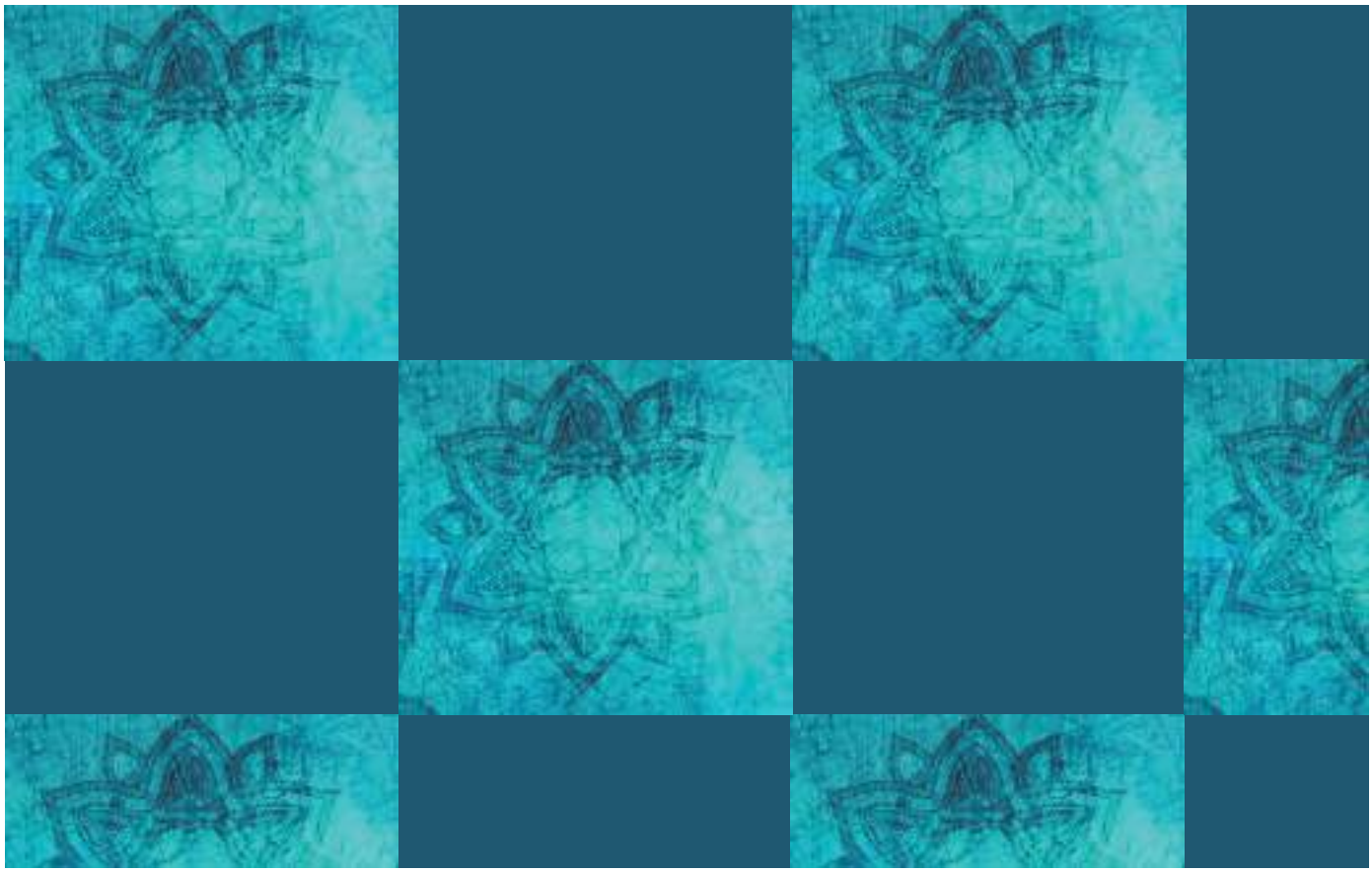

# Scaling up the health-systems response to violence against women:

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Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

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# ABBREVIATIONS

| | | |
|---|---|---|
| ANC | : | Antenatal care |
| ANM | : | Auxiliary nurse midwife |
| ART | : | Antiretroviral therapy |
| ASHA | : | Accredited social health activist |
| CDO | : | Community development officer |
| CEHAT | : | Centre for Enquiry into Health and Allied Themes |
| CHC | : | Community health centre |
| CLA | : | Criminal Law Amendment Act |
| CSO | : | Civil society organisation |
| CWC | : | Child welfare committee |
| CMO | : | Chief medical officer |
| CMS | : | Chief medical superintendent |
| DEO | : | Data entry operator |
| DEHO | : | Deputy executive health officer |
| DLSA | : | District Legal Services Authority |
| DV | : | Domestic violence |
| ENT | : | Ear, nose and throat doctor |
| FIR | : | First information report |
| FGD | : | Focus group discussion |
| HCPs | : | Healthcare providers |
| HIC | : | High-income country |
| HIV | : | Human immunodeficiency virus |
| HMIS | : | Health management information system |
| HR | : | Human resources |
| HOD | : | Head of department |
| ICMR | : | Indian Council for Medical Research |
| IEC | : | Information, education and communication |
| IPPF | : | International Planned Parenthood Federation |
| IHI | : | Institute for Healthcare Improvement |
| IPD | : | In-patient department |

| | | |
|---|---|---|
| IPC | : | Indian Penal Code |
| IRH | : | Institute for Reproductive Health |
| KI | : | Key informant |
| LGBTQA+ | : | Lesbian, gay, bisexual, transgender, queer and asexual |
| LMIC | : | Low- and 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 | : | Management information system |
| M&E | : | Monitoring and evaluation |
| MLC | : | Medicolegal 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-cognisable 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 |
| NUHM | : | National Urban Health Mission |
| OBGYN | : | Obstetrics and gynaecology |
| OPD | : | Outpatient department |
| OSCC | : | One-stop crisis centre |
| OSC | : | One-stop centre |
| PC | : | Police constable |
| PHC | : | Primary healthcare |
| PIP | : | Programme implementation plan |

| | | |
|---|---|---|
| POCSO | : | Protection of Children from Sexual Offences Act |
| PO | : | Protection officer |
| PWDVA | : | Protection of Women from Domestic Violence Act |
| RMO | : | Resident 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 |
| VAW | : | Violence against women |
| WHO | : | World Health Organization |
| UNDP | : | United Nations Development Program |
| UNFPA | : | United Nations Population Fund |
| WCD | : | Women and child development |

# EXECUTIVE SUMMARY

There has been a growing recognition of health systems' critical role and capacity to address violence against women (VAW) through multiple models of care. However, there are gaps in understanding how these models can be implemented in context of low-middle-income countries like India there are several gaps in understanding on implementing the critical role of health system to address VAW.

The Dilaasa model which was initiated as a collaborative project between the Centre for Enquiry into Health and Allied Themes (CEHAT) and the Municipal Corporation of Greater Mumbai (MCGM) in 2000 at a Municipal Corporation hospital in Mumbai is an evidence of a best practice on establishing a health systems' response to VAW. It aims at building capacity of the hospital staff to integrate a response to VAW into their clinical practice and provision of psychosocial care to survivors of violence through setting up a hospital based-crisis intervention department. The model is based on WHO's health systems' building blocks framework for health system strengthening. The building blocks comprise of- leadership and governance, coordination, service delivery, health infrastructure, health workforce, financing and health information system are strengthened.

This initiative has gained significant international recognition as an evidence-based model to institutionalise VAW as a legitimate and critical public health concern within the government health system. Over the years, Dilaasa has been replicated in several states of India at different levels of health systems. In 2016, the model was scaled-up to 11 secondary level government hospitals of Mumbai under National Health Mission.

The scaling up of such evidence-based public health models is recognised as an effective approach to address burden of VAW. Yet, there is little information on how to facilitate the scaling up of effective interventions. Given this, CEHAT

embarked on a study to understand the processes, barriers, facilitators and strategies for scaling up Dilaasa in 11 secondary level hospitals of Mumbai.

The study findings contribute in bridging the gap between knowledge and practice on establishing an effective health systems' response to VAW. A mixed-method design wherein key stakeholders involved in upscaling and functioning of Dilaasa departments were interviewed. Additionally, interviews with survivors of violence were conducted to capture their perspective along witth and was quantitative analysis of management information system (MIS) of 11 departments to understand profile of beneficiaries.

## Key Findings

- The mapping of scaling up of Dilaasa using a systematic framework indicated key role of effective dissemination of evidence and advocacy by CEHAT in securing commitment and ownership by National Health Mission (NHM), Maharashtra.The commitment by NHM is evident in financial allocation to program, recruitment of dedicated Dilaasa team and provision of a strategic location to department within the hospital.

- The existence of core group in form of trained senior healthcare providers at the level of each facility contributes in integrating a facility level response to VAW and effective functioning of Dilaasa departments. These providers played an important role in building capacity of hospital staff and creating a supportive environment for Dilaasa team to provide care to survivors.

- The role played by a designated senior medical officer with additional responsibility to oversee the functioning of Dilaasa (nodal officer) is crucial for effective monitoring of hospital's response to VAW.

- Dilaasa team consisting of two counsellors, two Auxiliary Nurse Midwives, and a data entry operator have established effective mechanisms in hospitals to identify cases of violence and engaging with doctors and nurses on VAW.

The active participation of Dilaasa team is essential to address issues like denial of medical services to survivors of violence.

- The active leadership at the level of health facility is an important determinant of the extent to which the core elements of Dilaasa model are replicated in 11 hospitals. The working together of core group healthcare providers, Dilaasa team members and nodal officer as a team created a facilitating environment for institutionalisation of response to VAW. The frequent transfer of trained healthcare providers is a factor which negatively impact hospital's response to VAW.

- Case documentation and the management of the information system requires to be strengthened for effective monitoring of Dilaasa departments. At the hospital level, regularisation of monitoring committee meetings is essential for improving service delivery to survivors.

- A sensitive and trained hospital staff is the fulcrum of the health systems' response to VAW. These trained providers are instrumental in actively identifying women facing violence based on their health complaints and referring them to Dilaasa departments. However, in financial allocation to Dilaasa by NHM, capacity building has been considered as a one-time activity. This a grave challenge as there is frequent transfer of providers and for bringing a change in attitude of providers, regular capacity building is very much required.

- The facility readiness (availability of resources and capacity of health facilities) impacts service delivery to survivors and can be improved by availability of standard protocols for guiding healthcare providers and Dilaasa team. Locating Dilaasa department within the out-patient premises is a key factor for improvement of service delivery. It provides visibility to the department and improves access to support services by women coming to hospital for various health complaints.

- CEHAT has played a significant role in facilitating the replication of core elements of Dilaasa model in each of the 11 hospitals. It has provided support to build a core team of trainers at each hospital, building capacity of Dilaasa team members, and strengthening service delivery.

- Multi- sectoral coordination is a core component of Dilaasa where team members work towards strengthening linkages with stakeholders providing support services which are not within the scope of health facility. There is a need to strengthen these linkages further with lower-level health facilities and establishing referral mechanisms. This will help in early identification and provision of services to survivors of violence.

- Active leadership at the level of the health facility provided support to Dilaasa team to address the challenges of infrastructure and service delivery within the facility.

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# CHAPTER 1

## INTRODUCTION

The World Health Assembly recognised violence against women (VAW) as a public health issue in 1996. The Assembly emphasised the role of the health system in addressing VAW because health services and healthcare providers are often the first point of contact for survivors of violence (Bhate-Deosthali et al 2012; WHO 2016). Women facing domestic and sexual abuse are more likely to suffer health consequences and therefore to use health services than other women. They are also more likely to trust healthcare providers (HCPs) and disclose the abuse to them (WHO 2013; Bhate-Deosthali et al 2012).

A legal mandate for a health sector response to VAW in India has existed under the Protection of Women from Domestic Violence Act (PWDVA 2005), the Protection of Children from Sexual Offences Act (POCSO 2012), the Criminal Law (Amendment) Act (CLA 2013) and the Ministry of Health and Family Welfare Guidelines (MoHFW 2014). But a policy-level impetus came only in 2017, when the National Health Policy (NHP) gave a clear directive to the health sector to address gender-based violence (MoHFW 2017).

In India, the Dilaasa model is one of the first health system-based initiatives to address VAW. It was set up by the Centre for Enquiry into Health and Allied Themes (CEHAT) and the Municipal Corporation of Greater Mumbai (MCGM) at a government hospital in Mumbai in 2000. The model aimed to a) institutionalise VAW as a public health issue by setting up a crisis intervention department providing psychosocial care to survivors on the premises of a public hospital, and b) train and build the capacity of the hospital staff to recognise VAW as a public health issue and integrate a response to VAW into clinical practice. The initiative was handed over to the MCGM in 2006 and has since been replicated

at different levels of health facilities in six states[1] -Kerala, Meghalaya, Karnataka, Gujarat, Haryana and Goa (details in Chapter 3).

In 2016, the Dilaasa model was integrated in the government's National Health Mission (MoHFW 2015a; MoHFW 2015b) in Maharashtra. The MCGM has now scaled it up at 11 public hospitals in Mumbai (Barnagarwala 2014).

Over the years, the Dilaasa model has received international recognition as an evidence-based scalable model for health-sector response to survivors of violence in low- and middle-income countries (LMIC) (Ravindran and Undurti 2010; WHO 2013; WHO 2016; WHO 2017; Pande et al 2017).

The scaling up of tested models is essential if we are to address the high prevalence and health burden of VAW (Colombini et al 2008). However, there is little understanding of the determinants and facilitators of a successful scale-up of such health interventions (Simmons et al 2007). Promoting such an understanding is critical if evidence-based interventions are not to remain restricted to limited settings (UNFPA and SVRI 2016). Scaling up evidence-based services can reduce the "know-do gap" and potentially address the burden of the impact of violence (Yamey 2012). Thus, scaling up evidence-based interventions can give target populations access to the most effective services and programmes available.

The scale-up of the Dilaasa model in 11 public hospitals of Mumbai by the MCGM provided CEHAT the opportunity to generate evidence on the upscaling of such interventions in the low-resource settings of LMICs. With this in view, CEHAT

[1] The Dilaasa model in these states was adapted to suit the local context and replicated under different names. Kerala's Bhoomika centres, funded by the National Rural Health Mission (NRHM), have been set up in 21 district hospitals. Meghalaya's Iohlynti centre, funded by the North East Network, was set up in a single district hospital. Karnataka's Soukhya intervention, in collaboration with the Bengaluru Municipal Corporation and St John's Medical College, has been implemented at 54 primary health centres. Goa's Dilaasa department, funded by the Ministry of Women and Child Development under its National Mission on Empowerment of Women, has been set up in a district hospital. In Gujarat, an NGO called SWATI has initiated a centre (also called SWATI) in collaboration with a rural hospital, district hospital and medical college hospital. In Haryana, hospital-based crisis intervention centres called Sukoon have been initiated in 11 district hospitals by the NRHM and State Health Systems Resource Centre.

undertook a study to understand the processes, barriers, facilitators and strategies for scaling-up Dilaasa.

The study also provides evidence on the role of health systems in the primary prevention of VAW (Garcia-Moreno et al 2015a). The response of health systems enables early detection of violence and the provision of services to prevent further abuse and mitigate the consequences of violence. Scaled health sector responses also make VAW more visible, further contributing to primary prevention.

In this chapter, we set the context for 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 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 the 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." VAW is a global public health problem, with one in every three women having faced violence (WHO 2021). VAW can have acute and chronic health consequences (Garcia-Moreno et al 2015b; Bhate-Deosthali et al 2012; Campbell 2002; WHO 2016) for women, which can lead to the 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 (SDGs) 5 and 6 acknowledge the impact of such violence, emphasising that the achievement of all the SDGs is linked to ending violence and discrimination (UN Women nd).

In the Indian context, about 29% of ever-married women aged 18 to 49 have experienced physical or sexual spousal violence (MoHFW 2021). There was a

3% increase in crimes against women between 2015 and 2016 (National Crime Records Bureau 2017). The majority of these cases were reported under the subhead "Cruelty by husband or his relatives" (32.6%), followed by "Assault on women with intent to outrage her modesty" (25.0%), "Kidnapping and abduction of women" (19.0%) and "Rape" (11.5%). It is important to note that National Crime Records Bureau (NCRB) data look only at cases registered with the police and therefore these numbers do not reflect actual prevalence of violence against women.

### 1.1.1. Interventions for responding to VAW

Feminist movements have played a significant role in advancing the rights of women and contributing to gender equity. An empirical analysis of policies in 70 countries has identified autonomous women's movements as the principal factor in bringing VAW to the forefront for policy change (Htun and Weldon 2012). These movements articulated the issue of VAW, raised awareness about it, and demanded government action (Weldon 2002).

In India, the women's movement had highlighted VAW in the late-1970s. The movement was galvanised by the brutal rape in 1972 of a tribal girl by policemen inside a police station. Class and caste violence had long been discussed in India, but this custodial rape case brought patriarchal gender-based violence (GBV) into the public domain for the first time. Women's groups organised several consciousness-raising activities, which provided an important platform for women to discuss and share their experiences with other women (Deosthali et al 2005).

Spurred by global feminist movements, numerous models to address VAW have been introduced in varied settings-community, school-based, criminal justice system and health system-based-over the last two decades.

### 1.1.2. Health systems-based interventions to address VAW in LMICs

Amongst different interventions to respond to violence against women and children, health sector-based models are widely recognised as most effective,

since women facing violence have inevitable contact with the health system (Colombini et al 2008; Garcia-Moreno et al 2015b).

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 et al 2018). Thus, the majority of health system-based interventions addressing 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) or one-stop centre (OSC). In LMICs, OSCs are the primary approach for a health-sector response to VAW.

Amongst LMICs, it was Malaysia in 1994 that first set up an OSC at a tertiary hospital to provide medical treatment and social support to survivors reaching out to the hospital. Since its inception in Malaysia, OSCs rapidly spread across the South-East Asian region, South African regions and Latin America. They are managed by the public sector, private sector, non-governmental organisations or a combination of these (Olson et al 2020). OSCs aim to provide multiple and simultaneous services, including healthcare and police/legal redress in one place so that survivors are not re-traumatised by having to narrate their stories to several different service providers. The provision of multiple services under one roof is convenient for the already traumatised survivor who must otherwise locate and travel to different service providers. Most of these OSCs are located within hospitals, as in Papua New Guinea and South Africa. In Peru and El Salvador, OSCs are standalone centres managed by the government or non-governmental organisations. OSCs in India are also situated in settings like hospitals, police stations and courts.[2]

[2] In 2012, India's Ministry of Women and Child Development (MWCD) envisaged the establishment of one-stop crisis centres in hospital settings. A review of OSC centres found that though several of them are located within or in the vicinity of district hospitals, they lack coordination with the health system, police and other stakeholders (Bhate-Deosthali et al 2018). As a result, they function as standalone centres and lack coordinated service delivery. This was also evident from the low referral of survivors to OSCs by healthcare providers. Further, the OSCs are run by on-call and pro bono staff, which also affects the quality of services.

According to a systematic review of the barriers and enablers of implementation and effectiveness of the OSC model in LMICs, women reported fear of stigmatisation in approaching standalone OSC centres and hesitation in approaching the police since the majority of officers are men. On the other hand, women found health system-based OSCs non-threatening and viewed healthcare workers as trustworthy for disclosure of abuse (Olson et al 2020). Standalone crisis centre models also tend to be resource-intensive, because they need separate space, infrastructure and staff, while relying on the health system for specialised services. This is a concern about OSCs in facilities where the caseload is low.

Integrating the response to VAW into health services involves integration of holistic services at three levels– provider, facility and system. Provider-level integration offers one or two services (such as counselling or psychological therapy) to survivors of violence, usually through vertical health programmes. The Domestic and Familiar Conflict Assistance programme (CONFAD in Portuguese) in Brazil, for instance, is a primary health centre-based counselling programme dedicated to survivors of domestic and sexual violence. It provides first-line therapeutic counselling to women by trained healthcare professionals including nurses, social workers and psychologists. No external referrals, however, are made to other support services, and this is a major limitation of this model.

Facility-level or comprehensive integration provides all services under one roof, but not by the same provider. For example, at the emergency department of a hospital, the attending doctor may treat the injuries of a survivor, but upon disclosure of violence, send her to the hospital counsellor. OSCs in Malaysia, Bangladesh, Namibia and Thailand offer multiple services, such as health, legal, welfare and counselling, in one location. Major limitations of this model are poor management and shortage of personnel, equipment and supplies. The Dilaasa model in Maharashtra, Bhoomika in Kerala and Sukoon in Haryana are examples of facility-level integration in the Indian context.

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

## 1.2. HEALTH SYSTEM-BASED MODELS TO ADDRESS VAW IN INDIA

In India, most of the existing health system-based models are led by NGOs. These models are located at different levels of health systems– at primary, secondary and tertiary hospitals.

India's health system-based models to address violence against women and children are presented in Table 1.

**Table 1: Indian models to address violence against women and children**

| Models | Examples | Features |
|---|---|---|
| Primary health system model | Soukhya, Karnataka | Auxiliary nurse midwives (ANMs) and community workers and doctors from maternity hospitals identify cases of violence. They are counselled by counsellors and also referred to external agencies for support |
| | SWATI, Gujarat | Counselling services are provided by health workers at community health centres (CHCs) while accredited social health activists (ASHAs) create awareness in the community |
| Secondary health system model | Bhoomika, Kerala<br><br>Iohlynti, Meghalaya | Counsellors and healthcare providers (HCPs) at district/secondary-level hospitals provide psychosocial and medical support to survivors of domestic and sexual violence. HCPs are trained to recognise and handle cases of violence. Referrals are made for legal services |

| Models | Examples | Features |
|---|---|---|
| | Sukoon, Haryana<br><br>Dilaasa Women's Crisis Centre, Goa<br><br>Dilaasa, Maharashtra | |
| Tertiary health system model | Vimochana, Karnataka | Counselling and legal services to burns victims at the burns unit of a tertiary hospital |
| | SNEHA, Maharashtra<br><br>SWATI, Gujarat | Psychosocial support to survivors of domestic violence and sexual violence in a tertiary hospital, and training of HCPs to respond to survivors |
| | NGO-based rape crisis centre, Delhi | Offers examination and evidence-collection for survivors of violence and refers them to an outside agency for counselling and support |
| NGO-based standalone centre | ANWESHI, Kerala | Provides counselling to survivors linked to a tertiary hospital. Also trains HCPs |
| Standalone model | Sakhi centres, all-India | The Sakhi centres provide a full range of services including basic medical care, counselling, shelter, police/ legal services. They refer survivors of sexual violence to hospitals for specialised care and examination. Approved by the government for implementation in 2015, these centres are currently operational in 506 districts across the country. |
| | Rape crisis centre, Delhi Women's Commission | Women examined and referred by a rape crisis centre in a hospital are offered counselling, legal assistance and assistance in police procedures |

*Source: Bhate-Deothali et al 2018; MWCD 2017*

A collaborative study between CEHAT, WHO and three tertiary health facilities of Maharashtra recently generated evidence on the use of the 'systems' approach to strengthening the health-system response to VAW. The project attempted to test approaches to the implementation of WHO's Clinical and Policy Guidelines on responding to VAW. The primary activities implemented by this project were capacity-building of healthcare providers, along with systems-strengthening activities such as introduction of standard operating protocols (SOPs), identification of private spaces for survivors, creation of job aids for healthcare providers (HCPs) and information, education and communication (IEC) material. The project trained providers to identify and provide first-line support to survivors of violence. The findings of this intervention research project indicate that HCPs need further skill-building to enable them to provide all the elements of first-line support to survivors (WHO et al 2021).

## 1.3. SCALING UP VAW INTERVENTIONS

There has been increasing focus on scaling up of health interventions so that their benefits 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 over time to reach a greater number of people (UNDP 2013). Expansion can also be in the context of inputs, outputs, outcomes and impact.

There is, however, little information on the process of scaling up effective VAW interventions. A review of the scaling up of the OSC model in Malaysia by Colombini and colleagues in 2012 pointed out that the presence of an adequate health infrastructure is imperative. Additionally, both the model and the health facility should be flexible enough to allow for adaptation in varied settings.

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

There is some information available in the literature about the process, factors and theories related to scaling up health interventions. A systematic review by Bulthuis et al (2020) of the evidence available on scaling up public health interventions in LMICs reported availability of financial, material and human resources as crucial factors influencing scale-up. 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 a scale-up's success. The review concluded that all these factors are interlinked and that a scale-up strategy is essential before a project is expanded.

Barker et al (2016) suggested a sequential, phase-wise approach to the adaptation of health interventions on a large scale. They identified four phases: (1) Set-up, which prepares the ground for the introduction and testing of the intervention; (2) Developing the scalable unit, which is an early test and demonstration phase; (3) Test of scale-up, which expands 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, enabling a larger number of sites to replicate the intervention. Barker et al also listed the factors that have an impact on the adoption of the intervention in new settings during scale-up. These include superiority of the intervention, effective leadership, and communication/ dissemination of information on the importance of the intervention.

Several frameworks guide the process of scale-up. Barker and colleagues have reviewed six existing frameworks that advocate for a sequential approach in the scale-up of health interventions in LMICs. The frameworks provide practical guidelines on working with organisations, health systems, and communities to implement and scale-up best practices.

The six frameworks are (1) Implementing Best Practices Consortium, (2) ExpandNet, (3) Management Systems International, (4) WHO, (5) Consolidated Framework for Implementation Research, and (6) G Yamey's Scaling up Global Health Interventions: A Proposed Framework for Success. All the frameworks advocate use of data to improve the future design of the work and to understand

factors that affect scale-up. Some frameworks highlight the significance of building the infrastructure required for full scale implementation and advocate testing resource requirements during the pilot project. Other frameworks talk about pre-planning, predictions of resource needs, and feedback after implementation.

Of these frameworks, ExpandNet provides the most systematic approach for increasing the coverage of services and fostering policy and programme development on a lasting basis. ExpandNet is a systems-oriented framework that assumes the intervention to be upscaled has already been tested as effective and therefore focuses on building the capacity of the whole system for effective adoption of the intervention. The institutionalisation of an intervention by local ownership and the use of an integrated approach are the key factors for an effective scale-up, according to this framework.

Since integration is an important aspect of public health interventions, our 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 the ExpandNet framework for scale-up and identification of the building blocks of health systems.

Effective delivery of health services is dependent on the existence of providers and services within the health system (Garcia-Moreno et al 2015a). The Dilaasa model is an integrated hospital-based intervention providing services by operationalising the building blocks of the health system. The core elements or building blocks 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 and plans for achieving these outcomes, including how to implement the intervention at multiple levels (policy, programme, and service delivery), how to advocate for the intervention, the organisational processes involved in implementation, and the costs and resources needed. These ExpandNet strategies offer the means to operationalise the building blocks of the health system to integrate a response to VAW within health services.

The framework below shows how CEHAT led strategies for the scale-up of a VAW response within the health system.

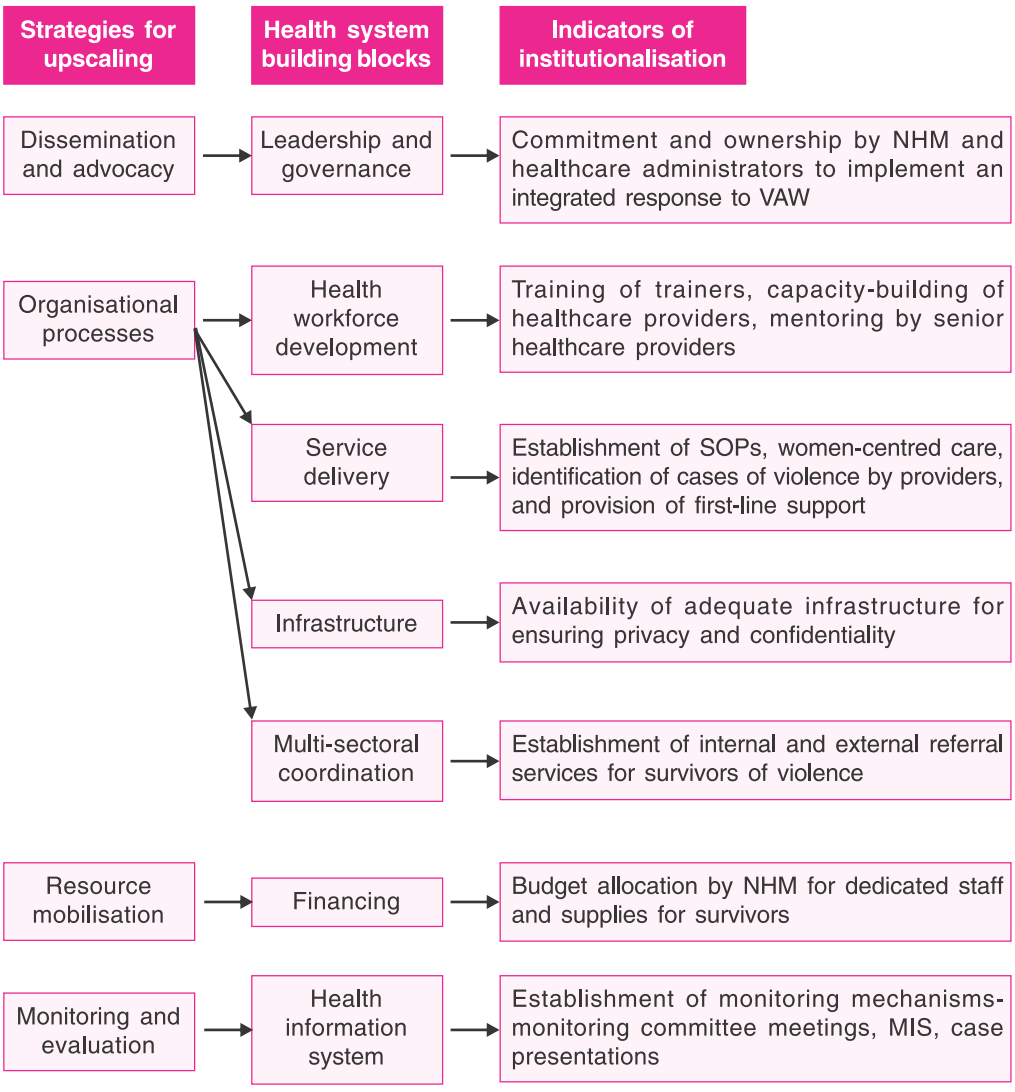
**a. Dissemination and advocacy,** including effective communication about the intervention by sharing the results of the research and evaluations on national platforms to inform government, policymakers and other key stakeholders about the significance and impact of the intervention. This strategy helped secure commitment and ownership from government officials and healthcare administrators.

