Understanding GBV across the Life Course: Trauma and Gender Violence among Older Women

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The purpose of this brief is to connect the life course approach to violence to a focus on older women's experiences with trauma and gender violence. It includes lifetime histories of IPV and its impact in older age, including changing abuser tactics; and, added risks for violence against older women from diverse perpetrators, including through harmful practices. Some preliminary recommendations for UNDP to consider including older survivors in future work on GBV through the life course perspective are offered.

The Sustainable development (SDGs), establish a new mandate for multilateral cooperation with the guiding principles of non-discrimination, human rights and to leave no one behind. Recognizing that the most vulnerable populations are often the least visible, the Post-2015 agenda commits all UN agencies to ensure their work is inclusive of marginalized groups and these populations are reflected in the data measuring progress on the SDG targets. The SDGs contain a specific target on violence against women and girls under Goal 5, as well as number targets related to the enabling environment for GBV reduction spread across other targets. These two aspects of the SDGs – a target on violence and leaving no on behind – offer an opportunity to focus on an often invisible group in the GBV discourse – women over 50 years of age.

Moving beyond the age limited sampling of the Demographic and Household Survey (DHS) and similar models[1], Goal 5 indicators on violence against women and girls are on track to measure prevalence of intimate partner violence (IPV) and non-partner sexual violence among those age 15 and older[2,3] thus continuing to measure experiences of violence for women beyond the age of 49. Similarly, Goal 16's target on reducing all forms of violence uses an indicator that measures the proportion of populations subjected to physical, psychological, or sexual violence in the previous year, regardless of age[4].

By setting indicators on violence that collect data on women and girls without an age cut-off, the SDGs complement the "life course" approach promoted by the World Health Organization (WHO)[5] and many others in the violence prevention field. The life course approach recognizes that all forms of GBV are rooted in gender inequality and power relationships. These relationships change over a life time, as do the specific risk and protective factors for both victimisation and perpetration of GBV. The life course approach also helps map out how experiences of violence are interconnected across the life course. For example, it is well documented that childhood experiences of trauma, increase the probability of men's perpetration and women's victimisation later in life. Early experiences of trauma, if untreated, can set both women and men on pathways that lead to delinquency, ill health, criminal behaviour and exposure to and use of violence. Preventing GBV through the life

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[1] Demographic Household Surveys (DHS) collect data among women and girls of reproductive age only, from age 15-49.

[2] Goal 5 is, "Achieve gender equality and empower all women and girls."

[3] SDG indicators as of writing (February 2016), will be finalized in March 2016 at the 47th Session of the UN Statistical Council.

[4] Goal 16 is, "Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels" with Target 16.1, "Significantly reduce all forms of violence and related death rates everywhere."

[5] Following the 2014 World Health Assembly Resolution on "strengthening the role of the health system in addressing violence against women and children," WHO and its regional commissions are finalizing a Global Strategy and Plan of Action to implement the resolution using the life course framework.

course framework reinforces what is already known to be best practices within the field, but insists on implementing effective interventions for survivors at every age and stage of development, building on the factors most associated with violence for different life stages.

A key population impacted by violence, yet often left behind in policy, programmes, and research on GBV is older women, age 50 and above. Nearly one-quarter (23.6%) of the female population worldwide is age 50 or older, yet most attention to the issue of GBV centres on women and girls of reproductive age, from 15 to 49 years. Due to limitations of sampling, very little prevalence data exist for women over 50, especially IPV experienced in the last 12 months. Violence against older persons in general has been addressed through the frame of elder abuse. Defined by WHO as harm to an older person age 60+ through any single or repeated act—physical, psychological, sexual, emotional, or financial—including neglect and abandonment. This definition of abuse lacks a specific gender lens, and is more general than IVP or non-partner violence experienced by women over 50. Nonetheless, research has established that older women experience violence at significantly higher rates than their male counterparts, even when controlling for their greater longevity compared to older men.

GBV across the Life Course: Effects of Prior Trauma and Risks for Ageing Women

It is widely accepted that risk of violence and abuse has an inverse relationship with age, stemming from the relatively limited availability of globally comparable data sets on GBV, such as WHO's 2013 study on global and regional estimates of violence against women, which examined the lifetime prevalence of IPV and non-partner sexual violence among women and girls age 15 to 69. Globally, the study shows that IPV rates peak at ages 40-44 (at 37.8%) and begin to taper off at ages 45 and older (from 29.2% for ages 45-49, to 22.2% among women ages 65-69). It is important to note, however, as WHO underscores in its data reporting, that only studies with primary data from population surveys (such as DHS) were examined, and therefore data on women aged over 49 years were "scarce and tended to be from high-income countries"[6]. For this reason, WHO cautions, "…it should not be interpreted that older women have experienced lower levels of partner violence, but rather that less is known about patterns of violence among women aged 50 years and older, especially in low- and middle-income countries."

