THE PREVALENCE OF VARIOUS HEALTH CONSEQUENCES RELATED TO GENDER BASED VIOLENCE: A STUDY IN KURNOOL DISTRICT OF ANDHRA PRADESH

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Chapter – V

Summary, Conclusions, Implications and Recommendations

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

5.0 Introduction

Gender-based violence (GBV) or violence against women (VAW) has become one of the major public health problems as well as human right issues. The Government of India has taken several steps to curb the same, but its magnitude is still high and the exact vulnerability is unknown due to cultural silence. This is mainly because of the existence of patriarchal dominated society in many parts in India and women's lower status / autonomy, the reporting is mostly tip of iceberg. However, in this process, women are facing a lot of physical and psychological health problems and thereby, suffering quietly at times even not taking needed treatment and/or even not allowed to take treatment. However, in the recent past some of the women who experienced violence against them are bold / courage enough to complaint against the perpetrators and even come forward to file FIRs at police stations and also cases at courts of law. In addition to this, some of such women who are admitted to hospitals for treatment too have started to open their mouth to report against the person(s) who involved in for causing physical and mental health problems.

Keeping this in mind, the present research work intends to study the physical and psychological health problems faced by those who women who experienced violence against them. Such study is felt to be more helpful for understanding under what circumstances the women have become victims of GBV and thereby, the types / forms of different physical and psychological health problems experienced by them as first hand

information. Such information is going to be more useful for proposing more appropriate/ beneficial strategies for preventing violence against women as well as to modify the punishments in the case of perpetrators.

5.1 Research Gaps and Need for the Present Study

Studies related to GBV are numerous around the World as well as in India. Most of these studies appear to be dealt with the causes for GBV, understanding the circumstances under which such violence has taken place, perpetrators of violence, etc. Additionally, some studies have focused to know or explore the factors that affect GBV and/or to find out the major determinants. But, few researchers only have attempted to investigate the physical and psychological problems experienced by the victims of GBV, that too, studying with small samples (mostly from those who registered cases at women police stations) and rarely in hospital settings. Keeping these research gaps into consideration, the present study felt to be first of its kind in exploring the physical and psychological health consequences due to GBV among those victims who reported different settings like, District General Hospital, One-stop police Centres, Women police stations and Domestic Violence Centres attached to the Offices of the Superintendent of Police at district level.

5.2 Methodology

This research work primarily intends to study the prevalence of various health consequences related to gender-based violence in Kurnool district of Andhra Pradesh State. To this end, a cross-sectional study has been carried out, adopting descriptive as well as analytical research designs, among 184 women who experienced gender-based

violence and subsequently, admitted / registered / filed FIRs at different centres (in Kurnool district) concerned under Domestic Violence Act, 2005 during four months (May to August) of the calendar year, 2019. The sample women were selected based on 20% of such women mentioned above. Data has been collected with the help of an Interview schedule and face-to-interviews. The data has been analysed mostly with frequency tables related to all the socio-economic and demographic characteristics of the sample respondents, their awareness / knowledge about GBV related aspects, physical and psychological health consequences of GBV and legal awareness of GBV. At the next stage, the associations between selected socio-economic & demographic characteristics and physical health & psychological health consequences as well as legal awareness about GBV have analysed adopting the cross-tabular analysis with Chi-square test of significance. Finally, an attempt is also made to make use of multivariate analyses like Multiple Linear Regression and Binary Logistic Regression Techniques to find out the principal determinants of physical health consequences and the extent of knowledge about legal measures related to GBV. All these analyses have been carried out with the assistance of IBM SPSS version 20.0 (for more details see Chapter III).

