# CHAPTER-VII

# SUMMARY, DISCUSSION, CONCLUSIONS AND SUGGESTIONS

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This chapter summarizes the major findings of the study. Highlights of the results of both the sub-studies i.e., the Women Users' Perspective Study and the Health Care Providers' Perspective study, are first presented separately and then discussion and conclusions are drawn to understand the health care system's response to domestic violence from women users' as well as health care providers' perspective. On the basis of the major findings and conclusions, the researcher has prepared a social work intervention plan for including the agenda of domestic violence in the public health care system of Gujarat.

## Summary of Results

## I. Perspective of Women Users

### *Profile of Women Respondents*

- Majority of the women respondents were young, below 40 years of age, had low educational attainment, were Hindus belonging to the reserved caste category. Most of them lived in urban areas and were not earning. However, those who earned, earned very little.

- The study included women respondents who were married recently as well as those who were married for a longer period of time and lived in nuclear families with less number of family members. Majority of the women respondents had children. There were a few women respondents (4.5 percent) who were pregnant at the time of interview. They were in that critical period of pregnancy (either, the first trimester of pregnancy or in the last trimester) when the chances of abortions / miscarriages are usually high.

- Majority of the women respondents reported that they were either poor or were from the low income group. There were 16 percent of women respondents who said that they belonged to middle income families.

Thus this study is clearly about those from the less privileged sections of the society who are in a disadvantaged position, not only because of their 'gender' but also because of their social standing; being 'less educated', 'lower in the caste hierarchy', 'economically dependent', 'recently married' or 'in a marital relationship for a long period' and being 'poor'. This study is also about those women who were young and in the most productive years of their lives.

- The study included almost an equal percentage of the women respondents (with marginal difference of 2-5 percent) from the selected five hospitals.

- Majority of the women respondents were non medico-legal cases (60.1 percent). Almost an equal percentage of inward and OPD women respondents were included in the study.

- Majority of the women respondents were seeking treatment from the selected government teaching hospitals for the first time.

***Details of Women's Health Problem, Treatment and Care***

- Majority of the women respondents of the study were those who were currently taking treatment from the hospital due to burns, hurt / injuries, orthopaedic problems, poison consumption or pain / swelling / bruises. There were almost one-third of the women respondents who were seeking psychiatric treatment at the time of the interview.

- One in every four women respondents reported that domestic violence was the cause of their current health problem. Almost one-third of the women (30.8 percent) who reported domestic violence as the cause of their health problem, had been hit by sharp edged objects, and almost one-fourth of them (23.1 percent) had admitted that they had attempted suicide because of domestic violence.

A similar pattern was observed in a hospital based study in Uttar Pradesh, in which a large proportion of women admitted to the hospital had been hit by blunt objects (KRITI Resource Centre, 2001).

- Self- blame, husband-related reasons, in-laws related reasons, non-fulfillment of dowry demands and emotional excitement in self were mainly perceived by women respondents as the underlying cause of their experiences of domestic violence.

- Almost one-third of the women respondents reported their current health problem as an accident, while the remaining 40 percent gave multiple reasons as causes of their health problem. Out of 53 women respondents who were under psychiatric treatment, 60.4 percent reported domestic violence as one the causes of their current health problem.

- One-fourth of the women respondents were identified by the researcher as the 'suspect cases of domestic violence'.

The findings of this study support that of another study conducted at the J.J. Hospital, Mumbai, which found that almost one in four women visiting the casualty department of the hospital were definitely cases of domestic violence (Daga et al., 1998).

***Women's Personal Background and Cause of the Health Problem - Domestic Violence***

- A comparatively higher percentage of survivors of domestic violence were found among women respondents in the younger age group (below the age of 40) than among those in the older age group.

- Survivors of domestic violence were found among women respondents belonging to all the religions and caste categories. One-fourth of Hindu women respondents, one-third of Muslim women respondents and half of women respondents belonging to other religions were found to be survivors of domestic violence. Survivors of domestic violence were found to be higher in percentage among women respondents from the SEBC and SC categories.

- Almost one-third of women respondents who were from rural areas and one-fourth of women respondents who were from urban areas were the survivors of domestic violence.

- The study found greater percentage of survivors of domestic violence amongst women respondents who were earning than among those who were not earning.

- Survivors of domestic violence were found amongst those women respondents who were married for a shorter duration as well as amongst those who were married for longer years.

- There were 7 women respondents who were pregnant at the time of interview. Of these 7 women respondents, 5 five of them reported domestic violence as the cause of their current health problem. Women's vulnerability increases when they are pregnant. Studies have shown that women are at greater risk of domestic violence when they are pregnant (Jejeebhoy, 1998b).

- One-fourth of the women respondents across all the three economic classes were found to be the survivors of domestic violence.

***Current Health Problem and Cause of the Health Problem – Domestic Violence***

- Proportionately high percentage of survivors of domestic violence were found amongst those who had suffered hurt / injuries, pain / swelling / bruises, and among those who had consumed poison. Less percentage of women respondents with burns and orthopaedic problems reported domestic violence as its cause. Possibly because it is easier 'cover up' burns or an orthopaedic problem 'as an accident' than to give a credible cover up story for grievous hurt or injury like stab wounds, or for poisoning, or other signs of obvious physical assault, as 'just an accident'. However, as many as 42.8 percent of women respondents who had consumed poison stated that they had consumed it by 'mistake'!

