LETTER TO EDITOR

Violence against Women: Making Sense of a Silent Pandemic

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Dear Editor,

Violence Against Women (VAW), is "any act of gender-based violence that results in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" [1]. The most described forms are Intimate Partner Violence (IPV) and non-partner sexual violence [1, 2]. But, VAW is a larger menace including emotional, psychological, financial and cyber abuse [3]. VAW harms health, and compromises women's rights, dignity, security and autonomy [1]. Certain groups are particularly vulnerable such as young girls, old women, those with disabilities, migrants, refugees, lesbian-bisexual-transgender women, indigenous, ethnic minorities and women living through humanitarian crisis [1]. According to estimates across 161 countries (World Health Organization (WHO), 2000-2018), at least 1 in 3 women experience IPV or non-partner sexual violence [1]. Global recorded prevalence of past-year IPV was 13%, lifetime IPV and non-partner sexual violence were 27% and 6% respectively [1]. Unlike most health estimates which show notable regional variation depending on the socioeconomic landscape, lifetime IPV estimates display minimal variation from 20% to 25% in Western Pacific, European and American regions to 31% to 33% in Eastern Mediterranean, African and South-East Asian regions, pointing to its pervasive nature [1].

In India, estimates of past-year and lifetime IPV are 18% and 35% respectively [2]. According to Phase-1 report (2019-2020) of National Family Health Survey (NFHS-5), prevalence of spousal violence has increased in 5 out of 22 states studied, with a range of 32% to 44% [4]. This warrants immediate attention and action.

Often unreported or under reported, VAW, has assumed humongous proportions following COVID-19 pandemic. The restrictions implemented for pandemic control have forced women into cramped living conditions and social isolation with their abusers with limited access to support [1, 5-6]. The socioeconomic impact of the pandemic with resulting economic uncertainties has intensified their vulnerability [6]. Countries such as France, Argentina, Cyprus and Singapore reported 25% to 35% increase in emergency calls reporting domestic violence in April 2020 [5]. Similar trends with demand for emergency shelter were also reported from Canada, Germany, Spain, United Kingdom (UK) and United States [5]. UK and Australia reported 50% to 100% increase in online abuse or bullying and intimate image abuse in March 2020 [5, 7]. Contrarily, few helplines and shelters in Italy and France reported slump in calls during early lockdown indicating probable lack of access to mobile phones due to restrictions, gender discrimination and digital divide [7]. The nation-wide lockdowns had rendered public spaces

unsafe, making women targets of sexual abuse and rape [5, 6]. Diversion of healthcare services to pandemic management, product shortages and supply chain interruptions has disrupted family welfare services exposing women to unplanned pregnancies, induced and illegal abortions [6]. Efforts against child marriage and female genital mutilation have been impeded [6]. Increased internet use for educational purposes and insufficient digital literacy has exposed women to cyber-violence by known and unknown perpetrators [5-6].

The management of the composite problem of VAW begins with understanding its deep roots across individual, family, community and societal levels [1]. Table 1 showcases the ecological model of factors influencing VAW and its impact on women. Figure 1 presents the preventive measures to be adopted at various levels.

Table 1: Violence against women: Influencing factors and Impact on women

Factors influencing perpetration and experience of violence [1, 8]	**Impact of VAW [1, 8]**
Individual Life Characteristics [1, 8] Lower levels of education Childhood maltreatment or family violence Harmful use of alcohol and addictive drugs Harmful masculine attitudes and behaviours Antisocial personality disorder Antisocial peers **Interpersonal Relationships and Household Characteristics [1, 8]** Poor parent-child bonding Male child preference Male controlling behaviours in families Marital discord and dissatisfaction Dependence on partner Belief in family honour and sexual purity Lack of women's participation in decision-making **Community Norms [1, 3, 8]** Harmful gender norms favouring male privilege Limited women's autonomy Adherence to rigidly defined gender roles and identities [3] Unequal distribution of power and resources between genders [3]	**Physical [1, 8]** Injuries and limited mobility Headache and Pain syndromes Gastrointestinal disorders Higher risk of non-communicable diseases [8] **Mental [1, 8]** Suicidal attempts and suicides Homicide Depression or Anxiety disorders Post-traumatic stress disorder Sleep and eating disorders Problem drinking and Substance abuse Risky sexual behaviours **Sexual and reproductive [1, 8]** Forced and Unintended pregnancies Induced and unsafe abortions Adverse maternal and neonatal health outcomes Traumatic fistula and other Gynaecological problems Sexually transmitted infections **Socioeconomic [8]** Restricted access to education and life skills Limited access to decent work Reduced productivity at work [8]

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Factors influencing perpetration and experience of violence [1, 8]	Impact of VAW [1, 8]
Ideologies of male sexual entitlement Attitudes that trivialise or glorify VAW Child marriages and forced marriage Poverty and unemployment Violence and crime in neighbourhood Influence of media and social media **Societal Norms, Laws and Policies [1,3,8-9]** Legitimate patriarchy [9] Inadequate access to education and paid employment for women [1, 9] Gender discrimination in institutions [9] Under representation of women in power and politics [9] Discriminatory laws related to property ownership, inheritance, marriage, divorce and child custody [8] Weak legal sanctions for VAW Dowry system	Loss of work days and wages [8] High human and economic costs for survivors, family and society[8] Financial dependence and hardships Stigmatization of victims and families Social isolation and lack of participation in regular activities or public life Child labour and Human trafficking **Intergenerational Effects in Children [8]** Low birth weight Increased risk of infant and childhood mortality and morbidity Increased risk of childhood injuries Developmental problems Behavioural and emotional disturbances Risk of becoming perpetrators of violence Harmful behaviours such as smoking, alcohol and drug abuse [8]

