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Violence against Women as a Health Care Issue

Perceptions and Approaches

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Violence is now widely recognized as a global public health concern (Garcia-Moreno et al. 2014a). Evidence shows violence, which may take various forms such as, caste/race violence, homicide, suicide, domestic violence, rape, or that inflicted in war and situations of armed conflict, is common and causes immediate and long-term health and social consequences for survivors/victims and their communities. Violence is a tool used to maintain the existing inequalities and imbalance of power between individuals/groups/communities. The inequalities may be based on gender, class, caste, religion, race/ethnicity, sexual orientation, and disability.

Violence was placed on the international agenda in 1996 when the World Health Assembly adopted Resolution (WHA 49.25: Forty-Ninth World Health Assembly, Geneva 20–25 May 1996), which declared violence 'a leading worldwide public health problem'. This resolution called for a scientific public health approach to prevent violence. It recognized that the health workers are often the first to identify the victims of violence and have the necessary technical capacity to help the victims (WHO 1997). The resolution called upon the WHO to initiate public health activities to: (*i*) document and characterize the burden of violence, (*ii*) assess the effectiveness of programmes, with particular

attention to women and children and community-based initiatives, and (*iii*) promote activities to tackle the problem at the international and country level.

Notable advancements in developing a public health approach were made in several developed countries such as the United Kingdom, Australia, and the United States of America. However, in developing countries there are several constraints: Non-recognition of violence against women (VAW) as a public health issue, limited resources, competing public health priorities, lack of clearly enunciated policies and protocols, among others (Bhate-Deosthali and Duggal 2013). Health care professionals play an important role in the treatment of injury, physical and/or psychological trauma, rehabilitation of victims, and prevention of further violence. While the public health system is recognized as one of the most critical sites for addressing the post-violence mechanism, in many countries it currently lacks the capacity and sensitivity to adequately and effectively respond to the needs of victims and survivors of violence. This lack of sensitivity is documented in situations of conflict as well as routine times (Medico Friend Circle [Bombay, India] 2002).

In India, even the medico-legal documentation (where there is a legal binding) of domestic violence, rapes, suicides, homicides, deaths in police custody, and caste or communal violence is neither accurate nor complete as there are no uniform protocols and procedures laid down. Here are some examples of the current health sector response.

> A woman comes for an abortion for an unwanted pregnancy resulting out of rape. She reports that a medico-legal examination was done a month back but she was not provided an emergency contraception (EC) to prevent the pregnancy.
>
> The post mortem reports of women killed in the communal riots in Gujarat 2002 made no mention of the sexual violence inflicted on them—There were injuries related to insertion of rods in vagina (MFC report).
>
> Patient reports to the hospital with a history of consumption of a bottle of insecticide and doctors record it as accidental consumption of poison. (Deosthali and Malik 2009)

These are not isolated examples but reflect common experiences of victims of violence in India.

The women's movement in India brought the issue of VAW into the public domain in the 1980s, campaigned for changes in law, and rallied for the setting up of counselling centres, shelters, and legal aid for survivors (Kumar 1993). The women's movement confronted the health system for its coercive population polices, highlighted the complete lack

of gender sensitivity within the system, and the insensitive response to rape, amongst others. However, the role of the health sector in responding to and mitigating violence did not become a rallying point.

Despite the fact that health professionals and health systems have a critical role in caring for survivors of violence, as well as in documenting the violence and collecting relevant evidence, there are several gaps in the provision of care and in the medico-legal response. Legal obligations have been cast upon the health sector for responding to VAW. The Protection of Women from Domestic Violence Act (PWDVA) 2005, recognizes health facilities as service providers and mandates that all women reporting domestic violence must receive free treatment and information about the law and appropriate referral services. The Criminal Amendment to Rape (CLA) 2013 (Government of India 2013), and the Protection of Children from Sexual Offences Act, 2012 (POCSCO 2012) now makes it mandatory for all hospitals, public and private, to provide free treatment to survivors of sexual violence. Despite these amendments, the health sector response to violence, in general, and violence against women and children specifically, remains suboptimal. There is a significant gap between legal provision and its implementation for the benefit of survivors and victims.

Violence against women is not recognized as a public health issue in India. The draft National Health Policy, 2015 does not cover aspects related to health sector response to VAW. At a broader level, the policy makes little contribution to operationalize comprehensive services to women facing violence.

