Violence against women is now well recognized as a public health problem and human rights violation of worldwide significance. It is an important risk factor for women's ill health, with far reaching consequences for both their physical and mental health.

Gender based violence takes many forms and results in physical, sexual and psychological harm to the women throughout their lives. Gender based violence often the manifestation of unequal power relation between men and women in society and the secondary status of the women because of which women have to suffer a range of health problems in silence.

Violence against women of which domestic violence is a part, is almost a universal phenomenon that cuts across the regional, social, cultural, economic boundaries and threatens the health, well-being, rights and dignity of women in streets, in workplace, and at home. The risk factors vary from culture to culture, but the consequences are almost similar all over the globe.

The Problem
Violence against women cuts a wide swath of suffering and death across the entire globe. The following statistics provide a snapshot of the depth and breadth of the problem.

- Globally an estimated one woman in five will be a victim of rape or attempted rape in her lifetime.
- Violence's toll on women's health exceeds that of traffic accidents and malaria combined.
- Violence kills and disables the same number of women between the ages of 15 and 44 as cancer does.
- Up to one in five women reports being sexually abused before the age of 15.
- More than 130 million girls have been subjected to female genital cutting worldwide.
- Approximately 800,000 people are trafficked across national borders and millions more are trafficked within their own countries. Approximately 80 percent of transnational victims are women and girls and up to 50 percent are minors.

Violence against women is “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”

Gender based violence extends across women’s life span which begins pre-birth with sex-selective abortion and battering during pregnancy; and continuing through infancy and childhood with differential access to food and medical care, and sexual abuse; during adolescence with dating violence, economically coerced sex, and forced prostitution; and in adulthood with violence from an intimate partner, marital rape, dowry abuse, homicide, and sexual harassment. The most common forms of violence against women are physical, sexual, and emotional abuse by a woman’s husband or intimate partner.

Gender Based Violence and Effects on Women’s Health
The most immediate physical health consequences are the consequences of injuries such as acute and chronic pain, cuts, burns, bruises, broken teeth, broken bones, damages to eyes and ears. For women the risk of injury from physical assault...
seems to increase when the assailant is an intimate. Chronic stress-related problems include functional gastrointestinal disorder, appetite loss and viral infections such as cold and flu. Violence during pregnancy poses a threat to health and at its extreme can result in death of the mother and her unborn child. The main health effect specific to abuse during pregnancy is the threat to health and risk of mother, fetus, or both from trauma. This can overlap intimate partner violence and child abuse. Gynecologic problems are the most consistent physical health difference between battered and non-battered women. Female genital mutilation (FGM), a culturally supported form of gender-based violence, is associated with a range of serious health problems, including infection, chronic pain, sexual dysfunction, and obstetric complications.

Sexual violence has profound impact on the mental, physical and reproductive health of the victim.

The physical side of abuse is easily seen, but the psychological wounds are hardly seen and these affect every single aspect of the life of the victim. The psychological impact of domestic violence affects women more than the physical injuries. Physical and sexual violence negatively impacts women’s mental health. Women who live with violent men tend, then, to develop serious health problems as a consequence of the repeated violence and fear they experience. Stark & Flitcraft (1996) have identified this as “Battered Woman Syndrome”, characterized by recurrent assaultive injuries, stress-related injuries, isolation, substance abuse and mental illness. Mental health consequences include depression, Post-traumatic Stress Disorder (PTSD), anxiety, sleeping disorder, eating problems, suicidal tendencies, and increased use of alcohol and other drugs. PTSD is commonly conceptualized as an anxiety disorder occurring subsequent to a traumatic event which is perceived as highly threatening. There is some evidence that PTSD is directly associated with more suicidal attempts and this mediates link between partner violence and suicidal attempts. Numerous researchers have documented that the “association between violence from one’s spouse, low self-esteem, and suicidal tendencies is very strong, especially when compared to the women’s pre-battering life phase”. Sometimes victims may take long time to recover from and may develop extreme symptoms years later in response to stressful incidents. Regular alcohol consumption by the husband, harassment by the in-laws, exposure to harsh physical discipline during childhood and witnessing father beating the mother during childhood were other factors that were strongly associated with increased risk of poor mental health.
How Common Is Violence Against Women?
Globally, at least one in three women has experienced some form of gender-based abuse during her lifetime. Violence against girls and women can begin before birth and continue throughout their lives into old age (see Figure 1). Women are reluctant to discuss abuse, and may accept it as part of their role.

