

**MEETING THE HEALTH NEEDS OF DOMESTIC
VIOLENCE VICTIMS:**

**ASSESSING THE UTILIZATION OF DOMESTIC VIOLENCE LAW
AND HEALTH SERVICES PREPAREDNESS IN COASTAL
ORISSA**

ROBERT A. BAKER-WHITE, J.D.
MAY 2010

Salus populi suprema lex. “The well-being of the people is the highest law.”

– Legal maxim

ABSTRACT.....	4
INTRODUCTION.....	4
Problem Statement.....	4
Project Objectives.....	5
BACKGROUND & CONTEXT	
Domestic Violence – An Overview.....	6
Domestic Violence in India and Orissa.....	7
Domestic Violence and Health Outcomes.....	9
Role of the Health Care System in Preventing Domestic Violence.....	10
Domestic Violence and the Law.....	12
Domestic Violence Law in India.....	13
METHODS.....	14
FINDINGS	
Three Phases of the PWDVA and Victim Utilization.....	15
◦ Phase One: Becoming aware and seeking help.....	16
◦ Phase Two: Gaining support and assistance.....	18
◦ Phase Three: Court resolution and relief.....	20
Health care professionals perceived roles and responsibilities regarding domestic violence.....	21
◦ Perceived Roles and Responsibilities.....	21
◦ Causes of Perceived Roles and Responsibilities.....	23
DISCUSSION.....	27
CONCLUSION AND REFLECTION.....	28
APPENDIX A	
TOPIC GUIDE – CARE PROVIDERS.....	30
APPENDIX B	
PROTECTION OFFICER QUESTIONS.....	32
APPENDIX C	
INTERVIEW CONSENT FORM.....	33
APPENDIX D	
BIBLIOGRAPHY.....	34

ABSTRACT

The issue of domestic violence is often viewed as a legal issue - something to be dealt with by police, attorneys and courts. Domestic violence, however, goes beyond the legal system and studies reveal the impact of the violence on women's health and well-being. This fact suggests the need for a multi-sector solution inclusive of health services and health care professionals. Unfortunately, uniform acknowledgment of needed collaboration has not resulted in significant systems integration. The Protection of Women from Domestic Violence Act, 2005 (PWDVA) gives legal protection to domestic violence victims while also providing specific relief for their health needs. This study examines the barriers to women's utilization of the PWDVA as well as the level of preparedness of the health system to address domestic violence in coastal Orissa.

Method: Individual and group interviews of health care professionals, domestic violence victims, attorneys representing victims, government officials, and advocates were conducted. The interviews were translated and transcribed and a thematic content analysis was performed.

Findings: Utilization of the PWDVA can be considered to have three phases: (1) women become aware of the law and choose to seek help, (2) women gain support and assistance, and (3) the court resolution and granted relief. During each of these phases a victim's utilization of the PWDVA is impacted by various factors. Additionally, the health system's level of preparedness to address domestic violence is found to be low. Health professionals perceive their role and responsibility to victims to be limited due to a lack of awareness, an inability to identify domestic violence victims, a fear of controversy, and a lack of resources. There is a need for training and improved skills to inquire patients about domestic violence, identify domestic violence victims and refer them to supportive services.

Conclusion. The domestic violence law in India is quite progressive as it includes health care services provisions and multiple remedies, however, effective utilization of the law is lacking. Understanding the factors impacting utilization allows for consideration of how to refine the PWDVA process so that it provides a positive influence on women's health and well-being. Furthermore, the preparedness of health services needs to be improved before a multi-sector approach to domestic violence will exist. More awareness needs to be created and more resources provided for the proper utilization of the law and increased preparedness.

INTRODUCTION

Problem Statement

Domestic violence is an issue encountered by both the legal and health systems. The health system addresses the negative health outcomes of domestic violence while the legal system focuses on intervention and prevention through criminal and civil laws. Both systems, however, struggle to give full consideration to domestic violence. The health care system often fails to take steps to intervene and prevent the violence while the legal system often fails to consider the impact its laws and procedures have on health outcomes.

The shortcomings of the health and legal systems in addressing domestic violence can be resolved through increased awareness by health care and legal professionals and improved coordination between the systems. The health system can go beyond simply treating the health outcomes of domestic violence and take an active role in preventing the violence through inquiry of patients, identification of victims and referrals to supportive services. The legal system can go beyond the prevention of future acts of violence and help address the health outcomes of domestic violence by becoming aware of how its procedures influence the health and well-being of the women who utilize the domestic violence law. These processes can then be modified so they no longer have a negative influence on women's health and well-being.

Project Objectives

This project looks at the role of the health system in preventing domestic violence and the legal system's role in influencing the health and well-being of women who utilize the laws. The first project aim is to assess and identify the factors that impact victims' utilization of the PWDVA. The effective utilization of the PWDVA can positively influence the health and well-being of domestic violence victims by providing them with protection from further violence, needed financial support, and compensation for injuries. The second project objective is to investigate the preparedness of the health services system in Orissa to work towards preventing domestic violence by assessing health care professionals' ability and willingness to intervene in domestic violence cases they encounter in their health practice. To accomplish these objectives key informants, including legal and government officials involved in the PWDVA's implementation and health care providers involved in the care and treatment of domestic violence victims, were identified and interviewed. A qualitative approach was chosen in order to obtain stakeholders' beliefs, attitudes and perceptions of addressing domestic violence and implementation of the PWDVA.

The project result is in an analysis of the PWDVA's utilization as well as an analysis of the preparedness of the health system to address domestic violence prevention. The results from the project will provide the Centre for Health and Social Justice (CHSJ), a Delhi-based organization which collaborates with local health and violence prevention efforts throughout India, with an analysis of how the Indian domestic violence law is being utilized by victims in coastal Orissa and the preparedness of the health system to address domestic violence prevention. The project is grounded within CHSJ's mission “to promote human development, gender equality, human rights and social justice with specific reference to the field of health, in its widest interpretation.” Recognizing the factors impacting the PWDVA's utilization will allow CHSJ and its partner organizations to advocate for the refinement and modification of the PWDVA processes that negatively influence the process has on women's health and well-being. Additionally, local service providers and victim advocates can use the analysis to build collaborative efforts and focus scarce resources on improving the implementation of the domestic violence law and preparing health care providers to assist domestic violence victims.

BACKGROUND & CONTEXT

Domestic Violence – An Overview

Domestic violence is any behavior or action that causes physical, sexual or psychological harm by one person against another who are related by consanguinity or affinity. Physical harm includes hitting, slapping, burning, and beating. Sexual harm refers to forced intercourse and rape. Psychological harm can be the threat of physical or sexual abuse as well as belittling, humiliating and name calling. Other controlling behaviors, such as isolation from family and friends, monitoring of movements and actions, and restriction of access to information, finances or assistance are also forms of domestic violence.¹

The behaviors and actions that constitute domestic violence occur in all countries and can be found within all social, economic, religious and cultural groups.² Domestic violence also occurs in all types of relationships: in same sex relationships as well as heterosexual ones, between unmarried couples, or family members. Women can be the perpetrator of domestic violence against men, however, this type of violence is rare. Men perpetrate the overwhelming majority of domestic violence against women.³ Women experiencing domestic violence face negative social, economic, and health outcomes and are often reluctant to get help due to being stigmatized, or are unaware of how to get help.⁴

The gender imbalance of domestic violence can be attributed to cultural, social and individual variables. For example, physical differences between men and women make women more likely to be victims of domestic violence. Additionally, attitudes about domestic violence are passed down through generations. A study by Martin, *et al*, in northern India interviewed husbands about their witnessing of domestic violence as children. The researchers found that men who witnessed domestic violence as a child were more likely to be physically and sexually abusive toward their wives than men who did not witness abuse.⁵ Often, social norms, patriarchal power structures and rigid gender roles do not adequately prepare women to protect themselves from violent partners. In many relationships where domestic violence occurs the woman is financially dependent upon the man, thereby making it difficult for her to resist the violence or leave the relationship. Many times the violence stems from the man's belief that he is exercising his right to maintain order or punish a wayward woman.

Worldwide, 10-50% of women have experienced domestic violence.^{6,7} Many incidents of

1 Krug G, Dahlberg L, Mercy J, Zwi A, Loranzo R, eds. World report on violence and health. World Health Organization. 2002. Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/index.html. Last accessed on May 17, 2010.

