

OXFORD INDIA STUDIES IN CONTEMPORARY SOCIETY

**EQUITY
AND ACCESS**
HEALTH CARE STUDIES IN INDIA

edited by
Purendra Prasad
and
Amar Jesani

OXFORD
UNIVERSITY PRESS

Violence against Women as a Health Care Issue

Perceptions and Approaches

Sangeeta Rege and Padma Bhate-Deosthali

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

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

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

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

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

A woman comes for an abortion for an unwanted pregnancy resulting out of rape. She reports that a medico-legal examination was done a month back but she was not provided an emergency contraception (EC) to prevent the pregnancy.

The post mortem reports of women killed in the communal riots in Gujarat 2002 made no mention of the sexual violence inflicted on them—There were injuries related to insertion of rods in vagina (MFC report).

Patient reports to the hospital with a history of consumption of a bottle of insecticide and doctors record it as accidental consumption of poison. (Deosthali and Malik 2009)

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

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

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

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

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

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

PREVALENCE OF VIOLENCE AGAINST WOMEN

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

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

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

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

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

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

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

HEALTH CONSEQUENCES OF VIOLENCE AGAINST WOMEN

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

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

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

HEALTH PROFESSIONALS' PERCEPTIONS OF VIOLENCE AGAINST WOMEN

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

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

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

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

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

CURRENT INTERVENTIONS ON VIOLENCE AGAINST WOMEN AS A HEALTH CARE ISSUE

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

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

Hospital-based Crisis Centre to Respond to VAW

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

(Deosthali and Malik 2009). The main objectives of the centre was to equip the health professionals to understand VAW as a health issue and respond to women in a sensitive manner. The second objective was to create psychosocial services within the hospital for women who wanted support in dealing with the violence. Dilaasa represents a redesigned 'one-stop crisis centre' (OSCC), focusing on delivering an integrated response to VAW within the existing roles and responsibilities of health professionals. The model has been found to be more sustainable than a traditional OSCC where a separate cadre of specialists is brought into the hospital setting (Garcia-Moreno 2015).

Women either report violence spontaneously or in response to questions from health care providers prompted by signs and symptoms presented in the outpatient or inpatient consultation. Once identified, they are provided medical treatment, their history of abuse is documented, evidence is collected in case of sexual violence if appropriate, medico-legal support offered and they are told about the Dilaasa crisis intervention centre. The hospital has put up posters and distributed cards, and pamphlets to create awareness about VAW as a public health issue. In instances of sexual violence, health professionals have been trained to use the WHO protocols for medico-legal care in sexual violence. This has enabled health professionals to understand circumstances of sexual violence, reject unscientific aspects such as finger test, hymenal status; conduct a gender sensitive examination along with evidence collection; provide reasoned medical opinion, and explain the absence of injuries and/or absence of forensic evidence which helps survivors in courts (American Medical Association 1992).

Besides equipping health professionals to play a comprehensive role, another core function of the hospital-based centre is that of psychosocial support and crisis intervention services. Such services were conspicuous by their absence in health system. Counselling principles followed by the crisis centre help women to put the onus of abuse on the perpetrator and take away blame from themselves. It also equips women with the necessary tools and strategies to heal from abuse as well as stop it. These principles though drawn from the women's movement in India as well as from literature on feminist counselling in the west, were customized to the context of a public hospital, and a methodology of counselling has also been developed (Bhate-Deosthali, Rege, and Prakash 2013; Rege 2010).

Modelled on the Dilaasa crisis centre is another hospital-based crisis centre set up by the Northeast Network (NEN) (WHO, CEHAT,

MoHFW 2016). Northeast Network, in the course of their work in Meghalaya, found that women faced several health concerns especially related to reproductive health because of the violence faced at the hands of their partners, but were unable to do anything about it despite reaching hospitals for treatment. This prompted them to carry out an assessment at a civil hospital in Shillong to understand the hospital response to VAW. They were alarmed to see that health professionals did not recognize violence as a concern that affected health. In order to ensure that women facing violence receive counselling services, NEN actively worked upon the referral system with the women's hospital in Shillong and after four years of persistence were successful in establishing a crisis centre within the hospital in 2011. Allotting of physical space to the centre and terming it as a crisis centre lent legitimacy to the issues of VAW within the hospital. Efforts are underway to get the crisis centre of the hospital recognized as a department of the hospital.

