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14 Rethinking gender-based violence and public health policies in India

Insights from Dilaasa, Mumbai, India

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Introduction

Domestic violence and sexual assault are the most pervasive forms of gender-based violence against women and pose a serious public health threat. There is a substantial evidence base across the world that relates gender-based violence to adverse outcomes for woman's physical, mental, sexual and reproductive health (Nakray in this volume; Campbell *et al.*, 2004; Heise *et al.*, 1999). Gender-based violence is associated with serious health problems, both long- and short-term, affecting women and children; these health problems include injuries, gynaecological disorders, mental health problems, adverse pregnancy outcomes and sexually transmitted infections (STIs) (Campbell *et al.*, 2004; Campbell, 2002; Jewkes *et al.*, 2002; Heise *et al.*, 1999; Heise *et al.*, 1994).

One of the most comprehensive global studies ever undertaken on domestic violence, under the auspices of the World Health Organization (Garcia-Moreno *et al.*, 2005) found that globally, one in six women are targets of domestic violence. Globally, 10 per cent to 69 per cent of women report intimate partner violence at least once in their lifetime, 6 per cent to 59 per cent of women report attempted or completed forced sex by an intimate partner in their lifetime, and 1 per cent to 28 per cent of women reported abuse during pregnancy by an intimate partner (Garcia-Moreno *et al.*, 2005).The study also highlighted that the proportion of ever-pregnant women physically abused during at least one pregnancy exceeded 5 per cent in eleven of the fifteen settings. Between a quarter and half of women who were physically abused in pregnancy were kicked or punched in the abdomen (Garcia-Moreno *et al.*, 2005: p. 16).

The main purposes of this paper are first, to provide an overview of gender-based violence in India (specifically domestic violence and rape); second, to outline the health consequences and the role of health services in India; third, to review the budgetary allocations made for the implementation of the Protection of Women from Domestic Violence Act (2005); and fourth, to share the insights from Dilaasa (Hindi: 'empathetic support'), an intervention model developed by the Centre for Health and Allied Themes (CEHAT) in a public hospital in Mumbai, India that involves interventions by health and social care professionals.

Overview of gender-based violence in India

The development of an appropriate policy response to gender-based violence is seriously hindered by the lack of an accurate evidence base. The National Family Health Survey (NFHS-3) and the National Crime Records Bureau (NCRB) (National Crime Bureau, 2010) provide an insight into the occurrence and the nature of violence against women. However, several issues have been raised in relation to the measurement of violence due to variation in the research designs, methods of data collection etc. (see Williamson; Jewkes; Coast *et al.;* and Mitra (a) in this volume). The NFHS-3 (2005–06) indicated that nearly two in five (37 per cent) married women have experienced some form of physical or sexual violence by their husband; one in four married women have experienced physical or sexual violence by their husband in the twelve months preceding the survey. One in ten married women has experienced sexual violence by their husbands, i.e. they have been physically forced against their will by their husband to have sex or perform other sexual acts they did not want to perform (International Institute for Population Sciences (IIPS), 2007). Sixteen per cent of never-married women have experienced physical violence since they were 15 years of age, generally by a parent, a sibling or a teacher. Of never married women, 1 per cent report having been sexually abused by someone (IIPS, 2007). The results at the national level vary at state levels. On an average, amongst ever married women 36 per cent report cuts, bruises or aches, 9 per cent report eye injuries, sprains, dislocations or burns, 7 per cent report deep wounds, broken bones or teeth or other serious injury, and 2 per cent report severe burns. Most abused women seek help from their own families and friends. Very few women seek help from institutions such as police (1.5 per cent), medical personnel (0.5 per cent) or social service organisations (0.05 per cent) (IIPS, 2007; see also Table 14.1). Similarly, other surveys related to sexual abuse indicate that 53 per cent of children across thirteen states reported facing some

Table 14.1 Number of women (minimum) facing domestic violence

	Lifetime / Ever experienced violence	*Experienced violence in last 12 months*
a. Prevalence of physical or sexual violence	34% (77 million)	19% (43 million)
b. Of above, reported some injury as consequence of DV	38% (29 million)	42% (18 million)
c. Sought some form of help	24% (18 million)	24% (10 million)
d. Of above, sought help from police	2% (0.36 million, or 360,000)	2% (0.2 million, or 200,000)
e. Sought help from a doctor	0.04% (0.0072 million, or 7,200)	0.04% (0.004 million, or 4,000)

Source: Computed from NFHS 2005–2006, for DV in past 12 months; for c, d, and e the percentage rates used for 'last 12 months' column are those as reported by women reporting violence 'ever' in their lives

form of sexual abuse and a survey in Goa found that 30 per cent had been sexually abused in the previous year (Kacker *et al.*, 2007; Patel and Andrew, 2001).

