



## 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.

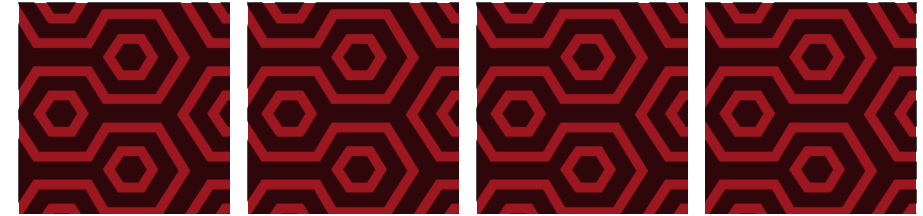
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# DOMESTIC VIOLENCE: FINDINGS FROM SERVICE RECORDS OF HOSPITAL-BASED COUNSELLING DEPARTMENT

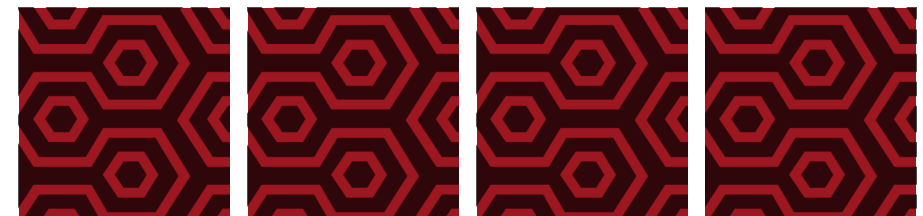


Centre for Enquiry into Health and Allied Themes, Mumbai



# HEALTH SYSTEMS' RESPONSE TO DOMESTIC VIOLENCE:

FINDINGS FROM SERVICE RECORDS OF  
HOSPITAL-BASED COUNSELLING DEPARTMENT



## Acknowledgements

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The research brief "Health systems' response to domestic violence: Findings from service records of hospital-based counselling department" is an outcome of analysis of 19 years case records of "Dilaasa" crisis department. Several healthcare administrators, providers, community development officers, and counsellors have worked extensively in development of sensitive practices towards violence against women (VAW).

We would like to begin by acknowledging Dr Seema Malik and her efforts to institutionalise a health care response to VAW. We extend our sincere thanks to healthcare providers including doctors and nurses of Bandra Bhabha Hospital, Mumbai for their consistent engagement on the issue of VAW. We take this opportunity to thank Chitra Joshi (Department in charge: Dilaasa at Bandra Bhabha Hospital) and Mrudula Sawant (senior counsellor and trainer) for their support in all the health facility based endeavours to respond to VAW.

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## Summary

Violence against women and girls is a global pandemic with one in every four women above the age of 15 experiencing intimate partner violence at least once in their life. This striking statistic is cited by the UN's review of the status of the Sustainable Development Goal of "eliminating all forms of violence against all women and girls in the public and private spheres" by 2030<sup>1</sup>. In developing economies such as India the prevalence is more severe. The National Health and Family Survey-5 (2019-2021) showed that one in three women in India between the ages of 18 and 35 have experienced some form of intimate partner violence in their lifetime<sup>2</sup>.



**1 in 3 women and girls**

**Experience Intimate Partner Violence  
between the ages of 18 and 35**

<sup>1</sup>UNDP (<https://www.undp.org/content/undp/en/home/sustainable-development-goals/goal-5-gender-equality/targets.html>)

<sup>2</sup>National Family Health Survey (NFHS-5) 2019- 21. (2021). International Institute For Population Sciences (IIPS) and ICF.

