Exploring the health care needs of women who experience violence in Uttar Pradesh, India

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A dissertation submitted to the University of Liverpool, Liverpool School of Tropical Medicine, International Health Research Group in Partial fulfillment of the requirements for the award of the Master in International Public Health (MIPH) Degree, 2009

EXECUTIVE SUMMARY:

Introduction:

Violence against women (VAW) is one of the most widespread human rights abuses and public health problems in the world today, affecting as many as one out of three women (PAHO & WHO, 2003). It is recently considered as a serious problem in India, affecting approximately 40% of women from the age group of 15-49 (National Family Survey 2005/06). The problem arises from the gender norms and socio-cultural construction of the Indian society where men are raised up to play masculine and dominant roles, ordering and controlling and women are raised to play submissive, weak and dependant roles. Violence is known to have a negative influence on the health of women and therefore health care providers (HCP) are held responsible for fulfilling the health care needs of those women. This study is focused mainly on understanding what it is like to be a woman who experienced violence and how that impacts on her health.

Aim:

To use exploratory qualitative research to identify strategies for health care providers to better meet the health needs of women experiencing violence in India.

Objectives:

(1) To identify the health care needs of women who experience violence in Uttar Pradesh, India.

- To identify the health care problems women face as a result of violence.

-To understand the health seeking behaviour of women experiencing violence.

(2) To draw some policy recommendations aimed at better meeting the health needs of WEV

Methods:

The research followed a Qualitative Research Methodology which due to its flexible nature allowed us to explore the sensitive and complex issue of violence. In-depth interviews with built in Critical Incident Narratives were conducted with 25 women who experienced violence by

means of a formulated topic guide which was refined along the process of data collection according to the emergent themes.

The majority were married middle aged women (20-46 yrs) residing in Uttar Pradesh state and were all recruited through HUMSAFAR Organization. Participant women had previously presented to HUMSAFAR organization to seek help with issues relating to VAW. Interviews were recorded then transcribed and thematic framework analysis method was used to analyze the data.

Main Findings:

Each and every woman interviewed suffered multiple HP as a result of the violence. HP included a range of mental and physical HP. At least one other family member's health was affected and commonly it was the children in the household. This led many women to use pain killers regularly and for prolonged periods often without consultation.

Women faced many barriers of access to health care starting from controlling behaviours of perpetrators locking them in the household, mocking them and not taking their HP as a priority. Decisions around how money was spent were mainly taken by perpetrators and/or in-laws. Alcohol abuse by perpetrators significantly contributed to women's HP.

Women's opinions on the attitudes of HCP varied, some were pleased with the way they were treated and others were disappointed. Successful HCP were mainly those who opened the discussion about violence, listened carefully, respected them, issued medical reports when needed, and maintained their confidentiality. Mocking, not caring for their privacy, reluctance when issuing a medical report were negative experiences with HCPs women revealed.

Most of the women preferred being seen by a female doctor, however some said that either female or male is fine as long as they are able to demonstrate care and all of the survivors welcomed the idea of having a health care visitor.

Implications for policy and research:

Special training and education should be provided to HCP around how to address the issue of VAW in the clinical setting with emphasis on the importance of opening up the discussion about violence, listening carefully, issuing medical reports, and respecting survivors.

Possibly providing health care visitors and/or placing one female doctor within health facilities who will attend to WEV.

A holistic and more comprehensive response is needed that goes beyond the responsibility of the HS to involve agencies providing shelter, education, crisis support and money for violence survivors ultimately leading to the optimum level of health and social wellbeing of violence survivors.

A key research complementing our research findings will be one that involves HCP participants, their views, opinions and possible difficulties they may be facing when addressing violence.

Further research is needed on how to find ways to protect women from perpetrators abusing alcohol and involve men and on how to identify possible strategies for addressing violence in resource poor settings.

WORD COUNT

Executive summary: 737

Total word count: 16,712

DEDICATION:

To all the battered women who suffer in silence....

To those of you who gave me the opportunity to listen....I felt your suffering but most important ...you survived

To my Parents, without you I wouldn't have made it through, thank you for your endless

support and guidance...

ACKNOWLEDGMENTS:

Many thanks to all those who made this project happen, special thanks to the client, Dr Abhijit Das and Mrs Archana for the guidance and support during my field work.

Many thanks to my translator, Mansi who was like a friend to me and shared the emotional trauma of hearing those heartbreaking stories during interviews day after day....your effort is appreciated.

Special thanks to all the case workers at HUMSAFAR organization, you have been like sisters to me and be sure that I never will forget the experience as well as your support.

Special thanks to Pamela Fergusson, my personal tutor for your patience and guidance.

Thank you to all staff members of the International Health group at the Liverpool School of Tropical Medicine for bringing us this far and challenging us to achieve this MIPH.

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LIST OF ABBREVIATIONS AND ACRONYMS:

WEV: Women experiencing violence

HCP: Health care providers

HP: Health problems

HS: Health sector

PV: Physical Violence

SV: Sexual Violence

UP: Uttar Pradesh

MoH: Ministry of Health

CHAPTER 1: INTRODUCTION

Definition of VAW:

In 1993, The United Nations Declaration on the Elimination of VAW provided a definition of Gender Based Violence calling it "any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or arbitrary deprivation of liberty, whether occurring in public or in private life." (UN, 1993)

This definition places VAW within the context of gender inequity as acts that women suffer because of their subordinate social status with regard to men (PAHO&WHO, 2003).

Types of Violence:

According to the WHO and for purposes of research the following definitions were given for the different types of VAW:

"Physical violence means a woman has been: slapped, or had something thrown at her; pushed, shoved, or had her hair pulled; hit with a fist or something else that could hurt; choked or burnt; threatened with or had a weapon used against her.

Sexual violence means a woman has been: physically forced to have sexual intercourse; had sexual intercourse because she was afraid of what her partner might do; or forced to do something sexual she found degrading or humiliating.

Though recognized as a serious and pervasive problem, ***emotional violence*** does not yet have a widely accepted definition, but includes, for example, being humiliated or belittled; being scared or intimidated purposefully.

Intimate-partner violence (also called "domestic" violence) means a woman has encountered any of the above types of violence, at the hands of an intimate partner or x-partner; this is one of the most common and universal forms of violence experienced by women."

(WHO, 2005)

"Financial violence, which means depriving her of financial means and bare necessities of daily life, it also includes taking away the assets, which a woman possesses or earns" (Sharma, 2005).

Our study will use the term "VAW", which will refer not only to husbands as perpetrators, but also extends to include other perpetrators within the home. This is for the reason that in the Indian context, the in-laws and extended family play a major role and are very much involved in the cycle of abuse.

VAW in Uttar Pradesh State:

The research was conducted in the north Indian state of Uttar Pradesh (UP) which despite having a population of over 175 million is one of the most backward places in the Indian subcontinent. It has a deeply entrenched caste system and is also amongst the poorest states in the country; the widespread poverty also leads to seasonal and annual migration within and outside the state as unorganized sector workers, with practically no state support and attendant vulnerabilities. (Das & Singh, 2009)

The status of women in UP is apparent from the fact that women's literacy gap between men and women is 27%, and the Gender Disparity Index at 0.520, both being the second lowest in the country. Maternal Mortality is the highest in UP and women bear a disproportionate burden of responsibility for Contraception. According to the national rime records Bureau figures for 2005 issued by the MOHA, UP ranked second in the recorded crimes against women.

A survey report by Martin in (1999) found that 46% of all men surveyed in the state admitted to physically abusing their wives, an earlier study by Naryana (1996) found that men consider wife battering as their natural right.

About the Client & HUMSAFAR Organization:

The research was conducted on behalf of Dr Abhijit Das from the Centre of Health and Social Justice; who is one of the founders of HUMSAFAR organization- the direct supporting organization for the study.

HUMSAFAR, a Support Centre for Women in Crisis was started on 25th November 2003, by a group of committed individuals to address the needs of women affected by violence in the state. The initial aim was to provide various forms of support to women survivors of violence, including paralegal, legal, medical, social mediation, rescue, shelter, and rehabilitation. As of 14 January 2008, HUMSAFAR has provided various forms of support to 353 women survivors.

HUMSAFAR works in close collaboration with other groups in different districts of UP state in India and in other states of the country to facilitate referral and casework for women facing crises, due to the violence in their lives. These networks also provide platforms and partnerships for capacity building and advocacy for issues of violence concerning women on a wider platform.

The client was interested in the study in order to understand whether health care providers and the public health system was adequately prepared to address the health needs emerging from widespread domestic violence and other forms of violence. In addition, the client felt that, although there is an acknowledged role of the health care sector in providing services when women face violence, there still has been little or no discussion of involving/integrating the health system in these efforts.

The study focused on the opinions, perceptions and experiences of women who experience violence. We aimed at understanding the effect of violence on the health of women and also on understanding their health seeking behaviour, the data was then utilized on how to find strategies that better respond to the emergent health care needs. Listed below are the aim and objectives of our study.

Aim:

To use exploratory qualitative research to identify strategies for health care providers to better meet the health care needs of women experiencing violence in India.

Objectives:

(1) To identify the health care needs of women who experience violence in Uttar Pradesh, India.

- To identify the health care problems women face as a result of violence.

-To understand the health seeking behaviour of women experiencing violence.

(2) To draw some policy recommendations aimed at better meeting the health needs of women experiencing violence in Uttar Pradesh.

CHAPTER 2: LITERATURE REVIEW

Prevalence of VAW:

In no country in the world are women safe from violence. VAW is exceedingly widespread and crosscuts between different cultures, societies and religions across the universe. ICRW in (2005) adds that it is found in epidemic proportions in various countries around the world.

One of every three women has, at some point in her life been the victim of sexual, physical or psychological violence perpetrated by men. Between 10% and 69% of women report having been assaulted by an intimate partner at some time in their lives (Heise, Ellsberg & Gottemoeller. 1999), and between 10% and 30% that they had experienced SP by an intimate partner according to surveys conducted in various countries (WHO, 2005).

Amnesty International in 2004 noted that VAW has long been shrouded in a culture of silence. Adding on, that, reliable statistics are hard to come by, as violence is underreported because of shame, stigma and fear of retribution.

United Nations in (1995) recognized that the lack of data and statistics on the incidence of VAW makes the elaboration of programs and monitoring of changes difficult.

Recognizing Violence:

Realizing the extent of the problem of VAW worldwide, establishing the need to address it and laying out efforts in order to combat it has only been adopted relatively recently. The United Nations Declaration on the Elimination of VAW laid a platform for working towards addressing the issue (UN, 1993). It was then that the previously mentioned definition was agreed upon. Governments were encouraged to support battered women and decided, that there is a need, to provide certain support services for women experiencing various types of violence.