5.3 Summary of Findings

5.3.1 Socio-Economic Profile of the Sample Respondents

The analysis of background characteristics of the sample respondents (***Section 4.1 of Chapter IV***) shows that the mean age of the (sample) women is 28.44±10.2 years. A large majority of them are Hindus (69%), residing in urban areas (62%), whereas 41 per cent and 29 per cent of them belonged to Backward Castes (BCs) and Scheduled Castes / Tribes (SC/STs), respectively. A greater percentage of the women (87%) are (currently)

married. While a little over 30 per cent of them have studied up to high school level & above, 27 per cent of them are illiterates. 43.5 per cent and 5.4 per cent of them reported to be homemakers and students, respectively, whereas the remaining of them are engaged in one or the other works such as employees (16%), tailoring / Goundas / Weavers (14%), cultivation / business (12%) and collies (9%). A simple majority (42%) of the respondents belonged to families that have (moderate) monthly income of Rs. 10,001–20,000, whereas one-third of them and little less than one-fourth of them (24%), respectively are belonged to lower (Rs. 10,000 & less) and little higher (Rs. 20,0001 & above) monthly family income brackets. More than half of the respondents (52%) are part of nuclear families followed by extended families (42%) and the remaining 6 per cent of them are dwelling in joint families. A greater proportion of the respondents' (85%) marriage has been arranged by parents and relatives and first marriage (type) to their current spouse (87%). Among the married women, the duration of married life is 9.54±9.85 years. The average number of living children is 1.48±1.22; of which, sons average is little higher (0.83±0.93) than that of daughters (0.65±0.80).

Among the married respondents, a simple majority of their spouses (36%) completed secondary school education followed by higher secondary school and above (29%). With regard to their parents' background information, nearly two-thirds of fathers stated to be illiterates (66%) followed by studied up to secondary school education (21%), whereas in the case of their mothers the corresponding percentages are 73% and 18.5%, respectively. While majority of respondents' fathers are engaged in cultivation / business (38%) followed by Goundas / Weavers / Painters, etc. (22.5%), 46 per cent of their mothers are homemakers followed by engaged in cultivation / business (27%).

5.3.2 Details about GBV, Physical Health Consequences and Its Associated Factors

An analysis of the details about various aspects of GBV (***Section 4.2 of Chapter IV***) revealed the following results. Majority of the respondents (42%) perceived the meaning of violence against women as 'physical act of aggression' followed by 'causing physical and sexual harm'. Violence at home setting is mostly the known one; of which 'battering and exploitation' (39%) and 'dowry related' (37.5%) are the mainly mentioned. 'Rape and sexual abuse' and 'sexual harassment' are the common forms of GBV take place at community. 28 per cent of the respondents perceived the prevalence of GBV as 200 per 1000 women followed by 150 per 1000 (18%) and 116 per 1000 (8%), and the remaining of them (47%) don't know about the same. Majority of the respondents (42%) viewed women are would face the risk of violence at any age of their life, whereas 39 per cent of them felt that women in the age range of 19–45 years are more vulnerable for violence. 'Individual and dyadic' is the most mentioned cause for violence (60%). According to a large majority of the respondents (64%) physical violence means, 'beating, pushing and grabbing, throwing something on women / pulling hair, hitting, kicking & biting, etc.', and staking means, 'creating high level fear of bodily harm' (41%) or 'fear of mind' (36%).

Slightly more than half of the respondents (52%) stated that they suffered (or suffering) from one or the other physical health problems – majority are from injuries (43%), especially external injuries (39%) and one or the other gastro-intestine / migraine problems (47%) and skeletal problems (31.5%). About 8 per cent have undergone any skeletal surgeries related to 'broken ribs / bones near heart', 'burns, injuries on neck', 'leg, face, shoulder', etc. A large percentage of them faced one or the other types of

