Oration

# 2nd Prof. HVJ Fernando Oration

# Gender Based Violence and the Forensic Medical Practitioner

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**Honorable Justice Buwaneka Aluwihare, PC, Judge of Supreme Court, our Chief Guest, Prof. Sampath Amaratunga, Vice Chancellor, University of Sri Jayewardenepura, the Guest of Honour, Past presidents, members of the Council and members of the College of Forensic Pathologists of Sri Lanka, Members of the family of Prof. HVJ Fernando, Distinguished invitees, ladies and gentlemen,**

GBV is currently not addressed adequately by the health care and other relevant sectors in Sri Lanka. It is a significant problem, and needs to be addressed as an important issue by the healthcare sector. [1]

According to WHO world report on violence and health (2002), violence implies the use of force of some kind by one individual, group, community or nation on another individual, group, community or nation. [2]It always results in harm and suffering for one group. There is always a power difference between the two groups wherever violence is inflicted: powerful committing violence against the powerless. In case of GBV, the power difference between male and female which has been created by gender attitudes plays a pivotal role. In child abuse, abuser is powerful and the child is powerless. In wife battering, husband is powerful and the wife is powerless. In elderly abuse-one who is taking care of is powerful and the elder is powerless.

An innocent child may later become a violent perpetrator. This transition takes a long time, with the influence of the society. According to an illustrative Conceptual Model of violence of Heise (1998), it depends on multiple factors at different levels such as individual, relationship, community and society. The individual factors are being male, witnessing violence as child, being abused as child, absent or rejecting father and alcohol use. The relationship factors are male control of decision making, male control of wealth and marital conflict. The community factors are poverty, unemployment, family isolation and community acceptance of violence. The society factors are gender norms, gender roles, Laws and notions of masculinity. [3] This explains why even with power difference, some engage in violence and some do not.

Sex implies biological differences (due to XX and XY) between men and women whilst gender implies the social differences between male and the female (3a). In patriarchal society, male becomes the powerful person and female is powerless even if she powerful than the male in the civil society. E.g. Educated and well earning wives may be assaulted by the husbands who are less educated with impunity and gender attitudes give the power to this uneducated person to assault. Wealthy wives are assaulted by poor husbands and gender attitudes have given the power to poor husbands. Therefore, it is not factors such as wealth, education and employment that create this power imbalance among males and females but the societal attitudes towards gender. Gender norms, attitudes and behaviours create power imbalance among males and females and some members of the society misuse this perceived and self-generated power which then leads to GBV.

Having the pictures of a stereotypical male and female is the stereotyping in gender. If an individual sticks on to this image, he/she is complimented. If not, he/she is punished or rejected. This is the process by which people learn the cultural norms, attitudes, and behaviors appropriate to their gender through

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sanctions. This is gender socialization. This helps the society to function as a society.

How does gender create a power difference among males and females? Gender gives different roles, responsibilities, expectations, privileges, rights, limitations, opportunities and access to services to these two groups. Here, the roles, responsibilities, expectations etc. are not balanced which leads to power imbalance. In a study done by Fernando (1991), on 40 families in the Kalutara district, "majority of the women accepted the subordinate status of women and believed that the male is more powerful". [4] In patriarchal society, the male becomes the powerful person and the female is left powerless.

The role of the male is to be the bread winner while the role of the female is to bring up the children. This is good enough but sometimes the responsibility given to the male is far too much. Farmers lose their harvest and they cannot pay the debts, which results in committing suicide. Here the gender role is detrimental to the male.

Some perpetrators justify violence by using gender norms as the basis. A study done by Haj-Yahia and De Soyza (2007) found that some wives believe "Occasional violence by a husband towards his wife can help maintain the marriage". [5] If a daughter runs in to trouble or gets pregnant, the mother gets blamed. "Mother is supposed to bring up the girls", it is the gender norm. Environment of the house or other reasons may be the cause, but the mother gets the blame. The people who like to resolve their issues through violence use this gender norm to justify assault. Husband may beat the wife and justify his violence on the fact that the wife has not looked after the child properly.

