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ROLE OF THE **HEALTH SECTOR** IN ADDRESSING **INTIMATE PARTNER VIOLENCE** IN INDIA

A SYNTHESIS REPORT

Padma Deosthali-Bhate, Sangeeta Rege, Poulomi Pal, Subhalakshmi Nandi,
Nandita Bhatla and Alpaxee Kashyap

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2018

Acknowledgements

The International Center for Research on Women (ICRW) and the Centre for Enquiry into Health and Allied Themes (CEHAT) are thankful to the Bill & Melinda Gates Foundation (BMGF) for their generous support to the project – Evidence Based Systemic Approach to Addressing Intimate Partner Violence in India: Creating a New Vision.

We also extend gratitude to the technical advisors for this project, A.K. Shiv Kumar, Avni Amin, Suneeta Dhar and Yamini Atmavilas, for their inputs and valuable feedback to this report. We also take this opportunity to thank Sanjida Arora and Vaishali Sharma Mahendra for their contributions toward this report.

We would like to thank members of the Program Development Committee of CEHAT, particularly Dr. Padmini Swaminathan and Dr U. Vindhya, for reviewing the first draft rigorously. We thank the Dilaasa team Chitra Joshi, Mrudula Sawant, Dr. Seema Malik, Dr. Mangala Gomare, Matron Sneha Chandan, SIC Vijaya, Dr. Meena Saujani and Dr. Rajani Jagtap as their intensive efforts at the health system form the fulcrum of this report. We also take this opportunity to acknowledge members of CEHAT's intervention team, Aarthi Chandrasekhar and Sujata Ayarkar and their consistent efforts to respond to survivors.

Overall, we would like to thank Kathryn Reitz and Kirsten Sherk for quality assurance and their invaluable inputs; Amajit Mukherjee for operations management and supervision; Sandeepa Fanda for her excellent program management assistance; Ketaki V. Nagaraju for her editorial support, and Nirshilla Chand and Sanjana Gupta for their substantive support. Also, we would like to thank Anagha Barve from AD Co-authors Documentation Services Pvt. Ltd. for providing external editorial support.

We are grateful to Sarah Degan Kambou and Ravi K. Verma for their support and encouragement.

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Content

ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BMC	Brihanmumbai Municipal Corporation
CBGA	Centre for Budget and Governance Accountability
CEHAT	Centre for Enquiry into Health and Allied Themes
CHC	Community Health Center
CIC	Crisis Invention Center
CSA	Child Sexual Abuse
CSO	Civil Society Organizations
DHS	Directorate of Health Services
DLSA	Delhi State Legal Services Authority
DV	Domestic Violence
DWCD	Department of Women and Child Development
FIR	First Information Report
FLHW	Frontline Health Worker
GBV	Gender Based Violence
GoI	Government of India
HCP	Health Care Professional
HP	Health Practitioner
ICRW	International Center for Research on Women
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
IPV	Intimate Partner Violence
MoHFW	The Ministry of Health and Family Welfare
MoWCD	The Ministry of Women and Child Development
MHRD	Ministry of Human Resources Development
NHM	National Health Mission
NHP	National Health Policy
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NMEW	National Mission for Empowerment of Women
NPCC	National Program Coordination Committee
NRHM	National Rural Health Mission
OSC	One-Stop Center
OSCC	One-Stop Crisis Center
PFO	Police Facilitation Officer
PIP	Program Implementation Plan
PRI	Panchayati Raj Institution
PWDVA	The Protection of Women from Domestic Violence Act
RCC	Rape Crisis Center
SOP	Standard Operating Procedures
SNEHA	Society for Nutrition, Education & Health Action
SWATI	Society for Women's Action and Training Initiatives
SHO	Station House Officer
VAW	Violence Against Women
WCD	Women and Child Development
WHO	World Health Organization

