



Challenges and gaps in addressing domestic violence and women's health in Health Policy of Bangladesh

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Introduction

- Situation of domestic violence in Bangladesh
- Health Policy
- Why domestic violence and women's health is a matter



Objectives

- To explore:
 - How domestic violence is addressed as a health issue at policy level;
 - How the policy communities interact with each other to deal with women's domestic violence; and
 - What challenges and gaps remain in addressing domestic violence.



Methods

- Case study methodology
- 28 respondents
- Snowballing method of selection



Findings

- National health policy
- Laws pertaining to domestic violence
- Actions and interactions of policy community
- Coordination and commitment of policy community
- Gaps in health sector
- Shelter homes
- Fund flow and role of donors
- The role of mastaans
- Under-reporting of violence



Conclusion

- Structural problems relating to gender, economy, laws, policies, religion and social psyche | discriminate women
- The State is neglectful to domestic violence and women's health

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Health Policy of Bangladesh**

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Abstract

This paper presents the findings from the Bangladeshi part of an international comparative study done on domestic violence policy communities in five countries. The principal focus here is to explore the extent to which domestic violence is understood as a health policy issue and addressed in the National Health Policy of Bangladesh.

The results are based on review of country level health policies and plans for the next five years and on the interview of policy-makers, service providers, health care professionals, lawyers and police force working at government and non-governmental organizations and woman victims as well.

The findings reveals that after the International conference on population and development in Cairo and Women's conference in Beijing, much emphasis has been placed on violence issues in Bangladesh, particularly by the government and non-governmental organizations (NGOs). However, domestic violence and its impact on women's health were not addressed as a discrete issue at policy level. More importantly, the National Health Policy did not state clearly how violence against women would be addressed not to mention women's domestic violence. However, in recent years the one stop crisis centre operating under the Ministry of Women and Child affairs had been in place in two tertiary hospitals in Bangladesh. The centre offered medical treatment for the immediate problems caused by domestic violence and also arranged legal and social supports for abused women through NGOs, but, they did not have any programs for violence prevention. Their communications with local NGOs allowed them to receive cases from far villages. Yet, reaching a population of 140 million through two State run centers raised questions about its effectiveness. Many NGOs relied on each other for linkages and partnerships to assist abused and vulnerable women, however, critical gaps existed in overall integrated coordination. The common barriers in this sector are: absence of government's concrete policies to address domestic violence and women's health; lack of understanding or sensitivity to the issue of gender based violence and how it affects women's health; insufficient laws tackling domestic violence; donor driven project; inadequate safety and security of victims and workers; limited communications between government and non-government agencies; lack of shelter homes; inadequate support for counseling; and lack of training and awareness of health providers, police, lawyers and other staff. It is crucial to have comprehensive understanding of the policy makers and planners about how domestic violence affects women's health, how gender inequity causes domestic violence and why it is important to address domestic violence in health policy. This will lead to better policies and strategies to improve the situation of women's health affected by domestic violence and facilitate abused women to receive appropriate health, legal and social supports in Bangladesh.

Introduction

Domestic violence is a universal crisis which not only affects women's health but also goes beyond to affect their social and economic lives (Fishback & Herbert 1997). This worldwide catastrophe, which has been gradually drawing global attention, is very much socially embedded and enhanced by laws, religions, judicial procedures and socio-economic state discriminating women. Despite efforts at global level, domestic violence receives less priority at national policy level, particularly in health policy, and as a result, health sectors are not much responsive to this particular issue. This research has begun as a response to the significance of a transnational study to examine the extent to which domestic violence is addressed at national policies in five countries. This would lead to a launching of an international research program to influence the policy-makers and program planners at international and national levels to address domestic violence and women's health. At this point, we will explore challenges and gaps in addressing domestic violence in Health Policy of Bangladesh.

The Problem

Domestic violence is not an uncommon occasion in Bangladesh. The exact prevalence in domestic violence is difficult to capture due to cultural understanding and sensitivity of the issues existing in the society. As domestic violence encompasses a range of issues, the magnitudes of the problem are observed in various forms and facts. In Bangladesh, it is prevalent in myriad ways, from wife abuse to rape, dowry killings, acid throwing, sexual harassment and mental torturing. Schuler (1996; 1998) identifies in a study that 38 percent of women are beaten by their husbands in rural areas of Bangladesh. The figure seems much higher in urban areas documenting 60 percent of adult women battered by their husbands in Dhaka city (GOB, 1999). Yet, on the other hand, a life history approach observes a much higher magnitude of the problem where 72 percent of women are severely beaten by their husbands in some point of their life (Ain-O-Shalish Kendro, 1998). The occurrence of physical abuse authenticates the enormity of the problem, and concurrently, substantiates the existence of verbal abuse, which is anticipated to be high at family levels. A recent study in rural areas reveals the extent of verbal abuse, which is inflicted by 67 percent of husbands and 24 percent of family members (Bhuiyan, Sharmin and Hanifi, 2003). This scenario elucidates the pervasiveness of physical and verbal abuse in domestic violence against wives occurring in Bangladesh.

Increasingly alarming are becoming incidences of rape, acid throwing, murder and suicidal deaths, most of which seemingly happen at family levels ((Jahan, 1988; 1994). It was reflected in violence related statistics at hospitals where 23 percent of women were raped and 22 percent were burnt with acid throwing (Azim, 1999). The number of rape seems to be low because women decline to be exposed for the fear of stigmatization or ostracization. However, the newspaper reports estimated a slightly high figure where 27 percent of violence during 1995-97 accounted for rape. It also revealed that deaths due to murder were 25 percent among all violence related deaths. The aftermaths of violence are expressed in several forms ranging from acute and chronic bodily sufferings including reproductive health problems to mental depression and post-traumatic disorder. The most

severe form is suicidal deaths, which accounted for 10 percent ranking the highest among the causes of deaths of women of reproductive age group (Fauveau, 1994). This situation mirrors the mental state of women indicating shame, disgrace and depression pertaining to domestic violence.

