

Engendering Health Information System in Bangladesh through Locating Health Care Needs of the Victims of Violence

Ishrat Khan

Department of Women & Gender Studies, University of Dhaka.

ARTICLE INFO

Article history:

Received: 17 June 2019;

Received in revised form:
17 July 2019;

Accepted: 27 July 2019;

Keywords

Gender,
Health Care,
Health Information,
Victims,
Violence.

ABSTRACT

To combat violence against women (VAW) and help VAW victims access proper health care facilities, ensuring a gender-friendly health information system is of special concern. The experiences of VAW victims in accessing and availing proper clinical and psychological services are determined by many factors. Among many, the location or distance of the nearest health care services, availability of doctors, mindset of the husbands, in-laws and relatives, the economic condition of the victim's family, duration of the treatment based on the severity of the injury are the main factors. Also, the naturalization of domestic violence against women in the grass-roots level is one of the major obstacles in engendering health information system in Bangladesh for which victims are not mostly being able to avail proper health care services. Creating awareness among community people and others involved in health care services and making them gender-aware has no other alternative.

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Introduction

Since the last decade, Bangladesh evidenced a gradual increase in violence against women (VAW) across the country, irrespective of class, gender, race or religious identities. Recent studies on VAW highlighted the extent of its severity resulting in depression, suicide, injury, homicide and many more (Ellsberg et al. 2011). A World Health Organization (WHO) study conducted in 2005 showed the alarming speed of violence against women in both urban and rural areas. Conducted among three hundred and eighty-nine women, this study reported various forms of violence resulting fourteen cases of suicide, along with spot death (2), injury (21), humiliation (12), abduction (4) and also, rape incidents (57). Unfortunately, 71% of the study population shared their experiences of spousal sexual abuse in their private life (WHO 2005 cited in Khatun and Khandaker, 2012). But how adversely this violence impacted women's physical and mental health specially within marital or intimate relationships still points to the less researched contents of this particular field. Considering the existing literatures in Bangladesh, violence was mostly highlighted on the basis of its nature and degree in which survivors' experience of victimization from a public health concern went unnoticed (Heise et al. 1999). Without considering violence from human rights perspectives, reducing the number of cases and ensuring justice for women is completely a far-reaching destination.

In 2011, the government of Bangladesh formulated a health policy with the primary concern of improving reproductive health resources and services. The government wanted to develop a system ensuring easy and sustained availability of health services specially for the poor communities in both rural and urban areas (Mahmood, S. 2012). The policy was mainly targeted to implement integrated programs for improving maternal, child health and

nutritional status at the union level while adopting satisfactory measures for installing safe and hygienic child delivery facilities in each village. But this policy failed to address the alarming rate of violence which required inclusion of engendering the Health Information System considering victim's health care needs.

This study therefore, attempted to locate ways of engendering HIS in Bangladesh, targeting the victims of sexual assault and also those suffering from reproductive health disorders, sexually transmitted infections or unwanted pregnancies. This study intended to explore the health care needs of VAW victims for further planning, decision making and policy formulation. It was designed to address the strategies for reducing violence through a three-tier strategy inspired by WHO (World Health Organization) and MWHFW (Ministry of Health and Family Welfare). The strategies were targeted to:

- 1) Adopt and implement policies for preventing VAW and protects victims by enhancing the capacities of government, improving information and providing support to NGOs and civil society.
- 2) Change attitude and behaviour of men, women, boys and girls to reduce discriminatory practices against women such as dowry, early marriage and trafficking.
- 3) Protect survivors of gender-based violence with immediate care, relief and rehabilitation through expansion, renovation and improvement of the existing shelter system.

Objectives

Main objective

To engender HIS ensuring a regular and systematic entry of VAW cases in the existing health information data source.

