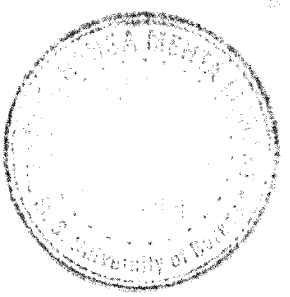
CHAPTER-II

REVIEW OF LITERATURE



CHAPTER-II

REVIEW OF LITERATURE

The conceptual, descriptive and theoretical literature review has been covered in the introduction chapter; this chapter puts together findings of the empirical researches related to different aspects of the present study namely domestic violence, its impact on women's health, response of healthcare system to it and women's experiences with the health care system.

The main focus of the review has remained to be on Indian Studies due to the specific socio-cultural context of the problem. However foreign studies are also referred to in the areas where not much of Indian literature is available, or wherever the findings from foreign studies have been found to be relevant.

This chapter is divided into four major sections. The first section on the **Domestic Violence: Magnitude of the problem** describes the prevalence of domestic violence in India drawing from various sources such as crime statistics and population based surveys. The section also gives brief historical analysis of the Indian studies related to domestic violence.

The second major section on **Domestic Violence - A Public Health Issue** reviews Indian studies that assess the impact of domestic violence on women's health, and examines studies related to the issue conducted in the context of health care system.

The third section includes review of researches related to **Health Care System's Response to Domestic Violence**, especially health care providers' response and attempts to understand reasons behind it.

And lastly **Silence Surrounding Domestic Violence** is mainly a review of studies related to women's experiences with the health care system, especially in the context of quality of care. Based on the review this section also explains the characteristics of women experiencing violence.

Domestic Violence : Magnitude of the Problem

Violence against women is globally pervasive. Accurately estimating the global burden of violence against women is not possible due to the absence of data on the incidences and its impact on the society in general and on lives of women in particular. Crime statistics though important, are inadequate for estimating the incidences of gender based violence because crimes against women are grossly under reported. Due to the concept of 'izzat' honour, 'prestige', accepted cultural practices, norms and the stigma associated with domestic violence, wife abuse, rape and sexual abuse, such forms of violence tend to be under reported and the data related to it is less easily collected.

However much progress has been made in the past few years in estimating the prevalence of domestic violence, wife abuse, sexual violence in both developed and developing countries. Evidences from different countries across the globe shows that domestic violence is the most endemic form of violence against women.

The summary report of the WHO multi-country study on women's health and domestic violence against women (2005) states that the proportion of women who had ever (i.e., over their life time) experienced physical violence by a male partner ranged from 13 percent in Japan to 61 percent in provincial Peru, whereas experiences of sexual violence were reported the lowest percent in Japan and highest in Ethiopia as high as 59 percent. The report results also indicate that across all ten countries where the study was conducted, 20 to 50 percent of women had experienced one or more type of emotional abuse within the past 12 months. Physical violence in intimate relationship is always accompanied by psychological violence and in one-third to one half of cases by sexual abuse. Most women who suffer any physical aggression generally experience multiple act overtime. Data from wide range of countries also suggest that domestic violence account for a significant number of deaths by murder among women (WHO, 2002). Interpersonal violence was identified as the tenth leading cause of death for women in the world between 15-44 years of age in 1998 (WHO, 2000).

Amongst all, the worst manifestations of violence against women in the world are found in the South Asian region, which has been called the most gender insensitive region in the world (Mahbub Ul Haq, cited in ICRW, 2004). One in every two women in South Asia face violence within their homes (Wecan, 2007). This means there is extreme injustice and inequality in every second family in the region. Several researches

carried out in the region prove that incidences of domestic violence in South Asia are highest in the world.

Prevalence of domestic violence in India: A statistical snapshot

India with the presence of myriad customs, traditions and cultures based on strong patriarchal, discriminatory values and practices are no exception, but a glaring example of a society having high incidences of domestic violence. Statistical evidences on the actual prevalence of domestic violence in the country are scanty. Lack of availability of systematic data makes the task of estimating the magnitude of the problem not only difficult but also daunting.

There are no official figures available in the country related to prevalence of domestic violence except those provided by the National Crimes Record Bureau (NCRB), Ministry of Home Affairs, and Government of India. As the NCRB data takes into account only the reported cases of crimes committed against women, it shows only 'the tip of the iceberg', i.e., reflecting only a small percentage of the actual magnitude of domestic violence. A research study by the Special Cell for Women and Children in Mumbai (1999) showed that only 33 percent of the women who sought help from the special cell due to violence approached the police for help. The multi site study undertaken by ICRW and INCLEN (2000) also revealed that less than 2 percent of the women facing domestic violence reported approaching the police to register complaints.

Despite this, figures provided by the Bureau are useful indicator of the trends in crimes against women. The NCRB data related to domestic violence are put under three major crime heads out of the total recorded crimes against women namely, dowry death (Section 302/304-B IPC), torture and cruelty by husband and/or his relatives (Section 498-A IPC) and Dowry Prohibition Act, 1961.

Table-1 : Crime Head-wise Incidents of Crime against Women, 2001-2005 in India

Sr. No.	Crime Head	Year				
		2001	**2002**	**2003**	**2004**	**2005**
1	Dowry Death (Sec.302/304 B IPC)	6851	6822	6208	7026	6787
2	Torture (Sec. 498A IPC)	49170	49237	50703	58121	58319
3	Dowry Prohibition Act, 1961	3222	2816	2684	3592	3204
4	Rape (Sec. 376 IPC)	16075	16373	15847	18233	18359
5	Kidnapping & Abduction (Sec. 363 to 373 IPC)	14645	14506	13296	15578	15750
6	Molestation (Sec.354 IPC)	34124	33943	32939	34567	34175
7	Sexual Harassment (Sec. 509 IPC)	9746	10155	12325	10001	9984
8	Importation of Girls (Sec. 366-B IPC)	114	76	46	89	149
9	Sati Prevention Act, 1987	0	0	0	0	1
10	Immoral Traffic (P) Act, 1956	1052	2508	1043	1378	2917
11	Indecent Rep. of women (P) Act, 1986	1052	2508	1043	1378	2917
	Total	143,795	143,094	140601	154333	155,553