Though less visible than the experiences of younger women, evidence of GBV among older women and its attendant trauma suggests there is a narrower gulf between ageing and younger survivors. Although older women report lower rates of physical and sexual forms of IPV than women below age 50, research from the United States and Europe suggests that the prevalence of non-physical IPV (including verbal, emotional, psychological abuse and coercive, controlling behavior) does not abate as women age (Dunlop et al., 2005; Mezey, Post, & Maxwell, 2002; Mouton, 2003; Stöckl & Penhale, 2015; Luoma et al., 2011). In fact, several studies have demonstrated that women who remain in abusive partnerships over their life course into older age are at greater risk for non-physical IPV than younger women, due to the changing tactics of ageing abusers, who reduce the frequency of physical violence and instead control their partners through economic coercion, psychological abuse, and verbal threats that take a mental and physiological toll on older women's health[7] (Mezey et al., 2002; Rennison & Rand, 2003; Stöckl & Penhale, 2015). The notion that women remain at a fairly constant risk for IPV across their life course, though forms of violence may differ in frequency with age, reinforces research that suggests older women survivors of lifetime trauma from non-partner sexual violence and earlier episodes of IPV are at higher risk of victimization from a partner or non-partner abuser in later life (e.g. Acierno et al., 2010).

[66] The study data comprised less than 6% representation of older women (50 years+); of the data on older women included, less than 1% were derived from low- and middle-income countries.

[7] Verbal and emotional abuse is associated with bone and joint problems, digestive issues, depression and anxiety, chronic pain, high blood pressure, and heart problems among older women (Fisher & Regan, 2006).

Like women and girls in earlier stages of life, older women are not only at risk for IPV, but also non-partner sexual violence and physical abuse, including harmful practices, such as the maltreatment of widows. As women enter older age, they can become vulnerable to acts of violence from a wider range of possible perpetrators, including: current and former intimate partners or spouses; family members (including adult children or grandchildren); neighbors, acquaintances or other members of the community; and caregivers (which can be a spouse or other family member in the home, or a stranger in an institutional setting). Because GBV is rooted in the unequal status of women, the unique risks for GBV among older women stem from the decreased legal, social, and health status of women as they age. In other words, perpetrators exploit the vulnerabilities associated with a victim's older age as well as gender. As a result, the level of risk for older women varies according to individual, social, and regional contexts.

Common ***risk factors for GBV for women over 50 at the individual level*** include: 1) dependence on a caregiver (as a result of lifelong disability or age-related health decline, including dementia[8]); 2) social isolation (either that an older woman lives alone and is therefore more vulnerable to stranger or community violence[9], or that contact with outside family and friends is restricted by a controlling partner or family member upon which she is economically or physically dependent for care); and, as previously discussed, 3) experiencing violence earlier in the life course.

Community-level risk factors for women over 50 include: 1) customary social norms regarding marital status (for example, in areas where a woman's social value is dependent on her being married, widows and single, never-married women are at higher risk for non-partner physical and sexual violence, and rejection from the community as result of lost social status following a husband's death is considered a form of emotional and psychological violence); 2) degree of social cohesion and intergenerational solidarity (which can be a protective factor when family ties are strong and mutual respect for all members of household are demonstrated through practicing non-violence; however, in situations of conflict or displacement, fragile economic security, or forced migration, older women may be at risk of non-partner physical and sexual violence[10], or abandonment—particularly those dependent on the care of others and seen as a burden to families in crisis); and, 3) intersectionalities of older women's identities and their addition of social stigma, depending on cultural context (as is the case with survivors of all ages, older women who belong to a particular ethnic or religious group, are of an indigenous population, are a sexual or gender minority, have a disability, or are HIV-positive, may be doubly vulnerable to violence at the community level where the intersection of age compounds socioeconomic disadvantages based on cultural acceptance or rejection of certain groups).

Finally, ***structural risk factors*** that bear influence on how and whether older women experience GBV include: 1) presence or absence of legal systems of equal inheritance and land rights, including their enforcement (where laws guaranteeing a widow's inheritance of her husband's assets or the right of women to hold property in their own names are nonexistent or loosely enforced, older women can be accused of witchcraft, intimidated with

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[8] Global data demonstrate that rates of abuse for people with dementia by their caregivers are high, ranging from prevalence of 34 to 62% (see Cooney & Lawlor, 2006; Cooper et al., 2009; Yan & Kwok, 2010; Wiglesworth, Mosqueda, and Mulnard, 2010).