- Comparatively higher percentage of the women respondents from GG Hospital Jamnagar reported that they were in the hospital due to domestic violence, whereas the same was reported least by women respondents of Sir, T. Hospital, Bhavnagar. Interestingly, both these cities are in the Saurashtra region of the state. We still need to scratch the surface to know the underlying reasons for this difference.

- One-fourth of the women respondents who were OPD patients and one-third of the women respondents who were inward patients were found to be survivors of domestic violence. Thus, any hospital based intervention programme planned for survivors of domestic violence would benefit women users of all types of cases, both inward and OPD patients. Survivors of domestic violence were found in higher proportion amongst those women respondents who were medico-legal cases. However, there were almost 10 percent of women respondents who revealed to the researcher that they were in the hospital due to domestic violence, but had not reported it to anyone.

- For the majority of survivors of domestic violence, it was their first visit to the hospital for seeking treatment.

***Perception of Quality of Care***

- Majority of the women respondents were comfortable with the sex of health care providers. They had shared the cause of their health problem with them and had found the health care providers' attitude and behaviour towards them to be good.

- Experiences at the time of intake and user-provider relationship were two aspects of the quality of care, where comparatively more women respondents reported their experiences as poor. This could be because for most of the women respondents, it was their first visit to the 'big sarkari dawakhana'. The site of the big hospital

which is huge not only in its physical size but also crowded by many patients can be a scary experience for anyone who is visiting it for the first time. Secondly, it can be an unpleasant experience for women who are in severe trauma needing immediate medical attention to have to (or have their family members) run around from one place to another to locate different departments, and wait for someone to attend to them. During such hours of crisis in their lives, what women need is supportive, caring and friendly environment (both in terms of physical accessibility and health care providers' availability). If that comes through it is a positive, good experience for women, else they remember it as a nightmare!

- Half of the women respondents found their experiences with the current treatment as 'fair'. Three-fourths of women respondents perceived that health care providers responded to them positively or somewhat positively on knowing the cause of their injuries / health problem. However, one-fourth of women respondents felt that health care providers responded to them negatively.

***Quality of Care and Survivors of Domestic Violence***

- Majority of the women respondents perceived the current treatment that they received from the hospital as 'good' or 'fair'. There were only 10.5 percent of women respondents who perceived the current treatment as 'poor'.

- Less percentage of survivors of domestic violence were found amongst those women respondents who had perceived the treatment as good or fair. Survivors of domestic violence were found more amongst those who had found the treatment as poor.

- Half of the women respondents described their experiences at the time of intake as 'poor'. And one-third of these women were survivors of domestic violence. Not many survivors of domestic violence were found amongst those (40.2 percent) women respondents who had good experience at the time of intake.

- Majority of the women respondents were comfortable with the sex of health care providers (86.7 percent). One-fourth of these women were the survivors of domestic violence. Comfort with the sex of doctor attending to women's reproductive health needs was considered as one of the quality indicators by women of rural areas of Maharashtra (Gupte et al., 1999). The present study found that for women users of Gujarat, the sex of the health care provider does not matter when they are attending to them for other health problems. However, as some of the in-depth case studies conducted in the present research have shown, sex of the provider matters when women are required to expose their body parts. They feel awkward or embarrassed when they have to expose their body parts to male doctors for check-ups or dressing.

- Majority of the women respondents (59.4 percent) reported that they had good experiences with the health care providers. But this category included very less percentage of survivors of domestic violence. They were found more amongst those few respondents who stated that they had poor experiences with the health care providers.
- Majority of women respondents (83.9 percent) shared the cause of their health problems with the health care providers, i.e., whether the current health problem was due to domestic violence, other reasons or just an accident. One-third of women respondents who did not share the cause of their health problem with the health care providers were the survivors of domestic violence.
- Almost one-third of respondents shared a poor relationship with health care providers and out of these, 42.2 percent were the survivors of domestic violence.
- Majority of women respondents (82.5 percent) perceived the attitude and behaviour of the health care providers as good. However, less percentage of survivors of domestic violence perceived the same. Almost three-fourths of the 23 women who perceived health care providers' attitude and behaviour as poor, were survivors of domestic violence.
- One-fourth of the women respondents perceived the health care providers' response as poor. Almost half 945.9 percent) of these women were the survivors of domestic violence.

- A significant association was found (at <0.05 level of significance) between cause of women respondents' health problem and (1) women's experiences at the time of intake; (2) experience with health care providers; (3) user – provider relationship; (4) attitude and behaviour of health care providers; (5) health care providers' response. In other words, the cause of the health problem determines how women perceive their experiences regarding each of these five indicators of quality of care. For instance, the study found that women respondents who reported domestic violence as the cause of their health problem were found more among those who perceived a poor experience on all the aforementioned five indicators of quality of care. This finding is corroborated when the cases of those who reported domestic violence as the cause of their current health problem were examined independently. The table on women respondents' experiences and perceptions of quality of care in Appendix-G shows that majority of these women respondents had poor experiences at the time of intake at the hospital and their relationship with the provider was found to be poor.

Several other studies on quality of care cited in the review chapter indicate that attitude and behaviour, competency and commitment of doctors and staff determine user's perceptions of quality of care.

***Prevalence of Domestic Violence in Women's Lives***

- Almost three-fourths of the women respondents had reported that they had experienced domestic violence sometime in their marital lives. These episodes of violence were not just single events. Over one-third of the women respondents (37.1 percent) admitted that they had experienced domestic violence in the last one year as well.

