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Tackling domestic violence and abuse using a rights-oriented public health lens

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Introduction

The framing of gender-based violence (GBV) as a ‘public health’ problem is relatively nascent, with earliest developments in the field dating back to the 1990s. Scholarship and policy debates in this period emphasised the ‘epidemic’ proportion that GBV had risen to; justifying a societal and systemic response. Such attention from the international health community was a result of the long-standing efforts of women’s movements and human rights advocates in highlighting the significant health burden imposed by GBV at both international and national levels (Mitra, 2011; Bhate-Deosthali, Rege, & Prakash, 2013). Internationally, a series of declarations on violence against women¹ (VAW), developed in the UN Commission on the Status of Women and UN General Assemblies in 1991 and 1993, highlighted the resulting physical, psychological, reproductive harms and morbidities among women. In some countries, this trend was marked by the establishment of specific institutions as well as legislative and constitutional reforms, for example, the formation of the National Centre for Injury Prevention and Control in the UK as part of the Centres for Disease Control and Prevention in 1991. However, it was only in 1996 at the World Health Assembly in Geneva when member states adopted a resolution declaring violence a leading worldwide public health problem and placed VAW as a core priority on the international agenda (Resolution WHA49.25: Preventing violence: a public health priority). It regarded the elimination of VAW as a prerequisite for women’s holistic health and instructed member states to implement a “comprehensive national strategy to promote women’s health throughout their lifespan” with due attention to “prevention and treatment of diseases and conditions affecting women, as well as responding to VAW” (CEDAW, 1999). Subsequently, the first World Report on Violence and Health brought out by the World Health Organization (WHO) in 2002 made a compelling case for adopting a public health approach. It critiqued the hitherto “reactive and therapeutic” response of the health sector, calling for a more comprehensive and holistic approach to tackle the complex phenomenon of violence.

A public health perspective on GBV, and more specifically on Domestic Violence and Abuse¹ (DVA), is predicated on its widespread health and social consequences as well as the growing acknowledgement of the role of healthcare institutions (e.g. health facilities) and professionals in timely recognition and response. However, in comparison to other approaches for example,
human rights, criminal justice or family violence (see the other chapters in this section of the Handbook), a public health perspective is much less understood (Nakray, 2013). Consequently, there are few empirical studies and insights on what a public health approach entails, not least how comprehensive health systems and strategies can be designed to effectively address DVA. Attending to this gap begs an important question: does classifying violence as a public health issue mark a shift in our approach to tackling violence and, if so, what does a public health response to DVA entail?

This chapter attempts to respond to this question by elucidating a public health perspective to examine DVA and its determinants and approaches that can prevent further occurrence and mitigate its consequences. The analysis presented in this chapter is structured around three objectives addressed in three corresponding parts. I first establish a public health imperative for attending to DVA by presenting the health burden resulting from it, as well as its wider socio-economic and societal burdens. For this purpose, I draw on existing population level studies and analysis on scale, magnitude, nature and consequences of DVA, and comment on the forms and types of victimisation that are omitted from the estimates and burden of disease measures. I then elaborate what a public health approach entails and the principles that could inform design of effective policies and programmes. Adopting a socio-ecological framework, I critically review the evidence base on risk factors of DVA and outline pathways to effectively tackle these risks, thereby preventing domestic violence. In the final section, I present examples of integrated health systems’ response to DVA, reviewing evidence on their effectiveness and highlighting promising areas for wider societal and institutional changes.

The chapter combines evidence from my research that examined health systems’ response to GBV in India and extensive review of scholarship and evidence in this field. It also draws on experiential learnings from my long-standing engagement with women’s movements and women’s health and rights advocacy on VAW. Central to this engagement were appraisals of interventions and policy advocacy in India around a range of DVA issues including sex-selection, inclusion/recognition of marital rape in rape laws, medical violence in delivering sexual and reproductive health services among others.

At the outset, however, it is important to note that the term ‘domestic violence’ remains contested and variously defined. Of particular relevance here is the Southern feminist critique of the dominant discourse that rests on a Western conceptualisation of DVA that involves an ‘intimate partner’ and a unified understanding of context as ‘nuclear household’, heteronormative institutions or that of stable political economies (Mirza, 2017; Kapilashrami, 2017; Alsaba & Kapilashrami, 2016). Elsewhere, I have argued that such framing overlooks the complex nature of ‘family’ in non-Western societies, the specificities (of culture and transitory contexts) in patterns of abuse and help-seeking, and the deep-rooted patriarchal norms and institutions within which such practices are embedded (Kapilashrami, 2017). Consequently, policy and institutional responses to DVA tend to focus primarily on presence of laws, availability of legal aid and counsel services, and processes of adjudication, assuming that the availability of these material goods/resources guarantees uptake by those most in need. Such perspective disregards any differences in social position of women (with regards to ethnicity, legal status, age, etc.) that prevent uptake of these provisions by some communities and in certain contexts (ibid.). Critiquing this perspective, in this chapter, I also discuss how public health approaches must go beyond such a restrictive paradigm that renders dimensions of diversity and structural inequalities invisible.

