CHAPTER-1

INTRODUCTION

CHAPTER – I

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Violence against women is a universal phenomenon. While it differs in its scope from one society to the other, it exists everywhere.

Every year, violence in the home and the community devastates the lives of millions of women (Heise, Pitanguy and Germain, 1994). Around the world, as many as one in every three women has been beaten, coerced into sex, or abused in some other way – most often by someone she knows, including by her husband or another male family member; one woman in four has been abused during pregnancy (UNFPA website).

Domestic violence is the most common form of violence against women world wide, with 10 to 50 percent of women reporting physical abuse by an intimate partner in their lifetime (WHO, 2000). In India, as a review of micro studies and national level data shows, 22 to as high as 79 percent of women surveyed in different parts of the country have experienced domestic violence.

Violence against women be it in any form, not only affects all aspects of women's health including their survival, but is also a risk factor for their ill health (WHO, 1996).

The adverse impact of violence on women's health has been acknowledged world wide, in various international covenants, conventions, conferences

and declarations (notable among them CEDAW 1992, World Conference on Human Rights 1993, Fourth World Conference on Women 1995) as a crucial human rights and public health issue. It is further declared as a 'Public Health Priority' by the 49th World Health Assembly of 1996 and the United Nations Population Fund in 1999.

Being the first point of contact for victims of domestic violence, health care delivery systems and health care providers are best placed to identify and respond to the victims of violence. However, the review of studies done so far and field realities worldwide indicate that the response of health care delivery system to this public health issue is not very encouraging. As also observed by WHO (2000) "Far from playing an proactive role, the health care system is usually unresponsive to the woman victim of violence".

The present study is an attempt to understand the response of the health care delivery system to this critical issue in the state of Gujarat, from the perspectives of women users and health care providers.

This chapter is an attempt to gain conceptual clarity and a better understanding of domestic violence and health care. It includes discussion on the definition of domestic violence, factors contributing to domestic violence and the various perspectives that have influenced societal and political responses to domestic violence.

The chapter discusses the concept of health and health care with particular reference to women's health, as women's health cannot be viewed in isolation of their socio-cultural context and environment.

Having established domestic violence as a determinant of women's health, the chapter concludes with the rationale for the present study.

Concept of Violence Against Women

Any scientific research related to violence must first begin by defining violence and its various forms in such a way that it facilitates its scientific measurement. However, defining violence against women is a difficult task because of varying cultural and sub cultural views on what constitutes violence, what are acceptable and unacceptable behaviours and what constitutes harm. These notions/views related to violence are not only culturally influenced but are also constantly reviewed as values and social norms evolve in societies from time to time.

The oldest, perhaps the most widely accepted definition of violence against women is contained in the United Nations Declaration against Violence against Women (1993). The document defines violence as "an act of gender based violence that results in, or 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 private life."

This encompasses physical, sexual and psychological violence, occurring in the family and in the general community, including battering, sexual abuse of children, dowry-related violence, rape, female genital mutilation, and other traditional practices harmful to women, non-spousal violence and violence related to exploitation, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state.

Some human rights activists have defined violence against women very broadly also including "structural violence" such as poverty and unequal access to health and education. But others have preferred to define it narrowly so as to not lose the actual descriptive power of the term (Heise, et al., 1994).

Violence against women, often referred to as 'gender based' violence thus includes a host of harmful behaviours directed at women and girls due to their sex. It refers to physical, psychological / emotional violence, sexual coercion and controlling behaviour occurring in the family and community. It also includes continuum of deprivation and discrimination, through the life cycle of women. While some forms of violence are direct and visible, many others are insidious and more hidden, making invisible both the nature and degree of the violation.

Forms of Gender-based Violence Throughout the Lifecycle of Women

- Pre-birth - sex-selective abortion, battering of the mother and its effect on the foetus
- Infancy to childhood - female infanticide, neglect of health care and nutrition, physical, abuse, sexual, psychological abuse, female genital mutilation
- Adolescence - child marriage, physical, sexual and psychological abuse, prostitution, pornography
- Adulthood - Sexual coercion, rape, sexual harassment, trafficking, partner violence, marital rape, dowry abuse, forced pregnancy and abortion, honour killing
- Old age - neglect, deprivation, widow abuse, suicide or homicide for economic reasons, physical, sexual abuse.

Source: Heise, et al., 1994

Crimes against women and girls such as rape, molestation, sexual harassment, psychological abuse by husband or his relatives or intimate partners are specific, legally recognized acts of violence, whereas violence against women covers all those forms of social and economic violations that are many times not captured by legal enactments.

Women are vulnerable to and/or can experience violence anywhere and at any point of time in their lives. At the same time one must acknowledge that when class, caste and ethnicity mediate, these make men equally vulnerable to certain forms of violence such as trafficking of young boys, child sexual abuse, bonded labour etc. However, because the experience of violence is overwhelmingly determined by gender related vulnerabilities, women and girls are found to be more at risk for it.

Defining and Understanding Domestic Violence

Of the various forms of violence against women, one of the most common forms is Domestic Violence.

Domestic violence is the violence that occurs within the private sphere, generally between individuals who are related through intimacy, blood or law. It can include any nature and type of violence taking place within the domestic place called home, household or family. It can be violence against women and girls of the family, violence between siblings, on child/children, elders of the family.

The Encarta dictionary (2003) uses the terms domestic violence, spouse abuse and intimate violence interchangeably. It defines domestic violence as physically or emotionally harmful acts between husbands and wives or between other individuals in intimate relationships.

Despite the apparent neutrality of the term, domestic violence is nearly always used as gender specific crime/act perpetrated by men against women; more so by the husband and his family members on the wife. This is because police and hospital records have indicated that the majority of victims of domestic violence are women. Even experiences of women's organisations, voluntary organisations working with women reflect that women are abused, harassed, tortured, coerced by their own partners or husbands, and marital family members within their own homes.

The British Council (1999) defines domestic violence based on the concept of gender violence given by the United Nations General Assembly while formulating the CEDAW declaration in 1993. It defines domestic violence as all such gender based violence and abuse taking place on women in adult marital relationships.

Thus the term domestic violence has almost become a synonym for violence against married women taking place within the four walls of the home, within the family.

