Health consequences

Violence has immediate effects on women's health, which in some cases, is fatal. Physical, mental and behavioural health (*1*) consequences can also persist long after the violence has stopped.

Violence against women and girls occurs in every country and culture, and is rooted in social and cultural attitudes and norms that privilege men over women and boys over girls. The abuse takes many forms, including:

- intimate partner violence (sometimes called domestic or family violence, or spousal abuse) which can be physical, sexual or emotional;
- dating violence;
- sexual violence (including rape) by strangers, acquaintances or partners;
- systematic rape during armed conflict;
- forced prostitution, trafficking or other forms of sexual exploitation;
- female genital mutilation (FGM) and other harmful traditional practices;
- dowry-related violence;
- forced marriage or cohabitation, including forced wife inheritance and 'wife kidnapping';
- femicide and the killing girls or women in the name of 'honour'; and
- female infanticide and deliberate neglect of girls.

While the prevalence and forms of violence against women in low- and middle-income countries may differ from those in higher-income countries, the health consequences seem to be similar across all settings (**Table 1**). However, the nature or severity of the effects of violence can be influenced by 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/AIDS prevalence; and legal and policy environments.

Effects on physical health

The health consequences of violence can be immediate and acute, long-lasting and chronic, and/or fatal. Research consistently finds that the more severe the abuse, the greater its impact on women's physical and mental health. In addition, the negative health consequences can persist long after abuse has stopped. The consequences of violence tend to be more severe when women

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TABLE 1

Common health consequences of violence against women (*2–5*)

Physical	Sexual and reproductive
• acute or immediate physical injuries, such as bruises, abrasions, lacerations, punctures, burns and bites, as well as fractures and broken bones or teeth • more serious injuries, which can lead to disabilities, including injuries to the head, eyes, ears, chest and abdomen • gastrointestinal conditions, long-term health problems and poor health status, including chronic pain syndromes • death, including femicide and AIDS-related death	• unintended/unwanted pregnancy • abortion/unsafe abortion • sexually transmitted infections, including HIV • pregnancy complications/miscarriage • vaginal bleeding or infections • chronic pelvic infection • urinary tract infections • fistula (a tear between the vagina and bladder, rectum, or both) • painful sexual intercourse • sexual dysfunction
Mental	**Behavioural**
• depression • sleeping and eating disorders • stress and anxiety disorders (e.g. post-traumatic stress disorder) • self-harm and suicide attempts • poor self-esteem	• harmful alcohol and substance use • multiple sexual partners • choosing abusive partners later in life • lower rates of contraceptive and condom use

experience more than one type of violence (e.g. physical and sexual) and/or multiple incidents over time (*6,7*).

Acute or immediate physical injury

Women are far more likely than men to experience physical injury as a result of physical violence by intimate partners (*6*). In the *WHO multi-country study on women's health and domestic violence*, between 19% (Ethiopia) and 55% (Peru) of women who had ever experienced physical violence by their intimate partner reported being injured as a result (*4*).

Chronic health problems

In most settings, women who have experienced physical or sexual violence by a partner at any time after age 15 are significantly more likely than other women to report overall poor health, chronic pain, memory loss, and problems walking and carrying out daily activities (*4*). Studies have also found that women with a history of abuse are more likely than other women to report a range of chronic health problems such as headaches, chronic pelvic pain, back pain, abdominal pain, irritable bowel syndrome, and gastrointestinal disorders (*2,3*).

Femicide[1]

Globally, women are most likely to be killed by someone close to them – male intimate partners commit 30–70% of all murders of women in settings as diverse as Israel, South Africa and the USA (*7*). In certain parts of the Middle East and south Asia, women are sometimes killed by close family members in the name of 'honour', for perceived sexual transgressions (*8*), while in settings

[1] For more information see the information sheet *Femicide* in this series.

such as the Indian subcontinent, newly married women are sometimes killed by members of their husband's family because of conflicts related to dowry (9).

However, just like men, women are also murdered by criminal elements in the community. Such killings can be random, but there are disturbing examples of systematic murders of women, particularly in Latin America.

Female genital mutilation[1]

FGM has serious health implications and no health benefits. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. All forms of FGM can cause immediate bleeding and pain and are associated with risk of infection. The presence of FGM increases the risks of obstetric complications and perinatal death (10). The more severe forms of FGM cause the greatest harm. Sexual problems are also more common among women who have undergone FGM – they are 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction, and are twice as likely to report a lack of sexual desire (11).

Effects on sexual and reproductive health

Gynaecological disorders and trauma

Women who experience sexual violence experience higher rates of gynaecological problems than other women, including vaginal infection, pain during intercourse, chronic pelvic pain and urinary tract infections (3,5). For example, population-based research from the USA found that women who experienced intimate partner violence had three times the risk of gynaecological problems compared to non-abused women (12). Even without sexual abuse, however, women who experience partner violence appear to have increased risk of gynaecological problems, though the reasons for this are not well understood (2).

Sexual violence sometimes produces gynaecological trauma, most notably in cases of rape with objects, or when a girl is forced to have sexual intercourse and give birth before her pelvis is fully formed (13,14). Gynaecological trauma may include tearing of the vagina; fistula (a tear between the vagina and bladder or rectum, or both); haemorrhaging, infection or ulceration; and other genital injury or complications during childbirth.