Another unique effort has been by a feminist organization, *Swati* (WHO, CEHAT, MoHFW 2016), based in rural Gujarat. *Swati* has been actively working on the issue of VAW and has played an important role in equipping rural women to deal with systems such as the police, judiciary, and panchayat and to demand their rights and ensure that they get justice. However they encountered problems with the health system when women accessed health services for violence-related care. This prompted *Swati* to start a dialogue with a community health centre (CHC) in one of the rural areas where they work. The dialogue led to the hospital authorities asking *Swati* to conduct training sessions for nurses and doctors on the issue of VAW. Engagement with the hospital led to a shared understanding that the hospital needs to respond to VAW, but that it did not have social workers and was already understaffed. *Swati* stepped in with a trained cadre of women volunteers from several villages that started providing psychosocial services at the level of the hospital. The relationship with the CHC eventually led to the creation of a dedicated space within the hospital for these services.

Strengthening Linkages with the Health System through Referrals

Since 2001 some organizations have liaised with the health system to facilitate availability of psychosocial services to women and children facing violence. These services are either based in the hospitals or in close proximity to hospitals. *Sneha*, a Mumbai-based organization, founded by health professionals and social workers found that hospitals cater to

the physical needs of women facing violence through medical treatment (WHO, CEHAT, MoHFW 2016). But beyond that women had no option but to continue to face abuse. *Sneha* recognized the urgent need to ensure that psychosocial services be provided to women facing any form of violence. This led to linking with the tertiary care hospital, where those women facing abuse could receive services from the *Sneha* counsellors. The allocation of space in the urban health centre of the public hospital and the availability of NGO counsellors made it possible for women to access psychosocial services. *Anweshi*, an organization based in Kozhikode, Kerala, is making similar efforts (WHO, CEHAT, MoHFW 2016). They have been providing counselling services, free legal aid, and shelter services to women facing violence. They have approached the Calicut Medical College to start referral services where women could start accessing different services of the *Anweshi* counselling centre.

Engagement with the Primary Health Care System and Accredited Social Health Activist Workers on Violence against Women

Efforts have also been made at the primary health care system to address VAW. Within the Indian health care setting, the health workers at the community level such as the Accredited Social Health Activist Workers (ASHAs), Auxillary nurse Midwife (ANM), Integrated Child Developmental Services (ICDS) workers, can be instrumental in increasing awareness on VAW, its health consequences and provide information on available services to respond to violence at the community level. One such initiative called *Soukhya* has been set up at primary health care centres in collaboration with St John Medical College, Bangalore to respond to domestic violence survivors (WHO, CEHAT, MoHFW 2016). The programme involves three cadres of municipal primary health care workers such as doctors, nurses, and community workers. Doctors are tasked with mentoring and supervising nurses and community link workers and assisting in responses to complex cases of VAW. Nurses, who are providing the bulk of primary care services, are responsible for identifying women facing violence, explaining the health impact of violence, and referring them to a social worker. Community-link workers, who are residents of the communities served by the health centre, primarily engage in outreach; for example, they identify pregnant women and mothers of young children and motivate them to seek antenatal, postnatal, and immunization services and have integrated an awareness initiative on VAW in their routine work.

Developing a Cadre of Community Health Workers to Respond to Violence against Women

Masum, a community-based women's organization working in Pune for almost three decades found that women faced oppression in their personal lives as well because of their caste and religious affiliations that resulted in violence (WHO, CEHAT, MoHFW 2016) but they were often hesitant to seek health care because the moment a medical diagnosis had been made they would be sent back to their natal families, especially if they suffered tuberculosis or had a mental health concern. Hesitation on the part of women to access health services and lack of specific systems and norms in the formal health system to address violence prompted Masum to develop community-based interventions to address these issues. Masum has trained a cadre of women health workers from the community equipped with knowledge of women's body and women's health, information about health issues and their management, using local herbs for common ailments. Masum has also engaged the ICDS and Accredited Social Health Activists (ASHA) workers on the issue of VAW and has imparted training programmes to facilitate interlinkages between violence and health and enable these workers to create awareness on such links.

Advocacy Efforts for Health System to Recognize Violence against Women

Advocacy initiatives have been carried out by organizations to improve the health care response to VAW. Sama and Tathapi have engaged both public and private health providers on the issue of VAW. They have carried out research to identify the gaps in responses of the health sector and the need for them to carry out their roles under the law in a systematic manner. Sama has actively worked since 2009 to bring the issue to the Jan Swasthya Abhiyan (JSA) platform.