The terms 'family violence', 'intimate violence', 'marital violence', 'gender violence', 'spousal abuse', 'wife abuse', 'wife battering', 'wife beating', 'wife assault' or 'domestic abuse' are often used for domestic violence. Each of these terms gives a new meaning to the concept of domestic violence by including various forms of violence in its preview. Different researchers have defined domestic violence differently.

The term 'family violence' used by many researchers in relation to domestic violence has different cross cultural and historical meanings. It covers a wide range of behaviours and includes domestic violence, child abuse and abuse of elderly. The concept includes all acts of violence, carried out by any family member against other family members (Agnes, 1984; Desai and Krishnaraj, 1987). Family violence is also defined as "day to day patterned and recurrent use of physical violence like pushing, slapping, punching, knifing, shooting and throwing objects by

one member of the family at another" (Gelles, 1997). Or as "any act of commission or omission by family members and any condition resulting from such acts and inaction which deprive other family members of equal rights and liberties and/or interfere with their optimal development and freedom of choice" (Pagelow, 1984 as cited in Madhurima, 1996).

In a study carried out in Bangalore, India, family violence is defined as "an act performed by a family member to achieve the desired conformity which carries negative emotional component" (Bhatti and George, 2001).

Other common terms that have been used to describe domestic violence are wife battering and wife beating. These are often understood as physical assault on the wife and viewed as very specific act of physical violence under the general concept of domestic violence (Subadra, 1999; Ahuja, 1998; Jejeebhoy, 1998a).

Some researches have used the term 'marital violence' to define violence against women in marital relationship, especially violence by husband on his wife (Sriram, 1988; Abraham, 1998; Mehta, Desai and Desai, 2000).

While the terms 'family violence', 'gender violence' with their too broad and general understanding and the terms 'wife battering', 'wife beating', 'marital violence' with their limited and specific understanding of domestic violence may capture a large universe of the experiences of

women, they are predicted on the assumption that women primarily live in nuclear families, and that physical violence is the only form of violence used against them. Across cultures, there are varieties of living arrangements ranging from joint families to nuclear families to single parent families. Also, women may be in an established relationship or in process of separation or divorce. Moreover domestic violence is a broad category including many forms other than physical form of violence.

In India, the public discourse and media have equated domestic violence with dowry violence. This is not a complete representation as it does not include psychological, physical and sexual abuse that women may be confronting daily and that may not be related to dowry. Even some of the Indian laws related to domestic violence view it within the context of dowry harassment (Sections 498-A, 304-B IPC). However the most recently enacted legislation, titled Protection of Women from Domestic Violence Act, 2005 of the country defines domestic violence from the human rights perspective. It defines domestic violence as "any act, omission or commission or conduct of the respondent shall constitute domestic violence in case it –

(a) harms or injures or endangers the health, safety, life, limb or well being, whether mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse and economic abuse; or

(b) harasses, harms, injures or endangers the aggrieved person with a view to coerce her or any other person related to her to meet any unlawful demand for any dowry or other property or valuable security; or

(c) has the effect of threatening the aggrieved person or any person related to her by any conduct mentioned in clause (a) or clause (b); or

(d) otherwise injures or causes harm, whether physical or mental, to the aggrieved person."

Here aggrieved person means any woman who is, or has been in a domestic relationship with the respondent and who alleges to have been subjected to any act of domestic violence by the respondent. And 'Respondent' has been defined under the act as 'any adult male person who is, or has been, in a domestic relationship with the aggrieved person and against whom the aggrieved person has sought any relief under this act; provided that an aggrieved wife or female living in a relationship in the nature of marriage may also file a complaint against a relative of the husband or the male partner'.

The definition given by the law details the different forms of violence faced by women and ensures that its interpretations are not left to the discretion of any redressal machinery to whom women may approach for assistance, interventions i.e., police, magistrate protection officer, social workers etc. The definition also recognizes even a single act of

commission or omission as domestic violence. In other words, women do not have to suffer a prolonged period of abuse before taking recourse to the law.

In present study domestic violence has been defined as subordination of women within marital relationship by their husbands, in-laws and/or other members of their marital family.

Factors Operating on Domestic Violence

Why does domestic violence occur? What causes men to be violent, abusive, and oppressive towards women? Why is the family such a violent institution? Why do women submit to domestic violence? What can society, social workers, health care system do about it? These are some of the questions that need to be answered to gain a clear understanding of domestic violence.

A clear understanding of the root cause of the issue is essential not only for planning actions to end violence and help women in abusive relationships, but also important for avoiding discouraging, conflicting or frustrating experiences of working on the issue at the macro level and with women victims/survivors of domestic violence and/or perpetrators of such violence at the micro level.

There are different theories explaining the factors that can be considered responsible for perpetuating domestic violence in any society. Among

the many theories, as described by Kurz (1993), two theoretical perspectives that have dominated domestic violence research are: the family violence perspective (e.g. Straus, Gelles and Steinmetz, 1980) and the feminist perspective (e.g. Dobash and Dobash, 1979).

For the family violence perspective, the unit of analysis is the family, whereas for the Feminist perspective, the unit of analysis is the relationship between men and women. This perspective encompasses all forms of violence against women, from sexual harassment at workplace to domestic violence (Kurz, 1993).

The family violence theories focus on characteristics of the individuals involved in the violence. The causes are considered eradicable, individual problems that are generally psychological or social-cultural in origin, such as mental illness, personality disorders, substance abuse, and structural stress.

Structural stress is a result of poverty, unemployment, limited educational resources, illness, and social approval and acceptance of violence in the society (Gelles, 1997). Men react by becoming violent towards women due to stress caused by their in ability to meet the demands on families. Violence is also looked at as an intergenerationally learned behaviour (Wallace, 1996; Gandhi, 1997). Children who are victim of violence or witness of spousal violence are more likely to react the same way to their children or spouses as adults.

This description of causation isolates incidences of domestic violence maintaining its position as a private and individual problem. Since domestic violence occurs all over the globe, in all socio-economic classes and across cultures, the causal explanations given by these theories by themselves are inadequate. Also, in these theories, the family is the location of the abused and the abuser. The family mystique, which defines family as private and above reproof, has served to keep domestic violence hidden, and made it a less attempted area of interventions.

