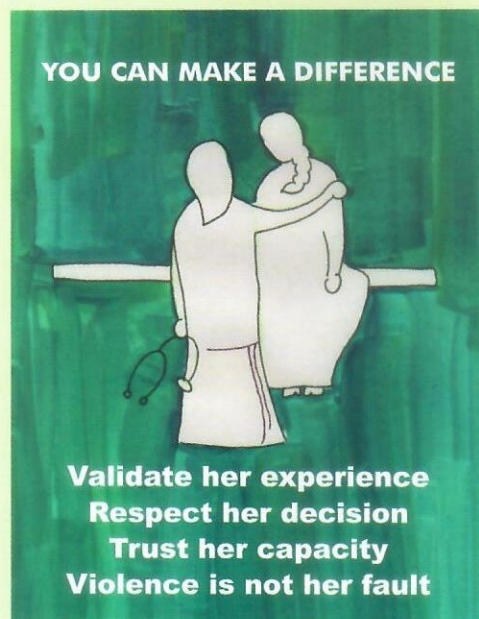


GUIDELINES FOR HEALTH PROFESSIONALS IN RESPONDING TO WOMEN FACING VIOLENCE



I. INTRODUCTION

The term "Violence Against Women" (VAW) encompasses a wide array of abusive behaviour that is directed towards a woman by virtue of the fact that she is a woman or that it affects women disproportionately (CEDAW). According to Article 2 of the UN Declaration for Elimination of Violence Against Women, "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" may be termed as Violence Against Women. Such an act may be carried out within the home (domestic violence), in the community (rape, sexual harassment, trafficking and forced prostitution) or by the State (custodial torture, violence against refugees, rape by government officials during war or ongoing conflict).

No matter where it occurs or in what form, violence restricts women's growth and prevents them from achieving their full potential as individuals.

In our society, violence against women is often socially sanctioned. For example, no eyebrows are raised when a husband, father, brother, son or even female members in the natal and marital home inflict violence upon other women in the family. Rather, such behaviour is viewed as the perpetrator's prerogative and abused women are left with little choice but to endure the resulting pain silently or face the unbearable social stigma and shame that is associated with speaking out. According to the National Crime Records Bureau, a total of 3,38,954

incidents of crime against women were reported in the country during 2016 (NCRB, 2016). This reflects the widespread prevalence of this problem, highlighting the need to stop regarding it as regarding it as a private issue and bring it out into the public.

Domestic violence is one of the most pervasive forms of violence against women prevalent in the world today. In addition to being a human rights issue, it has also been recognized as a health concern by the World Health Organisation in 1993. As part of its activities in this arena, WHO has issued a set of guidelines outlining the ethical responsibilities of doctors and other health care providers in responding to survivors of violence. The Protection of Women from Domestic Violence Act, 2005 has also identified health care providers as players in the implementation of the Act. Thus, in order for providers to assume their roles in mitigating the effects of violence and fulfill their responsibility as per the law, it is necessary to sensitize them towards the issue of domestic violence and provide them with the information and tools necessary to effectively screen, identify and respond to survivors. These guidelines, based on our direct engagement with health care providers through an intervention programme called "*Dilaasa*", were written with the goal of contributing to this educational process.

The Legal Mandate

The "Protection of Women from Domestic Violence Act '05", which came into force in October '06, has identified a "medical facility" as a player in implementation of the act and several roles of such a medical facility vis-à-vis women facing domestic violence have been laid down. According to Part II, Sec. 3 (i), Sub-section 17 of the Act, a medical facility cannot refuse treatment to the aggrieved woman under any circumstances. Further, if necessary, the person-in-charge of the medical facility is required to make a "domestic incident report" if one has not already been made and forward the same to the Protection Officer in that area. A medical examination report must also be given to the woman free of cost.

Section 357C of the Criminal Law Amendment Act 2013 mandates hospitals, both public and private, to provide immediate first-aid or medical treatment, free of cost, to survivors of sexual assault. This cannot be denied for the want of a police requisition. Refusal to provide treatment and medico legal examination is a punishable offence under Section 166B of the Indian Penal Code.

