GLOBAL HEALTH

The Global Prevalence of Intimate Partner Violence Against Women

Data from 81 countries was used to estimate global prevalence of intimate partner violence against women.

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Violence against women is a phenomenon that persists in all countries (*1*). Since the 1993 World Conference on Human Rights and the Declaration on the Elimination of Violence against Women, the international community has acknowledged that violence against women is an important public health, social policy, and human rights concern. However, documenting the magnitude of violence against women and producing reliable comparative data to guide policy and monitor progress has been difficult.

The most common form of violence that women experience is from an intimate partner (IPV). This violence may be physical, sexual, or emotional. Most research to date has focused on assessing the prevalence and impacts of physical and/or sexual violence by partners. The short- and long-term health impacts of women's exposures to physical and/or sexual IPV are multiple (*2*). For example, it is a leading cause of homicide death in women globally (*3*) and is associated with increased levels of depression and suicidal behaviors (*4*). Prospective research from South Africa and Uganda shows that women exposed to physical and/or sexual IPV are more likely to acquire HIV infection (*5*, *6*). The health and social impacts result in substantial economic costs, with one study estimating the cost of IPV at more than £15 billion in England and Wales in 2009 alone (*7*).

There are high-level global commitments to addressing violence against women and gender inequality, including IPV. The 2013 United Nations Commission on the Status of Women focused on prevention and elimination of all forms of violence against women and girls; the UN Secretary General's UNiTE Campaign focuses on ending violence against women; and Millennium Development Goal 3 aims specifically "to promote gender equality and empower women." Similarly, many national governments have laws that explicitly criminalize intimate partner violence.

There is growing consensus in the research community on how to document the prevalence of women's exposures to physical and/or sexual partner violence in an ethically responsible way (*8*). "Gold standard" research methods include the conduct of one-on-one interviews in private, where women are asked direct, specific questions about their experience of a range of violent acts, including slaps, punches, kicks, the use of weapons, and forced or coerced sex (*9*).

As a result of this consensus and a greater global commitment to addressing violence against women, over the past decade, there has been a rapid expansion in the number of population studies examining IPV prevalence. However, existing surveys vary considerably in the specific measure of exposures to violence used, the populations sampled, and other characteristics. This has resulted in a large body of available prevalence data, but underlying challenges in interpretation, because of the lack of comparability across studies. We here present a synthesis of current evidence that provides new estimates of global and regional prevalence of IPV against women.

Synthesizing Evidence to Estimate Prevalence

Our research involved two main steps [all detailed in supplementary materials (SM)]. First, we did a systematic review of all available global prevalence data from studies representative at national or subnational levels. We searched 26 medical and social science databases, performed additional analysis of the WHO Multi-Country Study on Women's Health and Domestic Violence (10 countries), and requested additional analysis of the International Violence Against Women Surveys (8 countries); Gender, Culture and Alcohol: An International Study (16 countries); and the Demographic and Health Surveys to 2009 (20 countries) to obtain further prevalence estimates.

Second, we used classical meta-regression methods to estimate women's lifetime prevalence of IPV (see SM). We modeled estimates for 21 global regions, adjusted for differences in study quality and characteristics, and provide age-standardized estimates, which reflect country age- and sex-specific population structures in 2010.

Data from 141 studies in 81 countries informed our estimates. Studies provided data on physical or sexual partner violence, or both, of different severity levels, occurring over different time periods and for age groups. The earliest study collected data in 1983; however, 96% of estimates that informed our model came from studies with data collected in 1999 or later. In all, 80% of estimates used a gold standard definition of IPV measurement (see SM).

The results show that globally, in 2010, 30.0% [95% confidence interval (CI) 27.8 to 32.2%] of women aged 15 and over have experienced, during their lifetime, physical and/or sexual intimate partner violence. There is considerable regional variation in the prevalence of physical and/or sexual partner violence (see the graph).

Implications for Policy

Given the high prevalence of IPV in all regions of the world, a greater focus on primary prevention is urgently needed alongside the provision of health, social, legal, and other support services (*10*). The prevention field is still in its nascence, but emerging evidence suggests several promising areas of intervention.

The strong association between exposure to violence in childhood and later experiences or perpetration of violence highlights the potential importance of interventions to prevent child maltreatment and witnessing of violence by their parents (*10*). For example, parenting interventions and social norm change to reduce the use of violence against children (*10*) and the provision of support to children living in violent families are possibilities.

Secondary education for women is consistently associated with lower levels of IPV, but women's employment has been shown to have the potential to either reduce or increase