VAW in India:

Widespread domestic VAW is considered as a serious problem in India. The recent National Family Survey conducted in the year 2005/2006 revealed that approximately 40% of women in India from the age group 15-49 suffered some form of violence. A law protecting women from several forms of violence was passed by the government in 2005 to address the problem. The law is known as the Protection of Women from Domestic Violence Act 2005 which took effect in 2006. Key elements of the law include the prohibition of marital rape and the provision of protection and maintenance orders against husbands and partners who are emotionally, physically, or economically abusive (The National Family Health Survey 2005-2006)

Men in India perceive that violence or force should be used in the family in order to conserve order or discipline. It is justified if a man uses violence against his wife, kids or even an intimate partner since he should be the one in control. Christopher et al. in (1997) found that the majority of men (two-thirds) felt that wives should follow the instructions of their husband, and one in four felt that the physical beating of a wife is justified if she disobeyed her husband.

The problem arises from the gender norms and socio-cultural construction of the Indian society. In General men are raised up to play masculine and dominant roles, ordering and controlling while women are raised to play submissive, weak and dependant roles. Women are given no authority or control. They are perceived as men's property, needing to be protected by them, and, in turn, serving, respecting and reliant on them for economic support.

Saravanan (2000) believed that a female child grows up with a constant sense of being weak and in need of protection, whether physical social or economic. Believing that, this helplessness has led to exploiting her at almost every stage of life. Cultural biases and the strong patriarchal social order, with its misplaced notions of masculinity and manhood, find reflections in domestic violence and controlling behaviours against wives (Majumdar, 2003).

WEV do not seek help and remain silent for reasons such as their concern about honouring their families. Jeyaseelan et al (2007) adds on that the sense of shame and embarrassment,

coupled with the need to keep it hidden so as to protect family honour, keeps many women silent. This adds upon the complexity of the matter and contributes further to the underreporting of VAW in India.

Socio-cultural factors contributing to VAW in India:

According to UNIFEM, (2002) more than 12 women die every day as a result of dowry disputes, mostly in kitchen fires designed to look like accidents. Stove-burning- a phenomenon that is common in India – could in some cases be linked to dowry demands. A study conducted in Chandigarh (India) by Sharma et al in (2002) found that married women comprised 78% of total female burn fatalities. 55% of these fatalities were aged 21-30 years. Ganatra et al. (1996) reported that 16% of maternal deaths in Maharashtra (India) during 1993 – 1995 were caused by VAW. Son preference in India is a well-documented phenomenon, and its implications for skewed sex ratios, female feticide and higher child mortality rates for girls have drawn research and policy attention. Less well researched are the underlying determinants of son preference as an ideology and its implications for living girls (ICRW, 2006).

VAW as a public health problem:

A highly important achievement of the last decade is the recognition of VAW as a major public health problem (PAHO&WHO, 2003). The combined efforts of grass-roots and international women's organizations, international experts, and committed governments have resulted in a profound transformation in public awareness regarding this issue.

Recognition of violence as a health and rights issue was underscored and strengthened by agreements and declarations at key international conferences during the 1990s, including the World Conference on Human Rights (Vienna, 1993), the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995).

Policymakers and health providers are now aware of the negative health outcomes of VAW (PAHO& WHO, 2003). Women who have been abused are more likely to suffer from HP than those who were not abused. Worldwide, it has been estimated that VAW is as serious a

cause of death and incapacity among women of reproductive age as cancer, and a greater cause of ill-health than traffic accidents and malaria combined (World Bank, 1993).The consequences of VAW are often devastating and long-term, affecting women's and girls' physical health and mental well-being. Its effects also compromise the social development of children in the household, the family as a unit, communities they live within and the society as a whole (PAHO& WHO, 2003).

Women who reported poor health or had a positive screening test on the Self-Reporting Questionnaire (a questionnaire used for assessing mental health status) were more likely to report both physical and psychological violence (being hit, kicked , beaten, demeaned, threatened, abandoned, and unfaithfulness of husband) compared to women reporting their health status as average or excellent (ICRW, 2000).

The WHO lists common health problems associated with violence, noting that those can result directly from violent acts or from the long-term effects of violence, the list includes:

- "**Injuries:** Physical and sexual abuse by a partner is closely associated with injuries. Violence by an intimate partner is the leading cause of non-fatal injuries to women in the USA.
- **Death:** Deaths from VAW includes honour killings (by families for cultural reasons); suicide; female infanticide (murder of infant girls); and maternal death from unsafe abortion.
- **Sexual and reproductive health:** VAW is associated with sexually transmitted infections such as HIV/AIDS, unintended pregnancies, gynaecological problems, induced abortions, and adverse pregnancy outcomes, including miscarriage, low birth weight and foetal death.
- **Risky behaviours:** Sexual abuse as a child is associated with higher rates of sexual risk-taking (such as first sex at an early age, multiple partners and unprotected sex), substance use, and additional victimization. Each of these behaviours increases risks of HP.
- **Mental health:** Violence and abuse increase risk of depression, post-traumatic stress disorder, sleep difficulties, eating disorders and emotional distress.

- **Physical health:** Abuse can result in many HP, including headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility, and poor overall health status." (WHO, 2008)

The role of the Health Sector (HS):

In order to be able to address the health care needs of WEV, adequately manage and treat their HP, the health care sector bears great responsibility. Women are known to be regular visitors of health institutions to receive health care for their HP occurring as a consequence of violence. Seeking medical attention at health facilities is often their first point of presentation, even though they more often conceal their experience of violence when approaching those facilities. Women who experience violence use more health care services (CDC, 2003, Ulrich 2003 & Wisner, 1999) yet are at risk for marginalization in the health care system due to the complexity of their physical and mental health needs (Corley & Goren, 1998).

WHO in (2005) stated that the health sector plays an essential role in the prevention of VAW, and is mainly responsible for early identification of abused women, referring them to appropriate services and providing them with the required care and treatment. WHO also adds that health services should be places where abused women feel secure, are treated respectfully and are not discriminated against, hence encouraging other abused women to seek help.

VAW is still relatively invisible because it typically occurs within household walls. Furthermore, many people view it as a routine and even acceptable feature of relationships between men and women (Kelly & Radford 1998). PAHO&WHO in (2003) adds on that "the dearth of consistent, reliable data on the magnitude of VAW, the scarcity or absence of gender-sensitive health research, and a lack of understanding about the causes of VAW are obstacles both to preventing VAW, and developing actions and efforts to address it".

Accountability of health care providers:

HCP often lack the awareness and experience in dealing with violence survivors when they present at health institutions. A great deal of criticism has been placed on how they are addressing the issue of VAW. Some argue that since health providers do not receive proper training or education on health matters related to violence, this will ultimately influence their preparedness in dealing with and supporting women who present at their workplaces.

PAHO & WHO in (2003) reported that during the time of their study, only a very few health providers had specialized training in dealing with WEV, and none had protocols or standards for care.

HCP perceive that abuse is rare in their practice or that IPV identification and referral are not part of their role or responsibilities (Sugg et al, 1993), as well as specific barriers to addressing VAW, including: lack of time to deal with a complex social issue; a fear of offending patients or retribution from the abuser; personal experiences with family violence; feeling helpless when clients disclose/experience violence; and not knowing how to recognize, ask about and respond to VAW (Hamberger, 2007, Cox, 2003, Heinzer & Crimm, 2002, Dowd et al, 2002, Alpert, 2007, Sugg et al, 1993, Thompson et al, 1998, Moore, Zaccaro & Parsons, 1998).

These barriers, many of which can be attributed to lack of education and training, affect the HCP's confidence in her/his ability to provide appropriate responses to WEV (Sugg et al, 1993).

One recent study of medical students using standardized patients found that the 3rd year students missed many of the domestic violence cases that they were presented with (Hoffstetter, et al. 2005), and another study of residents found that they were not very likely to ask any women about VAW (Miller et al. 2004).

Women's opinions around HCP:

In the scientific literature, the opinions of women on the attitudes of HCP towards them varied greatly. Most women reported difficulties and felt that providers were unable to help. This in turn led to their frustration, uncertainty and fear of re-victimization. They also reported lack of understanding and unacceptable behaviours such as indifference, questioning, mocking, and attempts to instil guilt; often even sexual harassment (PAHO&WHO, 2003)

Two qualitative studies reported patient-based barriers to disclosing abuse. These include the cost of medical services, the risk of losing their children, a perception that the health care provider could not help, feelings of shame, fear of the abuser finding out, and a lack of recognition that they are being abused (Hathaway et al, 2002, Petersen et al, 2003). One study of 41 survivors of VAW in a shelter explored the positive and negative effects of screening from the patient's point of view (Chang et al., 2005). Positive consequences included recognition that violence was a problem, decreased isolation, and feeling that the provider cared. Negative consequences included feeling judged by the provider, having increased anxiety about the future, feeling that the intervention protocol was cumbersome, and experiencing disappointment at the provider's response.

Studies reported that women mainly want the provider to (a) create an atmosphere of safety, support, and confidentiality; (b) provide access to resources; (c) be respectful and concerned; (d) take time to listen; (e) explain how violence can affect health; and (f) *not* pressure them (Battaglia, Finley, & Liebschutz, 2003; Burge et al., 2005; Burke et al., 2004; Chang et al., 2005, Dienemann, Glass, & Hyman, 2005; Hathaway et al., 2002).

Study Rationale:

"Despite the growing recognition of VAW as a public health and human rights concern, and of the obstacle it poses for development, this type of violence continues to have an unjustifiably low priority on the international development agenda and in planning, programming and budgeting" (WHO, 2005)

Quantitative studies and other qualitative studies have identified the need to address the issue of VAW as a serious Public Health problem. They also highlighted the possibility that the figures and statistics collected on prevalence of violence may actually be much higher when considering the issue of underreporting of violence which usually occurs as a result of many reasons such as embarrassment and fear from perpetrators.

Qualitative research is therefore needed to go in depth and further explore this sensitive and complex issue, providing us with an understanding of how being a woman who experiences violence influences her health and her access to health care. Battaglia, Finley, & Liebschutz, (2003); Burge et al., (2005); Burke et al., (2004); Chang et al., (2005), Dienemann, Glass, & Hyman, (2005) and Hathaway et al., (2002) identified the need for HCP to be caring, sensitive, create an atmosphere of safety, support and confidentiality, provide access to resources, be respectful and concerned, take time to listen, explain how violence can affect health and *not* pressure them. Our research is expected to add on to the literature around those expectations and inform policy around addressing the health care needs of WEV particularly in the Indian context.

CHAPTER 3: METHODOLOGY SECTION

Qualitative Research Methodology:

The research was conducted using Qualitative Research Methodology which is known to be ideal for exploring issues that are deeply rooted and embedded in cultures and societies; it is known to have the advantage in exploring social issues as well as opinions and attitudes of certain groups of people or individuals. The analysis and explanation building of qualitative research have a flexible nature which enables the understanding of the context and the complexity of phenomena by putting pieces of realities together, giving a holistic picture of the social world (Ritchie, 2003; Mason, 2002).