From such standpoint, I view DVA as rooted in unequal gender-power relations at the household and societal level that get mediated by multiple, interacting structures of inequalities
and oppression (race/ethnicity, caste, sexual orientation, religion). I also emphasise the centrality of a life cycle approach that sees violence as much wider, cutting across all life stages to include violence faced by children (e.g. excess child mortality among girls, sex-selective abortions, child marriage), adolescents and adults before and once married, as well as the aged in the domestic sphere. DVA is therefore not restricted to physical, emotional and psychosocial abuse experienced by women in hetero-sexual marital relationships but also those forms that place young girls, children and the aged at increased threat or incidence of such abuse.

**DVA – a public health ‘pandemic’**

The case for recognising DVA as a public health issue rests on recognition of two fundamental aspects: its pervasiveness (widespread prevalence) and its health and wider societal burden (i.e. DVA being a significant cause of morbidity and mortality, affecting not only individuals but households and communities). Cumulatively, these aspects have resulted in an indiscriminate use of public health terminologies such as ‘pandemic’, ‘epidemic’ for DVA (Knaul et al., 2020). I explore these two aspects next.

**Violence as a pervasive threat** relates to the public health understanding of population exposure and risk. According to this perspective, violence is viewed not as individual threats but as a pervasive, cyclical phenomenon with intergenerational effects, suggesting that no society and population group is immune.

While there are considerable regional and country variations, as per available statistics, the lifetime prevalence of violence in the domestic sphere (measured primarily in relation to intimate partner violence in ten countries) varies between 15% and 71% (Garcia-Moreno et al., 2006). A study examining prevalence of violence in marriage in five countries in South Asia (Jejeebhoy, Santhya, & Acharya, 2014) from 2000–2013 found 10–38% women reporting severe violence that included being hit, kicked, choked, burned, threatened with a weapon or forced to have sex over the course of their marital life. It’s noteworthy however that country-level statistical evidence on prevalence of DVA is scant, and varies substantially across studies due to differences in populations and settings, inadequate adaptation of tools and methodological challenges of standardisation and validation (Kalokhe et al., 2017). Moreover, these focus largely on physical beating and/or sexual abuse. Feminist research and advocacy agenda in Southern contexts brought to fore other forms of abuse in the private sphere including sex determination and termination, forced desertion on grounds of infertility, dowry-related torture and deaths, marital rape among others. Though small scale, these qualitative studies were critical in revealing the everyday nature of violence experienced by women across their life cycle (see Mitra, 2011) and establishing the imperative for state action. Scholars also highlight paucity of studies examining the experiences of elderly women (over 50), and those in live-in, same-sex relationships and also among indigenous women (Kalokhe et al., 2017).

**The health consequences** of DVA are manifold and widely recognised (WHO, 2013). Violence not only affects the physical, mental and emotional health and well-being of the individual woman survivor but has significant impact on their children, on families, households and communities and other institutions such as healthcare systems. **Three distinct levels** at which such impact is felt can be discerned.

At the individual level, most visible and direct effects on health and well-being are physical injuries ranging from cuts, bruises, aches and pains to broken bones and dislocations, burns among others (Garcia-Moreno et al., 2006). Although scant, evidence also indicates a strong association between DVA and poor mental health including higher risk of depression and suicide (Dutton
et al., 2006; Kumar, Jeyaseelan, Suresh, & Ahuja, 2005; Rose et al., 2010). While immediate effects (visible injuries) are more effectively and frequently captured by large-scale national and multi-country surveys, there’s mounting evidence on the longer-term and indirect adverse health outcomes of violence as it impacts on wider determinants of health (e.g. nutritional status, economic productivity, behaviours and practices).

