years, who usually resided in private homes in Auckland or one rural region (north Waikato).

Sampling strategy, participants and response rate. The survey was conducted by the School of Population Health at the University of Auckland, as part of the New Zealand Violence Against Women Study (a replication of the World Health Organisation [WHO] Multicountry Study;(Garcia-Moreno et al., 2005). A random sample of women aged 18 to 64 years was obtained from (a) Auckland, the largest city (population 1.2 million), containing 26.8% of the total New Zealand population of women aged 15 to 64 and (b) north Waikato, a rural region, containing 2.8% of the total population of women aged 15 to64. Potential participants were contacted by door-knocking at randomly selected households, following a population-based cluster sampling scheme. The starting point for each cluster consisted of a randomly selected street and dwelling number. From the starting point, interviewers in Auckland approached every 4th house, and interviewers in the Waikato approached every 2nd

house until 10 households per cluster had been reached. Nonresidential (e.g., commercial, retail, or industrial buildings) and short-term residential properties (e.g., hotels, motels, boarding houses) were excluded.

In households with more than one eligible respondent, one woman was randomly selected for safety and confidentiality reasons. If the woman selected was available, consent was sought and an interview arranged; otherwise, contact details were obtained. A minimum of three return visits were made to each household at different times on different days to maximize the chance of obtaining an interview. Some interviewers made up to nine repeat visits.

Data management. All questionnaires were checked for completeness, and participants were recontacted if necessary to obtain missing data. All data were double entered in Epi-Info, checked, and cleaned.

Response rate and sample size. An 88.3% household response rate and 75.8% eligible woman response rate was obtained, resulting in an overall response rate of 66.9%. It was not possible to calculate ethnic-specific or socioeconomic-specific response rates, as this information was not collected from individuals or households who did not complete a questionnaire. Of the 2,855 women who completed the full questionnaire, 2,744 were ever partnered and 111 had never had partners. Of the 2,744 women who were ever partnered, 67 did not have current partners but did have, in the past, a male partner with whom they did not live. Three cases had missing data related to the partner status. Of these, 1 did not have a current partner but did have a male partner with whom she lived in the past and 2 had current male partners but were living apart. As a result, we report data from a total sample of 2,674 ever-partnered women.

Definitions

With the exception of the definition for ethnicity, all definitions used in this study were comparable with those used by the WHO Multicountry Study on Women's Health and Domestic Violence Against Women (Garcia-Moreno et al., 2005).

The New Zealand Census 2001 ethnicity question was used to collect self-reported *ethnicity* data. Respondents were able to nominate multiple ethnic group affiliations. For the purpose of these analyses, each respondent was allocated to a single ethnic group using the New Zealand Census 1996 prioritization method (Ministry of Health, 2004).

Intimate partners included male current or ex-partners that the women were married to or had lived with, or current regular noncohabitating male sexual partners.

Physical violence was defined as having been slapped; or had something thrown at them which could hurt them; having been pushed or shoved; had their hair pulled; having been hit with a fist or something else; having been kicked, dragged, or beaten up; having been choked or burnt on purpose; or having been threatened with a gun knife or other weapon or had one of these weapons used against them.

Sexual violence was defined as having experienced one or more of the following acts: being physically forced to have sexual intercourse when the woman did not want to, having sexual intercourse because she was afraid of what her partner might do, or being forced to do something sexual that she found degrading or humiliating.

Women were asked about their agreement with *attitudes* in relation to the following:

1. the role of women and men in relationships (a good wife should obey her husband even if she disagrees, it is important for a man to show his wife

who is the boss, a woman should be able to choose her own friends even if husband disapproves);

2. a woman's obligation to have sex with her husband or her ability to refuse to have sex under certain circumstances (prompted list);
3. that a man has good reason to hit his wife under certain circumstances (prompted list); and
4. her belief that others outside the family should intervene in cases of mistreatment or that family problems should only be discussed with people in the family.

Analyses

The sampling scheme was taken into account in all analyses. All analyses were undertaken using survey procedures in SAS v9. Ethnic-specific prevalence estimates, with 95% confidence intervals were calculated with the two study locations combined. Chi-squared tests were used to examine differences between ethnicgroups in prevalence of violence. Logistic regression was used to investigate whether the prevalence of violence differed between ethnic groups after controlling for sociodemographic characteristics (age; education level; household income; ownership of phone, car and home; current marital status; number of people per sleeping room; New Zealand Index of Deprivation 2001 (NZ dep2001 score)[1]; and location (Waikato or Auckland).

Chi-square tests were used to examine differences between ethnic groups in proportions who agreed with attitude statements. Women's agreement/disagreement with each group of attitude statements is presented by ethnic group. However, women's beliefs about a wife's right to refuse sex with her husband is presented by

ethnicity and women's personal experience of IPV, as this was the only group of attitudes where the woman's personal experience of IPV influenced attitudes. Women's attitudes about the acceptability of IPV are presented as percentages for the total sample, as no ethnic differences were found.

Safety and Ethics Considerations

Written consent to participate was obtained from all respondents. All interviews were conducted in private (no children above the age of 2 years), and all participants, regardless of whether they disclosed abuse, were provided with a list of support agencies. In addition, ethical and safety recommendations for research on IPV, developed by the WHO, were followed as part of the conduct of the present study (WHO, 2001). Ethics approval was granted by the Human Subjects Ethics Committee of the University of Auckland (Ref number: 2002/199).