Vimochana, a Bangalore-based feminist organization, has actively worked with the health system for two decades (WHO, CEHAT, MoHFW 2016). Their work with the health system has been primarily on the issue of burns reported by women and the health care response to it. When they began their work at the hospital, it started as an investigative process of determining whether the burns in women were homicidal, suicidal, or accidental. Vimochana's work has shown that in most instances of burns in women could be homicidal, but women succumb

to family pressure, and worry for their children's future prevents them from disclosing the homicide. While Vimochana continues to work with families of women who have suffered burns and ensures access to justice for them, it also engages the health system to treat women with burns in a humane and dignified manner. In the course of Vimochana's work they pressed for infrastructural changes in the burns wards and ensured proper diets for women as both were severely lacking in the hospital. They have steadily advocated for the improvement of recording related to dying declarations by health professionals.

Government Initiated One-Stop Crisis Centres in Hospitals

Taking a cue from the different civil society initiatives along with a legal mandate for the health sector under the prevention of domestic violence act (PWDVA 2005), the Kerala state health department through its NRHM programme set up one stop centres called Bhoomika (WHO, CEHAT, MoHFW 2016). By 2011, these centres had been set up in 14 district hospitals of Kerala and are staffed with a counsellor each. Though the cadre of trained counsellors exists in the 14 districts, they have a heavy caseload. This does not permit them to undertake in-depth counselling and they often have to refer women to other counselling centres. There is little integration of these one-stop centres with the rest of the hospital activities. There is a need for establishing a model that includes participation from different cadres of health professionals in order to create a more integrated approach to the issue of VAW.

There is no single model for addressing VAW in the health sector. The three prominent models namely, ecological model, a multi-sectoral approach, and systems approach have informed the manner in which countries have designed national action plans, policies, and protocols (Columbini, Mayhew, and Watts 2008).

The ecological model has been applied in the primary health care approaches to respond to violence against women as it helps health professionals to identify risk factors and consider them for development of strategies to reduce the risk through broad-based prevention programmes. The model focuses on individual, relationship, community and societal factors, which increases risk of women facing violence. Factors such as early age of marriage, isolation, young age have been identified as individual risk factors. Similarly, a host of factors have been identified at relationship, community, and societal levels. The application of the ecological model is reflected in the work by Masum and Soukhya at the

level of primary health care, where health professionals and community health workers are equipped to identify risk factors and develop response with a focus on not just individual health needs but also on creating awareness amongst communities to aim for social change.

The multisectoral approach involves different stakeholders in responding to VAW. Implementing such an approach involves a coordinated response among agencies providing psychosocial support, legal aid, and shelter services and police aid. So a single sector is not responsible for the provision of all services. Such an approach is reflected in the efforts made by Sneha and Anweshi as they include inter-sectoral coordination to ensure comprehensive services for women facing violence as well as monitor referral networks to ensure that women are informed about their services.

The systems approach speaks of direct responsibilities of health service delivery organizations. This approach focuses on building skills and resources across an entire organization and not just individual health professionals. It aims to build an institution where the professional culture of an organization is changed and health professionals are convinced that responding to VAW is a part of their job responsibilities. Key elements of a systems approach would entail improving health professionals knowledge and skills about VAW, improving knowledge on national laws on VAW and role of the health sector, strengthening policies related to privacy and confidentiality of women reporting violence through improvement in clinical and infrastructural policies, drafting protocols for care and support to women facing violence, strengthening medical records and information systems, and ensuring the availability of educational and awareness materials for patient population.

Models such as the Dilaasa focus on the health care delivery approach as whole and integrate the response to VAW in the role of health professionals. Such an integrated approach is closely linked to systems approach where health professionals are equipped to screen women for violence, provide medical care, and basic emotional support followed by a referral in the same health facility to a counselling department.

This chapter presents various interventions with health system and health professionals for improving response to VAW by different organizations including initiatives by the government. However, few approaches have been properly evaluated and hence it is a challenge to motivate the

government to replicate such efforts. Despite legislation on responding to violence against women and the explicit role of the health sector, there are several challenges in implementing these roles on the ground. One of the reasons is the lack of technical and financial resources for implementation of health sector roles.

The preoccupation is with OSCCs and this is true of South Asia. The WHO Guidelines (2013) recommend that the ministries of health must adopt various models for provision of care at different levels of the health system and not focus narrowly on a single model for the entire country. The integration of VAW within clinical care is recommended at all levels from primary to tertiary levels notwithstanding the presence of a full-fledged OSCC. This is an important recommendation as low- and middle-income countries have limited resources across various sectors and OSCCs are highly resource-intensive. However, in India there seems to be fixation on OSCCs. The Ministry of Women and Child Development (MWCD) is currently charged with the setting up of one-stop crisis centres across the states with dedicated budgets (The Ministry of Women and Child Development 2016). Unfortunately, these centres are stand-alone crisis centres and no efforts are being made to foster collaborative partnerships with the health system to support these crisis centres. Nor are these crisis centres located in the hospitals despite global evidence on the utility of health institution based responses to VAW (World Health Organization 2013: 37).