Some survivours use gender norms as the basis to justify being beaten by the husband. Study done at Teaching Hospital Colombo North, by Kuruppuarachchi (2010), revealed that "Majority of the females believed that the violence by the male partner should be tolerated. [6]

"Male is expected to be more aggressive and more sexually active". It is a gender norm. According to Jayatunge (1998), in sexual assaults, perpetrators use such gender norms as excuses. [7]

How do gender norms and attitudes affect sexual GBV? "Women should not express sexual desire" is a societal norm. Therefore, males, especially husband do not expect the women to be proactive. When committing a rape, the perpetrator believes "Women who dress in a certain way are asking for sex". After committing the rape, the perpetrator justifies his act by using societal norms such as "Women who appear to want sex deserve to be raped". Finally, the society as a whole too justifies the rape by using some norms such as "Women who dress in a certain way are asking to be raped". Therefore, some gender norms justify the sexual abuse and the blame goes to the female.

According to WHO annual fact report (2014), factors specifically associated with sexual GBV perpetration have been identified [8]. One of them is "Gender attitudes of male sexual privileges". A study done by Miller (2002) on 105 female and 31 male sex workers found that "while female sexual purity is expected by society, engaging in sexual activities was recognized as a fundamental necessity for men". [9]Another factor is "weak legal sanctions for sexual violence". However, according to Jayaweera et al (2010), "low education and dependency prevent women escaping from an abusive environment to seek legal interventions". [10]

According to WHO annual fact report (2014), multiple risk factors were identified for being a perpetrator of GBV. [8]One of them is Low education. According to a study done by Hussein (2000) on 52 victims of Domestic Violence (DV) in Nuwara Eliya, Anuradhapura and Matara districts revealed low levels of education as a risk factor. [11]The other risk factor is "Exposure to child abuse or witnessing violence in the family". This reiterates that GBV is a learned behavior and not genetically determined. Further, violence seen and experienced as children, tend to generate violence later on, and this is called Yo-Yo syndrome. Study done by Moonasinghe (2002) also found that there was a link between history of physical and sexual abuse during childhood and becoming a perpetrator later in life. [12]The third factor is the presence of "Antisocial personality disorders". A study done in Galle by Vidanapathirana (2007) also confirmed this fact. [13]The fourth factor is "Having multiple partners or being suspected by their partners of infidelity". A study done by Jayaweera and others (2010) in 697 households over 6 districts, found 18.2% extra-marital affairs or suspicion. [10] Jayasuriya et al (2011) also confirmed that the partner's infidelity increases the risk of GBV. [14] Another factor is "Harmful use of alcohol". In a study done by Prof. Saravanapavananthan (1982), on 60 cases of wife battering, 70% violence had occurred when the

husbands were drunk. [15] In a study done on 116 survivours of wife battering done by Vidanapathirana (2014) at the Teaching Hospital, Colombo South also found that 69% husbands consumed alcohol regularly. [16] However, all drunks/ drug addicts do not beat their wives or rape women. According to Deraniyagala (1992), most batter only the partner, not any other person. [17] Jayatunge (1998) found that alcohol is not a cause, but a favourable condition for GBV. [7] Nirthanan (1999) [18] and Baklien and Samarasinghe (2004) [19] found that alcohol is possibly an excuse. Therefore, it can be assumed that getting rid of alcohol will never eradicate GBV.

According to WHO annual fact report (2014), multiple risk factors were identified for being a survivour of GBV. "Low education" is one of them. Vidanapathirana (2007), found that "low level of education (studied up to grade 5), was 16%". [13] "Witnessing violence between parents" is another factor and Vidanapathirana, (2007) also found that "8% of survivours had witnessed violence between parents". The "Exposure to abuse during childhood" is also a factor. A study done by centre for women's research (CENWOR) (2001) found that "girl-children of migrant women who expose to abuse during childhood, become victims of abuse". [20] However, Vidanapathirana, Vathsala, and Nanayakkara (2011) suggested that "there may be other markers which are specific to our setting and therefore risk assessment in GBV should be advocated based on a risk assessment tool that is suitable for Sri Lanka". [21]

