

DILAASA
EVALUATION REPORT

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1. INTRODUCTION

1.1. About this report

The *Dilaasa* project is a joint initiative of the Centre for Enquiry into Health and Allied Themes (CEHAT) and the Municipal Corporation of Mumbai (BMC). Conceived as public hospital-based crisis centre, preparatory work on the project started in August 2000, and the centre was established in BMC-run Bandra Bhabha hospital in 2001. Training of the hospital staff – both medical and paramedical – to be sensitive and responsive to the issue of domestic violence formed the pivotal thrust of the project. Core groups of trainers have since been formed in five hospitals and a second crisis centre has been set up in another public hospital, the Kurla Bhabha hospital. A training cell of key trainers from among staff of five BMC hospitals has also been created. The crisis centres were formally handed over to the staff of the BMC in 2006. Since then, CEHAT has been providing mainly technical support, and *Dilaasa* has been functioning as a project of BMC.

In late 2009, CEHAT requested the authors of this report to carry out an evaluation of the *Dilaasa* project. The purpose of the evaluation was outlined as follows:

- To evaluate the extent to which *Dilaasa* has been able to cater to the needs of women survivors of domestic violence
- To assess the extent to which this initiative is replicable in other settings for responding to domestic violence as a health issue
- To specifically review the feminist counselling and training models demonstrated by the project
- To review the usefulness of strategies used by the project for mainstreaming domestic violence as a public health issue

The evaluation was to be based on

- Key documents about the project: Annual reports, needs assessment studies, training reports and curricula, reports based on analysis of data gathered as part of counselling, detailed reports of the consultant guiding counselling
- Interviews with key project personnel, coordinator and mentors
- Interviews with a few hospital staff involved with the project
- Meetings with members of the training cell
- Observations and review of records in the counselling centre, and conversations with a small number of women survivors of violence

Visits to the crisis centres, meetings and interviews took place during the first week of January 2010. Document review was carried out subsequently. Notes were taken during the

observations. The interviews and meetings were taped with the permission of the respondents. This report draws on all these sources.

Considering the volume of work that has been carried out over a period of ten years by a large team of dedicated personnel, we can hardly claim to have grasped all its dimensions and depth within the brief period during which we got to know about the project. Nor can we hope to capture all the ingredients that have gone into this project in a brief report such as this. This report is a modest attempt to provide a broad overview of *Dilaasa's* work during the past decade and its key achievements; to critically reflect on the strengths and limitations of the *Dilaasa* model as a health sector intervention for survivors of domestic violence; and to make recommendations on the way forward.

In this first chapter, the next two sections will describe the context within which *Dilaasa* came into being, and its objectives and components. It will also summarise its major milestones during the decade 2000-2009. Chapter two will examine each of the three components of *Dilaasa*: crisis centre; capacity building and training; activities related to expansion and upscaling. Chapter three will pull together lessons learned about what constitutes the *Dilaasa* model and on prospects for replication and upscaling. The last section of this chapter will present recommendations of the evaluation team based on the information gathered, interactions with personnel and our own reflections.

1.1.1. The context

Gender-based violence as a major women's rights and health issue globally and in India

The term "*Gender-based violence*" is used to include all forms of violence against women and girls that is rooted in a worldview which rates men as superior to women and vests in them greater power, a worldview upheld by social institutions in many societies. Domestic violence (violence by any person in the natal/marital family, most commonly by the husband or intimate partner) is the most common and widespread form of violence experienced by women all over the world. Domestic violence includes physical, psychological or sexual violence. Usually, more than one form of violence co-exists.

Gender-based violence as especially domestic violence is also widespread in India. In 2007, crimes against women accounted for almost 10% of all crimes recorded. There were more than 20,000 registered cases of rape, an 8-fold increase from about 2500 cases in 1971. Close to 40,000 women registered cases of molestation. There were about 8000 cases of dowry deaths -women killed within their marital homes. More than 75,000 cases were registered of cruelty by husbands and relatives.¹

As we all know, only a small fraction of violence actually gets reported to the police. The national Family Health Survey-3, a country-wide survey carried out in 2005-06, found that

¹ National Crime Records Bureau. http://ncrb.nic.in/cii2007/cii-2007/FIGURES_2007.pdf. Downloaded 2 September, 2009

millions of women experienced violence in their lives and that most of them experienced it within their homes.

- One in three women aged 15-49 years has experienced physical violence and one in 10 has experienced sexual violence.
- Physical or sexual violence by husband has been experienced sometime in their lives by 40% of married women. One in four has experienced such violence within the past year (2004-05).
- 16% of never married women have experienced physical abuse by a parent, sibling or teacher.
- One percent of never married women have been sexually abused by someone. Of these, 27% reported that the abuser was a relative.²

Internationally, the rise of the feminist movement in the 1960s succeeded in bringing to limelight this hitherto invisible problem, which eventually led to its recognition as a major public health issue and a violation of the human rights of women. In November 1985, the United Nations General Assembly passed its first resolution on violence against women. The next major milestone was in 1993, when UN Declaration on the Elimination of Violence against Women was adopted. In the twenty five years since 1985, much has been done to gather evidence on the dimensions of the problem and to promote awareness on the seriousness of the issue.

The Indian women's movement first drew public attention to violence against women in the early 1980s when it organised against the gender-biased judgement by the Supreme Court in the case involving the rape of a young girl, *Mathura*, by policemen. In 1983, an amendment made to Section 498-A of the Criminal Procedure Code defined domestic violence and formally recognised domestic violence experienced by married women, as a crime³. Over the next couple of decades, support groups were formed which provided help to individual women facing domestic violence.³ Many autonomous women's groups and NGOs have set up services such as legal aid and shelter homes for women survivors of domestic violence. In 2005, a landmark legislation was enacted to deal comprehensively with domestic violence against women, "The Protection of Women from Domestic Violence Act 2005" (PWDVA). Previously, marital violence was a punishable crime under the Section 498-A of the penal code. However, the PWDVA is the first significant attempt in India to recognize domestic violence as a punishable crime, to extend its provisions to those in live-in relationships also, and to provide for civil remedies such as emergency relief for the victims and ensuring women's right to the matrimonial home, in addition to legal recourse.

² International Institute for Population Sciences (IIPS) and ORC Macro. *National Family Health Survey (NFHS-3): 2004-05: India*. IIPS, Mumbai, 2008.

³ Burte Aruna. *Breaking the culture of silence: Uniting to fight domestic violence*. Mumbai, Dilaasa and Cehat, 2008

It has provided for protection officers and for service providers, who can be NGOs, to enable women to effectively use the law.

Actors and factors responsible for the *Dilaasa* project

Dilaasa is the first attempt in India to establish a public-hospital based crisis centre. At the time when *Dilaasa* was established in 2000, violence against women had been recognised as a major women's rights issue. Services provided to women were mainly shelters and legal aid, and providing social and psychological support. Violence against women was not being discussed as a public health concern, although studies in India and in other countries had begun to provide evidence on the far reaching physical as well as mental health consequences of violence against women and especially of domestic violence. Although women victims of physical violence were seen in Casualty departments of government hospitals routinely, it appeared that the doctors were content to treat their physical injuries and not probe any further.

The idea of establishing a one-stop crisis centre within a public hospital had its roots in a meeting on sexual and reproductive health and rights which took place in 1998, when the then-coordinator of CEHAT heard about a similar project in Malaysia. The One Stop Crisis Centres (OSCC) in Malaysia were collaborations between NGOs and public hospitals to provide counselling support to women victims and survivors of domestic violence within a public hospital setting⁴.

CEHAT is a research centre of Anusandhan Trust, Mumbai. It was established to carry out academically rigorous and socially relevant health research; carry out health action for the wellbeing of disadvantaged masses; strengthening people's health movements; and realising the right to health and health care. CEHAT had been working on violence as a health issue since 1991. There were four major areas of violence that it was concerned with:

- Violence against women and girls (including domestic violence, sexual assault and sex-determination and sex-selection)
- Violence against children (e.g. conditions of juvenile homes)
- Violence by state agencies (e.g. investigation of torture, police custody deaths and police atrocities)
- Caste and communal violence⁴

In the late 1990s, CEHAT had completed a systematic review of studies on violence against women in India. It had just launched a community-based women-centred action and research project in a slum in Mumbai which studied the extent and nature of violence against women in the community and trained women to respond to domestic violence, as

⁴ Deosthali, Padma, Maghnani, Purnima and Malik Seema. *Establishing Dilaasa: Documenting the challenges*. Mumbai, Dilaasa and CEHAT, 2005

well as primary and reproductive health needs.⁴ CEHAT had also been associated with the Women-Centred Health Project (WCHP), a collaborative project between BMC, SAHAJ –an NGO, and the Liverpool School of Tropical health and hygiene to promote access to quality reproductive health services within the public health system.

CEHAT's work related to violence against women in the community and its association with the BMC through WCHP created an enabling environment for the NGO to approach BMC with the proposal of potential collaboration to set up a one-stop crisis centre within a BMC hospital. At the BMC end, the Executive Health officer showed interest and commitment; the coordinator of the WCHP was supportive. Most importantly, the superintendent of a mid-level hospital, with a background in Obstetrics and Gynaecology, showed interest in undertaking such a project. The third crucial ingredient was funding support and commitment from the Ford Foundation. A Ford-Foundation supported study-tour to Malaysia and Philippines convinced BMC's actors that a hospital was well suited to providing support to women facing domestic violence. They were also impressed by the feminist counselling model that they were exposed to in the Philippines and concluded that feminist counselling would form a crucial part of the support provided to women in the hospital-based crisis centres.

With funding support from the Ford Foundation, the Dilaasa project officially came into being in August 2000.

1.1.2. Goals, objectives and components

The major **goals** of the *Dilaasa* project were to

- Institutionalise domestic violence (and more broadly, Violence Against Women) as a legitimate and critical public health concern within the government hospital system
- Build capacity of hospital staff and systems to adequately, sensitively and appropriately respond to the health needs of the victims and survivors of domestic violence.

The **specific objectives** of this collaborative project were:

- To assist the Public Health Department of the Bombay Municipal Corporation (BMC) in setting up and running a crisis centre for women survivors of domestic violence at the KB Bhabha Municipal General Hospital, Mumbai
- To assist the Public Health Department of the BMC in creating a conducive environment and conditions for inter-departmental collaboration, and for collaboration with NGOs and other concerned groups for running the hospital-based crisis centre.
- In the last year of implementation, to help BMC in making the program a part of its routine services, and to replicate it in other hospitals in Mumbai as well as outside.

The **expected outcomes** of the project were that

- Hospital staff at all levels is sensitised to the issue of domestic violence
- Doctors and nurses identify women facing domestic violence and refer them to *Dilaasa*
- No episode of violence faced by a woman goes unrecorded at the hospital
- Other BMC hospitals start crisis centres

Dilaasa project had three major **programme components**:

- A public-hospital based crisis centre that provided social and psychological support to women facing domestic violence – referred by hospital staff or those coming directly.
- Capacity-building and trainers' training provided to BMC staff to constitute a training team responsible for training all hospital staff ; and technical support for training of all hospital staff
- Activities related to expanding the crisis centre to other hospitals of BMC.

1.2. Organizational structure and mechanisms and major milestones ⁵

Dilaasa, a partnership between a public (BMC) and private non-profit organization (CEHAT), was set up as an independent entity with an identity of its own, and drawing on the resources of both BMC and CEHAT.

The reason for choice of KB Bhabha Municipal Hospital as the site for the first Crisis Centre included the following:

The roles of BMC and CEHAT were clearly delineated from the beginning, and were as follows:

1.2.1. The role of BMC

- Governance: The Project Director was the Medical Superintendent of the hospital.
- Space: The BMC provided space within the hospital for *Dilaasa*. This consisted of two rooms for crisis centre work on the ground floor, within easy reach but not too close to, the Casualty department. The conference hall was made available whenever there was a training programme.
- Staff: A full-time social worker, a part-time doctor and a part-time clinical psychologist were deputed for the crisis centre. Apart from the deputed staff, a core group of 12 trainers was formed and sustained, with the active support of the project director. The trainers shouldered the responsibility for training all staff in the hospital, in addition to their routine tasks in the hospital.
- 24-hour shelter: BMC also provided a 24-hour temporary shelter for women survivors in one of the wards of the hospital. Up to ten beds were made available to the crisis centre where women with medical problems following violence were admitted.
- Medical and referral support: All departments of the K B Bhabha hospital and other municipal/government hospitals would provide referral and medical support to the survivors of violence free of cost, including investigations and their medical and surgical treatment.

1.2.2. The role of CEHAT

- Providing trained staff : CEHAT recruited a full-time project coordinator who had adequate skills to implement the various activities of the project. It also drew on contributions from consultants and resource persons. A mutually agreed list of consultants was drawn up by CEHAT and AMC, and included Dr. Amar Jesani, Aruna

⁵ Deosthali, Padma, Maghnani, Purnima and Malik Seema. *Establishing Dilaasa: Documenting the challenges*. Mumbai, Dilaasa and CEHAT, 2005

Burte, Manisha Gupte and Renu Khanna. This group of consultants provided support to the project throughout its course.