harassment (60%), mostly 'severely / very severely' (54%) and 'moderately' (40%) and 'very frequently' (46%) and 'frequently' (25%). While slightly more than one-third of the respondents (35%) are suffering from physical violence for more than 5 years, around one-third of them (33%) are undergoing such violence for less than a year only. 54 per cent of women obtained medical treatment from hospital, whereas 6.5 per cent of them have received physical care only. A large percentage of them (59%) have one or the other mild physical health problems such as sore muscle, sprain, strain, etc. An overwhelming percentage of the respondents (93%) felt that they have experienced severe injuries due to physical violence such as 'head injuries', 'sever burns' and 'knocked down to the extent of falling into unconscious. Another overwhelming percentage of them (90%) have ascertained one or the other chronic physical health consequences such as 'headache, back / abdominal pain', 'chronic pelvic pain / gastro intestinal problems', whereas 31.5 per cent of them perceived that they 'faced behavioural abnormalities', viz., consumption of alcohol / substance abuse, multiple sexual partners, choosing abusive partner later in life, etc., and 59 per cent of them reported to be having 'sleeping and eating disorders'.

Cross-tabular analysis of data on respondents' suffered or suffering from any physical health problems (52%) or not (48%) across selected background characteristics give in the following results. By and large, the percentage of women who suffered (or suffering) from one or the other physical health problems caused by GBV is increasing with an increase in their current age and duration of married life ($p<0.01$ and $p<0.05$, respectively). On the other hand, such percentage has showed a decreasing trend with in increase in their social class (caste background; from SC/STs to FCs; $p<0.01$), educational status of their own ($p<0.05$) and their husband ($p<0.05$), occupational level of

their own ($p<0.01$) and husbands ($p<0.10$) and monthly family income ($p<0.001$). While respondents belonged to Christianity suffered / are suffering from physical health problems due to GBV strikingly to a higher extent as against their Muslim and Hindu counterparts ($p<0.10$), such problems are found to be lower among those who are dwelling in semi-urban / urban areas as against their rural counterparts ($p<0.01$).

Binary logistic regression analysis on whether respondents suffered / suffering from any physical health problems (PHPs) due to GBV highlighted that the odds of experiencing PHPs are lower among those respondents who are engaged in 'cultivation / business / employment' as well as working as 'coolies / tailoring / Goundas' have showed significantly lower tendency to experience by PHPs ($p<0.001$ and $p<0.05$, respectively), studied higher secondary school level ($p<0.05$), whose spouses are Govt. / private employees ($p<0.01$), belonged to families that have higher monthly incomes ($p<0.05$) and living in semi-urban/urban areas ($p<0.05$) than their respective counterparts. Conversely, such likelihood is higher among those who are at middle adult ages (21-25 and 26-30 years; $p<0.05$ and $p<0.01$, respectively), belonged to Christianity ($p<0.01$) and whose duration of married life is 16 years or more ($p<0.05$) as against their counterparts.

5.3.3 Details of Psychological Health Consequences and Its Associated Factors

The analysis of different particulars related to psychological health consequences due to GBV (***Section 4.3 of Chapter IV***) showed the following results. For a majority of the respondents (35%), the meaning of psychological health is 'people with sound mind in sound body' followed by 'people with sound body in sound mind'. A large percentage of the respondents (58%), 'sharing happiness and behaving normal with others' is the

behaviour of psychological healthy individual and for some (17%) it is 'expecting love and affection from others'. A large majority of the respondents (69%) stated that the following are the severe psychological disorders due to GBV: PTSD, anxiety and self harm, depression, etc. According to majority of the respondents (44%), 'I can't escape from the violence' is the basic characteristic of psychological health, besides 'I can't live alone'. About 28 per cent expressed that 'unable to solve the problems' as the prime characteristic of poor self-esteem and 31.5 per cent of them reported to be experienced any type of psychological violence during childhood. More than half of the respondents (53%) felt 'forcing to die' after they faced violence and about 17 per cent developed 'doubting behaviour'. Around 46 per cent of the respondents suffered / suffering from psychosomatic problems such as 'irritable bowel syndrome', 'respiratory disorders' and 'hypertension'. About 54 per cent of the respondents suffered / suffering from psychological harassment for about 3-5 years of duration and another 25 per cent of them faced such experience for less than a year or so.

