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Violence Against Women as a Global Public Health Issue

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Abstract

Violence against women, especially intimate partner violence, is recognized as a global public health issue due to its prevalence and global reach. This article outlines the scope of the issue, with respect to its prevalence, health outcomes, and risk factors, and identifies key milestones that led to its global recognition: methodological and data advances, acknowledgment as a criminal justice and health issue, support by the global women's movement, and the robust evidence demonstrating that intimate partner violence is preventable. Key issues for the future include recognition and consideration of intersectionality in research, improvements in the measurement of other forms of violence against women, and the need to scale up prevention efforts that have documented success. Violence against women is an urgent priority as it affects individuals, their families and surroundings, and the entire global health community.

INTRODUCTION

Violence against women is a global human rights and public health issue, with serious often long-lasting social, developmental, and health effects for women and their children. In 1992, the Committee on the Elimination of Discrimination Against Women (CEDAW) asserted that violence against women is a form of discrimination, directed toward a woman because she is a woman or because it affects women disproportionately, including sexual harassment and exploitation (82).

One of the major forms of violence against women is intimate partner violence, which refers to any behavior by a current or former male intimate partner, within the context of marriage, cohabitation, or any other formal or informal union, that causes physical, sexual, or psychological harm (67). According to the World Health Organization (WHO), such behavior includes "acts of physical aggression, such as slapping, hitting, kicking and beating," as well as "acts of sexual aggression, such as forced intercourse and other forms of sexual coercion" (97, p. 4). The WHO definition is, however, not limited to physical and sexual intimate partner violence but also mentions psychological abuse such as intimidation and other controlling behaviors, such as monitoring movements, and reproductive coercion (97). There is also increasing evidence about the harmful and widespread nature of psychological and financial abuse, stalking, and controlling behavior committed by intimate partners.

Furthermore, other forms of violence against women are increasingly receiving attention, such as sexual harassment, nonpartner sexual violence, female genital mutilation, honor killings, and violence against LGBTQ+ people (6, 11, 22, 64). Many of these forms of violence overlap with each other. For example, dating violence on college campuses combines multiple forms of intimate partner violence along with nonpartner sexual violence and sexual harassment in interplay with technology-facilitated abuse (3). Meanwhile, advancements in communication technology—spyware, location trackers, devices that can record an assault and upload it to social media, and more—have introduced new forms of violence against women, with governments and technology companies lagging far behind in responding to such use (37, 43).

The last decade has seen important achievements resulting in the acknowledgment that intimate partner violence is a global public health issue, yet there is still a long road ahead to meet the Sustainable Development Target to eliminate all forms of violence against women and girls in the public and private spheres by 2030 (83). This article outlines the current evidence on intimate partner violence and then turns to why it became a global public health issue and outlines key next steps for the field.

PATTERNS OF INTIMATE PARTNER VIOLENCE OVER TIME

Nonfatal Intimate Partner Violence

The first comprehensive national studies on intimate partner violence were conducted by Statistics Canada in 1993 and the Centers for Disease Control and Prevention and the National Institute of Justice in the United States in 1994, and these studies provided data on the incidence and prevalence of physical and sexual intimate partner violence as well as stalking by an intimate partner. The US findings indicated that millions of Americans were affected by those forms of violence; 24.8% of women reported that they had ever been raped or physically assaulted by an intimate partner (81). A few years later, multiple countries in Europe conducted their own nationally representative surveys on violence against women, including Finland in 1997 (36), Sweden in 2000 (50), and Germany in 2003 (55). The highlighted prevalence rates across those countries were comparable to those of the United States, with one in four women in Sweden reporting physical violence and one in three having been subjected to sexual violence since the age of 15 (50). To target violence

against women and make comparisons internationally, two key international collaborations started around the turn of the twenty-first century. The International Violence Against Women Survey, a collaboration between the International Crime Victimization Surveys and Statistics Canada, provided internationally comparable, criminal justice–focused prevalence rates, mainly for high-income countries (59). The WHO Multi-Country Study on Women's Health and Domestic Violence (WHO MCS) was notable for increasing visibility of the issue in low- and middle-income countries. Conducted in 10 countries, in one urban and one rural site in each country, the WHO MCS established that 15–71% of women reported lifetime, and 4–54% reported past-year, physical and/or sexual intimate partner violence (30). Evidence from the WHO MCS was further supported by data emerging from the Demographic and Health Surveys (DHS), which utilized a domestic violence module to estimate the prevalence of lifetime and past-year physical, sexual, and emotional intimate partner violence and controlling behavior (21).

