Violence Against Women & Role of Health Professionals

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Violence against women (VAW) is known to have far-reaching health consequences on them. 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. (Garcia-Moreno et.al. 2005). Besides physical health consequences, violence is also known to have several psychological health consequences such as women developing 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, and nervous breakdowns. Violence against women has also been associated with other risk behaviours with adverse health outcomes such as drug and alcohol use. According to NFHS-3, the lifetime prevalence of physical or sexual violence among women of 15-49 years was found to be 34% while about 19% of these women reported experiencing violence in last 12 months preceding the survey. It is evident then that the health sector has a crucial role to respond to women and children reporting to the health care system.

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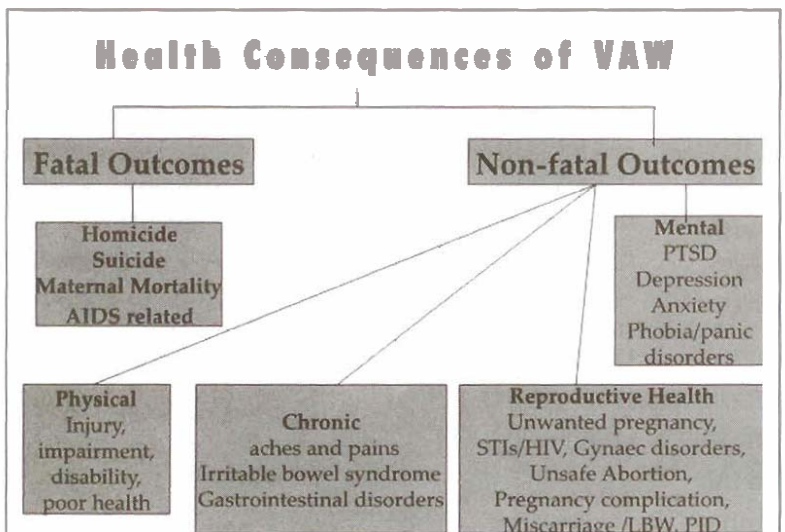

(Source: Guidelines for Healthcare Providers to Respond to Violence Against Women)

Legal responsibilities of health professionals

The Indian law vests legal responsibilities in the health professionals vis-a-vis different statutes such as the PWDVA (2005) , POCSCO (2012) and CLA (2013) . Each of these roles comprises therapeutic and medico-legal aspects.

Protection of Women from Domestic Violence Act (PWDVA) of 2005 expects health professionals to recognize signs and symptoms of domestic violence (both psychological and physical), provide complete medical and therapeutic care, record the

details of the abuse faced by the woman and also inform her about the PWDVA. Each health facility is expected to carry out this role at the minimum. Once they inform the woman about the law and she expresses interest in pursuing a case, the health provider must put the woman in touch with the Protection Officer (PO). Such a person has been designated under the PWDVA to facilitate all services such as registration of police complaint, coordinate services such as shelter services, legal aid, medical help and also counselling services. The POs are additionally expected to file DIR (domestic incident report) and forward it to the magistrate's office for speedy orders under the law. It is therefore pertinent that health professionals such as doctors and nurses be aware of the laws and obligations under the law.

In a nutshell, the roles of health professionals on responding to domestic violence as per PWDVA are

- Identification of abuse
- Provision of comprehensive medical support
- Documentation of past and current episodes of abuse in a medico legal form.
- Emotional support and information about the available remedies under the act and make appropriate referrals
- Filling of a DIR (domestic incident report) and referral to the Protection Officer (PO)

The law has also vested an important responsibility in health professionals in connection with survivors reporting sexual violence. The law related to child sexual abuse (Protection of Children from Sexual Offences Act 2012) and Criminal Law Amendment to Rape (CLA 2013) have mandated immediate medical and psychological first aid to all survivors of sexual violence irrespective of whether they have reached the hospital with / without police. In fact, non-provision of such medico-legal and therapeutic care to women and children seeking care can make the health professional liable for punishment and a fine (Sec 166 B of IPC).

