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Violence against women: an urgent public health priority

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Violence against women has been described as “perhaps the most shameful human rights violation, and the most pervasive.”¹ Addressing violence against women is central to the achievement of Millennium Development Goal (MDG) 3 on women’s empowerment and gender equality, as well as MDGs 4, 5 and 6.² It is also a peace and security issue. In spite of this recognition, investment in prevention and in services for survivors remains woefully inadequate.

Research on violence against women – especially male partner violence – has increased. Since 2005, when the first results of the World Health Organization (WHO) Multi-Country Study on Women’s Health and Domestic Violence³ were launched, the number of intimate partner violence prevalence studies increased fourfold, from 80 to more than 300, in 2008. We now have population-based prevalence data on intimate partner violence from more than 90 countries, although there are still some regions – such as the Middle East and west Africa – where there is relatively limited data. Similarly, there is also a growing body of evidence about the range of negative health and development consequences of this violence.

Women suffer violent deaths either directly – through homicide – or indirectly, through suicide, maternal causes and AIDS. Violence is also an important cause of morbidity from multiple mental, physical, sexual and reproductive health outcomes, and it is also linked with known risk factors for poor health, such as alcohol and drug use, smoking and unsafe sex.^{4,5} Violence during pregnancy has also been associated with an increased risk of miscarriage, premature delivery and low birth weight.^{6,7}

When the cumulative impacts on mortality and morbidity are assessed, the health burden is often higher than for other, more commonly accepted, public health priorities. In Mexico City, for example, rape and intimate partner violence against women was estimated to be the third most important cause of morbidity and mortality, accounting for 5.6%

of all disability-adjusted life years lost.⁸ In Victoria, Australia, partner violence accounted for 7.9% of the overall disease burden among women of reproductive age and was a larger risk to health than factors such as raised blood pressure, tobacco use and increased body weight.⁹

In addition to the human costs, research also shows that violence has huge economic costs, including the direct costs to health, legal, police and other services. In 2002, Health Canada estimated that the direct medical costs of all forms of violence against women was 1.1 billion Canadian dollars.¹⁰ In low-resource settings, relatively few women may seek help from formal services, but because of the high prevalence of violence, the overall costs are substantial. In Uganda, for example, the cost of domestic violence was estimated at 2.5 million United States dollars in 2007.¹¹

The broader social costs are profound but difficult to quantify.¹² Violence against women is likely to constrain poverty reduction efforts by reducing women’s participation in productive employment. Violence also undermines efforts to improve women’s access to education, with violence and the fear of violence contributing to lower school enrolment for girls. Domestic violence has also been shown to affect the welfare and education of children in the family.

This growing understanding of the impact of violence needs to be translated into investment in primary, secondary and tertiary level prevention: including both services that respond to the needs of women living with or who have experienced violence and interventions to prevent violence. WHO has recently published *Preventing intimate partner and sexual violence against women: taking action and generating evidence*.¹³ This publication summarizes the existing evidence on strategies for primary prevention, identifying those that have been shown to be effective and those that seem promising or theoretically feasible. The review highlights the urgent need for more evidence on effective prevention

interventions and for integrating sound evaluation into new initiatives, both to monitor and improve their impact and to expand the global evidence base in this area. It recognizes how infant and early childhood experiences influence the likelihood of people later becoming perpetrators or victims of intimate partner and sexual violence, as well as the need for early childhood interventions, especially for children growing up in families where there is abuse. It also recognizes the importance of strategies to empower women, financially and personally, and of challenging social norms that perpetuate this violence. Laws and policies that promote and protect the human rights of women are also necessary, if not sufficient, to address violence against women. In addition, health and other services need to be available and responsive to the needs of women suffering abuse. Concerted action is needed in all of these areas, but there is limited research on the most effective approaches.

To help address this gap, the *Bulletin* would like to invite submissions of papers describing research that addresses violence against women. We are particularly interested in research with a strong intervention focus, including ways to get violence against women onto different policy agendas and lessons about how to address some of the challenges policy-makers face; innovative approaches to prevention or to service provision, including community-based programmes in both conflict- and crises-affected and more stable settings; research to address more neglected forms of violence against women, and evidence on the costs and cost-effectiveness of intervention responses. Descriptive research that contributes to a better understanding of the global prevalence and costs of violence, or that provides evidence about the root causes of such violence will also be considered. Submissions can be made throughout 2011 at: <http://submit.bwho.org> ■

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