Reproductive Health Effects
Women’s reproductive and sexual health clearly is affected by gender-based violence. A U.S. study found that women who experienced intimate partner abuse were three times more likely to have a gynecological problem than were non-abused women.

These problems include chronic pelvic pain, vaginal bleeding or discharge, vaginal infection, painful menstruation, sexual dysfunction, fibroids, pelvic inflammatory disease, painful intercourse, urinary tract infection, and infertility. Sexual abuse, especially forced sex, can cause physical and mental trauma. In addition to damage to the urethra, vagina, and anus, abuse can result in sexually transmitted infections (STIs), including HIV/AIDS. Women who disclose that they are infected with HIV also may be subjected to violence. Early childbearing, often a result of early and forced marriage, can result in a range of health problems, including effects of unsafe abortion. Girls under 15 years of age are five times more likely to die in childbirth than women in their twenties. They also are at higher risk for obstetric fistula, which can result from prolonged and obstructed labor. Abuse limits women’s sexual and reproductive autonomy. Women who have been sexually abused are much more likely than non-abused women to use family planning clandestinely, to have had their partner stop them from using family planning, and to have a partner refuse to use a condom to prevent disease.

Addressing Violence through Reproductive Health Programmes

The health effects of violence against women are serious, far-reaching, and intertwined. Health care providers have the opportunity and the obligation to identify cases of abuse. For many women in developing countries, a visit to a health clinic for reproductive or child health services may be their only contact with the health care system. The health care sector can capitalize on this opportunity by ensuring a supportive and safe environment for clients, helping providers ask about abuse, and helping women receive the care they need. The steps involved in integrating gender-based violence into health programs have been outlined in a guide developed by UNFPA. Training practitioners to ask women about abuse in a direct interview can be an effective way to identify survivors of abuse. Screening of all women may be impractical, and even unethical if not done appropriately and confidentially. Screening of specific groups, such as women seeking prenatal care or other reproductive health services, may be more feasible. Screening programs need to overcome barriers at the provider and health care system levels. Providers perceive lack of training, time, and effective interventions to be primary barriers to screening. Providers also can be reluctant to screen because they:

- feel uncomfortable asking about the topic,
- are fearful of the woman’s response face cultural and language differences with clients,
- are afraid of offending clients

Laws under the Indian Penal Code (IPC)
- Dowry Prohibition Act: any property or valuable (direct or indirect) given before, at or after the marriage
Prophylaxis for STI can be given to survivors through emergency contraception. Health care providers may offer emergency contraception, safe abortion, post abortion care and STI prophylaxis or treatment. Many women may experience many consequences, including:

- **Unwanted pregnancy**
- **Sexually transmitted infections (STIs), including HIV/AIDS**
- **Complications from an incomplete or unsafe abortion**
- **Unwanted child bearing**

Survivors can access quality health services through emergency contraception, safe abortion, post abortion care and STI prophylaxis or treatment.