According to WHO annual fact report (2014), the root causes for being a perpetrator/ survivour in GBV are "societal attitudes accepting of violence" and "gender inequality and power difference". A study done by Jayatunge (1998) on a sample of 212 individuals, identified "superiority, authority and patriarchal attitudes related to GBV as root cause". [7]

In 1993, the UN Declaration on the Elimination of violence against women (VAW) offered the first official definition of GBV: "Any act of GBV that results in, or is likely to result in, physical, sexual, psychological or economic harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life". [22] In this definition, "only Women" have been identified as the survivours of GBV. But it is known that some men are being assaulted by women for the same gender attitudes. This drawback was overcome by the definition of United Nations High Commissioner for Refugees (UNHCR), (2003) where it was defined as "Any harm that is done against a person's will based on their gender, that has a negative impact on that person's physical and psychological health, development, and identity". [23] There the survivour is identified as person rather than men or women. Further this definition identifies different effects of GBV.

According to Inter Agency Standing Committee (IASC) (2005), "GBV is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females". [24] In this definition, the causes of GBV have been identified as "Gender differences between males and females".

According to the 'Prevention of domestic violence act No. 34 of 2005' "Domestic violence (DV) means, (a) an act which constitutes an offence specified in schedule I ;(b) any emotional abuse, committed by a relevant person within home or outside and arising out of the personal relationship between the aggrieved and the relevant person".[25] The "Schedule I" include, all the offences under chapter XVI of the Penal Code, extortion – section 372 of the Penal Code, Criminal intimidation – section 483 of the Penal Code or attempt to commit any of the above offences." In the definition, it significant that it has identified emotional abuse as a major component of abuse. The law defines "Emotional abuse" as "cruel, inhuman, degrading or humiliating conduct of a serious nature directed towards an aggrieved person". The "Relevant person" has been defined as "the spouse, ex-spouse or cohabiting partner".

According to Dr. Subhangi Herath, University of Colombo, (2011), "In Sri Lanka, there are no cultural or social practices that directly promote GBV, but there are cultural and social attitudes created through patriarchal ideologies and gender inequalities embedded in every social institution".[26] However, according to Vidanapathirana and Amararatne (2015), "virginity testing" is an example for cultural practice that indirectly contributes to VAW and it can lead to a lack of trust between the couple and emotional instability in woman. [27] There is no conflict with the society discouraging premarital sexual intercourse but using this crude practice is a violation of human dignity and leads to DV. Further, people tend to use "Hymenoplasty" and or changing of the place of residence as attempts of overcoming such negative social practices. [27]

According to UN Declaration (1993), acts of GBV include physical, psychological GBV including emotional abuse, sexual GBV including coercion, social GBV including controlling behavior and economical GBV. [22]GBV are usually combined such as physical violence always with emotional trauma and sexual violence usually with physical violence. *Sexual GBV* is any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. [8]

What we see is the direct violence; the tip of the 'ice berg' but the majority is structural and cultural violence which are unseen. Regarding the magnitude of GBV in the World, according to WHO global and regional estimates of violence against women (2013) "1 in 3 women throughout the world will experience physical and or sexual violence by a partner or non-partner". The prevalence was 23.2% in Europe, 24.6% in Australia, 25.4% in Russia, 29.8% in America, 36.6% in Africa, 37% in Middle East and 37.7% in Indian subcontinent. [28]According to the fact sheet of WHO (2014), 35% of women suffered IPV or non-partner sexual violence in their lifetime, 30% of women suffered physical or sexual IPV and 38% of murders of women was by IPV.[8]

The prevalence of GBV in Sri Lanka is not exceptionally low nor is exceptionally high. According to Jayasuriya et al (2011), in ever-married women 18-49 years in western province, lifetime prevalence of physical violence 34.4%, severe physical violence 19.8%, sexual violence 4.2% and emotional abuse 19%.[14]Therefore, according to recent research, it is on par with the average global situation. However, the types of violence seen in Sri Lanka may be different from some other countries.