¹ *Dilaasa* is a hospital based crisis centre, a joint initiative of the MCGM and CEHAT, established to sensitise Health care providers and train them to understand domestic violence as a health issue.

II. WHY VIOLENCE AGAINST WOMEN IS A HEALTH CONCERN

Impact of Domestic Violence on Health

Evidence from literature suggests that domestic violence carries an immense burden of disease owing to the fact that it has a profound impact on the physical and mental health of the survivors.

- 1 in 3 women throughout the world experience physical and/or sexual violence by a partner or sexual violence by a non-partner. The prevalence was found to be the highest in African, Eastern Mediterranean and South-East Asia Regions (WHO, 2013).
- Domestic violence has been linked to a host of different outcomes, immediate and long-term, like sapping women's energy, compromising their physical health including reproductive health, and making them more vulnerable to sexually transmitted infections including HIV/AIDS (WHO, 2005).
- A counselling intervention study by CEHAT in two public hospitals of Mumbai has found the prevalence of violence during pregnancy to be 16% (Arora, S, Bhate-Deosthali, P and Rege, S 2018)
- Research indicates that there is a close association between domestic violence during pregnancy and fetal/infant mortality, developmental abnormalities, and maternal mortality (Jejeebhoy, S.J., 1998; Ganatra B.R, Coyaji K.J, Rao, V.N 1998).
- Suicide is 12 times more likely to be attempted by a woman who has been abused than one who is not (Violence against Women in the Family, United Nations, New York, 1989).
- According to studies in Australia, Nicaragua, the United States of America and Zimbabwe, women who are abused by their partners are more likely to suffer from depression, anxiety and phobias as compared to non-abused women (WHO Report; Roberts, G.L. et al. 1998; Ellsberg, M. et al. 1999; Fikree, F. F. and Bhatti, 1999; Danielson, K. K. et al.1998).

The relationship between domestic violence and health is a dynamic one - women who suffer from diseases such as psychiatric illness, HIV/AIDS, Tuberculosis etc. often bear the brunt of violence.

Survivors' Contact with Health Professionals

In order to obtain treatment for the health complaints and injuries caused by violence, women approach the health facility. It is a well-known fact that on facing abuse, a woman is more likely to approach a doctor than a lawyer or the police. According to a multi-site study performed in seven cities in India, almost half (45.3%) of the women who faced violence reported injuries requiring treatment (INCLEN, 2000). Another study examining the cases of women recorded in the Emergency Police

Register of the Casualty Department in an urban, government-run hospital in Mumbai, found that two-thirds of the women above 15 years of age (66.7% or 497/745) were definitely or possibly cases of domestic violence (Daga et. al, 1998). Health professionals are hence in a strategic position to reach out to women facing violence, being the most certain and probably the earliest contact for a survivor of violence. Often, abused women approach health professionals who are not trained to recognize abuse. They end up treating only the immediate complaints, missing the opportunity to provide holistic care to these women. Early identification of women facing violence and appropriate intervention by health care givers can prevent the more severe health consequences that she will face if she continues to be abused. Women tend to have immense faith in health professionals and are more likely to reveal their problems to them than to anyone else. They are perceived as non-threatening, so women can approach them without arousing the suspicion of relatives who may be abusers or without the fear of being found out.

According to the "Counselling Impact Study" conducted in Dilaasa, all the respondents provided positive feedback with regard to the Centre's location within the public hospital setting and characterized this location as advantageous to women seeking services. Their reasons were as follows:

- Severe injuries resulting from violence can get immediate assistance in the hospital.
- Abused women can get both counselling and medical treatment in the same place which is not available elsewhere.
- Hospital location increases visibility of the services, thus promoting access to it.
- Women facing extreme restrictions on their mobility or suspicion from their abuser/s find it easier to come to Dilaasa on the pretext of hospital visit.

Documentation of Medico-legal Evidence

Vital documentation of health complaints resulting from abuse can be done at the health facility. Such documentation can be used by the abused woman in the court of law as evidence, if she chooses to pursue a legal course of action. This has been discussed in further detail in the later sections of this document.