In relation to sexual and reproductive health (SRH), a global review by WHO (2013) revealed that women who have experienced partner violence are at 16% greater odds of having a low birthweight baby, more than twice as likely to have an induced abortion and depression, and 1.5–1.6 times more likely to acquire HIV or syphilis in comparison to women who have not experienced violence (Jejeebhoy, Santhya, & Acharya, 2013). Associations between the experience of violence and reproductive health outcomes such as unwanted pregnancy, induced abortions and other obstetric and perinatal complications, pregnancy loss as well as infant and maternal mortality are reported in studies from both developing and developed countries (Bacchus, Mezey, & Bewley, 2004; Nasir & Hyder, 2003). These adverse outcomes result from both the direct but also indirect effects of DVA as it leads to, for instance, poor nutrition and higher levels of malnourishment, anaemia (Ackerson & Subramanian, 2008) and pre- and post-natal depression (Tiwari et al., 2008) among abused pregnant women. Studies also report how the experience of violence pushes individuals to high-risk behaviours and environments (e.g. decline in use of contraceptives, uptake of family planning using wider SRH services), resulting in adverse SRH outcomes such as teen pregnancy and higher incidence of HIV (Dunkle et al., 2006; Decker et al., 2009; Jejeebhoy, Santhya, & Acharya, 2010). The evidence suggests that DVA can considerably impact the progress made in SRH policy, truncating any possibilities of attaining SRH goals by 2030.

DVA also has considerable impact on families and households. Studies confirm the intergenerational effects of DVA that can lead to long-term suffering and affect the ability to develop positive relationships. A study examining risk factors for men’s perpetration of physical violence across eight low- and middle-income countries found witnessing parental violence was the strongest risk factor. Boys who witnessed their mother being beaten were 2.5 times more likely to abuse their partner (Fleming et al., 2015).

A second set of arguments that strengthened advocacy in favour of health programmes/services on DVA emphasises the wider societal costs of DVA and its growing burden on economic and social development. DVA places increased demands on overstretched health systems, and reinforces poverty by limiting educational attainment and economic productivity of the survivor and family (Duvvury, Callan, Carney, & Raghavendra, 2013). The impact of direct and indirect health consequences of violence on women’s workforce participation is now well established (World Development Report, 2012). While focus on economic costs (and the efficiency argument it is underpinned by) has been criticised for its departure from the focus on human rights, it has indeed facilitated the wider uptake and development of public health approach. Using varied methodologies, researchers successfully demonstrated the direct and indirect burden of violence; for example, a prominent UK study estimated the costs of DVA to the National Health Service and the criminal justice system at £1.2billion and £1billion respectively (Walby, 2004, 2009). The World Bank estimates the economic consequences of GBV at 1.2–3.7% of GDP in some countries as a result of lost productivity. This figure is greater than the average public spending of low-income countries on health as a proportion of GDP, which stood at 1.5% in 2016 (WHO, 2018).

The significance of documenting the impact of DVA on health notwithstanding, it is important to establish the bi-directional relationship between violence and health, and how
it perpetuates a cycle of ill-health, poverty and deprivation, and further violence. Pregnancy, ill-health and disclosure of illness increase women’s exposure to and experience of violence (Hegarty, 2011). For instance, women living with tuberculosis, HIV/AIDS and poor mental health in large parts of the global South are unlikely to get married, or if married, are threatened with abandonment and desertion. Disclosure in these circumstances has resulted in increased violence (Gupte, 2013), exacerbating their experience of (post-natal) depression, isolation and detachment, and vulnerability to further abuse.

What does a public health approach to violence entail?

I answer this question by first laying out the key principles or core premises of a public health approach to DVA. Drawing on these, I then propose a framework that can guide the development of a public health response to DVA.

Population level focus

The fundamental goal of public health is to promote, maintain and improve health of populations. Thus, by definition, public health moves away from the individual and targets communities and populations as a whole. Consequently, public health interventions are based on assessment of risks and focus on populations that are at greatest risk of ill-health or injury. A range of risk factors and environments associated with DVA have been identified in literature. Deriving from a socio-ecological framework, these can be identified as individual and interpersonal/relational factors, economic factors and factors related to the social, cultural and physical environment (see Figure 7.1). However, much less is understood about the distribution of these risks in society and differentiated vulnerabilities in relation to gender, ethnicity/race or migration status. I discuss these knowledge gaps in the next section.

Preventive focus

It is concerned as much with preventing violence, as with mitigating the harms associated with it. This demands attention to the ‘upstream’ determinants (i.e. the social, economic, political and structural) of DVA that must be tackled to reduce the consequences that can be observed ‘downstream’. Prevention strategies may target three levels: primary, which concerns efforts to prevent violence from happening by targeting risk environments; secondary, developed in immediate response to instance of violence and therefore needing a strong referral system to support services; while tertiary focuses on long-term care and rehabilitation needs in the wake of violence (Dahlberg & Krug, 2002). In view of the specific contexts and resource availability, policy and programme-level responses need to carefully consider which of these are universal and aimed at the wider population, and which should be targeted at populations most at risk.