This chapter describes the prevalence of VAW and the health consequences they suffer. It also touches on the perceptions of health professionals regarding violence against women. It then presents different approaches adopted by civil society organizations to engage the health sector to respond to VAW. While doing so it raises concerns about the lack of an institutionalized health care response and draws attention to the policy gaps that keeps the government from committing itself to ending all forms of VAW.

PREVALENCE OF VIOLENCE AGAINST WOMEN

Domestic violence and sexual violence are the most pervasive form of gender-based violence, cutting across caste, class, race, religion, and socio-economic background. But, there is little consistent evidence on the prevalence of these forms of VAW in India.

The National Family Health Survey (NFHS) and National Crime Records Bureau (NCRB 2014), provide some insight into the occurrence and the nature of violence against women. The National Family Health Survey (NFHS 2005–06) (IIPS 2009) included specific questions on domestic violence and its results indicated that the lifetime prevalence of physical or sexual violence among women of 15–49 years was 34 per cent, while about 19 per cent of these women reported being subject to violence in last 12 months preceding the survey. On an average, among married (the category 'ever married') women 36 per cent report cuts, bruises, or aches; 9 per cent report eye injuries, sprains, dislocations, or burns; 7 per cent report deep wounds, broken bones or teeth, or other serious injuries; and 2 per cent report severe burns. Abused women generally seek help from their own families and friends. Very few go to institutions, such as the police (1.5 per cent), medical personnel (0.5 per cent), or social service organizations (0.05 per cent). But this data is 10 years old; no new national household survey has been conducted since then.

The National Crime Records Bureau recorded a total of 124,791 sexual offences against women in 2014. This higher number is probably due to a change in the definition of rape, which now covers all forms of sexual violence beyond the peno-vaginal penetration. Additionally, 8,455 dowry deaths were recorded and 118,866 cases of cruelty by husbands. These data are of those women who mustered the courage of reporting offences to the police stations. A comparison of NFHS and NCRB data shows women's reluctance to seek a redressal mechanism.

These national-level surveys, however, do not record the frequency and impact of domestic violence and sexual violence. Neither do they calculate the impact of violence on women that lead to suicide attempts or repeat incidents of victimization. Emma Williamson (2013) points out that building such measures of impact while collecting data enables a deeper understanding of the prevalence of domestic and sexual violence. She points out that population-based national surveys collected by governments of different countries do not canvas data from independent domestic violence advocates, health professionals, shelter homes, and social workers, and so fail to include the number of women and children seeking support outside the system. This means that the national surveys on prevalence of VAW and children may not be the most reliable sources on this matter.

In the Indian context, community-based studies show a prevalence of VAW ranging from 17 to 80 per cent (Bhate-Deosthali 2016). Amongst

the different forms of VAW, the most commonly studied form is domestic violence and a bulk of the research contributes to the evidence on the prevalence of domestic violence against women. Even within domestic violence, the focus is on marital violence. No estimate of violence faced by girls and women from their natal family is available.

The variations related to the prevalence can be attributed to differences in the methodology, the manner in which questions are asked, the extent of rapport established and ways in which data is analysed. Studies conducted by institutions that report high prevalence are due to better tools and processes for enabling women to report violence of various forms. It is important to therefore note that there is no reliable data on VAW in India. Because of the underreporting as above, what is known/available is just the tip of the iceberg.

HEALTH CONSEQUENCES OF VIOLENCE AGAINST WOMEN

Violence against women is associated with a broad array of health consequences. Domestic violence, especially sexual violence has been associated with adverse outcomes to women's physical health including reproductive health, making them more vulnerable to sexually transmitted infections including HIV/AIDS and psychological well being (Garcia-Moreno et al. 2005). A study among 2,199 pregnant women in North India indicated that births among mothers who had faced domestic violence are 2.59 times more likely to lead to peri-natal and neo-natal mortality (Koski and Koenig 2011). Physical and sexual intimate partner violence is associated with miscarriage and reproductive health services should be used to screen for spousal violence and link to assistance (Johri et al. 2011).