III. WHAT CAN YOU, AS A HEALTH CARE PROVIDER, DO?

As health professionals, you have an ethical obligation to maintain the health of your patients who may be victims of violence and provide them with care. This care goes beyond mere treatment of physical injuries, to

identification of the root cause of ill-health, provision of psychosocial care and referral to appropriate agencies in cases of violence. In 2013, the World Health Organization published its landmark clinical and policy guidelines on responding to intimate partner violence (IPV) and sexual assault. Inclusion of these issues in medical education can inform health care providers in providing appropriate care including clinical and emotional support to women facing violence.

1. Identification of Intimate Partner Violence

Probing for abuse may either be carried out routinely, or in specific situations such as when indicators of abuse are identified. Routine probing helps identify more women facing violence as against waiting for the woman to disclose abuse. Services such as Casualty, Psychiatry, Gynaecology and Antenatal Care (ANC) are likely to see a large number of women who may be abused and provide a good opportunity for such an endeavour. Therefore, at least in these services, routine enquiry must be done. You must look out for the signs and symptoms of abuse in every woman patient that you see. If you suspect that a woman is being abused, probe with a great deal of sensitivity. Whether or not she reveals abuse is inextricably linked to how sensitive you are. Assure her of confidentiality. Tell her that in your experience, you have often seen women who report violence and reassure her that she will not be judged or endangered by disclosure. Considering the stigma associated with abuse, it is understandable that she may not be open to sharing her private oppression with you.

The recommendation for selective enquiry on clinical considerations is based on the fact that there is a high burden of universal screening in countries with high prevalence, particularly in settings with limited referral options and overstretched resources/providers. In such a scenario, selective enquiry is more likely to benefit women. You should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence in order to improve diagnosis/identification and subsequent care (WHO, 2013).

Minimum requirements for asking about partner violence

- A protocol/standard operating procedure
- Training on how to ask, minimum response or beyond
- Private setting
- Confidentiality ensured
- System for referral in place

If you are unable to provide first-line support, then you should ensure that someone else (within your health-care setting or another that is easily accessible) is immediately available to do so. (WHO, 2013).

Suggested screening questions

You may screen women for domestic violence by asking direct questions about abuse or indirect ones.

Direct questioning:

- Because violence is so common in women's lives, we have started asking all patients about it.
- Have you ever been kicked, punched, slapped, shoved or otherwise hurt by someone in your home?
- Has your partner ever forced you to have sex when you didn't want to? Has he ever refused safe sex?

Indirect questioning:

- Your injuries do not look like they are accidental. I am concerned that your symptoms may have been caused by someone hurting you. Did someone cause these injuries?
- Your complaints seem to be related to stress. Do you face any tensions with your partner/ at home?

(Adapted from the Family Violence Prevention Fund, San Francisco "Clinical Guidelines on Routine Screening")

2. Emotional Support

Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. You should, as a minimum, offer first-line support when women disclose violence. First-line support includes:

- Being non-judgemental and supportive and validating what the woman is saying
- Providing practical care and support that responds to her concerns, but does not intrude
- Asking about her history of violence, listening carefully, but not pressuring her to talk
- Acknowledging that it must be very difficult for her to live in a violent home, but assuring her that she is not alone and that help is available
- Conveying to her that violence is not her fault and that every person has the right to live a life free of violence.

3. Medical care for survivors of intimate partner violence and sexual assault

It is your primary duty to provide treatment for all the woman's injuries. Be sensitive but thorough while recording her history and examining her. Ensure that you ask about both current and past episodes of violence. Look for other injuries or scars that might be present as a result of the violence and attend to them. Women with

a pre-existing diagnosed or partner violence-related mental disorders (such as depressive disorder or alcohol use disorder) who are experiencing intimate partner violence should receive mental health care for the disorder delivered by health-care professionals with a good understanding of violence against women (WHO, 2013).

Clinical care for survivors of sexual assault

Take a complete history, recording events to determine what interventions are appropriate, and conduct a complete physical examination (head-to-toe including genitalia). The history should include the time since assault, type of assault, risk of pregnancy, HIV, sexually transmitted infections (STIs) and mental health status.

Emergency contraception: Offer emergency contraception to survivors of sexual assault presenting within 5 days of sexual assault, ideally as soon as possible after the assault, to maximize effectiveness. If a woman presents after the time required for emergency contraception (5 days), emergency contraception fails, or the woman is pregnant as a result of rape, she should be offered safe abortion, in accordance with national law.