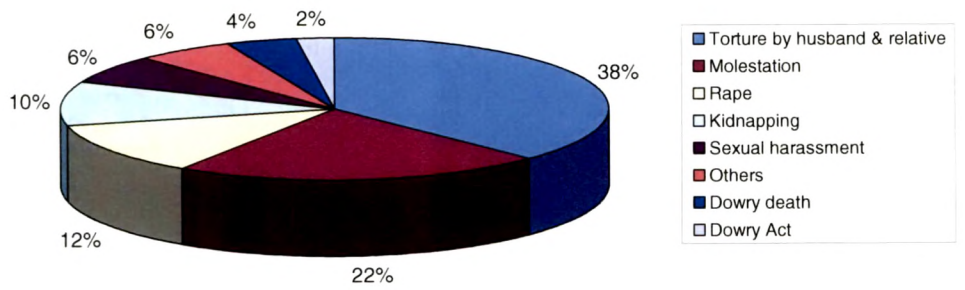
Source: NCRB, 2007

Between 2001-2005, the proportion of various IPC crimes committed against women towards the total IPC crimes has increased continually from 7.4 percent in 2001 to 7.9 percent during 2005. During the same period, number of reported cases of torture and cruelty by husband and/or his family has shown an increase by 3.3 percent, i.e., from 34.2 percent of the total crimes committed against women in 2001 to 37.5 percent in 2005 within the same category as given in the table below. However figures related to the cases reported as Dowry Deaths or registered under the Dowry Act have shown marginal decline.

The data also reveals that of the total 1,55,533 crimes that were committed against women in 2005, 68,310 cases were of domestic violence, i.e., 44 percent of total reported cases of crimes against women during the year 2005 were reported under sec. 302/304B, sec 498A and Dowry Prohibition Act, 1961 (Figure-3). The Crime clock 2005 of the NCRB shows that in India, one dowry death case gets reported every 77 minutes and one case of cruelty by husband and/or his relatives is registered every 9 minutes.

The government data also shows that one in five married women in India experience domestic violence from the age 15. Every six hours a young married woman is burnt alive, beaten to death or forced to commit suicide. According to government estimates 15,000 women suffer from dowry related violence every year (CWDS, 2002).

Figure-3: Total Recorded Crimes Against Women, 2005



(Torture by husband and relatives 37.5%. Molestation 22.0%, Rape-11.8%. Kidnapping-10.1%, Sexual Harassment-6.4%, Others-5.7%, Dowry Death-4.4%, Dowry Act-2.1%).

The National Family Health Survey (NFHS-III) was carried out in 2005-06 by the Ministry of Health and Family Welfare, Government of India in 29 states of the country. The survey included seeking information related to spousal violence from women respondents. The report released in 2007 reveals that over 37 percent of married women in the country are victims of spousal violence which includes physical or sexual abuse by husband (NFHS, 2007). It further reports that 45 percent of women in the country aged between 20 and 24 years are married off before they reach 18 years, which is the legal age for marriage. This percentage crosses 50 percent in eight states.

A nation wide survey on domestic violence carried out by International Centre for Research on Women (ICRW - INCLEN, 2000) also showed that 52 percent of women suffer at least one incident of physical or psychological violence in their life time. According to United Nations

Development Programme (2005), nearly 70 percent of married women between the age of 15 and 49 years face domestic violence in India. Even available micro studies support the government figures and other national level data indicating high prevalence of domestic violence ranging from 22 percent to 79 percent among surveyed women from different parts of India (ICRW-INCLEN, 2000; Mehta, Desai and Desai, 2000; Subadra, 1999; Visaria, 1999; Jejeebhoy, 1998; Rao, 1997; Mahajan, 1990).

Thus the data of Government of India as well as of other researches have identified home, the domestic place, as a major site of violence against married women and indicate high prevalence of domestic violence in the country.

Research in domestic violence: The beginning

The discovery related to women's issues in general and more particularly to domestic violence in the world at large began in the 70's when the International community celebrated the International Women's Year in 1975.

It is interesting that prior to 1971, violent family members were among the missing persons in family research even in the West. No article whose title contained the word 'violence' appeared in the Journal of Marriage and the Family before the special issue on Violence in November 1971 (Sriram, 1991).

The first in-depth analysis of the status of women in India was undertaken in 1971, when the Government of India appointed a committee on the status of women in India (CSWI) to examine all questions relating to the rights and status of women within the changing socio-economic conditions of the country. Though the landmark report "Towards Equality" had no chapter on violence yet it clearly states that the function of violence is to achieve the subordination of women. The widespread violence against women is seen as both an indicator and a means of perpetuating the low status of women, which also manifests itself through various not easily recognizable forms of structural violence such as low health status, lack of access to education, empowerment, health care facilities and so on (GOI, 1974).

In India, the credit for bringing the issue of domestic violence from the private domain into public discourse goes to the women's movement. The first publication of the earliest studies on domestic violence began in 1980 with Flavia Agnes' study of 50 battered women in Bombay followed by the published work of Noor Mohammed (1984) on battered wives in Indian Journal of Criminology 12(2) (Desai, 1991). His study was conducted among 500 socially and economically backward people from the slum areas of Kanpur.

Most of the researches that followed then in the eighties and early nineties revolved around the issue of dowry (Sakhare, 1985; Kishwar, 1986; Devi Prasad and Vijayalakshmi, 1988; Kumari, 1989; Sinha, 1989; Saroja and Chandrika, 1991; Paul, 1992; Devi Prasad, 1991).

Most of the researches that followed the 'Dowry-phase' in different parts of the country mainly attempted to understand the prevalence, forms, and causes of domestic violence and the way women coped with their situations. (Sriram and Bakshi, 1988; Omvedt, 1990; Bhaskaran, 1997; Jejeebhoy, 1998; Subadra, 1999; Sriram, 2001; Bhatti and George, 2001; Dabir, 2003; Khot, Menon and Dilip, 2004; Ganguli, 1990; Pathak, 1992; Visaria, 2000).

However there were also been studies on domestic violence as a crime, wherein domestic violence was examined in the specific context of legal interventions (Mohammad, 1989; Ahuja, 1987; Devasia and Devasia, 1989; Gandhi, 1997; Dave, 1999; Pathak, 2001; Dave and Solanki, 2001).