Cross-tabular analysis of respondents ever suffered / suffering from 1 and 2+ psychological health problems – PsyHPs – due to GBV (75% and 25%, respectively) across selected background characteristics has exhibited the following findings. The percentage of respondents who ever suffered / suffering from 2 or more PsyHPs is appeared to be increasing with their current age ($p<0.05$) and duration of married life ($p<0.001$). Conversely, similar percentage has decreased with an increase in their level of education ($p<0.01$), monthly family income ($p<0.05$) and to some extent with an increase in their social status (caste background; $p<0.10$). It is also conspicuous to note that Muslims and Christians have showed PsyHPs to a lower extent than the Hindus ($p<0.05$)

and similar percentage is also observed as lower among those residing in semi-urban / urban areas as against their rural counterparts ($p<0.05$).

5.3.4 Details of Legal Awareness about GBV and Its Associated Factors

An analysis of various details pertaining to legal awareness about GBV and its associated factors (***Section 4.3 of Chapter IV***) resulted into the following outcomes. As high as 71 per cent of the respondents are known about the availability of one or the other legal services related to GBV, viz., police department, courts and the village panchayats. While 43.5 per cent of the respondents affirmed the existence of women police station, just 4 per cent of them only stated to be aware of women protection acts. On the other hand, around one-fifth of the respondents (19%) are aware of local / general women protection services such as SHE-Teams and Women Employee Protection Cell / Mobile App. Details about women harassment and related aspects showed that 45 per cent of them are aware of such activities and the major reasons for such harassment stated are: alcoholism/ drug abuse, suspecting the character of woman (wife), unsatisfied marital relations and demand for dowry. Husband / brother-in-law are the major perpetrators for women harassment (53%) followed by father-in-law / mother-in-law / sister-in-law (25%); however, only 29 per cent of the respondents filed cases against the perpetrators mostly with the initiative / support of friends / relatives. The major reasons for not filing cases against perpetrators are: 'stigma' (39%), 'fear of future harassment' (19%) and 'fear of children's safety' (18%). With regard to resorting to any desperate measures to escape from harassment, while around 55 per cent stated that they resorted to measures like consuming poison / pesticides (43.5%), suicides with burns, strangulation, etc.,

whereas 45 per cent didn't made any such attempt. However, a large percentage of them (60%) have been saved by family members and some by neighbours (13%).

In this study, the overall awareness of legal / protective measures of the respondents is measured as pooled scores (*based on the responses provided to general awareness about legal services, women police station, women protection acts and local / general women protection services*) ranges between 0 and 4 (*higher scores indicating higher awareness, i.e., awareness about more legal / protective measures*). Subsequently, such pooled score has been cross-tabulated with their selected background characteristics. The results exhibit that, 24 per cent of them didn't have awareness about any of the legal/ protective measures, whereas 35 per cent of them knows about any 1 such measure, followed by 2 (18%), 3 (17%) and 4 measures (6%). Cross-tabular analysis results showed that the percentage of respondents who are having awareness about 3 or more such measures is higher among those who belonged to higher age groups (26–30 & 31 and above), forward castes, semi-urban/urban areas and families that have higher monthly incomes (Rs. 20,001 & above) than their respective counterparts. Likewise, such percentage is also found to be higher among those who are higher educated and whose husbands are also higher educated (secondary school and High school & above), whose husbands work as employees and whose duration of married life is much longer (16 years and above) than their respective counterparts. The Chi-square test results in all these regard have turned out as highly significant, i.e., $p<0.01$ and $p<0.001$, except for current age, $p<0.05$).