Specific objectives

To assess health care needs of the victims of VAW

To identify VAW victims support seeking practices and relevant experiences in the public health service

Research Design and Methodological Concern

This study followed feminist research methodologies combining qualitative and quantitative tools for data collection. Following feminist epistemological principle, it challenged the positivist ideas of traditional methodologies and androcentric biases from the field defining models and particular set of events by men (Biber and Nagy, 2007). The reason for choosing feminist research methodology was not merely to draw dominant avenues of knowledge building but also to consider the subjective experiences and concerns of researchers. As understanding subjectivity is prior to better understanding of qualitative research (Rennie, 2000a), this study ensured maintaining subjectivity from the beginning of the research to the end. It emphasized on understanding researchers' own experience which is often shaped by gender and other various identities (Mary in Benhab, 2007). A prior emphasis was given on researchers' narratives to reflect on their subjective experiences and identifying the struggles to situate themselves in challenging events. The overall discussion entailed further illustration on the reliability and triangulation of data at later stages.

As mentioned earlier, this study was combined of both qualitative and quantitative methods. Quantitative method was used to identify the availability or scarcity of health services in both public and private hospitals. A semi-structured questionnaire survey was carried out among the respondents from the rural and urban slums in which prior emphasis was given on the number of cases reported, quality of reporting, types of violence and also service provided within the institution.

For institutional assessment, K.A.B.P (Knowledge Attitude Behaviour and Practice) survey was carried out incorporating information about health behaviour and attitude of stakeholders for example service provider (the institution itself) b) service receiver and the community or family influencing the behaviour of the former two groups. The stakeholders included community-based groups providing legal, psycho-social, economic or other forms of support to victims of violence. It also included NGOs engaged in advocacy, legal and health care services, government entities responsible for developing and implementing meaningful policies, laws and international organizations providing technical assistance to the victim of violence. Exploring the gaps and challenges of the health sector, it emphasized on strengthening the capacity of stakeholders among organizations and empowering women as well.

As quantitative methods can never be purely objective, it was more logical to accept and include subjectivities, emotion and social position of researchers through qualitative analysis. For better inclusion of the voices of the victims and also to ensure reliability of data focusing on researchers' subjective experiences, this research relied on focus group discussion (FGD), in-depth interview (IDI) and participant observation (PO) as qualitative tools.

FGDs were conducted both in the rural and urban slums to have an overview of the current health care and victim supports services. FGDs later helped to identify the key subjects for in depth interviews. Initially, two women from each rural and urban slum were selected for in-depth interviews. In addition, participant observation tools were incorporated to assess health care services and mechanism in public hospitals of the targeted thana, upazila and district.

A participatory research technique PRA was ensured while operating the qualitative tools. It helped to identify the

number, location (the high-risk zone where abuse, sexual harassment took place) and quality of public health services (medical, legal, and other) available to the survivors. Archival records from the major service providers were collected to identify gender-disaggregated data. It helped further to understand the categories and rate of services delivered by the health institutions and the status of health information system as well.

Fieldwork

Locating VAW Victims in hard to reach communities

To cover diverse aspects of VAW victims from both individual and institutional settings; gender, age, marital status and geographical location were taken into consideration. Individual assessment mainly focused on the health care seeking behaviour of women aged between 15-49 who accessed or never accessed health services in the public hospitals.

For institutional level assessment, (One Stop Crisis) OCC members from the upazila, thana and district hospitals were randomly sampled. Along with the three urban slums in Dhaka, Rajshahi and Barisal; ten districts were initially chosen under the coverage of joint program run by WHO and UNFPA. Three villages from each of the ten districts were targeted as the prime location of this study. For purposive sampling in the slums, vulnerable areas were identified by the experienced local govt and non-government organizations. Sample areas were also identified from the newspaper records indicating the maximum number of incidents in different districts.

One of the key ways of locating violence victims from rural and urban slum settings was the use of kin networks. Researcher's own networks in the local Health Information System (HIS) and their newly developed connection with the domestic workers at the hotel in Gazipur helped them to reach local victims. In few hospitals where researchers were not welcomed, had to fake their identities. In some areas, community people were helpful to connect the researchers with the medical official or staffs and helped them visit the general wards. This connection was also helpful to meet the families and relatives of the victims in the later phase. In Jessore, Rajshahi and Narayanganj researchers' rapport with the ward boy, nurse and also doctors helped them to observe the conditions of the hospital services like accommodation and treatment of patients. It also created an avenue to meet victims' family members and relatives.

Though not very likely but support from the government officials in primary health care services was of great help in accessing HIS data. Specially in Rajshahi, it helped the researchers to scrutinize the information on violence consulting with the local NGOs and community people.