While reviewing the available researches related to women's health, the researcher realized that the domestic violence was a 'missing agenda' in women's health research. Some of the researchers in the field of health have viewed cases of burns, injuries on women as an issue of 'health and safety' (Anjaria, 1987). Examination of domestic violence in relation to women's health is an area that has gained attention only recently. Neither researchers, social workers, activists in the field of health, nor those working on the issue of domestic violence had linked the two i.e., domestic violence and women's health until mid nineties. It was only post ICPD Conference in 1994, Beijing Conference, 1995 and with the pioneering work of Lori Heise (1994) that the International community as well as those concerned in India recognized that violence

against women has a devastating impact on women's health; and that interventions related to women's health must address the issue of domestic violence and vice-versa.

Domestic Violence - A Public Health Issue

Lori Heise, Jacqueline Pitanguy and Adrienne Germain (1994) surveyed 40 key studies from different countries. They analysed 18 studies from a variety of less developed countries and discussed them in relation to the findings from studies in the developed countries to show that violence against women is a significant public health issue. In her World Bank Discussion paper, Lori Heise and others (1994) have used and analysed the data and concluded that "World Bank approximation is that rape and domestic violence approximately account for 5 percent of the healthy years of life lost to women of reproductive age in demographically developing countries. At a global level the health burden from gender based victimization among women age 15 to 44 is comparable to that posed by other risk factors and diseases already high on the world agenda, including the HIV, TB, Sepsis during child birth, canter and cardiovascular diseases."

There are very few studies in India on domestic violence that have focused on the issue from public health perspective. The following table is the summary of some of the Indian studies that have examined the impact of domestic violence on women's health.

Table-2: Indian Studies on Domestic Violence and Its Impact on Women's Health

Authors	Sample	Findings
Subramanian et al. (2007)	92,000 Indian households where domestic violence was reported by women	Women who were victims of domestic violence have a 37% increased risk of suffering from the common respiratory condition. Women who had not experienced domestic violence themselves but had witnessed such acts against other female members in the same household were at an increase risk of developing Asthma by 21% in comparison to women who lived in violence free environment.
Rao Athalye (2004)	300 women from the city of Mumbai and comparative study of 40 women in the age range of 38 to 39.	21.7% reported violence at home; victims of violence reported more daily hassles and health related symptoms as compared to women from non violent home (significant at <0.05 level of significance)
Visaria (2000)	346 currently married women in 5 villages of Kheda district of Gujarat	66% of women reported some form of psychological physical or sexual abuse's Physical violence was also reported to have caused injuries to women ranging from swelling, bleeding pain or stiffness; Nearly 10% of women reported of sexual assault in the form of either being hit in the vagina or being forced into sexual intercourse. 10 percent of women were seriously hurt by their husbands and needed medical attention.

Authors	Sample	Findings
Mehta, Desai and Desai (2000)	140 currently married women residing in two slum communities of Vadodara city	44% of women reported to having experienced some kind of physical, psychological or sexual violence sometime in their lives. 26% of women experiencing domestic violence narrated one / two episodes of violence in detail that demanded medical intervention; injuries, fracture and dislocation of bones, abortions and complications related to pregnancy.
Nair, Patel and Sadhwani (2000)	580 community members, including 280 men and 300 women from 12 villages of Savli Taluka, Vadodara district of Gujarat.	76% women reported of verbal abuse, 15% reported physical harassment 2% reported mental torture. Spousal violence was received as one of the important causes of injuries among women and emotional and physical strain was considered to lead women committing suicide.
Subadra (1999)	90 battered women from Tamil Nadu State Legal Aid Board's Counselling Center for Women, the All-women Police Station and Counselling Center cum Shelters run by voluntary organization in Chennai.	Women reported that continued violence had adverse multiple consequences on their health ranging from injuries to acute tensions and anxiety, lowering in self esteem and nervous breakdown to internalization of shame and guilt.
Jejeebhoy (1998b)	1,842 women aged 15-39 from two blocks in two districts each of Tamil Nadu and Uttar Pradesh	42-48% of women in Uttar Pradesh and 36-38% in Tamil Nadu reported having experienced beating from their husbands. Results indicated an association between domestic violence, pregnancy and infant loss. Women who have suffered beating appear to be significantly more likely than other women to have experienced fetal wastage or infant death in every group, irrespective of religion or region of residence.

Authors	Sample	Findings
Khan and, Townsend, Sinha and Lakhanpal (1997)	115 currently married women residing in two villages of Lucknow district in Central Uttar Pradesh	Out of 98 women who answered questions related to sexual coercion, 21% reported physical violence, 14% reported anger, and 32% reported sexual coercion by their husbands. Most of these women had experienced two or more unwanted pregnancies and higher rate of maternal morbidity.
Rao (1997)*	177 women of child bearing age and 130 men in three villages, potter community	22% of women were physically assaulted; 34% of those physically assaulted required medical attention
Ganatra (1996)	400 villages in Western India (population 686,000) and seven hospitals	15.7% pregnancy related deaths in the community series and 12.9% in the hospital series were associated with domestic violence
Sheshu and Bhosale (1990)*	120 cases of dowry deaths and 20 cases of intentional injury related to dowry, (1987-89), Maharashtra West India.	Intentional injury included physical violence (59%), mental torture (28%), molestation by family members and perversity (10%) and starving (3%). Cause of death in women who died: burns (46%) and drowning (34%).

(*cited in WHO, 2000)

Some of the Indian studies cited above and the work of Lorie Heise and others (1994) indicate that domestic violence has an enormous impact on women including her physical, reproductive as well as mental health. It reveals and emphasizes the need to address the issue as a public health concern. Even review of studies conducted at the health care settings in different parts of the world and in India show that women survivors of domestic violence visit health care services for medical attention and care.

Domestic violence and health care system

Studies in the United States indicate that battered women comprise 22 percent to 35 percent of all women seeking treatment in emergency rooms, 14 percent to 28 percent of all women seeking treatment in clinics, 50 percent of all women psychiatry out-patients and 64 percent of all women in psychiatry hospitals (cited in Heise, 1994).

In India, a study at the J.J. Hospital, Mumbai showed that 23 percent of women (almost one in four) visiting the casualty department of the hospital with, accident, injury, burn, poisoning or any other emergency were definitely domestic violence cases. The study had identified another 44 percent of women as 'possibly domestic violence' cases (Daga, 1998).