This mounting evidence was synthesized by the WHO and partners in 2013, resulting in the release of prevalence estimates on physical and/or sexual intimate partner violence and nonpartner sexual violence from 79 countries and 2 territories (93). By 2018, 153 countries had data available (97). An estimated 1 in 4 women experienced physical and/or sexual intimate partner violence in their lifetime; and 1 in 3 experienced physical and/or sexual intimate partner violence or nonpartner sexual violence, which captures mainly physically forced sex, namely rape, by strangers. Although the number of countries reporting nonpartner sexual violence data increased from 52 to 96 between 2013 to 2018, severe measurement issues remained, resulting in substantial underestimation (67). Most countries measured only attempted or completed physically forced intercourse, ignoring all other forms of nonpenetrative sexual violence (97). The 2018 estimates also included the global prevalence of last-year physical and/or sexual intimate partner violence: 13% among ever-partnered women aged 15 to 49 (97). Furthermore, the 2018 estimates shed light on the high burden of intimate partner violence experienced by adolescent and young women: 16% of ever-partnered 15- to 24-year-old women versus 9% of older ever-partnered women reported physical and/or sexual intimate partner violence during the previous year (97). The economic status of a country matters too. Past-year occurrence of intimate partner violence is higher in low- and middle-income countries than in high-income countries. Past-year rates are highest in the least developed countries and lowest in Australia and New Zealand (22% versus 3%, respectively); the past-year rates are 5% and 6% in Europe and North America, respectively. Overall, the 2013 and 2018 estimates highlight that intimate partner violence is a global and widespread phenomenon and a particular burden for young women and those from less-developed countries (93, 97).

Intimate Partner Homicide

The 2013 estimates also provided an overview of global intimate partner homicide rates. Similar to patterns in intimate partner violence, despite men being up to 4 times more likely than women to be victims of homicide (87), women are far more likely to be victims of homicide by an intimate partner; 30–50% of all homicides of females are committed by an intimate partner compared with 5–10% of homicides of males (74). In the United States, the country with the most reliable and long-term data on intimate partner homicide, the number of male, but not female, victims of intimate partner homicide has dropped considerably since the 1970s (25). The discrepancy has been attributed, in part, to an increase in marital age, with young age being a risk factor for intimate partner violence; better socioeconomic opportunities for women who reduce their dependence on male spouses; changes in laws to allow for no-fault divorce; and the greater availability of services, such as hotlines and shelters that support women who are experiencing

abuse to leave their relationships (15). Those factors led to a decrease in men's intimate partner homicide victimization but not women's, perhaps due to the observed timing of such homicides: Women who murder a male partner are most likely to do so while still in the relationship, whereas men tend to murder a partner during or after separation (42). These observations highlight the need to ensure women's safety when leaving an abusive partner.

Health Effects

A major driver to put intimate partner violence on the global health agenda is the large body of evidence on its health impacts on women—especially their mental health and sexual and reproductive health—and the effects on their children. Systematic reviews as early as 2001 (56) documented the multiple health outcomes of physical and/or sexual intimate partner violence, such as increased levels of depression, posttraumatic stress disorder, substance abuse, and suicidal ideation (12, 13). Furthermore, intimate partner violence emerged as a predictor for unintended pregnancy, miscarriage, and abortion; low infant birth weight; and sexually transmitted infections in women (33, 68). Recent cohort studies that follow women and their children over time increasingly bolster the evidence that women's exposure to intimate partner violence is linked to lower levels of breastfeeding, behavioral problems in young children, and children's higher likelihood of experiencing or perpetrating intimate partner violence themselves later in life (38, 49, 71). One possible explanation is that intimate partner violence and child maltreatment often co-occur in the same family, leading to similar health effects among women and children (32). Yet these studies are not free of measurement biases and appear to be deeply gendered, as many of them examine intimate partner violence by the male partner against the mother but only the mother's, not the father's, violence against the children (61). Moreover, witnessing violent behavior toward one's mother during childhood is a risk factor for adverse health outcomes (23), and children are sometimes collateral victims in violence targeting the mother. Despite the paucity of much-needed cohort studies and studies using biomarkers to establish the long-term effects of intimate partner violence, there is a strong body of evidence showing that intimate partner violence is an urgent public health issue with multiple negative health outcomes.