Some of the mental health outcomes of routinely suffering domestic violence include symptoms such as crying easily, inability to enjoy life, fatigue and thoughts of suicide; depression, feelings of anger and helplessness, self-blame, anxiety, phobias, panic disorders, eating disorders, low self-esteem, nightmares, hyper vigilance, heightened startle response, memory loss, nervous breakdowns, and it is associated with other risk behaviour associated with adverse health outcomes such drug and alcohol use (Deosthali and Malik 2009; Garcia-Moreno et al. 2005). Further, a study reported that the gamut of these mental health consequences for women facing violence can range from mental stress, anxiety, depression, disturbed sleep, psychosomatic disorders, and suicidal behaviour (Kumar et al. 2005). A study by Chowdhary and

Patel (2008) on effects of spousal violence on women's health in Goa shows that spousal violence is a causal factor for attempted suicide and sexually transmitted infections among women.

HEALTH PROFESSIONALS' PERCEPTIONS OF VIOLENCE AGAINST WOMEN

Despite evidence of the many ways in which violence affects lives of women, health professionals have considered domestic violence against women as a private matter (Deosthali and Malik 2009). They believe that their role is only to treat the disease and the physical manifestations of such violence. Such a biomedical approach does not facilitate the disclosure of domestic violence nor does it elicit appropriate and useful response from health professionals (Garcia-Moreno et al. 2015). Health professionals share sociocultural notions that sanction male dominance over women. These attitudes reinforce violence against women. Blaming women for violence faced by them, considering violence to be a part and parcel of married lives, believing that women must have provoked violence are some of the beliefs reflected amongst health professionals (Deosthali and Malik 2009).

Health professionals believe that their role in dealing with cases of sexual violence is restricted to forensic examination and evidence collection. They are unaware of the therapeutic role that they need to play especially in aspects such as psychological first aid and treatment. Even while carrying out the forensic role, health professionals restrict examination to assessing genitals. A tendency to overemphasize genital and physical injuries has been noted amongst health professionals (Deosthali and Malik 2009). Unscientific practices of examination in the form of finger test, determining hymenal status, and recording height-weight of the survivor to examine the possibility of resistance is the norm in medico-legal examination of sexual violence (Deosthali 2013).

One reason for the suboptimal response from health professionals may be attributed to the gaps in medical and nursing curricula. Analytical reviews of medical and nursing curricula point to the gaps in the curricula which do not equip health professionals to adequately respond to women and children facing violence (Deosthali 2013). This was evident in a study on 250 nursing and medical college students in an industrial city of Maharashtra. The study aimed to understand perceptions of medical and nursing students towards the issue of VAW. Half the

respondents were nursing students, the others pursuing medicine. The study found that a larger number of female students than male had more discouraging attitudes towards the issue of VAW. Male respondents were more likely to have victim-blaming attitudes towards those reporting abuse (Agrawal and Banerjee 2015). The differences in the perceptions can be attributed to the social milieu that male and female respondents belong to where gender-based discrimination is a norm. Add to this the fact that medical education in India has not taken cognizance of gender theories and perspectives in treating women and men (Subha Sri 2010). Consequently, the medical profession and system lack a gender sensitive perspective in responding to women facing violence.

Notwithstanding the above, it must be recognized that health professionals and health system can respond to the negative effects of VAW by providing supportive care. Supportive care comprises preventing, as well as mitigating, consequences of violence on women; addressing associated problems like depression, substance abuse, and providing immediate and long-term care.

CURRENT INTERVENTIONS ON VIOLENCE AGAINST WOMEN AS A HEALTH CARE ISSUE

Many developed countries have made steady progress in recognizing the importance of health systems response to VAW. They have integrated the responsibilities of the health sector in their national action plans, earmarked budgets for building capacities of health professionals, developed surveillance and reporting methods, and drafted protocols for documentation and service provision (American Medical Association 1992; Bacchus et al. 2012; Garcia-Moreno et al. 2014b). Developing countries are still struggling to respond to VAW in a systematic manner. Though the important role of the health sector and the need to integrate this concern in policies and programmes has been acknowledged, earmarking financial support for building capacities of health professionals, monitoring, and surveillance has still not been achieved.

The post-2000 era saw the initiation of different forms of engagements with the health sector on VAW (WHO, CEHAT, MoHFW 2016).

Hospital-based Crisis Centre to Respond to VAW

An early initiative in the Indian context was the establishment of a hospital-based crisis centre in a Mumbai suburb called Dilaasa