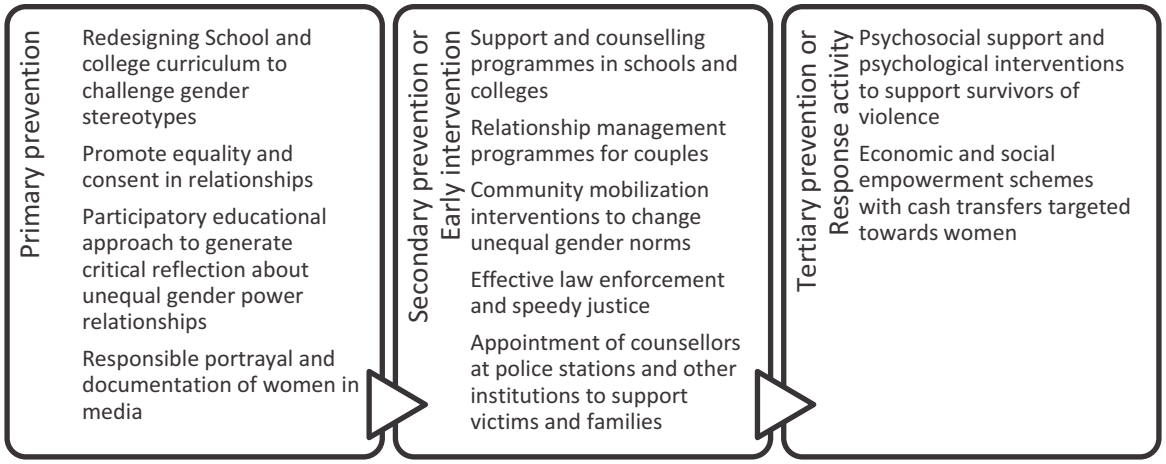

Fig. 1: Prevention and Control of VAW [1, 3, 8]

VAW poses a unique challenge. The victims are a marginalised group with least access to services owing to sociocultural, educational and economic barriers. WHO with other international agencies published RESPECT framework which incorporates 7 strategies- Relationship skills strengthening; Empowerment of women; Services ensured; Poverty reduced; Enabling environments created; Child adolescence abuse prevented and Transformed attitudes, beliefs and norms, addressing

policymakers to commit to prevention of VAW [1]. But the burden of VAW warrants added decentralised action at community level. It necessitates engaging stakeholders at every setting possible such as workplaces, schools, local councils, recreation and community health centres, media, faith communities, Anganwadis, adolescent, maternal and child health clinics [3]. Some innovative responses implemented by countries, during pandemic offer solutions worth adopting for regular situations.

"Silent solution", touch-phone-based call service with chatbot facility for location identity, launched by British charity, Refuge, helps women access support without speaking [10]. A similar instant messaging service in Spain provides psychological support through online chatrooms [5]. The Spanish Government encouraged women in distress to use code "mask-19" in pharmacies for immediate assistance [10]. France inspired by Spanish experience adopted "mask-19" initiative, with pop-up counselling centres in supermarkets and funding of hotel rooms for victims of domestic violence [10]. Telecommunication firms offered cost-free services to helplines in Antigua and Barbuda [5]. In UK, postal and delivery workers are trained to look for signs of abuse [5]. Apps like "Bright sky" provide discreet, camouflaged support and information to survivors [5].

The impact of VAW is predominantly health-related. Women exposed to violence are certain to use healthcare at some point of time and Health Care Providers (HCP) are often the first or only point of professional contact. Hence, health sector is in a distinctly accountable position in the multi-sectoral management strategy of VAW.

Health care services should be developed into women-centred, safe, trusted spaces. Comprehensive care catering to following basic needs-immediate physical, psychological health needs and ongoing safety, support and mental health needs, should be provided right from first point of contact [1, 11]. HCPs should be trained in identification of physical, emotional and social signs of violence through opportunistic screening with appropriate referral and support [1, 11]. Training in implementation of LIVES approach (L-Listen; I-Inquire about needs, concerns; V-Validate; E-Enhance safety; S-Support) could ensure effective management as evidenced in many countries [1, 11].

Prevention of VAW should be incorporated into population-level health promotion activities. Life skills and comprehensive sexuality education as part of Adolescent reproductive and sexual health programme and Integrated Child Development Services should emphasize equalitarian gender norms, respect, rights, bodily autonomy, accountability and online safety.

Consistent with, "Health-in-All-Policies" approach, health sector at all levels should be designed to coordinate with sectors such as police, justice, social services, education, shelter, child protection, employment and women empowerment to address determinants of violence, to facilitate timely referral for victims and implement violence prevention policies and programmes [1, 8]. In addition, sensitive and empathic collection of data on VAW with evaluation research of intersectoral prevention efforts should be prioritized [1, 8].

To summarize, VAW in any form is a major public health problem, capable of long-term physical, mental, reproductive health consequences and widespread sociocultural and intergenerational effects. A multi-pronged strategy involving all sectors targeted at individual, family and community levels is the immediate need of the hour.

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