### Key emergency services for survivors of sexual violence/abuse:

- **Treatment for physical injuries**: Some but not all survivors of sexual violence have physical injuries that need immediate attention, including general injuries and lacerations of genital area. The treatment can include, for example, first aid care and tetanus shots.
- **Preservation of forensic evidence**: Depending upon the local and national regulations, health care providers may or may not be able to collect forensic evidence without special certification. In any case, providers need to ensure that they do not take actions that will preclude the possibility of collecting forensic evidence, either by staff in the organization or by a forensic physician at another facility.
- **Emergency contraception**: Emergency contraception refers to methods that can prevent pregnancy after unprotected sexual intercourse has taken place. EC includes EC pills as well as intra uterine device (IUD). Emergency contraceptive pills (ECPs) can prevent unwanted pregnancies if used within 72 hours of the rape. As described by WHO "emergency contraceptive pills (ECPs) work by interrupting a woman’s reproductive cycle - by delaying or inhibiting ovulation, blocking fertilization or preventing implantation of the ovum. ECPs do not interrupt pregnancy and thus are not considered a method of abortion." ECPs should not be seen as a substitute for regular use of contraceptive methods. Women should be counseled concerning their future contraceptive needs and choices.
- **Safe abortion counseling and services**: Many women resort to self-induced or unsafe abortions when they become pregnant as a result of sexual violence.
- **Post-abortion care (PAC)**: Post abortion care services include emergency treatment for complications of spontaneous or induced abortion, designed to reduce morbidity and mortality from incomplete or unsafe abortion.
- **STI prophylaxis**: Prophylaxis for STI can be given to survivors in the form of special doses of antibiotics, anti-retroviral drugs or vaccinations. If given soon enough after exposure, STI prophylaxis can prevent disease.
Provide Follow-up Medical Care
A woman should be counseled to return for follow-up examinations one to two weeks after receiving initial medical care. Health care providers should monitor her follow-up care. Further tests and treatment, such as testing for or treatment of STDs or referral to other RH services, may be indicated during follow-up. Further visits may also be required for pregnancy and HIV testing.

Operational Issues:
- Any registered medical practitioner can conduct the examination and it is not mandatory for a gynecologist to examine such a case.
- In case of a girl/ woman every possible effort should be made to find female doctor but absence of availability of lady doctor should not deny or delay the treatment and examination.
- A male doctor can conduct the examination in the presence of female attendant.
- In case of minor/person with disability, his/her parent/guardian/ any other person with whom the survivor is comfortable may be present.
- In the case of transgender, survivor should be given a choice as to whether she/he wants female doctor or a male doctor.
- Police personnel must not be allowed in the examination room during the consultation with survivor.
- There must be no delay in conducting an examination and collecting evidence.
- Providing treatment and necessary medical investigation is the prime responsibility of the examining doctor. Admission, evidence collection or filling a police complaint is not mandatory for providing treatment.
- The history taking and examination should be carried out in a complete privacy in the special room.

REFERENCES
- International Journal of Interdisciplinary and Multidisciplinary Studies (IJIMS)
- Improving the health sector response to gender based violence-IPPF
- Guidelines and protocols for medico-legal care for survivors/ victims of Gender based violence-Government of India
Adverse Health Outcomes of Physical and Sexual Violence within Marriage: Experiences of Young Women in Maharashtra, India

Study Presented by Dr. Shireen J Jejeebhoy, Population Council, Delhi in a Consultative Meet at FPA India in the year 2007

Study was done in rural and urban sites in Pune district of Maharashtra. The study conducted by the KEM Hospital Research Centre (Pune), and the Population Council, in 2004-2005. A survey of young people (15-24) was done. About 2306 married young women was part of the study.

Key Findings of the study:
- Large proportions of young women reported the experience of physical violence and forced sex perpetrated by their husbands
- Based on the selected SRH indicators among young women it was found that -
  - Between 15% and 18% of young women reported that they had suffered from at least one SRH problem.
  - 21% had experienced pregnancy loss or child death.
  - 5% had at least one unwanted pregnancy.
- Women who were beaten or were forced into sex were significantly more likely than other women to have experienced SRH problem.
- Women who experienced physical violence were more likely than other women to have lost a pregnancy or child.
- Both physical and sexual violence perpetrated by the husband increase the risk of unwanted pregnancy

The next step would be to implement programs at – individual, community and health care facility level.