The negative health consequences of intimate partner violence were first compared globally with other health issues and risk factors for health outcomes in 2012 (48). The Global Burden of Disease project, which provides a comprehensive picture of mortality and disability across countries, time, age, and sex, documented that the impact of physical and/or sexual intimate partner violence in terms of disability-adjusted life years (DALYs) corresponds with other well-recognized risk factors, such as unimproved water and sanitation or drug use (48). Experiencing lifetime physical and/or sexual intimate partner violence is the eighteenth-leading level 2 risk factor for DALYs globally, and it is responsible for 11% of DALYs due to depressive disorders and nearly 14% of DALYs due to HIV in females (57).

Risk and Protective Factors

Several risk and protective factors for intimate partner violence have been identified to inform intervention development and advise policy. Whereas research on this issue initially developed in silos of sociology, feminism, and psychology, consensus emerged soon that intimate partner violence is a complex social issue that needs to be addressed at all levels of the socioecological spectrum. Based on Urie Bronfenbrenner's (7) human development model, Lori Heise (35), in her influential 1998 article, proposed an ecological model highlighting factors on the individual, relationship, community, and societal levels that are associated with male perpetration of intimate partner violence. This model has been further developed to encompass risk and protective factors

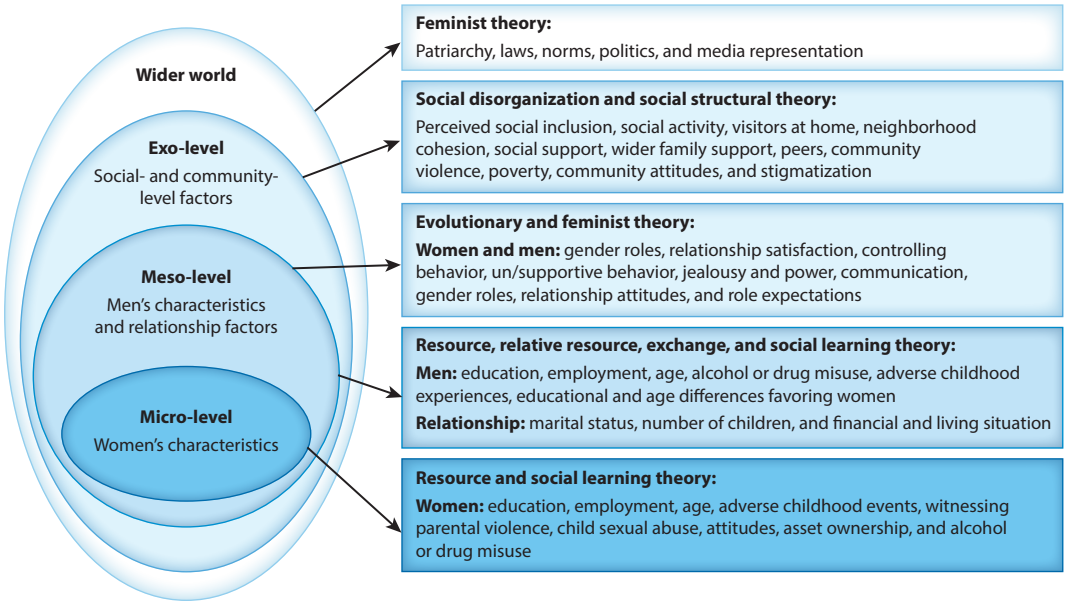

Figure 1

Overview of existing theories on risk and protective factors for intimate partner violence captured in an ecological framework.

and emphasize systemic factors that are based on gender roles, structures, and norms (displayed in **Figure 1**). However, most current research still focuses on individual- and relationship-level factors. In the last decade, studies have started to focus on what prevents or leads to men's perpetration of intimate partner violence and nonpartner rape. For example, the population-based UN Multi-Country Study on Men and Violence in Asia and the Pacific (26, 41) helped illuminate the relationship between experiences of childhood violence and neglect and the subsequent perpetration of intimate partner violence (27). More research is needed on considerations that might mediate the relationship between identified risk and protective factors, as not all characteristics are deterministic, and on the factors that influence men to become allies in reducing the perpetration of violence against women.

