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Editorial

Violence against women in India: Comprehensive care for survivors

Violence occurs in about 35 per cent of women globally in their lifetime[1]. In a study done in India, on about 10000 women, 26 per cent reported having experienced physical violence from spouses during their lifetime[2]. The prevalence could be as high as 45 per cent as indicated by data from Uttar Pradesh[3]. Latest figures from the National Crime Records Bureau[4] show that a crime was recorded against women every three minutes. Every hour, at least two women are sexually assaulted and every six hours, a young married woman is beaten to death, burnt or driven to suicide. It is appalling to learn that 28.4 per cent of pregnant women suffer domestic violence[5]. As a result of violence, women suffer social isolation, unemployment, income loss, poor self-care and fail to provide childcare, which is a grave concern. Multi-Country Study on Women's Health and Domestic Violence Against Women by the World Health Organization (WHO) reported that 40 and 60 per cent of women surveyed in Bangladesh, Ethiopia, Peru, Samoa, Thailand and Tanzania revealed that they had been physically and/or sexually abused by their close partners[6].

United Nations defines 'violence against women' as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life"[7] .The role of health professionals in providing care for the survivors can be better understood and addressed from the perspective of the WHO definition of 'health', which defines it as 'an individual's state of physical, mental and social well-being'[8].

Physical health: Intimate partner violence with sexual violence is associated with high risk of pregnancy, sexually transmitted diseases (STDs) and HIV infection[9]. Hence, there is a need to sensitize the doctors who will be able to immediately initiate prophylaxis for pregnancy, STDs and post-HIV exposure in survivors. Other symptoms which need to be addressed, include wounds, lacerations, cuts, bruises, contusions, menstrual disorders, vaginal discharge, dizziness, severe sexual dysfunction, and memory loss.

There should be a structured protocol for comprehensive assessment to provide holistic support in suspected cases, particularly in women presenting with physical injuries to general hospitals. Sometimes hospital admission for appropriate assessment in suspected violence may be required. District hospitals should have a full time, qualified, forensic medical professional and his/her availability could be possibly extended to *Taluk* hospitals. It should become a routine practice to compulsorily report all cases of violence against women and provide care to them. A detailed structured assessment of the survivors is to be incorporated in undergraduate curriculum and training.

Mental health: In a survey, 40 per cent of the survivors had poor mental health[10]. Violence leads to mental disorders such as depression, post-traumatic stress disorder (PTSD), anxiety disorders, self-harm and sleep disorders[9]. Chronic violence of increased severity is associated with severe depressive disorders. In a study of female psychiatric outpatients with history of intimate partner violence, 14 per cent were identified as having PTSD[11]. In another study on urban women, 22.3 per cent of them had suicidal thoughts and 3.4 per cent had attempted suicide[12]. The presenting physical symptoms may have psychological origin, *i.e*., somatoform disorders, where survivors seek cure of their imperceptible emotional distress through physical complaints. These include headache, back pain, neck pain, joint pains or stomach cramps. Psychologically, there is prevailing mistrust, loss of confidence, guilt,

shame and feelings of helplessness with particular reference to intimate partner violence.

All such patients presenting with a history of violence should undergo a standardized and simplified mental health screening, to exclude depression, PTSD and suicide risk. Some may need referral for a specialist mental health assessment. As a minimum standard, psychosocial support and counselling should be accessible and commenced early. This could be made a part of undergraduate training where students would learn to detect, counsel and refer the severely unwell survivors to specialists. There is a pressing need to develop guidelines for all cases of violence disclosed by women. Early detection, counselling and other psychological support in the long term is likely to significantly reduce psychiatric morbidity and mortality.

Social well-being: Social and economic costs of intimate partner and sexual violence have serious implications throughout our society[13]. A survey showed that only 25 per cent survivors sought help to end violence, whereas 33 per cent never told anyone[14]. The survivors hardly ever approached the police, yet felt secure in seeking physical health care in hospital settings. More often survivors return to perpetrators as they believe there is no other place to reside, which leads to further exposure to violence and it becomes a vicious circle. Women with disabilities (such as hearing, visually, speech and intellectual disabled) are highly vulnerable to sexual assault[15]. They may not be able to defend themselves during the crime and also post that fight for justice.

All district hospitals should have a woman and child welfare section with a medical social worker from the Social Welfare Department to assist survivors and also in crisis. Basic issues such as, transportation, food and also clothing are not generally addressed. All survivors should be given legal information including free legal aid. Non-governmental organizations (NGOs) working with women and children should be supported since these can contribute in providing holistic care. Community education and sensitization regarding women's rights, awareness on domestic violence act needs to be spread across all district hospitals. There is an urgent need to educate the public to stop victimizing or blaming the survivors. Family members may go through emotional distress and may not accept the survivor. Hence, there is a need to have family therapy to enable the family to cope and support the survivor.

Comprehensive care for survivors (CCS): Health and Family Welfare department of all states should work in liaison with judiciary, women and child welfare department, social welfare department, police department and NGOs to provide comprehensive care for survivors. All the sensitive issues rising out of the violence including crisis intervention, physical and mental care, legal aid, socio-economic support, temporary shelter, child custody, re-integration into society, confidence building, counselling, psychosocial support, family therapy, sexual counselling, vocational rehabilitation and follow up care should be delivered under one roof.

A supportive sensitive system needs to be developed, in which the survivor is assisted by a recovered survivor in educating, sensitizing, supporting, counselling, lodging the complaint, physical examination, fighting for justice, rehabilitation and re-integrating into society[15]. Improved socio-economic status, better education and also increased access to social support system possibly are protective factors against spousal physical violence and mental health issues[2]. There are innumerable challenges from political will to educating the society in implementing the comprehensive care programme. To address such complex issues, pilot projects need to be done in a few districts across the country. All sectors including education, health, legal, and judicial must work in liaison to address the issue[16]. There is an urgent need to train the health personnel, police department, judiciary, women and child welfare department and all other people involved in providing care.

The WHO indicates that it is necessary to recognize victims of intimate partner violence, sexual violence, or their suicidal behaviour. The individual cases of violence to women often first come to attention with health care providers. The psycho-social care is generally not available[13] and this leaves a large gap in terms of much required comprehensive care[7]. Recent WHO guidelines emphasize role for physicians and other health professionals, as key gatekeepers in efforts to monitor, identify, treat, and intervene[1].

In conclusion, violence against women creates a sense of insecurity and fear in the community. The complex issue can be tackled by providing comprehensive care pro-actively. A multi-dimensional and multi-agency team including access to psychosocial support is to be made available to deliver holistic care under one roof in district hospital setting. Also

implementing primary prevention programmes such as life skills training programme, gender sensitization and sex education in all schools and colleges will go a long way.

Vijaykumar Harbishettar[*] & Suresh Bada Math[**]
[*]University of Leeds, UK &
[**]Department of Psychiatry, National Institute of Mental Health & Neuro Sciences
Bangalore 560 029, India
[**]*For correspondence*:
nimhans@gmail.com, sbm@nimhans.kar.nic.in

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