The said scenario implicates the commonness of violence within the family. Violence is not a simple cause-effect relationship. It is produced within the social process, not separated from institutional, political, and economical power. In most societies, gender-based violence is largely a structural phenomenon embedded in the context of cultural, socio-economic, and political power relations reducing women to economically and emotionally dependent on men (Marcus 1993; Zaman 1999). Women's vulnerability to abuse is further reinforced by the existing cultural values, prevailing patriarchal norms, and the laws and practices of the State, religion and institutions, which continue to legitimize unequal rights and discriminatory treatment of women in the country (Zaman, 1999). In this regard, WHO (2002) states that to understand its intricacy, violence should be approached from multiple perspectives encompassing biological, social, cultural, economic and political. The ecological model illustrated in the World report explicates violence at individual, community and societal levels, and is appropriate for illuminating the complex nature of domestic violence (WHO, 2002).

At present, women are the victim of violence, and they die and suffer in silence. Women's sufferings lead to acute and chronic physical problems including psychological depression and suicide. The existing laws do not directly deal with domestic violence, and the judicial and legislative systems are not very much receptive to deal with this issue. The National Health Policy is still underway to be publicised. The Health Sector Reform documents, such as Health and Population Sectoral Program (HPSP) and Health, Nutrition and Population Sectoral Program (HNPS) bring issues of violence against women at surface, but domestic violence as a health issue is not yet prioritized. Even with the project-based trial of different interventions by the Government and national and international NGOs, it is still not clear how domestic violence as a health issue being addressed by them. Considering the fact, this research aims to explore how domestic violence is addressed as a health issue at policy level, how the policy communities interact with each other to deal with women's domestic violence and what challenges and gaps remain in addressing domestic violence.

Methods

The study used case study methodology and relied primarily on qualitative data. An expansive survey of literature was done to illustrate violence situation and the state of national policies and legal systems addressing violence in Bangladesh. Primary data were obtained through individual face-to-face interviews from three source groups: 1) the formal existing health policy community; 2) members of the DV prevention policy community; and 3) people affected by the policy but not involved in its development. Our sampling strategy was purposive, first identifying critical cases, and then using

snowball sampling techniques to broaden the sample based on the source groups. We made appointment with our respondents over telephone and then showed up to take interviews. Some interviews were carried out by just showing in office or meeting in crisis centre and shelter homes.

Individual interviews took about one to four hours. As a pilot, we interviewed 28 people from government, NGOs, women organizations and women victims. An interview guide was developed for interviewing each source group. We selected four interviewers, two having Masters in Anthropology, one in Environmental Science and the other in Nutrition. Most interviews were audio-recorded with permission. Our interviewers were not able to interview one respondent from a policy research NGO. Another respondent refused to talk on the next day.

All interviews were transcribed, reviewed by the interviewer, and entered into Atlas Ti to aid analysis and interpretation. Thematic analysis using memoing and coding, and immersion and crystallization were done along the lines of the study objectives. Connecting and legitimating through reviewing the texts and identified themes were done in conjunction with revisiting the relevant literature. Data were analyzed and triangulated to develop a thick and detailed description of each locale's existing DVHPC, its networks and advocacy coalitions, and the impact of national and international policies upon it. Data were analyzed and triangulated to develop a thick and detailed description of each locale's existing DVHPC, its networks and advocacy coalitions, and the impact of national and international policies upon it. In this way, local and disciplinary perspectives were brought to the interpretation.

National policies: Domestic violence and women's health

Following the declaration of the UN Decade of Women (1976-85), the Government of Bangladesh, women's organizations and the NGO sectors have undertaken several programs for the advancement of women's rights. The UN Convention of the Elimination of All Forms of Discrimination against Women (CEDAW) and the Beijing Platform for Action draw much attention to violence against women, and thus, at national level the countries acceded to put it into practice. In the country context, Bangladesh places emphasis on the role of State and NGOs to address violence against women. In March 1997 the Government of Bangladesh declared the National Policy for Development of Women under the Ministry of Women and Child Affairs. This comprehensive policy commits to develop women as a human resource, establish women's human rights, eliminate all forms of discrimination against women and girls, and recognize women's contribution in the social and economic spheres. The strategies are being implemented in different sectors in response to global concerns for gender discrimination.

The policies addressing women's violence and its consequences on health are not straightforwardly articulated in Bangladesh. In fact, the National Health Policy, which has been in draft stage for more than two decades, does not state the issue of gender-based violence. The project implementation plan for the Health and Population Sector

Program (HPSP) Strategy recognized violence against women as a public health issue requiring attention in public health facilities and the need for gender-sensitive health services, however, the designing of the program was not put into practice (Jahan, 2003). On the other hand, the Women Friendly Hospital Initiative (WFHI) was also introduced to address management of violence against women by offering training to health care professionals to sensitize them and to take a leadership role in this regard. As Haque and Clarke (2002) identifies, “the pace is slow and individual experience, commitment and attitudes have been found to affect the process. This is further compounded by the prevailing acceptance of violence and the seemingly low level of priority that is accorded to the issue”. Thus, the initiatives are working very poorly or not at all, as the period for the implementation of HPSP ended in 2003 and the strategisation of Health, Nutrition and Population Sector Programme (HNPSPP) has yet to come into effect. The One-stop Crises Centers (OCC) began at two tertiary hospitals in Bangladesh in 2001 during the period of HPSP operating under the Ministry of Women and Child Affairs to offer health services to victims of violence (Ministry of Health and Family Welfare, 1998a; 1998b). In the implementation plan of HNPSPP, the services of OCC will be expanded and the providers will be trained to manage violence cases capably (Ministry of Health and Family Welfare, 2005). Health services available to victims of violence at this point are inadequate and inaccessible. The services planned to be offered in future do not seem to meet people’s needs.