Exposure to fieldwork, researchers' note of disclosure

This section unpacks researchers' subjective experience and also their self-concerning validity and reliability. The subjectivity of the researchers mostly shaped by gender differences and their position in the society had ultimate impacts on the validity and reliability of research starting from note-taking till story sharing, meaningful writing and qualitative interpretation. To ensure a bias-free research context, this research, therefore, encouraged negotiation within researchers themselves with the social relations of the studied communities.

Convincing people to talk about their personal life is easier said than done. Conducting field work in the urban and rural slums was not an exception to that. As a result, the

assessments of violence were often interrupted, threatened by the local members. Even the researchers, a group of well-trained Gender Studies graduates who were familiar with feminist methodologies experienced several unwanted events. While seeking official permission to meet the VAW victims, researchers often experienced maltreatments from the hospital management. In many cases, hospital settings played negative role in collaborating with the communities.

Influence of the gatekeepers was also found significant in many places like Guptergaon Union Parishad in Sylhet. A majority of the respondents felt uncomfortable to participate in the FGDs in front of the male leaders of the Union Parishad. In Karwan Bazar, researchers found the victims uncomfortable and avoiding discussion about sexual abuse being closely monitored by the slum gatekeepers. To ensure comfort and trust, researchers later organized women only FGDs which helped them to collect data in a safer way.

Dealing with subjectivities: ensuring reliability

This section deals with researcher's experience of dealing violence victims in the studied areas. Researchers were conscious about listening to the respondents carefully to locate locally used words or terminologies like 'disturbance' or 'unhappiness' to connect with the events of violence or victimization. To cope with the existing cultural settings in the slums, researchers often had to compromise with their class positions, dress up style, food habit, even sometimes their concern for cleanliness and hygiene. They mingled with the slum dwellers, sat on the untidy floors and shared lunch with them without expressing any discomfort. Sometimes they paid positive attention even to the irrelevant discussions of the victims just to ensure they were not emotionally hurt.

Even in the occasions of confronting personal attacks, researchers acted sensible. In Shantipalli Slum of Gazipur, the interviewer had to fake his identity and introduced himself as a municipal worker to access entry at the hospital. He was later chased by the influential local community leader. The interviewer apologized to the leader and kept silent but did not expose the identity of his interviewees.

Possibilities of underreporting and overreporting were also considered to ensure the validity and reliability of the research.

Data Triangulation

Triangulation is usually thought of explaining complex ideas with multiple perspectives and meaning. It also refers to cross-check certain data of factual nature, validating findings by comparing data collected by a variety of methods, or from a variety of sources, researchers or via the variety of lenses of theoretical perspectives (Ely & Vinz. eds., 1997). To avoid mere chances of inaccurate observation and wrong interpretation, this study used the justified and validated knowledge gathered from the field as a commonly used technique for data triangulation.

Triangulation ensured the trustworthiness of the researchers while analyzing the essence of their observation and possible analysis. Repeating conversations to locate inconsistency were influential to ensure the reliability of collected data. To measure the validity of answers, victims were questioned for example: "when did your husband beat you for the first time?" Repetitively in the middle of the interview, questions like, "why did your husband beat you?" were asked.

Participant observation from the community and hospitals advantaged the researchers to locate the victims ensuring their admission, experience and health-seeking

attitudes. Consulting with the doctors, nurse or cross-checking records also significantly helped to validate data. Prescriptions, health cards, tickets for health treatment shown by the local victims outside the hospital aided further data authentication.

Locating the Health Care Needs of VAW Victims

This section located the clinical and psychological (emotional and counselling support) health care needs of VAW victims. It also highlighted the gap between existing and standard health care practices. The long term and short-term needs were identified from the interviews and group discussions with the victims, their relatives and relevant persons in the health care settings. For comparative analysis, psychological and clinical needs were also brought into consideration.

Health care needs of VAW victims

While identifying the health care needs of VAW victims, this research considered types, severity, intensity of the injury and also the response time for treatment. Considering the first three, health care needs were grouped into two major categories, short term immediate needs and long-term immediate needs.