In a study of the analysis of hospital records in Thane District, Maharashatra undertaken by the Tata Institute of Social Sciences, Mumbai health data (drawn from the medico-legal case papers and register) from 5 different types of health facilities such as the corporation maternal health home, the corporation and rural health post, the corporation hospital and clinic were analysed. The study looked at the reporting of injuries of not only women but male patients, and in the hospital not only the emergency and casualty departments but the out-patient departments of gynecology and obstetrics, chest and communicable diseases, ophthalmology, psychiatry general and surgery, and orthopaedics. Exit interviews were conducted with women who came

into the various department reporting injuries. Trained social workers asked a few additional questions apart from those noted down when the doctor was conducting his diagnosis. These women patients were then requested for an in-depth interview to be conducted with them.

The findings of the study indicated that more women report symptoms of violence to community based health facilities. At both community based and tertiary level facilities women in the age group of 18 years to 30 years reported the highest number of violence cases. Of the cases reported as domestic violence at the tertiary facility, only 13.5 percent were recorded as violence cases, and 38.8 percent were recorded as probable violence cases. The majority of violence cases and probable violence cases were reported as 'poisoning' cases. Further, women presenting with chronic illnesses such as tuberculosis and gynecological morbidity were found to report a higher level of domestic violence. Women reporting to medical, surgical and labour / postnatal clinic reported higher violence (Jaswal, 1999).

Evidence from rural Maharashtra shows that about 23 percent of women who accessed an NGO based health centers reported gynecological problems, and about 59 percent of these had experienced history of violence. The study established the link between health, poverty and low status of women and the incidence of violence. Women as women who accessed the NGO's legal and counselling centers had reported suffering from a number of health consequences due to violence (Gupte, 1999).

A population based case-control study, based both in community and hospital, that prospectively studied 121 maternal deaths with survivors of similar pregnancy related complications, indicates that apart from post-partum hemorrhage (30.6 percent) deaths caused by domestic violence (15.7 percent) was the second largest cause of pregnancy related mortality (Ganatra, Coyaji and Rao, 1998).

In another hospital based study of cases of violence against women in Uttar Pradesh, a total 508 hospital cases were collected. The study concluded that a very large proportion of admissions in the case of women were due to striking by blunt objects; women in reproductive age groups especially pregnant women were at high risk for injury. Burn was identified as a major risk for women and the cause of injuries in majority of women cases was attributed to medico legal cause (KRITI Resource Center, 2001).

The first Indian study (unpublished dissertation) on Domestic Violence among Female Psychiatry patients visiting the psychiatry department of the civil hospital in Gujarat indicated that the vast majority of psychiatry patients (88 percent) had experienced at least one type of abuse and one third (38 percent) of respondents had experienced physical, sexual as well as psychological violence. For majority of women, experiences of violence were not isolated single experiences (Mehta, 2004).

Health Care System's Response to Domestic Violence

Health care providers can play a crucial role in addressing domestic violence. As the health care system is the only institution that interacts with almost every woman at some point in her life, health care providers are well placed to recognize women experiencing domestic violence and help them especially when women visit the health care institutions in trauma or with injuries (both physical and psychological). Health care providers could take interest in women life's experiences. Positive response to such women would help change their perceived acceptability of violence in their relationship and would make it easier for women to access support services at an early stage. Moreover, the medical record of violence on women form an important evidence for police investigation and the legal procedures especially in medico legal cases like domestic violence.

Despite the significance that the health care delivery system assumes in responding to the issue, the implication of this on the roles and responsibilities due from the health care providers is hardly researched or reviewed. There are very few studies in India and abroad that have explored the health care system's response to the issue of domestic violence.

In the United States of America, the Pan American Health Organization (PAHO), was the first International health institution to recognize violence against women as a high priority concern way back in 1993 and had urged

all member governments to establish national policies and plans for the prevention and management of violence against women. However, progress in this regard has been slow. Although the country has published diagnostic and treatment guidelines for domestic violence, and the US Joint Commission on Accreditation of Health Care Organizations (JCAHO) required an evaluation of emergency room policies and procedure for dealing with abuse victims in its accreditation reviews. Inspite of this doctors and nurses rarely ask women whether they are being abused, even when there are obvious signs of abuse. Even facilities that have established guidance often do not enforce or monitor their implementation. Studies in USA have also found that few health care facilities have complied with the JCAHO requirements (Population Reports 1999).

A review of five studies assessing health care providers' attitude to screening for domestic violence (routine enquiry of some or all women patients for a history of domestic violence) was undertaken by Ramsay and others (2002) for the United Kingdom National Screening Committee. All the five studies included in the review were conducted in the United States). One study of primary care physicians in New England cited in the review found that only one third of the physicians were in favour of routine screening. In another study of the emergency department, 53 percent nurses responded that nurses should routinely screen all women for a history of domestic violence. The review

concluded that only a minority of doctors and half of the nurses were in favour of screening and wished to screen women for a history of domestic violence.

Response to domestic violence as a public health issue in India

The Government of India has recognized violence against women as one of the eleven areas of concern in its 1995 country report, for the Fourth World Conference on Women. It has ratified various international conventions on Women's issues such as the UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), Declaration on the Elimination of Violence Against Women, Beijing Platform for Action as well as the on the Right to Development, thereby guaranteeing women protection / support against any form of violence and evolving different measures mechanisms to address the issue at all levels. But at the field level it is found that the state intervention has continued to view – the issue of domestic violence as a crime, a social problem needing Welfare, Police and Judicial response (Mitra, 2000; Poonacha and Pandey, 2000). Even the National Policy for Empowerment of Women (2001) emphasizes on legal response and has sought to review discriminatory laws and establish an effective machinery to monitor the delivery of justice to women victims of violence.

However, it must be mentioned here that the newly enacted "The Protection of Women from Domestic Violence Act, 2005 in India"

includes the provision of medical care and facilities to women victims of violence. The act has recognized the impact of violence on women's health and includes related provisions.

Provision Related to Medical Help in The Protection of Women from Domestic Violence Act, 2005

Sec.7 If an aggrieved or on her behalf a Protection Officer or a service provider requests the person incharge of the medical facility such person in charge of the medical facility provide any medical aid to her, shall provide medical aid to the aggrieved person in the medical facility.