Types of GBV, in relation to age are as follows. Types of GBV during prenatal period include sex selection and violence during Pregnancy. Types found during infancy include female Infanticide and differential access to care and nutrition. Types of GBV found during childhood are child Marriages, child sexual abuse [29], child prostitution, child soldiers and labor, differential access to care and female genital mutilation. Types found during adolescence include molestations, rape, incest, sexual harassment at work, forced prostitution, trafficking, kidnapping and abduction and premarital pregnancy. Types in youth and adults include domestic violence, abuse of "domestics" working abroad, dowry related violence, homicide, sexual harassment at work, rape, molestation, desertion, prevention of use of contraception. Types of GBV in elderly people are abuse of the elderly and abuse of widows. This shows that GBV could affect an individual throughout the life cycle: from womb to tomb.

According to WHO annual fact report (2014), different types of GBV can occur in situations such as conflict, post conflict and displacement. [8] In a study done by Wijayathilake (2004) on GBV in the areas affected by the war in the Northern and Eastern regions of Sri Lanka concluded that GBV in such circumstances results a specific type of offence which requires to be dealt in a specific manner.[30] However, not all soldiers rape civilian women.

It has many far reaching negative health and non-health outcomes affecting the individual, family and society. According to WHO (2014), violence against women can result in physical, mental, sexual, reproductive health and other health problems, and may increase vulnerability to HIV. [8]

According to Vidanapathirana (2014), most common site of injury in wife battering is head and majority faced more than one assault. [16] Similar to Saravanapavananthan (1982) [15], the most common significant injury was black eye. [16]

The cycle of violence include three phases viz. tension building, battering and honeymoon phases. According to American College of Obstetricians &Gynaecologists, it is actually a coiled spring rather than a cycle because it escalates its severity and frequency after each episode. Initially a full cycle might take months but later it may come to few hours. Finally the woman prepares to be beaten at the evening and leads to subjugation and lost self-esteem. [32]

Eventually GBV leads to death of the survivour. In the triple murder by the father following his extra-marital affair, Vidanapathirana et al (2015) concluded that investigation of the social background of suspect/s is an important aspect of the criminal investigation process. [33]

GBV has many negative "Non-health outcomes" affecting the individual, family and society. Direct cost – reduce goods and services provide to survivours. Economic cost - reduce earning, productivity and growth. Social cost - impact on children and inter-generational transmission of violence. This indicates that GBV is a major barrier to development.

GBV affects individuals across generations viz. among children, parents and grandparents. Since violence is a learned behaviour, GBV influences the next generation.

There are several challenges to the forensic medical practitioner. In Sri Lanka, majority of the survivors (victims) of Gender Based Violence (GBV) including Domestic Violence (DV) are reported to forensic medical practitioners. The main objective as perceived by most forensic medical practitioners is to collect evidence mainly to facilitate the legal process, according to Vidanapathirana (2014) it is essential to focus beyond satisfying the legal requirement and provide necessary services to the survivours. [16] Delay in reporting to the police and Forensic medical practitioner is the other challenge. Prof. Saravanapavananthan (1982) found that 60% of the complaints were made to the police after 10 years of marriage. He attributed this delay to illiteracy and economic dependency of the survivours. Therefore, the national management policies of GBV should be evidence based.

The next challenge is the GBV of children, because they are the silent victims.

There are several opportunities to the improvement of the services rendered by the forensic medical practitioners. While complimenting the Ministry of Health for establishing "Care provision centres/ Mithuru Piyasa/ Natpu Nilayam" for survivours of GBV, it needs to be recognized that forensic medical practitioners could make use of such centres and services of other specialists for providing psychosocial support, rehabilitation and follow up of these survivours within a holistic approach.[16]

Desirably, in case of sexual abuse, the first contact medical officer should introduce services such as emergency contraceptive pills (ECP), STI prophylaxis and referring for medico-legal examination at the earliest opportunity. If such services have not been provided at that point, it is essential that the forensic pathologist needs to arrange such services when he or she does the medico-legal examination.
GBV violates most, if not all, human rights and affects sexual and reproductive health of the survivour: right to freedom from discrimination, right to life, right to integrity and security of the person, and right to the highest attainable standard of health. These can be violated by limiting decision making, curtailing the rights of access to reproductive health, limiting family planning services and safe abortion services where it is legal, limiting protection from STI and HIV and unwanted pregnancy and causing direct harm and mental health consequences.