Results based on multiple linear regression analysis on (overall) legal awareness (score) to combat violence against women revealed that, all the 7 variables included in the model together have explained 29 per cent variation in the legal awareness. Level of education of respondents has exhibited highest positive net effect on the legal measures ($p<0.001$) followed by urban residence ($p<0.01$), duration of married life ($p<0.01$) and social status ($p<0.01$). Monthly family income has also showed little positive net effect on the awareness of legal measures ($p<0.10$). However, the sign of effect of current age on such awareness is negative (indicating decreasing of awareness about legal / protective measures with increasing age), but this finding is turned out as statistically insignificant.

With regard to the role of different agencies and interventions suggested for violence against women and girls, the sample respondents provided the following opinions / suggestions. A large majority of the women (60%) perceived that the violence against women can be prevented (and/or to some extent). Of those stated to be prevented, the best possible ways stated are: 'improving women's education' and 'enacting strict laws' followed by 'imposing stringent punishments'. Of the suggested measures by Government for the victims of GBV, majority (56%) opined the need for 'providing of rescue homes for victims'. About half of them (49.5%) felt the need for immediate support or help from anyone of the persons / agencies like police and legal services, parents and family members and/or friends and neighbours. While a simple majority of the sample women (30%) expressed that the health service providers should 'show empathetic attitude and provide immediate care' followed by 'informing the police' (22%) when they approached them.

More than half of the respondents (54%) are of the view that interventions / strategies need to be focused on current husband or family members (who are the major perpetrators of violence) and around 21 per cent them felt that the Government should implement the laws related to VAWG and give punishment to the perpetrators without much delay. Around one-third of the respondents (34%) perceived that 'providing free transportation' (like ambulance services) to the victims of violence to reach the health care centres is the major step to be taken up to make use of medical and health services effectively. More than half of the respondents stated that the parents, teachers, etc. play a vital role in 'educating the present generation to strive towards creating of social climate with no tolerance to VAWG' and in 'stopping early marriage and early pregnancies'.

Based on few ***case studies*** of this study, it is understood that of the six women victims of GBV, five of them fallen prey to their husband's ill-treatment after marriage and one of them faced problem by brother-in-law, which has not been condemned by her husband. The violence against them mostly happened within 4-5 years of marriage, except in one case after 6-7 years. While five of them are arranged marriage and one is love marriage, two of them are second marriage to their husband. In almost all cases, husband's ill-treatment as well as doubting and cheating behaviour, behavior seeking large sums of dowry are the major reasons for violence, except in one case such violence is due to the misbehavior of brother-in-law. On the other hand, in two cases, in-laws are involved and in one case step-daughter and first wife are involved. While four of them are working and two are homemakers, four of them reported to Mahila Police Station for justice and four of them requested for punishment to those involved mainly their husband

/ brother-in-law / in-laws. While two of them decided to live separately, another two have successfully got divorce.

5.4 Major Conclusions and Discussion

In accordance with the present research work among those women who affected by GBV in Kurnool district, Andhra Pradesh State (and the concise findings provided in the earlier paragraphs), the following major conclusions are drawn.

On the whole, the sample victims of GBV are largely from lower socio-cultural strata, i.e., belonged to Backward Castes closely followed by SC / ST communities, illiterates and studied up to high school level, engaged in homemaking activities and in daily wage work (as coolies), and belonged to households of lower monthly family incomes. Obviously, their parents too and to some extent their spouses are also mostly belonged to such lower socio-economic strata / conditions. Such pattern is quite natural because of several socio-economic problems of the male members who are mostly illiterates and working in menial / lower status jobs, which in turn fetch lower incomes to them. Further, such conditions would crop up strained martial relations, alcoholism among male members, besides other adverse lifestyle habits. All these in turn would lead to violence against female members in the family (as they won't support or argue with the male members). Several studies conducted around the World and in India have also found more or less similar findings (for details see Chapter II).

A little over half of the respondents reported to be suffered / suffering from one or the other physical health problems; of which majority experienced external injuries on their bodies followed by gastro-intestine / migraine problems and skeletal problems.