Laws against domestic violence

The Constitution of Bangladesh and several special laws specifically protect women's rights to life and safety and severely punish offenders. The Penal Code, Criminal Procedure Code, Dowry Prohibition Act, and Repression of Violence against Women and Children Act 2000, among others, all contain provisions punishing those who dare commit any sort of crime against women (Rahman, 2001). Although the Bangladeshi government is party to several conventions and committed to upholding the rights of women and eliminating discrimination, the provisions of the laws are yet to be incorporated in the domestic legislation.¹ Moreover, the implementation of these laws is getting weaker in the past few years. As Saira Rahman said, no measure has been taken to strictly implement laws protecting women and as a result, crimes perpetrated against women have increased.

It is also reported that in the absence of a domestic violence law/policy, informal punishments are meted out by the police if the wife could prove obvious injury on her

¹ Although the Government has become part of the CEDAW convention, the government has held reservation to Section 2 that condemns discrimination against women in all forms and pursuing a policy to eliminate it, 13 (a) that guarantees equality of men and women in economic and social life and with family rights in particular, 16.1 (c) that ensures the same rights and responsibilities in marriage and dissolution and 16.1 (f) that provides equal rights with regard to guardianship, trusteeship and adoption of children –stating that these are contrary to the Shariah law of Islam. However in the face of pressure from women’s organizations, the government withdrew its reservations on 13 (a) and 16.1 (f). According to the periodic country report of State parties in January 3, 2003, the reservations on Section 2 and 16.1(c) are still there (Ameen, N, 2005).

body. In that case the husband pays a fine of Taka 300 to 500 (US \$ 5-8) to his wife. The Deputy Director, BLAST considers this as problematic and anticipates a more permanent official policy. Legal aid organizations along with women's groups have been pushing the government to implement a law. Recently, the Law Minister announced that the Law Commission of the Government is working on a framing of a Domestic Violence Act to address any form of abuses and violations at the household level (Daily Star, May 18, 2005). As Sabera Chowdhury points out,

The main problem is not the laws, we have many laws to protect women, we just don't have political commitment to implement these laws...if the government only implemented some laws properly that would go a long way in solving a major part of the problem of violence.

Acid violence is a common form of domestic violence. Laws against acid purchase and sale are in place in order to reduce acid violence. In reality, while a registration system for users of acid, such as, jewelers, medicine sellers and workers of battery factories and furniture exist, there is no monitoring of acid purchase, which is easily accessible and available. According to women's groups and staff at ASF, the government has set up a cell to monitor acid selling and buying. However, the "Acid Control Counseling" cell is not at all functional. The law states that both the accused person and the acid seller will get punishment, but it has never been implemented. It frustrates many organizations and groups, because if the law were effectively implemented with a ban on sale, there would be a direct reduction in incidences of acid violence. An NGO took on the task of directly writing to the Ministry regarding high incidences of acid violence and illegal sales of acids and the complete lack of implementation of the law in a particular rural area, but received no response. It seems that lack of political commitment and willingness of the State to implement laws reproduces more violence.

Actions and interactions of policy community

The policy community that includes Government, NGOs and women's organizations participates in different activities to address domestic violence. They vary in their objectives and organizational structures, with some aiming to provide health services, and others legal aid; some organizations work holistically with integrated programs, and others promote human rights and empower women through education and training; and some organizations provide temporary shelters to abused and distressed women. Most of the groups and organizations work in partnership with each other. The main strategies of these organizations to stop violence against women include publicizing and organizing around particular cases, legal awareness, health and legal aid services and conscientization of both women and men about gender-based violence.

The Government of Bangladesh has plans and programs to address violence against women. Since 1985 the National Development Plans have goals for increasing women's participation and empowerment by offering opportunities for education, employment and skill development emphasizing their involvement in bottom-up planning (Government of Bangladesh, 1997). The Government of Bangladesh endorsed the Beijing Platform for Action with no reservations. In March 1997 the Government declared the National Policy for Development of Women. The objectives of the National Policy are comprehensive in

scope and rest on the basic commitment to develop women as a human resource, establish women's human rights, eliminate all forms of discrimination against women and girls and recognize women's contribution in the social and economic spheres. Promoting gender equality and realizing the constitutional goal of equality between all citizens - women and men are the major aims of the Fifth Development Plan (1997-2002). The Ministry of Women and Child Affairs (MWCA) offers shelter homes to victims of violence, and arrange their legal and medical assistance. Along with other ministries, the MWCA initiated One Stop Crisis Centre in two tertiary hospitals including Dhaka and Rajshahi Medical College to render medical treatment, counselling and legal assistance to women victims of violence. The activities of One Stop Crisis Centres are being implemented by the Government with the assistance of NGOs. The Urban Primary Health Care Project, the partnership effort of the Government and an NGO, Bangladesh Women's Health Coalition actively participates in advocacy for violence prevention. The Government has launched women-friendly hospital initiatives in some hospitals in order to offer health services to victims of VAW and conducts advocacy workshops against violence with UNICEF and UNFPA.

