Violence against women and girls 5

Addressing violence against women: a call to action

Claudia García-Moreno, Cathy Zimmerman, Alison Morris-Gehring, Lori Heise, Avni Amin, Naeemah Abrahams, Oswaldo Montoya, Padma Bhate-Deosthali, Nduku Kilonzo, Charlotte Watts

Violence against women and girls is prevalent worldwide but historically has been overlooked and condoned. Growing international recognition of these violations creates opportunities for elimination, although solutions will not be quick or easy. Governments need to address the political, social, and economic structures that subordinate women, and implement national plans and make budget commitments to invest in actions by multiple sectors to prevent and respond to abuse. Emphasis on prevention is crucial. Community and group interventions involving women and men can shift discriminatory social norms to reduce the risk of violence. Education and empowerment of women are fundamental. Health workers should be trained to identify and support survivors and strategies to address violence should be integrated into services for child health, maternal, sexual, and reproductive health, mental health, HIV, and alcohol or substance abuse. Research to learn how to respond to violence must be strengthened. The elimination of violence against women and girls is central to equitable and sustainable social and economic development and must be prioritised in the agenda for development after 2015.

Published **Online** November 21, 2014 http://dx.doi.org/10.1016/S0140-6736(14)61830-4

This is the fifth in a **Series** of five papers about violence against women and girls

See **Online/Comment** http://dx.doi.org/10.1016/S0140-6736(14)61775-X and http://dx.doi.org/10.1016/S0140-6736(14)61840-7

Department of Reproductive Health and Research, WHO, Geneva, Switzerland (C García-Moreno MD, A Amin PhD)**; London School of Hygiene & Tropical Medicine, London, UK** (C Zimmerman PhD, A Morris-Gehring PhD, L Heise PhD, Prof C Watts PhD)**; Medical Research Council, Cape Town, South Africa** (N Abrahams PhD)**; MenEngage, Washington, DC, USA** (O Montoya MA)**; Centre for Enquiry into Health and Allied Themes, Mumbai, India** (P Bhate-Deosthali MSW)**; and National AIDS Control Council, Nairobi, Kenya** (N Kilonzo PhD)

Introduction

Violence against women and girls is a global phenomenon that historically has been hidden, ignored, and accepted. Child sexual abuse has remained a silent shame. Rape has often been a matter of stigma for the victim rather than the perpetrator. Violence in the home has been considered a private affair. Turning of the head and closing of the eyes have occurred despite global estimates that one in every three women will experience physical violence, sexual violence, or both, from an intimate partner, or sexual violence from someone other than a partner in her lifetime.[1] The full extent of abuse is even greater, with multiple different forms of violence around the world often remaining uncounted and under-researched (table 1).

All violence, including that against men and children, is a serious human rights and public health concern. Men and boys are at risk of different forms of violence from women and girls, most often gang-related and street violence in the hands of other men, which have substantial public health tolls. While recognising that investments are needed to address all forms of violence, particularly in view of the interconnections between exposure to violence in childhood and later risks of violence, *The Lancet* Series focuses on violence against women and specific forms of violence against girls. The forms of violence experienced by this population are frequently hidden, socially sanctioned, and not recognised or adequately addressed by the institutions that should respond.

International and global agendas

As Michau and colleagues[13] stress in the fourth paper in this Series, the tide of silence has been slowly turning thanks largely to the sustained advocacy and organising of women's movements locally and worldwide. The high prevalence of violence against women and girls and damage to the victims and society are being recognised. Indeed, empirical analysis of policy changes over time in 70 countries suggests that, of all factors, the presence of autonomous women's movements was the main driver of progressive government action on violence against women.[14]

Violence against children has only lately started to receive international attention.[15] Children—girls and boys—are at risk of physical violence, emotional abuse and neglect, and sexual abuse. The risk of sexual abuse for girls, however, is 2·5–3·0 times higher than that for boys.[16] Girls are also specifically affected by other forms of violence driven by gender inequality, such as forced and early marriage, sex trafficking, female genital mutilation (FGM), and other harmful practices.

Key messages

- Violence against women is a worldwide issue, with intimate-partner physical violence, sexual violence, or both, affecting one in three women, leading to substantial health effects that are important determinants of morbidity and mortality.
- Violence-prevention interventions can reduce levels of intimate-partner violence and should seek to address attitudes, norms, and beliefs that justify violence against women, link dominant notions of masculinity to male authority over women, and stigmatise victims, especially in low-income and middle-income countries.
- Political leadership and governmental investment are essential to reducing violence and should be used to include annual monitoring of prevalence of intimate-partner violence and promote change and coordinated response at a national level.
- The health sector, other sectors, and civil society have crucial parts to play in the prevention of and response to violence against women and children, particularly to eliminate stigmatising attitudes among health-care providers.
- Investment is required in research to collect data on the magnitude of all forms of violence against women and children, particularly forms specific to girls, and assess the effects of prevention and response strategies.

Correspondence to:
Dr Claudia García-Moreno,
Department of Reproductive Health and Research, WHO,
1121 Geneva 27, Switzerland
garciamorenoc@who.int

	Definition	Prevalence
Intimate-partner violence	Behaviour within an intimate relationship that causes or has the potential to cause physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviours[2,3]	30% of women who have ever been in a relationship worldwide have experienced physical violence, sexual violence, or both, from intimate partners,[1] and 38·6% of all female murders worldwide are estimated to be from intimate partners[4]
Sexual violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, acts to traffic, or other coercive actions directed against a person's sexuality by any person, irrespective of relationship to the victim, in any setting, including but not limited to home and work[2,3]	7% of women worldwide are thought to have been sexually assaulted by someone other than a partner since age 15 years, although data are lacking in some regions[1]
Child sexual abuse	The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or is not developmentally prepared for, or that otherwise violates the laws or social taboos of society, by adults or other children in positions of responsibility, trust, or power over the victim[5]	Around 20% of women and 5–10% of men report being sexually abused as children[5]
Trafficking of women and girls	Use of coercive, deceptive means or abuses of position of power for exploitation or forced sex work and various other forms of labour[6]	An estimated 11·4 million women and girls are trafficked worldwide (around 55% of the 20·9 million people estimated to be in forced labour)[7]
Female genital mutilation	All procedures involving the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons[8]	Highest concentration areas are in Africa and the Middle East, where more than 125 million women and girls alive have been cut in 29 countries[9]
Forced or early marriage	Marriage before age 18 years or without consent	More than 60 million women aged 20–24 years married before age 18 years worldwide, although about half of girls in early marriage live in south Asia[10]
Killings in the name of honour	Homicide of a member of a family or social group by other members due to the perpetrators' belief that the victim has brought shame or dishonour upon the family or community	1957 events cited to relate to honour killings occurred in Pakistan from 2004 to 2007[11] and at least 900 such murders occur every year in the Indian States of Haryana, Punjab, and Uttah Pradesh[12]