Facing such physical health problems by the victims of GBV indicate that women are physically weak as the perpetrators are largely males (spouses, brother or brothers-in-law and at times fathers-in-law) who show their male power / dominance (both physically and family related – being head of the family, breadwinner, legal heir to acquire / ownership of both movable and immovable property, etc.). Some of the studies carried out around the World and in India have showed, more or less, similar findings at different settings (for details see Chapter II).

The extent of suffered / suffering from PHPs by the sample victims is higher among those who are at middle adult age and who experienced longer duration of married life, besides among those who belonged to Christianity than the Hindus. It is natural that with increasing age and duration of married life women have more interaction and family life with their spouse as well as with members of conjugal family which may lead to several arguments, quarrels and misunderstandings and adjustment problems that flare up physical violence against married women (unless members able to adjust) and thereby, result in one or more PHPs. On the other hand, women belonged to Christianity are mostly converted from lower social strata of Hindus, who might be mostly illiterate and earning lower incomes, besides majority of their spouses have the habit of drinking alcohol and other adverse lifestyles, which in turn cause physical violence to a higher extent that largely result in PHPs.

There is a clear support for the lower prevalence of PHPs among those women belonged to higher socio-economic strata (who are engaged in cultivation / business, have high school education & above and belonged to household of higher family incomes,

besides residing in semi-urban / urban areas). These results indicate that women who have better access to economic resources and acquaintance of better education as well as living in urban environment are likely to experience physical violence to a lesser extent that end with lesser PHPs for them.

All the sample victims of GBV reported to be suffered / suffering from one or the other PsyHPs during their life time (75% with 2–3 problems and 25% with any one problem). Such pattern is natural due to lack of martial adjustments and arguments between couples, besides quarrels arise at the time alcoholic behaviour of spouses, property / money matters, doubting behaviour of spouses, sharing household works, nurturing the children, etc. In fact, for many physical health problems the psychological health problems operate / serve as lead up.

Women belonged to higher socio-economic status (such as higher educated, belonged to higher monthly family income category, higher castes and residing in semi-urban / urban areas) have exhibited lower prevalence of 2–3 PsyHPs. Such finding is obvious due to the fact that better educated behave rationally and thereby, have better understating / adjustment between spouses, besides have lower extent of financial and other day-to-day problems. On the other hand, there appears to be a clear increase in the extent of suffered / suffering from 2–3 PsyHPs, which is natural and observed as a common phenomenon among women / girls in the settings of lower socio-economic background.

A large majority of the sample women are aware about one or the other legal/ protective measures to combat violence against women. Such patter is mainly due to the

fact that all the women are victims of GBV, who would naturally come across such measures in due course of time. However, the point to be noted here is that about one-fourth of them reported to be no knowledge about any legal / protective measures to combat violence against women. Few studies from India have noted that the legal awareness among general public / women and/or selected sub-groups of women is fairly much lower (Gayathri, 2017; Tulsyan, 2016; Guru, 2015; Bilal et al., 2014).

The extent of awareness about legal / protective measures to combat violence against women is observed to be much higher among those who are educated, urban dwellers, belonged to higher social strata and households that have comparatively higher monthly incomes, and also among those whose duration of married life is longer. All these phenomena are on expected lines and thereby, support the fact that women belonged to higher socio-economic standing have the advantage of knowing / learning about the legal / protective measures that reduce / stop violence against women.

Majority of the women opined that the violence against women can be prevented through the possible ways such as 'improving women's education' and 'enacting strict laws' followed by 'imposing stringent punishments'. A large majority of the respondents felt the need for the interventions / strategies aimed towards the current husband or family members and some of them felt that the Government should implement the laws related to VAWG and give punishment to the perpetrators without much delay. From health providers' perspective, a simple majority of them stated that providing free ambulance services to the victims of violence to reach the health care centres is very much essential. Likewise, majority of the respondents opined that the parents, teachers,

etc. should play a vital role in educating the present generation to strive towards creating of social climate with no tolerance to VAWG and also in stopping early marriage and early pregnancies.