Mahila Parishad was set up in 1970 and has been very vocal on issues of gender based violence. Any Bangladeshi women aged 16 years and above supporting the ideology of the organization can become a member. The members are organized into committees at primary, upazila (subdistrict) and district levels. In 1972 the leaders of the organization pushed for a number of issues and were successful in passing a law-banning dowry in 1980. Naripokkho, a small independent women's organization was set up in 1983 and also extremely outspoken about gender-based violence matters. Then, the Bangladesh National Women Lawyers Association (BNWLA) is essentially an organizations fighting for women's human rights. It provides legal awareness training with the target of reaching 50 million women and some men (Marcus 1993). Another important organization, Ain-O-*Shalish* Kendra (ASK) was formed in 1989 dealing with women's legal issues and aid. It focuses on domestic violence issues providing shelter homes and free legal services to battered women. Bangladesh Legal Aid and Services Trust (BLAST) is a legal aid organization. Its primary goal is to improve access to justice for marginalised groups, particularly poor women, through providing legal aid and information and services. It has also implemented alternative informal courts in 120 villages all over Bangladesh.

BRAC, founded in 1972 is one of the largest NGOs in the world. Its twin goals are poverty alleviation and empowerment of the poor through integrated interventions in economic and social development, education and health, focusing on poor women. It makes women aware about human and legal rights. BRAC is linked up with Ain-O-*Shalish* Kendra (ASK) offering free legal aid services for battered and vulnerable women through 230 legal aid clinics. It also works with Acid Survivors Foundation (ASF) established in 1999 to provide support at grassroots activities to assist mainly acid violence victims and survivors. All work closely with the OCCs and Burn Unit of Dhaka Medical College Hospital to support burn victims and sexual assault cases. BWHC is one of the few NGOs focused on women's health issues operating 12 clinics in rural, semi-

urban and urban areas. BWHC clinics offer training in menstrual regulation with government health personnel. Marie Stopes, founded in 1988 focuses on women's reproductive health (and men).

All these organizations work with the government to offer prevention and management of violence. Some tried to influence the government to bring changes in the policy through advocacy. It is observed in Naripokko being involved in doing advocacy for acid violence victims when the government has taken initiatives to arrange services. It is reported that that public consultation was done in the creation of the HPSP and HNPS, but, the structure of policy and implementation was formulated by the government officials, donor communities and international experts. It seems that the violence prevention community works either in accordance with the government's objectives or does advocacy to bring a particular issue into lime light, but in the actual process of policy formulation, they remain invisible and their participation is not observed. This lack of participation, in fact, prevents formulation of pro-women policy and implementation of interventions. In this context, Jahan (2003) has emphasized on the lack of participation of gender equity advocates to push gender equity strategies to be operationalized during the implementation of the HPSP. Here, the State feminism would play a greater role if women's voices were heard in public policy formulation.

Coordination and Commitment of policy community

The government, NGOs and women organizations act and interact with each other to address violence against women following their organizational objectives. However, a number of caveats exist among them, which may have reduced somewhat the impact of their activities on violence. First of all, there is lack of clear understanding among the stakeholders as to the connectedness between domestic violence and women's health, why domestic violence should be treated as a health issue, and why it is important to work in coordination to address domestic violence.

The NGO sectors and women organizations work to reach out violence victims. It appears that all work independently. Some work in an integrated manner for different projects, but, their coordination remains confined to few organizations. As Toufiqa, a BWHC staff remarks, "Many groups work with many different projects for a while and then, after a while it gets lost. We are the development partners. Without mutual cooperation and coordination, we cannot work." Another staff comments, "Organizations work together and stand on the same platform...because it is time to integrate, coordinate all powers, then we can be a force to make a difference. But, on the other hand, when donors pressurize, we work together." As most projects on violence are donor-driven, without having clear understanding of all the issues, the government and NGO community implement programs at the field. Nevertheless, their willingness to reach services to victims of violence is expressed in their voice. The need of participation, sharing and coordination is felt necessary to create better opportunities to offer services for victims. One states, "The organizations in Bangladesh should work jointly in a platform. Some organizations have shelter homes, some do not have, some have money for treatment and some do not have. They could share their works."

The government still does not have a concrete policy on domestic violence. As Sabera Chowdhury explains, “We recognize dowry violence within a marriage but not just as domestic abuse.” Special tribunals for domestic abuse cases do not happen unless it is dowry and acid violence related, which makes domestic violence cases to wait for years for justice. Lack of political commitment and more importantly, abuse of laws deny services and justice. As Selina Khan from BNWLA comments,

There needs to have political commitment among government and lawmakers. Those who work at the policy level, sometimes politicians are not interested in making changes. Honesty is lacking and corruption is rife. There are about 400 NGOs/groups who are working on violence against women, but when it comes to decision-making - political interference and disruptions affect the impact of their work. Police cause problems. Victims when they go to the thana to complain or lodge a case, they find themselves harassed and given a hard time by the police. The police also abuse even the women lawyers who are actively involved in these cases. In addition, it is also lawyers, doctors and others who are also corrupt. Our work cannot progress as well as we would like it to. Where there is power it is often misused or abused, such as corruption or pressuring doctors to give the wrong certificates, or police are paid off/pressurized to remain silent or a political leader gives support to the miscreants. Sometimes in abuse the girl is raped, abused and murdered but the case is dressed up as suicide.

It is evident that corruptions at all levels give rise to a situation where the normal ways of giving and receiving services have been impeded. On the one hand, lack of understanding of coordinated services and on the other, lack of political commitment and corruptions produce fragmented services for violence victims and deprive them from receiving appropriate services.

Gaps in health sector

The National Health Policy does not articulate the issue of domestic violence, and the existing health system is not much responsive to recognize violence as a health issue not to mention domestic violence. As a result, the health infrastructures extending down to the grassroots are not being efficiently utilized to address violence issue. The doctors, nurses, paramedics and community level health workers are neither trained nor given responsibility to handle violence cases at primary, secondary and tertiary levels. Different NGOs have scattered health interventions for violence against women working alone or partnership with government and other NGOs.