The problem of domestic violence is complex as it includes many forms (e.g. verbal, physical and sexual violence) and has many factors influencing it (e.g. family honour, men's masculinity, women's' fear from perpetrators). It is also regarded as a highly sensitive area; women often hesitate to reveal information in the presence of their perpetrators or any other male. In addition, the use of a qualitative approach is also considered as a good way of exploring sensitive topics.

Objective (1): To identify the health care needs of women who experience violence.

In order to identify the health care needs of women, the study aimed at involving women who experience violence, health care workers and other key stakeholders who were expected to take part in the study. Qualitative method approaches including In-depth interviews and Critical incident narratives were selected as means to achieve this objective.

The reason why **In-depth interviews** were chosen goes back to their known benefit in generating rich data; they are also regarded as a good technique in maintaining confidentiality especially when it involves engaging into highly personal matters. Britten in (1995) concluded that qualitative interviewing is a flexible and powerful tool which can open up many areas for research. The issue of confidentiality was considered highly important when carrying out the study, given the sensitive nature of the topic explored.

Critical incident narratives were utilized to provide a better understanding to the researcher, presenting a complete story right from the beginning to the end where the researcher probed for more information. The approach is appropriate for exploring sensitive

issues and made it easier for women to open up and reveal their experiences and emphasize on what *they* considered as highly important.

CINs were built within our In-depth interviews. Focusing mainly on the pathways to health care chosen by a woman, and how, being a woman who experiences violence impacts on her health and her health seeking behaviour. The method was described by Flanagan in (1954) who noted that the aim of the CIT is the collection of information about the behaviour of people in certain significant and decisive situations in which the most upsetting experiences are especially noted. The CIT is a systematic inductive method which gives concrete descriptions of incidents of importance for the activity under investigation (Polit & Hungler, 1995).

We also used CINs to understand how women acquired their HP as a result of violence. This aided the researcher in differentiating between health problems that likely occurred as a result of violence and other existing HP encountered before they were facing violence. The topic guide was our primary steering tool during the interviewing process and assisted in focusing on our research objectives.

Objective: to understand how health care providers are currently addressing the problem of violence.

The above was one of our objectives before arriving to the field; our intentions were to include HCP to be interviewed using in-depth interviews. We thought of in-depth interviews as a technique to help us understand how staff is currently dealing with the widespread problem of violence in the country, what is being done, how services are provided, and in what manner.

The reason why we first chose In-depth interviews was because we expected them to serve by facilitating the generation of rich information from service providers, helping us understand and explore their views on what needs to be done with regard to addressing the women's health care needs. HCP past experiences and their exposure to cases of WEV would have provided us with rich data about how women are dealt with when presenting and seeking health care. A clearer view of how the problem is currently addressed and dealt with from the provider's vision would have been valuable. We also expected that, to understand

the reality and steps that are taken by HCP when attending to a woman who experienced violence.

Unfortunately after arriving to the field, we were not given permission to interview HCP. The researcher came to know that when the staff at HUMSAFAR organization attempted to arrange the appointments for interviewing doctors at hospitals in UP state. Doctors then asked for permission from their head of dept and one step lead to another, finally reaching a required permission from the Chief Secretary of the state. HUMSAFAR staff did take it up to the Director of Health in the state of UP who refused to allow the research to take place upon sending him a formal letter.

The timing was also not in our favour to be able to push forward and acquire the permission since the elections were on and no formal proceedings could have been arranged at the time being. That forced us into doing the research without fulfilling the second objective and talking to HCP and hence limited our study to only include women as our participants. The researcher then modified the t expectations from the project and was able to explore women's perspectives more deeply than would have otherwise through focusing on a narrower objective.

Objective (2): To draw some policy recommendations aimed at better meeting the health care needs of WEV.

Fulfilling the third objective was mostly done through the analysis of the data collected during the project. We were able to identify the HP of WEV as well as the barriers they face while seeking health care. However due to the problem encountered in the field regarding permission for interviewing health care providers, we were unable to fully understand the current situation and on ground practices in place to address the situation.

The research team was still able to use the data collected from WEV to draw policy recommendations and/or strategies aimed at providing health care services that better respond to their needs. That was done with input of members during the briefing presentation and was further supported by previous literature used specifically to back up our HCP limitation.

The researcher presented the preliminary findings to the staff of the Centre of Health and Social Justice on the 8th of June 2009 and a group of women activists and individuals from several organizations including representatives from Jagoori Organization, UNIFEM India, HUMSAFAR organization and Action aid India attended. The researcher was able to obtain

their comments and views on the preliminary findings of the study, and to also receive some insights which provided a clearer understanding to the analysis within the Indian context. The presentation was held before leaving the field. This method of peer checking was used as a means of enhancing the trustworthiness. Member checking is a concept defined by Lincoln and Guba (1985) as involving the testing of "data, analytic categories, interpretations and conclusions" with members of the stakeholder group(s) from whom the original information was collected. It is considered one of the most significant methods within qualitative research for establishing or strengthening the credibility of a study.

Sampling techniques and sample size:

The research used purposive sampling in which participants were selected in a way that enabled the researcher to answer the research questions. The logic and power of purposive sampling lies in selecting information-rich cases for in depth study. "Information rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposeful sampling" (Patton 1990).

25 women who suffered various types of violence at some time in their life participated in the study and took part in the in-depth interviews with built in Critical incident narratives. The researcher attempted to reach saturation, although given the time constraints, it was actually difficult to achieve. Strauss& Corbin in (1990) defined "theoretical saturation, in effect, as the point at which no new insights are obtained, no new themes are identified, and no issues arise regarding a category of data".

The sample size chosen was thought to be practical and manageable in terms of the timeframe provided to conduct the study (7 weeks) as well as to attempt to reach saturation.

Participants:

Our participants as mentioned earlier were women who where survivors of violence. Those women were identified and recruited with the help and aid of HUMSAFAR Organization. HUMSAFAR kept a register for cases who presented for support at the organization some time in their lives. Women selected from the registers were those whom we thought to have more or less recovered from their acute trauma's and struggles with violence, this outlook was supported by the fact that most of them were settling their cases via court proceedings or have already done so previously. Most of the survivors who participated where middle aged women, information around their characteristics is provided in Table 1.

Recruitment & Data collection process:

A list of women whom we thought were eligible was created and thereafter Case workers took on the responsibility of contacting them mainly through phone numbers and invited them to take part in the study. Case workers at HUMSAFAR Organization also took care of arranging the date and timings of the interviews which were mainly left for survivors to choose. Interviews took place during the period between 11th -29th of May 2009. 24 Interviews took place at HUMSAFAR Organization in a separate office provided for the purpose while we travelled to the home of one of the survivors for our final interview.

Case workers and the translator took turns to read the consent forms before starting the interviews since the form was translated in Hindi language. Some of the women read the consent form on their own. After signing the consent forms, the researcher asked if the participant had any questions or clarifications regarding the research before starting. The travel expenses of participants that enabled them to reach HUMSAFAR and return to where they lived were covered and a light snack was provided. Whenever a participant was distressed or broke down and cried we reminded her that she can leave if she wishes to discontinue and two interviews were not completed and stopped for that purpose. Another interview was stopped after a while by the researcher who felt emotionally distressed after conducting 4 interviews the same day and was unable to continue.

Case workers at HUMSAFAR were providing counselling to each and every survivor after completing the interview and scheduled them for a next follow up if needed.

All of the Interviews were carried out in Hindi language with a translator except for two in which survivors were comfortable with speaking English. English interviews were conducted mostly by the researcher and the translator explained to the researcher when an expression in Hindi language was made.

Topic guide:

An initial topic guide was developed before leaving to the field with support from the researcher's supervisor based on reading from the literature and consultation with the client in India.. After reaching the field inputs around the Indian context from Dr Abhijit and Mrs Archana was provided which helped in refining the guide, however, given the sensitivity of

the issue, the researcher was able to finalize the initial topic guide and chose to build in the CINs only after conducting the 1st interview.

In line with Qualitative research methodology, the researcher remained open to the data and refined the topic guide according to the emerging themes. Just to mention one of the outstanding emerging themes was that violence not only affected the health of the women but also had an effect on the health of her children and/or one other family member (refer to Results section).

Research Team:

The research was mainly conducted by the research team; the research team consisted of three individuals, one being the researcher (Nabtta Bashir), the translator (Mansi Jalota) with input from the researcher's personal tutor (Pamela Fergusson).

Case workers from HUMSAFAR staff fulfilled part of the research by contacting women, reading consent forms and providing support for participants after completing the interviews. Often case workers came along and sat during the interviews and probed for more information too.

The researcher is a medical doctor from Sudan with experience of clinical care. The researcher's medical background and experience of conducting patient consultations helped out when talking about HP and understanding the type of medical care a women is expected to receive in certain medical conditions. Skills and knowledge gained by the researcher during the MIPH qualitative research module also assisted throughout the project.

The translator was a female local citizen who was familiar with Hindi language used in UP state, and was currently doing her third year in undergraduate studies. She enjoyed basic translating skills and was fluent in English despite the fact that she received no prior training on translation. Both the translator and the case workers at HUMSAFAR Organization helped the researcher in understanding the Indian context during interviews.

The translator was given a brief orientation about the issue of VAW in India and the researcher emphasized on the issue of active listening as an important factor in allowing participants to open up and talk without restraints. More emphasis was on the importance of being non-judgmental. The researcher explained the aim and objectives of the research and

provided the translator with information about the research giving relative articles about VAW to read before starting off with the interviews on the 11th of May 2009.

Analysis:

Finally, all interviews of which were recorded after taking permission from participants were then translated and transcribed from Hindi Language into English. The translation of the interview recordings along with transcribing was carried out by a female lawyer who was working with an NGO and was familiar with social work and women's rights. Transcripts were then given to the researcher and completed by the 3rd of June. The two interviews conducted in English were transcribed by the researcher.

Along the process of transcribing the recordings, the researcher was listening to the recordings in order to be more familiar with the data and to start developing a thematic framework from it. The researcher and supervisor met and discussed the emerging themes. "Thematic framework is an analytic tool, which is used to classify and organize data according to key themes, concepts and emergent categories". (Ritchie & Lewis, 2003) The thematic framework was developed and ready for coding the data into.

The process of coding and charting the data was done manually; this helped in setting themes clearly in order to start making sense out of the data and understand what it tells us.

Input from members who joined the preliminary findings presentation (Refer to trustworthiness section), and discussions around the data with the personal tutor after presenting the emergent themes and transcripts, allowed diversity, welcomed new ideas and ways or views of explaining and interpreting the data.

The researcher wrote down observations and recorded important happenings throughout the process of data collection which helped out with the data analysis and its interpretation since in Qualitative Research analyzing the data starts right from the beginning of conducting the study even before collecting the data.