**b. Organisational processes,** including changes at the level of the organisation implementing the intervention. These processes include building the capacity of HCPs, supervision, and improvement in quality of services. This strategy aims to build champions within the health system, streamline service delivery and establish multisectoral coordination to provide a range of services to women.

**c. Resource mobilisation,** including costs to be allocated for the scale-up of the intervention. This results in a dedicated budget within the health system for responding to VAW.

**d. Monitoring and evaluation,** which helps set up monitoring and accountability mechanisms at the level of the health facility and provides an opportunity for timely course correction during the process of scale-up.

**Figure 1: Strategies for scale-up**



These strategies for upscaling depend on the interaction between the following four elements of scaling up:

First, an innovation must be well-defined during **the pilot** and then maintained throughout the scale-up process. While the intervention may see changes 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** should refer to those who facilitate the scale-up, and take active steps to speed up the scale-up process. 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 monitoring and evaluation plan (defining indicators, selecting methods), interpreting results and taking action based on the data.

Fourth, the **environment** refers to conditions outside 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 the specific objectives of the study, the research design, sampling, data collection methods/procedures, and the ethical considerations for this 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. Assessing the extent to which the components of the Dilaasa model were replicated in 11 peripheral hospitals of Mumbai;
2. Documenting the problems (if any) encountered by the 11 hospitals in establishing a health-sector response, the strategies adopted by them in overcoming these problems, and the processes adopted to make the model functional on a day-to-day basis;
3. Identifying the strategies that influenced the scaling up of the Dilaasa model in 11 peripheral hospitals.

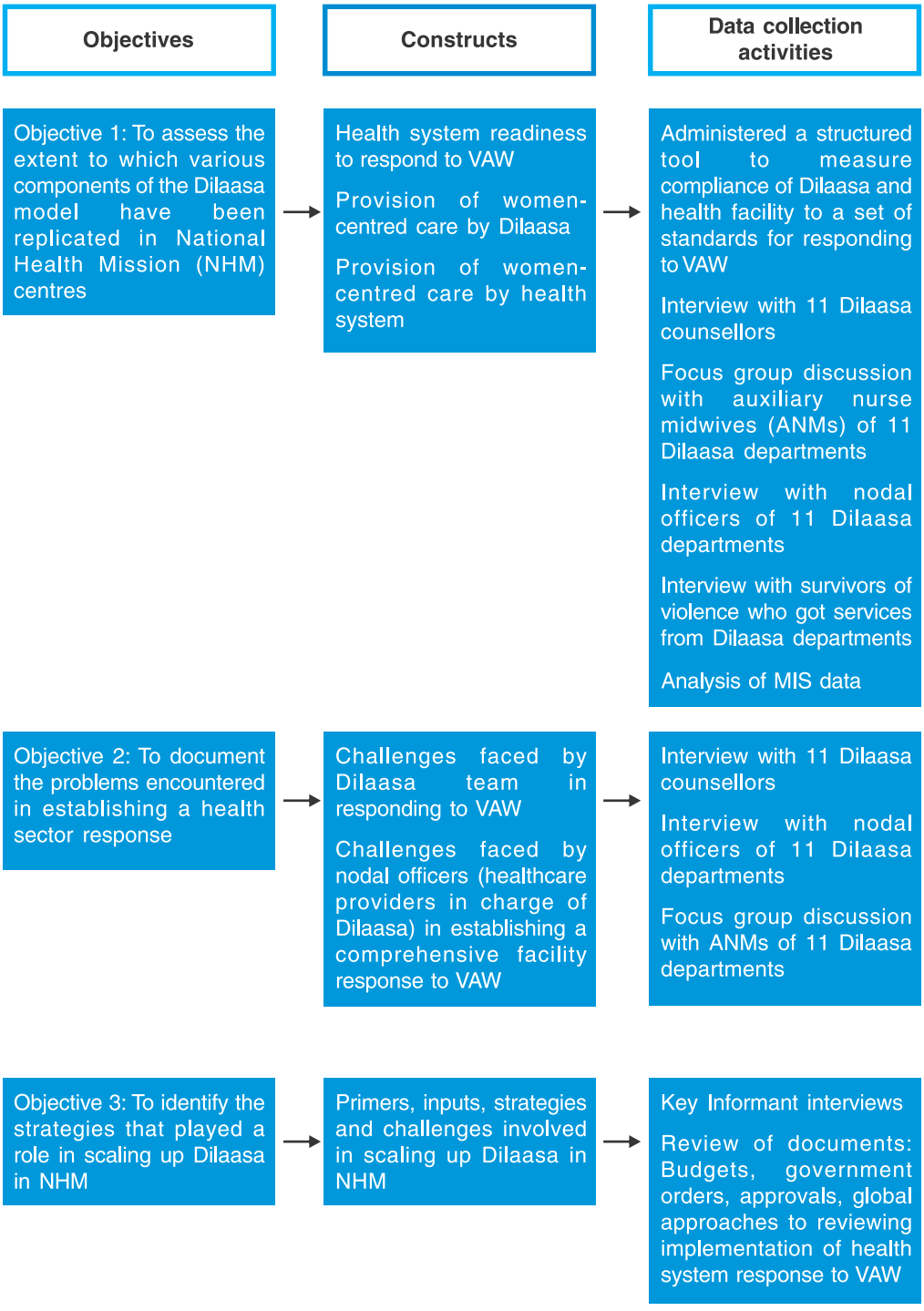
### 2.2. RESEARCH DESIGN

Considering the specific objectives of the study, a mixed method was used to obtain different but complementary 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 the healthcare provider's role in identifying and providing services to women facing violence. Quantitative data collection included

analysis of the service data maintained by 11 Dilaasa departments in the form of management information system (MIS).

The Dilaasa model was reviewed to understand the enablers and barriers influencing the scale-up process through information obtained from service providers, policymakers and key informants involved in the scale-up. Documents such as budgets, government approvals and orders were also reviewed. The extent to which the components of the Dilaasa model have been replicated in National Health Mission (NHM) centres was assessed using the health systems' building blocks approach. Qualitative interviews with Dilaasa team members and healthcare providers responsible for the functioning of the Dilaasa department in each hospital helped assess service delivery, leadership, multisectoral coordination, and infrastructure availability. Survivors of violence were interviewed to ascertain the users' perspective and analysis of MIS helped in understanding profile of users.

**Figure 2: Objectives, constructs and data collection activities carried out**



## 2.3. STUDY SETTINGS

The Dilaasa model has been expanded to 11 of 18 peripheral hospitals in Mumbai. Peripheral hospitals are secondary-level multispecialty hospitals connected to a tertiary hospital. Peripheral hospitals receive referrals from health posts and dispensaries, making them first-line treatment centres that reduce the burden on tertiary care facilities. These hospitals cover large geographical areas and cater to almost 75% of Mumbai's population. The 18 peripheral hospitals have a combined bed strength of more than 6,000.

Table 2 provides an overview of the 11 hospitals, including bed strength, location of Dilaasa departments within their premises, services available, and types of violence routinely addressed at the hospital.

**Table 2: Profile of 11 hospitals in the study**

| Hospital | Bed strength | Location of Dilaasa department | Availability of departments | | Types of cases referred | |
|---|---|---|---|---|---|---|
| | | | Casualty | Gynaecology | Domestic violence | Sexual violence |
| A | 324 | OPD premises | ✓ | ✓ | ✓ | ✓ |
| B | 520 | OPD premises | ✓ | ✓ | ✓ | ✓ |
| C | 304 | OPD premises | ✓ | ✓ | ✓ | ✓ |
| D* | 130 | OPD premises and casualty department | ✓ | No | ✓ | No |
| E | 180 | Top floor, next to pediatric ward | No | No | ✓ | No |
| F$ | 130 | Top floor, inside male ward | ✓ | No | ✓ | No |
| G | 580 | OPD premises | ✓ | ✓ | ✓ | ✓ |

| Hospital | Bed strength | Location of Dilaasa department | Availability of departments | | Types of cases referred | |
|---|---|---|---|---|---|---|
| | | | Casualty | Gynaecology | Domestic violence | Sexual violence |
| H | 210 | Top floor, next to medical records department | ✓ | ✓ | ✓ | ✓ |
| I# | 172 | Seventh floor | No | ✓ | ✓ | No |
| J | 105 | OPD premises | ✓ | ✓ | ✓ | No |
| K | 254 | OPD premises | ✓ | ✓ | ✓ | ✓ |

* Dilaasa team of this hospital operates in two different locations due to ongoing renovation in the hospital
$ The hospital's OPDs and IPDs have been shifted to two different locations due to renovations
# The Dilaasa department was shifted to another hospital in 2017

## 2.4. STUDY PARTICIPANTS, SAMPLE SIZE AND TECHNIQUE

The following participants were involved in our study:

**a. Dilaasa team:** The Dilaasa team in each hospital consists of two counsellors, two auxiliary nurse midwives (ANMs) and one data entry operator (DEO). The most experienced counsellor of the department was interviewed. In hospitals where both counsellors had similar 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 (as majority of the data collection was carried out during peak of COVID).

**b. Nodal officer:** A nodal officer (NO) is a healthcare provider who has the additional responsibility of overseeing the Dilaasa department at that hospital. Of the 11 nodal officers contacted, nine agreed to the interview. In two hospitals, the acting nodal officer was interviewed since the appointed NO was a senior

medical officer and unavailable for the interview due to the Covid-19 workload. At one hospital, the NO was on leave, and at another hospital, the NO refused an interview. Seven nodal officers were interviewed in-person and two online, via Zoom.

**c. Survivor interviews:** Nine survivors from 11 hospitals were contactable for interviews. Seven agreed to the interview, while two refused, citing personal reasons. One survivor agreed to the interview when approached on the telephone but did not turn up at the centre on the appointed day. Thus, six survivors were interviewed for the study.

Only survivors above the age of 18 were contacted for the interview. The researchers asked counsellors from every centre to provide a list of survivors aged 18+. From the list provided, selections were made on the basis of variation in cases– for instance, type of violence experienced (domestic and sexual violence), relationship with the abusers (women abused by husband, marital family, boyfriend and children were included in the study), and social context of survivors (women who are married, unmarried, those suffering from chronic illness). The research team made the final selection of survivors to be contacted. The process of contacting the survivor for interview and consent is described later in this chapter.

**d. Key informant interviews:** Key informants were included in the study to understand the process of scaling up Dilaasa. Informants associated with the first Dilaasa department in Mumbai and in upscaling Dilaasa departments at 11 peripheral hospitals in the city were shortlisted. Fourteen key informants were contacted during data collection. Of them, 10 agreed to the interview, while other four were unavailable. Five interviews were conducted online via Zoom, three in-person, and two on telephone.

The key informants included CEHAT team members involved in upscaling the initiative, officials from the union health ministry and NHM Maharashtra, healthcare administrators and health care providers involved in establishing Dilaasa, and

representatives from international agencies working on the issue of violence.

**e. Focus group discussions (FGDs) with ANMs:** Since the position of ANM was vacant at four of the 11 hospitals during data collection, seven ANMs were selected for the FGD. Each Dilaasa department has a team of two ANMs, but during the study period, only three hospitals had two ANMs on their team. At these three hospitals, the most experienced ANM was purposively selected for the FGD, and in other hospitals, those available were selected. The FGD was conducted online via Zoom.

## 2.5. DATA COLLECTION TOOLS

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

**a. Tool to assess the health system's readiness to respond to VAW:** To review the health sector's response to VAW in 11 peripheral hospitals, a semi-structured tool was prepared, covering the essential components of the Dilaasa model. Since Dilaasa is an evidence-based model, context-specific indicators on strengthening the health-system 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:** This interview guide aimed to understand the role of NOs, the health system's response to violence, ownership of Dilaasa by HCPs, and challenges faced by health facilities in responding to survivors of violence.

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

**e. Key informants:** The guide covered how the upscaling of Dilaasa occurred, the role of the key informant and strategies used in upscaling, and recommendations for upscaling this model.

**f. Additional respondents:** Two gynaecologists and two medical officers were interviewed using a semi-structured interview guide to understand their specific roles and responsibilities, their interface with the Dilaasa team, and their recommendations. Similarly, eight nursing superintendents were interviewed on the role of nurses in responding to VAW using a semi-structured guide. One DEO was interviewed to ascertain the system of data management and analysis at Dilaasa. A representative from the accounts department of NHM Maharashtra was also interviewed to understand financial allocations to Dilaasa departments.

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

**h. Quantitative data analysed:** These were from two sources:

- MIS data obtained from 11 Dilaasa departments, to analyse the pathways by which survivors reach Dilaasa, the types of violence disclosed by women, and the health consequences suffered as a result of the violence.
- Data on the budgets allocated to Dilaasa from 2015 to 2021, obtained from NHM Maharashtra's official website, were analysed to understand budgetary allocations and expenditure patterns.

**Table 3: Respondents, methods and sample size for the study**

| Respondents | Method | Sample size |
|---|---|---|
| Counsellors | Semi-structured interview guide | 11 |
| Nodal officers | Semi-structured interview guide | 9 |
| Key informants | Semi-structured interview guide | 10 |
| Survivors | Semi-structured interview guide | 6 |
| Doctors (other than nodal officers) | Semi-structured interview guide | 4 |
| Nursing superintendents | Semi-structured interview guide | 8 |
| ANMs | Semi-structured guide for focus group discussion | 1 FGD with 7 ANMs |
| DEO | Semi-structured interview guide | 1 |
| NHM Maharashtra accounts representative | Semi-structured interview guide | 1 |

## 2.6. PROCESS OF DATA COLLECTION

**Official sanctions:** CEHAT obtained permission to interview hospital staff and Dilaasa team members from the office of the deputy executive health officer of NUHM, Mumbai. Additionally, permission was sought from the medical superintendents of the 11 hospitals. The data collection continued for 11 months, from November 2020 to October 2021. The period of data collection was extended due to the disruptions caused by the 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 preferred language for the interview. After obtaining consent, the researchers contacted the survivor on the telephone number provided by the counsellor and explained the study. Survivors were given time to make a decision about participation. The interview was conducted only after they confirmed their availability.

Considering the sensitive nature of the interview with survivors, and anticipating the possibility of emotional distress during the interview, a professional counsellor

(not from Dilaasa) was present during the interviews. Three women were interviewed in person, while the other interviews were done on telephone. During the in-person interview, only the survivor, interviewer and a counsellor from CEHAT were present. To ensure privacy, the room was locked. The interviews conducted telephonically were scheduled in accordance with the convenience and safety of the survivor. Nominal compensation of Rs 800 was paid to all the interviewed survivors for the time spent by them as well as any travel expenses incurred. The amount was handed over to the survivor or, in the case of survivors interviewed on telephone, transferred to their bank account.

**Obtaining consent from other respondents:** An information sheet on the study, along with a consent form, was developed for respondents from the health system. The sheet and consent form were translated in the local language, and shared with respondents through WhatsApp and email before the interview. Respondents were given time to read the documents and revert to the research team with their decision on participation. Once a respondent consented to participate, a time and medium of communication for the interview was fixed. Two researchers were present during each interview. One researcher led the interview, while the other handled documentation and took note of any questions missed out.

## 2.7. DATA ANALYSIS

The duration of each interview was 45 minutes to 1.5 hours. All interviews were audio-recorded, transcribed and translated in English. Field notes on observed behaviour and nonverbal cues supplemented the audio recordings. All data, including recordings, transcripts and hard copies of notes, were stored electronically and password-protected.

The QDA software package Atlas.ti 6.2 was used for qualitative data analysis. To begin with, all transcripts were read three to four times by two researchers to identify the key themes underlying responses. Each transcript was coded separately by two researchers to refine the codes and sub-codes.

The MIS data collected were analysed using the Statistical Package for the Social Sciences Software (SPSS) version 20.0. Descriptive analysis at an aggregate level was done. Researchers carried out recoding of string variables from the data.

## 2.8. CHALLENGES DURING DATA COLLECTION

**a. Covid-19 pandemic:** The pandemic and public health measures introduced to address it had an impact on the research project. Data collection was to begin by March 2020, but was delayed because of the nation-wide lockdown following the pandemic. Public hospitals were overburdened with coronavirus cases, so training of HCPs across hospitals on VAW could not be conducted. Consequently, a survey conceptualised to assess the effect of capacity-building of HCPs (a survey on Knowledge, Attitude and Practice [KAP]) had to be shelved.

**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 hospital expenses in case they contracted the coronavirus.

## 2.9. ETHICAL CONSIDERATIONS

1. The study underwent a rigorous scientific and ethical review to conform with Anusandhan Trust's institutional ethics committee (IEC) requirements (Annexure 22).
2. During the interview, 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 made with respondents, and interviews were conducted in a private setting.

5. Participants were given the freedom to terminate the interview at any point or skip any question they chose not to answer.
6. Anonymity of respondents was ensured, and confidentiality of the data obtained was maintained throughout the study.
7. If the respondent was unwilling to have the interview recorded, before beginning or at any point during the interview, no recording was made.

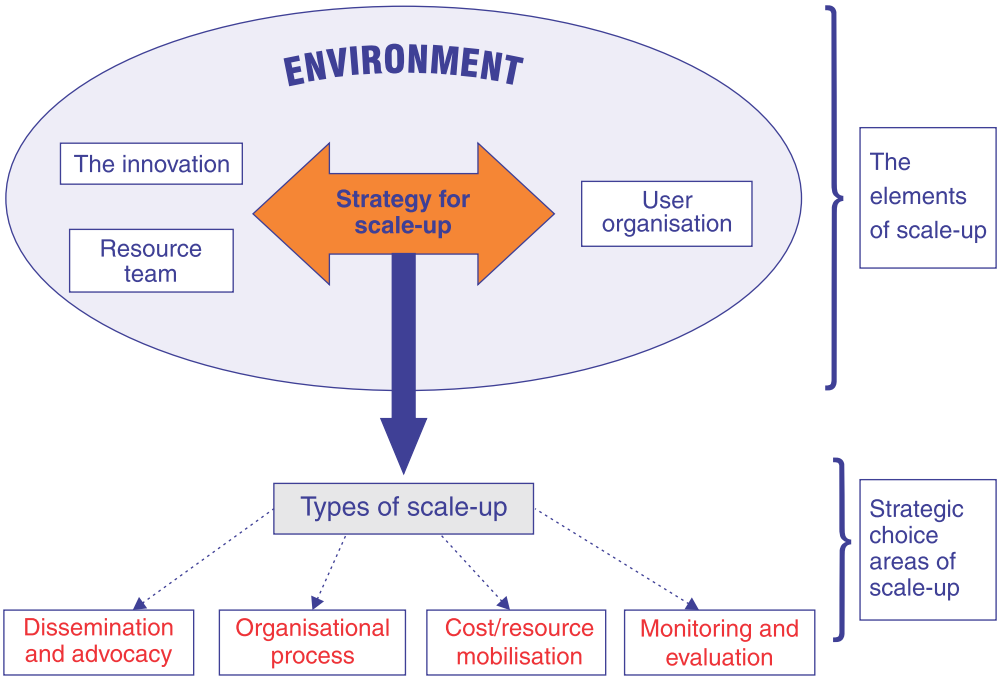
# CHAPTER 3

## REPLICATION AND SCALING UP OF HOSPITAL-BASED CRISIS CENTRE FOR VAW

### 3.1. INTRODUCTION

This chapter discusses the replication of the Dilaasa departments in the context of the ExpandNet/WHO framework, a systematic guide to scaling up an intervention. Our findings have been presented (Figure 3) across the five elements for scale-up and four key principles or strategic choice areas for upscaling discussed in the conceptual framework (Chapter 1). The five elements of scale-up (represented inside the oval in Figure 3) are: innovation, user organisation, environment, resource organisation and strategy for scale-up. The four strategic areas chosen for upscaling are: dissemination and advocacy, organisational process, cost/resource mobilisation, and monitoring and evaluation.

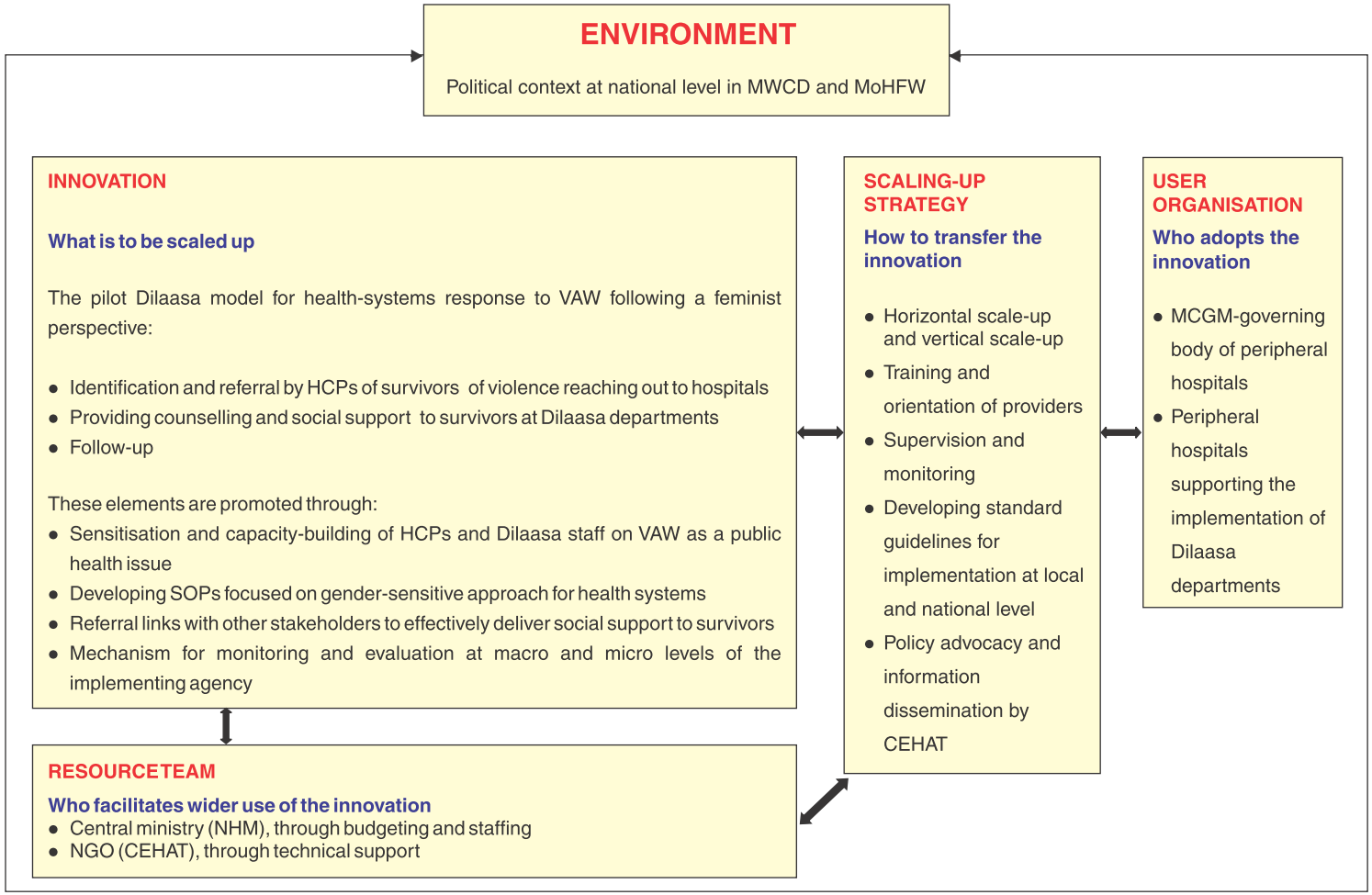
**Figure 3: The ExpandNet/WHO framework for scale-up**




Our discussion of the scale-up within the ExpandNet framework is divided into three parts. Part 1 describes what went into setting up the initial Dilaasa innovation–the pilot project at one Mumbai hospital. Part 2 is about the horizontal scale-up at a second Mumbai hospital. Part 3 is about the vertical scale-up and strategies adopted to replicate and upscale the model under the National Health Mission.

The discussion details the elements of the ExpandNet framework as used in the Dilaasa model: a) the innovation (what is to be scaled up); b) the resource team (NHM and CEHAT); c) the user organisation (MCGM and peripheral hospitals); d) the sociopolitical environment of the country, and e) the strategies adopted to upscale the innovation, including CEHAT's policy advocacy and engagement with opportunities and challenges while expanding the model (Figure 4).

**Figure 4: Design for scaling up Dilaasa model**

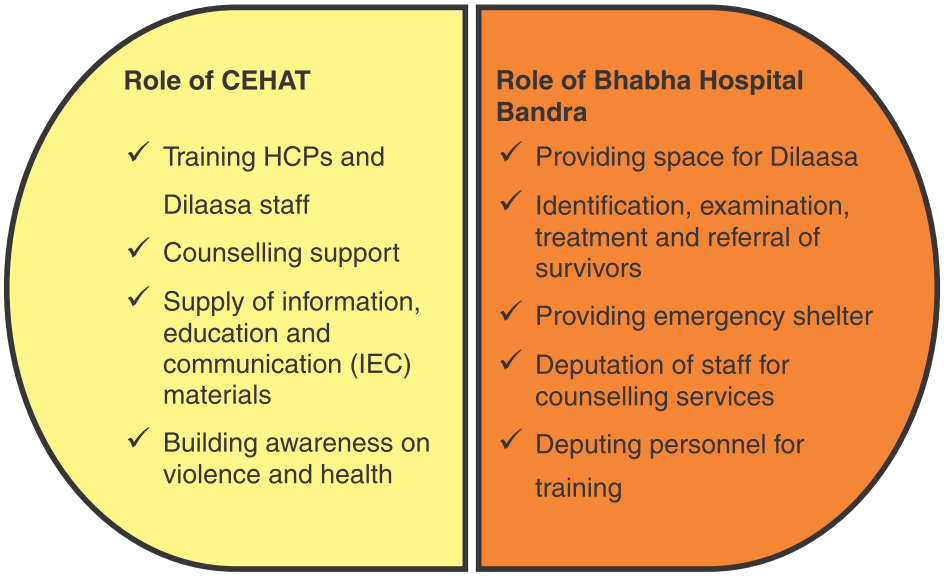


## 3.2. THE PILOT MODEL

The Dilaasa crisis intervention department was set up in 2000 at the K B Bhabha Hospital, a public hospital in Bandra, Mumbai (henceforth Bhabha Hospital Bandra). This pioneering project by CEHAT and the MCGM aimed to establish VAW as a legitimate public health issue and to institutionalise psychosocial services for women and children experiencing violence. Dilaasa was based on Malaysia's OSCC model, adapted to a public hospital setting in Mumbai.

The Dilaasa department drew upon existing hospital personnel and infrastructure. It was staffed by trained personnel who provided psychosocial support to survivors of violence, with a feminist perspective. The department was called 'Dilaasa' ('reassurance' in Hindi) at the suggestion of HCPs at Bhabha Hospital Bandra. CEHAT funded the centre for the three-year pilot phase, with MCGM expected to adopt and sustain Dilaasa at Bhabha Hospital Bandra thereafter.

**Figure 5: Roles assigned to CEHAT and Bhabha Hospital Bandra during the pilot project**



The Dilaasa department developed several gender-sensitive protocols for effective service delivery. The protocol began with training of hospital staff in understanding VAW as a public health issue, recognising their role in identifying violence as part of clinical enquiry, and ensuring psychosocial support in addition to medical care.

CEHAT conducted capacity-building sessions not only for the dedicated staff appointed for Dilaasa, but also for 800-1,000 HCPs from the hospital. CEHAT-MCGM drew a core group of inhouse champions of VAW from senior-to middle-level HCPs and trained them to spearhead the VAW initiative at the hospital. Identifying this core group was important firstly to ensure that the hospital staff and peer groups themselves legitimised VAW as a public health issue, secondly, to create inhouse capacity for training and sensitising HCPs within the hospital, and finally, to increase ownership of Dilaasa across the hospital.

A training of trainers (ToT) approach was employed to give the champions a thorough orientation on gender, violence, the links between violence and health, and the role of HCPs in gender-based violence. CEHAT's trainings were eye-openers for these healthcare providers who had hitherto considered patients reporting violence as a needless encumbrance in an already overburdened health system.

Next, a short-term orientation programme was designed for a core group of 40 trainers at the hospital. Of the 40 staff members deputed for the training, a few conducted trainings at their hospital independently, while some conducted training sessions along with CEHAT staff, and still others used IEC materials to discuss VAW with their peers. The core team members advocated for Dilaasa within the hospital and played a significant role in integrating Dilaasa as a department in the hospital.

Since VAW was a new area of work for the hospital, CEHAT-MCGM felt the need to create inhouse mechanisms for a critical review of the initiative's response, challenges and gaps. CEHAT-MCGM also felt it was important to

ensure sustainability of training in VAW at the peripheral hospital, and therefore a few HCPs–mainly doctors and nurses within the system–were trained as faculty for a training cell. In 2004, the chief medical superintendent of peripheral hospitals in Mumbai deputed 12 HCPs from each of five hospitals to be trained to join the training cell. The 12 trainers in turn trained HCPs in their respective hospitals on VAW. Eventually, 60 HCPs formed part of the training cell, building capacities on VAW and creating awareness about Dilaasa services in their respective hospitals.

In addition, social workers from all 16 peripheral hospitals were trained on violence as a public health issue. Select nurses from these hospitals were trained to offer first-line counselling support to identified survivors, with instructions to refer cases to the Dilaasa department at Bhabha Hospital Bandra for intensive counselling and psychosocial support.

## 3.3. REPLICATION

The ExpandNet framework defines horizontal scale-up as the extension of an innovation to different geographical locations or to larger populations. The success of the pilot model at Bhabha Hospital Bandra laid the ground for its replication in 2005 at the Bhabha Hospital in Kurla to serve Mumbai's eastern suburban population.

### 3.3.1. First replication of Dilaasa model under MCGM

After the successful implementation of the first Dilaasa department and the creation of a pool of trained champions, CEHAT was set for scale-up. The strategies adopted for a guided horizontal replication within Mumbai city were:

**1. Dissemination and advocacy:** CEHAT advocated the upscaling of the department at hospitals across the nation through workshops, dissemination of IEC material and engagement with hospitals and HCPs. The HCPs trained at different hospitals to be champions of a health-sector response to VAW advocated

that just one crisis department could not cater to the large population of Mumbai. Their demand for the establishment of another crisis department resulted in the MCGM initiating a department in the eastern suburbs.