- There were high percentage of the women respondents who were actual survivors of domestic violence. The prevalence of domestic violence was high even among those groups of women respondents who did not report domestic violence as the cause of their current health problem. This finding is quite in line with many other national and state level studies that have indicated high prevalence of domestic violence ranging from 22 percent to 79 percent among the surveyed women from different parts of India.

- Majority of the women respondents across all the three categories of causes of health problems (Domestic violence, Accident, Other causes) had experienced domestic violence sometime in their marital lives.

- Most of the women respondents, who the researcher defined as 'suspect cases of domestic violence' had reported that they had experienced domestic violence in the last one year.

*Views on Domestic Violence*

- Majority of the women respondents (81.1 percent) held progressive views related to forms of domestic violence. For instance, other than physical abuse, controlling women's mobility, their movement or income were also perceived as forms of violence.
- Majority of women respondents (59.4 percent) were traditional in their views related to what they considered as the causes of domestic violence. E.g. violence is a result of men's drinking habit, economic pressures, and the woman's fault.
- Almost two-thirds of respondents held traditional views on how a woman experiencing domestic violence should respond to the issue. E.g. women should obey in-laws and husbands, endure violence.
- Overall the view of majority of women respondents (69.2 percent) on the issue of domestic violence was traditional.

***Need to Seek Health Care Providers' Intervention in Domestic Violence***

- Almost half of the women respondents expressed that they would like health care providers to intervene in the issue of domestic violence.
- Half of the survivors of domestic violence expressed their need to seek health care providers' intervention in the issue of domestic violence affecting their lives. Even two-thirds of those who were in

the category of 'others', mainly women with mental health problems, also expressed their need to have health care providers' intervention in the issue. Chi-Square test results also indicated significant relationship between the 'cause' and the 'need'.

- User-Provider Relationship and the perceived need for intervention is found to be associated at <0.05 level of significance. Two-thirds of women respondents who shared good relationship with their providers expressed that they would like health care providers to intervene in the issue of domestic violence affecting their lives, whereas majority of those women users who shared poor relationship with health care providers expressed that they did not need any intervention / response from health care providers in this issue.

- Two-thirds of the women respondents who had perceived health care providers' response as positive stated that they would like health care providers to intervene in the issue of domestic violence.

- Women's perception of health providers' attitude and behaviour toward them did not affect their need to seek health care providers' intervention in the issue of domestic violence affecting their lives.

- Women respondents' need to seek health care providers' intervention in the issue of domestic violence is significantly associated (at <0.05 level of significance) with –

- The cause of the health problem shared by women respondents i.e., whether it was domestic violence, accident or other reasons.
- Women's relationship with health care providers i.e. User-Provider Relationship.
- Women's perception of health care providers' response.
- Women's views on domestic violence.

## II. Perspective of Health Care Providers

***Profile of Health Care Providers (HCP)***

- The study included perspective of male as well as female health care providers who were mainly young (below 45 years of age) with less than twenty years of work experience, married, Hindu, belonging to general caste category.
- Majority of HCP respondents were doctors (58 percent); 44 percent of HCP respondents were postgraduate, specialized or super specialized doctors and were teaching faculty members at the medical colleges attached to the selected hospitals. One-fourth of HCP respondents were nurses. The study also included CMOs and trained social workers.
- In all, HCP respondents were interviewed from 15 different departments for this study. Majority of the HCP respondents were

from the department of casualty / emergency, obstetrics and gynaecology, psychiatry, surgery, burn and plastic surgery (at a few of the hospitals these departments were interlinked / attached), medicine and the department of orthopaedics.

***Health Care Providers' Perception of Women's Health Care Seeking Behaviour***

- Majority of the HCP respondents perceived health care seeking behaviour of women patients (to whom they provide treatment and care) as good (44.7 percent) or fair (47.5 percent).

- Majority of the assistant professors, CMOs and resident doctors (younger in age), as well as half of the nurses perceived women's health care seeking behaviour as fair or poor.

***Treatment and Care Provided by Health Care Providers to Survivors of Domestic Violence***

- One-fourth of HCP respondents reported that in the last one week they had provided care to one to two women survivors of domestic violence.

- On being asked the frequency of observing, treating and providing care to women survivors of domestic violence in their work, one-third of the HCP respondents reported observing, on an average 1-3 such cases in a week, and almost one-fifth of them said that they encountered 1-3 such women daily in their work.

- Health care providers have observed and treated women survivors of domestic violence with minor injuries, major injuries, poison consumption, burns, fractures, suicide attempts, swelling/pains/aches/ bruises, scars/wounds, depression and other mental health problems.

- Half of HCP respondents reported that women survivors of domestic violence inform them about the cause of their health problem, if it is due to domestic violence. However, the other half opined that women survivors of domestic violence 'don't speak up' even when probed. They identified such women survivors of domestic violence as a 'suspect cases'.

- In-depth interviewing, pattern or type of injury, lack of congruity between the history and the pattern of injury, behaviour pattern of women patients or their relatives were mentioned as some of the basis on which HCP respondents identified women survivors of domestic violence as 'suspect cases'.

- Majority of HCP respondents expressed positive feelings towards the survivors of domestic violence. Almost one-third of HCP respondents expressed that they felt like doing something for women.

***Role Played by Health Care Providers in Medico-Legal Cases***

- Majority of doctors reported playing manifold roles in medico-legal cases. Very few HCP respondents mentioned specific tasks that are important for helping survivors of domestic violence get

justice i.e., taking proper history, proper documentation of injuries examined, etc.