1 INTRODUCTION

One in three women globally have experienced intimate partner violence (IPV) at least once in their lifetime (WHO, 2013). IPV – or the sexual, physical, economic, emotional, psychological violence or harm committed by a partner or ex-partner – is one of the most common forms of violence experienced by women. *Evidence-Based Systemic Approach to Addressing Intimate Partner Violence in India: Creating a New Vision,* a project undertaken by the International Centre for Research on Women (ICRW) with funding from the Bill & Melinda Gates Foundation, aims to build evidence and synthesize lessons learned across three community-level platforms that offer the most potential for sustained efforts to address systemic challenges related to IPV. These three platforms include: (1) women's collectives, (2) Panchayati Raj Institutions (PRIs – a three-tier system of governance) and (3) health systems, including frontline health workers (FLHW). The project seeks to collect, synthesize and advance lessons emerging from reviews, evaluations, model documentations, stakeholder workshops and expert reviews. Based on the findings and analysis from all three platforms, a framework for 'addressing IPV' is understood to include the following elements:

Box 1. A Framework for Addressing IPV

- Recognition and voicing of violence, and raising awareness about IPV
- Facilitating linkages with institutions and services for prevention of and response to IPV
- Creating an enabling environment, including political will, to address IPV in communities
- Create services for 'mediation'/alternate dispute resolution (ADR) though this aspect is relevant only to the platform of feminist collectives, not health system or PRIs.

For the health systems synthesis, the research finds that an important role played by the health sector is on facilitating institutional linkages, particularly though a hospital based model of crisis intervention and care.

The ultimate goal of the project is to deepen the body of knowledge on strategies and approaches within each platform and to identify what has worked and what could be strengthened to address IPV. The resulting syntheses will be used to inform policy and pathways to scale up a response for maximum effectiveness and sustainability. The focus of this synthesis report is the platform of health systems, including frontline health workers.

India's National Family Health Survey (NFHS) found that one in three married women has experienced IPV, with physical violence being the most common (30 percent), followed by emotional violence (14 percent) and sexual violence (7 percent) (IIPS and ICF, 2017). Yet, data shows that around 9 in 10 women have never sought help when they face violence (IIPS and ICF, 2017), thus it is clear that violence is vastly under-reported. Violence has major harmful effects on women's health and wellbeing especially on their sexual and reproductive health and mental health. Healthcare providers are often the first contact for women experiencing violence as they may access health services for treatment of physical and/or psychological trauma.

This report synthesizes the platform of health systems, and reviews the health sector response, including that of frontline health workers. ICRW collaborated with the Centre for Enquiry into Health and Allied Themes (CEHAT) to review health system responses to IPV, including the policies, strategies and practices that are supported institutionally by mandates, clear policy guidelines and protocols. As per the framework of 'systemic responsiveness' that was developed under this study, health systems' initiatives include recognition of IPV and education efforts to prevent it, typical 'response' initiatives such as facilitating referrals and institutional linkages, as well as the creation of an enabling environment. This report builds on CEHAT's existing efforts to establish evidence-based health sector models that respond to violence against women and to bring state and non-state organizations together to consolidate and document health sector responsiveness to this issue.

In addition to the health systems desk review, ICRW conducted formative research in the state of Uttar Pradesh (Benaras and Pratapgarh) to understand the role of FLHWs and conducted key informant interviews (KIIs) with health functionaries at the national and state level in three states: Delhi, Haryana and Maharashtra. The KIIs were conducted with a purposive sample of 26 individuals selected from the Ministry of Health & Family Welfare (MoHFW), Ministry of Women and Child Development (MoWCD), Departments of Health & Family Welfare, and Women and Child Development, the National/State Health Mission (NHM/SHM) and from tertiary and secondary level hospitals in the selected states. Program managers and service providers associated with programs such as Dilaasa, Sukoon and One Stop Centers (OSC) were also interviewed to understand their experiences, challenges

and suggestions to strengthen the health systems' response to IPV. The results of these interviews provided additional insight into the systemic responsiveness of the health sector to address IPV.

The findings and recommendations resulting from the desk review and interviews with frontline health workers, program managers, policymakers and service providers in this synthesis have been validated by health sector practitioners, experts, government representatives and donors who were presented with an early draft of the findings and preliminary recommendations at a meeting – the National Consultation on Systemic Responsiveness of the Health Sector to Address Intimate Partner Violence – held in New Delhi on July 3, 2018.

2 SUPPORTIVE LEGAL AND POLICY FRAMEWORKS

Legal and policy frameworks in India support women's protection from violence. While IPV specifies a focus on violence by an intimate partner irrespective of marriage, IPV in the context of this study is examined as spousal violence within the larger legal framework of domestic violence (DV) in India.