**2. Organisational process:** An additive strategy was adopted in horizontal upscaling–that is, new departments would be added in partnership with the original resource organisations, CEHAT-MCGM. Continuing capacity-building of HCPs was a crucial part of the replication process. CEHAT and members of the training cell trained personnel assigned to the Dilaasa department at Bhabha Hospital Kurla and other HCPs from the hospital.

**3. Resource mobilisation:** Bhabha Hospital Kurla deputed two nurses and the existing community development officer (CDO)[3] , who were trained on providing feminist counselling, for the department. Since the department was running with existing human resources at the time, it was functional only twice a week (Ravindran and Undurti 2010). Simultaneously, other CDOs in the hospital were being trained to support counselling. Since the Dilaasa department was born of a demand from the hospital staff, there was complete ownership of the department. MCGM provided funding support.

**4. Monitoring and evaluation:** A senior medical officer appointed as nodal officer for the centre oversaw its functioning. The hospital's VAW champions and medical superintendent monitored overall functioning of the department.

### 3.3.2. Advocacy efforts by CEHAT on VAW

In 2006, consolidating the experience from the two Dilaasa departments, CEHAT designed a nine-day national course on VAW and the Role of HCPs. In 2008, CEHAT began research at Bhabha Hospital Bandra on comprehensive healthcare services to survivors of sexual violence. Based on evidence from direct interventions with 94 rape survivors, training of HCPs, and implementation of the WHO proforma and guidelines on sexual violence, a legal petition was filed before the Nagpur bench of the Mumbai High Court and later in the Supreme

[3] The Community Development Officer is a medico social worker who navigates procedures for patients in need of financial aid, treatment, and addresses their psychosocial requirement.

Court in 2009.[4] It led to the formulation by CEHAT of uniform gender-sensitive guidelines for responding to sexual violence and establishing the right to healthcare for survivors of sexual violence.

Following this, champions from two other peripheral hospitals catering to a large number of sexual violence cases called for a uniform sexual violence protocol. Along with these champions, CEHAT formulated and implemented the existing uniform gender-sensitive guidelines for responding to sexual violence in four peripheral hospitals in Mumbai.

### 3.3.3. Replication in other states

Around the same time Dilaasa was being replicated at Bhabha Hospital Kurla, CEHAT was helping NGOs approach public hospitals in other states with the idea of adopting the Dilaasa model (Bhate-Deosthali et al 2018). CEHAT advocated the application of the principles and practices of the original model, but adapted to local contexts. These models were initiated at primary, secondary and tertiary levels of health systems (Rege et al 2020).

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

[4] A petition was filed before Nagpur bench of the Mumbai High Court to streamline medico legal response to sexual assault carried out in public hospitals. The verdict on the initial petition filed was regressive and against the petitioner (CEHAT). Therefore, a review petition was filed in the Supreme Court against the order of the Nagpur High Court. For details refer https://www.cehat.org/researchareas/project/1489663079

2. In Meghalaya, North East Network (NEN), a feminist organisation, collaborated with CEHAT to work with the police and health system. A series of capacity-building workshops/seminars were organised for NEN staff, senior health officials and policymakers, followed by intensive training on VAW for doctors and nurses of all district hospitals. This culminated in the establishment of the Iohlynti crisis centre at a district hospital in Meghalaya in 2011.

3. In Bengaluru in 2011, the Soukhya project and CEHAT collaborated to replicate Dilaasa in the primary health system of the Bengaluru Municipal Corporation, with the support of the Indian Council of Medical Research (ICMR). CEHAT provided the knowhow and capacity-building of doctors, nurses and link workers of the municipal corporation. Women coming for antenatal check-ups were screened for domestic violence and survivors were referred to a counsellor. The pilot demonstrated good results, but despite all efforts, it was not integrated in the system.

4. The National Mission for Empowerment of Women (NMEW) supported several pilot projects to address VAW nationwide. As part of this, CEHAT worked with Goa's Department of Medical Education and Research (DMER) and Directorate of Health Services (DHS) to set up a Dilaasa women's crisis centre in one district hospital.

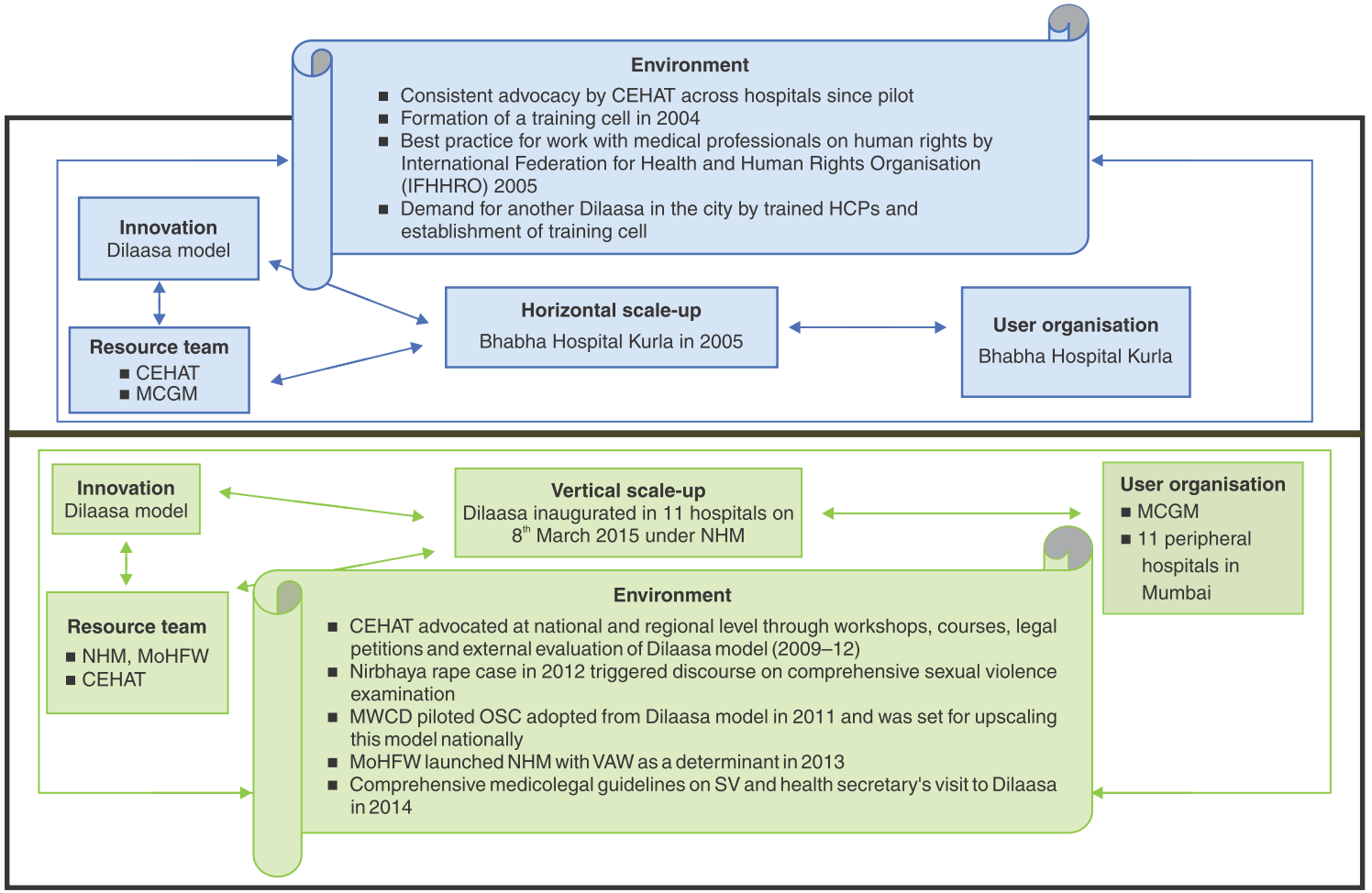
5. SWATI, an Ahmedabad-based feminist organisation working on VAW at the community level through mahila panchayats, decided to replicate Dilaasa in rural Gujarat. CEHAT conducted capacity-building of the SWATI team and staff of the selected health facility. A crisis intervention and support centre was set up at a sub-centre in 2012.

6. In Haryana, Sukoon centres, initiated by the State Health System Resource Centre (SHSRC) and NHM in 2017, were set up in 11 district hospitals. Two counsellors recruited by SHSRC conduct active surveillance to identify cases of violence, and provide identified survivors

of VAW with medical treatment along with psychological and legal support. NHM funds the initiative.

Following a decade of successful and effective functioning, an external evaluation of the Dilaasa model found it extremely effective for hospitals, without placing an additional burden on human resources (Ravindran and Undurti 2010). Thus, Dilaasa was ready for the next phase–the vertical scale-up.

**Figure 6: Milestones in establishing and scaling up Dilaasa departments within the public health system**



## 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 institutionalises it through national planning mechanisms, policy change or legal action (Simmons et al 2007). The upscaling of the Dilaasa model under NHM was based on vertical upscaling, where the innovation, with the complete package of interventions tested in the pilot, was adopted as a programme through national planning and policy advocacy.

### 3.4.1. Dissemination and advocacy

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

As the model 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 such a thoughtless diffusion of the innovation, because such implementations would have failed without systematic planning.

The national module on VAW and the Role of HCPs, initiated in 2006, became an annual training and resource materials such as guidelines for HCPs, guidelines for counselling, and training manuals were developed. CEHAT consistently engaged with policymakers, and advocated to make the health system responsive to VAW. Sufficient resource materials and awareness among policymakers and healthcare providers helped in moving to the next step.

CEHAT had a steady iterative plan for guided upscaling. Though the plan was to upscale Dilaasa at the national level, the project was first replicated in some states–Kerala, Meghalaya, Karnataka, Haryana, Goa and Gujarat–and adapted to their local contexts. Their success provided momentum for expansion of the model nationally.

Horizontal replication is a step towards accelerated vertical upscaling, as it guides adaptation and learning from different contexts prior to national scale-up. Therefore, CEHAT encouraged multiple adaptations of the model in different contexts and different states to foster scale-up at the national level.

### 3.4.2. Environment at the national level

***Scenario at Ministry of Women and Child Development (MWCD):*** The MWCD had already felt the need to address VAW across the country, thanks to advocacy from civil society organisations such as CEHAT. However, in 2011, MWCD's Joint International Mission for Empowerment of Women mandated the creation of a scientific, evidence-based approach for dealing with VAW. With Dilaasa gaining traction as a best practice model to respond to VAW, the ministry adopted the model and initiated a pilot based on Dilaasa in Jaipuria Hospital in Jaipur, Rajasthan, in 2011. Under its National Mission for Empowering Women (NMEW), the ministry planned to upscale 100 hospital-based crisis centres based on the Dilaasa model. According to a key informant highly-placed in the ministry, the pilot was funded by MWCD, found to be effective, and in 2012 was mandated for scale-up across all districts of India as the Sakhi OSC centres under the MWCD.

***Political context in the country:*** In December 2012, the Nirbhaya rape case[5] had put the discourse on VAW and the health system's response to rape survivors squarely in the public domain. Outraged by the brutal rape, civil society organisations drew attention to the lacunae in medical examination of

[5] The Nirbhaya rape case refers to the brutal gang rape and murder of a young girl in the national capital of India in 2012. The incident triggered widespread protests across India of the state and central government's failure to provide adequate security to women. The case resulted in major reforms to ensure the safety of women in India.

survivors–including the unscientific and unethical two-finger test–and the insensitivity of healthcare providers towards rape survivors, issues that CEHAT had advocated for decades. At the central level, VAW came to be accepted as a public health issue and the need to provide medical attention in a non-threatening, non-judgemental and non-interfering way was acknowledged.

The centre appointed two committees, under the leadership of Justice Usha Mehra and Justice J S Verma. The Justice Usha Mehra Committee was to identify the lapses of the authorities and make recommendations to improve women's safety. The committee's recommendation on the establishment of one-stop crisis centres at the district level led to the allocation of Nirbhaya funds for the scale-up of OSCs in general, rather than the Dilaasa model in particular (MHA 2013).

The Justice Verma Committee, appointed to study amendments to the sexual assault law, integrated the evidence presented by CEHAT on the need to replace archaic practices with sensitive care for rape survivors in the health system (Verma et al 2013). The report pointed to the need for comprehensive medicolegal guidelines for sexual violence survivors. At the ministry level, CEHAT presented evidence from the implementation of its gender-sensitive guidelines for responding to sexual violence in hospitals in Mumbai from 2008 to 2012 and advocated for gender-sensitive medical examination and healthcare for rape survivors. The Criminal Law (Amendment) Act, 2013 recognised the right to healthcare 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 across the country was developed collaboratively by the MoHFW and CEHAT in 2014.

As the only indigenous evidence-based public health model on VAW, several enthusiastic public health officials, including the union health secretary, visited and studied Dilaasa. During this period, the International Federation of Health and Human Rights Organisation (IFHHRO) and WHO recognised Dilaasa as a good practice model. Thus, Dilaasa came to be acknowledged as a sustainable evidence-based model at the national level.

***Scenario at Ministry of Health and Family Welfare:*** Around the same time, in 2013, the National Health Mission was launched, with violence against women as one of its determinants. The NHM, guided by the health secretary, aimed at partnership with NGOs to initiate innovative health programmes under the scheme. CEHAT advocated national-level scale-up of Dilaasa, stating that the Dilaasa crisis centres had already been functional in two hospitals under the Municipal Corporation of Greater Mumbai (MCGM) for over a decade and had been recognised by WHO as an efficient model on VAW for LMICs.

The then health secretary visited Mumbai in January 2014 to review projects proposed under NHM in Maharashtra and approved Dilaasa in 11 peripheral hospitals of Mumbai (MoHFW 2015a). CEHAT, along with the chief medical superintendent (CMS) of MCGM hospitals, submitted the proposal and budget for upscaling of Dilaasa in these 11 hospitals to the administrative headquarters of the NHM, Government of Maharashtra. The National implementation of the model was to be adopted gradually.

### 3.4.3. Resource team

NHM was responsible for cost and resource mobilisation and CEHAT also provided technical support. Dilaasa departments upscale was sanctioned on 8th March, 2015 while the departments became functional since 2016 in all 11 public hospitals.

### 3.4.4. User organisation

MCGM, the governing body of peripheral hospitals, and the 11 peripheral hospitals implementing the Dilaasa model are the user organisations in the vertical scale-up. MCGM provided space free of cost for Dilaasa near the OPD or casualty department in each hospital. HCPs at these hospitals had the responsibility of identifying, treating and referring survivors of violence based on regular training provided by champions from the respective hospitals. The medical superintendent of the hospital headed Dilaasa, and a medical officer supervised it to ensure

ownership of the department within each hospital.

### 3.4.5. Resource mobilisation

***Appointment of human resources for Dilaasa by NHM:*** Two full-time social workers/counsellor, two full-time health workers, and a full-time data entry operator-cum-accountant (DEO) were proposed for each Dilaasa department. The social worker/counsellor (master's in social work) was to counsel and facilitate services for women approaching Dilaasa. The health worker, trained in auxiliary nursing and midwifery, was envisioned as a bridge or interface between health systems and Dilaasa, to identify suspected cases of violence and develop a rapport with healthcare providers, especially nurses, during their routine ward rounds. The DEO (a commerce graduate) was responsible for managing the MIS data of the women reporting to Dilaasa for evidence-based research activities and maintaining the accounts of the department.

***Deputation of nodal officer for supervision of Dilaasa:*** A senior medical officer heads all the departments of a peripheral hospital. This hierarchy was retained while upscaling Dilaasa. A medical officer navigates the hierarchical structures within hospitals and deals with any challenges encountered at Dilaasa. The appointment of an in-house senior medical officer as nodal officer or department head of Dilaasa ensures ownership of Dilaasa by 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 NOs and medical superintendents of peripheral hospitals. A seven-day in-depth orientation training for each cadre was undertaken to build perspective and orient them to the challenges of working on violence against women and children.

"Before joining Dilaasa, everybody had a different perception about violence," said one participant about the perceived usefulness of these trainings. "Earlier we would blame the woman for violence but that perception changed through

this training. It did not change overnight, but as I started working here it changed with time."

Another participant said, "After the training, the way I looked at women, the way I looked at violence, my perspective changed completely..."

A standard operating procedure (SOP) for service providers, based on evidence generated from the pilot model, was instituted for:

- Identification, provision of medical support and referral of women to Dilaasa by HCPs within the health facility
- Counselling and supporting women at the Dilaasa department, and linking them to external social support agencies.

A resource directory of referral agencies, including police, shelter homes, protection officers, lawyers, child welfare department and skill development, was compiled by CEHAT for a 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 provided in three hospitals. Maintaining the confidentiality of the data became difficult due to lack of designated storage space, while the lack of a separate space for counselling survivors compromised the privacy and confidentiality of the information shared. The absence of a designated space also led hospital administrations to assign Dilaasa staff other clerical work.

A counsellor from a large-sized hospital says, "We joined Dilaasa on March 25, 2016, and at the time this (office space) was not ready. So we were asked to sit at the medical records department (MRD) downstairs and made to do all the work at MRD, like arranging case papers."

According to counsellors at the three hospitals that did not have a designated space from the beginning, office space was constructed a few months after the staff was appointed. Despite funds allocated for the construction of office space, the space allotted in many hospitals was inadequate. In seven hospitals, a single room instead of two rooms was allotted; in one hospital, the space constructed for Dilaasa was allotted for other purposes and Dilaasa was provided another room. Inadequate or shared office space in the department compromises the privacy and confidentiality of survivors and the information they share.

### 3.4.6. Financing the innovation

In the interests of decentralisation, NHM transferred varying degrees of decision-making and financial authority to local bodies. NHM was solely responsible for funding the programme, 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 programme implementation plan (PIP) for Maharashtra (Annexures 3-7).

The chief medical superintendent (CMS) of all peripheral hospitals under MCGM in Mumbai, along with CEHAT, identified the cost of setting up Dilaasa in 11 peripheral hospitals and submitted it to NHM. Incorporating the innovation in the user organisation called for capital costs for construction of cubicles/office space and furniture for the departments. This was proposed as a one-time budgetary allocation in Year 1. Similarly, the training cost for HCPs and appointed Dilaasa staff was earmarked as a one-time budgetary allocation by NHM. An additional annual budget for recurring personnel and operational costs (office expenditure) was proposed to sustain the project within the health system. According to the budget proposed by the CMS office, all the budgetary subheads listed in Table 4 were sanctioned, except salary for the nodal officer, for which NHM considered sharing personnel from the hospital to save costs.

**Table 4: Budget proposed by chief medical superintendent's office, budget estimates from NHM, and actual expenditure of Dilaasa departments in 11 hospitals from 2016-20 (in lakhs)**

| Year | 2014-15 | 2016-17 | | 2017-18 | | 2018-19 | | 2019-20 | |
|---|---|---|---|---|---|---|---|---|---|
| **Budget heads** | **Budget proposed by CMS office** | **Budgeted by NHM** | **Actual Expenditure** | **Budgeted by NHM** | **Actual Expenditure** | **Budgeted by NHM** | **Actual Expenditure** | **Budgeted by NHM** | **Actual Expenditure** |
| Personnel cost | 92.40 | 114.38* | 114.38 | 99.68# | 99.68 | 99.68# | 99.68 | 99.68 | 99.68 |
| Training cost | 5.0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| Implementation/ capital cost | 66.0 | 60$ | 42.83 | 0 | 0 | 0 | 0 | 0 | 0 |
| Operational cost! | 13.20 | 7.92 | 1.23 | 0 | 7.29 | 0 | 1.72 | 1.2 | 1.26 |
| Salary for nodal officer | 5.0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total budget allocated | 182.60 | 184.3 | 160.44 | 99.68 | 106.97 | 99.68 | 101.4 | 100.88 | 100.94 |

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

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

$ Rs 60 lakhs includes Rs 55 lakhs and Rs 5 lakhs budgeted for 2015-16 and 2016-17 in the NHM budget

! In 2016 Dilaasa departments in each hospital was allotted a fund Rs 5.48 lakhs per hospital (including capital cost and operational cost). NHM did not allocate additional operational cost from 2017-19 as balance amount from this initial transfer was utilised in the subsequent years as operational cost

*Source: Data on expenditure obtained from NHM accounts department*

Despite the allocation of the budget in NHM's 2015-16 PIP, its implementation was delayed. CEHAT's follow-up with NHM over a year resulted in staff recruitment by NHM in 2016-17.

The budgetary allocation by NHM included:

a. Personnel cost
b. Training cost
c. Operational cost
d. Implementation/capital cost.

Utilisation of sanctioned funds by hospitals is cumbersome: the NHM scheme calls for a separate bank account for the Dilaasa department, with two authorised signatories from the hospital. HCPs are routinely transferred in public hospitals, leading to frequent replacement of the authorised signatories and updating of their documents in accordance with bank protocols. Some disinterested NOs appointed for Dilaasa failed to update documents, and as a result, the Dilaasa accounts of three hospitals were frozen by the bank.

The salary allocated to human resources (personnel cost) remained the same as the proposed amount except for deduction of Rs 400 from the DEO's salary to ensure uniformity across DEOs appointed in all NHM programmes (Annexure 6). NHM sanctioned a training cost of Rs 2 lakhs as a one-time cost in Year 1 (2016-17) only, but since capacity-building for all Dilaasa staffers and healthcare providers was funded by CEHAT, how this amount was utilised in first year is not known. Training and capacity-building for VAW is not a one-time activity; it calls for continuing training on clinical knowledge and skills to respond to VAW as well as sensitisation on attitudinal biases related to gender equality and VAW. Reiterating the severity of the problem of VAW within the health system is crucial for building the competencies of HCPs dealing with survivors of violence (Garcia-Moreno et al 2015a). The NHM budget fails to factor in expenses for ongoing training and capacity-building of healthcare providers and Dilaasa staff, although this is the cornerstone of effective service delivery.

A one-time expenditure for civil work and furniture was proposed in Year 1 (2016-17). The budget proposed by the CMS office was Rs 6 lakhs per centre. The budget proposed by NHM PIP was also Rs 6 lakhs per centre, but NHM reduced the actual allocation for each centre to Rs 5.48 lakhs. This was a one-time capital cost allocated to each centre for cubicle construction, furniture and operational costs in Year 1.

The Dilaasa departments spent 73% of the total budget allocated by NHM in Year 1, of which 71% was spent on Dilaasa cubicle construction and furniture and 2% on operational costs (Annexure 4). In subsequent years, NHM did not allocate additional funds for operational costs of the Dilaasa departments. All these centres are forced to manage their operational costs from the initial amount deposited by NHM in 2016-17– Rs 5.48 lakhs.

The cost of Dilaasa's office expenditure had been proposed as an annual recurring budget to ensure sustainability of the innovation. The CMS office proposed a monthly operational cost of Rs 10,000 per centre, but the amount allocated by NHM was Rs 5,000 per centre.

Routine operational costs include:

a. Maintenance expenses for printer and computer
b. Telephone bills
c. Internet charges
d. Stationery charges
e. Meeting or routine training expenses such as tea and snacks for participants
f. Expenses for tea or snacks for survivors in need
g. Conveyance charges for Dilaasa staff travel to various referral agencies including police and shelter homes, as well as travel for official meetings or trainings.

Although the amount budgeted by NHM in 2015-16 was Rs 6,000 per month for each hospital, the allocation was reduced to Rs 5,000 when the centres were

initiated (2016-17). Since then the NHM policy restricts spending on each Dilaasa department to Rs 5,000 every month.

Operational costs are crucial for the day-to-day functioning of the department. Regular bills paid from the Dilaasa account across all centres include telephone and internet charges, which amount to approximately Rs 1,000 per month. Thus, the Dilaasa department is left with just Rs 4,000 for all other expenditure, including reimbursing the Dilaasa staff's travel expenses to referral agencies such as police and protection officers, tea and snacks for survivors, stationery and other maintenance expenses. According to a counsellor from one of the larger hospitals with high caseload, reimbursement for conveyance is often delayed due to shortage of funds, necessitating out-of-pocket spending by the Dilaasa team. Average out-of-pocket expenditure per month ranges from Rs 50 to Rs 1,000. This varies across centres since expenditure ranges from purchase of registers for documentation to travel to referral agencies and contributions to Women's Day celebrations at the hospital.

A few hospitals have included Dilaasa expenses in the hospital budget, which means that regular expenses such as telephone/internet bills, stationery and other maintenance charges are covered 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. One medium-sized hospital meets the entire expenditure for Dilaasa and the operational cost allotted by NHM remains unutilised. Thus, managing a Dilaasa department's expenditure varies in accordance with its level of integration in each hospital.

### 3.4.7. Monitoring and evaluation

Quantitative measures such as MIS data may not indicate the impact of service delivery and therefore Dilaasa has quantitative and qualitative mechanisms to monitor and evaluate the programme. Cases of violence require long-term follow-up and sustained intervention, making qualitative indicators important for

continuous monitoring of the quality of services provided, including documentation reviews to identify services provided to survivors and monthly case presentations to discuss challenging cases.

During the pilot phase, the enthusiastic core group and NOs of the hospital monitored and evaluated Dilaasa. But CEHAT felt the need for a more formal qualitative monitoring and evaluation process, with a monitoring committee within each hospital, and an advisory committee at the MCGM level for Dilaasas across 11 hospitals. The advisory committee, expected to meet annually, is required to facilitate administrative action and ensure efficient functioning of Dilaasa and an optimum response from hospitals to survivors of violence. The advisory committee included higher officials from municipal corporation, senior hospital administrators, senior police officials, and lawyers. The monitoring committee, expected to meet monthly, is an in-house committee comprising heads of major departments. Together, the advisory and monitoring committee ensure accountability of Dilaasa and ownership of the department from MGCM and peripheral hospitals.

The Dilaasa advisory committee, however, has met only once since the upscale, firstly because of the challenges of mobilising unmotivated and disinterested public officials, and secondly, because of lack of accountability from MCGM and the peripheral hospitals. The monitoring committees were functional in seven hospitals, but meetings had to be initiated by CEHAT. Thus, accountability at the level of MCGM and peripheral hospitals is a challenge. Health systems often have instability in leadership due to retirements or routine transfers. As the leadership shifts, so does the priority given to the innovation, leading to failure to establish accountability within the user agency.

Quantitative programme outputs are obtained by both the user organisation– MCGM and the resource team– CEHAT and NHM. The Dilaasa department's monthly reports to the user organisation and resource team detail the number of beneficiaries utilising the service, number of suspected cases screened, and follow-ups carried out. These monthly reports are merely quantitative data of the services provided and do not reflect actual service delivery. For example, the

Dilaasa team regularly screens multiple patients visiting the OPD to identify suspected cases of violence. A secondary-level public hospital's antenatal clinic (ANC) OPD receives 300-600 cases on average per day (Potharaju and Kabra 2011). The majority of them are screened, but this is not recorded in the monthly report, which is mandated to list only cases registered in Dilaasa case records.

## 3.5. CEHAT'S CONTRIBUTION 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 negotiations for an appropriate space in the hospital. This follow-up was necessitated despite Dilaasa finding a place in the NHM's PIP for 2015. The staff was appointed only in 2016, but job responsibilities were not defined by the NHM, leading to confusion about their roles and responsibilities. This was addressed through a dialogue with the NHM and the new staff, ensuring that Dilaasa staff was not assigned ad hoc clerical activities by the hospital.

### 3.5.1. Training of trainers

From 2014 onwards, even before the 11 Dilaasa departments were established, CEHAT conducted ToT sessions for HCPs from all 11 hospitals. The training included perspective on VAW as a public health and human rights issue, the role of HCPs in responding to survivors, comprehensive healthcare to rape and domestic violence survivors, communication skills, basic counselling, role as trainer, laws related to VAW, and management of a crisis intervention department. To streamline a gender-sensitive and comprehensive response to sexual violence, CEHAT advocated with MCGM to print the medicolegal protocol forms for SV examination released by the central government in 2014 and to provide sexual assault forensic evidence (SAFE) kits[6]. This was finally done in 2018.

[6] The Sexual Assault Care and Forensic Evidence or SAFE Kit is a 'Model Kit for Comprehensive Care and Documentation of Evidence in cases of Sexual Assault'. It contains all equipments required for examination and evidence collection in cases of sexual assault. MCGM was the only corporation to develop these kits for its public hospitals

### 3.5.2. Training Dilaasa staff

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

For convenient reference, all reading material related to counselling guidelines, information related to laws, pamphlets, posters and presentations used during the trainings were translated and made available in Marathi.

This was followed by training on laws and legal procedures, medicolegal procedures, interface with police, and how to conduct joint meetings with an abuser and/or family members. However, it is a well-known fact that a one-time training cannot ensure comprehensive counselling. Therefore, CEHAT set up a mechanism for trained and senior counsellors from CEHAT and Bhabha Hospital Bandra's Dilaasa department to visit NHM-based crisis centres every month, to demonstrate counselling and to conduct meetings on challenges in counselling and navigating health, police and legal systems. In 2019, a training session on understanding sexual diversities and responding to the needs of the LGBTQA+ community was conducted for Dilaasa staff. Counsellors from a few centres that received transgender cases shared positive feedback on counselling transgender survivors.

### 3.5.3. Monitoring quality of counselling

CEHAT visits Dilaasa departments to demonstrate counselling, read intake forms, provide detailed feedback on counselling, and carry out discussions with counsellors on the challenges they face. In addition, counsellors of all centres are brought together at a meeting for sharing and learning as well as expert

guidance. Case presentation at the meeting enabled counsellors to voice their challenges and learn from each other's experiences. It also helped identify the future training needs of these counsellors.

### 3.5.4. Setting up advisory committees

In March 2016, CEHAT had recommended setting up an advisory committee to oversee and support the 11 Dilaasa crisis centres. As soon as the crisis centres were set up, the CMS was approached with the proposition. However, the CMS office deemed this the responsibility of NHM, while NHM stated that their responsibility was to recruit staff rather than run the centres at the respective hospitals. Despite a series of discussions, the advisory committee was not set up and the matter was referred to the assistant municipal commissioner (AMC), 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 the executive health officer (EHO) and approved by the additional municipal commissioner. The advisory committee was announced by NHM at a meeting held on January 24, 2017.

