Upscaling Evidence Based Health Systems Response to Violence against Women and Children in eleven public hospitals in Mumbai: Review of its Implementation

Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai
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<thead>
<tr>
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<th>Full Form</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwives</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
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<tr>
<td>CDO</td>
<td>Community Development Officer</td>
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<tr>
<td>CEHAT</td>
<td>Centre for Enquiry into Health and Allied Themes</td>
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<tr>
<td>CHC</td>
<td>Community Health Centre</td>
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<tr>
<td>CLA</td>
<td>Criminal Law Amendment act</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>CWC</td>
<td>Child Welfare Committee</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CMS</td>
<td>Chief Medical Superintendent</td>
</tr>
<tr>
<td>DEO</td>
<td>Data Entry Operator</td>
</tr>
<tr>
<td>DEHO</td>
<td>Deputy Executive Health Office</td>
</tr>
<tr>
<td>DLSA</td>
<td>District Legal Services Authority</td>
</tr>
<tr>
<td>DV</td>
<td>Domestic Violence</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear Nose and Throat doctor</td>
</tr>
<tr>
<td>FIR</td>
<td>First information Report</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FLA</td>
<td>Free Legal Aid</td>
</tr>
<tr>
<td>HCPs</td>
<td>Healthcare Providers</td>
</tr>
<tr>
<td>HIC</td>
<td>High Income Country</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resource</td>
</tr>
<tr>
<td>HOD</td>
<td>Head Of Department</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>IHI</td>
<td>Institute for Healthcare Improvement</td>
</tr>
<tr>
<td>IPD</td>
<td>In-Patient Department</td>
</tr>
<tr>
<td>IPC</td>
<td>Indian Penal Code</td>
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</tbody>
</table>
IRH: Institute for Reproductive Health
KI: Key Informant
LGBTQA: Lesbian, Gay, Bisexual, Transgender, Queer, and Asexual
LMIC: Low to Middle Income Country
LIVES: Listen, Inquire, Validate, Enhance safety and Support
MBBS: Bachelor of Medicine and Bachelor of Surgery
MCGM: Municipal Corporation of Greater Mumbai
MIS: Mismanagement Information System
M&E: Monitoring and Evaluation
MLC: Medico Legal Case
MoHFW: Ministry of Health and Family Welfare
MWCD: Ministry of Women and Child Development
MO: Medical Officer
MRD: Medical Records Department
MRO: Medical Review Officer
MS: Medical Superintendent
MTP: Medical Termination of Pregnancy
NC: Non-cognizable Crime
NO: Nodal Officer
NCRB: National Crime Records Bureau
NGO: Non Governmental Organisation
NHP: National Health Policy
NFHS: National Family Health Survey
NHM: National Health Mission
OBGYN: Obstetrics and Gynecology
OPD: Out Patient Department
OSCC: One Stop Crisis Centre
OSC: One Stop Centre
PC: Police Constable
PEP: Post Exposure Prophylaxis
PHC: Primary Health Care
PIP: Program Implementation Plan
POCSO: Protection of Children from Sexual Offenses act
PO: Protection Officer
PWDVA: Protection of Women from Domestic Violence act
RMO: Residential Medical Officer
QDA: Qualitative Data Analysis
SAFE: Sexual Assault Forensic Evidence
SDG: Sustainable Development Goals
SVRI: Sexual Violence Research Initiative
SV: Sexual Violence
SOP: Standard Operating Procedure
SPSS: Statistical Package for the Social Sciences
STI: Sexually Transmitted infection
TB: Tuberculosis
TOT: Training Of Trainers
UN: United Nations
UPT: Urine Pregnancy Test
VAW: Violence Against Women
WHO: World Health Organization
UNDP: United Nations Development Program
UNFPA: United Nations Population Fund,
WCD: Women and Child Development
CHAPTER 1

INTRODUCTION

Violence against women (VAW) was recognised as a public health issue by World Health Assembly in 1996. It emphasised strengthening the role of the health system in addressing VAW. The critical role of the health sector in addressing VAW stems from the fact that health services and health care providers are often the first point of contact for survivors of violence (Bhate – Deosthali et al., 2012; WHO, 2016). Additionally, abused women are more likely to use health services than non-abused women due to health consequences of violence and also likely to trust HCPs with sharing and disclosure of abuse (WHO, 2013; Bhate – Deosthali et al., 2012). While there has been a legal mandate for a health sector response in India under the Protection of Women from Domestic Violence Act (PWDVA, 2005); POCSO, 2012; the Criminal Law Amendment to Rape (CLA, 2013) and the MOHFW Guidelines (2014); it was only in recently that it received a policy level impetus. In 2017, the National Health Policy gave a clear directive to the health sector to address gender-based violence (NHP, 2017).

In India, the Dilaasa model is one of the first health system-based initiatives to address VAW. It was set up jointly by CEHAT and Municipal Corporation of Greater Mumbai (MCGM) in one of the government hospitals of Mumbai in 2000. The model aimed at institutionalising VAW as public health issue through training/capacity building of the hospital staff and setting up of a crisis intervention department to provide psychosocial care to survivors. It was handed over to the MCGM in 2006 and replicated in five states (Kerala, Indore, Shillong, Gujarat and Bangalore) at different levels of health facilities.

In 2016, the Dilaasa model got integrated into the government’s National Urban Health Mission (NHM, 2016) in Maharashtra; and has now scaled up in 11 public hospitals in Mumbai by the Municipal Corporation of Greater Mumbai (MCGM) (Barnagarwala, 2014). Over the years, it has received international recognition as evidence-based scalable model for health sector response towards survivors of violence in Low Middle-Income Countries (LMIC) (Ravindran & Undurti, 2010; WHO, 2013; WHO 2017; Pande et al., 2017).

The scaling up of tested models is essential in addressing the high prevalence and health burden of VAW (Colombini, 2012). However, there is little understanding of the determinants and facilitators of a successful scale-up of health interventions (ExpandNet & WHO, 2007). Such
an understanding and analysis is critical to ensure that evidence-based interventions do not remain restricted to limited settings (UNFPA & SVRI, 2016). If evidence-based services are scaled up, the “know-do gap” reduces and the burden of the impact of violence can potentially be addressed (Yamney, 2012). Thus, scaling up evidence-based interventions is necessary to ensure the target population has access to the most effective services and programs available.

_Dilaasa_ model scale-up in 11 public hospitals of Mumbai by the MCGM gave CEHAT a unique opportunity to generate critical evidence on upscaling of evidence based interventions in low resource settings of LMICs. With this need in view, CEHAT undertook a study to understand the process, barriers, facilitators and strategies for scaling-up Dilaasa.

The study findings are also extremely relevant given the evidence on the role of health systems in primary prevention (Garcia – Moreno et al., 2015). Health systems response contributes substantially to primary prevention of VAW as it offers an opportunity for early detection of violence and provision of services for preventing further abuse and mitigating consequences of violence. Scaled health sector responses also help increase the visibility of the issue thereby further contributing to primary prevention.

In this chapter, we have attempted to set the context of the report by providing a brief background of the available evidence on the burden of violence against women, and tested interventions to address it with a special focus on health system-based interventions. The chapter also provides information available in the literature on scaling-up of health interventions.

1.1. BACKGROUND

According to United Nations (1993), “Violence against Women (VAW) is defined as any act of gender-based violence that results in, or is likely to result in physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life”. It is a global public health problem wherein one in every three women has faced violence (WHO, 2020). It can have serious acute and chronic health consequences (Garcia Moreno, 2014; Bhate – Deosthali et al., 2012; Campbell 2002; WHO, 2016) for women. These health consequences lead to inability to work, loss of wages, lack of participation in regular activities and limited ability to care for self and children (WHO, 2021). Sustainable Development Goals (SDG) 5 and 6 recognize the impact of such
violence, emphasizing that the achievement of all SDGs are linked to ending violence and discrimination (UN Women, n.d.1993) further highlighting the pertinence of the issue.

In the Indian context, about 29% of ever-married women aged 18 to 49 have experienced physical, or sexual spousal violence (NFHS 5, 2020). The incidence of crimes against women had increased by 3% between 2015 and 2016 (National Crime Bureau). The majority of these cases were reported under ‘Cruelty by Husband or His Relatives’ (32.6%) followed by ‘Assault on Women with Intent to Outrage her Modesty’ (25.0%), ‘Kidnapping & Abduction of Women’ (19.0%) and ‘Rape’ (11.5%). It is important to note that the NCRB data looks at only those cases that are registered with the police and therefore do not reflect actual prevalence.

1.1.1. Interventions for responding to VAW

Feminist movements have played a significant role in advancing the rights of women and contributing towards gender equity. An empirical analysis of policies in 70 countries has identified the presence of autonomous women’s movements as the main actor in bringing the issue of VAW to the forefront for policy change (Htun and Weldon 2012). These movements contributed by articulating the issue of VAW, raising awareness about it and demanding government actions (Weldon 2002a).

In India, the women’s movement had brought up VAW as an issue in the public domain in the late 1970s. The movement was galvanized by the brutal rape of a tribal girl by policemen inside a police station. It brought into the public domain the question of patriarchal GBV for the first time in India in addition to the class and caste violence that had long been highlighted. Women’s groups contributed by conducting a lot of consciousness-raising activities which provided an important platform for women to discuss and share their experiences with other women (Bhate-Deosthali & Rege).

As a result of the consistent efforts of feminist movements across the globe, numerous models to address VAW have been introduced in varied settings including community, school-based, health system-based and the criminal justice system in the last two decades.

1.1.2. Health systems-based interventions to address VAW in LMIC

Among the different interventions to respond to violence against women and children, the health sector-based interventions are widely recognised as one of the effective models since
women facing violence have inevitable contact with the health system (Colombini et al., 2008; Gracia-Moreno et al., 2015).

Although primary prevention is a crucial and well-established concept in the public health approach to VAW, in the context of violence against women and children it is still in its formative phase (Bhate-Deosthali, P. 2018). Thus, the majority of health system bases interventions to address VAW are focused on secondary and tertiary prevention.

A dominant health systems-based model known for its comprehensive services to survivors of violence is the One-Stop Crisis Centre (OSCC) also interchangeably known as One Stop Centre (OSC). In low-middle-income countries, the establishment of OSC is the primary approach to engage with the health sector to develop a response to VAW.

In LMIC, the OSC model was first adopted in Malaysia in 1994, set up in a tertiary hospital to provide medical treatment and further social support to survivors reaching out to the hospital. Since its inception in Malaysia, OSC were rapidly implemented across South East Asian Region, South African Regions and Latin American countries many of which are managed either by the public sector, private sector, non-governmental organisations or a combination (Oslon et al., 2019). The major aim of OSC is to provide multiple and simultaneous services like health care, police legal etc. in one place to avoid re-traumatisation among survivors by narrating the stories of trauma to multiple service providers. Provision of all these services under one roof additionally adds to the convenience of the survivor who otherwise travels from pillar to post to meet these multiple service providers post-trauma. Most of these OSCs are located within hospitals like in Papua New Guinea and South Africa. In countries like Peru, El Salvador the OSC centres are standalone centres managed by the government or non-government organisations. The OSCs in India is also situated in settings like hospital, police and courts.

According to a systematic review on barriers and enablers on implementation and effectiveness of the OSC model in LMIC, women reported fear of stigmatisation in approaching standalone OSC centres and lack of preference to approach police since most officers are men. On the other hand, approaching health systems based OSCs was considered non-threatening as women viewed health care workers as trustworthy for disclosure of abuse (Oslon et al., 2019). These
models are resource-intensive due to the need for separate space, infrastructure and staff etc. and it relies on the health system to offer specialised services. This is a concern about OSCs in facilities where the case load is low.

The integration of response to VAW into health services is an important element of health system-based models. It includes integration of holistic services at three levels: level of provider, the facility and system level. Provider level integration offers one or two services (counselling or psychological therapy) to the survivors of violence usually through vertical health programs. For example, in Brazil, through selective integration the CONFAD counselling program provides counselling services to survivors of violence and no external referrals are made. A major challenge for this model within the health facility is the medical hierarchies existing within the health systems leading to a lack of interest among other cadres of providers.

Facility level or comprehensive integration provides all services under one roof but not by the same provider. At the emergency, the department doctor may treat the injuries of the survivor, but upon disclosure of violence, she is sent to the counsellor for counselling in the hospital. The OSCs in Malaysia, Bangladesh, Nambia, Thailand offers all services like health, legal, welfare, counselling in one location. A major limitation of this model is poor management, manpower, equipment and supplies shortage and poor infrastructure. Dilaasa model, Bhoomika in Kerala and Sukoon In Haryana are examples of facility level integration in Indian context.

Systems-level integration provides basic services like screening and medical care in one facility and refers the survivor to other external facilities for specialised services. Coordination among various actors involved, absence of clear guidelines to train staff, underfunding and lack of legislative systems for integration are challenges for systems-level integration (Colombini et al, 2008). Soukhya in Karnataka and SWATI in Gujarat are examples of system level integration where providers in facilities and community health workers identify women facing violence and refer them to external support services.

1.2.HEALTH SYSTEMS BASED MODELS TO ADDRESS VAW IN INDIA

In India, most of the existing health system-based models are led by NGOs. These models are usually located at different levels of health systems i.e. Primary, secondary and tertiary level
hospitals. There is a standalone model established by NGO and is associated with a tertiary medical college hospital that refers survivors for counselling support to the centre. Standalone centres popular as the OSC model called Sakhi centre are fully funded by the Ministry of Women and Child Development located within the premise or 2 km away from the district hospital or district headquarters and established in every district in India since 2013 (Deosthali-Bhate et al., 2018; MoWCD, 2017). Various models existing in India to deal with VAW and children are presented in Table 3.

A review of OSCs established by the Ministry of Women and Child Development (MWCD) in India found that there is a lack of coordination between different service providers thereby defeating the purpose of OSCs (Bhate- Deosthali & Rege).

**Table 1: Types of models based on prevention based interventions**

<table>
<thead>
<tr>
<th>Prevention based model</th>
<th>Types of intervention</th>
<th>Features</th>
</tr>
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<tbody>
<tr>
<td>The primary level prevention model</td>
<td>School and college-based intervention program</td>
<td>Training programs and workshops for school children girls and boys to change social norms and create awareness about various forms of violence</td>
</tr>
<tr>
<td></td>
<td>High-level legislative reforms for the country</td>
<td>Implementation of laws and Acts to reduce VAW in the country</td>
</tr>
<tr>
<td>Violence prevention programs</td>
<td>Includes programs targeting underlying causes of violence like group training, social communication, community mobilisation and livelihood strategies to promote economic independence among women</td>
<td></td>
</tr>
<tr>
<td>Community-based training and workshops to empower women and girls</td>
<td>Training women for self-defence, promoting critical reflection on gender roles, supporting development communications</td>
<td></td>
</tr>
<tr>
<td>Secondary level prevention</td>
<td>Community mobilisation</td>
<td>The population-based participatory approach addresses gender norms through community-driven engagement with multiple stakeholders like police, teachers, religious and political leaders</td>
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<tr>
<td>---------------------------</td>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Women centred interventions for survivors of violence</td>
<td>Provision of a range of services like counselling, psychosocial support, advocacy, home visits and community support</td>
<td></td>
</tr>
<tr>
<td>Interventions for perpetrators</td>
<td>Court-mandated treatment programs including psychosocial counselling, group education or combining these interventions in couples therapy, substance abuse programs etc.</td>
<td></td>
</tr>
<tr>
<td>Health sector approach and One-Stop Crisis Centre</td>
<td>Comprehensive care for survivors of violence within the hospital for IPV and sexual violence</td>
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Source: Bhat-Deothali et al., 2018; MoWCD, 2017

Recently, evidence on the use of the “systems’ approach to strengthen health systems response to VAW has been generated through a collaborative study between CEHAT, WHO and three tertiary health facilities of Maharashtra. The project attempted to test approaches to implement WHO’s Clinical and Policy Guidelines on responding to VAW. Capacity building of the providers along with systems strengthening activities like the introduction of standard operating protocols, identifying spaces for ensuring privacy creating job aids for providers and information, education and communication material (IEC) were the primary intervention activities implemented in project. In this project, the providers were trained to identify and provide first line support to survivors of violence. The findings of the intervention research project indicate that the providers need more skill building to enable them to provide all the elements of the first line support to survivors.
1.3 SCALING UP OF VAW INTERVENTIONS

There has been increasing focus on scaling up of health interventions so that their benefits are expanded to reach more people, more quickly and sustainably (WHO and Expandnet, 2010). Scaling up has been defined as the process of expanding, adapting and sustaining successful policies, programmes or projects in different places and overtime to reach a greater number of people (World bank). The expansion can also be in the context of inputs, outputs, outcomes and impact.

There is little information available about the process of scaling up of effective VAW interventions. A review of the scaling up of OSCs in Malaysia by Colombini and colleagues in 2012 found that the presence of adequate health infrastructure is essential for scaling of OSCC model. Additionally, the model and health facility should be flexible enough to allow for the adaptations of the model in varied settings.

A review of evidence on approaches to scale up VAW interventions found that the integration of the intervention in the existing healthcare infrastructure and services is an efficient approach in scaling health system-based interventions (Remme, 2014).

There is some information available in the literature about the process, factors theories related to scaling up health interventions. A systematic review of the evidence available on scaling up of public health interventions in LMICs reported availability of resources in the form of financial, material and human are the crucial factors influencing scale-up (Bulthuis, 2019). Advocacy activities, positive change in policy environment and availability of data on monitoring and evaluation of the intervention were the other factors found to determine the success of a scale-up. The review concluded that all the factors are interlinked to each other and are primarily linked with the development of a scale-up strategy before scaling up.

A sequential approach has been suggested for the process of the adaptation of health interventions at a large scale. This approach mentions phase-wise implementation of the intervention. The four phases are: (1) Set-up, which prepares the ground for the introduction and testing of the intervention; (2) Develop the Scalable Unit, which is an early test and demonstration phase, (3) Test of Scale-up, which spreads the intervention to settings that are likely to represent contexts that will be encountered at full scale; and (4) Go to Full Scale,
which unfolds rapidly to enable a larger number of sites to replicate the intervention (Barker et al., 2016). The paper also enlisted factors having an impact on the adoption of the intervention in new settings during scale-up. These include superiority of the intervention, effective leadership, and communication for dissemination of information about the importance of intervention.

There are several frameworks that guide the process of the scale-up. Barker and colleagues have reviewed six existing frameworks that advocate for a sequential approach in the scaling up of health interventions in LMICs. The frameworks provide practical guidance for how to work with organizations, health systems, and communities to implement and scale up best practices.

The six frameworks were Implementing Best Practices Consortium, ExpandNet, Management Systems International, WHO, Consolidated Framework for Implementation Research, Scaling up global health interventions: a proposed framework for success. All the frameworks advocated for use of data to improve the future design of the work and understand factors that impact scale-up. Some frameworks highlight the significance to build the required infrastructure for full-scale implementation and advocate testing resource requirements during the pilot test of implementation. Other frameworks talk about pre-planning, predictions of resource needs, and feedback after implementation.

Out of these frameworks, the ExpandNet provides a systematic approach for increasing the coverage of the services and fostering policy and program development on a lasting basis. ExpandNet is a systems-oriented framework that assumes that intervention to be scaled has already been tested to be effective and focus on building the capacity of the whole system for effective adoption of the intervention. The institutionalisation of intervention by local ownership and the use of an integrated approach are the key factors considered by this framework for an effective scale-up. Since integration is an important aspect of public health
interventions, this study has used the ExpandNet framework to understand the upscaling of the Dilaasa model.

1.4. CONCEPTUAL FRAMEWORK

A conceptual framework is a structure that the researcher believes can best explain the natural progression of the phenomenon to be studied (Camp, 2001). For this study, a conceptual framework was developed using ExpandNet Framework for scale-up and health systems building blocks.

Effective delivery of health services is influenced by the existence of necessary elements of providers and services within the health systems (Claudia, 2015). Dilaasa model is an integrated hospital-based intervention providing services by operationalising building blocks of the health system. These core elements or building blocks of health system include

a. Leadership and governance  
b. Coordination  
c. Service delivery  
d. Health infrastructure  
e. Health workforce  
f. Financing  
g. Health information system

The ExpandNet framework considers two outcomes of a successful scale up- increase in coverage of services and institutionalisation of the intervention in government structures or policies. The framework outlines various strategies for achieving these outcomes. These strategies cover plans for how to implement the intervention at multiple levels (policy, program, and service delivery), how to advocate for the intervention, the organizational processes involved in the implementation and the costs and resources needed. These strategies of the ExpandNet framework are the means to operationalise building blocks of the health system to integrate response to VAW within the health services. The below framework shows how the strategies for the scale-up contributed towards essential elements of the health system for achieving institutionalisation of VAW response within the health system.

a. Dissemination and advocacy: include effectively communicating about the intervention by sharing the results of the research, and evaluation at national platforms to inform government,
policymakers and other key stakeholders about the significance and impact of the intervention. This strategy will help in getting commitment and ownership from government officials and healthcare administrators.

**b. Organisational Processes:** include changes at the level of the organisation which is going to implement the intervention. These processes include building capacity of the providers, supervision, and improvement in the quality of the services. This strategy can result in the building of the champions within the health system, streamlining of service delivery and establishment of multi-sectoral coordination to provide a range of services to women.

**c. Resource mobilisation:** include the cost which needs to be allocated for the scale-up of intervention. This results in a dedicated budget within the health system for responding to VAW.

**d. Monitoring and evaluation** is an essential strategy of scale up as it provides an opportunity for timely course corrections during the process of scale-up. This strategy contributes to the development of monitoring and accountability mechanisms at the level of the health facility.

**Figure 1: Strategies for scale up**
The above strategies for upscaling are influenced by the interaction between the following five elements of scaling up:

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>Availability of adequate infrastructure for ensuring privacy and confidentiality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi sectoral Coordination</td>
<td>Establishment of internal and external referral services for survivors of violence</td>
</tr>
<tr>
<td>Resource Mobilisation</td>
<td>Financing</td>
</tr>
<tr>
<td></td>
<td>Budget allocation for dedicated staff, and other supplies for survivors by NUHM</td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>Health Information System</td>
</tr>
<tr>
<td></td>
<td>Establishment of monitoring mechanisms- monitoring committee meetings, MIS, case presentations</td>
</tr>
</tbody>
</table>

**First, an innovation** must be well-defined during the pilot and then maintained throughout the scale-up process. While changes to the scale-up intervention may be made from pilot to scale-up, the essential elements must remain constant, as they are key to the intervention’s effectiveness.

**Second**, in an active implementation context, the **resource team** refers to those who facilitate the scale-up – take the active steps to move the scale-up process along. The team may be composed of researchers, representatives of user organisations, decision-makers, or service providers (Simmons et al., 2007).
Third, the user organisation represents those who are expected to implement the intervention on a large scale. The user organisation could be a ministry of health, multiple community-based organisations, or a network of institutions. Taken together, members of the resource team and user organisations represent the stakeholders who must be involved in designing the M&E plan (defining indicators, selecting methods, etc.), interpreting results and taking action based on the data.

Fourth, the environment refers to conditions outside of the user organisation that can influence the scale-up process. Taking the time to understand the unique context in which the intervention is being implemented allows implementers to make modifications to the innovation, or the scale-up strategy.
CHAPTER 2

METHODOLOGY

This chapter provides information about specific objectives of the study, research design, sampling, data collection methods and procedures. It also describes ethical considerations undertaken for the study.

2.1. OBJECTIVES OF THE STUDY

The overall purpose of the study was to understand the upscaling of Dilaasa in 11 peripheral hospitals of Mumbai in order to identify the facilitators, barriers, inputs and processes for scale up of VAW interventions.

The specific objectives of the study included:

1. To assess the extent to which various components of Dilaasa model has been replicated in 11 peripheral hospitals of Mumbai.
2. To document the problems (if any), encountered by 11 hospitals in establishing a health sector response; the strategies adopted by them in overcoming problems and the processes adopted to make the model functional on a day-to-day basis.
3. To identify the strategies that played a role in scaling up of Dilaasa model in 11 peripheral hospitals.

2.2. RESEARCH DESIGN

Considering the specific objectives of the study, a triangulation mixed method was used to obtain different but complimentary data on the same topic (Morse, 1991). For example the data from in-depth interviews with counsellors, Nodal officers and users of Dilaasa were triangulated to understand aspects of service delivery, women centred services and health care provider's role in identifying and providing services to women facing violence. The quantitative data collection was done to validate the experiences of respondents.

The Dilaasa model was reviewed to understand the enablers and barriers influencing the scale up process through information obtained from service providers, policy makers and relevant key informants who played a role in scaling up the model. Documents like budget, government approvals and orders were also reviewed for this purpose. The extent to which various components of Dilaasa model have been replicated in NHM centres was assessed by looking
at the operationalisation of building blocks of the health system. Qualitative interviews with Dilaasa team members and healthcare providers responsible for the functioning of Dilaasa centre in each hospital were done to assess service delivery, leadership, multi-sectoral coordination, and infrastructure availability. The users’ perspective was also collected by interviewing survivors of violence. A quantitative analysis of the management information system of 11 centres was done to validate the data from Dilaasa team members.

**Figure 2: Objective, constructs and data collection activities carried out**
Objective 1: To assess the extent to which various components of Dilaasa model have been replicated in NUHM centres

How the different building blocks of the health system have been operationalized in 11 peripheral hospitals?

Objective 2: To document the problems encountered in establishing a health sector response

Challenges faced by Dilaasa team in responding to VAW

Challenges faced by nodal officer (healthcare provider with the charge of Dilaasa) in establishing a comprehensive facility

Objective 3: To identify the strategies that played a role in scaling of Dilaasa in NUHM

Primers, Inputs, strategies and challenges involved in scaling of Dilaasa in NUHM

Data collection activities

Administered a structured tool to measure compliance of Dilaasa and Health facility to a set of standards for responding to VAW

Interview with 11 Dilaasa counsellors

Focus group discussion with ANMs of 11 Dilaasa

Interview with nodal officers of 11 Dilaasa centres

Interview with survivors of violence who got services from Dilaasa centres

Analysis of management information system of peripheral hospitals

Interview with 11 Dilaasa counsellors

Interview with nodal officers of 11 Dilaasa centres

Key informant interviews

Review of documents: Budgets, government orders, approvals, global approaches to reviewing implementation of health system response to VAW
2.3. STUDY SETTINGS

Dilaasa has been up scaled in 11 out of 18 peripheral hospitals in Mumbai. The peripheral hospitals are secondary level multi-speciality hospitals connected to a tertiary hospital. The peripheral hospitals receive referrals from health posts and dispensaries. Thus, peripheral hospitals are first-line treatment providers and reduce the burden on tertiary care facilities. These hospitals cover a vast geographical area and cater to almost 75% of Mumbai population. The 18 peripheral hospitals have a combined bed strength of more than 6000.

Table 3, gives a brief description of all 11 hospitals, like the bed strength, location of Dilaasa, services available, and types of violence cases routinely catered in the hospital.

Table 2: Profile of 11 hospitals in the study

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Bed strength</th>
<th>Location of Dilaasa department</th>
<th>Availability of departments</th>
<th>Types of cases referred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Casualty</td>
<td>Gynaecology</td>
</tr>
<tr>
<td>A</td>
<td>324</td>
<td>OPD premises</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>B</td>
<td>520</td>
<td>OPD premises</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C</td>
<td>304</td>
<td>OPD premises</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>D*</td>
<td>130</td>
<td>OPD premise and besides casualty</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>E</td>
<td>180</td>
<td>Top floor</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>F§</td>
<td>130</td>
<td>Top floor inside male ward</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OPD premises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td>-------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>G</td>
<td>580</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>H</td>
<td>210</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>I</td>
<td>172</td>
<td>No</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>J</td>
<td>105</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>K</td>
<td>254</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

* The hospital is currently in two different locations due to renovation, Dilaasa team sits in both these locations.
OPD in one location and Casualty, IPD and ICU in another location.

$ The hospital’s OPDs and IPDs are shifted to two different locations due to renovations.

€ The Dilaasa department was shifted to another hospital in 2017.

### 2.4. STUDY PARTICIPANTS, SAMPLING SIZE AND TECHNIQUE

Following participants were involved in our study:

a. **Dilaasa team:** Dilaasa team in each hospital consists of two counsellors, two Auxillary Nurse Midwives (ANM) and one data entry operator. Interviews were conducted with the most experienced counsellor of the department. In hospitals where both the counsellors had the same amount of experience, one of them was asked to volunteer for the interview. Thus, data were collected from 11 counsellors. Four of the 11 interviews with the counsellor were in-person while seven interviews were conducted online via zoom app.

b. **Nodal Officer:** A nodal officer is a healthcare provider who is assigned the additional role of functioning of Dilaasa in every hospital. Nodal Officers of the respective Dilaasa centres were contacted for interviews. Out of 11, 9 nodal officers agreed for the interview. In two hospitals the acting Nodal Officer was interviewed since the appointed Nodal Officer was a senior Medical Officer and unavailable for the interview due to workload during the COVID-19 pandemic. In one hospital, the Nodal Officer was on leave and in another hospital the Nodal officer refused for the interview. Seven Nodal
Officer interviews were conducted physically while the other two were conducted online via the zoom app.

c. **Survivor interviews:** Nine survivors were contacted from 11 hospitals for interviews. Out of these, seven survivors agreed to be interviewed while two women refused due to personal reasons. One survivor agreed for interview when she was contacted telephonically but did not turn up at the centre on the day of the interview. Thus six survivors were interviewed for the study. Only survivors who were above 18 years of age were contacted for the interview. Based on these criteria, the counsellors from every centre were requested by researchers to provide a list of the survivors. From the given list, the survivors were identified based on variation in cases. Few variations considered were including both forms of violence i.e. domestic and sexual violence, relationship with the abusers for example women abused by husband, marital family, boyfriend and children were included in the study; and social context of survivors like women who are married, unmarried, suffering from chronic illness etc were contacted for interview. The final selection of survivors contacted was finalised by the research team. The process of contacting the survivor for interview and consent taking is described further in the chapter.

d. **Key Informant interviews:** The key informants were included in the study to understand the scaling up process of Dilaasa. Informants were identified based on their association in initiating the first Dilaasa centre in Mumbai and in upscaling Dilaasa centres in 11 peripheral hospitals in Mumbai. Fourteen key informants were identified and contacted during data collection. Out of 14, 10 informants agreed to be interviewed. Five interviews were conducted online via zoom, three interviews were held physically and two were conducted telephonically.

The key informants included CEHAT team members involved in upscaling, officials from Ministry of Health, India and NHM, Maharashtra, healthcare administrators and health providers involved in establishing Dilaasa and representatives from international agencies working on the issue of violence.

e. **Focus group Discussion (FGD) with Auxiliary Nurse Midwife (ANM):** During data collection, since the post of ANM was vacant in 4 of the 11 hospitals, 7 ANMs were selected for FGD. Each Dilaasa has a team of two ANMs, but during the study period only 3 hospitals had two ANMs in their team. In these three hospitals the most
experienced ANM was purposively selected for the Focus Group Discussion and in other hospitals those available were selected. The FGD was conducted online via the zoom app.

2.5. DATA COLLECTION TOOLS

The data collection tools included a health system readiness tool, semi structured interview guides for in-depth interviews with counsellors, nodal officers, survivors, key informants, additional respondents and FGD with ANMs. Quantitative data sources like Medical Information System (MIS) data from 11 hospitals and data on budget from NHM. All the in-depth interview guides were semi structured.

a. **Tool to assess health systems’ readiness to respond to VAW:** To review the health sector response to VAW in 11 peripheral hospitals, a semi-structured tool was prepared covering the essential components of Dilaasa model. Since Dilaasa is an evidence-based model context-specific indicators on strengthening health systems response to VAW were included in the tool.

b. **Counsellors:** An in-depth interview guide was developed to understand the role of Dilaasa counsellors, their interface with the health system, provision of crisis intervention services, and challenges faced by them in providing services to survivors.

c. **Nodal officers:** The guide aimed at understanding the role of nodal officers, the health system’s response to violence, ownership by healthcare providers, and challenges faced by health facilities in responding to survivors of violence.

d. **Survivors of violence:** The interview guide included experiences of women using the Dilaasa services, how the centres responded to their needs, what were their expectations and their perspective on the services being provided and what needs to be done to improve them.

e. **Key informants:** The guide covered themes of how upscaling of Dilaasa happened, the role of the key informant in upscaling, strategies used for upscaling, and recommendations of key informants for upscaling of evidence-based model.

f. **Additional respondents:** Interviews with two gynaecologists and two medical officers were carried out using a semi-structured interview guide to understand their specific roles and responsibilities, interface with Dilaasa team and recommendations. Similarly, 8
matrons were interviewed using a semi-structured guide with a focus on the role of nurses in responding to VAW. One data entry operator was also interviewed to know about the system of data management and analysis at Dilaasa. One representative from NHM accounts department was interviewed to understand financial allocation to Dilaasa centres.

g. **ANMs:** The FGD guide focused on understanding the specific role of ANMs in Dilaasa, their interface with healthcare providers and recommendations for improving the functioning of Dilaasa.

h. **Quantitative data analysed:** These are from two sources -

- Medical Information System (MIS) data was obtained from 11 Dilaasa centres to analyse the pathways by which survivors reach Dilaasa, forms of violence disclosed by women and types of health consequences suffered by them as a result of the violence.
- Data on the budget allocated to Dilaasa from the year 2015 to 2021 was obtained from NUHM, Maharashtra’s official website. The data was analysed by the research team to understand budgetary allocation and its expenditure pattern.