2 Ibid, Krug.

3 Ibid, Krug.

4 Taket A, Nurse J, Smith K, Watson J, et. al. Routinely asking women about domestic violence in health settings. *British Medical Journal*. 2003;327:673-675.

5 Martin S, Moracco K, Barro J, Tsui A, et al. Domestic violence across generations: findings from northern India. *Intl Jrnl of Epidemiology*. 2002;31:560-572.

6 Ibid, Taket.

domestic violence are unreported so the actual incidence of domestic violence in any given country or location will likely be higher than estimated. Domestic violence is endemic in many countries. It is a behavior that is often deeply ingrained and accepted. Women of all ages are affected by domestic violence and it is the most common form of violence against them.⁸ Domestic violence has serious impacts on women's health and well-being as well as negative social impacts on families and communities. These factors make domestic violence a recognized public health issue.

In its 1993 Vienna Declaration, the World Conference on Human Rights declared that “[g]ender-based violence . . . [is] incompatible with the dignity and worth of the human person, and must be eliminated.”⁹ Two years later, the Fourth World Conference on Women in Beijing declared its determination to “[p]revent and eliminate all forms of violence against women and girls.”¹⁰ In 1996 the 49th World Health Assembly declared violence “a major and growing public health problem across the world.”¹¹ Since these declarations, the idea and acceptance of domestic violence as a public health issue has grown, however, as a public health issue domestic violence remains widely ignored and little understood.

Instead of a public health issue, prevention of domestic violence is primarily seen as a legal issue with laws prohibiting it and providing legal processes for victims to seek relief. There have been many calls for a multi-sectoral response to domestic violence, including the Vienna Declaration's assertion that elimination of violence “can be achieved by legal measures and through . . . cooperation in such fields as economic and social development, education, safe maternity and health care, and social support.”¹²

Domestic Violence in India and Orissa

Domestic violence in India is often considered a private family issue which is to be handled within the home. Any external intervention is typically unwanted and seen as unnecessary.¹³ These beliefs are based on deep-rooted cultural norms and patriarchal values. Domestic violence is viewed as “a burden that women are expected to bear in silence rather than ‘shame’ the family.”¹⁴ An investigation in northern India by Martin, et al, examined the association between

7 Carretta C. Domestic Violence A Worldwide Exploration. *Journal of Psychosocial Nursing*. 2008;46:26-35.

8 Kaur R and Garg S. Addressing Domestic Violence Against Women: An Unfinished Agenda. *Indian Journal of Community Medicine*. 2008;33:73-76.

9 Vienna Declaration and Programme of Action. World Human Rights Conference. Available at: <http://www.unhcr.ch/huridocda/huridoca.nsf/%28symbol%29/A.CONF.157.23.En?OpenDocument>. Last accessed on May 22, 2010.

10 Fourth World Conference on Women Beijing Declaration. Available at: <http://www.un.org/womenwatch/daw/beijing/platform/declar.htm>. Last accessed on May 22, 2010.

11 Ibid, Carretta.

12 Ibid, Vienna Declaration.

13 Lawyers Collective Women's Rights Initiative. Staying Alive: Third Monitoring & Evaluation Report 2009 on the Protection of Women from Domestic Violence Act, 2005. Available at: <http://www.unifem.org.in/PDF/Staying%20Alive%20Third%20M&E%20Report%202009%20%28final%29.pdf>. Last accessed on May 17, 2010.

14 Ibid, Lawyers Collective Women's Rights Initiative.

domestic violence and several socioeconomic variables. The researchers hypothesized that high family stress and high levels of family privacy were related to domestic violence. These variables included high stress factors (e.g., family poverty, education level, age at marriage, and number of children) and privacy factors (e.g., household size, inclusion of family members in household, and urban settings). The study found general support for the relationship between high stress variables and domestic violence, however, there was not strong support for a link between family privacy and domestic violence.¹⁵

India's National Family Health Survey-III (NFHS-III), conducted during 2005-2006 in 29 states, found that nearly forty percent (39.7%) of ever-married women experienced physical, sexual or emotional abuse by a husband after marriage. During the twelve months preceding the survey, 35% experienced physical violence, 10% sexual violence and 18% emotional violence. India's National Crime Records Bureau stated that in 2000 an average of 125 women per day faced domestic violence. By 2005, the average was 160 per day.¹⁶ A 2005 United Nations Population Fund report revealed that around two-thirds of married women in India were victims of domestic violence.¹⁷ Finally, violence in India kills and disables more women between the ages of 15 and 44 than cancer and its toll on women's health surpasses that of traffic accidents and malaria combined.¹⁸

Simister and Mehta examined the trends of domestic violence in India over the past several years. Their review of crime data and household surveys found an increase in the prevalence of cruelty by husbands from 30% to 60% between 1995 and 2007. The increase in violence against women correlates with changes in attitudes towards gender roles as women become less likely to accept a subordinate status to their husbands.

According to the NFHS-III survey, twenty-two percent (22%) of women who reported experiencing domestic violence from a current husband sought help. Of those seeking help, less than one-half percent (0.4%) sought help from a doctor or other medical personnel and fewer than one percent (0.6%) sought help from a lawyer. Because family violence is such a taboo subject in India and rarely discussed it is likely that the incidence and prevalence of domestic violence is under-reported. The reported data alone, however, indicates a high rate of prevalence within the country.

The state of Orissa and domestic violence. The state of Orissa is located in eastern India on the Bay of Bengal. Orissa's estimated population in 2009 was 40,025,000¹⁹ with 14.99% of the population living in urban areas in 2001. According to the NFHS-III 2005-2006, 41.2% of ever-married women in Orissa experienced spousal violence, slightly higher than the national rate. Thirty-three and a half percent (33.5%) experienced physical violence, 15% experienced sexual

15 Martin S, Tsui A, Kuhu M, and Marinsshaw R. Domestic Violence in Northern India. *Am Jnl of Epidemiology*. 1999;150:417-426.

16 Ibid, Kaur.

17 Ibid, Kaur.

18 Ibid, Kaur.

19 Projected Population. India Census website. Available at: http://www.censusindia.gov.in/Census_Data_2001/Projected_Population/Projected_Population.pdf. Last accessed on May 8, 2010.

violence, and 20% experienced emotional violence during the twelve months preceding the survey. Details regarding the types of physical abuse experienced by married women in Orissa and India are found in Table 1 below.

Table 1. Ever-married women, age 15-49, who suffered violence by husbands*		
	Orissa	India
Pushed, shaken, thrown something at her	13%	14%
Slapped her	32%	34%
Twisted arm, pulled hair	14%	15%
Punched with fist or something else	12%	11%
Kicked, dragged, beaten	14%	12%
Choke or burned her	4%	2%
Threatened or attacked with weapon	2%	1%

*National Family Health Survey (NFHS-3) 2005 – 06

According to the NFHS-III 18.6% of women in Orissa age 15 to 49 who experienced physical or sexual violence sought help. Sixty eight and a half percent (68.5%) of ever-married women never sought help or told anyone while almost eight percent (7.7%) told someone about the violence but did not seek help. Of those who sought help, 1.5% sought help from a lawyer, 2.3% from the police, and 1.0% from a social organization. The vast majority of those seeking help sought the help from their own family (75%). Unfortunately, the data for Orissa does not reveal the percentage of women who sought help from doctors or other health personnel. Overall, it is clear from the data that domestic violence is widespread while seeking help for it is rare.

Domestic Violence and Health Outcomes

Domestic violence has many negative health effects on its victims. These health outcomes are routinely encountered, assessed and treated by the health services system and include physical injuries ranging from assault (e.g., lacerations, fractures, internal organ injury), burns; chronic health problems such as irritable bowel syndrome, backache, headache, chronic pelvic pain, pelvic inflammatory disease; increased unintended or unwanted pregnancies, miscarriages, terminations, and low birthweight babies; gynecological problems; higher rates of sexually transmitted diseases, including HIV/AIDS; and, self-harm and suicide.^{20,21} Mental health issues can also occur as a result of domestic violence and include depression, fear, anxiety, low self-esteem, sexual dysfunction, eating problems, obsessive-compulsive disorder, and post-traumatic stress disorder.^{22,23}

20 Ibid, Carretta.

21 Ibid, Taket.

22 Ibid, Carretta.

23 Ibid, Taket.

An analysis by Ackerson and Subramanian of data from the 1998-1999 Indian National Family Health Survey, a nationally representative cross-sectional study of over 92,000 Indian households, found a strong association between a woman suffering multiple incidents of domestic violence and malnutrition.²⁴ The authors offer two possible explanations for the link between domestic violence and malnutrition. The first is that abusers withhold food from their victims as a form of control. The second explanation is that the violence results in psychological stress which causes physiological changes that lead to anemia and weight loss.²⁵ These injuries and health outcomes create a negative economic impact through the costly consumption of direct medical and mental health care services and indirect costs of lost productivity and wages.