One Stop Crisis Centre (OCC)

In recent years the One Stop Crisis Centre (OCC) operating under the Ministry of Women and Child affairs has been in place in two tertiary hospitals since 2001. There are plans to build another six in each division of the country. The OCC is an independent unit in the hospital functioning in close collaboration with emergency wards. In this centre, doctors, nurses, counselors, social workers, lawyers and police officers are appointed to offer services for 24 hours. It is an eight bed unit where medical treatment is

offered for the immediate problems caused by domestic violence and other kinds of violence. It also arranges legal and social support for abused women through NGOs. However, reaching a population of 140 million through two State run centers raises questions about its effectiveness. Bipul the coordinator of OCC also seems to agree,

We need to build a network. Suppose a woman victim wants to come from a remote area like Netrokona or Sylhet, she cannot come to us because she needs the initial assistance to bring her out from that area... she needs not only mental strength but also physical support. Look ASF has built a good network through BRAC... its fine.... The patients can come through them and they don't have anything to worry. Again I have seen in Malaysia how these works are done through Social Welfare Department. They are bound to give shelter to the patients. In the same manner if our country could build a powerful network and through it you can reach patients then it will be very good. Then the life of patients could be saved and the respect for law and enforcement will improve among masses. With that the people will also get justice and women will receive care.

In addition, problems of transportation from remote areas, financial costs of traveling, and social restrictions and purdah impact on poor women's ability to quickly seek care from OCCs. Toufiqa Rahman of BWHC suggests that the government should immediately set up interventions at thana and district levels so that victims are not forced to travel far just to avail of OCC located at Dhaka and Rajshahi Medical College Hospitals. She states, "To avail services to grassroots, political will needs to be strengthened, and accountability should be there."

Services at other Hospitals

All medical college hospitals, district hospitals and thana health complexes are equipped to examine women who have been raped, burned and physically violated and to issue them medical certificates. However, usually rape examinations are referred to at least the district level hospital. They are supposed to provide counseling and first aid services but, in reality, they do not. Moreover, hospitals do not document or record cases of violence against women properly. Many of the officials of the government health system admit that they did not have a role other than physical treatment of victims when dealing with cases of violence except to issue medical certificates. In addition, doctors who are called in to give their 'expert opinion evidence' are usually not trained to distinguish an injury as a result of an accident or violence, or the difference between injuries incurred from consensual or non-consensual sex.

Women Friendly Hospital Initiative

The WFHI is the part of the strategy addressed by the Government and UNICEF has been developed through the participation of health professionals (obstetricians, forensic pathologists, emergency doctors, psychologists, nurses, and paramedics), lawyers, magistrates and judges, civil society organizations, media professionals, people's representatives, health and public sector administrators, and development partners. The WFHI addresses violence against women in some district level hospitals where they train four personnel and orient all the workers in the unit about violence against women,

maintain privacy and dignity and properly maintain records and documents of violence cases.

The change in the design of HPSP where the government tried unification of two wings – Health and Family Planning was not accepted by the Family Planning professional body, and later the activities were not fully implemented. Although, there has not time to evaluate the impact of the WFHI experience, people who have participated in developing the course and providing training, have been largely sensitized. With the change of the government leadership in 2001, the new strategy addressing Health, Nutrition and Family Planning again proposes to initiate WFHI in hospital facilities, and at national level, the training curriculum are being revisited now through a series of workshops. As Haque and Clarke (2002) observe in previous WFHI, the process and efforts are complicated by the prevailing societal acceptance of violence and the seemingly low level of priority accorded to the issue. What seems very crucial at this moment and from previous experiences, it is time to sensitize the health care professionals at all levels irrespective of their involvement in this project.

Shortage of staff and supplies

Government health facilities be it shelter homes or thana health complexes, district hospitals and medical college hospitals are plagued with numerous problems – understaffing, shortage of drugs, continuous transfer of staff with many posts lying vacant for months at a time, and generally very little monitoring or accountability. Momotaz Begum from the shelter home explains her difficulties working within the government system,

A major problem we have is shortage of staff. There are many vacant posts and it takes more time to fulfill these posts for many reasons. For example, the post for doctor is still vacant here after the doctor of our Shelter Home resigned but we need a doctor but there is no one here to help the victims. Here there is no post for a nurse...in the government sector it is more time consuming to appoint any person because of all the bureaucracy.

The lack of or inadequate services in government health facilities cripple down the existing system which is already not efficiently operating.

Missing out mental health

Mental health seems to be missing out in health facilities dealing with violence. Many of the staff including health providers strongly felt that mental health is an important component of treatment, not just for acid violence victims but all victims of violence. Samia and Nadera, both of them staff working in Action Aid, argue for mental health support in health facilities,

We should consider mental health. If we think about acid survivors then mental support is require must. It is quite tough for victims to lead their normal life. Say for example- Noorjahan is an acid survivor and now she can lead her normal life. It took 10/12 years for her to get back to her normal life. So mental support is required to make themselves prepared to overcome their limitations. Now the health complex condition is poor.

Women need physiological support, advocacy and counseling. In some cases I saw women feel ashamed after being raped whereas the accused persons didn't feel ashamed at all and was living a normal life in society. We consider this incident as an accident and continuously try to make them understand that she doesn't need to feel ashamed because she is not to blame for what happened and is not responsible. In this way we provide them mental support.

A Staff working in a Shelter home recalls a story of a victim who became mentally ill and finally took refuge in brothel. She remarks,

When we got her at the Shelter she had been gang raped. We gave her medical treatment when her physical condition was severe. After we did litigation we took her to our Shelter Home. Though we kept her at our Shelter Home, we could not keep her under our control and ...she became a sex worker. She tried to escape from here, and she tried to commit a suicide. She was quite abnormal and we gave her medical treatment. We followed up her for few days and she was getting well. She kept running away from the shelter place. After six months I saw her at Kakrail with a man. That's means we could not protect her. We feel regret what it was happened? She became abnormal after that occurrence. I gave her the name 'Tuni'. She is lost and like her so many females who suffer from violence in this way.