- Technical assistance in setting up the crisis centre: CEHAT assisted the hospital in all possible ways to set up a crisis centre. This ranged for example, from renovating and setting up the crisis centre space; developing policies and protocols; involving experts as well as BMC staff in developing these operational procedures; and establishing linkages with other organizations. A consultant with expertise in feminist counselling provided constant guidance and support to the Crisis centre team. Counsellors made case presentations every week, facilitated by the consultant, and received feedback from colleagues and the consultant.
- Training of BMC staff: CEHAT was responsible for training a core group of trainers within BMC to carry out training on addressing gender-based violence within the health-care setting to staff at various levels. A group of highly skilled trainers, who were involved as resource persons from the beginning of the *Dilaasa* project – Manisha Gupte, Renu Khanna, Radhika Chandiramani were responsible for planning and implementing the trainers' training of key personnel from the hospital.
- Securing funding for the project: A very important contribution of CEHAT was to secure funding for the *Dilaasa* project from international donors.

1.2.3. Mechanisms for ongoing consultation and coordination

A number of mechanisms were established to facilitate coordination and communication across all members involved with the project.

The **project team** was led by the project director (medical superintendent of the hospital), and consisted of project co-ordinator, CEHAT staff working in *Dilaasa* and BMC staff deputed for the project. The project team met once a week.

The **coordination committee** was chaired by the project director (medical superintendent). It consisted of the project director, project coordinator, a counsellor from CEHAT and a social worker from the hospital. This committee was to meet at least once every month and take all major decisions pertaining to the project. This committee was functional only for the first couple of years. Subsequently, all decisions pertaining to the project were taken in joint meetings between the project director and the project coordinator.

An **advisory committee** was set up, with the Executive health officer of BMC as chairperson, the project director as secretary, and project coordinator, representatives from the state government and police department; a forensic expert and a representative of women's groups. This group was to provide strategic guidance to the project. In practice, it was difficult to get this group to meet regularly. The group met only three times during the project period.

The **core group** of key trainers from the KB Bhabha hospital had meetings once a month. When core groups were formed in four other hospitals, regular meetings were held but the periodicity of meetings varied.

1.2.4. Major milestones during 2000-2009

This section is based on information from the annual reports for the years starting 2000 April-2001 March to 2008 April-2009 March.

The first year of the project, namely **2000 August-2001 March** was spent on formative and preparatory tasks. This included

- Formative research on the perceptions of health care providers about violence against women; mapping the availability of shelters for women survivors of domestic violence; and analysis of medico-legal cases within the hospital
- Starting the process of training of a team of 40 trainers in KB Bhabha hospital:
- Orientation training of hospital staff by key trainers
- Setting up of the crisis centre within KB Bhabha hospital, on 20 March 2001.

April 2001-March 2002 was a year of evolving procedures for the functioning of the crisis centre. The training of key trainers from KB Bhabha hospital was completed, and 6 training pairs were created which continued with orientation training of hospital staff.

During **April 2002-March 2003**, further spade work was done to ensure screening of women for domestic violence in outpatient departments, and counselling processes were fine-tuned. Training of key trainers and hospital staff continued.

April 2003-March 2004 witnessed the expansion of trainers' training to four additional peripheral hospitals: Kurla Bhabha hospital; MT Agarwal Hospital, Rajawadi hospital and Cooper hospital. Training by the original team of resource persons was started for a team of 12 key trainers (core group) from each of these hospitals.

April 2005 saw the start of the second phase of the project, and *Dilaasa* became part of the larger initiative on "*Mainstreaming gender concerns within the public health system*". The objective of the *Dilaasa* project in this phase was to integrate completely the functioning of the crisis centre within BMC's activities; and to set up at least two more hospital-based crisis centres.

An important development during this year (**April 2005-March 2006**) was the initiation of a second crisis centre or "*Dilaasa* department" at Kurla Bhabha hospital, operating two days a week, and staffed completely by BMC staff. An expert counsellor from CEHAT made weekly visits to provide support.

In preparation for the setting up of the crisis centre, key trainers in Kurla Bhabha hospital had also carried out orientation training for several groups of hospital staff. In-depth training in counselling was carried out for *Dilaasa* staff of Kurla Bhabha hospital and Bandra Bhabha hospital, which was also joined by three staff members from MT Agarwal hospital. The core group of MT Agarwal hospital had also tried to hold orientation training of their staff, but met with limited success.

Another development was the creation of a “Training cell” with members of the core group from all the five hospitals where trainers’ training had been conducted.

During **April 2006-March 2007**, responsibility for counselling in the crisis centres in both Bandra Bhabha and Kurla Bhabha hospitals was entrusted to BMC staff who had received in-depth training in counselling by CEHAT’s resource persons. MT Agarwal hospital was able to organise several batches of training for hospital staff, and Cooper hospital also started its orientation training for staff. The Training Cell, constituted during the previous year now consisted of 37 members. Its members met regularly, had one training session on clinical ethics, and started developing modules for training hospital staff.

The core group of one more hospital – Rajawadi - started training staff, during **April 2007-March 2008**. The training cell expanded to have 57 members; met regularly, and had a training session on domestic violence as global public health concern.

The major highlight of the year **April 2008-March 2009** was the effort made to initiate training to set up crisis centres in public hospitals in two other states: Delhi, and Meghalaya. Work in training staff in the five BMC hospitals continued, as did the training of training cell members and counsellors. The crisis centres in Bandra Bhabha and Kurla Bhabha hospitals continued to function routinely, with BMC staff. Members of the training cell emerged as active advocates on the need for health sector response to domestic violence.

2. OVERVIEW AND REFLECTIONS ON *DILAASA*'S ACTIVITIES

This chapter presents an overview of work done and reflections on achievements and challenges, on each of the three major components of the *Dilaasa* project:

- 1) Public-hospital-based crisis-intervention centres
- 2) Training
- 3) Activities related to expanding the crisis centre in other hospitals of BMC.

2.1. The public-hospital based crisis intervention centres

This section provides an outline and critical evaluation of the crisis-centre and counselling component of the *Dilaasa* project. It describes the *genesis, philosophy and principles of the crisis intervention centre*, the *procedure* that is followed within the public hospital to refer women to the centre; the *procedure* in the centre after women are referred to it, the *ethical issues* that emerge in the process of counselling and the *supervision* of counselling that takes place. It then assesses the achievements and reflects on the gaps and limitations that would merit attention in order to further enhance the quality and effectiveness of the services provided.

This section is based on the following materials provided to us for the evaluation.

- Counselling impact study research report, October 2004 (Draft report)
- Six monthly reports submitted by Consultant (September 2001-September 2007)
- Challenges in domestic violence counselling: A casebook. Undated (Draft)
- Report of Dilaasa counselling centre March 2001 to February 2002
- Guidelines for Counselling: Women facing violence (Rege, 2008)
- Choosing to live: Guidelines for suicide prevention counselling in domestic violence (Burte, Rege, & Deosthali, 2005/2007)
- Annual Reports of Dilaasa for various years starting April 2001 and ending March 2007.

In addition, this section is also based on the observations and insights gleaned from the interviews conducted with counsellors and the counselling consultant, direct observation of a counselling session with one user and feedback sought from another three users during our visit to the Bandra and Kurla hospitals.

2.1.1. *Origins of the centre*

The hospital-based crisis centre began to function in March 2001, after several months of preparatory work including formative research and training of key trainers. It was set up as a department of the KB Bhabha hospital. Started as a three-year project, it was expected to

be handed over to the hospital and run by the BMC from 2004. The actual handing over of the centre was however done only in 2006.

The groundwork for the centre was laid by carrying out detailed analyses of hospital procedures and systems, in-depth interviews with hospital staff, and examination of the medico-legal register in the casualty department since this is the record that documents suspected cases of violence. It was recognised however that the casualty department deals mainly with serious injuries, and hence could be tapping only a small proportion of cases of violence, and that cases coming to the Out-patient department (OPD) with less serious injuries could go unreported unless the patient insists on making a medico-legal case. It was reported that in practice, the screening procedure was limited to all MLCs while the ideal procedure would be to screen all OPD cases.

It was therefore felt necessary to sensitise the hospital staff to enable them to identify and refer cases of domestic violence to Dilaasa. The first step in formalizing the centre thus began with gender-sensitization training of a group of key trainers within the hospital. Counselling was one of the seven modules in the training programme imparted to the key trainers. Key trainers then began to train in small batches all staff members of the hospital, health providers, administrative and support staff included. Section two of this chapter contains detailed descriptions of the various levels of training and their content and methodology.

Conceived from the beginning as a multi sectoral response to domestic violence, the centre sought to coordinate for legal aid/assistance with the police, and with other agencies such as shelter homes and local women's groups or *mahila mandals*.

This first crisis centre was staffed by CEHAT's workers as well as deputed staff from BMC. At the beginning of the project, the BMC had deputed a full-time social worker, a part-time doctor and a part-time clinical psychologist. The deputation of a nurse was promised but could not be achieved due to staff shortages. During the project period, the only BMC staff that remained constant was the full-time social worker. There was a high degree of turn-over among staff deputed part-time. This led to loss of trained personnel and need for repeated training of newly recruited counsellors. After CEHAT's staff withdrew in 2005-06, the crisis centre had to cope with fewer staff and high staff turn-over. In 2006-07, after repeated requests from the *Dilaasa* leadership, a second social-worker was deputed for three days a week and the staff consisted of two counsellors, and one physiotherapist and one sister-in-charge working part-time.

A second crisis centre was started in Kurla Bhabha hospital during 2005-06. From the very beginning, this crisis centre had only BMC staff, which included one social worker (full-time) and two nurses trained in counselling. This centre officially operates only for two days a week, but the counsellor may at times receive cases on other days. Both centres share the

same procedures and philosophy for providing psycho-social support to women survivors of domestic violence.

2.1.2. Systems and procedures

Women are referred to *Dilaasa* from the different departments in the hospital such as casualty, outpatient and inpatient departments, and also from other hospitals and health facilities of BMC.

From the beginning, the roles of health providers in the hospital with regard to the crisis centre were clearly defined. Doctors and nurses are required to

- Ask screening questions
- Identify women experiencing domestic violence
- Provide medical support
- Refer to Casualty if the identification was done in other OPDs or wards
- At the Casualty, complete the detailed documentation.
- Refer patients to the Crisis centre or get the Counsellors to visit the ward to meet the woman concerned

In addition, *Dilaasa* staff visit the Casualty department everyday and make sure that all women registered as medico-legal cases get the services of the Crisis centre.

Systems were introduced to track the referral process. The Hospital's case sheet was modified to stamp "Referred to *Dilaasa*". The Hospital's Management Information System (MIS) was modified to include a field in which casualty medical officers can keep a daily record of women referred to *Dilaasa*. This report was to be sent to the Project Director.

Besides referrals, as the counselling report documents, with increasing publicity, women are now found to come on their own, after having heard of the services provided by the centre.

When women present at the Crisis centre, the routine consists of the following steps:

- Filling of an intake form (See Annex 1) after obtaining the woman's consent
- Assessment of safety and formulation of a safety plan in consultation with the woman
- Referrals for medical help, MLC statement and registering of police complaint if needed
- Recording of present episode and history of violence
- Setting up of goals for the counselling in consultation with the woman after an understanding of her expectations
- This is followed by the counselling session.
- If the woman so desires, referral for legal counselling or to a shelter
- Fixing an appointment for follow-up counselling

Dilaasa liaised with organizations providing legal support and shelter for survivors of domestic violence. There were meetings with shelter homes for sharing experiences, and with *mahila mandals* working on violence at the community level. All these networking activities may be considered as steps towards establishing outreach and referral services for women clients of the crisis centre.

Women who had used *Dilaasa's* services were brought together in a meeting held on March 8, 2000, and this became an annual event. Subsequently, meetings for users became a way of remaining in touch with them. Letters would be sent to women's homes inviting them to participate in a meeting, and this was a non-threatening way of following up with women. Although only a small number of women actually attended the meetings, women seemed to miss the letter if they did not receive one, and got in touch with the centre to ask why they had not received a letter. This was valuable feedback on the fact that women appreciated the link to *Dilaasa* that these letters and meetings provided.

In the initial years, only women screened for domestic violence were referred to *Dilaasa*. In their visits to the wards, *Dilaasa* counsellors found that a large number of women admitted to the female medical ward following a suicide attempt had a history of domestic violence. This led in 2003-04 to the decision that all women suicide attemptees would be referred to *Dilaasa*. Women who did not report a history of domestic violence were counselled for suicide prevention, while survivors of domestic violence were registered as *Dilaasa* clients for whom the procedure listed above was adopted.

2.1.3. Philosophy and principles of counselling

The form of counselling adopted by *Dilaasa* is stated to be feminist, involving a commitment to certain core and interrelated values that have evolved from feminist philosophy and practice. The feminist orientation to domestic violence hinges on the understanding that such violence includes elements of *control* and *abuse of power* by the perpetrator. The context from which the perpetrator derives his (or her) power is from the larger socio-political one framed by power imbalances that exist at a societal level and reproduced within the family. In feminist counselling, a central goal of the counsellor is to communicate this vision and understanding of power and control dynamics to the clients. While keeping the individual's experience in focus, feminist counsellors strive to provide a larger picture of how clients' problems, fears, insecurities, and negative self-cognitions are entwined with patriarchal values and social constructions.