Feminists however, give broader overarching explanations related to domestic violence and view it beyond individual social or psychological situations. Domestic violence is seen in a social context tolerating the subordination of women. It is seen as structural rather than as isolated within individual relationships.

At the core of feminist theories is the unequal balance of power between men and women that is institutionalized within the patriarchal family (Heise, 1989). For feminists, family violence is a direct outcome of men's attempt to maintain control over the powerless members of the family – women and children. Thus it is the social and structural power that men have due to patriarchy over women that they commit violence against women (Kurz, 1993).

Feminists question the family mystique. The family is viewed as one of the powerful institutions oppressing women. While domestic violence is

viewed as a predictable and common dimension of a normal family life, it is understood not as a private matter but a social one (Personal is Political), which legitimizes intervention. They view women who have experienced violence as survivors of harrowing, life threatening experiences who have many adaptive capacities and strengths (Gondolf and Fisher, 1988).

The Ecological Framework for Understanding Domestic Violence

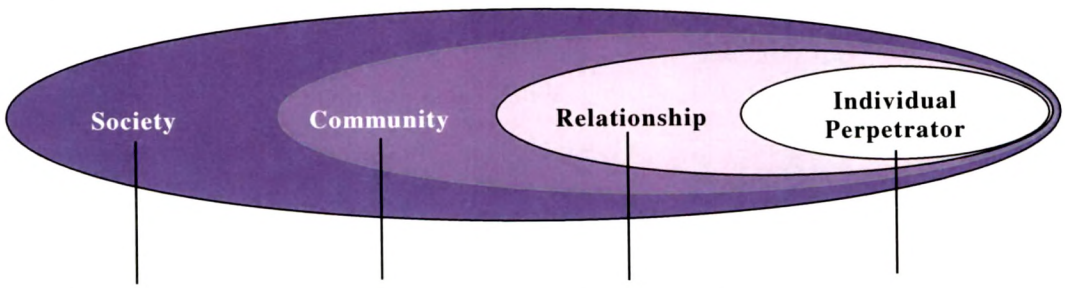
Theory construction to understand violence against women has revolved around a wide range of factors from personal pathological reasons to familial, interpersonal, social learning aspects and from community cultural dimension to the functioning of social systems and structures.

While no single theory can claim to fully explain the complexity of domestic violence, a need to develop a theoretical model which would comprehensively analyse the interplay of personal, situational and socio-cultural factors was felt amongst researchers. Lori Heise (1998) developed an integrated framework called the Ecological framework for understanding domestic violence by encompassing certain concepts from family violence theories as well as by adapting feminist understanding of gender relations and violence against women.

According to Lori Heise (1998), violence against women is the result of the interaction of factors at different levels of the social environment. The model can best be visualized as four concentric circles as given in

the figure below. The innermost circle represents the biological and personal history that each individual brings to his or her behavior in personal relationships. The second circle represents the immediate context in which abuse takes place – frequently the family or other intimate or close relationships. The third circle represents the institutions and social structures, both formal and informal, in which relationships are embedded – neighbourhood, workplace, social networks, and peer groups. The fourth, outermost circle is the economic and social environment, including cultural norms.

Figure-1: Ecological Framework of Domestic Violence



- Norms granting men control over female behavior
- Acceptance of violence as a way to resolve conflict
- Notion of masculinity linked to dominance, honor, or aggression
- Rigid gender roles

- Poverty, low socio economic status, unemployment
- Associating with delinquent peers
- Isolation of women and family

- Marital conflict
- Male control of wealth and decision-making in the family

- Being male
- Witnessing marital violence as a child
- Absent or rejecting father
- Being abused as a child
- Alcohol use

Source: Adapted from Heise, 1998 as given in Population Reports/CHANGE 1999

By combining individual factors with the findings of cross-cultural studies, the ecological model contributes to understanding why some societies and some individuals are more violent than others and why women – especially wives – are so consistently the victims of abuse/ violence.

Thus, the Ecological Framework, drawing from both the family violence and the feminist perspectives, explains several factors increasing the likelihood of men abusing their wives. Violence against women is seen as the result of the interaction of these factors at different levels of the social environment.

Factors perpetuating domestic violence in India

The summary given below gives a swift account of the four main factors that operate to perpetuate domestic violence in India.

- Cultural factors – include gender specific socialization, cultural definitions of appropriate sex roles and expectations of gender roles within relationships, belief in the inherent superiority of males, values that give men proprietary rights over women, notions of the family as private, under male control, customary practices related to marriage (dowry, bride price, etc.), acceptability and glorification of violence as a means to resolve conflict.

- Economic factors – include women's economic dependence on men, limited access to economic resources – money, property, lack of or limited employment opportunities in formal and informal sector, lack of or limited educational and training opportunities.

- Legal factors – include coexistence of different laws governing personal and public life i.e. customary laws, religious laws, etc.; discriminatory laws related to divorce, maintenance, inheritance, custody of child; absence of comprehensive definitions related to domestic violence encompassing all forms of violence that women may experience within marital relationships, lack of legal awareness of rights amongst women, gender insensitive police and judiciary system.

- Political factors include – Domestic violence not considered as a political agenda, notions that the family is 'private' beyond the control of the state, lack of political will to challenge personal, religious law, absence / limited access of women's organisations as a powerful political force, under-representation of women in power, politics, legal and medical profession.

Perspectives on Responding to Domestic Violence

A perspective is a way of understanding a situation through locating it within a personal frame of reference. Discourses, debates on a particular social issue and the society's actions, response to it are largely governed by the way that society views that social issue.

Domestic violence has been viewed from different perspectives. Different definitions of domestic violence discussed in the foregoing sections inform that it can be viewed either as a crime or a social problem or as a human rights issue or a health issue. A few of the common perspectives that have dominated different societies' views and their responses to domestic violence historically include :

The traditional perspective

It views domestic violence as a justifiable act, a 'rightful act' on the part of the husband. It is considered as a private affair, an intra familial issue that is a sanctioned, accepted evil of the society. Till this perspective dominated, it did not evoke any response from society. It rather gave social and cultural sanction to domestic violence.

The socio-legal perspective

It views domestic violence as a social problem affecting the quality of life of many women, children and families. This perspective accepts that domestic violence has serious social, economic consequences at individual, familial and societal end. Domestic violence affects the entire fabric of the society, directly and indirectly. This perspective also views domestic violence as a legal issue, a crime perpetrated against women by men/husbands and their family members. Women and their children are victims and others are perpetrators.