The Ministry of Health and Family Welfare (MoHFW) has recognized VAW as an issue only after the massive campaign post the brutal sexual assault and murder of a young physiotherapist in December 2012. Taking cognizance of the abysmal response to rape by health professionals, the MoHFW has formulated comprehensive medico-legal guidelines for survivors of sexual violence in 2014 (Verma, Seth, and Subramaniam 2013). A multisectoral advisory committee was established for the drafting of these guidelines that focus on therapeutic care as well as medico-legal aspects of sexual violence. Despite this progress, the draft NHP 2015 did not include VAW as a health care issue. The guidelines drafted by the advisory committee are an important step and it is now critical that different states in India ensure that these guidelines are adopted and implemented uniformly. However, these cover only sexual violence and not domestic violence.

The World Health Organization clinical guidelines of 2013 have been developed focusing on low- and middle-income countries and the specific recommendations made need to be translated into a clear policy

document of a health systems response to VAW by the MoHFW. In the absence of a clear policy the response will remain chequered and not systematic.

The health system in India has been slow in recognizing VAW as a health care issue despite a legal mandate for health professionals to respond to survivors of violence. Several promising interventions are in place that demonstrate what can be done by health workers and how the response can be integrated within the system. There is a need to develop a systems response so that individual doctors and nurses who respond to specific needs of survivors are supported by hospital-based interventions and clear policy guidelines and protocols.

REFERENCES

- Agrawal, S., A. Banerjee. 2015. 'Perception of Violence against Women among Future Health Professionals in an Industrial Township', *Industrial Psychiatry Journal* 19(2): 90–93. Available at: <http://doi.org/10.4103/0972-6748.90337>. Accessed on 7 August 2016.
- American Medical Association. 1992. *Diagnostic and Treatment Guidelines on Domestic Violence*. American Medical Association. Available online at: http://www.ncdsv.org/images/AMA_Diag&TreatGuideDV_3-1992.pdf.
- Bacchus, L., S. Bewley, C. Fernandez, H. Hellbernd, S. Lo Fo Wong, S. Otasevic, L. Pas, S. Perttu, and T. Savola. 2012. *Health Sector Responses to Domestic Violence in Europe: A Comparison of Promising Intervention Models in Maternity and Primary Care Settings*. London School of Hygiene & Tropical Medicine: London. Available online at: <http://diverhse.eu> and <http://diverhse.org>.
- Bhate-Deosthali, Padma 2016. *Neither Evidence nor Care: Situational Analysis of Health Sector Response to Sexual Violence*. Geneva: WHO.
- Bhate-Deosthali Padma and Ravi Duggal. 2013. 'Rethinking Gender Based Violence and Public Health Policies in India Insights from Dilaasa, Mumbai, India'. In *Gender Based Violence and Public Health-International Perspectives on Budgets and Policies*, Nakray Keerty (ed.), pp. 184–96. London: Routledge.
- Bhate-Deosthali, Padma, Sangeeta Rege, and Padma Prakash. 2013. *Feminist Counselling Practices in Domestic Violence*. New Delhi: Routledge.
- Chowdhary, N. and V. Patel 2008. 'The Effect of Spousal Violence on Women's Health: Findings from the Stree Arogya Shodh in Goa India', *Journal of Postgrad Medicine* 54(4): 306–12.
- Columbini, M., S. Mayhew, and C. Watts. 2008. 'Health Sector Responses to Intimate Partner Violence in Low- and Middle-income Settings: A Review of Current Models, Challenges and Opportunities', *Bulletin of World Health Organisation* 86(8): 635–42.