This awareness, coupled with an emerging voice and the skills to resist dominant norms, allows clients to locate the source of their distress not within themselves, but in the social context. The benefits of making the connections between individual distress and their social

contextual causes lie in clients' realisation that they are not alone, they are not to be blamed for whatever they are going through, that they did not cause these inequities, and that their experiences are not random. Instead, they come to recognise that they are part of a pattern of oppression, created by specific social institutions, structures or norms. The first task of the counsellor is therefore to **validate** women's experiences. What this means is that it is essential to adopt the woman's frame of reference while listening to her, and not to verify the truth of her claims. This is the first step to signal that the woman has every right to be heard, honoured and respected for what she is. Feminist counselling therefore in contrast to mainstream techniques approaches abused women as survivors of critical, life-threatening experiences, who have nevertheless several adaptive capacities and strengths.

From the counselling impact research report, the consultant's reports, and the interviews and observations made during our visit, it appears that the Dilaasa counsellors have been **effective** in making connections between the woman's difficulties and the larger context, validating her experiences of the violence, and being non judgmental in approach. While making connections between the personal and the political is more subtle, what is foregrounded and rightly so, is the creation of a space where women can be heard with respect, sensitivity, genuineness, and without being blamed. The impact report indeed points to the overwhelmingly positive feedback that the service got for facilitating a non-threatening atmosphere.

2.1.4. Ethical issues

Ethical issues of safeguarding and ensuring users' rights, maintaining confidentiality, and ensuring researcher's codes of conduct and responsibilities have been exhaustively discussed in the process of documenting the impact of counselling. There are two reports that refer to ethical issues – the "Counselling impact research report" (2004), and the "Challenges in domestic violence counselling: A casebook" (undated). While the former report painstakingly documents the ethical framework of the counselling process and the manner in which issues of confidentiality and rights were handled, the casebook presents extremely interesting ethical dilemmas confronted by the counselors that clearly went beyond the usual issues of consent and confidentiality.

Presented as 15 case studies, each story contains in the end a set of ethical questions that every counsellor needs to ask herself (or himself) about the appropriateness of the course of action. Each of these cases was debated within the team in case conferences and reflects the seriousness and sincerity of the counsellors to their work. While this is indeed useful and appreciable, one is rather puzzled to read that the rationale for the document was "the clear absence of any ethical guidelines for counsellors" (p.3). While it is to be admitted that in the absence of any regulatory body of practicing counsellors in the country, ethical issues and violations are not addressed as seriously as they deserve, one does not understand why manuals of ethical practices from the US or Europe were not consulted and adapted for use

here. Closer home, the resources of the Centre for Mental Health Advocacy, Pune also could have been used for this purpose although the ethical issues raised here pertain more to mental health problems and not exclusively to domestic violence.

The case book would have been more useful if the questions raised were answered to indicate how these dilemmas were resolved subsequently and also for the guidance and benefit of other counsellors. One case for instance raises the interesting but vexed question of boundaries – should counsellors extend their services to providing economic assistance, which would make a significant difference in decision-making for the woman. It would have been useful to know how counselors resolved such issues and how the enhanced understanding of the dilemmas got internalized subsequently into their work.

2.1.5. Counselling supervision

Counsellors were supervised by an external consultant, centre in charge and project coordinator. A weekly case review served as a site for supervision and capacity-building of counsellors. The six-monthly reports submitted by the Consultant for counselling are meticulous and painstaking and document the laborious process through which certain ‘non-negotiables’ were debated, learned, and ingrained by the team over the years. As the documents and our interviews with the counsellors attest, these principles referred to not regarding the woman as an object of pity, but instead to look at her agency, of validating and respecting her experience, of drawing the issue of violence into the medical system through sensitization among health care providers through training and of inclusion of gender inputs in the medical curriculum itself. The consultant has also played a key role in putting together manuals on guidelines for counsellors including one on suicide prevention.

These six-monthly reports, spanning several years from 2001 to 2007 could have been summed up in terms of lessons learned and the goals reached in a single, concise report that would have been more readable and handy. However, this is not to undermine the great care and effort that has gone into preparation of these consultancy reports.

Furthermore, while these ‘non-negotiables’ stemming from the driving philosophy and vision of CEHAT can be seen to have been established with a reasonably high degree of success, a somewhat major shortcoming is the inadequate institutionalization of supervision. In view of the importance of supervised counselling being a part of ethical guidelines, it is not clear why apart from having an external consultant, not much thinking and efforts have been made in this direction. Also, if the consultant has not been providing her services since 2007, it is not clear whether the hospital administration made any attempt to include supervision as a core activity in the set up of *Dilaasa*.

We understand from our interactions with the CEHAT staff as well as from some of the written materials that CEHAT has made several efforts to put institutionalization of counselling supervision in place. We would like to underscore the point that having an external consultant, and having joint case presentation meetings (of the staff of both the hospitals) at least once a month could be considered as a first step in setting in motion the process of institutionalisation. During these case presentation meetings, a number of important issues may be addressed: e.g. enhancing the quality of the counselling sessions, exchanging of notes, handling of ethical dilemmas and issues, specific strategies for handling 'difficult' clients and so on. These will undoubtedly be useful for the staff. Burn out issues of the counsellors if any can also be addressed if all the staff handling counselling meet regularly along with a consultant.

After having devoted considerable thinking and efforts on this project, it would indeed be counter-productive if the exercise of institutionalization of counselling supervision is not similarly thought through.

2.1.6. Counselling training

While the impact of the counselling training could be gauged from the interviews with the counsellors and the observations/interviews with the users, information on training content and materials used, and the training process, is very limited.

The annual reports mention some training efforts with counsellors. We have attempted to draw together the information scattered across various annual reports to form a picture of what may have been the training inputs during the decade 2000-2009.

Table 1: Counselling training sessions mentioned in Annual Reports

Year	Topics
2000 April-01 March	Counselling; Devising safety plans; Referrals to other departments of the hospital and to legal and social services; Stress management; Debriefing
2001 April -02 March	Sharing of experiences by women who had worked on the issue of domestic violence
2003 April-04 December	Review of the book "Feminist counselling in Action" by consultant and guided discussion among counsellors. Chapters of the book on "Feminist psychotherapy" presented by each of the counsellors
2005 April- 2006 March	Training for staff (8 members) from Bandra Bhabha, Kurla Bhabha and MT Agarwal hospitals to be deputed as counsellors: In-depth training on feminist counselling

2006 April- 2007 March	Training for counsellors of Kurla Bhabha hospital on Documentation; sexual violence (esp within marriage); and expanding the worldview of the counsellor to provide psychological support to women counselled
2007 April- 2008 March	Training for counsellors of Bandra Bhabha and Kurla Bhabha hospitals: on "Counselling suicide attemptees" One-day perspective-building training on social determinants that affect choices made by women survivors of domestic violence
2008 April-2009 March	Training for counsellors of Bandra Bhabha and Kurla Bhabha hospitals on "Child sexual abuse"

Source: Various annual reports of CEHAT

Counselling training materials themselves and reports on their use, in contrast to the gender sensitization training inputs, are not as elaborate. We found counselling training included in the following materials in addition to the notes/suggestions adopted following the case conferences elaborated by the counselling consultant.

1. Guidelines for Counselling: Women facing violence (Rege, 2008)
2. Choosing to live: Guidelines for suicide prevention counselling in domestic violence (Burte, Rege, & Deosthali, 2005/2007)
3. Module IV in the manual titled Process Documentation of Training of Trainers at Dilaasa, 2003.

All the three sets of materials listed above are excellent, relevant and in tune with the social context in which women experience domestic violence in our society. They are crisp, eminently readable with case illustrations, and easy to comprehend by even a lay reader. They provide very good source material for those wanting to do counselling and for those who wish to hone their skills. While there is absolutely nothing critical to comment about these materials, what is not equally forthcoming is documentation/recording of the impact and feedback to the counselling training provided to the staff.

We would have liked to see, for example

- An updated record (summary table) of number of counselling trainings provided since the inception of *Dilaasa* to the present, number and identity of participants, materials/modules covered
- A list of counselling training workshops/meetings conducted by other organisations (with dates and other details) that the counsellors were sent to update their skills
- Feedback of the participants to these trainings as given in the Process Documentation of Training of Trainers at Dilaasa (2003).

While some of the information mentioned above could be gleaned from the interviews (e.g., one learnt from a CDO and member of the core team that she had participated in the *Gender and Mental Health* workshop conducted by the Bapu Trust in Pune), it would have been more methodical if these details had been included in the form of a summary table. Since counselling services are the hallmark of *Dilaasa* centres, and their quality is crucial for the sustained functioning of the centre, the quality of training and its impact and learnings by the staff are equally important to be documented.

2.1.7. Coverage of counselling services

During the period 2001-2009, roughly 1811 women were served at the Dilaasa centre in Bandra Bhabha hospital for domestic violence, and a further 250 women were served at the Kurla Bhabha hospital. This includes 1357 women served during 2001-2006 at the *Dilaasa* department of the Bandra Bhabha hospital, on whom detailed data has been computerised and analysed. Analysis of the 1357 women served during 2001-06 shows that only 16% of the women were referred from casualty department. Direct referral by hospital staff accounted for 11%, about 8% were referred from OPDs and IPDs. Fourteen per cent (14%) were identified by Dilaasa counsellors through screening in the wards. Ten percent (10%) of the women had come after seeing the publicity materials about Dilaasa and almost 6% were self-referred. About 5% were referred from other hospitals and by community health volunteers.

In addition to the 'registered' users cited above, a number of "non-registered" users were counselled every year in the Bandra Bhabha *Dilaasa* centre. These were women referred from the female medical ward, and many of them had attempted suicide. However, they did not report a history of domestic violence, and were therefore counselled only for suicide prevention. Numbers mentioned in annual reports total to about 535 "non-registered" users during 2005-06 to 2008-09.

The following table provides a year-wise breakdown of clients served in the two hospitals, based on the consolidated data and annual reports:

Table 2: Numbers of women counselled in Dilaasa crisis centre s

Year	Bandra Bhabha hospital Crisis centre	Kurla Bhabha Hospital crisis centre
2001	82	Not in operation
2002	185	---do---
2003	257	---do---
2004	319	--do---
2005	264	--do---
2006	250	(2006-07) 80
2007 April-08 March	221	80
2008 April-09 March	233	90

Source: Tables based on *Dilaasa* data base and annual reports of CEHAT

The annual reports mention legal counselling provided to an average of 35 women per year during the first three years, which rose to between 70 and 90 women per year starting 2005-06. Details of the number of women who filed cases in courts and the outcome of these cases were not readily available.

Dilaasa has made and continues to make extraordinary, ongoing and sustained efforts to reach out to all women attending the hospital, which are worth emulating as part of the routine procedure for all hospital-based crisis centres in India. These efforts included

- Training of each and every staff member of the hospital on screening for domestic violence
- The development of a guiding list of signs and symptoms as a tool to guide screening (Annex 2)
- Ongoing discussions and interactions with health service providers in the different departments to reinforce the need for screening
- Active screening by *Dilaasa* team members (and subsequently, hospital staff) in inpatient wards
- Reporting by casualty medical officers on the numbers they referred to *Dilaasa* every day, and the numbers they did not refer; follow-up of this list by the *Dilaasa* team, to track doctors who usually fail to refer and to have a dialogue with them on referring women to *Dilaasa* for counselling.

Over the years, this resulted in an overall referral rate of about 54%.

Efforts were also made to publicise *Dilaasa* within health facilities and in the community through various means, including:

- Putting up posters about *Dilaasa* in all OPDs within the two hospitals where the crisis centres were established, and in all peripheral hospital, maternity homes and health posts
- Conducting poster exhibitions once a month in different OPDs of Bandra Bhabha hospital
- Targeted meetings in the communities served by Bandra Bhabha hospital in collaboration with NGOs working in these communities
- Distributing pamphlets about *Dilaasa* in various health facilities and through community outreach programmes such as health *melas*.
- Speaking about *Dilaasa's* work and distributing publicity materials in various NGO gatherings and meetings,

The sustained presence of *Dilaasa* over a period of 8-9 years would also have helped to make it known among users of the hospital, both through direct observation and through interactions with users of *Dilaasa*. About 16% of users had been self referred, including those who came after seeing the publicity materials, which indicates that these efforts have made some impact.

The fact that the number of users has remained around 250, after a peak of 314 in 2004 is intriguing, because the figures on prevalence of domestic violence from NFHS-3 indicates that one in four women, or 25% experienced some form of violence by their spouse during a one-year period preceding the survey (2). The prevalence of domestic violence in a Mumbai low-income community where CEHAT had worked on domestic violence was 17% in the year preceding the survey, and 64% of currently married women in the community had ever-experienced domestic violence in their life time⁶. These figures compare favourably with the intake of other NGOs/CBOs or special cells providing counselling services. However, judging by the figures on prevalence of domestic violence, it appears possible that there still remain a large number of women survivors of violence who are not being reached by the *Dilaasa* project, including those who do not reach a hospital in the first place. Further probing is needed to ascertain if this is indeed the case. Efforts may now need to be focused at the community level and among women, to find out what the barriers are, if any, to using *Dilaasa's* services, and to address these.

⁶ Khot, Anagha, Menon Sumita and Dileep TR. Domestic violence: Levels, correlates, causes, impact and responses: A community-based study of married women from Mumbai slums. Mumbai, CEHAT, 2004.

This may be the place to mention the limitations of data available on numbers of women served and details thereof. Key indicators are updated in the data base on an annual basis. It may be worthwhile reviewing and revising these indicators in so that information on performance is readily retrievable. For example, it was not easy to find information on the nature of services provided, number of women who were given appointment for follow-up counselling, numbers who kept the appointment and those lost to follow-up. Information on the numbers referred for legal counselling and the nature of services received, cases filed and outcome thereof, was scattered through the annual reports, but not tabulated and readily available.