Results

The distribution of prioritized ethnicity by region is presented in Table 1. Previous comparisons indicated there were no significant differences in the distribution of ethnicity of women in the study compared with the population of the two regions or the population of women in this age range in the total population (see Fanslow & Robinson, 2004).

Prevalence

Lifetime prevalence. Lifetime prevalence of physical and/or sexual IPV among Māori women (57.6%, more than 1 in 2) was significantly higher than that of Pacific women (32.4%, 1 in 3) and European/Other women (34.3%, 1 in 3). Asian women reported significantly lower lifetime prevalence of IPV (11.5%, 1 in 10)

compared with women of European or Other ethnic origin. These differences remained after controlling for sociodemographic characteristics and geographic location (Table 2). There was also a relationship between increased likelihood of violence and decreased income. Education was not associated with IPV after controlling for other variables in the model (data not shown).

12-month prevalence. Māori (14.1%) and Pacific (9.3%) women had the highest prevalence of physical and/or sexual IPV in the twelve months prior to the survey. These rates were more than two times higher than the 12-month prevalence reported by women of European/Other ethnic origin (3.9%), or Asian women (3.4%;Table 2).

Attitudes

Women's attitudes about the role of women and men in relationships. There were ethnic differences in the percentages agreeing with all of these statements. Pacific and Asian women were more likely to agree that it was "important for a man to show his wife who is the boss" (27.1% and 17.9%, respectively) and to endorse the statement that "a good wife obeys her husband even if she disagrees" (41.6% and 27.5%), respectively although Māori (17.2%) also endorsed this latter view more than the European/Other group (9.2%). Asian (16.9%) and Pacific (15.1%) women were less likely to agree that a woman should choose her own friends if her husband disapproves, whereas the majority of Māori (2.9%) and European/Other women (4.5%) believed in woman's right to choose friends even if her husband disapproved (Table 3).

Interactions between ethnicity, attitudes to refusing sex, and experience of IPV. Regardless of ethnicity or experience of IPV, more than 85% of women agreed

that a woman had a right to refuse to have sex with her husband regardless of circumstances. However, attitudes reported by Asian and Pacific women were mediated by their experience of IPV. Fewer Asian women who had experienced IPV agreed that a woman had a right to refuse sex to her husband, compared with Asian women who had not experienced IPV. The opposite was true for Pacific women. A higher proportion of Pacific women who had experienced IPV agreed that women had the right to refuse sex with their husbands, compared to those who had not experienced violence. This interaction was statistically significant (Wald $\chi^2 = 345$, df=3, $p < .0001$). Māori women and women of European/Other ethnicity almost universally reported that they considered that a woman had a right to refuse sex with her husband, regardless of whether they had experienced physical or sexual violence by an intimate partner (Figure 1). Women's experience of IPV did not affect women's other attitudes.

Women's attitudes about the acceptability of violence within relationships. Less than 0.5% of women across all ethnicities considered it acceptable for a man to hit his partner if: she does not complete her household work to his satisfaction, she disobeys him, she refuses sex with him, or she asks if he has other girlfriends (Table 4).

Some small but significant ethnic differences were found in women's agreement with justifications for a man using violence if he suspected or learned of the woman's sexual infidelity. Higher proportions of Pacific (11.3%), Asian (6.8%), and Māori (5.3%) women agreed that a man has a good reason to hit his wife if she was unfaithful, compared with the European/Other ethnic group (1.6%;Table 5). Far fewer women agreed with the acceptability of a man hitting his wife if he *suspected* she was unfaithful.

Privacy, keeping problems within the family. There was considerable variability between ethnic groups in terms of their perceptions that "family problems should only be discussed with people in the family." More than three quarters of Pacific women (76.5%), two thirds of Asian women (64.7%), half of Māori women (48.2%) and one third of European/Other women (31.1%) agreed with this statement.

When asked about their agreement/disagreement with the statement "If a man mistreats his wife, others outside of the family should intervene" the pattern was comparable, though of lower magnitude. One third of Pacific women (34.1%), one fifth of Asian (20.7%) and Māori (20.7%) women, and one tenth of European/Other women disagreed with this statement. (A higher level of disagreement means that people are more likely to think that others should *not* intervene.) Overall, more than two thirds of women felt that others outside the family should intervene if a man mistreated his wife/partner (Table 6).

Discussion

This study makes use of data from the NZ VAW Study, the largest study of violence against women ever undertaken in this country. It is also the first population-based study in New Zealand to identify Asian-specific prevalence of IPV. Findings reinforce previous work that indicates that IPV is a substantial problem and that prevention efforts across the whole population need to be sustained. However, the study also indicates that there is considerable variation between ethnic groups in terms of the prevalence of IPV experienced.

Ethnic-Specific Prevalence Rates in International Context

The 58% lifetime prevalence for Māori women is at the high end of the prevalence estimates found in the WHO Multicountry Study (Ethiopia: 71%; Bangladesh province: 61.7%, Tanzania province: 55.9%). The United States, Canada, and Australia have also reported a higher prevalence of IPV among indigenous populations compared with European groups (Malcoe, et al., 2004; Nancarrow & Schmider, 2007; Statistics Canada, 2006). Wahab and Olson (2004) reviewed risk factors associated with the occurrence of IPV and noted that "the treatment of Native Americans by colonizers, racism, exploitation of resources, seizure of land, introduction of alcohol, and disease… have profoundly negatively affected the values and lives of indigenous peoples" (p.355). These factors have also been noted as contributors to the problem of IPV among Maori (Kruger et al., 2004).