Access to safe abortion is an essential element of the right to treatment for rape survivors. According to section 5 of MTP act, pregnancy can be terminated at any stage if it causes harm or danger to woman's life, irrespective of the gestational age.

HIV post-exposure prophylaxis: Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 hours of a sexual assault. Use shared decision-making with the survivor, to determine whether HIV PEP is appropriate.

Post-exposure prophylaxis for sexually transmitted infections: Women survivors of sexual assault should be offered prophylaxis for chlamydia, gonorrhoea, trichomonas, and syphilis, depending on the prevalence. The choice of drug and regimens should follow national guidance. Hepatitis B vaccination without hepatitis B immune globulin should be offered as per national guidelines.
(Adapted from Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines, 2013).

4. Documentation

Documentation in cases of violence is an area in which health care providers are required to play a vital role as this provides critical (and several times the only) evidence of violence, which can be of tremendous use to the woman if she decides to access the legal system. Every woman who reports injury caused by violence is meant to be registered as a medico-legal case. Inform her that

whatever you document in the hospital can be used by her in a court of law. The history that you elicit from the woman should include details of resulting injury/injuries and of the violent episode (such as location of incident, relationship to abuser, severity and frequency of earlier episodes of violence, and other health consequences not apparent at the time of the medical visit). All these details along with the findings in examination should be recorded in the MLC register as well as on the case paper. (A sample of an ideal MLC documentation has been shown later in the document.)

Even if you do not work in Casualty, should you come across any abused woman in the OPD or in the wards, please document the history in her Indoor/OPD papers and refer her to Casualty to get an MLC recorded. You cannot, under any circumstances, refuse treatment to an abused woman and are required to give her a medical report free of cost. You must refer her to the Protection Officer in your area.

In instances of sexual violence, the MoHFW has recognized the critical role of medical documentation in corroborating the police data for legal proceedings. For this purpose, MoHFW has issued national guidelines & protocol for medico-legal care for survivors/ victims of sexual violence. (<http://www.mohfw.nic.in/showfile.php?lid=2737>)

5. Safety and Referrals

You can seek assistance of the social worker to enable the woman to keep herself safe while she returns to the abusive home. Make inquiries regarding her safety. If she is not safe to go back home, you can give her information about shelters or refer her to one, if possible. She shall be provided with alternatives such as neighbors, calling up the police help line, stepping out of the house if she preempts physical violence.

It is also important to address the emotional safety of survivors as they may feel low, sad and may have thoughts of ending life. In such cases, you can emphasize on speaking about these thoughts to someone as this can help survivor to unburden herself.

Further, It is your duty to inform every abused patient that there is no excuse for violence and that it is illegal in every form. Explain the importance of filing a police complaint - the significance of both a Non-cognizable Complaint (NC) as well as a First Information Report (FIR). In case of a woman facing domestic violence, you must also tell her about the Protection of Women from Domestic Violence Act and the rights that she has under this Act.

Providing the woman with all of the above information gives her options to choose the help available to her.