- Deosthali, Padma. 2013. 'Moving from Evidence to Care: Ethical Responsibility of Health Professionals in Responding to Sexual Assault', *Indian Journal of Medical Ethics* 10(1): 2–5.
- Deosthali, Padma and Seema Malik. 2009 'Establishing Dilaasa: A Public Hospital Based Crisis Centre'. In *NGOs, Health and the Urban Poor*, Vimla Nadkarni, Roopashri Sinha, and Leonie D'Mello (eds), pp. 140–60. Mumbai: Rawat Publications.
- García-Moreno, C.H., C. Jansen Watts, M. Ellsberg, and L. Heise. 2005. *WHO Multi-country Study on Women's Health and Domestic Violence against Women Initial Results on Prevalence, Health Outcomes and Women's Responses*. Geneva: World Health Organization.
- García-Moreno Claudia, Cathy Zimmerman, Alison Morris-Gehring, Lori Heise, Avni Amin, Naeemah Abrahams, O. Montoya, P. Bhate-Deosthali, N. Kilonzo, and C. Watts. 2014a. 'Addressing Violence against Women: A Call to Action', *The Lancet* 385(9978): 1685–95.
- García-Moreno Claudia, Kelsey Hegarty, Ana d'Oliveira, Flavia Lucas, Jane Koziol-MacLain, Colombini Manuela, and Feder Gene. 2014b. 'The Health-Systems Response to Violence Against Women', *The Lancet* 385(9977): 1567–79.
- García-Moreno, C.C. Kelsey Hegarty, Ana Flavia Lucas d'Oliveira, Jane Koziol-McLain, Manuela Colombini, and Gene Feder. 2015. 'The Health-Systems Response to Violence against Women', *The Lancet*, 385(9977): 1567–79.
- Government of India. 2005. *The Protection of Women from Domestic Violence Act (PWDVA), 2005*. Available at: <http://ncw.nic.in/acts/TheProtectionofWomenfromDomesticViolenceAct2005.pdf>. Accessed on 7 August 2016.
- . 2012. *The Protection of Children from Sexual Offences Act 2012*. Available at: <http://wcd.nic.in/sites/default/files/childprotection31072012.pdf>. Accessed on 7 August 2016.
- . 2013. *The Criminal Amendment to Rape 2013*. Available at: <https://www.iitk.ac.in/wc/data/TheCriminalLaw.pdf>. Accessed on 7 August 2016.
- International Institute for Population Sciences (IIPS). 2009. *National Family Health Survey (NFHS-3) India 2005–06*. Mumbai: International Institute for Population Sciences.
- Johri, M., R. Morales, J. Boivin, B. Samayoa, J. Hoch, C. Grazioso, I. Matta, C. Sommen, E. Diaz, H. Fong, and E. Arathoon. 2011. 'Partner Violence During Pregnancy in Guatemala: A Cross-Sectional Study', *BMC Pregnancy Childbirth* 11(49): 1–12.
- Koski, A.R. Stephenson, and M. Koenig. 2011. 'Physical Violence by Partner during Pregnancy and Use of Prenatal Care in Rural India', *Journal of Health Population and Nutrition* 29(3): 245–54.
- Kumar, Radha. 1993. *The History of Doing: An Illustrated Account of Movements for Women's Rights and Feminism in India 1800–1990*. New Delhi: Zubaan.

- Kumar, S., L. Jeyaseelan, S. Suresh, R. Ahuja, and India Safe Streeing Committee. 2005. 'Domestic Violence and Its Mental Health Correlates in Indian Women', *The British Journal of Psychiatry* 187(1): 62–7.
- Medico Friend Circle (Bombay, India). 2002. *Carnage in Gujarat: A Public Health Crisis*. Pune: Medico Friend Circle.
- National Crime Records Bureau. 2014. *Crime in India 2014*. Government of India, New Delhi: Ministry of Home Affairs, National Crime Records Bureau.
- Rege, Sangeeta. 2010. *Guidelines for Counselling Women Facing Violence*. Mumbai: CEHAT.
- Subha Sri, B. 2010. 'Women's Bodies and the Medical Profession', *Economic & Political Weekly* 14(17, 24 April).
- The Ministry of Women and Child Development. 2016. *One stop centre scheme: Implementation Guidelines for State Governments/UT Administrations*. Available at: <http://wcd.nic.in/sites/default/files/Final%20Approved%20Guideline%20OSC%20%20%281%29.pdf>. Accessed on 7 August 2016.
- Verma, Justice J.S., Justice Leila Seth, Gopal Subramaniam. 2013. *Report of the Committee on Amendments to Criminal Law*. Available at: <http://www.prsindia.org/uploads/media/Justice%20verma%20committee/js%20verma%20committe%20report.pdf>. Accessed on 9 August 2016.
- WHO, CEHAT, and Ministry of Health and Family Welfare. 2016. *Report on Best Practices in Health Sector for Responding To Violence Against Women*. Bangalore: CEHAT and WHO.
- Williamson, Emma. 2013. 'Measuring Gender Based Violence—Issues of Impact and Prevalence'. In *Gender Based Violence and Public Health—International Perspectives on Budgets and Policies*, Nakray Keerty (ed.), pp. 65–78. London: Routledge.
- World Health Organization. 1997. *Violence against Women a Priority Health Issue*. Geneva: WHO. Available at: http://www.who.int/violence_injury_prevention/media/en/154.pdf. Accessed on 7 August 2016.
- . 2013. *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines*. Geneva: World Health Organization.