

Addressing Domestic Violence within Healthcare Settings

The Dilaasa Model

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Women experiencing violence most often decide to seek legal action only after the violence has escalated and that too without having any documentary evidence. The Dilaasa crisis centres at two public hospitals in Mumbai since 2001 have been established out of the recognition that the public health system is an important site for the implementation of anti-domestic violence intervention programmes. The crisis centres therefore straddle both discourses of public health and gender. The paper offers critical insights into the model and its impact in terms of its ability to reach out to women who are undergoing abuse and offer them multiple services in one setting.

This paper critically reflects on the Dilaasa model, a health sector intervention for survivors of domestic violence. While the women's movement in India has been engaged with the issue of domestic violence for over three decades now, with campaigns, legal advocacy and support/case work being the predominant modes of engagement, violence against women has not been seen as a public health concern. This has been so, despite accumulation of evidence on the far-reaching physical and mental health consequences of violence of domestic violence (Jesani 2002; Bhate-Deosthali et al 2005). The Dilaasa project – consisting of two public hospital based crisis centres in Mumbai – represents the first such attempt in India to work with the public health system. It was established through a joint initiative of the Centre for Enquiry into Health and Allied Themes (CEHAT),¹ a Mumbai-based non-governmental organisation (NGO) and the Brihanmumbai Municipal Corporation (BMC). Originally established in a municipal hospital, K B Bhabha Hospital, Bandra in 2001, Dilaasa has since been replicated in three more sites: another municipal hospital, K B Bhabha Hospital, Kurla, Mumbai, at a medical college hospital in Indore and a civil hospital in Shillong. The Mumbai-based crisis centres were formally handed over by CEHAT 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 the BMC.

The study is based on (1) an external evaluation of the project carried out in 2010, and (2) an analysis of case records of the centre from 2001 to 2006. The external evaluators reviewed project documents such as annual reports, process documentation of trainings, reports of the crisis centres, and of the intervention research conducted; and carried out interviews with the staff of CEHAT responsible for the project and the staff of the Bhabha hospitals at Bandra and Kurla. In addition, data from case records of survivors (2001-06) of the Dilaasa crisis centre were analysed to understand their socio-demographic profile, their entry into Dilaasa, and the type of violence experienced by them.

This paper offers critical insights into the model and its impact in terms of its ability to reach out to women who are undergoing abuse and to offer women multiple services in one setting. It makes the case for upscaling the model and for bringing about changes in health policy to recognise the role of health professionals and health systems in preventing domestic violence and caring for survivors.

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1 Placing Dilaasa within the Women's Movement

"When the women's movement burst forth onto the public stage in the years following the Emergency, it did so most dramatically under the banner of 'violence against women'" (John 2008: 227). It was issues of rape and "dowry deaths" that galvanised formation of women's protest groups, bringing violence against women as an issue into the public domain in the 1970s. Internationally, the rise of the women's movement in the 1960s brought to light 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. Milestones included the passing of the first resolution against violence against women by the United Nations General Assembly in November 1985; the formulation of "Women's Rights as Human Rights in 1993 with the adoption of the UN Declaration on the Elimination of Violence against Women"; and the appointment of the UN Special Rapporteur on Violence against Women. Since then, much has been done to gather evidence on the dimensions of the problem and to create awareness on the issue.

The Indian women's movement first drew public attention to violence against women in the early 1980s when it organised a campaign against the gender-biased judgment by the Supreme Court in the case involving the rape of a young tribal girl, Mathura, by policemen. The anti-rape struggle that began in Mumbai with the establishment of the Forum against Rape in 1980 raised the issue of male violence for the first time in India in addition to class and caste violence (Kumar 1993). The following decades witnessed agitations, mass campaigns, public education, legal reform and advocacy to raise awareness about domestic and sexual violence and eliminate them. Support groups to provide help to individual women facing domestic violence were started and services such as legal aid and shelter homes were set up by autonomous women's groups and NGOs. Legal strategies too were evolved such as the amendments to laws on rape, the most significant being shifting the onus of proof to the accused in cases of custodial rape; the amendment made to Section 498A of the Indian Penal Code in 1983 that formally recognised "mental and physical cruelty to wives" as a crime, the laws pertaining to dowry deaths and sati, the Supreme Court guidelines for sexual harassment at the workplace, and the introduction of the law criminalising sex-determination tests (Bhate-Deosthali et al 2005; Burte 2008).