KEY MILESTONES IN THE LAST DECADE AND MARKERS OF DIFFERENCE

Acknowledging intimate partner violence as a global health concern began primarily with the International Conference on Population and Development in Cairo in 1994, which noted that gender equality and equity, empowerment, and the elimination of violence against women were cornerstones of development (82). In the following year, the Beijing Declaration and Platform for Action explicitly stated that women's rights are human rights. It further highlighted the need to prevent and eliminate all forms of violence against women and girls (85). The elimination of violence against women was not mentioned in the 2000 Millennium Development Goals (83) but became a separate target in the Sustainable Development Goals (SDGs) in 2015 (see the sidebar titled Sustainable Development Goal for Violence Against Women and Girls). One year later, in 2016, the World Health Assembly recognized violence against women as a global public health issue and endorsed a global plan of action to strengthen the role of the health system in addressing violence, in particular violence against women and children (95).

SUSTAINABLE DEVELOPMENT GOAL FOR VIOLENCE AGAINST WOMEN AND GIRLS

Sustainable Development Goal 5: Achieve gender equality and empower all women and girls

TARGET 5.2

Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

Indicator 5.2.1

Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual, or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age

Indicator 5.2.2

Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence

Compared with other global health issues, violence against women, with its focus on intimate partner violence, came onto the global public health agenda comparatively late and quickly obtained global recognition. The main enablers of this process are (*a*) internationally comparable data, (*b*) an active global women's movement, (*c*) simultaneous recognition as a health and criminal justice issue, and (*d*) evidence that intimate partner violence is preventable.

Internationally Comparable Data Due to an Agreed-Upon Definition and Measurement

The WHO Multi-Country Study on Women's Health and Domestic Violence (30) was key in addressing two main issues highlighted in the Beijing Platform of Action: the absence of gender-disaggregated data and the need for an agreed-upon measure of intimate partner violence. Through meetings of content experts from multiple countries and cognitive pretests, an acts-based measure to assess having experienced physical and/or sexual intimate partner violence was created, with the former capturing acts from being pushed to slapped to being threatened or hurt with a weapon and the latter assessing having been physically forced to have sexual intercourse (29). The measure developed by the WHO MCS is similar to the domestic violence module utilized in the DHS and most other nationally representative surveys on violence against women (8, 88); see the sidebar titled Domestic Violence Module (DHS) Questions for Physical and Sexual Intimate Partner Violence for an example. Acts-based questions about violence allow study participants to respond to questions about their experiences without having to label themselves as "victims" or having experienced intimate partner violence, a condition with which many women do not associate themselves even if they have experienced it multiple times and sustained severe injuries (4). Such measurement strategies also make explicit what is being assessed rather than assuming that respondents know what is meant by terms such as "domestic violence" and "sexual assault." It may be useful to note that very early research had already indicated the importance of acts-based questions to assess violence and abuse in relationships (79) and sexual assault (46). Unfortunately, double-barreled questions, i.e., questions that ask about more than one act, which are to be avoided in survey research, are still used in the DHS, thus, although the acts were made explicit, researchers are unable to determine which of the act or acts the study participant indicated to have occurred.

DOMESTIC VIOLENCE MODULE (DHS) QUESTIONS FOR PHYSICAL AND SEXUAL INTIMATE PARTNER VIOLENCE

(Does/Did) your (last) husband/partner ever:

1. push you, shake you, or throw something at you?
2. slap you or twist your arm?
3. punch you with his fist or with something that could hurt you?
4. kick you or drag you?
5. try to strangle you or burn you?
6. threaten you with a knife, gun, or other type of weapon?
7. attack you with a knife, gun, or other type of weapon?
8. physically force you to have sexual intercourse with him even when you did not want to?
9. force you to perform other sexual acts you did not want to?

Questions reproduced from Demographic and Health Surveys (**https://dhsprogram.com/pubs/pdf/DHSQMP/domestic_violence_module.pdf.pdf**).

Using acts-based questions that are largely similar to the measures used in the WHO MCS and the DHS allows for prevalence data to be compared across countries and tracked over time to mark progress. The latter is an important mechanism to help hold governments accountable in their commitment to meet SDG target 5.2 on the elimination of intimate partner violence through targeted action. The SDGs require countries to collect data to measure progress and advise them to change laws and implement programs to reduce intimate partner violence. **Figure 2** outlines how the timetables of key events and data collection overlap.

Similar advancements, such as the recognition of intimate partner violence against women being a global health and developmental issue and its inclusion in key policy documents such as the SDGs, have yet to be made for other forms of violence against women, including emotional and economic intimate partner violence, sexual harassment, and nonpartner sexual violence (97). Furthermore, specific questions need to be developed for groups that are especially vulnerable to violence, such as women with disabilities, women who are older, and LGBTQ+ persons (51–53, 62).