Sec 9(9) It shall be the duty of the Protection Officer to get the aggrieved person medically examined, if she has sustained bodily injuries and forward a copy of the medical report to the police station and the Magistrate having jurisdiction in the area where the domestic violence is aggrieved to have been taken place.

Sec 10(2) A service provider.... shall have the power to –

(a) record the domestic incident report in the prescribed form if the aggrieved person so desires and forward a copy thereof to the Magistrate and the Protection Officer having jurisdiction in the area where the domestic violence took place.

(b) get the aggrieved person medically examined and forward a copy of the medical report to the Protection Officer and the police station within the local limits of which the domestic violence took place.

In Gujarat, the most recently formed Gujarat State Nari Gaurav Niti 2006 (State Policy for Gender Equity) (WCD, 2006) recognizes the need to mainstream the gender perspective in the development processes, policies and programmes. It has also committed itself to eradicate all

forms of violence against women and girl children and has ensured women right to quality health care services through effective and decentralized management of health care systems.

However these are the beginnings at the policy level. But at the field level it is found that government health care programmes are far from addressing the issue. In her study of response to domestic violence (Mitra, 2000) had concluded, "...the efforts of Government of India have been diverged and show considerable degree of responsiveness to the problem. However it has only achieved partial success in its endeavour and it has addressed itself to this issue peripherally."

Domestic violence has neither assumed any importance as a public health issue nor does it even warrant any mention in the core areas of work of the health care delivery system till today.

Review of a few of the Indian studies on the response of health care providers to domestic violence indicate that health care providers, though aware of the issue, hesitate to (rather do not) respond to it in their work.

One of the recent studies examining the medico-legal response to domestic violence, dowry related violence and rape is by Shally Prasad, (1999), conducted in Delhi. Data for the study were collected during three separate field stays between 1991 to 1995. A total of 105 interviews using a semi-structured tool were conducted with 16 health care providers, 10 police officers, 6 case workers, 10 lawyers and

academics, 4 government officials, 40 women at the Crimes Against Women Cell (CAWC) of the New Delhi Police and 20 women through shelter and other women's non governmental organizations.

After examining the attitude and response of police and the legal profession to the issue, Prasad unveils the 'conspiracy of silence' on the part of physicians. She found that the police as well as the state employed physicians neither acknowledged the cause and the totality of women's injuries nor did they make referrals to counselling services or women's organizations. The physicians generally avoided involvement in such cases and denied health care assistance beyond treatment for immediate trauma. Often physicians deliberately did not ask questions on the cause of injuries because they did not want to be involved in a legal case.

A study that looked at developing treatment based on the needs of battered women in five cities in India revealed that only 12 percent of Psychiatrists interviewed, routinely checked for any history of abuse in women patients. 54 percent of the clinicians acknowledged that women's situation in everyday life was different and that gender played an important role in the mental health of the individual, and 29 percent of respondents felt that there was a vast improvement in women's quality of lives making their status equal to men and hence gender was irrelevant to mental health. However, most of those who acknowledged the varied context of women's lives reflected a lack of understanding of women's issues, as it was not evident in their practice. The study implied that

perhaps the experience of being female, experiencing violence and a lack of control of one's life leads women to develop psychological problems that may be constructed as 'illness'. The study concluded with a pertinent question to mental health professionals: "If women express a range of emotions (such as fear, helplessness, suicidal ideation, suicidal attempts and low self esteem) as a fallout of violence experienced, will it be termed as response to violent and incorrigible life situation or in fact sign of mental dysfunction? (Purewal and Ganesh, 2000).

Domestic Violence – An Ethical Responsibility

"In case of wife beating, although such battered women do approach doctors for treatment when severally beaten-up, their medical record would invariably show the injuries as accidental. While it is true that often women do not report the true cause of injury due to fear, even in those cases where such reporting is done, women have found the doctors uncooperative. Indeed examination of medical records by us had invariably shown that in all 'medico-legal' cases the doctors are tutored not to write detailed history of assault. The hospital managers and forensic experts have taken the stand that writing history of assault is the job of police and not doctors. Besides it is argued by not writing the history of assault the doctor would be able to protect him/herself better in the court of law. Not only that, the forensic experts have also taken positions that in medico-legal cases the doctors' role is only to collect forensic evidences and in such examination, no doctor-patient relation is established. Thus according to them there is no ethical obligation on doctor to care for survivors."

Dr. Amar Jesani (1998)

Source: Jesani, 1998b

In the study of Jaswal, (1999) mentioned earlier, health care providers were also interviewed, where questions were asked relating to their conceptualization of violence whether they did not recognize or feel the need to record the possibility of violence that was evident. The exercise was one of exploring their openness and sensitivity. Many of health care professionals had become sensitive during the course of the study. The findings indicated that there was a need for a more sensitive and efficient recording system which can respond to the needs of women patients reporting to any health facility and sensitization of community health workers to both forms of violence as well as gender issues. The researchers were of the firm belief that further research was needed to establish the health impact of violence before jumping into evolving new strategies for intervention.

In yet another study undertaken at the KEM Hospital and Research Centre, Pune, a qualitative, exploration was attempted before finalizing the design for an in-depth study to assess the health impact of violence in women's lives. A psychiatric and mental health clinic was established in the community. Interviews were held with different types of health practitioners, all of whom admitted to the knowledge of violence being prevalent, the underlying causes and the manner of abuse, but they did not do anything about it and just addressed the symptoms. The researchers were of the view that there was too much of a hurry in pushing at intervention without having a clear and complete picture of the dynamics and the context of violence (Ganatra, cited in Gopal, 2000).