Lifetime prevalence for the Pacific women surveyed in this study was approximately 1 in 3, which is approximately half the lifetime prevalence reported by Pacific women in some of their home countries, for example, (Samoa 46%; Garcia-Moreno et al., 2005). At 22.4%, the 12-month IPV prevalence in Samoa (Garcia-Moreno et al., 2005) was also approximately double the 12-month prevalence reported by Pacific women in the present study (9.1%). This 12-month prevalence is comparable to the 12-month prevalence for severe violence reported by another cohort of Pacific women in New Zealand (11%;Paterson, Feehan, Butler, Williams, & Cowley-Malcolm, 2007).

The lifetime prevalence rate for the European/Other ethnic grouping was also approximately 1 in 3, which is not dissimilar to prevalences reported for White populations in the United States (e.g., 22.1% physical partner violence, 7.7% sexual partner violence; Tjaden & Thoennes, 2000). New Zealand's 12-month IPV prevalence rates among European/Other women (3.9%) were somewhat higher than

those reported by White women in the United States (1.3% physical IPV; Tjaden & Thoennes, 2000).

Asian women reported the lowest lifetime prevalence (11.5%) of all groups surveyed in New Zealand. The reported prevalence estimates ("any IPV" lifetime: 11.5%, "any IPV" 12-month: 3.4%) were comparable to those reported by women in Japan (15.4% lifetime prevalence, 3.8% 12-month prevalence), as part of the WHO Multicountry Study (Garcia-Moreno et al., 2005). Estimates of IPV prevalence for immigrant populations of Asian/Pacific Islander origin in other countries (e.g., the United States, are not available (Tjaden & Thoennes, 2000). It has been suggested by some authors that strong socialisation focussed on maintaining harmony within family relationships may partly contribute to low reports of lifetime prevalence, either by making violence less likely to occur, or by discouraging reporting, so as not to violate socially sanctioned images of family harmony (Yoshioka, DiNoia, & Ullah, 2001). Other studies of family violence in Asian communities have identified how communities "cover up" family violence, or pressure women not to expose family violence so as not to bring their community into disrepute (Tse, 2007).

Further studies are needed to identify factors at the individual, community and societal levels that account for within-country differences in IPV prevalence.

Attitudes and Links With Changes Between Lifetime and 12-Month Rates

One of the purposes of the present study was to compare differences between ethnic groups within New Zealand, not only in terms of reported prevalence but to see if there were differences in the clusters of attitudes between different ethnic groups. Almost universally, women from all ethnicities did not find male partner violence against women to be acceptable under any circumstances. In fact, New Zealand

women of all ethnic groups expressed the least support for violence out of all the countries that participated in the WHO Multicountry Study (Garcia-Moreno et al., 2005). Sadly, however, this highlights the gulf between many women's realities and their beliefs, as many have experienced violence by their intimate partner even though they do not consider it acceptable.

Māori women had both the highest lifetime (57.6%) and 12-month (14.1 %) IPV prevalences. In contrast, Māori women also expressed attitudes that were absolutely clear that a man's violence against his partner was not acceptable under any circumstances and were in high agreement with beliefs about sexual autonomy. The findings clearly refute the notion that this is a group among whom violence is accepted. Māori women were midrange in terms of their beliefs about keeping problems within the family (48% agreeing), with 20% not thinking that others outside the family should intervene if a man mistreated his wife.

The Pacific women surveyed had a lifetime prevalence (32.4%), comparable to the prevalence among European/Other women, but had a higher 12-month rate (9.3%). Within New Zealand, they were the group that expressed the most agreement with traditional gender roles and most acceptance of justifications for a man beating his wife. They also expressed the least agreement with women's sexual autonomy, although this was mediated by their experience of abuse. (Interestingly, Pacific women who had personal experience of IPV were less likely to agree that a man could hit wife if she was unfaithful.) Pacific women were also the group most likely to think that family problems should be kept within the family and least likely to think that outside help should be offered in the case of a man mistreating his wife.

Asian women had the lowest lifetime prevalence of IPV (11.5%) and a low 12-month prevalence (3.4 %; comparable to European/Other). In contrast with

European or other women, they also expressed most agreement with a man's right to beat his wife under different circumstances and relatively low levels of agreement with beliefs about sexual autonomy. In the present study, Asian women also expressed high agreement with keeping family problems within the family, and low agreement with outside intervention in the case of a man mistreating his wife. This is consistent with qualitative research that reports that beliefs about family violence as a private matter are strong within the Asian community, as are beliefs in the importance of keeping marriages and relationships intact.

In general, Pacific and Asian groups were more likely to endorse the notion of family privacy, and be less receptive to outside intervention. They showed smaller differences between lifetime and 12-month prevalences (Pacific: 32.4-9.3= 23.1%; Asian: 11.5-3.4=8.1%), perhaps indicative that these attitudes inhibit them from seeking help, and increase the likelihood of them remaining in violent situations. Given that attitudes may mediate actions, instituting strategies that support cultural norms around the acceptability of seeking help in cases of IPV may help to enhance women's ability to access help.

The European/Other ethnic group showed the biggest difference between lifetime prevalence (34.3%) and 12-month prevalence (3.9%). These women were least likely to agree with any justifications for a man beating his wife, and the most likely to agree with beliefs about a woman's sexual autonomy. This group was also the least likely to want to keep problems within the family, and the most supportive of the notion that others outside should intervene if a man mistreated his wife.