- Majority of nurses did not see themselves playing any specific role in MLC cases related to survivors of domestic violence. They found their main role in assisting doctors, nursing and providing care and treatment.

***Interventions Made by Health Care Providers in Cases of Survivors of Domestic Violence***

- Almost two-thirds of HCP respondents stated that they had made some attempts to do something for the survivors of domestic violence. This included direct help like counselling women to do something about their situation, providing financial help, material help and personalized care. Some of the HCP respondents mentioned indirect help like counselling husbands or seeking others' help / support for the women.

- However there were one-third of HCP respondents who denied having made any effort to do anything other than routine, clinical work for the survivors of domestic violence. The most common reasons that they cited was that they did not consider it as part of their job / role or responsibility. Personal beliefs, lack of time and inadequate knowledge or skills to help such women were some of the personal constraints that respondents also gave as reasons for not being able to do anything to help such women out.

***Barriers Perceived by Health Care Providers in Addressing the Issue of Domestic Violence***

- Almost two-thirds of HCP respondents perceived self role and competency related reasons either as somewhat or very important barrier deterring them from addressing the issue of domestic violence in their work.

- These respondents included almost half of HCP respondents who were CMOs, social workers; three-fourths of those respondents who were professors; almost one-third of associate professors, assistant professors, and nurses; and majority of resident doctors who had perceived that addressing the issue of domestic violence was not their role and that they were not competent to handle it. Thus health care providers across different categories of occupations had found self role and competency related reasons as a barrier in addressing the issue of domestic violence.

- Almost two-thirds of HCP respondents perceived institutional factors (e.g. No scope to do anything due to low position in hierarchy; no privacy; no authority to intervene beyond treatment and care; heavy workload) as obstacles hindering them from addressing the issue of domestic violence in their work. These respondents included almost two-thirds of professors, assistant professors, CMOs and three-fourths of nurses, social workers, who considered that institutional reasons were working as somewhat or very important barrier for them in addressing the issue of domestic violence.

Thus findings of the study support the earlier international and national researches (e.g. Population Reports, 1999; Barge et al., 2000; Prasad, 1999) that have found that health care providers' perception related to their own self role and competency and institutional reasons work as major obstacles restricting them from intervening in the issue of domestic violence.

The findings have major implications for policy as overcoming these barriers would require mainstreaming of the issue of domestic violence in the training agenda (beginning from medical, paramedical education to developing skills and perspective of existing health care personnel) as well as in the agenda of the health care delivery system i.e., developing mechanisms and procedures to address the issue at the institutional level.

- Majority of the HCP respondents (70.9 percent) held progressive views on the issue of domestic violence. However, half of the assistant professors (those who were presumably young and at the entry level in the occupation of teaching) held traditional views on the subject. E.g. the women should do what their in-laws and husbands expect them; women should endure violence; violence is a result of economic hardship or the husband's drinking habit.

- Three-fourths of married male HCP respondents and half of married female HCP respondents talked about their personal experiences of domestic violence. Male HCP respondents stated that they had committed psychological violence on their wives.

Similarly, half of the married female HCP respondents shared that they had also experienced domestic violence in their marital lives. However, very few HCP respondents talked about experiences of physical or sexual violence that they committed (as a male) or experienced (as a female) on / from their partners.

***Type of Response Given by Health Care Providers to Survivors of Domestic Violence***

- Half of the HCP respondents responded positively to women survivors of domestic violence, whereas the other half responded some what positively (42.6 percent) and negatively (7.8 percent). 'Trying to console the survivor of domestic violence', 'Never did any action that would indicate that they were not interested in women's problem', or 'Never got angry on her' were some of the positive responses that majority of HCP respondents made.
- Very few HCP respondents tried to involve a trained social worker while working with women survivors of domestic violence. The probable reason could be non-availability of social workers in the department or even at the hospital!
- Asking the woman's natal family members about the woman being subjected to domestic violence, telling the marital family members that they were wrong or informing organizations working on the issue were some of the positive actions that very few HCP respondents made.

- Younger HCP respondents (below 35 years of age) were more positive in responding to survivors of domestic violence. Majority of HCP respondents (between 35-55 years of age) responded somewhat positively.

- Almost half of the male as well as female HCP respondents responded positively to women survivors of domestic violence (53.4 percent and 45.6 percent respectively). However, majority of the other half in both the groups responded somewhat positively to women survivors of domestic violence.

- Majority of the single HCP respondents responded positively to women survivors of domestic violence.

- Majority of resident doctors, social workers, CMOs and assistant professors made positive response to women survivors of domestic violence. However, majority of nurses reported making somewhat positive response to women survivors of domestic violence.

- Majority of HCP respondents with less number of years of work experience responded positively to survivors of domestic violence than those with more number of years of experiences.

- HCP respondents' personal experiences of domestic violence were not found to be associated with the type of response that they made to the survivors of domestic violence.

- Type of response that HCP respondents made towards women survivors of domestic violence was not found to be significantly associated with the views that HCP respondents' held on the issue of domestic violence. Almost half of the HCP respondents who held progressive views as well as traditional views on the issue of domestic violence had responded positively to the survivors of domestic violence.

- Half of those HCP respondents who perceived Women's Health Care Seeking Behaviour as Good or Fair responded positively to the survivors of domestic violence.