TRUSTWORTHINESS:

Peer checking:

The researcher presented the preliminary findings to the staff of the CSHJ and a group of women activists and NGO representatives. The researcher was able to obtain their comments and views on the preliminary and received some insights which provided a clearer understanding to the analysis within the Indian context. The presentation was held before leaving the field. This method of peer checking was used as a means of enhancing the trustworthiness.

Translation:

As part of enhancing trustworthiness, some of the interviews were transcribed by the researcher typing down the English components of those interviews. This was done after returning from the field and the researcher's transcripts were checked against the same interview transcripts collected from the main transcriber.

Richness of the data:

Reaching saturation was not achieved given the short time frame but the data generated was rather rich with opinions, views and perceptions from the ladies and served in informing policy and decision making for HCP working against violence to address women's HP.

ETHICAL CONSIDERATIONS:

Ethical approval was obtained from the ethics committee of the Liverpool School of Tropical Medicine before commencement of field work.

Our 25 participants were selected from the registers were those whom we thought to have **likely recovered** from their acute trauma's and struggles with violence, this outlook was mainly supported by the fact that most of them were settling their cases via court proceedings or have already done so previously. The selection was mainly done by case workers who well knew and followed up all the cases presenting at the organization. We then sat down and discussed some basic information about the women and were briefed about how far they were with their court proceedings.

Consent forms were translated into Hindi and read before each interviews by either the case workers or the translator, women then were asked to sign the consent forms and were asked if they had any clarifications or questions around the research. Light was shed on the issue of confidentiality and how the data from recordings will be used thereafter especially on the issue of their names/family member names and perpetrators.

The interviews were conducted within the organization of HUMSAFAR which is expected to be convenient for most of the women, since they have presented sometime in their lives and likely felt safe and familiar with the **location**.

The **timings** of the interviews started after 10:30 am and ran up to 5:00pm mainly being flexible around women's daily obligations. It was convenient for some of them to arrive in the morning after completing their earlier household work. Many also chose to come later in the day after finishing their jobs. We also travelled to a woman who was not able to come to HUMSAFAR organization.

Transportation fees and a small snack were paid for each of the women participating.

Two **interviews were stopped** either because women chose not to continue or when we felt they got too distressed. One interview was also stopped when the researcher became emotionally distressed.

Case workers provided support and **basic counselling** for each women following the interviews and scheduled follow up sessions when necessary.

For **confidentiality** purposes, only by the person who transcribed, the translator, the researcher and the researcher's personal tutor were allowed to access the transcripts and taped recordings of interviews. Names of survivors and other names mentioned during the interview were placed with pseudonyms when transcribing.

LIMITATIONS AND CHALLENGES:

Working with survivors was very challenging, given the sensitivity of the issue and interviews were centred on exploring what is regarded as highly personal information. It was also emotionally draining, at times survivors cried when recalling some of the incidents and hurtful remarks. We needed to stop the recording and then resume if she chose to. Stirring conversations was also challenging since the translation was going both ways and both the researcher and translator felt uneasy to break off and switch to another question.

The mental status of both the researcher & translator was affected since we were listening to heartbreaking stories interview after another. This was also aggravated because of the time constraint where we often had to conduct 4 interviews without breaking in between.

The researcher's medical orientation often hindered the research where it was more focused on signs, symptoms and illnesses of women and often less focused on the survivors' views.

Language was obviously a very huge constraint, it was very emotionally draining not being able to speak directly to the woman and still be able to make her feel comfortable and safe whilst communicating. Also, the researcher was sometimes unable to understand many of what she was telling although there were many similar words with Hindi Arabic language and needed to put more effort into understanding the body language when they pointed out where their pain is and described how they were pulled or slapped.

The researcher arrived late to the field due to issues regarding the visa and the actual time of data collection was tight, so conducting the interviews in a short time was one of the constraints.

Developing the topic guide and assessing how to go by building in the CINs into the in-depth interviews was challenging, the researcher was only able to decide on the suitable way to do it after conducting the first interview.

The majority of the women contributing in the study have chosen to present at some time for help at HUMSAFAR Organization. Those are mostly women who were likely faced with

extreme violence, viewed violence as unacceptable, already settled or are settling their cases via court proceedings and received at least some basic counselling before on violence and its effects. This likely will have an influence on the data collected where we will probably encounter more HP and controlling behaviours of perpetrators as well as more barriers of access to health care. Probably women will also be more aware of their mental and physical problems after receiving special care from the organization.

We were unable to interview HCP which formed one the greatest limitations to the study where their views and opinions were expected to have been valuable [refer to objective (2)].

OPPORTUNITIES:

Survivors were willing to reveal their experiences; many times they would continue telling us about their court proceedings and their experiences with violence even after we have completed the interviews. Many of them told us in the end that they felt revealed and were happy to share their experiences with the research team.

HUMSAFAR staff support and assistance: Arranging interviews with survivors is not an easy job, but case workers at HUMSAFAR put much effort into contacting and recruiting women. They also provided basic counselling to women whenever was needed and routinely after completing the interviews

The researcher having Arabic language as mother tongue helped a lot since it there were many similar words in Hindi. That provided the researcher with at least a faint understanding during interviews and gave the opportunity to cross check at times when the translator translated back the answers.

Researcher's Medical background was also of much use; history taking from patients during the clinical years was used when trying to understand their health care problems. It also aided when asking about the type of medical services woman received when presenting at health institutions.

Dissemination of the results:

The peer checking mentioned earlier was an initial step in disseminating the data, in which some of the representatives of NGOs and women's organizations attended and the preliminary findings of the study were presented to them prior to leaving the field.

The study will be written and stored in the library both in electronic version and hard copy. In order to disseminate the findings of the study, an electronic version of the research will be sent to the HUMSAFAR Organization and will be encouraged to take part in disseminating the study to WEV. Also the researcher will attempt to send an electronic copy to a number of women's organizations especially those who attended the presentation.

CHAPTER 4: RESULTS

A range of abusive behaviours and acts were experienced by women, those included physical, sexual, emotional and financial abuse.

A common form we came across was PV, almost experienced by every woman included in our study. Women were under continuous physical beating which often times involved not only whipping with hands but moreover the utilization of other objects like wires, bats, rods, gas cylinders for beating and even attempts of burning via unbolting the gas cylinder.

Verbal humiliation was countless and women time and again were unwilling to disclose what they named as "bad words" preferring to keep them to themselves and hence reflecting how offending and unacceptable they found them to be. However, some of the women did reveal some of the humiliating remarks e.g. being called a prostitute and characterless.

"He always says that, you are not good looking and you are black and you look like a servant and I'm much better than you, I'm good looking and you can't stand with me, everybody says that you are not good for me and about my complexion, you can't give birth to a child, you slept with many other persons before marriage and you do some business, sexual business, you are involved with that"

Humiliation goes even further than verbal humiliation and is coupled with controlling behaviour as well.

"He used to spit in my mouth and tell me that I should swallow it, when I was pregnant he used to beat me with his shoes…He used to say that I am your husband and you should do whatever I say, If I want to you to swallow my spit, you should do it. After this I fell ill and vomited for a month because of infection"

A very common type of violence was financial violence; women were sometimes left without food, were not cared for during pregnancy and perpetrators. Payments for medical consultations and treatments for women and their children were also not provided.

Decisions around how to spend the money was taken by the perpetrators who may oftentimes be the in-laws. Women were given no control over how to spend their household money.

Sometimes this financial gap would be compensated by someone taking over the expenses, a member of their natal family and/or one of their in-laws. Frequently it is the father, brother or mother from the women's natal side; quite often also it is the mother in-law or the father in law especially paying for the children's education expenses and medical care. Relatives were also mentioned by the women, offering help at times and at other times the contrary.

"…At that time my situation had gone worse, like I was a servant, I was not being provided food for two months and 15 days, my daughter was also in the same condition, she was very weak, she was not taken care of, not even asking whether you have eaten anything? Nothing! There was nothing!

Financial violence experiences accompanied by controlling behaviour and threats were common; perpetrators took over women's earnings and constantly demanded payments pressuring women to also bring money from their natal families (often dowry demands).

Women often took on piece work and jobs to make up for the financial gap at times and even daughters took over work and left their education to be able to cope with the issue of financial violence.

Women who took on domestic work to be able to provide fees often worked in up to 12 homes to be able to fill the financial gap. Most were stitching Sarees, teaching and doing hand embroidery. One woman said that she rented her house to provide her children's expenses.

Often this places a burden on their health as well as a consequence of taking on those jobs, for example one woman explains how she suffers from headaches because of the stress of embroidery work which needs to be completed at a specific time. Many were suffering from back ache and generalized fatigue after taking on domestic work.

It was evident from our data that no distinct type of violence existed in seclusion. WEV were facing various sorts of abuse including controlling behaviours', acts of humiliation, mocking, physical torture and verbal threats. Every other type of violence was almost infrequently associated and intertwined with another type of abuse.

Rape threats were reported by several women

"…he also sent three boys to rape me and throw me out of the house"

Perpetrators often throw women out of their homes. Some of the women were left to sleep outdoors alone or in the company of their children.

“My husband has beaten me very badly and threw me out of the house at 11:30 in the night”

Locking women and/or a family member at home was also experienced by some of the ladies:

“My husband took me home and locked me inside a room and told my children that they should not tell anyone about this,

Marital rape was not uncommon and forcing women to engage into sexual behaviours’ they found degrading and unacceptable such as forcing them into watching porno movies, forceful sex.

”At all times he would make me do oral sex with him forcefully”

A perpetrator imposing violent behaviour was natural scenery and often times it extended to influence children and/or another family member at home. This woman tells us how he used to beat her son:

“My husband beats him with a rod, that’s how he got the shoulder problem”

It is not always the children who are abused; it extends to involve a family member or an outsider as well. A woman reported that her husband abused her sister verbally.

The mother in law often falls as a victim of abuse either by her family or her in laws.

Although some of the perpetrators slapped their children, threw them off the terrace and certainly did not spare them from their violent behaviour, other women said that the perpetrator never touched the children or abused them in any way.

Extreme cases of controlling behaviour was evident reaching up to the level of finding it offending that the woman has slept without his permission accusing her of being a disrespectful wife and thereafter beating her for that very reason.

Many survivors were overworked taking on household responsibilities and extra work as well, some felt that it was planned so as to cause them harm

Regarding education, although some women felt that violence would not have occurred had they been well educated and thought it would protect and empower them.

Other women felt that it was that it was a reason that contributed to their experience with violence where they were taunted because of their educational level.

Some women revealed that the perpetrator discriminated between girls and boys and clearly chose/preferred sons over daughters. Between frustration and sadness, she said:

"I want my husband to see that she is not inferior to a boy, she can do everything! I want to show him that both girls and boys are equal! Whenever my daughter sees her friends with their fathers; she always asks me "Where is my father?" What should I tell her? That he has left us because I gave birth to you."