Table 1: **Overview of types of violence against women and girls**

Despite the emergence of violence against women on international and national agendas, investment remains woefully inadequate. Compared with national public expenditure on entertainment, sports, or election campaigning (for example, the 2010 FIFA World Cup cost around US$3·5 billion), only $100 million is benchmarked for investment into violence programmes by 2015 by the UN Trust Fund.[17] Around the world, services for women, men, and children experiencing violence are severely underfunded. Indeed, the economic recession has led to reductions in government core funding to domestic and sexual violence services in many settings.[18] Investment in interventions to prevent violence against women is also often very limited.

Violence as a risk factor for poor health in women

The physical and mental effects of violence against women are many and profound and short and long term. Consequences of exposure to violence, such as women's lack of control over sexual and reproductive choices, have other long-term effects that result from increased risk of unwanted pregnancies and unsafe abortions, HIV, and low-birthweight babies.[1] Additionally, emerging biomedical evidence suggests that these long-term effects result from the combined effects of chronic stress, trauma-related responses, and accelerated cellular ageing.[19] Unsurprisingly, women exposed to violence make much greater use of health services than non-abused women, even years after the violence has ended.[20–22]

Evidence on the health effects of violence against women and girls comes largely from studies on intimate-partner violence and child abuse.[1,15] FGM is associated with prolonged labour, obstetric lacerations, haemorrhage, and difficult delivery, as well as maternal death.[23] For other forms of violence, there is far less evidence.

Exposure to violence in childhood has many and frequently long-term health effects, including increased risk of alcohol abuse, substance abuse, self-harm, and further victimisation in later life.[24] Most data, however, come from cross-sectional analyses, and prospective studies on the health trajectories of survivors are lacking. Research into the causes and health effects of rape, trafficking, violence perpetrated in the name of honour, and intimate-partner homicide, is even more limited.

Social and economic burdens

Violence against women and girls is a barrier to their equal participation in society and affects overall social and economic development.[25] For example, estimates of lost productivity from domestic violence against women range from 1·2% of the gross domestic product in Brazil and Tanzania to 2·0% in Chile.[26,27] The annual cost of intimate partner violence was estimated to be $5·8 billion in the USA in 2003, £22·9 billion in England and Wales in 2004, and UK£4·5 billion in Australia,[28–30] and included those related to health care, legal, police, and other social protection services. A study in South Africa estimated the economic impact of gender-based violence to be between at least

Panel: Detailed recommendations for action against violence

Recommendation 1: show leadership

- Demonstrate leadership by publicly condemning violence against women and girls and advocating for gender equality
- Include in the post-Millennium Development Goals framework a stand-alone goal on gender equality, including a target to eliminate violence against women
- Develop, make publicly available, and monitor national plans of action that include specific operational actions, budgets, and measurable targets for each sector or multiple sectors that span health, social welfare, police, justice, education, child protection, and gender equality, and include capacity-building and system-strengthening strategies
- Establish national coordinating mechanisms with sufficient authority and budget to develop, implement, and monitor actions to address violence against women across sectors
- Ensure adequate resources are available to support the implementation of national plans in all relevant ministries, and for the engagement of women's movement and women's organisations

Recommendation 2: develop and enforce laws, implement policies, and strengthen capacities of institutions

- Strengthen and enforce laws and policies to prohibit all forms of violence against women and girls, including those that prohibit intimate-partner or domestic violence, sexual violence, sexual harassment, early and forced marriage, female genital mutilation, and trafficking
- Ensure national laws, policies, and institutions in all sectors promote equality for women and men and eliminate all forms of discrimination against women, for instance in ownership and inheritance of assets, custody of children resulting from a partnership, freedom to travel, and freedom to enter and leave marriage and access divorce, and address other forms of discrimination that women and girls might experience, such as by class, caste, disability, and others
- Support women's equal access to education, income, and safe job opportunities through legislation and sector-specific strategies
- Support actions that challenge discriminatory attitudes and behaviours towards women and girls, including explicit and tacit approval of violence against them, male control of female behaviour, and constructs of masculinity that encourage male violence
- Support social policies that promote equality in relationships, for example, in child care and parental leave

Recommendation 3: invest in violence prevention

- Invest in programming that supports communities to challenge social norms promoting discrimination and explicit and tacit approval of violence against women and girls, including constructs of dominant masculinity and passive femininity that support male violence
- Support interventions that work in communities with women and men, girls, and boys to change the social norms that perpetuate gender inequality, including violence against women and girls, with priority given to interventions that foster collaboration between programmes for women and men and between boys and girls
- Address individual risk factors, such as exposure to violence during childhood, alcohol and other substance abuse problems
- Seek opportunities to include and assess programming to promote gender equality or empowerment (ie, gender transformative) in different sectors, including microfinance, agriculture, water and sanitation, and other development programming for women, men, or both
- Fund programmes that provide care and support to survivors of violence, including outreach and mentor or advocate programmes
- Encourage work with the media to promote non-acceptability of violence against women and supportive and non-judgmental attitudes towards women and girls experiencing violence
- Strengthen local prevention of and response to violence by fostering collaborations between service providers and civil society, with priority given to those working in relation to women's rights
- Seek synergies in investments across sectors, forms of violence, age groups, and vulnerabilities, particularly different forms of violence against women and children