2.1.8. Impact of counselling

The counselling impact study

The impact of the counselling services offered by *Dilaasa* was examined through a study of 27 users – current, former, and those termed as non-returning. The report is dated October 2004 and what was provided to us still appears to be a draft and is not complete (Appendices for instance are missing, and the document contains track changes). While we do not understand why this is so, what we also do not understand is why no further impact study was done.

If the *raison d'être* of any impact or evaluation study is to enhance the quality of service provision and hence user care, it would seem fundamental that the activity of evaluation or assessment of outcomes is carried out more systematically and regularly. This is the means by which an evidence base for counselling can be built that is grounded in practice and owned by practitioners. Referred to as practice-based evidence (Barkham & Mellor-Clark, 2000), the ideal but pragmatic aims of quality evaluation are to

- Demonstrate the *appropriateness* of service structures
- Enhance the *accessibility* to service provision
- Monitor the *acceptability* of service procedures
- Ensure *equity* for all potential service recipients
- Demonstrate the *effectiveness* of service practices
- Improve the *efficiency* of service delivery

While some of these aims may seem rather difficult to implement in our context, they are not impossible and in fact have been attempted by the *Dilaasa* team themselves in their study.

Based on users' perceptions of the nature and quality of services provided, the set of outcome indicators developed to evaluate the intervention programme were

- Physical and mental health
- Individual capacity and achievement of life goals

- Awareness about systems of inequality and gender violence
- Significance of Dilaasa to women

The interventions that were made were

- Providing emotional help
- Helping make safety plan
- Making referrals to other services and agencies
- Calling for joint meetings (with the abuser/family)

Although Dilaasa has reported 1357 plus users during the period 2001-2006, the fact that the impact study has sampled 27 women only, limits the confidence in the reliability of any interpretation. Clearly the tasks of data mounting, statistical analysis and report production have been onerous. If impact assessment however is to be viewed as a dynamic activity then it is suggested that weekly data-quality checking and input, and perhaps quarterly data synthesis and in house review be done. Even if CEHAT does not visualize as active a role as it had earlier, evaluation of impact is necessary to ensure quality and sustainability of the project.

The impact study is based on fairly lengthy open-ended interviews with the users, recorded in audio tape or in hand, and then transcribed and translated into English. The narratives were then content analyzed. While this was a good approach to follow in view of the fact that this was the first evaluation, developing of outcome measures – standardized questionnaires at pre and post levels, would facilitate the collection of a comprehensive set of process and outcome data informed by the relative strengths of research, evaluation and audit.

The impact study has heavily and exclusively relied on the user to provide evaluation data. While this is correct in view of the central focus of the study being assessment of effectiveness of the intervention, it needs to be pointed out that quality evaluation should also, in the best traditions of research, evaluation and audit, include collecting data from both provider and user to link service context and process to outcome – to ultimately inform the development and enhancement of practice.

Learnings from the counselling impact study

- a) The users provided the most positive feedback for the rapport the counsellors had been able to establish in their ability to make them relax and open up; in their treatment of the user with regard and without being condescending or patronizing; and in not blaming the woman for her problems; and in validating her experiences of

abuse. While emotional support was the most frequently cited positive impact, the users also reported positive changes in health status, more so in psychological well-being and less so in physical health; and changes in consciousness – that women should not be blamed, should not accept violence and that women are not fated to suffer silently. The intervention of *Dilaasa* in matters related to registering of complaints with the police was also reported to be effective.

These changes reported by the women as a consequence of the intervention are indeed noteworthy, and speak of its efficacy.

b) Feedback was however more diverse in the following domains

- Counsellors's strategies of safety were reported to be impractical and unrealistic, not necessarily because of the counsellors' errors of judgment but because this reflects the dearth of options and resources for women in abusive relationships, particularly for women from low-income backgrounds
- Suggestions of temporary shelter were viewed as untenable
- Inability of the centre staff to undertake home visits was viewed rather unfavourably since they felt this could have been an effective strategy to reduce/prevent further violence
- Joint meetings, the only intervention strategy used with abusers, was not frequently employed while the women's perception was that counselling should focus on the abusers also.

c) The feedback provided raises several vexatious questions, related to the wider context and not necessarily to *Dilaasa's* manner of functioning – about lack or dearth of shelter and economic resources for women, and about the need to include abusers in intervention programmes with its implications for further work load, the insensitivity of agencies such as the police, about the inability of such centres to function as one stop solutions for women in distress, and about deeply-entrenched and negative beliefs about women and women living alone.

d) Although this is not being suggested as a means to overcome all of the above mentioned concerns, issues such as home visits (which clearly the women perceive as a tool to monitor and pressurize the abuser to amend ways) can perhaps be included if CEHAT visualizes making insertions into state health policy and linkages with personnel like the CHGs. Not only would such an inclusion make the health care needs of women from disadvantaged groups in particular and the need for protection against domestic violence more visible in state policy, it would ensure a continuous chain of assistance and monitoring for the woman.

Furthermore, in view of the reported perception of *Dilaasa* intervention as having a likely deterrent effect by the abused women, it is all the more necessary to buttress

the role of an 'external' agency to mount pressure on a 'private' matter in order to prevent or reduce escalating violence.

Users' perspectives

This section is based on the feedback that we obtained from three of the users (one in Bandra Bhabha and two in Kurla) who had been requested to come to the hospital during our visit, and on the direct observation of a counselling session in progress in Bhabha hospital.

The four women, all repeat users of Dilaasa's services, had varied personal histories but were all from a low income background, representing the catchment areas of the hospitals, and very little educational attainments and skills or economic resources. The first case was that of a 50 year old woman with seven children, with a history of physical abuse, but who now said that the violence had stopped primarily because of the threat of arrest that her husband perceived if she complained to Dilaasa against him. She in fact said with a broad smile lighting up her otherwise weather-beaten face, that she did not have to actually threaten him with arrest. All she had to do was to tell him that she "was going to the hospital, to meet the Dilaasa people". Apparently these words had a pronounced deterrent effect. She said she was now able to live in her house without the husband constantly harassing her to get out (therefore *no fear of being shelter less*); she was able to have her say in matters related to her daughters' marriages (*decision making in intra household and family domains*) and was able to move in and out of the house freely to wherever she wanted without fear of her husband's reprisals (*freedom of mobility and autonomy*).

While such statements do not reflect enhancement of the quality of the marital relationship, they indicate that the woman's needs at the present juncture are being met and she is free from the fear of violence and violence being actually carried out.

The second and third cases are those of young women in their twenties, with children in tow, and who had visited Dilaasa several times. Both of them had been victims of brutal violence, one with scars of injuries still on her body, and the other whose husband had attempted to murder by hanging. It is significant to note that one of them had read an advertisement about Dilaasa in the newspaper and showed up in the centre with her child. She said she was given food, temporary shelter, and helped to secure a job. In both cases, what was interesting to know was that despite the brutality of violence they had experienced in the hands of their husbands earlier, they were continuing to live in the matrimonial home. This is significant, considering the fact that not having a proper shelter for women, in a metro city, is fraught with insecurities and hazards. As in the previous case, here too the women were able to resist violence primarily because they could use the name of Dilaasa. Although the women themselves did not say this, this implies their increased assertiveness to counter violence – an outcome of their experience with Dilaasa.

The fourth case is of a 50 year old muslim woman with three children, who reported that she had been abused physically and psychologically since 12 years, and is now being forced out of the house by her mother-in-law. (The husband's role seemed rather vague since she did not have much to say about him except to say that he was on "his mother's side"). She is presently staying elsewhere (in rented accommodation) since the house has been locked up following the lodging of a NC after she was beaten up by her mother-in-law and some neighbours. She reported that the house was in the name of her mother-in-law, who was now trying to sell it. The primary concern was therefore shelter for herself and her children. This was the first time she had visited Dilaasa.

The counselling session that took place for about 30 minutes was conducted by a staff nurse and our observations of the session are as follows.

- The counsellor's attitude and demeanour were warm, friendly, and she was able to put the user at ease soon.
- She identified and listed the user's strengths and resources and repeated them several times to reinforce the positive factors in her case
- She asked for potential sources of support (natal family) so that the user could enlist them
- She explained the Domestic Violence Act and the remedy of claim to matrimonial home available to women. The user appeared relieved to hear this.
- She told her not to retaliate physically.
- The user was told to keep all documents related to her safely.
- The safety plan was not relevant here since she was presently not in contact with her abuser, her mother-in-law
- The Intake sheet was not filled in the presence of the woman, although it was in front of the counsellor. She jotted down some points in the beginning. Presumably the intake form is filled up later.

What the counsellor did **not** do was to ask for a joint session with the husband and/or the mother-in-law, which seems to be so crucial in this case. The user also left the session, not too convinced by the statements of the counsellor to be assertive and strong in the face of the mother-in-law's assaults since she obviously needed a more concrete assurance that her house would not be sold and she would be able to return to the house. There seemed to be a disjunction in expectations, which the counselor did not seem to address. No subsequent session was proposed or planned which means that the woman left, not knowing whether she could return for help.

All the four cases cited above are those of women who are continuing to live with their husbands, or as in the last case, who wants to live in the matrimonial home. Tying this observation with the finding in the Counselling Impact study report that a majority of women do not want to leave the marriage, it indeed strengthens the **case of exploring and**

reinforcing the need for solutions, other than the legal ones envisaged in the Domestic Violence Act.

A centre that purports to provide services that extend beyond the domains of the police and law, thus seems to be a model that will work well, in tune with the needs of women for access to resources, stable (seemingly at least) marriages, and freedom from violence. If this is the case, then enlisting the men and their involvement in the counselling services needs to be more emphasized than what is being currently attempted by Dilaasa.

We understand that conducting joint meetings with the husband and/or his family has not been a stated objective of Dilaasa's counselling model. We also understand that such meetings are held only if the woman explicitly asks for it.

We suggest that conducting joint meetings with the husband and/or his family be included more firmly in Dilaasa's model. Conducting joint sessions with men may be suggested to the woman as a measure, and then held only if the woman wishes so. This suggestion is being made only in view of the felt need of many women to opt for a relatively violence-free marriage and to learn ways and means to prevent violence, rather than face the hazards of life outside marriage. This will not apply to those cases where the woman herself is not interested in continuing with the marriage and insists on closure.

This point was brought home to us further by one of the users with whom we interacted in Kurla hospital. She had been a victim of severe physical violence and yet she opted to continue with her marriage only after Dilaasa's intervention prevented recurrence of the husband's violence.

Involving men and emphasizing on their responsibilities need not be construed as deviating from the tenets of feminist counselling since the woman's point of view and the non-negotiability of violence will always be in centre focus.

Furthermore, the centre's linkages with other agencies, state institutions and non-governmental, to address women's needs for shelter and other resources, need to be emphasized more effectively than what is being attempted at present so that it can be more responsive to these multiple needs. Prevention or reduction of domestic violence, needless to emphasize, cannot be done in a vacuum without exploring and formalising the options offered to the women, and monitoring prevention either through the centre's own follow up sessions, or through a network of personnel like community health workers.

2.2. Training of health providers to respond to domestic violence

One of the unique features of the *Dilaasa* project is the considerable investment it has made in training. It has followed a two-pronged strategy: high quality and in-depth training for a core group of health providers, and extensive coverage of not only all health providers but all other hospital staff with some basic and essential knowledge and skills. In addition, there

were also occasional training programmes organised for key stake-holder groups. (Training for staff of the crisis centres has already been discussed in the previous section).

As mentioned earlier a training needs assessment was carried out before the training of key trainers. The training of key trainers for gender-sensitization and screening for domestic violence was thorough and went on for more than a year before the centre actually started functioning. The core group of trainers also have been effective in conducting subsequent training for the hospital staff.

In this section, we first present a summary based on key documents and reports on the three levels of training: e.g. objectives, content, duration, and structure. This is followed by a discussion of the “achievements and gaps” of the training component of the *Dilaasa* project. This latter section is based on the detailed process documentation of the training of key trainers, and on interviews and discussions we had with members of the training cell, hospital staff in Bandra Bhabha and Kurla Bhabha hospitals and members of the *Dilaasa* team, and our own reflections on these.

2.2.1. Training of Key trainers

The *Dilaasa* team believed that it was important to sensitise all hospital staff of KB Bhabha hospital to issues related to gender-based violence before the crisis centre was set up. They approached a team of three resource persons: Manisha Gupte, Radhika Chandiramani and Renu Khanna, all with considerable expertise and experience in working on gender, health and violence issues, among others. Discussions between the resource persons and the *Dilaasa* team on the modalities of training all hospital staff led to the decision to select a core group of hospital staff to be trained as key trainers. The key trainers were in turn to be responsible for training of all hospital staff, in small batches.

Forty hospital staff – including medical and paramedical personnel- were selected as the core group to be trained as key trainers. Training was to be conducted in two batches of twenty each. The two groups named themselves as “*Pragati*” (progress) and “*Prerana*” (inspiration).

The first trainers’ training programme in KB Bhabha hospital:

Training of key trainers took place during October 2000-August 2001 , with most sessions completed before the crisis centre started functioning. During this period, there were seven training sessions of one-day each (effectively 4 hours per day) conducted for two groups of key trainers. Table 3 below lists the topics and objectives of the seven sessions.