Multisectoral

Affecting these wider (distal and proximal) determinants of DVA calls for a multisectoral and integrated approach that involves creating safe public spaces and establishing appropriate referrals and links with other public sector agencies (such as health services, police, shelter, judiciary, employment, and the information, education and communication sectors).
Evidence-informed policy and planning

An effective public health response requires a clear definition of violence (form, sites) and a robust evidence base that can inform the development, implementation and monitoring of violence prevention policies and programmes. Absence of data also limits the advocacy space necessary to demand responsiveness and hold governments accountable for inaction. Such evidence base must provide evidence on what works, with what resources, and in what contexts (i.e. the enabling conditions in which certain programmes tend to have greater uptake and impact).

Notably, since DVA is a result of deep-rooted patriarchal norms and gender power relations operating at multiple levels in society (household, community, public and private institutions), any response developed to reduce or eliminate it must go beyond tackling its symptoms and affect the multi-dimensional and complex pathways in which these forms present themselves and the multifactorial risks underlying them. Measuring effectiveness of such responses may not therefore be amenable to randomised controlled trials and experimental research designs but require more complex mixed-methods approaches and qualitative insights to capture the short-, mid- and long-term effects of interventions on norms, perceptions, attitudes and behaviours.

Risk-based (rights-oriented) public health approach to tackling DVA: framework

Development of effective response strategies necessitates a detailed assessment of risk factors and ‘environments’ that heighten women’s vulnerability to (or to protect them from) DVA. However, such understanding of risk environments/factors is inadequate, supported by few empirical assessments and micro-level studies. Among these, only a few factors are more commonly reported and strongly evidenced across contexts and there is no overall consistency (Flury & Nyberg, 2010). The most expansive review of evidence on the risk and protective factors provided by Heise (2011) and subsequently updated (Heise & Fulu, 2014; Fulu, Jewkes, Roselli, Garcia-Moreno, & on behalf of the UN Multi-country Cross-sectional Study on Men and Violence research team, 2013) concludes that the evidence base is highly skewed towards Western high-income contexts. It is also deficient in accounting for the peculiarities of ‘Southern’ contexts and family structures in which violence takes place.

Empirical studies have tended to focus more on individual and interpersonal factors; much less on the impact of wider socio-economic, cultural, environmental and institutional factors or environments that place women at increased likelihood of DVA and the pathways through which they shape individual risks and vulnerabilities. Evidence is particularly deficient in situating violence amid the wider shifts and transformations brought about by globalisation, urbanisation, climate change, war and conflict and large-scale population movements resulting from these trends. The challenge, in part, is the diversity of contexts and populations to be studied, failure of research methods to capture more contextualised yet large population-level studies on a sensitive subject as DVA, and the absence of a broader socio-ecological framework guiding these studies.

Methodological limitations notwithstanding, evidence suggests that no single factor causes DVA. A socio-ecological model, first proposed by Bronfenbrenner (1979), considers the interaction of multiple factors incorporated into different levels of the “social ecology” (individual, interpersonal, community, societal). Its application to DVA studies therefore allows for a multi-dimensional and holistic understanding of DVA to emerge and effectively inform interventions, behaviours and attitudes for social change (Heise, 1998). Taking a socio-ecological approach, and adapting the framework to incorporate a more explicit focus on institutional and structural influences, in Figure 7.1, I present a framework to guide the development of a public health
Using a rights-oriented public health lens

Figure 7.1 A public health framework for tackling DVA

**Macro-social environment**

**Institutional environment**

**Socio-economic factors**

**Individual and relational factors**

(kinship ties, education and income, spousal alcohol use)

**PRIMARY**

- Population level public health messaging/awareness generation.
- Gender training of health workers and professionals across different specialities.
- Education; focus on gender and sexuality in schools.
- Policy development; budget allocation.

**SECONDARY**

- Emergency services.
- Help lines and counselling.
- Screening and medical attention incl. for STIs/mental health.
- Interventions with judiciary and police, shelter homes.

**TERTIARY**

- Long term care, rehabilitation and re-integration needs of survivor.
- Reduction of trauma and any disabilities arising from violence.
approach to tackle the multiple, interacting risk factors of DVA. As a departure from the earlier models, which identify the levels or sites in which the determinants operate (e.g. individual, interpersonal, community and societal), I focus primarily on categories of determinants. This allows examination of the nature of risk and enables development of strategies that can effectively address these.