Some staff recognize the need for appropriate counseling and a focus on mental health services, but this appears to be sadly lacking in most health facilities available.

Doctor's reluctance to certify a case

Women victims of violence face barriers to receive medical services. A medical certificate issued by doctors, is mandatory for seeking legal service. One of the respondents said that once a woman is being raped, she requires a medical certificate issued by a medical doctor certifying a rape case after thorough physical examination, and then, the victim will be able to submit a complaint to the police. A common concern among policy community is the lack of female doctors available in health centers and the reluctance of the doctors to tend to women. According to a report, only two female doctors were posted in the total thirteen medical college hospitals, and female doctors do not prefer to work in the forensic department (Naripokkho and Bangladesh Mahila Parishad). Most women who become victims of rape and other kinds of abuse have to be physically examined. In the government health facilities, women victims are treated predominantly by male doctors and the experience they face in undertaking the medical check-up is very unpleasant. Male doctors examine the victim in the presence of a nurse. The presence of a male doctor after the rape is doubly traumatic, particularly in a country where religion, gender and modesty plays an important role in women's lives, discouraging women and their family members from seeking care from a male doctor. Hashrat Ara of Marie Stopes, comments,

One thing is very important to improve these types of work we have to keep females in every sector. In Marie Stopes our doctor, counselor, paramedics, and nurse are all female. Because of the cultural norms of our society only women can talk freely with women.

Male doctors are reluctant to give certificates immediately for rape cases. This is because of their lack of training, and socially-entrenched, biased attitudes towards women who come forward to report rape. A repeated concern in the interviews was that most doctors humiliate and traumatize the victims further by openly doubting whether the female was 'really' raped or it was consensual sex. Farida (from BLAST) explains, "A major problem is that often the victim is treated badly. When she is admitted in the hospital the doctors and nurses do not behave well with the victim and they assume 'she is a bad girl.' They see her as the problem, 'someone who asked for the problem.'" This is reflected in the final medical report with the doctor's biases impacting on the report with many male doctors reluctant to write it down as a rape case. BLAST and ASK staff believe that in the hospitals where the female doctors carry out the procedures, it is much easier for the victim. A staff speaks of the dilemmas of working in such a system:

We have dealt with such cases that we have send her (victim) to hospital for forensic report and she has been again victimized of violence for the second tome by doctors or ward boys. Where will you go then? The girls say the 'I was better before why did you send me for medical report?

Doctors are also reluctant to certify rape cases, as they are then obligated to appear in court in Dhaka and if need be outside of Dhaka to present on behalf of the witness. This takes away time from overworked and understaffed doctors. Besides, many of the doctors run their own private practice in the evenings to earn extra income. As a result, what happens invariably is that female victims often have to wait for a couple of hours for doctors to come and certify their state. A new law was passed which allows any qualified MBBS doctor to give the certificate after examination of the victim. Thus, victims are no longer forced to go to specific doctors and government clinics for the forensic report. Usually the doctor provides two certificates, one for the woman and the other for the police. Finally, a critical problem mentioned in the interviews is corruption and intimidation by hoodlums or powerful well-connected individuals/politicians. Doctors are often pressured into giving the false certificates. Doctors and police are paid off or pressurized to remain silent if political parties, especially the ruling one give support to the miscreants.

Shelter homes

Shortage of shelter homes for women is observed in government and NGO sectors. It is unclear how many shelter homes exist for battered women, even after interviewing the government health officials dealing with violence. In our data we found that there are four shelter homes at Dhaka city each run by the Government of Bangladesh, Ain-shalish Kendra, Bangladesh Mohila Parishad and BNWLA, and one at Rajshahi run by the Government. The Government reports indicate the shelter homes are inadequate with very poor quality of services and care. A government staff member working in a shelter home points out, "There are women violence restrain cells in every prison located at district and sub-district levels, but no arrangements for Shelter Home. Here, they arrange to resolve their problems, and counsel in those cells. But women need shelter." The Department of Women Affairs under the Ministry of Women and Children Affairs runs the cells, and monitors and deals with instances of violence against women. The cell is also meant to provide legal assistance to abused women through counseling (Naripokkho and Bangladesh Mahila Parishad). Frequently mentioned in interviews were budget

constraints, which impact on the number of shelter homes establishment and the quality of living conditions and care provided there. This perhaps results in underutilization of the government run shelters.

Fund flow and the role of donors

Financial constraints are identified as a major factor contributing to not successfully offering support to women victims of violence. Many organizations felt frustrated at not being able to provide 24 hours security of victims, insufficient manpower in the rural areas, unable to monitor and work closely with the police, low quality and number of shelter homes and inadequate health facilities in hospitals. All the organizations and the government projects rely on mainly donor or state funding to manage their programs. Although donors are praised and appreciated for their support they are also blamed by some for their short-term vision and goals, shifting agendas that result in erratic funds, all of which do impact negatively on some organization's programs. A few staff members of organizations believe that donors are wasting funds with misappropriation of priorities and often do not inject enough money to make concrete changes possible in violence interventions. A staff member of an organization echoes a sentiment felt by quite a few,

The budget amount is not too little to run the project but it is not sufficient. NGOs will be satisfied that they got that amount of budget that they required. But in true sense to prevent/stop violence, the donor approach that means global approach is not right. Let me explain the approach...donors will give money to produce pens, when these pens will get damaged they will send 'experts' to supervise the procedures. They will fix a framework here for using these pens. Every year they will provide support. But they will never provide enough money to actually make a difference for what we need to do ...but they will send little amounts...they will never show any interest to set up any infrastructure. So, the amount of budget that we need globally for violence against women, they have capability to provide but they don't. The money we are given is not enough for extension to remote areas. Manpower and funds are not available. More investment is required in remote areas from district levels to lower levels in terms of distance and logistics support. Awareness level will increase if we want to go to grass root level. But there isn't enough money, and available resources and insufficient help.