Table 3. Content and objectives of training modules for key trainers

Module no.	Topic	Objectives
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1	Domestic violence: An orientation	<ul style="list-style-type: none"> • To get the group to break the silence around violence • To introduce the concept that domestic violence is a public health issue • To share information about <i>Dilaasa</i> as a hospital-based project • To motivate the group to become key trainers
2	Gender	<ul style="list-style-type: none"> • To create awareness about the difference between sex and gender • To sensitise participants about manifestations of gender • To create awareness about patriarchy and power
Module no.	Topic	Objectives
3	Violence and the role of the health care provider	<ul style="list-style-type: none"> • To create awareness regarding the role of a health care professional in dealing with domestic violence • To train them to care for women patients facing domestic violence
4	Counselling	<ul style="list-style-type: none"> • To impart skills required by key trainers to communicate with women patients who report abuse and maltreatment • To help them gain an understanding of the concept of counselling, and the principles involved in it.
5	Role of trainer	<ul style="list-style-type: none"> • To help understand the principles of adult learning • To gain understanding of the different methods involved in conducting a training session
6	Communication skills for trainers	<ul style="list-style-type: none"> • To help participants understand the methods, principles, roles and tasks involved in conducting training sessions • To gauge the preparedness of participants in conducting training sessions
7	Gender-based violence and the role of health care providers	<ul style="list-style-type: none"> • To understand gender-based violence and its manifestations • To understand the health consequences of violence against women • To bring about the realisation that violence is a public health issue • To explore the role of health-care providers in dealing with gender-based

		violence <ul style="list-style-type: none"> • To think of an integrated and ward-wise plan to address the issue of violence against women
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Participatory methodologies were used in each of the sessions, including games, case study discussions in small groups and facilitated discussions around key issues. For each session, extensive handouts were prepared and circulated to participants. These would serve as valuable resources and reference materials in their future role as trainers.

Follow-up training for key trainers

From the various reports it appears that the core group of key trainers met regularly once a month, and that each of these meetings also included some element of training. These meetings were mainly to involve the key trainers in developing a module for orientation of hospital staff on gender-based violence, as a part of ongoing efforts to increase their ownership of the project. The meetings also provided space for key trainers to clarify doubts that they still had and reiterated several concepts. Details of topics covered or issues discussed in these meetings are not available from the documentation provided.

The one major follow-up training for this group appears to have taken place in 2002-03. This was a three-day training “*Strengthening the role of health care providers in responding to domestic violence*”. The training was supported and facilitated by resource persons from the Family Violence Prevention Fund, San Francisco. The sessions focused on the experiences of the domestic violence prevention movement in the USA, lessons learnt; and challenges faced in working with the health system.

This training was also the first step towards expansion of the project to other BMC hospitals. Teams from three other hospitals of the BMC, as well as from two non-governmental organisations (SNEHA and AAROH) participated in this training. The two NGOs had started work on domestic violence at the urban health centres of Sion hospital and Kalwa hospitals respectively.

Subsequent trainers’ training programmes

The annual report for 2003-04 mentions that trainers’ training was carried out for core groups from four more peripheral hospitals: Kurla Bhabha, MT Agarwal, Rajawadi and Cooper. Each hospital had a core group of 12 key trainers selected, a total of 48. They were divided into two batches of 24 each for purposes of training.

Ten one-day sessions for each of the two groups are reported to have been conducted during 2003 April-04 December. Topics covered are listed as follows:

- i. Domestic violence as a health issue
- ii. Dilaasa-Concept and work done so far
- iii. Gender
- iv. Gender-based violence and its impact on health
- v. Violence as a human rights issue
- vi. Role of health care provider in responding to victims of domestic violence
- vii. Principles of adult learning; methods of participatory training; planning and conducting sessions
- viii. Counselling
- ix. Communalism
- x. Medical ethics and human rights

It is evident that a number of changes were made to the training curriculum used for the first batch of key trainers. We understand that process documentation was undertaken for this second round of training, which included details on the objectives and methodology or on participants' feedback and assessment of the effectiveness of training. However, this is still in the form of a draft report and was not made available to us at the time of this evaluation.

Following the creation in 2005-06, of a "training cell" constituted of core-group members from all five hospitals with core groups, a few training sessions for cell members are mentioned:

- In 2005-06, a two-day residential programme included the following topics: understanding human rights; rights-based approach; power analysis in terms of caste, class and religion; politics of population; and planning for future work
- In 2006-07, a two-day training on clinical ethics covered: provider-patient relationship, privacy and confidentiality, informed consent in patient care, coping with "difficult patients and situations", end-of-life care and medical futility; resource allocation and rationing of care. This occasion also marked the formal inauguration of the training cell.
- In 2007-08, a two-day training was organised on the international movement against domestic violence and the various responses to domestic violence

2.2.2. Training of hospital staff

The core group of key trainers in KB Bhabha hospital, and subsequently in Kurla Bhabha, MT Agarwal, Rajawadi and Cooper hospitals, organised regular training sessions for hospital staff in an attempt at 100% coverage.

Of the 40 participants from the KB Bhabha hospital who attended the first trainer's training programme, 12 became key trainers. They worked in pairs to form six training teams. An orientation module of about 4 hours duration was developed by the members of this first

core group, and refined and finalised based on feedback from the first few sessions. In 2002-03, a follow-up module was also developed with a view to reinforce the messages.

Content and methodology

The orientation module began with an introductory talk about the power imbalances in provider-patient relationships as one form of violence, and linking this to the issue of domestic violence faced by women. The next is a group activity where three groups discuss different case studies, to identify the different forms of violence (physical, sexual, psychological, economic) faced by women, and to analyse the links between gender-power inequalities and domestic violence. The third is again a small group activity with each group role playing a situation in which a woman experiencing violence presents at the hospital. This is followed by a discussion on the potential for health care providers to provide assistance to the women. The session ends with explaining the role of *Dilaasa* within the public hospital setting, and seeking the active support of all staff in screening and/or referring women survivors of violence to the *Dilaasa* centre.

The follow-up module consists of two main sessions. The first session aims to impart skills to be used for screening women for domestic violence. It includes tips for screening – possible opening questions, the need to provide information and tell her that she is not responsible for the violence; and to refer to *Dilaasa*. The session also provided guidance for documentation – such as describing specifics (who did this, how, what health consequences); and avoiding biased or obfuscating language (e.g. “alleged” violence; “history of assault” without mentioning who the assaulter is).

The second session discusses in detail the cycle of violence and why women stay in violent relationships, so that staff may develop empathy with the woman’s situation and not blame the victim.

Both modules provide participants opportunity for active participation through group work, role plays and guided discussions. When these modules were implemented in other hospitals, there was considerable innovation in methodology, with new case studies and role plays and screening of films.

In 2008-09, a few sessions were organised in Kurla Bhabha and MT Agarwal hospitals on communication skills, as a way of dealing with the ire of patients confronting a crumbling health system.

Coverage

Information on the number of sessions held each year and the numbers who attended is found in the various annual reports. The *Dilaasa* project succeeded in reaching all 443 hospital staff in the Bandra Bhabha hospital with the orientation module within a short-span of three years. Subsequently, orientation training had to be repeated every few years to cover newly recruited staff. However, it appears that not all staff could be recruited for the follow-up module: 13 batches are mentioned as having undergone follow-up training, which may have covered roughly half of all staff.

There is no information on the extent of coverage of hospital staff in the other four hospitals. A rough estimate of the numbers covered in the remaining four hospitals works out to about 930 hospital staff. The numbers of batches trained, based on details in the annual reports, are as follows:

Kurla Bhabha hospital	16 batches
MT Agarwal hospital	12 batches
Rajawadi hospital	6 batches
Cooper hospital	5 batches

2.2.3. Other training

- During 2002-03, Community health workers from Bandra were included as participants in the orientation training for hospital staff in the KB Bhabha hospital.
- In the same year, a workshop was conducted for police inspectors and sub-inspectors from the Western region, Bandra.
- In 2003-04, counselling training was conducted for community health workers working in two health posts in the eastern suburbs where another NGO was planning to set up a counselling centre in collaboration with BMC. This two-day training programme covered the following topics related to counselling : *What is counselling; Understanding women-centred counselling; counselling approach adopted at Dilaasa, practice in counselling skills; ethics in counselling; documentation required in a counselling centre.* Participants were also introduced to the topic of violence against women and its health consequences.
- During April-December 2004, hospital social workers from all 16 peripheral hospitals of BMC were trained in counselling skills. This was a five-day training programme based on a training module developed by the *Dilaasa* team and counselling consultant.

2.2.4. Achievements, challenges and gaps

Training curricula and design

The training programme for **key trainers** includes substantive information about gender and domestic violence, as well as skills required of a trainer. Further, it is packaged into short modules which can be delivered within time period of about five hours (including lunch-break), a pragmatic choice given the time constraints within a public hospital setting. The messages have been kept simple and direct, and the participatory methodology used makes assimilation of new knowledge and skills easier.

Orientation and follow-up modules for all **hospital staff** have likewise risen admirably to the challenge of paring down to the essential minimum the messages that need to be conveyed and packaging these into sessions of no more than four hours each.

Both these sets of training modules would, with some revisions and updating form excellent prototypes for training of key trainers and hospital staff elsewhere in India. Unfortunately, the project has not come up with training manuals that would enable a trainer to conduct similar training programmes. There is, indeed, a detailed report documenting the process of the first training of key trainers, which provides insights into the training process, and also includes all the resource materials used. But in its current form, this is not a training tool, since it does not provide any guidance to trainers on how the training should be designed, organised and facilitated.

An unpublished and not quite finalised manual exists for the orientation module, which has not included the follow-up session or the new methods and materials used in later versions of the orientation training.

Similarly, a five-day module for training of counsellors is mentioned, but does not seem to have been published as a manual for use by other trainers.

There are a number of gaps in documentation. For example, the process documentation of trainers' training for the second batch of core group members from the four hospitals: Kurla Bhabha, MT Agarwal, Rajawadi and Cooper, which seems to have adopted a revised curriculum, is yet to be finalised and published. No detailed descriptions are available of the topics covered in the monthly meetings of core groups which were also meant to be "refresher" courses, or of other follow-up training. In other words, we have only a partial picture of the training content, process and methodology into which much painstaking effort has been invested.

Coverage

The extent of training coverage achieved by *Dilaasa* is remarkable. Running training programmes for health professionals and hospital staff is not an easy task, given the demands of the hospital routine. On a rough estimate, a minimum of 1450 hospital staff have undergone an orientation training on domestic violence as a health issue and the role of health providers in screening women for violence. Having such a vast pool of hospital

staff exposed to the issue of domestic violence within one city is sure to have an impact on the way health facilities respond to domestic violence.

Even more commendable is the project's ability to sustain its training efforts through a period of ten years, despite all the ups and downs it faced in recruiting people for training. The process documentation of the training of key trainers and the various annual reports give indications of the tough struggle this process has been.

- Medical training does not orient professionals to be interested in the social dimensions of health problems. Most health professionals come with a view that domestic violence is not their issue. To make an impact on such participants through mandatory training sessions of about 8-10 hours in total is a formidable task.
- Many key trainers could not attend all the training sessions because of hospital duties". Some joined the day's session too late to fill up pre-test sheet while others left too early to fill in the post-test sheet.
- Every year there are some new staff joining the hospital and orientation sessions have to be organised for them. So the task is a never-ending one.
- Getting RMOs (Resident Medical Officers) and interns to attend the training was difficult. Their posting in the hospital was only for a short period, but they are an important group to be trained because it is they who actually manage the outpatient departments. Conversations with key trainers as part of this evaluation revealed that currently the orientation training is compulsory for all hospital staff, and participants are deputed for training by their departments, with the option of stating that they were "unwilling" to go for training. Most staff members chose not to offend their superiors, so "unwillingness" was rare..
- Transfer of key trainers to other hospitals, and unfilled vacancies increased the workload of existing staff. This made it difficult for key trainers to find time to conduct orientation training.
- In 2008-09, there were serious impediments to conducting orientation training in hospitals. There were consistent staff shortages, and lack of essential services such as ultra sonography and x-rays. Staff were facing the ire of patients as well as coping with an increased work load, and could not carry out training of hospital staff as planned.

It is not clear whether the situation has improved subsequently, and whether training of hospital staff continues to take place.

Institutionalisation of the training process and the role of the Training Cell

Training of hospital staff has not been institutionalised, and does not take place routinely as part of the activities of the health facility concerned. It falls to the core group of key trainers, with active facilitation by *Dilaasa* to organise the orientation sessions, including making all the logistical arrangements, recruiting participants and conducting the sessions. To do all this over and above the tasks required of them as hospital staff demands superhuman efforts and commitment on their part.

Moreover, roles and responsibilities of different members of the core group have not been formalised, making the task of team work extremely challenging. A few people end up shouldering most of the responsibility repeatedly.

The problem is further accentuated by the fact that new members have to be inducted to the core group to replace those who have been transferred out. There are several members in the core groups of hospitals who have not attended the training of key trainers and therefore lack the skills to be trainers themselves. I

According to the annual report for 2008-09,

"..The turn over in the hospital is ...large. Therefore with new nurses and doctors coming in, there is a need to create awareness about this issue. However trainings are difficult to organise due to the staff crunch."

It seems probable that the practice of orienting every single member of the hospital staff may eventually fade away unless alternatives are found to the ad hoc practices that currently exist.