In a study of the health care providers' perspective on addressing violence as a public health issue undertaken by Centre for Operations Research and Training (Barge, 2000), interviews were conducted with 12 government and 16 private doctors, 34 supervisors and 62 grassroots Workers (ANMs and male health workers) from there primary health centres (PHCs) in Patna district (Bihar) and six PHCs of Vadodara district (Gujarat). The key findings of the study were that providers were very much aware and acknowledged the prevalence of domestic violence. They opined that though domestic violence occurred in all kinds of families, it was more prevalent in families from socially backward communities, those with low income and illiterate. A higher proportion of male health care providers (62 percent) than female health care providers (43%) believed that violence was increasing. Habit of drinking alcohol was reported as the main cause of violence. Depression, malnutrition, bad effect on children, suicide, injuries and disolcalities, miscarriages, low birth weight baby were mentioned as the consequences of violence. In the three months preceeding the study 82 percent doctors, 71 percent lady health visitors and 55 percent of female health workers reported having received case of domestic violence, like minor cuts or injuries, swelling and pregnancy complications. Treatment/medicines (39 percent), counselling (40 percent) or referral (15 percent) were the service provided to these patients. None of the providers mentioned playing a proactive role in either screening or

reporting cases of domestic violence, though they said that they could identify such cases. There was a reluctance to get involved in medico legal cases among providers. They intervened only at the victims' request and only as far as the victims explicity wanted them to. Besides providers' own perception of violence as a personal matter, victims reluctance to reveal the real cause of their injuries coupled with, lack of support from the community and difficulty in persuading victims to take legal actions and fear of violent reprisals from the perpetrators were factors that deterred them from intervening. Only 5 percent providers considered violence as a public health issue, this was still lower at 2 percent in the case of health workers. Most of them perceived violence as a social or personal problem.

On the basis of review of few of the studies stated above and the works of (Ramsay, et al., 2002; Verma and Khanna, 2000; Menon, et al., 2000; Jesani, 1995, 1998 and WHO, 1996) reasons related to the slow or lack of response of health care providers can be enlisted as health care providers' –

- Belief that it is not their business to know the cause of women's ill health or the physical injuries on women.
- Limited perception of their role as symptom treatment provider or to dressing the wounds or prescribing medicines (functions of medical mode).
- Lack of education in or experience of screening.

- Lack of clinical guidelines and other practical barriers to routine screening.
- Negative feelings i.e., feeling of inadequency, powerlessness and isolation, lack of knowledge to help the woman.
- Fear of offending or endangering women or their relatives.
- Beliefs that they cannot intervene in such a case unless 'they are ordered' by their superiors.
- Lack of time and space availability to deal with the needs of women victims.
- Not wanting to get into medico legal problems.
- Identification with victims or offenders.
- Personal values, attitudes, beliefs towards Domestic violence (e.g. women provoke violence, women are able to stop violence by changing their behaviour, it's alright to get it sometime etc.)
- Belief that women do not reveal the truth as they do not want help or want to do anything about it.

Thus barriers for health care providers in addressing domestic violence can be summarized to be in the areas related to their technical competence, skills and resources, their own cultural stereotypes and social attitudes, institutional constraints and women's reluctance and vulnerability to seek help.

The Medico-Legal Process

In India, Domestic Violence is classified as a medico-legal case under Sec. 498-A, 304-B of IPC. In the state of Gujarat, the Police and the Casualty Medical Officers (CMO) / State employed physicians play a central role in the investigation of domestic violence as well as the initiation of the medico-legal process. All women seeking state assistance for domestic violence must first register their case at the local police station and request written police authorization for a specific medico-legal examination for the purpose of collecting medical evidence. Although women can seek medical attention immediately if required (in case of grievous injuries) State employed physicians / Casualty Medical Officers must inform the police to make it a police case. Only state employed physicians / Casualty Medical Officers are authorized to complete the medico-legal report and collect medical evidence admissible in court. Therefore if women want to press charges for domestic violence or even protect their ability to do so in the future, they must seek medical care from the state employed physician.

Silence Surrounding Domestic Violence

One question that perplexes most people working on the issue of Domestic violence is: Why do women not seek help to end domestic violence and go back to abusive relationships.

Responding to domestic violence is hindered by women's reluctance to seek help. Not only does it result in under reporting of violence but is also often cited by Health Care Providers as a reason for not intervening or responding. Therefore it is important to understand the underlying reasons for women's reluctance to speak up as to break the silence surrounding domestic violence.

The reasons for women's reluctance to come out with the truth, seek help for their domestic violence related problems can be divided into two broad areas namely: Characterization of Women Experiencing Violence and Deficiencies in Health Care System.

Characterization of women experiencing violence

From childhood Indian women are taught to be tolerant, self-sacrificing, to keep silence, not disclose their private matters/problems of the home to anyone for fear of 'losing izzat' (honour), 'family name'. Women are also socialized to believe that it is husband's right to abuse them, beat them hence domestic violence is a normal part of marriage. Many women hesitate to disclose or do not want to seek help due to lack of parental or family support, lack of a safe place to go to as refuge, economic dependency, lack of self confidence or for the sake of their children (Mehta, et al., 2000; Visaria, 1999; Pathak, 1992; Sriram, 1991; Desai and Krishnaraj, 1987).

Ahuja (1998) and Kornblit (1994, cited in Gandhi, 1997) have summarized these reasons largely by drawing from others in the form of five models briefly presented below.

Traditional socialization model

Women, wives endure violence because they are traditional; they think that husbands have a right to beat their wives and its wives duty to tolerate. Women do not have a right to protest or express their resistance

to such behaviour. They believe what they are 'taught' from childhood, they mindlessly accept the traditional 'sex role ideology' delivered by the socialization process.

Learned helplessness model / Post Traumatic Stress Disorder (PTSD)

According to this approach, battered woman becomes "psychologically paralyzed" as a result of learned helplessness. The women feel that she deserves to be beaten and accepts it as a fulfillment of her expectations.

Psychological entrapment model

This model argues that women continue to live in violent relationship because she thinks that she has invested substantially in the relationship and hence she cannot quit. The more time and effort a woman has invested in marital relationship, difficult it is for her to leave that relationship.

Relative cost / benefits model

According to this model the victim first analyse the cost and benefit of stay back / quit the relationship and then takes the decision. When the available alternatives are less attractive compared to the present situation, the woman decides to continue living in the relationship.

The theory of reasoned action

A woman's decision to not leave the abusive relationship is governed by her under estimation or over estimation of the consequences of leaving.

Walkers' Cycle Theory of Violence

The Tension-Building Phase

As the name of this phase implies, tension increases within the relationship, at which time the husband may engage in minor battering of his spouse. The wife attempts to calm him by agreeing to his demands, becoming more nurturing or simply attempting to stay out of his way during this phase. The victim may rationalize that perhaps she is really at fault and deserves the abuse, accepting the batterer's faulty logic as her own. Women who have been in a battering relationship for any extended period of time know only too well that the minor battering will increase in time. A women may try to withdraw more from the abuser in an attempt to avoid more conflict, but the tension in the relationship will continue to increase until the batterer explodes in a fit of rage.