The Protection of Women from Domestic Violence Act (PWDVA), instituted in 2005, is a legislation aimed at protecting women from violence in domestic relationships. The Indian Penal Code also has provisions that criminalize acts of 'cruelty' by a husband or other members of the marital family, which was commonly used even prior to the law. The Criminal Law Amendment Act, 2013 and Protection of Children from Sexual Offences Act, 2012 have expanded the definition of rape to include penetrative and non-penetrative sexual violence.

India is a signatory to human rights conventions such as the International Covenant on Economic, Social and Cultural Rights and Convention on Elimination of All Forms of Discrimination against Women that put the onus on the government to recognize violence against women as a human rights issue. India is also among the more than twenty countries that have agreed to implement the World Health Assembly's "Global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls and against children" in 2016. (World Health Organization, 2016)

The strategic directions of the Global Plan of Action include areas specific to the health sector such as:

Strengthening health system leadership and governance

E.g., advocacy within the health system and across sectors; setting and implementing policies; financing, including budget allocations; regulation; oversight and accountability for policy and programme implementation; and strengthening coordination of efforts with other sectors

Strengthening health system delivery and capacity of health care providers

E.g., improving service infrastructure, referrals, accessibility, affordability, acceptability, availability and quality of care; integrating services; ensuring access to quality, safe, efficacious and affordable medical products and vaccines; and training and supervision of the health workforce

Strengthening programming to prevent IPV

E.g., identifying people at risk and carrying out health promotion activities, as well as contributing to multi-sectoral actions

Improving information and evidence

E.g., carrying out epidemiological, social science and intervention research; improved surveillance, including through health information systems; and programme monitoring and evaluation

Implementation Challenges

Despite the legislative and policy mandates with explicit direction for the health sector, there is no definitive roadmap for improving the health systems response to violence against women in India. Limited technical and financial resources for the health sector inhibit implementation of programming to reduce intimate partner violence, specifically. For example, most health professionals are not trained to investigate violence and respond to the needs of survivors. Medical and nursing education does not include training on various aspects of recognizing risk and outcomes associated with gender-based violence. Efforts to collaborate with different levels of the health system to set up models demonstrating the necessary health system support to survivors of violence have frequently come from external non-profit organizations, rather than being internally driven.

3 KEY COMPONENTS OF THE HEALTH SYSTEMS' RESPONSE TO VIOLENCE AGAINST WOMEN: DATA, GUIDANCE AND TRAINING

Critical components to a systemic health sector response to violence include data collection and analysis, policy and program guidance and training for healthcare professionals. A review of this area found some information available along with numerous gaps in these key components.

A Number of Indicators on IPV are Available to Inform Programming

Health programming to address intimate partner violence must be informed by relevant data. In India, the MoHFW has carried out the NFHS since 1992-93 with the International Institute for Population Sciences (IIPS). In addition to providing state-level data on various indicators of health and nutrition, the NFHS also has indicators to assess prevalence and attitudes to gender-based violence, including intimate partner (spousal) violence, types of violence, abuser characteristics, sources of help, injuries and more. Since 1992, the survey has been carried out in 1998-99, 2005-06 and 2015-16, thus enabling a review of trends.

Policy and Program Guidance Is Not Widely or Consistently Implemented

While there are several promising interventions demonstrating how health systems responses to IPV can be integrated (see Table 1), it remains a challenge to ensure that healthcare responses are supported through clear policy guidelines and clinical protocols and not left to individual doctors and nurses to respond independently.

Clinical guidelines developed by the WHO in 2013 recommend that health systems responses to VAW be integrated within clinical care at all levels (primary to tertiary) and have flexible models for provision of care at various levels (WHO, 2013). To date, the MoHFW has not translated these recommendations into clear policy and program guidelines.

The public outcry after the brutal sexual assault and murder of a young physiotherapist in December 2012 led the MoHFW to formulate comprehensive medico-legal guidelines for survivors of sexual violence in 2014.

These guidelines, drafted by a committee comprised of members of different sectors and representatives of all ministries, focused on survivors' rights to health care and gender-sensitive medico-legal procedures.

India's National Health Policy (NHP) did not recognize violence against women as a health care issue until 2017. The policy now clearly mandates that all survivors of violence must receive free services and recommends that gender sensitization training be carried in all health facilities and that it be included in the medical curriculum (GoI, 2017).