**Individual and relational factors** concern women’s individual and familial context, which are often mediated by other gradients of social disadvantage. Commonly reported risk factors for DVA include low income, illiteracy or having no further education, prior history of abuse experienced/witnessed in childhood (Jewkes, Levin, & Penn-Kekana, 2002) and men’s harmful use of alcohol, drugs and problem gambling and multiple sexual relationships (Jeyaseelan et al., 2007; Mahapatro, Gupta, & Gupta, 2012; Muelleman, DenOtter, Wadman, Tran, & Anderson, 2002; WHO, 2012, 2019). Much less attention is given to kinship norms and ties and particular context in which marital arrangements are formed (for example, dowry, son-preference in family) when examining risks and considering protection mechanisms. A qualitative study in Ghana (Sedziafa & Tenkorang, 2016) contrasted experience of DVA in patrilineal and matrilineal societies and found the experience of emotional, physical, and sexual abuse was more continuous, pervasive and aggressive in patrilineal society as compared to matrilineal society. Here, it is important to highlight the variations in the forms of families and interpersonal relationships that characterise different contexts (Ghosh, 2004) but are often omitted in the dominant discourse on DVA. Women from diverse ethnicities and patriarchal cultures are subjected to abuse by not only the spouse but also members of extended family, especially female kin such as the mother-in-law and sister-in-law (Mirza, 2017). While older women in these families are subject to the authority of men, they are also delegated authority over younger daughters-in-law to ensure conformity to patriarchal social norms (Kapilashrami, 2017). Violence in this case takes the form of everyday abuse exercised in domains of the economic, social and political (freedom of movement and other liberties), also referred to as ‘coercive control’ (Stark, 2009). Studies from India and other South Asian countries expand our understanding in this regard; identifying correlations between wife beating and abuse and factors such as social isolation, lack of resources, early age at marriage, type of marriage/habitation, strained relations with in-laws, absence of children (in general or especially a male child) and other factors such as social stress and illiteracy (see Mitra, 2011).

Drawing from the earlier points, a public health approach to tackle individual and interpersonal factors must therefore not only improve women’s access to education, social and vocational skills, but simultaneously work with women, girls, men and boys to promote gender-equitable attitudes and behaviours and healthy and pleasurable relationship skills, and target behaviours involving harmful drinking, gambling, etc. in the household.

**Economic factors** demand particular attention here. While occurrence of DVA cuts across class/economic divisions in society, poverty is identified as a critical risk factor for violence (Evans, 2005; Heise et al., 1994). Not disregarding this evidence, Southern feminist scholars have questioned the link between poverty and domestic violence, arguing against seeing this as a phenomenon occurring only in socio-economically deprived class and calling out the invisibility of other classes in assessments of violence (Vindhya, 2005; Mitra, 2011). The relationship between economic independence and violence is more complex. On the one hand, there is evidence to suggest that poverty determines women’s vulnerability to violence limiting access to and control over income, assets and entitlements (housing, employment) – resources necessary to seek help, justice or exit abusive relationships. On the other hand, women’s acquisition of financial independence may place them at greater risk of violence from spouse and families as evident
from reports of abuse among women who are sole earners of the family and seen as transgressing gender norms (Jewkes et al., 2002). The mixed evidence on the impacts of micro-finance programmes aimed at women’s economic empowerment concurs with the previous point. While loan holdings and employment opportunities are shown to improve women’s bargaining position in the family, it may also act as a precursor to violence. Studies reporting household-level impact of programmes such as Grameen bank suggest an increase in DVA resulting from the changes in power relations brought about by shifting gender roles (see Kabeer, 2005 for more detailed examination of evidence on micro-finance). These differences notwithstanding, evidence suggests that the protective mechanism in such income- and employment-generating programmes is a greater degree of social capital (networks, non-material resources including information) and self-confidence and self-worth that are affected through these (Jewkes et al., 2002; Nakray, 2013).

**Socio-cultural factors** concern the norms, values, expectations and rules around which a society is structured and governed, and which shape the conditions in which people live, work and thrive. Among these, the system of gender – and its constituent patriarchal norms, relations, expectations around roles, division of labour – is prominent in sanctioning social control and legitimising violence in cases of transgression from these norms by women. Such a system, on one hand, sanctions practices such as dowry, son-preference and forced marriage that place women at greater risk of DVA (e.g. bride-burning, sex-selective abortion and infanticide, desertion and punishment for not fulfilling their ‘duties’) and limits opportunities and capabilities of women to break the cycle of violence. For example, withdrawing girls from schools, denying opportunities for education and earning a secure livelihood and income are known to increase women’s risk to violence (Bates, Schuler, Islam, & Islam, 2004). On the other hand, it privileges male power and normalises ideas of aggressive masculinity and passive femininities that are linked to women’s submission and tacit acceptance of violence to ensure conformity to societal norms.

Here, I bring to scrutiny the nomenclature and artificial dichotomy created in violence scholarship between certain forms of DVA framed in terms of ‘culture’ (e.g. ‘honour’ killings or female genital mutilation) and that which are perpetrated within families in the West (e.g. spousal murder/hate and domestic violence homicides or femicide). While notions of honour, shame and social control underpin all the aforementioned acts of violence, explanations for the latter often centre on perpetrators’ characteristics. Such representation marks a false distinction between ‘Southern’ and Western values and creates racialised imagery of victims. Dismissing such dichotomy, feminist scholars (Gupte, 2013; Shier & Shor, 2016) demand attention to the unequal gender norms that underpin all forms of violence in the ‘domestic’ sphere and the weak community and societal sanctions that allow their occurrence.