While a few believe that the organizations should not be solely reliant on donors or the government but they should generate funds in other ways. Some suggest that there needs to be local resource mobilization from within the country. One staff points out,

As ASF is a donor support organization so its fund is limited. Because of this, out of a 100 survivors we can only provide support to ten survivors. What will happen for rest of the ninety survivors? In that case we should mobilize resources from community levels or could motivate businesses so that they can provide educational support or start a small business for a number of survivors. Recently, we began to communicate with Ministries and with NGOs that give incentives or micro credits. Budget is not sufficient and with the amounts we are given we are unable to provide

medical support, legal support to survivors. Again, we couldn't extend our support staff in rural areas because of our shortage budget.

The government is seen to be too bureaucratic with projects hanging in the balance while the Government Ministries take their time 'sorting through papers' and delay handing over the money. A government staff working in a shelter home complains of bureaucracy and the frustration of waiting long periods for funds to come in, which have directly impacted on her program. She reluctantly reveals due to fear of losing job,

The budget is not sufficient. We do not maintain the expenditure of food, shelter for women in the shelter home. Now this project is closed. It goes under revenue in June 2001. After that we are working with our total budget. For example-we needed Taka 20 lacs to accelerate this project but we got Taka 5 lacs. As a result, we were not able to bills of food, medicines. We have not been given any money since last January (2004). The suppliers provided us food and medicine without any payment; but are no longer willing to provide these goods because of due bills. We do not maintain the quality of service at shelter home.

The budgetary constraints and the slow fund disbursement in the government give rise to poor quality service in shelter homes and their non-functioning state. On the other hand, the donors and international experts play a crucial role in national health sector reforms, as the State relies on them for financial assistance in carrying out interventions.

The role of *mastaans*: Safety and security of women victims

If the perpetrators of crimes are *mastaans* or politically well connected individuals, many problems arise. Over and over again, staff in many of the organizations spoke of the need to ensure the 'safety and security' of both women and staff who were involved in prosecuting cases, particularly if the cases involved *mastaans*. Hashrat Ara from Marie Stopes explained, "A few days back we referred a rape of a schoolgirl case to the OCC in Dhaka. But the family was facing so many threats from the *mastaans* that the family was forced to withdraw the case." Similarly, the Deputy Director of ASK said, "Yesterday a woman came here to give complain but she didn't give any written complaint. She told me that she was threatened, and thus, scared to write down her complaint." Most of the staff in legal aid organizations complained that often eyewitnesses would receive death threats from *maastaans*. BLAST was recently forced to acknowledge defeat in a case when *mastaans* began to threaten and harm the victim's family. Fouzia Ahmed, a senior official from BLAST states:

In this case, Eva (well known case) was murdered by the local *mastaans* in the village. The family took it up with BLAST (through the assistance of local field level BLAST workers) and BLAST was unable to convict the miscreants. The family was threatened by the local *mastaans*, and one by one, members dropped out, fearing for their lives. In fact, Eva's sister had acid thrown in her face due to this case being taken up by BLAST. BLAST was unable to take the case any further as they could not guarantee the safety of the family members. They did assist in finding a shelter refuge for the sister who had acid thrown in her face. Eventually BLAST stopped pursuing the case. This is the reason why BLAST staff often sit with the

local elites community to encourage them to provide support for the victims, in order for them to take their case to BLAST.

The threats and intimidation are not reserved for only victims and their family members but even staff working with victims of violence receive threats from *mastaans*, some of whom are perpetrators, whereas others just enjoy intimidating the workers for their own amusement. A staff member remarks,

Anonymous letters come to our managers from *mastaans* who want to frighten us. They write in the letter, 'we will see how you go back to home; we are standing in the streets waiting for you.' When we don't have any security how will we work? Only policy does not work. It is not possible for only Marie Stopes to do anything. Many incidents of this type happen in Bangladesh in what numbers they are reported? No work is done in this matter.

There have been times when the police fear harm from *maastans*. In an interview one of the police officers complained of their vulnerability in dealing with powerful *maastans* and their inability to control them. As Rahela Khan, Police Sub-inspector states, "Although we have complained to the Ministry we have received no response. Since most of the *mastaans* have political links, they do not fear arrest." The statement made by the police highlights the dysfunctional relationship between the political parties, *mastaans* and the State, which is apparent in the enforcement of law and order.

Under-reporting of domestic violence: Poverty, gender and silence

Poverty, economic insecurity, attitudes of society toward women and gender issues usually discourage women from reporting domestic abuse. Women remain silent, despite they face abusive behavior from husbands due to fear of separation or divorce. Selina Khan, the lawyer of BNWLA, makes comments in this regard, "Parents hand over guardianship to husbands soon after marriage and discourage separation even if there is abuse. Moreover, due to poverty and social stigma many women are reluctant to report against their husbands." This fact is supported by more voices. Dr. Hamida Khan of Marie Stopes observes the under-reporting in many areas. She explains,

During this time we have treated mostly women. We find a large number of women coming in who suffer from domestic violence. I have seen from my experience till now that women come with burn and cuts as a result of domestic violence. Again some come for forced abortions...these women don't come to take legal action or want justice. They come just to survive, silently and secretly they come to us for our help. I have gone through these experiences. I don't pressurize them. I am taking care of their mental health and doing counseling and trying to bring them under a process. In our country, women face lack of assurance and insecurity...