Table 3: Respondents, methods and sample size in the study

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Method</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellors</td>
<td>Semi-structured interview guide</td>
<td>11</td>
</tr>
<tr>
<td>Nodal officers</td>
<td>Semi-structured interview guide</td>
<td>9</td>
</tr>
<tr>
<td>Key informants</td>
<td>Semi-structured interview guide</td>
<td>10</td>
</tr>
<tr>
<td>Survivors</td>
<td>Semi-structured interview guide</td>
<td>6</td>
</tr>
<tr>
<td>Doctors (other than nodal officer)</td>
<td>Semi-structured interview guide</td>
<td>4</td>
</tr>
<tr>
<td>Matrons</td>
<td>Semi-structured interview guide</td>
<td>8</td>
</tr>
<tr>
<td>ANMs</td>
<td>Semi-structured guide for focus group discussion</td>
<td>1 FGD consisting of 7 ANMs</td>
</tr>
</tbody>
</table>
2.6. PROCESS OF DATA COLLECTION

Official sanctions: Permission to interview hospital staff and Dilaasa team members was obtained by CEHAT from the office of Deputy Executive Health Officer of National Urban Health Mission, Mumbai. Additionally, permission was also sought from the Medical Superintendent of all the 11 hospitals. The data collection lasted for 11 months from November 2020 to October 2021. The period of data collection was extended due to COVID-19 pandemic.

Obtaining consent from survivors: Survivors to be interviewed were first contacted by the counsellor to obtain first level consent after explaining the study. The counsellor fixed a date, time, location (physical or telephonic) and comfortable language for the interview. After obtaining consent the researchers contacted the survivor telephonically on the phone number provided by the counsellor and explained the study. Survivors were given time to decide about their participation. When they confirmed their availability the interview was conducted as scheduled with the survivor.

Considering the sensitive nature of the interview with survivors and anticipating possibilities of emotional distress during the interview, a counsellor (not Dilaasa counsellor) was involved. Three women were interviewed physically while other interviews were telephonic. During the in-person interview, only the survivor, interviewer and CEHAT counsellor were present. To ensure privacy, the room was locked. The interviews conducted telephonically were scheduled as per the convenience and safety of the survivor. All the interviewed survivors were provided nominal compensation of Rupees 800 for the time spent by them as well as for travel expenses incurred, if any. The amount was either handed over to the survivor or transferred to their bank account in case of telephonic interviews.
Obtaining consent from other respondents: An information sheet about the study along with a consent form was developed for respondents from the health system. The sheet and consent form were also translated into the local language. They were shared with respondents through WhatsApp and email beforehand. Respondents were given time to read and get back to the research team for participating in the study. Once a respondent consented to participate, a time and medium of communication were decided for the interview. There were two researchers present during each interview. The interview was led by one researcher while another researcher ensured the documentation and took an account of any missed question by interviewing researcher.

2.7. DATA ANALYSIS

Each interview lasted between 45 minutes to 1.5 hours. All interviews were audio-recorded, transcribed and translated in English. The audio recordings were supplemented by field notes that comprised of observed behaviours and nonverbal cues. All data including recordings, transcripts and hard copies of notes were saved and stored electronically with a password.

Qualitative data analysis was carried out with the help of QDA software package Atlas.ti 6.2. To begin with, all transcriptions were read repeatedly (3-4 times) by two researchers to identify key themes underlying the responses. Each transcript was coded separately by two researchers to refine the codes and sub-codes.

The MIS data collected was analyzed by using Statistical Package for the Social Sciences Software (SPSS) 20.0 version. Descriptive analysis at an aggregate level was done. Appropriate recording of string variables was carried out by researchers.

2.8. CHALLENGES DURING DATA COLLECTION

A. COVID-19 Pandemic: The pandemic and public health measures like lockdown during pandemic had an impact on the research project. The data collection was to be initiated by March 2020 but COVID 19 pandemic had entered India resulting in a subsequent nation-wide lockdown. So data collection could not be initiated. Public hospitals were already overburdened with COVID 19, so training of HCPs across hospitals could not be conducted. This impacted the implementation of a survey conceptualised to assess the effect of the capacity building of HCPs – a survey on Knowledge, Attitude and Practice (KAP). This aspect was dropped due to the unavailability of HCPs for capacity building training on VAW.
B. Pandemic related risks- Data collection during the pandemic especially in hospital settings posed an additional risk for the research team. A protocol was developed for the research team to ensure compliance with COVID appropriate behaviour. The research team was insured for accidents and Corona Kavach policy which covers hospital expenses for COVID-19.

2.9. ETHICAL CONSIDERATIONS

1. The study underwent a rigorous scientific as well as ethical review after which all the aspects as stipulated by the Anusandhan Trust IEC were covered (Refer Annexure 22).
2. During the interview, the respondents were informed about the objectives of the study and voluntary participation was encouraged.
3. Informed written or verbal consent was obtained from all the respondents in the study.
4. An appointment was obtained from the respondents and the interviews were conducted in a private setting.
5. The participants were given the freedom to stop the interview at any point or skip any question which he/she did chose not to answer.
6. Anonymity of the respondents was ensured and confidentiality of the data obtained was maintained throughout the study.
7. If the respondent did not wish to audio tape, before beginning or at any point of time of the interview, a recording was not done.
CHAPTER 3

REPLICATION AND SCALING UP OF HOSPITAL BASED CRISIS CENTRE FOR VAW

3.1. INTRODUCTION

This chapter presents the replication of Dilaasa centres in relation to ExpandNet/WHO framework. The ExpandNet/WHO framework is a systematic guide to scaling up an intervention developed by an organisation. Findings have been presented across five elements for scale up and four key principles or strategic choice areas for upscaling details mentioned in conceptual framework—chapter 1 (Fig 3). The five elements for scale up are innovation, user organisation, environment, resource organisation and strategy for scale up based on types of scale up adopted represented inside the oval. The four strategic choice areas for upscaling include dissemination and advocacy, organisational process, cost/resource mobilisation, and monitoring and evaluation.

Figure 3: The ExpandNet/WHO Framework for scale up
The discussion of the scale up within the ExpandNet framework is divided into three parts. The first part describes what went into setting up the innovation- Dilaasa model. The second part is the scale up strategies to replicating and upscaling the model under National Health Mission (NHM) in India.

The elements of the ExpandNet framework mainly innovation, the resource team -NHM and CEHAT, the user organisation- MCGM and peripheral hospitals, the socio-political environment of the country and the strategies adopted during the process of disseminating the innovation, and engagement with the various opportunities and challenges to successfully expand the innovation are highlighted. (Refer figure 6 for details)

**Figure 4: Design of scaling up Dilaasa model**
ENVIRONMENT
Political context at national level
MWCD and MoHW

INNOVATION
What is to be scaled up:
The pilot DiJaSa model for health systems response to VAW following a feminist perspective:
1. Identification and referral of survivors of violence reaching out to hospitals by HCPs
2. Providing counselling and social support to survivors at DiJaSa centres
3. Follow-up

These elements are promoted through:
- Sensitization and capacity building of HCPs and DiJaSa staff on VAW as a public health issue
- Developing SOPs focused on gender sensitive approach for health systems
- Referral link with other stakeholders to effectively deliver social support to survivors
- Mechanism for monitoring and evaluation at macro and micro levels of the implementing agency

SCALING UP STRATEGY
How to transfer the innovation?
- Horizontal scale up and Vertical scale up
- Training and orientation to providers
- Supervision and monitoring
- Developing standard guidelines for implementation at local and national level
- Policy advocacy and information dissemination by CEHAT

USER ORGANISATION
Who adopts the innovation?
Peripheral hospitals supporting implementation of DiJaSa
- MGM governing body of peripheral hospitals
- Peripheral hospitals

RESOURCE TEAM
Who facilitates wider use of the innovation?
1. Central ministry (NHM): through budgeting and staffing
2. NGO (CEHAT): technical support
3.2. THE PILOT MODEL

The Dilaasa crisis intervention department the innovation was established in 2000 in K B Bhabha hospital, Bandra a public hospital in Mumbai. This pioneering effort was a joint initiative of CEHAT and the MCGM to establish VAW as a legitimate public health issue and institutionalise psycho social services for women and children experiencing violence. The Dilaasa’s concept was and adapted from the One Stop Crisis Centre (OSCC) in Malaysia to adapt to public hospital in Mumbai. The Dilaasa department drew upon existing hospital personnel and infrastructure to establish VAW as an issue of public health importance. It was set up as a department of the hospital, staffed by trained personnel who provided psycho social support to all survivors of violence, following a feminist perspective. The department was named “Dilaasa” based on suggestions from HCPs in the hospital which means ‘reassurance’ in Hindi. During the pilot phase, CEHAT funded the centre for three years and later MCGM was expected to adopt and sustain Dilaasa service in Bhabha hospital, Bandra.

Figure 5: Roles designated to CEHAT and Bhabha hospital Bandra during the pilot project
The centre developed various gender sensitive protocols for effective service delivery: The hospital staff was trained on understanding VAW as a public health issue and their role in identifying violence as part of clinical enquiry, ensuring psychosocial support in addition to medical care.

CEHAT carried out capacity building and trained staff appointed for Dilaasa along with 800-1000 HCPs from the hospital. The need to develop in-house champions with HCPs from senior to middle level providers within the health systems was identified by CEHAT-MCGM referred as core group in the hospital. Cultivating these champions intended firstly to ensure uptake of VAW as a public health issue as training by peers gave legitimacy to the issue, secondly to create an in-house capacity to train and sensitise HCPs within the hospital and finally to increase ownership of Dilaasa across the hospital. A Training of Trainers (ToT) approach was adopted to cultivate champions through orientation on concepts like gender, violence, violence and its linkages to health, and role of HCPs in gender based violence. CEHAT’s training were eye-openers for champions who traditionally considered patients reporting violence as a burden to the already overburdened health systems.
The core group were capacitated with conducting short-term orientation program based on a training content and execute plan designed for their hospital. Of the 40 deputed for the training, a few members solely conducted training in their hospital, some conducted training along with CEHAT staff, while other used IEC materials and discussed on the issue with their peers. The core team members advocated for Dilaasa within the hospital and played a significant part in welcoming and integrating Dilaasa as a department in the hospital.

Training was later identified as a crucial process, as the issue of VAW was a new area of work for the hospital. It was critical to carry out periodic awareness for it with health workers. To sustain sensitivity among HCPs, it was necessary to create mechanisms for consistent dialogue, review of the response, challenges and gaps hence CEHAT-MCGM identified the need to train HCPs mainly doctors and nurses within the system to ensure sustainability of the training on VAW proposing the formulation of a training cell with in-house faculties. Through the Chief Medical Superintendent of peripheral hospitals, six HCPs from 16 hospitals were deputed to be trained as trainers for the training cell in 2004. The trainers, trained HCPs in their respective hospitals on the issue of VAW. Of the total HCPs trained 12 were deputed to form the training cell while others publicised about Dilaasa and issues on VAW in their respective hospitals. Social workers from all the 16 peripheral hospitals were also trained on violence as a public health issue. Selected nurses from these hospitals were trained to offer first line counselling support to identified survivors and were instructed to refer cases to Bandra Bhabha for further counselling and psycho-social support. Dilaasa centre at Bhabha hospital Bandra offered psycho-social services to survivors of all forms of violence from across peripheral hospitals in Mumbai.

3.3. THE REPLICATION

According to ExpandNet, horizontal scale up occurs when the innovation is extended to different geographical sites or extended to serve a larger population Success from the pilot model at Bhabha, Hospital Bandra laid grounds to replicate it in Bhabha Hospital, Kurla, to serve Mumbai’s eastern suburban population. During this period Dilaasa was also replicated in other states across India.
First replication of Dilaasa model under MCGM

After the successful implementation of the first Dilaasa centre and a creating pool of trained champion CEHAT and was all set for scale-up. CEHAT advocated the model at central level, to various states and within peripheral hospitals in Mumbai and recommended its uptake tailored to the local needs. The strategies adopted for a guided horizontal replication within Mumbai city are described below.

1. **Dissemination and advocacy:** CEHAT advocated to upscale the centre in different hospitals across the nation through workshops, dissemination of IEC materials and engagement with different hospitals and HCPs to build their interest. Sustained advocacy by CEHAT steered a felt need for another centre among champions from across the hospitals. They realised that just one crisis centre cannot respond to the large population of Mumbai and demanded establishment of another crisis centre since referral to Bandra Bhabha was cumbersome for many survivors. Hence a centre in the eastern suburbs initiated by MCGM due to pressing demand from champion HCPs.

2. **Organisational process:** An additive strategy was adopted in horizontal upscaling i.e. to add another centre along with previous or original partners CEHAT-MCGM. Capacity building of HCPs in the hospital was identified as a crucial process during replication. Human resources assigned for Dilaasa centre and other HCPs from the hospital were trained by CEHAT and existing members of training cell.

3. **Resource mobilisation:** The hospital deputed two nurses and existing Community Development Officer (CDO) for the centre, who were trained on providing feminist counselling. Since the centre was run using existing human resources, it was functional twice a week (Ravindran et al, 2011). Other CDO’s in the hospitals were trained to support counselling. Since the centre was born out of demand from the hospital staff, they widely promoted the department. MCGM provided funding support.

4. **Monitoring and evaluation:** A senior medical officer appointed as nodal officer for the centre monitored its functioning. The champions from the hospital and Medical Superintendent of the hospital monitored the overall functioning of the department.

Dilaasa department at Bhabha hospital, Kurla, Mumbai was established in 2005 out of recognition by HCPs that psycho-social services are important component of health care services.
Advocacy efforts by CEHAT on VAW:

Consolidating the experience from two Dilaasa centres a nine-day national course on VAW and the Role of HCPs was developed by CEHAT in 2006. Since 2008, CEHAT initiated efforts towards providing comprehensive health care services to survivors of sexual violence through research conducted in Bhabha hospital, Bandra. Based on evidence of direct interventions with 94 rape survivors, training of HCPs, and implementation of WHO proforma and guidelines a challenging legal petition was filed in Nagpur High Court and Supreme Court in 2009. It led to uniform gender sensitive guideline for responding to sexual violence and establishing right to health care for survivors of sexual violence. Following this champions from two other peripheral hospitals catering to large number of cases of sexual violence recognised the need for a uniform sexual violence protocol. CEHAT along with these champions formulated and implemented the existing uniform gender sensitive guideline for responding to sexual violence in four peripheral hospitals in Mumbai.

Replication in other states in India:

Around the same time after replication in Bhabha, Kurla, CEHAT was also assisting NGOs to engage with public hospitals and other states to adopt the Dilaasa model (Bhate-Deosthali et al., 2018). The replication in other states adapted and applied the principles and practice from the original model but adopted it to suit their local context. These models were initiated at different primary secondary and tertiary levels of health systems.

1. The department of health, Government of Kerala replicated the model under NRHM in 2009. It established Bhoomika centres in all district hospitals (21) in Kerala. Two counsellors were recruited for each of the centres. CEHAT was engaged in training of the counsellors in feminist counselling. The work of these centres was reviewed by the district monitoring committee chaired by the District Collector. It was noted that the centre staff was finding it challenging to work with the hospital staff on VAW and so CEHAT worked with the NRHM officials to designate a doctor in charge for sensitisation of hospital staff and integration of Bhoomika centre in the hospital. All the designated doctors were trained by CEHAT on guidelines and SoPs.

2. The NEN, a feminist organisation initiated work with the police and health system and collaborated with CEHAT for the work with health system. A series of capacity
building workshops/seminars were organised for the NEN staff, senior health officials, policy makers, followed by intensive training on VAW for doctors and nurses of all district hospitals. This culminated in the establishment of IOHYNT centre at a district hospital of Meghalaya in 2011.

3. Samuha, St John Hospital called Soukhya project and CEHAT collaborated to replicate Dilaasa in the primary health system of the Bangalore Municipal Corporation through support from ICMR in 2011. CEHAT provided the know-how, and capacity building of doctors, nurses, and link workers of the corporation. Women coming for ANC were screened for DV and survivors were referred to a counsellor. This was a pilot that showed good results but despite all efforts it was not integrated in the system.

4. The National Mission for Empowerment of Women (NMEW) supported various pilot projects for addressing VAW. Through this, CEHAT worked with the DMER and DHS of Goa to set up a Dilaasa Women’s crisis centre in one district hospital.

5. SWATI a feminist organisation based in Ahmedabad, engaged in responding to VAW at community level through mahila panchayats decided to replicate Dilaasa in Gujarat. CEHAT conducted capacity building of SWATI team, and staff of the selected health facility. A centre was set up in a sub centre in 2017.

Following a successful decade of effective functioning, the model was externally evaluated and was found to be highly effective for hospitals without additional burden on human resources (Ravindran et al., 2011). Thus, the next phase for Dilaasa, the scale-up, was planned.

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**Figure 6: Milestones of establishing and scaling up Dilaasa centres within the public health system**
**Environment**

- Consistent advocacy by CEHAT across hospitals since pilot
- Formation of a training cell in 2004
- Best practice for work with medical professionals on human rights by IRRO 2005
- Demand for another Dilaasa in the city by trained HCPs and establishment of

**Horizontal scale up**

- Bhabha Hospital Kurla in 2005

**Innovation**

- Dilaasa model

**Resource team**

- CEHAT

**User organisation**

- MCGM

**Vertical scale up**

- Dilaasa inaugurated in 11 hospitals

**Resource team**

- NHM, MoHFW

**Environment**

- CEHAT advocated at national and regional level through workshops, courses, legal petitions and external evaluation of Dilaasa model (2009-2012)
- Nirbhaya rape case in 2012 triggered discourse on comprehensive sexual violence examination
- WCD piloted OSC adopted from Dilaasa model in 2011 and was set for upscaling nationally
- MoHFW launched NHM with VAW as a determinant in 2013
- Comprehensive medicolegal guidelines on SV and health secretary’s visit at Dilaasa

**User organisation**

- 11 peripheral hospitals in Mumbai
3.4. THE SCALE UP

Vertical scale up occurs when the government decides to adopt an innovation at the national or sub-national level and this is institutionalised through national planning mechanism, policy change or legal action. The upscaling of Dilaasa model under NHM was based on vertical upscaling, where the innovation, a full package of interventions tested in the pilot was adopted as a program through a national planning mechanism due to policy change and legal action.

Dissemination and advocacy:

The external evaluation of Dilaasa in 2011 demonstrated high feasibility for a hospital based crisis intervention model. Despite its relevance and replication in an additional hospital in 2005, it had not been replicated or discussed at MoHFW post 2005. CEHAT advocated for the adoption of the model through several regional as well as national workshops, evidence sharing and dialogue with departments of health at central and state government level. CEHAT consistently advocated for integration of Dilaasa in a national program under various departments like health and women and child development.

As the model it gained popularity and international recognition there was mounting pressure to upscale it spontaneously. For example, MCGM proposed to adapt and implement this model in all health facilities by appointing interns from Social Work colleges across Mumbai as counsellors. CEHAT strongly opposed this thoughtless diffusion of an innovation as without systematic planning, these implementations would have failed as a program.

The national course on VAW and role of HCPs started in 2006 was offered annually in collaboration with ICMR, state governments in other states and developed resource material such as guidelines for HCPs, guidelines for counselling, manuals etc. CEHAT consistently engaged with policy makers, and advocated to make health system responsive to VAW. Sufficient resource materials and awareness among policy makers and health care providers was a stepping stone for the next step.

CEHAT had a steady iterative plan for guided upscaling. Though the plan was to upscale it at the national level it was replicated in various states and adapted to their local context like in Kerala,
Meghalaya, Karnataka, Goa and Gujarat. Their success served as momentum for further expansion of the model at national level. The horizontal replication was identified as a step to accelerate vertical upscaling, as it acts as an initial guide to adapt and learn from different context prior to national scale up. CEHAT therefore had multiple adaptations of the model in different context and different states to foster national level scale up.

The environment at national level:

Scenario at Ministry of Women and Child Development: A felt need to address the issue on VAW across the country was already conceived by The Ministry of Women and Child Development (MWCD) due to advocacy from various civil society movements like CEHAT. However, in 2011, MWCD’s Joint International Mission for Empowerment of Women mandated creating a scientific, evidence based approach for dealing with VAW. Advocacy efforts by CEHAT resulted in Dilaasa gaining traction as a best practice model to respond to VAW. The Ministry adopted the model and initiated a pilot based on Dilaasa model in Jaipur in 2011. The Ministry under its (National Mission for Empowering Women NMEW) planned upscaling 100 hospital based crisis centre based on Dilaasa model. According to a key informant from higher office of MWCD the pilot was funded by MWCD and was found to be effective and was mandated to scale it up by the Ministry in 2012.

Political context in the country: In December 2012, the Nirbhaya rape case referred to a brutal gang rape and murder of a young girl at the national capital of India in 2012. The incident triggered widespread social outrage across India protesting against state and central government’s failure to provide adequate security to women in India. The incident resulted in major reforms to ensure safety of women in India.
attention sensitively in a non-threatening, non-judgemental and non-interfering approach was acknowledged.

Two committees under the leadership of Justice Usha Mehra and Justice Verma were appointed by the centre. Justice Usha Mehra committee to identify lapses on the part of authority and recommend suggestion to improve women’s safety. The committee recommended establishment of One Stop Crisis centre at district level leading to allocation of Nirbhaya funds for the same and scaling up the concept of OSC rather than the Dilaasa based model (Mehra et al., 2013).

Justice Verma Committee, appointed to report amendments to sexual assault law, integrated evidence presented by CEHAT on the need to change archaic practices and replace them with sensitive care for rape survivors in the health system. (Verma et al., 2013). The report established the need for comprehensive medico-legal guidelines for sexual violence survivors. At the Ministry level, CEHAT presented evidence from the implementation of its gender sensitive guideline for responding to sexual violence in hospitals in Mumbai from 2008 to 2012 and advocated for the need to integrate gender-sensitive medical examination and the need to focus on health care of rape survivors. The Criminal Law (Amendment) Act, 2013 recognised the right to health care of survivors and made it mandatory for all public and private hospitals to provide care. Thus, a uniform proforma for examination of sexual assault survivors to be used across the country was developed collaboratively with the Ministry of Health and Family Welfare and CEHAT in 2014.

Dilaasa being the only indigenous evidence-based model on VAW was visited by multiple enthusiastic public health officials including the health secretary from national level to understand its functioning as a public health based model. During this period Dilaasa model already recognised as a good practice model by the International Federation of Reproductive Rights Organisation (IFFHRO) and WHO, was now acknowledged as a sustainable evidence-based model at the national level.

**Scenario at Ministry of Health and Family Welfare (MoHFW):** During this period in 2013 the National Health Mission (NHM) was launched including violence against women as a determinant. The NHM guided by the Health Secretary aimed partnership with various NGOs to initiate innovative health programs under the scheme. CEHAT advocated national level scale up of
Dilaasa since in Maharashtra, Dilaasa crisis centres were already functional in two hospitals under BMC for two decades and were recognised by WHO as an efficient model on VAW for LMICs. Yet its implementation nationally was turned down and suggested to be implemented in other hospitals in Mumbai. The then Health Secretary visited Mumbai in January 2014 to review projects proposed under NHM, Maharashtra and approved Dilaasa in 11 peripheral hospitals of Mumbai (MoHFW, 2015). CEHAT along with the Chief Medical Superintendent (CMS) of MCGM hospitals, prepared the proposal and budget for upscaling of Dilaasa in these 11 hospitals and submitted it to the administrative headquarters of the Government of Maharashtra NHM, Maharashtra

**Resource team:**

CEHAT was the resource teams for Dilaasa scale up, NHM through its cost and resource mobilisation while CEHAT provided technical support. Dilaasa was inaugurated on 8th March 2015.

**User organisation:**

MCGM the governing body of peripheral hospitals and the 11 peripheral hospitals implementing the Dilaasa model are user organisations in the vertical scale up. MCGM provided space free of cost for Dilaasa near OPD or casualty in each hospital. The health care providers of these hospitals had the responsibility to identify, treat and refer survivors of violence based on regular training provided by champions from the respective hospitals. Dilaasa was headed by the Medical Superintendent of the hospital and supervised by a medical doctor to ensure ownership of the department within each of the hospitals.

**Resource mobilisation:**

**Appointment of human resources for Dilaasa by NHM:** For the Dilaasa model, it was proposed to hire two full-time social workers, two full-time health workers and a full-time Data entry operator cum accountant. The social worker (Masters in Social Work) was to counsel and facilitate
services for women reaching Dilaasa department. The health worker trained in Auxiliary Nursing and Midwifery (ANM) was envisioned to be a bridge or interface between health systems and Dilaasa, to identify suspected cases of violence, develop a rapport with health care providers especially nurses during their routine ward rounds. The Data entry operator cum accountant (a commerce graduate) managed the Management Information System (MIS) data of the women reporting to Dilaasa department for evidence-based research activities and maintained accounts of the department.

Deputation of Nodal Officer for supervision of Dilaasa: In peripheral hospitals, all the departments are headed by a senior medical officer who supervise and coordinate the activities. This hierarchy was followed while upscaling Dilaasa department. A medical officer navigates through hierarchical structures within the hospitals and facilitates Dilaasa’s service delivery whenever encountered with challenges. The appointment of a Nodal Officer, an in-house senior medical officer as departmental head of Dilaasa ensured ownership of the Dilaasa as a department of the hospital.

Capacity building of human resources at Dilaasa: Rigorous training and capacity building was conducted by CEHAT for all the social workers, ANMs and DEOs appointed by NHM, along with the Nodal Officers and Medical Superintendents of peripheral hospitals. Seven days of in-depth orientation training for each cadre was undertaken to build perspective and orient them to expected challenges while working on violence against women and children. Positive feedback from two participants on the perceived usefulness of the training was:

“Before joining Dilaasa everybody had a different perception about violence. Earlier we would blame the woman for violence but that perception changed through this training. This perception did not change overnight but as I started working here it changed with time”

“After that, the way I looked at women, the way I looked at violence - my perspective changed completely...”
The Standard Operating Procedure (SOP) based on evidence generated from the pilot model for the service providers was instituted for:

- Identification, provision of medical support and referral of women to Dilaasa by HCPs within the health facility
- Counselling, providing additional support and linking the women for social support is carried out at Dilaasa centre.

A resource directory of referral agencies like police, shelter homes, protection officers, lawyers, child welfare department, skill development etc. was created by CEHAT for smooth referral process. Strong linkages between all agencies were established for effective service delivery.

Infrastructure development: Although a one-time capital expenditure was allotted for infrastructure development a designated space for Dilaasa was not however provided in three hospitals. This lead to challenges in maintaining the confidentiality of the data due to lack of designated storage space, lack of space for counselling survivors compromising on privacy and confidentiality of the information shared by survivors. Lack of designed space lead hospital administration to assign Dilaasa staff other clerical work. A counsellor from a large-sized hospital shares:

“we joined here on 25th March 2016, at that time all these (office space) was not ready. So at that time we were asked to sit at Medical Records Department (MRD) downstairs. So we were made to do all work at MRD, like arrange case paper in order and all”

According to counsellors, office space was constructed subsequently after a few months of appointing staff. Despite funds allocated for the construction of office spaces, the space allotted in many hospitals was not adequate. In seven hospitals a single room instead of two rooms were allotted, in one hospital the space constructed for Dilaasa was allotted for other purpose and Dilaasa was provided with another room. Inadequate provisions or shared office space in the department leads to compromise in privacy and confidentiality of survivors’ information shared.

**Financing the innovation:**
To decentralise, NHM transferred varying degrees of decision-making and financial authority to local bodies. NHM was solely responsible for funding the program, auditing its expenses and appointing human resources, while the functional responsibility lay with MCGM and its peripheral hospitals. The NHM earmarked Dilaasa in its routine Program Implementation Plan (PIP) for Maharashtra (Refer Annexure 3-7 or details).

The Chief Medical Superintendent (CMS) for all peripheral hospitals under MCGM in Mumbai along with CEHAT identified cost of setting up Dilaasa in 11 peripheral hospitals and submitted it to NHM. Adding the innovation into the user organisation required capital cost for construction of cubicles/ office space and furniture for the department, proposed in the first year as a one-time budgetary allocation. Similarly, the training cost for HCPs and appointed Dilaasa staff earmarked as one-time budgetary allocation by NHM. An additional recurrent yearly budget as personnel cost and operational cost (office expenditure) was proposed to sustain the project within the health systems. According to the budget proposed by the Chief Medical Superintendent (CMS) office, all budgetary subheads as mentioned in Table 6 were sanctioned except salary for Nodal Officer since NHM considered sharing personnel from the hospital for cost-saving.

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Table 4: Proposed budget by Chief Medical Superintendent (CMS) office, budget estimated by NHM and actual expenditure of Dilaasa departments in lakhs for 11 hospitals from 2016 to 2020
Despite the allocation of the budget in 2015-2016 NHM’s PIP, its implementation was delayed. CEHAT rigorously followed up with NHM for a year to initiate the centre thereafter staff recruitment was carried out by NHM in 2016-17.

Adding an innovation into the user organisation calls for the mobilisation of resources from the health systems to promote sustainability. The budgetary allocation by NHM included:

1. Personnel cost
2. Training cost
3. Operational cost
4. Implementation/capital cost

*the expenditure in 2016-17 included additional service tax which is not considered in the subsequent financial years due to the implementation of GST

#NHM budgeted for additional nine centres in 2017-18 and additional five centres in 2018-19 in their actual budget. The table shows allocation for 11 centres hence difference in allocation

$ Rs 60 lakhs include Rs 55 lakhs and Rs 5 lakhs budgeted for 2015-17 and 2016-17 in the NHM budget

Source: Data on expenditure obtained from NHM accounts department
Irrespective of fund sanctions, its utilisation by the respective hospital is cumbersome due to the existing structure of the NHM scheme which calls for a separate bank account for the Dilaasa centre, with two signatory authorities from the hospital. HCPs are routinely transferred in public hospitals leading to replacing signatory authorities frequently and updating their documents as per bank protocol. Disinterested Nodal officers appointed for Dilaasa to fail to update documents as a result three hospitals’ Dilaasa accounts were frozen by the bank.

The salary allocated to human resources (personnel cost) remained the same as the proposed expect deduction of Rs 400 for DEO salary to ensure uniformity across DEOs appointed in all NHM programs (refer to Annexure 6 for details on salary). A training cost of Rs 2 lakhs was sanctioned by NHM as a onetime cost for the first year only, yet its utilisation in the first year is unknown since capacity building for each Dilaasa staff and health care providers were funded by CEHAT. Training and capacity building for VAW is not a one-time activity as it includes clinical knowledge and skills to respond to VAW along with sensitization regarding attitudinal biases related to gender equality and VAW. Reinforcing the severity of the issue (VAW) within the health system is crucial to building competencies of HCPs dealing with survivors of violence (Garcia-Moreno et al., 2015). The NHM budget however, fails to factor in expenses for ongoing training and capacity building of health care providers and Dilaasa staff, the cornerstones to effective service delivery.

An implementation cost for civil work and furniture a one-time expenditure was proposed for the first year 2016-17. The budget proposed by the CMS office was Rs. 600,000 per centre. The budget proposed by NHM PIP was also Rs 600,000 per centre while the actual allocation to each centre was reduced to Rs 5.48lakhs per centre by NHM. This allocation was provided as a one-time capital cost amount for cubicle construction, furniture and operation cost in the first year to each centre.

Of the total budget allocated by NHM, Dilaasa centres spent 73% of the amount in the first year; of which 71 % was spent on Dilaasa cubicle construction and furniture, 2% was utilised as operational cost (Refer Annexure 4 for details). In the subsequent years NHM did not allocate additional funds as the operational cost to Dilaasa centres. All these centres are forced to manage their operational cost from the initial amount deposited by NHM in 2016-17 i.e. Rs. 5.48 lakhs

Operational cost for Dilaasa department’s office expenditure was proposed as a yearly recurring budget for the sustainability of the innovation. The proposal by the CMS office proposed a monthly
operational cost of Rs. 10000 per centre but the amount allocated by NHM was Rs 5000 per centre. The routine expenditure under operational cost includes:

a. Maintenance expenses for printer and computer,
b. Telephone bills,
c. Internet charges,
d. Stationary charges,
e. Meeting or routine training expenses like arranging tea and snacks for participants
f. Expenses for arranging tea or snacks for survivors in need and
g. Conveyance charges of the Dilaasa staff who travels to various referral agencies like police, PO, shelter home with survivors to facilitate the services and also travel for official meetings or training.