**Table 5: List of advisory committee members**

| Sr. No. | Officers of Dilaasa Advisory Committee | Designation |
|---|---|---|
| 1 | Additional municipal commissioner (AMC) | Chairman |
| 2 | Chief medical superintendent (peripheral hospitals) | Member secretary |
| 3 | Executive health officer | Member |
| 4 | Deputy executive health officer | Member |
| 5 | Assistant health officer | Member |
| 6 | Medical superintendent/deputy medical superintendent/chief medical officer (respective peripheral hospitals) | Member |
| 7 | Representative from CEHAT | Member |
| 8 | Legal expert | Member |

In January 2017, CEHAT discussed with the deputy executive health officer its concern about an advisory committee comprising entirely of doctors and administrators. CEHAT pointed out that feedback on the reach and utility of the centres also needs to be sought from civil society organisations. Senior counsellors from the Dilaasa Bandra centre who had shaped the counsellors of NHM, also needed to be brought onto the advisory committee to lend their expertise. This, however, remains a challenge.

## 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 health systems. 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 within the public health system.

The innovation has helped women claim their right to a violence-free life. It has also improved the health and wellbeing of women, since violence often has health consequences.

# CHAPTER 4

## FIDELITY TO THE ESSENTIAL ELEMENTS OF DILAASA MODEL

This chapter describes the extent to which the 11 peripheral hospitals have adhered to (a) the essential elements of the Dilaasa model and (b) the building blocks of health systems while establishing a comprehensive health-systems response to VAW.

### 4.1. FIDELITY TO ORIGINAL DILAASA MODEL

Fidelity, according to Durlak and DuPre (2008), is adherence to, or maintenance of, the key components of an intervention or programme. Fidelity is essential in achieving the demonstrated effects of a successful intervention and for its successful upscaling. However, adaptation to the local context is also important in ensuring sustainability. Thus, a balance between fidelity and adaptation is essential, where the upscaled intervention maintains the core components even as it is tailored to the local context (Durlak and DuPre 2008).

For this study, fidelity has been assessed using data from interviews with counsellors and nodal officers as well as data from a survey of health facility readiness. The findings on fidelity have been presented in accordance with the building blocks of heath systems.

***4.1.1. Leadership and governance*** refers to the role and functions of healthcare providers with managerial responsibility, including implementation of policy frameworks, supervision, mentoring, establishing coalitions, and monitoring mechanisms. Several strategies were conceptualised under leadership and governance in the pilot Dilaasa model (2000), and these were intended to be upscaled as core elements of the health system response to VAW.

All 11 hospitals have a nodal officer who is a medical doctor, with additional responsibility of the hospital's response to VAW. These NOs were appointed by medical superintendents of the respective hospitals and have both clinical and administrative responsibilities (Annexure 2). CEHAT provided essential training to the NOs to strengthen their hospital's response to VAW.

As evident from interviews with nine NOs (two were unavailable for interview), the primary responsibility of nodal officers is to monitor activities of the Dilaasa department, address the concerns of HCPs and Dilaasa staff in handling cases of violence, and review monthly reports and accounts of Dilaasa before submission to the municipal corporation. Nodal officers handle the logistical requirements and finances of Dilaasa, as well as interdepartmental referrals. They also facilitate the emergency shelter and other needs of women who are unsafe if they return home.

Nodal officers have evolved different ways to oversee the functioning of Dilaasa. These include seeking feedback from survivors about services received, and regular communication with the Dilaasa team on difficulties faced in the provision of care to the survivor.

Leading the capacity-building of HCPs at their hospital on VAW and its health impact is one of the NO's core responsibilities. NOs orient and conduct trainings and refresher courses for doctors and nurses, with help from Dilaasa and CEHAT staff. They request a list of participants for training from different departments in consultation with the nursing head. Of the nine nodal officers, six affirmed that they make an effort to arrange and conduct trainings on VAW for new staff, and refresher trainings for old staff. The other NOs cited challenges like high workload and low turnout of participants as reasons for inconsistent training of HCPs.

The nodal officer is also responsible for facilitating monitoring committee meetings for periodic reviews of the Dilaasa/health-system response to survivors of violence. Each hospital has a monitoring committee, which comprises (a) the nodal officer; (b) representatives from medical and nursing staff such as the

senior medical officer, nursing superintendent, sister-in-charge of key departments such as emergency/casualty, obstetrics and gynaecology, paediatric, medicine and general surgery; (c) police constable on duty at the hospital; (d) Dilaasa counsellors; (e) ANMs; and (f) representatives of CEHAT. The committee discusses challenging cases, difficulties encountered with external agencies such as the police and child welfare committee, and gaps in the response to survivors. Seven of the 11 hospital monitoring committees conduct regular meetings and reviews. Frequent transfer of healthcare providers and the inability of committee members to coordinate a date for the meeting are challenges faced by monitoring committees.

***4.1.2. Health workforce development:*** A sensitive and efficient response to VAW demands adequate and trained staff. The training of HCPs should focus on changing their knowledge, attitudes and practices. There is significant evidence to show that frequent training is essential to develop staff competencies (Garcia-Moreno et al 2015a). Therefore, building the capacity of HCPs has been seen as an integral component of the Dilaasa model.

Every hospital was envisaged to have a core group for VAW, trained by CEHAT. This is a group of sensitised HCPs, across cadres, who have undergone intensive training on the health-system response to survivors of violence and are committed to promoting a sensitive response to VAW in their health facilities.

The core group trains other HCPs at their facility and facilitates access to care for survivors. The training of HCPs focuses on building an understanding about VAW as a public health issue and the legal mandate of providers, addressing myths around VAW, building skills to identify the signs and symptoms of violence, and providing first-line support to survivors. In addition, providers of the gynaecology department are trained in conducting medicolegal examination of survivors of sexual violence, collecting evidence, and providing medical treatment. Trainings are conducted more frequently for resident doctors who are at the forefront in providing these services because they are transferred every six months.

Trainings include doctors and nurses to increase team spirit as well as ownership of the programme. The training content is delivered through participatory methods such as role-play and case study.

Of the 11 hospitals, five were found to have a core group that conducts regular trainings of staff. As with the monitoring committees, however, frequent HCP transfers hamper the functioning of the core group.

The Dilaasa team in each hospital includes two counsellors, two ANMs and one DEOs. Table 6 lists the roles and responsibilities of the Dilaasa team, uniform across all 11 centres. Counsellors appointed in the Dilaasa department are male and female, with a master's degree in social work (Annexure 1). Nine of the 11 counsellors interviewed had experience of 1-28 years in social work within the healthcare sector, while two counsellors interviewed had no prior experience.

**Table 6: Role of Dilaasa counsellor, ANM and DEO**

| Role of Dilaasa counsellors | Role of ANMs | Role of DEO |
|---|---|---|
| Providing emotional support to survivors, reassuring survivors about Dilaasa as a safe space they can visit at any time | Identifying survivors of violence while conducting rounds of casualty department and wards with the counsellor | Entering data of cases registered with Dilaasa |
| Providing counselling to survivors based on feminist principles,[7] assessing the safety of survivors, and developing a safety plan along with the survivor | Delivering talks in the wards and OPDs about violence as a health issue, health impact of violence, rights of women, services provided through Dilaasa | Conducting periodic analysis of data and generating reports |
| Making referrals to relevant hospital departments for any medical needs of survivors | Providing first-line psychosocial support to survivors of violence | Managing Dilaasa funds and bank documents |

[7] Feminist principles are rooted in the belief that power and inequalities within a relationship must be questioned and that 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.

| Role of Dilaasa counsellors | Role of ANMs | Role of DEO |
|---|---|---|
| Providing social support and linking survivors to additional resources such as skill-building/income-generation activities, support groups and community-based organisations | Assisting DEOs in entering data and preparing monthly reports in required formats | Issuing cheques for expenditure, and reimbursing Dilaasa staff for conveyance |
| Going on ward rounds to identify women facing violence | | Submitting expenditure to NHM for audit at the end of the financial year |
| Helping trainers/core group members organise quarterly or biannual trainings, as required by hospital staff | | |
| Providing support to healthcare providers for medicolegal examination and evidence collection in case of rape | | |
| Coordinating with various stakeholders like police, CWC[8] and shelter homes to provide comprehensive care to survivors | | |
| Maintaining documentation of cases of violence registered with Dilaasa | | |

[8] The child welfare committee (CWC), established under the Juvenile Justice Act, 2000, is responsible for the care, protection, treatment, development and rehabilitation of children in need. The committee makes provision for the basic needs of the child and protects his/her human rights.

The Dilaasa team works from 9 am to 4 pm on weekdays, and 9 am to 1 pm on Saturdays. A counsellor and ANM conduct morning rounds to identify cases in the wards, OPD and casualty department. The counsellors and ANMs on the team make rounds on alternate days, ensuring that one counsellor always stays at Dilaasa in case a woman comes in for counselling. In the absence of a second counsellor, the ANM takes daily rounds alone and the counsellor accompanies her occasionally.

At the time of data collection, the positions of four counsellors, seven ANMs and four DEOs were vacant. There is a high rate of attrition among Dilaasa team members because of the unfavourable terms of employment offered to staff by the external recruitment agency.

National Health Mission programmes privatise some components of the health system in an attempt to ensure greater efficiency and better outcomes. This includes recruitment of human resources across cadres. All NHM initiatives adopt a similar approach, with human resources being appointed on a contractual basis by an outsourced agency. Such outsourcing, NHM believes, reduces government's liabilities and paperwork, avoids union demands, and boosts the productivity of employees.

Such contractual short-term employment, however, is exploitative and a matter of concern. It has led to job insecurity and instability among Dilaasa staff. For example, there is a failure to renew contracts, erratic tenure of appointment, abrupt changes in the clauses of the contract such as a 'no leave policy', absence of increments, and delays in crediting monthly salary. Parallel control of counsellors and Dilaasa staff by nodal officers of the hospital and the NHM/outsourcing agency leads to confusion and can impede Dilaasa's work. It also causes administrative challenges in coordinating the two systems.

The study also revealed malpractices and corruption by the outsourcing agencies. For instance, the agency charges Rs 500 as a one-time fee for initiating every annual increment for staff, while the percentage of increment is left to the whims

of the outsourcing agency. The outsourcing agency makes random decisions on increments for ANMs and counsellors– annually or semi-annually, or upon renewal of contract. According to one DEO, their contract renewal has been pending since 2018-19, which means no increments since then, as increments are provided only upon renewal of contract. No maternity leave is provided to women, however they are expected to resign and rejoin work.

***4.1.3. Training of the Dilaasa team:*** All new Dilaasa counsellors go through a five to seven days training by CEHAT to build their perspective on VAW. The training includes sessions on sex and sexuality, gender equity, family attitudes towards women, forms of violence against women, identification of violence, personal laws, laws related to VAW, POCSO and legal aspects of violence against children, conducting joint meetings, and handling professional burnout.

Monthly case presentations facilitated by CEHAT are an important part of the continuing capacity-building of counsellors. These monthly sessions enhance counselling skills, broaden knowledge, address challenges in counselling and facilitation of referral services, provide a forum for discussion of emotional and ethical dilemmas, and strengthen team spirit. This is where counsellors can discuss their struggles, unburden their pressures, and address the burnout that arises from hearing stories of violence every day. Apart from initial training sessions, CEHAT conducts regular refresher trainings in the form of seminars, webinars and workshops.

The high turnover of Dilaasa staff is a major deterrent to capacity-building, since the skills for dealing with cases of violence accrue with time and experience.

## 4.2. INFRASTRUCTURE, EQUIPMENT AND COMMODITIES

Each hospital is responsible for ensuring availability of the infrastructure, equipment and commodities required to provide appropriate care in cases of violence against women.

***4.2.1. Infrastructure and supplies:*** All 11 hospitals have space/rooms in different departments to ensure auditory and visual privacy in cases of domestic violence. Of the 11, seven hospitals carry out medicolegal examination of sexual violence cases, while the rest do not have the facilities to do so and therefore refer cases to other hospitals. In five of these seven hospitals, medicolegal examination is carried out in the gynaecology department, while in the other two, the examination is carried out in the labour room using screens. Our interviews with nodal officers pointed to the difficulty in maintaining privacy, especially during OPD hours. The seven hospitals have access to a toilet attached to, or close to, the consultation/examination room, which can be locked from inside, and is equipped with a disposal bin and water supply.

The Dilaasa department must be at a location that is easily accessible to women and children. Of the 11 centres, eight were conveniently located in OPDs or near emergency departments. In the remaining three, centres were located near IPDs, making access challenging for survivors.

All 11 hospitals have access to a common drinking water facility for survivors, patients and hospital staff. Only one Dilaasa department provided drinking water inside the centre. There are no separate toilets inside the centres and survivors must access common toilets in health facilities.

All 11 Dilaasa departments have a phone connection, either direct or an extension. However, at the time of data collection, only seven were functional.

### *4.2.2. Furniture and supplies*

**Table 7: Availability of furniture and supplies in 11 hospitals**

| Furniture and supplies | Availability in 11 hospitals |
|---|---|
| **Hospital** | |
| Chairs for survivor, companion and provider (minimum of three chairs in the consultation/examination room) | ✓ |
| One desk between provider and survivor | ✓ |
| A door, curtain or screen for visual privacy during physical examination | ✓ |
| One examination table for examination of physical injuries | ✓ |
| A washable or disposable cover for the examination table | ✓ |
| Adequate light source in the examination room/space | ✓ |
| Angle lamp or torch/flashlight for pelvic examination Access to a lockable cabinet, room or other units for secure storage of survivor case paper/files/register, and medical supplies | ✓ |
| **Dilaasa** | |
| Desk and chair for counsellor, survivor and accompanying persons if any | ✓ |
| Desk and chair for DEO | Three Dilaasa departments have no desk and chair for DEOs due to shortage of space |
| Computer for maintaining case records | In one hospital, the computer is in the NO's room due to shortage of space |
| Adequate and secure storage facility for counselling records and other documentation | In one hospital, the cabinet is in the NO's room due to shortage of space |
| Adequate light and ventilation in centres | ✓ |

### *4.2.3. Administrative supplies*

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

| Administrative supplies | Availability in 11 hospitals |
|---|---|
| **Hospital** | |
| Job aids and IEC material on VAW for provider and survivor | ✓ |
| Printed copy of MoHFW 2014 guidelines and protocols for medicolegal care for survivors/victims of sexual violence | ✓ |
| **Dilaasa** | |
| Printed copies of intake forms and follow-up forms | In one hospital where the computer and storage cabinet are in the NO's office, only the Dilaasa team has access to the cabinet where records are kept securely locked. |
| Registers and stationery for documenting suspected cases of violence, Dilaasa letterhead for referral services, inward and outward registers | One hospital was unable to purchase registers and stationery as its account clearance was pending |
| Health education and information material for survivors in the form of posters, pamphlets | ✓ |
| Resource directory for meaningful referral of survivors to other support agencies | ✓ |

### *4.2.4. Financing*

Budget allocation for dedicated staff, services to survivors, and capacity-building of providers is essential to sustain the systems' response. In 2015, the central government sanctioned Rs 60 lakhs to the MCGM under NHM for setting up the 11 Dilaasa departments. NHM supports the routine expenditure of Dilaasa, including salaries of the team.

An analysis of the budget shows that the money received for infrastructure and setting up of Dilaasa was in accordance with the amount proposed by the CMS office for that year. But interviews with counsellors revealed that there was a delay in disbursement to hospitals. Because there was no office space initially, counsellors had difficulty in effective delivery of services. In addition, the budget considered capacity-building of healthcare providers a one-time activity, and therefore no money was allocated for refresher trainings.

As mentioned earlier, Dilaasa team members are poorly paid. In addition, innumerable formalities make the funds for office expenditure inaccessible, forcing counsellors to spend from their own pockets and then follow-up for reimbursement. Chapter 3 provides details of the budget and budgetary challenges.

#### *4.2.5. Service delivery*

Strengthening service delivery through protocols and guidelines is vital for meeting the minimum standards of care and enhancing access to services within the health system (WHO and ExpandNet 2010). Implementation of the SOPs developed by CEHAT is important for effective service delivery at the 11 Dilaasa departments.

#### *4.2.6. Privacy, consent and confidentiality*

Privacy, as conceptualised at Dilaasa,is 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 the right to the data shared (informational privacy).

**Table 9: Availability of auditory and visual privacy in 11 hospitals and Dilaasa departments**

| Auditory and visual privacy | Availability in 11 hospitals |
|---|---|
| **Hospital** | |
| Sexual violence case examination, evidence collection and treatment | At two hospitals, examination is conducted in the labour room using screens. Maintaining auditory privacy is a challenge |
| In cases of domestic violence, spaces in IPD and OPD are used | ✓ |
| If the survivor is accompanied by relatives/any other person, health providers create an opportunity to speak to the survivor alone | ✓ |
| **Dilaasa** | |
| Separate rooms in Dilaasa to ensure auditory and visual privacy | Of 11 centres, only four have two separate rooms. At one centre, the room is divided with a glass partition and curtains |

Consent implies the right of the survivor to decide for herself and agree to receive or refuse medical treatment, medicolegal examination, intervention and care. The type and extent of treatment and care should be her choice as long as she is above the age of 12 in cases of sexual violence. It is the healthcare provider's responsibility to share with survivors accurate and understandable details, the range of options available to them, and the pros and cons of each option. In cases of sexual violence, healthcare providers take written consent, while at Dilaasa, counsellors take verbal consent.

**Table10: Provisions for obtaining consent at 11 hospitals**

| Consent | Availability in 11 hospitals |
|---|---|
| **Hospital** | |
| Consent before providing information on services, procedures, and laws governing violence against women and children | ✓ |
| Informing about mandatory reporting under POCSO Act for survivors under 18 years of age | ✓ |
| **Dilaasa** | |
| Consent before providing information on services and procedures of Dilaasa departments | ✓ |
| Consent is taken from minors after discussing the safety of the child | ✓ |

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

**Table11: Compliance with confidentiality clause at 11 hospitals**

| Confidentiality | Availability in 11 hospitals |
|---|---|
| **Hospital** | |
| All records kept in a locker: medicolegal forms, VAW register, forensic evidence register and any other documents with identifying information about the survivor | ✓ |
| Confidentiality of survivor and case details maintained | ✓ |
| Chain of custody for forensic evidence followed | ✓ |
| Confidentiality of non-medicolegal cases | ✓ |
| Sharing case documentation, including medicolegal evidence, rape proforma and discharge card, with police and survivor | ✓ |
| Nullifying case-sensitive information | ✓ |
| **Dilaasa** | |
| Intake forms, VAW register, and any other documents with identifying information about the survivor kept in a locker | ✓ |
| Confidentiality maintained about survivor and case details | ✓ |
| Anonymity maintained while discussing survivor's case | ✓ |

At all 11 hospitals, the history of violence, and details of survivors and abusers are not disclosed, unless for medical or medicolegal procedures. Case details are not shared with persons not involved in the provision of care to the survivor.

The chain of custody for forensic evidence is prescribed, and strictly observed, at the seven hospitals that handle sexual violence cases. In medicolegal cases, the examining doctor is responsible for collecting and drying evidence; labelling is done by the examining doctor or nurse; and sealing of evidence is done by the medical records officer (MRO) or casualty officer. The sister-in-charge of the obstetrics and gynaecology department or other examining department is responsible for securing the evidence and handing it over to the police in medicolegal cases.

Any sensitive information that needs to be destroyed is shredded by the MRO in the presence of the medical superintendent at all 11 hospitals.

Referring to survivors by name or identifiable details is avoided while providing feedback or discussing a case with doctors or team members; the registration number of the case is used as a reference at all 11 Dilaasa departments.

There are limits to confidentiality in cases where the counsellor identifies or recognises suicidal thoughts in a survivor. Dilaasa counsellors may decide to inform a family member about such a situation and involve the family member in safety planning for the survivor. However, the counsellor first explains to the survivor the need to disclose the information to family or friends with whom the survivor feels comfortable.

## 4.3. MEDICAL TREATMENT FOR SURVIVORS OF VIOLENCE

Comprehensive care demands availability, accessibility and affordability of a range of medical services to survivors of violence. Table 12 presents the elements of medical treatment across the 11 hospitals.

**Table12: Availability of medical treatment for VAW in 11 hospitals**

| Medical treatment | Availability in 11 hospitals |
|---|---|
| Offering essential care to survivors of violence 24 hours a day or helping them access alternative facilities such as referral to larger hospitals | ✓ |
| Providing treatment free of cost | In nine hospitals, survivors are required to pay for essential diagnostic tests and medicines not available at the hospital. In cases where a survivor is unable to pay, counsellors request the hospital to waive charges |

| Medical treatment | Availability in 11 hospitals |
|---|---|
| Providing medical treatment without requiring survivors to file a police report | Two hospitals insist that cases of sexual violence be reported to the police before treatment is provided, even if the survivor does not want to register a complaint |
| Keeping medicolegal forms in the examination room, ensuring accessibility, privacy and confidentiality | ✓ |
| Equal access to care, regardless of identity and marital status | At one hospital, unmarried pregnant women face barriers in accessing abortion |
| Emergency shelter at hospitals | At one hospital, due to high patient load, shelter is offered only to survivors requiring clinical care for physical injuries |
| Follow ministry guidelines for documentation and examination of sexual violence cases | ✓ |
| Routine enquiry about violence by healthcare providers during prenatal check-ups | ✓ |
| Obtaining consent of adult women in cases of abortion (consent of the husband/partner is not required for abortion in adult women) | ✓ |
| Consent for abortion of unmarried women under 18 years of age | In all the hospitals, providers inform the police if the survivor is unmarried, under 18 years of age and pregnant. This is mandatory under POCSO. However, police reports are filed only after first informing minor survivors about the implications of such a report |
| Offer medical abortion | None of the hospitals offer medical abortion unless demanded by Dilaasa staff |

The study found that at two hospitals some SV survivors were asked to report to the police before getting medical treatment. In cases of child survivors facing sexual violence, hospitals provide the required care and treatment but explain to the parents that reporting to the police is mandatory under the POCSO Act, 2012 (MWCD 2012). If parents do not report the case to the police, the hospital must.

In nine hospitals, survivors have to pay for expensive diagnostic tests or medicines not available at the facility, while other services are free of cost. However, data from the 11 hospitals revealed that survivors who are destitute or homeless are unable to pay even for subsidised inhouse diagnostic services, and request the Dilaasa counsellor to waive the cost. In such cases, the counsellor explains the socioeconomic circumstances of the survivor to the hospital administration, which considers the request.

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

## 4.4. DOCUMENTATION OF CASES BY HEALTHCARE PROVIDERS

All 11 hospitals are required to put in place systems for safe and secure storage of all documentation that may be relevant in court cases or for provision of care to the survivor in the future. For example, in medicolegal cases (MLCs[9]), the provider should record the name of the abuser (where available) and relationship with the survivor (where applicable). It is important to note the abuser's relationship with the survivor to understand whether the abuser of violence is known to the survivor or unknown.

[9] A medicolegal case is a hospital record of a suspected case of violence based on medical inference or diagnosis by the attending doctor. Investigation by law-enforcement agencies is essential to fix responsibility on the cause of the injury or ailment.

**Table13: Documentation process at 11 hospitals**

| Documentation of cases | Availability in 11 hospitals |
|---|---|
| Recording of abuser details | ✓ |
| Verbatim history-taking | ✓ |
| Systematic storage of documents: Filing of police records such as FIR, along with medical records of survivor | ✓ |
| Documents containing survivors' safe contact details | ✓ |

## 4.5. PROVISION OF PSYCHOSOCIAL SUPPORT: SCOPE OF SERVICES, ASSESSMENT OF SAFETY, MULTISECTORAL REFERRALS

All the Dilaasa departments follow feminist principles[10] of respecting a survivor's autonomy and choices and avoiding victim-blaming (where the survivor is blamed for inviting violence). Counsellors are required to be mindful of, and incorporate into their services, the values and principles of feminist counselling. Survivors are often in need of multisectoral services and it is important for Dilaasa teams to liaise with other agencies to facilitate access. When referring a survivor to another agency, the counsellor is required to say only that the woman is registered at Dilaasa, not sharing any other confidential information.

This section discusses only Dilaasa's fidelity to the core principles and elements of psychosocial support for survivors of domestic and sexual violence. Details about actual psychosocial support provided follow in another chapter.

### *4.5.1. Safety assessment and safety plan for all survivors*

A safety assessment helps the counsellor understand the threat to the survivor– the frequency and severity of violence, and 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.

[10] This was evident from the interviews with counsellors where they were asked about specific case examples and how they intervened in those cases.

**Figure 7: Elements of safety plan when a survivor decides to leave an abuser's home**

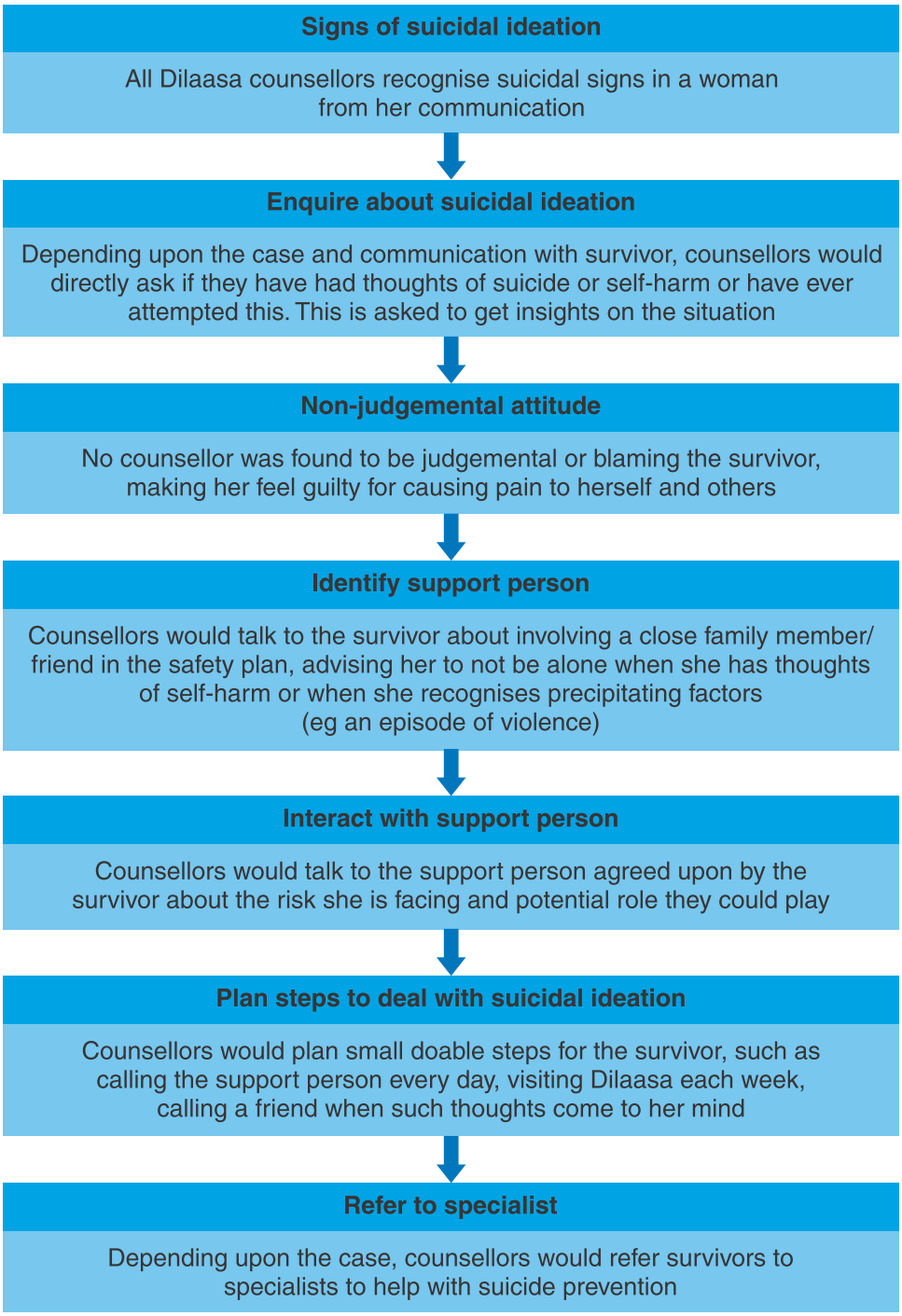
We found that all Dilaasa counsellors assess the safety of the survivor by enquiring about the severity of the violence and its consequences.

All counsellors ensure that a survivor has an alternative safe place to reside if she is leaving the abuser's home. They also discuss how she can reach the safe address, whether she has the support of someone who lives close by, whether she has sufficient money, and what essential items to carry with her, including documents, keys, clothes, mobile phone and telephone numbers. If a survivor has children, counsellors discuss plans for the children's safety.

### *4.5.2. Safety assessment in cases of attempted suicide*

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 special importance here. Figure 8 lists the protocol counsellors adhere to in cases of attempted suicide or suicidal ideation.

**Figure 8: Safety assessment protocol in cases of attempted suicide**



## 4.6. MULTISECTORAL COORDINATION

### *4.6.1. Referrals and liaison with other resource agencies*

Survivors of violence often need support from several different resource agencies/support structures, including the police, judiciary, shelter homes, child welfare committees, protection officers, or NGOs providing vocational training, education of children, or support for children/persons with special needs. Survivors may need information, guidance and assistance in reaching out to these agencies.

**Table14: Compliance with multisectoral stakeholders in 11 hospitals**

| Multisectoral coordination | Compliance at 11 Dilaasa departments |
|---|---|
| Explaining police procedures to survivors | ✓ |
| Facilitating police procedures, addressing challenges in registration of complaint, writing complaint letter | ✓ |
| Explaining medicolegal procedures to survivors in cases of violence | ✓ |
| Preparing survivors to appear in a court of law– for example, preparing for statements, providing information about different court procedures | ✓ |
| Providing information to survivors about different laws and free legal aid cell | ✓ |
| Liaison with protection officers, shelter homes and child welfare committee | ✓ |

The study found that counsellors from all 11 hospitals offered referral & liaisoning support through facilitating police complaints, filing medicolegal cases for violence, preparing survivors for court hearing, services from protection officers, shelter homes and CWC. Counsellors / ANMs often accompanied the survivors hesitant to visit these agencies alone for the first time.

## 4.7. DOCUMENTATION AND HISTORY-TAKING

Every Dilaasa department should have standardised intake forms and casualty/ inpatient papers, and should maintain copies of medicolegal examination reports, charts and registers recording a survivor's experience of violence.

a. ***Details of the survivor in intake forms:*** The counsellor at each Dilaasa department notes details of a survivor in the intake form on her first visit. These details include identifying information, contact information, a narrative about the incident, safety plan including address and contact number of a safe place, details of non-cognisable offence/first information report filed, and details of the MLC. 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 of the session to ensure there is no loss of information from poor/ limited recall.