Unintended and unwanted pregnancy

Women who experience physical intimate partner violence or forced sexual intercourse by any perpetrator appear to be at greater risk of unintended or unwanted pregnancy than women with no history of abuse, both in the short term and over the course of their reproductive lives (1). Studies have documented pregnancy rates after non-partner rape ranging from 5% among women in the USA (15) to 17% among adolescents in Ethiopia and 15–18% among girls and women seeking help at rape crisis centres in Mexico, Thailand and the Republic of Korea (16). The risk of unwanted pregnancy may occur, directly through forced sexual intercourse or difficulty in negotiating condom or contraceptive use in an abusive relationship, or indirectly via high-risk sexual behaviours linked to a history of sexual abuse in childhood or adolescence (5).

[1] For more information see the information sheet *Female genital mutilation* in this series.

Abortion/unsafe abortion

Girls and women who become pregnant as a result of forced sexual intercourse often terminate their pregnancy, whether or not safe abortion is available. Intimate partner violence, rape by non-partners and transactional sex are all associated with higher rates of termination of pregnancy. For example, the *WHO multi-country study* found that, in nearly all settings, women who had experienced physical or sexual violence by an intimate partner also reported significantly higher rates of induced abortion than other women (4).

For example, in southern Nigeria, where abortion is often unsafe, young women who had experienced transactional or forced sexual intercourse were significantly more likely than other women to report ever having an abortion (17). In a 1996 study from the USA, 32.2% of pregnant rape survivors kept the infant; 50% underwent induced abortion; and smaller proportions gave the infant up for adoption or had a miscarriage (5.9% and 11.8%, respectively) (15).

HIV and other sexually transmitted infections

Studies from many high- and low-income settings have found that women who are HIV positive are more likely than other women to have experienced physical and sexual violence (18). In research from India and South Africa, for example, intimate partner violence was found to be strongly associated with a woman's risk of contracting HIV (19,20). Violence may increase women's vulnerability to HIV and other sexually transmitted infections, through direct and indirect pathways – for example:

- intimate partner violence makes it difficult for women to refuse sexual intercourse or negotiate condom use (18);
- forced sexual intercourse may tear the vagina, increasing the risk of HIV transmission (18);
- childhood sexual abuse may increase rates of high-risk sexual behaviours later in life, including less condom use, multiple partners, and experiencing subsequent violence (21); and
- fear of violence may prevent women from seeking HIV testing, counselling or services, including services for preventing the transmission of HIV to infants (18).

It is important to note that violence against women is not only a possible risk factor for HIV, but, can occur as a consequence of disclosure of HIV-positive status (18).

Maternal mortality and other pregnancy-related consequences

Evidence links physical and sexual violence during pregnancy to many complications, including: low maternal weight gain, miscarriage and stillbirth (3,21,22), and low-birth-weight babies. For example, a study in Nicaragua found that nearly one quarter of mothers of low-birth-weight infants had experienced physical intimate partner violence during pregnancy, compared with 5% of mothers who had not (23).

Another often overlooked consequence of violence against women during pregnancy is maternal death. In settings as diverse as Bangladesh (24), India (25) and the USA (26), intimate partner violence accounts for a substantial proportion of deaths among pregnant women. For example, a study in

400 villages in rural India found that 16% of deaths among women during pregnancy resulted from partner violence (25); and femicide was the leading cause of pregnancy-associated death in the USA state of Maryland between 1993 and 1998 (27). In the UK, more than 14% of maternal deaths occur in women who have told their health professional they are in an abusive relationship (28).

Effects on mental and behavioural health

Both physical and sexual violence have been linked to a greater risk of adverse mental health outcomes among women (3). The most prevalent include depression (14), suicide attempts, post-traumatic stress disorder, other stress and anxiety disorders, sleeping or eating disorders and psychosomatic disorders (5,6). Physical and sexual abuse in childhood have also been associated with a host of subsequent risk behaviours, including early sexual activity; alcohol, tobacco and drug abuse; multiple sexual partners; choosing abusive partners later in life; and lower rates of contraceptive and condom use (21,29). Women who report a history of early sexual abuse often report feelings of worthlessness and difficulty distinguishing sexual from affectionate behaviour, maintaining appropriate personal boundaries, and refusing unwanted sexual advances. Studies have consistently linked a history of child sexual abuse with a higher risk of experiencing sexual violence later in life (21,29).

Increased use and cost of health services

Women who experience intimate partner violence have more health needs and seek health services more frequently than the general population, and their use of these services rises as the frequency and severity of violence increases (30). A large US study found that the use of health services was highest among women in ongoing abusive relationships (31).

By contrast, women who experience intimate partner violence are less likely to seek preventive care, such as mammograms, cholesterol and blood pressure checks and cancer screening. This has clear implications for the overall health of women who experience violence, and also for health-care costs, since prevention is usually more cost effective than treatment (30). In a study of more than 3000 women in the USA, annual health-care costs were 42% higher among those currently experiencing physical intimate partner violence, and 19–24% higher among those who had experienced it within the past five years (31).

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The full series of "Understanding and Addressing Violence Against Women" information sheets can be downloaded from the WHO Department of Reproductive Health web site: http://www.who.int/reproductivehealth/publications/violence/en/index.html, and from the Pan American Health Organization web site: www.paho.org

Further information is available through WHO publications, including:

Summary of the expert meeting on health-sector responses to violence against women
http://whqlibdoc.who.int/publications/2010/9789241500630_eng.pdf

WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses
http://www.who.int/gender/violence/who_multicountry_study/en/

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