The Explosion or Acute Battering Phase

During this phase the abuser loses control and engages in major incidents of assaultive behaviour. This intense violence aggression is what distinguishes this phase from the minor or occasional battering that takes place in the first phase. When the first serious attack is over, both parties may feel shock, disbelief, and denial. For example, the woman may attempt to minimize her injuries.

The Calm, Loving, Respite Phase

This phase is characterized by contrite loving acts on the part of the abuser. The batterer may understand that he has gone too far during the previous phase and will beg forgiveness and promise never to let it happen again. The woman will want to accept the abuser's promises that he can change and that his loving behaviour is an inducement for her to stay in the relationship.

Source: Wallace, 1996

Deficiency in health care system

Deficiencies in health care system also make it difficult for women victim to seek care and help (Jejeebhoy, 1997). Experiences of victims / survivors of domestic violence with the health care system is an area that is hardly explored (rather unexplored) in India. And most of the studies focusing on women's experiences with the health care system are related to quality of care of family planning services and family welfare programmes or rather of the maternal health and reproductive health services provided by public health facilities. But a study conducted in Nairobi concluded that women prefer not to inform or seek help from health care providers because of lack of concern shown by the health personnel for women's psychological well being and provision of treatment for only physiological ailments treatment, rude, blandly unsympathetic, insensitive approach towards them, little time or minimum time spent with them in interactions, examining / treating in a routine fashion, ailment diagonised and treatment prescribed in a perfunctory manner (IPPF discussion paper, undated).

Further many women do not volunteer to give information unless they are asked directly about violence. Shame, fear of reprisals from husband or his family members or fear that they would be blamed for it are also some of the important reasons that women don't 'speak up' (Population Reports, 1999).

Review of Indian studies related to quality of care indicate that most of the earlier researches on quality of care are either focused on quality of physical infrastructure in the facilities (CORT, 1995, 1996, 1997; Mavalankar and Sharma, 1999; Townsend, Khan and Gupta, 1999 and Subrahmanyam, 1997) or on health care providers' perspective of quality of care (Khan, et al., 1995; Iyer and Jesani, 1999; Bhatia, 1999).

The historic International Conference on Population and Development held at Cairo in 1994 followed by the pioneering work of Koenig and Khan (1999) on improving the quality of care in India's family welfare program based on various micro level researches conducted in different parts of the country brought about a paradigm shift in viewing and making government programmes more client oriented with an emphasis on the quality of service and care from the client (Users') perspective.

One of the largest countrywide studies undertaken by the Ministry of Health and Family Welfare, Government of India related to maternal and child health and utilization of health services provided to mother and children is the National Family Health Survey (NFHS). The NFHS-2 survey conducted in 1998-99 post ICPD asked women users several questions related to the perception of quality of care that they received during their most recent visits to a health facility in the twelve months preceeding the survey.

Specific dimensions of quality indicators covered were whether women received the service they went for, the waiting time before receiving the service, whether the staff at the health facility spent enough time with them, whether the staff talked nicely to them and whether the staff respected their privacy, if they needed privacy. Women were also asked their opinion regarding the cleanliness of the facility.

The NFHS-2 all India results related to public sector showed that 90 percent of ever married women were satisfied with the amount of time the staff spent with them. 63 percent of women said that the staff talked to them nicely, 68 percent of women reported that the staff had respected their need for privacy and 52 percent of women rated the health facility as very clean.

On comparing the national level findings related to some aspects of quality of care with the Gujarat state level results on the same aspects we find the state on a better footing. The results of NFHS-2 for the state of Gujarat showed that virtually all respondents who visited the public sector health facility had said that they received the services for which they had visited the facility, 87 percent of women had reported that the staff talked to them nicely, 86 percent of women who said that they needed privacy during their visits were satisfied that the staff respected their need for privacy and 80 percent of women who visited public sector health facility found it clean. However according to NFHS-2

women in Gujarat rated the quality of care at the private sector higher than the government sector facilities on all the indicators of quality of care related to the most recent visit to a health facility.

Examining results of the micro level study of Roy and Verma (1999) undertaken during the same period, we find that majority of women from Tamil Nadu and Karnataka perceived (and presumably experienced) a reasonably high quality of interpersonal relations with service providers. But most women in West Bengal and Bihar did not report such positive perceptions regarding doctors behaviour, level of attention of clinic staff to health and family planning needs and level of privacy provided to family planning clients.

"The degree of communication between the provider and the client largely determines how favourably the clients regards the service. And barriers to the communication are the clients' ability to understand the provider's message or the providers not taking enough time to communicate effectively" (Murthy, 1999).

Almost similar view was echoed in a study of conducted by Manisha Gupte and other in rural areas of Pune district, Maharashtra during 1996. The study found that for women, doctors' attention to them, respect shown to them and sex of doctor attending to them were the quality indicators. Women also perceived doctors' empathy, concern counselling and confidentiality as important elements of health care (Gupte, 1999).

A work of Leena Sumaraj (1991) with a sample of 480 women cases from Ayurvedic and Allopathic hospitals reflected that availability of doctors at the time of visits, was one of the important indicators of quality of care considered by women. Observations made during study revealed that longer the treatment that female availed in the hospital, the better was the opinion the hospital obtained.

In another qualitative work on clients' perspective of the quality of care in health service by Dr. Zamir (2002) clients visiting FPAI clinics were asked to describe care. Women clients' description indicated this as a combination of drugs, doctor and service. The component of doctor in their description of care involved doctors' behaviour. Dr. Zamir divided twenty seven characteristics related to the doctor mentioned by clients into four domains as stated in the following Box.

In the same study clients used three different subjective frames to assess quality of care, namely exposure, experience and expectations. Exposure was described as visits made to different hospitals / clinics, availability of doctor and service. Experience was described in terms of cure and care. Expectation was described as the level of satisfaction derived from visiting the hospitals / clinics. Comparing clients assessment of three kind of clinics – government, private and FPAI, the study concluded that client found government services unreliable, limited, no information gained, providers talked little about care, did not touch them for check ups and communication with them was one way. Clients felt that their expectations were not met at the government clinics.