   Also, counsellors said they make rough notes soon after the session. If the survivor consents to two team members being part of the session, the counsellor conducts the session while the ANM takes notes.

   Details of subsequent visits are recorded in follow-up forms or registers by the Dilaasa team at all 11 centres.

b. ***Details to be noted in registers:*** The casualty register at the casualty department of the 11 Dilaasa departments records the account of women who have presented over the previous 24 hours as cases of assault, fall, poison-consumption, attempted suicide, or bleeding from vagina. Amongst the details noted are name, age, nature of the complaint, time of reaching the hospital, whether treated on outpatient basis, and referral to Dilaasa.

c. ***Documentation of ward visits and identified cases of violence:*** The ANMs of 11 Dilaasa departments record details of their communication with

women during active case-finding in wards or OPD waiting areas. ANMs find it difficult to complete the required documentation on the same day, but they make sure it is completed in the following two days.

The ANM refers cases identified during rounds to the counsellor for counselling. The case is noted in the identification register. Further notes include whether or not the survivor chose services from Dilaasa. An intake is filled if they agree to share their history and choose to avail of Dilaasa services.

## 4.8. MONITORING AND EVALUATION

Monitoring and evaluation strengthens 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 2015a). This mechanism promotes accountability for quality service from stakeholders and implementers. A survivor feedback mechanism, case reviews and debriefs by staff are used for monitoring and evaluation.

Monthly or quarterly monitoring committee meetings are conducted to review cases handled by Dilaasa and give feedback to HCPs on proforma filled in cases of violence. Discussion may focus on written commentary and why HCPs should refrain from commenting on the status of the hymen (commenting only when injuries are related to the incident of violence), mentioning past sexual history, or conducting the two-finger test[11]. The concerns of HCPs and Dilaasa staff, such as collection of samples by police within the required time, are also discussed at these meetings. At seven hospitals, HCPs and Dilaasa staff discuss challenging cases at monitoring committee meetings. At the other four hospitals that do not have a committee, difficulty in cases is discussed with senior HCPs or the nodal officer.

[11] The two-finger test is an unscientific medical test used by providers to determine if the hymen is intact or not. This test violates the right of rape survivors to privacy, physical and mental integrity and dignity.

A management information system is maintained by the DEO at each Dilaasa department. The MIS contains information about the cases registered at Dilaasa. This information is used to generate reports on the type of cases being registered with Dilaasa, referrals from the health system, the expectations of survivors, and services provided. Based on this MIS, monthly reports are prepared and submitted to NHM.

CEHAT conducts capacity-building of DEOs in managing the MIS. However, the high turnover of the Dilaasa team is a barrier to effective maintenance and utilisation of the MIS system.

# CHAPTER 5

## PROVISION OF WOMEN-CENTRED CARE

This chapter describes the women-centred care delivered to survivors of violence by the health system and explains how the essential elements of the Dilaasa model work on the ground. It elaborates on the different pathways through which women facing violence reach the hospital and Dilaasa departments, and the clinical care and psychosocial support provided to them by Dilaasa counsellors. Finally, this chapter looks at the challenges faced by hospitals and Dilaasa in providing sensitive care to survivors.

### 5.1. PATHWAYS LEADING SURVIVORS TO DILAASA

The pathways that lead a survivor of violence to Dilaasa seeking support services (Figure 9) fall into two broad categories– those referred to Dilaasa by the hospital, and those coming directly to Dilaasa.

HCPs may identify women and girls seeking healthcare at different departments of the hospital as survivors of violence and refer them to Dilaasa. The police also bring VAW survivors to hospital for medical examination related to sexual violence.[12] Amongst the women who may access Dilaasa directly are those who have heard about Dilaasa services from ex-clients, those who have seen Dilaasa's IEC material, and those who have been referred by the police, a shelter home or NGO.

[12] Parents lodge a missing complaint when they are not able to trace their children. Sometimes young girls decide to go out with their friends without informing their parents. In other cases, girls have been found at a relative's home after quarrelling with their parents. Sometimes they elope with their boyfriends. Once a missing complaint is lodged, these young girls are traced by the police and brought to hospital for examination to find out whether they have faced any form of violence while they were missing.

**Figure 9: Pathways leading survivors to Dilaasa**

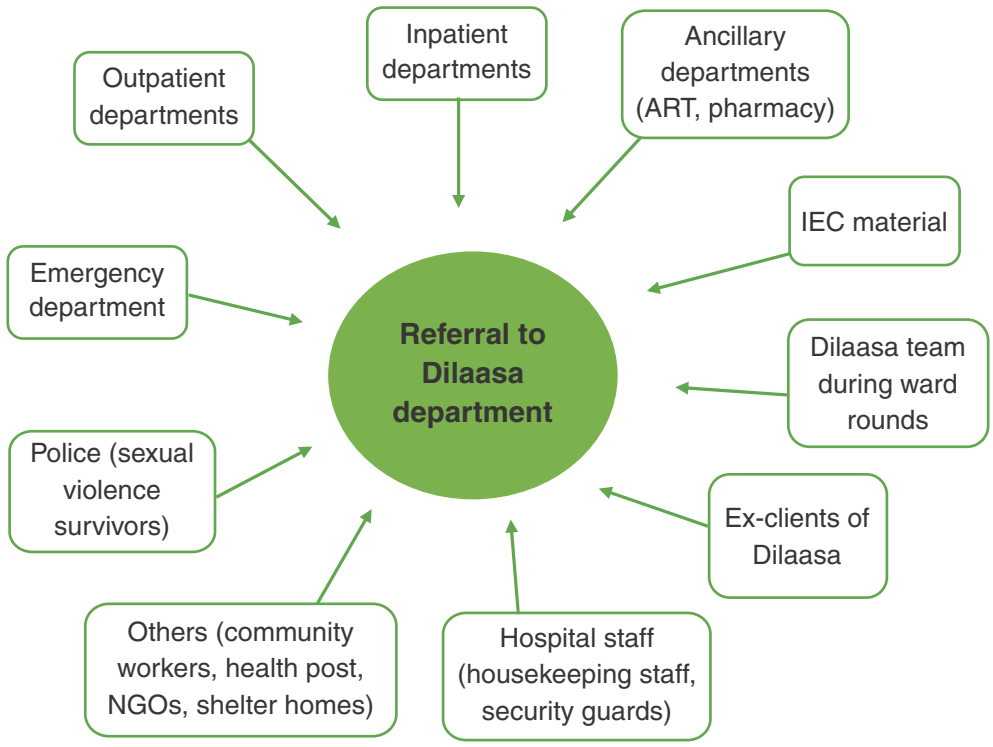



Figure 10 shows the pathways of referral for domestic violence cases, and Figure 11 shows the pathways that bring survivors of sexual violence to Dilaasa.

Figure 10: Pathways bringing DV cases to Dilaasa

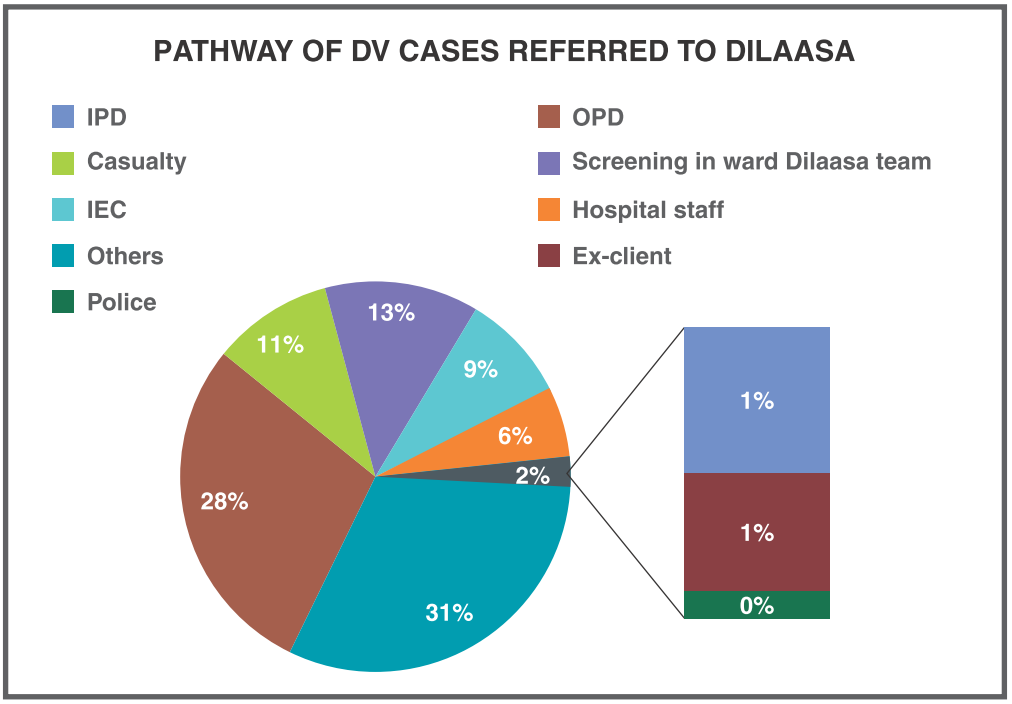
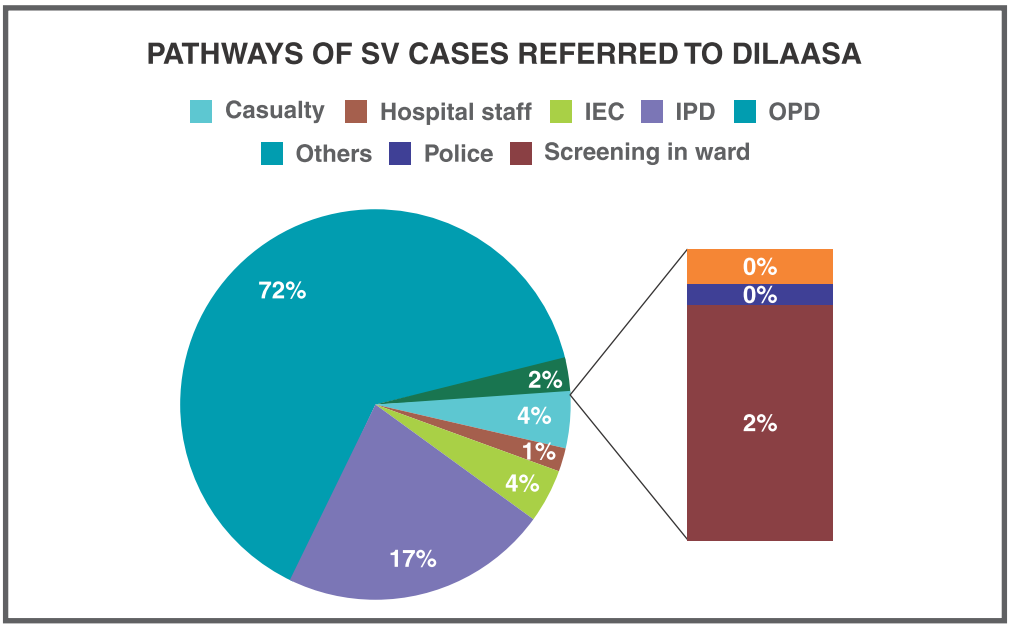



Figure 11: Pathways bringing SV cases to Dilaasa



Analysis of MIS data showed that survivors reach Dilaasa mainly through the health system (88% of DV cases and 96% of SV cases), with a small percentage referred by agencies outside the health system (Figures 10 and 11).

**Table 15: Frequency and percentage of DV and SV cases referred from each hospital in 2018-19**

| Hospitals | Frequency of DV cases | Percentage of DV cases | Frequency of SV cases | Percentage of SV cases |
|---|---|---|---|---|
| A | 468 | 19.0 | 491 | 57.6 |
| B | 53 | 2.2 | 190 | 22.3 |
| C | 235 | 9.5 | 25 | 2.9 |
| D | 133 | 5.4 | 0 | 0 |
| E | 375 | 15.2 | 0 | 0 |
| F | 125 | 5.1 | 0 | 0 |
| G | 245 | 9.9 | 103 | 12.1 |
| H | 57 | 2.3 | 3 | 0.4 |
| I | 127 | 5.2 | 16 | 1.9 |
| J | 349 | 14.2 | 0 | 0 |
| K | 297 | 12.1 | 25 | 2.9 |
| Total | 2,464 | 100 | 853 | 100 |

## Identification of violence by HCPs

The interviews with healthcare providers revealed a range of health complaints that prompted them to ask women about violence. Table 16 lists some of the signs and symptoms of violence that providers mentioned.

**Table16: Signs and symptoms that help providers identify cases of violence**

| Common signs and symptoms | Uncommon signs and symptoms |
|---|---|
| • Repeated health complaints with normal reports<br>• Chronic anaemia<br>• Chronic headache<br>• Sudden rise in blood pressure<br>• Bodyache<br>• Sudden weakness in the leg<br>• Fractures<br>• Feeling dizzy<br>• Repeated pregnancies<br>• Repeated birth of girl-child<br>• Multiple abortions<br>• Presence of self-inflicted injuries such as cuts or bruises on the body<br>• Vague complaints<br>• Cases of 'accidental' fall<br>• 'Accidental' consumption of poison | • Pregnant women reporting late for labour<br>• Patient's complaints not matching signs and symptoms<br>• Sudden deafness due to slap on the face<br>• Sudden loss of vision or bruised eye<br>• Cases in which husband describes symptoms on behalf of the wife<br>• Absence of visitors following childbirth, especially of girl-child<br>• Women admitted without accompanying relatives<br>• Patients who are numb (unable to express their health complaints)<br>• Children admitted with continuous abdominal pain without underlying pathology<br>• Skin infection in genital area in paediatric patients |

According to the nodal officers, in cases reported as accidental fall, women usually say they fell down the stairs, while HCPs find no injuries related to an accidental fall. Similarly, women report vague complaints like "not feeling good", or say "something is happening *(kuch toh ho raha hai)*."

Sensitive enquiry by HCPs may enable women to disclose the violence they experience, though they may not do so at the first meeting. As a nodal officer from the small-sized Hospital D, who had worked as a senior medical officer in a public health department for 12 years, said: "I treated a woman with maggots in her hair and asked her to follow-up after a week, but she came after a month.

Someone with maggots will not delay treatment as it causes a foul odour. I felt suspicious and so took her to a private place for examination and asked her if she had any problem. She did not respond to my enquiry at that point. But after a few days she came to me and told me about the violence she had been facing."
A nursing superintendent from Hospital G, a large hospital, explained how nurses identify survivors of violence, especially when women are admitted in the wards: "Sometimes, during a procedure or examination of a patient, nurses may find a mark or something on the patient's body and ask how she got it, did someone hit you, does your husband beat you, or do your in-laws beat you? If the woman says yes, they refer her to Dilaasa. If she says no but the nurse continues to be suspicious, she may still refer the patient to Dilaasa."

## 5.2. PROVISION OF CLINICAL CARE TO SURVIVORS OF VIOLENCE

### *5.2.1. Medical treatment*

HCPs ensure that all women facing violence receive immediate and primary medical treatment. Smaller hospitals that do not have facilities to assist survivors refer them to large hospitals. For example, cases of accidental poisoning are referred for an X-ray to detect possible internal injuries, or are referred to a psychiatrist at a larger hospital after the patient has been stabilised. In cases of sexual violence too, smaller hospitals may refer survivors to another hospital after first-aid because they are not equipped to carry out a medicolegal examination.

According to the SOPs, hospitals are expected to provide all services free of cost to survivors of violence, but this is not possible at every hospital. When a hospital does not offer certain diagnostics or is short of supplies or medication, patients are told to make their own arrangements. Services at public hospitals are generally subsidised– Rs. 10 for an X-ray, for instance-so patients and survivors of violence do not generally request a waiver of fees. The study found that survivors of violence are often unaware that services for them are free and as a result, at nine of the 11 hospitals, survivors incurred out-of-pocket

expenditure. When a survivor is homeless or destitute and unable to pay even for subsidised services, the counsellor explains the socioeconomic status to the hospital administration and requests a waiver. In such circumstances, two hospitals waive the cost of inhouse services. For services offered outside the hospital, the social worker handling the case may manage to raise funds. One hospital, for instance, was unable to support an RT-PCR test for a survivor, so the nodal officer paid the cost of the coronavirus detection test at an external laboratory.

In all cases of violence, HCPs inform survivors about Dilaasa services and refer them for psychosocial support. As Dilaasa functions like an OPD, its services are available until 4 pm. In case women/children facing violence report after 4 pm, HCPs note the survivor's safe contact details and inform counsellors about the case the following day. The counsellor follows up with the survivor the next day, providing information about Dilaasa services and arranging for counselling sessions.

Accidental poisoning complaints are invariably attempted suicides. In all such cases, HCPs enquire whether the survivor has been facing any form of violence and refer her to Dilaasa. Patients admitted to hospital are accompanied to the Dilaasa department for counselling by a helper, but if the survivor is unable to walk, the HCP ensures that the counsellor visits the ward and attends to her needs. When survivors are referred to other hospitals for medical treatment, HCPs note their contact number and request Dilaasa counsellors to assist them. If there is an underlying psychiatric issue that needs special attention, the Dilaasa team coordinates with psychiatrists and assists the women with psychiatric intervention or therapy. Only two of the 11 hospitals had an inhouse psychiatry department.

However, the study found that Hospital B, a large-sized hospital, was referring all cases of accidental poisoning to the psychiatry department for evaluation. This is a major gap, since all women facing violence may not need psychiatric referral.

Hospital protocol requires all survivors of sexual violence to be examined and provided medical treatment immediately. However, the study noted that HCPs at two hospitals were busy with their existing workload, and survivors of sexual violence had a long wait. Some hospitals have addressed this problem by ensuring additional doctors on call. One nodal officer felt that the emphasis on the legal mandate of providers in sexual violence cases, and the difference Dilaasa was making was slowly bringing a positive change to the perceptions and practice of healthcare providers.

For rape survivors, every hospital ensures informed consent (for those above 12 years of age), privacy, choice of sex of examining doctor, collection of relevant samples, and maintenance of the chain of custody for forensic material.

The examining doctor informs the survivor about the nature and purpose of the examination and obtains consent for

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

The examining doctor documents the refusal of any of these procedures as informed refusal. While taking the survivor's history, the doctor ensures that details of the incident are noted verbatim and in private. If privacy is a concern because other patients or male hospital staffers are present in the ward, the survivor is examined in a room adjoining the labour ward. A senior gynaecologist examines a female survivor and completes the case documentation. A gynaecologist examines a girl-child, while a senior surgeon or paediatrician examines a boy-child in a room adjoining the casualty department. The examining doctor ensures that the required samples are collected, sealed by the MRO, and handed to the police. The doctor and nodal officer are responsible for ensuring that the police deliver the sample to a forensic laboratory within 36 hours of sample collection.

HCPs were found to be extra vigilant in providing care to sexual violence cases because of the legal mandates associated with SV. However, despite the legal mandates for survivors of domestic violence, implementation at the ground level by HCPs was found to be weak.

*Explaining a medicolegal case and its purpose*

When HCPs identify a woman facing violence, they explain that registering a medicolegal case (MLC) will help ensure her safety, and provide evidentiary proof of violence for possible legal proceedings in the future. The providers reported that survivors often hesitate to proceed with the MLC when the abuser is a spouse or family member. HCPs explain to survivors that registering an MLC does not mandate them to go to the police. A survivor can still choose not to go to the police or file a formal complaint. When HCPs find a survivor reluctant to pursue an MLC, they reach out to Dilaasa counsellors to help explain its importance.

One nodal officer with 30 years of clinical experience said, "Survivors fear that by filing an MLC they may face a backlash from their husbands or in-laws and that is when the Dilaasa counsellor can help in boosting survivors' morale. This has helped many cases reach their conclusion."

The MLC process is conducted in the casualty department where HCPs make note of the survivor's contact number, take her history, and provide MLC documents to her. The MLC process requires HCPs to document who brought in the survivor, who assaulted her, the time of the incident, and injuries suffered by her. The HCP asks the person accompanying the patient to wait outside the department to facilitate disclosure by the survivor. Nodal officers underscored the importance of documenting the history in the survivor's own words.

*Enquiry about safety of survivor*

After referral to Dilaasa by HCPs, counsellors discuss safety concerns with the

survivor: is she safe at home, is a support person available, does she have an alternative safe place to reside? Based on the safety assessment, emergency shelter is offered at the hospital. Nodal officers said that their hospitals provide emergency shelter for women facing violence (also called emergency admission or social admission) for two to three days, or until she finds a safe place to live. Hospitals prioritise emergency shelter for pregnant women or those who have serious injuries due to violence. One small hospital with a well-integrated Dilaasa department had provided emergency shelter to 30 women in the four years since the department was set up. On the other hand, at a large hospital with a shortage of beds, the hospital authorities ask the police, community development officer or Dilaasa team to find alternative shelter options because emergency admission/shelter is a challenge for them.

Another nodal officer from the large-sized Hospital G said, "We give admissions to women even if they don't need inpatient care as they don't have a home to go to and are being abandoned by the husband. Women are admitted in the female medical ward, trauma ward, or ICU."

### 5.2.2. Barriers and challenges in identifying cases of violence

To identify the signs and symptoms of violence against women, HCPs must first recognise VAW as a public health issue, and internalise their role in identifying violence as part of clinical practice. When asked about the barriers and challenges they face in identifying cases of violence and ensuring referral to Dilaasa, several NOs and counsellors pointed to the turnover of resident doctors every six months and the attitudinal problems of new doctors in the absence of consistent training to integrate Dilaasa with their medical practice.

However, even after consistent capacity-building, some NOs said attitudinal problems persist, with some HCPs continuing to say, "This is not my job" when questioned about low referrals to Dilaasa. In their interviews, counsellors echoed this concern about the attitude of HCPs.

This ingrained attitudinal bias amongst healthcare providers despite consistent training indicates a refusal to look beyond the biomedical model and acknowledge violence as a public health issue.

***Challenges in providing clinical care to survivors***

Procedural clarity: HCPs demonstrate a lack of clarity about the procedures for medicolegal examination and collection of evidence in cases of sexual violence. The SOPs require doctors to collect only relevant evidence, but they tend to collect all evidence, relevant or otherwise. Thus, regular training should cover the procedures to be followed for sample collection and recording of information in cases of sexual violence.

Coordination with police: Nodal officers revealed that one of the biggest challenges is follow-up with the police for collection of samples in cases of rape. When the police fail to collect samples on time, the hospital or NO reaches out to senior police officers and asks them to state the reasons for not collecting evidence in writing. Hospitals also ask the police for a written statement when they fail to take the newborn baby of a minor survivor before the child welfare committee, which decides whether the baby should remain with the survivor or be placed in a shelter or given for adoption.

If the police bring a survivor to hospital, HCPs are required to hand over a signed copy of the filled proforma. After examination by a senior doctor, the police must wait for his/her signature. This can be a challenge as doctors could be busy in the operation theatre or not be in a position to leave patients, whereas the police want the proforma immediately.

Another challenge in dealing with the police is their interference in the process of history-taking. In such cases, HCPs ensure that the history is documented in the words of the survivor.

HCPs interviewed mentioned no challenges in dealing with domestic violence,

where the doctor's role is limited to identification of cases. It is in sexual violence cases, for which they are mandated by law to carry out several procedures, that HCPs face challenges.

## 5.3. PROCEDURE TO SUPPORT SURVIVORS OF VIOLENCE

The Dilaasa team provides psychosocial support to survivors referred by healthcare providers and survivors who approach the department directly. Counsellors speak to survivors either at the department, in the department where they are admitted, or over the telephone. The counsellor speaks to inpatients at their bedside, in an adjoining room/private space, or wherever the patient is comfortable. Telephone counselling is usually employed during follow-ups when the woman has already visited Dilaasa or when she is in the midst of a crisis after Dilaasa working hours and needs help from the counsellor.

During the Covid-19 lockdown, counsellors offered telephonic counselling to survivors of violence unable to reach Dilaasa departments physically, along with additional support services like legal interventions and shelter homes. The different strategies employed by counsellors to provide psychosocial support are described below.

### *5.3.1. Providing information about Dilaasa*

Counsellors stated that the moment a woman enters Dilaasa, their first step is to explain the role of the crisis department, its services, and the confidentiality it guarantees.

One counsellor explained how they introduce the centre: "Initially we introduce ourselves. We tell her this is Dilaasa's office. The mahanagar palika (municipal corporation) has started this centre to help women who face violence at home. Based on the 2005 law, women 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 in a state of panic, the counsellor offers water and snacks, asks the woman to wash her face, calms her down and stabilises her before introducing Dilaasa. Medical treatment is prioritised for women suffering any form of injury or physical pain. She is also reassured that the department is not an extension of the police station, nor is it staffed by doctors. This is important because the centre's location within the hospital or in OPD premises can make a woman hesitant to share her concerns.

### *5.3.2. Providing assurance about privacy and confidentiality*

Counsellors assure the women of privacy and confidentiality. The door of the Dilaasa department is shut to ensure privacy, and visual privacy is ensured at all hospitals. However, according to some counsellors, auditory privacy is a problem at three hospitals where Dilaasa is located adjacent to another department. Maintaining privacy is also difficult when two survivors come for counselling at once and there is only one room. In such a situation, the counsellor requests one woman to wait for the completion of the earlier session, or takes her to another private space for counselling. While counselling adolescents or women accompanied by family members, the counsellor ensures that the survivor is alone in the counselling room while parents or family members wait outside during the session.

Seven Dilaasa departments are staffed by two female counsellors, three have one male and one female counsellor, while one has two male counsellors. Women can choose a male or female counsellor. Sometimes women do not open up to a male counsellor, especially in cases of sexual violence. This can be a challenge if no female counsellor is available. Male counsellors admitted that asking women questions about rape is not always easy for them. Two male counsellors said that training helped them overcome this challenge over time but two other male counsellors said they still struggle to communicate with survivors of sexual violence. One way around this when a survivor chooses a female counsellor but none is available, is to have another female Dilaasa staff member, such as an ANM or DEO, present during counselling alongside the male counsellor.

### *5.3.3. Emotional support*

While offering emotional support, the counsellor attempts to break the formal barrier and put the woman at ease. Counsellors from all 11 centres described the four principles they follow in providing emotional support:

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

*a. Addressing a survivor's guilt or blame*

Validating a woman's experience reassures and relieves her. The counsellor needs to help a woman overcome feelings of guilt, anger and hopelessness. Giving the survivor the message that she is not at fault is crucial, especially in cases of attempted suicide. Counsellors revealed that HCPs often consider women committing suicide for what they feel are minor reasons a burden on the health system. They blame them for increasing their workload-providing emergency treatment and healthcare and carrying out MLC procedures. The woman's family also blames her since hospitalisation adds to household expenditure and disturbs routines. Addressing women's guilt on all these counts is important.

Counsellors interviewed said that several women have lived with violence for years before coming to Dilaasa. Women often believe they are the cause of the violence inflicted upon them, since the violence is usually justified as an attempt to correct their deficiencies (such as not serving food on time, not serving warm food, adding extra salt to the food, or not doing household chores). The woman facing violence often blames herself, feeling that her own actions invite and perpetuate violence.

One counsellor said, "Often a survivor says that 'all this has happened because

of me. If I had not done so-and-so this would not have happened'. 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 also described how they deal with the stigma faced by rape survivors. Often a survivor may have already visited multiple service providers like the police and casualty department before arriving at Dilaasa and been subjected to labelling and stigmatisation. At the police station, a woman is forced to relive the trauma of violence as she describes the incident all over again. In a busy casualty or gynaecology department, doctors treat them as a burden. According to one counsellor, some doctors blame the survivor for provoking violence; others feel that the young girls have been enjoying themselves while saddling them with the additional burden of performing an abortion.

Rape survivors routinely face such victim-blaming. In such situations, a counsellor said, "We explain that you are not at fault here, you have been forced, and you should not blame yourself. The person who has committed the bad deed, he should lose respect in society."

Counsellors also see cases of LGBTQA+ community members admitted to hospital following assault and poisoning since all case's of attempted suicide are referred to Dilaasa. One counsellor described the case of a transgender: "There was a case where a transperson was hit by his brother and was thrown out of the house, saying, 'You act like a girl… Don't stay with us ... People laugh at us.' This led the transperson to consume poison. The person felt, 'I am an outcaste from society and now from my family as well, so where do I go?'"

The counsellor explained that this was not the person's fault, that society shames those who are different, and that the trans community is now recognised by Indian law. The house was in the name of the trans person, so there was no possibility of ouster, the counsellor explained. The transperson was also encouraged to record a police complaint, as in this case too, violence had precipitated the suicide attempt.

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

Dilaasa counsellors use everyday examples to explain power dynamics to survivors. They cite discrimination against women or daughters within a household, women not being allowed to make decisions about their lives, traditions such as women eating last at home or getting insufficient food, violence inflicted on women by the family, and increase in severity of violence when women dare to retaliate.

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

*c. Respecting women's autonomy*

At Dilaasa departments, the woman's autonomy is prioritised. Many women referred to Dilaasa through the health system are unaware of the range of services offered, and since Dilaasa is located in a hospital setting, women are not able to, or are unwilling to, openly discuss their history of violence at the first visit. Additionally, they may not trust the counsellor enough to share their personal story at the first visit. In such situations, the counsellor does not force women to speak out.

As one counsellor put it, "We tell them, it's okay if you don't want to say anything. Not everyone can open up quickly. And you may also feel, why should I tell them my story? So if you feel this way, then no problem, if not today, maybe later, whenever you feel the need, you can come and speak to us."

Once women do open up, they are told about the options available to them as survivors of violence, and their freedom to choose any of them. While some may feel the need to separate from their husbands, others may want to continue their relationship. Counsellors respect a woman's decisions, but encourage her to think through the pros and cons of the decisions she has chosen 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 she chooses to separate from her husband, she is informed about legal provisions.

"If a woman comes to me for counselling, I don't force her to choose a course of action right away," a counsellor explained. "I tell her to think about it and let me know after two or three days, because she may be confused. I ask her to speak to her parents and then decide, and accordingly we will help her."

*d. Recognising the impact of violence on health*

Women facing violence often face health problems. Increased workload at home can result in lack of rest and sleep, manifesting as headache, bodyache, backache, fatigue and other complaints. Often women are unable to distinguish between ill health due to physiological reasons and illness resulting from violence. Such women are unable to recover from their illness despite multiple visits to hospital. Counsellors who are trained to identify the health consequences of violence make women aware of the difference.