Protection from unwanted pregnancy can be achieved by introducing emergency contraceptive pills (ECP). According to Gold (1997), when initiated ECP within 72 hours, risk of pregnancy is reduced by 75%. [34] If LRMP is doubtful, pregnancy test should be performed and forensic medical practitioners can refer survivours of sexual assault to an obstetrician to prescribe ECP. This reiterates the importance of offering ECP to prevent possible teenage pregnancies. [27]

According to Kawsar et al (2004), prevalence of STI among the survivours of sexual assault is about 26%.[35] Workowski et al (2002) stated that the routine prophylactic therapy is often recommended because follow up with these patients can be difficult.[36] Therefore, evidence of STI is not essential to refer to STI unit. Vidanapathirana and Amararatne (2015) stressed that though the prophylaxis treatment of STI is not given to victims of sexual assault in Sri Lanka, it should be prescribed at least when there is evidence of penetration. [27]

Another opportunity of improvement in the management is the psychosocial rehabilitation of the survivours of GBV. According to Campbell et al. (2007), deliberate self-harm in survivours of sexual assaults is about 26%.[37] Kawsar et al, (2004) stated that psychological consequences may appear at different times.[35] Therefore, according to Vidanapathirana and Amararatne (2015), psychological symptoms or signs are not necessary to refer to the mental health expert.[27]

It is mandatory to adhere to the basic guiding ethical principles such as safety, confidentiality, respect, non-discrimination, responsibility, compassion, being non-judgmental, and survivours right to decide. When providing medico-legal services to the survivours of GBV, the facility should have room with a door that could be closed and locked to discuss issues with the survivor in confidence and safety. Confidentiality is essential to prevent client loss. To ensure non-discrimination past experiences, opinions, views and attitudes should not be allowed to influence the way we provide care to the survivors. Do not use judgmental statements such as "no wonder you get molested when you wear such clothes" and "If you go around at night you are inviting trouble". Listen and treat the survivours with

respect. GBV survivor undergoes a traumatic, degrading and humiliating treatment from the perpetrator. Treating her with respect is very important for her recovery. Avoid repeating her story in multiple interviews by adopting "joint examination". Not only survivours, respect guardians of children also and strengthen their self-esteem and self-respect. Every adult survivor has a right to decide such as the right to choose, stop telling their story or stop the examination at any time and have the right to decide whether they want legal or any other services.

We need to change our attitudes towards survivors. According to Vidanapathirana (2014), out of 64 direct admissions, 18 survivours of wife battering requested not to inform police. Sound mind adult victims of criminal cases have a right to refuse informing to the police. GBV has not been listed under the offences that public should give information mandatorily (section 21 of the criminal procedure code of Sri Lanka). The survivor's choice in initiating legal action should be retained. [16]

Re-victimization within the health system which is another issue that adds stress and strain to the survivour could be prevented by developing "Joint examination system" among the care providers such as forensic medical practitioners, psychiatrists, gynaecologists and counselors/ trained befrienders while recognizing the right of the survivor of refusing a medico-legal examination. The stake holders and policy makers should understand the importance of multidisciplinary approach in providing care. [16]

According to Vidanapathirana (2014), medical professionals both in government and private sector have a responsibility of referring survivors to a dedicated centre at the nearest hospital. [16] There, the survivor's choice in taking legal action should be retained considering the implications.

Making temporary shelters such as "one-stop crisis centres (OSCCs)", available for survivours is a need which has not been satisfactorily fulfilled so far. This is a patient centered management centre characterized by teamwork of multi-sectoral and interagency network for the management of woman and child victims of violence. It collaborates with different agencies such as social welfare, shelter, 'legal-aid' assistance, court procedure, police service, etc.