Recommendation 4: strengthen the role of the health sector

- Integrate continuing supervision, mentorship, and training on violence against women into medical, nursing, public health, and other relevant curricula at undergraduate and in-service levels, to challenge stigmatising attitudes and ensure that health providers know when and how to ask about violence and how to respond appropriately, including first-line psychological support
- Increase awareness among health-care providers, policy makers, managers, and the general public of the prevalence and the health burden of violence against women and children, including forms specific to girls, and the importance of prevention
- Create an enabling policy and professional environment for health professionals to respond appropriately to violence against women
- Ensure that violence against women and girls is addressed in relevant health initiatives, including those related to sexual and reproductive, adolescent, maternal, neonatal, and child health, mental health, HIV prevention, and programmes for the prevention of substance abuse

(Continues on next page)

(Panel continued from previous page)

- Address violence faced by health staff, as well as violence and discrimination perpetrated by health-care providers, through for example, establishing sexual harassment policies and policies on abuse and disrespect of patients
- Support mechanisms to promote coordination and collaboration among sectors at national and local levels, to improve services for survivors of violence
- Support the developmment of a global plan of action to strengthen the role of the health system within a national response involving multiple sectors to address interpersonal violence, particularly against women and children that builds on existing relevant work by WHO (World Health Assembly Resolution 67.15)

Recommendation 5: invest in research, data collection, and civil society

- Implement national population-based surveys of violence against women that measure the magnitude, risk factors, and consequences every 5 years to monitor progress
- Make data collection and reporting on violence against women and its health burden a national requirement, ensuring that such assessments cover all forms of violence that women and girls might experience
- Support research to address key knowledge gaps, for instance with longitudinal studies on the health and other consequences of intimate-partner and sexual violence and studies to improve understanding of previously poorly researched forms of violence, including trafficking, rape, and sexual abuse during conflict, and violence against high-risk groups, such as women and girls with disabilities
- Invest in violence-prevention research and programme assessments, including of ways to tackle key structural drivers of violence, such as gender inequality and social norms that condone forms of violence against women, and support research that promotes effective partnerships between researchers and people developing and implementing programmes, by including intervention costs, scalability, and suitability for replication
- Support assessment and implementation research, including on health sector interventions and services, and approaches to intervention scale-up
- Document the costs and cost-effectiveness of violence programming to inform resource planning and priority setting
- Invest in building capacity to do research on violence against women and girls, particularly in low-income and middle-income countries

R28·4 billion and R42·4 billion for the year 2012–13, which represents between 0·9% and 1·3% of gross domestic product annually.[31]

A call to action

Eliminating violence against women and girls is achievable, but it requires sustained action to ensure that political commitments translate into meaningful change, and support for coordinated, well funded, evidence-informed strategies implemented by governments, communities, and civil society partners. On the basis of the evidence presented in this Series, we call on national and local leaders and policy makers to commit to the five actions described here (panel).

Show leadership

While violence against women occurs daily in epidemic proportions and causes widespread morbidity and death, it cannot be resolved with a classic clinical intervention, such as identifying a pathogen, drug, or vaccine. The reduction of violence requires interventions from different sectors and changes in individual and institutional discriminatory behaviours and attitudes. It demands a concerted effort by inspired and inspiring leaders and sustained national and local investments. Despite increasing global attention being given to violence against women and children, leadership on the issue is still weak. As with other threats to public health, development, and community security, the elimination of violence against women requires the force and influence of a large body of committed, vocal leaders, including policy makers, survivors of violence, academics, and advocates at high political levels and from within communities.

Strong leadership and advocacy are required to motivate regular commitment of financial and other resources, including in health plans and budgets. Gender equality, with reductions in violence against women as a crucial target, should be a goal in the sustainable development agenda following on from the Millennium Development Goals, which end in 2015.

Many governments have developed national plans of action to address violence against women and girls or children, but few have dedicated budget lines and domestic spending to support them. Gaps remain between commitments and implementation, with investment being limited in most settings. Adequate financing and coordination of efforts are complicated by the breadth of ministries that have roles to play, including health, gender equality, development, education, justice, and social welfare. The effective implementation of national plans to address violence against women requires sector-specific budgets within all relevant ministries, and support for the continued engagement of women's organisations.

Increased investment in prevention and response to violence has a strong economic rationale. In Australia, it is estimated that the National Plan of Action on Violence against Women could save US$23 673 per woman prevented from experiencing violence.[32] Cost-benefit assessments of the 1994 Violence against Women Act

and civil protective orders in the USA also conclude that the benefits of such interventions to taxpayers outweigh their costs many times over.[33]

Develop and enforce laws, implement policies, and strengthen capacities of institutions

Violence against women is a widespread social problem rooted in the unequal distribution of resources and power between men and women, and institutionalised through laws, policies, and social norms that grant preferential rights to men.[24] Initially, research into the causes of violence focused on single-issue explanations, such as personality or mental health disorders, history of sexual abuse, or alcohol abuse, in the perpetrators and victims. However, violence against women is now widely recognised to result from a complex interplay of individual, relationship, community, and societal factors.[24,34] Macro-level economic, social, and political factors act in combination with variables at the community and individual levels to predict an individual's likelihood of being victimised or perpetrating abuse.[35,36] Ecological analysis (where the group rather than the individual is the unit of analysis) across 88 surveys of partner violence showed that country-level variations in the prevalence of partner violence over the previous year correlate with those in women's status, inequalities in women's economic and political entitlements compared with men's, and social norms that condone intimate-partner violence and male control of female behaviour.[37]

Although women's status is improving in many regions of the world,[38] more than 600 million women worldwide live in countries where domestic violence is not deemed to be a crime. In 53 countries marital rape is not recognised.[39] In some countries, laws and legal structures sustain and foster systematic discrimination against women and girls, for instance in relation to property and inheritance, age of marriage, and ability to freely enter and leave marriage. In many countries, state laws operate alongside traditional religious, customary, or indigenous laws that promote male pre-eminence and that might even include penalties for female victims of violence.[40] Where progressive legislation exists, implementation lags far behind, and impunity prevails in most settings. Even in high-income countries with reasonable gender equality, attitudes that condone violence or blame women for their victimisation remain established.[41] Indeed, such views might be accentuated by other forms of discrimination, such as by race, caste, class, religion, or sexual orientation.