Short term immediate needs included primary health care supports for example, first aid, bandage, pain killer, ice bag treatment etc. Unless the condition of the victims worsened, they were hardly taken to district hospitals. Even in severe cases of bleeding, or any broken organs the primary treatment was provided at the household by pouring water or rubbing ice. The specialized facilities for the victims of rape, burning or acid violence available in the medical colleges within ten study areas were not at all satisfactory. Only four among ten districts had medical colleges with functional burn units (Dhaka, Chittagong, Barisal and Sylhet Medical College Hospital).

The short-term needs of the VAW victims and their experiences at the health care service providing facilities can be put into two major segments- short term psychological needs and short-term clinical needs. Short term needs usually involved clinical checkup, tests, x-ray, prescribed antibiotic or pain killers often injections or stitches and also psychological support from the nearest ones. Secondary immediate needs included emotional support from relatives, parents, and in-laws.

The long-term needs of the VAW victims and their experiences at the health care services were grouped into three categories, a) emergency support for the victims (where the life of the victim is in danger) b) long term clinical procedure where the victim may need to undergo surgery or intensive observation by the service providers and, c) long term psychological counselling. Long term needs were generally required for two cases, when injuries were severe and potentially lethal (serious internal and external bleeding, losing a limb or any other body part) and also when particular types of violence (domestic violence, acid throwing, burning and rape) took place. In both the case, victims required intensive health care support depending on the severity of the injury. These specialized treatments were associated with expensive critical surgery and intensive post-operative care.

Health care needs considering the types of violence

The health care supports for VAW victims varied with the type, degree and severity of violence experienced. The following table represents the common types of violence occurred in the studied areas.

Table 1. Types of Violence occurred in the study areas.

District	Types of violence							Total
	Wife battering	Dowry related violence	Rape	Burning	Acid Throwing	Trafficking related violence	Others	
Rangpur	6	4	0	0	0	0	0	10
Jessore	6	1	1	0	0	2	0	10
Barisal	5	3	1	0	0	0	1	10
Patuakhali	5	3	0	0	0	1	1	10
Rajshahi	4	1	3	1	0	1	0	10
Chittagong	4	4	0	0	1	0	1	10
Narayanganj	5	4	0	0	0	0	2	11
Sylhet	6	4	2	0	0	0	2	14
Dhaka	7	4	1	0	0	0	1	13
Gazipur	4	6	0	0	0	0	1	11
Total	52	34	8	1	1	4	9	109

Alongside the common forms of violence, sexual harassment, strangulation, verbal abuse and eve-teasing were addressed by the victims and other relevant persons.

Wife battering was identified as one of the most common forms of violence among ten districts resulting physical injuries like bruise, bleeding along with long-term physical consequences like loss of organs. Husbands, in-laws and relatives were the commonly identified perpetrators.

Rape, sexual harassment and forced pregnancies had several consequences like internal bleeding, prolonged gynaecological problems and psychological trauma. Husbands, partners, relatives or unknown persons were identified as potential perpetrators. Respondents identified medicines, antibiotic treatments as short-term needs, often DNA tests were required to prove the incidents of rape. The long-term clinical needs included specialized operations, prolonged medication and physiotherapy.

The incidents of rape often came up with social prices. In most of the cases, defame of social position or the family status of the victims, social ostracization became so important that the families preferred not to take them to the hospitals unless the injuries were serious. In the long run, it contributed in developing other sexual diseases like gonorrhoea, chlamydia and trichomonas or affecting their pregnancies.

The need for female doctors was repetitively addressed by the victims as they were not comfortable to open up and expose their vaginal injuries to the male doctors. This touch sensitivity, therefore, led them to another psychological trauma.

Hospitals were also reluctant to provide immediate services to the victims in some areas. Instead of supporting the victims with Hepatitis B vaccine to stop severe bleeding or multiple assailants to prevent HIV, reducing the risk of pregnancy often became the prior issue.

"The doctor who tested me was also a man. I was frozen in fear and shame when I saw another man touching me. That was really stressful for me to let myself exposed to another man..."