5.5 Policy Implications

Based on the foregoing empirical analysis of data and findings, and the major conclusions drawn, some of the following policy implications have been suggested for the likely reduction in GBV and improving the women's health and well-being.

- Being a Global problem, first of all, strategies may be evolved to generate the awareness of violence against women / girls and the adverse effects of GBV in causing physical and psychological problems so as to make present generation to think and act favourably towards women / girls' right to live pain free life.

- Efforts have to be aimed to improve the women's overall socio-economic status, in terms of accessing higher education, occupying better positioned jobs and thereby, earning independent / personal income, by which women would have access to monetary resources and develop autonomy. All these would make them self-confident and self-reliant, which in turn develop courage among them to protect or defend themselves from different forms of violence triggered by male members at family / community level and also senior female family members.

- Women empowerment should be emphasized. Women should be given respect and love at their workplace as well as at family/home also. More and more expert

health care professionals (like gynaecologists, psychiatrists and obstetricians) should be made available to identify the problem as early as possible.

- Providing and improving overall education of girls would help them in empowering against the domestic violence. Additionally, the male partners should be educated to instil values such as giving respect for women and importance of women in the family and everybody' life.

- Strategies should be evolved by the Government to introduce gender sensitization programmes at an earlier age through schools, which is likely to have a positive effect on the perceptions towards feminine sex in the long-term.

- Steps may be initiated to modify or revise the societal norms to give strict punishments for people breaking social rules and violating / not adhering to legal measures related to GBV, regulation and society culture and for doing such inhuman activity.

- Stringent actions should be taken up against the people harassing women and involved in GBV and efforts also be made to implement the Domestic Violence Act, 2005 as well as Dowry Prohibition Act, 1961 in an effective manner.

- Service providers involved in combating violence against women viz., Police, Counsellors, Lawyers, Nursing Staff and Doctors, Staff of NGOs, members of SHE-Teams, Self-Help Groups, etc. need to be educated the intricacies related to GBV such as magnitude of the problem over a period of time and making them to

have better insight into the problems relative GBV by providing special in-service training from time-to-time.

- Strategies may be initiated in identification of GBV and its physical and psychological health consequences through innovative approaches such as regular screening for domestic violence by physicians at health facilities with a screening tool and involvement of community level workers such as ASHA and Anganwadi workers in screening of illiterate and married women for GBV by interacting with them regularly.

5.6 Recommendations

Based on the findings and conclusions of this study, the following specific actions are recommended to prevent or control GBV and also to provide safety measures to girls / women in general and victims of GBV in particular.

- At Individual Level

    - Adults of both gender and men in particular have to be sensitized about the GBV against women at various stages of life.

    - Girls and women as well as victims of GBV need to be provided with help-lines including *Disha type app* to inform and get help on time for any violence takes place against them.

    - Girls and women from health consequences need to be given appropriate treatment at public and private hospital facilities without much delay taking into the consideration of their socio-economic background.

- Victims of GBV as well as persons accompanying / helping them need to be properly treated when the approach to give complaints / filing FIRs / registering cases at different centres.

- Cases / complaints filed / registered by the victims of GBV at women police stations, fast track courts and family courts need to be speedily looked in to and the punishments / corrective measures aimed towards perpetrators have to be implemented at the earliest.

- Young girls and boys need to be provided with gender sensitization and women's importance at family and societal levels through school and colleges by making changes in curriculum.

- Girls and women who experienced / experiencing psychological ill health and physical injuries need to be provided immediate care and if possible appropriate legal protection or another form of assistance to safeguard their interests in the short-term. Also in the long-run, it would be better to provide the existing security requirements or viable alternatives may be created according to the current situation.

➢ At Family Level

- At first, the young married couples need to be advised / counseled just before and/or at the time of marriage about the need for adjustment of their married life and how to overcome the petty problems cropped up by different family members / close relatives.