Nevertheless, important changes are emerging in many parts of the world. For example, the reform of family laws in Ethiopia in 2000 raised the minimum age of marriage, removed the ability of husbands to deny their wives permission to work outside the home, and required the consent of both spouses in the administration of marital property.[42] More broadly, a summary of legal and property restrictions on women's rights in 100 countries in the past 50 years showed that half of all restrictions present in 1960 were removed by 2010, and that 125 countries had passed legislation that outlawed domestic violence.[38]

Social policies that support childcare and engage fathers, such as generous paternity leave in the Netherlands and Scandinavian countries, might also contribute to shifting norms about male and female behaviour. They have, however, not yet been assessed for their effects on violence.

Violence against women and girls is not just a story about unhealthy individuals, families, or relationships, but about unhealthy social norms and, often, the damaging consequences of poverty. Part of the solution to such violence, therefore, lies in addressing the drivers of gender inequality and other forms of discrimination. Relevant factors include legislative, economic, and cultural structures, and legal, educational, workplace, police, family, religious, sports, media, and other institutions that might fuel inequalities in women's and girl's access to education and social and political participation. Transformation of such structures into mechanisms to promote women's rights will require persistent and undaunted government, local, and other leadership.

Invest in violence prevention

Alongside the social and legislative revisions, direct and consistent investment in community programming is needed. In the first paper in this Series, Ellsberg and colleagues[43] present evidence of the effectiveness of interventions to prevent violence against women and girls, which illustrates that prevention is possible. Well designed and well delivered interventions can achieve notable effects when implemented in the timeframe of programmes (eg, 2–3 years). The most successful interventions use multiple approaches, engage with many stakeholders over time, and seek to address various risk factors underlying violence (figure).

Evidence related to the prevention of violence is beginning to grow. Most evidence comes from industrialised countries and is focused on programmes for perpetrators of intimate-partner violence. The findings suggest that these programmes have, at best, limited effect on the risk of future perpetration. In contrast, interventions implemented through contact with health outreach workers, mentor advocates, or both, aimed at supporting women who have experienced violence show more promising outcomes, as do some school-based programmes aimed at preventing dating violence and programmes to prevent exposure to violence in childhood. The latter, however, have not been assessed for effects on later violence.[43]

Research in low-income and middle-income countries has focused mainly on assessment of the effects of violence-prevention programmes. The results from participatory group training programmes for men, women, or both, are promising.[44–46] Such training typically entails an interactive series of meetings or workshops

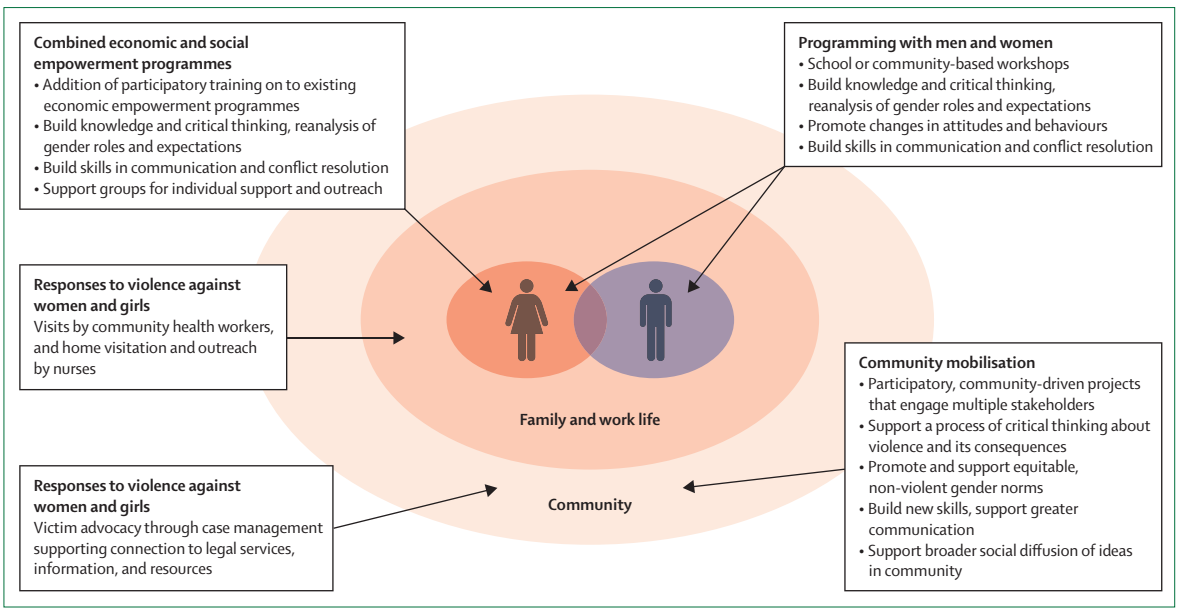

Figure: **Promising interventions to address violence against women and girls[43]**

with women and men, overseen by trained facilitators. The major goals of such programmes are to prevent or reduce violence, address underlying expectations about male and female roles and behaviour, and enable the development of new skills for communication and conflict resolution.[47]

As shown by Jewkes and colleagues[48] in this Series, there is a diverse range of group-based interventions for violence prevention that involve boys and men. Evidence on the outcomes of such interventions is mixed. The main outcomes are attitudinal changes, but changes in perpetration of violence or shifts in broader social norms are often not achieved. Jewkes and coworkers stress that interventions with boys and men should address harmful notions of masculinity, including the oppressive use of power, rather than focus solely on men's use of violence. They conclude that a focus on men alone is not sufficient, and that effective prevention must include women and girls to achieve meaningful changes in community norms away from those that sustain inequality and violence.[48]

Women's economic dependence on their partners or other men may make them less able to avoid or leave violent relationships. Ellsberg and colleagues[43] suggest, however, that economic programming alone is insufficient to reduce women's risk of violence. Social protection mechanisms, such as unconditional cash transfers, have had varying effects. In some settings, increasing women's access to cash seems to have reduced violence, but evidence also suggests that loans or employment increase the risk of violence in the short term.[49,50] Importantly, the combining of programmes to facilitate economic and social empowerment could substantially lower levels of intimate-partner violence. The IMAGE trial[47] showed that the addition of a training intervention that focused on gender equality to an existing programme concerned with microfinance loans reduced levels of intimate-partner violence by half. This finding points to the potential to deliver large-scale violence prevention interventions at low cost, by piggy-backing women's empowerment training on to existing economic or educational programmes, although this approach would need to be monitored and assessed.