Despite substantial advancements in the measurement of intimate partner violence, existing estimates still likely underrepresent its scale. Intimate partner violence is considered a private

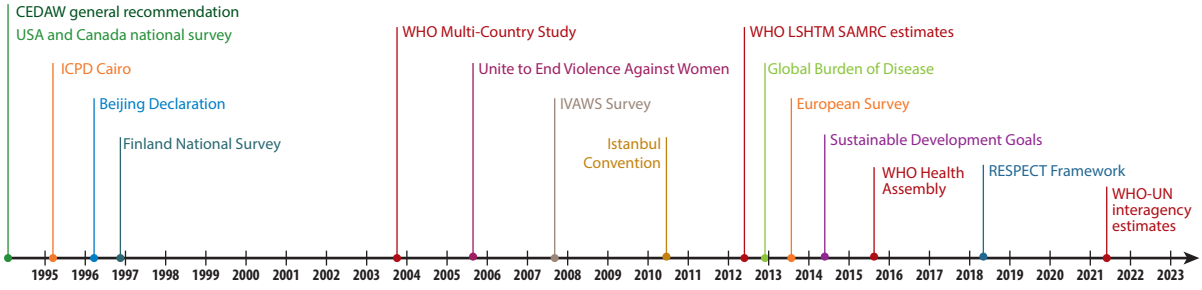

Figure 2

Timeline of key events and major data collection points on violence against women and girls. Abbreviations: CEDAW, Committee on the Elimination of Discrimination Against Women; ICPD, International Conference on Population and Development; IVAWS, International Violence Against Women Survey; LSHTM, London School of Hygiene and Tropical Medicine; SAMRC, South African Medical Research Council; UN, United Nations; WHO, World Health Organization.

matter in most parts of the world; women typically disclose it only to close friends and family members. Indeed, in the WHO MCS, 21–66% of women had never revealed their experience of intimate partner violence to anyone before the survey. To facilitate disclosure, high-quality surveys asking about violence against women need to ensure certain standards (92). Comparing two methods of DHS questionnaire administration in Nicaragua, Mary Ellsberg and colleagues documented that a separate survey about violence against women with trained interviewers who were sensitized to the personal nature of the questions, ensured privacy during administration, asked the questions in a nonjudgmental manner, and offered referrals led to higher disclosure rates than on a standard survey (18). The widespread implementation of such procedures is crucial to fully elucidate the nature and scope of violence against women.

Active Global Women's Movements

Intimate partner violence received international, regional, and national attention and debate due to decades of advocacy and action by women's and feminist movements. In the early 1970s, grassroots efforts developed to respond to women's experiences of violence and their need for shelter, support, counseling, legal services, and health care related to the violence experienced in their homes. Grassroots rape crisis efforts launched during the early 1970s as well, and they addressed largely rapes by strangers; the acknowledgment of sexual violence more broadly as well as sexual assault in the context of a relationship came much later (2, 31). These local responses grew to national and international levels, and women's movements remain central in ensuring that the issues stay on policy agendas and that high-quality prevention programs are designed and implemented to reduce violence against women and girls (54).

Empirical evidence suggests that the presence of autonomous women's movements is a main driver of progressive government action to eliminate intimate partner violence. In the United States, consciousness raising in the 1960s and 1970s led to rape law reform and the establishment of the National Center for the Prevention and Control of Rape. The latter funded the first large community-based epidemiological surveys about sexual assault then was quietly disbanded during the Reagan administration in the 1980s. A primary goal of these efforts was to change the public discourse from blaming the woman for the violence she experienced to a framework based on the notions that intimate partner violence is not acceptable, the perpetrator is accountable, and there is no excuse for such violence. Progress is uneven, and these pressures continue ranging from behind-the-scenes policy work to public marches in response to particularly horrific incidents of violence and/or inept systems responses to such violence. Adequate resources are essential to support the engagement of the women's movement and women's organizations as well as the development, implementation, and monitoring of national plans in all relevant sectors (31).