A Training Cell had been created in 2005-06 by the *Dilaasa* project for institutionalising the training process. It included members of the various core groups. The intention was to make this a formal unit of BMC. Starting out with 28 members, the Cell grew to have 37 and subsequently 57 members by 2008-09. This would be a step in the right direction, provided it is formalised and provided with a clear terms of reference and an adequate budget.

The precise role played by the training cell during 2005-2009 is not very clear from the annual reports. It appears that they did not replace the core groups in hospitals, or take over any part of the former's responsibilities. They seem to be engaged in parallel activities – preparation of training modules, undergoing additional training on a wide range of topics related to rights and ethics and on the international movement against domestic violence. The positioning of domestic violence within a larger framework of rights and ethics is commendable. However, it remains unclear why there was not more emphasis on deepening their expertise in addressing domestic violence or in honing their training skills through practical opportunities for training.

Annual reports mention, as a positive factor, that “*Training cell members was steadily expanding the scope of their work beyond domestic violence*” (Report 07-08). This was because the scope of the training cell was set as “improving quality of care”. Locating public health response to domestic violence within the larger framework of improving quality of care is strategic and may help institutionalise the training cell within the public health system. However, it would be worthwhile re-examining how this strategy is implemented, so that the primary task of institutionalising training for hospital staff on domestic violence gets adequate attention.

Effectiveness and impact of the training

Effectiveness and impact of the two levels of training: that for key trainers, and that for hospital staff, may be assessed on the basis of a small number of available indicators.

For the training of key trainers, there is some documentation of feedback and effectiveness. In addition, manifestations of any improvements in their knowledge and skills, and the effectiveness with which they played the role of key trainers, would indicate the impact of the trainers’ training .Information pertaining to this is available from annual reports to some extent. A group discussion with some of the core group members forms the basis of much of our comments in this section.

For the training of hospital staff, the extent to which they apply their knowledge for screening and referral of women seen in the hospital is one indicator. Interviews with a selection of hospital staff who have attended the orientation sessions was another important source of information.

Effectiveness and impact of training of key trainers

The following are some indicators of the effectiveness of trainers’ training:

- According to the process documentation report of the trainers’ training, the seven-module training programme for the first batch of key trainers (from Bandra Bhabha hospital) was highly effective. At the end of the first training, most participants could
 - List different types of violence that women faced, and identify sexual coercion as a form of violence
 - Draw up various forms of violence that women faced from birth to death
 - Understood the links between patriarchy and violence and give real life examples
 - List the role of health professionals : Taking the woman into confidence and asking her about violence in a sensitive manner

- Training effectiveness is also clear from the number of sessions held for hospital staff. The training has equipped trainers with the motivation and confidence to become trainers.
- Trainees participated in the development of the orientation module, created power point presentations, developed a short poem on the concept of a safe home; identified films to screen; developed role plays. This indicates effective application of skills imbibed in their training.
- Many of the key trainers became advocates for the role of public health system in responding to domestic violence. For example, two doctors made a presentation for medical educators on how to deal with difficult patients. Another doctor conducted an orientation programme on Violence against Women and the role of health providers.
- Core group members of the Rajawadi hospital advocated with superiors for setting up a crisis centre within their own hospital. They also took the initiative to introduce the sexual assault evidence kits (SAFE kits) within their hospital.

An important lacuna is the absence of any documentation on assessment of the quality of the sessions conducted by key trainers, which is an important indicator of how effective the trainers' training was.

The following observations are based on a brief meeting with a small group of key trainers

- The members of this group were clearly exceptional: inspired and inspiring, highly committed and motivated. One person had already worked with rural women's groups earlier, and had always wanted to make a difference to women's oppressed situation, while another had always been an innovator and initiator, and so on. What this indicates is the apt selection of participants for the key trainers' training.
- The training had succeeded in bringing out the best in participants and motivating them. Key trainers were highly appreciative of the high quality of resource persons who provided them with "*up-to-date knowledge and skills*". One person said that the training gave her a lot of confidence, and inspired her because it was an opportunity to be a "*part of something different, something socially worthwhile*". Others mentioned that the training contributed to growth at a personal level. One trainer said that when someone went beyond the call of duty to be involved in work such as *Dilaasa* training, s/he usually earned the respect of his/her colleagues. One person shared how she had been personally shaken up when a woman who had repeatedly appeared at the OPD complaining of headaches was admitted later after attempted suicide after consuming poison. "*If only I had spoken to her, if only I had referred her*

to *Dilaasa* (from another hospital)”. Luckily, the woman survived the suicide attempt and the health care provider got involved with *Dilaasa* activities.

- Key trainers were all convinced that domestic violence against women is indeed a public health issue, and that addressing domestic violence is a part of a health provider’s responsibility. More than one person could articulate with clear arguments why this was so, citing examples from within the hospital.
- Key trainers were convinced that *Dilaasa* was a valuable intervention and a worthy cause. For example, by providing a space for the women to ventilate their distress, health providers were able to detect suicidal ideation and prevent suicides. The staff reported that they felt good about being able to make a small difference in the lives of the women who approached them for help. Some observed that another positive feature of the centre was that currently Muslim women who formed a sizeable population in the catchment area of the two hospitals were also accessing the services of the centre. By rendering itself accessible (through its publicity materials distributed in the neighbourhoods near by and placed in several places in the hospital, and through word of mouth), the centre was thus able to remove a key barrier to access to health care by specifically socially and economically disadvantaged groups.
- Several key trainers explained the content and process of the orientation training, and the need for appropriate scheduling of the sessions taking into account the routine in the hospital and the availability of staff in different departments. They appeared to be comfortable in their roles as trainers and organisers of training.
- Two key trainers explained how they sought to inspire the trainees in the orientation. One said that he tapped on every person’s desire to help others, and to be exceptional, do something extra over and above regular duties as hospital staff. Another said that when trainees realise that their behaviour with patients could have been more sensitive, and it was within their capacity to help women in distress, they become convinced of the need for *Dilaasa* and are ready to do their part in the process. A matron explained how she would discuss with trainees about how to make time within their busy schedule to talk to women who had been admitted after attempting suicide, and how just a few minutes of talking to a woman in distress could make a big difference to her wellbeing and safety.
- Some remarked that not all core group members should be expected to facilitate training sessions, since not everyone is comfortable with being a trainer. It would be important to define the different tasks that go into running regular orientation and to divide responsibilities according to the aptitudes and skills of different members.

They hoped that the formalisation of a BMC Training Cell would help in working out clear roles and responsibilities for different members.

- Time constraints and work-load were major challenges and key trainers conveyed the extraordinary efforts needed on their part to find time to meet the demands of being a core group members and even more so, to schedule and recruit participants for training.

Effectiveness and impact of orientation training of hospital staff

According to various annual reports of CEHAT, orientation of hospital staff did not yield the desired result, viz. of motivating doctors to screen women routinely and to refer them to *Dilaasa*. This is mentioned not only in the early years, but right up to the ninth year of orientation training, in 2008-09. One of the reasons seems to be the large staff turn over, which means that at any point in time there is still a significant number of staff members who have not received the message about routine screening.

In our conversations with key trainers, we found that many were not altogether satisfied with the outcome of the training they had imparted. Key trainers felt that trainees did not always apply the new knowledge they gained in the orientation training. According to one key trainer, her expectation from trainees was not met in one aspect: that every trainee should think of screening and referral for domestic violence as a routine part of their work as health care providers.

These negative comments notwithstanding, our own impression is that the training has been very effective in conveying the essential messages, especially given the challenges.

Key trainers were able to identify the following as positive outcome of the training:

- The doctors now know that cases can be referred to *Dilaasa*, and were referring patients to the centre. Casualty Medical Officers mention 'assault by husband' instead of 'assault by known person' and to recognize such cases as well as cases of poisoning as domestic violence
- Both medical and paramedical staff was able to identify and detect cases of domestic violence. They now recognised that the mission of the hospital can be a larger one than mere treatment of a woman's injuries.

Interviews with a records keeper in the casualty department of one hospital, and with the casualty medical officer of another hospital made a deep impression on us. Knowledge and values have been successfully transferred and this is a remarkable achievement indeed.

The casualty record keeper told us that it was only after *Dilaasa* came, and after the training, that hospital staff have realised that they can do something to help women survivors of domestic violence. He believed that the *Dilaasa* department was playing a very useful role. “*Now we can give them moral support. Consciousness of staff has increased*”. He said that because of the training, medical officers have begun writing the exact identity of the assaulter in the MLC register, rather than just mention whether it was assault by known or unknown person. They refer the women and stamp the register saying “referred to *Dilaasa*”. He added that women experiencing violence also came to other OPDs, often repeatedly, and because of the training, doctors and nurses were able to refer them to *Dilaasa*. Of what use was this to the women? “*Women are confident that the hospital people understand their problem and are willing to help*” He suggested that a guide book should be made available to each and every health provider, on domestic violence and screening for signs and symptoms within the hospital setting.

The casualty medical officer who had recently attended an orientation training was able to list all the major steps related to what a health provider should do to help a woman survivor of domestic violence. He also emphasised the need for screening women beyond the casualty department, because a significant proportion of women presented with signs and symptoms other than assault or injury. He believed that *Dilaasa* department in his hospital was performing an important task.

It appears from these limited encounters that the orientation trainings played an important role in sensitising hospital staff and increased ownership of the *Dilaasa* project. They however fell short of ensuring that this awareness translated into effective screening and referral in the casualty, and out patient and inpatient wards.

Given the shortage of time and personnel, and the extraordinary effort involved in organising orientation training sessions month after month and year after year by a handful of overworked but dedicated individuals, it may time to start reconsidering the modalities through which hospital staff are sensitised. Two questions need to be asked:

- Can sensitising staff on gender and domestic violence be achieved through mechanisms other than face-to-face ad hoc training sessions facilitated by voluntary key trainers and organised within the hospital setting?
- Is it imperative to achieve 100% coverage of all hospital staff, or could the effort focus on key personnel?

2.3. Activities related to expanding the crisis centre to other hospitals

One of the programme components of *Dilaasa* was the expansion of the crisis centre to other hospitals.

Training and capacity-building appears to be the most important pathway through which expansion has been achieved. As mentioned in the previous section, after putting in place a crisis centre and a core group of trainers within the KB Bhabha Hospital, Bandra, core groups from four more BMC hospitals were trained, who in turn are engaged in orienting all hospital staff in their respective hospitals. The project has successfully created one more crisis centre in Kurla Bhabha Hospital, operational since 2006-07.

What the road-map is towards creating crisis centres in other hospitals is not clear. Core group members from the three hospitals without a crisis centre were keen to establish one in their respective health facilities. It appears that much will depend on the in-house advocacy efforts of these core groups and the support from those in leadership within BMC's health department.

The annual report for 2003-04 outlines two additional sets of activities through which the expansion of Dilaasa was sought to be achieved:

- Through creating awareness about gender-based violence and its consequences on women
- Through creating awareness about the crisis centre and its services

The audience was other hospitals, health posts and maternity homes of the BMC, as well as non-governmental organisations and the community at large

Table 4 below lists activities related to these objectives:.

Table 4. Activities related to expansion of the crisis centre listed in annual reports

Year	Activities
2001 April-02 March	Printing of posters and calendars on domestic violence and distributing it to all departments of Bandra Bhabha hospital and to various organisations
2002 April-03 March	Posters and calendars printed and put up in all the health posts and dispensaries of Bandra and peripheral hospitals of BMC Organisation of a health <i>mela</i> and putting up a stall in a health camp providing information to women on violence and women's rights
2003 April-04 March	Posters put up in all 24 peripheral hospitals of BMC, maternity homes and health posts of BMC in Bandra East and West, Calendars distributed to all hospitals and ward offices of Mumbai. Poster exhibition on Violence against women in Bandra and Churchgate metro railway stations
2004 April-December	Participation in the International Campaign of 10 days of Action Against Violence Against Women, including a "night out" for adolescents and a group discussion on "gendered spaces". Sessions on gender-based violence conducted with grassroots activists, college students. <i>Dilaasa</i> model presented in a meeting organized by the National Commission for Women Poster exhibitions in hospitals, and stall on domestic violence in a health <i>mela</i>
2005 April-06 March	Collaboration with the All India Institute for Local Self Government (AIILSG), Mumbai to organize three workshops on Violence against women as a health issue covering about 100-120 participants.

Year	Activities
2006 April-07 March	Participation in <i>Stree Mukti Sampark Samiti</i> (SMSS) to call for effective implementation of the Protection of Women from Domestic Violence Act (PWDVA) Chalking out the role of medical officer under the PWDVA Organised with <i>Masum</i> and AIDWA a parallel session on Violence Against Women in the Second National People's Health Assembly to focus attention on the role of health care providers under PWDVA.
2007 April-08 March	Presentation at a National Conference of the Society of Midwifery and nurses association India (SOMI) on the role of nurses in responding to domestic violence Calendar and posters developed , printed and disseminated. A comprehensive booklet on "Breaking the Culture of Silence" (around domestic violence) was produced and disseminated.
2008 April-09 March	None reported; efforts made to train organisations in other states to replicate <i>Dilaasa</i>

A quick review of the above table indicates that a number of activities have been undertaken, but they do not form a part of any cohesive strategy that would contribute to expanding the number of crisis centres within the BMC set-up. It leaves unanswered the questions

"Who is to be influenced?"