Though these are important steps, it is now critical that different states in India ensure that these guidelines are adopted and implemented uniformly. As of 2018, only nine states have adopted the national guidelines related to sexual assault and only some states, such as Delhi, Goa, Haryana, Kerala, Madhya Pradesh, Maharashtra, Meghalaya, Orissa, and Uttar Pradesh have taken some initiative to train health professionals on use of these guidelines as well as addressing IPV or domestic violence. In the absence of clear policies and widely implemented clinical guidelines, the health systems response will remain checkered and unsystematic.

Frontline Health Worker Training Efforts Need Further Study

Accredited Social Health Activists (ASHAs) are community health workers organized by the government of India's MoHFW as part of the National Rural Health Mission (NRHM). As part of their training module, the MoHFW prepared a handbook educating ASHAs about different forms of violence, how the experience of violence changes throughout a woman's lifecycle and how to recognize the signs and symptoms in women experiencing violence. While the extent and quality of capacity building of ASHAs across states is uneven, the handbook clarifies the two-fold role of ASHAs (MoHFW, n.d.):

- **Preventing violence** through increasing awareness, mobilizing communities against acts of violence against women and building partnerships with other health committees and Panchayati Raj Institutions (PRIs);
- **Addressing violence:** Attending to the individual women who have suffered from violence, providing emotional support and sharing information regarding places or persons to contact for health services and legal recourse.

However, there is little to no evidence on whether this is an effective institutional mechanism, given that frontline workers are volunteers with no remuneration, little institutional support and who are overburdened with work. Frontline workers are expected to respond to domestic violence when the health facilities are not equipped to provide the essential services to survivors of violence. There is also evidence that they, themselves, are victims of domestic violence and sexual harassment and sexual assault.

The potential of this strategy, therefore, needs to be explored further in the context of global evidence on primary prevention and work with communities.

4 CURRENT HEALTH SECTOR PROGRAMMING MODELS

There are various models of 'crisis intervention centers' (CICs) for addressing violence, within current policies and programs of government and non-governmental organizations. Some of them are located within the hospitals and some outside the health system. The analysis of hospital-based centers has formed the bulk of this study.

Dilaasa: A Government-run Hospital-based Center

An early initiative in the Indian context was the establishment of a hospital-based crisis center in a Mumbai suburb called Dilaasa (Bhate-Deosthali, et al., 2005). Dilaasa represents a redesigned 'one-stop crisis center' (OSCC), with focus on delivering an integrated response to violence against women within the existing roles and responsibilities of health professionals. The model has been found to be more sustainable than a traditional OSCC where a separate cadre of specialists is brought into the hospital setting (Garcia-Moreno, 2015).

Women either report violence spontaneously or in response to questions from healthcare providers prompted by signs and symptoms presented in the outpatient or inpatient consultation. Once identified, they are provided with medical treatment, their history of abuse is documented, evidence is collected in case of sexual violence if appropriate and medico-legal support offered and are given information about the Dilaasa crisis intervention center. The hospital has put up posters and distributed cards and pamphlets to create awareness about violence against women as a public health issue.

