

Review Article

Strengthening role of health sectors in gender based violence

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ABSTRACT

Gender based violence (GBV) is a global public health concern that has only relatively recently received significant research and policy attention. GBV is a common reality in the lives of women and girls in many parts of the world, developing and industrialised countries alike. It has been recognized as a violation of basic human rights of women and of their exercise of fundamental freedom. GBV against women has now been acknowledged as a major public health issue. It affects people of all socioeconomic backgrounds and education levels. The management of GBV essentially requires combined effort of health care services, social welfare and law enforcement. The response of health services to GBV is an international priority. Although efforts have been made in this direction, the attended cases represent just the tip of the iceberg, as majority of the cases are not reported due to social pressures from family members or social stigma of defamation. Real change in these cases can only be brought about by educating healthcare providers and better law enforcement. To conclude it is therefore necessary that every member of society and organizations are duty bound to ensure that every woman lives a violence free life.

Keywords: GBV, Prevention, Health care facility, Safety plans

INTRODUCTION

The declaration on elimination of violence against women adopted by the UN General Assembly in 1993, defines violence against women as any act of gender based violence against women that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private spaces.¹ GBV occurs as a cause and consequence of gender inequities. It includes a range of violent acts mainly committed by males against females, within the context of women and girls subordinate status in society, and often serves to retain this unequal balance (Human Rights Watch, 1996). According to WHO report, among women aged 15-44 years, gender violence accounts for more deaths and disability than, cancer, malaria, traffic injuries or war put

together.² The center for diseases control in the US 3 has defined four different types of violence such as (1) Physical violence; (2) Sexual violence; (3) Threat of physical or sexual violence; and (4) Psychological or emotional abuse. Economic violence is another category of violence identified by the UN special report on violence against women. This is perpetrated usually by an intimate partner or family member and includes economic blackmail, control over money a woman earns, denial of access to education, health assistance or remunerated employment and denial of property rights.⁴ Gender-based violence against women takes many forms and occurs throughout a woman's life cycle. Heise et al⁵ describes the different forms of violence that women experience throughout their lifespan. Article 2 of the UN Draft declaration on violence against women identifies three areas in which violence commonly takes place.⁶

These includes;

- Violence occurring within the family
- Violence occurring in the general community and
- Violence perpetrated or condoned by the state

Determinants of GBV

GBV is a complex and multidimensional problem embedded within the broader socio-economic, political at a glance and cultural context with traditional norms influencing the likelihood of GBV. GBV is more prevalent in situations of political, social and economic inequity and conflict; as well as in patriarchal societies with rigid notions of manhood, weak institutions, poor access to information and poor reinforcement of human rights; societies where violence is socially accepted as a means to settle inter-personal disputes. Female empowerment might increase GBV temporarily when traditional gender roles are challenged, but living in a community where women are empowered and have higher socio-economic status is protective against GBV.^{7,8} Poverty and lack of economic opportunities make men more likely to engage in violence and substance abuse, increasing the risk of GBV, World Bank, 2000. The odds of domestic violence are about six times higher when the husband gets drunk frequently, compared to not at all.⁹ The risk of GBV is particularly high among prostitutes, where the perpetrators commonly include law enforcement officers, e.g. 49 percent of female sex workers in Bangladesh had been raped and 59 percent beaten by the police within the previous year. A less obvious high-risk group is females with disabilities.¹⁰

Magnitude of GBV

GBV is arguably the most widespread of all human rights violations, a pervasive and systemic public health issue affecting all socio-economic and cultural groups throughout the world at a high cost to the individual and society. Worldwide, an estimated one in three women will be physically or sexually abused; and one in five will experience rape or attempted rape in their lifetime (WHO, 1997). The large majority of GBV takes place in the home, where the victim often experiences repeated attacks.¹¹ Sixty to 80 percent of sexual perpetrators are males known to the victim.¹² While men might be exposed to GBV the health impacts on women are often more severe. From 1993 to 2001 about 33 percent of all US female homicide victims, but only four percent of males, were killed by an intimate partner (US Department of Justice, 2003). Studies from developing countries report somewhat similar findings.¹³ The prevalence and incidence rate² of GBV varies depending on the type of violence and the population included in the study. Most studies focus on DV, IPV, or SV. GBV is often seriously underestimated due to measurement problems, the sensitivity of the issue, stigma and ethical concerns. Most

studies use non-standardized methodologies and comparability is rarely possible. Demographic Household Surveys (DHS) use standardized sentinel questions and modules. The prevalence is substantially higher and closer to the true value with the use of modules.