In 2010, the NCRB (National Crime Records Bureau, 2010) recorded that an estimated 22,172 cases of rape were reported; of these, 8.9 per cent (1,975) were girls under the age of fourteen. 40,613 cases of molestation were registered by women and girls all across the country. This data is based on the crime records that are registered at police stations and might only provide an overview of cases that have been registered in police stations. As per the NCRB records, the total number of crimes against women in 2010 was 2,005,009; the number of cases of domestic violence, including cruelty by husband and relatives and dowry deaths, was reported as 103,442, which is 50 per cent of the estimate derived from NFHS data (200,000 cases reported to police). See Table 14.2 for a clear break-down of the figures. The number of rape cases in the same year was 22,172.

Domestic violence has been associated with adverse outcomes to women's physical health – including reproductive health, and with making them more vulnerable to sexually transmitted infections including HIV/AIDS – and to psychological well-being (Garcia-Moreno *et al.*, 2005). Studies have documented the widespread prevalence of domestic violence, its adverse impact on women's health and the need for improving the identification, documentation and referral of such cases (Koenig *et al.*, 2006; Martin *et al.*, 1999; Jejeebhoy, 1998). A study of 2,199 pregnant women in North India indicated that births among mothers who had faced domestic violence are 2.59 times more likely to lead to peri-natal and neo-natal mortality (Koenig *et al.*, 2006). Physical and sexual intimate partner violence is associated with miscarriage, and reproductive health services should be used to screen for spousal violence and link to assistance (Johri *et al.*, 2011).

A strong association is indicated between spousal violence and poor mental health amongst women (Kumar *et al.*, 2005). Longitudinal studies have established spousal violence is associated as an independent risk factor for two adverse women's health outcomes, that is, sexually transmitted infections and attempted suicide (Chowdhary and Patel, 2008). Some of the negative results on women's mental health include symptoms such as crying easily, inability to enjoy life, fatigue, thoughts of suicide, depression, feelings of anger and helplessness, self-blame, anxiety, phobias, panic disorders, eating disorders, low self-esteem, nightmares,

Table 14.2 Selected crimes against women

Type of offence	*Cases*
Kidnapping and abduction of women and girls	29,795
Molestation	40,613
Sexual harassment	9,961
Cruelty by husband and relatives	94,041
Importation of girls (sex trafficking)	36
Rape	22,172
Dowry deaths	8,391

Source: National Crime Records Bureau 2010

hyper-vigilance, heightened startle response, memory loss, and nervous breakdowns. Spousal violence is associated with other risk behaviours associated with adverse health outcomes such as drug and alcohol use (Garcia-Moreno *et al.*, 2005; Deosthali *et al.*, 2005; Breckenridge and Salter in this volume). Several studies have highlighted the importance of a public health approach in gender-based violence (Mahapatro *et al.*, 2011; Heise *et al.*, 1999). It should also take into consideration the role of various health and social security policies (Patel in this volume).

Gender-based violence and the role of health services

The United Nations General Assembly in 1993 passed the Declaration on the Elimination of Violence against Women. The 1996 resolution of the forty-ninth World Health Assembly declaring violence as a public health priority endorsed recommendations made at prior international conferences to tackle the problem of violence against women and girls and to address its health consequences (Fatusi and Oyeledun, 2002). This resolution ended by calling for a plan for action for progress towards a science-based public health approach to preventing violence (Heath, 2002). It recognised that health workers are often the first to identify victims of violence and have the necessary technical capacity to help the victims (World Health Organization, 1996). Most notable advancements in a public health approach have been made in several developed countries such as the United Kingdom (see Williamson in this volume), Australia (Alston; Western and Mason; Breckenridge and James in this volume), and the United States (Ramos in this volume). However, in developing countries it is severely constrained because of a lack of clearly laid down policies and protocols, and most attention is paid to the implementation of the law, which does not receive adequate budgetary resources either (see Patel; Mitra (a) and (b); and Turkhanova in this volume).