A public health approach needs to go beyond strong enforcement of legislation (for example, against dowry, sex-selective abortions, female genital mutilation) to simultaneously tackle social norms (related to education, employment, marriage) through comprehensive gender and sexuality education across institutions and mass-media public awareness campaigns. Such campaigns should be aimed at creating a zero-tolerance for DVA among the public and promoting gender-sensitive stances in the community, health sector, judiciary and with law-enforcing officials.

Institutional factors relate to laws, formal rules and institutions that are in place (or not) to intervene and break the cycle of violence. Core social institutions such as schools/educational institutions, family, religion and state institutions such as legislature, judiciary among others are sites where disadvantage is accumulated over the life-course. Attention to these is crucial as they foster a social environment that reinforces disadvantage and allows abuse to occur with
impunity. For instance, while education is seen as a critical protective factor for DVA, the environment in schools and the absence of an empowerment approach in educational programmes (including sex-education programmes) may reinforce gender stereotypes and continue to place women and girls at greater risk (Haberland & Rogow, 2015; Le Mat, 2017). Institutional analysis in DVA studies is restricted to the responses of the police and education sector, overlooking their role in perpetuating the cycle of violence and re-victimisation. Absence of laws, lack of gender-sensitive policies and women-friendly spaces may result in re-victimising women and increasing their risk to DVA. For example, ‘no recourse to public funds in the UK’ disregards the familial context of abuse that migrant brides find themselves in and limits their recourse to legal and financial support and justice systems, trapping them in abusive relationships (Graca, 2017). A similar disregard for the upstream determinants of violence was seen in early proposals to address sex-selective abortions in India that penalised women for termination of pregnancy; failing to address the commercial determinants of this practice and hold healthcare providers, especially in the unregulated private sector, to account. This was subsequently amended in the pre-conception and pre-natal diagnostic test act that was adopted in India.

From an institutional perspective, a public health intervention to DVA must therefore bring attention to school, youth settings, work places as well as other institutions such as police, judiciary and healthcare systems, and target gender and sexuality norms that underpin social attitudes that may condone and re-victimise survivors. Such attempts can not only help reduce aggressive incidents in intimate relationships and families as a whole (by changes in gender norms and attitudes) but also offer a supportive environment to survivors of abuse.

Macro-environmental factors concern broader conditions of living and working and encompass the natural, social, geo-political and the physical environment, which create heightened risk of DVA. While violence is pervasive and women in a variety of contexts are vulnerable to incidence of abuse, certain contexts and environments exacerbate these risks and grossly undermine women’s access to support and justice systems. These include, for example, ‘upstream’ determinants such as political conflicts, state repression, climate disasters, all of which may lead to forced displacement and migration, which impact the ‘downstream’ or more ‘proximate’ determinants of violence (e.g. changes in family and kinship structures, income and livelihood opportunities), yet remain under studied in DVA research. Women living in conflict situations or as refugees and asylum seekers in transit and host countries experience cumulative risks that increase their vulnerability to DVA (Pittaway & Rees, 2006). My research in transit contexts of Serbia and the Balkans and in Scotland revealed that migrant women experience a greater burden of silence and get deterred from justice-seeking because reporting DVA in the wider context of racism and a growing anti-migrant sentiment is viewed as adding to the family’s suffering and community’s honour.

Scholars are beginning to draw attention to this major lacuna in DVA studies that fail to consider the relationship between the macro processes of globalisation, transitions in climate and population movements, and the community and individual experiences of DVA (Fulu & Miedema, 2015). A nascent but growing body of work is highlighting the gendered nature of these forces and how they produce sexualised and racialised bodies, and masculinised institutions and identities (Ferguson, 2008; Andrijasevic, 2009; Alsaba & Kapilashrami, 2016), with complex and contradictory effects on women in areas of labour, livelihoods, sexuality (see Doyal, 2002; Rege, 2003; Kabeer, 2001). Feminist scholars have thus focused on flows of violence between states, local communities and individuals (Das & Kleinman, 2001; Mitra, 2011), placing DVA in a continuum of violence inextricably linked to the wider socio-political and economic developments. Yet, such understanding has not translated to empirical investigation
of these links to examine the nature of risks produced and how such risk is distributed in society across different axes of marginalisation (e.g. race/ethnicity, religion, sexuality) (Kapilashrami & Hankivsky, 2018). Critical questions remain unanswered: who are most at-risk population groups in these contexts; what is the current status of legal protection and other support services; how can their access be enhanced? Such assessment exacts explicit adoption of an intersectionality framework that, as emphasised elsewhere, integrates a feminist political economy perspective for more in-depth examination of how these broader shifts in ecology and political economy re-structure gender power relations in households/families and communities and create distinct risk environments (Alsaba & Kapilashrami, 2016). This empirical gap renders DVA interventions that do not consider the changing context of vulnerabilities ineffective.

