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REVIEW ARTICLE

Domestic violence, women's health, and the sustainable development goals: integrating global targets, India's national policies, and local responses

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Abstract

Domestic violence (DV) is a serious public health concern, affecting women's health and well-being. An international governance framework, through the United Nations' Sustainable Development Goals and national policies in India have committed the country to attempt elimination of violence against women. Even so, efforts remain starkly inadequate for altering conditions under which women experience DV. This review paper aims to develop an evidence-based, integrated life cycle model to alter conditions that perpetuate DV and related vulnerabilities in society. The analyses identify and determine community-based innovative practices and policies. We propose a collaborative 'R5 model' to incorporate a multi-stage response to break the cycle of gendered vulnerability. The model identifies five stages of vulnerability in the lives of victims of violence: rescue, recovery, rehabilitation, resilience, and reform. This approach can result in promoting a proactive state-society engagement to uphold the rights and the welfare of women. We recommend the 'R5 model' to bridge the global SDG targets, national policies, and local practices.

Keywords Domestic violence · Sustainable development goals · India · Integrated model · Health sector response

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Introduction

Domestic violence (DV) is a serious public health problem, affecting women of varied cultures and regions worldwide. DV affects a woman's physical, mental, and reproductive health, along with child health [1]. Anxiety and Post-Traumatic Stress Disorder may linger even after an abusive relationship ends, with fear or loss of family [2]. This pain is accentuated by a cultural expectation that a woman is responsible to hold a family together. Society considers any act that may disintegrate a family to be deviant. Thus, women avoid reporting DV; the lack of reports reinforces gendered norms of female victimization. Although in 2005, the government of India enacted the Protection of Women from Domestic Violence (PWDV) Act, the current healthcare response remains limited to routine medical screening and treatment of violence injuries and trauma [1].

Studies of DV in healthcare settings suggest that healthcare providers are a survivor's first or only culturally accepted point of contact. Her integrity is maintained when she interacts with healthcare providers [3]. Despite the acceptability of healthcare, only a fraction of abused women seek help [4]. Thus, it is important to examine underlying causes of DV that impede successful outcomes from government policies. Its architects expect the National Policy for Women (2016) in India, "to create an effective framework to enable the process of developing policies, programs, and practices which will ensure equal rights and opportunities for women in the family, community, workplace and in governance" [5]. But the country's institutional responses to DV are neither holistic nor integrated. Instead, society victimizes women, and the system tolerates the accumulation of disadvantages for them [6, 7]. Government departments increasingly seek collaboration as each recognizes that no single department can resolve complex societal problems [8, 9]. Countries vary in capacity, resources, and power to address victims' multiple needs [10]. If a woman chooses to seek assistance other than medical, this may increase her risk at home. Although healthcare providers have recognized this problem, the need persists for an integrated model to detect DV and protect women from it.

Sustainable development goals: the global target

Despite the adoption of the United Nation's Sustainable Development Goals (SDGs) by member countries, there is no adequate integrated, operational framework for addressing DV [11]. Although 193 member countries adopted the SDGs, more than 600 million women live in countries where DV is not a crime, and in 53 countries that do not acknowledge marital rape as abusive. According to a report of the World Bank, 59 countries lack laws protecting women from sexual harassment in the workplace [12]. Countries lack a community-based intuitional design for collaboration or lack capacity to implement collaborative approaches to improve outcomes.

To eliminate DV, the SDGs call for an integrated operational design to achieve targets, using indicators as a basis for measuring outcomes to support national

planning and reporting. Achieving SDGs health targets not only means the absence of disease or disability, but also the presence of well-being. The SGDs encourage addressing DV in the ways other public health efforts have eliminated diseases [13]. Prerequisites include incorporation into policies of scientific knowledge, social practices, and administrative functions. The gender-responsive implementation of the 2030 Agenda for SDGs for the first time addresses all forms of violence against women with exclusive targets and measurements [14, 15]. The SDG 5.2 aims to "eliminate all forms of violence against all women and girls in public and private spheres, including trafficking and sexual and other types of exploitation"; SDG 5.3 calls for countries to "eliminate all harmful practices, such as a child, early and forced marriage and female genital mutilation" [16], including SDG target 16.1 and 16.2 [17].

The World Health Organization (WHO) global action plan for strengthening the role of health systems in addressing interpersonal violence [18] complements the SDGs' call to institutionalize a governance framework [16]. Thus, inclusion of the health system is central to integrating social and political enablers of gender equality to eventually eliminate violence against women [19, 20]. Without the integration of various interventions by other government institutions beyond health and community initiatives, achieving the vision of SDG will be difficult [21].