**Individual level:**
- Interventions for youth must encompass prevention of gender based physical and sexual violence:
  - reproductive rights and the rights of women within marriage
  - partner communication and negotiation skills
  - gender double standards and countering traditional gender stereotypes
  - Can physical/sexual violence issues be effectively folded into existing interventions (life and livelihood skills, sexuality education, etc)?

**Community level:**
- Raising awareness, countering traditional gender stereotypes and sensitising stakeholders
- Sensitizing teachers, law enforcers and others
- Countering public perception of violence that blames the victim
- Recognition of the rights of women within marriage

**Health Care Facility level:**
- Training of health care providers to address prevention, help identify and support victims
- Screening by health care providers for physical, sexual violence
- Violence must be probed in routine SRH sessions
- Availability of counselling services
- Accessibility of emergency contraception and HIV post-exposure prophylaxis (in case of sexual violence)
Abstracts accepted for APCRH conference on Gender based violence are as follows:

**Reproductive health Impact in clients attending reproductive health clinic In Lucknow district of Uttar Pradesh in India**

Dr. Monique Kamat, Dr. Kalpana Apte, Mr. Vishwanath Koliwad

**Introduction:**
In the Indian scenario the phenomenon of violence against women within the family is complex and deeply embedded. In Uttar Pradesh, 37% of women, 37 percent have ever experienced physical violence and 8 percent have ever experienced sexual violence. In all, 50 percent of women aged 15-49 in Uttar Pradesh have experienced physical or sexual violence, including 45 percent of ever-married women. Spousal violence Two in five ever-married women (41%) report having been slapped by their husbands; 15-17 percent report having their arms twisted, being pushed, shaken, kicked, dragged, or beaten up, or having something thrown at them. Nine percent report that their husbands have physically forced them to have sex.

**Hypothesis:**
The association of GBV with sexual and reproductive health needs including abortion among married or partnered women of reproductive age in reproductive health clinic of Lucknow of FPA India.

**Good practices at FPA clinic observed during study**
The counselors and clinicians in Lucknow clinic are trained in dealing with survivors of Gender-Based violence prior to the study. Referral link for those affected have been established in Lucknow before the initiation of the study. All clients are screened after consent for GBV. Counseling is essential service delivered to all clients availing of services at the clinic. All information is Confidential.

**Methodology:**
This study examines the association of GBV with induced abortion among married or partnered women of reproductive age in reproductive health clinic of Lucknow FPA India. Data were drawn from a cross-sectional survey of 518 women aged 18-49 years in FPA INDIA Clinic of Lucknow. SGBV support and care is a regular service as part of integrated package of service delivery.

**RESULT:**
There have been 518 new registered cases in sexual and reproductive clinic. Of these 60% of clients are abortion seekers. 50.1% (260 absolute) of clients accepted to undergo Sexual and Gender-based violence screening as routine. The prevalence of any type of GBV was 58% have suffered Domestic Violence in some form (% 19.3% physical violence, 10.4% sexual violence, and 28.3% emotional violence). Age Break down 20-24 years is 7.84%, 25 to 29 yrs 28.10%, 30-34 yrs is 35.29 %and 35 years and above is 28.7%. Physical violence was significantly associated with induced abortion, and all three types of violence were associated with repeat abortion.

**Conclusion**
GBV is omnipresent in Lucknow district of Uttar Pradesh and is linked to increased risks of induced abortion and repeat abortion. The findings suggest that a pathway underlying this relationship is increased risk of unintended pregnancy due to part to ineffective use of contraceptives. These findings emphasize the importance of screening and identification of GBV and incorporating women’s empowerment in reproductive health and family planning programs.
Understanding Violence Against Women during the Reproductive Life Cycle
Armin J Meegad, Director MBE, Dr. Kaipana Apte, Ast Secretary General (Org Imping), Vishwanath M. Killawad, Secretary General, FPA India

INTRODUCTION
Recently there have been a dramatic increase in the status of women in India. However, women continue to face atrocities despite amendments in the criminal law made consequent to the “Gang Rape” scandal in Delhi. This study was conducted to gain a better understanding, contribute to existing body of knowledge, and to further the issue of violence against women.