Many times women would need to take critical decisions concerning their life and well being when dealing or trying to escape extreme violence and sadly enough that would require them to put up with the consequences that occur as a result of taking up those resolutions:

"When I came back home and on the 11th of January eight people approached my house with kerosene wanting to burn me, my Aunt and one of my neighbours were there while they were trying to break into my house from the door, they put a stool beside the wall so that I can jump from a 10 feet wall and escape, I jumped from there to save my life and I landed in a position that hurt my hip bone and back, I was four months pregnant at that time and my baby position twisted, he was lying transversely"

The same lady had to go for a Caesarean section to deliver that baby and suffers from chronic backache due to a disc slip as a consequence of jumping and landing compellingly on the ground.

Some women felt that the occurrence of violence is very common and acceptable; this understanding was also supported by many of the women's family members as well as the Indian society:

"My family has taught me culture and values and told me before my marriage that you should live properly in your husband's home and obey his orders"

The impact of their families had a significant effect on the way they adjust and/or cope with violence, some of the women said that they would want to stay with their families for longer

but were told that they cannot be able to support them financially or there was not enough space for both them and their children. Despite that they ran to their families to escape the violence and stayed there for a while only to come back again. Some were supported by their colleagues, neighbours and village people

Health Problems (HP):

Each and every one of our study participants suffered a range of HP which they related to their experience with violence. Women disclosed various symptoms and complaints when asked about their health and health related problems. HP included a range of both physical and mental health issues, mostly experienced in conjunction with each other.

1.1 **Mental HP:**

It was obvious that women's mental health and well being was jeopardized when experiencing violence, it indeed formed one of their immense as well as serious health burdens. Women realized that their mental health burdens were very deep.
Some of the women had a sense of self-blame and kept on thinking where did they go wrong and why this was happening to them only, why are they faced with so many troubles in their lives.

Some of the women revealed that their experience with violence has lowered their self esteem and made them lose confidence, become irritable and forgetful. One of them related her forgetfulness with her head injury.

"I became very weak and my self confidence was lowered, even today I don't feel comfortable and confident. I forget things and become angry quickly. I have also started thinking negatively"

Several women fell into the pit of depression as a result of the violence; they added that they felt they are worthless and lost strength, further adding that they felt no longer strong as they were before their marriage.

"I don't know what happened to me, I was a strong lady before also and now also I'm strong, but in that period, I was not strong, I felt totally that I am nothing."

Upon asking about their health, some of our participants referred to their mental HP directly stating that they were mentally unwell or mentally very weak.
Tensions and stress were common and many felt that the tensions were the reason behind their headaches, forgetfulness and sleeping disturbances. Worries about the future of their children, how they will be able to go on and secure their education was one of their major concerns, this also inflicted the sense of self-blame when unable to provide their children with the optimal care.

Women cried repeatedly and related that to other physical HP such as headaches and eye problems.

Humiliation and degradation was also a burden on the mental health of women, crying, this woman revealed her heartbreaking story:

"One day he pulled me out of the house on the open and he ripped my Saree in front of everyone, he left me standing there exposed and voiced out, 'anyone can have her if he desires to' "

Many women feared the perpetrators and panic when the perpetrator's time was shortly returning home. They felt helpless and lonely when they kept on facing the same problems over and over again.

Mental health burdens often reached an extreme; two of the women told us that they thought about committing suicide:

"….At that time I felt like I should jump into river Gomti and end my life"
Women also shared with us their feelings of despair and being cheated on and mistreated although they themselves never harmed their perpetrators.

Physical HP:

Women suffered various physical HP as a result of the different types of violence. As mentioned earlier, a couple of woman related their physical HP to their mental health burdens.

Experiences with different types of violence widely varied across our participants but none of the survivors was free of symptoms or physical illnesses. Each and every one of those women was having at least one or two physical HP.

Although some felt they had recovered from their HP and that their health was improving, many were still suffering from chronic pain.

Physical beating lead to a variety of physical HP:

Encountered physical HP included Weakness and chronic pain in the form of back aches, fatigue, waist pain, joint pain and headaches. Some suffered from Ear problems especially when the physical beating involved being slapped on the face. One of the survivors had her left ear ripped as a result of PV when her husband pulled her earrings.

"I have many health problems, I have weakness, I suffered a car accident, I have a head trauma and my husband has made me fall from the terrace."

"My waist keeps on paining and my body aches and I have headaches as well, my eyes itch because I used to cry a lot"

A wide range of musculoskeletal problems were reported by violence survivors, among those was weakness, back pain, inability to take certain positions such as sitting or standing, swellings, joint pain which were often chronic.

Headache was one of the major HP reported by women and was always accompanied with another physical illness and/or mental health disturbances.

Some of the women had physical illnesses which held serious health consequences in the future e.g. one will not be able to conceive another child due to a back injury.

Some had dietary problems, mainly unable to eat or had an inappropriate diet. One of the survivors was discovered to be anaemic and related it to her weakness and lack of appetite.

"When you have problems at home, how can you manage to eat?"

Bleeding, cuts & bruises and bites were very common and encountered on almost a daily basis. Common areas included hands, arms, face legs, thighs, and back.

Three of the women who experienced SV suffered genitourinary problems as a result of the violence, those included sexually transmitted diseases, labial tears, cervical swellings, unwanted pregnancy, genital bleeding, urethral problems and urinary incontinence.

When severe, violence did not spare women from car accidents and life threatening traumas and conditions. Our study came across two cases of car accidents where the perpetrator was driving carelessly.

"I have many health problems, I have weakness, I suffered a car accident, I have a head trauma and my husband has made me fall from the terrace."

Women also told how violence has lead to abortions, some were spontaneous and others were non-spontaneous. Many felt that their abortions were planned before hand by their perpetrators and/or in-laws

Women also reported that their children and/or one other family member suffered HP, whether physical and/or mental as a result of violence. Direct influence on the children's mental health was seen by mothers, they reported lower school performance, ill confidence and depression often requiring psychiatric consultations, counselling and even anti-depressants.

One of the women told us how when her husband calls and her children talk to him over the phone, they would tell him that they wish if he would break a leg, or die which reflects their bitterness and anger towards the perpetrator.

Physical HP also occurred as a result of the violence and influenced children where they were sometimes slapped, shoved away, beaten, pulled, thrown from the terrace and kicked. Physical HP that we came across included bruises, cuts, shoulder dislocation, dietary problems and weakness.

Mothers were trying their best to protect their children and family members, risking their own health and wellbeing and eventually suffering serious consequences at times.

Many of the survivors' parents were influenced either directly or indirectly. Directly, by evidencing and being abused themselves by the perpetrator most frequently by verbal remarks and often times physically. Indirectly by self-blame and feeling responsible for the suffering of their daughters and/or grandchildren, some even revealed that to their daughters that they should have been more careful when choosing their husbands

particularly when it was an arranged marriage. Parents were also burdened mentally to the extent that marrying the rest of their daughters was seen as a problem. Parents also suffered from anger, frustrations and bitterness upon hearing the hurtful and humiliating remarks their daughters expressed.

The use of medications and ointments with the intentions to relief symptoms was ordinary; mainly pain killers. Women often used medications without consulting doctors and most of them were not able to recall the names of the medicines they were taking.

"My stomach used to swell and I used to take painkillers three- four times a day. It used to happen four – five times in a week"

At times they did not know what the medications were for. Women often purchased medicines from a chemist themselves, other times their husband or a family member did so.

One of the survivors told us that her husband had given her some pills intentionally that made her feel drowsy and fell unconscious afterwards, he and his sister were subsequently willing to burn her and her Saree did catch fire that day.

Ointments were used by a number of the women to relieve their aches and pains from physical beating. The regular and often prolonged use of pain killers is known to have adverse health outcomes especially without consulting doctors. Women also trusted perpetrators and ingested drugs purchased by them.

Alcohol abuse and the use of prescription drugs by perpetrators was a major problem contributing to violence. Women were struggling with their husband's drinking and gambling habits, all of which are harmful to their own health and in due course to their wives health too. Few of the women told us that there has to be a limit when someone drinks alcohol but this limit is always exceeded and that's when problems keep on arising, beatings become severer and they "start acting like they are animals". Occasionally, women were abused only when the perpetrator was under the influence of alcohol.

Women also felt that their husbands where misusing drugs and told us how the doctor would advise them to take a certain number of tablets per day which they exceeded, they

also felt that their husbands were irresponsible and unable to take full control of their lives and that's why they were permanently on anti-depressants and were mentally ill.

Health seeking behaviour:

Women experiencing PV never sought help from a doctor until and unless their injuries were severe. The regular beatings which resulted in bruises and cuts which often took a lengthy time to heal where mostly left untreated.

Sometimes women would retire to self treatments, massage, herbal remedies, bandaging their cuts on their own, applying ointments and rarely, they chose to approach traditional healers. Few of the ladies said that they approached doctors for treatment of headaches and sleeping disturbances where they were put on sleeping pills and pain killers.

Bandages and skin ointments where provided by the perpetrators, neighbours, relatives, parents and friends. Sometimes women would send their children to purchase the ointments while the perpetrator is outdoors if they had the money.

Women always told us that they preferred seeking health care especially when severely injured but many of them were unable to at the time they wanted. Barriers to access were partly due to the controlling behaviour imposed on them from the perpetrators where they were not allowed to leave the household.

"He never let me out of the house after abusing me because he thinks that I will go out and tell everyone"

Another barrier was the financial constraints imposed on the women, decisions around financial matters within the household placed women's health lower down in their priorities.

"They said that wasting money on your health is uh, worthless, spending that money on our business will be fruitful, so be as you are…as you are here with a lot of problems, your illness problems, and your mother and father has just supplied you to us like this only, without caring about you, without medications and they have put all this on us, so why should we take care about your health? Why should we buy

medications for you? Stay as you are… so, this is the reply that I used to get when I used to talk about my health to them"

Not only were women not allowed leaving the household, in fact, upon complaining about their symptoms to either their husband's or in-laws, they were not taken seriously. Perpetrators mocked, mitigated and contributed to the worsening of their HP.

"After the day the whole family had beaten me while I was pregnant on my stomach, I started complaining to my husband about the pain in my stomach but my husband used to mock me and say to me that "oh you have pain in your stomach, you have a tumour and it's going to grow and you will die of it, and when I used to ask him to take me to the doctor, he used to refuse and would not allow me to leave the house"

Although some of the survivors did report their experience with violence to HCP, the majority preferred not to. Various reasons were given; some felt that it is personal and should not be revealed to strangers, others felt that if only HCP asked, woman would feel comfortable in sharing the information. Some felt that it is useless, since HCP will not be able to help nor will they be willing to listen. Many perceived that if they told HCP they would laugh and/or mock them, and some felt that they cannot help out with the issue of VAW, adding that HCP duties do not go beyond bandaging their wounds and providing treatment for the resultant injuries. A number of survivors felt insecure because their in-laws and/or perpetrator were at the health institution and were fearful of the consequences upon returning home.