An integration of global targets, national policies, and local responses

Although the policy provides an important platform for strengthening and scaling up the contribution of public health for achieving the SDGs, an integrated system is required to ensure the well-being of women. Apart from design and capacity, SDGs operating in a male-dominated administrative system push victims of DV into seclusion. Contested legal and administrative procedures, customary laws, and societal norms foster a gap between state and society [1, 22]. During the last decade, the Government of India (GoI) adopted declarations, resolutions, and international agreements in national policies. Several state governments designed intervention strategies for well-being and healthcare schemes for the survivor. Some important interventions include PWDV Act, 2005 [23], the National Policy for Women (2016), gender budgeting in all government interventions, and a One-Stop Centers [24] scheme to integrate assistance to women affected by violence, both in private and public spaces. The GoI institutionalized gender budgeting through development of a system to classify transactions, and formation of cells in each Ministry to identify gender-related goals and ways to achieve them using audits of annual budget allocations and expenditures [25]. Within the central government framework, states began to adopt gender budgeting, starting with Odisha in 2004; since then, 15 states of India's 29 have adopted gender budgeting [26]. More than 70 ministries or departments draw grants from the GoI. Of those, 57 ministries have gender budget cells, but only 34 have reported allocations in 2020–21 [27].

Despite the government's commitment to gender equality, institutions remain poorly resourced and inadequately responsive to gender. Breaking the cycle of

abuse from one generation to the next requires effective laws, policies, and interventions, timely identification of DV, and easy access to services. Lack of integration among programs aggravates inefficient use of limited resources [1]. Implementing the SDGs will require more policy coherence—both vertically and horizontally—and participation of non-state actors [28]. Women-centered interventions in clinical practice will be needed to improve individual outcomes, including a woman's skills and confidence to fulfill her needs [29, 30].

The context and the objective

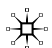
Though multiple government agencies address particular concerns of DV victims, they fail to transform the circumstances that impede women's capacities to escape the gendered cycle of vulnerability [13]. DV is a dreadful problem; its causes are varied, and government responses have been insular [9]. We need to devise more strategic, integrated practices and collaborate to strengthen capacity. Only such efforts will enhance the public value of government programs in transforming gender relations for the state and society to eliminate violence and promote equitable opportunities for women [14]. We identified a need to broaden approaches to women facing DV, and an operational framework to integrate multiple programs and practices.

This review article aims to provide an evidence-based model for the cycle of gendered vulnerability caused by DV. We examine five stages of vulnerability in the lives of victims of violence: rescue, recovery, rehabilitation, resilience, and reform. We propose a 'R5 model' and describe strategies to improve outcomes based on collaboration among service providers sharing a pool of diverse resources across institutions and communities. The goal is to shift focus from episodes of trauma recovery and conflict mediation to an empowerment model with effective collaboration between the state and society at large.

Methods

We began the literature review using four key terms: domestic violence, India, policy, and practice. We identified 157 articles, case studies, and policy documents in the public domain. We excluded articles that addressed individual cases of violence or single factors, such as the age of marriage, dowry, prevalence of DV, health consequences of DV, perpetrators' behaviors, or a particular area, community, or caste. We included articles and cases that focused on the macro interpretation of DV policy and practice. Using these criteria, we selected 55 articles and policy documents for detailed analysis of innovative community-based cases that overcome cultural and institutional barriers in achieving policy objectives by

(1) reducing the gap between the desired and delivered public value by public services, and



(2) redressing factors impeding desired outcomes during utilization of public services.

We then conducted a content analysis of existing public services for victims of DV and identified common concerns among women using public services and those providing them. We focused on multi-component schemes applied successfully to similar issues, a public health approach to DV, barriers to adopting this approach, and a roadmap for strengthening the capacity of healthcare workers to break the vicious cycle of vulnerability.

Results

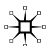
We identified five stages of vulnerability in the lives of victims of violence: rescue, recovery, rehabilitation, resilience, and reform, that form the R5 integrated model. This model specifies the roles and responsibilities of healthcare providers to enhance the quality of care and directs policymakers to design public services that are socially acceptable and allow women to exercise value judgment, make decisions to take timely action to prevent DV.

Rescue

The Rescue stage of the integrated model is intended to save an endangered life at the source. Families perpetuate DV with the onset of marriage; vulnerability is greater for women married at an early age [31]. A study comparing 38 countries suggests societies in which traditional gender norms and culture perpetuate the low status of women, and those that compel child marriage, demonstrate a stronger relationship with Interpersonal Violence [32]. DV occurs in families across generations, thus it persists. Rescue requires liberation of girls from child marriage.