- Almost half of HCP respondents who observed survivors of domestic violence more frequently as well as those HCP respondents who found survivors of domestic violence less frequently in their work responded positively to them.

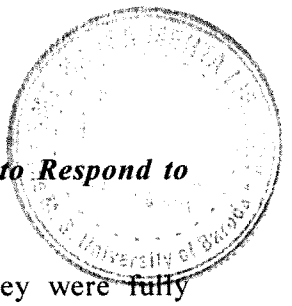
- A significant association was seen between HCP respondents' perception of self role and competency related reasons as a barrier in addressing the issue of domestic violence and the type of response that they made to the survivors of domestic violence. Two-thirds of those HCP respondents who perceived self role and competency related reasons as unimportant reasons obstructing them in addressing the issue of domestic violence responded positively to the survivors of domestic violence. Whereas almost half of those HCP respondents who perceived these reasons as major, barriers responded somewhat positively.

- When HCP respondents did not perceive institutional factors related reasons as an important barrier obstructing them in addressing the issue of domestic violence, they responded to the survivors of domestic violence positively. This shows the need for measures to remove institutional barriers to facilitate HCPs to respond to women survivors of domestic violence.

- Chi-Square test results indicated significant relationship between the type of response that HCP respondents made to survivors of domestic violence and their (1) age; (2) marital status; (3) occupation; (4) years of work experience; (5) perception of women's health care seeking behaviour; (6) perception of self role and competency as a barrier in addressing the issue of domestic violence; and (7) HCP respondents' perception of institutional factors as a barrier in addressing the issue of domestic violence.

- Younger HCP respondents, those who were single, those with fewer years of work experience, and those who were at the entry level of their occupation (resident doctors and assistant professors, and social works, and CMOs) were more likely to respond positively to survivors of domestic violence.

- Those who perceived women's health care seeking behavior as good or fair, those who did not perceive self-role and competency as a barrier and those who did not perceive institutional factors as a barrier, were more likely to respond positively to women survivors of domestic violence.





- Almost two-thirds of the respondents said that they were fully prepared and ready to reach out to women survivors of domestic violence who were under their care in terms of their willingness, required knowledge and skills.
- Between one-third and half of the HCP respondents indicated that they did not have information related to organizations where they could refer women survivors of domestic violence. They also indicated that they lacked skills in identifying survivors of domestic violence amongst other women users and could not specifically advise women as to how to handle violent situations.
- Almost half of the resident doctors and assistant professors, one-third of CMOs who responded to the study expressed that they were not fully prepared to reach out to or help women survivors of domestic violence.
- HCP respondents who did not perceive self role and competency related reasons as barriers were fully prepared to help out women survivors of domestic violence.
- When HCP respondents do not consider institution related reasons as an important barrier obstructing their attempt to reach out to women, they find themselves fully prepared to help survivors of domestic violence.

- Almost three-fourths of HCP respondents talked about the support services that they would like to have in order to be able to intervene in domestic violence cases. Majority of them asked for appointments / visits of social workers in each departments as well as a separate cell / department in the hospital where they could refer women survivors of domestic violence.

- Almost two-thirds of HCP respondents had specific knowledge requirements and asked for information on institutions / organizations where they could refer such cases, legal knowledge related to domestic violence, information on procedures to be followed in cases of survivors of domestic violence.

- Half of the HCP respondents talked about creating an institutional environment that would facilitate the provision of assistance to women survivors of domestic violence. Creating a women-friendly environment, setting up protocol and formal set procedures and support and cooperation from authorities, colleagues were some of the requirements that most of HCP respondents asked for.

- Almost one-fourth of HCP respondents expressed their need for development of specific skills such as counseling communication, trauma care and crisis intervention skills.