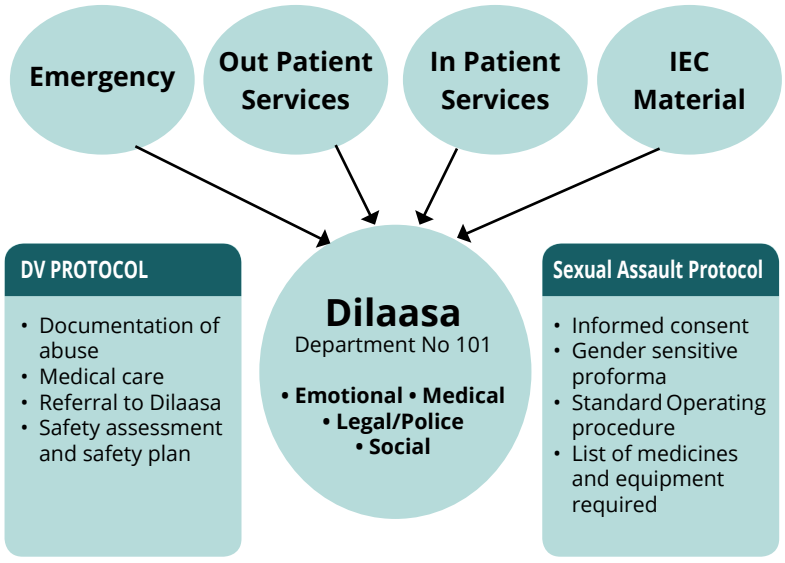
The hospital-based center provides psychosocial support and crisis intervention services. Counseling principles followed by the crisis center help women to put the onus of abuse on the perpetrator and not blame themselves. It also equips women with the necessary tools and strategies to heal from abuse as well as stop it. An external evaluation of Dilaasa found it to be an evidence-based and sustainable hospital-based model for responding to domestic and sexual violence. This evaluation also highlights that the location of the crisis center in a public hospital enhances accessibility and early detection of VAW, with many women identified within two years of facing abuse. Contact of married women in child-bearing age-groups with health services makes it possible to identify violence during their antenatal care visits. The center has established protocols for documentation of the abuse, its severity, assessment of safety, mental health impact and development of a safety plan. Since 2006, the crisis center established in Mumbai has been functioning as a part of the public hospital.

In instances of sexual violence, health professionals follow WHO protocols which has enabled them to understand circumstances of sexual violence, reject unscientific aspects such as a finger test[1] or hymenal status, conduct a gender sensitive examination along with evidence collection, provide reasoned medical opinion and explain the absence of injuries and/or absence of forensic evidence which helps survivors in courts. Doctors have been equipped to provide reasoned medical opinion and explain the absence of injuries and/or absence of forensic evidence that helps survivors in courts. This experience of implementing these protocols formed the basis for demanding national protocols and guidelines that are victim-centered and respect the right to healthcare for survivors of sexual violence through an intervention in court as well as policy advocacy. Subsequently, the Ministry of Health set up a national committee and has recently disseminated national protocols and guidelines.

Staffing consists of one full-time social worker, one part-time social worker, one part-time nurse, one counselor and one part-time physiotherapist. They are deputed by the hospital to this department. CEHAT provides technical support in terms of training and monitoring of quality of services.

Since its inception, they have counseled 250 new women each year who have registered as users with the center and also 150 women who were referred by other departments for issues

Dilaasa represents an integrated model for responding to gender-based violence (GBV):



[1] The Supreme Court of India has banned the two-finger test on rape survivors in 2016 as a violation of women's right to privacy. In this test, two fingers of an adult (doctor who conducts the medical examination of the rape survivor) are inserted in the vagina of a female. Women's rights activists in India have been against the premise of using such tests.

Estimated Costs of a Dilaasa Crisis Center per year in INR* (2012)

Initial cost of training of counselors and health care providers and some infrastructural cost	600,000
Human resources: One full-time and one part-time social worker, one part-time nurse, one part-time physiotherapist.	1,600,000
The running cost of the crisis center includes expenses for telephone, photocopying, travel with survivors, supervision and monitoring of quality of services, data management	800,000
Total	3,000,000

(*US Dollars (USD) to INR (INR) exchange rate for October 1, 2012: 1 USD=52.38 INR)

such as "accidental consumption of poison," which have been found to be cases of attempted suicide. Almost 390 cases have been registered as a result of referrals from emergency and other departments of the hospital. Each woman receives three counseling sessions and almost 50 percent women do follow up with the crisis center.

The *Dilaasa* crisis center is a joint initiative of the Brihanmumbai Municipal Corporation (BMC) and CEHAT located in Bhabha Hospital, Bandra (West), in the western suburb of Mumbai, an administrative unit within the city of Mumbai with a population of 337,000. The total female population is 155,200. The overall cost of setting up and running unit is INR 3,000,000 annually in Bandra (West), Mumbai. This indicates that in Bandra an average of INR 19 is spent for each woman for provision of domestic violence services. It is important to note that the additional costs for the hospital is only INR 1,400,000 that is INR 9 per woman as the existing staff of the hospital has been retrained and deputed to manage the crisis center.