**This brief** provides an extensive analysis of data gathered through two decades of service records from Dilaasa<sup>3</sup>. It shows us trends of demographic of survivors, most common forms of violence, and the importance of public health system based response to domestic violence given the immense negative impact on the health of the survivors. The survivors coming to a crisis intervention department that is integrated within the hospital system are distinctly different from those reaching police stations, courts and NGO run counselling centres outside the health facility. Given the location of the department within a public hospital, the data show that most of the women reaching the Dilaasa department are from economically marginalised groups. Very often, healthcare providers are the first ones to encounter survivors of violence. Thus, the data from a response to violence established at the level of a health facility is useful in developing interventions for early identification of women facing violence and provision of support services to them.

The information in this brief will help advocate for implementation of appropriate health facility based interventions including building capacity of health care providers (HCPs) in developing an essential response to survivors.

<sup>3</sup> a hospital-based crisis department established by the Centre for Enquiry Into Health and Allied Themes (CEHAT) in partnership with the Municipal Corporation of Greater Mumbai (MCGM)

## About Dilaasa

In India, the Centre for Enquiry into Health and Allied Themes (CEHAT) has been actively involved in establishing a comprehensive health sector response to violence against women for more than two decades. In its wider scope, Dilaasa responds to rape and related sexual violence against women, however this research brief focuses on their work with domestic violence. Dilaasa was set up in the year 2000 in partnership with Municipal Corporation of Greater Mumbai (MCGM) as an intervention program on domestic violence and sexual assault at the hospital level to provide crisis intervention

services to women and to demonstrate the role of health professionals. The model has been adopted in several states of India at different levels of health system<sup>4</sup>. For example, in Kerala, Meghalaya, Karnataka, Haryana, Goa and Gujarat. Several intensive advocacy efforts of CEHAT, resulted in integration of the Dilaasa model in the government's National Urban Health Mission in Maharashtra in 2015 and scaling up at 11 peripheral hospitals in Mumbai.

<sup>4</sup> Publishers, M., Distributors 4753/23, Road, A., & Delhi 110 002, D. (n.d.). Violence against Women and Girls: Understanding Responses and Approaches in the Indian Health Sector. Routledge & CRC Press. Retrieved February 10, 2023, from <https://www.routledge.com/Violence-against-Women-and-Girls-Understanding-Responses-and-Approaches/Rege-Bhate-Deosthali-Ravindran/p/book/9780367134723>



## Methodology

The first Dilaasa department was established in 2000. Over the next two decades, the department has been well integrated into the health system. This brief is based on the analysis of the 19 years of data from service records collected during intake and follow-up of survivors by the counsellors. The intake form filled out by the counsellors includes information about demographic, socio-economic details of survivor, forms of violence experiences, health consequences, support sought by the survivor, and services provided by the counsellor.

A Management Information System (MIS) has been established to manage and streamline the service records. This system helps us in keeping track of each case and generating reports periodically. The service data is transferred to the MIS on an ongoing basis. The data entry operator and counsellor enter the data jointly which ensures validation of information. The identifiers in the form are redacted and a unique registration number is given to each case in the MIS. The analysis based on the service records is carried out at an aggregate level and if individual case studies are used, all identifiers are removed.

A total of 4076 women were registered and provided services through Dilaasa in 19 years. On average, there were about 215 cases per year with 82 as minimum and 319 as the maximum number of cases in the year 2001 and 2004 respectively. Of the 4076, a total of 3435 cases have been considered after removing cases with missing information for selected key variables like age, marital status, years of abuse etc.

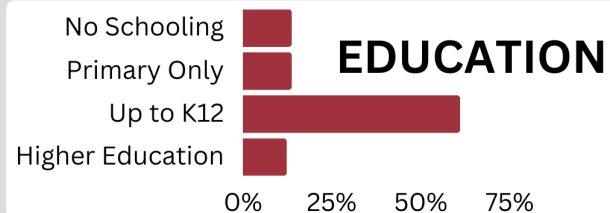
## Socio-Economic Profile of Survivors

Analysis of two decades of service records of survivors from the Dilaasa department shows that most women facing violence who sought out intervention services are within the age group of 18 and 35 years. Majority are married, either unemployed or in low-income/daily wage jobs and with 10 or 12 years of schooling.