GBV as major public health problem

A large body of evidence documents the often severe and long lasting impact of GBV on human health including, but not limited to: (i) fatal outcomes; (ii) acute and chronic physical injuries and disabilities, (iii) serious mental health problems and behavioral deviations increasing the risk of subsequent victimization and (iv) gynecological disorders, unwanted pregnancies, obstetric complications and HIV/AIDS. GBV has devastating consequences, not only for the person who experiences it, but also those who witness it, in particular children. Victims of GBV often have severe feelings of guilt and are stigmatized and blamed by family, friends, and society. This often compounds the damaging consequences of GBV (WHO, 2002). GBV undermines the dignity, autonomy and security of the victims; and the overall social and economic development of the entire society, hereby often re-enforcing gender inequalities.

Economic impact of GBV

In 1993 the World Bank estimated that nine million Disability Adjusted Life Years (DALYs) are lost annually, alone, due to IPV. While this might be an over estimate, domestic violence and rape ranks higher than cancer, motor vehicle accidents, war and malaria in the global estimates of selected risk factors for increased morbidity, disability and mortality, accounting for an estimated 5 to 16 percent of healthy years of life lost by females aged 15 to 44 years of age WHO, 2002. The costs of GBV and the impact on economic growth and poverty reduction are substantial, but the estimates of costs vary substantially based on the data and methodology used, the inclusion or exclusion of different categories, and the monetary value allocated to human life and suffering. Most, of the few studies available, are from High Income Countries and largely based on crime reports, hospital records and surveys, underestimating the true prevalence and not including the impact of witnessing or being the victim of GBV as a child. The most commonly used approach is the accounting methodology incl. (1) direct costs due to expenditures on prevention, health care etc. (2) indirect costs due to lost productivity, impaired quality of life and cost of time.

Gender-based violence in India

A majority of the studies related to gender based violence in India are about intimate partner violence. These studies have found that violence perpetrated by the husband on his wife is very common and experienced by a large number of women in the country. Most of these studies are based on self-reporting by women and/or their

husbands in community surveys. There are also a few studies based on hospital and crime-records data.

Community surveys

One of the few multi-centric studies of intimate partner violence in India was carried out by ICRW.¹⁴ This study was carried out in seven cities, namely, Lucknow, Bhopal, Delhi, Nagpur, Chennai, Vellore and Thiruvananthapuram. The study found that overall about 50% of the women had experienced physical or psychological violence at least once in their married lives. About 44 % reported at least one psychologically abusive behaviour and 40.3% women reported experiencing at least one form of violent physical behaviour. The reporting of any form of violence was highest among rural women followed by women in urban slum areas. Similar proportions of women 45% to 50% in rural and urban slum areas reported physical violence. Significantly fewer urban non-slum women reported either psychological or physical violence than rural or urban slum women.

Similar findings emerged from the NFHS II survey 1998-1999 which collected information based on self-reporting by women, of experiencing violence from an intimate partner.¹⁵ The survey found that at least 1 in 5 ever married women in India have experienced domestic violence since the age of 15 and at least 1 in 9 had experienced domestic violence in the 12 months preceding the survey.

There are a number of studies covering one or more states of India. Many of these provide information only on experience of physical assault from husbands by wives. The prevalence figures vary widely, probably as a result of varying definitions of what constitutes physical violence. Some studies have focused specifically on low-income households, and find a very high prevalence of intimate partner violence. In a study by Mahajan and Madhurima among lower caste households in Punjab, 76% of the women reported domestic violence, one third of who reported regular beatings.¹⁶ Another study by Mahajan¹⁷ in a village among scheduled castes and non-scheduled castes found that 75% of the scheduled caste wives reported being beaten.

A number of recent studies have interviewed men to find out how many of them report beating their wives. The most recent of these was by ICRW in four states in India, namely Rajasthan, Tamil Nadu, Punjab and Delhi.¹⁸ The men reported very high levels of violence, as high as 85% of the men reported engaging in at least one form of violent behaviour in the past twelve months. Seventy two percent reported engaging in emotional violence, 46% reported control, 50% reported sexual violence and 40% reported of physical violence.

There are only a couple of studies that point to the fatal consequences of gender-based violence against women.