Jharna, a rape victim in Rajshahi

Trafficking that took place within or beyond national border was often thought of having no connection with the

health care needs for the victims. Many women in the studied areas were trapped with the false promises of getting new jobs by the traffickers and fell victim of violence and forced sex. Their denial of working in the brothels left them into drudgery like forced beggary and vulnerable to severe torture. Some of them had to sacrifice their organs like kidneys, pancreas, arms, legs and eyeballs which were forcefully extracted and sold to engage them in beggary.

"I was trafficked from Sharsha (Jessore) and ended in the brothel of Kolkata which was nothing short of hell. I was locked in a room with no lights and adequate airflow. One day I failed to earn the minimum amount and I was beaten brutally by the pimp. I was bleeding but did not get exemption from selling sex to the customers. They always forced me to have sex and removed my ovary through an operation (three months ago). I still cannot walk and so much hate my life." (Ruksana, Victim, Jessore)

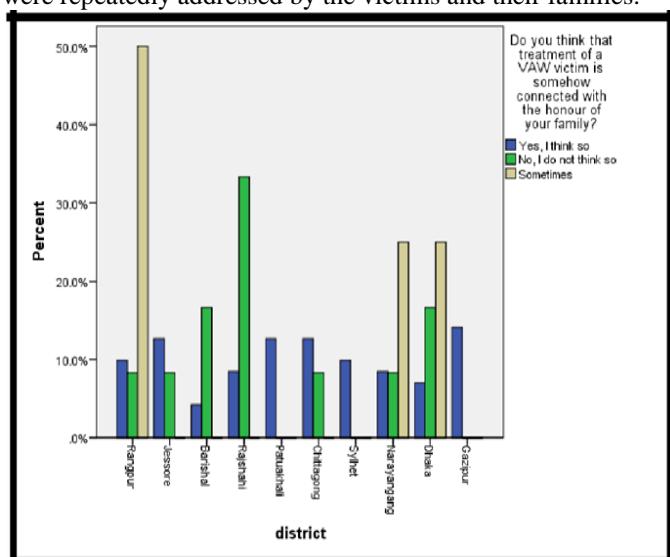
Victims of trafficking seldom got the required health care services. Immediate needs for special care and clinical treatments were urgently required for the trafficked victims because of their horrific experiences. Psychological counselling and emotional support from the families was important to regain the mental strength of those victims. Specialized operations, artificial limb implants, DNA testing and HIV/AIDS tests together with other preventive diagnoses and extensive physiotherapy were some of the required treatments.

Victims of **burning and acid throwing** were less common in the areas but possible fatalities, severity and the intensity of such violence caused permanent damages to a number of respondents' bodies. Scars and burn marks caused by acid often sustained for lifetime resulting damages to sensory organs like ear, nose or eyes, visual and hearing impairment or, lingering pain due to internal damage of the skin. Plenty of water, pain killer or antibiotics along with proper emotional support were required for early recovery depending on the severity and degree of burning. Specialized operations, long term physiotherapy or facial surgery are needed for severely burnt victims.

Acid violence had far-reaching impacts on victims which caused lifelong bodily disfigurement or making them physically challenged. Long term surgical treatment, in-depth intervention from psychologists and counsellors were needed to ensure their physical recovery and psycho-social viability within communities. Respondents identified the need of expert psycho-social counselling, emotional support from the close relations and opportunities to share their experiences to release their trauma. will help them confront the realities instead of hiding the trauma.

Other Health Care Needs Addressed

Besides short term and long-term needs, the other identified needs from the field were the distance of the nearest health complex, inadequate bedding and admission arrangements at the public hospitals or one stop crisis centers (OCC), behaviour of the doctors and hospital staffs, willingness and financial capacities of victims' families of the VAW victims etc. The need of female doctors for the victims were repeatedly addressed by the victims and their families.



Fear of defaming family dignity As incidents of VAW are often mixed with family honor, seldom the VAW victims receive better treatments or any treatment at all. Incidents of violence were often considered as internal family that should be kept private and between husband and wife. The health providers shared that the rich group rarely comes to the government hospitals to hide their names from the government register book. The following graph depicts such responses of the people.