Though the amount budgeted by NHM in 2015-16 was Rs 6000 per month for each hospital, the allocation was reduced to Rs 5000 upon initiation of the centre i.e 2016-17 and has remained constant till date. Each Dilaasa centre is restricted to spending this stipulated amount each month as per NHM policy.

Operational cost is crucial for day to day functioning of the department. Regular bills paid from Dilaasa account across all centres are telephone bills and internet charges which approximately amounts to Rs 1000 monthly. Thus the Dilaasa centre is left with merely Rs. 4000 for the rest of the expenditure like reimbursing Dilaasa staff travelling to various referral agencies (police, protection officer etc), tea and snacks for survivors, stationary expenses and other maintenance activities. According to a counsellor from one of the large size hospitals with high caseloads, reimbursement for conveyance is often delayed due to a shortage of funds leading to out of pocket expenditure by Dilaasa team. The average out of pocket expenditure per month ranges from Rs 50 to Rs 1000. This amount varies across centres since the expenditures range from purchasing register for documentation, travel to various referral agencies to contributing to Women’s day celebration in the hospital.
A few hospitals have included Dilaasa expenses as part of the hospital budget hence regular expenses like telephone bills, internet bills, stationery and other maintenance charges are paid by the hospital. Two hospitals exhausted their funds and requested additional funds which were sanctioned by NHM. In other hospitals, fund management despite the shortage is unknown. In a medium-sized hospital, the entire expenditure for Dilaasa is met by the hospital and the operational cost allotted by NHM is not utilised at all, while for few other routine bills like telephone, internet, and stationary were paid by the hospital. Managing Dilaasa department’s expenditure varies based on its level of integration at each hospital.

**Monitoring and evaluation (M&E):**

M&E refers to various mechanisms created to monitor and evaluate the program. Dilaasa has a qualitative and quantitative monitoring mechanism. Qualitative measures on program outputs were monitored since cases of violence require long term follow up and sustained intervention. Quantitative measures of the program like MIS data may not indicate the impact of the service delivery, hence qualitative indicators to continuously monitor the quality of services provided were included reviewing documentation to identify interventions provided to survivors, monthly case presentations to discuss challenging cases etc was instituted by CEHAT.

During the pilot phase, Dilaasa was monitored and evaluated by the enthusiastic core group and nodal officers of the hospital. CEHAT realised the necessity of an overarching monitoring and evaluating body in the hospital and at the governing body level forming a monitoring committee within the hospital and the advisory committee at MCGM level for Dilaasa’s across 11 hospitals. These committees were devised as qualitative monitoring mechanisms to review performance of Dilaasa and discuss challenges faced by the department.

The advisory committee expected to meet annually facilitated administrative actions ensuring efficient functioning of Dilaasa and optimum response from hospitals to survivors of violence. It included members from senior hospital administrators, higher officials from police, representatives from lawyers etc. The monitoring committee expected to meet monthly is an in-house committee with HODs from major departments of the hospital to monitor the functioning of Dilaasa within the hospital. The advisory and monitoring committee ensured accountability of Dilaasa and
ownership of the department with MGCM and peripheral hospitals.

The Dilaasa advisory committee met once since the upscale due to challenges to mobilise unmotivated and disinterested public officials to initiate another advisory committee meeting additionally clubbed with lack of accountability from MCGM and peripheral hospitals. The monitoring committees were functional in seven hospitals, the meetings of which were initiated upon request from CEHAT. Thus, accountability at the level of MCGM and peripheral hospitals to adopt the innovation is challenging. Health systems often have instability in leadership due to retirements or routine transfers. As the leadership shifts so does the priority and effort given to the innovation, leading to failure to establish accountability within the user agency.

Program outputs i.e. quantitative outputs are obtained by both the user organisation i.e. MCGM and by the resource team i.e. CEHAT and NHM. Dilaasa department sends monthly reports to both the user organisation and resource team on the number of beneficiaries utilising the service, refers to other stakeholders, the number of suspected cases screened, and follow-ups carried out by Dilaasa. The monthly reports are merely quantitative data of the services provided and cannot be substantiated to the actual service delivery. For example, Dilaasa team regularly screens multiple patients visiting the OPD to identify suspected cases of violence. A secondary level public hospital ANC OPD on an average receives almost 300-600 cases per day (Potharaju and Kabra 2011) of which the majority are screened but the same is not recorded in the monthly report as the report mandated only cases registered in Dilaasa case records. Hence the monthly reports are under-reported as it reports only registered cases while the Dilaasa team screen multiple women in OPD and IPD to identify a single case of violence.

3.5. CEHAT’s INPUTS IN SCALING UP DILAASA

CEHAT’s role began with rigorous follow up with NHM for a year to initiate the setting up of Dilaasa departments, beginning with recruitment of staff and negotiating an appropriate space in the hospital. This was despite Dilaasa finding its place in the NHM’s PIP for 2015. The staff were appointed only in 2016 but job responsibilities of these staff were not laid down by the NHM which led to confusion about their roles and responsibilities. This was addressed through a
dialogue with the NHM and the staff. This ensured Dilaasa staff do not get used in an ad hoc manner for clerical activities by the hospital staff

Training of trainers:

Prior to establishment of Dilaasa centres, CEHAT carried out training of trainers (TOT) of HCPs from these 11 hospitals from 2014 onwards. The training included perspective on VAW as a public health and human rights issue, role of HCPs in responding to survivors, comprehensive health care to rape and DV survivors, communication skills, basic counselling, role as trainer, laws related to VAW, running a crisis intervention department. For streamlining a gender sensitive response to sexual violence. CEHAT advocated with BMC to print medico-legal protocol forms for SV examination released by Government of India in 2014 and to provide SAFE kits to provide comprehensive response to sexual violence. This was finally done in 2018.

Training Dilaasa staff:

A seven-day training on feminist counselling was jointly organised by CEHAT and MCGM for newly appointed counsellors, ANMs, nurses and data entry operators under Dilaasa. After the training, each Dilaasa counsellors visited crisis centre at Bhabha Hospital, Bandra and spent two days with senior counsellor to understand counselling process, procedure for documentation, identifying strategies to respond to survivors of sexual violence. This offered an opportunity to share feedback and challenges in providing quality services to survivors.

All reading material related to counselling guidelines, information related to laws, pamphlets, posters and presentations used during the course of the training were made available to the counsellors in Marathi for convenient reference.

This was followed by training on laws and legal procedures, medico-legal procedures, interface with police, and how to conduct joint meetings with abuser and/or family members. However, it is a well-known fact that just one-time training cannot enable counsellors to carry out comprehensive counselling. Hence, a mechanism was set up by CEHAT, wherein trained and senior counsellors from CEHAT and Dilaasa at K.B Bhabha Hospital, Bandra would visit NHM based crisis centres on a monthly basis, conduct meetings to understand challenges in counselling
and provide them with support to navigate health systems, police and legal systems as well as demonstrate counselling for them. Recurrent training sessions were conducted for Dilaasa counsellors by CEHAT. In 2019 a training session on understanding sexual diversities and responding to needs of LGBTQ community were conducted for Dilaasa staff. Counsellors from few centres which received transgender cases shared positive feedback in skilfully counselling transgender survivors.

**Monitoring quality of counselling:**

CEHAT visits Dilaasa centres to demonstrate counselling, read intake forms, provide detailed feedback on counselling and carry out discussions with the counsellors about challenges faced by them. However, it was critical to bring counsellors of all centres in a meeting for mutual sharing and learning as well as to provide expert guidance. The method of case presentation enabled them to voice their challenges and also help to identify future training needs of these counsellors as well as learn from each other’s experiences.

**Setting up Advisory Committees**

CEHAT had recommended setting up an advisory committee to oversee and provide support to 11 Dilaasa crisis centres after establishment of Dilaasa in March 2016. As soon as the crisis centres were set up, the Chief Medical Superintendent (CMS) was approached with the proposition. However, this was deemed as the responsibility of NHM by CMS office whereas NHM stated that their responsibility was to recruit staff rather than running the centre in the respective hospital. Despite a series of discussions, the advisory committee was not set up and the matter was referred to the AMC (Assistant Municipal Commissioner, Health). The AMC took note of it and organised a review meeting of Dilaasa in October 2016. Finally, in January 2017, the Advisory committee for Dilaasa was set up by Executive Health Officer (EHO) which was approved by Additional Municipal Commissioner (AMC). The same was announced at a meeting held on 24th January 2017 by NHM staff present for the meeting.

**Table 5 : List members of committee and their role.**
CEHAT raised the issue with the Deputy Executive Health Officer in January 2017 and expressed concern that an advisory committee cannot comprise of doctors and administrators, as feedback needs to be sought from civil society organisations about the reach of the centres and its utility. It was also pointed out that those senior counsellors from Dilaasa, Bandra centre who have shaped the counsellors of NHM need to be brought on to the advisory committee to lend their expertise. This remains a challenge till date.

3.6. OUTCOMES OF SCALE UP

Before the scale up, a formal mechanism to give voice to the needs of women and children facing violence did not exist within the health systems. Earlier women reaching out to health systems were treated solely for their medical complaints. With the establishment of Dilaasa a mechanism for offering psychosocial support to distressed women and children was created in the public health system.
The innovation contributed to empowering women on their rights to lead a violence-free life within the legal mandate. It contributed to improving the health and well-being of women since often violence is associated with health consequences. The details are presented in the forthcoming chapter on service delivery. National programs streamline and privatise components of the health system to seek efficiency and better outcomes. A similar approach was practised across all initiatives under NHM, the human resource person was to be appointed on a contractual basis by an outsourced agency as per NHM’s mandate. Such contractual short term employment is a manner of concern as it is exploitative in nature.

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<tr>
<td>● Employees hired are contractual staff, saves rigmarole of payment of salaries and liabilities to the Government.</td>
</tr>
<tr>
<td>● Fear of unions backlash is avoided</td>
</tr>
<tr>
<td>● Recruiting agency manages attrition and recruitment of new employees</td>
</tr>
<tr>
<td>● Ensures productivity among employees due to job insecurity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disadvantages of outsourcing HR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Additional administrative charges at 7.5% are paid to the outsourcing agency</td>
</tr>
</tbody>
</table>

Source: Interview with officials from the higher office of NHM

These reforms to privatise components of the health system at the national level lead to job insecurities and instability among Dilaasa staff. For example, failure to renew contracts, erratic tenure of appointment, abrupt changes in the clause of contract like ‘no leave policy’ for staff, lack of increment, delays in crediting monthly salary etc. Dual control on counsellors and Dilaasa staff by Nodal officers of the hospital and NHM/outsourcing agency leads to confusion and can impede Dilaasa work. There was a lot of administrative challenges in coordinating two systems, one NHM/outsourcing agency and the second the hospital authorities. Malpractices and corruption by the outsourcing agencies were highlighted during the study, to avail increments every year the agency charges Rs 500 as one time fees towards initiating increment. The percentage of increment
is left to the whims and fancies of the outsourcing agency. The ANM and counsellors received increment either annually or semi-annually or upon renewal of contract or as per the outsourcing agencies decision. According to a DEO, their contract renewal is pending since 2018-19 leading to no increments since then, as the increment is provided upon renewal of the contract. Women employees are not provided maternity leave and are expected to resign and rejoin.
CHAPTER 4

FIDELITY TO THE ESSENTIAL ELEMENTS OF DILAASA MODEL

This chapter describes the extent to which the various essential elements of Dilaasa model have been maintained in 11 peripheral hospitals. It provides information on the degree to which the building blocks of health systems have been adhered to while establishing a comprehensive health systems response to VAW in 11 hospitals.

4.1. FIDELITY TO ORIGINAL DILAASA MODEL

Durlak and Dupre (2008) refer to the adherence or maintaining of the key components of an intervention or program as fidelity. To achieve the demonstrated effects of a successful intervention, fidelity is very critical for a successful upscaling. However, adaptation to the local context is also extremely important for ensuring sustainability. Thus, a balance between fidelity and adaptation is essential where the upscaled intervention maintains the core components while tailoring to the context (Durlak & Dupre, 2008).

For this study, the fidelity has been assessed using data from interviews with counsellors, nodal officers and by administering a health facility readiness survey. The findings on fidelity have been presented using health system building blocks.

4.1.1. Leadership and governance essentially entail the role of the healthcare providers with managerial responsibility. Such a managerial role includes implementation of policy frameworks, supervision, mentoring, establishing coalitions and monitoring mechanisms. Various strategies were conceptualised under leadership and governance in the pilot Dilaasa model (2000) and were also intended to be upscaled as core elements of health systems’ response to VAW.

All 11 hospitals have a nodal officer who is a medical doctor with the additional responsibility of the hospital’s response to VAW. These nodal officers (NO) were appointed by Medical
Superintendents of respective hospitals and have both clinical and administrative responsibility (Refer to Annexure 2 for details). NOs were provided with essential training by CEHAT to strengthen their hospital’s response to VAW.

As evident from interviews with 9 NOs (3 were unavailable for interview), the primary responsibility of the Nodal Officers is to monitor activities of the Dilaasa department. Further, they address concerns of HCPs and Dilaasa staff in handling cases of violence, review monthly reports and accounts of Dilaasa which are to be submitted to Municipal Corporation. Logistic requirements and finances of Dilaasa are also taken care of by NOs.

Nodal officers have evolved different ways to oversee the functioning of Dilaasa. These include seeking feedback from survivors about services received from Dilaasa. Regular communication with the Dilaasa team is also carried out to inquire about any difficulties faced in the provision of care to the survivor. Their role involves facilitating procedures like emergency shelter for women found to be unsafe to return home, facilitating internal -departmental referrals amongst others.

One of the core responsibilities of NO is to lead the capacity building of the providers. This entails creating awareness about violence against women and health. NO orient and conduct training for resident doctors and refresher training for existing doctors, nurses with help of Dilaasa and CEHAT staff. They seek a list of participants for training from different departments and in consultation with the nursing head - Matron. Usually preference is given to staff who have not been trained, and accordingly, make required staff available for training and ensuring that the work of the department is not affected. Out of 11, 6 officers mentioned that they take efforts to arrange and conduct training on VAW for new staff, and refresher training for old staff. The other NOs cited challenges like high workload and low turnover of participants for organising training of healthcare providers leading to inconsistency in training.

Another responsibility of the nodal officer is to facilitate “monitoring committee” meetings for periodic review of the health system response to survivors of violence and services of Dilaasa. These committees are set up at each of the hospitals. Monitoring Committee is comprised of 1 Nodal officer; representatives from medical and nursing staff like Senior MO, matron, sister in
charge from key departments such as emergency/casualty, obstetrics and gynaecology, paediatric medicine, general surgery; Police Constable on duty at the hospital, Dilaasa counsellors ANMs, and representatives of CEHAT. In meetings, NOs, along with other members discuss challenging cases, difficulties encountered with other agencies such as police, CWC and gaps in the response to survivors. Out of 11, in 7 hospitals monitoring committees conduct regular meetings and reviews hospitals’ response to cases of violence. Frequent transfer of healthcare providers and the inability of committee members to come together for a meeting are challenges faced by monitoring committees.

<table>
<thead>
<tr>
<th>Leadership and governance</th>
<th>Aspects of non-compliance</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Organising training for staff</td>
<td>Workload of NOs</td>
</tr>
<tr>
<td></td>
<td>Functioning of monitoring committees</td>
<td>Disinterested staff members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frequent transfer of healthcare providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Difficulty in coming together for a meeting</td>
</tr>
</tbody>
</table>

4.1.2. Health workforce development: Adequate and trained staff is critical to respond sensitively to VAW and improve outcomes. The training of healthcare providers should focus on bringing change in knowledge, attitude and practice of healthcare providers. There is significant evidence to show that frequent training is essential to develop competencies among staff (Garcia-Moreno et al., 2015). Building the capacity of health care providers is an integral component of the Dilaasa model to establish sustainability.
It was envisaged that every hospital will have a core group for VAW. This is a group of sensitised health care providers across the cadres who have undergone training related to health system response to survivors of violence and are committed to promoting it in their health facilities. The role of core group members includes conducting training of other healthcare providers in their health facility and extending support in facilitating access to care for survivors. The core group providers in the hospital are trained by CEHAT.

The training of providers is focused on building understanding about VAW as a public health issue, addressing myths around VAW, the legal mandate of providers, building skills to identify signs and symptoms indicating violence and providing first-line support to survivors. In addition, providers of the gynaecology department are also trained on conducting a medico-legal examination of survivors of sexual violence, evidence collection, and providing medical treatment. These trainings are held regularly, as, resident doctors who are at the frontline of providing these services, change every six months. The training includes a mix of doctors and nurses as participants to increase team spirit as well as ownership of responding to VAW among all the cadres. The training content is delivered through participatory methods like role plays, case studies etc.

Out of 11, 5 hospitals were found to have a core group conducting regular trainings of staff members. Similar to the monitoring committee, there are challenges of frequent HCPs transfer in case of a functional core group

Dilaasa team in each hospital includes two counsellors, two Auxiliary Nurse Midwives (ANMs) and 2 data entry operators. The roles and responsibilities of the Dilaasa team which were found to be uniform across 11 Dilaasa centres are mentioned below in Table 7. Counsellors appointed in the Dilaasa department are both male and female with Master in Social Work degrees (Refer Annexure 1 for details). Nine counsellors among 11 interviewed had previous experience in the field of social work ranging from one year to a maximum of 28 years. All nine counsellors had worked in the health care sector. Two out of the 11 counsellors interviewed did not have previous experience.

**Table 6: Role of Dilaasa counsellor, ANM and Data Entry Operator**
<table>
<thead>
<tr>
<th>Role of Dilaasa counsellors</th>
<th>Role of ANMs</th>
<th>Role of Data entry operator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing emotional support to survivors- reassuring survivors about Dilaasa as a safe space where they could visit when they want</td>
<td>ANMs are involved in identifying survivors of violence through Casualty and ward rounds with the counsellor</td>
<td>Entering data of cases registered with Dilaasa</td>
</tr>
<tr>
<td>Providing counselling to survivors based on feminist principles(^2) and assessing the safety of survivors and developing a safety plan along with survivor</td>
<td>ANMs deliver health talks in the wards, OPDs about violence as a health issue, health impact of violence, rights of women, services provided through Dilaasa</td>
<td>Conducting periodic analysis of data and generating required reports.</td>
</tr>
<tr>
<td>Making a referral to the relevant hospital department for any medical needs of survivors</td>
<td>ANMs provide first-line psychosocial support to the survivors of violence.</td>
<td>Managing Dilaasa funds and bank documents</td>
</tr>
<tr>
<td>Providing social support and linking survivors to additional resources such as skill-building, income generation activities, support groups and community-based organizations</td>
<td>Assisting data entry operators in entering data and preparing monthly reports in required formats.</td>
<td>Issuing cheque for expenditure, reimbursing Dilaasa staff for conveyance and monthly accounting expenditure.</td>
</tr>
<tr>
<td>Carrying out ward rounds to identify women facing violence</td>
<td></td>
<td>Submitting expenditure to NHM for audit at the end of the financial year</td>
</tr>
</tbody>
</table>

\(^2\) Feminist principles are rooted in the firm belief that power and inequalities within a relationship must be questioned and women must be encouraged to understand that the cause of violence lies outside, external to them; in the inequalities arising out of the larger oppressive structures of society.
Counsellors help trainers/core group members organize training once in three months or twice a year as per the requirements of hospital staff.

Counsellors provide support to healthcare providers for medico-legal examination and evidence collection of rape survivors.

Coordinate with various stakeholders like police, CWC, shelter homes and so on to provide comprehensive care to survivors.

Maintaining documentation of cases of violence registered with Dilaasa

They work from 9 am to 4 pm on weekdays and 9 am to 1 pm on Saturdays. Morning rounds are conducted by the counsellor and ANM for active identification of cases in the wards, OPD and Casualty. The rounds are carried out alternatively among two counsellors and two ANMs. During rounds, the other counsellor stays in Dilaasa OPD in case a woman reaches out for counselling. In the absence of a second counsellor, ANM takes daily rounds alone and the counsellor accompanies the ANM a few days a week.

At the time of the data collection, 4 positions of counsellors, 7 ANMS and 4 data entry operators were vacant. There is a high rate of attrition among Dilaasa team members. Reasons range from low salaries, the contractual nature of the job, no provision of paid leaves to staff, no maternity leave and lack of yearly increment. The recruitment and management of the Dilaasa team have
been outsourced to an agency by NHM which is also one of the reasons for poor human resource management. This has been observed across cadres for recruitment of human resources under National health mission programs/activities.

4.1.3. Training of the Dilaasa team: All Dilaasa new counsellors are provided 5 to 7 days of training by CEHAT, to build their perspective on VAW. The training includes sessions on Sex and sexuality, Gender Equity, perception of the family towards women, forms of violence against women, identification of violence, Personal Laws, Laws regarding VAW, POCSO and legal aspects of violence against children, conducting joint meetings, handling professional burn out etc. Monthly case presentations facilitated by CEHAT are an important source for ongoing capacity building of counsellors. It is an avenue to enhance counselling skills, broaden their knowledge and skill, discuss challenges in counselling and facilitation of referral services, hear about emotional and ethical dilemmas, and strengthen team spirit. It helps the counsellors to discuss their struggles, unburden pressure and handle burnout from hearing stories of violence. Apart from initial training sessions, refresher trainings in the form of seminars, webinars, workshops are regularly conducted by CEHAT.

High attrition among Dilaasa team members is one of the major deterrents to their capacity building. As the skills for dealing with cases of violence are also gained with experience the high turnover of the Dilaasa team makes it challenging for CEHAT to build the capacity.

4.2. INFRASTRUCTURE, EQUIPMENT AND COMMODITIES

The hospital should ensure the availability of required infrastructure, equipment and commodities to provide appropriate care in cases of violence against women.

4.2.1. Infrastructure and supplies All 11 hospitals have space/rooms in various departments to ensure auditory and visual privacy in cases of domestic violence. Out of 11 hospitals, 7 carry out
a medico-legal examination of sexual violence cases while the remaining do not have facilities hence refer to other services. In 5 out of 7 hospitals providing care to survivors of sexual violence, medico-legal examination is carried out in the Gynaecology department. In 2 hospitals, the examination is carried in labour room using screens. The interviews with nodal officers pointed towards difficulty in maintaining privacy, especially during OPD hours. The 7 hospitals have access to toilet/latrine attached to the consultation/examination room or close to the room that can be locked from the inside, with a disposal bin, and water supply.

Dilaasa department must be in a location that is easily accessible for women and children. Out of 11 hospitals, 8 centres were located in accessible places such as OPDs or near emergency departments. In the remaining three, centres were located near IPDs making it challenging for survivors to access services.

All 11 hospitals have access to a drinking water facility which is used commonly by survivors, patients, and hospital staff. However, only one Dilaasa centre has the provision of drinking water inside the centre. There are no separate toilets inside the centres and survivors access common toilets in health facilities.

All 11 Dilaasa centres have a phone line connection which is either direct or an extension. However, at the time of data collection, only seven were found to be functional.

4.2.2. Furniture and Supplies

Table 7: Availability of furniture and supplies in 11 hospitals

<table>
<thead>
<tr>
<th>Furniture and supplies</th>
<th>Availability in 11 hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairs for survivor, companion, and provider (minimum of 3 chairs in the consultation/examination room);</td>
<td>✓</td>
</tr>
<tr>
<td>Requirement</td>
<td>Status</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>One writing table/desk between the provider and the survivor</td>
<td>✔️</td>
</tr>
<tr>
<td>A door, curtain or screen for visual privacy during the physical examination as and when required;</td>
<td>✔️</td>
</tr>
<tr>
<td>One examination table for examination of physical injuries as and when required</td>
<td>✔️</td>
</tr>
<tr>
<td>A washable or disposable cover for the examination table</td>
<td>✔️</td>
</tr>
<tr>
<td>An adequate light source in the examination room/space</td>
<td>✔️</td>
</tr>
<tr>
<td>Angle lamp or torch/flashlight for a pelvic exam;</td>
<td>✔️</td>
</tr>
<tr>
<td>Access to a lockable cabinet, room or other units for secure storage of survivor paper files/register; and medical supplies</td>
<td>✔️</td>
</tr>
<tr>
<td><strong>Dilaasa</strong></td>
<td></td>
</tr>
<tr>
<td>Availability of desk and chair for counsellor, survivor, and accompanying persons if any</td>
<td>✔️</td>
</tr>
<tr>
<td>Desk and chair for the data entry operator</td>
<td>3 Dilaasa centres have no desk and chair for data entry operators due to a shortage of space</td>
</tr>
<tr>
<td>Availability of computer for maintaining records of cases</td>
<td>In 1 hospital, the computer is in NO’s room due to a shortage of space.</td>
</tr>
<tr>
<td>Adequate secure storage facility for storing records of counselling and other documentation</td>
<td>In 1 hospital, the cabinet is in NO’s room due to a shortage of space.</td>
</tr>
<tr>
<td>Adequate light and ventilation in centres</td>
<td>✔️</td>
</tr>
</tbody>
</table>
### 4.2.3. Administrative supplies

#### Table 8: Availability of administrative supplies in 11 hospitals

<table>
<thead>
<tr>
<th>Administrative supplies</th>
<th>Availability in 11 hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
</tr>
<tr>
<td>Job Aids on VAW for provider and survivor</td>
<td>✓</td>
</tr>
<tr>
<td>A printed copy of the MoHFW 2014 guidelines and protocols for medico-legal care for survivors/victims of sexual violence</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Dilaasa</strong></td>
<td></td>
</tr>
<tr>
<td>In one hospital where computer and storage cabinet are placed in NO, only Dilaasa team has access to the cabinet and records are kept under lock and key.</td>
<td>✓</td>
</tr>
<tr>
<td>Printed copies of intake forms and follow-up forms</td>
<td></td>
</tr>
<tr>
<td>Registers and stationery for documenting suspected cases of violence seen, Dilaasa letterhead for referral services, inward and outward registers</td>
<td>1 hospital was unable to purchase registers and stationery as its account clearance was pending.</td>
</tr>
<tr>
<td>Health education, information material for the survivor in the form of posters, pamphlets</td>
<td>✓</td>
</tr>
<tr>
<td>Resource directory for meaningful referrals of survivors to other support agencies</td>
<td>✓</td>
</tr>
</tbody>
</table>
4.2.4. Financing is crucial for strengthening of health system’s response to VAW. A dedicated budget allocation for providing services to survivors, building the capacity of providers, and having dedicated staff is essential for the sustainability of the systems’ response. A sum of Rupees 35 crore was sanctioned by the central government to MCGM under NHM for the setting up of Dilaasa centres. The routine expenditure of Dilaasa including the salaries of the team is supported by NHM.

An analysis of the budget shows that the money received for infrastructure and setting up of Dilaasa was as per the amount proposed by the Chief Medical Superintendent (CMS) office. However, the interviews with counsellors found that there was a delay in the disbursement of money to hospitals. Due to a lack of office space, counsellors faced challenges in delivering the services effectively. The capacity building of healthcare providers was conceptualised as a one-time activity. Thus, no money was allocated for refresher training of providers.

As mentioned earlier, Dilaasa team members receive low salaries. The funds for office expenditure are inaccessible due to a lot of formalities. Due to this, counsellors are forced to spend money from their pocket and also the reimbursement takes a lot of time. The details of the budget and challenges are mentioned in third chapter.

4.2.5. Service delivery

Strengthening service delivery through protocols and guidelines is a key characteristic to meet the minimum quality of standards of care and enhance access to services within the health system (WHO, 2010). In 11 Dilaasa centres, the implementation of Standard Operating Protocol (SOP) developed by CEHAT is important for effective service delivery.

Privacy, consent and confidentiality

The intervention in Dilaasa operationalises PRIVACY as the right of the survivor to have access to a personal space (physical privacy) for sharing her experience of violence and undergoing a physical examination, as well as her right to the data she shares (informational privacy).
Table 9: Availability of audio and visual privacy in 11 hospitals and Dilaasa Centres

<table>
<thead>
<tr>
<th>Audio and visual privacy</th>
<th>Availability in 11 hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>Sexual violence cases examination, evidence collection and treatment</td>
<td>As mentioned earlier, in 2 hospitals it is done in the labour room using screens. Maintaining audio privacy is a challenge</td>
</tr>
<tr>
<td>In cases of domestic violence- spaces in IPD and OPD are used</td>
<td>✓</td>
</tr>
<tr>
<td>If the survivor is accompanied by relatives/any other person, the health providers create an opportunity to speak to the survivor alone</td>
<td>✓</td>
</tr>
<tr>
<td>Dilaasa</td>
<td></td>
</tr>
<tr>
<td>Separate rooms in Dilaasa to ensure audio and visual privacy</td>
<td>Out of 11, only 4 centres have two separate rooms. In one centre the rooms are divided with a glass partition and curtains.</td>
</tr>
</tbody>
</table>

CONSENT implies the right of the survivor to decide for herself and to agree to receive – or refuse – medical treatment, medico-legal examination intervention and care. The type of treatment and care, as well as the extent of it, should be her choice as long as she is above the age of 12 in cases of sexual violence. It is responsibility of providers to share accurate and understandable details, the range of options available to the survivor and the pros and cons of each option. In cases of sexual violence, written consent is taken by Health care providers while in Dilaasa counsellors take verbal consent is taken by counsellors from survivors.

Table 10: Provision to obtain consent in 11 hospitals

<table>
<thead>
<tr>
<th>Consent</th>
<th>Availability in 11 hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td></td>
</tr>
</tbody>
</table>
Consent before providing information on services, procedures, and laws governing violence against women and children

- ✔️

Informing about mandatory reporting under POCSO Act

- ✔️

**Dilaasa**

Consent before providing information on services, and procedures, of Dilaasa centres

- ✔️

Consent in cases of minor assessing safety survivors

- ✔️

**CONFIDENTIALITY** is defined as the survivor’s right to have personal, and identifiable information kept private by the provider/facility. Unless mandated by the court of law, the provider shall not give access to the survivor’s records to anyone else. If any discussion on the case is needed, all identifying markers shall be removed and the case should be anonymized. This is vital in ensuring the safety of survivors of domestic and sexual violence.

Table 11: Provision for confidentiality in 11 hospitals

<table>
<thead>
<tr>
<th>Confidentiality</th>
<th>Availability in 11 hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>Records in a locker- medico-legal forms, VAW register, forensic evidence register and any other documents with identifying information about the survivor</td>
<td>✔️</td>
</tr>
<tr>
<td>Confidentiality maintained about survivor and case details</td>
<td>✔️</td>
</tr>
</tbody>
</table>
Follow the chain of custody
Confidentiality of non-MLC cases
Sharing case documentation with police and survivor - MLC, Rape proforma, discharge card
Nullifying case sensitive information

Dilaasa
Records in a locker: intake form, VAW register, and any other documents with identifying information about the survivor
Confidentiality maintained about survivor and case details
Maintaining anonymity in discussing survivor’s case

In 11 hospitals, the history of violence, survivors and abusers is not disclosed unless for medical or medico-legal procedures. The case details are not issued/shared with persons not involved in the provision of care to the survivor (i.e., for medical or medicolegal purposes)

The chain of custody for forensic evidence is laid down and strictly observed in 7 hospitals addressing cases of sexual violence. In medico-legal cases (MLCs) the examining doctor in 7 hospitals is responsible for collecting and drying of evidence; labelling is done by the examining doctor or nurse, and sealing of evidence is done by Medical Record Officer (MRO) or Casualty Officer. In 7 hospitals sister-in-charge of the OBGYN department/examining department are designated for securing the evidence and handing it over to the police in case of MLCs.

Any sensitive information that needs to be destroyed is shredded by MRO in presence of the Medical Superintendent in 11 hospitals.
Referring to survivors by names or identifiable details is avoided while providing feedback or discussing the case with the doctors or team members, the registration number of the case is used as a reference in 11 centres of Dilaasa.

There are limits to confidentiality in cases where the counsellor identifies or recognizes suicidal thoughts in a survivor. In such a situation, the counsellors of 11 Dilaasa’s may decide to inform a family member about it and involve the person in safety planning for the survivor. However, the counsellor first explains to the survivor the need for disclosing the information to family or friends with whom the survivor feels comfortable with.

4.3. MEDICAL TREATMENT FOR SURVIVORS OF VIOLENCE

Availability, accessibility and affordability of a range of medical services to survivors of violence is important for comprehensive care. Table 13 below shows various elements of medical treatment across the 11 hospitals.

