1.7. Consequences of gender-based violence

This sub-chapter provides information on the impact of GBV on women's health (1.7.1) as well as information on the life-cycle approach to gender-based violence (1.7.2) and on the impact on violence on children (1.7.3).

1.7.1 The impact of gender-based violence on women's health [1]

GBV seriously affects all aspects of women's health: physical, sexual and reproductive, mental and behavioural health. Health consequences of GBV can be both, immediate and acute as well as long lasting and chronic; indeed, negative health consequences may persist long after the violence has stopped. The more severe the level of violence, the greater the impact will be on women's health. Furthermore, exposure to more than one type of violence (e.g. physical and sexual) and/or multiple incidents of violence over time tends to lead to more severe health consequences (WHO 2002, Johnson/Leone 2005, both cited in WHO/PAHO 2012a).

GBV can result in women's deaths. Fatal outcomes may be the immediate result of a woman being killed by the perpetrator, or in the long-term, as a consequence of other adverse health outcomes. For example, mental health problems resulting from trauma can lead to suicidality, or to conditions such as alcohol abuse or cardiovascular diseases that can in turn result in death. HIV infection as a result of sexual violence can cause AIDS and ultimately lead to death (Heise et al 1999, WHO 2013).

The World Bank estimates that rape and domestic violence account for 5% of the healthy life years of life lost to women age 15 to 44 in developing countries. Every year lost due to premature death is counted as one disability-adjusted life year (DALY) and every year spent sick or incapacitated is counted as a fraction of DALY, depending on the severity of the disability. At the global level, the number of disability-adjusted life years (DALY) lost by women in this age group is estimated at 9.5 million years, comparable to other risk factors and diseases such as tuberculosis, HIV, cardiovascular diseases or cancer (World Bank 1993, cited in Heise et al 1994).

A recent study published by the WHO in 2013 systematically reviewed studies providing data on health effects of physical and sexual intimate partner violence and non-partner sexual violence against women. The review identified, among others, the following consequences of violence against women:

- Globally, 38% of all murders of women are reportedly committed by intimate partners.
- Out of all women who experienced physical and/or sexual violence by an intimate partner, 42% experienced injuries, as a result.
- Compared to women who have not experienced partner violence, women survivors of such violence face a 16% higher risk of having a low-birth weight baby, are more than twice as likely to have an induced abortion, and are more than twice as likely to experience depression.
- In some regions, women who experienced sexual intimate partner violence are 1.5 times more likely to acquire HIV and 1.6 times more likely to have syphilis, compared to women who have not experienced such violence.
- Women who have experienced non-partner sexual violence are 2.3 times more likely to have alcohol use disorders and 2.6 more likely to have depression or anxiety, compared to women who have not experienced such violence (WHO et al 2013).
While health consequences of GBV are similar across low-, middle- and high-income countries, the nature or severity of the effects of such violence may vary according to context-specific factors, such as poverty; gender inequality; cultural or religious practices; access to health, legal and other support services; conflict or natural disaster; HIV prevalence; and legal and policy environments (WHO PAHO 2012a).

Figure 3 summarizes the consequences of GBV on women’s physical, sexual and reproductive, mental and behavioural health.

**Figure 3: Health consequences of violence against women and girls [2]**

1.7.2 The life-cycle approach to gender-based violence [1]

Violence can occur during any phase of women and girl’s lives. Many women experience multiple episodes of violence that may start in the prenatal period and continue through childhood to adulthood and old age (see table 6).

A global synthesis of lifetime prevalence data on intimate partner violence reveals high prevalence rates among young women, indicating that violence starts early in women’s relationships. Among ever-partnered women aged 15-19 years, 29% have experienced physical and/or sexual violence by an intimate partner. Prevalence reaches its peak in the age group of 40-44 years (37.8%) and declines for women aged 50 years and older. However, this fact does not necessarily imply that older women experience lower levels of IPV. Rather, it is assumed that less is known about patterns of violence affecting women in this age group, especially in low- and middle income countries (WHO et al 2013).

Understanding GBV through a life-cycle approach can help health professionals to understand the cumulative impact of violence, especially in terms of its long-term effects on the lives and health of women and girls. Violence experienced in one phase can have long-term effects that predispose the survivor to severe secondary health risks, such as suicide, depression, and substance abuse (Heise et al 1994). Evidence suggests that the earlier in a woman’s life violence occurs, especially sexual violence, the deeper and more enduring its effects are (Burnam et al 1988, cited in Heise et al 1994).