NZ Attitude Findings in International Context

The attitudes expressed by women in New Zealand are unusual internationally in that there was almost universal agreement among women of all ethnic groups that violence by a male partner against his wife is unacceptable for reasons such as not completing housework adequately, refusing sex, or disobeying her husband. Although there was greater variation between ethnic groups in agreeing that a man might be justified in beating his wife if she was unfaithful (1.6% European/Other, 5.3% Māori, 6.8 % Asian, 11.3% Pacific), there was still little belief that violence was acceptable. In sharp contrast, in 8 of the 15 WHO sites, more than half of the women surveyed agreed that this was a justification for wife beating (Garcia-Moreno et al., 2005).

Attitudes about sexual autonomy were measured by women's agreement with a woman's right to refuse sex to her husband under certain conditions. Again, the New Zealand data are most notable for their lack of variation, with more than 90% of women from all ethnic groups agreeing that a woman had the right to refuse sex under all of the conditions mentioned. These findings are aligned with those obtained from the urban sites in other countries surveyed by the WHO (Brazil city, 1.3 %; Brazil province, 2.9%; Peru city, 0.5%; Serbia and Montenegro, 1.0%; Thailand city, 0.5%; Thailand province, 2.0%;Garcia-Moreno et al., 2005).

Strengths and Limitations of the Study

Even after controlling for a range of sociodemographic characteristics, pronounced ethnic differences in prevalence of IPV were identified, with Māori women experiencing IPV on a lifetime basis twice as often as Pacific and European/Other women. This is consistent with findings from The New Zealand National Survey of Crime Victims (NZNSCV), which also reported that the prevalence of IPV was considerably higher among Māori women (49.3% of ever-partnered Māori reported at

least one incident or threat of physical violence compared with 24.2% European, 23.3% Pacific, 24.9% Other; Morris, Reilly, Berry, & Ransom, 2003). Although the assessment questions and methods differed between the present study and the NZNSCV (e.g., assessments of sexual violence were not included in the NZNSCV, and it used computer-assisted self-interviewing instead of face-to-face interviews), the magnitude of the difference between Maori and other ethnic groups was comparable.

It is beyond the capability of this present, cross-sectional study to identify how attitudes are shaped and how these attitudes may directly influence women's actions, and the occurrence or nonoccurrence of violence. However, the advantage of this large-scale epidemiological study of the general population is that it allows us to gauge ethnic-specific attitudes among women about the acceptability of violence within relationships; to gauge attitudes to gender roles within marriage, including sexual fidelity; to gauge attitudes about keeping family problems private and the acceptability of outside intervention; and to explore if these attitudes are similar or different among women of different ethnic groups. While this will not allow us to predict what individuals will do, it may help to provide us with understanding of how these attitudes may influence responses to violence and help-seeking behaviours.

Sampling for the study was representative of the two regions surveyed, which contained 30% of the eligible population in New Zealand at the time of survey, and, as such, is likely to be broadly generalizable to the whole of the country (see Fanslow & Robinson, 2004). While overall response rates were relatively high (67%), the recruitment strategy employed meant it was not possible to determine if there were differential response rates by ethnic group or socioeconomic position. Despite these potential sources of bias, the study was conducted on a large population-based sample

that was interviewed by trained staff using a well-validated instrument. It provides previously unavailable information and allows for international comparisons.

Ethnic-specific calculations of prevalence and information on attitudes are based on information from women. As a consequence, they should not be extrapolated to men. For example, although Māori women experience the highest rates of IPV, it is not necessarily the case that this violence was most likely to be perpetrated by Māori men. Likewise, although the majority of women interviewed espoused agreement with egalitarian gender norms and women's rights to sexual autonomy within marriage (and were almost unanimous that IPV was unacceptable), it is not clear to what extent these attitudes are shared by men.

Although these prevalence estimates and expressed attitudes are broadly indicative of the relative scale of IPV within different ethnic groups, there are likely to be intragroup variations. Further breakdown of prevalence estimates according to specific Pacific, Asian, or other ethnic communities was not possible within the present study because of the small sample sizes within the disaggregated ethnic groups. Other studies have indicated there may be differences between subgroups (Yohioka, et al., 2001). In addition, there may be intragroup variation based on other factors. Among Pacific communities, differences may exist between New Zealand-born versus Island-born individuals, according to length of time spent in New Zealand or according to age (Paterson et al., 2007). Qualitative studies by Koloto and Sharma (2005) and Hand et al. (2002), provided examples of some of the ways these differences may play out in terms of knowledge of support services, and understanding of how to access services, while Paterson et al. (2007) signaled that factors such as cultural alignment may also influence prevalence. There may also be differences in rates between different Māori hapū (subtribes), as has been suggested

among diverse Native American tribes and regions (Malcoe, et al., 2004). Further research exploring these issues would be of value.

This study has focussed on exploring *women's* attitudes the about the acceptability of men's violence against women. If true gains are to be made in preventing IPV (and lowering the overall lifetime prevalence), then further attention will need to be paid to addressing the attitudes of men. Other studies have documented how attitudes to violence help mediate the relationship between experiencing violence when growing up and engaging in violence against spouses in later life (intergenerational transmission of violence; Markowitz, 2001), and how subscription to patriarchal masculine ideology contributes to sexual aggression (Murnen, Wright, & Kaluzny, 2002).