Table 12: Availability of medical treatment for VAW in 11 hospitals

<table>
<thead>
<tr>
<th>Medical treatment</th>
<th>Availability in 11 hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer essential care to survivors of violence 24 hours a day or help them to access alternative facilities like referring to large hospitals for medical treatment</td>
<td>✓</td>
</tr>
<tr>
<td>Providing treatment free of cost</td>
<td>In 9 hospitals, survivors are required to pay for essential diagnostic tests and medicines not available in the hospital. In cases, where woman is unable to pay, counsellors request hospital for waiving the charges</td>
</tr>
<tr>
<td>Providing medical treatment without requiring them to report to the police</td>
<td>Two hospitals follow the requirement of reporting to police before providing treatment to survivors of sexual violence. This is done even if survivor doesn’t wasn’t to make a complaint.</td>
</tr>
<tr>
<td>Keeping medico-legal forms in the examination room which ensures accessibility, privacy and confidentiality</td>
<td>✓</td>
</tr>
<tr>
<td>Equal access to care regardless of identity</td>
<td>In one hospital, there are barriers faced by unmarried pregnant women to access abortion.</td>
</tr>
<tr>
<td>Emergency shelter in hospitals</td>
<td>In one hospital, shelter is offered only on clinical grounds due to high patient load</td>
</tr>
<tr>
<td>Follow Ministry guidelines for documentation and examination in cases of sexual violence</td>
<td>✓</td>
</tr>
<tr>
<td>Routine enquiry of violence during pregnancy by healthcare providers</td>
<td>✓</td>
</tr>
<tr>
<td>Consent in cases of abortion of adult women - doesn’t require the consent of husband/partner for abortion in adult women</td>
<td>✓</td>
</tr>
<tr>
<td>Consent in cases of abortion of unmarried women under 18 years of age</td>
<td>In almost all the hospitals, providers inform police if the survivor is unmarried, under 18 years and pregnant. This is due to mandatory reporting under POCSO. However, it is done after informing minor survivors about its implications</td>
</tr>
<tr>
<td>Offer medical abortion</td>
<td>Most of the hospitals don’t offer medical abortion even if the gestation period is 12 weeks</td>
</tr>
</tbody>
</table>

In two hospitals, it was found that some survivors were asked to report to the police before getting medical treatment. In cases of child survivors facing sexual violence, hospitals provide required care and treatment but explain to parents about mandatory reporting to Police as per POCSO Act, 2005. If parents do not report to the police, then the hospital does the needful.
In 9 hospitals survivors have to pay for expensive diagnostic tests or buy medicines if not available in the facility, the rest of the services are free of cost. However, as per data from 11 hospitals, survivors who are destitute or homeless are unable to pay for subsidised in-house diagnostic services, so they request Dilaasa counsellor to waive off the cost. Under such circumstances, the counsellor would place a request to the hospital administration explaining the socio-economic circumstances of the survivor, and the request is considered by the administration of all hospitals. Some women may not request a waiver as the charges are subsidised.

Seven hospitals have a gynaecology department that provides women-centred abortion services to survivors. Providers do not ask husband/partner for consent for abortion in cases of adult women. In cases of a minor reporting pregnancy, the matter is presented before the child welfare committee with help of Dilaasa staff and hospitals and are given the required direction as per law.

### 4.4. DOCUMENTATION OF CASES BY HEALTH CARE PROVIDERS

It is a best practice for the hospital to put in place systems for safe and secure storage of relevant documentation that is of relevance in court cases or for provision of care to the survivor in future. For example, in MLC cases provider should record the name of the abuser (where available) and relation with the survivor (where applicable). It is important to note the abuser relation with the survivor to understand whether violence is inflicted by the person known to the survivor or unknown.

**Table 13: Documentation process in 11 hospitals**

<table>
<thead>
<tr>
<th>Documentation of cases</th>
<th>Availability in 11 hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recording of abuser details</td>
<td>✓</td>
</tr>
<tr>
<td>History taking in verbatim</td>
<td>✓</td>
</tr>
<tr>
<td>Systematic storage of documents- Keeping police records such as FIR, along with medical records of survivor</td>
<td>✓</td>
</tr>
<tr>
<td>Documents containing survivors’ safe contact details</td>
<td>✓</td>
</tr>
</tbody>
</table>
4.5. PROVISION OF PSYCHOSOCIAL SUPPORT – SCOPE OF SERVICES, ASSESSMENT OF SAFETY, MULTISECTORAL REFERRALS

Provision of psychosocial support to the survivors of domestic and sexual violence involves several aspects. The counsellors should be mindful of and incorporate the values and principles of feminist counselling into their services. Survivors are often in need of multi-sectoral services and it is important for Dilaasa teams to liaison with other agencies to facilitate access for the survivors. When referring a survivor to another agency counsellor should only say that the woman is registered at Dilaasa. Other confidential information should not be shared. The provision of psychosocial support in this chapter describes fidelity with core principles and elements while the details are mentioned in another chapter. All the Dilaasa centres follow feminist principles\(^3\) of respecting survivors’ autonomy and choices and avoiding victim-blaming the survivors for the violence.

4.5.1. Safety assessment and safety plan for all survivors

Safety assessment of survivors of violence helps the counsellor understand the threat to the woman in the context of frequency and severity of violence, and in terms of the impact the violence has on the woman’s physical and mental health. Assessing the immediate safety of the woman and providing help to make her feel safe is an important step in the crisis intervention process.

Figure 7: Elements of Safety Plan in emergency when survivor decides to leave abuser’s home

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\(^3\) This was evident from the interviews with counsellors where they were asked about specific case examples and how they intervened in those cases.
4.5.2. Safety assessment in cases of attempted suicide

The counsellors should be aware of the special counselling needs of women who attempt suicide or have suicidal thoughts because of domestic or sexual violence. Assessing the safety of the survivor is of great importance here. To be able to help such a survivor, it was noted that in accordance with the protocol, or based on the SOPS???, counsellors practice the following points:

**Figure 8: Steps of safety assessment in cases of attempted suicide**
4.6. MULTI-SECTORAL COORDINATION

4.6.1. Referrals and liaison with other resource agencies

Survivors of violence often need support from several resource agencies/support structures including the police, judiciary, shelter homes, child welfare committees, protection officers, various NGOs providing specific help such as vocational training, help for the education of children, support for children or persons with special needs etc. The survivors may need information, guidance and assistance for availing support from these resources.

Table 14: Compliance with multi-sectoral stakeholders in 11 hospitals

<table>
<thead>
<tr>
<th>Multi-sectoral coordination</th>
<th>Compliance in 11 Dilaasa Centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explaining to survivors about police procedures</td>
<td>✔</td>
</tr>
<tr>
<td>Facilitating procedures with police- address challenges in registration of complaint, writing complaint letter etc.</td>
<td>✓</td>
</tr>
<tr>
<td>Explaining medico-legal procedures to survivors in cases of violence-</td>
<td>✓</td>
</tr>
<tr>
<td>Preparing survivors for appearance in court of law- for example, preparing for statements, providing information about different court procedures</td>
<td>✓</td>
</tr>
<tr>
<td>Providing information to survivors about different laws and free legal aid cell</td>
<td>✓</td>
</tr>
<tr>
<td>Liaison with protection officers, shelter homes and Child Welfare Committee (CWC)</td>
<td>✓</td>
</tr>
</tbody>
</table>

4.7. DOCUMENTATION AND HISTORY TAKING

The Dilaasa department should maintain/ have standardised intake forms, casualty, inpatient papers, copies of medicolegal examination, charts, and registers that collect information about a survivor’s experience of violence.

a. **Details of the survivor in Intake Forms** Details of the survivor which include identifying information, contact information, a narrative about the incident, safety plan including address and contact number of a safe place, details of FIR/NC, MLC are noted in the intake form by the counsellors of 11 centres on the first visit by the survivor. The interviews with counsellors indicated that there are some challenges in filling up intake forms after counselling sessions due to the high workload. However, they ensure that the forms are filled within two days after the session to ensure there is no loss of information from poor/limited recall.
Also, Counsellors, mentioned that they make rough notes soon after the session. If the survivor gives consent for two team members to be part of the session, then the counsellor conducts session while the ANM makes notes of the session.

Details of subsequent visits are recorded into follow up forms or registers by the Dilaasa team of 11 centres.

b. **Details to be noted in registers** Casuality register of 11 Dilaasa centres include the account of women who presented as cases of assault, fall, poison consumption, attempted suicide, bleeding from vagina in Casualty department in the past 24 hours. Details include name, age, nature of the complaint, time of reaching the hospital, whether treated on an outpatient basis, referral to Dilaasa

c. **Documentation of ward visits and identified cases of violence** The ANMs of 11 Dilaasa centres records details of their communication with women during active case finding in wards or OPD waiting areas. However, ANMs finds it difficult to complete the required documentation on the same day but they make sure that it is completed within the next two days.

In 11 Dilaasa centres, cases identified during rounds are referred to the counsellor for counselling. The case is noted in the identification register. Further notes include whether or not the survivor choose or did not choose services from Dilaasa. An intake is filled if they agree to share the history and choose to avail services from Dilaasa.

### 4.8. MONITORING AND EVALUATION

Monitoring and evaluation strengthen the health system’s response to VAW by providing information on the training needs of providers, monitoring progress, helping plan budgetary allocation and providing data on what works and what does not work in the given context (Garcia-Moreno et al., 2015). This mechanism promotes accountability among stakeholders and implementers to provide quality service. This can be achieved through a survivor feedback mechanism, case reviews and debriefs by staff.

Monthly or quarterly Monitoring Committee meetings are conducted to review cases handled by Dilaasa, give feedback to HCPs on proforma filled in cases of violence. Discussion may focus on
written commentary and the reasons to not, comment on the status of the hymen (to comment only when injuries are related to the incident of violence), or mention past sexual history, or conduct the two-finger test\(^4\). Concerns of HCPs and Dilaasa staff are also discussed in the meeting such as collection of samples by police in required time. Challenging cases are discussed by HCPs and Dilaasa staff in monitoring committee meetings across 7 hospitals. In the remaining 4 hospitals that do not have a committee, difficulty in cases is discussed with senior HCPs or Nodal Officer. At Dilaasa, a Management Information System is maintained by the data entry operator in each centre. The MIS contains information about the cases registered in Dilaasa. This information is used to generate reports on types of cases getting registered with Dilaasa, referrals from the health system, expectations of survivors and services provided. Based on this MIS, monthly reports are prepared and are submitted to NHM.

The capacity building of the data entry operators to manage MIS is being carried out by CEHAT. However, the challenge of high turnover of the Dilaasa team is also a barrier to the effective maintenance and utilisation of the MIS system.

\(^4\) Two – finger test is unscientific medical test used by providers to determine if hymen is intact or not. This test violates the right of rape survivors to privacy, physical and mental integrity and dignity.
CHAPTER 5

PROVISION OF WOMEN-CENTRED CARE

This chapter describes the provision of women-centred care to survivors by the health system and explains delivery of essential elements of Dilaasa model. It elaborates on various pathways through which survivors reach hospital and Dilaasa, provision of clinical care and psycho-social support provided by Dilaasa counsellors to assist women facing violence. The chapter also looks at the challenges faced by the hospitals and Dilaasa in providing sensitive care to survivors.

5.1. PATHWAY OF THE SURVIVORS TO DILAASA

There are different ways through which a survivor reaches the Dilaasa for seeking support services to address violence. The figure 9 presents the various pathways by which a survivor may reach Dilaasa. They are broadly categories as those referred by the hospital to Dilaasa and those coming directly to Dilaasa. Women and girls seeking health care from the various departments of the hospital may be identified as survivors of violence and referred to Dilaasa for further support services. Police also bring VAW survivors to hospital- for medical examination related to sexual violence, elopement of young girls, and missing cases of young girls. Women may also access Dilaasa centre directly as they may have heard about Dilaasa services from ex-clients, information, education and communication (IEC) material or may be referred by police, shelter home, NGOs and so on.

5 Parents lodge a missing complaint wherein they are not able to trace their children. Young girls at times decide to go out with their friends without informing their parents, in some cases girls have been found at a relative’ place after quarrel with parents or in case of elopement with their boyfriend. Once a missing complaint is lodged these young girls are traced by police and brought to hospital for examination to find out whether she faced any form of violence while she was missing.

6 Parents lodge a missing complaint wherein they are not able to trace their children. Young girls at times decide to go out with their friends without informing their parents, in some cases girls have been found at a relative’ place after quarrel with parents or in case of elopement with their boyfriend. Once a missing complaint is lodged these young girls are traced by police and brought to hospital for examination to find out whether she faced any form of violence while she was missing.
The pathways of referral for DV and SV cases to Dilaasa is shown in figure__.
Figure 10: Pathway of DV cases referred to Dilaasa

Figure 11: Pathway of SV cases referred to Dilaasa
The analysis of the MIS data showed that the survivors reach Dilaasa mainly from the health systems (88% of DV cases and 96% of SV cases) and are referred from agencies outside the health system (Refer figure 10 and 11 for details).

**Table 15: Frequency and percentage of DV and SV cases referred from each hospital**

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Frequency of DV cases</th>
<th>Percent of DV cases</th>
<th>Frequency of SV cases</th>
<th>Percent of SV cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>468</td>
<td>19.0</td>
<td>491</td>
<td>57.6</td>
</tr>
<tr>
<td>B</td>
<td>53</td>
<td>2.2</td>
<td>190</td>
<td>22.3</td>
</tr>
<tr>
<td>C</td>
<td>235</td>
<td>9.5</td>
<td>25</td>
<td>2.9</td>
</tr>
<tr>
<td>D</td>
<td>133</td>
<td>5.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>E</td>
<td>375</td>
<td>15.2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F</td>
<td>125</td>
<td>5.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>G</td>
<td>245</td>
<td>9.9</td>
<td>103</td>
<td>12.1</td>
</tr>
<tr>
<td>H</td>
<td>57</td>
<td>2.3</td>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td>I</td>
<td>127</td>
<td>5.2</td>
<td>16</td>
<td>1.9</td>
</tr>
<tr>
<td>J</td>
<td>349</td>
<td>14.2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>K</td>
<td>297</td>
<td>12.1</td>
<td>25</td>
<td>2.9</td>
</tr>
<tr>
<td>Total</td>
<td>2464</td>
<td>100</td>
<td>853</td>
<td>100</td>
</tr>
</tbody>
</table>
Identification of violence by HCPs

The interviews with healthcare providers revealed a range of health complaints based on which providers actively ask women about violence. Following are various signs and symptoms shared by providers in identifying cases of violence.

Table 16: Signs and symptoms shared by providers to identify cases of violence

<table>
<thead>
<tr>
<th>Common Signs and Symptoms to identify cases of violence</th>
<th>Uncommon Signs and Symptoms to identify cases of violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Repeated health complaints with normal reports</td>
<td>• Pregnant women reporting late for labour</td>
</tr>
<tr>
<td>• Chronic anaemia</td>
<td>• Patient’s complaints do not match with signs and symptoms</td>
</tr>
<tr>
<td>• Chronic Headache</td>
<td>• Sudden deafness due to slap on a face</td>
</tr>
<tr>
<td>• Sudden rise in Blood Pressure</td>
<td>• Sudden loss of vision or bruised eye</td>
</tr>
<tr>
<td>• Body ache</td>
<td>• Cases in which husband speaks on behalf of his wife about her symptoms</td>
</tr>
<tr>
<td>• Sudden weakness in the leg</td>
<td>• Lack of visitor post-childbirth especially girl child</td>
</tr>
<tr>
<td>• Fractures</td>
<td>• Admitted women without relatives</td>
</tr>
<tr>
<td>• Feeling dizzy</td>
<td>• Patients are numb (unable to express their health complaints)</td>
</tr>
<tr>
<td>• Repeated pregnancies</td>
<td>• Children admitted with continuous abdominal pain without underlying pathology.</td>
</tr>
<tr>
<td>• Repeated birth of girl child</td>
<td>• Skin infection in genital area in paediatrics</td>
</tr>
<tr>
<td>• Multiple abortions</td>
<td></td>
</tr>
<tr>
<td>• Presence of self-inflicted injuries like cuts or bruises on the body</td>
<td></td>
</tr>
<tr>
<td>• Vague complaints</td>
<td></td>
</tr>
<tr>
<td>• Cases of accidental fall</td>
<td></td>
</tr>
<tr>
<td>• Accidental consumption of poison</td>
<td></td>
</tr>
</tbody>
</table>

As per Nodal officers in cases of accidental fall, women usually reported that she just fell from stairs, while HCPs do not find the injuries related to an accidental fall. Similarly, women report vague complaints like “not feeling good” or would say “something is happening (kuch toh ho raha hai).”
Sensitive enquiry by HCPs may enable women to disclose about violence, they may not do so immediately but in subsequent meetings and this is seen in example below;

A Nodal Officer from hospital D, a small sized hospital working as senior medical officer since 12 years in public health department shared:

“I treated a woman having maggots inside her hair and asked her to follow up after a week but she came after a month. Someone having maggots will not delay treatment as it stinks a lot. I felt suspicious and so took her to a private place for examination and asked her if she has any problem. She did not respond to my inquiry at that point. After few days she came to me and shared about violence she has been facing.”

Interviews with Matron from hospital G, a large sized hospital enabled an understanding related to how nurses identify violence survivors especially when women are admitted in wards;

“Sometimes the nurses may go to the patient for some procedure or during examination they may find a mark or anything on the patient’s body and may ask how did she got it, did someone hit you, does your husband beat you or do your inlaws beat you? If the woman says yes then they refer these woman to Dilaasa. But if she says no and still the nurse feels suspicious she may still refer the patient to Dilaasa.”

5.2. PROVISION OF CLINICAL CARE TO SURVIVORS OF VIOLENCE

Medical Treatment:
HCPs ensure that all women facing violence receive immediate and primary medical treatment. Smaller hospitals that do not have the required facilities to assist survivors are then referred to large hospitals. For example, cases of accidental poisoning, are referred for an X-ray, or to a psychiatrist to larger hospitals after stabilising the patient. In, cases of sexual violence too if the hospital does not have required infrastructure and personnel, first aid is offered and then survivors are referred to other hospitals if the facility cannot carry out medico-legal examination.
According to SOP, hospitals are expected to provide all services free of cost to survivors of violence but this is not streamlined in all hospitals. When the hospital does not have provision for certain diagnostics or is short of supplies like medications all patients are routinely expected to make their own arrangements for it. Services in public hospitals are generally subsidized like Rs 10 for an X-ray, hence patients do not request a waiver in general and the same is applicable for survivors reaching out to public hospitals. Lack of awareness among survivors of violence about free services for them results in their out of pocket expenditure which was found in 9/11 hospitals during the study. However, in situations where the survivor is homeless or destitute and unable to pay for subsidized services a waiver request is made, during which the counsellor requests the hospital administration explaining the socio-economic status of survivor. In these circumstances two hospitals waived the cost of in-house services, while in case of service offered outside the hospital the social worker of the hospital is requested to make provisions which may be successful in few cases. One hospital was unable to support survivor to take a RT-PCR test for COVID 19 conducted outside the hospital the nodal officer paid for the service.

In all cases of violence, HCPs inform survivors about Dilaasa services and refer them for psycho social support. As Dilaasa functions like an OPD its services are available till 4 pm. In case women /children facing violence report after 4 pm, HCPs note down survivors’ safe contact details and inform counsellors about the case the next day. The counsellor follows up with the survivor very next day and provide information about Dilaasa services and arranges for counselling session as per the survivor’s convenience.

In cases of accidental poisoning, it is a set practise in all hospitals for providers to enquire whether survivor is facing any form of violence. It has now been established that accidental poisoning complaints are invariably an attempt to suicide. In all poisoning cases, HCPs inquire about the violence faced by the survivors and refer all cases to Dilaasa. Survivors admitted in hospitals are accompanied by a helper to visit the Dilaasa centre for counselling but if the survivor is unable to walk then HCP ensures that the counsellor visits the ward and reach out to survivor’s needs. In cases where survivors are referred to other hospitals for medical treatment then HCPs note the contact number of survivors and inform Dilaasa counsellor to carry out needful interventions. In case there is an underlying psychiatric issue that requires special attention, Dilaasa team coordinate with psychiatrists to assist women for psychiatric intervention and therapeutic treatment. Two of
the 11 hospitals had a psychiatric department. In hospital B a large sized hospital, a major gap identified was that all cases of accidental poisoning are referred to psychiatry department for evaluation as a protocol. Referral to Dilaasa is within the perview of the psychiatry department if a history of violence is identified. This protocol is problematic since all women facing violence may not need psychiatric referral.

As per hospital protocol, all survivors of sexual violence must be provided immediate medical treatment and examined at the hospital without delay. But in reality, delays have been noted in two hospitals as upon arrival of survivors of sexual violence, HCPs are busy with existing workload resulting in a long waiting period. Some hospitals have addressed this issue by keeping additional doctors on call. Further, a Nodal Officer reported that emphasising the legal mandate of providers and the importance of Dilaasa in assisting cases of sexual cases, help in changing the practice of providers.

For rape survivors, informed consent for above 12 years of age, privacy, choice of sex of the examining doctor, collecting relevant samples, and maintaining chain of custody are done in the hospital.

As per nodal officers and counsellors, the examining doctor obtains informs the survivor about the nature and purpose of the examination and obtains consent for:

- medical examination for treatment,
- medico-legal examination and
- sample collection for clinical and forensic examination.

Refusal to any of these procedure is documented as informed refusal by the examining doctor. During history taking the doctor ensures that details of the incident are noted in in verbatim of the survivor and in private. If maintaining privacy is a concern due to the presence of other patients in wards, or of male hospital staff (ward boy) then the survivor is examined in a side room of a labour ward. A female survivor is examined by a senior gynaecologist who carries out required case documentation. A girl child is examined by a gynaecologist while a boy child is examined by a senior surgeon or a paediatrician in a side room of the Casualty. Examining doctor ensures that
required samples are collected, sealed by the Medical Review Officer (MRO), and handed over to Police. Doctor and Nodal Officer oversee Police delivering the sample to forensic laboratory within 36 hours from time of sample collection.

Overall while providing medical care for the survivors of violence, HCPs were cautious in cases of sexual violence due to the legal mandate associated with it. While despite the legal mandate for domestic violence its weak implementation at the ground level leads to its disregard among HCPs.

*Explaining Medico-Legal Case and its purpose*

When HCPs identify women facing violence, they explain to women about significance of a medico-legal case ensured for woman’s safety and an evidentiary proof of violence faced for future legal proceedings. The providers in their interviews reported that many a time survivors hesitate to proceed with medico-legal case (MLC) procedure when the abuser is her husband or a family member. HCPs explain to survivors that registering an MLC does not mandate them to go to the police. The choice of going to the police or filing a formal complaint lies with a survivor. On occasions of reluctance from survivors HCPs reach out to Dilaasa counsellors to explain the essentials of filling an MLC case. A Nodal Officer with 30 years of clinical experience mentions,

“*Survivors fear that by filling an MLC case they may have to face back lash from husband or in laws and that is when Dilaasa counsellor comes handy in boosting survivors’ morale and that has helped many cases to reach conclusion*”

The MLC is done in the Casualty department where HCP note down the survivor’s contact number, take history and provide MLC documents to the survivor. Nodal Officers also spelt out details of what is noted and underscored the importance of documenting history in the survivors words such

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7 A Medico-Legal Case can be defined as a hospital record of suspected cases of violence based on medical inference or diagnosis of doctor in which investigations by the law-enforcing agencies are essential to fix the responsibility regarding the causation of the injury or ailment.
as: survivor brought by whom, assaulted by whom, time of the incident, and injuries suffered by the survivor. HCP asks the person accompanying the survivor to wait outside the department to facilitate disclosure by the survivor.

In all cases of VAW, patient is informed about the importance of medico-legal documentation and how it works as evidence. How they should preserve it, how making MLC does mean making a police complaint but if she goes to police station with it the MLC is useful as evidence.

**Enquire about Safety of Survivor:**

After referral to Dilaasa by HCPs, Dilaasa counsellors discusses safety concerns with survivors. This is done by asking questions related to the survivor’s safety at home, availability of a support person, and whether the survivor has an alternate safe place to reside. Based on the survivor’s safety assessment, emergency shelter is offered in the hospital. Nodal Officers mentioned that their hospital provides emergency shelter, (also referred to as emergency admission or social admission) for women facing violence for two to three days or till the time survivor has a safe place to reside. Hospitals prioritize emergency shelters for pregnant women or those who have serious injuries due to violence. One of the small sized hospital with Dilaasa well integrated as a department provided 30 emergency shelter to women since four years of its establishment. In a large hospital with a shortage of beds, the hospital authorities inform the Police, CDO, or Dilaasa team to find alternate shelter options and they mentioned that emergency admission/shelter is a challenge.

A Nodal Officer from hospital G a large sized hospital mentioned said "*We give admissions to women irrespective of medical conditions as they don’t have a home to stay and are being abandoned by the husband. Women are admitted in the female medical ward, trauma ward, or ICU*”.

**Barriers and challenges in identifying cases of violence**

Identifying signs and symptoms by health care providers indicates recognition of Violence against Women as a public health issue. Nodal Officers and Counsellors were asked about barriers and challenges faced to ensure referral to Dilaasa they pointed out lack of consistent trainings, change
of doctors every 6 months, attitudinal challenge and need for inducting new doctors to understand Dilaasa as challenges in identifying cases of violence.

Despite consistent capacity building efforts, some nodal officers also expressed attitudinal concerns by providers - “It is not my job” is also a response they get when questioned about low referrals from HCPs. Counsellors expressed similar concerns with regards to attitude of HCPs interviews also revealed that bringing a change in the attitude of providers is a challenge.

The ability to identify signs and symptoms of violence indicated their level of acceptance of VAW as a health care issue and the recognition of their role as HCPs. Ingrained attitudinal bias among health care providers despite consistent training suggest disregard to acknowledge violence as a public health issue and stringent adherence to look beyond biomedical model.

Challenges in providing clinical care to survivors:

Procedural clarity: A challenge among providers in cases of sexual violence is about lack of clarity regarding procedures to be followed for medico-legal examination evidence to be collected. The Standard Operating Procedure expects doctors to collect only relevant evidence but the mainstream practice is to collect all evidence whether relevant or not. Thus, regular training should cover the procedure to be followed for sample collection, and filling out information in cases of sexual violence.

Coordination with Police: Nodal Officers shared that one of the biggest challenges is follow-up with the police for the collection of samples in cases of rape. When the police fail to collect samples on time due to busy schedule, the hospital or Nodal officer reach out to senior police officers and ask them to give in writing the reasons for not collecting them This is also done when police fail to turn up for producing new born baby of minor survivor in front of Child Welfare Committee, that decides whether or not the baby should be with the survivor or placed in shelter or be given for adoption.

For the survivors brought by police, providers have to hand over a signed copy of the filled proforma to the police. When the examination is done by a senior doctor, the police have to wait for their signature. This can be a challenge as at times doctors are busy in the operation theatre and
not in a position to leave patients. whereas the police want work to be done immediately, and doctors are busy attending to other patients.

Another challenge in dealing with the police is the interference of police with “history” given by survivors. In such cases, HCPs ensure that the history is documented in words of the survivor.

There were no challenges stated by HCPs in dealing with cases of Domestic Violence (DV). In DV cases, doctors limit themselves in identifying cases but in case of Sexual Violence (SV) they are mandated by the law to carry out the required procedure and have mentioned related challenges in SV cases.

5.3. PROCEDURE TO SUPPORT SURVIVORS OF VIOLENCE
Dilaasa team provides psychosocial support to survivors referred by healthcare providers and to survivors who come directly to seek support. Counsellors speak to survivors either in the centre, IPD or over the telephone. In the IPD, the counsellor speaks to the survivor either near the patient’s bedside or in a side room or a private space within the IPD or wherever the patient is comfortable to speak. This is done usually when the patient is unable to move out of bed or if she is unable to walk. Telephonic counselling is usually carried out during follow-ups when the woman has already visited Dilaasa or is in crisis post Dilaasa’s working hours and needs help from the counsellor.

During COVID 19 lockdown, counsellors offered telephonic counselling to survivors of violence unable to physically reach Dilaasa centres along with additional support services like legal interventions, shelter home etc. Provision of psychosocial support involves the following strategies employed by counsellors.

5.3.1. Providing information about Dilaasa
Counsellors stated that the moment a woman enters Dilaasa, they first explain the role of the crisis centre, its services, and explain the principle of confidentiality practised by the Dilaasa team members. This is followed as the first step by all counsellors as women are referred to the crisis centre and may not be aware of available services.
A counsellor stated:

“Initially we introduce ourselves. We tell her this is Dilaasa’s office. Mahanagarpalika (Municipal corporation) has started this centre to help women who face violence at home. Based on 2005 law, woman must not face violence at home. And if any woman is facing such violence at home, we are here for her safety.”

If the survivor is in severe distress and a state of panic, the counsellor offers water, provides snacks, asks the woman to wash her face, calms down the woman and stabilises her, thereafter the introduction of the department is done. Medical treatment is given priority for woman suffering from any form of injury or physical pain. She is also explained that the centre is not an extension of police station neither it is manned by the doctor. It is communicated as the centre is located within the hospital or in the premises of other OPD which can create some hesitations for woman to share her concerns.

5.3.2. Providing assurance about ensuring privacy and confidentiality
Counsellors assure women about maintaining privacy and confidentiality. A mechanism followed to ensure privacy is to shut the door of the Dilaasa department. In all hospitals, visual privacy is maintained, but audio privacy is a problem in three hospitals where Dilaasa is located adjacent to another department as stated by counsellors. Maintaining privacy is also a problem when 2 survivors come for counselling at the same time and there is only one room. In such a situation counsellor request women to either wait for the completion of the earlier session or takes the woman to another private space for counselling. While counselling adolescents or women accompanied by family members the counsellor ensures the survivor is alone in the room and parents or family members wait outside the counselling room during the session.

Three Dilaasa centres are staffed with male and female counsellors while one has two male counsellors. At these centres woman are given an option to choose a male or female counsellor. A major challenge in when female counsellor is unavailable is counselling women who do not open up with a male counsellor especially sharing history of incident in cases of sexual violence. Another challenge revealed by male counsellors was asking questions to the episode of rape with
survivors. Two counsellors reported having overcome this challenge over time with training but the other two counsellors still struggle to communicate with the survivors of sexual violence. One way of overcoming this challenge is providing survivors with the option to choose the sex of the counsellor and if a female counsellor is unavailable then a other female Dilaasa staff like ANM (Auxiliary Nurse Midwives) or DEO (Data Entry Operator) is present during the counselling session along with a male counsellor.

5.3.3. Emotional support

Providing emotional support is a very important element of psychosocial care to survivors. While offering emotional support attempts are made by the counsellor to break the formal barrier and put the women to ease. All counsellors from 11 centres mentioned about four principles followed to provide emotional support

- Addressing survivor’s guilt or blame
- Communicating that violence is an issue of power
- Respecting woman’s autonomy
- Recognising the impact of violence on health

a. Addressing survivor’s guilt and blame

The approach of validating the woman’s experience reassures her and she feels relieved. The counsellor helps the woman to overcome the feeling of guilt, anger and hopelessness. Giving the survivor the message that she is not at fault is very crucial especially in cases of attempted suicide. Counsellors shared that often in such cases, HCPs consider women committing suicide for minor reasons as a burden to the health system and blame them for increasing their workload since the patient must be provided emergency treatment, health care, carry out their MLC procedures etc. The woman’s family also blames her since hospitalisation takes a toll on their household expenditure and disturbs their routine functioning. Hence addressing women’s guilt is important to take the blame away from the survivor.

Counsellors described in the interviews that women facing violence have tolerated violence for years before reaching Dilaasa. Women believe they are the cause of violence inflicted upon them, since violence is usually portrayed as an attempt to correct their deficiencies like not serving food
on time, not serving warm food, adding extra salt to the food, not doing household chores etc. The women facing violence often blames themselves and is guilt of her actions that perpetrate violence.

A counsellor said “often survivor says that ‘all this has happened because of me. If I had not done so and so this would not have happened’. But we explain to her that violence does not occur because of someone’s fault. Violence cannot be justified at all- there is no reason or excuse for violence.”

Counsellors discussed the importance of dealing with stigma faced by rape survivors It is often the case that she may have already visited multiple service providers like police, casualty etc. before reaching Dilaasa and may have been subjected to labelling and stigmatisation. In the police station women has to narrate the entire incidence retraumatising her, in the casualty and gynac department the doctors consider these cases as a burden due to their busy schedule. According to counsellor, few doctors blame the survivor for provoking violence or feel young girls enjoy and increase our burden while seeking abortion.

Victim blaming is commonly faced by rape survivors. In such situations conveying the message of not holding herself responsible is a challenge. A counsellor narrates:

“we explain to her that you are not at fault here, you have been forced upon, and you should not blame yourself. And the person who has committed the bad deed, he should lose respect in the society.”