### AGE RANGE

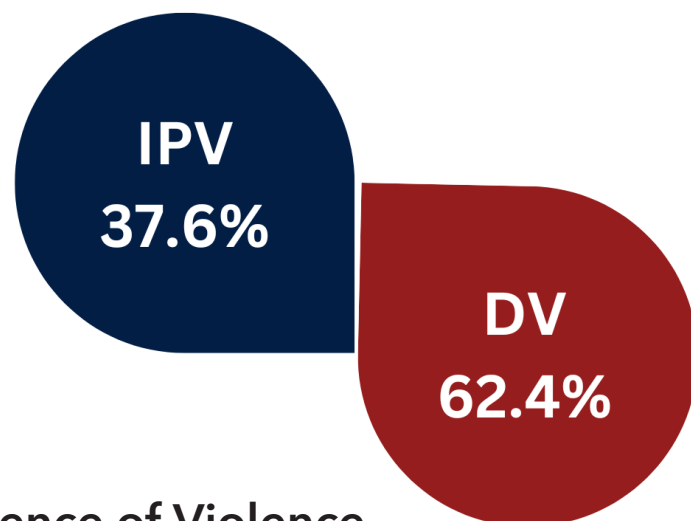


### MARITAL STATUS



### EMPLOYMENT

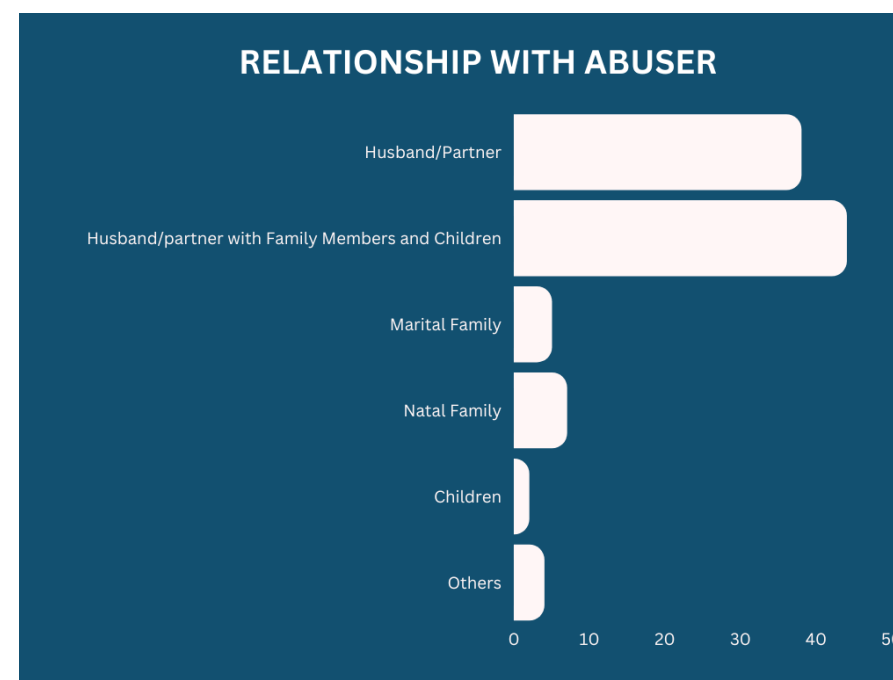
**89%** of women are either unemployed or in the informal sector



## Experience of Violence

Survivors shared with the counsellors about the relationship with their abuser(s), lifetime experience of violence, and duration of abuse while narrating their experience of facing violence. In global parlance, the violence experienced by women is legally defined by their relationship with the abuser. Under Indian law, domestic violence (DV) is defined as any form of physical, sexual, emotional and/or verbal abuse that injured, threatens, or endangers the physical, mental and emotional wellbeing of the aggrieved person. Intimate Partner Violence (IPV) can only occur between romantic partners who may or may not be living together in the same household. In India, the DV laws encompass violence perpetrated by an intimate partner under the same umbrella. The data show that much of the violence faced by the women seeking services at the Dilaasa departments was perpetrated not only by their intimate partner but also by the wider natal and marital family.