Many of our respondents agreed to the fact that due to structural problems in the society, women silently accepted the gendered role.

Socio-economic status and class shapes not only attitudes but also the manner in which the situation is dealt with and justice is meted out. Staff members speak of poorer families who are reluctant to become embroiled in lengthy financially burdensome trials, and worry about the social stigma for the female victim. For middle class families, it is rarely about costs, and the issue is usually one of prestige. Families are not willing to lose

their family honor and reputation by submitting a case in court. Interestingly in cases, where the abuser is rich and the victim poor, justice takes a backseat. Frequent reports in newspapers highlight cases of poor maid servants assaulted by their wealthy employers (both men and women), with the rich avoiding prosecution by virtue of their status, connections to powerful ministers, or bribing of the police and even the victims family.

In many cases, not seeking justice is sometimes seen as the most pragmatic solution for many women and their lawyers. Many respondents shared that most cases are held up in courts for long periods and with little financial support or emotional backing from the family, the woman loses her patience 'emotionally, physically and mentally.' For cases of rape and dowry, there are special courts established under the Women and Child Oppression act to try certain offenses. The 2000 Act provides for setting up of special courts one in each district, with ten established so far. But, women seeking formal justice in Bangladesh mean facing numerous obstacles. One woman victim stated that police are often unwillingly or unable to offer assistance, and once women gain entry into the courtroom, they confront gender discrimination and hostility from predominantly educated male judges and magistrates who preside in these cases.

Women's security is not ensured in this society. Many of them shared that women could not protest against domestic violence due to fear of another kind of violence outside home. As the coordinator of OCC explains,

We often talk about violence against women. If you fight with your wife you can go to your father's house and stay there for two days there is no problem. But do the parents of the girl accept her in the same manner? Never! A girl has nowhere to go. As males, you and I can go and sleep in Ramna Park, but, will a girl be able to do this? Hooligans can snatch money from you and me, but, many more things will happen to that girl. You think a little.

Domestic violence is often treated as a 'family matter' or 'private affair between husband and wife'. The health providers and police were observed to be dismissive of incidents occurring to women. Selina's husband regularly tortured her, but when she went to the police, they encouraged to return her to husband. She said, "I was crying and explained to the police what happened...everybody from police department told me to go back home but I didn't. I want to get justice. I will manage eyewitness, collect evidence against him..." Many activists and field staff are involved in working on violence. Their extreme frustration is that laws are not meant to serve women suffering from domestic violence. One of them states,

There is no special law to deal separately with domestic violence in the country. That is why if there are any cases, usually money is exchanged and there is divorce, but there is no punishment on the perpetrators who pushed and physically harassed the women. As a result even the police are reluctant to acknowledge or even take on cases where the husband is physically abusive, claiming it as a family matter.

The Assistant Director of Naripokkho remarks,

From our work in monitoring police cells we found that when women get the courage to go to a police station and share their problems, then police says 'husbands will beat their wives, just tolerate it? You go to family

court. A good woman doesn't come here.' But family court doesn't deal in criminal cases.

It appears that not only laws are lacking, but lawmakers also bear negative views about women victims of violence. On the other hand, the police are seen to be overworked, underpaid, and frustrated. Due to their involvement in multiple tasks, such as, chasing criminals, writing reports and appearing in court, most of them remain reluctant to investigate cases of violence. The health providers also refuse to diagnose a domestic violence case in order to avoid hassles of case-filing and appearing in courts. It suggests that problems in the system give rise to a situation where the workers do not perform their task accordingly. This causes under-reporting of domestic violence and hence, inadequate care of victims. All work together to act as a critical barrier to improving the situation of violence against women in the country.

Conclusion

This research is undertaken in Bangladesh as a part of a transnational study to investigate what challenges and gaps remain in addressing domestic violence in National Health Policy of Bangladesh. The structural problems relating to gender, economy, laws, policies, religion and social psyche all discriminate women and disregard a crucial issue occurring in women's daily lives, which is domestic violence. Even after the ICPD and Beijing conference the State still remains neglectful to violence, gender and health issues and more importantly, to gender-based domestic violence. The Project Implementation Plans of HPSP and HNPSP do address violence against women by providing health, legal and social services to victims, but the connectedness of domestic violence and women's health is not being recognized and as a result, domestic violence is not seen as a health issue. The approach of One Stop Crisis Centre operating under the Ministry of Women and Child affairs is quite comprehensive, but, on the other hand, their service provision is not adequate to cover a wide range of population in Bangladesh. In addition, negligence of stakeholders as observed in doctor's reluctance to certify a case and lawmakers' unwillingness to follow it up reveals lack of gender-sensitivity to and less priority of this particular. The involvement of many NGOs and women's organizations does not arise from their own concerted effort and commitment. The implementation of many activities against violence is largely the result of donors' influence, which is driven by the post ICPD and Beijing conference follow-up activities. On the other hand, service sector relies on donor funds, which reflects lack of long term plan of the government in the country. Structural and systemic factors rooted in culture, socio-economic state, laws, religions, education and political situations legitimize gendered hierarchies and discriminatory treatment of women. As a result, the State remains less responsive to prioritize the issue of domestic violence in National Health Sector Reforms and thus, allow women's sufferings from all the consequences of gender-based violence occurring within home premises. It is, therefore, crucial to have comprehensive understanding of the policy makers and planners about how domestic violence affects women's health, how gender inequity causes domestic violence and why it is important to address domestic violence in health policy. This will lead to better policies and strategies to improve the situation of women's health affected by domestic violence and facilitate abused women to receive appropriate health, legal and social supports in Bangladesh.

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