- Family members of victims of GBV have to be sensitized and provided with information about the importance of girls / women in the family and adverse effects of violence against them including the legal aspects and the consequences to be faced by the perpetrators causing GBV.

- At Society Level

    - At society level, strategies may be planned and propagated highlighting the importance of role of girls and women and the need for safety to them at society level making use of advocacy measures and campaigns, besides mass media channels.

    - Religious and community leaders have to be imparted about the women's status in the society, raising consciousness about girls / women and the legal / protective measures to combat violence against them.

- At Government Level

    - Government has to take initiatives to formulate policies and modify the existing ones for preventing institutions at regular intervals say about once in 10 years or so depending upon the changing times as violence against girls / women is taking place differently over a period of time.

    - Efforts have to be made by various Government departments such as social justice, education, police and law, health and family welfare, women and child welfare, etc. to advocate various approaches to combat violence against girls / women as well as their safety and welfare by developing networking among these departments.

    - Efforts may be initiated and taken up by the Government departments to make the Government institutions like police stations/ counselling centres, hospitals / trauma units and also free legal aid cells to provide the services to the victims of GBV with less hassles and women- / victims-friendly services rather than following / adhering to cumbersome procedures and rules / regulations.

- The Government need to look into the rehabilitation of capacity building for victims and survivors as well as mechanism of safeguarding and providing services, shelter homes, etc. have to be enhanced in due course of time.

➢ Role of Non-Government Organizations (NGOs)

- NGOs may be encouraged to play a vital role in improving the status of women and uplifting their motivation and courage to live fear free life in the day-to-day life at the societal level through various socio-economic training programmes offered by them to girls / women.

- Members of the NGOs may be taken up surveys or enumerate in a small way to understand the prevalence of GBV in the society / community in which their services are provided by seeking funds from the Government agencies and other funding agencies.

- NGOs have to create co-ordinated efforts with local and community leaders as well as Government agencies like Police / Courts, etc. in arranging programmes to girls / women at regular intervals about their roles / responsibilities and also make attempts in providing help to the victims of GBV as and when there is a need.

➢ Role of other Stakeholders

- Gender sensitization programmes need to be aimed towards different stakeholders such as police personnel, counsellors working for victims of GBV, lawyers and judges, besides medical officials / staff and religious and community leaders.

- Steps need to be undertaken for in-service training programmes among those stakeholders who are dealing with victims of GBV informing about the day-to-day changes or modifications taking place in the GBV and its corrected measure, if any.

5.7 Directions for Future Research

From the foregoing research experience of the researcher, some of the following research proposals are suggested to carry out future research related to various aspects of GBV and its health consequences.

- ❖ There is need for large-scale field-based studies at the National, State and Districts levels to understand the different aspects of GBV and its effect on women's physical and psychological health consequences in a holistic manner.

- ❖ Studying victims of GBV approaching different stakeholders such as Courts, Police Stations, Health Facilities (Hospitals), may be carried on comparative basis so as to understand the intensity / severity of GBV as well as the circumstances under which women's health is affected due to GBV.

- ❖ Qualitative studies making use of in-depth interviews of victims of GBV of different sub-groups of population viz., age-wise, rural-urban wise, community-wise, etc. may be carried out to explore in detail about the role of GBV in hampering women's physical and health consequences.

- ❖ There is need for studies in understanding the extent of Knowledge and Attitude about the Domestic Violence Act as well as the impediments in its

implementation and also the barriers to approach the different legal / protective agencies of GBV.

- Future studies also need to focus explicitly on the role of health care providers / facilities in providing medical and health care services to the victims of GBV and also the pathways to recovery from abusive experiences and how health services / health care providers can play a role in the journey of rehabilitation.

- Studies are also suggested to collect data on long-term basis on the role of GBV in causing mental and physical health consequences making use of standardised definitions and validated scales as well as the long-term implications of GBV and its adverse health impacts.