RESEARCH PAPER | Social Science | Volume : 4 | Issue : 8 | August 2014 | ISSN - 2249-555X

Awareness on Domestic Violence Against Women and Related Health Outcomes in a Hill District of Nepal

KEYWORDS: Domestic Violence, Women, Health outcomes, Dadeldhura

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ABSTRACT *Violence against women is a socio-health issue. Its various forms are pervasive in distribution. Objective: To investigate married women's awareness related to domestic violence and health outcomes among women in Dadeldhura district of Nepal. This was a cross-sectional study; conducted during May-August 2013 among 384 married women of reproductive age in Dadeldhura district of Nepal.*

About 78% had heard of violence. Discriminations were major form of violence (69.6%). Mass media was the major source of information regarding violence related matters. Intimate partner was the main (63.81%) perpetrators of violence. Major reasons for violence are substance abuse, insufficient dowry, birth of female child and inter-caste marriage. Only one-third of victimized woman shouts help after incident and access care (21.2%). Majority of the respondents stated that physical damage and psychological disorders are the main consequences of violence. Women's empowerment and awareness activities are useful to curb down violence against women.

Introduction

Violence against women is a chronic health issue of social origins that contravene human rights, crumple social cohesion; and produce adverse economic, social and health outcomes (Lamichhane et al, 2011). Its ramifications have made to sacrifice the lives, tortures, disfigurement in physical, psychological, sexual and economic aspects in life (UNICEF, 2000). Various types of violence experienced by woman during life time are the expressions of social inequalities; affecting socialization and legitimization (UN, 1994). Violence against woman is an endemic phenomenon in all societies; however, the nature and magnitudes are differential (National Research Council, 1996). It is an outcome of interaction of individual, family, community and the societal factors (World Health Organization, 2006). Most common forms of violence are physical and sexual abuse by their husbands or other intimate male partners (Adhikari and Tamang, 2010). Poverty, unemployment and alcohol abuse in Nepal has made to trigger the domestic violence in Nepal. Meanwhile, dependent relationship enables to exercise the abusive attitudes (ICPD, 1994). Although, some paradigms have been shifted, there is little attention on the health consequences of violence and the needs of abused women (Outlook, 2002). Still there are huge lacunae remain in the understanding of violence against women (UN 2003). Hence, this study was carried out to investigate the awareness of married women of reproductive age about the violence against the women and the health outcomes in Dadeldhura district of Nepal.

Materials and Methods

A descriptive cross- sectional study was conducted during May-August 2013 in Dadeldhura district of Nepal. A total of 384 married women of reproductive age (15-45 years); representing from a Village Development Committee (rural) and the Municipal area (Urban) were selected by quota sampling. Data were collected by female enumerators through individual interview using a semi structured questionnaire. Data analysis was done by using SPSS (16.0 Version) and percentage, mean, medians and standard deviation were applied.

Results and Discussion

Background characteristics of respondents

Out of 384 respondents, almost two-fifth respondents were 20-29 years followed by 23.4 percent were 30 -39 years of age. About a quintile respondents were adolescents (18.2%) and another almost equal number of respondents were over 40 years old. The mean age of respondent was 29.4±4.1 years. More than three-quarters (76.0%) were the rural residents. Almost two out of every five respondents were Dalits followed by Chhetri (30.7%), Brahmin (22.9%) and others (7.3%) respectively. Brahmin and Chhetri are considered High caste whereas Dalits are lower caste in Nepal. More than a quarter of respondents were illiterates and most (29.4%) of them were educated upto primarily level. have had primary level education among literates.

Table 1: Background characteristics of respondents

Characteristics	No. of respondents	Percentage
Age (in years)		
< 20	70	18.2
20 -29	150	39.1
30 -39	90	23.4
40+	74	19.2
Residence		
Urban	92	24.0
Rural	292	76.0
Caste		
Brahmin	88	22.9
Dalit	150	39.1
Chhetri	118	30.7
Others	28	7.3
Literacy status		
Illiterates	102	26.6
Primary	113	29.4
Secondary	103	26.8
≥10+2 level	66	17.2

Awareness and experiences about Violence against women and health outcomes

Out of 384 respondents, 300(78.1%) respondents have heard about domestic violence against women whereas almost quintile of them did not know about the same. In

spite of the majority had awareness about violence against women, they disagree to accept domestic violence due to familial concerns and they remain silent (ESCAP/UN, 2007). Our findings concur with the prevalent practices in Nepal. Of 200 respondents who have ever heard about violence, almost seven out of every ten understood the discrimination in any forms are violence and other forms of violence are physical touch, mental torture and biting. Lamichhane et al (2011) reported that there are several forms of violence such as verbal abuse, beating and coercive sex. Further, about half of the women experiences physical violence and psychological violence; one fourth experience sexual violence Similarly, "report on violence against women" also make known that physical, sexual, psychological and economic violence are common forms of violence against women. The topmost violence is discrimination and psychological abuse (USAID, 2009).

Mass media was observed to be the principal source of message regarding violence related issues; and other means of information were I/NGO's activities and family personnel. Mass media like newspapers, pamphlets, public posters, radio etc are major sources of information (USAID 2009). Similarly, these findings steadily configure that mass media are leading sources of awareness among needy population.

