

Reforms urged to tackle violence against women in India

India's medical system needs to be more responsive to the needs of women who have been victims of interpersonal violence, say experts and campaigners. Amy Yee reports from Mumbai.

Nearly every day at least one woman comes to Mumbai's public hospitals seeking treatment for bruises, burns, or poisoning. In the past, such injuries were usually treated as accidents by doctors and victims who tacitly knew they were the result of domestic or sexual violence. "Everyone knows that a woman doesn't accidentally drink half a bottle of pesticide", said Padma Deosthali, director of the Center for the Enquiry into Health and Allied Themes (CEHAT), a non-governmental organisation (NGO) in Mumbai. "It's a conspiracy of silence." In India, it is not uncommon for women to poison themselves in an attempt to escape abuse, but the reasons behind this desperate act are often glossed over by medical staff.

Since 2000, hundreds of staff at Mumbai's 16 free government hospitals have been trained to recognise signs of violence against women with help from CEHAT. They can now offer better services and treatment, and suggest services at Dilaasa, India's only crisis centre for violence against women, based at Kurla Bhabha Hospital in Mumbai's Bandra West neighbourhood. Dilaasa started as a joint effort led by CEHAT with the Brihanmumbai Municipal Corporation (BMC), which oversees public hospitals in this city of 20 million.

Violence against women has been in the spotlight after the vicious gang rape and death of a 23-year-old woman in Delhi last December. After the brutal attack, thousands of protesters took to the streets of India's capital, and months later heated discussion continues about the insidious issue.

Violence against women is prevalent worldwide, but in India a third of women have faced some form of physical violence, according to the country's 2004–05 national health

survey. More than 75 000 cases of cruelty by husbands or relatives against women were registered in 2009, according to the National Crime Records Bureau.

In addition to loud calls for legal, police, and social reforms in India, there is an urgent need to overhaul medical guidelines; there is no standard national protocol for medical examinations of victims of sexual violence and treatment for them. In India, cursory, ad-hoc medical examinations are the

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norm and are often "degrading and counter-productive", said Human Rights Watch. In a 2010 report, the advocacy group highlighted the now infamous "two finger test" often used by Indian doctors to test the elasticity of rape victims' hymens to gauge their sexual activity.

In India, most doctors and nurses are not trained to treat violence against women as a larger health threat. "Nothing beyond the medical aspects of the problem gets recorded, much to the disadvantage of the patients in case legal proceedings are initiated", said a CEHAT paper. "Most health professionals do not even recognise this as part of their professional duty."

Victims typically receive no guidance on legal aid and police procedures, nor psychological counselling. "There is a huge gap in training and in the medical curriculum", said Claudia Garcia-Moreno, team leader in the Department of Reproductive Health and Research at WHO. "Doctors and nurses graduate without this training."

Hospitals and clinics have an important role in curbing violence against women as they are often the first stop for victims. A report from a commission led by J S Verma, former chief justice of India, in January, suggested reforms to India's Government that included development of medical guidelines heavily based on CEHAT manuals and policy recommendations.

Syeda Hameed, member of the Indian prime minister's planning commission in Delhi, visited Dilaasa in late February. The planning commission is considering setting up 100 crisis centres across India modelled on Dilaasa, which pioneered an improved system for aiding victims. Two other crisis centres were started by CEHAT in Indore in central India and Shillong in the northeast, though only the latter is still functioning.

In a recent visit to Bhabha Hospital, hundreds of people sat in a cavernous lobby waiting for general medical attention. Pastel posters along the walkway to the lobby featuring female silhouettes subtly warn about violence against women and children. Dilaasa's counselling unit sits in a small office near the outpatient paediatrics clinic.

For the 2010 Human Rights Watch report see <http://www.hrw.org/node/92724>

For more on CEHAT publications see <http://www.cehat.org/go/Publications/Home>



Thousands of Indians protested about the gang rape and death of a woman in Delhi

Since 2000, about 3000 women in Mumbai have registered at the centre. (BMC took over Dilaasa in 2006 and CEHAT now acts as an adviser.) After initial treatment for physical injuries at any Mumbai Government hospital, patients are told about Dilaasa, which means “empathetic support” in Hindi. If they do go to Dilaasa, they might be referred to doctors in Bhabha Hospital for further treatment, and are also offered counselling, legal guidance, or help filing police reports.