**Intimate partner or the husband** was an abuser in most of the cases. Women reported violence exclusively from an intimate partner or husband in 38% of the cases. However, the 44% of the cases of violence were perpetrated by the intimate partner/husband along with family members, both marital and natal, and children. Therefore, the intimate partner or husband was cumulatively reported to be involved in the violence in 82% of the cases. There were about 8% of unmarried women reported facing violence from their natal family alone, which is often not recognised as domestic violence.





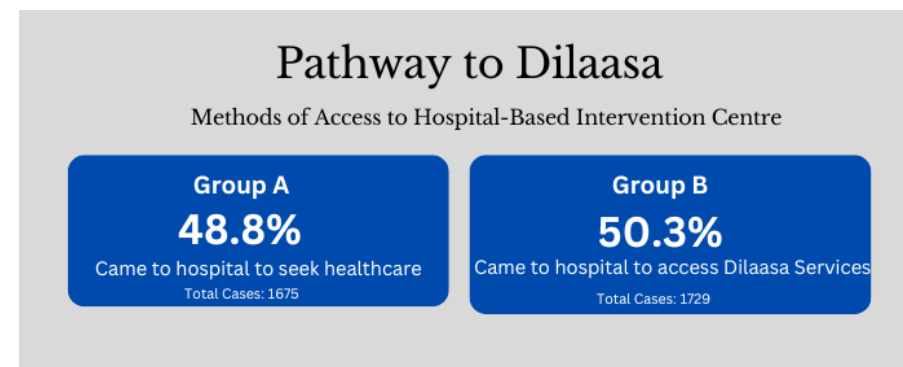
## Forms of Violence Experienced by Women in their Lifetime



**All women** reported some form of emotional violence including verbal abuse. Some other forms included insults/criticism, threats to harm her and/or her natal family, infidelity by the husband and restricting mobility. Young girls reported that their families were forcing them into and preventing them from having a choice of partner. Forced sexual intercourse or marital rape was the commonest form of sexual violence reported by women. Some reported being forced to watch pornography and forced to have sex with other men. Women facing sexual violence also reported that partners withheld sexual pleasure. Reproductive control was reported in the form of forcing women to have children, not using contraception, and forced abortion. The commonest form of financial violence reported was not providing money for household expenditure, followed by denying access to any money, denying food and shelter. Women also reported that partners demanded money or forced them to take loans. Control was reported in the form of not allowing a woman to seek employment or being forced to work.