This perspective suggests social welfare measures like setting up of family counselling centers, shelter homes etc. and legal measures like enacting acts, making legal provisions, setting up of family courts, and legal aid centers, as some of the ways to respond to the issue.

The human rights perspective

Based on the Universal Declaration of Human Rights (1948) and subsequent international covenants and conventions, this perspective views domestic violence (rather any violence against women) as an act against the fundamental notion of humanity, eroding women's sense of being human. It views women's rights as human rights and violence against women as a violation of women's human rights. Moreover, it believes that the state and its agencies (social, political, legal, health, etc.) have an obligation to protect, support and help women victims of violence. Failure of the state and its agencies to carry out any obligations (action or omission) that violates women's human rights against violence is also seen as the one inflicting further violence against women.

This perspective advocates the use of international instruments, declarations, covenants and acceptance or ratifications done by the member countries for ethical, political and legal actions as well as for the purpose of making the member country accountable to international communities. Advocacy is the response that is promoted by this perspective.

The feminist perspective

Feminists view violence not as private, family matter but a social issue. The feminist approach to violence believes in understanding domestic violence from the experiences of women from their own frame of reference. They criticize theories related to domestic violence that blame or implicate women for the violence either as helpless victims or as provocative women, who ask for abuse, because these theories revictimize women victims. They view women who have experienced violence as "survivors" who have many adaptive capacities and strengths.

According to feminists, research on violence against women must aim at developing theories and models that reflect women's experiences, from their own frame of reference. Advocacy for women must be women-centered.

The public health perspective

The most recent and less explored perspective, it looks at domestic violence not as a health problem but as a risk factor for ill health for a large number of women.

The present study is based on the view that domestic violence affects women's health and that no attempt to improve women's health would yield positive results in the long run unless the issue of domestic violence is addressed by the health care system of the country. Having discussed

the concept of domestic violence in detail, let us now look at the concepts of health and health care with special reference to women's health.

The Concept of Health

Health is one of those terms which most people find difficult to define although they are confident of its meaning. As health is a relative concept, it cannot be and is not perceived the same way by all members of a community or a society (e.g. biomedical scientists, social scientists, women activists, etc.).

The Vedic ideal of health, the widely prevalent traditional model of healthcare in India, defines health "as the state of enlightenment – a perfectly integrated state of mind, body and behaviour; and an enriching, evolutionary relationship with the cosmic counterparts – sun, moon, planets and stars."

The WHO (1948) has defined health as "a state of complete physical, mental and social well being and not merely absence of disease or infirmity." In recent years, this statement has been amplified to include the ability to lead a "socially and economically productive life" (WHO, 1978, cited in Park, 2002).

Some of the other definitions of health are:

"Freedom from pain, stress, discomfort and boredom and adaptation to social and biological environment" (Dubos, 1968).

"Health is not only absence of illness but the prevalence of congenial social, psychological and physical conditions where a person can achieve his/her optimum and enjoy life peacefully and satisfactorily" (Bajpai, 1998).

"Health is a personal and social state of balance and well being in which a person (woman) feels strong, active, creative, wise and worthwhile, where her body's vital power of functioning and healing is intact, where her diverse capacities and rhythms are valued, where she may decide and choose, express herself and move about freely" (WAH: Approach Document, 1999).

Health has evolved over the centuries as a concept from an individual concern (absence of disease) to wellbeing of individuals, society determining social development (Bajpai, 1998) to a powerful tool for women's empowerment (Batliwala, 1993) or as relative to the aspirations of individual or groups thus defined in relation to the users' perspective.

It has also evolved from being a welfare concern to a fundamental human right encompassing the whole quality of life and a worldwide social goal. It is not mainly an issue of doctors, social service and hospitals but an issue of social justice.

A brief account of the varying concepts of health is enumerated here.

Biomedical concept

Traditionally health has been viewed as an "absence of disease". If one was free from disease then the person was considered healthy. This concept is known as the "biomedical concept". It has minimized the role of the environmental, social, psychological and cultural determinants of health.

Ecological concept

Here health is viewed as a dynamic equilibrium between human beings and their environment and disease a maladjustment of the human / organism to environment (Dubos, 1968). The ecological concept raises two issues, namely imperfect human being and imperfect environment.

Psycho-social concept

Health is not only a biomedical phenomenon but also one, which is influenced by social, psychological, cultural, economic and political factors of the people concerned. Here health is both a biological and a social phenomenon.

Holistic concept

A synthesis of all the above concepts, it recognizes the strength social, economic, political and environmental influence on health. This view corresponds with the earlier Vedic view held in India that health implies a sound mind in a sound body in a sound family in a sound environment.

Quality of life concept

Recently, a broader concept of health has been emerging, that of improving the quality of life of which health is an essential component. Quality of life as defined by WHO (1976, cited in Park, 2002) is "the condition of life resulting from the combination of the effects of the complete range of factors such as those determining health, happiness, education, social and intellectual attainments, freedom of action, justice and freedom of expression." A recent definition of quality of life is "a composite measure of physical, mental and social well being as perceived by each individual or by group of individuals – that is to say happiness, satisfaction and gratification as it is experienced in such life concerns as health, marriage, family, work, financial situations, educational opportunities, self-esteem, creativity, belongingness and trust in others" (Nagpal and Sell, 1985 as cited in Park, 2002).

Right to health concept

The Universal Declaration of Human Rights adopted by United Nations (1948) recognizes that all human beings are born free and equal in dignity and rights. It speaks of the Right to Health in the following terms, "Everyone has the right to a standard of living adequate for the health and well being of himself and of his family including food, clothing, housing and medical care and necessary social service."

The preamble to the Constitution of the WHO affirms that it is one of the fundamental rights of every human being to enjoy "the highest attainable standard of health" (cited in Park, 2002). Most of the countries of the world have accepted the idea of the right to health.

In India, right to health is not a fundamental right. The Constitution of India has dealt with it in its Directive Principles of State Policy. Article 47 of the constitution states that "the state shall regard the raising level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". Further "the state shall in particular will direct its policy towards securing.... that the health and the strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter vocations unsuited to their age or strength...." (Premi cited by Ramchandrandrudu, 1997).