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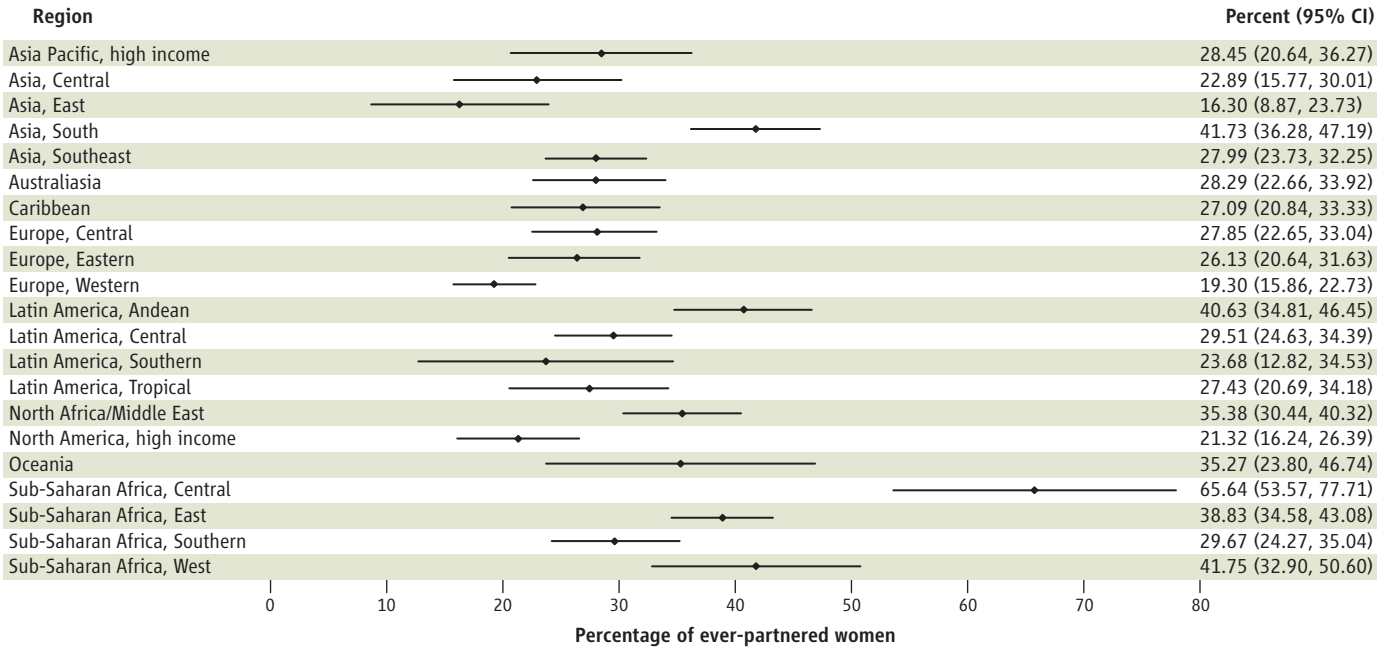
Published by AAAS



Regional prevalence of IPV, percentage of ever-partnered women. See SM for details.

risk, depending upon geocultural context. In rural South Africa, an intervention that combined economic and social change program components showed a 55% reduction in past year levels of IPV over 2 years (*11*).

At the societal level, there is a need to challenge social norms that may condone some forms of IPV and male control over women, as well as norms that result in IPV being seen as a private issue, rather than a public concern. There are many promising social change interventions, including initiatives to support increased local activism against violence, to engage men and boys in violence prevention, and to use the media to promote nonviolent and gender equitable relationships and encourage neighbors to take action when violence occurs (*10*). Interventions to challenge social norms that promote problematic alcohol use among men, which is commonly associated with an increased severity and frequency of perpetration of IPV against female partners, are also needed (*12*).

The UN estimates that more than 600 million women live in countries where domestic violence is not considered a crime (*13*). Laws are important both to symbolize the unacceptability of IPV, as well as to provide a potential mechanism of legal recourse for women. At the national level, there is a need also to promote equal economic rights and entitlements for women—including equal access to formal wage employment, equal participation in schooling, and access to secondary education—and to address potentially discriminatory family law that may limit women's ability to divorce or maintain custody of their children (*14*).

Given the impacts and high prevalence of IPV it is likely that many women using health services are experiencing or have histories of abuse. The WHO, along with other professional health bodies, have produced guidance on how best to provide health care and support to women who have experienced violence (*15*). This work highlights the potential for health services to help identify, support, and refer women who are experiencing IPV and the need to support children growing up in households where there is IPV. It also identifies potential health sector entry points for an effective response.

IPV is a complex issue, and there are no quick-fix solutions. However, the global variation in the levels of violence highlight that IPV is not inevitable. There are multiple, important intervention entry points, and a concerted, multisectoral response is needed. Alongside the provision of services, an increased investment in violence prevention should form a central part of an expanded response. Research has a central role in this initiative, to support learning about the impact of different promising interventions being implemented globally, their costs, and how to take interventions to scale. Without such investments, the high levels of IPV documented here may continue unabated. The international community must honor commitments it has made over the past decade and devote resources to reducing violence against women, including IPV.

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Acknowledgments: We thank S. Kishor, K. Graham, H. Johnson, L. Heise, L. Petre, J. Astbury, J. Campbell, L. Davidson, M. Ellsberg, R. Jewkes, R. Naved, J. Mercy, H. Resnick, L. Sadowski, L. B. Schraiber, A. Taket, M. Yoshihama, the Economic and Social Research Council, Sigrid Rausing Trust, and the UN Development Programme, UN Population Fund, WHO, World Bank Special Programme of Research, Development, and Research Training in Human Reproduction.

Supplementary Materials

www.sciencemag.org/cgi/content/full/science.1240937/DC1

10.1126/science.1240937