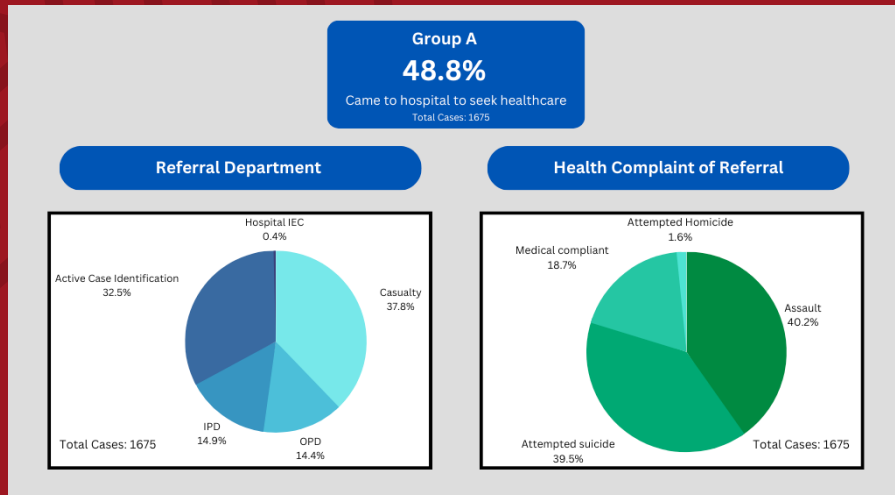
## Pathway to Dilaasa

Of the 3435 women who found their way to Dilaasa to seek intervention services, half came through the healthcare system and the other half through referrals from outside the system such as friends, community members, NGOs, law enforcement or communication materials. This shows the importance of having a hospital-based intervention service. For many of these women, approaching law enforcement or other NGOs may not only be difficult, but it may also put them at additional risk of violence from their abusers. The location of Dilaasa within a public sector hospital as an out-patient department (OPD) is provides safe and non-stigmatised access of support services to survivors. Women survivors could reach Dilaasa through several pathways, thus increasing the reach of the services and making Dilaasa more accessible to survivors in need of services.



\*There were 31 women in which survivors accompanied their relatives to hospital for seeking healthcare and came to know about Dilaasa

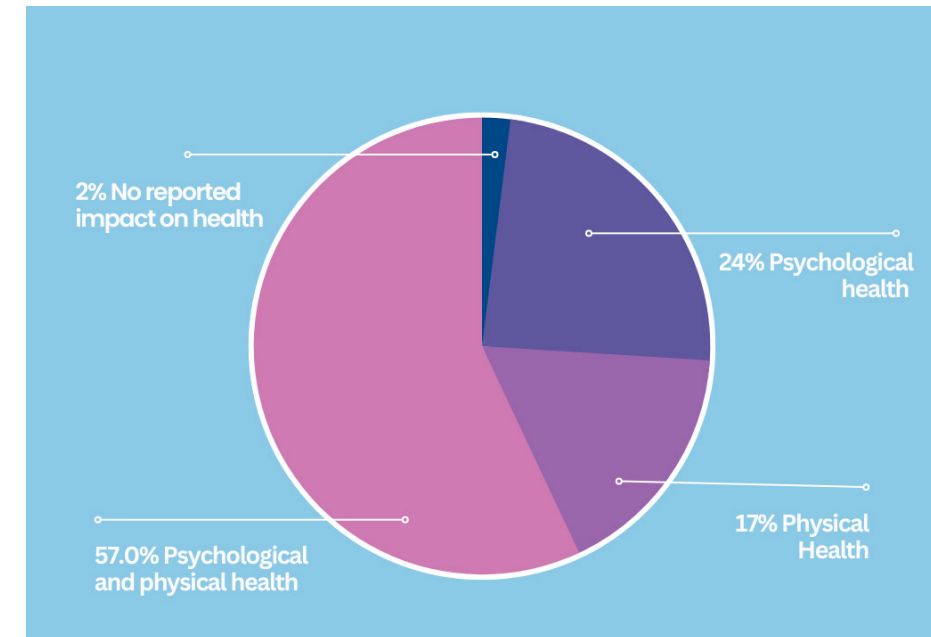
**Majority of the women** referred from the health system were in the hospital for assault related injuries indicating the incident of violence had occurred just prior to their reporting in the hospital. Almost an equal percentage of women were admitted for attempted suicide, most commonly by the ingestion of poisonous substances.



The presence of hospital-based intervention services with appropriately trained healthcare providers is critical at this stage of the survivor's pattern of abuse as they may be most receptive to help and services.