One of the key impediments to the early identification of gender-based violence is the inadequate training of health care professionals such as General Practitioners (GPs) and administrative staff to specialist domestic violence agencies, as provision of training improves referrals (Feder *et al.*, 2011). Health professionals are ideally placed to identify domestic violence but cannot do so without training on raising the issue, or knowledge about the available advice and support services (Taket *et al.*, 2003). Studies with providers showed that training enhanced their awareness of indications of, and risk factors for, IPV, and community-based referral sources, and enhanced their self-efficacy in responding to IPV. Training has been found to lead to positive changes in provider knowledge, attitude and beliefs about sexual assault (Donohoe, 2010; Milone *et al.*, 2010). Screening of women for domestic violence in reproductive and child health programmes requires sensitisation and training; institution-wide changes are also required to provide services effectively (Guedes *et al.*, 2002). The stigma surrounding domestic violence means that many of those affected are reluctant or do not know how to seek assistance.

Women's disclosure depended on non-judgemental, non-directive and individually tailored enquiry by the health professionals that was based on an appreciation of the complexity of partner violence (Feder *et al.*, 2006; see also Mitra (b) in this

volume). In cases where women disclose violence, some of the key preferences outlined by survivors of violence include: (a) treat me with respect and concern; (b) protect me; (c) documentation; (d) give me control; (e) immediate response; (f) give me options; (g) be there for me later (Dienemann *et al.*, 2005). Similarly, Chang *et al.* (2005) also highlighted the importance of reducing stigma around gender-based violence whilst interacting with the women clients. Nurses on in-patient post-partum units are well-positioned to screen women for intimate partner violence (IPV) yet low screening rates suggest that barriers to screening exist. There is an inverse relationship between rates of screening for IPV and nurses' perceptions of barriers (Guillery *et al.*, 2012). A systematic review of screening for domestic violence in health care settings concluded that although there was insufficient evidence to recommend screening programmes, health services should aim to identify and support women experiencing domestic violence. The review highlighted the importance of education and training of clinicians in promoting disclosure of abuse and appropriate responses (Taket *et al.*, 2003). Three distinct types of services have been identified by Colombini *et al.* (2008): these include 'provider-level integration', where the same provider provides a range of services during the same consultation; 'facility-level integration', where a range of services is available at one facility but not necessarily from the same provider; and 'systems-level integration', where there is a coherent referral system between facilities so that, for instance, a family planning client who discloses violence can be referred to a different facility (possibly at a different level) for counselling and treatment.

In India, the response of health systems and professionals to the issue has been abysmally poor. Despite the critical role that health professionals and health systems have in responding to violence, the medical and nursing education does not consider violence as a health issue. The medico-legal documentation of domestic violence, rapes, suicides, and homicides, deaths in police custody, caste or communal violence is not properly recorded as there are no uniform protocols and procedures for this. One of the reasons for this is that health professionals are not trained to investigate violence and respond to specific needs of victims (Deosthali *et al.*, 2005; Jesani, 2002). Medical education should incorporate training on various aspects of recognising risk and outcomes associated with gender-based violence and also to respond and care for the victims and survivors. However, it is important that medical interventions cannot address gender-based violence alone and they need to be embedded in progressive developments in legal and social policy interventions (see also Jewkes; Patel and Mitra (a) and (b) in this volume).

Critical analysis of gender-based violence interventions in India with specific reference to the Protection of Women from Domestic Violence Act 2005

The health sector plays a pivotal role in early identification of gender-based violence and its impacts and making appropriate referrals for further interventions. However, in India, major initiative towards addressing domestic violence has been through the Protection of Women from Domestic Violence Act (2005) (see also

McQuigg; Turkhanova in this volume). The National Policy for the Empowerment of Women (Ministry of Women and Child Development, 2001) recognised the need for institutional mechanisms for providing assistance to the survivors of violence. The Planning Commission recognised the role of medical professionals in identifying and making referrals for women and children suffering from violence (The Planning Commission of India, 2008). There is no policy initiative in this direction as such.

The women's movement in India has played a significant role in advocating a law against domestic violence. The Protection of Women from Domestic Violence Act (2005) is regarded as a landmark judgement (Ministry of Law and Justice, 2005). It defined domestic violence as 'any act that harms, injures, endangers, the health, safety, life, limb or well-being of the person or tends to do so'. It includes 'physical, sexual, verbal, emotional abuse or intention to coerce her or any person related to her to meet any unlawful demand for dowry or any other property/valuable security' and which would 'also have the effect of threatening her or any person related to her' (Ministry of Law and Justice, 2005).