The One Stop Center (OSC) Scheme: A Government-run Multisectoral Model

The establishment of OSCs is based on a survivor-centered approach to providing services related to domestic and sexual violence. Not all OSCs are located within the hospital setting. However, the Umbrella Scheme of 2012 made provisions for setting up hospital-based crisis centers in 100 hospitals along the lines of the Dilaasa model. The hospital-based crisis centers were envisaged as having strong linkages with the police and the courts. If a woman decides to take police assistance and wants to get a First Information Report (FIR) registered, the centers shall have the provision of calling the required police station and record the FIR at a place the woman is comfortable in, followed by the statement under Section 164.[2] Such a center is expected to provide the necessary linkages and support to survivors in accessing justice.

The OSCs as envisaged under the MoWCD scheme addresses domestic violence and sexual violence. The standard operating procedures

[2] Under this section of the Indian Penal Code any Metropolitan Magistrate or Judicial Magistrate may, whether or not he has jurisdiction in the case, record any confession or statement made to them in the course of an investigation before the commencement of the inquiry or trial.

that have been issued for the functioning of these centers provide clear direction on linking up with the Protection of Women from Domestic Violence Act (PWDVA) infrastructure. OSCs are currently being set up one per state with a center-state sharing of funding resources.

In the first OSC scheme roll out, 36 OSCs 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 MoWCD OSC scheme did not take into account the existing models of response such as hospital-based, police and court OSCCs (see below). Instead, the scheme proposed the setting up of the new structure under the MoWCD close to a hospital if possible.

OSC staffing is expected to consist of a full-time administrator, a full-time caseworker, an on-call psychologist, an on-call health worker, police facilitation officer stationed at the OSC and an on-call legal aid authority lawyer.

Review of the Existing OSC Centers Finds Weaknesses That Could Hinder Roll Out

The MoWCD carried out an evaluation of its centers and is in the process of upscaling it (Ministry of Women and Child Department, 2016). The authors have reviewed the report and based on the data presented several issues emerge that require deliberation so that the roll out is better informed.

- **Improve coordination:** 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 hospital. 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 in the same premises. The police facilitation officer (PFO), although deputed at the center, cannot file FIRs and so the woman still has to go the police station to file one. 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. 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. Similarly, OSC has no mechanism for coordinating with the Protection Officers, service providers under the PWDVA. This is essential as most women reporting violence are facing domestic violence.

- **Clarify medical staff roles:** 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 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.

- **Remain dedicated to service delivery:** The current profile of women reaching Nari Niketan shelter-based OSC show that women who are destitute and in need of shelter are brought by the police to this OSC. Thus, the OSC ends up operating as a

shelter rather than carrying out coordinated service delivery.

- **Ensure financial resources are adequately utilized:** There is a tendency and push for outsourcing of services; full-time staff should be recruited at the OSC in order to ensure accountability and ownership. The budget for paying people who are on-call should be better utilized to offer quality services.

- **Create a woman-centered approach to counseling:** The approach adopted by OSCs is extremely concerning as it hinders women's ability to deal with violence. Invariably the abusive person (often husband) is called to the OSC and a joint meeting is conducted to verify true/false cases, thus jeopardizing women's safety and mobility. These methods are tantamount to victim blaming and also question the veracity of the woman. There is no protocol for carrying out crisis intervention and having a feminist approach to counseling in the current OSC.

The MoWCD has now issued standard operating procedures (SOPs) that clearly establish the quality of counseling, the pathways to care and the linkages to other systems such as the PWDVA infrastructure of protection officers and service providers, as well as the legal service authority for assisting women in accessing justice and other social support. SOPs such as this address the gaps emerging from studies that highlight the need for strengthening counselling services, facilitating access to shelter, and linking survivors with legal aid, within hospital-based rape crisis centers in Delhi (CEHAT Trainings, CBGA, 2017). These centers did not have clear mandates even for the counsellors – unlike the Dilaasa model – and the recent SOPs may address this limitation.

Other Health Sector Programming Models

Table 1 provides an overview of additional health sector models initiated by civil society organizations (CSOs) and a few by the state under its national health program. These models cut across the different levels of health system- primary, secondary and tertiary in both rural and urban areas. At the primary level there are maternity homes, ASHAs, ANMs and health workers that have been sensitized to addressing violence against women, at the secondary level there are rural hospitals and peripheral hospitals and at the tertiary level, teaching hospitals are prepared to address violence.