Clients' Perspective

Characteristics of FPAI doctor

- *Counselling*
  - *Listens*
  - *Explains*
  - *Advises*
  - *Ask Questions*
  - *Informs*
  - *Understands clients*
  - *Psychological*
  - *Provides Emotional Support*
- *Interpersonal communication*
  - *Talks affectionately*
  - *Good natured*
  - *Smiles*
  - *Does not get angry scold*
  - *Is not disrespectful*
  - *Acts as one of family*
  - *Satisfies expectation*
- *Social Concern*
  - *Takes proper care of the poor*
  - *Does not distinguish between Rich and poor*
  - *Helps in the hour of need*
  - *Visits village / home*
  - *Visits repeatedly*
- *Job related*
  - *Does not just write prescriptions*
  - *Explains the prescription Through checkup*
  - *Informs about precautions*
  - *Tells when to come next*
  - *Informs about effects of drugs*
  - *Does not prescribe unnecessary medication*

Adapted from: Zamir, 2002

Similarly another study on customers' as well as providers' study of Rameshan and Singh, (2005) indicated that customers' satisfaction level with the current services of PHCs differed. Skills and dedication of doctors, quality and operations of various facilities, registration procedure, availability of basic services, free medicines from doctors and punctuality of doctors and staff were some of the reasons for

customers' satisfaction / dissatisfaction on current services of PHCs. Important factors that contributed to the quality determination cited in the study were availability of facilities and the behaviours of doctors and staff, skills and commitment of staff, commitment and competency of doctors, greediness of doctors and staff and apathetic attitude of doctors, staff of district health officials.

Same trends emerged from a comparative study of users' perspective of the quality of family planning services in a public sector unit and a non government clinic run by a charitable private trust hospital of Vadodara city by (Joshi and Mirani, 1999). Women users using NGO clinic found doctors better skilled and the provision of privacy in consultation room to be better than in the government clinics. While users felt more free to ask questions to providers at the government clinics due to less social distance, few received satisfactory answers to their questions. The study had concluded that providers from both public and private sector needed to incorporate client responsive and bias free counselling to improve / enhance their efficacy.

However majority (70-85 percent) of women respondents in a quality assessment study of twelve Community Health Centres (CHCs) of Vadodara district had reported that providers were co-operative and friendly during consultations and had encouraged the women to ask questions. Women were satisfied with the answers given to them by

providers. Like other studies mentioned earlier, this study also reported that considerable scope existed in government sector health facility is such as CHCs to improve the quality of services particularly in the area of privacy, explaining to the patient about her problem/disease, how to take medicine and when to return to the clinic for follow up services as it was explained only to 57 percent, 44 percent, 43 percent and 50 percent of women respectively.

The most recent qualitative study to document women's perception and experiences of mental health services in the state of Gujarat with specific reference to quality of care included indepth interviews with 30 women seeking care from the public hospitals and hospital for mental health in Vadodara and Ahmedabad and a private practioner in Vadodara and village of Devgadh Baria. The study revealed that Women's overall experiences as out patients and in patients in government hospitals have not been good and that quality of care is perceived as poor.

The client provider communication was found wanting and no privacy was available during physical checks ups or counseling. Women's comfort with doctor and appreciation of their emotional support were some of the positive findings of the study. Dissatisfaction with the behaviour of the staff of the hospital however emerged as an issue. A negative and careless attitude, rude behaviour and general apathy characterized the approach of the staff (Kapadia, Khanna, Mehta, 2005).

What Women Consider Supportive Behaviour in Health Care Providers

Medical Support

- Taking a complete history
- Detailed assessment of current and past violence
- Gentle physical examination
- Treatment of all injuries

Emotional Support

- Confidentiality
- Directing the partner to leave the examination room
- Listening carefully
- Reassuring the woman that abuse is not her fault and validating her feelings of shame, anger, fear and depression.

Practical Support

- Telling the patient that spouse abuse is illegal
- Providing information and telephone numbers for local resources such as shelters, support groups legal service.
- Asking about children's safety.
- Helping the patient begin safety planning.
- Scheduling a follow up visit.

Source: WHO, 2000

One of the only study on 'Giving a voice to women survivors of domestic violence through recognition as a service user group' that the researcher could find during her review search was the study by Audrey Mullender and Gill Hague (2005). The study was about finding out whether women have a voice in specialist domestic violence services in U.K. and how

effective they considered domestic violence service to be. The study project involved primary as well as secondary data and use of quantitative and qualitative methods of data and it included interviews with 112 women survivors, 82 service providers and key personality in national agencies. The study revealed that both professionals working with abused women and survivors themselves think that the absence of domestic violence service users and ex-users from decision making structures and policy making consultation is a major barrier to the development of a more effective response to domestic violence. While the study showed that there was widespread interest in the issue at policy level, there was a less effort to seek women's participation or provide resource to domestic violence programmes. Practical and attitudinal obstacles, portrayal of women as unreliable informants and decision maker were considered as some of the barrier in involving women inspite of them being 'in the experience'.

Chatterjee (1990) has presented a model comprising four factors namely Need, Permission, Ability and Availability that determine utilization of health care services by women. Need refers to the extent of ill health among women, permission is the result of social factors which dictate whether women would seek health care. Ability is determined by the economic factors which enable women to meet the cost of health care and availability of services for women includes locations, timings, nature and quality of care.

Even the survivor theory given by Gondolf and Fisher (1988) explains *"Battered women are the active survivors and not the helpless victims."* It proposes that battered women remain in abusive situations not because they have been passive but because they have tried to escape with no avail. Battered women respond to more severe abuse with increased help seeking.and the range of help sources contacted by the women increases as the batterer's anti social behaviour increases. The theory also indicates that women are likely to leave relationship when it gets clear to them that abusive, violent husband is not going to change or that he has become more dangerous.

The survivor theory emphasize on the **"System Failure"** i.e. helping sources appear to have failed to respond effectively especially when woman had tried to seek its help or when violent husband or batterer had been elusive or unresponsive to the interventions designed to address such behaviour.

Thus women's behaviour of seeking health care providers intervention, help, support for their domestic violence problem must be viewed in the context of their socio-cultural background, need to change their life situations and perception of the nature and quality of care provided to them.

And most importantly in the context of system's responsibility to respond to women survivors wherever and whenever they approach to seek help.