With the link between domestic violence and health outcomes firmly established, it is imperative for health care providers to take an active role in preventing the abuse. Beyond simply treating the physical and mental injuries caused by domestic violence, health care professionals can help prevent the violence and resulting health outcomes by identifying those patients who experience domestic violence and referring them to supportive services.²⁶

Role of the Health Care System in Preventing Domestic Violence

Health care professionals can not only provide treatment for the resulting health outcomes of domestic violence but can also help prevent the violence by identifying domestic violence victims and referring them to support services. Health care professionals have a unique opportunity to intervene in domestic violence situations since they have access – often private, confidential access – to victims when they seek either related or unrelated health care treatment. By taking a proactive role in identifying victims and preventing domestic violence, health care professionals can reduce the negative health effects of the violence, thereby reducing the number of women treated for physical and mental injuries and the burden on the health system.

Inquiring about domestic violence. Inquiry about domestic violence by health professionals can uncover hidden cases of domestic violence, change the perceived acceptability of violence in relationships, make it easier for women to access support services earlier, change health professionals' knowledge and attitudes towards domestic violence, help reduce the social stigma of domestic violence, and help maintain the safety of women experiencing domestic violence.²⁷ It is important for health care professionals to inquire about domestic violence since the disclosure of abuse is unlikely to occur without direct questioning.²⁸ It is not information women are likely to simply volunteer to their doctor or nurse. With such a high prevalence of abuse, the evidenced health effects of the abuse, and the unlikelihood of voluntary disclosure, it is important for health professionals to inquire directly about domestic violence. The inquiry can lead to disclosure by the victim and successful intervention by the health care provider.

24 Ackerson L and Subramanian SV. Domestic Violence and Chronic Malnutrition among Women and Children in India. *American Journal of Epidemiology*. 2008;167:1188-1196.

25 Ibid, Ackerson.

26 Ibid, Taket.

27 Ibid, Taket.

28 Ibid, Taket.

Health care professionals have the opportunity to inquire about domestic violence because of their frequent contact with individual patients. Women routinely access health services for primary care, maternity care and care for their children. Also, those women who experience domestic violence may access services to address the physical injuries resulting from the abuse. These factors place health care professionals in the position to identify domestic violence victims. Additionally, inquiring about abuse and identification of victims by health care professionals can lead victims to access support services which have been shown to benefit women and children.²⁹

The development and implementation of a system of inquiry is dependent upon the organization and capacity of the health services system as well as the local agencies to which victims will be referred. Inquiring about domestic violence should be made in a non-judgmental manner and health care professionals should be able to give clear information on local agencies offering advocacy and support services.

Barriers to inquiry. Factors that prevent health care professionals from inquiring about domestic violence include the fear of offending female patients, the potential of putting the patient at risk by asking about abuse, and a belief in possessing a lack of expertise to help patients experiencing domestic violence.³⁰ Other barriers to inquiring about domestic violence include a lack of time, doubts of the efficacy of inquiry, a lack of privacy in the health services setting, and lack of proper training in how to frame the question.³¹

Barriers to disclosure. Inquiring about domestic violence doesn't mean the patient will disclose the abuse and receive assistance. Women may refuse to disclose the abuse due to feelings of shame and denial. She may be fearful of the abuser's or others' reaction to the disclosure. Also, fear of negative consequences regarding children can prevent a woman from disclosing abuse. A health professional with an unpleasant attitude toward abuse can also discourage a victim from disclosing domestic violence, while a perception that the health professional is uncaring, too busy, lacks interest, uncomfortable with the topic, or not listening may also prevent a victim from disclosing abuse.³² Finally, female patients' concerns about breaches in confidentiality can be a barrier to disclosure.³³

Training for inquiry and disclosure. It is recommended that no inquiry be made until health care professionals are trained and protocols are established that prioritize the safety of patients.³⁴ Establishing these protocols and providing training to health professionals on the inquiry about and disclosure of abuse will allow health care professionals to overcome ambivalent attitudes about domestic violence, alleviate any difficulties in the framing of questions about abuse or

29 Ibid, Taket.

30 Ibid, Taket.

31 Ibid, Carretta.

32 Ibid, Carretta.

33 Ibid, Taket.

34 Ibid, Taket.

seeing the patient privately, and learn proper recording techniques. Health care professionals can also learn more about the legal implications of domestic violence and the need for confidentiality after disclosure. Training can also provide health care professionals with awareness of the individual, social and cultural factors surrounding domestic violence, thereby helping them understand the frustration that often comes along with a victim's responses and the safety needs of patients. After a victim makes a disclosure of abuse the health care professional must be able to address the problem by identifying available resources and making proper referrals. Therefore, it is important to increase the health care professionals' knowledge of local advocacy and support services.

It has been shown that training health care professionals to properly respond to disclosures of abuse and increasing their knowledge of available services encourages them to inquire about abuse and alleviates concerns about creating controversy.³⁵ Also, if a health care professional feels there is limited time to inquire, he can be trained to recognize the indicators of abuse, thereby allowing him only inquire in suspected cases.

Several studies have shown that training alone does is not associated with increased screening and identification of domestic violence victims. Beyond training health care professionals about domestic violence screening, other practices that can increase screening and identification rates include: adding a domestic violence screening question to the patient's medical history questionnaire, providing feedback to those who are screening of the efficacy of the screening, ensuring patient privacy, and having on-site resources available. Additionally, the health system can help build awareness about domestic violence through information and media campaigns, and with displays of information about domestic violence and the victim support services.³⁶

Domestic Violence and the Law

The effective utilization of the domestic violence law and the legal process the law creates influences the health and well-being of those who utilize it. Understanding how to maximize the law's positive impact on health allows the law to share medicine's principle of "above all do no harm." "Too often, however, we see how the legal system can negatively impact the people who become involved in it. The process of civil litigation, for example, can negatively impact people both emotionally and financially through its time-consuming and often psychologically draining processes."³⁷

The most obvious influence domestic violence law has on health and well-being is the prevention of future physical injury. Therefore, proper implementation of the laws protecting victims, adequate utilization of the law by victims, high levels of awareness among victims, and an understanding of the health impacts by legal professionals should result in improved health outcomes for women. Court systems are adversarial by nature and set out procedures that

35 Ibid, Taket.

36 Ibid, Taket.

37 Schma W, Kjervik D, and Petrucci C. Therapeutic Jurisprudence: Using the Law to Improve the Public's Health. *J Law Med Ethics*. 2005;33(4 Suppl):59-63.

victims have little control over. Victims are asked to recount the abuse and can face questioning about her credibility, memory, and veracity. These factors can prevent victims from utilizing the law that is meant to protect her or may cause her to stop the proceedings before they are completed. Lack of social support and severity of abuse have been found to impact a victim's effective utilization of the law. Other barriers to the utilization of the law include confusion and frustration over delays in the court proceedings, fear, and conflict over whether the abuser should be punished.

The ability to effectively utilize the domestic violence law influences a victim's health and well-being. If the domestic violence law is not effectively implemented or utilized – for example, when women are not aware of the law or face barriers to utilizing the law fully – the legal process will have a negative effect on women's health and well-being. Therefore, it is important for those who take part in the legal process, such as lawyers, judges, and victim advocates, to understand the influence the legal process has on the health and well-being of the women who seek to use it.

Domestic Violence Law in India

Before 2005 there was no law in India specifically addressing domestic violence. Women who experienced domestic violence had to rely upon a variety of criminal and civil laws to gain legal relief and protection from the abuser. These various legal remedies were time consuming and confusing since several different courts had to be accessed and various claims filed. Also, there was no law granting victims of domestic violence immediate relief, which is an important need for women seeking to escape violent relationships. To overcome these shortcomings the Indian legislature enacted the Protection of Women from Domestic Violence Act, 2005 (PWDVA). The PWDVA attempts to solve the problems victims faced with the earlier legal provisions by creating a single law to address domestic violence, provide women easier access to court, and grant immediate relief.³⁸

Quicker access to court is facilitated through the Protection Officer, who is the governmental implementer of the law charged with guiding victims of domestic violence through the legal process and assisting them in meeting their immediate needs. The PWDVA also directs state governments to identify Medical Facilities which are instructed to provide free medical assistance to domestic violence victims upon their request or that of the Protection Officer. The Protection Officer is to assist the victim in filling out the form requesting relief and the law mandates a resolution of the case with sixty days of filing.