In Western India, a study in 400 villages and seven hospitals found that 15.7% of the pregnancy related deaths in the community series and 12.9% in the community were because of domestic violence.

Another study by Seshu and Bhosale in Western India related to dowry deaths and intentional injuries found that 59% of women had experienced physical violence, 28% mental torture, 10% molestation by family members and perversity, and 3% starvation.

Hospital-based studies

A hospital based study investigating casualty records in Mumbai by Daga, Jejeebhoy and Rajgopal found that as many as 23% i.e. almost one in four of the casualties could be classified as definite cases of domestic violence. Women attributed the assault to family members or known persons or in case of burns; a minority of women attributed their burns to their husbands. Another 44% appeared to be possible victims of violence, but 19% refused to name the perpetrators of the assault, 9% attributed their burns to kitchen stoves and 16% appeared to be clear cases of attempted suicide. A large proportion of these women were in the age group of 20 to 34. A significant proportion of women had suffered from serious and life threatening injuries and almost one in eight had been injured because of domestic violence, one quarter of the attempted suicide cases and three in five of burn cases with burns covering half of their bodies.¹⁹

Data from crime records

Data for 1999 show that of all the crimes reported in the country, 7% constitute crimes against women. One in every five murder in 1999 in India was that of a woman. Personal enmity, property disputes, love intrigues, dowry and gain were the main reasons for the murders. The all-India rate for crimes against women per 100,000 populations was 13.8. The crime rate of cases of cruelty by husbands or relatives was as high as 4.4, for dowry was 0.7 and 0.9 for sexual harassment cases in every 100,000 population.²⁰

One study looked at the records of domestic violence complaints lodged by women in 2001 at the special cell in the city of Mumbai.²¹ The study found that complaints of violence were highest in peak reproductive years and declined significantly thereafter. The peak was in the 25-34 age group (37%), followed by 18-24 age group (28%). Only 14% of women who complained of violence were above 35 years old and only 5% were in the age group 45-54 years. It is likely, therefore, that women experiencing violence and cruelty in the household, especially in the hands of their husbands, end up as part of the suicide statistics, never to be counted among victims of gender-based violence.

Why should the health sector be involved?

Until recently, the responsibility for remedying or containing violence in most modern society's fell on the judicial system, police and correctional services, and in some cases the military. The health sector, both public and private, was relegated to the role of providing care after the event, when the victims of violence came forward for treatment.

The role of the health sector

GBV is very common, but most health care providers fail to diagnose and register GBV, not only due to socio-cultural and traditional barriers, lack of time, resources and inadequate physical facilities; but even more so due to lack of awareness, knowledge and poor clinical practices with limited direct communication and failure to do a full physical examination, not to mention register and monitor the effectiveness and quality of care. Further the fear of violence and stigma reduces many victims willingness to use health services (WHO, 1998). The large majority turns to informal networks of friends and community members for help.¹⁴ The health sector can minimize the prevalence and impact of GBV though improved:

1. Primary prevention; e.g., promote community awareness and prevent GBV.
2. Secondary prevention; e.g., early identification, confidentiality, monitoring and respectful treatment of survivors addressing physical, mental and reproductive health care needs.
3. Tertiary prevention; e.g. more long-term counseling, mental health care and rehabilitation.
4. Referral to social, economic and legal support.
5. Improving the patient provider interaction is the most feasible, affordable and efficient intervention within any health care system aiming to address the survivors of GBV effectively. Many countries are building capacity to prevent and manage GBV, and while the effectiveness of the various approaches still needs to be evaluated, there is no doubt that violence is preventable.

With the recognition of gender-based violence as a major public health and human rights issue over the past two decades, gender-based violence has begun to feature in the agendas of international health organizations and government health sectors.

A resolution passed by the Pan American Health Organization (PAHO) in 1993 urged all Member States to establish national policies and programmes to prevent and manage gender-based violence. The world health organization followed suit with a World Health Assembly resolution in 1996 that declared violence against women

as a public health priority.²² Professional associations in a number of industrialized countries have developed protocols for identifying and managing women affected by intimate partner violence and sexual assault. National health sector policies in many latin American countries have included guidelines for addressing gender-based violence, and pilot programmes to train health professionals are on-going in many developing countries around the world.²³

The potential role of health care providers

Health providers are in a unique position to intervene in preventing and managing the health consequences of gender-based violence. This is because health facilities are probably the only public institution that almost all women will come in contact with at some point in their lives, for pregnancy and delivery-related care and contraception or in the process of seeking health care for their children.