IV. What are some of the signs and symptoms that can help you in identifying women facing domestic violence?

Gynaecology/ Obstetrics	Medicine	Casualty	Pediatric	Surgery
<ul style="list-style-type: none"> History of assault Repeated Pregnancy Repeated birth of girl child Spontaneous abortions MTP cases Reversal of TL Unwed mothers/ Pregnant widows Chronic Leukorrhea Post-partum psychosis Injury marks on labia, breast, and/or other sexual organs Abrupton of placenta Pelvic Inflammatory Disease Infertility Multiparity All ANC/cases History of fall during pregnancy 	<ul style="list-style-type: none"> History of consumption of poison Breathlessness Fainting spells Swelling/tenderness Repeated health complaint with normal reports Chronic Anemia Constant body ache, headache, and/or backache Sudden weight loss Tuberculosis (TB) Pyrexia of unknown origin Chronic patch of TB Convulsions Irritable Bowel Syndrome Loss of appetite 	<ul style="list-style-type: none"> Assault Poisoning / Attempted Suicide Burns Fractures Falls Pregnancy with history of fall / assault Women with unexplained bruises, CLW, lacerations, and/or abrasions Repeated health complaints despite normal reports 	<ul style="list-style-type: none"> Child abuse (all cases) Sexual abuse Lack of concentration Chronic abdominal pain Repeated headaches IW, contusion, lacerations, bruises White discharge prior to attaining puberty Burning micturition Child not breast-fed Bed-wetting Anemia 	<ul style="list-style-type: none"> History of assault Abdominal trauma Burns Reporting Falls All women with IW, Contusion, lacerations, and/or bruises
Skin				
<ul style="list-style-type: none"> STIs RTI HIV+ and AIDS patients Repeated allergies Eczema/Eczematous change Allergic rashes around the neck, thighs, waist, and/or forehead Fungal infection 				
ENT				
<ul style="list-style-type: none"> Perforated eardrum All injuries and fractures Locked jaw H/o reduced hearing capacity Chronic discharge from ears Sudden loss of voice Difficulty in swallowing 				
Psychiatry				
<ul style="list-style-type: none"> Depression Insomnia Attempted Suicide Anxiety / tension Self harm Obsessive Compulsive Disorder Eating disorders Substance abuse Repeated health complaints 				
Orthopaedic				
<ul style="list-style-type: none"> All fractures All falls/assaults at home Minor sprains Ligament injury Contusions Chronic ache in back, shoulder, neck 				
Ophthalmology				
<ul style="list-style-type: none"> Eye injury Bruised eye 				
Dentistry				
<ul style="list-style-type: none"> Jaw fracture Broken teeth 				
VCTC				
<ul style="list-style-type: none"> All HIV+ cases All remaining patients 				

IDEAL MEDICO-LEGAL CASE DOCUMENTATION

MEDICO LEGAL CASE

BMPP-41-2006/07-10,00,000

HC-44

BRINANMUMBAI MAHANAGARPALIKA

KMNO

Hospital.

No. of Living	No. of Living
Boys	Girls
BANDRA (R) (M) (F) (G)	
Advised: Vasectomy/Tubectomy MTP/ IUCD/Nirodh Oral Pills.	
Accepted	Date

O.P.D. Reg. No. XXXXX

2.05 pm

Dept. No.

M

(F) C

Date XY/Nov 2015

Name MNO Age 36yrs

Religion XY Address ABCD

Casualty No. QRS

Indoor Reg. No.

X-Ray Report No.

DIAGNOSIS

Clinic Path. Reg. No.

History Chief Complaints :-

Informant: Self BB - neighbour
History of → H/o of assault by husband and sister-in-law by slaps, pulling of hair, pushing yesterday at home at about 9 AM

Examination Findings :- complain of +c/o - ↑ frequency of urine, sudden tremors & gets up from sleep suddenly after the quarrel
no H/o UC (unconsciousness) / vomiting
convulsion / ENT bleed

Investigation :- on examⁿ of E : GCF pt is ambulatory, vital stable

+ve = pain (P+) neck (backside)
(positive finding) no other external injury seen

Rx (treatment given)

Inj Voveran (3cc) IM

T Indocid 1-1-1

T Rantac 1-0-1
fu. in OPD / SOS

PTD

Referred to
Dilaasa Dept_{dr}

**WHAT IS YOUR
ROLE AS
A HEALTH CARE
PROVIDER?**

IDENTIFY ABUSE

- ◆ Look out for signs and symptoms revealing abuse
 - ◆ Probe sensitively
- ◆ Assure her of confidentiality and prioritise her safety

EMOTIONAL SUPPORT

- ◆ Listen carefully
 - ◆ Believe in her
- ◆ Validate her experience
- ◆ Convey that violence is not her fault
 - ◆ Assure her that she is not alone

**INFORMATION AND
REFERRAL**

- ◆ Inform the patient that violence is illegal
- ◆ Convey the importance of filing a police complaint
 - ◆ Ask about her safety
 - ◆ Refer her to other agencies for further help

MEDICAL SUPPORT

- ◆ Take a thorough history
- ◆ Assess for both current and past histories of violence
 - ◆ Attend to all injuries

DOCUMENTATION

- ◆ Register a Medico-legal case and document details in the MLC register as well as the case paper
 - ◆ Collect forensic evidence in case of sexual violence
 - ◆ Make a *Domestic Incident Report* if it is domestic violence

However, each one of these interventions has personal as well as legal implications which the woman herself must consider. Keep in mind that every woman is an expert on her own life and you must respect her autonomy to make decisions.