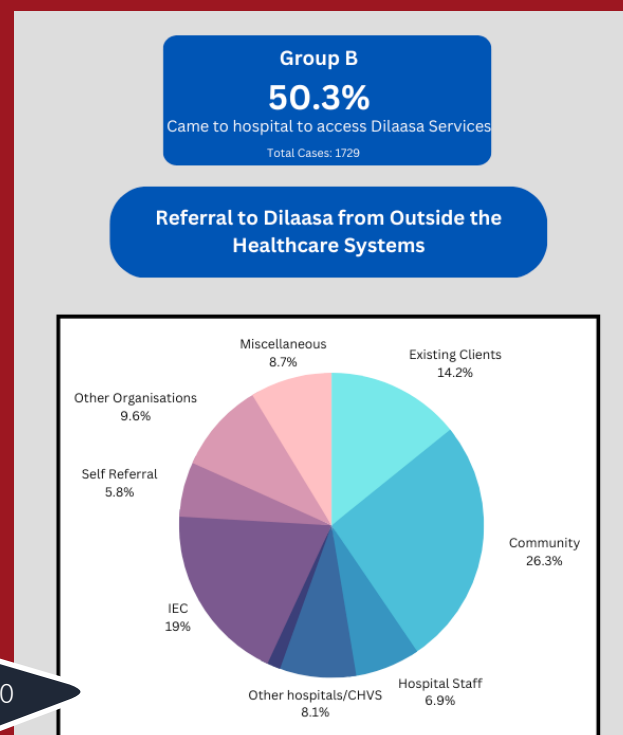
Apart from these obvious signs of abuse and violence, there are covert signs of violence which can be identified by trained providers in both the in-patient and out-patient departments. Some of the most seen covert signs included lack of sleep, anxiety, repeated health complaints and unwanted pregnancies.

Women who had previously availed services from Dilaasa were another source of referrals. The importance of word-of-mouth is seen here with almost 40% of survivors becoming aware of and being encouraged to avail services through community members and other survivors.

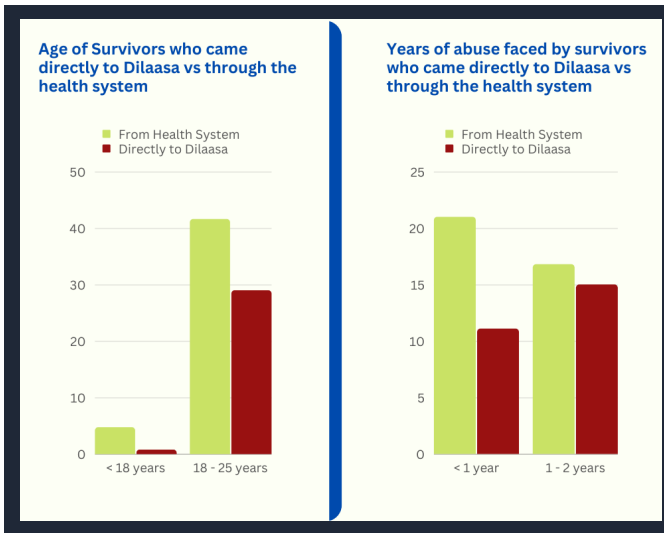


### Impact of violence on health survivors

The impact of violence on mental health was reported by about 92% of women. Depression and feelings of nervousness, tension, and worry were also reported by the majority of the women. Other mental health effects reported included fear, anxiety, and loss of sleep. Almost 32% of women reported having attempted suicide at some point in life. Physical injuries such as cuts, bruises and broken bones were predominantly reported. Abortions, stillbirths, and miscarriages were another health outcome of physical violence reported by the survivors.



The other half of survivors accessing services at the Dilaasa department came through non-hospital or healthcare-based pathways. The most common source of information about Dilaasa in the non-health system setting were family members, relatives, and acquaintances.