The counsellors interviewed emphasised that the violence faced by women affects not only their physical but also their psychological wellbeing. They also said that women suffering from diseases such as tuberculosis (TB), asthma, human immunodeficiency virus (HIV), cancer, or mental illness find it difficult to handle household responsibilities. This leads to violence from in-laws and husband. Thus, a woman with a pre-existing disease that affects her daily functioning can face violence that further affects her wellbeing.

A counsellor told us about a woman who had contracted HIV from her husband, but was being blamed for the disease and isolated by her in-laws. In the process of counselling, she disclosed that her infection was contracted from her husband. Counsellors made her aware of her legal right to stay in her marital home.

In the process of counselling, the focus is on discussing self-care, the importance of continuing medical treatment and prioritising their health, and on the skills to negotiate with abusive family members.

"We always begin with a woman's concerns related to health and explain the impact of her thoughts on her health," said a counsellor. "It is important to communicate to women the importance (of recognising) the health consequences of violence."

Many women reach Dilaasa with low confidence levels and counsellors encourage them and boost their self-confidence. Sometimes counsellors encounter difficult and discouraging situations. Like the counsellor handling the case of a woman who committed suicide as she found herself unable to save her four daughters (aged 17, 14, 5 and 4) from their father, who sexually abused the two elder daughters. Despite the relatives revealing the abuser's location, the police failed to arrest him.

Another important aspect of counselling is addressing the fear of stigma and labelling faced by a victim and her family in cases of sexual violence, especially when the abuser is a family member and the survivor is a minor who does not have a say in the family. Family members of survivors facing sexual violence also fear that once the community learns about the abuse, finding a marriage partner for the survivor will be difficult.

## 5.4. SAFETY ASSESSMENT AND PLAN

After obtaining a woman's history of violence, counsellors said, it is essential to ensure her safety. The safety plan varies, depending on the context of each woman and the violence faced by her. The plan is developed in a participatory manner by exploring the feasibility of the options open to her.

Several questions are asked to assess the severity and frequency of violence, change in the nature of violence over time, and women's perception of their

safety at home. Based on all this, the safety plan is prepared. Each woman's situation is unique, depending on whether she is going back to the abusive home or leaving it.

A woman returning to an abusive home is advised various strategies in case the violence escalates. She could, for instance, grip the husband's hand to stop him hitting her, or leave the room/house if she senses the abuse is about to begin. If leaving is not an option, she could shout for help so that someone from the neighbourhood intervenes, or she could tell the neighbours to knock on the door or ring the doorbell when they hear her scream, and call the police if they hear her call for help. Counsellors also suggest that women involve their older children in stopping the violence rather than witnessing it. The children can be trained about whom to call, which neighbours to intimate, or when to call the police on helplines 100 or 103[13]. These strategies can bring the violence to a halt, albeit temporarily.

Counsellors clarified that the efficacy of these strategies is contextual. For example, if a woman is slightly built she will find it difficult to restrain her husband physically. Sometimes the neighbours are the husband's relatives or friends and refuse to help. But the counsellors also recount cases where women have successfully used these strategies to reduce violence.

If a woman has decided to leave her home, counsellors help her explore informal and temporary sources of shelter, such as family, friends or neighbours. Information is also provided about formal sources of shelter: emergency shelter in the hospital and shelter homes for the long term. Counsellors encourage women to plan for their exit from the house by keeping important documents in their custody and preparing their children if they feel the children may not be safe at home.

[13] 100 is the police helpline number in India and 103 is the police helpline number for crimes against women in Mumbai city. These are 24-hour, 365-days toll-free telephone numbers.

Counsellors facilitate emergency shelter in the hospital if a woman's life is threatened and she has no place to go. All hospitals are expected to provide emergency temporary admission for 24 to 48 hours, during which time counsellors can locate alternative accommodation. Once a shelter home is arranged for the woman, she is discharged from the hospital.

Women reaching the Dilaasa departments come alone or, occasionally, accompanied by children. If they say they need shelter, they are usually admitted to the female medical ward and the children to the paediatric ward. But many hospitals do not have a paediatric ward, and in such cases, counsellors can find it difficult to negotiate the admission of children.

Safety assessments of survivors include enquiries about suicidal thoughts. When women endure violence over long periods, they can get frustrated and angry and may express thoughts of suicide to the counsellor. Figure 12 presents the steps taken by counsellors to address suicidal thoughts among survivors.

**Figure 12: Steps followed in suicide prevention counselling by Dilaasa counsellors**

1. Encourage women to overcome thoughts of suicide and support them in dealing with violence
2. Explain the consequences of poisoning on their physical health and life
3. Discuss techniques to overcome violence, such as:
   - Staying away from situations or places where violence occurs
   - Visiting a friend or relative whose company they enjoy
   - Turning to hobbies such as listening to music or watching a movie
   - Contacting the counsellor on telephone or in person when she has suicidal thoughts, so that the counsellor canintimate a family member or friend to keep close watch on the woman.

A counsellor from Dilaasa recounted the 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 when the boy refused to marry her. Since she had a sexual intercourse with him, she considered herself "not suitable" for any other man. Counsellors discussed notions of virginity with the woman, and reassured her that consensual sex is not wrong. Multiple counselling sessions helped her overcome her feelings of despair.

## 5.5. NEGOTIATION FOR NON-VIOLENCE: JOINT MEETING

Counsellors at Dilaasa may also conduct joint meetings with the perpetrator of violence at the survivor's request. In their experience, some women feel that abusers are more likely to take a hospital authority seriously. Other women request a joint meeting when they do not want to approach the police or take legal action against their husbands to avoid bringing disrepute to the family.

A joint meeting promotes dialogue between women and their abusers and enables negotiation of non-violent and safe spaces for women within the family. Counsellors help the woman to spell out her concerns; they also inform women that such dialogues may or may not effect meaningful change in the abuser's conduct, so an alternative plan of action must be kept ready.

Counsellors contact the abuser on the telephone or send a letter explaining the purpose of the meeting, though sometimes a woman may persuade the husband (the abuser) to attend a joint meeting herself.

Before the joint meeting, the counsellor helps women list and discuss their expectations. A mock session is held at the Dilaasa department to prepare her for the meeting. Once the woman is prepared, a convenient date is fixed.

During the joint meeting, the Dilaasa counsellor acts as facilitator. The meeting is centred around the woman's interests, and she is encouraged to speak before the abuser is given an opportunity to respond. Counsellors clarify that violence is non-negotiable and all violent means of resolving conflicts have to end.

The modality of conducting joint meetings varies across centres. At some centres, husband and wife sit together, and each is allowed to speak out, while other centres encourage the husband and wife to speak to the counsellor individually, after which a joint meeting is held.

A counsellor described the method adopted at her centre to resolve problems with a husband who refused to give his wife household expenses: "In a joint meeting, we told the husband about the survivor's concerns. Then the husband put forward his points. We communicated to the husband that beating is violence and it is wrong, and he may have to face legal action if it continued. Therefore, it was better for both of them to stay together peaceably, with the husband giving his wife the required money. If not, in the future he would have to give her maintenance."

In the experience of counsellors, these meetings make abusers aware that the woman has formal support and that she can file a police complaint or case against him. The counsellors explained that sometimes such meetings are successful and sometimes not. Changes in the behaviour of the abusive person are often not lasting. At this juncture, a woman may decide to take legal action. Counsellors also stated that despite advance preparation, arguments between the spouses become heated, leaving no space for discussion. In such situations, joint meetings have little success. Another challenge is that abusive spouses, despite follow-up, may not show up for a meeting.

Counsellors at Dilaasa have work experience in other counselling spaces. One of them said that when she first joined she would call the abuser as she did at her previous place of work. But she only learnt how to conduct joint meetings after 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 approaching Dilaasa are informed about the Protection of Woman from Domestic Violence Act (PWDVA) 2005 (also known as the DV Act) (Ministry of Law and Justice 2005) by counsellors to ensure a basic understanding of the act. According to the PWDVA, a protection officer (PO) is responsible for providing legal guidance to a victim of domestic violence. The counsellor refers the woman to a PO when she decides to proceed legally against her husband and marital family. The PO files a case under PWDVA on behalf of the woman, assigning her a government advocate/public prosecutor. All these services are to be provided free of cost to the woman under this law.

"We inform a woman of what she will receive under this act: expenses for education and other basic requirements for her children; an end to physical, mental and economic violence; a protection order if she is facing physical violence," one counsellor explained. "Also, if the husband is not giving her money and she is at home and not working, maintenance can be sought under this act." The counsellor fixes an appointment with the PO. The procedure for filing a case with the PO is explained to the woman. The counsellor may accompany the woman to the PO for her first appointment if she is hesitant.

Women are sometimes hesitant to file a case against their marital family members, fearing permanent separation from their husbands. In such cases, counsellors tell the women about the benefits of filing under PWDVA: "We inform the survivor that filing a DV case doesn't mean she separates from her husband...In fact, a DV case is filed to bring the husband and wife together. A DV case is for women who do not receive what they are entitled to…If you (survivor) file a case under this act against your husband or in-laws, there can still be a settlement. A husband may think that instead of giving so much maintenance, I would rather take care of my wife, and her married life can be sorted out. So, she has the option of settlement even if she files a DV case. The settlement would happen through the courts, but it would be good for her future."

Another important provision explained to the woman is Section 498-A[14] of the Indian Penal Code (IPC), which is a criminal law. The counsellor briefs the woman on the law and cautions her to file a case under this section only if she is certain she no longer wishes to stay with her husband and marital family, since he and his relatives would face jail terms under this section.

Hospitals also receive cases of elopement in which girls under 18 years of age run away with their boyfriends, and these cases are referred to Dilaasa. Counsellors inform the minors involved in consensual sexual acts about the law. Counsellors say that parents who disapprove of sex between minors tend to file a police complaint, which ultimately leads the minor to follow procedures governed by rape laws. In addition, minors getting pregnant reach out to hospitals for medical treatment. Under the Criminal Law (Amendment) Act of 2013, the age of consent in India is 18 years, which implies that any sexual activity below 18 years of age, irrespective of consent, is statutory rape under Section 375 of the IPC. POCSO 2012 makes filing a complaint with the police mandatory in cases of minors subjected to sexual violence. Survivors and their parents are also informed about laws governing medical termination of pregnancy.

### *5.6.1. Referral to lawyer*

In cases a survivor needs legal counselling from a lawyer, the Dilaasa counsellors inform women that there are private lawyers who can be retained pro bono. CEHAT facilitates a lawyer who provides legal advice to survivors. Meetings with lawyers are arranged at the request of survivors who want to file a court case against the abuser. During these sessions, the survivor clarifies her doubts about access to the legal justice system-the laws applicable in the woman's case, how to answer questions posed by the judge or abuser's advocate, and so on.

[14] Section 498A of the Indian Penal Code (IPC) is a criminal law applicable in cases of cruelty to a woman by her husband or his relatives. It carries imprisonment for a three-year term and a fine.

### *5.6.2. Information on types of police complaints*

The importance of recording a police complaint after facing violence is explained to women. Such a complaint has evidentiary value if a woman decides to pursue legal action in the future. Counsellors emphasise the difference between filing a non-cognisable (NC) complaint and a first information report (FIR) by describing them as 'small' and 'big' complaints. A non-cognisable or 'small complaint' (chhota complaint in Hindi and Marathi), is when the police make a diary entry. Sometimes they summon the abuser and warn him to stop harassing the woman. They may even put him behind bars for some time. An FIR or '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 an NC is filed. But on filing an FIR the abuser is sent to jail since it is a criminal case. Counsellors noted that women do not always know the difference between an NC and FIR, so explaining it clearly is important in enabling her to make a decision. A woman is encouraged to file an FIR once repeated NCs have been filed at the police station.

According to a counsellor: "When (the) police warn them (husband/abuser) in this way they may not react (inflict violence) for the next four to five days, but later it may start again. Warning by the police may work out for some people but not for others."

## 5.7. MULTISECTORAL COORDINATION

Violence against women is a multidimensional issue. No single agency can provide all the required services. A comprehensive response requires Dilaasa to establish links with agencies outside the hospital setting. Dilaasa therefore offers referral services to agencies such as the police, CWC, protection officer, and shelter home, all of which provide support and services beyond the scope of the health system. Counsellors are involved in multisectoral coordination when survivors find it difficult to follow-up with several different agencies.

### *5.7.1. Police*

Counsellors coordinate with the police in helping survivors register NCs and FIRs. Often, counsellors told us, the police refuse to register a complaint against the abuser and send the survivor back saying it is a domestic matter. They also revealed that when women file an NC repeatedly, the police are reluctant to record it. In such cases, counsellors call up the police, explain the condition of the woman, and request them to address her concerns.

However, the police usually do not refuse to file a complaint if a survivor carries an MLC record with her. Therefore, one counsellor from a large hospital said she ensures that women without medical complaints reaching out to Dilaasa for an FIR/NC get an MLC documented citing disturbed mental health. Further, counsellors tell survivors that if the police refuse to file a complaint, they should ask them for a written response. Approaching police officials at higher levels can help get a complaint registered.

Consistent engagement with the police, counsellors reported, creates a rapport with police officials, leading to smooth functioning. Such a rapport prompts the police to contact the Dilaasa team and fix a time when they can bring a rape survivor in for counselling, because they realise its importance. When that police official is transferred, however, the Dilaasa team has to begin the process of establishing rapport with the new personnel all over again. In recent times, despite the rapport, some hospitals have failed to get complaints registered because the police were busy with lockdown management in the midst of the Covid-19 pandemic.

Nevertheless, there are also instances of sensitive police response. On one occasion, a woman police constable shared her home-cooked food with a survivor of sexual violence.

Counsellors stated that the police do not report cases of sexual violence to hospital immediately after the complaint is filed. They fail to understand that this

is a violation of the rape law, which prescribes sensitive treatment of women/ children. Nor do they understand that a delay can lead to loss of evidence since the survivor may pass urine, wash herself or change while she is kept waiting. Most often, survivors are brought to hospital for medical examination at night since the police feel the hospital is not so busy at night. There is no consideration for a survivor who has been at the police station for hours getting her case recorded, being taken to a hospital only at the end of the day.

One counsellor also mentioned corruption by the police. In a POCSO case, the police changed a girl's statement under the influence of her father, the abuser. The police threatened her, forcing her to change her statement. Though the girl's relatives repeatedly 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 marital homes despite escalating violence. At most, they look for an informal shelter. However, in a few cases where women do want a shelter home, the counsellors facilitate it.

The counsellors interviewed said they are familiar with some shelter homes, their rules and regulations, the condition of their rooms, intake capacity and food facilities. They also check if the shelter homes provide any livelihood training to women, such as tailoring and beauty parlour skills. Once they establish a rapport with an official of the shelter home, they only have to make a phone call to ensure that a survivor gets shelter.

When required, counsellors said they seek help from CEHAT to arrange for a shelter home. Finding a shelter home for pregnant unmarried women and vulnerable women suffering from diseases like TB and HIV is a challenge. Many shelters do not allow children above the age of 10-12 years to be accommodated with their mother. In other shelters, only women are accommodated, and children

of any age are not allowed. Such rules discourage women who want to keep their children with them from opting for shelter homes.

One counsellor described the case of a woman whose husband suspected her of infidelity and who was being physically abused by everyone in the household. She filed multiple NCs when her father-in-law approached her with sexual intent, but the police took no action. She did not want to return home and therefore stayed with a friend, requesting the counsellor to arrange shelter for her. The counsellor contacted the women after two days when a shelter was arranged, but she refused to go, preferring to stay and work with her friend.

The reasons why women commonly refuse admission to shelters are listed in Figure 13.

**Figure 13: Common reasons why women refuse to go to shelter homes**

**Why women do not avail of shelter homes**

- Admission for children is denied
- Strict rules and regulations at the shelter
- Financial instability and reluctance to disturb the family dynamics, especially when children are involved
- Preference for employment that provides accommodation
- Fear of the abuser locating the shelter and creating a scene
- No admission for vulnerable survivors, such as pregnant women and children with HIV

### *5.7.3. Child welfare committee*

The hospital approaches the child welfare committee (CWC) through the police to arrange a medical termination of pregnancy (MTP) for survivors under 18 years of age with advanced pregnancy (above 20 weeks), or minor girls delivering a baby they want to give up for adoption. POCSO 2012 mandates the production

of a minor survivor of violence by the police before the CWC. When the police fail to produce survivors before the CWC, counsellors need to follow-up, and sometimes counsellors have to accompany survivors to the CWC because the police are absent.

A counsellor from the large-sized Hospital B discussed how rapport with the CWC was built when a minor survivor wanted to hand over her newborn baby to a relative:

"The three-member committee explained to us clearly that this is not Dilaasa's work and it is the duty of the police to bring the client to the CWC. We had a very fruitful conversation with CWC members. They shared their contact number with us, which they usually do not do; they even took our numbers. Now if we have to refer a case to the CWC, they remember that I am the counsellor from hospital X."

A counsellor from another large hospital, however, felt that the CWC may not always entertain a Dilaasa counsellor without the presence of the police: "The CWC do help us, but they have this notion that this case is from such-and-such police station, so the case should come from there...The police must come and take them (survivors)."

### *5.7.4. Protection officer*

Counsellors have to contact the protection officers appointed for implementation of the PWDVA. They usually contact the POs and share the details of the survivor before making a referral. They also ask survivors to call the PO regularly to know the status of their case.

The majority of counsellors interviewed said that POs connect with Dilaasa and encourage them to refer women who want to avail of the provisions of the PWDVA. POs have also helped counsellors replace lawyers if women do not get the required support from the appointed one. However, counsellors from four Dilaasa

departments stated that POs can also be corrupt and can mislead women. Protection officers demand bribes from survivors visiting them to file a domestic violence case, ostensibly for completing the paperwork for the case. In one such case, the PO informed a woman that her documents in her maiden name and with the natal family's address needed to be changed to prove she was married, and that he would get this done if she paid him. According to the counsellors, POs demand bribes ranging from Rs 500 to Rs 5,000.

The counsellor from the Dilaasa department at Hospital E came up with some innovative strategies to deal with corrupt POs, and shared them with Dilaasa members from all 11 hospitals at a monthly case presentation:

a. accompanying the survivor for the meeting with the PO,

b. ensuring all documents of the survivor were in place before meeting the PO,

c. informing the survivor in advance that the PO's services are free of cost,

d. asking the survivor to call the counsellor if a bribe was demanded.

In one instance, the women visiting a PO were actually advised not to visit or call Dilaasa because the PO was handling the case. The counsellor found out about this misleading advice when she met a survivor during her OPD visit to the hospital. Therefore, the counsellor devised further strategies to deal with corrupt POs, including:

a. Informing survivors in advance to return to Dilaasa after meeting with the PO,

b. Sending a letter to the PO requesting an appointment for the survivor and ensuring that receipt was acknowledged and brought back to Dilaasa by the survivor,

c. Reporting malpractices to the WCD department,

d. Building a rapport with the PO.

# CHAPTER 6

## SURVIVORS' PERSPECTIVE: BENEFICIARY EXPERIENCE AT DILAASA

This chapter profiles the survivors registered at Dilaasa departments in 2018-19, providing insights into the users of the Dilaasa crisis intervention departments, their backgrounds, the kinds of violence they suffer, and their perspectives on Dilaasa's support. It also presents interviews with six survivors of violence, recording their experiences and perspectives on Dilaasa services. These interviews are presented as case studies.

### 6.1. PROFILE OF USERS OF DILAASA SERVICES IN 2018-19

The data from all hospitals for the year 2018-19 have been analysed. The year 2018-19 was selected for analysis as all 11 Dilaasa departments at the peripheral hospitals were fully functional by then.

As we have seen, documentation and maintenance of records at the hospitals is uneven and therefore only reliable data have been included. The actual number of survivors registered was much higher, but data on basic variables were not available. Nevertheless, this analysis presents an accurate picture of the response of the Dilaasa departments to VAW (Table 17).

During the year, a total of 3,317 survivors received care and support from the Dilaasa departments. Of them, 74% were survivors of domestic violence and 26% survivors of sexual violence. Of the 11 hospitals, only seven respond to survivors of sexual violence.

**Table 17: Forms of violence reported at Dilaasa departments in 2018-19**

| Forms of violence | Frequency | Percent |
|---|---|---|
| DV | 2,464 | 74.3 |
| SV | 853 | 25.7 |
| **Total** | **3,317** | **100.0** |

### 6.1.1. Survivors of domestic violence

Across the 11 hospitals (described in Table 2), 2,464 survivors of DV received psychosocial, medical and legal aid. Hospital A registered the highest number of survivors in a year (Table 19), followed by Hospitals E and J, and then K and G. Over the years, evidence from the Dilaasa pilot model reveals that a number between 250 to 350 new cases presenting at a peripheral hospital with casualty and major clinical departments equivalent to a district hospital, indicates active identification of survivors at the facility. Of the seven hospitals falling into this classification, two have low numbers. Challengess at both these hospitals reflect in the numbers of cases reaching the Dilaasa department.

Five of the 11 hospitals (D, E, F, I and J) have lower bed strength and variable clinical departments, with not all providing gynaecological care and some without even a casualty/emergency department. While three of the five have an average of 128 cases registered per year, two hospitals (E and J) registered 350-375 survivors. The active identification of women facing violence at these two hospitals is noteworthy.

**Table18: Hospital-wise domestic violence cases reported in 2018-19**

| Hospital | Frequency | Percent |
|---|---|---|
| A | 468 | 19.0 |
| B | 53 | 2.2 |
| C | 235 | 9.5 |
| D | 133 | 5.4 |
| E | 375 | 15.2 |
| F | 125 | 5.1 |
| G | 245 | 9.9 |
| H | 57 | 2.3 |
| I | 127 | 5.2 |
| J | 349 | 14.2 |
| K | 297 | 12.1 |
| **Total** | **2,464** | **100.0** |

***Profile of survivors***

*Age*

Seventy-six percent of survivors were less than 35 years old. This is the childbearing age-group that has inevitable contact with health facilities for sexual and reproductive health. In the absence of Dilaasa, they would have received only medical care, but active sensitisation of hospital staff enabled them to speak out about the violence they face and seek Dilaasa services.

Women aged 36-50 years also sought support (17%). Four percent of survivors were less than 18 years of age and 3% were above the age of 50. Thus, women across all age-groups are able to reach Dilaasa for support and care to stop domestic violence in their lives.

*Marital status*

Most of the survivors experiencing DV were married at some point in their lives. Of them, 89% were currently married and living with their spouse, 4% were separated/widowed/divorced/deserted. Seven percent were single women experiencing violence from their natal/parental families, which is a significant number.

*Education and employment*

Education and employment are considered to be factors that prevent and protect women from domestic violence. While 11% of survivors were illiterate (never been to school), 44% had completed primary education, 34% had completed secondary education, and 11% were graduates, postgraduates or had completed a vocational course.

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

*Relationship with survivor*

The relationship with the abuser is important because it indicates the nature of support and the strategies required to end abuse and keep a woman safe. Sixty percent of survivors reported violence from their husbands, and 21% from the husband and marital family. Violence from the marital family alone was 9.5% and that from the natal family 7%. One percent of women reported abuse from their children (this could be higher since Dilaasa teams have categorised violence from children under violence from marital family). This is significant as the National Family Health Survey (NFHS) data focus on intimate partner violence, disregarding the fact that women experience violence from other members of the family as well.

*Years of abuse*

Domestic violence occurs in a continuum; it is never a single incident/episode, and intensifies over time. Therefore, identifying abuse early is critical. The cycle of violence, as illustrated by the Mahila Sarvangeen Utkarsh Mandal (MASUM) for the Indian context, highlights the need to break this cycle as early as possible to prevent harm, injuries, self-harm and/or death (Gupte and More 2015).

Thirty-nine percent of women reported to Dilaasa within two years of experiencing abuse, and 24% within three to five years. The fact that over 60% of women reached Dilaasa within five years of abuse is significant, as it points to the potential of this intervention to stop violence and mitigate the consequences of violence. Survivors, however, have also reached Dilaasa after more than six years of abuse.

*Forms of domestic violence and its health consequences*

Survivors reported various forms of violence. Physical and emotional forms of violence were the highest, followed by financial and sexual. Most of the women reported at least two or three forms of violence simultaneously. Sixty-five percent of survivors reported that the violence had affected their physical health and 62% said it had 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 come to the hospital for medical care as an outpatient or inpatient, and been identified by the hospital staff during clinical care or during ward rounds by the Dilaasa team. The ward rounds are an important strategy used by Dilaasa teams to identify survivors of violence. From talking about Dilaasa in various wards to speaking to women based on the signs and symptoms of DV, they have found ways to identify survivors. This is in addition to the obvious

cases of assault, repeated abortions and poisoning that may be referred to the department.

**Table19: Profile of domestic violence survivors using Dilaasa services in 2018-19**

| Profile | Number | Percent (%) |
|---|---|---|
| **Age** | | |
| 0-12 | 4 | 0.2 |
| 13-17 | 92 | 3.7 |
| 18-25 | 791 | 32.1 |
| 26-35 | 1,088 | 44.2 |
| 35-50 | 418 | 17.0 |
| 51 and above | 71 | 2.9 |
| **Marital status** | | |
| Married | 2,195 | 89.1 |
| Single | 166 | 6.7 |
| Widowed | 55 | 2.2 |
| Separated | 28 | 1.1 |
| Divorced | 15 | 0.6 |
| Deserted | 5 | 0.2 |
| **Education** | | |
| Illiterate | 269 | 10.9 |
| Primary education | 1,080 | 43.8 |
| Secondary education | 847 | 34.4 |
| Graduate | 217 | 8.8 |
| Post-graduate | 49 | 2.0 |
| Vocational course | 2 | 0.1 |
| **Employed** | | |
| Homemaker | 1,481 | 60.1 |
| Informal sector | 280 | 11.4 |
| Formal sector | 216 | 8.8 |
| Self-employed | 119 | 4.8 |
| Domestic worker | 368 | 14.9 |
| Others | 177 | 7.2 |

| Profile | Number | Percent (%) |
|---|---|---|
| **Years of abuse** | | |
| One-time incident | 2 | 0.1 |
| Less than 1 year | 10 | 0.4 |
| 1 to 2 | 946 | 38.4 |
| 3 to 5 | 586 | 23.8 |
| 6 to 9 | 439 | 17.8 |
| 10 and above | 481 | 19.5 |
| **Relationship with abuser** | | |
| Husband | 1,475 | 59.9 |
| Marital and extended family | 290 | 11.8 |
| Husband and marital family | 509 | 20.7 |
| Natal family | 161 | 6.5 |
| Children | 29 | 1.2 |
| **Forms of violence** | | |
| Physical violence | 1,833 | 74.4 |
| Emotional violence | 1,530 | 62.1 |
| Sexual violence | 952 | 38.6 |
| Financial violence | 1,406 | 57.1 |
| **Health consequences** | | |
| Physical health consequences | 1,600 | 64.9 |
| Psychological consequences | 1,530 | 62.1 |
| **Pathway to Dilaasa** | | |
| Health system | 2,407 | 97.6 |
| Other hospitals | 32 | 1.2 |
| Others | 7 | 0.2 |
| Ex-client | 18 | 0.7 |

### 6.1.2. Survivors reporting sexual violence

In 2018-19, the number of survivors who reported with sexual violence was 853 (Table 20). Most of them reported at Hospitals A (58%), B (22%) and G (12%). The other hospitals received about two SV cases per month. One in two survivors were less than 18 years of age, so the case was registered under POCSO, which mandates coordination with the CWC, police and child institutions.

Eighty-eight percent of survivors of sexual violence were single (never married). Five hundred of the 750 SV cases of single women were of elopement or false promise to marry.

**Relationship with abuser**

Thirty-four percent of survivors said the abuser was a known person. Only 7% reported rape by an unknown person/stranger. Fifty-nine percent 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 rape cases themselves against a boyfriend who was refusing to marry them after sexual contact.

**Years of abuse**

While most had reported after a single incident of sexual violence (55%), many survivors had reported the violence after being abused for one to two years or even more than five years.

**Table 20: Hospital-wise sexual violence cases in 2018-19**

| Hospital | Frequency | Percent |
|---|---|---|
| A | 491 | 57.6 |
| B | 190 | 22.3 |
| C | 25 | 2.9 |
| G | 103 | 12.1 |
| H | 3 | 0.4 |
| I | 16 | 1.9 |
| K | 25 | 2.9 |
| **Total** | **853** | **100.0** |

**Table 21: Profile of sexual violence (rape) survivors using Dilaasa services in 2018-19**

| Age | Frequency | Percent |
|---|---|---|
| 0-12 | 99 | 11.6 |
| 13-17 | 368 | 43.1 |
| 18-25 | 238 | 27.9 |
| 26-35 | 110 | 12.9 |
| 36-50 | 31 | 3.6 |
| 51 and above | 7 | 0.8 |
| **Total** | **853** | **100.0** |
| **Marital status** | **Frequency** | **Percent** |
| Deserted | 1 | 0.1 |
| Divorced | 18 | 2.1 |
| Live-in relationship | 3 | .4 |
| Married | 46 | 5.4 |
| Separated | 19 | 2.2 |
| Single | 750 | 87.9 |
| Widow | 16 | 1.9 |
| **Total** | **853** | **100.0** |

| Relationship with abuser | Frequency | Percent |
|---|---|---|
| Acquaintance | 184 | 21.6 |
| Boyfriend | 500 | 58.6 |
| Marital family | 1 | 0.1 |
| Natal family | 41 | 4.8 |
| Neighbour | 68 | 8.0 |
| Unknown | 59 | 6.9 |
| **Total** | **853** | **100.0** |
| **Years of abuse** | **Frequency** | **Percent** |
| 1-2 years | 283 | 33.2 |
| 3-5 years | 81 | 9.5 |
| 6-9 years | 4 | 0.5 |
| Less than 1 year | 14 | 1.6 |
| One-time incident | 471 | 55.2 |
| **Total** | **853** | **100.0** |
| **Pathway to Dilaasa** | **Frequency** | **Percent** |
| Health system | 817 | 95.9 |
| IEC material | 33 | 3.9 |
| Other hospital | 1 | 0.1 |
| Other organisation | 1 | 0.1 |
| Police | 1 | 0.1 |
| **Total** | **853** | **100.0** |

## 6.2. CASE STUDIES

The research team contacted nine survivors of violence across the 11 hospitals. Six of them agreed to participate in the study. Their experiences are presented as case studies (all names have been changed), each case study recording the violence faced by the survivor, her experience at Dilaasa, the counsellors' response to her needs, and her perspective on Dilaasa's services. The case studies include women facing physical / emotional / sexual / financial violence from husbands, boyfriends, in-laws, and from the adult child of one survivor. The case studies include violence against a woman with a chronic disease, a woman facing sexual violence from her husband, and a case of false promise of marriage.