Counsellors have also seen cases of LGBTQA+ community admitted to hospitals with complaints of assault and poisoning. All cases of attempted suicide are referred to Dilaasa. A transgender person in the process of counselling revealed to the counsellor-

“There was a case where a trans person was hit by his brother and was thrown out of the house,saying, ‘you act like a girl… you don’t stay with us .. This and that... people laugh at us and all.’ This led the trans person to consume poison. The person felt, ‘I am outcaste for the society and now from my family as well, so where do I go?’
The counsellor explained that this is not the person’s fault and discussed that God creates people differently. He also discussed that the trans community has now been recognised by Indian law and that everyone should have access to education. The person was worried about what would happen once discharged from the hospital. The counsellor discussed that since the house was the name of the trans person, the trans person could not be legally removed because—after all ownership belonged to the trans person. Efforts were made to remove self-blame by discussing how society shames people if they are different and do not conform to rigid social norms. Besides this, the trans person was also encouraged to record a police complaint as this was violence that compelled the trans person to take their own life.

b. Violence against women as an issue of power and control

Dilaasa counsellors explain to survivors about power differentials by giving examples of discrimination of women or daughters within the household, women not being allowed to make decisions of their lives, traditions such as women eating last at home or getting an insufficient meal, violence inflicted on women by family, increase in severity of violence when women retaliate.

Counsellors demystify violence by discussing that violence is inflicted on women irrespective of their class, caste or employment status.

c. Respecting women’s autonomy

At Dilaasa centre the woman’s autonomy is prioritised. Many women referred to Dilaasa from the health systems are unaware of the range of services offered and since Dilaasa is located in the medical setting, women are not able to or are unwilling to openly discuss their history of violence. Additionally, they may not trust the counsellor to share her personal story in the initial visit, in such situations the counsellor does not force women to speak out
As per a counsellor “We tell them, its ok, if you don’t want to say. And everyone may not just open up fast. And you may also feel, why should I tell them my story. So if you feel this way, then no issues, maybe not today, but even later on whenever you feel the need, you can come here and speak to us.”

Once women open up they are offered options to exercise their choice. The women are informed about the freedom to opt for choices offered by Dilaasa or choose other options as per her situation. While some may feel the need to separate from their husband, others may wish to continue their relationship with their husband. The counsellors follow the policy of respecting women’s decisions. While doing so they encourage women to put down their thoughts on the pros and cons of whichever decisions that each of them chooses to make.

If the woman decides to stay with her abusive husband and family, she is offered a plan to keep herself safe during episodes of violence. If the woman chooses to separate from her husband then she is informed about legal provisions.

A counsellor stated “If a woman comes to me for counselling, then I don’t force her to choose an option right away. I tell her to think about it and let me know after 2-3 days, because she may be confused. So then I ask her to come after 2-3 days, also to speak to her parents and then decide and we will help you based on that”

d. Recognising the impact of violence on health

The above three principles focus on offering emotional support to women, this aspect focuses on creating awareness among women facing violence. Often women are unable to distinguish between the ill health as a consequence of violence. Despite multiple visit to hospital they are unable to recover from their ill-health. Counsellors who are trained to identify health consequences of violence points it out to the women.

The counsellors expressed that violence faced by women affects not only physical but their psychological well-being. They also mentioned that women suffering from diseases such as TB,
Asthama, HIV, Cancer, or having mental health illness makes it difficult for them to fulfil household responsibilities. This leads to episodes of violence that women faces from in-laws and husband. Thus, a woman having disease that affects her daily functioning is prone to facing violence which further affects her wellbeing.

An example was provided by a counsellor where a woman contracted HIV from her husband, the in-laws blamed her for the disease and isolated her. In the process of counselling, she was supported and she disclosed that her infection was due to her husband. Her legal right to stay in her marital house was explained. In the process of counselling, the focus is on discussing self care, importance of continuing medical treatment, prioritising their health and also skills to negotiate with the abusive family members.

Women facing violence may also face health problems. Increased work load at home can result in lack of rest and sleep manifesting as health complaints like headache, body pain, back pain, fatigue etc.

A counsellor informed “We always start with her concerns related to health, (we tell her) the impact of her thoughts on her health. Because (violence) has an effect on health. It is important to communicate to them the importance of health consequences of violence. Explaining this to the women is always helpful”

An important issue flagged by counsellors was about encouraging women and increasing their self confidence. Many women reach Dilaasa with low confidence. A difficult experience was narrated by a counsellor. She mentioned that a woman committed suicide as she found herself unable to save four daughters aged 17 years, 14 years, 5 years and 4 years old from their father, who sexually abused two elder daughters. Despite the relatives revealing the abuser’s location police was unable to arrest him and put him behind bars.

Another important aspect of counselling is to address fear of stigma and labelling faced by victim and their family in cases of sexual violence. The fear is more pertinent in cases when the abuser is a family member and survivor is a minor who does not have a say in the family. Family members
of survivor facing sexual violence also fear that once the community people learns about the abuse, finding a marriage prospects for survivor becomes difficult.

5.4. SAFETY ASSESSMENT AND PLAN

Counsellors stated that upon obtaining the history of violence endured by the woman, it is essential to enquire regarding her safety. The safety plan varies depending on the context of each woman and the violence faced by her. It is developed in a participatory manner by exploring the feasibility of various options offered to women.

A series of questions are asked to assess the severity and frequency of violence, change in nature of violence over time and women’s perception of their safety at home. Based on all of this, the safety plan is prepared. Each woman’s situation is unique depending on whether she is going back to the abusive home or stepping out.

A woman returning to an abusive home is advised various strategies in case the violence escalates. Strategies such as holding the husband’s hand to stop him from hitting, leaving the room/house if the woman senses that abuse is going to start. If leaving is not an option, shouting for help so that someone from the neighbourhood could intervene, informing neighbours in advance that they should knock on the door or ring the doorbell when they hear her scream, informing the neighbours to call the police if they hear her call for help is suggested. Counsellors also suggest women involve their older children in stopping violence rather than witnessing it; train them about who to call, by intimating neighbours or calling the police on helplines 100 or 103. These strategies help in the temporary cessation of violence by the abuser.

Based on counsellors experience they mentioned the effectiveness of these strategies are contextual. For example, if the women are thin built they find it difficult to hold their husband’s

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8100 is police helpline number in India and 103 is police helpline number for crime against women in Mumbai city, India. These are 24 hours, 365 days toll free telephone number.
hand. At times the neighbours are husband’s relatives or know her husband since childhood in these circumstances neighbours refuse to help. While in one of the case described by counsellor the women used both these strategies stepping out of the house and intimating neighbours to successfully reduce violence.

If a woman has decided to leave house her home, counsellors discuss and explore with her about informal sources of shelter for a few days, like family, friends, neighbours. Information is also provided about formal sources of shelter: emergency shelter in the hospital and formal shelter home services for the long term. Counsellors encourage women to plan their exit from the house by keeping all important documents in their custody, as well as prepare their children if they feel that the children may not be safe in the house.

Counsellors facilitate emergency shelter in the hospital if a woman has a threat to her life and has no place to go to. All hospitals are expected to provide emergency temporary admission for 24 to 48 hours. Counsellors stated that when women are admitted for 24 or 48 hours, it provides them time to locate alternative shelters. Once a shelter home is arranged for the woman she is discharged from the hospital and sent to a shelter home.

Women reaching Dilaasa centres either come alone or sometimes are accompanied by children. If they express the need for shelter, the woman is usually admitted to the female medical IPD and the child is admitted to the pediatric IPD. But this can be done in very few cases since many hospitals do not have a paediatric ward. Counsellors have to negotiate it with the hospitals for admission of children.

Safety assessments of survivors also include asking them about suicidal thoughts. As women endure violence for a long period, they feel frustrated and angry and assume there is nothing left in life for them. These women may express thoughts of committing suicide to the counsellor. The figure 10 below presents the steps taken by counsellors to address suicidal thoughts among survivors.

Figure 12: Steps of suicide prevention counselling followed by Dilaasa counsellors
STEPS OF SUICIDE PREVENTION COUNSELLING

1. Encourage women to overcome thoughts of suicide and support them to deal with violence.
2. Explain the consequences of poisoning on their physical health as well as their life.
3. Discuss techniques to overcome violence such as—distractions
   - Staying away from situations or places of violence,
   - Visiting a friend or relative whose company they enjoy,
   - Practice hobbies like listening to music or watching a movie,
   - Contact the counsellor telephonically or in person when she gets suicidal thoughts, the counsellor then intimates a family member or friend to keep a close watch on the woman.

A counsellor from one of the Dilaasa OPD shared a case of a 24-year old woman who attempted suicide. She was in love with her boyfriend and they had planned to get married. Both the families were involved and wedding preparations were in full swing and then the boy refused to marry her. Since she already had sexual relations with him, she considered herself not “suitable” (counsellor’s verbatim) for any other man. Counsellors discuss the notion of virginity with women, that there is nothing wrong with having physical relations. It was explained that she has her life ahead of her and is yet to experience it. The counsellor after multiple counselling sessions helped her to overcome her feelings of despair.

5.5. NEGOTIATION FOR NON-VIOLENCE – JOINT MEETING

Counsellors at Dilaasa conduct joint meetings with the perpetrator upon request from the survivor. In the experience of counsellors, some women feel that abusers may pay heed to an authority in a hospital and hence request for a joint meeting. Some women request a joint meeting when they do not want to approach the police or take legal actions against their husbands to avoid ruining the family’s reputation.
The objective of the meeting is to enable women and abusers to engage in a dialogue and enable negotiation for non-violent and safe spaces for women within the families. Counsellors mentioned that they help the woman to put forth her concerns; they also inform women that such meetings may or may not be successful, so there is a need to have an alternate plan of action in case the talks do not materialise into concrete changes in abuser’s conduct.

**Figure 13: Objectives of conducting joint meeting**

<table>
<thead>
<tr>
<th>OBJECTIVES OF JOINT MEETING</th>
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<tr>
<td>1. Engage in a dialogue with the abuser</td>
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<tr>
<td>2. Put forth the woman’s concerns to the abuser</td>
</tr>
<tr>
<td>3. Negotiate for a non-violent space within the family</td>
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Counsellors contact the abuser telephonically or by letter to explain the purpose of the meeting, sometimes women ask the husband (abuser) to accompany them for the joint meeting.

Preparation for the joint meeting entails helping women list down their expectations and discuss them with the counsellor. A mock session of the joint meeting is held with the woman at the Dilaasa centre to prepare her for the joint meeting. Once the woman is prepared for the meeting a convenient date is fixed.

During the joint meeting, the Dilaasa counsellor acts as a facilitator. The meeting is centred around the woman’s interest. She is encouraged to put forth her points and then the abusive person is also given chance to put forth points. Counsellors clarify that violence is non-negotiable and all violent means of resolving conflicts have to be stopped.

The modality of conducting joint meetings varies across centres. In some centres both the husband and wife sit together, and each of them is allowed to speak out and resolve their differences. While in some centres the husband and wife speak to the counsellor individually and then later a joint
meeting is carried out. A counsellor shares the steps of the joint meeting followed in her centre with a husband who refuses to give household expenses to his wife:

“In a joint meeting, we tell the husband about survivor’s concerns. Then the husband would put forth his points. We communicate to the husband that beating is violence and it is wrong, and husband might have to face legal actions if it continues. So, it is better both of them stay well together and the husband from now give the required money to his wife or else in future he has to give maintenance.”

In the experience of counsellors, these meetings alert abusers that the woman has formal support and that she can file a police complaint or file a case against him. The counsellor explained that sometimes such meetings are successful and at other times not. Changes in the behaviour of the abusive person also don’t last long. At such a juncture women decide to take legal action.. Counsellors also expressed that despite advance preparation, arguments between the spouses become heated and this does not leave any space for discussion, in such situations too joint meetings do not have a successful outcome. Another challenge is that abusive spouses despite all follow-ups do not come for a meeting. Counsellors at Dilaasa have worked in other counseling spaces as part of their previous work experience. One of them said that she continued to call the abuser as she did in her earlier workplace. It was only later that she came to know about how to conduct joint meetings through a training session by CEHAT where the objectives, principles and steps to be followed in a joint meeting were explained.

5.6. PROVIDING INFORMATION ABOUT LAWS
All women are informed about the Protection of Woman against Domestic Violence Act 2005 (PWDVA) (also referred to as DV Act) by Dilaasa counsellors since they have a basic understanding and clarity about the Act and sections for violence. According to the PWDVA, a Protection Officer (also referred to as PO) is responsible to provide legal guidance to a victim of domestic violence and assisting them in securing correct order under the act. The counsellor refers the woman to a Protection Officer when she decides to proceed legally against her husband and marital family. The Protection Officer files a case on behalf of the woman under PWDVA. The protection officer assists the woman in filing a court case and assigning a government
advocate/public prosecutor for her. All these services are to be provided free of cost to the woman according to PWDVA.

This provision available under the law is explained to the woman by the counsellor. A counsellor stated:

“We inform her what she will receive under this Act; expenses for education and other basic requirement for her children, one can stop physical, mental, economic violence through this act, a protection order can be carried out under this Act if she is facing physical violence and stop the violence she is facing. Also, if the husband is not giving her money, then maintenance can be sought under this Act if she is at home and not working”.

The counsellor fixes an appointment with the Protection Officer. The procedure for filing a case with the Protection Officer is explained to the woman. The counsellor may accompany the woman to the Protection officer for her first appointment if she is hesitant.

At times, women are hesitant to file a case against their marital family members fearing separation from their husbands and of being accused of ruining the reputation of their family. In such cases, the woman is told about the benefit of filing PWDVA. A counsellor narrated:

“We also inform the survivor that filling a DV case doesn’t mean she separates from her husbands... In fact filling a DV case is to bring husband and wife together, DV case is for those woman who do not receive what they are entitled for...If you (survivor) file a case under this Act against your husband or in laws still, there can be possibility of settlement. Husband might think instead of giving so much maintenance I would rather take care of my wife, and her married life can get sorted. So she has option of settlement even if she files a DV case. The settlement will happen through court but it will be good for her future.”
Another important provision explained to the woman is Section 498 A\(^9\) of the Indian Penal Code (IPC) which is criminal law. The counsellor orients the woman about it and cautions the woman to file a case under this section if she no longer wishes to stay with her husband and his marital family since he and his relatives would face jail terms under this section.

Hence, a woman considering reuniting with her husband in the future is explained the implications/consequences of filing a case under this Act.

Hospitals also receive case of elopement in which the girls under 18 years of age run away with their boyfriend, these cases are referred to Dilaasa. Counsellors are involved in providing information about laws to minors involved in consensual sexual relations. Counsellors express that parents who disapprove relations between minor tend to file police complaint which ultimately leads the minor to follow procedure governed by rape laws. Also, minors getting pregnant reach out to hospital for medical treatment. As per Criminal Law Amendment Act of 2013 age of consent in India is 18 years which implies that any sexual activity below 18 years of age irrespective of consent would amount to statutory rape as per section 375 of the India Penal Code. The Protection of Children from Sexual Offenses (POCSO) Act, 2012 makes it mandatory to file a complaint for police in cases of minors being subjected to sexual violence. Survivors and their parents are also oriented about laws governing medical termination of pregnancy.

**Referral to lawyer**

In case of violence, survivor needs legal counselling from a lawyer. CEHAT has facilitate a lawyer who provides legal advice to survivors of Dilaasa, also counsellors have identified private lawyers who are willing to assist women. These meetings are arranged with lawyer at the request of the survivors who want to file a court case against the abuser. During these sessions the survivor

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\(^9\)Section 498A of Indian Penal Code (IPC) is a criminal case applicable in cruelty to woman by her husband or any relative of her husband punishable with an imprisonment for a term of three years and also fine.
clarifies doubts about access to the legal justice system like laws applicable for the woman’s case, answering questions posed by the judge or the abuser’s advocate.

**Informing about types of police complaint**

Women are explained the importance of recording a police complaint after facing violence. Such a complaint has evidentiary value if a woman decides to pursue legal action in the future. Counsellors convey the difference between filing a Non Cognisable (NC) complaint and a First Information Report (FIR) as ‘Small and Big’ complaints. Non Cognisable complaint is referred to as ‘Small Complaint’ (Chota complaint in Hindi and Marathi) where the police make a diary entry. Sometimes they summon the abuser and warn him to not harass the woman, they may even put him in the lock-up for some time. An FIR referred to as ‘Big Complaint’ (Bada complaint in Hindi and Mota complaint in Marathi) is a cognisable offence. The counsellor explains to the woman that the abuser is not jailed when NC is filed. On filing an FIR they are sent to jail since it is a criminal case. Most counsellors stated women don’t always know the difference between NC and FIR hence explaining it is important to enable her to make a decision. Apart from this, the woman is encouraged to file FIR, once numerous NCs are filed in the police station.

According to a counsellor:

“So when (the) police warns them (husband/abuser) in this way they may not react (inflict violence) for 4-5 days, but later it may start again. It (warning by police) may work out for some people but may not work out for others.”

**5.7. MULTI-SECTORAL COORDINATION**

Violence against Women is a multidimensional issue, no one agency can provide all services, a comprehensive response requires Dilaasa to establish links with agencies outside hospital setting. Dilaasa offers referral services to agencies like police, Child Welfare Committee (CWC), protection officer, and shelter home to survivors for additional support services which are out of the scope of the health system. Counsellors are involved in multi-sectoral coordination in situations when survivors find it difficult to follow up with various agencies.


5.7.1. Police

Counsellors coordinate with police for assisting survivors to register NC and FIR. They share that a lot of times police refuse to register any complaint against the abuser and send back survivors saying that it is a domestic matter. Counsellors also discussed that when women repeatedly go and file an NC, after the first two times there is reluctance on part of the police to record it. In such cases, counsellors call up the police and explain to them the condition of the woman and request them to address her concerns.

Some counsellors also shared that usually, police do not refuse to file a complaint if a survivor carries an MLC paper with her. Hence, a counsellor from large hospital ensures women without medical complaints reaching out to Dilaasa for an FIR / NC gets an MLC documented on the pretext of disturbed mental health. Further, counsellors tell survivors that if the police refuse to file a complaint, then they should request a written response from the police. Counsellors also shared that approaching higher police officials help in registering a complaint.

Counsellors shared that consistent engagements with the police over the period has led to having a rapport with police officials in a few hospitals leading to smooth functioning. Such rapport enables the police to contact the Dilaasa team and decide time they can bring the rape survivor for counselling as they realise its importance. But when the police get transferred, the Dilaasa team has to restart the process of establishing rapport with new police personnel. In some hospitals because of COVID duties, despite rapport with police, they were neither able to register complaints nor reach out to women facing violence because they were tasked with lockdown management. There are also instances of sensitive behaviour by police, in one instance a Woman Police Constable shared her home cooked food for a survivor of sexual violence.

Survivors who report sexual violence to the police station are brought to the hospital at night for examination, as a lot of time is spent in recording complaint and other aspects. Counsellors expressed that police do not report cases of sexual violence to hospitals immediately after the compliant is filled. There is no understanding that it is a violation of the rape law which prescribes
sensitive treatment of women /children. Neither do they understand that it can lead to loss of evidence since the survivor may pass urine/ cleanse/ have a bath/change etc. during her waiting period. Most often survivors are brought at night since police feel the hospital is considerably free at night than during the day. There is no consideration for a survivor who has been in the police station and is being taken to a hospital at the end of the day.

One of the counsellors mentioned corruption by police. In a POCSO case, the girl’s statement was changed by police under influence of her abuser, her father. She was threatened by the police to change her statement. Though the girls’ relatives constantly informed the police of her father’s whereabouts, they failed to arrest him.

5.7.2. Shelter homes
The experience of Dilaasa counsellors indicates that most women do not want to leave their homes despite escalating violence. Even in instances where violence has escalated, they may decide to stay in the same home or seek out an informal shelter. However, in a few cases where women want a shelter home, the counsellors facilitate it.

Counsellors shared they have visited some shelter homes to meet their officials and know about their rules and regulations, conditions of the room, intake capacity, food facilities. They also check if the shelter homes provide any training to the women like tailoring, beauty parlour etc. Once they establish rapport with an official of the shelter home they just have to make a phone call while facilitating shelter for a survivor.

Counsellors shared that if required they seek help from CEHAT to arrange for shelter home. They reported that finding a shelter home for pregnant unmarried women, and vulnerable women suffering from diseases like TB, HIV is a challenge. Additionally, if a woman wants to leave the house and keep her children with her, many shelters have rules that children above 10-12 years of age cannot be accommodated with the mother. In some shelters only women are accommodated, children of any age are not allowed. These rules of shelter homes discourage women to opt for such set ups where children are sent to a different shelter.
A counsellor narrates her experience where the women was doubted by her husband and physically abused by everyone in the household. Her father-in-law approached her with bad intentions when alone at home. Despite multiple NC no action was taken by police. She did not want to return back home hence left her marital home and stayed with her friend temporarily and requested counsellor to arrange shelter for her. Counsellor contacted the women after 2 days when shelter was arranged, but she refused to avail it due employment constrains with shelter admission. According to counsellors, refusal to avail shelter is common due to its stipulated regulations on inmates.

The common reasons for women to refuse shelter admission are enlisted in figure 14.

**Figure 14: Common reasons for women refusing shelter**

<table>
<thead>
<tr>
<th>WOMEN DO NOT WANT TO AVAIL OF SHELTER FOR FOLLOWING REASONS</th>
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<tr>
<td>• Denying admission for her children in the shelter</td>
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<tr>
<td>• Norms of shelters -strict rules and regulations</td>
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<tr>
<td>• Fear due to financial instability and reluctance to disturb their family dynamics especially in case of children.</td>
</tr>
<tr>
<td>• Preference for employment with accommodation arrangement</td>
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<tr>
<td>• Fear of locating shelter by abuser and creating a ruckus</td>
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<tr>
<td>• Refusal to admit vulnerable survivors like pregnant women and children with HIV</td>
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### 5.7.3. Child Welfare Committee

Child Welfare Committee (CWC)\(^{10}\) is approached by the hospital through police for survivors under 18 years of age with advanced preganancy (above 20 weeks) for Medical Termination of Pregnancy (MTP), or minor girls delivering baby wants to hand over the new born for adoption. The Protection of Children from Sexual offenses Act, 2012 mandates production of minor survivor by police in front of CWC. Counsellors at times has to do follow up with police when they fail to produce survivors to CWC. In some cases, counsellors had accompanied survivors to CWC due to absence of police.

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\(^{10}\) Child Welfare committee established under the Juvenile Justice Act, 2000 is responsible for the care, protection, treatment, development and rehabilitation of children in need of care & protection. They make proisions for basic needs of the child and protect their human right.
A counsellor from large sized hospital B, shared an experience of building rapport with the CWC where a minor survivor wished to hand over her newborn baby to her relative.

“The three-member judge explained to us very well that this is not Dilaasa work and it is the duty of police to bring the client to CWC. We had a very good conversation with CWC members. They shared their contact number with us which they usually don’t do - they even take our numbers. Now if we have to refer a case to CWC, they remember that it is from counsellor of X hospital. So this is how we have built our rapport.”

A counsellor from a large-sized hospital felt CWC may not always entertain Dilaasa counsellor without the presence of police:

“They (CWC) do help us, but then they have this notion, that this case is of such and such police station, so the case should come from there, this should be done, that way... It is just that the police must come and take them (survivor).”

5.7.4. Protection Officer

Counsellors have to contact Protection Officers (PO) appointed for implementation of PWDVA by the Women and Child Department. They usually contact the Protection Officers and share with them the details of the survivor before making a referral. They also inform survivors to call Protection Officers regularly to know the status of the case.

Majority of counsellors narrated that POs connect with Dilaasa and encourage them to refer women who want to avail of PWDVA provisions. They have also received help from POs in replacing lawyers if women do not get the required support from the appointed one. A major challenge with PO is corruption and misleading women which was mentioned by counsellors from four Dilaasa centres. The centre from hospital E, came out with innovative strategies to deal challenges with PO.

Dealing with corruption of Protection Officers
Protection Officers ask for bribes from survivors visiting them to file a Domestic Violence case. The PO demands money from the survivor on the pretext of carrying out paper work for the case. In one case the PO informed the women that her documents with her maiden name and natal family’s address needs to be changed to prove she is married. The PO assured her to do the needful is she pays him. According to the counsellors, PO demands bribe of around Rs 500 to Rs 5000. The counsellor reinstated few measures to avoid corruption which was shared with Dilaasa members of all the hospital in monthly case presentation:

i. accompanying the survivor for meeting with PO,

ii. ensuring all documents of the survivors were in place before meeting PO,

iii. informing the survivor in advance that PO’s service is free of cost,

iv. requesting survivor to call the counsellor on demand of bribe

In another instant the women visiting PO were advised not to visit or call Dilaasa by PO since the case is with PO. This practice by the PO came to the notice of counsellor when counsellor met a survivor during her OPD visit in the hospital. In order to overcome this practice the counsellor devised other strategies like:

i. Informing survivors in advance to return to Dilaasa after meeting with PO

ii. Sending a letter to PO requesting appointment for meeting with survivor and ensuring the acknowledged copy of the letter is brought back to Dilaasa by the survivor

iii. Reporting to Women and Child Development (WCD) department regarding malpractices

iv. Building rapport with the PO
CHAPTER 6

SURVIVORS’ PERSPECTIVE- BENEFICIARY EXPERIENCE AT DILAASA

This chapter provides an insight into the users of the Dilaasa crisis intervention departments and their perspectives on Dilaasa. It provides a glimpse of who is accessing these services through the analysis of the profile of survivors registered in the year 2018-2019. The team also interviewed some survivors to understand their experiences with the Dilaasa services and those are presented here as case studies.


The data from all hospitals for the year 2018-2019 have been analysed. This year was selected as the setting up of Dilaasa departments took variable time and this year was considered as the time when all departments were fully functional.

As reported earlier, the documentation and maintenance of records is uneven and has been a challenge and so only the data that were reliable have been included. The actual number of survivors registered are much higher but data on basic variables were not available. But these do present a picture of how the departments are responding to and preventing violence (refer table 18). A total of 3317 survivors received care and support from Dilaasa during the year. Of these, 74% were survivors of domestic violence and 26% were survivors of sexual violence. Of the 11 hospitals, only 7 respond to survivors of sexual violence.
Table 17: Forms of violence reported to Dilaasa centre since 2018-2020

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<thead>
<tr>
<th>Forms of violence</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>DV</td>
<td>2464</td>
<td>74.3</td>
</tr>
<tr>
<td>SV</td>
<td>853</td>
<td>25.7</td>
</tr>
<tr>
<td>Total</td>
<td>3317</td>
<td>100.0</td>
</tr>
</tbody>
</table>

6.1.1. Survivors of Domestic violence

Across the 11 hospitals, 2464 survivors of DV received psycho-social, medical and legal support. As seen in Table 19 hospital A registered the highest number in a year, followed by hospital E and J, and then K and G. Over the years, the evidence from the Dilaasa pilot model is that a number between 250 to 350 new cases in a peripheral hospital that has a Casualty and major clinical departments which is equivalent to a district hospital, indicates that there is active identification of survivors in the facility. Taking this into account, of the seven such hospitals, two have low numbers. There are issues in both the hospitals and that is reflected in the numbers reaching the department.

But the other five hospitals (D, E, F, I & J) have lower bed strength, clinical departments are variable with not all providing gynaecological care, some don’t even have a casualty/emergency department. While three of these have an average of 128 per year, two hospitals E and J registered 350-375 survivors. The active identification in these two hospitals is noteworthy.

Table 18: Hospitals wise DV cases reported

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>468</td>
<td>19.0</td>
</tr>
<tr>
<td>B</td>
<td>53</td>
<td>2.2</td>
</tr>
<tr>
<td>C</td>
<td>235</td>
<td>9.5</td>
</tr>
<tr>
<td>D</td>
<td>133</td>
<td>5.4</td>
</tr>
<tr>
<td>E</td>
<td>375</td>
<td>15.2</td>
</tr>
</tbody>
</table>


<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>125</td>
<td>5.1</td>
</tr>
<tr>
<td>G</td>
<td>245</td>
<td>9.9</td>
</tr>
<tr>
<td>H</td>
<td>57</td>
<td>2.3</td>
</tr>
<tr>
<td>I</td>
<td>127</td>
<td>5.2</td>
</tr>
<tr>
<td>J</td>
<td>349</td>
<td>14.2</td>
</tr>
<tr>
<td>K</td>
<td>297</td>
<td>12.1</td>
</tr>
<tr>
<td>Total</td>
<td>2464</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Profile of survivors:

Survivors reaching the Dilaasa departments are mostly young married women. Seventy six percent of survivors were less than 35 years. This is the child bearing age group who have an inevitable contact with health facilities for sexual and reproductive health. In the absence of Dilaasa they would have received only medical care but active identification and sensitisation of hospital staff enabled them to speak out about violence and seek Dilaasa services.

Age

Women aged between 36 to 50 years also sought support which was seventeen per cent. Four per cent survivors were less than 18 years of age and three percent were above 50 years. Women across all age groups are able to reach Dilaasa for support and care to stop domestic violence in their lives.

Marital status

Survivors experiencing DV were predominantly married at some point in their lives. Of these, 89 per cent were currently married and living in the relationship, four per cent were separated/widowed/divorced/deserted. Seven per cent survivors were single women who were experiencing violence from their natal/parental families, which is a significant number.

Education and Employment
Education and employment are considered to be protective factors against experiencing domestic violence. While 11 percent of survivors were illiterate (never been to school), 44% of the survivors had completed primary education, 34% had completed secondary education, 11 percent were graduate/PG or had completed vocational course.

In terms of employment, large majority (60%) were home makers. Amongst those who were engaged in some paid work (40%), 15% were domestic workers, 9% were in formal sector, 11 per cent in the informal sector and 5 were self employed.

*Relationship with survivor*

The relationship with the abuser is important to understand as it provides insight into nature of support required and strategies for stopping abuse and keeping her safe. 60% survivors reported violence from their husbands, and 21 per cent reported violence from husband and marital family. Violence from marital family was 9.5 and that from natal family 7 per cent. One percent of women reported abuse from their children- this could be more as some teams have categorised violence from children under violence from marital family. This is of significance as the NFHS data focus on Intimate partner violence, but women experience violence from other members of the family also.

*Years of Abuse*

Domestic violence occurs in a continuum and never a single incident/episode. It is therefore accepted that identifying abuse early is critical as violence only increases over time. The cycle of violence has illustrated by CEHAT and MASUM for the Indian context highlight the need to break this cycle as early as possible to prevent harm, injuries, self harm and/or death. 39 per cent women reported within 2 years of abuse, 24% within 3 to 5 years. The fact that over 60 per cent women reached within 5 years of abuse is critical as it has potential for intervention to stop violence and mitigate consequences. Survivors have also reached Dilaasa after more than 6 years of abuse.

*Forms of violence and health consequences*
Survivors reported various forms of violence. Physical and emotional forms of violence were the highest, followed by financial and sexual. Most of them reported at least 2 or 3 forms of violence. 65 per cent survivors reported that violence had affected their physical health and 62% said that it has also affected their psychological health. This is significant as Dilaasa is equipped to provide medical and psychological support.

Pathway to Dilaasa

An overwhelming number of survivors reached Dilaasa through the health system. They had reached the hospital for medical care at the Casualty, OPD or admitted in IPD, and they were identified by the hospital staff as part of clinical care or through ward rounds by Dilaasa team. The ward rounds are an important strategy and the Dilaasa teams have their unique ways of doing this. From talking about Dilaasa in various wards to speaking to women based on associated signs and symptoms of DV, they have found ways to identify survivors of violence. This is over and above the obvious cases of assaults, repeated abortions, poisoning that may be referred to the department.