METHODS
The study was conducted in New Delhi and Mumbai.
• 5 FGIs with 40 girls/women between 10-14 years (13), 15-19 years (15), and 35-60 years (14).
• 4 In-depth interviews with women survivors of GBV.
• Soft spots of vulnerability in a woman’s life were identified by the groups through an exercise.

Respondents list of types of violence which occur to girls/women:
• Drinking alcohol and beating wife (most common)
• Rape (after watching blue films and being in a drunken state)
• Torturing wife for not having male children
• Hitting/hashing
• Dowry demands-sometimes the in-laws family send her home for bringing less dowry. In some cases, the girl commits suicide as she is unable to cope up with the situation on being regularly tormented by the in-laws family
• Human trafficking – sometimes husband himself sends his wife to earn “easy” (according to the husband) money
• Husband demands wife – because of this, marriage may break up and the woman undergoes lot of tension
• Before marriage - acid attack, kidnapping, rape, etc. can occur if a boy proposes to a girl and if she is not willing
• After marriage - if the wife is beautiful, the husband usually doubts that she is having an affair and keeps torturing her for no fault of hers. If the victim wants to complain to the police & go to the court of law, the in-laws become more violent and sometimes also kill the girl.

Experience of GBV

Reasons for GBV

Almost all men in the area drink. There are several liquor joints in the area and this is where the men go before they reach home from work. (Victims from both Mumbai and New Delhi)

“Two months ago, a eleven year old from our neighborhood was raped and they found candles inserted inside her. This was done by a boy known to her” (18 year old, New Delhi)

“Almost all men in the area drink. There are several liquor joints in the area and this is where the men go before they reach home from work” (Victims from both Mumbai and New Delhi)

“Two months ago, an eleven year old from our neighborhood was raped and they found candles inserted inside her. This was done by a boy known to her” (18 year old, New Delhi)

MAJOR FINDINGS
Restrictions on movement of girls laid by mothers, fathers and brothers (both younger and older to them).
• Stay away from boys in the neighborhood and ‘never talk to them’
• Reach home before 7 pm
• No wearing jeans
• Elder are women do not leave their daughters alone at home.

“Two months ago, a eleven year old from our neighborhood was raped and they found candles inserted inside her. This was done by a boy known to her.” (18 year old, New Delhi)

“Almost all men in the area drink. There are several liquor joints in the area and this is where the men go before they reach home from work.” (Victims from both Mumbai and New Delhi)

**After the “D武器” rape case ("Police") things have gotten worse rather than improved. These perpetrators should have been hanged in public after being shot with wide. Only then men would fear their actions. Right now, they think that whatever they do, nobody is going to figure it out.

“Almost all men in the area drink. There are several liquor joints in the area and this is where the men go before they reach home from work. (Victims from both Mumbai and New Delhi)

Figure 1: Soft spots of vulnerability in a woman’s life

Scores of vulnerability

Time line in a woman’s life

12
10
8
6
4
2
0

9 9 9 5 8 10 6

5-6 years
10-14 years
15-19 years
25-39 years
40-64 years

CONCLUSIONS
- Women are not aware of their rights
- Most perpetrators were knew to the victim
- They suffer violence in silence
- They do not reach out for medical help because of stigma and discriminatory practices among the health care providers

RECOMMENDATIONS
- Generate awareness on women’s rights including SRH
- Introduce sexual education among young people
- Capacity building of health care providers for sensitive approach in dealing with cases of violence against women.