Thus the above different understandings of health can be broadly divided into two approaches: the *biomedical approach* and the *social understanding of health.*

As the present study focuses on Health Care for Women (as survivors of Domestic Violence) it is important that the concept and understanding of women's health be also explained.

Understanding Women's Health Problems

Women's health has been a largely ignored area for a long time, and it is only recently that some documentation is being done on the subject. The deeper one digs, the more complicated it seems. The easy way out is to define women's health or illness in biomedical terms. Even today most health-related professionals are taught that women's health is a matter of nutrition or perhaps poor hygiene, bad obstetric practices and so on. But a closer look reveals that this simple explanation is inadequate to explain the myriad factors that affect each other and in turn affect women's health. To define women's health it is important first to understand the factors affecting women's lives that in turn affect their health, since most of the factors that affect women's lives, directly and indirectly also affect their health.

There are two main approaches to understand women's health.

- The biomedical approach, which focuses on anatomy, physiology, pathology disease agents, susceptibility and resistance, investigations, therapy and quality of services.
- The social approach, which examines various determinants that affect women's health. It explains the socio-cultural determinants (gender, religion, traditions, educational status), biomedical determinants (biology), economic determinants (poverty, environmental degradation, work) and violence as some of the major determinants of women's health.

The Biomedical and Social Approach in Understanding Women's Health

Bio Medical Approach	Social Approach
• Anatomy	• Poverty
• Physiology	• Environment
• Pathology	• Gender
• Disease Agents	• Religion
• Susceptibility and resistance	• Cultural Beliefs and Traditions
• Investigations	• Education
• Therapy	• Violence
• Quality of Services	• Self Concept
	• Access to services

Source: KRITI Resource Centre, undated

Women's health however, must be defined holistically so that it encompasses all the determinants affecting women's health. A holistic view of women's health recognizes that biological, psychological, social-cultural, economic, violence and life style issues affect women differently than men, and that women require specialized services and care. The holistic approach strives to address all aspects of women's health and all sources of ill-health across their entire life cycle. The underlying principle is that addressing the distinctive concerns of each stage of women's lives, will help in improving their overall health and well being (Joshi and Joshi, 1997).

The holistic health approach also recognizes that women and men are human beings with full and equal human rights. The general comment No.14 on Article 12 of the International Covenant on Economic, Social

and Cultural Rights recognizes women's human right to health and elaborates it to include "the right of everyone both men and women to the enjoyment of the highest attainable standard of physical and mental health (CESCR, 2000)."

This definition acknowledges that the women's right to health embraces a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life. It extends to the underlying determinants of health, including violence.

Domestic Violence as a Determinant of Women's Health

Domestic Violence is one of the important sources of women's ill health. It is called 'hidden epidemic' because it is widely prevalent in the privacy of the home. The consequences of any abuse, violence on anybody can be profound, extending beyond the health and happiness of individuals to affect the well being of entire communities/society. In the case of women, these consequences are graver, consequential because of their disadvantaged position in the society.

A close examination of the widely accepted definition of violence against women given by the UN Declaration on the Elimination of Violence Against Women (1993) and/or the latest legal definition of the domestic violence given in the Indian legislation (Protection of Women from Domestic Violence Act 2005) indicate that both the definitions

accentuate the health, safety, and well being of women. They recognize that violence, be it in any form – threats, coercion, deprivation, physical sexual, verbal, emotional economic abuse, harm - affect women's physical, psychological sexual and reproductive health.

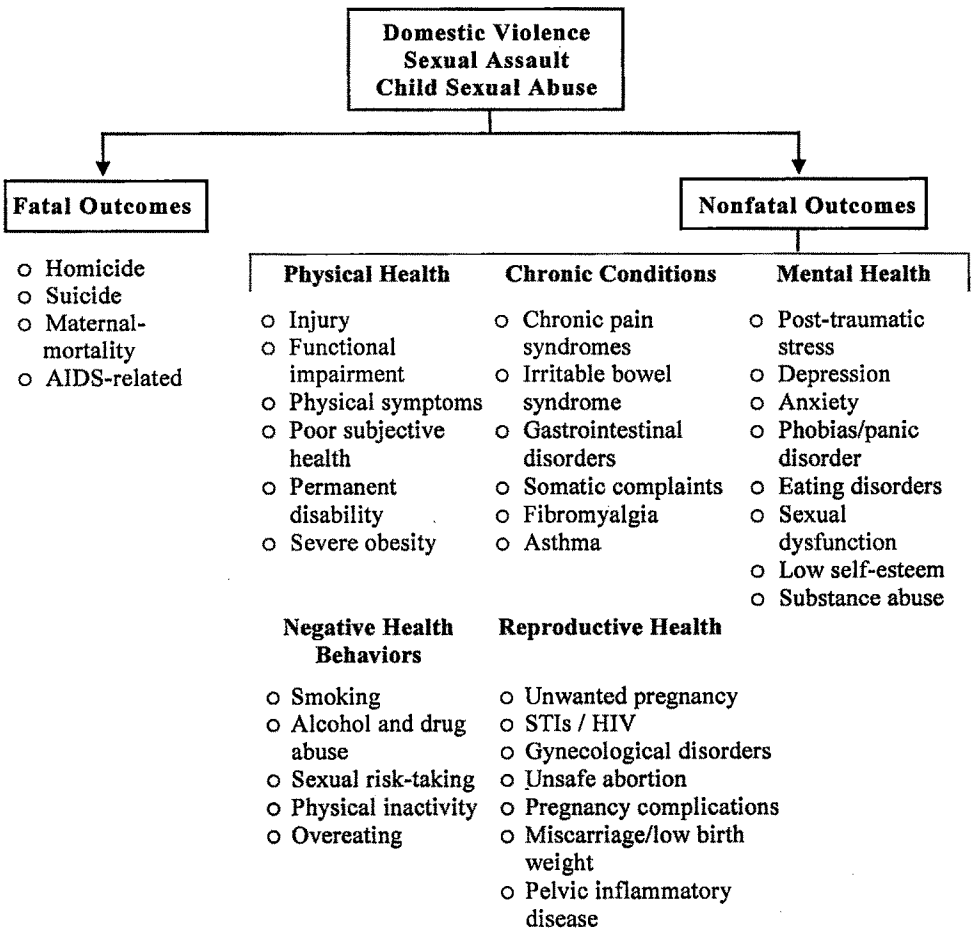
Given below is the brief description of the ways domestic violence impinges on women's health.