"What is to be achieved through such influencing?"

"What indicators may be used to assess progress towards the goal".

3. THE 'DILAASA MODEL': LESSONS LEARNED AND RECOMMENDATIONS

This chapter is laid out in two major sections. The first section pulls together lessons learned about what constitutes the *Dilaasa* model, in terms of its philosophy and vision, the organisational structures, components and mechanisms that have enabled its functioning, and the procedures and practices evolved over time which have been vital for the successful running of a crisis centre within a public hospital over a period of nearly a decade. It ends with reflections of the project's leadership on steps needed for upscaling this model.

The second section consolidates the reflections on various activities made in the previous chapter to make recommendations on the way forward.

3.1. The '*Dilaasa* model'

3.1.1. *Dilaasa's perspective on domestic violence*

In the present context of weakening of national and local public institutions, and the increasing recognition that the health care needs of vulnerable population groups such as those living in low income settings get marginalized, despite a high density of public and private health care providers and institutions in urban areas, *Dilaasa's* venture is indeed a template providing room for optimism and renewed hope. That an initiative like this can breach the citadels of bureaucratic indifference and insensitivity to address the health care needs and rights of disempowered women is indeed commendable.

We gained understanding and critical insights into the philosophy, vision, practice and functioning of the project through the documents provided to us by Cehat and the extensive and fruitful interviews and consultations we had with a range of individuals – the staff of Cehat responsible for the project and the staff of the Bandra Bhabha and the Kurla Bhabha hospitals.

The ideological position fuelling the entire project can be described as two fold:

1. Locating the importance of domestic violence as an issue within the larger *societal context of gendered inequalities and violence*
2. Pushing for recognition of domestic violence as a *public health concern* within the medical context that is largely unresponsive to issues such as domestic violence perceived as falling beyond the medical purview.

The *Dilaasa* project therefore straddles both these discourse – of public health and of gender – and represents an excellent example of the conflation of the two, demonstrating its viability and achievability in practice.

Our observations of this ideological position in practice lead us to call attention to the double-pronged strategy of Cehat – a) ensuring that domestic violence is not medicalised and b) sensitising medical staff to perceive it as a health issue *and* at the same time as a societal issue of gendered inequalities and vulnerabilities. This is significant in our view since such a perspective helps to bring domestic violence within the health discourse while simultaneously avoiding the implications of medicalisation of distress with its socio-political dimensions of the distress being overlooked.

The reflections and comments made by the hospital staff attest to the ingraining of this perspective, which can be credited to the clarity in goals, commitment and genuineness in approach and functioning of CEHAT staff.

3.1.2. Organisational structure and mechanisms

The initiative taken by Cehat to establish a hospital-based crisis centre reflects the following strategic objectives – (a) partnership of an NGO with the public health system (b) sensitization of the public health system to domestic violence and institutionalization of domestic violence as a legitimate public health concern and (c) building the gender-sensitization capacity of the hospital staff.

The challenges and tensions associated with entering into a state health care system by a non-governmental organization at that are clearly documented and demonstrate that sensitive, responsive individuals in decision-making positions in particular within this large, bureaucratized and seemingly amorphous health care system do play a crucial role in taking things forward. The role of key functionaries such as the Medical Superintendent in assenting to this project in the first place and subsequently owning it as part of the hospital structure, in involving the hospital staff unions as part of a transparent and democratic decision making process, in deputing staff for training and subsequent responsibilities, and in ensuring that other facilities and resources are made available, has been shown to be vital to the continued functioning of the project. It shows that without the administrative backing of the higher echelons such a project would have been difficult to take shape.

Why locate a crisis centre within a public hospital?

Dilaasa offers some important lessons on the suitability of a public hospital as the setting for a crisis centre.

- They are used by a large number of women from marginalised sections of society
- Women who suffer serious injury can be immediately helped, because they would almost always appear at the casualty department. Good documentation of the case history can also be an important basis on which the woman could seek legal recourse if she chooses to.

- The age group that is most affected by domestic violence (below 30 years) comes to the hospital for pregnancy, delivery and contraceptive services and for health care for their young children. If there is routine screening and referral of all women who attend the hospital, there is scope for reaching out to women at a much earlier stage of the onset of violence than would be possible through a stand-alone crisis centre which women have to voluntarily come to.
- Women who are afraid of returning home because of threat of violence can be admitted “under observation” for a period of 24 hours, which allows time for working out the next steps: referring her to a shelter or finding a safe space with relatives/friends.
- Users as well as staff of crisis centre can be assured of safety from potential threats from the perpetrators, because the hospital has a security system and can also immediately refer the matter to the police. :
- Many hospitals have a social work department and can depute social workers to work in the crisis centre.

Why a public-private partnership, and what makes it work well?

The model of public-private partnership that *Dilaasa* represents seems to be very important for a hospital-based crisis centre. The NGO brings skills in research, documentation and training and most importantly, in feminist counselling. It constitutes an important support-system for the functioning of the crisis centre, through intensive inputs into the training process and into honing feminist counselling skills among counsellors. Meeting the administrative challenges of setting up a crisis centre amidst the busy and back-breaking schedule of running a public hospital are already a lot for the hospital leadership to handle. An NGO with the right perspective and expertise would be an essential component to maintaining the quality of services provided.

Some important lessons emerge about characteristics of partners and modalities for functioning that contribute to a successful and sustained public-private partnership as a form for health system-response to domestic violence:

- The key functionary – Medical superintendent of the hospital – shared the perspective of *Dilaasa*, and viewed the crisis centre not merely as a project but as a public health as well as a social issue. She is convinced that a public hospital is one of the best locations for a crisis centre, and is an ambassador for the cause of addressing domestic violence against women as a health issue
- *Dilaasa* was created as a department of the hospital. This led to clarity on the chain of command and decision-making processes. The Medical Superintendent was the

Project Director, and all staff – those deputed by BMC and by CEHAT – worked under her leadership. Decisions regarding the project were however, always made in consultation with the project coordinator, a CEHAT employee.

- Roles and responsibilities for the health facility and the NGO were clearly spelt out. Training, research and technical support was the responsibility of the NGO, while service delivery was the health facility's responsibility.
- Both parties trusted each other; both were deeply committed to the issue and to making the project work. Issues arising from the wide differences in institutional cultures; and teething problems related to logistics and administration were therefore worked through in a spirit of cooperation and joint responsibility for a larger cause.

3.1.3. Major components of the model

Training

Within the curriculum, training, and practice in medical settings, domestic violence has not been addressed as a public health concern and consequently medical staff in hospitals are neither equipped nor sensitised to the issue.

Dilaasa's leadership has rightly recognised that lack of training and sensitisation of hospital staff is a challenging barrier to identification of domestic violence as a public health issue. Therefore detection of injuries arising from violence against the woman in the home, providing treatment with a gendered understanding in view, and providing referrals to other related services such as counselling, legal aid etc. are all steps that need to be undertaken by medical staff but are seldom done in view of the dominant perception of domestic violence as a 'personal issue', not within the domain of health and illness.

A well-designed and pragmatic training prototype has been created by *Dilaasa*, which has successfully built '*the capacity of hospital staff and systems to adequately, sensitively and appropriately respond to the health needs of victims and survivors of domestic violence.*'

Salient features of the training component of *Dilaasa* are as follows:

- A two-pronged training strategy is adopted, involving intensive training for a 'core group' within each hospital; and coverage of all hospital staff with orientation to domestic violence as a gender and public health issue as well as essential messages on the role of health provide.
- The core group is encouraged to become an in-house team that owns the project, has imbibed the perspective of the project, acts as advocates within and outside the hospital for the project and is responsible for preparing training modules and training of all hospital staff.

- Active participation of male doctors as core group members and key trainers is an important ingredient in the success of the training. Gender-based violence does not get relegated as a “women’s activity”, but gets acknowledged as a public health concern because of the participation of male professionals.
- Inclusion of various cadres of hospital staff in the core group is an imperative, and 100% coverage of all hospital staff with orientation training is aimed for.
- The entire training for the Core group takes place before the crisis centre is set up. Experiences in the crisis centre inform the content of the training for hospital staff and also create the motivation and interest among participants.
- There is careful planning of training process and content with a view to perspective-building, as well as developing knowledge and skills for screening women experiencing domestic violence and for counselling.
- The training content is packaged to fit into the busy schedule of the public hospital without compromising on quality and weakening its impact on trainees.
- A large enough number of members are selected to participate in the trainers’ training, to allow for a substantial loss due to transfer or work load. 40 members were trained in Bandra Bhabha hospital and a team of 12 key trainers eventually emerged.
- Steps are taken to institutionalise training through the formation of a Training Cell for BMC, with experienced members from core groups of different hospitals. The Training Cell would eventually be responsible for planning and running regular training sessions for orientation and for updating knowledge and skills.

Crisis centre

A very important lesson to be learned from *Dilaasa*’s experience about how hospital-based crisis centres need to reach out to potential users is that only 16% of users presented at the casualty. This implies that referrals from casualty department alone would miss out the majority of potential users.

Systems have been put in place through a process of constant review and fine-tuning to ensure that women are referred from all inpatient and outpatient departments and the casualty department and from other hospitals. Considerable efforts have gone into publicising the centre among potential users. There is effective monitoring and tracking to ensure that screening happens as extensively as possible and that women are referred to *Dilaasa*:

What does the ‘*Dilaasa* model’ crisis centre offer the woman survivor of violence?

As one of the prime movers of this project emphasised, the crisis centre was conceptualized as creation of a space (literally a physical space too) for women to speak out their distress, to become more aware, and where the healing process could begin, and on the likely preventive function that such centres could offer, with increasing numbers of women coming forward to report their experience of domestic violence.

The crisis centre has lived up to its vision, and high quality feminist counselling is provided to the women approaching the centre. They have been able to make connections between the women's difficulties and the larger context; validating her experiences of the violence and being non-judgemental in approach.

Quality control measures in place include case reviews on a regular basis in the presence of an expert. Needs of the woman user is at the centre of the functioning of the crisis centre. Utmost importance is given to ensure the safety of the woman user, to her healing, and to "above all, doing no harm". Referral to other organisations for legal counselling and for shelters makes the service more comprehensive.

3.1.4. Possibilities for replication and upscaling

Replicability

The *Dilaasa* model offers a reasonably well-defined prototype for replication in other settings.

One of the objectives of the *Dilaasa* project was to create at least two more crisis centres in peripheral hospitals of BMC. This objective has been partially met, with the setting up of the crisis centre in the Kurla Bhabha hospital. Many of the tasks had already been streamlined through experiences in Bandra Bhabha hospital, and their implementation in the second centre was relatively simpler. One important change was that the crisis centre staff were all deputed by BMC, right from the beginning and supervision is less intensive. It would be important to carefully monitor and study the quality and effectiveness of functioning of the second BMC centre, to be able to draw conclusions about replicability of the *Dilaasa* model within BMC

Attempts have also been made to replicate the model in other states: Indore in Madhya Pradesh, Bangalore in Karnataka (with Samata), Shillong in Meghalaya and in Delhi. Detailed process documentation and reflection on these initiatives could contribute significantly to our understanding of what it takes to successfully run a crisis centre within a public hospital.

Upscaling

The medical superintendent and one of the project consultants came up with a number of insights into what may be involved in upscaling the *Dilaasa* model.

- The PWDVA has opened up a major window of opportunity for garnering political support within the health system for domestic violence interventions
- A Government Order or Policy on the role of health providers and health facilities in responding to domestic violence and in PWDVA would give the green signal to health administrators
- Health administrators would be convinced to start crisis centres if they see a successful one like *Dilaasa* in operation. They would be wary of risking unknowns.
- The current Training Cell could become a valuable resource for training other health department staff. People from health departments are likely to be more receptive to hear from their own ilk.
- Crisis centres are ideally located within secondary hospitals (200 plus beds) with a casualty department. They are large enough to have sufficient workload without the bureaucratic hurdles of a medical college hospital. Hospitals that have nursing schools attached to them would also be an excellent choice.
- No more than four to five crisis centres would be needed even for a city like Mumbai. Other hospitals can be trained to screen and refer women to these crisis centres. No more than one crisis centre in a district hospital may be needed within a district.
- Crisis centres should ideally be created as separate departments within a hospital setting. If this is not feasible, they could be placed under the social work department or the nursing department - both of which have a “caring” function within health facilities. Locating it as part of a clinical department would be a mistake, it would medicalise the issue. If there is no other option, the department of Obstetrics and Gynaecology is another possible site to locate the crisis centre.
- There should be an integrated system of screening and referral. At the primary care level, ANMs and medical officers may be trained to screen and refer; at the secondary level, counselling services as well as referral to legal and other resources may be provided. Medical colleges and nursing colleges could play a significant role in training pre-service health professionals on domestic violence as a public health issue.

3.2. Recommendations

These recommendations are based on the information gathered from documents, interactions with various actors related to the *Dilaasa* project, discussions between the two members of the evaluation team and individual reflections of evaluators.