Table 19: Profile of users of Dilaasa services for the year 2018-2019

<table>
<thead>
<tr>
<th>Profile</th>
<th>Number</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-12</td>
<td>4</td>
<td>.2</td>
</tr>
<tr>
<td>13-17</td>
<td>92</td>
<td>3.7</td>
</tr>
<tr>
<td>18 to 25</td>
<td>791</td>
<td>32.1</td>
</tr>
<tr>
<td>26-35</td>
<td>1088</td>
<td>44.2</td>
</tr>
<tr>
<td>35-50</td>
<td>418</td>
<td>17.0</td>
</tr>
<tr>
<td>51 &amp; above</td>
<td>71</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>2195</td>
<td>89.1</td>
</tr>
<tr>
<td>Single</td>
<td>166</td>
<td>6.7</td>
</tr>
<tr>
<td>Widowed</td>
<td>55</td>
<td>2.2</td>
</tr>
<tr>
<td>Separated</td>
<td>28</td>
<td>1.1</td>
</tr>
<tr>
<td>Divorced</td>
<td>15</td>
<td>.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td><strong>Deserted</strong></td>
<td>5</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>269</td>
<td>10.9</td>
</tr>
<tr>
<td>Primary</td>
<td>1080</td>
<td>43.8</td>
</tr>
<tr>
<td>Secondary</td>
<td>847</td>
<td>34.4</td>
</tr>
<tr>
<td>Graduate</td>
<td>217</td>
<td>8.8</td>
</tr>
<tr>
<td>Post- Graduate</td>
<td>49</td>
<td>2.0</td>
</tr>
<tr>
<td>Vocational course</td>
<td>2</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Employed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home maker</td>
<td>1481</td>
<td>60.1</td>
</tr>
<tr>
<td>Informal sector</td>
<td>103+177</td>
<td>4.2+7.2</td>
</tr>
<tr>
<td>Formal sector</td>
<td>216</td>
<td>8.8</td>
</tr>
<tr>
<td>Self- employed</td>
<td>119</td>
<td>4.8</td>
</tr>
<tr>
<td>Domestic worker</td>
<td>368</td>
<td>14.9</td>
</tr>
<tr>
<td>Others</td>
<td>177</td>
<td>7.2</td>
</tr>
<tr>
<td><strong>Years of abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One time incident</td>
<td>2</td>
<td>0.1</td>
</tr>
<tr>
<td>Less than 1</td>
<td>10</td>
<td>0.4</td>
</tr>
<tr>
<td>1 to 2</td>
<td>946</td>
<td>38.4</td>
</tr>
<tr>
<td>3 to 5</td>
<td>586</td>
<td>23.8</td>
</tr>
<tr>
<td>6 to 9</td>
<td>439</td>
<td>17.8</td>
</tr>
<tr>
<td>10 &amp; above</td>
<td>481</td>
<td>19.5</td>
</tr>
<tr>
<td><strong>Relationship with abuser</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>1475</td>
<td>59.9</td>
</tr>
<tr>
<td>Marital and extended family</td>
<td>290</td>
<td>11.8</td>
</tr>
<tr>
<td>Husband and marital family</td>
<td>509</td>
<td>20.7</td>
</tr>
<tr>
<td>Natal family</td>
<td>161</td>
<td>6.5</td>
</tr>
<tr>
<td>Children</td>
<td>29</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Forms of violence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical violence</td>
<td>1833</td>
<td>74.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>Emotional violence</td>
<td>1530</td>
<td>62.1</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>952</td>
<td>38.6</td>
</tr>
<tr>
<td>Financial violence</td>
<td>1406</td>
<td>57.1</td>
</tr>
<tr>
<td><strong>Health consequences</strong></td>
<td></td>
<td></td>
</tr>
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<td>Physical health consequences</td>
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<td>64.9</td>
</tr>
<tr>
<td>Psychological consequences</td>
<td>1530</td>
<td>62.1</td>
</tr>
<tr>
<td><strong>Pathway to Dilaasa</strong></td>
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<td></td>
</tr>
<tr>
<td>Health system</td>
<td>2407</td>
<td>97.6</td>
</tr>
<tr>
<td>Other hospitals</td>
<td>32</td>
<td>1.2</td>
</tr>
<tr>
<td>Others</td>
<td>7</td>
<td>0.2</td>
</tr>
<tr>
<td>Ex-client</td>
<td>18</td>
<td>0.7</td>
</tr>
</tbody>
</table>

### 6.1.2. Survivors reporting sexual violence.

In the year 2018-2019, the number of survivors who reported sexual violence were 863 (refer table 21). These were mostly reported at hospital A (58%), B (22%) and G (12%) The other hospitals received about 2 cases of SV per month. One in two survivors were less than 18 years of age where the case is registered under POCSO. In all such cases the procedure requires coordination with the CWC, police and child institutions.

88% of survivors were single (never married), which points to a large number of cases of elopement or false promise to marry.

**Relationship with abuser**

The abuser was a known person as reported by 34% of survivors. Only 7% reported that they had been raped by an unknown person/stranger. 59 % of survivors reported that the abuser was a boyfriend. This includes cases of elopement where the parents had filed a case of kidnapping and rape against the boyfriend as well as survivors who had filed case of rape as the boyfriend was refusing to marry them after sexual contact.
Years of abuse

While most had reported after a single incident (55%), there were many survivors who had been abused for a longer period, from 1-2 years to even more than 5 years before they reported it to anyone.

Table 20: Profile of Sexual Violence (Rape) survivors at Dilaasa for the year 2018-2019

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-12</td>
<td>99</td>
<td>11.6</td>
</tr>
<tr>
<td>13-17</td>
<td>368</td>
<td>43.1</td>
</tr>
<tr>
<td>18-25</td>
<td>238</td>
<td>27.9</td>
</tr>
<tr>
<td>26-35</td>
<td>110</td>
<td>12.9</td>
</tr>
<tr>
<td>36-50</td>
<td>31</td>
<td>3.6</td>
</tr>
<tr>
<td>51 &amp; above</td>
<td>7</td>
<td>.8</td>
</tr>
<tr>
<td>Total</td>
<td>853</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deserted</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Divorced</td>
<td>18</td>
<td>2.1</td>
</tr>
<tr>
<td>Live-in relationship</td>
<td>3</td>
<td>.4</td>
</tr>
<tr>
<td>Married</td>
<td>46</td>
<td>5.4</td>
</tr>
<tr>
<td>Separated</td>
<td>19</td>
<td>2.2</td>
</tr>
<tr>
<td>Single</td>
<td>750</td>
<td>87.9</td>
</tr>
<tr>
<td>Widow</td>
<td>16</td>
<td>1.9</td>
</tr>
<tr>
<td>Total</td>
<td>853</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship with Abuser</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquaintance</td>
<td>184</td>
<td>21.6</td>
</tr>
<tr>
<td>Boyfriend</td>
<td>500</td>
<td>58.6</td>
</tr>
<tr>
<td>Marital family</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Natal family</td>
<td>41</td>
<td>4.8</td>
</tr>
<tr>
<td>Neighbour</td>
<td>68</td>
<td>8.0</td>
</tr>
<tr>
<td>Years of abuse</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>1- 2 years</td>
<td>283</td>
<td>33.2</td>
</tr>
<tr>
<td>3- 5 years</td>
<td>81</td>
<td>9.5</td>
</tr>
<tr>
<td>6- 9 years</td>
<td>4</td>
<td>.5</td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>14</td>
<td>1.6</td>
</tr>
<tr>
<td>One time incident</td>
<td>13</td>
<td>1.5</td>
</tr>
<tr>
<td>One time incident</td>
<td>458</td>
<td>53.7</td>
</tr>
<tr>
<td>Total</td>
<td>853</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pathway to Dilaasa</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health System</td>
<td>817</td>
<td>95.9</td>
</tr>
<tr>
<td>IEC</td>
<td>33</td>
<td>3.9</td>
</tr>
<tr>
<td>Other Hospital</td>
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<td>0.1</td>
</tr>
<tr>
<td>Other Organisation</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Police</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Total</td>
<td>853</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 21 : Hospital wise sexual violence cases

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>491</td>
<td>57.6</td>
</tr>
<tr>
<td>B</td>
<td>190</td>
<td>22.3</td>
</tr>
<tr>
<td>C</td>
<td>25</td>
<td>2.9</td>
</tr>
<tr>
<td>G</td>
<td>103</td>
<td>12.1</td>
</tr>
<tr>
<td>H</td>
<td>3</td>
<td>.4</td>
</tr>
<tr>
<td>I</td>
<td>16</td>
<td>1.9</td>
</tr>
<tr>
<td>K</td>
<td>25</td>
<td>2.9</td>
</tr>
<tr>
<td>Total</td>
<td>853</td>
<td>100.0</td>
</tr>
</tbody>
</table>
6.2. CASE STUDIES

The research team was able to establish contact with nine survivors across the 11 hospitals. Of these, six survivors agreed to participate in the study. Their experiences are presented as case studies in this section. Each case study captures violence faced by the survivor, her experience at Dilaasa, counsellors response to her needs, and her perspective on Dilaasa as a department. The case studies include women facing physical-emotional-sexual-financial violence from husband, boyfriend, in-laws, and also from the adult child of a survivor. These include women having chronic disease being subjected to violence, a woman facing sexual violence from her husband, and a case of a false promise of marriage. Women mentioned in the case studies were referred by doctors of casualty department, counsellor assisting HIV patients in hospital, ex client, and one case was self reported.

Case 1

Rani
Age: 29 years
Education: 5th std
Abuser: Boyfriend and his parents
Year of referral: 2021
Type of violence: False promise of marriage, sexual and emotional violence.
Referral pathway: Examining doctor

Rani lived with her parents, two brothers and one sister. She was married (child marriage) at the age of 14 years. She faced physical violence from her partner and so came back to her maternal home forever. In due course both her parents passed away due to illness and her siblings got married. She had no means to support herself and so took up a job as a domestic maid. She now lives along with other maids as paying guests.
As life moved on Rani was in a relationship with a boy whom she had met at a family function. The boy promised to marry Rani in near future. He would insist on having sexual relations to which Rani agreed as they were planning to get married. When Rani discovered that she was pregnant the boy asked her to abort the child. As they had not tied a knot, she agreed to do so. Later, she was pregnant for the second time and the boy again insisted that she abort the child. Rani did not agree to the abortion and reached out to boy’s family to arrange their marriage. The boy’s family did not give approval to their 4 years of relationship.

Rani then decided to lodge a police complaint. Boy’s family attempted to influence police to not consider her complaint but that did not work out and a case under section 376IPC of rape was filed. Rani was brought to hospital for medical examination by police. Examining doctor after knowing her history referred her to Dilaasa for support.

Counsellor provided emotional support to Rani. At that moment she was in a dilemma whether to proceed with the abortion or not. Also, one of Rani’s relative was ready to adopt the child. Counsellor provided legal guidance on laws related to adoption, medical termination of pregnancy (MTP), domestic violence act. Rani decided to go ahead with MTP but wanted to continue with legal complaint filed against her boyfriend. Boy’s family made attempts to influence Rani to withdraw her complaint by offering financial assistance for her medical needs but she did not agree.

For MTP, police told Rani that in cases of rape MTP cannot be carried out. Counsellor corrected the police by explaining legal provisions that allow Rani to choose a MTP. At the hospital, HCPs were not providing support to Rani for conducting MTP and they instilled fear about medical complications in her case. HCPs advised her to give child for adoption and would encourage her to not proceed with abortion. But with the help of counsellor Rani was admitted in hospital for carrying out MTP. But providers would pass inappropriate comments towards Rani because she was unmarried and pregnant, the child would never have a father’s name. HCPs questioned Rani’s sexual relation with her boyfriend for such a long period without marriage. They would insist that Rani should convince her boyfriend for marriage. Rani’s rights to privacy, confidentiality, and treatment with dignity were not respected by the hospital staff.
Rani was not provided post abortion treatment for 3 days. After counsellor’s intervention the required treatment was carried out. Hospital demanded relative’s signature for Rani’s discharge and would not provide her with medical documents for legal case. Rani lost her cool with the HCPs due to lack of support. Counsellor raised these concerns with senior HCPs and Rani’s needs were meet.

On legal front, boy’s family misguided Rani by asking her to sign a legal bond to solve the matter. Rani was told that the bond states that the boy apologises for his mistakes and is ready to provide monetary compensation. But the counsellor read the bond which mentioned that Rani is mentally disturbed, she trapped the boy in the case, and is solely responsible for it. After hearing all this, Rani did not sign the legal bond. She was also prepared by counsellor on how to give statements in court of law.

Counsellor would frequently reach out to Rani and her roommate to enquire about her well being and safety. She was assisted in finding an alternate shelter by the counsellor when her owner evicted her after knowing her case. Rani sees counsellor as an elder sister who looks after her in absence of her parents.

As per court’s interim order, abuser spent 1.5 months in under-trial prison and is released on bail. Final judgment is awaited. Rani spoke at length about how the counsellor intervened at every stage and questioned the police, hospital staff and the abuser and his family. She was in a vulnerable state due to her pregnancy and had to face hostility from all quarters. The counsellor was her only steady support who navigated all systems to ensure she received medical, social, emotional and legal support.

Case 2

Rena

Age: 30 years
Education: Dentist
Years of marriage: 7 years
Number of children: 1 boy 4 years old
Abuser: Husband and marital family
Year of referral: 2021
Type of violence: Emotional, financial, domestic violence
Referral pathway: Ex client

Rena was a minor when her mother was divorced. She was brought up by her maternal family. Her elder uncle took responsibility of Rena and supported her education. While studying in college Rena was in a relationship with a boy. The boy was not from the city and so Rena’s family was hesitant to give approval for the marriage. However, the boy’s family portrayed that they had a high socio economic status and the boy ran a business of his own. This convinced family members that Rena would have a secure future.

Things changed drastically after marriage with husband showing disinterest in sexual relations and spending nights out with his friends. The husband was not involved in running any business and would ask Rena to pay bills during outings. Rena was not allowed to work and was only occupied in doing household chores. Rena’s family also had to bear all medical expenses for her pregnancy. Rena had to take care of her child along with domestic work without anyone’s support. Rena shared her concerns with her uncle and the two families met for a discussion. During a heated argument Rena’s uncle was physically attacked and Rena decided to leave her in laws place with her child. Rena was referred to Dilaasa by an ex client. During initial counselling sessions Rena would find it difficult to express her concerns as she was affected by all that was happening to her. Counsellor helped Rena in dealing with feelings of guilt and failure of not sustaining her marriage. Counsellor helped her to narrate her experience of violence without any fear. Rena wanted her child’s custody and the counsellor explained laws that would assist, this. Husband made lot of efforts to persuade Rena to give a chance to their relationship. Over a period of time Rena gained confidence and was able to communicate to her husband about her concerns and expectations in a relationship. Rena’s elder uncle who was also affected by all this was regularly counseled by the counsellor.

Counsellor conducted multiple sessions with Rena and her uncle. Initially they were scared to face the situation as they would get threatening messages from husband and in laws. Rena and her uncle would visit Dilaasa almost every second day for emotional support and guidance to face the situations. Rena and uncle would consult counsellor on phone when they found it difficult to
answer husband and in laws. They would feel relieved after having conversation with the counsellor. Over a period of time they became confident in handling threatening messages from Rena’s marital family. Counsellor guided them to file police complaint as part of safety plan. Rena and their family members were advised to check child’s safety first in case of threats and to intimate neighbours.

Counsellor prepared Rena to present her case in front of Protection Officer (PO) and legal aid lawyer. Counsellor facilitated meetings with PO and the lawyer which was challenging in times of pandemic. Rena was helped in drafting application and getting required documents. Counsellor discussed with lawyer about filling complaint under laws (Domestic Violence Act or under section 125IPC) that would benefit Rena. She got her first date in court. She expects to get all her valuables and belongings from husband but is aware that court processes take time.

Rena and her uncle consider the counsellor to be a family member who is always available for any queries. They say that it would have been impossible to address their problems without the counsellor as it was first time in their family had come across such challenges. Rena says, “Counsellor understood my case better than me.” From listening to her experience, helping her to understand what was happening, supporting her to take an informed decision and helping her regain her confidence and power in herself. She is now focusing on well-being of her child and her professional career. Her uncle is active in referring cases to Dilaasa.

Case 3

Asha
Age: 40 years
Education: Nil
Years of marriage: 17 years
Number of children: 3 (2 daughter aged 20 and 16 years, 1 boy 14 years old)
Abuser; Husband and marital family
Type of violence: Domestic and Sexual violence
Year of referral: 2021
Referral pathway: Self reported
In 17 years of married life Asha faced domestic violence from her husband and marital family. In one such incident of violence she had attempted suicide by consuming 40 sleeping pills. In fear of a police complaint, husband admitted Asha in a private hospital. Not listening to doctor’s advice, husband took early discharge from the hospital. Not caring about Asha’s health after discharge, husband attempted to have forced sexual relations. Witnessing the act, Asha’s elder daughter questioned her father but she was verbally abused by him.

Asha inquired about Dilaasa services when she had come to hospital for general check-up. Counsellor assured confidentiality and she felt comfortable sharing about violence inflicted by husband and in laws. She was advised to take some steps to check violence and to not tolerate it. She was suggested to use contraceptive methods to prevent unwanted pregnancies, and was referred to doctor for low hemoglobin count and excessive bleeding. For her safety counsellor told Asha to call police or Dilaasa for any need. In escalation of violence, she was oriented to immediately leave home with her children and was taught to use basic defence technique to protect herself. Counsellor would regularly interact with Asha’s brother who was supportive towards her well being.

After another incident of domestic violence, Asha decided to endtake her life by sleeping on a railway track. While Asha was going towards railway track, she passed by the hospital where Dilaasa was located. It was non-working hours of Dilaasa but she decided to spend some time in the waiting room. After gathering her thoughts and remembering advice by counsellor which was to live for her children, she calmly went home.

Counsellor assisted Asha in lodging a police complaint, carried out joint meeting that helped in curbing violence for a brief period. Asha was told about legal remedies available under Domestic Violence Act, and was provided a private lawyer free of cost as requested by counsellor. After facing repeated violence from her husband and in laws, Asha decided to live separately with her children. With support from counsellor, and her brother she managed to get a room to reside.

Asha says that ‘she falls short of words to express gratitude towards counsellors support in providing guidance, accompany her to meet lawyer at a time when she was short of confidence to move around the city.’ With motivation from counsellor Asha has initiated a lunch box service. Today, along with her elder daughter who has a job she feels more confident to manage her well-
being and support her children’s education. Asha now regularly refers other women in distress to Dilaasa.

CASE 4

Geeta
Age: 36 years old
Education: Post Graduate
Years of marriage: 13 years
Number of children: 2 (daughter 12 and 11 years old)
Abuser: Husband
Type of violence: Domestic and sexual violence
Year of referral: 2021
Referral pathway: Referred from casualty

Geeta has been married for 13 years. Her husband owns a shop and earns around Rs. 1 Lakh per month. She is a post graduate and worked as a teacher with earnings of around Rs 15000 per month but her husband did not like Geeta being financially independent. Her husband refuses to give money for household expenditures but having a job helped her manage expenses. Geeta has faced physical, sexual, emotional, and financial violence from her husband throughout her marriage life.

Geeta’s husband would express his dislike towards her and would suspect her of having an extra marital affair. He would threaten to disfigure her face by throwing acid. He would not allow her to socialise with any individual outside of their family. Geeta has been subjected to physical violence which included kicking on abdomen, hitting with objects, pushing, and pinching. Husband would force Geeta to have sexual relations. Facing violence for a long period impacted her health. She developed Polycystic Ovarian Disease (PCOD) as one of the health consequences of violence. She had to borrow money from her brother for treatment as husband would not provide any kind of support.
During Covid pandemic, Geeta lost her job and found it difficult to manage household expenses. Severity of violence against her increased to an extent that she had thoughts of committing suicide. She no longer wished to continue staying with her husband. A friend informed Geeta about domestic violence act and how she can make use of it to stop violence. But Geeta found no support from her maternal family and was told to tolerate violence to save marriage. She could not gather courage to take action as her husband was influential and rich.

In one instance of domestic violence Geeta was hit on her eye due to which she suffered a lot of pain. This time she informed her friend about the incident, who helped her reach out to a lawyer. The lawyer advised her to first visit a municipal hospital to get required medical treatment. The doctor in casualty gave needed treatment and inquired about the incident. Knowing about violence Geeta faced, doctor with her consent carried out medico legal examination. She was oriented about services of Dilaasa and was referred to counsellor.

At Dilaasa, Geeta was given emotional support, the counsellor discussed with her that she should not blame herself for violence and helped her build confidence. Since the immediate concern of Geeta was that she did not want to go back home she was informed about shelter home services. But learning that shelter homes only allow women to reside and not their children she decided to stay back at her marital home. Counsellor discussed safety plans with Geeta about calling police and neighbours for help. Geeta’s children were also prepared to reach out to police during episodes of violence. Counsellor informed Geeta about her legal rights under domestic violence act. She was told to keep her valuables and documents at a safe place. She was encouraged to become financially independent.

For her safety with help of counsellor Geeta decided to lodge a non cognizable (NC) police complaint. Though police did not respond to her complaint, husband was taken aback after knowing about it. Currently, Geeta stays at her marital place with no incident of violence for a year after lodging a police complaint. She has started working and is satisfied with her professional growth. She feels supported by Dilaasa and feels free to approach counsellor at any time in need.

CASE 5
Nilima

Age: 55 years old
Education: 11th standard
Number of children: 3 sons (35 years, 34 years and 32 years)
Abuser: Second son and his wife
Type of violence: Domestic Violence
Year of referral: 2017
Referral pathway: Referred from ART centre

Nilima is a HIV positive patient and has 3 sons. Her husband passed away 7-8 years ago, he was HIV positive which was known to family after he passed away. After his death family members were tested for HIV infection and Nilima turned out to be positive. She used to run a job placement agency before her husband’s death. After his death family’s financial condition deteriorated. But they managed with her son’s salary which was minimal. Nilima received ART treatment from government hospital.

Her two younger sons are married however her youngest son got separated from his wife. She stayed with her elder son, her second son and his wife and their child (grandson). Her daughter in law used to be verbally abusive towards her and fought with her constantly due to her HIV status despite being aware about it before marriage. She would not allow Nilima to touch her son and would insult her in front of other people. Nilima was disturbed after facing abuse not only from daughter in law but also the daughter-in-law’s mother. The son did not intervene and allowed the abuse to continue. Their current residence is registered in the name of Nilima’s mother. But the second son wants the house to be registered in his name so they often fought with her. Nilima faced health concerns and was hospitalised multiple times with low CD4 count and other opportunistic infections.

Nilima was distressed due to emotional abuse and left home with the intent to commit suicide. But her elder son located Nilima and brought her back home. Counsellor at ART centre frequently counselled Nilima as she was disturbed and worried about her HIV status. Counsellor also found
out that she was missing her medications and on enquiring learned about her history of violence and referred her to Dilaasa.

At Dilaasa, the counsellor offered emotional support as she was upset due to her HIV status and violence. The counsellor had multiple sessions and provided her much needed support. Counsellors oriented Nilima about her legal rights regarding property and suggested her to visit Protection Officer to avail remedies under Domestic Violence Act, 2005 She was advised to file non cognizable police complaint for her safety which she did after initial hesitations. The police provided assistance in filling complaint and warned her son and daughter in law.

Dilaasa simultaneously referred Nilima to another organisation that supported survivors of VAW located near her residence this helped her to get prompt support when needed. Dilaasa counsellor offered an option of having a joint meeting with abusers. She was keen on having a joint meeting and requested her son and daughter in law but they refused.

During this period her elder son’s marriage was fixed. But his fiancee refused to take care of his mother after knowing Nilima was on ART. Her elder son called off the wedding since he wanted to take care of his mother. The elder son then met with an accident and the entire expense for treatment was met by Nilima by selling her jewellery. The eldest son was working but had loans to repay and due to accident he had lost his job. Their financial condition became extremely poor after elder son’s accident that she had to eat food served outside temple.

Nilima was tensed about their financial condition and had stopped taking her medicines. Dilaasa counsellor supported her and connected to various agencies that provided employment. Counsellor networked with agencies that facilitated pension widow scheme to help Nilima fulfil her financial need. Nilima frequently visited Dilaasa since she felt relieved and supported by the counsellor.

After her elder son’s recovery he found a job and their financial condition slowly improved. Her elder son often contacted Dilaasa counsellor when Nilima would not cooperate with HIV treatment. Dilaasa counsellors had a discussion with the elder son and encouraged him to keep Nilima motivated to continue treatment. Nilima was convinced by her elder son and counsellor to
resume her treatment. Also Dilaasa counsellor helped Nilima draft a complaint application under Domestic Violence Act as she had to frequently face violence. Counsellor facilitated appointment with Protection Officer, free legal aid lawyer and a case was filled.

Nilima filed a case to stop violence and wanted abusers (son and daughter in law) to move out of her house. She also wanted transfer of title of the house in her name. The abusers have moved out of the house and are staying in a rented place.

Nilima currently stays with her elder son who looks after her. They together run their job placement agency. She is regularly taking her ART and visits Dilaasa when she comes to hospital for treatment. She is grateful for the emotional support offered by Dilaasa counsellor during her distress times that helped in dealing with her situation and move on with her life.

Nilima is currently happy and in good health. Her placement agency is successful. She is grateful to Dilaasa for their help. The Dilaasa counsellor refers women looking for employment to her placement agency. She found jobs for three women referred by Dilaasa counsellor.

CASE 6

Rinku

Age: 25 years old
Years of marriage: 3 years
Education: Auxiliary nurse midwife
Number of children: None
Abuser: Husband and marital family
Type of violence: Domestic Violence
Year of referral: 2020
Referral pathway: Referred from casualty
Rinku has been married for 3 years. She was born and brought up in a village, and is a health worker by profession. She was working in her village before marriage. She is from a poor household. During her marriage proposal she was told her husband works in Mumbai. She quit her job in the village and shifted to Mumbai after her wedding. After marriage she realised her husband was unemployed and she felt betrayed. But as her husband’s family were wealthy and they could afford to meet their daily needs. Her marital family included her mother and father in law, and also brother in law and his wife. Her husband’s family stayed in a huge three storied house with separate rooms for everyone. Domestic violence started after a few months of marriage.

Rinku suffered from hyperthyroidism, due to which her mother in law was upset. She would blame her for being weak and sick all the time. The marital family refused to pay for her treatment and told her get money from her parents which was not possible as they were poor. Within a few months she conceived and during her pregnancy she faced a lot of domestic violence. Her mother in law emotionally abused her and husband, father in law and brother in law would physically assault Rinku. Her father in law was a drug addict and kicked her on her belly once during her pregnancy. She had a miscarriage and stated that it was due to physical violence from marital family.

After a few months Rinku conceived again and this time also violence continued. She went to her natal home for delivery. She went home just before the COVID lockdown and delivered a baby boy during lockdown period. But the baby developed some heart complications for which her natal family treated him but the child passed away within a month. Rinku believes the child’s health issue was due to the violence inflicted on her during pregnancy. After the delivery and even after the child’s death nobody from the marital family called or paid a visit. They did not even call her to ask for the baby’s well-being after delivery. Her marital family did not bother to bring Rinku back to Mumbai. After six months of Covid lockdown was relaxed, Rinku’s parents brought her back to Mumbai to her marital home.

Rinku’s mother in law was upset that she came back. She decided to shift her to another house. They (in-laws) rented a tiny house far from their home and asked her to shift there along with her husband. In laws bought her few essentials and shifted Rinku.
Rinku’s husband would not stay with her in this rented house. Her husband would visit her only twice or thrice in a week. He would come late night to meet Rinku and leave early morning. Her neighbours would often comment on her husband’s absence. Her in- laws paid her rent and husband would bring groceries and food whenever he visited, as Rinku did not have money to survive. Husband would bring enough small quantities of groceries whenever he visited. Rinku often raised issues with her husband regarding insufficient food and his absence from home. Her husband did not want to have children but Rinku wanted and this led to conflicts between them.

One night they fought over these issues and husband physically assaulted Rinku. She was hit in the eye and it was swollen and red. She went to the police station close to her house. They ignored her complaint and told her to visit a hospital for treatment. She went to the hospital next day morning. In the casualty she was crying in pain so the doctor inquired about assault. She revealed about the assault to the doctor and said that she wanted to file a police complaint. The doctor provided medical treatment, registered a medico legal case (MLC) and referred her to Dilaasa.

At Dilaasa the counsellor explained about its services and discussed safety plans with Rinku. She was told to call 100 or 103 whenever she faced assault. She was also told to file a non cognisable (NC) police complaint at the earliest to check on violence, which she did despite facing non cooperation from police. The importance of legal documents like NC, MLC was explained to her. Rinku was explained about provision of emergency shelter in the hospital, and was advised to reach out to casualty doctor if she faced any violence. In an incident of assault by husband at night, Rinku received emergency shelter in hospital with help of the counsellor.

Counsellor learned about Rinku’s education qualifications and motivated her to take up a job. She found a job at a dispensary near her house and was paid Rs.8000 per month. In laws were upset with Rinku getting a job, and she continued facing violence from them. She would often go to temple to spend some time but her husband would suspect that she has an extra marital affair. Her husband did not trust her despite several clarifications. In-laws stopped paying rent of the home as she had started working, this made it difficult for Rinku to manage her financial requirement.
One day when Rinku was at work, her mother in law was determined to throw her out of the rented house and she locked the house. When Rinku reached home she was surprised and spoke to the landlady but she was not allowed to enter the house. The landlady said that she was tired of all the drama happening in her house. In desperation, Rinku called her husband multiple times but he did not take the call. Finally her mother in law answered the phone, and told her that her father in law was admitted in a hospital due to all the troubles caused by Rinku. Mother in law refused to give address of the hospital and she realised that they were lying about father in law’s illness. She did not know the location of her marital house and so had to spend the night on a pavement without food and water. She called her parents who were in the village and they responded that they would pick her up the next day. She informed Dilaasa counsellor that she is going to her village with her parents. The counsellor suggested that Rinku record a police complaint and state all details of the episode of violence, which she did before leaving for her village.

A few days later Rinku called the Dilaasa counsellor and informed her that she was determined to file for a divorce. The counsellor acknowledged her feelings and decision and oriented her about procedure to file a divorce. Before Rinku could file for a divorce she received a legal divorce notice filed by her husband and was summoned by the court. She was scared after receiving such a notice. The counsellor explained the details of the notice stating that her husband had filed for divorce a month after she left with her parents. Counsellor connected Rinku with a legal expert and started preparing her for court procedure and attendance. The lawyer advised that she should seek compensation for travel from village to the city. Rinku is yet to decide a further course of action but she is firm with the decision to divorce her husband and demand compensation. She feels supported by the Dilaasa counsellor in her troubled time and legal process to be followed in coming months. Currently Rinku has found a job in her village and is supporting her parents financially.

The case studies reveal the severity and episodes of violence faced by survivors leaving them emotionally and financially vulnerable. They describe incidents that led to the survivor taking action against the abuser which includes approaching police, Dilaasa, and hospital. The case studies reveal support provided by Dilaasa in form of emotional support, safety planning, and legal guidance. Lastly, survivors mention the role played by Dilaasa in dealing with violence and
counsellors assistance in helping survivor take hold of their life in not only dealing with abuser but by being financially independent and standing up for their rights. The location of Dilaasa in the hospital makes it accessible to a range of survivors as seen through the case studies.
CHAPTER 7
DISCUSSION

It attempts to lay out the factors including barriers and opportunities that had an impact on strengthening health systems’ response to VAW in upscaling of 11 Dilaasa centres. The chapter also provides recommendations from key informants on how to further harness the building blocks of the health system to improve health systems’ response to VAW.

7.1. BUILDING BLOCK OF HEALTH SYSTEMS RESPONSE TO VAW

7.1.1. Leadership, political will and governance

Leadership, political will and governance is the core component to generate ownership and sustainability of the health system-based interventions. Dilaasa was replicated in one more hospital in 2006 but not in other hospitals in the city. The inclusion in the NHM which was fuelled by a massive campaign in the country and push for VAW services enabled its establishment in the 11 hospitals.

Presence of core group: At the hospital level, the presence of core group that consists of a team of trained senior doctors and nurses facilitates the functioning of Dilaasa. The existence of such a group made all the transitions smoother. The findings from the study show that the presence of an enthusiastic active core group provides visibility to the issue of VAW within the health system.

It was found that most hospitals had one or two HCPs (doctors/nurses) who had already been part of the Training Cell of the MCGM or had been sensitized to VAW through earlier efforts by CEHAT and Dilaasa. They welcomed the idea of setting up a department in their hospital and supporting its setting up. They provided initial support by taking on the responsibility of NO, deputing staff for training, and creating an enabling environment for the Dilaasa team to visit wards and set in a mechanism for identification of cases. Even when some of the key doctors were transferred, the Dilaasa team was able to establish rapport with new staff and also demand accountability.
Many of the NOs were core group members (4) and their role in hospitals A, C, K And F was a great support in integrating the Dilaasa. However, hospital H and J did not have staff that were active core group members and while the NOs here are supportive they have not really been active. The role of Dilaasa team in hospital J has ensured a remarkable performance (discussed later) but that was not the case in J where the team could not establish itself.

Thus, it was found that hospitals where the core group, nodal officer and Dilaasa team were able to work together, the integration of the department has been achieved.

However, frequent transfers of healthcare providers and the workload of NOs are barriers to providing oversight to respond to VAW.

The presence of a standard operating protocol at the level of the health system is an important indicator as well facilitator to generate ownership from the healthcare provider. The SOP provides evidence-based guidance to healthcare administrators for implementing and overcoming challenges for a holistic systems’ response to VAW.

**The Dilaasa team** has played a pivotal role in establishing Dilaasa as a hospital department and for institutionalizing it in the hospital system. They have faced a lot of push back from the system, from being told that they don’t belong here, not being allowed to use common amenities, being asked to do other hospital work. The insensitivity of the staff to patients in general and survivors in particular has been a matter of concern for most of them. They have been supported by CEHAT in raising these issues including violations to the nodal officer or monitoring committee. Navigating the hospital procedures has been challenging for most.