The Act recognises service providers in public health facilities and mandates that all women reporting domestic violence must receive free treatment and information/appropriate referral to protection officers under the act. Some of the provisions of the law include: the appointment of the Protection Officers at Block Levels (an administrative unit which could be referred to as sub-district) who will record complaints of domestic violence, facilitate specific protection, and/or get restraining orders from the magistrates' court; register providers who can offer counselling, shelter and legal aid to survivors and support them through grants or set up such services; train medical facilities and doctors to record complaints of domestic violence and direct women to service providers or protection officers; and create awareness about the law amongst various stakeholders such as the judiciary, police and so on (Lawyers Collective, 2009).

In the reported cases of sexual assault there is a clear role defined under criminal law for medical professionals that mandates their role in medical evidence collection and documentation of the same. Through an order of the Supreme Court of India in 1994, the National Commission for Women (NCW) was directed to evolve a Scheme for the relief and rehabilitation of rape survivors. This was drafted by the NCW in 2005 and revised in 2010; it includes interim compensation to be offered to the victim, and provision of budgetary requirements to be transferred to state governments as grant in aid from the national government for the setting up of a district-level committee to consider and decide on claims and for monitoring of the scheme. The scheme allows an interim relief of Indian Rupees (INR henceforth) of 20,000 and up to INR 50,000 for rehabilitation. A final settlement of up to INR 1,30,000 is permissible (Ministry of Women and Child Development, 2010)

The laws fail miserably in terms of making resources available for services and actions to implement the laws (Jhamb, 2011). At one level the national government has made a beginning by making some allocations via specific schemes to address provisions of these laws, but the state governments lag far behind, especially given the fact that the subjects being dealt by these laws are in the State List. Table 14.3

Table 14.3 Budget allocations for selected programs of Ministry of WCD, GoI 2009-2012 (Rs. crores[1])

Program	*2009–10 Budget estimate*	*2009–10 Actual expenditure*	*2010–11 Budget estimate*	*2011–12 Budget estimate*
Short-stay homes	15.90	17.35	23.25	33.30
Swadhar (mostly grants to NGOs for running homes and services for DV victims)	13.50	14.97	30.00	34.21
Scheme for relief and rehabilitation to rape victims	53.30	0.09	36.20	133.20

Source: Budget Expenditure Volume 2009-10 and 2011-12

Budget Estimates: The Annual Financial Statement or the statement of detailed estimates of receipts and expenditure of the Government for the Budget Year, or with respect to each financial year[1] Crore is a unit in the South Asian numbering system equal to ten million

gives a brief overview of allocations under the Ministry of Women and Child Development for specific programs dealing with domestic violence and sexual assault. Given the scale of these problems as we have seen in the above discussion, these allocations are too insignificant.

For instance according to the Ministry of Women and Child Development Annual Report there are only 287 facilities, most run by non-governmental organisations, and most located in large cities. These facilities aim to support women and girls in difficult circumstances, such as women who have undergone abuse. There is no specified ratio of *Swadhar* (Hindi: 'independence') centres per unit of the population. Further, these centres have been entrusted to non-governmental organisations that operate with meagre funds (see Table 14.3). The centres are not able to recruit trained personnel for service provision as the salary permissible for a full-time counsellor is merely INR6,000 per month (Ministry of Women and Child Development, 2012).

The same is true for the rape-related allocations under the Scheme for relief and rehabilitation of rape victims. The number of reported cases of rape have been steadily increasing over the years. In 2009 it was 21,397, and in 2010 it increased to 22,172. Despite this rise, it is peculiar to find merely INR 36.2 crores budgeted for 2010–2011. Even if we go by the registered rape cases (which is perhaps only the tip of the iceberg), even then the allocations for the rape relief program is awfully poor. Taking just the number of registered cases – 22,172 in a year – the expected budgetary allocation of INR200,000 per victim requires INR 443.44 crores. The cost of one visit to a health facility is likely to cost a survivor INR1,000 (in expenditure on health services; travel or loss of employment). The actual expenditure by the rape victim might vary as some of them might require surgical interventions. These estimates do not actually measure the economic impact; the social and health costs to an individual exceed the actual allocations (Rajadhyaksha, 2011).

Jhamb (2011) has analysed the budgets for governments of federal states in India for domestic violence related programs and activities. Most of this information was gathered using the Right to Information Act, Government of India, 2005, which mandates timely response for citizen requests for government information, and also allows citizens information on state budget documents. This is the only compiled information on state-level budget allocations (Table 14.4).