The women whose case studies are presented here were referred to Dilaasa by doctors of casualty departments, counsellors assisting HIV patients in hospital, and ex-clients. One case was self-reported.

### CASE 1: RANI

Age: 29 years
Education: Class 5
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 a sister. She was married when she was only 14 years old. Her husband physically abused her, forcing her to return permanently to her maternal home. Over time, both her parents fell ill and died, and her siblings got married. To support herself, she took a job as a domestic worker. She now lives with a roommate as a paying guest.

Rani got into a relationship with a boy whom she met at a family function. He promised to marry her. He insisted on having sex, and Rani agreed as they were planning to get married. When Rani discovered she was pregnant, her boyfriend told her to have an abortion. As they were not married, she agreed. Later, she got pregnant for the second time and the boy again insisted she abort. This time Rani did not agree and approached the boy's family, asking them to arrange their marriage. But his family did not approve of their four-year relationship.

Rani then decided to lodge a police complaint. The boyfriend's family attempted to influence the police to dismiss her complaint but that did not work out and a case of rape was filed under Section 376 of the IPC.[15] The police brought Rani to hospital for a medical examination.

[15] According to Section 376 of the Indian Penal Code, rape is punishable with imprisonment of seven to 10 years, and a fine.

The examining doctor, after taking her history, referred her to Dilaasa for support. At the time, Rani was undecided about proceeding with the abortion. One of Rani's relatives was ready to adopt the child if it was born. The Dilaasa counsellor briefed Rani on the laws related to adoption, medical termination of pregnancy and domestic violence. Rani decided to go ahead with the MTP, but was firm about pressing legal charges against her boyfriend. His family tried to get Rani to withdraw her complaint by offering financial assistance for her medical needs but she rejected their offer.

The police told Rani, erroneously as it happens, that in cases of rape, MTP is not possible. The counsellor corrected the police, explaining the legal provisions that did in fact allow Rani to opt for an MTP. At the hospital too, HCPs were not supportive of her decision to abort and they instilled fears about possible medical complications in her case. The HCPs advised her to have the baby and give it up for adoption.

Despite the absence of support from HCPs, Rani was admitted to hospital for the MTP with the counsellor's help. Even at this stage, healthcare providers made inappropriate remarks about Rani's unmarried and pregnant status and the child who would never have a father's name. Eyebrows were raised about Rani's long-term sexual relationship with a man outside of marriage. In complete disregard of Rani's rights to privacy, confidentiality and dignity, the hospital staff kept advising her to convince her boyfriend to marry her.

After the abortion was finally carried out, Rani was provided no post-abortion treatment for three days. Treatment began only after the counsellor's intervention. The hospital demanded a relative's signature for her discharge and would not hand over the medical documents she needed for the legal case. Again, the discharge procedures were completed only after the counsellor intervened with senior HCPs.

The boy's family had tried to dupe Rani into signing a legal bond in which, she was told, the boy apologised for his mistakes and was ready to provide monetary

compensation. When the counsellor read the bond, however, it stated that Rani was mentally unstable and had trapped the boy in the legal case. After hearing this, Rani refused to sign the bond.

The counsellor prepared her on giving statements in court. The counsellor would frequently reach out to Rani to enquire about her wellbeing and safety. When her landlord evicted her on finding out about her case, the counsellor helped her find alternative shelter. Rani now sees the counsellor as an elder sister who looks after her in the absence of her parents.

In accordance with the court's interim order, the abuser spent 45 days in undertrial custody before being released on bail. A final judgment is awaited.

Rani spoke at length about how the counsellor had intervened at every stage and questioned the police, the hospital staff, and the abuser and his family when she was in a vulnerable and distraught state because of her pregnancy and the hostility she was facing from all quarters. The counsellor was her only support, Rani said, navigating every system to ensure she received medical, social, emotional and legal support.

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**CASE 2: RENA**

Age: 30 years
Education: Dentist
Years of marriage: Seven
Number of children: One son, four 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, so her maternal family brought her up, with an uncle taking responsibility for her and supporting her education. In college, Rena was in a relationship with a man who was not from Mumbai,

which made Rena's family hesitant to approve their marriage. However, the boy's family convinced them that they were well-off, the young man ran his own business, and Rena would have a secure future.

Things changed drastically after marriage, with the husband showing little interest in sexual relations with his wife, spending nights out with his friends. He was not running any business and would ask Rena to pay the bills. She was not permitted to work and was only occupied with household chores. Rena's family had to bear all the medical expenses for her pregnancy, and Rena was left to take care of her child, along with all the domestic work, with no support.

Rena shared her concerns with her uncle, and the two families arranged to meet. During a heated argument, Rena's uncle was physically assaulted, which was when Rena decided to leave her in-laws' place with her child.

An ex-client referred Rena to Dilaasa. During the initial counselling sessions, Rena appeared overwhelmed, and would not open up. The counsellor helped Rena deal with her feelings of guilt and failure at not being able to sustain her marriage, and helped her narrate her experience of violence without fear. Rena wanted custody of her child and the counsellor explained the laws that could help her. Her husband, meanwhile, tried to persuade Rena to give their relationship another chance.

Slowly, Rena was able to communicate her concerns and expectations from their relationship to her husband. The counsellor also conducted sessions with Rena's distraught uncle. Initially they were scared by the threatening messages they got from the husband and in-laws. Rena and her uncle would visit Dilaasa almost every second day for emotional support and guidance and consulted the counsellor on the phone whenever they found themselves in a difficult situation with the husband and his family. They would be reassured after a conversation with the counsellor.

Finally, they developed the confidence to handle the threatening messages from Rena's marital family. The counsellor helped them file a police complaint as part of the safety plan. They were advised to check on the child's safety first in case of threats and to keep the neighbours informed of the situation.

Next, the counsellor prepared Rena to present her case before the protection officer and legal aid lawyer, facilitating these meetings even in the midst of the Covid-19 pandemic. She helped Rena draft the application and get the required documents together. The counsellor consulted the lawyer about the comparative benefits of filing the complaint under the Domestic Violence Act or Section 125 CRPC[16]. Eventually, Rena got her first date in court. She expects to get all her valuables and belongings back from her husband, but is aware that court processes take time.

Rena and her uncle now look upon the Dilaasa counsellor as a family member, always available to help. It would have been impossible, they said, to address their problems without the counsellor as it was the first time their family had dealt with such a situation. "The counsellor understood my case better than me," Rena says. She was always there-from listening to Rena, helping her understand what was happening, supporting her to take an informed decision and enabling her to regain confidence in herself. Rena is now focusing on the wellbeing of her child and her professional career. Her uncle is active in referring cases to Dilaasa.

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**CASE 3: ASHA**

Age: 40 years
Education: Nil
Years of marriage: 22
Number of children: Three (two daughters, aged 20 and 16 years, and one son, 14 years old)
Abuser: Husband and marital family

[16] Under Section 125 of the Code of Criminal Procedure (CrPC) the husband is liable to maintain a wife who is unable to maintain herself by providing monthly maintenance to her and their children.

Type of violence: Domestic and sexual violence
Year of referral: 2021
Referral pathway: Self-reported

Asha had faced domestic violence from her husband and marital family throughout her 22 years of marriage. Following one incident, she had attempted suicide by consuming 40 sleeping pills. Worried about a police complaint being filed, her husband had admitted Asha to a private hospital. Disregarding the doctor's advice, he insisted on an early discharge from the hospital. Unconcerned about Asha's fragile health after discharge, he forced her to have sex. Asha's elder daughter confronted her father, only to be verbally abused by him.

Asha enquired about Dilaasa services when she came to hospital for a general check-up. The counsellor assured her of confidentiality and she felt comfortable discussing the violence inflicted by her husband and in-laws. She was advised to take some steps to check the violence and not to tolerate it. Contraceptive methods were suggested to prevent unwanted pregnancies, and she was referred to a doctor for low haemoglobin count and excessive bleeding.

The counsellor told Asha to call the police or Dilaasa if the need arose and to leave the house immediately with her children if the violence escalated. She was also taught basic self-defence techniques.

After another incident of domestic violence, Asha was suicidal again. As she walked towards the railway track, she passed the hospital where Dilaasa was located. The department was closed for the day, but she decided to spend some time in the waiting room. After gathering her thoughts and reflecting on the counsellor's advice to live for her children, she pulled herself together and went home.

The counsellor helped Asha to lodge a police complaint and organised a joint meeting that briefly curbed the violence. The counsellor told Asha about the legal recourse available under the Domestic Violence Act, and found her a private

lawyer who would work pro bono. But after a fresh onslaught of violence from her husband and in-laws, Asha decided to live separately with her children. With support from the counsellor and her brother, she managed to find a room on rent.

Asha said she could not find words to express her gratitude to the counsellor for her guidance and for accompanying her to the lawyer at a time when she had no confidence to move around the city by herself.

Motivated by the counsellor, Asha has set up a small catering service. Now, along with her elder daughter who has a job, she feels more confident about managing her family and supporting her children's education. Asha now regularly refers other women in distress to Dilaasa.

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**CASE 4: GEETA**

Age: 36 years old
Education: Postgraduate
Years of marriage: 13
Number of children: Two daughters (12 and 11 years old)
Abuser: Husband
Type of violence: Domestic and sexual violence
Year of referral: 2021
Referral pathway: Referred from casualty department

Geeta has been married for 13 years. Her husband owns a shop and earns around Rs 1 lakh per month. She is a postgraduate and used to work as a teacher, earning a monthly salary of around Rs 15,000, but her husband did not like her being financially independent, even though having a job helped her manage expenses since he gave her no money for household spending. Geeta has faced physical, sexual, emotional, and financial violence from her husband throughout her marriage.

Geeta's husband would suspect her of having an extra-marital affair and threaten to disfigure her by throwing acid on her face. He would not allow her to socialise with anyone outside of their family. She was subjected to physical violence- kicked in the abdomen, hit with objects, pushed and pinched. He would also force her to have sex.

The prolonged violence affected Geeta's health. She developed Polycystic Ovarian Syndrome (PCOS) as one of the health consequences of violence. She had to borrow money from her brother for treatment as the husband would not provide any kind of support.

During the Covid-19 pandemic, Geeta lost her job and found it difficult to manage household expenses. The violence increased to such an extent that she contemplated suicide. She felt she could no longer stay with her husband. A friend informed Geeta about the Domestic Violence Act and advised her to use it to stop the violence. But Geeta found no support from her maternal family, being told to tolerate the violence to preserve her marriage.

The day he hit her on the eye Geeta informed her friend, who helped her find a lawyer. The lawyer advised her to first visit a municipal hospital to get medical treatment. The doctor in the casualty department treated her and asked how she got the injury. When she told him, the doctor carried out a medicolegal examination, with her consent, told her about Dilaasa's services and referred her to a counsellor.

At Dilaasa, the counsellor explained that she should not blame herself for the violence. Since Geeta did not want to return to her husband's home, she was told about shelter homes. Finding that shelter homes do not admit children, however, she decided to go back to her marital home. The counsellor discussed safety plans with Geeta, telling her to call the police and neighbours when necessary. Geeta's children were also prepared to reach out to the police when the violence escalated. The counsellor informed Geeta about her legal rights under the Domestic Violence Act. She was told to keep her valuables and

documents in a safe place, and was encouraged to become financially independent again.

With the counsellor's help, Geeta decided to lodge a non-cognisable (NC) police complaint. Though the police took no action following her complaint, the husband was taken aback. One year after lodging the NC complaint, Geeta has been living with her husband without any further violence. She has started working again, and is satisfied with her professional growth. She feels supported by Dilaasa and feels free to approach the counsellor at any time.

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**CASE 5: NILIMA**

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

Nilima is an HIV-positive patient with three sons. Her husband passed away seven or eight years ago. The family only found out about that he was HIV-positive after his death. When the family members were tested for HIV, Nilima was found to be positive. She used to run a job placement agency before her husband died. After his death, the family's financial condition deteriorated, but they managed on her son's meagre salary. Nilima also began antiretroviral treatment (ART) at the government hospital.

Her two younger sons are married, but her youngest son is separated from his wife. Nilima lived with her eldest son, second son and his wife and child. Her daughter-in-law would be verbally abusive, fighting with her constantly because of her HIV status despite being aware of it before she married into the family. She would not allow Nilima to touch her grandson and would insult her in front of other people. Nilima was disturbed at the abuse from her daughter-in-law and

the daughter-in-law's mother. The son did not intervene and allowed the abuse to continue. Their current residence is registered in Nilima's mother's name. Nevertheless, the second son fought with her, demanding that the house be registered in his name.

During this period, Nilima was hospitalised several times with low CD4 count and other opportunistic infections. The emotional abuse distressed her, and on one occasion, she left home with the intention of committing suicide. Her eldest son found her and brought her home. The counsellor at the ART centre was also frequently counselling Nilima about her HIV status. The counsellor who found she was skipping her medications enquired about her history of violence and referred her to Dilaasa.

The Dilaasa counsellor held multiple sessions with Nilima, informing her about her legal right to the property and advising her to visit a protection officer and seek redress under the Domestic Violence Act, 2005. She was advised to file a non-cognisable police complaint for her safety, which she did after initial hesitation. The police helped her file the complaint and issued a warning to her son and daughter-in-law.

Simultaneously, Dilaasa put Nilima in touch with another civil society organisation close to her house that supported survivors of VAW. Here she could get emergency support when needed. The Dilaasa counsellor suggested a joint meeting with the abusers. Nilima asked her son and daughter-in-law to attend, but they refused.

During this period, her eldest son's marriage was arranged. But on finding out that Nilima was on ART, his fiancée refused to take care of her. Her son called off the wedding. Unfortunately, he had an accident shortly after, and Nilima had to sell her jewellery to fund his treatment. The eldest son had been working, but had loans to repay and lost his job because of the accident. Their financial condition became so precarious that Nilima was forced to eat at a community kitchen outside a temple.

She was tense about their financial condition and had stopped taking her medicines. The Dilaasa counsellor guided her to several agencies that provide employment and put her in touch with organisations that could help her apply for the widow's pension scheme. Nilima visited Dilaasa frequently for the counsellor's support.

After her eldest son recovered, he found a job and their financial condition slowly improved. He was also in touch with the Dilaasa counsellor, contacting her when Nilima refused to cooperate with the HIV treatment. Together, they motivated Nilima to resume her treatment.

Meanwhile, the domestic violence by the other son and daughter-in-law continued, and Dilaasa helped Nilima draft a complaint under the Domestic Violence Act. The counsellor facilitated an appointment with the protection officer and free legal aid lawyer, and a case was filed to stop the violence and get the abusers to move out of her house. She also sought transfer of the title of the property in her name.

The abusers have since rented a place and moved out of Nilima's house. Nilima and her eldest son live together and run their placement agency together. She is happy and in good health, taking her ART regularly and visiting Dilaasa when she comes to the hospital for treatment. She is grateful for the emotional support offered by the Dilaasa counsellor, which helped her deal with her situation and move on with her life.

The Dilaasa counsellor refers women looking for employment to Nilima's placement agency. So far, Nilima has found jobs for three women referred by the Dilaasa counsellor.

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## CASE 6: RINKU

Age: 25 years old
Years of marriage: 3
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 department

Rinku was born and brought up in a poor household in a village. She was a health worker in her village before she was married. She was told that the man she was to marry worked in Mumbai. She quit her job and shifted to Mumbai after her wedding. That was when she realised her husband was unemployed. However, her husband's family, which included her mother-in-law, father-in-law, brother-in-law and his wife, was wealthy. They lived in a large, three-storeyed house with separate rooms for everyone.

The domestic violence began a few months into the marriage. Rinku suffered from hyperthyroidism, which annoyed her mother-in-law. She would blame her for being weak and sick all the time. The marital family refused to pay for her treatment and told her to get money from her parents, which they did not have. Within a few months, she conceived, and during her pregnancy too she faced domestic violence. Her mother-in-law would emotionally abuse her, and the husband, father-in-law and brother-in-law would physically assault Rinku. Her father-in-law was a drug addict and once kicked her in the belly during her pregnancy. She had a miscarriage and stated that it was due to the physical violence from her marital family.

After a few months, Rinku conceived again, but this time too the violence continued. She went to her parent's home for the delivery just before the Covid-19 lockdown, and delivered a baby boy during the lockdown. The baby developed some heart complications and though her parents got him treated, the baby died

within a month. Rinku believes the child's health problem was caused by the violence inflicted on her during pregnancy.

After the delivery and even after the child's death, nobody from the marital family called or visited. They did not even call to ask about the newborn's wellbeing. They appeared to have no intention of having Rinku back in Mumbai. After six months, when the lockdown was relaxed, Rinku's parents took her back to Mumbai. Rinku's mother-in-law was upset at her return and decided to shift her to another house. The in-laws rented a tiny house far from their home, bought a few essentials, and moved her in. Rinku's husband would not stay with her in this rented house. He would visit twice or thrice a week, coming late at night and leaving early in the morning. Her neighbours would often comment on her husband's absence. Her in-laws paid her rent and the husband would bring a few groceries and small amounts of food when he visited. She was given no money. Rinku often complained to her husband about the insufficient food and her husband's absence. Her husband did not want children but Rinku did, and this led to further conflicts between them.

One night they fought again and the husband physically assaulted Rinku. He hit her in the eye, leaving it swollen and red. She went to a police station close to her house. They ignored her complaint and told her to visit a hospital for treatment. She went to the hospital the next morning. In the casualty department, as she cried in pain, the doctor asked about the injury. She told him how it happened and said she wanted to file a police complaint. The doctor provided medical treatment, registered a medicolegal case, and referred her to Dilaasa.

The Dilaasa counsellor explained their services and discussed safety plans with Rinku. She was told to call the helpline numbers 100 or 103 whenever she was assaulted. She was also told to file a non-cognisable police complaint at the earliest to check the violence, which she did despite an uncooperative police. The importance of legal documents like the NC and MLC was explained to her. Rinku was reassured that the hospital provided emergency shelter. She was advised to reach out to the casualty doctor if she faced further violence. Following

a subsequent assault by her husband one night, Rinku did get emergency shelter at the hospital with the help of the counsellor.

The counsellor learned about Rinku's qualifications as an ANM and motivated her to take up a job. She found a job at a dispensary near her house, earning Rs 8,000 per month. The in-laws were upset about Rinku getting a job, and she continued to face violence from them. She would often visit a temple to pass the time, but her husband suspected her of having an extramarital affair. He refused to trust her despite several clarifications. The in-laws stopped paying the rent of the house after she started working, which made it difficult for Rinku to manage her financial requirements.

One day while Rinku was at work, her mother-in-law locked her out of the rented house. When Rinku reached home, she was surprised and spoke to the landlady, but was not allowed entry. The landlady said she was tired of all the family drama going on in her house. In desperation, Rinku called her husband, but he did not take her calls. Finally, her mother-in-law answered the phone, and told her that her father-in-law was admitted to hospital, thanks to all the trouble caused by Rinku. She refused to give the address of the hospital and Rinku realised they were lying about her father-in-law's illness. She did not know the location of her marital house and had to spend the night on a pavement, without food or water. She called her parents in the village and they promised to pick her up the next day. She informed the Dilaasa counsellor that she was going to her village with her parents. The counsellor suggested that Rinku record a police complaint, spelling out the details of the violence. Rinku did so before leaving for her village.

A few days later, Rinku called the Dilaasa counsellor and told her that she was determined to file for divorce. The counsellor endorsed her decision and told her about the procedure to follow. Before Rinku could file for divorce, however, she received a divorce notice filed by her husband and was summoned by the court. She was nervous. The counsellor explained the details of the notice, telling her that her husband had filed for divorce a month after she left with her parents. The counsellor connected Rinku with a legal expert and started preparing her for

court procedures and attendance. The lawyer advised that she seek compensation for travel from the village to the city as well.

Rinku has not yet decided on a further course of action. But she is resolved to divorce her husband and demand compensation. She knows she has the support of the Dilaasa counsellor in all her troubles and through the legal process that is to follow.

At present, Rinku has found a job in her village and is supporting her parents financially.

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The six case studies documented above reveal the frequency and severity of the violence faced by survivors, and the extent to which violence leaves the women emotionally and financially vulnerable. They indicate how the location of the Dilaasa departments within the health system makes the service much more accessible to survivors from different socioeconomic backgrounds. The case studies demonstrate how the survivors found the agency to take action against the abusers, and how Dilaasa supported them with counselling, safety planning, and legal guidance. Finally, the survivors recount how Dilaasa helped them not only in dealing with the violence and the abuser but in taking control of their own lives by becoming financially independent and standing up for their rights.

# CHAPTER 7

## DISCUSSION

This chapter highlights the factors that have had an impact on the health system's response to VAW, as seen in the process of upscaling Dilaasa at 11 peripheral hospitals in Mumbai. It reveals the barriers and opportunities in strengthening the health system's response. Finally, it presents the recommendations of key informants on further harnessing the building blocks of the health system to enhance the health-system response to VAW.

### 7.1. HARNESSING THE BUILDING BLOCKS OF THE HEALTH SYSTEM TO RESPOND TO VAW

#### 7.1.1. Leadership, political will and governance

Leadership, political will and governance are essential in generating ownership and sustainability of health system-based interventions. The Dilaasa intervention of 2000 had been upscaled in only one additional hospital in Mumbai by 2006. It was only when fuelled by a massive campaign in the country demanding VAW services Dilaasa was included in the National Health Mission that it was possible to expand it to11 hospitals.

***Presence of core group:*** At the hospital level, the presence of a core group consisting of a team of trained senior doctors and nurses facilitates effective functioning of the Dilaasa department. The existence of such a group made every aspect of project implementation smoother. This study demonstrates the extent to which an enthusiastic and active core group can provide visibility and legitimacy to the issue of VAW within the health system.

Most of the Dilaasa hospitals had one or two HCPs (doctors/nurses) who had already been part of the training cell of the MCGM or had been previously

sensitised to VAW by CEHAT and Dilaasa. They welcomed the idea of setting up a crisis intervention department in their hospital and supported its implementation wholeheartedly. Their initial support included taking on the responsibilities of the nodal officer themselves or facilitating appointment of an NO, deputing staff for training, and creating an enabling environment for the Dilaasa team to visit wards and set up systems for identification of cases. Given the environment created by this core group, even when some of the key doctors in the group were transferred, the Dilaasa team was able to establish a rapport with the new staff.

Four of the initial NOs appointed were core group members, and their role in Hospitals A, C, K and F[17] contributed greatly to the integration of Dilaasa within these hospitals. On the other hand, Hospitals H and J did not have any active core group members, and while the NOs here were supportive, they were not active. The role of the Dilaasa team in Hospital H has ensured a remarkable performance, but that was not the case in Hospital J, where the hospital could not integrate Dilaasa as a department of the hospital.

Thus, the study found that hospitals where the core group, nodal officer and Dilaasa team were able to work together seamlessly were the ones where the department was best integrated. However, the frequent transfers of healthcare providers and the workload of NOs are two factors that hamper their response to VAW.

The efficacy of an active and engaged core group is enhanced when there is a standard operating protocol within the health system, since the SOPs give HCPs evidence-based guidance on implementing and overcoming the challenges of a holistic systems response to VAW.

The Dilaasa team itself has played a pivotal role in establishing Dilaasa as a hospital department and institutionalising it in the hospital system. This is despite

[17] Table 2 provides brief details about the hospitals.

the resistance faced from the system from being told they don't belong there, to being denied use of common amenities and being saddled with routine hospital work in addition to their Dilaasa duties. The insensitivity of the staff towards patients in general and survivors of violence in particular has made the Dilaasa team's work more difficult. CEHAT has supported the team in raising these issues before nodal officers or monitoring committees, but navigating hospital procedures has been challenging for the most part.

Despite this, all the teams have been able to establish Dilaasa as a hospital OPD and to create a niche for work on VAW within the hospital. All the hospitals, with a single exception, have a substantial Dilaasa caseload, and this is attributed solely to the initiative of the Dilaasa team in identifying cases of violence through ward rounds, speaking about DV in the OPD space, and engaging with hospital cadre at all levels on VAW.

None of this would have been possible, however, without political will, most notably in the allocation of funds for upscaling Dilaasa, recruitment of dedicated staff for Dilaasa, deputation of NOs at each hospital, and provision of a strategic location for Dilaasa within each hospital.

Our key informants have provided valuable recommendations on further strengthening leadership, political will and governance. They pointed to the need to strengthen accountability mechanisms at the hospital level for effective institutionalisation of VAW services. They also recommended a protocol to establish linkages with smaller health facilities. This will help in establishing a continuum of care for a survivor of violence and will contribute to early identification and access to support services by survivors of violence. These linkages should be complemented by building the capacity of HCPs at smaller 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 could be strengthened to provide VAW services from a public health perspective. The resources of OSCs can be best utilised by establishing linkages with the health system, enabling early identification of violence.

An advisory committee comprising officials from the governing body was set up, but it met only once. An active advisory committee can play a significant role in expanding this model to other districts of Maharashtra and to other Indian states.

National and international health policies and action plans are needed to facilitate a more comprehensive and sensitive response to VAW within the health system. In addition, the inclusion of a response to VAW in the accreditation process of hospitals-such as the National Accreditation Board for Hospitals and Healthcare Providers (NABH)-can incentivise more hospitals, private and public, to initiate the setting up of Dilaasa departments.

### 7.1.2. Human resource development

The health-systems response to VAW builds on the presence of an adequately trained staff to respond sensitively. The findings of this study indicate that the support provided by CEHAT in conducting trainings for NOs, core group members and Dilaasa staff helped in building their capacity. CEHAT also supported ongoing capacity-building of the Dilaasa staff through refresher trainings and case presentations. Detailed and well-defined roles and responsibilities for staff also support effective utilisation of human resources.

Ongoing incremental training of Dilaasa staff and monthly case presentations have been useful in providing technical inputs. These trainings brought forth gaps on specific needs of LGBTQA+ survivors of violence. Dilaasa teams trained and sensitised to the specific needs of this group, paved the way for services to a small number of transgender and lesbian survivors.

Most of the 11 peripheral hospitals have included a session on Dilaasa in their routine orientation to hospital departments for newly-recruited HCPs. However, the ongoing capacity-building of HCPs has not yet been institutionalised, as the training on VAW is still not part of the hospital chart. As the case studies reveal,

victim-blaming and lack of sensitivity of HCPs remains a challenge, and therefore a training strategy that ensures regular and renewed training of all staff is critical.

The key informants recommend defining the role of civil society organisations in building the capacity of the health system and assessing the quality of response. This can ensure that the health system takes ownership of VAW as a public health issue and remains accountable. They further recommend that training content be tailor made for each cadre of providers. Training and capacity-building sessions can be facilitated at the tertiary level of the health system, which is already invested with resources and engaged in other kinds of training. Policy directives will be required to mandate the inclusion of routine VAW trainings.

The allocation of dedicated staff in the form of the Dilaasa team can be based on the size and patient load in each hospital. The presence of both male and female staff on the team could be more effective with more focused training of male staff members.

The role of ANMs at different levels of the health system needs to be defined while scaling up the health response to VAW in rural and urban settings. ANMs can be a very effective resource in interfacing with and building the capacities of community health workers, other ANMs, anganwadi workers, community health volunteers (CHVs) and ASHAs at the grassroots level to address VAW through first-line psychological support and referral to larger centres.The interface between ANMs and HCPs, especially in identification and referral of suspected cases of violence, also needs to be strengthened. A policy action plan to incentivise ASHAs for case identification and referral to higher facilities or OSCs for treatment and psychosocial support for women and children facing violence can be considered to improve the health and wellbeing of this vulnerable population.

### 7.1.3. Infrastructure, equipment and commodities

Infrastructure, equipment and commodities constitute the hardware of the health system, and are central to its performance. The allocation of a dedicated budget supports the availability of infrastructure and supplies. One important observation thrown up by this study is that medical supplies did not pose a problem, as Dilaasa department is integrated within the hospital. This is not the case with standalone OSCs, so integration of the OSC in hospital care may be seen as a critical component for adaptation of the model in LMICs. Olson et al (2020) report that most standalone OSCs were constrained by the absence of medical supplies and medical staff.

However, factors such as ineffective leadership can lead to unproductive utilisation of infrastructural resources even when they are available. For instance, abortion services could be denied even when available, or examination of rape survivors could be undignified even at hospitals flush with infrastructure. 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, regardless of size and infrastructure, can set up a Dilaasa department by utilising resources effectively. However, the location of Dilaasa within OPD premises, along with a separate room to ensure auditory and visual privacy, is non-negotiable in every case.

### 7.1.4. Financing

The sustainability of health system-based interventions depends on financing. A dedicated allocation of funds is needed to ready the health facility and build the capacity of healthcare providers. The absence of a specific budget line item for annual training, for instance, was a major constraint in it becoming part of the hospital calendar.

Lack of information among healthcare administrators on how to access the allocated funds could also be a barrier as the funds are not part of the hospital budget but have to be managed through a separate account. Funds may therefore need to be included as part of the hospital budget for smoother utilisation. Lack of clarity on the use of these funds, coupled with the rigmarole of a separate bank account for each hospital, contributed to poor utilisation of funds for services such as transport, food/tea for survivors, with Dilaasa team members often ending up bearing this expense from their minimal salaries.

Financing also covers recruitment of adequate and effective staff. The recruitment policy for staff, including salaries and nature of employment, is an important indicator of health system financing. Poor pay for Dilaasa staff, along with the contractual nature of the job and the absence of security and benefits, leads to increased attrition and affects the provision of quality services to survivors. Salaries should be commensurate with qualifications and workload. The key informants recommended long-term contracts for the Dilaasa team and increase in their salaries as part of effective utilisation of funds.

### 7.1.5. Service delivery

Effective and sensitive service delivery is the raison d'être of VAW projects such as Dilaasa, located within the health system. Unlike OSCs elsewhere, which often do not provide psychosocial care, the trained and designated staff at Dilaasa has ensured psychosocial care to all survivors.

This study has provided evidence of several facilitators and barriers to effective service delivery in a public health setting.

The location of Dilaasa within the hospital set-up is a key facilitator, aiding access to services by survivors. This is evident from analysis of the MIS data from the 11 Dilaasa departments and indicates that survivors are being actively identified. The fact that a small number of survivors of violence are also approaching Dilaasa

directly indicates that the community now knows about the department and sees its services as relevant.