All of them have been able to establish Dilaasa as one of the OPDs and created a niche for work on VAW in the hospital. Except for one, all hospitals have a substantial case load and this is solely the initiative and active role played by the team in identifying cases of violence through ward rounds, speaking about DV in the OPD space, constantly engaging all cadre of hospital staff on the issue and sensitizing them.
Additionally, the upscaling of Dilaasa was facilitated by political will which manifested in the form of allocation of funds for upscaling of Dilaasa, recruitment of dedicated staff for Dilaasa, the deputation of NOs at the level of each hospital and provision of suitable location within the hospital for Dilaasa.

The key informants provided substantial recommendations on how leadership, political will and governance can be strengthened further. There is a need to strengthen the accountability mechanisms at the hospital level for effective institutionalization of VAW services. A protocol to establish linkages with a smaller level of health facilities should be implemented. This will help in establishing a continuum of care for a survivor of violence and will also contribute to early identification and access to support services by survivors of violence. These linkages should be complemented by building the capacity of providers of smaller level health facilities to identify and provide first-line support to survivors of violence. Further, the one-stop crisis centres located within or close to the hospitals can be strengthened to provide VAW services from a public health perspective. The resources of the OSCs can be best utilised by establishing linkages with the health system which offers early identification of violence.

An advisory committee comprising of officials from the governing body was set up but met only once. They can play a significant role in providing oversight, recommendation and serve as the voice for this model to be taken by the other districts in the state as well as other states in the country.

Health policies and action plans nationally and internationally necessitate a comprehensive and sensitive response to VAW within the health system. The next step should be to develop indicators that can become part of the accreditation of hospitals – NABH – so more hospitals-private and public can initiate the setting up of Dilaasa departments.

7.1.2. Human Resource development:

The health systems response to VAW builds on the presence of adequate trained staff to respond sensitively. The findings of the study indicate that the support provided by CEHAT by conducting
training for NOs, core group members, and Dilaasa staff helped in building the capacity of the staff. CEHAT also supported ongoing capacity building of Dilaasa staff by organising refresher training and case presentations. The presence of detailed roles and responsibilities of staff also supports the effective utilisation of human resources.

Ongoing incremental training of Dilaasa staff and regular monthly case presentations have been useful in providing technical inputs. The gap in care for survivors of violence who are LGBTQA+ has been documented. But the Dilaasa teams have been trained and sensitised to the specific needs of this group. It has paved the way for ensuring services for at least some transgender and lesbian survivors.

The core group is an entity that needs to be strengthened for ownership and integration of VAW services. Most hospitals have included a session on Dilaasa in routine orientation to hospital departments for newly recruited HCPs. The routine capacity building activities for HCPs have not been institutionalised as the training on VAW has not been included in the hospital chart and demotivates providers to build their capacity. Victim blaming and lack of sensitivity of HCPs remains a challenge and hence training strategy that ensures regular training of all staff is critical.

The recommendations on human resource development include defining the role of civil society organisations in building the capacity of the health system and quality assessment of response. This is to ensure that the health system takes ownership of VAW as a public health issue and remains accountable. Further, the training on VAW should be regularized with specific content for each cadre of the providers. These training and capacity buildings can be facilitated at the tertiary level of the health systems that are already invested with resources and engaged in training. The inclusion of VAW as a routine must be mandated with policy directives.

The allocation of dedicated staff in the form of Dilaasa team can be based on the size and patient load in the hospital. Further, the presence of both male and female staff as part of Dilaasa team can be effective with more focused training of male staff members. It is important to develop the specific roles and responsibilities of ANMs from the health perspective and this will also enable the increased ownership of the response by the health system.
ANMs interface with HCPs especially in the identification and referral of suspected cases of violence must be strengthened considering ANM a trained resource within the health system. Strengthening this role enables Dilaasa to cater to non-referral by HCPs reaching out to the health systems.

ANM’s role must be carved out to engage with different levels of health systems during scaling up for both rural and urban settings. ANM is an effective resource to interface and build capacities of community health workers, ANM, Anganwadi workers and CHVs (Community Health Volunteers)/ ASHA’s at the grassroot level to address VAW through first-line psychological support and facilitate referral to higher centres. A policy action plan to incentivise ASHA for case identification and referral to higher facilities or OSCs for treatment and psychosocial support to women and children facing violence can be considered to improve the health and well-being of the vulnerable population.

7.1.3. Infrastructure, equipment and commodities

Infrastructure, equipment and commodities constitute hardware of the health system which influences its performance. The presence of a clear SOP before setting up of health systems response facilitates the building of systems’ readiness to respond to VAW. The allocation of a dedicated budget also supports the availability of infrastructure and supplies. One important observation is that medical supplies did not pose a problem as the medical care was integrated as part of routine hospital care. This is a departure from the OSCs elsewhere and a critical component of adaptation to LMIC. Oslen (2019) and Garcia-Moreno (2015) report that most OSCs were constrained due to lack of medical supplies, availability of medical staff as these resources had been pulled out from the hospital departments to the OSCs.

However, factors like ineffective leadership can lead to unproductive utilization of infrastructural resources even if they are available like denial in providing abortion services, dignified examination of rape survivors etc. Thus, capacity building of healthcare administrators on the best use of available resources is an important facilitator in this context.

The recommendations from key informants indicate that any hospital even those of varied sizes and with different in infrastructure can establish Dilaasa by effective utilization of resources. The
location of Dilaasa within the OPD premises along with a separate room to ensure audio and visual privacy is a non-negotiable requirement for effective response to VAW.

7.1.4. Financing

Financing the health system-based interventions is fundamental to ensure sustainability. This is facilitated by dedicated allocation of funds for building readiness of health facility and capacity of providers. Lack of allocation of a specific budget line item for training annually was a major constraint in that becoming part of the hospital calendar.

Lack of information among healthcare administrators about how to access the allocated funds is a barrier in this context as the funds are not included as part of the hospital budget but have to be managed through a separate account. There is a need to consider the inclusion of the funds as part of the hospital budget for smooth utilisation. Lack of clarity in using these funds coupled with the rigmarole of a separate bank account for each hospital contributed to lack of utilisation of funds for the provision of services such as transport, food/tea for survivors. Dilaasa team members have often borne this expense out of pocket despite minimal salaries.

Recruitment of adequate and effective staff also comes under financing. The recruitment policy of the staff including salaries, and nature of employment are important indicators of health system financing. Poor pay of Dilaasa staff along with contractual nature of job without any security and benefits lead to increase attrition and also affects the provision of quality services to survivors. Salary needs to be commensurate with their qualification and workload.

The key informants suggested long term contracts for Dilaasa team and increase in salaries as a recommendation for effective utilization of funds.

7.1.5. Service delivery

Service delivery is an important element of the health systems’ response to VAW. The presence of a tried and tested standard operating protocol for the Dilaasa department facilitates the availability and appropriateness of VAW services. The SOP can guide providers to uphold the rights of survivors in challenging cases that pose ethical dilemmas due to legal obligations for
providers. Unlike other OSCs elsewhere where psychosocial care was not provided in many settings, the trained designated staff at Dilaasa has ensured that psycho social care was provided to all survivors.

Two SOPs – one for the hospital and one for the department were found to be effective in ensuring the quality of care. Hospitals created an effective mechanism for responding to survivors who came to the hospital after Dilaasa was closed\textsuperscript{11}. Dignified medical care was a constraint due to negative attitudes of providers as seen in routine delays in examining rape survivors, continued examination in labour room as opposed to private space, insensitive comment/remarks, turning away of girls and women seeking an abortion, survivors having to pay user fees.

The location of Dilaasa to some extent determines the access to services by survivors. The location creates enhanced accessibility as evident from analysis of MIS of 11 Dilaasa centres. This means that survivors are being actively identified.

The presence of emergency and all clinical departments in hospitals was found to be conducive as it ensured a steady referral to Dilaasa and the department was able to establish itself as one of the OPDs of the hospital. This was found useful in the hospitals A, C, G and K. The rationale for presence of Dilaasa was widely accepted by the hospital staff as cases of assault, consumption of poisoning, rape were clearly recognized as cases of violence that required additional care and support that Dilaasa was expected to provide.

The hospitals that did not have emergency department found it challenging to impress upon the hospital system the role of Dilaasa in the hospital. The Dilaasa team in hospital E was welcomed by the senior doctor who was a core group member but they found it hard to establish themselves. The hospital staff was not able to see role of Dilaasa team and questioned their presence, and ill-

\textsuperscript{11} Dilaasa operates from 9 am to 4pm on weekdays and 9am to 1pm on Saturdays. The department is closed on Sunday.
treated them initially when it came to sharing hospital resources. The team beat this with resilience and established themselves. Their case load is high as their presence in OPD and IPD is strong.

It is important to also mention how mid-size hospital D, where the OPD and IPD are in different locations has been able to strengthen the response to VAW. The NO and the Dilaasa team have been innovative and created a roster for Dilaasa team’s presence at both the facilities. They have formed a message group for coordination and roped in nurses and other staff to actively identify cases of violence.

Those coming directly is an indicator that the community knows about the department and that its services are seen as relevant.

The study also found out that if Dilaasa is not located in OPD due to lack of infrastructure, access to services can still be ensured by more effective referrals from health systems. The readiness of a health facility in form of adequate infrastructure, supplies and commodities to ensure audio and visual privacy affects the service delivery. Capacity building of the providers and Dilaasa team to provide services to vulnerable population also influences the comprehensiveness of available services.

The recommendations based on assessing the upscaling of Dilaasa centres emphasised development of a protocol contextualised at the level of different types of health facilities. This protocol should be developed in a participatory manner involving healthcare administrators to ensure the implementation. The healthcare administrators should be actively involved in sensitization programs on responding to VAW. Protocols should be followed. This is essential to enable the Dilaasa team to provide survivor-centred services as lack of interest in VAW and insensitivity of the hospital staff was reported as a major concern by the counsellors in this study.

Even hospitals without casualty are able to respond to survivors and are demonstrating the role of health system in early detection of violence.

A peculiar experience has been with a hospital that was nationally recognized as one of the best practices for responding to sexual violence. It received media coverage as well as accolades and visits from various quarters including media. The setting up of Dilaasa under NHM in this hospital
was an opportunity for the hospital to improve their response to domestic violence. The hospital already had a core group and a monitoring committee in place. But around the same time, the hospital was upgraded to a medical college. The administration underwent a complete change with this expansion. The Dilaasa team increasingly faced more and more hurdles in engaging the staff on VAW. What was deemed as best practice was questioned by senior medical staff and insensitive and unscientific practices such as comments on the presence/absence of hymen, mindless collection of swabs from the body (not indicated by history) have found their way. There is a constant review of proformas and debate with concerned staff as the administration is not taking a stand on SOP. At the same time, the team is not able to garner support of other departments in identifying cases of violence. As it is a large hospital, the number of rape survivors reporting to the hospital is high leaving very little time for the team to go for ward rounds or any other activities for identification of DV survivors. This has led to a very low referral of cases to Dilaasa. Survivors reporting assault or consumption of poison are not being referred to Dilaasa.

7.1.7. Multi-sectoral coordination

Multisectoral coordination is crucial for a comprehensive response to survivors of violence by ensuring the provision of services that are beyond health systems’ response. The most significant finding is the smooth coordination with other sectors. The fact that Dilaasa was never designed to provide all services in one place has been most useful in ensuring better coordination with other sectors.

It is important to also mention how mid-size hospital D, where the OPD and IPD are in different locations has been able to strengthen the response to VAW. The NO and the Dilaasa team have been innovative and created a roster for Dilaasa team’s presence at both the facilities. They have formed a message group for coordination and roped in nurses and other staff to actively identify cases of violence.

The factors like the establishment of rapport with stakeholders by Dilaasa counsellors, presence of resource directory, the inclusion of stakeholders like police in monitoring committee and proactive stakeholders like police personnel are facilitators for establishing linkages with other stakeholders.
Barriers include lack of sensitization and clarity among stakeholders about their role and frequent transfer of representatives of stakeholders like police personnel. The staffs are cognizant of the limitation of the police, shelters, courts and can prepare survivors to navigate these services.

The recommendations include developing coordination with the smaller facilities (NGOs, maternity homes, community health workers-ASHA workers, self-help groups) linked to the hospital to ensure a referral pathway for survivors and a continuum of care. Establishing linkages and orienting a one-stop crisis centre should also be a part of multi-sectoral coordination. Sensitisation of stakeholders and a clear agreement about their expected response should be a part of health systems response.

7.1.8. Monitoring and evaluation of the health system’s response to VAW are important to generate evidence on the effectiveness of the system’s strengthening activities. Documentation of cases by counsellors of Dilaasa can serve as an important source of information for monitoring the health systems response.

Although Dilaasa staff were trained in documentation, that has been the weakest. Variations of documentation register, lack of understanding about what the intake sheet expects them to document, multiple registers, lack of collation of all data were some of the challenges in documentation. This needs attention as this is crucial public health data. Poor documentation and data management, variable record-keeping act as barriers. Further, the ineffective management information system at the level of Dilaasa is also a barrier for monitoring and evaluation.

The monitoring committee at the hospital level has been functional only when activated by the NGO and the Dilaasa departments. Lack of participation by NOs and its membership are barriers to the monitoring of the activities of Dilaasa within the hospital. A routine and more functioning MC will ensure the quality of care and sensitive response by HCPs.

At the level of the governing body, routine monitoring and evaluation of Dilaasa activities are crucial to sustain and ensure optimal service delivery and sustainability of the program, which was envisioned through advisory committees. The non-functional advisory committee points to a lack of accountability at the level of leadership for VAW activities though NHP 2017 provides clear directives for health sector response to gender-based violence.
Though monitoring at the level of the governing body is carried out through monthly reporting of cases, the gaps in data due to the nature of reporting required is ineffective for monitoring and evaluation of the centre. Robust data management and documentation is essential to understand the extent of VAW reported in the hospitals and its impact on health.

The recommendations for effective monitoring and evaluation include consistent training for the smooth functioning of monitoring committees. The capacity of the Dilaasa team needs to be built up to overcome the challenges of documentation and maintaining of data in MIS.

### 7.2. CONCLUSION

The presence of a trained and a sensitive team consisting of core group, Nodal officer and Dilaasa team played out as most important factor in establishing and integrating health systems’ response to VAW. Active leadership in hospital created a conducive environment for Dilaasa team which helped them to address various challenges of infrastructure and service delivery. This is an important learning for upscaling of health systems’ response to VAW as there is considerable variation among health facilities in terms of infrastructure and service delivery.
REFERENCES


World Health Organization & ExpandNet. (2009). *Practical guidance for scaling up health service innovations*. http://apps.who.int/iris/bitstream/handle/10665/44180/9789241598521_eng.pdf;jsessionid=E185FE33524B3EE7C5DF1A22E3EB9C52?sequence=1


ANNEXURES
**ANNEXURE 1**

Demographic profile of Counsellors interviewed for the study

<table>
<thead>
<tr>
<th>Sr. no.</th>
<th>Hospital Name</th>
<th>Sex</th>
<th>Education</th>
<th>Work experience before Dilaasa</th>
<th>Work experience at Dilaasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>HBT</td>
<td>Female</td>
<td>MSW</td>
<td>Total: 3 years</td>
<td>January 2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 years- Kotak Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>foundation-as Assistant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Manager for Parent Intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Shradhanand Mahila Ashram,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sion Hospital</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>BDBA</td>
<td>Female</td>
<td>MSW,</td>
<td>Kotak education foundation:</td>
<td>August 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>LLB</td>
<td>counselling parents</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Cooper</td>
<td>Female</td>
<td>MSW</td>
<td>Total: 10 years</td>
<td>March 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 years in HIV counselling</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Bar girls project</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NGO in Karnataka</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>MW Desai</td>
<td>Female</td>
<td>MSW</td>
<td>3 years as counsellor in Vasai</td>
<td>March 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>police station</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Kasturba-</td>
<td>Female</td>
<td>MSW</td>
<td>Social investigator in Bombay</td>
<td>May 2016</td>
</tr>
<tr>
<td></td>
<td>Siddhart</td>
<td></td>
<td></td>
<td>cancer registry</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>VN Desai</td>
<td>Female</td>
<td>MSW</td>
<td>Nehru Yuva Kendra</td>
<td>March 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIV counselling</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>SVDS</td>
<td>Female</td>
<td>MSW</td>
<td>1 year experience in HIV</td>
<td>March 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>counselling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Gender</td>
<td>Degree</td>
<td>Experience</td>
<td>Date</td>
</tr>
<tr>
<td>---</td>
<td>---------------</td>
<td>--------</td>
<td>--------</td>
<td>------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>8</td>
<td>Shatabdi</td>
<td>Male</td>
<td>MSW</td>
<td>1 year conduct survey in research</td>
<td>August 2016</td>
</tr>
<tr>
<td>9</td>
<td>KMJ</td>
<td>Male</td>
<td>MSW</td>
<td>No experience</td>
<td>March 2016</td>
</tr>
<tr>
<td>10</td>
<td>MT Agarwal</td>
<td>Male</td>
<td>MSW</td>
<td>28 years in adolescent health projects</td>
<td>March 2016</td>
</tr>
<tr>
<td>11</td>
<td>Rajawadi</td>
<td>Male</td>
<td>MSW</td>
<td>No experience</td>
<td>March 2016</td>
</tr>
</tbody>
</table>
## ANNEXURE 2

Demographic profile of Nodal Officers interviewed for the study

<table>
<thead>
<tr>
<th>Sr. no.</th>
<th>Hospital Name</th>
<th>Sex</th>
<th>Qualification/Specialization</th>
<th>Other departments allocated to nodal officer</th>
<th>Years of experience in public hospital</th>
<th>No. of VAW training sessions/days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>BDBA</td>
<td>Female</td>
<td>MBBS</td>
<td>Administrative in-charge of the hospital</td>
<td>11</td>
<td>One session of 1 day training</td>
</tr>
<tr>
<td>2.</td>
<td>Cooper</td>
<td>Female</td>
<td>MBBS</td>
<td>MRO department</td>
<td>22</td>
<td>No training received</td>
</tr>
<tr>
<td>3.</td>
<td>MW Desai</td>
<td>Female</td>
<td>MBBS</td>
<td>Medicine and Adult OPD</td>
<td>7</td>
<td>Two training sessions received</td>
</tr>
<tr>
<td>4.</td>
<td>VN Desai</td>
<td>Male</td>
<td>MBBS</td>
<td>Administrative in-charge of the hospital</td>
<td>29</td>
<td>One session of 3 days training</td>
</tr>
<tr>
<td>5.</td>
<td>SVDS</td>
<td>Female</td>
<td>MBBS</td>
<td>Casualty department</td>
<td>14</td>
<td>One session of 2 days training</td>
</tr>
<tr>
<td>6.</td>
<td>Shatabdi</td>
<td>Male</td>
<td>MBBS Obstetrician and Gynaecologist</td>
<td>Administrative in-charge of the hospital</td>
<td>30</td>
<td>Four training sessions received</td>
</tr>
<tr>
<td>7.</td>
<td>KMJ Phule</td>
<td>Female</td>
<td>MBBS</td>
<td>Casualty department</td>
<td>12</td>
<td>One training session</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Gender</td>
<td>Profession</td>
<td>Position</td>
<td>Sessions</td>
<td>Training Details</td>
</tr>
<tr>
<td>---</td>
<td>---------------</td>
<td>--------</td>
<td>------------</td>
<td>----------------------------------</td>
<td>----------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>8.</td>
<td>MT Agarwal</td>
<td>Female</td>
<td>MBBS</td>
<td>Administrative in-charge of the hospital</td>
<td>20</td>
<td>One session of 9 days training</td>
</tr>
<tr>
<td>9.</td>
<td>Rajawadi</td>
<td>Female</td>
<td>MBBS</td>
<td>Pharmacy Department</td>
<td>25</td>
<td>One session of 3 days training</td>
</tr>
</tbody>
</table>
ANNEXURE 3

Budget allotted according to NUHM’s published data from 2015-2020 in lakhs

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Activity</th>
<th>2015-16 (n)</th>
<th>2016-17 (n)</th>
<th>2017-18 (n)</th>
<th>2018-19 (n)</th>
<th>2019-20 (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total HR budget</td>
<td>91.87 (11)</td>
<td>114.38 (11)</td>
<td>181.61 (20)</td>
<td>144.99 (16)</td>
<td>99.68 (11)</td>
</tr>
<tr>
<td>2</td>
<td>Training</td>
<td>2.0</td>
<td>2.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>Office expenditure</td>
<td>6.6 (11)</td>
<td>7.92 (11)</td>
<td>14.40 (20)</td>
<td>11.52 (16)</td>
<td>6.60 (11)</td>
</tr>
<tr>
<td>4</td>
<td>Civil work</td>
<td>55 (11)</td>
<td>5.0</td>
<td>45 (9)</td>
<td>25 (5)</td>
<td>-</td>
</tr>
<tr>
<td>5</td>
<td>Total (2+3+4)</td>
<td>63.6</td>
<td>9.92</td>
<td>36.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grand total</td>
<td>155.47</td>
<td>124.3</td>
<td>241.01</td>
<td>181.51</td>
<td>116.28</td>
</tr>
</tbody>
</table>

n-number of Dilaasa centres, parenthesis is number of Dilaasa centres
ANNEXURE 4

Total budget allocated by NUHM for Civil work, furniture and office expenditure for 2016-17

<table>
<thead>
<tr>
<th>Items</th>
<th>Budget Allocated by NUHM</th>
<th>Budget spent by Dilaasa centre</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount in Rs</td>
<td>6030000</td>
<td>2439350</td>
<td>1843931</td>
<td>123368</td>
<td>4406649</td>
<td></td>
</tr>
<tr>
<td>% of allocation</td>
<td>100%</td>
<td>40%</td>
<td>31%</td>
<td>2%</td>
<td>73%</td>
<td></td>
</tr>
</tbody>
</table>
## ANNEXURE 5

Yearly budget allocated by NUHM to hospitals and the amount spent by hospitals in lakhs from 2016 to 2020

<table>
<thead>
<tr>
<th>Year</th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-19</th>
<th>2019-20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Budget Allocated by NUHM</strong></td>
<td>60.30</td>
<td>0.00</td>
<td>0.00</td>
<td>1.20</td>
</tr>
<tr>
<td><strong>Total amount spent by 11 Dilaasa centre</strong></td>
<td>44.07*</td>
<td>0.73</td>
<td>1.73</td>
<td>1.27</td>
</tr>
<tr>
<td><strong>Amount carried forward for next year</strong></td>
<td>16.23</td>
<td>8.94</td>
<td>7.21</td>
<td>7.15</td>
</tr>
</tbody>
</table>

* Rs. 44.07 lakhs was spent on civil work, furniture and office expenditure. Office expenditure for 2016-17 was Rs.1.23 lakhs
ANNEXURE 6

Salary proposed by CMS office and Salary allotted by NUHM for the year 2016-17

<table>
<thead>
<tr>
<th>Post</th>
<th>Proposed Salary</th>
<th>Salary by NUHM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monthly Salary</td>
<td>Monthly Salary</td>
</tr>
<tr>
<td></td>
<td>Total budget</td>
<td>Service* tax</td>
</tr>
<tr>
<td>Medical Social Worker (counsellor)</td>
<td>20000</td>
<td>20000</td>
</tr>
<tr>
<td></td>
<td>5280000</td>
<td>4900</td>
</tr>
<tr>
<td>Health Worker (ANM)</td>
<td>10000</td>
<td>10000</td>
</tr>
<tr>
<td></td>
<td>2640000</td>
<td>2450</td>
</tr>
<tr>
<td>DEO</td>
<td>10000</td>
<td>9600</td>
</tr>
<tr>
<td></td>
<td>1320000</td>
<td>2352</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9240000</td>
<td>11438000</td>
</tr>
</tbody>
</table>
ANNEXURE 7

Total budget proposed for civil work & office expenditure by CMS office and total budget allotted for civil work & office expenditure by NUHM for the year 2016-17

<table>
<thead>
<tr>
<th>Type of budget</th>
<th>Proposed by CEHAT</th>
<th>Allotted by NUHM</th>
<th>% of funds allotted based on proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One time expenditure</td>
<td>Recurrent expenditure</td>
<td>Total budget proposed</td>
</tr>
<tr>
<td>Budget heads</td>
<td>Civil and Furniture</td>
<td>Office expenditure</td>
<td>Civil and Furniture</td>
</tr>
<tr>
<td>Annual budget Per unit</td>
<td>600000</td>
<td>120000</td>
<td>720000</td>
</tr>
<tr>
<td>Annual budget for 11 hospitals</td>
<td>660000</td>
<td>132000</td>
<td>792000</td>
</tr>
</tbody>
</table>

*NUHM allotted the fund to each Dilaasa centre
ANNEXURE 8

Informed Consent Form for Dilaasa Counsellor Interview

Upscaling Evidence Based Health Systems Intervention Model across eleven public hospitals in Mumbai: A Review of its Implementation

Principle Investigator: Sangeeta Rege
Centre for Enquiry into Health and Allied Topics [CEHAT]

Introduction

Good day. My name is _______________, and I work for CEHAT which is the research centre of Anusandhan Trust. This centre is involved in research, training, service and advocacy on health and allied themes. I am doing a research on implementation of Dilaasa model in 11 peripheral hospitals of Mumbai. I am going to give you some information and invite you to be a part of this research telephonically. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research. If this consent form contains any information you do not understand, please let me know. Please ask me to stop as we go through the information and I will take time to explain.

Purpose of the research

The purpose of this study is to understand the functioning of Dilaasa centre in your hospital, provision of crisis intervention services, existing challenges and recommendations.

Type of Research Intervention

We would like to conduct a interview with you at a date and time of your choosing. The interview should take between 30 to 40 minutes.

Participant Selection

You are being invited to take part in this research because we feel that your experience as a counsellor can help us understand more about hospital-based crisis intervention services.

Voluntary Participation
Your participation in this research is entirely voluntary. This means that it is your choice whether to participate or not. If you choose not to participate, it will not affect your job in any way. You may change your mind later and stop participating even if you agreed earlier.

**Procedures**

I will share this form with you for your thorough reading and willingness to participate. If agreed, I will schedule an appointment with you for the telephonic interview. The interview will be conducted on a conference call where I, ________________ will speak to you, and ______________ will also be present to take notes about what we discuss.

The interview will start with us making sure that you are comfortable. We can also answer questions about the research that you might have. Then we will ask you questions about your role in carrying out routine activities of Dilaasa, challenges and recommendations. The interview will be conducted over the phone when it is convenient for you and no one else apart from the note taker will be present during this interview. If you give permission, we would like to also record the interview as it would be difficult for us to write down all the important issues mentioned by you at the time of interview. The recording will be kept in a password-protected computer folder. The information recorded is confidential, and no one except members of the research team will have access to the recording. The recording will be destroyed after 6 months once they have been transcribed and translated.

**Risks**

There is no risk associated with your participation in this study. But in case you feel uncomfortable talking about some of the topics you can refuse to answer them.

**Benefits**

There will be no direct benefit to you, but your participation will help us understand the processes and guiding principles involved in provision of crisis intervention services.

**Reimbursements**

You will not receive any monetary compensation for participating in this research.

**Confidentiality**

We will be very careful to make sure that anything you say in this interview is not heard or shared with anyone outside the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. We will not write your name on the recording and will only keep a record of your name and other identifying information separate from the actual interview. Only the researchers will know what your number is, and we will keep that information password protected. It will not be shared with or given to anyone.

**Sharing the Results**
Nothing that you tell us will be shared with anybody outside the research team, and nothing will be attributed to you by name. Following the research, we will publish the results so that other interested people may learn from the research.

**Right to Refuse or Withdraw**

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job in any way. You may stop participating in the discussion at any time that you wish without your job being affected.

**Whom to Contact**

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact: Sanjida Arora (Survey No. 2804 & 2805, Aaram Society Road, Vakola, Santacruz East, Mumbai- 400055, +91-22-26373154)

This proposal has been reviewed and approved by Anusandhan Trust’s ethics committee which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the institutional review board (IRB) - Dr. Anant Bhan, Survey No. 2804 & 2805, Aaram Society Road, Santa Cruz (East), Mumbai- 400 055, +919420160170

I have read the information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Signature of Participant ___________________

Date __________________________ Day/month/year

I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this ICF has been provided to the participant.

Signature of Researcher /person taking the consent________________________
ANNEXURE 9

Informed Consent Form for Nodal Officer Interview

Upscaling Evidence Based Health Systems Intervention Model across eleven public hospitals in Mumbai: A Review of its Implementation

Principle Investigator: Sangeeta Rege
Centre for Enquiry into Health and Allied Topics [CEHAT]

Introduction

Good day. My name is _______________, and I work for CEHAT which is the research centre of Anusandhan Trust. This centre is involved in research, training, service and advocacy on health and allied themes. I am doing a research on implementation of Dilaasa model in 11 peripheral hospitals of Mumbai. I am going to give you some information and invite you to be a part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research. If this consent form contains any information you do not understand, please let me know. Please ask me to stop as we go through the information and I will take time to explain.

Purpose of the research

The purpose of this study is to understand the functioning of Dilaasacentre in your hospital, role played by different professionals, existing challenges and recommendations.

Type of Research Intervention

We would like to conduct an interview with you. The interview should take between 30 to 40 minutes

Participant Selection

You are being invited to take part in this research because we feel that your experience as a Nodal Officer can help us understand more about the implementation of Dilaasa.

Voluntary Participation

Your participation in this research is entirely voluntary. This means that it is your choice whether to participate or not. If you choose not to participate, it will not affect your job in any way. You may change your mind later and stop participating even if you agreed earlier.
**Procedures**

The interview will be conducted by __________________ and __________________ will also be present to take notes about what we discuss.

The interview will start with me, making sure that you are comfortable. We can also answer questions about the research that you might have. Then we will ask you questions about your role in carrying out routine activities of Dilaasa, challenges and recommendations. The interview will be conducted at a place which is convenient to you and no one else apart from the note taker will be present during this interview. If you give permission, we would like to also record the interview as it would be difficult for us to write down all the important issues mentioned by you at the time of interview. The tape will be kept in a locked cabinet. The information recorded is confidential, and no one else except members of the research team will have access to the tapes. The tapes will be destroyed after 6 months once they have been transcribed and translated.

**Risks**

There is a no risk associated with your participation in this study. But in case you feel uncomfortable talking about some of the topics you can refuse to answer them.

**Benefits**

There will be no direct benefit to you, but your participation will help us understand the determinants, facilitators and challenges faced in successful implementation of Dilaasa

**Reimbursements**

You will not receive any monetary compensation for participating in this research.

**Confidentiality**

We will be very careful to make sure that anything you say in this interview is not heard or shared with anyone outside the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. We will not write your name on the tape recording, and will only keep a record of your name and other identifying information separate from the actual interview. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone.

**Sharing the Results**

Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. Following the research, we will publish the results so that other interested people may learn from the research.
Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job in any way. You may stop participating in the discussion at any time that you wish without your job being affected.

Who to Contact

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact: Sanjida Arora (Survey No. 2804 & 2805, Aaram Society Road, Vakola, Santacruz East, Mumbai- 400055, +91-22-26373154)

This proposal has been reviewed and approved by Anusandhan Trust’s ethics committee which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find out more about the IRB, Dr. Anant Bhan, Survey No. 2804 & 2805, Aaram Society Road, Santa Cruz (East), Mumbai- 400 055, +919420160170

I have read the information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Signature of Participant ___________________

Date ___________________________

Day/month/year

I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this ICF has been provided to the participant.

Signature of Researcher /person taking the consent______________________
ANNEXURE 10

Informed Consent Form for Key Informant Interview

Upscaling Evidence Based Health Systems Intervention Model across eleven public hospitals in Mumbai: A Review of its Implementation

Principle Investigator: Sangeeta Rege

Centre for Enquiry into Health and Allied Topics [CEHAT]

Introduction

Good day. My name is _______________, and I work for CEHAT which is the research centre of Anusandhan Trust. This centre is involved in research, training, service and advocacy on health and allied themes. I am doing a research on implementation of Dilaasa model in 11 peripheral hospitals of Mumbai. I am going to give you some information and invite you to be a part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research. If this consent form contains any information you do not understand, please let me know. Please ask me to stop as we go through the information and I will take time to explain.

Purpose of the research

The purpose of this study is to understand the determinants, facilitators and challenges in upscaling of Dilaasa in 11 peripheral hospitals of Mumbai.

Type of Research Intervention

We would like to conduct an interview with you. The interview should take between 30 to 40 minutes

Participant Selection

You are being invited to take part in this research because we feel that your experience as key administrator who supported upscaling of Dilaasa will help us in understanding facilitators for successful implementation.

Voluntary Participation

Your participation in this research is entirely voluntary. This means that it is your choice whether to participate or not. If you choose not to participate, it will not affect your job in any way. You may change your mind later and stop participating even if you agreed earlier.
**Procedures**

The interview will be conducted by _____________ and ______________ will also be present to take notes about what we discuss.