Also, women who are victims of sexual assault are required to be brought to health facilities by the police, and those who have been seriously injured physically come to the emergency department of hospitals for immediate care. A health provider who is well informed and trained to manage the victims sensitively could make a world of difference to the woman traumatized by the assault. Negative attitude towards the woman experiencing violence, including the belief that the women may have provoked the violence or that women who continue to stay in violent relationships have only themselves to blame, may be another factor that prevents the health provider from responding sympathetically to a woman suspected to be experiencing violence.²⁴ The lack of institutional support and the absence of clear institutional policy and guidelines may be other reasons that come in the way of a sympathetic and proactive role by health providers when dealing with women experiencing gender violence. There is need to develop context-specific guides to help the health care provider.

Supporting women who disclose violence or abuse

The very act of asking a woman about abuse and listening to her disclosure with empathy and sensitivity is an act of support. It helps women feel that the violence is not their fault, and can be the beginning of a process of changing their situation. What do women disclosing violence want of health care providers? A study from Wisconsin, USA of 115 women who had been battered by their male partners offers some insights. According to them, supportive behaviour would include the following²⁵:

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 room
- Listening carefully
- Reassuring the woman that the 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 and legal services
- Asking about the children's safety
- Helping the patient begin safety planning²⁵

Detailed documentation

Careful documentation of the injuries and symptoms with which a woman presents, as well as of the history of abuse is another way in which health providers can help. Documentation should not only include the nature of injuries and symptoms but also the identity of the abuser as reported by the woman and the nature of his relationship to the woman. This will help future medical follow-up. In case the woman takes legal action, such documentation of a history of abuse by a health provider would prove to be powerful supporting evidence.²⁶

Safety plan

Another action that health care providers can take to help women experiencing intimate partner violence is to review a safety plan with them. The following is a list of issues to discuss with the women, whether or not they are thinking of leaving the abusive relationship.²³ They could draw on these to develop their own specific safety plan as appropriate. Developing a safety plan could help the woman to be prepared to leave the relationship safely in case the violence accelerates.

Supportive institutional environment

The support available to health providers within their health facilities could make an important difference to how effectively they can undertake the task of screening for and providing support to women experiencing

violence.²⁷ For example, if the top management of a hospital considers gender-based violence interventions an important priority, then a number of initiatives can be undertaken within that hospital that would strengthen the efforts of individual providers. This could be included as:

- Training all staff members who interact with patients, from the security guard at the gate to the receptionist and the pharmacist;
- Making available health education material and information material on gender based violence and organizations that provide support at strategic points in several departments of the hospital.
- Providing adequate physical space for the departments which screen women experiencing violence to ensure privacy, confidentiality and safety.
- Displaying prominently posters which mention that patients are encouraged to talk to health care providers about their experiences of violence and most importantly.
- Developing an integrated institutional protocol which clearly states what different levels of staff are expected to do when they encounter a woman who has experienced gender-based violence.

Principles of good practice

The past few decades of experience in addressing gender-based violence has led to a number of lessons learnt on good practice. These may be summarized as follows.^{13,26}

- Both national and local level actions are needed to address gender-based violence. National policies play an important role in creating formal mechanisms and in adopting standard norms. For abused women to have access to the services they need, these national actions have to be backed by coordinated community-level initiatives.
- Action is needed across sectors in order to provide an adequate and timely response especially to low-income women.
- The safety of women should guide all decisions relating to interventions. No intervention should be developed that could potentially jeopardize the woman's safety.
- Training alone does not help. Training has to be accompanied by changes in institutional cultures in a direction that supports its staff's involvement in GBV issues, and provides adequate recognition and resources.

There is a need to establish a strong network with other groups working on this issue like women's organizations, crisis shelters for women, legal support groups, help lines, counseling services and the police. And therefore, a health system that is geared to respond to the needs of the

women facing violence must be able to maximize and expedite women's access to relevant services. Any system to help victims of violence who reach the health system needs to be identified and necessary help provided. But any structures that are put in place have to be sustainable. If interventions should cease to be pilot projects in few institutions and on the contrary should become pervasive, sustainable and replicable across the entire health system then it is important to devise them, from national and international experiences and which can be run from within the existing structures.

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