## III. Response of the Health Care System to Domestic Violence: Findings from Case Studies

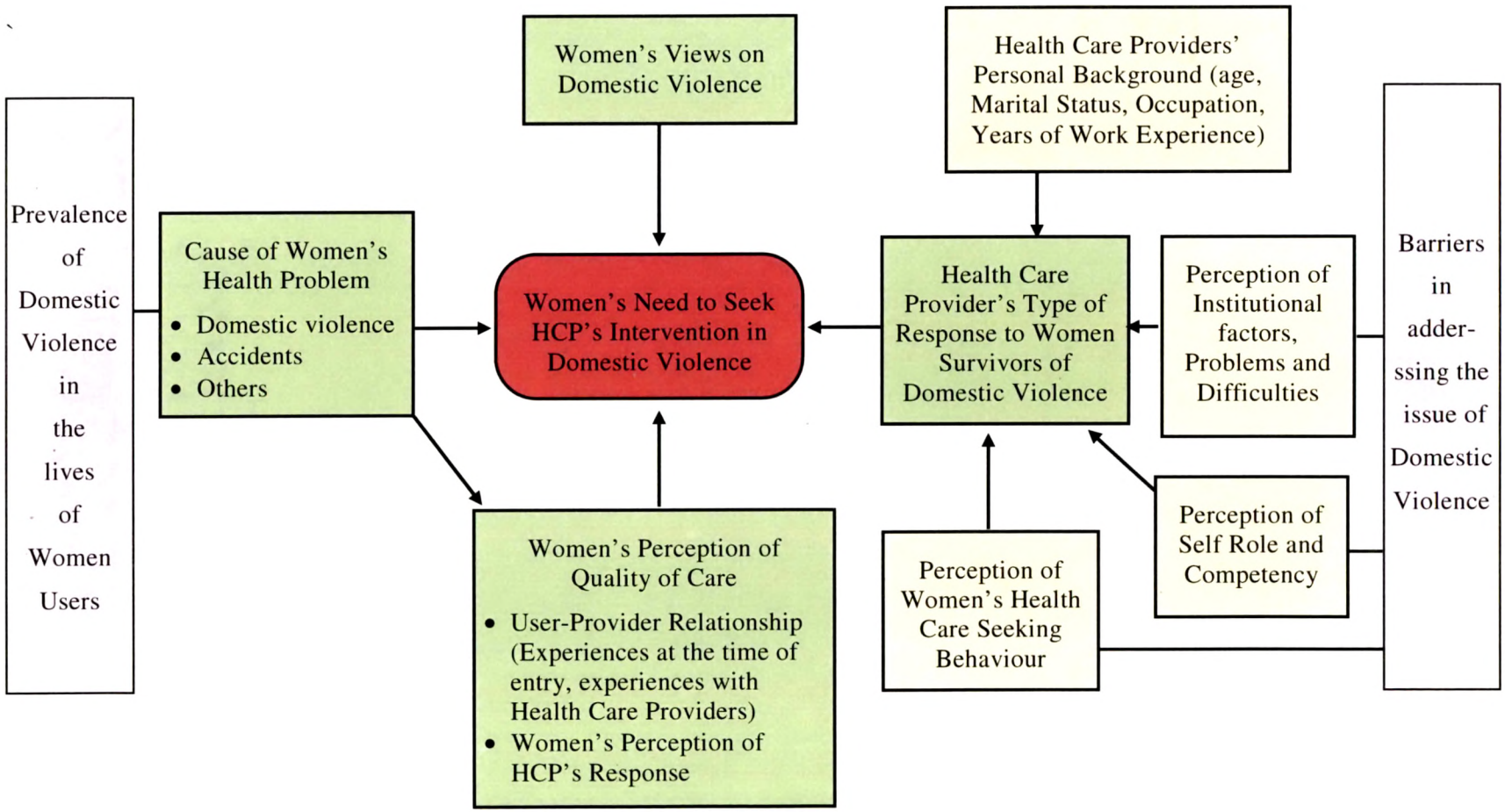
Among the 30 case studies of women survivors of violence were 17 women respondents with some physical injuries (including one suspect case of domestic violence) and 13 women respondents with mental health problems. The following findings emerged from the case studies:

- The health problems resulting from domestic violence that women survivors present with vary from mental health problems, cuts and bruises, multiple fractures, multiple stab wounds, severe burns, poisoning (attempted suicide) and even infant death.
- The abusers are mostly their husbands but in some cases the perpetrators of violence include members of the extended family; a brother-in-law, a sister-in-law.
- Women survivors' perception of the quality of care was influenced by the type of experience they had with the health care services and the health care providers.
- Experiences were perceived as good, when women survivors received immediate attention and treatment for their problem, when providers showed interest and involvement and paid attention to them. Women liked it when health care providers talked to them about their problems patiently. Women survivors felt good when health care providers intervened in their problems and tried to help them in some way.

- Providing information on the infrastructure facilities and attending to their other requirements such as food, medicine, and bed were also found to be good experiences.
- Women perceived quality of care as poor when they had negative experiences such as not being attended to immediately, or being left unattended for a long period of time, not being given adequate information on the procedures and infrastructure facilities available to them.
- The responses of the health care providers varies – from listening sympathetically to intervening on the woman's behalf; from being disinterested in knowing the real cause of the injuries to out rightly refusing support in filing a complaint for the sake of maintaining domestic harmony.
- Women do not report or share their experiences of domestic violence with the health care providers either because they are not asked about it or because they do not see any role for the providers. However, they felt good when health care providers intervened.
- When survivors of domestic violence approach the health care system they need: immediate attention by health care providers, information about the procedures and facilities available to them, sympathetic and supportive behaviour from providers, opportunity to share their experiences of domestic violence and some mechanism for redressal.

*Figure-24: Domestic Violence & Health Care*

***Women Users' and Health Care Providers' Perspectives: Emerging Linkages***



## Domestic Violence and Health Care - Emerging Linkages

A schematic diagram of the linkages between domestic violence and health care, from both women users' and health care providers perspectives, that have emerged from the study is presented in Figure 24.

It is well appreciated that these observations are very preliminary and further investigations are required to test the validity of these linkages.

The framework shows that women users of the health care system have expressed their need to have health care providers' intervention in the issue of domestic violence, irrespective of the cause of their current health problem, as there is a high prevalence of domestic violence in their lives. Women's perception of quality of care and their experiences with the heath care facility is found to be very significant in determining their need to seek health care providers' intervention in the issue of domestic violence. Thus the framework highlights three important indicators of quality of care that women users consider significant namely – their experiences at the time of entry into the hospital, experiences with health care providers and perception of health care providers' response to them. For example, those who felt scared, lost, unwelcome, unattended for a long period of time, described their experiences as negative and the quality of care as poor. Those who were well attended, when the HCP was sympathetic, did not blame them, took interest in them, listened to them or even at times stood next to them for a while, found their experiences positive and found the quality of care as good. This finding of the study

underscores the need to address the issue of quality of care within the public health care system of the state from the users' perspective.