Violence within the family drew serious attention through dowry deaths or bride burning and later, the issue of battering. It was also realised that women faced domestic violence that were not necessarily related to dowry demands alone. Silence and social stigma over the issue of domestic violence were broken when women publicly fought against the abuse experienced in the "safe haven" of the home (Agnes 1990, 1992; Kumar 1993; Burte 2008). The feminist slogan "the personal is political" was used to effectively demystify the "private" space of the home, making it possible for individual women to come forward and share their agony and pain. The movement brought to the fore the assertion that all women have the right to violence-free lives and that domestic violence inhibits women from realising their rights and full potential in all

aspects of their lives – in social, economic and political spheres. The state also responded to the growing pressure created by the sustained campaigns taken up by these groups on the issue of violence. During the 1980s and 1990s, the establishment of free legal cells, family counselling centres, family courts and special cells at police stations initially formed in Mumbai, and subsequently, in several places across the country, created many spaces for victims of domestic violence. These have helped individual women, and to a certain extent, sensitised the public systems to respond to the issue of domestic violence.

In 2005, the landmark legislation, "The Protection of Women from Domestic Violence Act" (PWDVA) was enacted, making it the first significant law in India to recognise domestic violence as a punishable crime, extending 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.

Defining domestic violence as "any act that harms, injures, endangers, the health, safety, life, limb or well-being of the person or tends to do so". PWDVA includes "physical, sexual, verbal, emotional abuse or intention to coerce her or any person related to her to meet any unlawful demand for dowry or any other property/valuable security" ...[and] "also have the effect of threatening her or any person related to her" (PWDVA, 2005). The act recognises public health facilities as service providers and mandates that all women reporting after domestic violence must receive free treatment and information/appropriate referral to protection officers under the act. The Act is the result of cumulative efforts made by women's movement for a law that provides specific remedies for women experiencing domestic violence, whereby they could approach the state directly and get a protection order to stop violence in the home without having to put the husband behind bars or having to leave her matrimonial home to escape violence (Jaising 2002). Under the aegis of the Lawyers Collective that drafted the bill, the implementation of this law too has been monitored annually since it was passed and consistently drew attention to the continuing challenges such as scarce budgets, problems with nature of appointment of protection officers under the law (contractual vs regular, independent charge vs additional charge), lack of training of police and judges on the law (Lawyers Collective and Women's Rights Initiative 2011).

While the women's movement's engagement with the problem of violence finds several forms, its interface with the health system has been a complex one. In many instances the women's movement has had to take an antagonistic stance against the health system as, for instance, in its confrontation against its role in the implementation of coercive population policies, its lack of sensitivity in dealing with reproductive and sexual health needs of women and the overall lack of gender sensitivity within the system. At the same time, the movement, in its attempts to sensitise the system, has highlighted several lacunae in the existing health system, as for example, drawing attention to the failure to document important forensic evidence in the event of sexual assault, which severely

limits survivors' ability to attain justice. Working with the health system becomes critical in the efforts to address domestic violence against women for several reasons. Most often women experiencing violence decide to seek legal action only after the violence has escalated but they have no documentary evidence to prove it. Health providers fail to document the woman's history of victimisation as well as recent episodes of violence, which are critical in divorce and criminal cases to seek compensation. When women victims of violence present themselves at the emergency room or other departments of hospitals, they are usually treated for their physical symptoms and no further probing is done. However, working closely with the health system has not been among the strategies employed by the women's movement in its struggle against gender-based violence (Jesani 2002).

The Dilaasa centre, set up in 2001, seeks to address precisely this gap. It has emerged out of the recognition that the public health system is an important site for the implementation of anti-domestic violence intervention programmes, for more than one reason. Public hospitals are often the first contact for survivors as violence of any form causes physical and/or psychological trauma. Women survivors may or may not report to domestic violence but will seek treatment. Furthermore, medical evidence forms important documentary evidence. There is fairly extensive evidence that domestic violence has an impact on women's health in myriad ways – both directly and indirectly – and can lead to chronic debilitating conditions and even death. Apart from injuries, disability, mental health consequences of violence include 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. Self-harming behaviour is also a serious consequence of victimisation and includes refusal of food and drinking, suicide ideation and attempts, and generally neglecting oneself and one's health (WHO 2005; Campbell and Lewandowski 1997; Heise et al 1994).

2 The Dilaasa Model

2.1 Dilaasa's Perspective on Domestic Violence

The ideological position guiding the Dilaasa project can be described as twofold: (a) locating the importance of domestic violence as an issue within the larger societal context of gendered inequalities and violence, and (b) pushing for recognition of domestic violence as a public health concern within the medical context that is largely unresponsive to issues perceived as falling beyond the medical purview. The Dilaasa project, therefore, straddles both these discourse – of public health and of gender – and represents an example of the conflation of the two, demonstrating its viability and achievability in practice. The concept of public hospital-based crisis centres is well-established globally, and lessons learnt from such centres in the United States, Malaysia and Philippines shaped the conceptualisation of this project. In the context, in India, which is presently witnessing weakening of national and local

public institutions with the healthcare needs of those living in urban low income settings getting marginalised despite a high density of public and private healthcare providers and institutions, Dilaasa's venture is a modest attempt to plug this gap.

2.2 Organisational Structure and Mechanisms

Dilaasa was set up with the following strategic objectives: (a) partnership of an NGO with the public health system, (b) sensitisation of the public health system to domestic violence and institutionalisation of domestic violence as a legitimate public health concern, and (c) building the gender-sensitisation capacity of the hospital staff.

The distinctiveness of this initiative lies in the fact that it was conceptualised as a joint project in terms of human resources and management. The team, consisting of professionals from CEHAT and the staff deputed by the public hospital, was led by the medical superintendent of the hospital. All decisions regarding the project on the policy or programme were taken jointly by CEHAT and the hospital management, facilitating creation of a sense of ownership of the project among the hospital staff.

Dilaasa was created as a department of the hospital so that there could be clarity on the chain of command and decision-making processes, and on the definition of roles of doctors, nurses and social workers. Since the project director was the medical superintendent of the hospital, it was possible for her to make various systemic changes to integrate this programme within the hospital setting. Her role in involving the hospital staff unions, in deputing staff for training and subsequent responsibilities, and in ensuring that other facilities and resources were made available, proved to be vital to the continued functioning of the project. Within a few years, once the concept was demonstrated and administrators and health providers were convinced that domestic violence was indeed an important public health issue, an enhanced sense of ownership of the project was seen from within the health system.

This attitude of the hospital staff is best demonstrated by the fact that the replication of this centre was carried out by a core group of another hospital out of a sense of deep concern for women reporting at this hospital. Another hospital's core group went beyond this and identified the poor management of sexual assault and demanded support from CEHAT in improving their response to the issue (Ravindran and Vindhya 2009).

3 Major Components of the Model

The Dilaasa model comprises a public hospital-based crisis centre for women which provides counselling services informed by a feminist perspective to which women are referred from within the hospital and from other health facilities. In its pursuit to provide comprehensive care at one place, Dilaasa liaises with Majlis, a Mumbai-based legal services organisation for legal support to Dilaasa clients; and with several shelters that provide temporary or permanent shelter. Linkages with community-based organisations and/or *mahila mandals* too have been established so that women coming to the centre could be referred to them for local support and other needs if any. The

second major component of the model is training of health providers and all other staff of the hospital.

3.1 Women's Referral to the Dilaasa Crisis Centre

Women are referred to the crisis centre not only from the casualty, but also from the outpatient and inpatient departments. This is because the casualty department deals mainly with serious injuries, and hence, could be tapping only a small proportion of cases of violence. Cases coming to the outpatient department (OPD) with less serious injuries could go unreported. Doctors and nurses in all departments of the hospital have been trained to ask screening questions and identify women experiencing domestic violence. Women from OPDs are provided medical care, referred to casualty for medico-legal documentation and then referred to the crisis centre. If the woman is admitted in the hospital, the counsellors are called to the ward to speak to the woman concerned.

In addition, crisis centre staff visit the casualty department everyday and make sure that all women registered as medico-legal cases (MLCs) get the services of the centre. Referrals to Dilaasa are also made from other hospitals and health facilities of municipal corporation. Besides referrals, with increasing publicity, women are now found to come on their own, after having heard of the services provided by the centre.

Systems have been introduced to track the referral process. The hospital's case sheet has been modified to stamp "Referred to Dilaasa" on the case sheets of women reporting injuries. The hospital's management information system (MIS) has been modified to include a field in which casualty medical officers can keep a daily record of women referred to Dilaasa. This report is sent to the project director. When women present themselves at the crisis centre, the counsellor first obtains the woman's consent after explaining the services provided by Dilaasa. An intake form is filled with details of the woman's socio-demographic characteristics and past history of violence. This is followed by counselling.

3.2 The Counselling Process

There is a marked difference between the mindset of a woman who steps into Dilaasa and another who may go to any other counselling centre. A woman coming to Dilaasa has been referred by a hospital staff when she comes to the hospital for treatment and may not be prepared to talk about personal issues, especially domestic violence. The time factor is another distinguishing one which poses a challenge as women coming to Dilaasa are rarely able to sit for more than 45 minutes unlike other counselling centres where counselling sessions are long-drawn. Their follow-up, therefore, depends on their first contact with the centre. Dilaasa's counselling practice is embedded in a strong feminist framework (Worell and Remer 2003).

Feminist counselling practice questions abuse; it provides the necessary tools and strategies that equip women with skills that facilitate healing and stop violence. 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.

In addition to making connections between the personal and the political, it is the creation of a space where women can be heard with respect, sensitivity, genuineness, and without being blamed. Women have overwhelmingly said that Dilaasa indeed provided a non-threatening atmosphere which was facilitated by counsellors, as revealed in the following excerpts from interviews with the survivors.

I felt... like... I could share whatever problem I had with them and I could get a direction, help from them for future, what I must do next. ...They [the counsellors] nicely heard everything I said. When they were listening to me, thus, I also felt that I should tell them everything that's happening with me. They also listened very well and explained the steps ahead.

When two friends are talking, then they talk right from the heart. This Dilaasa also makes you talk from your heart. I feel benefited by it.

I was very confident that all these things would remain confidential, so I could talk freely (Counselling Impact Study 2004, CEHAT, unpublished).

Safety assessment and planning form essential components of counselling women facing domestic violence. In addition, efforts to provide multiple sources in consonance with women's needs are made as, for instance, there are referrals for medical help, preparation of a medico-legal statement and registering of a police complaint if needed. The goals for counselling are set up in consultation with the woman after an understanding of her expectations. An appointment for follow-up counselling is fixed at the end of the counselling session. Women who are afraid of returning home because of threat of violence are admitted "under observation" for a period of 24 hours, which allows time for working out the next steps such as referring the woman to a shelter or finding a safe space with relatives/friends. Extending her stay at the hospital also provides her necessary time and space to make a decision. Quality control measures in place for counselling include case reviews on a regular basis in the presence of an expert. The needs of the woman user are 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 adhering to the principle above all of "doing no harm".

3.3 Impact of Counselling

Interviews with survivors showed that they provided the most positive feedback for the rapport the counsellors had been able to establish with them and the counsellors' ability to make them relax and open up. They appreciated that the counsellors treated them with regard and without being condescending or patronising; that they did not blame the woman for her problems; and that they validated the woman's experiences of abuse.

Till today I could not tell anybody what I had hidden in my mind that how the people from my in-laws side are. They never allowed me to go to the neighbours, not to any relatives nor even to my mother. That is why I could not talk to anybody. I kept everything in my mind only. After coming to Dilaasa and talking to [the counsellor], I opened up

my mind and told her everything and now my mind is relieved and I feel my head has also cooled down. There are some incidents which still make me cry when I remember them. But in that situation I think I can come out.

I have suffered a lot and now onwards I have to be strong and carry on. I have got three daughters. If I live in fear... for how many days can I live fearing my husband? I have to face him so whatever I have to do should be done with firm mind, at once. ...I have been suffering from this torture of getting beaten for so many years. But now I cannot bear it any more. So I am going to be strong and will not allow him to even touch me.

Now I have become very strong that I can talk. Fear has gone (Counselling Impact Study 2004, CEHAT, unpublished).

While emotional support was the most frequently cited positive impact, the survivors also reported positive changes in health status, more so in psychological well-being and less so in physical health. They also reported changes in consciousness – that women should not be blamed, should not accept violence and that women are not fated to suffer silently.

I feel nice, worry has reduced. I feel that somebody is there with me [I feel] courage has come in me. I am not scared of anybody.

...After my marriage, my co-sister-in-law (*Jethani*) had told me that women's lives are like this only. We have to live like that! So that stuck in my head. She had told me not to say anything back home, not to say anything to my mother. That brings even more shame/defamation (*badnami*). So that also stuck in my head. So I had never thought that there exists any organisation where we can share our problems. But now that I have discovered, I can now come here and open my heart... It [the change in my thinking] is due to the fact that they [counsellors at Dilaasa] explained things to me, that I have been able to move ahead in life. Earlier I used to think, I have to live like this only but now I do not think that way.

I felt it this way earlier, because all of them blamed me. ...Meaning whatever I did they made me feel this way and they beat me. I felt like this, 'Yes, I have done something wrong.' But later I thought, 'No, I am not wrong. I have not done anything wrong. They only forced things [marriage] on me'.

...Till my marriage I used to think that women must be wrong, they are doing some mistakes. But now I know a woman is not wrong. So I am sure that the violence I was facing was total injustice. I had not committed any mistake why I should be blamed? I do not know about other women. So the whole thing is wrong, unless she is pressurised a woman will have no interest in spoiling the peace of the house (Counselling Impact Study 2004, CEHAT, unpublished).

The intervention of Dilaasa in matters related to registering of complaints with the police was also reported to be effective. Women recognised the importance of registering complaints with the police and of medico-legal documentation.

...It is for our safety also [to file NC and MLC]. When there is nobody then the help is available there only...Earlier I had no knowledge about it (Counselling Impact Study 2004, CEHAT, unpublished).

Survivors also commented on the relevance of the model.

One gets two kinds of help – physical as well as mental. Here one gets mental support that helps in increasing one's self-confidence and when one gets treatment for physical wounds, one must be recovering fast.

Women in emergency receive treatment and services.

Medicines are provided, which saves cost and we do not have to travel to another place for meeting lawyer and getting other help as everything is available here.

The location provides more privacy, confidentiality and for women who had restrictions on mobility or whose partners were suspicious, it

was possible to come to the hospital (Counselling Impact Study 2004, CEHAT, unpublished).

However, women felt that counsellors' suggestions for strategies for the woman's safety – (e.g. shouting aloud/moving out of the house/holding the perpetrator's hand) were not very practical and realistic. This was not necessarily because of the counsellors' errors of judgment, but was more a reflection of 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 crisis 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, were not frequently employed by Dilaasa, but women's perception was that counselling should focus also on the abusers.

The feedback provided also highlights major challenges related to addressing domestic violence that are rooted in the wider social context. These include deeply-entrenched and negative beliefs about women, those living alone, the lack or dearth of shelter and economic resources for women, the insensitivity of agencies such as the police to the issue of domestic violence, the inability of crisis centres to function as one stop solutions for women in distress:

They [the counsellors] said they will arrange for my stay somewhere. But in Mumbai one cannot get any place. So for many years I have been staying with my husband for the house only. I am not at all important to him. The room is in his name ...Only for one man we four souls are suffering (Counselling Impact Study 2004, CEHAT, unpublished).

It may not be within the scope of individual crisis centres to find solutions to all these challenges, and a much larger effort is needed to bring about changes in social perceptions, policies and to increase investments in interventions to prevent and address domestic violence.

3.4 Training

Domestic violence has not been addressed as a public health concern even within the medical and other health professional curriculum, training and practice in medical settings. Consequently, medical staff in hospitals are neither equipped nor sensitised to the issue, posing a major barrier to running an effective crisis centre. Detection of injuries arising from domestic violence against women, providing treatment and referrals to other related services such as counselling and legal aid are all steps that need to be undertaken by medical staff but these are seldom done. The dominant perception of health professionals is of domestic violence as a "personal issue" and not within the domain of health and illness. The training modules for Dilaasa are designed based on this assessment of the dominant view. The training prototype created by Dilaasa, aims to build the capacity of hospital staff and systems to adequately, sensitively and appropriately respond to the health needs of victims and survivors of domestic violence. A two-pronged training strategy was adopted, involving intensive training for a "core group" within each hospital; and coverage

of all hospital staff to orient them to domestic violence as a gender and public health issue as well as essential messages on the role of health providers. The training was found to be most effective when staff of the hospital or the “core group of trainers” conducted training for the rest of the staff. This facilitated recognition by hospital staff of Dilaasa as their own programme, and not as an NGO activity foisted from outside. The core group was encouraged to become an inhouse team that owned the project, had imbibed the perspective of the project, acted as advocates within and outside the hospital for the project and was 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. Ongoing inputs are provided for core groups to enhance their perspectives and skills, for example, on topics such as improving quality of care and patient rights.

Steps have been 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. The module for orientation of all hospital staff, developed by the core group has similar objectives and topics as the core-group’s training. The methods used vary according to the comfort level and skills of the core group of trainers. A three-hour orientation was conducted for all staff of the hospital. Following this, the follow up training sessions were also conducted to build skills for screening and gain deeper understanding into domestic violence and its causes. 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.

3.5 Design of Training

The training process and content were planned with a view to perspective-building, as well as developing knowledge and skills for screening women experiencing domestic violence and for counselling. Using a participatory methodology, with concepts explained through stories, individual and group exercises and case studies, the emphasis was on understanding domestic violence as an issue of power and control rather than only looking for symptoms and providing medical care. This also helped health providers to identify various forms of domestic violence and its possible health consequences.

The training content was packaged to fit into the busy schedule of the public hospital without compromising on quality and weakening its impact on trainees. The training of core group was an intensive exercise that involves high quality inputs from experts in the field and this requires at least eight full days of training. At first this seemed impossible. Staff could not be pulled out of the hospital routine even for a day at a time. The training was conducted over a period of eight

months with one day of training every month. While doing this, it was ensured that a large group was selected to participate in the trainers’ training, to allow for a substantial attrition due to transfer or workload. Forty members were trained at Bhabha Hospital in Bandra and a team of 12 key trainers eventually emerged.

If the training of core group was a challenge, the orientation was even more so. The training had to be conducted without disturbing any of the hospital functions and so the training duration could be only two to two and a half hours. At times these sessions were reduced to only one hour. In such times, the trainers had to rely on their training skills and creativity in changing methods, using posters to role plays to skits to sustain the interest and involvement of the trainees. The training workshop usually started immediately after the outpatient services were over. The orientation training was compulsory for all hospital staff, and participants were 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.

3.6 Barriers Faced

Since 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 an issue that does not concern them. To make an impact on such participants through mandatory training sessions of about three to six hours in total is a formidable task. Another issue is that 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. This is clearly demonstrated by the fact that CEHAT has invested in training of 88 staff as trainers but there are only 49 members currently in the training cell. The ongoing training of core group members and sustaining a core group in the hospital despite transfers/promotions/workload requires lot of perseverance.

Getting resident medical officers (RMOs) and interns to attend the training is difficult. Their posting in the hospital is only for a short period, but they are an important group to be trained because it is they who actually manage the OPDs. The introduction to Dilaasa was therefore included in their regular orientation to the hospital. This ensured that all batches of doctors were introduced to Dilaasa as one of the several departments of the hospital.

3.7 Impact of Training

The impact of training was assessed by the evaluators through a group discussion with a select group of health providers at the two hospitals and also members of the training cell conducted by the evaluators. From this discussion where the evaluators asked the group to reflect on the impact the training had on them, it emerged that the key trainers seemed to be 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. Some illustrative themes and excerpts from this discussion are presented here:

Making a Difference: “If only I had spoken to her, if only I had referred her to Dilaasa (from another hospital)”. This statement was made by a trainer referring to how she had been personally shaken up when a woman who had repeatedly appeared at the OPD complaining of headaches was admitted later after she had made a suicide attempt consuming poison. Luckily, the woman survived the suicide attempt and the healthcare provider got involved with Dilaasa activities. 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 nearby 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 healthcare by specific socially and economically disadvantaged groups.

The casualty record keeper told the evaluators that it was only after the establishment of Dilaasa and the training that hospital staff realised that they can do something to help women survivors of domestic violence. He said that the Dilaasa department was playing a very useful role. “Now we can give them moral support. Awareness 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 have started referring 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. When asked of what use was this to the women, he said “Women are confident that the hospital people understand their problem and are willing to help”.

Recognition in the Hospital: 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.

Setting an Example: 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 realised that their behaviour with patients could have been more sensitive, and it was within their capacity to help women in distress, they became convinced of the need for Dilaasa and were 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 well-being and safety.

A 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. This is a pointer to the level of internalisation of the issue by the staff. This medical officer 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 the Dilaasa department in his hospital was performing an important task. It appears from these excerpts that the orientation trainings had played an important role in sensitising the hospital staff and increasing ownership of the Dilaasa project.

3.8 Strategies to Integrate Dilaasa within the Hospital System

It was realised early on in the project that training sessions alone were not enough to change the everyday practice of health professionals. Even if they participated wholeheartedly in the training and agreed that health professionals had a role in helping women survivors of violence, they often found this difficult to practice. Over the years several efforts were made to facilitate the health providers’ task in order to translate the training and sensitisation into practice.

A department-specific list of signs and symptoms was prepared as a tool to guide screening of women by doctors from several departments. Ongoing discussions and regular interactions were held with health service providers in the different departments to reinforce the need for screening. In addition, Dilaasa team members (and subsequently, hospital staff) actively screened women in inpatient wards. This also served to demonstrate how-to-screen for domestic violence to the staff, especially nurses. The medical superintendent/project director of Dilaasa made it mandatory for casualty medical officers to report on the numbers they referred and those that they did not refer to Dilaasa. The Dilaasa team followed-up this list to track doctors who usually failed to refer and to have a dialogue with them on referring women to Dilaasa for counselling.

Efforts were also made to publicise Dilaasa within other health facilities and in the community by putting up posters about Dilaasa in all OPDs within the two hospitals where the crisis centres were established, and in all peripheral hospitals, maternity homes and health posts; conducting poster exhibitions once a month in different OPDs of Bhabha Hospital, Bandra and organising meetings in the communities served by this

hospital in collaboration with NGOs working in these communities. All these efforts have been instrumental in increased referral by hospitals, direct access by survivors and acceptance of domestic violence as a public health issue by the hospital system.

4 Effectiveness of Public Hospital-based Crisis Centre

4.1 Evidence from Case Records

Dilaasa offers some important lessons on the suitability of a public hospital as the setting for a crisis centre. This section is based on the evaluation as well as analysis of case records of 1,357 survivors who accessed services from 2001 to 2006.

4.2 Survivor Profile

Since public hospitals are used largely by people from the lower socio-economic strata, the survivor profile of Dilaasa too indicates a similar picture. On an average 250 women registered each year in one hospital (Bhabha Hospital, Bandra) and 70 per year in Bhabha Hospital, Kurla which is fairly smaller with limited clinical departments and operates only for two days a week. These numbers are significantly large when compared to the numbers accessing counselling centres located in non-health settings in India that are said to register less than 100 women in a year.² Table 1 depicts the number of women accessing the services of the two crisis centres.

Table 1: Number of Women Counsellled at Dilaasa Crisis Centres (2001-08)

Year	Crisis Centre 1	Crisis Centre 2
2001	82	Not operational
2002	185	Not operational
2003	257	Not operational
2004	319	Not operational
2005	264	Not operational
2006	250	80
2007	221	80
2008	233	90

Source: Case records of Dilaasa 2001-08.

appear to be most affected by domestic violence; these women also come to the hospital for pregnancy, delivery and contraceptive services and for healthcare for their young children. Therefore, 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.

4.3 Type of Violence Reported

Emotional violence was reported by almost all women (96%), while 82% reported physical violence. About 71% reported financial violence and 42% of the women reported sexual violence. Fifteen per cent of those reporting financial violence reported that there were dowry demands. Of those reporting sexual violence, 67% reported marital rape.

4.4 Expectations of Survivors

Forty per cent of survivors wanted information on rights: they wanted to know what their rights are, 25% wanted advice on

what they should do and 7% wanted financial support. Amongst those who articulated a specific expectation, most wanted help from the centre to stop violence in some way, threaten the abuser, call for a joint meeting, "tell him to improve", and so on. It is important to understand this against the fact that most of the women may be speaking out for the first time. When women find it difficult to even label and state their ongoing experience as violence, it is understandable that most of them may not have specific expectations. It, therefore, poses a challenge for the centre as the first contact becomes most critical in order to reach out to women.

4.5 Type of Complaint Reported by Survivors

Around two-thirds (62%) of the women registered at Dilaasa who had come to the hospital for treatment of a health complaint, were screened for violence and referred to the crisis centre for counselling. Thirty-eight per cent of the women came directly to Dilaasa for counselling services with no specific health complaint.

Amongst those reporting health complaints, 31% reported an assault, 16% had attempted suicide, 13% came for some medical complaint and were referred to the crisis centre. Seven were instances of homicide, and three women reported rape (Table 2). The women who were admitted in hospital after an attempted suicide were categorised by the hospital as "accidental poisoning". As a result of active screening by counsellors and nurses, it was realised that these were actually cases of attempted suicide following experience of violence. The family had misreported it because of fear of legal proceedings. Medical complaints mainly included reproductive health complaints (50 women), mental health complaints (37 women), and orthopaedic complaints (23 women). Eight per cent were pregnant when they sought Dilaasa services. Besides them, 52% of the married women reported that they had faced violence during pregnancy. Although they were likely to have come in contact with health professionals for pregnancy-related care, they were not screened for domestic violence.

Table 2: Type of Health Complaint Reported by Survivors at the Time of Referral

	Number	Per Cent
Assault	426	31
Attempted suicide	207	15
Medical complaints*	169	13
Assault and attempted suicide	16	1
Medical complaint and assault	13	1
Homicide	7	1
Rape	3	0
No health complaint	516	38
Total	1,357	100

*The medical complaints included reproductive health complaints (50), psychiatric complaints (37), orthopaedic complaints (23), BP/heart (8), TB/asthma (12), weakness (13) and other 15.

4.6 Referral Path

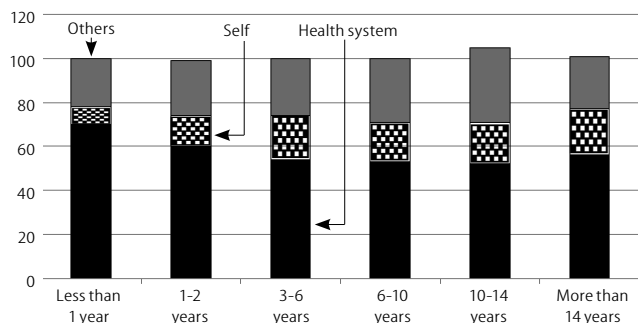
More than half (56%) the survivors were referred to the crisis centre by health professionals. While 32% of these came from casualty, 26% were screened in wards, 20% were referred by staff from various levels of the hospital. Eleven per cent came from the OPD and 3% from the inpatient departments, 8% came from other hospitals or were referred by community health volunteers employed by BMC. Ten per cent (10%) of the women

came to Dilaasa after seeing the project's posters or pamphlets. These have been put up in all departments of the hospital as well as distributed to other municipal hospitals. The promotional material is also distributed to all patients and their families. This works in many different ways, survivor may read it and come to the centre, a family member – father or brother – may read about it and bring the survivor, reading the poster may encourage the survivor to speak out about abuse to the doctor and nurse which may result in a referral.

4.7 Number of Years of Violence before Detection by Health Professionals

The presence of a crisis centre within a public health facility coupled with active screening by health professionals facilitates the early detection of domestic violence, because women who approach it for a health concern are referred to the crisis centre. One-third of the women who sought services had faced violence for less than two years. More than 50% women were able to reach within six years of abuse. A significant proportion (70%) of women who sought services within one year was screened by health professionals (Figure 1).