Experience and evidence are growing that social diffusion approaches are effective to support the development of gender-equitable norms in communities. Multiple stakeholders should be involved, including male and female community members, youth, political and other leaders, police, and teachers, to challenge unequal gender norms and the social acceptance of violence against women and girls, and to promote new behaviours. This approach has been used to address intimate partner violence and HIV risk (eg, the SASA![44] and SHARE[51] programmes in Uganda) and challenge FGM (eg, the TOSTAN model in Senegal[52]). These interventions have yielded encouraging outcomes that support the role of the social diffusion approach in altering gender-related attitudes and behaviours at the community level.[44,51,52]

Michau and colleagues[13] underscore that changing highly entrenched and gendered issues such as violence is achievable. Drawing on their operational research and programmatic experience in Uganda, India, and Nicaragua, they argue that a fundamental driver across all types of violence against women and girls in low-income and middle-income countries is unequal power relations between men and women. They assert

that shift is needed towards egalitarian or equitable relations for violence to be reduced. The active engagement of women's organisations and civil society more broadly will be required.

Policies and funding frequently focus on single specific forms of violence, such as sexual violence in conflict, FGM, or forced and early marriage. This targeted attention risks missing the fundamental insight that many types of violence share gender inequality as a root cause. Vertical programming also misses opportunities for synergy. For example, research shows that in areas of conflict, even among women who have been raped by combatants, the dominant form of abuse is intimate-partner violence[53] and, therefore, needs to be addressed in programmes designed to respond to sexual violence in conflict. Similarly, programmes addressing violence against children and women should create synergies and improve coherence.

Programmes to address individual risk factors, such as child abuse, exposure to domestic violence, or substance or alcohol abuse, are also important for prevention of violence.[24,54] Strategies to prevent child maltreatment, which is associated with experience, perpetration, or both, of violence include home visitation and parenting programmes.[55] The latter approach needs to include a gender equality dimension to promote egalitarian attitudes and relationships. Engaging with young people of both sexes to promote these attitudes is also important. Some promising examples are mentioned by Michau and colleagues.[13]

Strengthen the role of the health sector

As described throughout this Series, violence against women and girls results in various—often severe and enduring—physical and mental health problems. Yet, the health sector has barely begun to recognise its potential role and responsibility in responding to violence against women.[56] As for smoking three decades ago, violence was historically seen as private behaviour, beyond the scope of medical professionals. Increasingly, however, this attitude is changing. In 2014, the World Health Assembly made a resolution on strengthening the role of the health system in addressing violence, in particular against women and children, especially girls. This resolution indicates that high level global commitment to strengthening health systems, building capacity of health-care providers to respond to women subjected to violence, collecting data and evidence on what works, and advocating from multiple sectors for governments to challenge the acceptability of violence against women and girls are needed.[56]

Addressing violence as a health issue is a good use of resources. Two studies in the UK found that training and support programmes to help primary health-care workers deal with domestic violence were cost-effective interventions.[57] Research from the USA found that an intervention targeting women with co-occurring mental and substance abuse disorders and a history of exposure to violence was effective at improving outcomes at no additional cost.[58]

The health sector has been slower than other sectors to integrate violence against women and girls into its professional mandate. Some substantial achievements have been made at the policy level, as described by García-Moreno and colleagues in this Series.[59] For example, WHO and many professional bodies have highlighted the health effects of violence against women and girls, and have developed guidance for health professionals on how to respond. Countries have assessed various models to provide care to victims of intimate-partner and sexual violence, including one-stop crisis centres, where a combination of health, legal, and counselling services are available. Other approaches in some clinical settings include training providers to know when and how to ask about violence and to provide comprehensive post-rape services in emergency departments.[60] Each has its limitations and assessment is needed to identify the most effective models for different settings.

Increases in the numbers of health professionals routinely trained and able to respond effectively to abuse (first-line support, treatment and care for consequences of violence, safe referral to other services, post-rape care, and proper documentation) are needed.[61] Inclusion of the topic of violence against women in the training curricula of student doctors, nurses, midwives, and other health workers could help improve professional attitudes and service responses.[61]

Survivors of violence are seen in many health settings, including accident and emergency departments, sexual and reproductive health services, primary health care, and mental health services. A stronger integration of programmes related to violence against women into maternal and child health care, adolescent sexual and reproductive health programmes, HIV services, and services for mental health and alcohol or substance abuse disorders could provide important opportunities for synergistic programming and learning.