Scarcity of transportation facilities

Lack of transportation and proper communication were two major factors challenging the access to health care supports. Due to heavy downpour (marsh lands of Sylhet and low-lying lands in Barisal) and tidal surge, natural calamities (coastal areas of Chittagong and Patuakhali) access to hospitals were denied. During monsoon, it was impossible for the patients at Bashkhali to access medical facilities or ambulance support during emergency. Other private cars or micro bus were not affordable for the victim's families.

Filthy environment of the hospitals

The environment or the health complexes often went unnoticed. The unhygienic, filthy environment were the reasons of discomfort of the victims and their families compelling them to admit in private clinics for better treatment facilities. Due to clumsy and noisy surrounding, unclean beds, patients were often compelled to buy expensive beds and other amenities beyond their affordability.

The influence of the middle-men and reluctant attitude of the health care service providers

The influence of middle men in accessing doctor's appointment or further facilities within the hospitals hindered poor victims' access to public health care support. It was not always possible for the victims to break this syndicate. Instead of accessing free medical facilities, they had to end up making liaisons with those middle-men and paying extra.

Threats from local leaders and perpetrators

Shelter seeking attitude of perpetrators from the local political elites or influential was commonly observed. Specially the rape and domestic violence perpetrators sought shelters from the local influential groups to escape from the local police. This also helped them to create pressure on the victim's family for not reporting it to the police or the local hospitals. While conducting interviews in Jessore, we observed a local leader threatening the OCC Coordinator to write a false report on a particular rape case. Another case was observed in Patuakhali where the local leaders were threatening the doctor not to admit the victims of domestic violence.

Victims' Experience of Seeking Health Care Services

This section discusses the experiences, preferences of seeking health care supports and also the hidden facts to access those facilities. It also emphasized on the role of families and nearest ones including the health care providers to ensure the existing services available for them.

"my husband beat me brutally and broke my leg. When I went to Sadar Hospital, neither doctors nor nurses treated me well. I did not find the free medicines and paid 55 taka instead. Quality of treatment is always bad when you are specially poor!" (Nurjahan, Victim, Gazipur)

The existing health care settings were mostly found less functional or inadequate to provide special treatment to the VAW victims. Many have complained that the community clinics were only open once in a week or twice sometimes if there was any occasion of government officials visit. Hospitals were found providing immediate short-term needs even without examining the degree and severity of their pain.

Data collected from the field identified the probable access points for health facilities and the following table represented those starting from the neighbours, local pharmacies to Upazila Health complex, district hospital and so on. The table also reflected the majority of victims' preference to avail health supports from the public hospitals (44%) and also from the local pharmacies (32.1%).

Conclusion

This research explored the culture of normalizing violence and its acceptability in Bangladesh and came up with recommendations to challenge the overall situation in the health care systems. To improve the overall situation of violence, it therefore argued for a gender disaggregated data set and a coordinated rescue mechanism between the law enforcing agency and health care providers.

As mentioned earlier, due to the lack of access to HIS data sources this research fails to give any detail, informed recommendation on engendering HIS data sources.

Table.2. Access point for health care services.

District	Where did you go immediately for treatment?					Total
	public hospital	Traditional healer	Village doctor	pharmacy	elsewhere	
Rangpur	3	1	1	5	0	10
	30.0%	10.0%	10.0%	50.0%	0.0%	100.0%
Gazipur	6	1	0	3	0	10
	60.0%	10.0%	0.0%	30.0%	0.0%	100.0%
Jessore	5	0	1	4	0	10
	50.0%	0.0%	10.0%	40.0%	0.0%	100.0%
Barisal	3	0	5	3	1	12
	25.0%	0.0%	41.7%	25.0%	8.3%	100.0%
Rajshahi	4	0	2	2	0	8
	50.0%	0.0%	25.0%	25.0%	0.0%	100.0%
Patuakhali	4	0	1	4	1	10
	40.0%	0.0%	10.0%	40.0%	10.0%	100.0%
Chittagong	3	0	5	1	0	9
	33.3%	0.0%	55.6%	11.1%	0.0%	100.0%
Sylhet	5	3	0	6	1	15
	33.3%	20.0%	0.0%	40.0%	6.7%	100.0%
Narayanganj	4	0	1	5	1	11
	36.4%	0.0%	9.1%	45.5%	9.1%	100.0%
Dhaka	11	0	0	2	1	14
	78.6%	0.0%	0.0%	14.3%	7.1%	100.0%
Total	48	5	16	35	5	109
	44.0%	4.6%	14.7%	32.1%	4.6%	100.0%