Despite having been outlawed in 1929, child marriage continued to be prevalent. Aiming to eliminate child marriage, the Government of Madhya Pradesh introduced a community-based "Lado campaign" to integrate efforts of critical government departments and allied public service providers (department of health, ministry of home, social justice, transport authority, department of education, printing press) with those of private practitioners and other service providers. It mobilized men and women in communities to gain the support of stakeholders outside government, non-governmental organizations (NGOs), to implement year-round an action plan from the State Vision document. This strategy reduced child marriage drastically in one year, preventing 51,835 such marriages. It engaged 1.6 million lakh community cadres and sensitized all 50,000 villages in a series of workshops and regular interactions [33]. The GoI observed that strict prohibition of early marriage would lead to traumatic situations for families because it involved money, their credibility in society, and customary values.

The integration of community-based efforts and those of government departments resulted in timely action and systemic changes in community norms. The



government overcame challenges with a community-based strategy, and effective coordination among all departments by adhering to a well-conceived operational plan. The *Lado* campaign experience suggests DV and early marriage is rooted in the culture, and integrated approach to redress can succeed as demonstrated here.

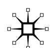
Recovery

The Recovery stage means redefining one's life after the violence. A model (*Dilasa*) crisis center was established in the public hospital with a collaborative effort between an NGO (CEHAT) and a municipal government hospital in Maharashtra. The experience suggests, "when women who are afraid returning home because of the threat of violence are admitted under observation for 24 h" in a hospital, this allows time for recovery by working out next steps, referring the women to shelters, or finding a safe space with relatives or friends. Extending such a hospital stay also provides time and space for each woman to make a decision [34].

Individuals interpreted their personal and environmental strengths that led to recovery differently; understanding enabled dimensions of healing. State-led Family Counselling Centres (FCC) have become socially acceptable agencies for resolving DV using legal and administrative functions [35]. They provide space for abused women to recover with police protection, healthcare, and other advantages. Thus, FCC is a collaborative model that promotes social, legal, and administrative ease for individuals, families, and communities [36]. Before FCC, women survivors remained vulnerable without access to or use of benefits from police, judiciary, healthcare, and counseling services, or both [35]. Abused women who experienced delay or lacked access to services to which they were entitled, suffered psychological distress and physical health problems and were prone to depression. Women coped with their mental health by using public facilities and entitlements at the FCC [37]. The integration of FCC with NGOs and police efforts enabled FCC to mediate power differences in the women's families and facilitate more effective exercise of women's rights [38, 39]. In line with the FCC model, the One-Stop Centre (OSC) has been established in all the districts across the country to integrate under one roof support and assistance to women affected by violence in private and public spaces. It facilitates immediate use of emergency and non-emergency services (medical, legal, psychological, and counseling support integrated) with a 24-h Helpline.

Rehabilitation

The Rehabilitation stage depends upon an intervention to separate victims, from abusive partners to address the womens' legal rights and needs. While recovery brings new purpose in life, rehabilitation is a process of learning skills to succeed [40]. Shelter for rehabilitation of women provides them space free from fear and inculcates desire to reincorporate meaning in lives. Shelter homes in India (called *SwadharGreh)* [41] provide women a place to reside for a year, with basic facilities and services. These facilities offer space for safe rehabilitation and services (food, clothing, legal aid, medical treatment, counseling, advocacy, skill-based training,



economic and social security, educational and preventive community outreach) for women and children away from abusive partners, along with referrals mental agencies and legal services. They enable women to rehabilitate emotionally and economically and to deal with litigation over marital disputes. In 2017, 551 *SwadharGreh* operated in India, however, they are distributed unevenly across states. It is important to assure standardized use and benefit of these facilities and services for disadvantaged women across the region.

Resilience

The Resilience stage enhances an individuals' ability to recover from violence with minimum losses and in a limited period of time. It is the capacity of a person or system to maintain its core purpose and integrity in the face of changing circumstances. Herrman et al. note that "effective clinical care and public health workers to develop resilience require partnerships across health and non-health sectors" [42]. Resilience grows with community engagement promoted by the government to alter the social position of women in society. GoI-initiated state-led *Shaurya,* India's first community-led initiative, aims to promote resilience by reducing crimes against girls and women in Madhya Pradesh. Local processes of collective action engage and empower the entire population of a local community; they do not impose an external action for the community [43]. Six districts of Madhya Pradesh piloted *Shaurya Dal* as a strategy for social integration. Each formed groups of 5 women and 5 men to fight crime and injustice by creating an enabling environment. These groups work with multiple government departments to ensure sustained economic support including technical and financial entitlements of families. This partnership supplements the low police-to-population ratio by connecting families in need to timely and socially acceptable entitlements. Successful experimentation with *Shaurya Dal* has created a desire among young girls to ensure justice for women.

Punitive administrative measures alone do not prevent nor curb violence against girls and women [44]. Reducing crime requires integration of law enforcement with a community-led strategy. These newer, state-led, community-based models put community cultural sustainability at the forefront. Resilience is a consequence of women seeking timely rescue, recovery, and rehabilitation in their communities. Increases in domestic decision-making power, financial independence, and self-care [45] improve women's income and reduce insecurities [46]. Without resilience and empowerment, it is difficult to reinstate women in their central positions within their families. Studies conducted by Bhartiya Stree Shakti suggest that women do not want to break away from family, but want rights to restore their dignity and a place in their families and society [47].