Impact on health

A growing body of research that has emerged in recent years across the world reveals that domestic violence is detrimental to women's health including their very survival. The impact that domestic violence has on women's health can be both immediate and/or long term, fatal and/or non-fatal, direct and/or indirect.

Based on the available scientific literature Lorie Heise, Jacqueline Pitanguy and Adrienne Germain (1994), summarized the health consequences that have been associated with domestic violence or intimate partner violence as given below.

Figure-2: Health Outcomes of Violence Against Women



Adapted from: Population Reports / CHANGE, 1999

Apart from the direct health consequences, domestic violence also increases women's risk of future ill-health. Studies show that those women experiencing domestic violence experience ill-health more frequently than other women, with regard to physical functioning, psychological well being and the adoption of further risk behaviours. The conclusion of the multi country study undertaken by WHO (2005) states that the influence of violence/abuse can persist long after the

violence itself has stopped. The more severe the abuse, the greater its impact on women's physical and mental health. Also, the impact over time of different types of abuse and of multiple episodes of abuse appears to be cumulative.

Impact on physical health

The most apparent consequences (obvious, many times visible) that domestic violence can have on women include a range of physical injuries like cuts bruises, broken bones, chronic injuries like hearing loss, headaches, joint pain and permanent disability.

However, it is not the injury that is the most common consequence of domestic violence. The more common outcome of domestic violence are "functional disorders" among women put in the figure above as chronic conditions. It covers a host of ailments that many times have no identifiable medical cause such as irritable bowel syndrome, fibromyalgia, gastro intestinal disorders and various chronic pain syndromes. Women experiencing domestic violence also have reduced physical functioning, develop obesity and spend more days in bed compared to other women (Population Reports, 1999).

Impact on mental health

The impact domestic violence has on women's mental health is even more severe than the impact it has on women's physical health. The psychological damage caused by violence lasts longer or sometimes

forever. Experience of violence affects women's self esteem and makes them more vulnerable (puts them at greater risk of) to a variety of mental health problems including depression anxiety, phobia, post traumatic stress disorder, suicide, suicide attempts and substance abuse.

Depression

In recent years, depression has gained recognition the world over as one of the major health problems, suffered more by adult women than men. While women's biology can be its main cause, poverty, gender based discrimination and violence puts women at greater risk than men.

Post Traumatic Stress Disorder (PTSD)

Domestic violence is a trauma; a traumatic event for women when they pass through it or experience it. During this period many times women feel helpless or threatened of death or injury. Women victims of such trauma experience post traumatic stress disorder (PTSD), an acute anxiety disorder. Its symptoms include mentally reliving the traumatic event through flashbacks or "flooding"; trying to avoid anything that would remind one of the trauma; becoming numb emotionally; experiencing difficulties in sleeping and concentrating; and being easily alarmed or startled (Population Reports, 1999).

Suicide

One of the worst impacts that domestic violence can cause is suicide or attempt to commit by women victims.

Substance abuse

Some women use alcohol or other illicit drugs as a way to cope with the domestic violence increasing their vulnerability to further victimization.

Impact on reproductive health

Domestic violence and sexual violence can cause reproductive health problems because they are intertwined with sexuality, fidelity, pregnancy and child bearing (Epstein, 1998). Domestic violence undermines women's sexual and reproductive autonomy and jeopardizes their health in number of ways.

Sexual autonomy and unwanted pregnancies

In many parts of the world, especially in India, marriage is considered as a license for having sex, an important marital obligation to be fulfilled by wives. It gives husbands right to unconditional sexual access to their wives and the power to enforce this right through force, if required. Women in many countries including India lack sexual autonomy and are powerless to refuse unwanted sex or to insist on use of the contraception resulting in increasing their risk to unwanted pregnancies.

Contraception use

Many women are afraid to raise the issue of contraception or its use for fear that their partners might respond violently (Population Reports, 1999). Many men from some cultures react negatively to the use of

contraceptives because of their suspicion over their wives faithfulness towards them, viewing use of contraception as an affront to their masculinity or for fear of losing control over their wives.

Sexually transmitted infections (STIs)

Women victims of domestic violence are at increased risk of STIs as abusive husbands are more likely to have engaged in extra marital sex and to have STI symptoms exposing their wives to infection.

HIV / AIDS

An Executive Director of UNAIDS had once noted that "Violence against women is not just a cause of the AIDS epidemic, it can also be a consequence of it", especially when it is domestic violence (cited in Population Reports, 1999). Disclosure of HIV/AIDS status of women may result in domestic violence against women or its fear may also prevent women approaching voluntary counselling and testing related to HIV/AIDS.

High risk pregnancies

Around the world, researches have shown that women are more at risk of experiencing domestic violence while they are pregnant. Pregnancy increases women's vulnerability to violence.

Violence before and during pregnancy can have serious health consequences for women and their children. Pregnant women who have experienced violence are more likely to delay seeking prenatal care and

less likely to gain sufficient weight. They are also more likely to have unwanted or mistimed pregnancies, vaginal and cervical infections and bleeding during pregnancy.

In addition to injury, violence may cause premature labour, miscarriages, abortions, stillbirth and delivery of premature or low birth weight infant with reduced chances of survival. It may also have a serious impact on pregnancy outcomes. Domestic violence may be responsible for a sizeable but under recognized proportion of pregnancy related deaths (Ganatra, Coyaji and Rao, 1998).

Other gynecological problems

Irregular vaginal bleeding, vaginal discharge, painful menstruation and sexual dysfunction are some of other gynecological problems that may be associated with domestic violence.

Domestic violence not only affects women's health enormously, but is also an impediment to development. Given the long term severe impact of violence on women's health, women who have suffered such violence are more likely to be long term users of health services thereby adding, increasing health care costs.

In addition, living in a violent relationship affects and hinders women's ability to participate in the world, public life and deprives society of women's full participation in all the aspects of development.

Social and economic development cannot take place in a society where women cannot lend their labour or creative ideas fully; especially when they are burdened with the physical and psychological scars of violence beginning from their own home (Heise, 1989 cited in Carrillo, 1992).