**Table 6: The life-cycle approach to GBV [3]**
1.7.3 The impact of violence on children [1]

Like violence against women, violence against children is a global problem. It takes a variety of forms and happens in many settings: the home and family, in schools and educational settings, in institutions such as orphanages, children’s homes or detention facilities, places where children work, or in the community. Children experience violence most commonly from people who are parts of their lives—parents, school mates, teachers, employers, boyfriends/girlfriends, spouses or partners (UN Secretary General 2006a).

Much violence against children remains hidden. Many children are afraid to report incidents of violence they experience. This fear is closely related to the stigma attached to reporting violence, especially in cases of rape or other forms of sexual violence. Another factor is the social acceptance of physical, sexual or psychological violence by both, perpetrators and children as normal. Further, there is a lack of safe or trusted ways for children to report violence (UN Secretary General 2006a).

Violence against children in the family frequently takes place in the context of discipline, in the form of physical, cruel or humiliating punishment. It is often accompanied by psychological violence, such as insults, belittling, name calling or rejection (UN Secretary-General 2006b, Durrant 2005, both cited in UN Secretary-General 2006a). Furthermore, there is increasing acknowledgement of the occurrence of sexual violence in the home (Finkelhor 1994, WHO 2005a, both cited in UN Secretary-General 2006a).

Children are also directly or indirectly affected by intimate partner violence committed against their mothers, in the following ways (Walker/Edwall 1987, cited in Warshaw/Ganley 1996):

- intentionally injuring children in order to threaten or control the survivor (e.g. using a child as a physical weapon by throwing her/him against the woman) or physically or sexually abusing a child as a way to coerce the woman into doing something;
- unintentionally injuring the children during an attack on the survivor (e.g. injuring a child when the mother is pushed against the wall when holding the child or kicking a child who is trying to stop the attack against her/his mother);
- creating an environment where children witness the abuse or its effects, through directly watching the assault, overhearing it or seeing the aftermath of the injuries; and
- using the children to coercively control the survivor while the partners live together or after separation.

Violence against children in its different forms has a negative impact on children’s physical, psychological and sexual health. Further, witnessing intimate partner violence against their mothers? even when the child is not physically targeted?has shown negative social and health consequences for children, including anxiety, depression, poor school performance and negative health outcomes (WHO 2002, cited in WHO/PAHO 2012b). For example, prevalence research in Armenia shows that the rate of children who have frequent nightmares is nearly two times higher for children whose mothers experienced partner violence, compared to those children whose mothers did not. Similarly, the percentage of children who are aggressive and who wet their bed often is almost three and 1.5 times higher, respectively, among children who were exposed to intimate partner violence against their mothers compared to those who were not (UNFPA 2010). Furthermore, it is well-established that exposure to intimate partner violence against the mother increases the risk of boys perpetrating and girls experiencing intimate partner violence later in life (see chapter 1.3).
Box 5: Consequences of intimate partner violence on children? research from Serbia

In 2013, the Autonomous Women?s Center conducted a qualitative study among 170 women from 12 towns/municipalities in Serbia, to assess the impact of intimate partner violence on children (Ignjatovic 2013). The sample included women survivors of intimate partner violence who are mothers of at least one minor child and have addressed women?s organizations for support. The study revealed, among others:

- In more than two thirds of the cases, the children witnessed violence committed by their father against their mother; in almost half of the cases, children experienced violence themselves.
- In more than 40% of the cases, children tried to protect the mother from violence or prevent the father from acting violent, which put them at major risk of harm.
- Mothers report the existence of physical injuries to children, sleep disturbances and loss of appetite (in every fourth case, respectively), as well as night urination in every fifth case.
- The following changes in behaviour were reported: children being quiet and withdrawn (50%), restless, disobedient or irritable and prone to shouting (every third case), or showing physical and verbal aggression (every fourth child).
- Most commonly reported reactions of children to their violent fathers included fear, avoidance of any contact or unconditional obedience. It was observed that obedience decreased over time, as a result of age and increasing independence. In some cases, however, children insisted on contacts with the father, due to authentic emotions for him but also as a result of manipulative behaviours on the part of the perpetrator.

For a diagram showing pathways and health effects of intimate partner violence, see WHO 2013, figure 1.

This methodology estimates the healthy life years of life lost to men and women due to different causes (World Bank 1993, cited in Heise et al 1994).

Downloads:
- Figure 3 Health consequences of violence against women and girls [2]
- Table 6 The life-cycle approach to GBV [3]
- Programming for integration of GBV within Health System [5]


Links: