

## 10. *Nature of Services Available to Women Survivors*

*One Stop Crisis Centres—Review and Recommendations*

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### **Setting the Context**

Domestic violence is one of the most common forms of violence experienced by women in India. The latest estimate by the World Health Organization (WHO) (2013) states that one in three women experience some form of violence. This is just the tip of the iceberg, as there is underreporting of violence due to high level of acceptance of domestic violence and the stigma attached to women who report and complain about domestic violence. It is the feminist movement in India that brought domestic violence into the public domain, much like in most other countries where the movement against violence against women has been led by feminist groups. One of the

known interventions in domestic violence, started by women's groups, was the consciousness-raising (CR) activities that provided a space for women to share their experiences with women in similar situations, develop links between their personal experiences and the political context in which these are structured. Domestic violence interventions in the form of support groups, crisis interventions services, shelter, legal aid amongst others, are three decades old. Most of these interventions focus on psycho-social and legal support. The emphasis on each of these differs based on the genesis of the services. The counselling services set up by women's groups emphasize on social support for empowerment, while those set up by trained social workers/counsellors emphasize on psychological and social support (Rege and Aarthi, 2012).

The chapter presents the existing evidence on One Stop Centres (OSC) in terms of their location, objectives, and impact. It presents a landscape of services for responding to Violence Against Women (VAW) and presents evidence on OSCs. It argues for an evidence-based approach in setting up of responses for survivors of domestic violence.

### **PWDVA Mandate for a Comprehensive Response**

Domestic violence could take any form—physical, emotional, sexual, and/or financial—within the household. The abuser/s could be a woman's husband and/or other members of the natal or marital families. Such violence cuts across boundaries of class, caste, religion, community, and nation. It is rooted in the social, economic, political, and cultural structures that place women in unequal and vulnerable positions. Domestic violence is often used as a tool to subjugate and control them. Such behaviour is generally perceived to be routine within families and has been historically accepted as such.

One of the most significant milestones in the domestic violence movement is the enactment of the Protection of Women from Domestic Violence Act (PWDVA). The drafting of the act and the advocacy for its enactment was led by the Lawyers Collective through a nation-wide consultative process involving feminists, social workers, activists, lawyers, and other stakeholders. The PWDVA is a unique law as it recognizes the dynamic situation of women facing domestic violence and their multiple needs; it was drafted based on evidence of several years of service provision by organizations responding to domestic violence. The appointment of and role of PO was envisioned based on the experience of many years of case work with survivors of domestic violence. Up until the passing of the PWDVA survivors of domestic violence could only file under the criminal law provision under 498A IPC which resulted

in most cases in the immediate arrest of the partner. The arrest resulted in women being thrown out of their marital homes or in escalation of violence. Moreover, women only wanted the violence to stop, but there was nothing in law that could help them. The PWDVA and the response model envisaged within it was a response to this critical gap in women's access to justice. For the first time, women who reported domestic violence could also access reliefs such as right to residence, protection order, interim maintenance amongst others reliefs.

The response model envisaged under the law lists a number of stakeholders such as POs, SPs, medical facilities, thus recognizing that women experiencing domestic violence may go to any of these at different points in time. So the entry and access to the law was kept open and the reliefs under the law were over and above what was being offered by counselling centres.

Further, the law extends its provisions to relationships in the nature of marriage, and most importantly, provides a comprehensive list of various forms of violence such as physical, emotional, sexual, and financial for the first time in India. By doing so, it recognizes that behaviour that was hitherto considered 'normal' or a 'part and parcel' of married life was now recognized as a form of domestic violence punishable by law, for example, recognizing the deeply entrenched son preference and its impact on women, the law categorizes 'insult for not having a male child' as a form of emotional abuse. Similarly, forced sexual intercourse by a husband or intimate partner is recognized as sexual violence, thus providing women who are victims of marital rape a recourse to legal redressal. Despite this recognition of marital rape in PWDVA in 2005, the amendments to the rape law in 2013 did not include rape by husband as part of the definition of rape due to the misogynist and patriarchal attitudes of parliamentarians. However, forced sexual intercourse by the husband living separately, whether under a decree of separation or otherwise, is recognized as rape. This is an important aspect to be mentioned here, as there is evidence of a large number of women experiencing sexual violence in marriage and for them, the PWDVA is the only legal recourse. Dilaasa crisis intervention centre reports that 42 per cent of women registered with them report sexual violence within marriage (Bhate-Deosthali et al. 2012).

The entire infrastructure envisaged under the PWDVA such as protection officers and SPs was to enable women to effectively use the law and offer an alternative worldview, strengthen their capacities to stop violence without blaming themselves or compromising their lives to preserve their marriage. As seen in the annual monitoring reports compiled by Lawyers Collective

over the years, this infrastructure has been developing in different ways with varied effectiveness across states. Despite the strong demand by women's groups under the AMAN network that has been consistently demanding better implementation of the PWDVA, the state has not made adequate provisions for the same. The Umbrella Scheme of 2012 which allocated approximately Rs 1,100 crores for the setting up of POs office and training of all stakeholders exists only on paper.

### **Domestic Violence—Extent and Consequences**

There is sufficient evidence from India that domestic violence is widespread. Despite lack of accurate evidence base, it is well accepted that domestic violence is the most pervasive form of gender based VAW affecting their health and well-being. The estimates from community-based studies vary from 18 per cent to 70 per cent (Daga et al. 1999; Rao 1997; Mahajan 1990; Visaria 1999; Khot et al. 2004). The variations related to the prevalence can be attributed to differences in the methodology, the manner in which questions are asked, the extent of rapport established, and ways in which data are analysed. The National Family Health Survey (NFHS)-3 indicated a lifetime prevalence rate of domestic violence at 34 per cent among women of reproductive age (15–49 years). According to NFHS-3 data, 19 per cent of women experienced physical or sexual violence in last 12 months preceding the survey. On an average, amongst married women who reported violence in the last 12 months, 42 per cent reported some kind of injury; 40 per cent cuts, bruises, or aches; 10 per cent reported eye injuries, sprains, dislocations, or burns; 7.5 per cent reported deep wounds, broken bones or teeth, or other serious injury; and 2 per cent reported severe burns. Most abused women seek help from their families and friends, very few go to institutions such as the police (1.5 per cent), medical personnel (0.5 per cent), or social service organizations (0.05 per cent). But these data are 10 years old; no new national household survey has been conducted since then. The National Crime Records Bureau (NCRB) recorded 8,455 dowry deaths and 1,18,866 cases of cruelty by husbands. These data cover only those women who mustered the courage to report at the police stations. A comparison of National Family Health Scheme and NCRB data indicate the reluctance among women in approaching redressal mechanisms.

Living in abusive relationships and abusive families is known to affect survivors' mental and physical health. There is growing evidence on the range of physical and mental health consequences of domestic violence—both immediate as well as long-term (Garcia-Moreno et al. 2005). It impacts

women's health in myriad ways, directly and indirectly, and can lead to chronic debilitating conditions, including death. A study among 2,199 pregnant women in North India indicated that child birth among mothers who had faced domestic violence are 2.59 times more likely to lead to pre-natal and neo-natal mortality (Koski et al. 2011). Physical and sexually intimate partner violence is associated with miscarriage, and reproductive health services should be used for screening of spousal violence and link to assistance (Johri et al. 2011).

In addition to injuries, disability and mental health consequences of violence include symptoms such as crying easily, inability to enjoy life, fatigue and thoughts of suicide, depression, feelings of anger and helplessness, self-blame, anxiety, phobias, panic disorders, eating disorders, low self-esteem, nightmares, hyper vigilance, heightened startle response, memory loss, and nervous breakdowns (Deosthali et al. 2009; Garcia-Moreno et al. 2005). Further, a study reported that the gamut of mental health consequences for women facing violence can range from mental stress, anxiety, depression, disturbed sleep, psychosomatic disorders, and suicidal behaviour (Kumar et al. 2005). A study by Choudhary and Patel (2008) on effects of spousal violence on women's health in Goa shows that spousal violence is a causal factor for attempted suicide and sexually transmitted infections among women. One way in which women attempt suicide in India is by burning themselves; other common methods include consumption of poisonous substances such as pesticides, insecticides, or kerosene.

### **Tracing the Evolution of Responses to Domestic Violence in India**

The feminist movement in India brought the issue of VAW into the public domain in the 1970s. The rape of Mathura (in 1972), a tribal girl, by two policemen in the police station became the starting point of the anti-rape struggle in India that began in Mumbai in 1979–80 and expanded to other cities. The years after that witnessed agitation, mass campaigns, public education, legal reform, and advocacy to raise awareness about these forms of violence. Violence within the family drew serious attention, given the large number of dowry deaths or bride-burning cases in the country at that time, and later, the issue of physical abuse and battering was also brought to the fore. There was also a realization that women often faced domestic violence unrelated to dowry demands. The gaping silence and social stigma around domestic violence was also being broken during this period.

## NGO Response

In addition to raising awareness about VAW, autonomous women's groups, along with non-governmental organizations (NGOs) such as Vimochana, Women's Centre, and Saheli, were the first to establish some kind of infrastructure and services to care for and provide support to women survivors of domestic violence. These were autonomous women's groups that provided counselling and shelter to women survivors of domestic violence. They also organized awareness drives on the issue of bride burning, dowry deaths, and domestic violence through street plays and campaigns.

## Government Response

The State also responded to the growing pressure created by the sustained campaigns taken up by these groups on the issue of domestic violence. During the 1980s and 1990s, the establishment of free legal cells, family counselling centres, family courts, and special cells at police stations in the city of Mumbai were some steps taken to provide redress to survivors of domestic violence.

## Health Sector Response

Research evidence indicated that large numbers of women were accessing health facilities for treatment of health consequences of domestic violence, but the health system was treating only the physical symptoms and injuries. Dilaasa—a joint initiative by Centre for Enquiry into Health and Allied Themes (CEHAT and the Municipal Corporation of Greater Mumbai—was set up in 2001 with the aim to sensitize the public health system on domestic violence as a public health issue and set up a hospital-based crisis centre for provision of services for domestic violence survivors. The hospital staff has been trained to recognize domestic violence, to document present and past incidents of violence, provide treatment, and refer them for crisis intervention services to Dilaasa. This model has been replicated in several settings.

Since then, there has been consistent work by health and women's groups to sensitize the health system on issues related to VAW. The health policy in India recognized gender-based violence as an issue only in 2017 after this consistent engagement since 2000. The first ever policy directive issued by the Ministry of Health (MoH) was in 2014, on the guidelines and protocols for medico-legal care for survivors/victims of sexual violence. But there has been

no such directive for responding to domestic violence, which is extremely common and requires a public health response, despite the PWDVA mandating a role for medical facilities. The 2017 policy provides an opportunity for the MoH to issue specific guidelines for responding to domestic violence in tune with the PWDVA.

### Evidence from Existing Response Models Akin to the OSC Model

In India, OSCs have been conceptualized and set up in different settings such as health, police, and courts. The following section presents the existing models that appear to be working and must be sustained through adequate allocation, capacity building, and monitoring exercises. Learnings from these can inform the new OSCs being set up by the Ministry of Women and Child Development (MWCD).

#### Crisis Centres Located within Health Facilities

Table 10.1 provides a glimpse into models set up in tertiary- and secondary-level hospitals. Dilaasa was set up in 2000 in Mumbai and has been replicated in several places.

It has established strong linkages for ensuring

- o police support by telephone calls to police stations when survivors want to register a complaint;
- o social support such as shelters, children's institutions, hostels, financial aid, income generation/skill building amongst others;
- o legal support lawyers—voluntary as well as NGOs and SLSA;
- o support during court trials—public prosecutors;
- o in case of children, strong linkages with Child Welfare Committees (CWCs) have been fostered.

**Figure 10.1** Models set up in tertiary- and secondary-level hospitals.

Source: CEHAT (2012) Comprehensive health care response to sexual assault, report, CEHAT Mumbai. Available at <http://www.cehat.org/go/uploads/Publications/R87%20Establishing%20a%20Comprehensive%20Health%20Sector%20Response%20to%20Sexual%20Assault.pdf>; Bhate Deosthali Padma, Manghnani Poornima, Malik Seema (2005) Establishing Dilaasa: Documenting the Challenges. Report, CEHAT Mumbai. Available at <http://www.cehat.org/go/uploads/Dilaasa/estabdilaasa.pdf>.

**Table 10.1** Models Set up in Tertiary- and Secondary-level Hospitals

Name	Location	Staffing	Services	Funding	Components
Dilaasa	11 peripheral hospitals in Mumbai	-social workers deputed to the centre or hired for the centre	-DV and rape -Medical -Police, legal and social support through strong referral mechanism	Ministry of Health	Training of health professionals police and counsellors
Bhoomika	21 centres across 21 district hospitals in the state	Social workers hired for the centre	Counselling for DV Referral to state legal aid for legal services	NRHM	
IOHLYNT	Based in Shillong civil hospital	Deputation of social worker from dept. of social welfare	Psycho social support Police aid Referral to PO and legal aid Emergency shelter	DWCD, NRHM	Training of HCP Training of police personnel
Sukoon	Five centres in district hospitals	Health resource centre	Psycho social support Links with police stations, and POs	NRHM and DHS	Training of hospital staff
Dilaasa Women's Crisis Centre	1 crisis centre in North Goa district hospital Plans for 1 crisis centre in South Goa district hospital	Supported by NMEW and DHS	Psycho social support Linkages with PO, legal aid Emergency shelter services	NMEW, WCD	Training of health care providers at the level of hospitals and community health centres awareness programs in communities

Source: WHO & CEHAT (2015) National Consultation on Health Sector Responses to VAW. Report (unpublished). Mumbai: CEHAT.

An external evaluation of Dilaasa found it to be an evidence based and a sustainable hospital-based model for responding to domestic violence and sexual violence. It has been set up as a department of the hospital, the OSC has to present aggregate data on how many women and children received services every month, nature of health consequences, and the like. A monitoring committee oversees the activities of the hospital-based OSC.

The pathway for women to these centres is unique as they are identified by health providers and referred to the centre, and women arriving at the centre thereafter, read IEC material that has been put up at the facility level for creating awareness about domestic violence. Some efforts are being made at the primary level through training of ASHA workers. However, this approach raises several ethical and practical issues as the secondary- and tertiary-level of health systems do not have the required skill and infrastructure for responding to domestic violence.

### Crisis Centres Located within Police Stations

In Mumbai, special cells for women and children were set up in 1984; located within the police stations, these were started as a project of the TISS. These were established to enable women to access reforms in laws such as Section 498A IPC, to protect women against cruelty within marital families and harassment pertaining to dowry demands. The special cell engages in counselling women when they approach police stations and helps facilitate police procedures. An important area of the work of the special cell is to sensitize police personnel to the issue of VAW and to ensure comprehensive services from the police station for women who come to the police. After women reach the police stations, the police officer puts the woman in touch with the special cell worker, the worker then coordinates for additional services as required by the women, such as coordination for health services, legal aid, and shelter facilities. Another important component of the special cell's work is making home visits to assess the situation of the woman and carrying out joint meetings with perpetrators. The special cell workers are expected to coordinate with women and visit civil and criminal courts to assist them with legal proceedings.

The special cell started in 1984 in one police station of Mumbai and was replicated in two additional police stations in Mumbai by 1994. In 2001, the Government of Maharashtra entered into a formal collaboration with TISS, Mumbai and the United Nations Development Fund for Women (UNIFEM) and the special cells were replicated in seven districts of Maharashtra. At the completion of the collaboration contract, the Department of Women and Child Welfare took over the special cell

programme and replicated it in 16 districts of Maharashtra. The period between 2009 and 2013 also saw the expansion of special cell in other states such as Delhi, Orissa, Gujarat, Haryana, Madhya Pradesh, Andhra Pradesh, and Rajasthan. In each of these states, the special cells have been established by different agencies, some by the state and some by the NGOs. Special cells operating in different states either with the support of NGOs or Women and Child Departments (WCD) have not yet sought to seek the OSC funds for cells in the police station (Dave 2014). These cells have been providing services to survivors of violence for several years. It is not clear why these have not been designated as OSCs. The role of the various ministries such as WCD and Home is in question, as these cells are under WCD but located in police stations.

### Rape Crisis Centre at the Delhi Commission of Women

The Delhi Commission has been implementing the Rape Crisis Cell Programme for Women since 2005 to provide legal assistance in cases of sexual assault through collaboration with crisis intervention centres (CIC) in each of its districts. The CIC are outsourced to NGOs. After a case of rape or sexual assault is reported, the concerned investigation officer or the station house officer (SHO) must inform a CIC counsellor. The CIC counsellor arrives at the police station and performs all immediate crisis-response activities like counselling of the victim, informing her of her legal rights, and helping her with procedures to be followed, including the medico-legal certificate (MLC) examination. The rape crisis centre (RCC) lawyer provides legal assistance and support to the victims of sexual assault in courts. These lawyers support the victim during court proceedings, oppose bail applications of the accused/s, and move applications seeking victim compensation. The programme regularly takes up cases of extreme brutality, violation, and inaction of authorities (that is, police or hospitals). The RCCs are funded through the state women and child department and Central Social Welfare Board. There is no information pertaining to recognizing RCCs as OSC under the MWCD scheme, neither has the Delhi Commission for Women sought funds from MWCD to support RCCs.

### Court-Based One Stop Centre (OSC)

In order to facilitate humane psychological, medical treatment to the victims of crime during the investigation, crime, and thereafter, it is important to have support services at the level of the court. It is a known fact that there

is a complete absence of support to navigate the court procedures, understand the court procedures and its implications, and provide support and handholding throughout the court proceedings. This necessitates the establishment of a court-based OSC. Such an OSC has been established by the Delhi State Legal Services Authority (DLSA) and has been functional since 31 March 2016. One judicial assistant and one orderly are posted in the centre. Psychological/emotional counsellors sit for a few hours on weekends or come in when the centre has prior notice of a victim. The centre is primarily used for recording of statements of minors and victims of sexual offences by Magistrates under Section 164 CrPC.

The role of the court OSC is to assist the survivor of VAW right from the investigation to completion of the trial. The OSC assists in disbursement of compensation, witness protection, and any other services as required by the survivor. The OSC works in close coordination with the public prosecutor and makes provision for counsellors to accompany the survivor to courts. The counsellors and the lawyer assigned to the survivor are familiar with the court proceedings and communicate the progress of the case to the survivor from time to time.

The above section presents the various OSCs located in different systems such as police, health, and judiciary. They are providing women-centred services to survivors and there is an urgent need to strengthen these structures, instead of creating new ones. The centres can be part of a strong referral system so that women have multiple places to go to for support and counselling through their struggle for justice.

### **Understanding the Origins of OSC**

OSC as a method for responding to rape or domestic violence have been operational in the West since the 1970s and in South Asia for more than a decade. Several OSC models in countries such as England and Wales, Rwanda, Zambia, Australia, South Africa, Malaysia, Phillipines, and Bangladesh have different histories and origin. The Australian rape crisis centre was the outcome of the feminist movement and is based in a community set-up. This centre receives survivors who seek services for healing from the consequences of rape and for those who wish to engage in group therapy. The entire programme is volunteer-led, where volunteers undergo six-week training. The rape crisis centres in England and Wales runs a Sexual Assault Referral Program (SARC) which operates as centres to provide emergency medico-legal services, however, in some places they are not able to provide

medical treatment and care, in which case they are referred to hospitals for treatment. The SARC centres, after carrying out medico-legal service, refer for medical aid and psycho-social services as the focus is on the collection of forensic evidence in a sensitive manner. USA has models that include hospital-based services for domestic violence and rape through the department of social workers at the hospital and a team of volunteers trained to provide on-site support for rape survivors 24x7. The way in which this operates is that the hospital calls a hotline number as soon as a rape victim comes to the hospital and a volunteer on duty comes in and facilitates the entire medical examination and also provides basic support. The ones in South Africa are located in hospitals but linked to the public prosecutor's office and so focus on the judicial outcome. The ones in Rwanda are located in the police station with the same focus on support for the judicial process. These services have been focused on domestic violence or rape, thus having two separate services running in the same facility to respond to these two forms of VAW. Recognizing the need to set up OSCs to respond to all forms of violence within low resource setting, the initiatives in South Asia seek to provide comprehensive service to all survivors primarily located in hospitals. Malaysia, Phillipines, and Bangladesh set up such models that focused on training of health professionals on identifying violence amongst patients and carried out service provision to survivors. Many of these models were dependent on NGOs for providing counsellors and thus the quality and availability was subject to availability of NGO members. This dependence posed a barrier in integrating these into the existing health-care services.

### **OSC as the State Response to VAW**

The OSCs became a buzzword in the context of the Justice Verma Committee (JVC) Report and the Justice Usha Mehra Committee Report. Recommendations of these reports were in response to the mass agitations following the brutal physical and sexual assault on a young woman in the capital city and her subsequent death in December 2012. The JVC was set up to review the existing law and infrastructure, and make recommendations. The JVC Report 2013 highlighted the institutional biases towards rape within the police, health, and judiciary that prevent access to and delivery of justice and made recommendations for changes in law and at all levels of the criminal justice system. The Usha Mehra Committee also made recommendations for setting up crisis centres for rape survivors and inter-sectoral collaboration. The Government of India was compelled to take swift action,

which resulted in several positive changes in a span of one year. Amendment of the rape law, setting up of a telephonic help line by the chief minister's office in Delhi, and gender sensitive protocols for medico-legal care were some of the concrete steps taken by the government. The Government of India also launched a 10 billion rupees fund called the Nirbhaya Fund and was expected to support all the initiatives to be undertaken to increase the safety of women and mitigate VAW. In the same vein, the MWCD Union of India launched a new scheme namely Nirbhaya Centres which adopted the OSC model. Despite existing models of OSC such as Dilaasa, the scheme did not build on it. The model is a joint initiative of CEHAT and the Municipal Corporation of Greater Mumbai. An external evaluation carried out in 2010 has recommended its upscaling, as this had integrated a health response to VAW within the hospital. The initial focus of the OSC scheme was to only focus on survivors of rape. But considering that an OSC necessitated creation of an entire infrastructure, personnel, and response mechanisms, it was important to expand the scope of these interventions to all forms of violence against women and children. Civil society and women's groups' consistent dialogue with MWCD led the department revising its proposal to extend the response at these centres to all forms of VAW.

The OSCs, as these are now called, are being set up one per state with a centre-state sharing of funding resources. The OSCs, as envisaged under the MWCD scheme, do address domestic violence and sexual violence. The SOP that have been issued for the functioning of these centres provides clear direction on linking up with the PWDVA infrastructure. The establishment of OSCs is based on a survivor-centred approach to providing services. It would be useful to trace the origin of this model. The Umbrella Scheme of 2012 made provision for setting up of hospital-based crisis centres in 100 hospitals on the lines of Dilaasa. The hospital-based crisis centres were envisaged as having strong linkages with the police and the courts. Where a woman decides to take police assistance and wants to get a FIR registered, the centres shall have the provision of calling the required police station and record the FIR at a place where the woman is comfortable, followed by the statement under Section 164. Such a centre is expected to provide the necessary linkages and support to survivors in accessing justice.

### Objectives

The key aim of an OSC is to provide multiple services such as emotional support, police aid, shelter services, and legal aid as well as rehabilitation

services under one roof. But this is highly resource intensive and poses challenges in low- and middle-income countries. Personnel from various systems such as the police, health, and social justice cannot always be expected to be deputed full time at these centres due to huge human resource crunch and other systemic problems. For example, in centres where there are one police personnel deputed full time, their role is limited to informing the woman about police procedures and does not extend to registering an FIR at the centre. This information can be provided by the centre staff and the local police can then be called to file the FIR. What has been found to be useful and effective is to set up strong referral mechanism with multiple SPs so that women are able to access services easily.

### **Review of the Existing OSC under the MWCD Scheme**

The MWCD OSC scheme did not take into account the existing models of response such as hospital-based, police, and court OSCs, instead, the scheme proposed the setting up of the new structure under the MWCD close to a hospital if possible. But it was left to the states to decide on the location of OSCs. The OSC aims to provide integrated support and assistance under one roof to women affected by the violence of all forms. MWCD developed specific guidelines on 17 March 2015 for setting up OSC scheme. The location of the OSC was proposed to be in a government hospital or within a radius of 2 km if the space of 132 sq. m was not available in the hospital or within a medical facility. In the absence of space in the hospital, OSC was proposed to be built within hospital premises or within a 2 km radius on a separate piece of land. The revised guidelines of August 2016 gave first preference to the hospital or medical facility or staff quarters with the provision of five rooms with a total carpet area of 132 sq. m. If that is not possible, then government institution like Nari Niketan was preferred site of location of OSC. In the first OSC scheme roll out, 36 OSC were proposed, one OSC was to be established in every State/UT on a pilot basis in a hospital, or within a 2 km radius of a hospital. The OSC is expected to have a full-time administrator, a full-time case worker, on call psychologist, on call health worker, police constable stationed at the OSC, and an on call state legal aid authority lawyer.

The finance ministry created a fund called 'Nirbhaya' in 2014 with a corpus of Rs 1,000 crores, with the same amount being added annually. One of the schemes funded by the Nirbhaya Fund is the OSC Scheme. The OSC scheme in its initial stages set out to set up one OSC per state.

However, between June 2016–17, such OSC had been set up in different states. These are: Chhattisgarh (Raipur), Andhra Pradesh (Vijaywada), Haryana (Karnal), Odisha (Bhubaneswar), Chandigarh, Pondicherry, Goa (Bambolim), Karnataka (Udupi), Rajasthan (Jaipur), Diu (for Daman and Diu and Dadar and Nagar Haveli), Uttarakhand (Haridwar), Uttar Pradesh (Banda), Andaman and Nicobar Islands (Port Blair), Arunachal Pradesh (Paptimpore), Kerala (Thiruvananthapuram), Meghalaya (Shillong), and Nagaland (Dimapur).

The MWCD has carried out an evaluation of its centres and is in the process of upscaling them. The authors have reviewed the report, and based on the data presented, several issues have emerged that require deliberation so that the roll out can be better informed.

Several of these OSCs are located in the vicinity of hospitals or within the hospitals, but there is no coordination between the police, OSC staff, and hospitals. When a woman reporting violence comes to the hospital with health consequences she gets treated, but does not receive a referral to the OSC located within the same premises. Women reaching OSC for services and those wanting to file a police complaint cannot avail of the medico-legal and police post of the hospital. These women are taken to another police station to record a complaint. A coordinated approach requires that when a woman accessing OSC services decides to register a complaint, the police on duty of the hospital should coordinate with the specific police station so that the police can reach the OSC to record the complaint. The police facilitation officer (PFO), although deputed at the centre, cannot file FIRs and so the woman still has to go the police station to file one. So, it is not useful to have someone from the police department round the clock at the OSC. There is a need for better coordination of local police with the OSC where, once a call is made from the OSC, the police must immediately facilitate recording of FIR. The FIR must be recorded at the OSC based in a hospital at the behest of the woman.

Medical staff deputed at the OSC is either on call or round the clock. The profile of the medical staff is that of auxiliary nurses and their role is to accompany the woman to the nearest hospital and access medical care. Nurses and auxiliary nursery and midwifery (ANMs) have no mandate to 'treat' or carry out medico-legal documentation of cases of violence. Thus, the full time or part time auxiliary nurse does not have a role at the level of the OSC. OSC has no mechanism for coordinating with the POs and SPs under the PWDVA. The infrastructure created for the implementation of the PWDVA thus remains a parallel mechanism, if proper linkages are

not created. This is essential as most women reporting violence are facing domestic violence.

The current profile of women reaching Nari Niketan shelter-based OSC shows that women who are destitute and in need of shelter are brought by the police to this OSC. Thus, OSC ends up operating as a shelter rather than carrying out coordinated service delivery.

Outsourcing of services: there is a tendency and push for outsourcing of services and we need to demand that full-time staff is recruited at the OSC in order to ensure accountability and ownership. The budget for payment to people on call should be better utilized to offer quality services.

Interventions: there is a concern with regard to the approach adopted by OSCs to enable women to deal with violence. Invariably the abusive person (often the husband) is called to the OSC and a joint meeting is conducted to verify true/false cases. Often, women are not prepared for these joint meetings and calling the husband may jeopardize their safety and mobility. These methods tantamount to victim blaming and also question the veracity of the woman. There is no protocol for carrying out crisis intervention or for a feminist approach to counselling in the current OSCs.

The MWCD has now issued standard operating procedures (SOP) that clearly lay down the quality of counselling, the pathways to care, and the linkages to other systems such as the PWDVA infrastructure of POs, SPs, as well as the legal service authority for assisting women in accessing justice and other social support. The SOP document is available on the MWCD website and is a robust document that lays down the roles and responsibilities of each functionary, the quality of services to be provided, the ethical principles to be adhered to, the referral agencies, and the linkages with other programmes and schemes of the state.

Despite the several limitations pointed out about setting up rape crisis centres, the Delhi government went ahead and implemented this recommendation and set up rape crisis centres in few hospitals in Delhi such as Ram Manohar Lohia and Safdarjung. These have merely marked out separate room for examination and collection of medical evidence in instances of sexual assault survivors. No effort has been made to provide comprehensive services such as counselling support, shelter services, and referrals to legal aid. They are asked to go to the Delhi commission women. The existing hospital team of counsellors and psychologists has not been assigned any role here and the focus is evidence collection, and counselling is outsourced. (CBGA 2017).

## Way Forward

The entire campaign to end VAW after the Delhi rape incident demanded a change in institutional responses to VAW. OSCs are set up as one mechanism of creating an institutional response, but in reality the functions and activities of OSC have been outsourced to different agencies thus making non-state players accountable for an institutional response. There is a danger in essentializing OSCs as the only response to VAW. VAW is a complex reality and its roots are deeply entrenched in society. Therefore, there is a need to look at the different structures and increase competencies of those structures. The OSC centres which are stand-alone centres with on call staff are not integrated within any of the systems/institutions and therefore accountability of these centres will be a huge challenge. The SOPs that have been issued by the MWCD for setting standards for intervention services are women-centred, but for its implementation, rigorous training and monitoring is required. The state must make provision for the same and ensure that women survivors of violence are not further blamed or victimized. The OSCs must therefore be equipped to coordinate support for women from various agencies in a way that women are not shunted from one place to another.

In India, the two existing models, namely, the Special Cell for Women and Children located in the police station, and Dilaasa, integrated into the public hospital system, have shown positive results and there should be an effort to upscale these models. The court based OSC should be reviewed as it is well documented that the legal battle is long, intimidating, and tiring, and support at the level of the courts can help women to continue with the legal system. There is a need to understand that crisis intervention services need to be set up within different institutions such as the health department, police stations, and courts that survivors have to access for justice and care.

Over the last three decades, there has been a demand for the state to set up services for survivors of domestic violence. However, one of the main concerns of the feminist groups has been the quality of services being offered by many of the state-run centres. With their focus on 'preserving marriage', 'reconciliation', compromise, they fail to question domestic violence and often minimize it as a 'conflict' or a 'quarrel' within the home. This is due to the complete lack of a feminist perspective and women centred approach in their response. Feminist interventions locate the roots of VAW within structures and institutions that are gender unequal. It questions abuse and puts the onus of abuse on the perpetrator, rather than the victim. The SOP of the OSCs and the training of OSC teams by the National Institute of

Public Cooperation and Child Development (NIPCID) do include feminist perspective in responding to VAW. It is important that women's groups be involved in the monitoring of these centres so that they are able to provide support and empowerment to survivors of domestic violence and sexual violence, and help them in their access to justice and in improving their well-being.

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