The global burden of violence against women

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Expert working group on interpersonal violence

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Work builds on previous national analyses of health burden of violence against women

- **Mexico City** - rape and intimate partner violence against women account for 5.6% of all DALYs. (Lozano RA 1999).
- **South Africa** partner violence, male on male violence, and child sexual abuse second leading cause of healthy years of life lost amongst adults (Norman R et al, 2007)
- **Australia**, burden of intimate partner violence responsible for 8% of overall disease burden for women 18-44 years of age, greater than other recognised risk factors for poor health (Vos et al 2006)
Aims of the global burden analysis for violence

- Systematically review & synthesize global evidence on:
  - The population prevalence of women’s exposures to physical and/or sexual violence from a partner
  - The population prevalence of women’s exposure to sexual violence from someone other than their partner
- Systematically review & synthesize evidence on the health impacts of these exposures to violence
- Use findings to produce:
  - global & regional estimates of prevalence of intimate partner violence and non-partner sexual violence
  - synthesize findings on health impacts of different violence exposures
Overview of methods

- Review of evidence global prevalence of exposure
- DISMOD3 produces models of national, exposure by age
- Systematic review & meta-analysis to obtain estimates of relative risk & calculation of PAFs

ESTIMATES OF HEALTH BURDEN (DALYS)
What does the evidence say?
Huge growth in available data on population prevalence of intimate partner violence

2005: 10 initial countries, now 15

2013: 81 countries

Some data gaps remain
30% partnered women have experienced violence from a partner.
Less data on non-partner sexual violence – but findings suggest that highly prevalent

**Lifetime prevalence** of non-partner sexual violence by WHO region

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Prevalence, %(^a)</th>
<th>95% CI, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low- and middle-income regions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td>11.9</td>
<td>8.5 to 15.3</td>
</tr>
<tr>
<td>Americas</td>
<td>10.7</td>
<td>7.0 to 14.4</td>
</tr>
<tr>
<td>Eastern Mediterranean(^b)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Europe</td>
<td>5.2</td>
<td>0.8 to 9.7</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>4.9</td>
<td>0.9 to 8.9</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>6.8</td>
<td>1.6 to 12.0</td>
</tr>
<tr>
<td>High income</td>
<td>12.6</td>
<td>8.9 to 16.2</td>
</tr>
</tbody>
</table>
38% of female homicides perpetrated by an intimate partner

The proportion of intimate partner homicides among female homicides

Impacts on injury and pregnancy outcomes

- 31% - 54% of women experiencing IPV reported injuries
- 13% - 33% of those injured have had severe injuries

- IPV and low birth weight: pooled OR 1.16 (95% CI: 1.02-1.29)
- IPV and preterm birth: pooled OR 1.36 (95% CI: 1.10-1.61)
- IPV and abortion: pooled OR 2.16 (95% CI: 1.88-2.49)
## Bi-directional relationship with depression

Devries et al. 2013. PLOS Medicine

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Odds Ratio (95% CI)</th>
<th>% Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IPV-incident depression</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chowdhary</td>
<td>2008</td>
<td>0.88 (0.26, 3.00)</td>
<td>3.27</td>
</tr>
<tr>
<td>Suglia</td>
<td>2011</td>
<td>1.09 (0.60, 1.90)</td>
<td>11.41</td>
</tr>
<tr>
<td>Ackard</td>
<td>2007</td>
<td>1.92 (1.22, 3.00)</td>
<td>15.79</td>
</tr>
<tr>
<td>Salazar</td>
<td>2009</td>
<td>2.01 (1.08, 3.78)</td>
<td>10.11</td>
</tr>
<tr>
<td>Taft</td>
<td>2008</td>
<td>2.12 (1.69, 2.65)</td>
<td>28.68</td>
</tr>
<tr>
<td>Loxton</td>
<td>2006</td>
<td>2.51 (2.07, 3.06)</td>
<td>30.73</td>
</tr>
<tr>
<td><strong>Subtotal (I-squared = 50.4%, p = 0.073)</strong></td>
<td></td>
<td>1.97 (1.56, 2.48)</td>
<td>100.00</td>
</tr>
</tbody>
</table>

| Depression-incident IPV                                  |      |                     |          |
| Nduna          | 2010 | 1.67 (1.18, 2.36)   | 51.84    |
| Lehrer         | 2006 | 1.86 (1.05, 3.29)   | 19.09    |
| Salazar        | 2009 | 2.42 (1.46, 4.02)   | 24.28    |
| Jonsson        | 2011 | 3.47 (1.11, 10.84)  | 4.80     |
| **Subtotal (I-squared = 0.0%, p = 0.481)**               |      | 1.93 (1.51, 2.48)   | 100.00   |

**NOTE:** Weights are from random effects analysis
Conclusions 1: Exposures to violence is bad for women's health!
Conclusions 2

1. Violence against women prevalent globally
   – 30% partnered women have experienced physical and/or sexual violence
   – 1/3 women will experience partner violence or non-partner sexual violence in their lifetime

2. Violence against women an important public health issue

3. National responses need to strengthen services & invest in prevention
3 main lessons for global targets & monitoring

1. It is possible to obtain population level data on women’s exposure to different forms of violence
   - Substantial experience on how to obtain data in an ethically responsible and reliable way
   - More reliable measure of prevalence than data from police or other services
   - Use of standardized questions greatly facilitates monitoring & comparison

2. Still important data gaps
   - Ability to routinely monitor the relationship between homicide perpetrators & victims
   - Longitudinal data from low and middle income countries on health impacts of violence exposure
   - Data on the health impacts of exposure to non-partner sexual violence

3. A feasible post-MDG gender indicator could be on violence against women
   - Increasing experience on how to collect population data in an ethically responsible way
   - Needs further discussion about what indicator would be most feasible and relevant
THANK YOU!

For more information: www.genderviolence.lshtm.ac.uk

Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence

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Intimate Partner Violence and Incidence of Symptoms and Suicide Attempts: A Systematic Review of Longitudinal Studies

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Abstract

Background: Depression and suicide are responsible for a substantial burden of disease. Intimate partner violence (IPV) experience is associated with increased risk of depressive disorders at increased risk of violence. We aimed to investigate the extent to which incident depression and suicide attempts, and vice versa, in both women and men.

Methods and Findings: We conducted a systematic review and meta-analysis of longitudinal studies. This paper includes 10 studies with 22,000 records that were screened for study eligibility. We included studies with complete data on incident depression and suicide attempts, and vice versa, with a minimum follow-up period of 6 months. The studies were divided into two groups: studies with a focus on IPV and studies with a focus on depression. Our review identified 36 studies that met our inclusion criteria. All studies included female participants. Random effects meta-analyses were used to generate pooled estimates. The results of the meta-analysis showed a significant association between IPV and depression, and between depression and suicide attempts.

Conclusions: IPV is associated with incident depressive symptoms, and depression is associated with incident IPV. These findings highlight the importance of preventing IPV to reduce the risk of depression and suicide attempts, and vice versa.