In-laws often fabricated lies in attempt to cover up for their son (the perpetrator) at health institutions, stating a false causation e.g. she fell in the rain or fell from the stairs.

Women's **opinions on the attitude and behaviour of HCP's** towards them varied widely. Those who reported a positive experience said, for example, that health staff had asked and offered advice around violence, counselled their children and filed medical reports when needed, some were glad to have the doctor scold the perpetrator although at times that has lead to them suffering another episode of beating upon

returning home. One of the survivors was happy to have the doctor joke about the matter.

Negative experiences of HCP included their being insensitive, not caring or not asking about the cause of their injuries, bad intentions and even harassment by male doctors in particular.

An important issue frequently reported by the women was that some doctors asked for bribes to complete medical reports. Women felt vulnerable as these reports are necessary to instigate court proceedings.

They also revealed that some of the doctors had to refer them to the police station before attending to them despite their presenting with life threatening conditions:

"After my brother in law hit me using the wooden part of an axe on my head, they took me to the hospital but the doctors said that he would not attend to me and said that I should go to the police station since this is a criminal case, they then took me to the police station and I was bleeding, my Saree was drenched in blood, the policemen referred me back to the hospital saying that I am severely injured and should be seen by a doctor immediately."

Comments and opinions around the **attitude of policemen** were almost uniformly negative. A few of the women had visited the all female police stations and felt that they were no better than the other stations. Police officers were mocking them, harassing them, scolding them and advising them to return home despite risk of continued violence.

Corruption came across very strongly and police officers were said to receive bribes from the perpetrators and/or in-laws side so that cases filed by women do not proceed to court. Filing a case sometimes required knowing someone within the police force or having a high-profile relative.

Although most of the women felt that policemen had a negative attitude towards them, a few were satisfied with how they were treated and supported and felt protected whenever they chose to seek help from police stations.

Women's **motivation and strength** to go on was primarily derived from the love and care for their children, that came out very strongly, they decided not to take their lives so that they would live to support them and protect them from harm and try to fulfil the role of fathers. Very proudly women would speak of their children after stopping the recording telling how much they love them and how they are willing to provide them with all they can give. Another major source of strength was religion, when attempting to comfort them; they would tell that god will always be there to help you as long as you are of good nature. They also added that perpetrators will never live in peace and will eventually receive their deserved punishment.

Women's parents were also a source of strength, although at times they would send them back to their home and advise them to adjust since violence is acceptable and common. This led women to feel uncomfortable when wanting to move to their parent's house, they insisted on home shelters they can stay at whenever violence becomes severe or if they wished to file for divorce.

Preferences:

Many of the women felt that a female doctor would be more understanding and caring, this will in turn make them feel comfortable in sharing their experiences with her and reveal causes of their HP while male doctors will probably laugh and mock about it. Some felt that either is fine whether male of female as long as they are caring, supportive and sensitive to the issue of VAW.

All of the women felt that a health care visitor will be very helpful for them and for similar women; they added that the most benefited are those not allowed leaving the household and who are not able to pay fees e.g. transport fees and/or consultation fees. They also believed that since the health care visitor has come all the way to ask about them and their health care problems, it reflects his/her sensitivity and caring where they will feel comfortable in revealing their HP.

Few of the women felt that shelter homes will be helpful to support them whenever they are thrown out of the house instead of always running to their natal families.

Free medications for violence survivors was mentioned by a number of them where they can seek health and not worry about the medical expenses and breaking the financial gap where they do not await their in-laws, husbands or natal families and chose to go receive health care whenever they desire.

CHAPTER 5: DISCUSSION:

We focused mainly on understanding what it is like to be a woman who experienced violence and how that impacts on her health. This was done through exploring their HP, studying the different pathways they selected when seeking health care, and valuing their opinions and expectations from HCP to address VAW in India.

VAW & Public health priorities:

Previous literature and studies have over and again highlighted the importance of addressing VAW and placed it as a global public health priority. However, although VAW has gained a lot of attention in the past decade (PAHO&WHO, 2003), there still seems to be a huge gap in addressing and responding to it in an effective manner, especially from a health care perspective. What is being done around VAW was mainly pressed by the activist movement and hence has been focused on the human rights dimension of the problem. The complexity of VAW requires the involvement of many sectors to be able to deliver the proper response to deal with it.

1.1. Health comes first:

The women's movement has been globally successful in making some gains in improving the status of women, and in particular addressing VAW. In India the domestic violence act, passed in 2005 is a clear representation that women's human rights to safety and security are being taken more seriously at a national level. Extending those rights, however to the lived experience of women who experience violence, remains a challenge. This is particularly evident when evaluating health and health care.

It is obvious from our study, that health should be a priority; WEV are entitled to receive health care when necessary and the HS is held responsible for fulfilling that. CDC, (2003) Ulrich, (2003) & Wisner (1999) reported that women who experience violence use more health services, often seeking medical attention from health facilities is their first point of presentation. Yet, the technicality of providing services for women obviously cannot be easily achieved given the multiple barriers they face. Therefore examining ways in which health services can be equitably accessed is necessary, especially in the context of developing countries where health services are usually poor.

1.2. Existing laws addressing VAW:

In India and many other countries, a law protecting women from various types of violence is in action, the law is known as the Protection of Women from Domestic Violence Act 2005**,** which took effect in 2006. Key elements of the law include the prohibition of marital rape and the provision of protection and maintenance orders against husbands and partners who are emotionally, physically, or economically abusive (The National Family Health Survey 2005-2006) but despite the existence of such laws and policies, women still face many problems and barriers which impact and further exacerbate the adverse health outcomes violence results in. For example our study findings point out that, those women encountered problems and barriers such as difficulties in issuing medical reports, being mocked at by staff members in health facilities and police stations and were imprisoned in the household by perpetrators.

In 2003 the WHO stated that there is increasing evidence and awareness among HCP and policy makers of the negative health outcomes of VAW, they also added that women who have been abused are more likely to suffer from HP than other women who were not abused (WHO, 2003). This emphasizes the importance of access to health care and other services. For example, although the government created all women police stations to make it easier for women to access and feel comfortable in reaching out, those stations seemingly do not fulfil their intended purpose, very few in our study reported using them and those who did had reported a negative experience; this may be placing women's lives, safety and health in jeopardy

1.3. VAW requires more attention:

The World Bank in (2003) reported VAW to be a greater cause of ill health and incapacity among women of reproductive age than traffic accidents and malaria combined, that alone calls for appropriate health service provision to WEV. Another reason why VAW requires more attention is the issue of underreporting that leads to the underestimation of prevalence rates. Moreover, it is not only women who suffer from the negative health outcomes of violence, according to our study findings, the health of at least one other family member is affected; this is commonly the children in the household, who are particularly vulnerable.[*Refer to illustration (1)*]

2. Training & Education of HCP:

2.1. Complexity of violence & women's expectations:

Recent literature mentions that the complexity of the HP associated with violence makes it difficult for HCP to be well prepared in dealing with violence survivors when they present at their workplaces. However, women's expectations for improved care are reasonable and achievable. For example;, demonstrating care, listening carefully and sensitively to their complaints, attending to them promptly (since it adds upon their suffering if they needed to queue), providing advice when necessary, comforting them and maintaining their confidentiality.

2.2. Training HCP:

The provision of special training and education for HCP around how to address VAW is thought to enable them and help restore the gap in knowledge when dealing with violence survivors. A study by Aksan & Aksu in (2007) assessed the training needs for addressing violence in an emergency setting in Turkey; they found out that 89.9 % of their health care provider participants did not receive any previous training on violence. They also added that HCP might share the same cultural norms and prejudices with victims or perpetrators of IPV, which would affect their professional attitudes.

This is supported by the findings of our study, when (for example) some of the HCP asked women to settle down and go back home since there was no alternative. This predominantly reflected how they viewed violence as an acceptable and normal event. However it can be argued that the hopelessness feeling providers report may be the reason behind such attitudes. PAHO & WHO in (2003) revealed that it is often hard for providers to accept is that they may not be able to entirely solve the problem, they often feel that there is little they can do when a woman discloses abuse. Training health providers may therefore guide the way to a win-win situation where both survivors and HCP can be satisfied.

It is important to note that some women did have positive experiences with their HCP. Women were noticeably pleased with providers who were sensible, asked them about their experience with violence, listened carefully, mutually respected them, demonstrated care and maintained their confidentiality. Successful providers were mainly those belonging to the private sector, women were generally unhappy with the services provided in governmental

institutions, although there were few examples of successful providers within governmental settings.

3. Coordination and community participation:

The research findings point out, that, it is not only the health care providers who are going to solve the problem and break the barriers of access to health care; it is the comprehensive response from the society and organizations which will produce positive results. Our findings are supported by findings from PAHO & WHO, (2003) which showed that the success of interventions depended on the availability, quality, and coordination of services, and, most of all, on the commitment of the providers.

In our study the responses and advice from family members, friends and neighbours play an essential role in shaping women's decisions concerning violence. Unless the surrounding community is aware of the risks and serious health consequences of violence they may stand in the way of addressing violence and preventing it from occurring.

4. HCP can influence policies against Violence:

Asking women about their experience with violence came out in our study as an important reason that makes women feel comfortable and consequently choose to reveal/report their experience with violence to HCP. This finding is consistent with other researchers which state that experience has shown that many women are willing to talk about violence, but it is usually necessary for health personnel to take the initiative and open the discussion. McCauley et al. (1998) & Gerbert et al.(1999) said that what providers say and do can have an important influence on a woman's course of action. This further supports and suggests that HCP can rather adopt simple practices when dealing with violence survivors which ultimately lead to positive outcomes. In (2003) PAHO&WHO have placed screening for violence as top priority in their agenda for addressing VAW; they added that programs without a screening policy identify only a fraction of women requiring assistance. If women are uncomfortable to disclose their experiences then screening policies will be rendered ineffective.

5. Economic violence & women's empowerment:

5.1. Financial violence affects women's health:

It is obvious that our study findings put a lot of weight on financial concerns and difficulties faced by WEV directly affecting their health. Firstly, it plays a fundamental role in shaping the different pathways women choose when seeking health care or when deciding to leave their HP untreated and deal with their chronic aches and pains unaided because the decisions around money spending was taken by perpetrators. Secondly, it places an enormous burden on their health; mentally through the continuous anxiousness, worries and concerns about how to provide money to run the household and secure their children's future. Physically by overworking and taking on the accessible types of jobs which due to their nature, result in a range of medical problems including headaches, backache, exhaustion.

5.2. Employed hence Empowered?

Their troubles do not end there, for even after women fall under the group of "Employed" and seem to be empowered by earning their own money, they remain vulnerable where the power relation and controlling behaviour of perpetrators enables them to take over their earnings and squander them on gambling and alcohol consumption which again deteriorates women's mental status.