The participation of the health sector requires addressing various cultural (medical and local culture) and health-system barriers and other challenges that hinder implementation by health-care providers, even when trained. For example, changing longstanding beliefs held by doctors and nurses that their sole role is to treat disease and the physical manifestations of ill health can be difficult. Moreover, practitioners may need to revise cultural beliefs (and practices) about abuse as a norm, the taboo of intervening in others' private matters, and gender biases in medical education.[62,63] Systems (eg, protocols, referrals, mentoring for health-care providers) also need to be put in place to enable the health system to participate in addressing violence.[61]

The role for health professionals in primary prevention is even less widely discussed than treatment. Yet, just as governments have sought to prevent

	Indicator	Data sources	Status worldwide
Show leadership	The presence of a national action plan, allocated budget, or both, to address violence against women and girls	UN Secretary General's database on Violence Against Women; UN Women	Data being collected on national action plans; data on budget allocation are not routinely collected
Create equality	The presence of any laws that discriminate between women and men	Women Business and Law Study, World Bank; Social Institutions and Gender Index, OECD	Data on a range of discriminatory laws are collected through global in-depth studies.
Change norms	More than 50% of women, men, or both believe that some form of violence against women or girls is acceptable	Demographic and Health Survey; WHO Multi-Country Study	National data are available for some countries
Challenge sectors	National standard operating procedures or guidelines in place to provide care and support for women experiencing intimate-partner violence, sexual violence, or both	National Health System Surveys	Not systematically collected
Invest in research, data collection, and civil society	National population-based surveys on the prevalence of violence against women and girls implemented in the past 5 years	WHO Global Health Observatory	Increasingly available in high-income countries

Table 2: **Indicators for national, regional, and global action to address violence against women and girls**

smoking and drug abuse and to encourage healthy eating, the public health community needs to advocate and raise awareness about the health burden of violence, challenge the acceptability of norms that might condone violence, support the development of non-violent relationships, promote the reduction of alcohol use, and support children exposed to their parents' violence.[63] Additionally, the health sector can support research on the effectiveness of health-related or other interventions.

The health sector needs to be part of the response from multiple sectors. Whether responding to survivor needs or working to prevent violence, effective interventions require collaboration, including with social services, law enforcement, and civil society advocates. Each sector offers specific expertise, and effective coordination will foster coherence and efficient use of resources.

Invest in research, data collection, and civil society

Research and evidence have been important in getting violence against women and girls on to the political agenda. In the 1990s, a small number of academics were researching this issue. Methodological uncertainties, including whether collection of population-based data on women's exposures to violence was feasible and whether research would retraumatise women or increase their risk of abuse, presented real challenges. With the shortage of prevalence data, the issue was a low priority on the agenda of governments and funders.

Early methodological discussions and large research initiatives, including the WHO multicountry study on women's health and domestic violence, helped consolidate guidance on the best approaches to researching violence against women in an ethically responsible way with standardised questions.[64] Subsequently, these methods have been incorporated into a range of research programmes, including the Demographic Health Surveys Program, and supported a rapid increase in the collection of population data on violence against women. National survey data on women's exposure to intimate-partner violence are now available from 90 countries, compared with the global review on intimate-partner homicide for which only 66 countries had data that could be used.[4] Some regions, such as west Africa and the Middle East, still have limited data.[65] Data on non-partner sexual violence are far less commonly collected. A systematic review in 2012 found population data from 56 countries.[66] Better data exist for the 29 countries where the practice of FGM is concentrated, which have been collected through demographic and health surveys and multiple indicator cluster surveys.[9] Estimates of trafficking of women and girls are also emerging.[67] Reliable data on prevalence are essential to guide the allocation of resources, plan interventions, and monitor progress.[9]

Drawing from the HIV axiom of know your epidemic, know your response, a coordinated agenda to address violence against women and girls requires a clear understanding of the forms of violence present in an area, the specific social norms and beliefs that sustain the abuse, and the macro and micro factors that underpin gender inequality and support violence. Rather than research each type of violence separately or develop single-issue services, such as rape crisis centres, violence prevention must take into account the full range of violence a woman has or may experience across her lifespan. The effects of trauma are cumulative, and violence experienced during childhood or adolescence can increase the risks of experiencing violence, perpetrating violence, or both, in later life.[68] Similarly, at particular times women might be vulnerable to multiple forms of violence, for instance adolescents are particularly vulnerable to violence by multiple perpetrators. Documenting the full life burden of violence in research and programmes, rather than single incidents or types of violence, will better enable practitioners and researchers to respond effectively, understand the relations between multiple types and episodes of violence, and capture the multiple potential benefits of effective prevention and response programming.

The experiences of survivors should infuse and inform all programmatic responses to abuse. Currently, most of the intervention evidence is for intimate-partner violence and FGM, but as Ellsberg and colleagues[43] highlight, even for these types evidence it is mostly limited to small-scale single-component interventions in a few countries. Much less evidence is available to inform programmes on trafficking, rape, and abuse in conflict.

The small amounts of evaluation evidence cannot be used as an excuse for inaction. We need to build on the evidence that does exist, scale up approaches and

programmes that have been shown to work, expand and adapt from one context to another, and continue to monitor and assess outcomes. A greater investment in formative research to facilitate adaptation, operations research to encourage learning and course correction over time, and, ultimately, assessment of effects are desperately needed. Supporting strong partnerships between researchers and programmers is likely to produce the most relevant evidence to facilitate translation and upscaling of successful strategies.

Key indicators to monitor progress

Violence against women and girls is not just another women's issue, but is a public health and development problem of concern to all. Its elimination should be part of the post-2015 Sustainable Development Goals (SDGs), just as the elimination of apartheid was an important goal of the 1970s and 1980s for the worldwide community. Addressing violence against women is also important for other SDGs, particularly those related to maternal and infant mortality and HIV. Progress towards each of the actions related to our five recommendations will be needed to help move the world towards the elimination of violence against women and girls.

We also proposed indicators to monitor progress at regional and global levels (table 2). Data are available only from some countries, as they are not yet routinely compiled. These indicators should be revisited in 5 years' time to assess how many countries have data and how they have progressed.

Conclusions

In many regions in the past 50 years women's status has improved markedly. In too many settings, however, women remain second-class citizens, are discriminated against, and made subservient to men. Even where women enjoy many freedoms, the fear and reality of male violence persists.

With increased recognition on how many women's, men's and children's lives are affected by violence, and growing evidence on how to respond to and prevent violence against women and girls, there is no excuse for inaction. Although the achievement of healthier lives for women and girls, free from violence and discrimination, is ambitious, it is central to an equitable sustainable development agenda and must be prioritised. On the eve of a new global development agenda, we call for greater action and an explicit commitment to the elimination of violence against women and girls.