There are several legal remedies a victim can request under the PWDVA. These requests can be granted as part of an *ex parte* order (i.e., an order issued before a hearing is held) and also in final orders after a hearing. The court can grant a protection order enjoining the abuser from contacting the victim, thereby preventing any further acts or threats of domestic violence. A residence order can be issued granting the victim possession of the marital home. Custody orders regarding the couple's children can be also be issued. A maintenance order can be granted

38 Ibid, Lawyers Collective Women's Rights Initiative.

by ordering the abuser to meet the victim's financial needs and incurred expenses such as medical bills, and a compensation order can be issued to compensate the victims for any injury beyond any actual monetary loss or expenditure.³⁹

For the past three years, since the enactment of the PWDVA in October 2006, the Lawyers Collective Women's Rights Initiative (LCWRI) has monitored and evaluated the implementation of the PWDVA. LCWRI reports on the PWDVA have investigated the appointment of Protection Officers throughout the states, inadequate budgetary issues, coordination efforts of government offices and the types and number of reliefs granted. Its last report, in November 2009, examined the attitudes of Protection Officers toward victims of domestic violence and the PWDVA.

METHODS

A qualitative study was conducted to identify and analyze the impact the PWDVA has on the health needs of domestic violence victims and the preparedness of the health system to address domestic violence. In-depth interviews were coded and analyzed for themes, followed by the formation of hypotheses and findings.

From July to August 2009, in-depth and group interviews were conducted with 67 respondents. Respondents included victims of domestic violence residing at shelter homes, victims of domestic violence who filed petitions under the PWDVA, shelter home workers, attorneys who represent domestic violence victims, other domestic violence advocates and NGO workers, doctors and other care providers, and district level government officials. Key informants were located in the districts of Cuttack, Puri, Khurda, Jajpur, and Bhadrak, five of Orissa's coastal area districts and were identified through a combination of convenience and snowball sampling. See Table 2.

Table 2.	Domestic violence victims	Shelter home workers	Health care and health service providers	District officials	Other service providers (e.g., attorneys)	Total
Cuttack	9	1	6	1	10	27
Puri	7	2	2	2	-	13
Khurda	-	1	1	1	-	3
Jajpur	8	3	1	1	-	13
Bhadrak	8	1	1	1	-	11
Total	32	8	11	6	10	67

The interviews varied in length from 15 to 60 minutes. Interviews were conducted using interview topic guides that were developed in collaboration with Sunita Singh, of CHSJ. Topic

³⁹ Ibid, Lawyers Collective Women's Rights Initiative.

guides were developed for each subset of stakeholders. The topic guides were reviewed and modified after each interview to reflect new lines of questioning and incorporate new learning. The key informants were interviewed regarding the utilization of the PWDVA and role of the health system in addressing domestic violence. By interviewing protection officers and those familiar with legal system I was able to inquire about the utilization of the PWDVA by victims of domestic violence. Through interviews with physicians and other health professionals I was able to discern the preparedness of the health system to address domestic violence.

Before each interview, informed consent was obtained from the respondent. Using the WHO guidelines for interviewing victims of domestic violence, an informed consent form was developed in both English and Oriya. Ms. Mohanty was also provided training on obtaining informed consent. Respondents were made aware of the purpose of the interview, that their identities would remain confidential, the right to refuse to answer any questions, and their ability to stop the interview at any time.

The interviews with doctors, lawyers, and some government officials were conducted in English. When a respondent did not speak English, interviews were conducted with the aid of a research assistant, Suchismita Mohanty, in Oriya and/or Hindi. During the interview Ms. Mohanty interpreted stakeholder responses allowing me to ask follow-up questions. All interviews were recorded with a digital audio recorder. I then transcribed the interviews conducted in English and Ms. Mohanty and another research assistant, Santosh Kumar, translated and transcribed the interviews conducted in Oriya.

After translation and transcription a thematic content analysis was conducted, whereby the interviews were coded. The codes were then grouped into themes and hypotheses as to the utilization of the PWDVA, the health impacts of the PWDVA and the preparedness of the public health care system were made.

FINDINGS

Two findings emerged from the thematic content analysis. The first finding considers the PWDVA process to have three phases during which a victim's utilization of the law can be impacted. The three phases are: (1) A victim becomes aware of the law and seeks help, (2) A victim gains support and assistance, and (3) A court resolves the case and grants relief. A victim's ability to effectively utilize the PWDVA will positively or negatively influence her health and well-being and during each of these phases. The second finding reveals the perceived roles and responsibilities health care providers have toward victims of domestic violence and examines the factors underlying these perceptions.

THREE PHASES OF THE PWDVA AND VICTIM UTILIZATION

Factors present during each of these phases impact a victim's effective utilization of the PWDVA. For example, during the first phase her decision to use the law cannot occur until she becomes aware of it. During the second phase the workload of Protection Officers and gender issues can

limit the victim's utilization of PWDVA provisions. Finally, in the third phase lack of awareness of the law by judges and delays in the court's decision making process impact effective utilization of the PWDVA. See Figure 1.

Figure 1. THREE PHASES OF THE PWDVA AND VICTIM UTILIZATION		
Phase One: Becoming aware and seeking help	Phase Two: Gaining support and assistance	Phase Three: Court resolution and relief
Factors Impacting Effective Utilization of the PWDVA by domestic violence victims		
<ol style="list-style-type: none"> 1. The victim's awareness of the domestic violence law 2. The victim's inability to find the Protection Officer 3. The costs with locating the Protection Officer 	<ol style="list-style-type: none"> 1. The Protection Officer's dual roles 2. The Protection Officers large workload 3. Lack of monetary and personnel support for the Protection Officer 4. Failure to recognize all the relief a victim needs 	<ol style="list-style-type: none"> 1. Delays in the court proceedings 2. Judge's lack of awareness of domestic violence law

Phase One: Becoming Aware and Seeking Help

Phase One of the PWDVA process begins when a victim becomes aware of the PWDVA, decides to utilize the law, and contacts a Protection Officer. Several factors impact the victim's utilization of the PWDVA, thereby influencing her health and well-being. These factors include her awareness of the law, her ability to locate and contact the Protection Officer, and the financial costs she bears in seeking assistance.

Awareness of the PWDVA

Awareness of the PWDVA is the first step to a domestic violence victim utilizing its provisions and gaining relief. Several organizations are making efforts to increase awareness of the PWDVA. For example, one shelter home is conducting village-level meetings about the PWDVA's provisions to spread awareness. In some districts village-level health workers, known as Angawadis, are encouraged to refer victims to Protection Officers for assistance. Some advocates believe it is important for awareness of the PWDVA to spread beyond the women who experience domestic violence to community and family members, government officials, health care professionals and legal professionals.

“We have awareness meetings in this regard and we see the impact and more and more women are coming forward. They know their rights.”

– Shelter home worker

One reason given for the lack of awareness of the PWDVA is its recent implementation by the state government. Overall, advocates and Protection Officers are confident that awareness of the law is growing and that more victims will take advantage of its protection and relief. Even with the growing awareness, the sentiment is that more awareness is needed.

*“Woman does not know what is the Protection Officer, even the community, those who can extend help to the woman **they do not know who is the Protection Officer, whether there is a provision of Protection Officer, where there is a domestic violence law**, because this is only in 2006, people do not know, and ordinary citizens cannot understand the law, we cannot expect that every peoples can know the law, where it is implemented, who are the agencies, what are the mechanisms, they do not know.”*

– Legal Advocate

Women who leave an abusive situation and become aware of the PWDVA do not always seek the law's remedies. They choose to pass up the opportunity to receive an order for compensation, maintenance, or protection. Various reasons are given for choosing not to file a claim under the PWDVA. Some women do not want to become involved in a process that will result in confronting and reestablishing ties with their abuser; they escaped the violence and have no desire for further contact. Other women do not believe it is socially proper or culturally allowable for a wife to bring a legal claim against her husband.