Figure 1: Referral to Centre and Years of Abuse



Another important indicator of early detection of violence is the fact that for many women Dilaasa is the first formal agency that they have approached. Sixty per cent of the women had never been to the police, while 40% had approached police before coming to Dilaasa. These were largely women who reported to Dilaasa after assault or had come to the centre directly. These were also women who had faced abuse for more than four to five years.

5 Challenges and the Way Forward

The model and experience of Dilaasa demonstrates that public hospitals are indeed an important site for setting up crisis intervention services dealing with domestic violence and can play a critical role in providing services to women facing such violence. Due to its location in a public hospital, it is accessible to a large number of women, especially those from the marginalised groups. The trained staff are able to see the signs of domestic violence amongst their patients and thus identify abuse at an earlier stage. The location also makes follow-up easier for women as they can come on the pretext of a hospital visit. However, it represents an intervention that is possible only at the secondary and tertiary level of healthcare system. As it is not integrated with the other levels, follow-up care is

constrained as there is no way to reach women until they come back. It also relies on the commitment (often voluntary) of the hospital staff to take on the tasks of training and referral in the absence of a clear policy statement. It may have expanded to several hospitals, but it rests on the commitment of the administrator and staff of that facility.

The consequences of violence on the health of women are recognised in the definition of domestic violence itself given in the PWDVA. The Act also mandates a clear role for health facilities and health professionals that includes identification, providing information, documentation and referral. However, the health departments have till date not issued any government resolution or circular in this regard which is a serious lacuna as the health system is the first contact for any survivor of violence. In their fourth monitoring and evaluation report on the PWDVA, 2005, *Staying Alive, 2010*, the Lawyers Collective notes the role health facilities can and should play citing Dilaasa as an example. It is important that this is followed by the necessary policy directions from the central and state health departments. Such a government order or policy on the role of health providers and health facilities in responding to domestic violence will ensure that health managers, administrators and doctors take this seriously.

There is a need to start similar crisis centres in public health institutions all over India and the following are our recommendations:

- Crisis centres can be ideally located within secondary hospitals (200 plus beds) with a casualty department in cities or district/rural hospitals more than 60 beds with casualty. Such hospitals are large enough to have sufficient workload without the bureaucratic hurdles of a medical college hospital.
- Crisis centres can 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 “caring” function within health facilities. Locating it as a part of a clinical department would be a mistake since 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. It is important that the crisis centre is integrated into the routine functioning of the health facilities rather than an add-on service. All levels of staff can play significant roles, and, therefore, they should be trained for enhancing their respective roles.
- Training of in-service personnel in domestic violence (and other issues) should 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. Training cells such as the one in BMC may be constituted with members from “core groups” of hospitals with crisis centres. These training cells would be valuable resources for training other health professionals. People from health departments are likely to be more receptive to hear from their own ilk.
- In addition, social workers or their equivalent in all health facilities with crisis centres should be trained in the perspective as well as skills required in order to provide feminist

counselling to women facing domestic violence. They can play a critical role in responding to immediate needs and preventing further abuse and harm.

- Since women experiencing domestic violence may access a public health facility at any level, there should be an integrated system of screening and referral. At the primary care level, auxiliary nurse midwives 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. Initiatives to address domestic violence within healthcare settings would, therefore, have to systematically engage with different levels of the healthcare system.
- While one cannot underscore the importance of training of in-service professionals, it is critical that efforts be made to influence 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. At the same time, training on the new domestic violence law could form part of continuing medical education so that medical professionals are made aware of the law and their role.
- Dilaasa has produced guidelines on the role of health professionals in addressing domestic violence against women.

These guidelines could inform health sector policies related to domestic violence and also be endorsed by professional associations. 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 would go a long way in influencing policymakers, health professionals, women and society at large.

To conclude, while efforts such as providing services to individual women survivors in the public hospital setting may seem depoliticised, and a departure from the original advocacy campaigns and political aims of the women's movement, the problem remains of what is to be done when an individual woman in distress seeks help. There is dearth of spaces where women experiencing domestic violence can receive empathetic support, where their experiences are validated and they are not blamed for the violence perpetrated against them, following principles of feminist counselling. While campaigns and advocacy are essential for eliminating domestic violence, there is a need to underscore the importance of such spaces and services for women in abusive relationships to rebuild their lives and well being.

NOTES

- 1 CEHAT is the research centre of Anusandhan Trust engaged in health research and policy advocacy on right to health and healthcare.
- 2 Documentation of counselling practices across the country (22 such services) indicates that other centres receive less than 70-75 women per year (Bhate-Deosthali, Prakash and Rege, *Feminist Counselling Practices in Domestic Violence*, forthcoming).

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