Contributors

All authors created the conceptual framework and contributed to the original text. CG-M and CW led the drafting of the paper, and CZ, AM-G, LH, and AA provided substantive editorial input. All authors commented on drafts and all read and approved the final version. CG-M and AA are staff members of WHO. The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions or policies of WHO.

Declaration of interests

We declare no competing interest.

References

1 WHO, London School of Hygiene and Tropical Medicine. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization, 2013.

2 Heise L, García-Moreno C. Violence by intimate partners. In: Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva: World Health Organization; 2002; 87–121.

3 Jewkes R, Sen P, García-Moreno C. Sexual violence. In: Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva: World Health Organization; 2002; 149–81.

4 Stöckl H, Devries K, Rotstein A, et al. The global prevalence of intimate partner homicide: a systematic review. *Lancet* 2013; **382:** 859–65.

5 WHO, International Society for Prevention of Child Abuse and Neglect. Preventing child maltreatment: a guide to taking action and generating evidence. Geneva: World Health Organization, 2006.

6 United Nations Office on Drugs and Crime. Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the United Nations Convention against Transnational Organized Crime. In: United Nations. United Nations convention against transnational organized crime and the protocols thereto. Vienna: United Nations Office on Drugs and Crime, 2004; 41–51.

7 International Labour Office. ILO global estimate of forced labour: results and methodology. Geneva: International Labour Office, 2012.

8 WHO. Eliminating female genital mutilation: an interagency statement. Geneva: World Health Organization, 2008.

9 United Nations Children's Fund. Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. New York, NY: United Nations Children's Fund, 2013.

10 WHO. Sixty-fifth World Health Assembly, provisional agenda item 13.4: early marriages, adolescent and young pregnancies: report by the Secretariat. March 16, 2012. http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_13-en.pdf (accessed Oct 15, 2014).

11 Nasrullah M, Haqqi S, Cummings KJ. The epidemiological patterns of honour killing of women in Pakistan. *Eur J Public Health* 2009; **19:** 193–97.

12 Round up. Law policy. *Reprod Health Matters* 2010; **18:** 226–30.

13 Michau L, Horn J, Bank A, Dutt M, Zimmerman C. Prevention of violence against women and girls: lessons from practice. *Lancet* 2014; published online Nov 21. http://dx.doi.org/10.1016/S0140-6736(14)61797-9.

14 Htun M, Weldon S. The civic origins of progressive policy change: combatting violence against women in global perspective, 1975–2005. *Am Polit Sci Rev* 2012; **106:** 548–69.

15 United Nations Children's Fund. Hidden in plain sight: a statistical analysis of violence against children. New York, NY: UNICEF, 2014.

16 Putnam FW. Ten-year research update review: child sexual abuse. *J Am Acad Child Adolesc Psychiatry* 2003; **42:** 269–78.

17 UN Women. UN Trust Fund to End Violence against Women. http://www.unwomen.org/en/trust-funds/un-trust-fund-to-end-violence-against-women (accessed Aug 12, 2014).

18 Towers J, Walby S. Measuring the impact of cuts in public expenditure on the provision of services to prevent violence against women and girls. Jan 30, 2012. http://www.trustforlondon.org.uk/wp-content/uploads/2012/01/VAWG-Cuts-Full-Report.pdf (accessed Sept 23, 2014).

19 Humphreys J, Epel ES, Cooper BA, Lin J, Blackburn EH, Lee KA. Telomere shortening in formerly abused and never abused women. *Biol Res Nurs* 2012; **14:** 115–23.

20 Bonomi AE, Anderson ML, Rivara FP, Thompson RS. Health care utilization and costs associated with physical and nonphysical-only intimate partner violence. *Health Serv Res* 2009; **44:** 1052–67.

21 Ansara DL, Hindin MJ. Formal and informal help-seeking associated with women's and men's experiences of intimate partner violence in Canada. *Soc Sci Med* 2010; **70:** 1011–18.

22 Black CM. Intimate partner violence and adverse health consequences: implications for clinicians. *Am J Lifestyle Med* 2001; **5:** 428–39.

23 Berg RC, Underland V. The obstetric consequences of female genital mutilation/cutting: a systematic review and meta-analysis. *Obstet Gynecol Int* 2013; **2013:** 496564.

24 WHO and London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva: World Health Organization, 2010.

25 World Bank. Voice and agency: empowering women and girls for shared prosperity. Washington, DC: World Bank, 2014.

26 WHO. Manual for estimating the economic costs of injuries due to interpersonal and self directed violence. Geneva: World Health Organization, 2007.

27 Morrison A, Orlando MB. Social and economic costs of domestic violence: chile and nicaragua. too close to home. In Morrison A, Biehl ML, eds. Inter-American development bank. Washington, DC: Inter-American Development Bank, 1999; 51–80.

28 Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Costs of intimate partner violence against women in the United States. March, 2003. www.cdc.gov/ncipc/pub-res/ipv_cost/ipv.htm (accessed Aug 12, 2014).

29 Walby S. The cost of domestic violence. London: Women and Equality Unit, Department of Trade and Industry, 2004.

30 Department of Social Services. The cost of domestic violence to the Australian economy: part 1. Canberra: Commonwealth of Australia, 2004.

31 Khumalo B, Msimang S, Bollbach K. Too costly to ignore—the economic impact of gender-based violence in South Africa. Johannesburg: KPMG Services, 2014.

32 The National Council to Reduce Violence against Women and their Children. The cost of violence against women and their children. March, 2009. https://www.dss.gov.au/sites/default/files/documents/05_2012/vawc_economic_report.pdf (accessed Oct 15, 2014).

33 Andersen-Clark K, Biddle AK, Martin SL. A cost-benefit analysis of the Violence against Women Act of 1994. *Violence Against Women* 2002; **8:** 417–28.

34 Heise LL. Violence against women: an integrated, ecological framework. *Violence Against Women* 1998; **4:** 262–90.

35 Fulu E, Jewkes R, Roselli T, García-Moreno C, for the UN Multi-country Cross-sectional Study on Men and Violence research team. Prevalence of and factors associated with male perpetration of intimate partner violence: findings from the UN Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific. *Lancet Glob Health* 2013; **1:** e187–207.