3.2.1. *Counselling*

- The *Dilaasa* model purports to provide services that extend beyond the domains of the police and law, services that are in tune with the desire of most women to stay within their married relationship but prevent violence by the partner. The counselling services provided are valuable, but may need to be reviewed to include the following components:
 - Enlisting the men and their involvement in the counselling services, not on an ad hoc basis, but as part of the policy of the centre, because most women want to stay in the relationship provided the violence ends. All women should be provided the option of joint sessions with their husbands and/or members of the husband's family, but such joint sessions would take place only if the woman wishes to have these.
 - Strengthening the centre's linkages with other agencies, state institutions and non-governmental, to address women's needs for shelter and other resources.
 - Monitoring prevention either through the centre's own follow up sessions, or through a network of personnel like community health workers
- Supervised counselling being a part of the ethical guidelines, there is need to set up mechanisms within the *Dilaasa* structure for this in order to sustain counselling quality and to ensure that it has a central place in all replications of the model
- The publication "*Challenges in domestic violence counselling: A case book*" would be more useful if rather than just raise questions about the ethical challenges involved in domestic violence counselling, answers about how these dilemmas were resolved were also included. Such an addition would help in the guidance of other counsellors.
- Assessment of counselling outcomes and impact needs to be carried out more systematically and regularly. Outcome measures have to be developed and standardised questionnaires administered at pre and post counselling in order to collect a comprehensive set of process and outcome data informed by the relative strengths of research, evaluation and audit.
- Considering that the quality of counselling services is pivotal to the centre, the inclusion of counselling training as a regular and frequent activity has also not been given as much importance as it should have been.
- There is need for better documentation of counselling training. As elaborated in chapter 2, while we gathered information about what kind of counselling training was being provided, by whom and to whom, and what the participants had learnt in

the process, such information needs to be documented and recorded more formally rather than be in the form of oral histories.

- A Counselling Training Manual to guide trainers in similar settings would facilitate keeping the feminist perspective intact when hospital-based crisis centres are set up elsewhere.

3.2.2. Training

- An urgent priority (well-recognised by project personnel) is the institutionalisation within BMC of the Training Cell. Training constitutes the backbone of the *Dilaasa* project and deserves much of the credit for the project's remarkable achievements. Several of the individuals interviewed, both doctors and para medical staff, recommended continuous, regular and frequent rounds of training so that the issue of domestic violence and the need for the health care system to be responsive to it is kept in focus. Making training an add-on activity for core group members in the hospital is simply not sustainable.

Training of in-service personnel in domestic violence (and other issues) should therefore become part of the health system functions, recognised as a vital activity, have dedicated staff and an adequate budget, and carried out in a systematic and methodical manner.

- Supplementary strategies may be experimented with to cover a range of relevant target audiences: health staff from the primary care level of the health system; students of medical and nursing colleges; as part of CME (Continuing Medical Education).
- It is worth carrying out an intervention research study to assess the relative merits of targeted versus universal training of hospital staff on domestic violence, to decide on strategies suitable for resource-constrained settings.
- Mechanisms are required to ensure systematic documentation of training programmes. There are a number of gaps in documentation and we have only a partial picture of the training content, process and methodology into which much painstaking effort has been invested.
- As in the case of counselling, there is need to collect a comprehensive set of process and outcome data on the coverage, quality, outcome and impact of training.
- Training modules used for training of key trainers and hospital staff may be developed into user-friendly training manuals complete with instructions on methodology and resource materials and handouts that can guide trainers elsewhere to implement similar training.

3.2.3. Activities related to expanding the crisis centre to other BMC hospitals

- A clear road-map needs to be developed on expansion: the number of BMC hospitals within which to introduce crisis centres; the time-frame within which this will be done; NGO and other partners (if any) who will be involved; whether there will be complementary services provided at the primary care level; and so on.

3.2.4. Advocacy

- Advocacy is not a stated objective of the *Dilaasa* project, and this seems to us to be a significant omission. The logic of a project such as *Dilaasa* is one of “demonstration”: to experiment and create a model that may be successfully upscaled within the public health system. Advocacy would be the most effective pathway through which the issue will be mainstreamed within the public health system, and such upscaling would be achieved. Not attempting to inform and influence state policy in a more decisive manner is indeed a shortcoming in our view.

It is time to make insertions into state health policy to make the need for protection against domestic violence more visible. This would be very important if we want to put in place a comprehensive health system response at the primary, secondary and tertiary care levels and ensure a continuous chain of assistance and monitoring for the woman.

- Another urgent priority is to produce research papers in international peer-reviewed journals. There is a great deal of evidence gathered through years of research and through the data base. The project does itself and the women it serves a major disservice by not contributing to the body of knowledge on this important issue.
- The following are some suggestions for advocacy initiatives in the immediate future:
 - Influencing the leadership and policy makers of BMC to issue a policy on the response required of BMC health facilities to violence against women, and to develop a strategy including who would be suitable collaborators in this advocacy initiative, who are the key actors to win over and what the various opportunities for doing so may be.
 - Influencing medical and nursing educators/educational institutions and students to integrate violence against women into the curriculum, so that those newly entering the system have some exposure to the issue
 - Influencing professional associations to issue resolutions and guidelines on the role of health professionals in addressing domestic violence against women
 - Carrying out a sustained media campaign on domestic violence as a public health issue, and on the role of crisis centres based in public health facilities in providing support to women survivors of domestic violence.

Annex 1. Dilaasa Crisis Centre for Women: Intake Form



DILAASA: CRISIS CENTRE FOR WOMEN INTAKE FORM

(Please tick the relevant information)

Reg No: _____ Date: _____

Time interview started: _____ Time interview ended: _____

Referred by: _____ Date of MLC (whether done from Dilaasa): _____

Name: _____

Age (DOB) _____ Religion _____

_____ Muslim _____ Christian
_____ Hindu _____ Others
_____ Buddhist

Marital Status: Single Married (first/second wife) Separated, Widowed, Deserted,
Living in relationship, Divorced, Others

Number of years of marriage/Date of Marriage: _____

Present address (Mention Landmark) _____ Safe address (Mention Landmark) _____

Phone No. Res.: _____ C/o.: _____ Work place: _____

Can we get in touch with you? If yes, where and how?
By Phone _____ By letter _____ can't get touch in touch with you _____

Relationship to the Safe address /phone number
Specify the relation. (Natal Family, Marital Family, Employers, Neighbors/Friends Others)

Name: _____

Education: Illiterate Primary (Specify) Secondary Higher education Graduate
Post graduate Vocational courses others

Occupation: Not Employed Domestic worker Informal sector (Specify)
Formal sector Self-Employed Home maker others

Financial status
Woman's Income (Daily wages/ Weekly/Monthly) _____
Family Income (Daily wages/ Weekly/Monthly) _____
Do you have any assets in your name? Movable/Immovable _____

Do you have any important documents with you?

Marriage certificate	Marriage photo	Birth certificate of children
Ration card	List of streedhan	Receipts of Jewelry
Investments in your name	Voter card	Health reports
Academic certificates	Property papers	Bank account

Information about children

Name of child	Sex	Age	Any other information
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Her Relationship to the abuser: Husband Marital family (Specify) Natal family (Specify)
Children Others

Name of abuser:

Address and Telephone Number of work place:

Police station nearest to residence:

Police station nearest to incident:

Date: NC No.:

Medical treatment:

If referred from hospital record the following from the case paper

What was found on examination?

What is the treatment prescribed?

Pregnant status: Yes Months No NA

DILAASA: CRISIS CENTRE FOR WOMEN
Section II History of Violence

Details of present/recent incident of violence

History of Violence

Number of years you have experienced violence:

Types of violence faced

(Please tick from each type of violence) (a body map can be used to help the woman talk about where she was assaulted)

Physical	Emotional	Sexual	Financial
Beating, slapping by hand	Verbal abuse	Forced sex	Not allowing her to seek employment
Pinching	Persistent criticism	Painful sex	Denying her access to any money.
Pulling hair	Isolation	Withholding sexual pleasure	Denying right to her own income
Pushing, shoving	Threats to kill her	Sexual advances from other family members	Asking her for an explanations for every expenditure
Twisting the arm	Threats to remarry	Denying her the use of contraceptives	Denying her food and shelter
Banging the head on the wall and floor	Husband not communicating with her	Forcing her to have children	-Demanding money
Punching the face		Forced oral sex	Dowry demands
Punching the chest	Threats against her family	Forced anal sex	Any others
Punching the abdomen	Suspicion	Any others	
Kicking the chest	Restricting Mobility		
Kicking the stomach	Humiliating her in public		
Kicking her on the face	Extra marital affair		
Belting the woman	Any other		
Human bites on different body parts			
Use of blunt instruments			
Use of sharp instruments			
Strangulation			
Forcing her to consume poison			
Any others			

Narrate incidents of violence and her life story:

What do you do after the incident of violence? (Cry, sit in a corner, leave the house, go to your natal home, talk to the children go to sleep, nothing carry on with work, make a police complaint, suicidal ideation)

In what way is the violence affecting your physical and psychological health?

Are there others family members affected by violence?

Name	Age	Sex	Type of violence and its effect.
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SAFETY ASSESSMENT

The following questions could be asked to assess her safety. These are situations where there is a possibility that the woman may face more violence. By asking these questions, the counselor would help the woman gauge her own safety. The more the number of yeses, the unsafe her going back would be. After asking these questions, the counselor would ask her if she feels safe to go back. The woman may say she feels unsafe but wants to go back or may say she feels safe. Here it is important to draw up a safety plan with the woman so that she can protect herself. A safety plan would have to be drawn up even if the woman answers "No" to the above questions.

1. Has the physical violence increased in frequency over the past year?
2. Has the severity of physical violence increased over the past year? (from kicks and blows there is use of instruments?)
3. Does he or his family threaten to kill you? If yes, then do you believe that they can kill you?
4. Does he and/or his family threaten you with second marriage? If yes, how serious do you think the threat is?
5. Have you thought of committing suicide? If yes, then have you attempted it, do you have any plan of committing suicide?
6. Is he violent towards your children and/or other family members? If yes, then has this increased in the past year?

SAFETY PLAN

Safety plan discussed with woman (Physical and Psychological):

Expectations from the center (In the woman's words) –

DILAASA: CRISIS CENTRE FOR WOMEN
Section III Intervention
(Discussion with the woman)

Reg of complaints (MLC, Police complaint)

Medical (Refer her to an OPD/IPD, Explain the health complaints that the woman is suffering)

Emotional Support (Reassure her that violence is not her fault, help her to understand the pattern of abuse, share with her that she is not alone, coping mechanism make specific suggestion like attend women's meeting, engage in paid work, skill building etc, stress on her strengths, helping her to link it to a larger oppressive structure in which we live and how violence against woman happens most of the time.)

Social Support (Income generation, Skill building, Educational Support for children such as Balwadi, boarding schools)

Shelter:

Police (Information and explanation on the importance of filing an NC and other complaints)

Legal Counseling (her rights, procedure for injunction, stay order, maintenance, divorce)

Impressions: Woman's Perception about her situation (a more holistic picture about her life)

Counselor's analysis of the woman's situation –

Future plan discussed with woman:

Reg of complaints:

Medical:

Emotional Support:

Social Support:

Safety/ Shelter:

Police:

Legal Aid:

Date

Feedback from the team

DILAASA: CRISIS CENTRE FOR WOMEN
Follow up session

Name: File No. Reg. No.

Discussion with the woman: Date:

Safety Assessment and Plan:

Reg of complaints:

Medical:

Emotional Support:

Social Support:

Safety/ Shelter:

Police:

Legal Aid:

Future Plan:

Team Feedback:

Annex 2. Signs and symptoms that signal the need to ask about gender-based violence by departments to which women may present

Casualty	Gynecology/Obstetrics	Psychiatry	Medicine
<ul style="list-style-type: none"> - Rape/ sexual assault - Assault - Poisoning/ Attempted suicide - Burns - Fractures - Falls - Pregnancy with history of fall/assault - Unexplained bruises, CLW, lacerations and/or abrasions - Repeated health complaints despite normal reports - Old scars or fractures in different stages of healing 	<ul style="list-style-type: none"> - History of assault - History of fall during pregnancy - Repeated pregnancy - Spontaneous abortion - Repeated birth of girl child - MTP - Reversal of tubal ligation - Pregnant single women , widows - Chronic leucorrhoea - Postpartum psychosis - Injury marks on labia, breast and/or other sexual organs - Abruptio placentae - Pelvic inflammatory disease - Infertility 	<ul style="list-style-type: none"> - Depression - Insomnia - Attempted suicide - Anxiety/tension - Self harm - Obsessive compulsive disorder - Eating disorders - Substance abuse - Repeated health complaints 	<ul style="list-style-type: none"> - History of consumption of poison - Breathlessness - Fainting spells - Swelling - Tenderness - Chronic anemia - Aches and pains - Sudden weight loss - Tuberculosis - Repeated health complaints despite normal reports - Pyrexia of unknown origin - Convulsions - Irritable bowel syndrome - Loss of appetite
Orthopaedic	Surgery	ENT	Skin
<ul style="list-style-type: none"> - All fractures - All falls at home - Minor sprains - Ligament injury - Contusions - Chronic ache in back, shoulder, neck 	<ul style="list-style-type: none"> - History of assault - Abdominal trauma - Burns - Contusion, lacerations and/or bruises 	<ul style="list-style-type: none"> - Perforated ear drum - Injuries and fractures - Locked jaw - History of reduced hearing - Chronic discharge from ears - Sudden loss of voice - Difficulty in swallowing 	<ul style="list-style-type: none"> - STIs - RTIs - HIV - Repeated allergies - Eczema - Eczematous change around the neck, thighs, waist, forehead - Fungal infection

Source: Dilaasa. Guidelines for health professionals in responding to women facing violence. Mumbai, CEHAT, undated