6. Can our findings be generalized?

When questioning our research findings and whether they can be generalized, there is no doubt that they can be generalized in the Indian context, since our study involved participants from various casts, who had different traditional beliefs and socio-cultural norms. Although most of them resided in UP, India, some of them had spent part of their life in areas/regions outside the state, or were not originally from there.

It is important to note that women do not seek help unless their experience with violence reaches an extreme. This may bias our results, because our participants will likely fall under the category who experienced "extreme violence" and are hence likely to report more HP and obstacles when accessing health care.

A number of our participants also received counselling sessions, upon selecting the women from HUMSAFAR registers, and due to ethical reasons, the aim was to include women who

gave us the impression that they have likely recovered from their acute traumatic stages with violence; reflected by the fact that they were settling their cases using court proceedings. This will apparently influence our results as well, women who participated will probably be more aware of some of the consequences and health outcomes of VAW especially mental health aspects because they were likely to have discussed those during previous counselling sessions.

Several findings are however comparable to international literature. WHO (2008) list of HP associated with violence included Injuries, death, sexual & reproductive, mental and physical HP, all of which were encountered in our study. We specifically attribute the possibility of death in our study to the evidenced homicidal attempts by perpetrators. However, the list also included a range of risky behaviours that are likely to occur on the long run, (please refer to WHO list) in our study we did not come across any except to a limited extent, the possible misuse of drugs by these women. It is worth noting that our research findings point out that, women took on risky behaviours and decisions as means of escaping and/or dealing with violence that might have lead to much more serious health consequences such as disability or death. The explanation may simply be that those health outcomes are long term projections that may perhaps occur with their children in the future and cannot be evaluated in a straightforward manner. Another important finding in our research is that violence resulted in car accidents encountered by two women in our study, this may be included in the WHO list under "injury" however it was not explicitly mentioned, further exploration is needed to figure out whether it is a common outcome of violence or not.

Researcher's position:

As mentioned in the methodology section the researcher is a medical doctor with a three years background of clinical experience in a developing country setting (Sudan), conducting the research and taking part in understanding and interpreting the findings as most qualitative researcher's point to, forms part of the research itself. Acting as a health care provider previously and dealing with cases of PV in particular has made the researcher recognize many things. Firstly, being a HCP puts you under great responsibility when dealing with health care problems of violence survivors.

The gap in knowledge and training is evident, the researcher received no prior education or special training on how to attend to a woman who experienced violence when she presents at a health care facility. However, the researcher did ask about the incident in privacy and

listened carefully to what the woman was telling, but did not escape the feeling helpless and of not much use even after doing so.

From a personal point of view, educating HCP about their and what further support/referral they can provide to women will be useful. The importance of community participation in enabling WEV to enjoy the optimum level of health, as WHO defines also involves the social wellbeing of a person. This cannot be achieved except with the aid of community organizations and agencies that provide shelter, loans, education, and services beyond medical care.

CHAPTER 6: RECOMMENDATIONS:

Following on from the discussion, when addressing the issue of VAW and appropriately meeting the health care needs of WEV, our research findings support the idea that a rather comprehensive response is required which extends to include agencies, organizations, community members but mainly health care providers.

In order to tackle the problem, altering the behaviour and working in opposition of existent power relations and socio-cultural norms to achieve gender equity is needed. It is challenging to ensuring a comprehensive and coordinated response to address VAW as public health problem particularly in resource poor settings. Yet, that does not justify standing back and not searching for practical strategic options that will be useful to WEV in the present time and possibly aid in achieving gender equity in the long run.

We will focus on women's experiences and expectations from health care providers however we will also support our chosen options by previous literature and research findings when necessary.

Training HCP:

Special training and education should be provided to HCP around how to address the issue of VAW in the clinical setting. Relevant information according to the context should be included within the training for example the current laws addressing the problem of VAW, knowledge about organizations offering support to these women, shelter homes, crisis support and agencies offering legal advice on the matter. This knowledge is expected to help particularly in referring women when further support is needed.

In order to meet the health care needs of WEV, the training should emphasize the importance of asking and opening up the discussion around their struggle with violence, listening carefully, respecting, providing them with advice when appropriate, issuing medical reports, admitting them for a while if their safety is thought to be in jeopardy. PAHO&WHO in (2003) stressed that it is not only mental health specialists who will be able to provide quality care for victims of violence. This points out that, training HCP to acquire basic counselling skills is expected to help in addressing VAW. It is also important to clearly state what is expected from HCP when attending to WEV. PAHO and WHO in (2003) stated that HCP are expected to be able to fulfil those responsibilities (refer to table 1). According to

our findings, women regularly use pain killers often without consultation; this particularly requires attention from HCP who should be aware of the adverse effects resulting from prolonged use of those medications.

Female HCP:

Since most of the women who participated in the study revealed that, they will be more comfortable when being seen by a female HCP; this may be option to look into. It will be challenging however, to have a female HCP hired at every health facility in the country. Planning human resources for health in a resource poor setting is therefore required. The MOH will likely be responsible in finding out which female cadre will be appropriate to fulfil this duty. Therefore, it may seem much more practical to focus efforts in training HCP from both sexes on how to deal with violence and acquire the needed skills when attending to WEV.

Health care visitors:

Our research findings support the idea of having a health care provider visit women where they live, asking about their HP and addressing their needs, this will be very useful particularly for women who are not allowed outdoors and who may still be suffering from HP which require attention.

Existing vaccination campaigns and/or programs endorsing health visitors for example reproductive health providers such as village midwives may be a way of integrating the service of attending to WEV at their homes. This may in turn support screening strategies, informing them about their rights and also in developing safety plans mentioned in table 1.

It is necessary to note that, this may not be a successful strategy for some of the women, since perpetrators may be present at home during the health visit. Another thing is that we might be putting the health visitors' safety at risk drawing them nearer to dangerous perpetrators who may feel offended by the idea. Integrating the services with other existing programs involving health care visits is expected to help with safety, so that the health visitor first evaluates and chooses if she can invade into the subject or not. This may be tricky, since health visitors may then choose to discard the responsibility of asking about violence and its health outcomes and prefer to for example just vaccinate the children and leave without asking about violence to reduce their workload.

Possible ways can be explored by further research on which cadres will be able to take on the responsibility and how integration may be done wisely. The MoH and specifically the department of HRH may be interested in this piece of information.

Community Participation:

Programs targeting the community to address the barriers of access to health and attempt to deal with the negative impact community and family members often play when advising about violence. Mothers of survivors could be the initial targeted group since they have great influence on their daughters' decisions to put across the straightforward point that violence is unacceptable and may be very dangerous and life-threatening at times. Health education around the adverse health outcomes of violence should be provided starting with mothers and extending to include perpetrators, fathers, brothers and finally reaching out to other community members.

Involving Men:

It is thought that an effective program addressing VAW requires involving men. ICRW (2000) said that it is recognized that any attempt to prevent violence must address men as perpetrators and further added that we must move beyond seeing men as perpetrators only. In relation to our research findings, alcohol abuse for example, has come out as a widely contributing factor to the occurrence of violent events, especially resulting in physical and verbal abuse. This calls for a conjoined action involving treatment and rehabilitation of perpetrators who are suffering from drug addictions and abuse of alcohol. Further research is however needed on how to find effective ways to involve men in addressing VAW.

CHAPTER 7: CONCLUSION:

The research aims at understanding how to address the health care needs of WEV by the HS. However in order to achieve that, and upon exploring the HP and barriers of access to health care women were facing, it was obvious that a holistic and more comprehensive response is needed that goes beyond the responsibility of the HS. This follows on, and is supported by previous literature. Our study is centred on the opinions, perceptions and experiences of women who participated, even though at first we planned to include HCP, our aim was still to focus on how HCP can better meet the health care needs identified by women.

Our participants were mainly married and middle aged WEV residing in UP state and were recruited through HUMSAFAR organization.

The study included women who experienced different types of abuse and controlling behaviours, violence took the forms of physical, emotional, financial and sexual violence and it was noticed that no type of violence existed in solitude. Each and every one of our participants reported multiple HP whether physical or mental HP as a result of violence, and at least one other family member's health was affected; commonly the children in the household, who are particularly vulnerable.

Women reported barriers of access to health care including, financial problems where decisions around money is taken by perpetrators, psychosocial barriers such as being unable to leave the household, the Impact of family members on women's decisions, the negative and often positive attitudes of HCP & police officers.

Participants shared the characteristic of having possibly gone through extreme violence, viewed violence as unacceptable and already received counselling services; in addition many of them are resolving their cases through court proceedings. This may have a direct influence on our results where are more likely to come across health care problems, serious illnesses, mental HP and barriers of access to health care.

Women also provided their comments, opinions and expectations from HCP, stating they were satisfied when they asked them about their experience with violence, listened carefully, mutually respected them, demonstrated care and maintained their confidentiality. Many also added that they preferred being attended to by a female health care provider where they will

feel more comfortable and easily reveal their experiences to. The idea of a HCP visiting them at home was welcomed by all the survivors; they believed that it will be useful particularly for women who are not allowed leaving the household and the poor who cannot afford to pay for medical expenses.

A pronounced limitation to our study is our inability to interview HCP and understand what they are currently doing in order to address VAW. Their views will also be valuable as means of understanding how it is like from their own perspective and difficulties they may be facing regarding the issue.

When interviewing and talking to survivors about their experiences, it was clear that revealing those experiences was somehow relieving; women said it was helpful to have someone to listen.

HCP need be trained around their responsibility towards WEV. A coordinated and integrated response is needed not only from the HS but from agencies and organizations providing different support for women, so that these women are able to enjoy the optimum level of health.

A key research complementing our research findings will be one that involves HCP participants, their views, opinions and possible difficulties they may be facing when addressing violence and attending to WEV that turn up at their workplaces and to identify possible strategies for addressing violence in resource poor settings and the possibility of integrating existing services that involve health visitors.

