FROM OTHER JOURNALS

Domestic violence as a public health challenge

There is extensive evidence of the physical and mental health consequences of domestic violence for its survivors. This article describes the Dilaasa project, intended to influence the mindset and approach of healthcare workers towards victims of domestic violence. The project is a collaboration between a non-governmental organisation and the municipal corporation set up a crisis centre in a municipal hospital – a model that was replicated in other hospitals in later years. The project identifies domestic violence as a larger social issue embedded within gender inequalities and calls for its recognition as a public health concern. It liaises with Majlis, a legal service organisation, and several shelters and community-based women's groups towards providing comprehensive care under one roof. Women are referred to the crisis centre from the casualty, OPD and other departments that deal with patients suffering serious injuries and trauma which may be caused by domestic violence. Since our medical curriculum does not yet perceive domestic violence as a medical issue, hospital staff is unprepared to deal with it. So the woman is sent back into the same dangerous environment, with no acknowledgement that the violence is bound to continue. Thus staff need to be trained to recognise such cases and deal with them ethically and with sensitivity. Locating crisis centres in public hospitals allows women access since even women who are not allowed to go out of the house on their own are rarely denied a hospital visit. Interviews with survivors who had undergone counselling at Dilaasa found that the programme had an impact on the women's live. However, despite Dilaasa's success, the intervention exists only at the secondary and tertiary levels of the healthcare system, though such crisis centres are needed across all levels of public health institutions in India.

Bhate-Deosthali P, Ravindran STK, Vindhya U. Addressing domestic violence within healthcare settings – The Dilaasa model. *Econ Pol Wkly*. 2012 Apr; 47(17):66-75.

Tuberculosis control in India

This article is a response to another article entitled "Innovative tuberculosis control in India" by Nora Engel and Wiebe Bijner (*EPW*, 28 January 2012). The author presents a case for public expenditure in laboratory research, drug and diagnostic manufacturing and the clinical management of tuberculosis so that the disease is controlled in a profit-indifferent manner across the world. In any discussion on tuberculosis control, it is imperative to consider nutrition, sanitation and social inequality in access to health care as contributors to the prevalence of TB, the author says. Identifying a weakness in the Engel-Bijner article, Mishra discusses the need to address politically fraught approaches and issues in TB control, rather than using solutions based on management and governance approaches alone.

Mishra A. Tuberculosis control (discussion). *Econ Pol Wkly*. 2012 Apr; 47(15):79-80.

Estimating childhood malnutrition

This article reports findings from a study on the high levels of childhood malnutrition in six backward states of India. The study finds that officials at all levels grossly underestimated the extent of malnutrition in their areas. Although the anganwadi centers were functioning in all the surveyed districts, only 25% of weighing scales were functioning, and only one-third of the anganwadi workers were able to interpret growth curves and graphs. The gaps identified at district and sub-district levels included staff shortages, poor roads and delay in release of funds revealing serious deficiencies in both funding and implementation. Supplementary feeding material was available only for about 50% of the total period. The constraints expressed by anganwadi workers were: poor cooking infrastructure, lack of adequate space and clean drinking water, and difficulties in food distribution. Infrequent home visits, seasonal migration, and location of anganwadis away from the hamlets of discriminated communities further affected the utilisation of services. Another impediment was poor clinical diagnostic approaches.

The establishment of centralised kitchens with efficient food distribution and the extension of anganwadi services to children of migrant families would be steps in the right direction. The authors recommend concerted action by the Integrated Child Development Scheme and health services, supported by interventions against the social determinants of childhood malnutrition.

Dasgupta R, Arora N K, Ramji S, Chaturvedi S, Rewal S, Suresh K, Deshmukh V, Thakur N. Managing childhood under-nutrition, roles and scope of health services. *Econ Pol Wkly*. 2012 Apr; 47(16):15-9.

Conflict of interest: is disclosure a remedy?

Disclosure of conflicts of interest (COI) is considered an essential step to counter bias and ensure transparency and credibility in medicine. This article looks at the loopholes in the COI declaration mechanism of the American Psychiatric Association (APA) and the reasons for the failure of disclosures

alone as a mechanism to combat the bias generated by COI. APA is responsible for updating the Diagnostic and Statistical Manual (DSM) of mental disorders. This redefines diagnosis and treatment categories, thereby expanding the scope of pharmaceutical companies. Since 70% of the DSM task force members are financially linked with pharmaceutical companies, it is difficult to ignore the COI of the association and its recommendations. The APA allows members to receive US $ 10,000 as payments and US $ 50,000 as stocks from pharmaceutical companies. Likewise, there is no restriction on research grants from pharma companies and the money received for participation in speakers bureau (a platform used by prominent physicians to promote pharma products and influence other physicians) can be disguised as honorarium, thereby not revealing its true origin. The editors argue that merely disclosing COI cannot be considered as a solution to ease the bias component. They cite Cosgrove and Krimsky and point out that the disclosure of COI merely makes these conflicts more open, crowds the information available to the patient or user thereby blinding them, and tends to give a sense of freedom from responsibility to the provider, as the COI has already been declared. The authors further cite Loewenstein, who has proved that disclosure of COI promotes biased recommendations, as the providers feel that their recommendation has to be justified, thus resorting to "strategic exaggeration" about the concerned drug. Patients also tend to trust the doctors more and place their advice above the disclosure of COI. The authors warn about the danger of using disclosure as a one point remedy for COI, and argue that it might actually worsen the bias rather than diminishing it.

The PLoS Medicine Editors. Does conflict of interest disclosure worsen bias? *PLoS Med.* 2012 Apr;9(4):e1001210. doi:10.1371/journal.pmed.1001210

It, V, down there or vagina?

The female genital organs are usually referred to using generalised terms and references, implying negative, even shameful, associations. The authors have presented the issue humorously in this article. Advertisements are not allowed to use the word 'vagina' even for products like douches and tampons specifically meant for the vagina. This aversion to using the word vagina is not limited to TV commercials or films. The authors cite from two studies, one from 20 years earlier and another published very recently, which revealed similar attitudes among women about their discomfort regarding using the word 'vagina'. Giving another example of a study published in the *Journal of Sexual Medicine* in 2010, the authors point out that even gynaecologists and physicians prefer euphemisms and used the term 'down there' in a survey questionnaire among women. Refusal to use accurate and specific terms about the female genital organs tends to "reduce all female genital organs to the vagina" and perpetuates ignorance amongst women about the different parts and the different functions and problems. This in turn leads to ineffective communication with the healthcare provider. The authors remind us about the power of language and how naming or not naming something can provide or deny legitimacy to something. They urge men, women, doctors and advertising companies to use specific terms for female genital organs so that the different organs and the different functions of those organs are recognised and legitimised.

Rodriguez S, Schonfeld TL. The organ-that-must-not-be-named: female genitals and generalised references. *Hast Cent Rep*. 2012 May-Jun;42(3):19-21.

Contributions by Arpan Tulsyan, Rakhi Ghoshal and Divya Bhagianadh. Compiled by Divya Bhagianadh e-mail: drdivyabhagianadh81@gmail.com