The framework also shows the importance of women's views about domestic violence in determining their need to seek health care providers' intervention in the issue of domestic violence as the study has found significant association between the two. For instance, higher percentage of women holding progressive views expressed their need to seek health care providers' intervention. This finding of the study reiterates the need to work with women on this issue and devise strategies for attitudinal changes in them empowering them to fight violence rather than enduring it.

On the other side, health care providers' response to women survivors of domestic violence is determined by their perception of women's health care seeking behaviour, whether they consider it as Good, Fair or Poor; perception of institutional factors, problems and difficulties (e.g. 'I have so much of workload that even if I want, I can't do anything about it') perception of self-role and competency (e.g. 'It's not my job' / subject') act as barriers in addressing the issue of domestic violence. Health care providers' personal background characteristics like age, marital status, occupation and years of work experience are also found determining the type of response that health care providers make to the survivors of domestic violence. Younger HCP respondents, those who were single and those with lesser number of years of work experience were more likely to respond positively to survivors of domestic violence.

Thus women's need to seek/ have health care providers' intervention/ response in the issue of domestic violence will be addressed only when such barriers are addressed by the health care system, e.g. (1) addressing the issue of health care providers' perception of their role in responding to women survivors of domestic violence or building on/strengthening their competency to respond to women survivors of domestic violence. (2) building institutional climate, ethos, policy and making domestic violence as part of health care system's agenda; (3) Gender sensitization of health care providers to bring about attitudinal changes in understanding 'why' of women's health care seeking behaviour in their psycho-socio-cultural context.

## Discussion and Conclusion

The findings of both the sub-studies summarized above together provide a broad picture of the way the health care system responds to women users in general, and to the issue of domestic violence in particular.

A strong conclusion drawn from the analysis of both quantitative and qualitative data is that domestic violence is prevalent in the lives of women users approaching the public health care system of the state. But there is a 'silence' around the issue both on the part of women users and health care providers. Domestic violence is in the 'silence zone' of the public hospital. There are many reasons for this as the present study unfolds. Women approaching the health care system with any health

problem look to health care providers mainly to address first their current physical or psychological health needs and help them recover from it. Similarly, health care providers also view their role mainly as providers of medical treatment and care, addressing physiological symptoms; ailment and helping patients recover from their medical problems.

The linkages between women's personal life situations affecting women's health and leading them to hospitals, for example domestic violence, most of the time go unrecognized by health care providers. And even if they do recognize it and perceive a role for themselves in doing something for women, they find it difficult to intervene due to the paucity of time, unavailability of space for privacy, no patience and time to work at the pace of women, feeling of subordination ('I cannot do, unless my seniors tell me to do so') or other pressing demands of their profession.

Women Users view health care services sought by them as 'Sarkari Daya' (State's charity). For women, coming from poor socio-economic background, whatever little that they get for 'free' from the state run hospital is viewed as privileges (be it 'a bed to sleep on', 'a fan over one's head' or 'an egg a day'). Thus they are overwhelmed by all that they get 'free'. This coupled with a sense of gratitude (for getting recovered, becoming alright) fulfills all their expectations from the health care system. Women users are happy and satisfied with all that they get.

As Leela Visaria (1999) puts it "but for poor women users of rural Gujarat, the poor quality of reproductive health care did not matter as they were not knowledgeable about standards of care or even type of assistance they were entitled to receive."

However the study results have indicated that women are 'silent' about domestic violence at the health care system not because they do not want help or any intervention from health care providers. On the contrary, many want the health care system to address this issue affecting their lives. While on the one hand they have expressed the need for health care providers' intervention in the issue of domestic violence, on the other hand women have also expressed the need to have good user-provider relationship, experiences at the time of entry and experiences with health care providers. Some of the case studies narrated in the Case Studies chapter have indicated that when women have found 'a listener', 'empathizer', 'supporter' in the health care providers, they have found the health care system intervening in their domestic violence issue positively, helping them in some way.

The Case Studies chapter also includes narrations of those women survivors who did not have very positive experiences with the health care system. They found health care providers unsympathetic, unapproachable and not willing to extend any help.

Health care providers' response to women survivors of domestic violence gives women strength and courage to cope with the issue. They have expressed their need to seek help from health care providers in terms of guidance, support to them in their struggle against domestic violence, counselling to their husbands, in-laws, providing details of organizations helping women in distress, etc.

On their part, health care providers have indicated their willingness and preparedness to intervene and address the issue of domestic violence in their work provided their requirements in terms of support services, specific knowledge requirements, and creation of a conducive institutional climate are addressed. Both the groups i.e., women users and health care providers have expressed the need to have social workers who could play an active role in addressing the issue of domestic violence at the health care delivery system level.

Breaking the 'silence' around the issue of domestic violence would require time, patience, specialized knowledge and skills. Most importantly, creation of an institutional environment that is women-friendly would require interventions that are sensitive and based on women's needs. Social workers trained to intervene at all the levels of the system are in a position to take up this challenging task.

Moreover, because domestic violence is a difficult and intractable health and social problem of our society, it demands socio-medico interventions, a multidisciplinary response to women survivors of domestic violence.

## Suggestions

The aim of this study was to draw up a social work intervention plan for including domestic violence as an agenda in the public health care system of the state based on users' as well as providers' perspectives.

While the public health care delivery system of India is divided into three levels: primary, secondary and tertiary, this study has focused on the tertiary level of the health care delivery system.

Based on the linkages that have emerged from the present study, between domestic violence and health care, from both women users' and health care providers' perspectives, a social work intervention plan has been prepared and presented here. As the main site of the study was government teaching hospital of the state, the suggested plan is meant for implementation at that level only.