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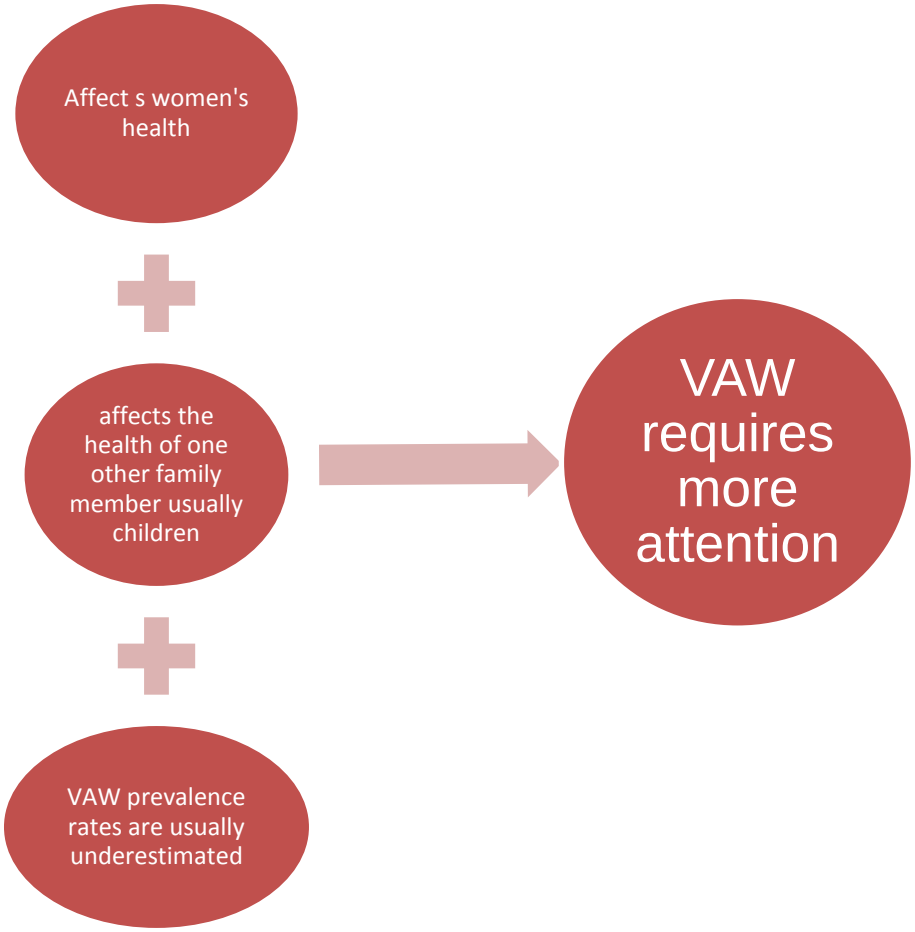

Reasons why VAW requires more attention in Public Health

Participants	*AGE*	*TYPE OF VIOLENCE*
1. Married	*36*	*Physical violence*
2. Married	*58*	*Financial violence and emotional violence*
3. Widow	*26*	*Physical, emotional and financial violence*
4. Filed for divorce	*26*	*Severe Physical violence, Dowry harassment, Sexual violence and emotional violence*
5. Married	*42*	*Emotional and Physical violence*
6. Married	*27*	*Physical violence*
7. Married	*28*	*Physical Violence and sexual violence*
8. Married	*46*	*Physical violence*
9. 3rd wife	*30*	*Physical violence & financial violence*
10. Married	*40*	*Physical violence & financial violence*
11. Disserted by Husband	*20*	*Emotional violence*
12. Married	*26*	*Physical Violence*
13. Married	*26*	*Physical Violence*
14. Married	*30*	*Physical Violence*
15. Violence in the past	*50*	*Emotional and physical violence*
16. Married	*30*	*Mental violence, dowry*
17. Married	*34*	*Emotional violence, physical violence & sexual violence*
18. Married	*26*	*Emotional violence*
19. Filed for divorce	*28*	*Emotional violence & dowry harassment*
20. Married	*21*	*Emotional & Physical violence*

Table 1:*Some characteristics of 20/25 of the women who participated in our study*

Topic Guide used for in-depth interviews with built in Critical Incident Narratives:

1. Questions about health and health problems

    a. Forgetfulness
    b. Back ache
    c. Headache, migraine
    d. Sexual violence: urinary incontinence, bleeding.
    e. Mental health, worries and anxieties
    f. Nature of pain
    g. Worsening and improvement of symptoms

2. Questions around health seeking behavior
    a. Decisions around seeking health care
    b. Presentation and reporting violence
    c. Expectations from health care providers
    d. Self medication
    e. Traditional healers and herbal remedies

3. Questions on medications and treatments used
    a. Type of medications
    b. Frequency
    c. Relieve of symptoms
    d. Side effects
    e. Preferences and usefulness of medications

4. Opinions and questions about incidents requiring medical intervention
    a. Severe injuries
    b. Bruises
    c. Use of injurious objects e.g. pipes, knife.

5. Perceptions around violent behavior and mental influence on survivors
    a. Reasons behind violent behavior e.g. alcohol, money, jealousy etc and their relation to mental status
    b. Feelings of survivors around violent behavior and their relation/influence on mental health

6. Financial difficulties and their effect on health
    a. Availability of financial support
    b. Overwork and relation to mental and physical health
    c. Coping strategies and social support e.g. family

Continuation of Topic Guide used for in-depth interviews with built in Critical Incident Narratives

7. Relation of health problems to violence
    a. narrating incidents which lead to each health problem
    b. Perceptions around health problems and their relation to violence
    c. Beliefs and coping strategies

8. Influence of violence on other family members:
    a. Effect of violence on the health of children/family member
    b. Critical incidents and examples of violent behavior towards family members
    c. Coping mechanisms and health seeking behavior
    d. Feelings and mental status around children/family abuse

9. Opinions and preferences on improving health services
    a. Doctor Preferences e.g. male or female doctors
    b. Private or government
    c. Doctors asking about their experience with violence
    d. Health care visitor
    e. Reasons behind preferences and usefulness
    f. Attitudes of doctors/health care providers

10. Questions around police services
    a. Opinion on attitudes of policemen
    b. Preferences
    c. Expectations of services
    d. usefulness

Table 2.How can health care workers best support women living with abuse?

1. Assess for immediate danger. *Find out whether the woman feels that she or her children are in immediate danger. If so, help her consider various courses of action. Is there a friend or relative who can help her? If there is a women's shelter or crisis center in the area, offer to make the contact for her. Some hospitals and clinics have adopted explicit policies allowing abused women to be admitted overnight if it is unsafe for them to return home (Josiah 1998; Leye et al. 1999). Leaving a violent partner temporarily does not necessarily end the violence, however. The most dangerous moment for a woman with an abusive partner is often immediately after she leaves or announces her decision to leave a relationship (Campbell 1995).*

2. Provide appropriate care. *For women who have suffered sexual assault, appropriate care may include providing emergency contraception and presumptive treatment for gonorrhea, syphilis, or other locally prevalent STIs. Unless clearly necessary, clinicians should avoid prescribing tranquilizers and mood-altering drugs to women who are living with an abusive partner since these may impair their ability to predict and react to their partners' attack.*

3. Document the woman's condition. *Few providers adequately document cases of abuse against women. In Johannesburg, South Africa, a review found that in 78% of cases of abuse providers had not recorded the identity of the perpetrator. Clinical records included such graphic but general descriptions as "chopped with an axe" or "stabbed with a knife" (Motsei and the Centre for Health Policy 1993). Careful documentation of a woman's symptoms or injuries, as well as of her history of abuse, are helpful for future medical follow- up. Documentation is also important in the event that she decides to press charges against the abuser or to seek custody of the children. Documentation should be as thorough as possible and clearly state the identity of the offender and his or her relationship to the victim.*

4. Develop a safety plan. *Although women cannot prevent violence from recurring and they may not be ready to report their partner to the police, there are ways that they can protect themselves and their children. These include keeping a bag packed with important documents, keys, and a change of clothes, or developing a signal to let children know when they need to seek help from neighbors. Health care providers should review a sample safety plan with the woman and decide together which actions may help in her situation (see Box 6-6.). Sample safety plans can also be taped to the walls of the clinic's restroom and examining room, where women may read them in privacy and without embarrassment.*

5. Inform the woman of her rights. *When a woman takes the step of disclosing her situation, it is crucial that medical practitioners reaffirm that the violence is not her fault and that no one deserves to be beaten or raped. The penal codes of most countries criminalize rape and physical assault, even if specific laws against domestic violence do not exist. Medical staff should find out what legal protections exist for victims of abuse and where women and children can turn for genuine help in enforcing their rights.*

6. Refer the woman to other community resources. *Health care providers can help victims of abuse through early detection and by referring them to available local resources. The needs of victims generally extend beyond what the health sector alone is able to provide. Therefore it is essential that health care providers know in advance what other resources are available to help victims of abuse. It is especially useful for health workers to meet personally with others who provide services for victims of violence because providers will be more likely to refer a woman to someone whom they know when there is a face behind the name.*

(From: Heise, Ellsberg, and Goettemoeller 1999)

Consent Form for Women who experience Violence

My name is Nabbta Bashir Hamad and I am from Sudan. I am studying at the Liverpool School of Tropical Medicine in the United Kingdom. I am here in India to conduct a research project requested by Dr Abhijit Das. With me is my translator Mansi who will do the translation.

The aim of the study is to identify strategies for health care providers to meet the health needs of women experiencing violence in India. You were selected to participate in this research because as a woman having experienced violence you will contribute to the study.

You may have not talked to someone regarding your experiences with violence before and we do realize that is a sensitive topic. The interview will take place in a place where you feel comfortable.

Your participation in the research will be voluntary. It is your decision to choose to participate or not, and you can change your mind and withdraw from the study at any time you wish. Your decision in doing so will be respected. The time required for the interview/Focus Group Discussion will take around 30-60 minutes.

You are invited to participate in the study so that we able to talk to you about your health needs and ask you about your opinion of what needs to be done to improve the situation for you and other women who have similar experiences, we would also want to know about your experience with violence and how that may have affected your health and your health seeking behaviour. We would also like to ask you of the type of care you received.

The information you give to us will be treated as confidential and anonymous. As for Focused Group discussion the research team can not guarantee confidentiality and the reason is it is not possible in a group setting. However, members of the group are encouraged to keep the discussion confidential between each other.

You do not have to answer any question which makes you feel uncomfortable or if you think it is too personal. I would like to assure you that your participation in the study or refusal will not affect the type of care you are provided.

If you agree we will record the interview, and then make notes from the recording. After the notes are complete, the recording will be erased. Only I and my two assistants will have access to this information. A report will be made with the findings and presented to the Centre of Health and Social Justice.

If after the discussion you feel like you want to talk to the research team will be ready to talk to you or give you some information about counseling services available in your area. This research will not bring any benefit to you, but we hope it will help in improving services for women who experience violence. You will not receive any incentive but we will cover your transportation costs and offer you a small snack.

We will not keep your name with the information you provide, we will instead use a number/code. You do not need to worry that results will be announced with your names. Everything you say will be treated confidential. Do you have any questions or queries about the study you want to ask about?

If you are willing to participate please sign below

I have read and understood the information or it has been read to me. I have been given the opportunity to ask questions and they have been answered to my satisfaction. I consent voluntary to take part in this study. I understand that I can withdraw at any time without affecting the service that is provided to me.

Name of participant:

Signature of Participant:

Date:

If illiterate

I have witnessed the reading of this form to the possible participant, and I agree that he/she has had an opportunity to ask questions, and that he/she has consented freely.

Name of witness:

Signature of witness:

Date:

Figure 2: The effect of financial violence on the health of women experiencing violence