Search for Protection Officer

The time and effort it takes to locate and contact a Protection Officer can hinder a victim's utilization of the PWDVA. The PWDVA requires at least one Protection Officer per district. The law does not disallow multiple Protection Officers in a district, however, the practice has been to appoint only one. This practice results in individual Protection Officers being tasked with providing services to district female populations ranging from 1,130,000 to 650,000.⁴⁰ Furthermore, the Protection Officers are based at the district headquarters, which are large urban areas often far removed from rural areas by poor roads and long distances. Locating the Protection Officer can prove challenging for victims who must travel several kilometers to a large, unfamiliar city. Also, sign postings for the Protection Officer's office, often located in a large government office building, can be indistinct. While there is no cost to file a claim under the PWDVA some informants pointed out how victims end up bearing significant expenses for food and lodging when traveling to the district headquarters to contact the Protection Officer.

40 Based on 2001 census figures.

“I have a advertisement board downstairs.”

– Protection Officer

*“So I advised them, why did not you go to the protection officer because this comes under domestic violence . . . **but she does not know where the protection officer's office**, so I gave her the telephone number of the protection officer and address. She went there, but the protection officer, she did not find the protection officer there.”*

– Legal advocate

*“Those who come they come with great difficulties as **they have no money**. . . . **She is coming from far off places with hungry belly.**”*

– District Social Work Officer

Phase Two: Gaining Support and Assistance

The second phase of the PWDVA process occurs after a victim makes contact with the Protection Officer and seeks relief under the PWDVA. Factors that impact the victim's utilization of the PWDVA and influences her health and well-being during this phase include the workload and multiple roles of Protection Officers and the understanding of available relief.

Protection Officer Workload and Roles

All Protection Officers in the study held other district government positions, such as program officer of the Integrated Child Development Scheme (ICDS), in addition to their Protection Officer posting. The dual roles creates a tremendous workload for the Protection Officers and only allows them to dedicate part of their time to assisting domestic violence victims. Protection Officers are responsible for making an initial inquiry into the allegations of abuse which often requires traveling to the victim's village. Additionally, Protection Officers are in charge of serving the court hearing notice on the abusers.

*“Again, I am a program officer also. **I am not only Protection Officer. So the workload is very hostile.** As a program officer I have to . . . execute some programs . . . I have to assist in the ICDS programs.”*

– Protection Officer

*“Yes, yes, court notice to the respondent. It has to be served only by protection officer **but protection officers have no . . . manpower to serve it.**”*

– District Social Welfare Officer

The fact that the Protection Officer is also in charge of ICDS does allow Protection Officers to establish close working relationships with health care professionals. These close relationships are beneficial to victims who are in need of medical assistance. Additionally, many Protection Officers have formed close working relationships with supportive services and other victim advocates.

*“[W]e also **have good relationship with the [Chief District Medical Officer], all the doctors.** As ICDS personnel we have very good cooperation from the doctors, every doctor, every doctor in our district. So they treat them free. It is very easy for me because I am the program officer and **I am also related to them in other schemes so it is easier to take the help of the doctors for the victims.**”*

– Protection Officer

Little or no personnel and monetary assistance is given to Protection Officers for the fulfillment of their duties. They must travel to the villages to investigate abuse allegations and coordinate supportive services for victims. One Protection Officer who was interviewed was able to employ two support staff through an Oxfam project. Monetary assistance for the execution of the Protection Officers duties and victim assistance is limited. One District Social Welfare Officer stated that only 5,000 rupees (approximately \$100) was allocated by the government for victim medical assistance. Confidentiality of victim statements and privacy are other concerns. The office of the Protection Officer is usually shared with other government officials which leads to a lack of privacy when discussing sensitive, personal matters with victims.

*“And district government has provided us some **monetary help which are not sufficient. I have no single room to counsel the parties.** They are not free to express their opinion, I am sitting within all the officials.”*

– Protection Officer

Relief Requests Made

The PWDVA allows victims to request several forms of relief including compensation for injuries, possession of the family home, and monetary relief for medical expenses. Women rarely discuss their medical needs with Protection

Officers or request compensatory relief for medical expenses. Occasionally a petition will be filed and include medical bills incurred by the victim.

“In most of the cases the victims are demanding for protection order, maintenance order, residence order, and compensation order. The victims are mostly worried that they should get maintenance order as she was dependent on her family and now she has no such support. Some women also demand that she should be allowed to live in their home as she has equal right in the family.”

– Protection Officer

*“Yes, victims of domestic violence have health needs because they are poverty stricken. Once they are poor they do not take care of her own health. But **they are not posing with their health problem before the judicial officers or protection officers** but they are hiding. When there is poverty people will think of bread and butter. They are having some health problem but they are not exposing or demanding for that.”*

– District Social Welfare Officer

Phase Three: Court Resolution and Relief

The third phase of the PWDVA process occurs after the petition is filed with the court. Factors that influence the law's effective utilization during this phase include the judge's own awareness of the PWDVA and delays in the court decision-making process.

Court Delays and Awareness

Final decisions on PWDVA petitions are supposed to occur no more than sixty days after the claim is filed, however, these decisions are often delayed and in one case was delayed for two years. Delays occur because some judges and magistrates are not aware of the PWDVA and its provisions. Protection Officers also complain of delays being caused by courthouse politics, whereby cases filed by attorneys are readily heard by judges while those filed by Protection Officers do not make their way to the judge.

“The magistrate said that since is a new act we don't have much experience on this. 'If you find anything on this then please let me know,' magistrate said.”

– Protection Officer

“[W]e have filed cases in court, the judges are not aware of this new act.”

– Lawyer

*“The problem we face is, whichever cases goes through the advocates, they register those cases at court very soon but **those cases which the Protection Officers forward it, they delay to register.** Some cases are being done and some are delayed. The problem is when I assure the victims that your case will be solved within sixty days it is delayed years. So the victims will lose faith on this act.”*

– Protection Officer

HEALTH CARE PROFESSIONALS' PERCEIVED ROLES AND RESPONSIBILITIES REGARDING DOMESTIC VIOLENCE

The second finding addresses the preparedness of health care professionals in the coastal districts to intervene in domestic violence cases. This finding first examines the perceived roles and responsibilities of health care professionals then explores the factors underlying these perceived roles and responsibilities. Figure 2 illustrates this finding.

Perceived Roles and Responsibilities

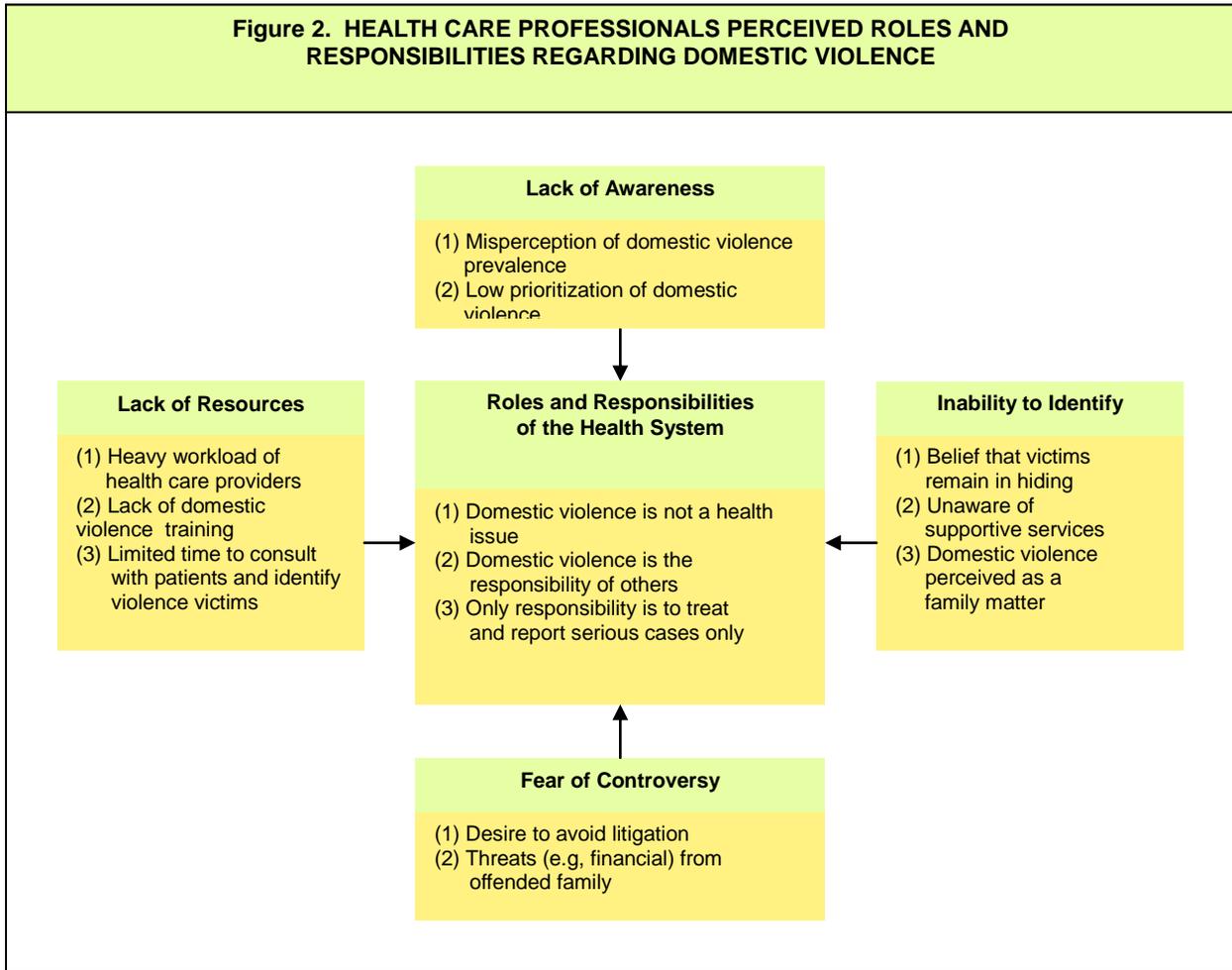
Respondents from the health services system expressed a belief that their roles and responsibilities with regard to domestic violence is limited. These responsibilities and roles are constrained by (1) the belief that domestic violence is not a health issue, (2) the idea that the issue of domestic violence is the responsibility of others, (3) the unwillingness to do more than treating resultant injuries and only intervening in serious cases. Each of these factors impact the willingness of health care professionals to work toward preventing domestic violence through inquiry, identification and referral.