## Breaking the Silence around Domestic Violence: An Agenda for Social Work Intervention

### *Working with Authorities*

An agenda for change at the public health care system (here, at the teaching hospitals) will have to begin with policy makers' and state authorities' support and involvement, especially from the Commissionerate of Health and Medical Services, Medical Education and Research, Department of Health and Family Welfare, Government of Gujarat.

- **Sharing the findings** of the study to establish the need for the health care system to respond to the issue of domestic violence by bringing about policy changes e.g., **Setting up formal procedures/protocol** to identify survivors of domestic violence among women health care users.

- **Recognizing the need of women users** to seek health care providers' response to the issue of domestic violence affecting their lives and developing small possible mechanisms, to begin with e.g., **permission and support** to set up a Crisis Center at the hospital, organizing short courses/workshops/ seminars on the issue for health care providers.

- **Working with hospital authorities** at the hospital level; seeking their support, co-operation and willingness to 'do something about the issue' by facilitating the process of inclusion of the agenda of domestic violence directly at the hospital level.

***Providing Direct Services***

- **Set up a Crisis Center** at the teaching hospital to ensure that women survivors of domestic violence visiting the hospital receive emotional support, and that every episode of violence inflicted on a woman gets recorded.

- **Appointment of Social Workers** at the select departments of the hospital, especially departments like casualty/emergency, surgery, burns, medicine, obstetrics and gynaecology with an objective to

identify women survivors of domestic violence and extend them support in their struggle against domestic violence. Or inclusion of the agenda to address the issue of domestic violence in their work wherever they exist.

***Liaisoning and Working with Health Care Providers of the Hospital***

Working with health care providers at the hospital is of utmost importance. Here addressing their needs to develop competency in the area of working with survivors of domestic violence must be addressed.

- **Preparing a check-list** for health care providers to identify women survivors of domestic violence and orienting them on its use.
- **Identifying key health care providers** of each department, within each occupation category and involving them in the process of planning practical strategies for working with survivors of domestic violence within their set up.
- **Organising different short courses / workshops / orientation programmes** for health care providers of different occupation categories and addressing specific roles that they could play with survivors of domestic violence, e.g. workshop for doctors, CMOs must include sessions on identifying abuse, screening checklist, documentation detailing necessary in MLC or how to make a Domestic Incident Report (DIR) as required in The Protection of Women from

Domestic Violence Act, 2005; Short course for nurses may not include the documentation detailing session, but must have information and referral related details and sessions on Principles of Counselling.

- **Being in regular touch** with key health care providers and others and providing them support (if required) in their own life situations or in terms of extending information, reinforcing their involvement.

***Liaisoning and Net Working with Other Systems***

- **Police** – Referral of women survivors of domestic violence seeking police / legal action.

- **Other support groups** like women's organizations, shelter homes, donor agencies, lawyers, etc. where women survivors of domestic violence could be referred, if required.

***Women Survivors of Domestic Violence as Partners for Change***

- No social work intervention program is possible, viable or effective without the participation of community / group / service users for whom it is designed. Thus **involving women survivors of domestic violence in** any intervention program as partners in decision making process, implementation would definitely yield positive results if not for anyone else, for 'A WOMAN' – as a journey towards change itself would be an 'empowering experience' for her.

## Suggestions for Future Researches

Research in domestic violence is a difficult pathway. Because of its complex and invisible nature, research in this area is not only quite challenging but also demanding in terms of time, resources, skills, etc. Following are some of the areas that are suggested for any researcher interested in taking up this difficult task.

***Identified Areas***

- This study focused on women users and health care providers at the tertiary level of the public health care system of the state. The study of women users' and health care providers' perspectives of primary and secondary level of the system would be extremely useful in designing intervention programmes that are closer to women at the community level. For instance:
  - A study could be undertaken of women survivors of domestic violence visiting PHC, community health centre or an urban health care centre, or any other community based health care services, to find out their needs, perceptions and their experiences with the health care system.
- For designing a holistic intervention plan it is important that policy and decision makers be involved in the health program be involved in the study. The study of this group of stakeholders would bring deeper insight into the subject. For instance:

- A study could be undertaken on the views and perceptions of policy and decision makers on domestic violence as a public health issue, and the ways in which the state could respond to it.

***Collaboration***

- Researches on any social issue in the field of health or in the health setting would yield different perspectives, if these were carried out as partnership between social workers and health care providers who are part of the system. Multidisciplinary effort towards developing an intervention programme based on research findings would make the entire effort more meaningful as it is a joint ownership, a collaborative effort. For instance:

  - A collaborative action research project between the college / faculty / department of social work and the teaching hospitals' departments like psychiatry, burns, obstetrics and gynaecology, medicine, surgery, orthopaedics, and skin and VD to respond to the needs of women survivors of domestic violence visiting these departments.

***Methodology***

- Research in the area of domestic violence attempts to scratch those surfaces that are not only sensitive, but also extremely painful. Researches in this field have to be carried out with due sensitivity and ethically.

- Qualitative researches help identify the subtler aspect of domestic violence and translate the coldness of numbers into the words, emotions and realities of those voices that are yet to be heard! Whereas action research, being intervention-based lead towards empowerment of the groups/communities, at whom it is aimed. For instance:
  - On the basis of the present study, it would be worthwhile to undertake an action research to respond to the needs of women survivors of domestic violence at the tertiary level of the health care system.