Simultaneous Recognition as a Criminal and Health Issue

While the DHS and the WHO MCSs raised awareness of the prevalence and health impacts of intimate and nonpartner sexual violence, international crime surveys such as the International Violence Against Women Survey and national crime surveys, such as the British Crime Survey, led to an increase in awareness regarding the criminal nature of violence against women and girls. Violence against women became a greater focus of laws and policies. In 2017, 141 countries had laws on intimate partner violence (28). However, the passage of laws and development of administrative policies are essential but insufficient in and of themselves. Monitoring to ensure their enactment and appropriate implementation is crucial. Carefully designed evaluations can lend insight but are not common in this field, and, notably, progress is inconsistent. For example, efforts to create national-level legislation to improve criminal justice responses and provide services

to victims of domestic violence began in 1990 in the United States, and the Violence Against Women Act (VAWA) was made into law in 1994. With substantial backing, the Act was renewed and strengthened by Congress in 2000, 2005, and 2013, although certain provisions were challenged, sometimes successfully, in court. Subsequent reauthorization was delayed due to intense and prolonged opposition to some of the proposed additions and revisions. A series of compromises led to the eventual passage of the next version of the VAWA in March 2022, and some of the provisions were quickly challenged in the courts. As of 2023, more than $14 billion in tax dollars had been spent through VAWA, the bulk of it for law enforcement and criminal justice purposes, yet no comprehensive evaluation of the effectiveness of the Act and the accompanying expenditures has been conducted (2, 34, 66). This process is not unique to the United States nor is the lack of formal evaluation for the overall effects of funded legislation. In Europe, the European-wide Violence Against Women Survey conducted by the Fundamental Rights Agency in 2013 (20), together with the active women's movement, collectively led to the passing of the Istanbul Convention in 2014, while several countries in Africa implemented national action plans, such as the 2016 passing of the National Plan of Action to End Violence Against Women and Children in Tanzania for 2017–2021 (84). What is needed now is the successful implementation of such laws around the globe, accompanied by sufficient budgets and formal evaluations.

These advancements raised awareness of violence against women, challenged existing social norms that cast intimate partner violence as a private matter, improved the collection of administrative data, and drew attention to improving law enforcement responses to domestic violence incidents in many countries. Improving law enforcement responses includes better training of police officers about how to respond to domestic violence calls and provisions such as adding trauma-informed victim services personnel who accompany patrol officers as they respond to sexual and domestic violence calls and who can provide support to victims. Nonetheless, most such incidents continue to go unreported to police. The policy and legal advancements also led to a recognition of intimate partner violence as an important factor in custody decisions in locales around the world (86).

Policy makers have also criminalized previously ignored forms of abuse, such as, in the United Kingdom and South Korea, up-skirting, namely, taking photos under women's skirts without their knowledge (47) and, in Scotland and Ireland, coercive control, which addresses various forms of psychological harm and coercive and controlling behavior. Whether these laws reduce violence against women or create additional concern about law enforcement's role in addressing societal ills remains to be seen.

Even with these improvements, progress still needs to be made. As of 2017, only 42% of 189 countries had legislation that explicitly criminalizes marital rape, 40% have provisions that cover sexual harassment in educational settings, and 18% had laws that cover sexual harassment in public spaces (28). Even if legislation is established, the implementation of laws and national action plans remains weak and underfunded. Furthermore, backlash occurred in several countries around the world: For example, Russia in 2017 decriminalized domestic violence that does not require hospital treatment (65).

Intimate Partner Violence Is Preventable

One of the major milestones that provided global attention to the issue of intimate partner violence is the existence of robust evidence based on randomized controlled trials demonstrating the fact that intimate partner violence is preventable.

In North America and Europe, there has always been a strong focus to develop adequate programming, including through shelters and hotlines, that provides abused women with legal, social, and financial assistance. Great strides have been made in the health care fields, with health

care interventions addressing the care needs of both the mother as well as her children, such as routine screening for intimate partner violence as a secondary prevention strategy to identify and refer women, including during pregnancy (60, 89), and effective interventions that utilize home visitation programmed during pregnancy (39, 70). The development of clinical and policy guidelines by the WHO in 2013 has been a major milestone for the health sector's response to abused women. These guidelines led to a standardization in recommendations on how health care providers should identify and clinically care for survivors of intimate partner violence and how to organize services and training for health care providers across different settings (94). Substantive evidence has also emerged about the effectiveness of bystander interventions with young people in the United States (9).