Domestic Violence Is Not a Health Issue Beyond the physical injuries that result from domestic violence, such abuse is not perceived to be a health issue and, therefore, is not a concern for health care professionals. Other public health issues such as infectious disease control and disease surveillance are held to be the responsibilities of health care professionals – not inquiring about and identifying domestic violence.

“We are not concerned in that sector. These types of violence. We are not directly concerned with that.”

– Doctor

“Doctors are not concerned with family violence.”



Someone Else's Role Health care professionals view domestic violence as a family matter and not within the “jurisdiction” of health services. Instead, domestic violence is perceived as an issue to be dealt with by other entities such as the local government, the police, womens' advocacy groups, and other social organizations.

*“When there is a controversy, like a woman is victimized somewhere, **the administration takes that.**”*

– Doctor

Treat and Report Serious Cases Only Health care professionals attempt to limit their intervention in domestic violence cases to the treatment of any resultant injury and to the occasional reporting of serious incidents to the police. They are quick to point out that there is never any delay in the treatment of patient injuries and that medical services are readily

administered. However, very little is done beyond the provision of medical care. Health care professionals are not trained to counsel domestic violence victims nor do they routinely inquire about the abuse or refer victims to supportive services.

*“Anytime the victim comes she gets the services immediately, **there is no delay in giving medicines or services.**”*

– Doctor

Health care professionals will inform the police when they treat serious injuries, such as burns. Informing the police of such a serious case requires the physician to fill out an examination report which becomes part of the police investigation. Doctors clearly see the completion of this report as one of their responsibilities with regards to domestic violence victims, however, such reports can be taken away from their medical duties. The police are not informed if the doctor considers the injuries to be minor, or if the health care professional believes the victim would deny the abuse.

*“We are **concerned about the treatment and the examination report.** We are concentrating on these two points.”*

– Doctor

*“**These cases we do not report to the police. Because in the police investigation she will deny. Definitely deny. When she burning case, that my husband has beaten me, in that case we inform the police.**”*

– Doctor

Causes of Perceived Roles and Responsibilities

Four thematic categories of causes for the health services system and health care professionals' perceived roles and responsibilities were identified. See Figure 2. The categories include: (1) Lack of Awareness, (2) Inability to Identify, (3) Fear of Controversy, and (4) Lack of Resources. Each category is characterized by its own underlying phenomena and described in the following sections.

Professional Lack of Awareness

There is a lack of awareness of the prevalence of domestic violence and a view that domestic violence is a low priority for health care professionals. As noted above, according to the NFHS-III survey 41% of ever-married women respondents in Orissa experienced domestic violence in the twelve months preceding the survey. Health care professionals, however, repeatedly stated that domestic violence is rare in Orissa. They are unaware of the true numbers of

women experiencing domestic violence. Furthermore, health professionals held domestic violence as a low priority.

*“Domestic violence we do not have much of the incidence of domestic violence, of domestic violence reported to us in this district. **Domestic violence is very stray, sporadic cases.**”*

– Doctor

*“That sort of family violence **we don't see much here.** . . . We don't see that much of family violence in our area.”*

– Doctor

*“**Family violence is subordinate, secondary, not primary**”*

– HIV/AIDS Counselor

**Inability
to
Identify**

The failure to identify domestic violence cases results in health care professionals limiting their role to injury treatment only. Health care professionals report that it is difficult to identify victims of domestic violence women often hide the abuse.

*“**They hide that their husbands has beaten.** They show that they are injured on road accident or something.”*

– Doctor

The idea that women are hiding the abuse, however, runs counter to the notion that patients, including victims of domestic violence, see health care professionals as a source of help and relief.

*“They think of the doctor as **the most compassionate people who can give them some solace, can, having heard their problems, difficulties, can give them shelter, can ask the police to give help to them.** That is why they come to us.”*

– Medical Officer

*“People **believe in doctor** but doctor has no time, doctor only does medical side.”*

– HIV/AIDS Counselor

The inability to identify domestic violence cases also stems from a cultural unwillingness to intervene in what is seen as a family matter.

*“When we wed **everything else has to be good**, the violence and the domestic violence.”*

– Medical Officer

Fear of Controversy

Health professionals are wary of becoming involved in what is seen as a family matter when their intervention could lead to additional work or personal consequences. The consequences health professionals can face when assisting a domestic violence victim underlie the perception that their only responsibility is to treat injuries and leave interventions up to others. Domestic violence is viewed as a family matter and inquiry about the abuse by a health professional can harm the family's reputation. Harming a family's prestige puts the health professional at both financial and physical risk, thus, from the health care professional's view, it is better not to inquire about the abuse and offer support.

*“Her request for help is a **disclosure of a family matter**.”*

– Doctor

*“If we suspect, I will tell, **the family may issue a case against me**, and they say that [the health professional] is harassing [and] some lakhs of rupees we must get compensation. [The doctor] **must give compensation**.”*

– Doctor

Because of their heavy workload and limited time, health professionals are reluctant to become involved in any criminal litigation that may result from their reporting of domestic violence incidents to the police. The filling out of examination reports for police investigations and testifying in court proceedings are tasks that take the health professionals away from their primary medical duties.

*“If we get into that thing then **we'll be inside litigation always**.”*

– Doctor

“As a health personnel we don't get into that litigation.”

– Doctor

**Lack of
Resources
and Training**

A final factor that influences the roles and responsibilities of the health system is its lack of resources. Without adequate resources health professionals are unable to properly inquire and identify victims of domestic violence and refer them to supportive services. Many of the physician positions in the districts are unfilled and many hospitals and clinics are understaffed. Administrators reported doctor population ratios of 1:20,000 and 1:30,000. The result is an increased patient load that does not allow adequate time to inquire about domestic violence.

*“Daily it will be 100, 200, 300 patients he is seeing. Four hours a day, two hundred forty minutes, three hundred patients, **less than a minute for a patient to be check up.** Over and above he has to do other works.”*

– Doctor

A lack of knowledge of supportive services also limits a treating doctor's ability to identify victims of domestic violence. There is evidence of coordination and knowledge of supportive services at the higher levels of health services administration, however, this knowledge and coordination is not filtering down to the treating doctors due to heavy workloads and limited time with patients.