Most of Dilaasa’s patients are from poor or lower-middle-class backgrounds, though upper-class, educated women occasionally come in or call the centre’s hotline. “Some of them just want to talk”, said Chitra Joshi, a Dilaasa counsellor for the past 13 years.

At Bhabha Hospital, doctors use a revised, highly detailed questionnaire based on WHO guidelines to accurately take a victim’s history. The new form is four pages long with more specific questions. The conventional questionnaire is two pages and only requires broad descriptions of sexual assaults. For example, only vaginal penetration by a penis is considered rape in India so oral, anal, and other assaults are not specified on the medical form. Other crucial details such as time elapsed since the assault, whether the victim cleaned herself, and other injuries or circumstances are left out.

Bhabha is also equipped with comprehensive kits to properly collect evidence from victims. The cardboard boxes contain dozens of plastic bags and paper envelopes with printed labels that indicate, for example, “swab of blood stain on body”, “vaginal smear”, “nail clipping”. There is even a red stick of wax used to seal envelopes. “We don’t have to run to find things”, said Aditi Phulpagar, a gynaecologist and assistant professor at Bhabha. “Even swabs were not available before.”

Dilaasa has trained 100 nurses, doctors, and hospital staff as core trainers who have gone on to train

hundreds of peers at Mumbai government hospitals to raise awareness about violence against women. The centre has published a manual with step-by-step instructions for doctors to undertake scientific and sensitive examinations of victims. “I learned exactly how to do an exam [of a victim] and deal with the patient and police”, said Phulpagar. “Every hospital must have an institute like CEHAT to raise awareness.”

Education about this issue is especially important in India where violence against women is usually considered a personal affair, not a health issue. “Medical staff thought it was not their business, that it was something for the police, that it was part and parcel of married life”, said Seema Malik, chief medical attendant of Mumbai’s Government hospitals and a gynaecologist by training. “Doctors didn’t understand the reasons for the symptoms [of violence]”, she added. “Staff had a similar view—that if a woman had acts of domestic violence against her she must have done something wrong.”

Doctors in India are often reluctant to treat cases for fear of liability or harassment from husbands or family members. Sometimes they perfunctorily collected medical evidence but neglect to offer further treatment or preventive care, such as emergency contraception or HIV tests. Dilaasa training underscores that violence against women is unacceptable and that offering medical and social services is the medical staff’s duty.

Dilaasa’s efforts are a positive step, but far more needs to be done. India’s Director General of Health Services modified its protocol in 2011 to remove the “two finger test”. This was a welcome move, said Meenakshi Ganguly, South Asia director of Human Rights Watch. However, most hospitals still use these outdated examination techniques. The “two finger test” remains in India’s medical school textbooks, and medical students and

nurses receive no specific training on how to examine and treat victims of sexual violence.

Only Bhabha and two other government hospitals in Mumbai—Rajawadi Hospital and Oshiwara Maternity Home—have updated questionnaires and medical kits for examining victims. Other hospitals still use outdated forms and lack examination kits, though hospital staff have been trained. Government bureaucracy keeps other city hospitals from adopting the new forms. CEHAT has received requests for hundreds of rape kits from hospitals across India although that is not its role.

Pramod Nagarkar, medical officer at Cooper Hospital in Mumbai, said every day at least one woman is admitted to his hospital for fractures, burns, or a suicide attempt by poison. There are also less obvious cases of mental or psychological abuse: one woman’s husband refused to give money for her diabetes medication, notes Nagarkar. Only about 20% of women opt to go to Dilaasa for further treatment or counselling; many victims lack the family support to do so.

Nagarkar was trained by CEHAT, which was funded by the Ford Foundation and now Tata Trust. He estimated he has trained 600 government hospital staff across Mumbai. Initially, “even administrators have said it’s not a health issue, it’s a police issue”, he said. It was also not unusual for hospital staff to be annoyed about admitting “yet another” bothersome case of poisoning.

This situation is despite India’s landmark 2005 Domestic Violence Act, which was 10 years in the making. However, the law is still unevenly enforced in India, and far more work remains in battling violence against women. “The biggest lacuna is that health policy doesn’t recognise violence against women as a public health issue”, stressed Deosthali. “Our policy is silent on the issue.”

Amy Yee