Reform

The Reform stage means transforming state and society functions to address DV. It follows rescue and recovery that afford women immediate relief, and rehabilitation, and resilience to build women's capacities to adjust. The first four stages may

not succeed without policy reform. After the enactment of the PWDV Act 2005, women gained rights, unequivocally, to seek justice against DV. A unique intervention is a Behavioral Intervention Package (BIP) at LN hospital, New Delhi. It includes trauma recovery and empowerment activities to break co-dependence with the abuser; coping mechanisms, yoga (relaxation techniques and exercise); and life-building skills for pregnant women attending antenatal care in the hospital. [48]. The research team adopted a non-judgmental, flexible approach to form relationships with each survivor. This relational model developed trust and the willingness of women to participate. Participants reported deep trust in the intervention and the development of immediate bonds with staff. Many reported greater clarity in thinking about their problems and felt relief by sharing their problems. Support from their husbands increased, accompanied by greater awareness of the impact of stress on a developing fetus and its long-term effects. Credibility and trust are critical factors for establishing a shared language to discuss personal experiences of trauma and the symptoms of traumatic stress, to allow survivors to establish a network of support, and to see the potential for change [49].

Discussion

Although India introduced reforms, reform without gender-sensitive ease of access to the advantages offered by the literature and discussed above have impeded desired results. Current parallel approaches adopted by multiple agencies to 'violence' may rescue women for a moment but, fail to break the cycle of abuse without cumulative outcome. Single-purpose organizations produce fragmentation and hamper effectiveness and efficiency for lack of cooperation and coordination [50]. In the cycle of violence, women lack holistic opportunities and social licenses to link improved experience with all the services and facilities, even when entitled to do so. The R5 integrated operational model describes the interdependent stages for integrating institutional structures, people, and processes to achieve global targets, implement national policies, and improve local practices.

The model integrates resources, actors, and public action (institutional and community) as a most effective strategy [51]. It can reorient the psychosocial, legal, and public health systems along with communities to prevent violence through the integrated system approach we have described. Another important finding is that health facilities and providers can operate as a socially acceptable 'gateway' for women to seek integrated benefits, including services. Unlike police and judiciary, by entering services through a health portal, women can overcome a cultural barrier to use of rights and entitlements.

Learning across the world suggests that rescue, recovery, rehabilitation, resilience, and reform do not eliminate violence standing alone [52]. The integrated R5 model should combine a proactive state-society engagement to enable women to exercise their rights and improve their welfare by integrating the health system with many additional elements. The model's critical advantages over previous approaches include

- understanding collaboration among diverse psychosocial, legal public services, and
- identification of health systems as a platform to integrate government departments with community members and activities [53].

The model relies on community resources, cultural action, low-budget interventions, and goal-oriented operational clarity for a sustainable solution. The evidence points to the importance of integration of hospital activities for easing treatment of disease and distress. The health system's unique advantage lies in its social acceptability and capacity to integrate non-clinical care and clinical cure. The health sector remains less engaged in the multi-sectoral response to prevent and respond to violence. Many hospital programs seek to increase the rates of participation in psychosocial programs; however, high rates of mental healthcare use remain unlikely if survivors do not deem healthcare providers credible and trustworthy [54]. Hospital protocols need to evolve 'health plus' guidelines to provide people-centered health services. Health services need to evolve to fulfill culturally accepted first-line support; care for injuries and mental trauma, along with other health services including for emergencies. Health services need to ease the use of legal and shelter services [55].

Conclusion

Escape from the cycle of violence requires a multi-stage approach to integrating global SDG targets, national policies with collaborative local practices. While the rescue stage eliminates an immediate threat resulting in momentary recovery; rehabilitation transforms women from a state of vulnerability and converts pain to a source of strength to strive for resilience. The R5 model has potential by incorporating a multi-stage collaborative response to break the cycle of gendered vulnerability caused by DV. The R5 model can guide policymakers to elaborate the role of NGOs, legal, and health providers where an institution can integrate allied public services to improve effectiveness, efficiency, and accountability for the prevention of DV. Proactive public health and women's rights agencies in partnership with communities have the potential to create a sustainable model. Policy reforms to eliminate violence and reduce vulnerability must reorient the public health system to engage multiple agencies and communities to empower women. Thus, strengthening the inclusive collaborative institutional structure and clarifying the roles of all in responding to all stages of violence are essential to promote the quality of care and cure for women in a just society. Further, this may alter the conditions that propagate cycles of vulnerability and improve SDGs' targets related to violence against women.

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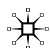

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