*“Here at the district level we want to sit down and discuss it, but that, the organization, myself, the police, the judicial officer we are in touch. Because I am not treating doctor only, I am an administrator superintendent of the hospital, I get more time to talk about these things, but **down below who is a treating doctor and also an administrator he does not have much time to give to this system.**”*

– Medical Officer

Belief that victims will not admit the abuse to police is another reason why health care professionals do not report identified incidences of violence. One provider recalled a case in which he identified a victim of domestic violence and got her to admit to him that her husband caused her injuries. The doctor failed to report the case to the police believing the patient would deny the abuse. This doctor and several others also spoke about the lack of training health care professionals receive regarding domestic violence.

*“I have no training. No training. We are just trained as medical graduates, **we are not trained in that aspect. That is the social side.** We are not trained. We have trained in diseases, only in diseases.”*

DISCUSSION

Increasing PWDVA's Positive Influence on Health and Well-Being. Several things can be done to remove the barriers to the PWDVA's effective utilization and increase the law's positive influence on the health and well-being of domestic violence victims. Increasing awareness of the PWDVA is the first step for giving victims access to the law's relief. Spreading awareness of the law the community in general and legal professionals and health care providers specifically can help to ensure that awareness of law makes it victims who are unable to find out about it for themselves. This increased awareness can be made through media campaigns, public health campaigns, and professional trainings. Awareness alone, however, will not guarantee a victim's utilization of the PWDVA. In some instances cultural beliefs regarding the inability of a wife to sue her husband will prevent utilization of the law. In fact, this cultural beliefs may actually have a positive influence on well-being by reducing the stress that comes with litigation and facing one's abuser.

The next step to increasing victim utilization is to increase the visibility of the Protection Officer and reduce the difficulties victims face in contacting the Protection Officer. The law permits more than one Protection Officer in a district. Having multiple Protection Officers will allow easier access to the legal system and provide greater utilization of the law. Posting the additional Protection Officers outside of the district headquarters would also increase visibility of the Protection Officer and utilization. Increasing the number and locations of Protection Officers reduces the financial costs domestic violence victims currently bear in their attempt to contact the Protection Officer and utilize the PWDVA.

Without a sense of confidentiality a victim may be unwilling to disclose important information, thereby limiting the assistance the Protection Officer can give and the relief the victim may seek. These factors limit the victim's utilization of the PWDVA and can affect her health outcomes by not allowing her the full protection of the legal process. Providing areas for private and confidential disclosures to both Protection Officers and health care providers can help to increase the utilization of the PWDVA.

Ensuring that a victim requests all the relief she is entitled to is another way of increasing the effective utilization of the PWDVA. Ascertaining whether the victim has any medical expenses is an important step Protection Officer and attorneys should take in order to improve the well-being of victims. Victims who contact Protection Officers are generally focused on acquiring possession of the home or maintenance from the abuser and not expressing concern about their medical and health needs. This can be accomplished by providing Protection Officers with adequate resources and personnel to complete her duties under the PWDVA.

Court delays severely limit the utilization of the law by victims. If a victim is in need of monetary relief in order to obtain medical services her health can be jeopardized. Furthermore,

long delays without relief can lead to a victim's return to her abuser out of financial need. Court delays also erode confidence in the legal system and prevent others from seeking the protection found under the PWDVA.

Changing the Perception of Health Care Providers. Health care providers' current perceptions of domestic violence can be changed through increased training about domestic violence screening, increased coordination between the health system and support services for victims, and protecting health care providers from liability when they assist a victim.

Doctors routinely attend training sessions for their medical practice. One recommendation is to develop a curriculum to train the doctors on how to screen patients for domestic violence. It is also important to make health care providers aware of supportive services available to victims and of the efficacy of these services. In many districts personal connections already exist between the Protection Officer and medical officers. The next step is to institutionalize these relationships so that effective, widespread coordination can occur.

Finally, addressing doctors' concerns about litigation is an important step to changing their current perceptions about assisting domestic violence victims. Removing the fear of being sued and becoming involved in litigation will make it less difficult for health care providers to screen for domestic violence and assist victims. Making screening and/or reporting of domestic violence mandatory would remove a doctor's liability from upset family members. A mandated duty to screen and report will mean that a doctor is simply following his legal duties and not maliciously interfering in a private family matter.

CONCLUSION & REFLECTION

Limitations and Weaknesses. Limitations I faced included not being from the culture and not speaking either Hindi or Oriya. Also, before this project I lacked a solid understanding of the systems, both legal and health, I was interacting with. Having some inside knowledge would have been beneficial. I was basically asking questions about these systems while learning about them. These factors played negatively into my limited time of eight weeks in Orissa. I would have been nice to follow up with some of the key informants to clarify and validate answers or ask new questions that arose out of other interviews. It was challenging to access the high level government officials since they had limited time and were more unwilling to speak than lower level officials.

This project initially began as a project examining the health needs of domestic violence victims but when questioned about health needs victims could not or would not name any needs. I could not find a good way to ask these questions. Perhaps the victims' lack of response to my questions pointed to an answer of another question, however, I chose not to pursue that and instead refocused my attention on the utilization of the law and the health system's preparedness. This refocusing took time and the adjustment caused me to move away from interviewing victims of domestic violence and seeking out Protection Officers, health care providers and other advocates instead. The refocus was also very broad and I could have narrowed the project's

scope to be more manageable and concise.

With health care providers I found myself sometimes moving too quickly to the subject of domestic violence. This left some health care providers confused about the project's purpose. The project covers a broad geographical area, one that is actually smaller than originally planned. This made for some long travel days while trying to squeeze in several interviews during each trip. The long distances and travel times also prohibited revisiting informants.

Strengths. One of the strengths of the project comes from my background as an attorney who practiced domestic violence law. I found a lot of the stories told by victims, attorneys, and other advocates to be quite familiar. This helped to counter my unfamiliarity with culture and language as it meant we all shared something in common. I also feel that having a basis for understanding the legal process was beneficial and it allowed me to quickly understand the PWDVA provisions and procedures. My previous experience in interviewing victims of domestic violence also helped as it taught me to give the victim the power over the process and not re-victimize them.

Conclusion and Reflection. This project has helped to bring awareness that domestic violence is a public health issue. For some health care providers it was a novel reframing of domestic violence from an individual and family issue to a public health issue. Attorney's commented that they would now be careful to consider health issues of clients. Many of issues brought up in the project are already known components of the domestic violence issue, however, having a study that confirms those suspicions will be helpful. This project also shows local organizations who are already doing domestic violence training where additional training and collaboration is needed. Hopefully this project will help those organizations also influence the way in which the PWDVA is being implemented by advocating for more resources for Protection Officers and resolutions to the reasons for court delays. The project compares nicely with the previous literature. It was apparent that the more support a victim had the more likely she was going to effectively utilize the PWDVA. Also, it is obvious from my observations that more than providing training to doctors about domestic violence screening is needed. The training is a valuable step but not the only one needed in order for the health system to address the issue of domestic violence.

APPEDIX A

Violence Victims Health Needs In-depth Interview Topic Guide – Care Provider

First, I'd like to ask you some questions about you and your organization.

What is your name? What is the name of your organization? What is your title? Tell me about your organization.

What services does your organization provide? How does a person access your services? How is your organization compensated for the services you render?

What areas/districts does your organization serve?

Describe how your organization is structured.

Now, I'd like to ask you some questions about violence against women.

Tell me about the different forms of violence against women you have observed through your employment.

Does your organization have a protocol for identifying and serving victims of violence? Is this a written protocol? May I see a copy of the protocol? How is your staff trained to identify victims of violence?

Think about a woman who you assisted that experienced violence. Tell me about her. What kind of violence did she experience? How did she obtain your services?

What health problems (sicknesses, illnesses, injuries, mental illness, addiction, hunger) did she have? How did you assist her?

Did she have any difficulties in obtaining your services?

Has a woman ever disclosed to you that someone tried to prevent her from obtaining your services?

How were you paid for the services you provided?

What health issues (sicknesses, illnesses, injuries, mental illness, addiction, hunger) have you observed in other women who you know experienced violence?

Have you ever treated the children of women who experienced violence? Tell me about a time you assisted a child of a woman who experienced violence.

What health issues have you observed in the children of women who experienced violence?

What relationship have you observed between women who experience violence and care during pregnancy?

Has your organization ever assisted a rape victim? What services did you provide? What

could a rape victim who became pregnant and did not want to be pregnant do?

Have you ever encountered a woman who suffered violence who worried about having AIDS or STDs? What services did you provide?

Under what circumstances would your organization be unable to assist a violence victim? If you are unable to provide the needed services to the violence victim what can she do?

Tell me about other organizations, agencies or groups your organization collaborates with to help victims of domestic violence?