Thus domestic violence is a pertinent issue, a health issue affecting large number all those women of the world who live in agony, pain, stress and suffer in silence, within their own homes in their marital relationship.

The Concept of Health Care

Inherent in the Right to health is the Right to Health Care. If health is the state of well being of people, all efforts that go into caring and achieving better well being will automatically constitute health care (Jesani, 1998a).

Health care includes medical care as well as socio-economic, cultural determinants like nutrition, environment, behaviour, etc. as they have long-term impact on improving the health status of people. It encompasses an entire range of the pro-people developmental activity and change. Health care is defined as a multitudes of services rendered and efforts undertaken with individuals, families and communities by the agents of the health services or professions for the purpose of promoting, maintaining, monitoring or restoring health.

Characteristics of health care include :

- Appropriateness (relevance): whether the service is needed at all in relation to essential human needs, priorities and policies.
- Comprehensiveness: whether there is an optimum mix of preventive, curative, rehabilitative and promotional services.
- Adequacy: if the service is proportionate to requirement.
- Availability: between the population of an administrative unit and the health.
- Accessibility: this may be geographic accessibility, economic accessibility or cultural accessibility.
- Affordability: the cost of health care should be within the means of the individual and the state.
- Feasibility: operational efficiency of certain procedures logistic support, human and material resource.

Perspectives on Health Care

Like any other social science concept, health care too has also undergone changes at the different points of time along with the ideas prevalent in the wider society at that particular point of time or in relation to wider changes taking place in social values. While these changes can be put historically on a continuum, as progression of ideas

about health care, it cannot be seen as discontinuous of any phase. There is usually a period of transition when one paradigm is giving way to another and quantitative becomes qualitative change.

Some popular models of health care are the medical model, the social management model, the marketing model.

The medical model of health care

Based on the biomedical concept of health this model defines the aims of health care in term of the cure of specific disease through physical intervention e.g. drugs, surgery. Wider factors associated with the development of disease such as psychological and environmental factors, are not focused on. Persons are reduced to bodies. The model does not take into account social and behavioural processes associated with the development of disease, e.g. women's ill health and social inequality.

The social management model of health care

Based on the social understanding of health, this model of health care focuses on changing the structure and fabric of society as well as individual behaviours for health and welfare. The aim of health care under this model is disease prevention and positive health promotion through health care interventions.

The marketing model of health care

This model holds the view that economic development and welfare can best be achieved through the promotion of 'free markets' that allow individuals to act in their own interests with a minimum of state interference. This model views state intervention to promote health and welfare as problematic because it is seen as promoting a 'dependency culture', a drain on public expenditure and a monopoly power given to health care providers.

Alternative to the popular models of health care, especially in the Indian context are the indigenous model of health care, the comprehensive model of health care and the emerging empowerment model of health care.

The Vedic model of health care

In India since ancient times, based on the Vedic concept of health there exists an indigenous model of health care having a community orientation. *"Sarve santu niraamayaaha"* (All should be free from disease / All should be healthy) is the spirit that has sustained this traditional model. The Vedic approach to health is the approach through Veda – the complete knowledge of Natural Law, which expresses itself in the structures and functions of the human physiology, human behaviour and the human relationship with the inner divine content of life and the outer cosmic content of life.

Comprehensive model of health care

The term comprehensive health care was used in India by the Bhore committee (1946). It defined the comprehensive model of health care as having the following criteria.

- Provide adequate preventive, curative and promotive health services.
- Be as close to the beneficiaries as possible.
- Have the wide cooperation between the people, the service and the profession.
- Be available to all irrespective of their ability to pay; look after specially the vulnerable and weaker sections of the community.
- Create and maintain a healthy environment, both in homes as well as working place.

The empowerment model of health care

This model focuses on the commonalities and differences of perspective and interest, both within and between various groups of 'stakeholders' in the health system, i.e. actual users (women); the wider public; health workers and their collective representatives; and national and local governments. The model emphasizes on power-sharing mechanisms and views health as an important tool (strategy) to empower people. Users are seen as the primary producers of their own health and as having rights and obligations as citizens to participate in decisions about the provision of care.

This model has been followed by the feminist health activists in India while working with women to address their health needs using the process that ultimately empowers women (Khanna and Shiva, 2002).

Public health model of health care

This model focuses on prevention at three different levels namely primary, secondary and tertiary. It is the best suited to address the specific needs of women's health. According to Heise (1998) a public health approach to health care includes a multidisciplinary approach, focuses on prevention and works from a socio political analysis of health. Public health approach to violence starts with science (epidemiology and social science) and ends at community mobilization and empowerment. It involves a range of community actors such as social workers, police, judiciary, planners and policy makers and not just health service and medical personnel.

The Concept of Health Care System

What goes along with the concept of health care is the concept of health care system set up to deliver health care services. It constitutes the management and organisational matters related to the health care: planning, determining priorities, mobilizing and allocating resources, translating policies into services, evaluation and health education (Park, 2002).

The components of health care system include concept of health; ideas (e.g. equity, coverage, effectiveness, efficiency, impact); objects (e.g. hospitals, health centers, health programmes) and persons (e.g. providers and customers/users). In brief, the health care system is the mechanisms set up for the production and distribution of health care.

It is important to understand is that while health care services as a system may be staffed, organized, administered and financed differently in different societies, it has a common goal, which is to serve, help, diagnose, cure, educate and rehabilitate people through the health personnel, health care providers. The aim of health care system is health development, empowerment – a process of continuous and progressive improvement of the health status of a population thereby leading towards empowerment.

Concept of Users and Providers

As the present study is based on women users' and health care providers' perspective, it is necessary to understand these terms as their meanings change in different contexts.

Users

Users and potential users of any health care system may be viewed as 'patients', 'clients', 'consumers' or 'citizens'. Each of the terms indicate different balance of power vis-à-vis the providers.

Patients passively surrender control over both means and ends. Patients are part of the medical model of health care and are expected to obey doctors' instructions.

The term 'client' brings end to control of providers, and is used in a wide range of caring contexts especially social work. A client has more legitimate 'say' over what he or she should do, conveying greater degree of active participation. However a client is expected to respect not only providers 'expertise' but also means / agency / welfare organisation providing that expertise.