36 Abramsky T, Watts CH, García-Moreno C, et al. What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health* 2011; **11:** 109.

37 Heise L, Kotsadam A. Exploring cross-national and multi-level correlates of partner violence: a test of the gender hypothesis. *Lancet Glob Health* (in press).

38 The Organisation for Economic Co-operation and Development. Social institutions and gender index. 2012. http://genderindex.org/data/ (accessed Sept 26, 2014).

39 Hallward-Driemeier M, Hasan T, Rusu AB. Women's legal rights over 50 years: what is the impact of reform? Washington, DC: World Bank, 2013.

40 United Nations Development Fund for Women. UN Trust Fund to End Violence against Women http://www.unwomen.org/~/media/Headquarters/Media/Publications/UNIFEM/EVAWkit_08_Factsheet_UNTrustFund_en.pdf (accessed July 10, 2014).

41 Gracia E. Intimate partner violence against women and victim-blaming attitudes among Europeans. *Bull World Health Organ* 2014; **92:** 380–81.

42 World Bank. Women, business and the law 2014: removing restrictions to enhance gender equality. London: World Bank, 2013.

43 Ellsberg M, Arango D, Morton M, et al. Prevention of violence against women and girls: what does the evidence say? *Lancet* 2014; published online Nov 21. http://dx.doi.org/10.1016/S0140-6736(14)61703-7.

44 Abramsky T, Devries K, Kiss L, et al. Findings from the SASA! study: a cluster randomised controlled trial to assess the impact of a community mobilisation intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC Med* 2014; **12:** 122.

45 Hossain M, Zimmerman C, Kiss L, et al. Working with men to prevent intimate partner violence in a conflict-affected setting: a pilot cluster randomized controlled trial in rural Côte d'Ivoire. *BMC Public Health* 2014; **14:** 339.

46 Jewkes R, Nduna M, Levin J, et al. Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomized controlled trial. *BMJ* 2008; **337:** a506.

47 Kim JC, Watts CH, Hargreaves JR, et al. Understanding the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa. *Am J Public Health* 2007; **97:** 1794–802.

48 Jewkes R, Flood M, Lang J. From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls. *Lancet* 2014; published online Nov 21. http://dx.doi.org/10.1016/S0140-6736(14)61683-4.

49 Koenig MA, Ahmed S, Hossain MB, Khorshed Alam Mozumder AB. Women's status and domestic violence in rural Bangladesh: individual- and community-level effects. *Demography* 2003; **40:** 269–88.

50 Schuler SR, Hashemi SM, Riley AP, Akhter S. Credit programs, patriarchy and men's violence against women in rural Bangladesh. *Soc Sci Med* 1996; **43:** 1729–42.

51 Wagman J, Gray R, Campbell J, et al. Impact of an integrated intimate partner violence and HIV prevention intervention: a cluster randomized trial in Rakai, Uganda. AIDS; Melbourne; July 20–25, 2014.

52 Diop NJ, Askew I. The effectiveness of a community-based education program on abandoning female genital mutilation/cutting in Senegal. *Stud Fam Plann* 2009; **40:** 307–18.

53 International Rescue Committee. Let me not die before my time: domestic violence in West Africa. New York, NY: International Rescue Committee; 2012.

54 Heise L. What works to prevent partner violence? An evidence overview. December, 2011. http://strive.lshtm.ac.uk/system/files/attachments/What%20works%20to%20prevent%20partner%20violence.pdf (accessed Oct 15, 2014).

55 Macmillan HL, Wathen CN, Barlow J, Fergusson DM, Leventhal JM, Taussig HN. Interventions to prevent child maltreatment and associated impairment. *Lancet* 2009; **373:** 250–66.

56 WHO. World Health Assembly Resolution on Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children. Geneva: World Health Organization, 2014.

57 British Columbia Centre of Excellence for Women's Health. Review of interventions to identify, prevent, reduce and respond to domestic violence. April, 2013. http://www.nice.org.uk/guidance/ph50/resources/review-of-interventions-to-identify-prevent-reduce-and-respond-to-domestic-violence2 (accessed July 17, 2014).

58 Domino ME, Morrissey JP, Chung S, Huntington N, Larson MJ, Russell LA. Service use and costs for women with co-occurring mental and substance use disorders and a history of violence. *Psychiatr Serv* 2005; **56:** 1223–32.

59 García-Moreno C, Hegarty K, Lucas d'Oliveira AF, Koziol-Maclean J, Feder G. The health-systems response to violence against women. *Lancet* 2014; published online Nov 21. http://dx.doi.org/10.1016/S0140-6736(14)61837-7.

60 Colombini M, Mayhew S, Watts C. Health sector response to intimate partner violence in low- and middle-income settings: a review of current models, challenges and opportunities. *Bull World Health Organ* 2008; **86:** 635–42.

61 WHO. Responding to intimate partner violence and sexual violence against women: WHO clinical policy guidelines. Geneva: World Health Organization, 2013.

62 Warshaw C. Intimate partner abuse: developing a framework for change in medical education. *Academic Med* 1997; **72** (suppl): S26–37.

63 García-Moreno C. Dilemmas and opportunities for an appropriate health-service response to violence against women. *Lancet* 2002; **359:** 1509–14.

64 WHO. WHO Multi-country study on women's health and domestic violence against women. Geneva: World Health Organization, 2005.
65 García-Moreno C, Watts C. Violence against women: an urgent public health priority. *Bull World Health Organ* 2011; **89:** 2.
66 Abrahams N, Devries K, Watts C, et al. Worldwide prevalence of non-partner sexual violence: a systematic review. *Lancet* 2014; **383:** 1648–54.
67 Zimmerman C, Hossain M, Yun K, et al. The health of trafficked women: a survey of women entering post trafficking services in Europe. *Am J Public Health* 2008; **98:** 55–59.
68 Anda RF, Felitti J, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. *Eur Arch Psychiatry Clin Neurosci* 2006; **256:** 174–86.