As a model for standard practice of HIS, the government of Bangladesh has accepted the Health Metrics Network (HMN) framework (see Annex 1) in 2009 but it has not considered gender as a lens to identify different components. The framework should emphasize on making legislative, regulatory and women friendly planning framework of HIRS. There should be specific direction to ensure women's active participation in the formulation process of legislation, regulation and plan. A clear guideline for women's recruitment providing specialized services for VAW victims (OCCs and Forensic department etc) and data management should be of immediate concern.

Developing a web-based follow up mechanism can help trace information on victim's receiving immediate treatment or continuing further. This process can be done using a web-based referral system through linking the community clinics with Thana and District level service providers. Any patients after receiving treatment at the upper level of health care facilities will be referred to the community clinics for reporting and monitoring purpose. The network among health care service providers and GoB, civil society actor needs to be strengthened immediately to coordinate information exchange and experience sharing in a regular manner.

It should be noted here that the HNM has identified six components of which data source is one (see Annex 2). Identifying strategies to engender HIS data source based on VAW victim's health care needs, some specific recommendations should be followed. As many of the victims prefer availing services from informal sectors like village doctor or local pharmacy, recognizing these as valid data source may drastically improve the number of VAW cases available for the policy maker through HIS network.

This mechanism should also introduce adequate gender training for the doctors, nurse and other health care providers with the emphasis on increasing the number of female doctors. Specially the nurses involved in the health care setting need specialized training to develop skills as Sexual Assault Nurse Examiner (SANE) to handle victims of rape, sexual assault or other domestic violence. In many cases, female doctors do

not want to involve in forensic departments that requires their witness in the court. Special provision should be taken to exempt female doctors from such duties.

To provide adequate logistic supports at the district level, at least a special rescue team coordinating with the OCCs and law enforcing agencies should be deployed. OCC should be held responsible for providing emergency special supports to the victims of sexual violence and trafficking. Psychological counselors should be deployed at community level.

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Annex

Annex 1

Before 2005 there was no global standard for Health Information System. There was no common structure of HIS for Countries. The components and practices varied country to country. The need for a global and unique Health Information System was realized by the World Health Authorities. The World Health Organization (WHO) felt that without a standard HIS, their policy and program interventions have been disrupted. If there was a unique system, the decision-making process regarding policies and programs could be easier. Therefore, a unique and standard HIS was required to take global, regional and national health initiatives. The World Health Organization (WHO) took an initiative to set a standard practice of Health Information System worldwide. WHO, as a host, launched Health Metrics Network (HMN) along with financial assistance from other donor agencies to help countries and other partners improve global health by strengthening the systems that generate health-related information for evidence based decision-making. HMN dealt with mainly Health Information and Statistical Systems and Health information production and Use. Then it established the "HMN Framework" as a standard practice of Health Information System (HMN 2009).

Annex 2

Health Metrics Network (HMN) has identified six components of Health Information System. These are: Health Information System Resources, 2. Indicators, 3. Data sources, 4. Data Management, 5. Information Products and

Dissemination and use. The HMN has also put those six components into three broad stages: 1. Inputs, 2. Processes and 3. Outputs.¹ According to the 'HMN framework', Health Information Resource System (HIRS) is, considered as input of overall HIS, is obligatory for a Standard HIS. The HIRS includes – 1. Legislative, regulatory and planning frame work, 2. Personnel, financing and logistics support 3. Information and Communication Technology, and 4. Co-ordination among the other components. Then, the 2nd, 3rd and 4th components are considered as processes. The 2nd component is mainly about a core set of indicators and related targets for the three domains of health information:

1. Determinants of Health (e.g socio economic and demographic factors and environmental factors),
2. Health System (e.g Policy, financing and service availability etc) and
3. Health Status (e.g Levels of Mortality and Morbidity).

The third component includes Data sources specially Population based (Census, Surveys etc) and Institution based (Individual records, Service records etc). The final stage consists of the component 5th and 6th. The 5th and 6th components deal with Information products and dissemination and use respectively.