Practice Implications

To buttress the beliefs about the unacceptability of violence within different ethnic groups and to reinforce the acceptability of help seeking in situations of violence, it may be helpful to identify and advertise ethnic-specific attitudes and responses that reinforce these ideas. Campbell, Masaki, and Torres (1997) stated that "the seeds of changing public perception about domestic violence are rooted in every cultural history" (p. 79). They document wide-ranging historical examples of responses to protect women from violence in Japan, India, and Thailand, as part of demonstrating that many cultures have invested efforts to support safety and nonviolence. Currently, there are a number of innovative and community-based responses to IPV emerging from the Asian and Pacific communities in the United States. Furthering understanding of these initiatives more widely may help with diffusion of these innovations within New Zealand (Kim, 2005). These ideas may also push the

boundaries of European established/ Western ideas that have tended to focus on individualized responses (e.g., shelters for women) to the exclusion of strategies that focus on men and communities (Kim, 2002). Homegrown "indigenous innovation" can also play a strong role in developing Māori responses to violence (Grenell & Pivac, 2006).

Policy Implications

To move forward in preventing IPV, New Zealand's responses to need to be maintained and expanded (Fanslow, 2005), and the current policy focus on the issue maintained (e.g., reduction of family violence is currently one of the top five government priorities for inter-departmental response; Ministry of Social Development, 2004).

Ethnic- specific differences in prevalence also provide us with clues about the sorts of interventions we should offer. Māori and Pacific women reported the highest prevalence of IPV within the previous 12 months. Culturally specific services (e.g., by Māori, for Māori) might be one way of meeting this need and have been a long-standing feature of women's refuges (National Collective of Independent Women's Refuges, Inc., n.d.). However, for Pacific women, shame and other issues associated with membership of close-knit communities may prohibit access to such services.

There are also likely to be resource issues (i.e., access to skilled staff as well as financial resources) that make the provision of a multitude of parallel services nonviable. For these reasons, it is important to establish and support the development of cultural competencies among mainstream service providers. Other fields have started to address these needs (e.g., Alcohol and Drug Treatment Workforce Development Advisory Group, 2001), and may provide examples that could be used

to further articulate cultural competency within violence intervention services for victims and perpetrators. Adequate and sustained funding for services is also required, to build expertise, and prevent burnout of workers.

In addition to service-based responses to victims and perpetrators, there are increasing calls for wider community responses to IPV, from Māori (Kruger et al., 2004), Asian and Pacific communities (Kim, 2002), and from the perspectives of Europeans and others (Fanslow, 2005; Krug, et al., 2002). Common elements of these recommendations include calls for more prevention-oriented approaches, including holistic visions of well-being (e.g., fostering development of healthy individuals and healthy relationships); approaches that take into account families and communities as well as interactions between two individuals; and approaches that pay more recognition to historical and cultural contexts, rather than adopting a "one-size fits all" model of response.

A focus on education is also regarded as one of the fundamental mechanisms for changing behaviour at the individual and collective levels. This can take a variety of forms, including school-based programs aimed at reducing IPV perpetration and victimization (e.g., Foshee et al., 2004), or social marketing approaches aimed at whole populations (e.g., Donovan, Francas, & Patterson, 2003). The national media and community campaign against family violence in New Zealand ("It's not OK"), which features a number of high profile men and women defining and taking a stand against family violence, was conducted after the data collection for the present survey was undertaken. This social marketing programme has strongly influenced the attitudes of men about perpetrating violence, with reports from service providers about increases in men's self-referral to nonviolence services (Yee, 2009). These

strategies show promise, and their widespread implementation could support ethnic-specific prevention activities.

Practice, policy and research recommendations for indigenous communities in other countries may be relevant for Māori. Wahab and Olson's (2004) suggestions included: "adopting macro-level interventions that will support the rebuilding of institutions in Native American communities, provide employment and training opportunities; utilize interventions that support self-determination, empowerment and pride," and ground interventions in empowerment models (p.362). These suggestions are similar to "homegrown" New Zealand recommendations (Grennell & Pivac, 2006), and other health advocacy work that documents how reduction of socioeconomic and other disparities in the wider community may help to reduce the disproportionate burdens born by the Māori (Blakely, Fawcet, Atkinson, Tobias, & Cheung, 2005).

Conclusion

Intimate partner violence is a key social issue of our time. Virtually all women in the present study reported that they considered it unacceptable for a man to hit his wife under any circumstances. Addressing women's attitudes about gender roles in order to promote equality, and reinforcing the acceptability of seeking outside intervention in cases of IPV are also important avenues to pursue. Intervention efforts may also benefit from development and support of both culturally specific specialist services and embedding cultural competencies within general services. Although addressing attitudes may be an important strand of action to eliminate IPV, attempting to shape attitudes alone will not be enough. We need to continue to address wider societal factors like poverty, racism and colonisation. Above all, we need to engage men.

Note

1. The New Zealand Index of Deprivation 2001 *(*NZ dep2001 score) is a measure of socioeconomic deprivation calculated from nine variables (including household income [receving government benefit or below income threshold], home ownership, single-parent families, employment, qualifications, overcrowding, access to telephone, and access to car) drawn from the 2001 census data for each of its "meshblocks" or neighbourhood areas. NZDep2006 scores are grouped into 10 bands or deciles, with Decile 1 being the least deprived and Decile 10 the most deprived (Salmond & Crampton, 2002).