Now I'd like to ask you some questions about your organization and its relationship with the shelter homes and the shelter home residents.

Tell me what you know about the shelter homes in your district or area.

What is your organization's relationship with the shelter homes in your district?

Tell me about a time when a woman from the shelter home came and received your services.

If a woman at the shelter home was unable to come to your organization for services what would happen? What could she do? Who could she contact?

Does your organization provide services to the babies and children of the women at the shelter home? How is your organization compensated for these services?

If a woman from the shelter home comes to your organization for services for herself or a child and your organization is unable to provide them what happens?

Tell me about any time your organization had difficulties in providing services to a woman or child who lived at the shelter home?

Thank you for your time. I have learned quite a bit about your organization and its services. This information will be helpful as we study the health needs of women who experience violence. Your answers are a contribution to this project. As a reminder, the information you provided will be kept secure and confidential. Do you have any questions? Again, thank you for your participation.

APPEDIX B

Protection Officer Questions

1. What can a woman who is a victim of domestic violence do to stop the violence? How can a woman who suffers domestic violence stop the violence?
2. What kind of help does she need if she leaves her husband or home?
3. Who can she contact for help?
4. How can they help her?
5. Where can she go if she needs medical treatment?
6. What are the reasons a woman goes to a medical facility after contacting you?
7. What steps do you take to assist a domestic violence woman who has medical needs?
8. What barriers have you encountered in referring domestic violence victims to medical facilities?
9. How did you overcome these barriers?
10. What effect has the PWDVA 2005 had on the community?
11. What recommendations do you have for future implementation of the domestic violence law?
12. Is there anything else you would like to add?

APPENDIX C

My name is Robert Baker-White. I am studying at the University of Washington in the United States. These are my colleagues _____. We are interested in discovering the health needs of women who live at swadhars in Orissa. To help us answer our question we plan to interview 20-30 women who live at swadhars across Orissa and we chose you because you currently live at a swadhar. We would like to talk to you and know hear about your experiences of coming to and living at the swadhar. We assure you that we will not disclose you identity and anything you tell us will be treated with strict confidence. Allowing us to interview you will help us learn about and understand the health issues faced by women living at swadhars.

If you agree to speak with us we would like to record the interview on an audio recorder and take some written notes. We will do this because we may not remember everything we discussed. The recordings will be kept in a secure place and will only be accessed by members of the research team. You may decline to talk to us and there will be no negative consequences if you refuse to be interviewed. If you agree to be interviewed you can decline to answer any question you are not comfortable with and you can stop the interview at any time. Do you have any questions? If you think of any questions later please do not hesitate to ask. Would you like some time to think about participating in the interview or would you like to talk to someone? If you agree to the interview please sign this consent form. Thank you.

Informed consent for health needs interview.

1. I understand the purpose of the interview and consent to being interviewed.
2. I understand that I have the right to withdraw my consent or refuse to answer any questions at any time.
3. I understand that refusing to answer any question or withdrawing my consent will not result in any negative action toward me.
4. I understand that the information I provide will be used in strict confidence.

Name _____ Signature _____

Date _____ Witness _____

APPENDIX D

1. Ackerson L and Subramanian SV. Domestic Violence and Chronic Malnutrition among Women and Children in India. *Am J Epidemiology*. 2008;167:1188-1196.
2. Ahmed-Ghosh H. Chattels of Society: Domestic Violence in India. *Violence Against Women*. 2004;10:94-118.
3. Bandyopadhyay m and MacPherson S. Women and Health: Tradition and Culture in Rural India. Brookfield VT: Ashgate Publishing Company; 1998.
4. Bent-Goodley T. Culture and Domestic Violence: Transforming Knowledge Development. *J Interpers Violence*. 2005;20:195-203.
5. Bent-Goodley T. Health Disparities and Violence Against Women: Why and How Cultural and Societal Influences Matter. *Trauma Violence Abuse*. 2007;8:90-104.
6. Carretta C. Domestic Violence A Worldwide Exploration. *Journal of Psychosocial Nursing*. 2008;46:26-35.
7. Cattaneo LB and Goodman L. Through the Lens of Therapeutic Jurisprudence: The Relationship Between Empowerment in the Court System and Well-Being for Intimate Partner Violence Victims. *J Interpers Violence*. 2010;25:481-502.
8. Fourth World Conference on Women Beijing Declaration. Available at: <http://www.un.org/womenwatch/daw/beijing/platform/declar.htm>. Last accessed on May 22, 2010.
9. Gittelsohn J, Bentley M, Pelto P, Nag M, and et al., eds. Listening to Women Talk About Their Health Issues and Evidence from India. New Delhi: Har-Anand Publications; 1994.
10. Heise, L. Violence against women: An integrated, ecological framework. *Violence Against Women*. 1998;4(3):262-290.
11. Jayaseelan L, Kumar S, Neelakantan N, Peedicayil A, et al. Physical Spousal Violence Against Women in India: Some Risk Factors. *J Biosoc Sci*. 2007;39:657-670.
12. Jordan C. Intimate Partner Violence and the Justice System: An Examination of the Interface. *J Interpers Violence*. 2004;19:1412-1434.
13. Kaur R and Garg S. Addressing Domestic Violence Against Women: An Unfinished Agenda. *Indian J Comm Med*. 2008;33:73-76.
14. Kermode M, Herrman H, Arole R, White J, et al. Empowerment of women and mental health promotion: a qualitative study in rural Maharashtra, India. *BMC Public Health*. 2007;7:225-235.
15. Krug G, Dahlberg L, Mercy J, Zwi A, Loranzo R, eds. World report on violence and health. World Health Organization. 2002. Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/index.html. Last accessed on May 17, 2010.
16. Lawyers Collective Women's Rights Initiative. Staying Alive: Third Monitoring & Evaluation Report 2009 on the Protection of Women from Domestic Violence Act, 2005. Available at: <http://www.unifem.org.in/PDF/Staying%20Alive%20Third%20M&E%20Report%202009%20%28final%29.pdf>. Last accessed on May 17, 2010.
17. McKie L. Review Article: Gender, violence and health care: implications for research,

- policy and practice. *Sociology of Health & Illness*. 2003;25:120-131.
18. Martin S, Moracco K, Barro J, Tsui A, et al. Domestic violence across generations: findings from northern India. *Intl J Epidemiology*. 2002;31:560-572.
 19. Martin S, Tsui A, Kuhu M, and Marinshaw R. Domestic Violence in Northern India. *Am J Epidemiology*. 1999;150:417-426.
 20. Minsky-Kelly D, Hamberger LK, Pape D, and Wolff M. We've Had Training, Now What? Qualitative Analysis of Barriers to Domestic Violence Screening and Referral in a Health Care Setting. *J Interpers Violence*. 2005;20:1288-1309.
 21. Misra P. Domestic Violence Against Women: Legal Control and Judicial Response. New Delhi: Deep & Deep Publications; 2007.
 22. Projected Population. India Census website. Available at: http://www.censusindia.gov.in/Census_Data_2001/Projected_Population/Projected_Population.pdf. Last accessed on May 8, 2010.
 23. Simister J and Mehta P. Gender-Based Violence in India: Long-Term Trends. *J Interpers Violence*. 2010;doi:10.1177/0886260509354577.
 24. Taket A, Nurse J, Smith K, Watson J, et. al. Routinely asking women about domestic violence in health settings. *British Medical Journal*. 2003;327:673-675.
 25. UN Division for the Advancement of Women, Economic Commission for Europe and World Health Organization. Violence against women: a statistical overview, challenges and gaps in data collection and methodology and approaches for overcoming them. Available at: <http://www.un.org/womenwatch/daw/egm/vaw-stat-2005/docs/final-report-vaw-stats.pdf>. Last accessed on May 28, 2010.
 26. Vienna Declaration and Programme of Action. World Human Rights Conference. Available at: <http://www.unhchr.ch/huridocda/huridoca.nsf/%28symbol%29/A.CONF.157.23.En?OpenDocument>. Last accessed on May 22, 2010.
 27. Wuest J, Ford-Gilboe M, Merritt-Gray M, and Lemire S. Using Grounded Theory to Generate a Theoretical Understanding of the Effects of Child Custody Policy on Women's Health Promotion in the Context of Intimate Partner Violence. *Health Care for Women International*. 2006; 27:490-512.
 28. Zoucha R. Considering Culture in Understanding Interpersonal Violence. *J Forensic Nursing*. 2006;2:195-196.