Having explored the value added by a public health lens to the work on DVA and outlined its core premise, I now turn to evidence on effective strategies and interventions. The purpose of this chapter is not to offer a comprehensive review of that evidence; rather I highlight key messages from available international and regional reviews.

### Evidence on effective public health strategies and health systems’ response to DVA

Global and regional evidence on what works to prevent and effectively respond to DVA point to a dearth of rigorous evaluations and report mixed evidence (Heise, 2011; Solotaroff & Pande, 2014 for South Asia). Limitations notwithstanding, these evaluations suggest the importance of interventions that are multisectoral, have an explicit gender focus and simultaneously target risk factors at multiple levels of society – individual, household, community, institutional and structural (Solotaroff & Pande, 2014). Furthermore, campaigns that target and change underlying attitudes and gender norms are regarded effective in bringing DVA to public attention if using established community networks, change agents and applying innovative media with bold messaging (ibid.).

While there is little evaluation of services targeting specific needs of survivors, integrated health systems’ responses are gaining popularity as a promising response to the multiple needs of survivors and also as preventative approaches. The UN Framework to underpin action to prevent violence (UN Women, 2015) presents a comprehensive systems approach to eliminating violence, suggesting a continuum of interdependent and mutually reinforcing interventions. Three foci of such action identified in the framework are:

<table>
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<th>Prevention</th>
<th>Focusing at the population level and on the range of settings in which gender relations and violent behaviour are shaped.</th>
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<tr>
<td>Early intervention</td>
<td>Focusing on individuals and groups at a higher risk of experiencing/perpetrating violence and the factors contributing to that risk.</td>
</tr>
<tr>
<td>Response</td>
<td>Focusing on building systemic, organisational and community capacity to respond to those affected by violence.</td>
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Several health system interventions have been implemented in the last few decades on the premise that healthcare facilities are a key entry point for women seeking treatment for a variety of physical, sexual, psychological and reproductive morbidities resulting from violence, though they may not disclose as such. This arguably places the health system in a unique position to offer women “a safe environment where they can confidentially disclose experiences of
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violence and receive a supportive response” (Garcia-Moreno et al., 2015, p. 1567) that attends to its diverse health consequences.

Reviewing international evidence on their effectiveness, Spangaro (2017) identifies specific interventions – for example, first-line responses, routine screening, counselling women, child protection notification, training and system-level responses – as effective in reducing the extent of harm from DVA. Scholars also identify healthcare systems’ ability to go beyond addressing the health consequences to enhance access to justice by facilitating responses of other sectors such as criminal justice, social work (Temmerman, 2015). In doing so, they may be effective in breaking the cycle of abuse and preventing further recurrence.

Among comprehensive systems responses, an approach that holds promise is ‘one-stop crisis centres’ (OSCC) established in tertiary-level hospitals in several countries in South Asia. For example, the Multi-Sectoral Programme on VAW in Bangladesh with the Ministry of Women and Children Affairs, the OSC Management Centres in Nepal under the Ministry of Health and Population, the Dilaasa programme offered in partnership with a women’s health non-government organisation and the Municipal Hospital in Mumbai and Bhoomika implemented by the government of Kerala in India. By linking with other departments and critical services, these centres facilitate access to a range of services needed by survivors of violence including medical attention, shelter, rehabilitation, psychosocial and legal counselling (including individual and family counselling) and crisis management. Studies examining the functioning and impact of OSCC report promising results; for example, growing uptake of services and acceptance in local communities, improvements in women’s access to support services and their potential to empower women in situations of abuse (Kapilashrami, 2018; Kirk, Terry, Lokuge, & Watters, 2017; Jewkes, 2014). Services were found particularly responsive and sensitive to women’s complex needs when these interventions were embedded in feminist approaches to counselling women survivors (for example, the Dilaasa model in Mumbai) and offered routine and refresher gender trainings for counsellors, wider hospital staff as well as other service providers (e.g. police).