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REFERENCES

Alcohol and Drug Treatment Workforce Development Advisory Group. (2001). *Practitioner competencies for alcohol and drug workers in Aotearoa, New Zealand*. Wellington, New Zealand: Alcohol Advisory Council of New Zealand.

Blakely, T., Fawcett, J., Atkinson, J., Tobias, M., & Cheung, J. (2005). *Decades of disparity II: Socioeconomic and mortality trends in New Zealand, 1981-1999*. Wellington, New Zealand: Ministry of Health.

Campbell, D. W., Masaki, B., & Torres, S. (1997). "Water on Rock": Changing domestic violence perceptions in the African American, Asian American, and Latino communities. In E. Klein, J. Campbell, E. Soler, & M. Ghez. (Eds.), *Ending domestic violence: Changing public perceptions/Halting the epidemic* (pp. 64-87). Thousand Oaks, CA: Sage.

Chalk, R., & King, P. A. (1998). *Violence in families: Assessing prevention and treatment programs.* Washington, DC: National Academy Press.

Donovan, R. J., Francas, M. & Patterson, D. (2003). Case study 18: Freedom from fear. In: J. R. McColl-Kennedy (Ed.). *Services marketing*. Brisbane, Queensland: Australia: John Wiley.

Ellsberg, M., Jansen, H., Garcia-Moreno, C., Heise, L., & Watts, C. (2008). Intimate partner violence and women's physical and mental health in the WHO Multi-Country Study on Women's Health and Domestic Violence: An observational study. *Lancet, 371,* 1165-1172.

Fanslow, J. L. (2005). *Beyond zero tolerance: Key issues and future directions for family violence work in New Zealand*. Wellington, New Zealand: Families Commission.

Fanslow, J. L., & Robinson, E. (2004). Violence against women in New Zealand: Prevalence and health consequences. New Zealand Medical Journal, 117, 1173-1184. Retrieved May 12, 2010, from http://www.nzma.org.nz/journal/117-1206/1173/

Field, C. A., & Caetano, R. (2004). Ethnic differences in intimate partner violence in the U.S. general population: The role of alcohol use and socioeconomic status. *Trauma, Violence & Abuse, 5,* 303-317.

Flood, M., & Pease, B. (2009). Factors influencing attitudes to violence against women. *Trauma, Violence & Abuse, 10,* 125-142.

Foshee, V., Bauman, K., Ennett, S., Linder, F., Benefield, T., & Suchindran, C. (2004). Assessing the long-term effects of the Safe Dates Program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. *American Journal of Public Health, 94,* 619-624.

Garcia-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women: Initial results on prevalence, health outcomes and women's responses.* Geneva, Switzerland: World Health Organization.

Grenell, D., & Pivac, A. (2006, February). *Amokura - Indigenous innovation*. Paper presented at the 10th Australasian Conference on Child Abuse and Neglect, Wellington, New Zealand. Retrieved August 18, 2009, from http://www.nzfvc.org.nz/accan/papers-presentations/abstract258v.shtml

Hand, J., Elizabeth, V., Martin, B., Rauwhero, Y.H., Burton, M., Shelby, S., et al. (2002). *Free from abuse: What women say and what can be done.* Auckland New Zealand: Public Health Promotion, Auckland District Health Board.

Kim, M. (2002). *Innovative strategies to address domestic violence in Asian and Pacific Islander Communities: Emerging themes, models and interventions.* San Francisco: Asian and Pacific Islander Institute on Domestic Violence.

Kim, M. (2005). *The community engagement continuum: Outreach, mobilization, organizing and accountability to address violence against women in Asian and Pacific Islander communities*. San Francisco: Asian and Pacific Islander Institute on Domestic Violence.

Koloto, A. H., & Sharma, S. (2005). The needs of Pacific women when they are victims of family violence. *Social Policy Journal of New Zealand, 26,* 84-96.

Krug, E., Dahlberg, L., Mercy, J., Zwi, A., & Lozano, R. (2002). *World report on violence and health*. Geneva, Switzerland: World Health Organization. Retrieved August 18, 2009, from http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf.

Kruger, T., Pitman, M., Grennell, D., McDonald, T., Mariu, D., Pomare, A., et al. (2004). *Transforming whanau violence: A conceptual framework. An updated version of the report from the former Second Māori Taskforce on Whanau Violence* (2nd ed.). Wellington, New Zealand: Te Puni Kokiri. Retrieved May 12, 2010, from http://www.nzfvc.org.nz/goodpracticedocument.aspx?doc=4

Malcoe, L.H., Duran, B. M., & Montgomery, J.M. (2004). Socioeconomic disparities in intimate partner violence against Native American women: A cross-sectional study. *BMC Medicine,*: *2*(20), 1-14.

Markowitz, F. E. (2001). Attitudes and family violence: Linking intergenerational and cultural theories. *Journal of Family Violence, 16,* 205-218.

Ministry of Health. 2004. *Ethnicity data protocols for the health and disability sector*. Wellington, New Zelaand: Author

Ministry of Social Development. (2004). *Opportunities for all New Zealanders*. Wellington, New Zealand: Author.

Morris, A., Reilly, J., Berry, S., & Ransom, R. (2003). *The New Zealand National Survey of Crime Victims, 2001*. Wellington, New Zealand: Ministry of Justice.

Murnen, S. K., Wright, C., & Kaluzny, G. (2002). If "boys will be boys" then girls will be victims? A meta-analytic review of the research that relates masculine ideology to sexual aggression. *Sex Roles, 46*, 359-375.