One of the issues raised by Jhamb (2011) is that the central government has not allocated budgetary funds for the implementation of the act, although some few federal governments have made some provisions. Of the 28 states in India 15 have made allocations for the implementation of the Act and 12 states do not have a separate budget for the implementation of the Act; the budgetary allocation varies from INR200,000 (that is the state of Meghalaya) to INR530,00,000 per year (that is the state of Karnataka).The budgetary expenditure is largely spent on salaries and awareness creation. No notable changes have been made in the last three to

Table 14.4 States that have planned schemes for Protection of Women from Domestic Violence Act (Indian Rupees in lakhs)

State	*2008–09*		*2009–10*		*2010–11*		*2011–12*
	Budget Estimates	*Exp.*	*Budget Estimates*	*Exp.*	*Budget Estimates*	*Exp.*	*Budget Estimates*
Karnataka	150	146.62	292.34	109.76	723.22*	348.2	530.22
Madhya Pradesh	292	108.76	250	85.3	309.98	95.96	221.79
Maharashtra	–	–	–	–	47.54	29.48	200
Kerala	100	99.97	115	114.63	250	168.24	200
Andhra Pradesh	99.82	99.6	98.4	98.4	61.28*	111.28	114
Haryana	25*	23.72	80*	NA	80	67.25	80
Assam	0.01	Nil	84	84	76.5	76.5	50
Uttarakhand	50	Nil	50	Nil	50	NA	50
Manipur	–	–	0.45	0.45	8	8	45
Delhi	5	4.04	22	6	45*	40	40
Orissa	Nil	Nil	Nil	Nil	25	NA	25
Meghalaya	3.2	3.2	3.5	3.5	2.3	NA	2
Sikkim	10	0.51	8	6	2	1.92	No allocation yet

Notes:

1 At the time of writing, one British pound was equivalent to 86 Indian rupees, and one US dollar to 55 Indian rupees.

2 A lakh is a unit in the Indian numbering system which equals 100,000, and a crore is ten million.

3 B.E. denotes Budget Estimates: The Annual Financial Statement or the statement of detailed estimates of receipts and expenditure of the Government for the 'Budget Year' or with respect to each financial year.

4 Exp. denotes Expenditure, * Revised Figures, RTI was not filed in J&K, No response received from Lakshadweep

Source: Jhamb 2011

four years. The budget allocations do not take into consideration prevalence of violence in the states.

Dilaasa as an intervention model: estimating costs of a public health approach for the National Policy on Gender-based Violence

In India, the women's movement raised the issue of domestic violence and sexual assault in the 1980s, campaigned for several changes in the law, and also rallied for the setting up of counselling centres, shelters and legal aid for survivors. However, interventions by the health sector were largely unaddressed (Bhate-Deosthali *et al.*, 2012; Deosthali *et al.*, 2005; Jesani, 2002). The Centre for Health and Allied Themes (CEHAT), established by the *Anusandhan* Trust, recognised gender-based violence is a public health and human rights issue. Since 1998, it has engaged with the health care professionals on the issue by setting up health care models that are gender sensitive and that provide comprehensive health care services for survivors of domestic violence and sexual assault. This includes provision of social and psychological support, documentation of violence, legal services and provision of follow up medical care. One of the priority areas of interventions recognised by CEHAT is the training and capacity building of health care providers.

In India the Dilaasa project marks a pioneering attempt by CEHAT to work on gender-based violence from a public health approach. It includes the establishment of two crisis centres based in hospitals in the city of Mumbai. The two guiding principles of Dilaasa are to locate domestic violence within social contexts, and to recognise domestic violence as a serious public health concern (Ravindran and Vindhya, 2009). It was first established through a joint initiative of the CEHAT and the Municipal Corporation of Mumbai. Originally established in a municipal hospital, K. B. Bhabha Hospital, Bandra (a suburb in Mumbai), in 2001, Dilaasa has since been replicated in three other public hospitals across the country: K. B. Bhabha Hospital Kurla Mumbai, at a medical college hospital in Indore (large industrial city in Madhya Pradesh) and a civil hospital in Shillong (the state capital of Meghalaya). Dilaasa provides training to the hospital staff, both medical and paramedical, on responding to domestic violence. It also provides emergency shelter and legal counselling to the victims. The counselling provided to women largely follows the principles of feminist counselling, including situating domestic violence as a result of a patriarchal society, and recognising that a woman is not responsible for undergoing violence; its ultimate objective is to empower women. Dilaasa is also an integrated model of public health intervention which mobilises various professionals in public health settings to identify gender-based violence at the early stages and initiate interventions (Colombini *et al.*, 2008)