More than half of the respondents said that they have seen the cases of violence where the husband/intimate partner was the foremost perpetuator of violence. USAID (2009) reported that violence by intimate partner ranges from 15-17 percent. Studies from Thailand and India ascertained that physical abuse by intimate partner exceeds 20 percent and 45 percent respectively. The contributory role of intimate partner for domestic violence identified in this study is higher than that was reported in other studies. Multiple reasons for the violence against women were observed; out of which lack of knowledge, denial to sex, insufficient dowry, birth of female child and inter-caste marriage were principally reported for observed violence. Alcohol and drug use low income and unemployment were some of the major reasons for violence against women in rural communities (ICPD, 1995; DFID/SAATHI/Asia foundation, 2010). Findings of this study concur with the results of Lamichhane et al (2011) in Nepal.

Table 2 Awareness and experiences about Violence against women and health outcomes

Status (n=300)	No. of respondents	Percentage
Meaning of domestic violence *		
Physical torture	78	26.0
Mental torture	71	23.6
Biting	76	25.3
Discrimination	209	69.6
Sources of Knowledge*		
Mass media	210	70.0
I/NGOs	88	29.4
Friends/Family	77	25.6
Ever observed violence against women		
Yes	165	55.0
No	135	45.0
Person involved in the violence (n=165)*		
Husband/boy friend	111	67.3
Parents	17	10.3
Family members	37	22.4
Causes for observed violence (n=165)*		
Lack of knowledge	22	13.3
Denied to sex and substance usage	28	17.0
Due to insufficient dowry	19	11.5
Due to giving birth girl child	6	3.6
Inter-caste marriage	16	9.7
Shouting for help if she experiences violence (n=165)		
Yes	55	33.2
No	110	66.8
Access for health care facility after violence (n=165)		
Yes	35	21.2
No	66	40.0
Don't know	64	38.8
Awareness about health consequences of violence *		
Reproductive health related problem	53	17.8
Physical health problem	223	74.3
Mental health problem	227	75.6

***multiple responses**

As reported in table 2, one-third of the victims of the violence shouted for help once after the event; however, two-third of them did not disclosed in spite of the incident of violence. Only a quintile of respondents stated that violence victimized case access the health care; nonetheless, major portion of them did not go for health care. Gender based violence report from Nepal and Thailand reported that lack of facilities to deal with trauma and psychosocial counseling, legal mechanisms, and the absence of police within close proximity leaves many cases unreported.

About three- quarters of respondents opined that mental health and physical problems occur due to the violence while 17.8 percent of them were aware about the adverse reproductive health outcomes due to violence (table 2). Physical and reproductive health outcomes: injury, unwanted pregnancy, Gynecological problems, pelvic inflammatory disease and self injurious behaviors are adverse health outcomes due to violence (UNICEF, 2000).

Conclusion

Almost eighty percent of the respondents had awareness about violence against women and discrimination is the major manifestation. Mass media is principal means of awareness violence related issues. More than half had ever observed the cases of violence and husband//intimate partner was the main person to perpetrate violence. Only few victimized persons shout for health services following violence. Major adverse consequences of violence as are physical damage and mental health problems. Women's empowerment and awareness activities might be useful to curb down the violent activities against women.

Acknowledgement: I am grateful to Professor Dr. S. Gunasekaran, Department of Applied Research, GRI-DU, Gandhigram, VDC/municipal officials' of the study area and the respondents of this study for their cooperation and support.

Volume : 4 | Issue : 8 | August 2014 | ISSN - 2249-555X

REFERENCE Adhikari, R .and Tamang, J. (2010). Sexual coercion of married women in Nepal. BMC Women's Health,10:31. | DFID/SAATHI/Asia Foundation (2010). Preliminary Mapping of Gender Based Violence in Nepal. Kathmandu. | Editorial (1994). International Conference on Population and Development, Cairo, 1994. | Editorial (2002). Violence against Women: Effects on Reproductive Health. Outlook 20:1. | ESCAP/UN. (2007). Violence against Women: harmful traditional and cultural practices in the Asian and Pacific region. Gender Equality and Empowerment Section, Social Development Division Economic and Social Commission for Asia and the Pacific. United Nations Conference Centre Bangkok, Thailand. | Lamichhane, P., Puri, M., Tamang, J. and Dulal, B. (2000). Women's Status and Violence against Young Married Women in Rural Nepal. BMC Women's Health, 11:19. | National Research Council (1996). Understanding Violence against Women, Washington, D.C. National Academy Press, 40–44. | UNICEF.(2000). Domestic violence against women and girls. UNICEF, Italy. Innocent digest, 6. | United Nations (1994). Declaration on the Elimination of Violence against Women; Resolution A/RES/48/104, UN General Assembly. | United Nations General Assembly (2003). United Nations Declaration on the elimination of violence against women. (Proceedings of the 85th Plenary Meeting), Geneva. | USAID.(2009). Violence against women: A summary of Findings. Egypt. | World Health Organization (2006). National Report on Violence and Health Nepal. WHO Kobe Centre. |