Changes in the rape law also necessitates that the current medico-legal practices be overhauled in order to ensure good quality comprehensive services for women and children reporting sexual violence. Till 2013 there was a complete lack of scientific medico legal care in instances of sexual violence. The practice of health professionals focused on age-old archaic and unscientific practices such as two-finger test, measurement of height- weight to determine extent of resistance offered by the person on whom sexual

violence occurred and recording the status of the hymen (IJME Padma's paper). Many health professionals would only focus on medico-legal examination and evidence collection. Those surviving the sexual violence were sent back without any health care. Despite evidence that sexual violence led to a range of health consequences such as sexually transmitted infections including HIV, unwanted pregnancies, infections and a range of psychological health consequences.

Efforts to engage the health care system to respond to violence against women

One of the first efforts made to engage the health sector to respond to violence against women was through the setting up of a hospital based-crisis centre in Mumbai. CEHAT, a research institution of the Anusandhan Trust, collaborated with K B Bhabha Municipal Hospital in a Mumbai suburb to set up "Dilaasa" – a hospital based crisis centre in 2001 . The centre had 2 important functions; one was the provision of crisis intervention services to women and children facing violence. Second was building capacities of health professionals to identify health consequences leading to violence and providing them with care and treatment. The Dilaasa crisis centre was replicated by the MCGM in another hospital in eastern suburb in 2005. Consistent engagement with the public health care system along with training and dialogue with doctors and nurses helped in the creation of a cadre of trained health professionals as trainers. Doctors and nurses as trainers started representing the Dilaasa through a "training cell". Members of training cell also initiated the creation of comprehensive health care services to sexual violence survivors in 2008. These observations go to show that health professionals were not only motivated to screen and support women and children, but were also keen that health professionals of other

hospitals be made aware of their roles. For this purpose they were also willing to conduct awareness and training of health professionals from other hospitals.

While several efforts were underway at the level of municipal hospitals, it was also important to understand the scalability of the Dilaasa model. An external evaluation of the Dilaasa crisis centre was conducted in 2009 to understand the upscalability of such centres in other hospitals as well as health care systems in the country. Evaluation of Dilaasa brought to light that location in the hospital made it possible for women to follow up easily and they could do it on the pretext of a hospital visit. Women in the reproductive and child bearing age have an invariable contact with the hospital, it is possible to detect abuse at an earlier stage and also work towards reducing the intensity of violence.

Encouraging results of the evaluation led to making similar efforts in states such as Meghalaya, Karnataka, Gujarat, Maharashtra and Rajasthan.

Efforts by Government of India

A positive step was taken up by the central health ministry in 2013 (MoHFW, 2013). The Ministry set up an expert panel to advise them on drafting of a protocol which was in tune with the changes in rape law and also provided complete therapeutic care and psychological first aid. The committee comprised experts from different fields such as forensic medicine, psychiatry, pediatrics, lawyers, womens rights experts and health advocates. The protocol and guidelines were finalized through a consensus building process with different constituencies. The protocol is based on the recommendations by the World health organization on medico legal care for victims of sexual violence 2002 as well as changes in Indian law. The guidelines recognize a range of constituencies facing sexual violence such as women, children, sex workers people with intellectual and psycho social disabilities, transgender people and those subjected to caste and communal violence. Specific guidelines have been provided to deal with such marginalized communities.

Different states are in the process of adopting the MOHFW protocol and guidelines for comprehensive medico-legal and therapeutic response to people reporting sexual violence.

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Challenges

- Despite recognition that violence against women and children is an important health issue and the health system at all levels need to respond to it, the national health policy drafted in 2015 does not refer to violence against women as a critical issue that requires attention of the health system .
- Efforts are being made by the Ministry of Women and Child Department (MWCD) of setting up crisis centres to respond to violence against women. However there is no mention of the need to work closely with health departments. Despite evidence that health consequences of violence bring women and children to a health facility , the linkages with the health system have not been thought of in the rolling out the MWCD schemes.
- The criminal justice system, health care system and police department, each has a role to play in responding to violence against women and therefore specific ministries need to have integrated programs for responding to violence against women. ■

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