Dilaasa is located in a 450-bedded peripheral hospital located in Bandra West, a suburb of Mumbai. The service providers include one full-time social worker, one part-time social worker, one part-time nurse, one counsellor and one part-time physiotherapist. They are deputed by the hospital to this department. Each social worker works in Dilaasa for two consecutive days and for designated hours and on

the other days they perform their prescribed duties with the other departments of the hospital. On an average, they have counselled 250 new women each year who have registered as users with the centre and also 150 women who were referred by other departments for issues such as 'accidental consumption of poison' which have been found to be cases of attempted suicide. Almost 390 cases have been registered as a result of referrals from emergency and other departments of the hospital, after the health and social service providers received training from CEHAT. Each woman receives three counselling sessions and almost 50 per cent of the women do follow up with the crisis centre. Since 2006, the crisis centre established in Mumbai has been functioning as a part of the public hospital. CEHAT provides technical support in terms of training. Amongst the users, a large number of women reached the centre within one year of experiencing abuse. In the last two years, the hospital has provided services to 15 victims of sexual assault.

The Dilaasa crisis centre is located in Bandra (West), an administrative unit within Mumbai which has a population of 337,000. The total female population is 155,200. The overall cost of setting up and running a unit here is INR30,00,000 a year. This indicates that in Bandra an average of INR19 is spent per woman for provision of domestic violence services. It is important to note that the additional costs for the hospital is only INR14,00,000, that is INR9 per woman, as the existing staff of the hospital has been retrained and deputed to manage the crisis centre.

At the national level, considering 300 million women in the age group 15–49 years, this requires an allocation of INR 1113.4 crores (that is an allocation of INR 19 per woman). As shown in Table 14.4, the highest allocation for implementation of the Protection of Women from Domestic Violence Act (2005) by a state government is INR 5 crore and seven states in fact have budgeted less than a one crore, which is grossly inadequate. Despite models like Dilaasa, which is now well acknowledged by the Ministry of Women and Child Development and other offices, the proposed NCW scheme for implementation of Protection of Women from Domestic Violence Act (2005) makes an estimate for only INR 75 crores for setting up offices for Protection Officers at block levels across the country. Such meagre allocations are not likely to provide any quality services. The scheme also proposes setting up special cells at block levels; the estimate for this is INR 110 crores which is way below the projected allocation based on the Dilaasa costing,

Table 14.5 Estimating the costs of a Dilaasa Crisis Centre per year (Indian Rupees)

Initial cost of training of counsellors and health care providers and some infrastructural cost	6,00,000
Human resources: One full-time and one part-time social worker, one part-time nurse, one part-time physiotherapist	16,00,000
The running costs of the crisis centre, including telephone, photocopying, travel with survivors, supervision and monitoring of quality of services, and data management	8,00,000
Total	*30,00,000*

given that there are over 4,000 blocks in India. Similarly, if the state is really committed to provide relief to rape victims, then on the basis of just the registered cases a minimum of INR 443.44 crores is required. Even one visit to a health facility for a survivor requires an allocation of minimum INR 2.2 crores (INR1,000 per victim per visit).This demonstrates that current allocations are highly inadequate to address the bare minimum needs of women. This does not take into consideration the need for health interventions, or the social, psychological and economic rehabilitation of the victims.

To conclude, Dilaasa presents a model for public health intervention in a developing country. The project, which started as an initiative of the CEHAT, has now become an integral part of public hospitals. The success of Dilaasa provides vital insights for a public health approach in India, which lacks direction in terms of developing a coherent strategy for addressing gender-based violence. Based on the Dilaasa model one can estimate that the costs are not currently covered by the government budgets in India. Clearly the current approach of the Government of India should be reviewed and new strategies should receive budgetary resources. The Dilaasa model illustrates that by directing the necessary human and financial resources a sustainable public health approach can be developed in India. It could result in positive outcomes for individual women and also society as a whole. However, as it has been clearly illustrated in this chapter, gender-based violence is not currently recognised as a public health issue. There are no allocations in the budgets to address gender-based violence as a public health issue. The allocations under the Protection of Women from Domestic Violence Act (2005) are awfully inadequate. The government will have to make a strong commitment to address gender-based violence and direct necessary budgetary resources towards addressing this serious problem. It is important that all health facilities are notified under the Act as a 'Medical Facility'. This would form the first step towards recognising gender-based violence as a public health issue, which would have to be followed with adequate allocation of funds for the training/capacity building of providers for identification of abuse and for provision of social and psychological support for women reporting violence at health facilities.

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