[9] Living alone, particularly when coupled with poor health or mobility challenges, increases the risk of isolation and creates barriers for older women to access social services to protect them from or respond to violence. Worldwide, almost half of older women live alone, due to being widowed, divorced, or never married (UN Department for Economic and Social Affairs, 2012).

[10] For example, 15.5% of women seeking post-rape care from a hospital in the conflict-affected areas of the Democratic Republic of Congo between 2000-2010 were age 55 and older (Harvard Humanitarian Initiative, 2010); reporting from Northern Iraq featuring survivors of sexual violence highlight how Yazidi women ages 40-80 deemed too older for enslavement by their captors were murdered in a mass grave by the Islamic State of Iraq and the Levant (ISIL) (Al Jazeera & the Associated Foreign Press, November 2015).

threats of violence or publicly beaten and murdered, in order to drive them away from their land[11]); 2) systemic poverty (for women in low, middle and high-income countries alike, poverty in older age can augment risk of violence by limiting their ability to leave abusive partners or situations or access legal or other remedies for support as a survivor of violence; this financial insecurity is often driven by the state, either directly through the apparatus of laws that discriminate against older workers and prevent women from paid employment past a certain age, or indirectly through the lack of a guaranteed state pension that would otherwise provide an independent source of economic stability); finally, 3) lack of awareness and visibility at the policy level on GBV across the life course, elder abuse and GBV experienced by women over 50 resulting in little to no criminal penalties for perpetrators, nor resources for survivors (very few countries that have national action plans on GBV/violence against women include older women as an impacted population; fewer countries, still, have enacted national policies or legislation criminalizing elder abuse[12], which, despite the lack of particular attention to older women, at least raises awareness among service providers and law enforcement that older persons are also subject to violence and therefore require intervention).

Conclusions

Despite historic inattention to survivors in the latter stage of the life course, the political climate for including older women as a core population in prevention and response to GBV is now ripe with opportunity. Through its operationalization of the mandate to "leave no one behind" by expanding data collection for women past reproductive age in the SDG indicators, the Post-2015 agenda is set to reinforce the life course approach to interpersonal violence advanced by WHO. Given the rapid rate at which the world is ageing, moreover, it is time for older survivors to be counted[13]. As UNDP develops an enhanced approach and accompanying programmatic guide to GBV, it can consider the following strategies for the inclusion of older women:

1) Support increased visibility of older survivors of GBV by institutionalizing data collection at the country level that aligns with the SDG indicators' recommendation to measure prevalence of IPV and non-partner sexual violence among women age 15 and older—rather than relying on preexisting country models based on the DHS;

2) Mainstream a life course approach to violence throughout its policies, programming, and research studies on GBV, encouraging projects that recognize the linkages between early childhood exposure to trauma, victimization and perpetration in adolescence and adulthood, and the perpetuation of violence in older age, and design interventions accordingly;

3) Finally, as a general principle, mainstream the SDG concept of "leaving no one behind" in the discourse used to describe, illustrate, and market UNDP's work on GBV, at all levels. At a granular level, this means including images of older women alongside those depicting younger women and girls in outreach materials for survivor services; at the highest level, it is the transformation of UNDP's default terminology associated with GBV so that women and girls "of all ages" or violence "across the life course" is normalized.

Gender-based violence is rooted in unequal roles prescribed to women and men, upheld by social norms that tolerate the disparate treatment of women and girls at every level of society, and at every age. A comprehensive response to this violence, therefore, must meet survivors where they are in their stage of life.

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[11] The harmful practice of accusing older women (typically widows) of witchcraft is often a tactic to remove them from their land holdings, and is also exercised by communities as an explanation for sudden deaths from HIV/AIDS. The practice has been recorded in regions of Africa, South Asia and the Pacific (UNFPA & HelpAge International, 2012; ActionAid UK, 2012; UN OHCHR, 2009).

[12] Globally, 59% of countries have national legislation criminalizing elder abuse, mostly those from high-income settings. This compares with 98% of countries with national legislation against rape, and 87% of countries with national legislation against IPV (WHO Global Status Report on Violence Prevention, 2014).

[13] By 2030, the world population of older adults (age 60+) will rise to 1.4 billion, and reach 2 billion in 2050. Predominantly living in low and middle-income countries, the majority of the older population will be (as it is today) female (UNFPA, 2012).