The concept of 'consumer' is from the ideology of the free market. It holds the idea that the recipients of health care can decide which services to purchase, avail of and that they can influence the provisions of health care through their purchasing power.

'Citizens' are the primary producers of their own health and have direct power over service provisions. Citizenship implies involvement by users of the health system in decisions about the provision of services (Potter, 1988 as cited in Heyman, 1995).

The term 'users' imply neutrality about the power relationships. Users may include people with health problems and their informal carers as well as potential users who would use services, if the need arose.

Health care providers

Health care personnel / providers are the important components of the distributive aspect of health care system. While the traditional concept of health care providers ranged from *vaid, hakims* to faith healers, the modern concept includes a joint effort of many groups of workers both medical and non-medical, namely physicians, nurses, social workers, health assistants, trained dais, village health guides and a host of others.

The concept of 'health team' is in vogue now. The health team approach aims to produce the right mix of health personnel / providers to provide full health coverage to the entire population. The WHO defines 'health team' as "a group of persons who share common health goal and objectives, determined by community needs and towards the achievements of which each member of the team contributes in accordance with his / her competence and skills and respecting the functions of the others (Park, 2002)." Thus composition of health care providers includes both professionals and auxiliary health personnel, who are needed to provide health care. As per the Government of India norms, health care providers include doctors, nurses, health workers (male and female), trained dais (birth attendants), health assistants, pharmacists and lab technicians.

Quality of Care and the Health Care System

Quality of care is one of the important factors affecting users' choices about the use of health care services, the type, extent, duration, etc. Understanding quality of health care from the users' perspective is extremely useful for both, health care service providers and users. Users' feedback on quality of care would provide both policy planners and health care providers insight into the availability and accessibility, appropriateness and effectiveness of the services provided by them. It is an indicator reflecting whether the health care services are responding to the needs and wants of those clients (users, patients) for whom these are set up, planned targeted and delivered.

A number of definitions of quality of care exist as patients (users), professionals (health care providers) and authorities (policy makers, planners) have different notions of what constitutes good quality care.

A simple definition offered by Shield and colleagues (2003) defines quality of care as a combination of access (whether users get the care they need) and effectiveness of clinical and interpersonal care (whether the care is effective when they get it).

According to another definition, quality of care is defined by way the clients are treated by the system or the actual process of care giving and by the focus on the clients' or users' perspective of services (Hull, 1994 as cited in Das, 2004).

Quality of care is also defined as the degree of match between the client's view of the performance of the services and the service providers' view that determines clients' satisfaction (Ishikawa, 1985 as cited in Das, 2004).

According to Abou-Zahr (as cited in Das, 2004) quality of care is doing the right thing rightly, at the right time, with the right attitude.

From the various definitions given above, it is clear that health care providers' attitude towards the client, the clients' perspective of the services and their satisfaction with the same, as well as a technical appropriateness and the achievement of desired health outcomes are important components of quality. Other important aspects of quality include management issues like access, training and infrastructure.

Quality of care in women's health

Quality of care has been defined differently under different frameworks, depending on the specific service program.

Because family planning programmes and reproductive health programmes are considered as women specific health care programmes, the quality of care frameworks applicable to women are developed in the context of either of these programmes. Notable among them is the quality of care framework proposed by Judith Bruce (1990), which incorporates six elements: namely, choice of methods, information given

to users, technical competence, interpersonal relations, mechanism to encourage continuity and appropriate constellations of services.

While the Judith Bruce formulation is a very robust definition and has been applied to measure quality of services for a long time, in recent years the increasing focus on clients' perspectives has led to the addition of other components to this framework.

The UNFPA has developed a reproductive health quality framework which includes nine elements. Of these nine elements, five are applicable in all situations, while four are specific to the different reproductive health conditions. This framework is broadly divided into two elements: namely, general elements (including service environment, client providers' interaction, informed decision-making, integration of services and women's participation in management) and second elements (service specific elements, which include access to services, equipment and supplies, professional standards and technical competence and continuity of care) (Das, 2004).

While women patients in different health care set ups may have different views on some aspects of care, by and large their views would be common on aspects such as health care providers–client (users') relationship, attitude and behaviour of providers with clients, and accessibility of services.

While the above mentioned definitions of general quality of care do apply to women's health, gender and sensitivity are two dimensions that need to be further elaborated in the quality of care frameworks for women's health. Increasing the sensitivity of the health care system to women's needs and demands is a major challenge in health care today.

'Quality of care for women' can be best defined by understanding women's views on quality of care within the health care system. This is important given that priorities in health care continue to be determined by professionals and health authorities with patriarchal mind sets.

Domestic Violence and Health Care - A Syllogistic Tie

There exists a natural tie between the domestic violence and health care. As domestic violence has a profound impact on a large number of women's health and on their health care seeking behaviour, it is pertinent for the public as well as private health care delivery system to recognize and respond to it.

Health care providers in public health care delivery system have high level of public contact not only in numbers but also qualitative interactions. They assume significance, as they are the first point of contact for any victim of domestic violence. A woman with obvious fatal or non-fatal injuries is more likely to be taken first to a health care provider than to the police, social welfare or women's organizations.

Health care providers are also in a position able to identify women victims of violence as they may notice evidences of violence when women seek treatment for other conditions and refer victims of violence to other services or to the justice delivery system, provide empathy, support, and document injuries, which is critical to evidence gathering and securing justice for women.

Moreover, if the goal of health care is improvement of the health status of the population, health development and empowerment of people, it is important that domestic violence become a part of the agenda of the health care system.

In view of this, it becomes essential to evolve an intervention plan that would bring in the concept and agenda of domestic violence into the health care delivery system. The present study is an effort in this direction.

For intervention programmes to be viable, effective and useful it is essential that they include users' as well as providers' perspective and participation (Pachauri, 1994; Joshi and Joshi, 1997). Hence the present study aims to capture women's needs and their perspective of the health care system based on their experiences while seeking treatment and care from it. The study also attempted to understand health care providers response to the issue of domestic violence and reasons behind their response.

After having discussed important concepts related to the present study and establishing a rationale for the study in terms of the syllogistic tie between domestic violence and health care, the following chapter reviews the available empirical evidences regarding domestic violence and the health care system's response to it as well as women's experiences with the quality of health care services.