The interview will start with me, making sure that you are comfortable. We can also answer questions about the research that you might have. Then we will ask you questions about your role in carrying out routine activities of Dilaasa, challenges and recommendations. The interview will be conducted at a place which is convenient to you and no one else apart from the note taker will be present during this interview. If you give permission, we would like to also record the interview as it would be difficult for us to write down all the important issues mentioned by you at the time of interview. The tape will be kept in a locked cabinet. The information recorded is confidential, and no one else except members of the research team will have access to the tapes. The tapes will be destroyed after 6 months once they have been transcribed and translated.

**Risks**

There is a no risk associated with your participation in this study. But in case you feel uncomfortable talking about some of the topics you can refuse to answer them.

**Benefits**

There will be no direct benefit to you, but your participation will help us in understanding the different strategies used for upscaling of Dilaasa.

**Reimbursements**

You will not receive any monetary compensation for participating in this research.

**Confidentiality**

We will be very careful to make sure that anything you say in this interview is not heard or shared with anyone outside the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. We will not write your name on the tape recording, and will only keep a record of your name and other identifying information separate from the actual interview. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone.

**Sharing the Results**

Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. Following the research, we will publish the results so that other interested people may learn from the research.

**Right to Refuse or Withdraw**
You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job in any way. You may stop participating in the discussion at any time that you wish without your job being affected.

Who to Contact

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact: Sanjida Arora (Survey No. 2804 & 2805, Aaram Society Road, Vakola, Santacruz East, Mumbai- 400055, +91-22-26373154)

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I have read the information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Signature of Participant ___________________

Date __________________________

Day/month/year

I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this ICF has been provided to the participant.

Signature of Researcher /person taking the consent_______________________
ANNEXURE 11

Informed Consent Form for Woman Survivor Interview

Upscaling Evidence Based Health Systems Intervention Model across eleven public hospitals in Mumbai: A Review of its Implementation

Principle Investigator: Sangeeta Rege
Centre for Enquiry into Health and Allied Topics [CEHAT]

Namaste,

Thank you so much for coming to Dilaasa. I am working with CEHAT organisation which is the research centre of Anusandhan Trust. This centre is involved in research, training, service and advocacy on health and allied themes. We are conducting a study on women’s experiences here at the Dilaasa Crisis Centre for Women at this hospital.

Purpose of the research

The purpose of this study is to learn from you about your experiences coming to Dilaasa and seeking services. The questions we will be discussing today are related to what your expectations have been of Dilaasa, whether or not those expectations were met, and the types of support you have received from Dilaasa for your health, your safety, and ability to achieve your personal life goals. We are speaking with many other women who have come to Dilaasa. All the experiences you and other women share can then be brought together. This information can help us and others to improve programs and provide the most useful and appropriate services for women facing violence. We want to tell you that you have the right to refuse to participate in this interview. You also have the right to refuse to answer specific questions or stop the interview completely, even after the interview begins. Your decision to participate or not to participate in the study will not affect the quality of services you receive from Dilaasa or from other departments within this hospital. Your participation in this interview is separate from your meetings with the counsellors at Dilaasa and it is completely voluntary.

Risks and Benefits

You are very brave to have come to the Dilaasa Crisis Centre. We understand that you may have taken some risk to come here. Your participation in this study will require you to spend additional time here, and we want to let you know that this may add to the difficulties you already faced by coming here. We also want to inform you that the questions we would like to ask you are related to painful memories or experiences you may have had with regard to violence and the interview process may prove to be emotionally distressing. Despite these difficulties, we feel that your participation in this study is very valuable. Sharing your experiences and thoughts will be very helpful to us and other organizations in our efforts to help other women who face violence.
Reimbursements

You will receive monetary compensation for participating in this research.

Procedure

The interview will take around 30 to 40 minutes. We want to assure you that the information you provide here today will be kept confidential. For those who agree to participate in the study, in addition to the information we obtain from the interviews, we will also include in the study the information provided by you to the counsellors on previous visits to the centre that is contained in our files. The purpose of using this information is to avoid asking you for information during the interview that you have already provided to us at Dilaasa. This information may include details about your age, religion, marital history, the types of violence you have faced, visits to Dilaasa, and your medical history.

We would also like to ask for your permission to use an audio tape recorder to record our discussion. The only purpose of this recording is to make sure that we do not miss anything you say during the interview. The tape will be erased once we have transcribed the interview. It is not mandatory to record this interview. You may chose to participate in the interview with or without this recording.

Confidentiality

We will be very careful to make sure that anything you say in this interview is not heard or shared with anyone outside the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. We will not write your name on the tape recording, and will only keep a record of your name and other identifying information separate from the actual interview. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone.

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact: Sanjida Arora (Survey No. 2804 & 2805, Aaram Society Road, Vakola, Santacruz East, Mumbai- 400055, +91-22-26373154)

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I have read the information, or it has been read to me. I have had the opportunity to ask questions about
it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Signature of Participant ____________________

Date __________________________

   Day/month/year

I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this ICF has been provided to the participant.

Signature of Researcher /person taking the consent________________________
ANNEXURE 12

Informed Consent Form for Focus Group Discussion of Dilaasa team member; Auxiliary Nurse Midwife (ANM)

Upscaling Evidence Based Health Systems Intervention Model across eleven public hospitals in Mumbai: A Review of its Implementation

Principal Investigator: Sangeeta Rege
Centre for Enquiry into Health and Allied Topics [CEHAT]

Introduction

Good day. My name is _______________, and I work for CEHAT which is the research centre of Anusandhan Trust. This centre is involved in research, training, service and advocacy on health and allied themes. I am doing a research on implementation of Dilaasa model in 11 peripheral hospitals of Mumbai. I am going to give you some information and invite you to be a part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research. If this consent form contains any information you do not understand, please let me know. Please ask me to stop as we go through the information and I will take time to explain.

Purpose of the research

The purpose of this study is to understand the functioning of Dilaasa centre in your hospital, role played by different professionals, existing challenges and recommendations.

Type of Research Intervention

We would like to conduct an interview with you. The interview should take between 30 to 40 minutes

Participant Selection

You are being invited to take part in this research because we feel that your experience as a Dilaasa team member can help us understand more about the implementation of Dilaasa.

Voluntary Participation
Your participation in this research is entirely voluntary. This means that it is your choice whether to participate or not. If you choose not to participate, it will not affect your job in any way. You may change your mind later and stop participating even if you agreed earlier.

**Procedures**

The interview will be conducted by _______________ and ______________ will also be present to take notes about what we discuss.

The interview will start with me, making sure that you are comfortable. We can also answer questions about the research that you might have. Then we will ask you questions about your role in carrying out routine activities of Dilaasa, challenges and recommendations. The interview will be conducted at a place which is convenient to you and no one else apart from the note taker will be present during this interview. If you give permission, we would like to also record the interview as it would be difficult for us to write down all the important issues mentioned by you at the time of interview. The tape will be kept in a locked cabinet. The information recorded is confidential, and no one else except members of the research team will have access to the tapes. The tapes will be destroyed after 6 months once they have been transcribed and translated.

**Risks**

There is a no risk associated with your participation in this study. But in case you feel uncomfortable talking about some of the topics you can refuse to answer them.

**Benefits**

There will be no direct benefit to you, but your participation will help us understand the determinants, facilitators and challenges faced in successful implementation of Dilaasa

**Reimbursement**

You will not receive any monetary compensation for participating in this research.

**Confidentiality**

We will be very careful to make sure that anything you say in this interview is not heard or shared with anyone outside the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. We will not write your name on the tape recording, and will only keep a record of your name and other identifying information separate from the actual interview. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone.

We will ask you and others in the group not to talk to people outside the group about what was said in the group. You should know, however, that we cannot stop or prevent participants who were in the group from sharing
things that should be confidential. Participants will be asked not to use any names during the focus group discussion

Sharing the Results

Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. Following the research, we will publish the results so that other interested people may learn from the research.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job in any way. You may stop participating in the discussion at any time that you wish without your job being affected.

Who to Contact

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact: Sanjida Arora (Survey No. 2804 & 2805, Aaram Society Road, Vakola, Santacruz East, Mumbai- 400055, +91-22-26373154)

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I have read the information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Signature of Participant ___________________

Date __________________________

Day/month/year

I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this ICF has been provided to the participant.

Signature of Researcher /person taking the consent________________________
### ANNEXURE 13

**Semi Structure Interview Guide for Counsellor Interviews**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Probes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Please describe your role at Dilaasa.</td>
<td>a. What are your responsibilities at the Dilaasa centre?</td>
</tr>
<tr>
<td></td>
<td>b. What is your typical day like at the centre?</td>
</tr>
<tr>
<td>2. Can you explain the purpose/ role of Dilaasa centre in a hospital?</td>
<td>a. What are the linkages between violence and health? Which departments refer women to you?</td>
</tr>
<tr>
<td></td>
<td>b. Is there any difference in Dilaasa centres and other crisis centres not located in hospital? Please explain.</td>
</tr>
<tr>
<td>3. Please describe your interface with the hospital.</td>
<td>c. Besides counselling, do you create awareness about Dilaasa at the level of departments, hospital OPDs, patients and relatives?</td>
</tr>
<tr>
<td></td>
<td>d. Are you aware of the role of nodal officer, medical officer, matron and have you approached them in difficulties? What has been their response?</td>
</tr>
</tbody>
</table>

### Nature of services offered by Dilaasa

<table>
<thead>
<tr>
<th>Questions</th>
<th>Probes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Please describe basic procedures once a woman/ girl enters the Dilaasa centre.</td>
<td>a. How do the counsellors introduce the Dilaasa centre and its services?</td>
</tr>
<tr>
<td></td>
<td>b. Is consent of the woman/ girl sought? If yes how?</td>
</tr>
</tbody>
</table>
c. Are the procedures different for women referred by the HCPs from women who walk in to the centre on their own?
d. What are the strategies used by counsellors to reach out to the women admitted in the hospital?

5. Can you explain the crisis counselling steps implemented by Dilaasa and what principles do you use to guide your counselling process?

<table>
<thead>
<tr>
<th>5. Can you explain the crisis counselling steps implemented by Dilaasa and what principles do you use to guide your counselling process?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. What are the messages you provide while extending emotional support?</td>
</tr>
</tbody>
</table>

6. How do you assess safety of women? If she is unsafe what do you do?

<table>
<thead>
<tr>
<th>6. How do you assess safety of women? If she is unsafe what do you do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How do you assess severity of violence? If woman is found to be unsafe in the domestic environment, what alternatives are suggested?</td>
</tr>
<tr>
<td>b. Have women availed of emergency hospital admission?</td>
</tr>
<tr>
<td>c. What are the steps to follow-up if a woman is found to be unsafe but wishes to go back to the same environment?</td>
</tr>
<tr>
<td>d. What are intervention strategies in cases of suicidal ideation?</td>
</tr>
</tbody>
</table>

7. As you implement a crisis intervention model, please describe how you carry out the following –

Registration of police complaint, provision of legal counselling, access to shelter homes, linkages with child welfare committees

| 7. As you implement a crisis intervention model, please describe how you carry out the following –
Registration of police complaint, provision of legal counselling, access to shelter homes, linkages with child welfare committees |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Please describe your experience in facilitating each of these services.</td>
</tr>
<tr>
<td>b. Please describe difficulties encountered in facilitating these services.</td>
</tr>
<tr>
<td>c. How do you resolve them?</td>
</tr>
<tr>
<td>d. Please describe one such case based on each of these interfaces.</td>
</tr>
</tbody>
</table>

8. Please describe your role in responding to rape survivors when they reach hospital.

<table>
<thead>
<tr>
<th>8. Please describe your role in responding to rape survivors when they reach hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. What does your role entail?</td>
</tr>
<tr>
<td>b. In cases where you assist HCPs what exactly is the intervention you carry out?</td>
</tr>
</tbody>
</table>
### 9. When do you carry out joint meetings between survivor and abuser? Please explain procedures and principles involved in it.

| a. | Please describe steps in conducting joint meetings? |
| b. | How do you go about it? Please give us an example. |
| c. | What are the things you take care of? |
| d. | When joint meetings do not reach a positive conclusion, what steps do you take? |

#### Training, supervision, and burnout

<table>
<thead>
<tr>
<th>10. What was the nature of training received for implementing crisis counselling services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td>c.</td>
</tr>
<tr>
<td>d.</td>
</tr>
<tr>
<td>e.</td>
</tr>
<tr>
<td>f.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. Have you experienced burnout or a sense of fatigue while dealing with so many cases of violence?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td>c.</td>
</tr>
</tbody>
</table>

| 12. Can you recommend what else needs to be done for improving Dilaasa services? Training of counsellors, hospital staff, SOPs |
Thank you very much for sharing your experiences with us today. Your participation is very much appreciated.
ANNEXURE 14
Semi Structure Interview Guide for Nodal Officers of Dilaasa

Please note: These interviews will be conducted with nodal officers appointed for each of the Dilaasa centres across 11 hospitals. A nodal officer is a healthcare provider who has been given administrative charge of Dilaasa in a hospital.

Themes to be explored:
- Description of the role and responsibilities of nodal officers
- Their understanding of the Dilaasa crisis centre, its functions
- Their understanding of interlinkages between different forms of violence and its health effects in the forms of health complaints with which women and girls reach hospitals
- Knowledge about existing standard operating procedures, policies for a coherent hospital response to VAW
- Challenges faced by nodal officers in implementing their role, barriers from the hospital, other providers
- Training received by them, its content and whether it was adequate
- Recommendations for improving Dilaasa services and its reach to survivors of VAW

1. Role Description
   - Please tell us what your responsibilities as a doctor are in the hospital.
   - Your responsibilities as a nodal officer.
   - Years of service in public hospital, specialization and years of experience.

2. Can you explain the concept of Dilaasa crisis intervention department at the hospital?
   - What are the reasons for setting up such a centre in a hospital?
   - What are the services offered by the centre? (women-centric care)
   - What are the health complaints with which violence against women is associated?

3. Do you have a standard operating procedure (SOP) for responding to VAW/GBV?
   - What are the components of the SOP?
   - Ask procedures for dealing with assaults, accidental consumption of poison, sexual violence against adults and children?
   - Please explain nature of responsibilities allocated to different HCPs
• Experience of interface with police, CWC and any other agency required to facilitate support for survivors

4. **Please explain routine activities undertaken in your role as nodal officer.**
   • Organising trainings, meetings, representing Dilaasa in meetings.
   • Facilitating procedures for Dilaasa counsellors. Please provide examples.
   • Challenges faced in facilitating services (unavailability of doctors, lack of willingness, infrastructural issues, etc.).

5. **What are difficulties you face facilitating services for VAW survivors? Have you learnt any strategies while dealing with these challenges? Please describe.**

6. **What was the nature of training you received to take on this role? Please describe its content, frequency of trainings, methodology, usefulness etc.**

7. **What are your recommendations for improving Dilaasa services and institutionalising it as a hospital service?**
   • Strategies for increasing the visibility of Dilaasa in hospital
   • Strategies to strengthen the coordination between Dilaasa and other departments
ANNEXURE 15

Semi Structure Interview Guide for women survivors
<table>
<thead>
<tr>
<th>Questions</th>
<th>Probes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Please start by telling me how you first came to the Dilaasa Crisis Centre for Women.</td>
<td>c. What led you to come to Dilaasa?</td>
</tr>
<tr>
<td></td>
<td>d. Did anyone ask you about violence? Who was it? (doctor/nurse/counsellor?)</td>
</tr>
<tr>
<td></td>
<td>e. Were you spoken with in OPD or in IPD?</td>
</tr>
<tr>
<td></td>
<td>f. What did the health care provider say to you? What support did you receive from provider? How did you feel about it?</td>
</tr>
<tr>
<td>2. What were your expectations of Dilaasa when you came for the first time? To what extent has Dilaasa met or not met your expectations?</td>
<td>a. Can you list your expectations?</td>
</tr>
<tr>
<td></td>
<td>b. Did the counsellor help you in identifying and meeting your needs? If yes, please specify.</td>
</tr>
<tr>
<td><strong>Women centered approach by the counsellors at Dilaasa.</strong></td>
<td></td>
</tr>
<tr>
<td>3. How would you describe your experiences of sharing things about yourself with the counsellors here? Of all the things that are in your mind, how much are you able to share with the counsellors?</td>
<td>a. Was there anything about the counselling session that made it easy or difficult for you to talk about your experiences and feelings? [Probe for details.]</td>
</tr>
<tr>
<td></td>
<td>b. How would you describe the counsellor’s way of listening to you?</td>
</tr>
<tr>
<td></td>
<td>c. How supported do you feel by the counsellors at Dilaasa? Do you feel that you are alone or do you feel that they are here to support you?</td>
</tr>
<tr>
<td></td>
<td>d. Do you feel that you wanted your problems to be addressed differently and not the way suggested by the counsellor?</td>
</tr>
<tr>
<td>4. Did your health get affected by violence?</td>
<td>a. What were the physical and psychological health effects of living in violence?</td>
</tr>
</tbody>
</table>
Psycho social Intervention Services

1. One of the main goals of the Dilaasa Crisis Centre is to work directly with women to create a plan of action that helps to ensure their safety and the safety of their children. This is referred to as the “safety plan.” We would like to know how you feel about the safety plan that you and Dilaasa developed.
   a. What did the counsellor(s) say to you about your safety or about returning to the abusive home?
   b. Did you feel that your life was at threat? Was emergency hospital admission offered to you? Or were you referred to a shelter home?
   c. What have been your experiences of trying to use this safety plan? How has it worked? How has it failed? How has this safety plan affected the violence you face? (Has it helped to prevent further injuries or helped to reduce the severity of additional assaults? Has it increased the violence?)

2. It is important to create evidence related to violence faced by women and so Dilaasa facilitates recording police complaint. We request you to explain your experience of making a police complaint with Dilaasa’s assistance.
   a. What did the counsellor discuss with you with regards to police complaints?
   b. What was the facilitation for recording police complaint (phone calls made to police station, explained procedure and how to approach police, accompanied survivor)
   c. Was the facilitation useful? (Yes/No) Please explain.

3. Have you ever had a meeting arranged by Dilaasa with the people in your family that are/were abusing you? If so, please tell us about your experiences with this joint meeting.
   a. Were you able to speak freely to or about your [INSERT “Relationship of abuser to woman”] during this joint meeting?
   b. During the meeting, did you fear any violence from your [INSERT “Relationship of abuser to woman”]?
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 4. Did you need legal advice with regards to the violence faced?        | a. Were you explained about the specific laws and legal procedures pertaining to your complaint?  
                                                                 | b. Did you meet a lawyer? Were you satisfied with the meeting?          |
|                                                                        | c. Was this meeting helpful or useful to you? How so? What were your expectations of this meeting? Were these expectations met? |
                                                                 | b. How was access to healthcare services facilitated?                    |

**Feedback for Dilaasa services**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 11. Was this the first time that you sought formal support?             | a. Can you tell us how and what information or resources you have gained as a result of your contact with Dilaasa?  
                                                                 | b. Has there been a change in your health status? Please explain how or how not. 
                                                                 | c. Do you see any changes in your coping strategies? For example not blaming oneself for violence, seeking parental support, not feeling ashamed to disclose violence. |
| 12. Can you explain if contact with Dilaasa has assisted you in dealing with violence? | a. What prompted you to refer her to Dilaasa?                                      
                                                                 | b. If you have not referred, will you refer a woman if she is encountering violence? If yes, why and if no, could you provide reasons? |
| 13. Have you referred any woman to Dilaasa centres?                     | a. What prompted you to refer her to Dilaasa?                                      
<pre><code>                                                             | b. If you have not referred, will you refer a woman if she is encountering violence? If yes, why and if no, could you provide reasons? |
</code></pre>
<p>| 14. Please provide feedback about the location of Dilaasa in a public hospital. | Please explain advantages and disadvantages.                                         |</p>
<table>
<thead>
<tr>
<th>15. Are there any resources, services, or information that are not offered by Dilaasa, but which you think should be provided? What are they? How do you think these resources or services will help you and other women?</th>
</tr>
</thead>
</table>

*Thank you very much for sharing your experiences with us today. Your participation is very much appreciated.*
ANNEXURE 15
Semi Structure Interview Guide for Key Informant

These interviews shall be conducted with key administrators of National Health Mission under which Dilaasa activity is funded. (Executive health officer of Public health department of MCGM, Deputy Executive health officer who has the charge of overseeing Dilaasa centres under NHM, Medical superintendents implementing the Dilaasa crisis centres, ex- Health Secretary (MoHFW) who encouraged MCGM to replicate these centres, Senior CEHAT advisors responsible for the setting up of Dilaasa centre in 2000)

Themes to be explored through KII's are:

- Role they can and have played in replication and/or implementation of Dilaasa crisis centres in Hospitals
- Understanding of Dilaasa model in public hospitals
- Understanding of current policy and program environment on health care and reccomendations for integrating response to VAW in it
- Reflections on factors that led to insitutionalisation and their reccomendations
- Barriers and challenges at the level of the health system in recognising Dilaasa as an integral part of hospital services
- Reccomendations for how other states can set up Dilaasa centres in hospitals

1. Role Description
   - Please tell us about your responsibilities and mandate of your current role.
   - Years of service, specialization and years of experience

2. Can you explain the concept of Dilaasa crisis intervention department at the hospital?
   - What is the rationale for setting up psycho-social services in a hospital?
   - What are the responsibilities of doctors and nurses of hospitals towards Dilaasa?

3. What are the monitoring mechanisms in place for overseeing the Dilaasa activities?
   - Please describe if protocols exist, if hospital committees are formed for monitoring activities.

4. What is the mechanism of training new health care providers appointed at the hospital to respond to VAW?

5. What has been your role in the context of replication of Dilaasa crisis centres?
6. Does Dilaasa have external linkages for additional services required by women? Police, legal, shelter, CWCs support amongst others? Please describe.

7. What according to you are key factors that led to the integration of Dilaasa? What has been your role in it? Do you think Dilaasa is now like any other department in the hospital?
   - If yes, how do you think this has been done? What has been your role in it?
   - If not, what do you think are the obstacles in Dilaasa being regarded as one of the departments in the hospital? What do you think should be done additionally to make Dilaasa crisis centre a part of the hospital?

8. Do you think existing health programs and policies have the scope for integrating a health care response to VAW? (National health policy. 2017) Please describe how this can be done.
   - What can be done at the level of primary health centre, secondary hospitals, tertiary care hospitals and medical colleges?
   - What are the changes required in existing health system to integrate healthcare response to VAW?

9. If Dilaasa has to be set up in other states, what are your ideas on
   - Budget and infrastructure (allocation, responsibility of state etc.)
   - Personnel required and kind of training needed
   - Linkages with other resources such as?
OBJECTIVES OF CONDUCTING FGDs:

- To understand roles and responsibilities of different team members of Dilaasa.
- To document existing protocols/procedures for responding to VAW.
- To understand challenges faced by the Dilaasa team in carrying out Dilaasa activities (from the hospital staff, administration, police personnel, agencies such as CWC, legal authorities, shelter homes).
- To understand extent to which Dilaasa is institutionalised as a hospital service and to seek inputs for improving the functioning of Dilaasa.

GUIDE FOR FGD:

1. What are the roles of each of you at the Dilaasa centre? What is the procedure of reporting and to whom?

   - Did you receive training to carry out the role given to you? How were you oriented to responsibilities assigned to you?
   - What is the hospital procedure/SOP/hospital policy for responding to suspected cases of violence against women (VAW)?

2. Facilitator will specifically probe for medical complaints related to accidental consumption of poison, rape, assaults.

   - Is there a standard operating procedure (SOP) for responding to these complaints? Describe the protocol for each of them.
   - Is the SOP followed by all departments? (Probes with examples from SOP)
   - What are the challenges you face in ensuring compliance to SOP?
   - What do you do in cases when SOP is not followed?

3. What are the mechanisms for monitoring existing response to VAW at Dilaasa?

   a. Facilitator will specifically probe about the role of monitoring committees of the hospital (frequency, action taken).
   b. Describe recent monitoring committee meeting and issues discussed in it.
   c. Are there any mechanisms for monitoring of counselling services? Please describe them and present issues raised in a recent meeting.
   d. Are there incremental trainings for monitoring of counselling services?
4. Can you describe your day at Dilaasa?

a. Facilitator specifically requests each participant to speak about their day. This may involve ward rounds to speak to women/girls about Dilaasa services, creating awareness in OPDs, reading emergency registers to identify if women/ girls suffering from violence are admitted to hospital, carrying out crisis interventions, follow up, any other).

5. In the past month, how many referrals has the crisis centre received from the hospital?

a. Facilitator will specifically probe for departments, nature of health complaints, type of violence, cadre of health care providers that made referrals.
b. Name the nature of health complaints among women/ girls missed by HCPs in their referrals to the Dilaasa crisis centres.
c. How many referrals have come from outside the hospital?

6. What are the activities undertaken to create awareness amongst HCPs on health consequences of VAW?

a. Please explain about training activity for HCPs and its frequency.
b. Who are the members responsible for training and orientation of HCPs to VAW?

7. Do you face any obstacles in getting support from other agencies such as police, CWC, Protection Officers under PWDVA, other hospitals, courts etc.?

a. Facilitator will ask about challenges faced from each of these systems. How do you overcome these obstacles?
b. Describe the kind of rapport established with these agencies- do you know the persons in charge? Are they aware of Dilaasa’s functions?

8. Do you think Dilaasa is now like any other department in the hospital? If yes, how do you think this has been done? If not, what do you think are the obstacles in Dilaasa being regarded as one of the departments in the hospital? What do you think should be done additionally to make Dilaasa crisis centre a part of the hospital?
1. How long you have been working in this hospital? And how long you have been associated with Dilaasa?
2. As a matron what is your role on Dilaasa?
3. According to you what roles can Nurses play in Dilaasa? How do you ensure this role is carried out in your hospital by nurses?(Roles: awareness about Dilaasa, first line psychological support, identify and refer suspected cases)
4. How do nurses identify cases of violence (DV/SV)? What is the procedure followed once the suspected cases are identified?
5. Can you share any case example referred to Dilaasa?
6. What is the process of sensitizing nurses on VAW?
7. How is training (frequency, duration, attendance, content, selection of staff for training, challenges encountered-participation) on Dilaasa/violence carried out among nurses?
8. What are the good practices in handling cases of violence in your hospital?
9. What are the challenges you or nurses have encountered in handling cases of violence?
10. According to you, what role can Dilaasa ANM play in hospital on VAW?
11. Any challenges you have faced w.r.t. your role in Dilaasa?
ANNEXURE 19

Semi-structured Interview guide for Doctors (other than Nodal Officer)

1. What was your role in Dilaasa? How long were you associated with Dilaasa?
2. Can you share your experience of working with Dilaasa in your hospital?
3. Can you describe the challenges or problem encounter by Dilaasa in executing its day to day work in your hospital? What do you think is the reason for these challenges and what can be done to address these challenges?
4. Can you talk about the functioning of Monitoring Committee (meetings held to discuss the filled proformas) in your hospital? What can be done for smooth functioning of the committee?
5. Are HCPs (doctors, matron, nurses) sensitized and motivated to support Dilaasa? If not, what are the reason for lack of cooperation and what can be done about it? Do they attend trainings arranged by Dilaasa?
6. What can be the strategies to improve referral to Dilaasa?
ANNEXURE 20

Semi-structured Interview guide for Data entry operator

1. How long you have been working in Dilaasa?
2. What is your role in Dilaasa? Can you tell us your daily routine at Dilaasa / Hospital?
3. Do you face any challenges while performing your role? Can you share these challenges and explain how do you deal with it?
4. Do you have any concerns wr.r.t. documentation? If Yes, how do you deal with it.
5. Do you perform tasks apart from role given to you? Can you share your challenges if any, while performing these roles and explain how do you deal with it?
6. How does Dilaasa team divide / manage workload?
ANNEXURE 21

Semi-structured interview guide for NUHM accounts representative

As per the budget in 2016-17 funds were allocated for 11 centres, in 2017-18 funds were for 21 centres, in 2018-19 funds were allocated for 16 centres plus additional budget for civil work of 21 centres, for 2019-20 and 2020 and 2021 the budget was again for 11 centres.

1. Need clarity on the budget provided for these additional centres. Where were these additional centres proposed? What was the hindrance in initiating these new centres?

2. In each of the years, how much funds were proposed and how much was spent? (I'm unable to match proposed funds, allotted funds and expenditure)

3. What are the budget heads allocated for these funds (apart from HR salary)? What is included in office expenses?

4. What is the total expenditure allotted per month per Dilaasa? What is the criteria of these expenditures?

5. In the yearly audit what was the expenditure of each Dilaasa against the allocated amount?
ANNEXURE 22

ETHICAL CONSIDERATIONS

Work done at CEHAT is reviewed by an Institutional Ethics Committee (IEC) which is a multi-disciplinary independent body. The IEC consists of both external and internal members which are selected by trustees of Anusandhan Trust based on their expertise and scientific knowledge.

CEHAT also has a Program Development Committee (PDC) that provides programmatic direction to CEHAT. It monitors and maintains the quality of CEHAT’s work and sees to it that it fits in with the overall objectives. All dissemination material is reviewed by the PDC. The PDC comprises of members from various disciplines like social sciences, social work, law, journalism and others. In addition to this, experts from other fields are also consulted on important documents pertaining to policy advocacy. It might be important to mention here that CEHAT has pioneered in evolving “Ethical Guidelines for Social Science Research in Health” (NCESSRH, 2000) and “Ethical Guidelines for Counselling Women Facing Domestic Violence” (CEHAT, 2012).

We began with the understanding that ethical guidelines are critical, not only to protecting the safety of respondents and researchers, but also to ensuring data quality (Ellsberg M. and Heise L., 2005). Since the study site is within the workplace of the potential participants, the participants may feel pressured to consent to participate.

1. Utmost care was taken so that the participants do not feel pressured to participate. The option to decline participation or to withdraw from the study at any point without consequences to their job, was stated overtly right at the start as part of the consent process. We maintained the privacy during the interview and anonymity of those who agreed to participate; as well as those who declined.

While permission was sought from senior administrators whom we considered as gatekeepers, free and informed consent was sought from participants after ensuring anonymity and confidentiality of information.

2. There may be some inconvenience to the participants as all of them are working professionals.

All interviews happened at a convenient time and place of the respondents and prior appointments were sought. They may be given, (as per the direction of the CEHAT IEC), a nominal compensation, not amounting to inducement.

3. A fundamental requirement of all research is that it is relevant

VAW as public health issue is important and relevant and therefore how public-sector hospitals, to begin with, should institutionalize the health care response as part of their core work. Public sector hospitals also have some of the most marginalized population seeking services, and in this sense, the response they provide becomes that much more pertinent in the complete absence of options for the marginalized survivors. Moreover, abused women are more likely use health services and trust health care providers more.
4. Potential for distress among care givers

To enable an in-depth understanding of any topic in qualitative research it is essential that there is an exploration of the reasons and context of the participant’s experiences (Richards HM and Schwartz LJ, 2002). This requires, in depth probing towards understanding the more intricate linkages. The present study investigates the implementation of the health care response to violence against women and children by the relevant staff of 11 Dilaasa Centers and associated hospitals. Even though the study looks into understanding the implementation of the health care response, the nature of the purpose of such a response may result in some respondents being overwhelmed by their own experiences or by the experiences of the survivors that they help.

We made an attempt to anticipate any distress during the interviews / focus group and be prepared to provide counselling to these respondents as and when needed. Interview with survivor were conducted along with a professional counsellor dealing with VAW to alleviate the distress.

5. Addressing possible expectations of the respondents

It is possible that the respondents may feel that all of that shared by them will be implemented or addressed. At the time of seeking consent, we clarified the purpose of the study and how their sharing will contribute towards it.

6. Informed consent

Written informed consent or verbal informed consent was sought from the participants after they have been given verbal information regarding the study; its objectives; purpose; matters of privacy, confidentiality and anonymity (with utmost care being taken to mask identifiers); future use of anonymous data for research purpose etc. This information was shared in writing with names and phone numbers of the principal investigator as well as the Chair of the IEC. A copy of the information sheet in their language of choice was shared with the participants based on the mode of interview. In case of physical interview a copy of the information sheet was handed over to the participants while in online interviews a copy of the information sheet was sent to them either via email or through WhatsApp (for survivors).

7. Safety of the participants:

Survivors of violence were also our respondents. It is paramount that their rights as participants are respected and protected. Besides seeking informed consent, we ensured their privacy, confidentiality and anonymity. Moreover, we did not delving into traumatic areas of their lives since this may lead to some distress. Our interviewers included a professional counsellor experience in counselling VAW to provide immediate emotional support and empathy and counselling. We also provided them the space to be able to leave the interview midway. They were assured that there will be no consequences, and they will be able to continue to seek care and services from the hospital as well as the centers, if they choose to withdraw at any stage.