Nancarrow, H., & Schmider, J. (2007). *Aboriginal and Torres Strait Islander family violence : Facts and figures*. Mackay, Australia: Queensland Centre for Domestic and Family Violence Research, Central Queensland University, Record. Retrieved November 19, 2009, from http://www.noviolence.com.au/public/factsheets/indigenousfactsheet.pdf

National Collective of Independent Women's Refuges Inc. (n.d). *Te Tiriti o Waitangi and parallel development.* Retrieved August 18, 2009, from http://www.womensrefuge.org.nz/index.cfm?objectid=0CFAF54E-1321-AE99-698D3F49357E3F8C

Paterson, J., Feehan, M., Butler, S., Williams, M. & Cowley-Malcolm, E. T. (2007). Intimate partner violence within a cohort of Pacific mothers living in New Zealand. *Journal of Interpersonal Violence*, 22 , 698-721.

Salmond, C., & Crampton, P. (2002). *NZDep2001 index of deprivation user's manual.* Wellington, New Zealand: Department of Public Health, Wellington School of Medicine and Health Sciences, University of Otago.

Statistics Canada. (2006). *Measuring violence against women: Statistical trends 2006*. Ottawa, Ontario.: Author. Retrieved August 18, 2009, from http://www.statcan.gc.ca/pub/85-570-x/85-570-x2006001-eng.pdf

Tjaden, P., & Thoennes, N. (2000). Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the National Violence Against Women Survey. *Violence Against Women, 6*, 142-161.

Tse, S. (2007). Family violence in Asian communities, combining research and community development. *Social Policy Journal of New Zealand, 31*, 170-194.

Wahab, S., & Olson, L. (2004). Intimate partner violence and sexual assault in Native American communities. *Trauma, Violence & Abuse, 5*, 353-366.

World Health Organization. (2001). *Putting women first: Ethical and safety recommendations for research on domestic violence against women.* (WHO/FCH/GWH/01.1). Geneva, Switzerland: Author. Retrieved August 18, 2009 from http://www.who.int/gender/violence/womenfirtseng.pdf

Yee, S. (Producer). (2009, July 12). *Half way home*. [Radio documentary]. In J. Perkins (Executive Producer), *Spectrum.* [Podcast retrieved from Radio New Zealand]. Retrieved May 12, 2010, from http://www.radionz.co.nz/national/programmes/spectrum/20090712

Yoshioka, M. R., DiNioia, J., Ullah, K. (2001). Attitudes toward marital violence: An examination of four Asian communities. *Violence Against Women, 7,* 900-928.

Table 1. Prioritized Ethnicity, by Region.

	Auckland n (%)	Waikato n (%)
Māori	165 (11.5)	223 (15.7)
Pacific	202 (7.1)	5 (0.3)
Asian	210 (14.6)	18 (1.3)
NZ European/Other	858 (59.8)	1,173 (82.7)

Table 2. Prevalence of Intimate Partner Violence Reported by Ever-Partnered Women, by Ethnic Group

Prioritized Ethnicity	Physical	Sexual	Any IPV (physical and/or sexual)	Physical and/or sexual IPV
	% (95%CI)	% (95% CI)	% (95% CI)	OR (95% CI)
Lifetime prevalence				
Māori (*n*=353)	53.5(47.3-59.6)	29.1(23.1-34.3)	57.6(51.6-63.7)	1.72(1.27-2.33)
Pacific (*n*=168)	31.5(24.0-39.0)	14.9(8.7-21.1)	32.4(24.9-40.0)	0.82(0.52-1.29)
Asian (*n*=152)	10.1(5.0-15.1)	3.8(0.7- 7.0)	11.5(6.4-16.7)	0.27(0.14-0.50)
European/Other (*n*=1,994)	30.3(28.1-32.5)	16.0(14.3-17.7)	34.3(31.9-36.3)	1.00 p<0.0001
12 month prevalence				
Māori (*n*=339)	12.5(8.5-16.5)	5.7(2.9-8.6)	14.1(9.9-18.4)	2.40(1.43-4.30)
Pacific (*n*=163)	8.4(3.7-13.0)	4.2(0.4-8.0)	9.3(4.4-14.2)	2.49(1.12-5.52)
Asian (*n*=151)	2.9(0.2- 5.6)	0.5(0.0-1.4)	3.4(0.6- 6.2)	0.92(0.34-2.49)
European/Other (*n*=1,956)	3.7(2.6- 4.7)	1.1(0.5-1.7)	3.9(2.9- 4.9)	1.00 p<0.01

Note: Logistic regression model included age, education level, household income, ownership of phone, car, and home, current marital status, number of people per room slept in. New Zealand Index of Deprivation 2001 score and the location (Waikato or Auckland) as well as the design effects.

Table 3. Attitudes About the Role of Women and Men in Relationships, by Ethnicity of Respondents

Attitude	Māori		Pacific		Asian		NZE/Other	
	% (95% CI)	*n*	% (95% CI)	*n*	% (95% CI)	*n*	(95%CI)	*n*
Percentage who agree								
A good wife obeys her husband even if she disagrees	17.2 (13.1-21.4)	383	41.6(33.7-49.5)	190	27.5(19.8-35.2)	170	9.2(7.7-10.7)	2,073
It is important for a man to show his wife/partner who the boss is	7.5 (4.9-10.2)	385	27.1(19.5-34.6)	189	17.0(11.9-24.0)	170	4.3(3.3-5.4)	2,093
Percentage who disagree								
A woman should be able to choose her own friends even if her husband disapproves	2.9 (1.3-4.5) [a]	384	15.1 (9.7-20.5) [a]	189	16.9 (10.4-23.4) [a]	167	4.5 (3.5-5.4) [a]	2,084

[a]Note: Higher levels of disagreement indicate that women are less likely to think that women should choose their own friends if their husband disapproves.