Yet, significant barriers to their effective implementation exist. Prominent among these are ‘organisational constraints’ including lack of trained and specialised staff, budget, and varied success in integrating support services (e.g. linking women with lawyers for legal guidance, NGOs for rehabilitation, police for security) (Colombini, Mayhew, Ali, Shuib, & Watts, 2012; Jewkes, 2014), poor working conditions including physical space and infrastructure, short-term contracts as well as wider hostility and low prioritisation of abuse cases among wider medical staff (Kapilashrami, 2018; Solotaroff & Pande, 2014). In the study in India, I found the OSCCs operated in a very hierarchical healthcare system where counsellors were entrusted with increased administrative demands of keeping records and entering data for other services, doctors and managers (ibid.). Coordination of OSCC and counselling was mediated by gender-power relations (between counsellor and other medical staff; between counsellor, survivor, and their families) and embedded in the formal and informal rules, norms, and an organisational culture resistant to change (Kapilashrami, 2018). The absence of training and supportive supervision of counsellors not only increased staff burnout from isolation, secondary trauma or ‘compassion fatigue’ but also prevented development of trusting relationships with abused women (Kapilashrami, 2018).

These challenges are less accounted for in literature and signal an absence of a critical and comprehensive understanding of healthcare systems as social institutions and sites of pervasive systemic violence. Studies examining health-seeking experiences among women survivors of abuse report service providers’ attitudes and view of domestic violence as a ‘private’ matter (Jejeebhoy et al., 2014; Colombini, Mayhew, & Watts, 2008). Similarly, as argued elsewhere,
historical experiences of coercive sterilisation programmes, obstetric violence, invasive medico-legal examination to determine “habituation” to sexual intercourse in case of sexual violence (Pitre & Lingam, 2013) reflect the deep-seated gender bias prevalent in attitudes and practices of healthcare professionals (Kapilashrami, 2018). In these contexts, interface with the healthcare system may result in further victimisation, violate women’s right to privacy and dignity, and reinforce a culture of silence and impunity that hinders women’s access to help-seeking and justice.

These system-wide deficits notwithstanding, there is growing optimism on the impact of integrated health-sector interventions, supported by process documentations that reveal critical learnings and promising practices (Bhate-Deosthali, Ravindran, & Vindhya, 2012; Kapilashrami, 2018; Solotaroff & Pande, 2014). Acknowledging this potential, Garcia-Moreno et al. (2015) highlight three levels and pathways of prevention where healthcare systems can play a crucial role: primary prevention to detect risk environments and raise awareness; secondary prevention requiring early identification, referrals for legal aid, acute care and long-term support services; and tertiary level intervention involving support for mental and physical rehabilitation of the survivor.

**Conclusion**

DVA is a complex phenomenon driven by multiple interrelated risk factors that operate at different levels of social ecology, though ultimately, DVA results from gender and sexual norms that patriarchal societies are deeply entrenched in. Therefore, responding to it requires a multi-pronged approach and the participation of multiple sectors and institutions.

Different theoretical and conceptual frameworks have been utilised to understand and effectively respond to DVA. While criminal justice, human rights and family violence have contributed significantly to our understanding of DVA and informed interventions, the magnitude of DVA, its pervasive psychosocial, health and wider societal burdens render it a public health priority. A public health approach to DVA focuses at population-level risk factors and environments and proposes a multisectoral and integrated approach aimed at reducing risks and enhancing protecting factors. Such approach is premised on establishing links with other public sector agencies (such as law enforcement/prosecution, health services, forensic laboratories, social welfare, shelter, employment) and creating safe public spaces. Integrating rights and feminist principles within a public health approach has the potential to go beyond a siloed response to DVA, and offers sector-wide intervention that address the systemic nature of gender power relations, socio-cultural norms, and wider inequalities that impede effective responses.

Such an ambitious goal of eliminating DVA also demands implementation of laws and policies that promote gender equality, appropriate resource allocation to prevention efforts, alignment of interventions with evidence on risk and protective factors, close monitoring, and above all, political commitment and leadership to bring about change. As illustrated in the above example of integrated health-sector interventions, a rights-based public health response can not only facilitate early identification of signs of abuse and offer support services to women, but it also has the potential to be a vehicle for women’s access to justice.

**Note**

1 The interchangeable use of terminologies to denote GBV in this section illustrates the evolving discourse on gender-based violence. The author views GBV as an all-encompassing and appropriate terminology to refer to violence that is rooted in gender inequality and directed against a person, in
majority cases women, due to their gender. However, the term violence against women was of common usage in international policy developments and milestones in the '90s that brought to fore the violence experienced by women and placed the unequal gender power relations and status of women on the global agenda. Domestic violence and abuse (DVA), the focus of this book, refers to a form or sub-set of GBV that is defined with respect to the particular domain in which violence is exercised. As described on earlier, the author considers DVA to be a broader construct than intimate partner violence as it is applicable to diverse contexts and kinship formations.

**References**


Using a rights-oriented public health lens