In low- and middle-income countries, where prevalence rates are substantially higher, especially current levels of intimate partner violence, there has been a remarkable increase in evidence on what works to prevent intimate partner violence. One of the first clinical trials to prevent intimate partner violence, the IMAGE (Intervention with Microfinance for AIDS and Gender Equity) trial in South Africa, proved effective in significantly reducing intimate partner violence by 55% among women in microfinance programs who received a participatory learning and gender, empowerment, and violence action curriculum (63). Evidence of the UK-funded What Works to Prevent Violence Against Women and Girls project, which encompasses evidence from several randomized controlled trials and several other key interventions and other studies, was summarized in a WHO and UN Women framework: RESPECT (96). The framework outlines strategies for governments to invest in to prevent and reduce rates of intimate partner violence: strengthening relationships; empowering women; ensuring service provision; reducing poverty; eliminating childhood abuse; and transforming norms, attitudes, and behaviors (96). Among the most promising interventions that documented substantial reductions in intimate partner violence, according to the What Works programs, are economic transfer programs that are combined with social empowerment programs; parenting programs to prevent child maltreatment; community activism to shift harmful gender norms; school-based interventions to reduce dating, sexual, and peer violence; and couple interventions (45). A notable program among them is the community mobilization intervention SASA! from Uganda, which, working through trained community activists and community-based activities, significantly prevented intimate partner violence by addressing gender inequality and norms regarding the acceptability of violence, using power as a key concept to start discussions (1).

In addition to demonstrating the sheer magnitude of prevalence, outlining solutions and interventions at different socioecological levels that each work to prevent intimate partner violence has been crucial in recognizing intimate partner violence as a global health concern. The next step is for governments to implement programs at scale. The allocation of sufficient resources toward prevention programming requires political will, reconciliation of competing priorities, and government accountability (28).

OUTLOOK AND AREAS TO MOVE FORWARD

Tremendous achievements have been made in the process of adding intimate partner violence to the global public health agenda, yet many gaps remain.

Acknowledging Intersections

As the prevalence of intimate partner violence against women has been well established through national prevalence surveys worldwide, it is time to focus on vulnerable population groups, such as women living with disabilities (51), older or adolescent women (77, 78), LGBTQ+ women (98),

ethnic and minority women (91), and, in light of global patterns, migrant women and women who were trafficked (69).

Prior studies outlined high levels of physical and/or sexual violence by partners among trafficked women and women in conflict settings, with 95% of trafficked women in a landmark study in Europe reporting physical and/or sexual violence while being trafficked (100) and 54% of women in a refugee camp in South Sudan reporting past-year physical and/or sexual intimate partner violence (17). A recent systematic review of research on women affected by natural disasters indicated that increased intimate partner violence during or after a natural disaster can be attributed to an increase in stressors that appear to trigger men's violence against women, an increase in environmentally enabling factors such as limited police presence, and an exacerbation of underlying drivers of violence against women, such as financial dependence of women on men and rigid gender norms (80). These examples of violence associated with forced migration likely have limited applicability to voluntary migration. Nonetheless, whether women migrate legally or illegally, for work, education, or marriage, their risk of violence at the hands of an intimate partner is expected to increase, particularly if they are in a new setting with a different language and culture, where they do not know how to access services and cannot rely on the same social and family networks. Few studies have assessed the scope and nature of violence against migrant women who migrate for education and employment legally and into different employment sectors (44, 75, 76, 101).

The cumulative impact of multiple forms of violence that women experience over their life span, such as adverse childhood experiences and being exposed to community violence, needs to be explored in addition to violence in their relationships (99). Adolescents remain a crucially understudied population, as they might simultaneously experience violence in their homes by a parent or caretaker, in school by peers or teachers, and by a partner in their relationships (19). All populations and marginalized groups merit further research on the effects of structural violence in the political and cultural systems in which they live, such as public health, child welfare, and justice systems (24, 73). In addition, it is important to acknowledge that national and cultural contexts sometimes present risks that are not observed or are not common elsewhere, for example, acid attacks in India and threats with a firearm in the United States (72).

Improving Measurement Beyond Physical and Sexual Intimate Partner Violence

Agreement about the definition and measurement of physical and sexual intimate partner violence has been crucial in elucidating the scope of the problem and will be helpful in tracking changes over time. Similar advances are needed for other forms of abuse, including sexual harassment and technology-facilitated violence.