V. HEALTH SYSTEM RESPONSES TO DOMESTIC VIOLENCE

For effectively reaching out to women facing domestic violence, not just individual carers, but the entire health system needs to take on the onus of change. There is a need for the administration to adopt a gender-sensitive approach towards each aspect of the health system, including budgeting. In addition to training hospital staff on the issue of domestic violence as a health issue, providing necessary infrastructure and institutionalizing the response to domestic violence will help every health professional to fulfill his/her role in this endeavour. Following are some of the ways in which the health system can contribute.

Training on Domestic Violence as a Health Issue

1. Train health professionals towards issues such as Gender, Human Rights and VAW. Create awareness among health professionals (Doctors, Nurses, Physiotherapists, Occupational therapists, Social Workers and Labour Staff) about violence against women and its detrimental impact on women's health.
2. Work towards incorporating the above training in medical and nursing curricula.
3. Train Community Health Volunteers / Community Development Officers to recognize and respond to abuse in communities. Encourage them to spread awareness about the issue amongst communities that they work with.

Ensure Early Identification of Victims of Domestic Violence

4. Train all staff to identify abuse and respond accordingly.
5. Prominently display posters enumerating symptoms/ complaints associated with a history of abuse relevant to each OPD clinic. This will prompt health professionals to probe for abuse while recording history.

6. Display posters in prominent locations in the health facilities and distribute pamphlets to all women patients in order to motivate them to get help.
7. Screening of certain cases such as those of attempted suicide, burns and rape must be incorporated in protocols for their management as they are most likely to be facing severe domestic violence.

Improve Infrastructure and lay down Protocols

8. Develop protocols for responding to women facing domestic violence which must be adhered to by every health care provider.
9. Incorporate screening questions into routine history-taking protocol.
10. Provide adequate space in OPD clinics to ensure privacy during screening. Evolve administrative and information systems which respect the confidentiality of women facing violence.

Direct Support to Survivors

11. Co-ordinate with various women's groups, counselling services, legal services and shelters so that women who are screened can be referred there for further assistance.
12. Evolve a multi-disciplinary team within the hospital to respond to the medical, social, emotional needs of abused women.

Changing Community Attitude

13. Encourage Community Health Volunteers to spread awareness about the issue of domestic violence within the community.
14. Dialogue with young men and abusers in order to prevent violence.
15. Respect choices made by women patients.
16. Promote a "Zero-tolerance" approach to violence within the health care system.

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Dilaasa – CRISIS INTERVENTION DEPARTMENT FOR WOMEN AND CHILDREN

Dilaasa departments in BMC Hospitals located in Mumbai

- K. B. Bhabha Hospital, Bandra (W) ☎ 022-26400229/26422775/26422541 • K. B. Bhabha Hospital, Kurla (W), ☎ 022-26500241/26500144 • Shatabdi Hospital, Kandivali (W) ☎ 022-28647002 • M. W. Desai Hospital, Malad (E) ☎ 022-28774216 • Siddharth Municipal General Hospital, Goregaon (W) ☎ 022-28782886
- Hindurudayasamrat Balasaheb Thakarey Trauma Care Municipal Hospital, Jogeshwari (E) ☎ 022-28224078
- R.N. Cooper Municipal General Hospital, Vileparle (W) ☎ 022-26210043 • V.N. Desai Hospital, Santacruz (E) ☎ 022-26182083 Ext - 340 • Rajawadi Hospital, Ghatkopar (E) ☎ 022-21020144 • Krantiveer Mahatma Jotiba Phule Municipal Hospital, Vikroli (E), ☎ 022-25770799 • Swatantryaveer V.D. Savarkar Municipal Hospital, Mulund (E) ☎ 022-25631125 • M. T. Agarwal Hospital, Mulund (W) ☎ 022-25601888
- Madanmohan Malviya Shatabdi Hospital, Chembur ☎ 022-25500038