Table 4. Percentages of Women Agreeing With “In Your Opinion, Does a Man Have a Good Reason to Hit His Wife if":

	N	Percentage Who Said Yes (95% CI)
She does not complete her housework to his satisfaction	2,849	0.2 (0.02- 0.4)
She disobeys him	2,848	0.5 (0.2 -0.8)
She refuses to have sexual relations with him	2,848	0.1 (0.02-0.3)
She asks him whether he has other girlfriends	2,846	0.4 (0.1-0.6)

Note: Ethnic-specific estimates are not provided as there were no differences between ethnic groups.

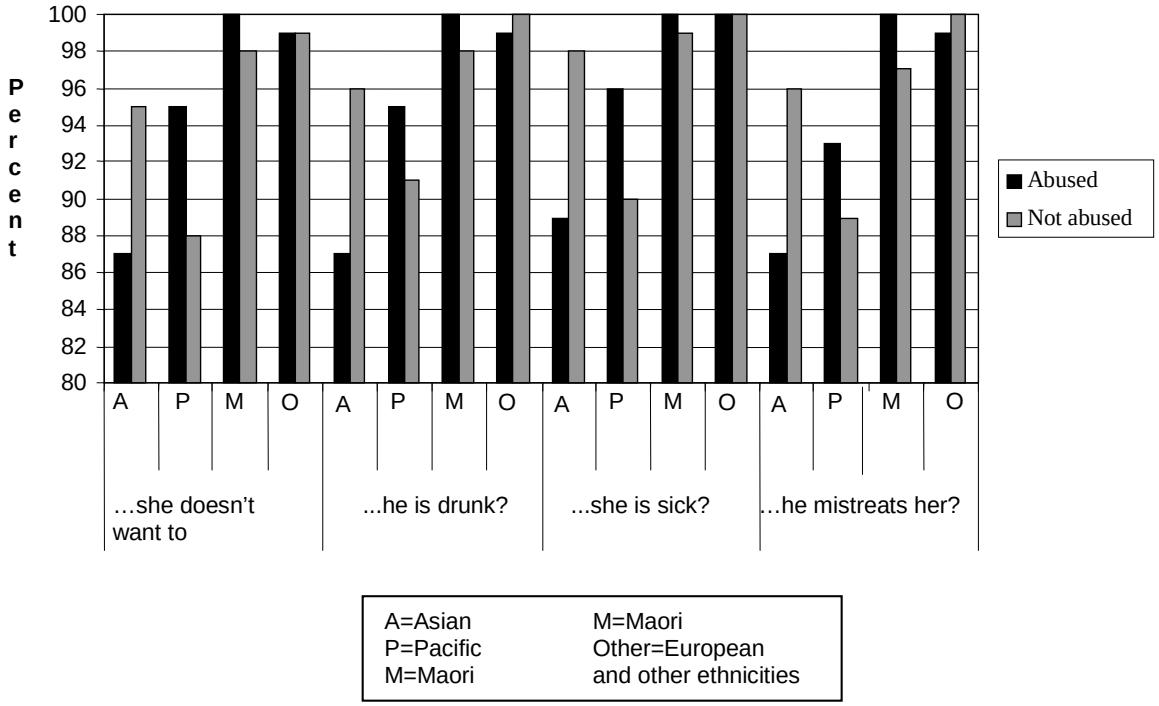
Table 5. Percentages, by Ethnicity, of Women Agreeing with “In Your Opinion, Does a Man Have a Good Reason to Hit His Wife if":

	Māori		Pacific		Asian		NZE/Other	
	% (95% CI)	*n*	% (95% CI)	*n*	(95% CI)	*n*	(95% CI)	*n*
Percentage who say yes								
He suspects she she is unfaithful	1.2 (0.1-2.3)	386	3.9(0.7-7.1)	192	2.1(0.0-4.2)	168	0.5(0.05-0.87)	2,093
He finds out she is unfaithful	5.3 (3.0-7.7)	383	11.3 (6.0-16.7)	192	6.8 (3.0-10.5)	168	1.6 (1.0-2.2)	2,092

Table 6. Women's Attitudes About Privacy and Keeping Problems Within the Family

	Māori % (95% CI) *n*	Pacific % (95% CI) *n*	Asian % (95% CI) *n*	NZE/Other % (95% CI) *n*
Percentage who agree				
Family problems should only be discussed with people in the family	48.2 (42.7-53.7) 381	76.5 (69.3-83.7) 192	64.7(56.3-73.2) 170	31.1(28.9-33.3) 2,076
	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)
Percentage who disagree				
If a man mistreats his wife others outside of the family should intervene	20.7 (16.3-25.0) 374	34.1(26.2-42.1) 190	20.7(14.0-27.5) 167	9.3(7.8-10.7) 2014

Figure 1: Percentage of women who agree to the question: 'In your opinion, can a a married woman refuse to have sex with her husband if...' by ethnicity and experience of IPV.



Bios

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