Another opportunity to improve the medico-legal examination of survivors of GBV is providing emotional support. The emotional state of the survivour will affect the medico-legal examination process such as leading to denial, hiding evidence, fear to report, and repeated suicide attempts. In order to conduct a medico-legal examination, principles and skills such as building up a good rapport, being empathetic, active listening, being non-judgmental, appropriate questioning, showing available options, supports the survivour to take positive decisions and strengthening or empowering the survivour are important to make the medico-legal process a success.

In non-judgmental listening, use phrases such as: "I am concerned for your safety (and the safety of your children)", "You are not alone and help is available", "You don't deserve the abuse and it is not your fault" and "Stopping the abuse is the responsibility of your partner not you". Provide information so that she gets the assistance she needs. Assess the risk to her and the children. Help her to have a safety plan. Assess the results of the violence. Provide the necessary clinical care for her injuries. Fulfill the legal obligations. Support her, assessing whether she's in immediate danger and refer her to sources of help. These are the best things you can do for her but never advise a woman to leave her partner. Women are at high risk of injury or murder when they leave a violent partner, so leaving immediately might not be the best option. Never make decisions for her, she decides for herself what she wants to do next and you should help her by identifying the available options.

All GBV survivours undergo emotional impact. Providing emotional support is an essential component in all GBV services. 'Listening' has a therapeutic value and 'Counseling/Befriending' needs special training and includes principles as well as skills. Vidanapathirana (2014) stressed to establish "Health Care Provision centres/Mithuru Piyasa" in each hospital and requested you to influence to establish such a centre at your institution. At such centres mainly befriending and counseling is done but no shelter facilities are provided. [16]

It is necessary to understand the Prevention of DV Act, 2005 in Sri Lanka in order to sensitize the survivour about the options of getting legal help through the Act.

For Rehabilitation of the perpetrator neither short or nor longer custody arrests are effective in the long run. [38] According to Vidanapathirana (2014), most cases are settled by non-custodial methods such as mediation boards or suspended sentences. According

to Dobash (1997), in USA, 'Battering Intervention and Prevention Program' (BIPP) uses individual counseling. [39] Similarly, under DV act, 'Mandatory family counseling', is done in Sri Lanka.

Rarely, survivours can conflict with the forensic medical practitioner because of, unexpected outcome, unexpected cost and unmet expectations. In Sri Lanka, the 'unmet expectations' concern mostly. However, some expectations are realistic such as adequate time, doctor's interest, helpful office staff, doctor's competence, respectful treatment and listening to survivours. Therefore, the tips to avoid conflicts resulting in law suits include treatment with respect and dignity throughout the care process, involve the patient and family, use appropriate communication skills and build a good rapport, avoid medical language and choose words carefully respecting the local customs and sensitivities. Further, avoid criticizing another health care provider's management with words or gestures and prepare patients by giving them sufficient knowledge without expecting them to know. Adequate documentation and record keeping is essential.

Forensic medical practitioners should try to get rid of gender attitudes. This tends to blame and shame the woman. Biased behaviour affects the manner in which she is treated and may lead to delays and stigmatization. Gender attitudes also affect the self-esteem, inhibit rehabilitation efforts, devoid the return for follow up and in turn forms a bad image of the health institution. Therefore, these precautions may save you!

Can't we be perpetrators of GBV? Sexual violence can occur at work places and male doctors can abuse the female patients because they are powerless.

Finally, 22nd-26th of February 2015, Dr. Lakshman Senanayake, Dr. Manoj Fernando and the author developed and introduced three [3] online courses on GBV for the expatriate specialists and medical officers (MO) newly recruited to the Maldives Health Service, the existing specialists and MOs and the nurses of Maldives and the orator recommends such online programme to Sri Lanka to make awareness among stake holders.

## Conclusions

GBV is an important subject, possibly we have been providing services, but probably without understanding the full impact to survivours because we focus mainly on the medico-legal aspects but not the holistic approach. As recommendations, ensure guiding principles of the management of survivours, improve the communication with patients and focus beyond satisfying the legal requirement when providing medico-legal services for the survivours of GBV. Also recommends the College of Forensic Pathologists of Sri Lanka to take the leadership to develop a national guideline on GBV in Sri Lanka.

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