The sexual assault prevention and women's empowerment movements #MeToo and Time's Up, which reverberated around the world beginning in 2017, increased the global conversation about sexual harassment. Yet it is not clear whether these discussions will lead to systemic and systems change. One issue hampering the ability to observe trends is the lack of an agreed-upon definition and measurement tool. A 2021 systematic review of the prevalence and measurement of sexual harassment in low- and middle-income countries documented this shortcoming and highlighted that many studies focused on single settings in which harassment may occur, such as the workplace, schools, and public transit, thereby underestimating the scope of harassment given that it is known to occur in multiple areas of women's lives (64). Furthermore, sexual harassment was defined both objectively, through the identification of the act, and subjectively, through the perception of the individual who experienced the act. As a result, studies asking participants directly whether they have been sexually harassed reported a far lower range of the prevalence of sexual harassment compared with those studies that used questions based on the behavior they experienced

(0.6–26.1% versus 14.5–98.8%, respectively) (64). Greater understanding of the constructs underlying the concept will accelerate development of a measure for global use.

Similarly, technology is changing both the forms of relationship-based and other violence that women experience as well as creating new venues to prevent and address such violence. Research to date has tended to examine the occurrence of a range of abusive behaviors—for example, tracking movement as well as activities online, harassment and shaming via social media, nonconsensual filming of sexual activity, and/or online posting of such images—in defined populations such as college students. Protecting children from such predation has garnered attention from a variety of groups. UNICEF undertook a 14-country study to understand when and how digital technology might facilitate sexual abuse and exploitation of children, both online and offline, to identify priority areas for intervention by governments and other organizations (16). Similar large-scale surveys are urgently needed for adult women.

Advances in statistical techniques show great promise for the field. For example, machine learning is in wide use in many settings, including those addressing violence against women (5). Machine learning can help inform criminal justice and child custody decisions when administrative actions depend on forecasts of problematic behavior. Is there a high probability, for instance, that a particular abuser will be violent again? The techniques require large data sets that can be linked to specific outcomes, such as the arrest of an abuser, a requirement that can be met more easily in locales such as Norway, where personally identifiable data are routinely collected and linked, but less easily in other areas where privacy laws prohibit these practices or in low- and middle-income countries, where data systems may be inadequate or simply do not exist. Yet access to appropriate data can be achieved from local agencies that collect the required information as a feature of their administrative records and can permit the use of such data in service of particular agency goals, such as intervening before violence is repeated. The use of these statistical techniques needs to remain grounded in the applied research that constitutes the field of violence against women. Being able, for example, to identify men known to be abusive who are likely to escalate their violence against an intimate partner is most useful if there are effective interventions that prevent repeat violence.

Expanding Our Knowledge on What Works to Prevent Violence Against Women

The field of preventing violence against women, especially intimate partner violence, now has a range of robustly tested, effective prevention programs. The next step is to take these programs to scale and to rigorously monitor and assess the attendant process to ensure program fidelity and to avoid backlash and potential harm (58). These actions are also necessary when adapting and expanding existing programs to meet the needs of new groups and groups that are at especially high risk of intimate partner violence (58). Doing so will help develop the knowledge base about which components of an intervention are essential and what steps are needed to transfer programs that were tested in one population or setting to another.

In addition to scaling up prevention efforts, the field will benefit from focusing more on response interventions in low- and middle-income countries. Services, regularly described as inadequate in high-income countries, are even more limited elsewhere. Successful models such as one-stop crisis centers, in which health care, counseling, police assistance, and legal aid are available at the same time and space (10, 90), can provide a template and may prove particularly useful to women who experience violence.

As a last point, the field will benefit from exploring additional strategies about how to engage men, ideally early in life when social norms and attitudes about gender and violence are formed. The majority of programs to prevent violence against women have focused on women; however,

some evidence indicates that other models can be effective, for example, working with couples and engaging men in their role as fathers (14, 40). In addition to prevention, after-the-fact interventions with men who have been violent merit effort; widely implemented batterers' intervention programs in the United States have limited positive impact. The field will benefit from grappling more with understanding how men can be engaged as allies.

CONCLUSION

In sum, the violence against women field, especially with regard to intimate partner violence, has generated substantial evidence on the scope of the problem and robust evidence about intervention programs, showing that violence against women is preventable for the general population of women and for those most at risk. Continued progress is needed to address remaining gaps to reach those at highest risk of violence and to ensure that programs are conducted at scale to eliminate violence against women. This is an urgent priority as each case of violence in a woman's life is a tragedy for herself and for those around her, affecting not only the woman and her health and well-being, but also her family and community. Violence against women is an issue for individuals, communities, and the global health community.

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