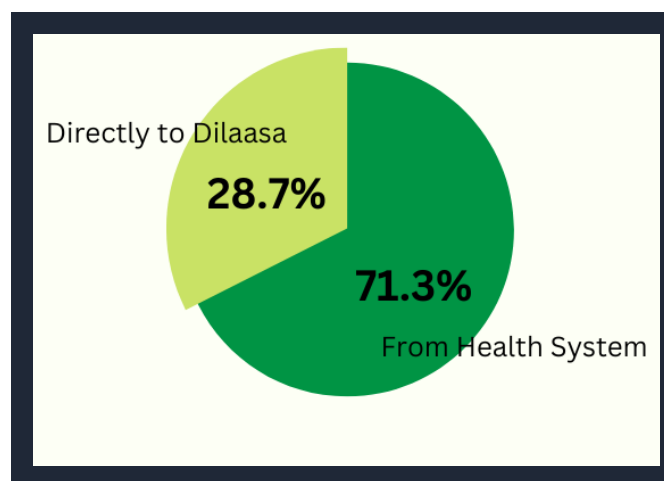


## Role of Health System

The acute short- and long-term impacts on the health of the survivors highlights the need to assess the importance of a hospital-based intervention service.

1. **The first critical role** of the health system is in the early identification of signs of violence. A comparative analysis of the socio-economic demographics shows a significant difference in the age of women between those who reached Dilaasa through the health system and the ones who came directly. Women who were referred by healthcare providers were much younger, thereby indicating health system response as an opportunity for early identification of violence. Similarly, more proportion of women (21.0%) with less than one year of abuse were referred by healthcare providers as compared to women who came directly to Dilaasa (11.1%).

2. **The importance of early identification** by the health system is further bolstered by the fact that almost 3/4th of women who didn't seek any support, formal or informal, before reaching Dilaasa were referred by the health system.



3. **The need of integration** of clinical enquiry about violence during pregnancy into routine antenatal care services is another route to early identification of violence. More than half of survivors (57.8%) ever experienced violence during pregnancy which points out the need to integrate protocol for identification and responding to violence in antenatal care services. In nearly 34.4% of the cases where pregnant women were referred to Dilaasa by healthcare workers, unwanted pregnancy was a primary health complaint of women.

4. **Self-harm behaviour** including suicidal ideation and attempt are common mental health consequences of domestic violence. When women who survive a suicide attempt reach a hospital, the case is invariably recorded as that of 'accidental consumption of poison' and women are provided only medical treatment. Prior to creation of Dilaasa department, there was no attempt made by providers in hospital to probe the underlying factors that triggered off the attempt and to address the mental health aftermath of suicide attempts. Over the years this has changed and all women and girls admitted with history of 'accidental consumption of poisoning' are provided suicide prevention counselling and those who disclose history of domestic violence are registered at Dilaasa for services.

5. **The data from service records** highlights the widespread prevalence (49%) of sexual violence in a marital relationship in form of forced sex and reproductive control and its health consequences. It is important to note that despite non- recognition of marital rape by law, a sensitive enquiry within health facility can enable disclosure and support seeking to mitigate sexual violence within marriage.

## Conclusion

The feasibility and sustainability of health systems' role in Indian healthcare facilities is evident from CEHAT's recent collaborative work with WHO, Geneva and three tertiary health facilities in two districts of Maharashtra. The findings of the intervention research indicate that training of healthcare providers along with establishing protocols, referral linkages and improving privacy and confidentiality can enable healthcare providers to ask about violence, provide first-line support and make external referrals. Thus, presence of a facility-based crisis department is indispensable for building a health systems' response to violence against women (VAW).

The National Family Health Survey (NFHS) accounts for violence from husband only and doesn't capture violence from other family members. Our analysis shows that most women reported facing violence from their husband and marital relationships. Thus, design of interventions for VAW including enquiry by HCPs should focus on violence not only from intimate partner but also from other family members in domestic relationships. It has implications for the national level estimates on violence against women. India's largest household level National Family Health Survey captures violence from husband only. This implies that the prevalence of domestic violence assessed by National Family Health Survey is under-reported as it doesn't account for violence from other members of the household. Therefore, the interventions to address violence against women should not only focus on violence from an intimate partner but also from other members in a domestic relationship. The enquiry by healthcare providers about violence should also consider domestic violence.

To conclude, health facility based VAW interventions in form of capacity building of HCPs, system readiness and provision of crisis interventions services are significant in early identification, secondary prevention of violence, addressing health consequences due to violence provision of support services to survivors.