The presence of emergency and other clinical departments at Hospitals A, C, G and K was found to be conducive for steady referral to Dilaasa and complete integration of the department in the hospital. There was a more widespread acceptance of Dilaasa as a hospital department among staff at these hospitals, as well as a recognition that cases of assault, consumption of poison and rape are actually cases of violence, calling for specialised care and support that only a department like Dilaasa can provide.

Hospitals that did not have an emergency department found it more challenging to internalise the role of Dilaasa within the hospital system. For instance, a senior doctor who was a core group member welcomed the Dilaasa team at Hospital E, but they found it difficult to establish themselves because the hospital staff started out questioning their presence and refusing to share hospital resources with them. The team managed to beat this hostile reception with resilience and now their caseload is high as their presence in the OPD and IPD is strong.

The mid-sized Hospital D, where the OPD and IPD are in different locations, has been able to strengthen its response to VAW because the nodal officer and Dilaasa team have been innovative in ensuring Dilaasa's presence at both facilities. They have formed a message group for coordination and roped in nurses and other staff to actively identify cases of violence.

The study also found that if Dilaasa is not located in an OPD because the infrastructure is not available, access to services can still be ensured by more effective referrals from different departments.

The readiness of a health facility in terms of adequate infrastructure, supplies and commodities to ensure auditory and visual privacy also affects service delivery.

The presence of tried and tested SOPs facilitates the availability and appropriateness of VAW services. Two sets of SOPs-one for the hospital and one for the department-were found to be effective in ensuring quality of care. Well-defined SOPs can guide healthcare providers through challenging cases and ethical dilemmas involving their legal obligations as providers.

The negative attitude of HCPs is the principal barrier to sensitive medical care. This is visible in the frequent delays in examination of rape survivors, examination in the labour room instead of a private space, inappropriate comments/remarks, the turning away of girls and women seeking abortion, and user fees being demanded from survivors.

The key informants emphasised development of SOPs that are contextualised to different levels of health facilities. They recommend that these protocols be developed in a participatory manner, with the involvement of healthcare administrators.

Healthcare administrators should be actively involved in sensitisation programmes on the response to VAW, since disinterest in VAW and insensitivity of the hospital staff was reported as a major concern by the counsellors interviewed as part of this study.

The 520-bed Hospital B, which was nationally recognised for its Dilaasa department and its response to sexual violence, has found itself in a peculiar situation. It had received media coverage, accolades and visits from various quarters. The hospital already had a core group and monitoring committee in place. However, when the hospital was upgraded to a medical college, the administration underwent a complete change. The Dilaasa team faced more and more hurdles in engaging the staff on VAW. What had been deemed a best practice was suddenly being questioned by senior medical staff. Insensitive comments on the presence/absence of the hymen and unscientific practices such as the mindless collection of swabs from the body (not indicated by a patient's history) were being observed. There was a constant review of proformas

and debate with concerned staff as the administration was not taking a stand on the SOPs. At the same time, the team was not able to get the support of other departments in identifying cases of violence. As this is a large hospital, the number of rape survivors reporting to the hospital is high, leaving very little time for the Dilaasa team to go on ward rounds for identification of DV survivors. This has led to a very low referral of cases to Dilaasa. Even survivors reporting assault or consumption of poison are not being referred to Dilaasa.

### 7.1.6. Multisectoral coordination

Multisectoral coordination is crucial for a comprehensive response to survivors of violence, including provision of services that are beyond the purview of health systems. The most significant finding of this study is Dilaasa's smooth coordination and rapport with multiple sectors, including the police, legal aid services, livelihood training centres, shelters and courts. Dilaasa was never intended to provide all these services in one place, but it can and does prepare survivors to navigate all these services. The inclusion of stakeholders such as the police in monitoring committees helps establish a rapport with different stakeholders.

Recommendations to increase multisectoral coordination further include developing networks with smaller facilities (NGOs, maternity homes, and self-help groups) to widen the referral pathways for survivors, facilitate early identification of violence, and provide a continuum of care. Establishing linkages with other one-stop crisis centres should also be part of multisectoral coordination. These linkages need to be complemented by building the capacity of healthcare providers at smaller health facilities to identify and provide first-line support to survivors of violence.

### 7.1.7. Monitoring and evaluation

Monitoring and evaluation of the health system's response to VAW is important in generating evidence on the efficacy of the system's approach and activities.

Documentation of cases by Dilaasa counsellors is an effective way of monitoring the health system response.

Although Dilaasa staff were trained in documentation, this has been the weakest part of project implementation. Variations in documentation registers, poor understanding about what the intake sheet should document, and missing data collation were some of the challenges in documentation. This needs attention, as poor documentation and data management and variable record-keeping act as barriers to the creation of crucial public health data. The ineffective management information system at Dilaasa also hampers monitoring and evaluation.

The monitoring committee at the hospital level has been functional only when activated by CEHAT and Dilaasa departments. This poor participation of NOs and committee members obstructs effective monitoring of the activities of Dilaasa within the hospital. A more active monitoring committee will improve the quality of care and the sensitivity of HCP response.

Regular monitoring and evaluation of Dilaasa activities through advisory committees at the governing body level is equally important. A non-functioning advisory committee points to a lack of accountability for VAW at the leadership level, even though the National Health Policy 2017 provides clear directives for the health sector response to gender-based violence.

Although there is a monthly reporting of cases to the governing body, the gaps in data and documentation referred to above make it ineffective for meaningful 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 smooth functioning of the monitoring committees, and augmenting the documentation capacity of the Dilaasa team.

## 7.2. CONCLUSION

The presence of a trained and a sensitive team, consisting of a core group, a nodal officer and the dedicated Dilaasa staff, emerged as the most important factor in establishing and integrating the health systems' response to VAW. Active leadership at the hospital level created a conducive environment for the Dilaasa teams, also helping them address infrastructure and service-delivery challenges. This is an important learning for upscaling the health-system response to VAW, as there is considerable variation among health facilities in terms of infrastructure and service delivery.

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# ANNEXURE

## ANNEXURE 1

### Demographic profile of counsellors interviewed for the study

| Sr. no. | Hospital Name | Sex | Education | Work experience before Dilaasa | Working at Dilaasa since |
|---|---|---|---|---|---|
| 1. | A | Female | MSW, LLB | Total: 5 years<br>Kotak Education Foundation: counselling parents | August 2017 |
| 2. | B | Female | MSW | Total: 10 years<br>Five years in HIV counselling<br>Bar girls project<br>NGO in Karnataka | March 2016 |
| 3. | C | Female | MSW | Total: 3 years<br>Two years at Kotak Education Foundation as assistant manager for parent intervention programme<br>Shradhanand Mahila Ashram<br>Sion Hospital | January 2020 |
| 4. | D | Male | MSW | No prior experience | March 2016 |
| 5. | E | Female | MSW | Three years as counsellor in Vasai police station | March 2016 |
| 6. | F | Male | MSW | Twenty-eight years in adolescent health projects | March 2016 |
| 7. | G | Male | MSW | No prior experience | March 2016 |
| 8. | H | Male | MSW | One year's experience conducting research survey | August 2016 |
| 9. | I | Female | MSW | Two years' experience<br>Social investigator in Bombay cancer registry | May 2016 |
| 10. | J | Female | MSW | One year's experience in HIV counselling | March 2016 |
| 11. | K | Female | MSW | Four years' experience<br>Nehru Yuva Kendra<br>HIV counselling | March 2016 |

## ANNEXURE 2

### Demographic profile of nodal officers interviewed for the study

| Sr. no. | Hospital Name | Sex | Qualification/ Specialisation | Other departments allocated to nodal officer | Years of experience in public hospital | No of VAW training sessions/ days |
|---|---|---|---|---|---|---|
| 1. | A | Female | MBBS | Administrative in-charge of the hospital | 11 | Single one-day training session |
| 2. | B | Female | MBBS | Medical records department | 22 | No training received |
| 3. | D | Female | MBBS | Medicine and adult OPD | 7 | Two sessions |
| 4. | E | Male | MBBS | Administrative in-charge of the hospital | 29 | One three-day session |
| 5. | F | Female | MBBS | Casualty department | 14 | One two-day session |
| 6. | G | Male | MBBS Obstetrics and Gynaecology | Administrative in-charge of the hospital | 30 | Four training sessions |
| 7. | H | Female | MBBS | Casualty department | 12 | One training session |
| 8. | J | Female | MBBS | Administrative in-charge of the hospital | 20 | One nine-day training session |
| 9. | K | Female | MBBS | Pharmacy department | 25 | One three-day training session |

## ANNEXURE 3

### Budget allocated to Dilaasa departments from 2015-20 (in lakhs)

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

Note: Number of Dilaasa departments proposed for that year in parenthesis. Actual number of Dilaasa departments remains 11.

Source: National Health Mission published data

## ANNEXURE 4

**Total budget allocated by National Health Mission for civil works, furniture and office expenditure and amount spent (2016-17)**

| Items | Budget Allocated by NHM | Budget spent by 11 Dilaasa departments | | | |
|---|---|---|---|---|---|
| | | Civil works | Furniture | Office expenditure | Total |
| **Amount in Rs** | 60,30,000 | 24,39,350 | 18,43,931 | 1,23,368 | 44,06,649 |
| **% of allocation** | 100% | 40% | 31% | 2% | 73% |

## ANNEXURE 5

### Annual budget allocated by National Health Mission to hospitals and amount spent by hospitals from 2016-20 (in lakhs)

| Year | 2016-17 | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|---|
| **Budget allocated by NHM** | 60.30 | 0.00 | 0.00 | 1.20 |
| **Total amount spent by 11 Dilaasa departments** | 44.07* | 0.73 | 1.73 | 1.27 |
| **Amount carried forward for next year** | 16.23 | 8.94 | 7.21 | 7.15 |

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

## ANNEXURE 6

**Salary proposed by chief medical superintendent office and salary allotted by National Health Mission for 2016-17**

| Post | Proposed salary | | Salary by NHM | | |
|---|---|---|---|---|---|
| | Monthly salary | Total budget | Monthly salary | Service* tax | Total budget |
| Medical social worker (counsellor) | 20,000 | 52,80,000 | 20,000 | 4,900 | 65,74,000 |
| Health worker (ANM) | 10,000 | 26,40,000 | 10,000 | 2,450 | 32,87,000 |
| DEO | 10,000 | 13,20,000 | 9,600 | 2,352 | 15,78,000 |
| TOTAL | | **92,40,000** | | | **114,38,000** |

## ANNEXURE 7

**Total budget proposed for civil works and office expenditure by chief medical superintendent office and total budget allotted by National Health Mission for 2016-17**

| Type of budget | Proposed by CEHAT | | | Allotted by NHM | | | |
|---|---|---|---|---|---|---|---|
| | One-time expend-iture | Recurring expend-iture | Total budget proposed | One-time expend-iture | Recurring expend-iture | Total budget allotted | % of funds allotted based on pro-posal |
| Budget heads | Civil and furniture | Office expend-iture | | Civil and furniture | Office expend-iture | | |
| Annual budget per unit | 6,00,000 | 1,20,000 | 7,20,000 | 4,76,180 | 72,000 | 5,48,180* | 76% |
| Annual budget for 11 hospitals | 66,00,000 | 13,20,000 | 79,20,000 | 52,38,000 | 7,92,000 | 60,30,000 | |

* NHM allotted fund to each Dilaasa centre varied slightly

## ANNEXURE 8

### Informed consent form for Dilaasa counsellor interview

### Upscaling evidence-based health systems intervention model across 11 public hospitals in Mumbai: A review of its implementation

**Principal investigator: Sangeeta Rege**

**Centre for Enquiry into Health and Allied Themes (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 the 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 the Dilaasa department in your hospital, provision of crisis intervention services, existing challenges and recommendations.

**Type of research intervention**

We would like to conduct an 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 a telephonic or in-person interview. The interview will be conducted by _____ and _____ will also be present to take notes about what we discuss.

The interview will begin 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 during the 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 recordings will be destroyed after six 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 nothing you say in this interview is 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 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 400 055, +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 institutional review board (IRB), contact Dr Anant Bhan (Survey No 2804 & 2805, Aaram Society Road, Santacruz [East], Mumbai 400 055, +91 9420160170)

**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 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 11 public hospitals in Mumbai: A review of its implementation

**Principal investigator: Sangeeta Rege**

**Centre for Enquiry into Health and Allied Themes (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 the 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 the Dilaasa department in your hospital, the 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 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 begin 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 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 during the interview. The tape will be kept in a locked cabinet. The information recorded is confidential, and no one except members of the research team will have access to the tapes. The tapes will be destroyed after six 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 nothing you say in this interview is 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 keep that information under 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 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 400 055, +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 institutional review board (IRB), contact Dr Anant Bhan (Survey No 2804 & 2805, Aaram Society Road, Santacruz [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 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 11 public hospitals in Mumbai: A review of its implementation

**Principal investigator: Sangeeta Rege**

**Centre for Enquiry into Health and Allied Themes (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 the 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 30 to 40 minutes

**Participant selection**

You are being invited to take part in this research because we feel that your experience as a key administrator who supported the 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 begin 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 convenient to you, and no one else, apart from the note-taker, will be present during this interview. If you give permission, we would also like to record the interview as it would be difficult for us to write down all the important issues mentioned by you during the interview. The tape will be kept in a locked cabinet. The information recorded is confidential, and no one except members of the research team will have access to the tapes. The tapes will be destroyed after six 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 keep that information under 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 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 400 055, +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 institutional review board (IRB), contact Dr Anant Bhan (Survey No 2804 & 2805, Aaram Society Road, Santacruz [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 11

### Informed consent form for women survivor interview

### Upscaling evidence-based health systems intervention model across 11 public hospitals in Mumbai: A review of its implementation

**Principal investigator: Sangeeta Rege**

**Centre for Enquiry into Health and Allied Themes (CEHAT)**

**Namaste,**

Thank you so much for coming to Dilaasa. I work with CEHAT, 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 of 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 programmes 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 organisations 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, which 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 choose to participate in the interview with or without this recording.

**Confidentiality**

We will be very careful to make sure that nothing you say in this interview is 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 keep that information under 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 400 055, +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 institutional review board (IRB), contact Dr Anant Bhan (Survey No 2804 & 2805, Aaram Society Road, Santacruz [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 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 for auxiliary nurse midwives (ANMs)

### Upscaling evidence-based health systems intervention model across 11 public hospitals in Mumbai: A review of its implementation

**Principal investigator: Sangeeta Rege**

**Centre for Enquiry into Health and Allied Themes (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 the 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 the Dilaasa department in your hospital, the role played by different professionals, and existing challenges and recommendations.

**Type of research intervention**

We would like to conduct a group discussion with you. The discussion 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 begin 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 that 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 also like to record the interview, as it would be difficult for us to write down all the important issues mentioned by you during the interview. The tape will be kept in a locked cabinet. The information recorded is confidential, and no one except members of the research team will have access to the tapes. The tapes will be destroyed after six 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 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 nothing you say in this interview is 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 keep that information under 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 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 400 055, +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 institutional review board (IRB), contact Dr Anant Bhan (Survey No 2804 & 2805, Aaram Society Road, Santacruz [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 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-structured interview guide for counsellor interviews**

| Questions | Probes |
|---|---|
| 1 Please describe your role at Dilaasa | a. What are your responsibilities at the Dilaasa department?<br>b. What is your typical day at the centre like? |
| 2 Can you explain the purpose/role of Dilaasa department in a hospital? | a. What are the linkages between violence and health? Which departments refer women to you?<br>b. Is there any difference in Dilaasa departments and other crisis centres not located in hospital? Please explain |
| 3 Please describe your interface with the hospital | c. Besides counselling, do you create awareness about Dilaasa at the level of departments, hospital OPDs, patients and relatives?<br>d. Are you aware of the role of nodal officer, medical officer, nursing superintendent, and have you approached them in difficulties? What has their response been? |
| **Nature of services offered by Dilaasa** | |
| 4 Please describe basic procedures once a woman/girl enters the Dilaasa department | a. How do the counsellors introduce the Dilaasa department and its services?<br>b. Is consent of the woman/girl sought? If yes, how?<br>c. Are the procedures different for women referred by HCPs and for women who walk into the centre on their own? |

| Questions | Probes |
|---|---|
| | 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 you use to guide your counselling process? | a. What are the messages you provide while extending emotional support? |
| 6 How do you assess safety of women? If she is unsafe, what do you do? | a. How do you assess the severity of violence? If a woman is found to be unsafe in the domestic environment, what alternatives are suggested?<br>b. Have women availed of emergency hospital admission?<br>c. What are the steps to follow if a woman is found to be unsafe but wishes to go back to the same environment?<br>d. What are the intervention strategies in cases of suicidal ideation? |
| 7 As you implement a crisis intervention model, please describe how you carry out the following:<br><br>Registration of police complaint, provision of legal counselling, | a. Please describe your experience in facilitating each of these services<br>b. Please describe difficulties encountered in facilitating these services<br>c. How do you resolve them?<br>d. Please describe one such case based on each of these interfaces |

| Questions | Probes |
|---|---|
| access to shelter homes, linkages with child welfare committees | |
| 8 Please describe your role in responding to rape survivors when they reach hospital | a. What does your role entail?<br>b. In cases where you assist HCPs, what exactly is the intervention you carry out?<br>c. Can you describe the challenges while facilitating support for survivors of sexual violence? |
| 9 When do you carry out joint meetings between survivor and abuser? Please explain the procedures and principles involved | a. Please describe steps in conducting joint meetings<br>b. How do you go about it? Please give us an example<br>c. What are the things you take care of?<br>d. When joint meetings do not reach a positive conclusion, what steps do you take? |
| **Training, supervision, and burnout** | |
| 10 What was the nature of training received for implementing crisis-counselling services? | a. At what stage were you provided training and by whom? What were its contents? Were you trained on counselling children and adolescents?<br>b. What are the situations you encountered where training was not adequate? How did you go about it (approached someone)? |

| Questions | Probes |
|---|---|
| | c. What are the provisions for ongoing training and support?<br>d. What are your suggestions for training of counsellors?<br>e. Is there supervision of your work as counsellor?<br>f. Whom do you approach if you are stuck at some point or wish to seek clarification about what needs to be done in a particular case? |
| 11 Have you experienced burnout or a sense of fatigue while dealing with so many cases of violence? | a. You have been working here for a considerable period of time now. Do you get tired listening to the same stories of violence?<br>b. What do you do when you experience such fatigue?<br>c. What motivates you to continue your work here at the Dilaasa department? |
| 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-structured interview guide for nodal officers of Dilaasa

**Please note:** These interviews will be conducted with nodal officers appointed for each of the Dilaasa departments across 11 hospitals. A nodal officer is a healthcare provider who has been given administrative charge of Dilaasa at 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 form 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 a public hospital, specialisation and total years of experience

**2. Can you explain the concept of the 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?
- What are the procedures for dealing with assaults, accidental consumption of poison, sexual violence against adults and children
- Please explain the nature of responsibilities allocated to different HCPs
- Tell us about your experiences 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 the difficulties you face in 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, methodology and usefulness**

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-structured interview guide for women survivors**

| Questions | Probes |
|---|---|
| 1. Please start by telling me how you first came to the Dilaasa crisis centre for women | a. What led you to come to Dilaasa?<br>b. Did anyone ask you about violence? Who was it (doctor/nurse/ counsellor)?<br>c. Did anyone speak to you in OPD or in IPD?<br>d. What did the healthcare provider say to you? What support did you receive from the provider? How did you feel about it? |
| 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? | a. Can you list your expectations?<br>b. Did the counsellor help you in identifying and meeting your needs? If yes, please specify |
| **Women-centred approach by counsellors at Dilaasa** | |
| 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? | 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]<br>b. How would you describe the counsellor's way of listening to you?<br>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? |

| Questions | Probes |
|---|---|
| | d. Do you feel that you wanted your problems to be addressed differently and not the way suggested by the counsellor? |
| 4. Did the violence affect your health? | a. What were the physical and psychological health effects of living in violence? |
| 5. Did you discuss these health effects with the counsellor? What was the nature of healthcare support provided? | a. Was a referral made to a hospital department? Did you get the required medical treatment?<br>b. Was the Dilaasa counsellor able to facilitate it?<br>c. Any suggestions for what was done well and what could have been done better? |
| **Psychosocial intervention services** | **Probes** |
| 6. 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?<br>b. Did you feel there was a threat to your life? Was emergency hospital admission offered to you? Or were you referred to a shelter home?<br>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?) |

| Psychosocial intervention services | Probes |
|---|---|
| 7. It is important to create evidence related to violence faced by women and so Dilaasa facilitates recording a 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 about police complaints?<br>b. What was the facilitation for recording police complaint (phone calls made to police station, explained procedure and how to approach police, accompanied survivor)<br>c. Was the facilitation useful? (Yes/No) Please explain |
| 8. 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?<br>b. During the meeting, did you fear any violence from your [INSERT relationship of abuser to woman]?<br>c. Was this meeting helpful or useful to you? How so? What were your expectations of this meeting? Were these expectations met? |
| 9. Did you need **legal advice** with regard to the violence faced? Can you elaborate on services offered by Dilaasa? | a. Were the specific laws and legal procedures pertaining to your complaint explained to you?<br>b. Did you meet a lawyer? Were you satisfied with the meeting? |

| Psychosocial intervention services | Probes |
|---|---|
| 10. Please describe your experience of the **medicolegal procedure** facilitated by Dilaasa | a. Time taken at the health facility<br>b. How was access to healthcare services facilitated? |
| **Feedback for Dilaasa services** | |
| 11. Was this the first time you sought formal support? | |
| 12. Can you explain if contact with Dilaasa has assisted you in dealing with violence? | a. Can you tell us how and what information or resources you have gained as a result of your contact with Dilaasa?<br>b. Has there been a change in your health status? Please explain how or how not<br>c. Do you see any changes in your coping strategies? For example, not blaming yourself for violence, seeking parental support, not feeling ashamed to disclose violence |
| 13. Have you referred any other woman to Dilaasa departments? | a. What prompted you to refer her to Dilaasa?<br>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? |
| 14. Please provide feedback about the location of Dilaasa in a public hospital | Please explain advantages and disadvantages |

| Psychosocial intervention services | Probes |
|---|---|
| 15. Are there any resources, services, or information that are not offered by Dilaasa, which you think should be provided? What are they? How do you think these resources or services will help you and other women? | |
| ***Thank you very much for sharing your experiences with us today. Your participation is very much appreciated.*** | |

## ANNEXURE 16

### Semi-structured interview guide for key informant

These interviews shall be conducted with key administrators of the National Health Mission, under which Dilaasa is funded, the executive health officer of the public health department of MCGM, the deputy executive health officer who has charge of Dilaasa departments under NHM, medical superintendents implementing the Dilaasa crisis centres, the ex-health secretary (MoHFW) who encouraged MCGM to replicate these centres, and senior CEHAT advisors responsible for the setting up of the Dilaasa department in 2000.

**Themes to be explored through key informant interviews:**

- 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 programme environment on healthcare and recommendations for integrating response to VAW
- Reflections on factors that led to institutionalisation and their recommendations
- Barriers and challenges at the level of the health system in recognising Dilaasa as an integral part of hospital services
- Recommendations for how other states can set up Dilaasa departments in hospitals

**1. Role description**

- Please tell us about the mandate and responsibilities of your current role
- Years of service, specialisation and years of experience

**2. Can you explain the concept of the Dilaasa crisis intervention department at the hospital?**

- What is the rationale for setting up psychosocial 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 Dilaasa activities?**

- Please describe if protocols exist, if hospital committees are formed for monitoring activities

**4. What is the mechanism of training new healthcare 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, such as police, legal, shelter, CWC support? Please describe**

**7. What according to you are the 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 to Dilaasa being regarded as one of the departments of the hospital? What else in your opinion should be done to make the Dilaasa crisis centre a part of the hospital?

**8. Do you think existing health programmes and policies like the National Health Policy 2017 have scope for integrating a healthcare response to VAW? 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 the existing health system to integrate the 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...

## ANNEXURE 17

### Semi-structured focus group discussion guide with ANMs

**Objectives of conducting FGDs**

- To understand the 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 or shelter homes)
- To understand the 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 is your role at the Dilaasa department? 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/policy/SOP/ for responding to suspected cases of violence against women?

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

- Is there a standard operating procedure for responding to these complaints? Describe the protocol for each of them
- Are the SOPs followed by all departments? (Probe with examples from SOPs)

- What are the challenges you face in ensuring compliance to SOPs?
- What do you do in cases when the SOPs are not followed?

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

a. Facilitator will specifically probe the role of the hospital monitoring committee (frequency of meeting, action taken)
b. Describe a recent monitoring committee meeting and the issues it discussed
c. Are there any mechanisms for monitoring of counselling services? Please describe them and issues raised at 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 her day. This may include 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 healthcare 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 the health consequences of VAW?**

a. Please explain the training activities for HCPs and their frequency
b. Who are the members responsible for training and orientation of HCPs?

**7. Do you face any obstacles in getting support from other agencies such as police, CWC, protection officers under PWDVA, other hospitals or courts?**

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 accomplished? If not, what do you think are the obstacles to Dilaasa being regarded as one of the departments in the hospital? What else do you think should be done to make the Dilaasa crisis centre a part of the hospital?**

## ANNEXURE 18

### Semi-structured interview guide for nursing superintendent

1. How long have you been working in this hospital? And how long have you been associated with Dilaasa?
2. What is your role in Dilaasa?
3. According to you, what roles can nurses play in Dilaasa? How do you ensure this role is fulfilled by nurses in your hospital? (Roles include awareness about Dilaasa, first-line psychological support, identifying and referring 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 examples of cases referred to Dilaasa?
6. What is the process of sensitising nurses on VAW?
7. How is training (frequency, duration, attendance, content, selection of staff for training, participation, challenges encountered) 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 your nurses have encountered in handling cases of violence?
10. According to you, what role can the Dilaasa ANM play on VAW within a hospital?
11. Any challenges you have faced with regard to your role in Dilaasa?

## ANNEXURE 19

### Semi-structured interview guide for doctors (other than nodal officers)

1. What was your role in Dilaasa? How long have you been associated with Dilaasa?
2. Can you share your experience of working with Dilaasa in your hospital?
3. Can you describe the challenges or problems encountered 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 them?
4. Can you talk about the functioning of the 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, nursing superintendents, nurses) sensitised and motivated to support Dilaasa? If not, what are the reasons for lack of cooperation, and what can be done? Do HCPs attend trainings arranged by Dilaasa?
6. What strategies can improve referral to Dilaasa?

## ANNEXURE 20

### Semi-structured interview guide for data entry operators

1. How long have you 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 you deal with them?
4. Do you have any concerns with regard to documentation? If yes, how do you deal with them?
5. Do you perform tasks apart from the role given to you? Can you share your challenges, if any, while performing these tasks and explain how you deal with them?
6. How does the Dilaasa team divide/manage workload?

## ANNEXURE 21

### Semi-structured interview guide for NUHM accounts representative

In the 2016-17 budget, funds were allocated for 11 centres, in 2017-18 funds were allocated for 21 centres, in 2018-19 funds were allocated for 16 centres (plus an additional budget for civil works at 21 centres), for 2019-20 and 2020-21, the budget was again for 11 centres.

1. Could you provide clarity on the budget sanctioned for these additional centres? Where were these additional centres proposed? What was the hindrance in initiating these new centres?
2. In each of these years, how much was proposed and how much was actually spent (I am 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 department? What are the criteria for these expenditures?
5. In the yearly audit what was the expenditure of each Dilaasa department 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, selected by the trustees of Anusandhan Trust, based on their expertise and scientific knowledge.

CEHAT also has a programme development committee (PDC) that provides programmatic direction to CEHAT. It monitors and maintains the quality of CEHAT's work, and ensures that it conforms to the organisation's overall objectives. All dissemination material is reviewed by the PDC. The PDC comprises members from various disciplines, including the social sciences, social work, law and journalism. In addition, experts from other fields are consulted on important documents pertaining to policy advocacy. It might be important to mention here that CEHAT has pioneered the evolution of the "Ethical Guidelines for Social Science Research in Health" (NCESSRH and CEHAT 2000) and "Ethical Guidelines for Counselling Women Facing Domestic Violence" (Jesani et al 2012).

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

#### 1. Consent and voluntary participation

Utmost care was taken to ensure 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 in the beginning as part of the consent process. During the interview, we maintained the privacy and anonymity of those who agreed to participate. We also maintained anonymity of those who declined.

While permission to conduct interviews was sought from senior administrators whom we considered 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 took place at a time and place convenient to the respondents, with prior appointments. Some participants were given (in accordance with the directions 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 a public health issue is important and relevant and therefore how public sector hospitals should institutionalise the healthcare response as part of their core work is relevant. Some of the most marginalised populations seek services at public sector hospitals. Their response becomes that much more pertinent in the absence of options for marginalised survivors. Moreover, abused women are more likely to use health services and more likely to trust healthcare providers.

**4. Potential for distress among caregivers**

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 and Schwartz 2002). This requires in-depth probing to understand the more intricate linkages. The present study investigates the implementation of the healthcare response to violence against women and children by the staff of 11 Dilaasa departments and associated hospitals. Even though the study aims to understand the implementation of the healthcare response, the situations they are responding to (violence) may result in some respondents being overwhelmed by their own experiences or by the experiences of the survivors they help.

We attempted to anticipate any distress during the interviews/focus group discussions and to be prepared to provide counselling to respondents as and when needed. Interviews with survivors were conducted along with a professional counsellor dealing with VAW to alleviate the distress.

**5. Addressing possible expectations of respondents**

Respondents could feel that all the issues shared by them would be implemented or addressed. At the time of seeking consent, we clarified the purpose of the study and the extent to which their sharing would contribute to it.

**6. Informed consent**

Written informed consent or verbal informed consent was sought from the participants after they had 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, and so on. This information was shared in writing, along with the names and phone numbers of the principal investigator as well as the chairperson 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 hard 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 via email or WhatsApp (in the case of survivors).

**7. Safety of the participants**

Our respondents included survivors of violence. Respecting and protecting their rights as participants is paramount. Besides seeking informed consent, we ensured their privacy, confidentiality and anonymity. Moreover, we did not delve into traumatic areas of their lives since this could lead to some distress. Our interviewers included a professional counsellor experienced in counselling on VAW to provide immediate emotional support and empathy and counselling. We

also provided respondents the option of leaving the interview midway, with the assurance that there would be no consequences, and they would be able to continue to seek care and services from the hospital as well as the centre if they chose to withdraw at any stage.


**Centre for Enquiry Into Health And Allied Themes**

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service, welfare and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realising the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through database and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Violence and Health.

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