The CSOs here include research institutes, feminist groups and health researchers who are experienced with health sector programming for violence against women. These efforts began in 1998 much before the Nirbhaya incident in 2012.[3] One of the common components of these models is provision of services to survivors of domestic violence, rape and child sexual abuse (CSA). The services are survivor-centric counseling and coordination with other sectors. Most of them have established formal links with protection officers, legal aid services, police, shelters and so on. The second component is training of health professionals which included training health providers on identifying violence

[3] In December 2012 Jyoti Pandey gang rape case in New Delhi drew national wide attention and protests, leading to amendments to the Criminal Law in India and mandated changes in the legislation as well as changed the discourse of sexual assault and rape. Popularly it was known as the Nirbhaya (fearless) incident.

by understanding signs and symptoms and in provision of basic psychological support, provision of privacy and confidentiality and medico-legal care. The CSOs have also painstakingly carried out documentation of process, along with continuous monitoring and data analysis. They have engaged in advocacy within the facilities where the models have been set up as well as with local and state health systems.

In addition to these below, advocacy initiatives have been carried out by organizations such as SAMA and Tathapi to improve the health care response to violence against women. They have engaged both public and private health providers on the issue of violence against women and have consistently worked with different cadres of the health system in urban and rural areas to sensitize them to issues of violence against women and motivate them to improve their response to survivors.

Each of programming models described here require sustained financial and resource allocation, effective capacity building and ongoing monitoring of their work. There is an urgent need to strengthen these structures rather than create new ones. Lessons from these programs can inform a more nuanced health systems approach to violence against women in general and intimate partner violence, in particular. Many of these have been replicated or adapted from the Dilaasa model.

5 CRISIS CENTERS IN OTHER LOCATIONS

There are other forms of OSCs operating in police stations (Dave, 2015), courts, legal aid centers, and are operated by different departments. Many of them are not directly linked to the hospitals for providing care and therapy to survivors of violence.

Rape crisis centers in hospitals

The Delhi government set up rape crisis centers in a few of its 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 counseling support, shelter services and referrals to legal aid. They are asked to go to Delhi Commission of Women for counseling services. The existing team of counselors and psychologists has not been assigned any role here and the focus is evidence collection, with counseling outsourced.

Crisis centers located within police stations

In Mumbai, special cells for women and children are located in police stations. They were established to enable women to access reforms in law such as Sec 498A to protect women against cruelty by marital families and also harassment pertaining to dowry demands. The special cell engages in counseling women at the level of police stations and helps facilitate police procedures. An important area of the work of special cell is to sensitize police personnel to the issue of VAW and enable comprehensive services from the police stations. 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. Special cells operating in different states either by the support of NGOs or the support of WCD have not yet sought the

OSC funds for cells in the police station (Dave, 2015). It is not clear why these have not been designated as OSCs.

Rape Crisis Center at the Delhi Commission of Women

The Delhi Commission is implementing the Rape Crisis Cell Program for Women since 2005 to provide legal assistance in cases of sexual assault through collaboration with crisis intervention centers in each of its districts. The Crisis Invention Centers 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 Crisis Intervention Center (CIC) counselor. The CIC counselor arrives at the police station and performs all immediate crisis-response activities, such as counseling the woman, informing her of her legal rights and helping her with procedures to be followed, including the medico-legal certificate (MLC) examination. The Rape Crisis Center (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 program regularly takes up cases of extreme brutality, violation and inaction of authorities (i.e. 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 OSCs under the MoWCD scheme, and neither has the Delhi Commission sought funds from MoWCD to support RCCs.

Court-based OSCs

Support services at the level of the court can facilitate the best psychological, medical and humane treatment for the survivors of crimes during the investigation and thereafter. Currently, there is a complete absence of support to navigate the court procedures, understand the court procedures and its implications and provide support throughout the court procedures. This necessitates the establishment of a court-based OSC. The role of the court OSC is to assist the survivor of violence from the beginning of the investigation to completion of the trial. The OSC assists in disbursal of compensation, witness protection and any other services as required by the survivor and works in close coordination with the public prosecutor and makes a provision of counselors to accompany the survivor to the courts. The counselors and the lawyer assigned to the survivor stay abreast of the court proceedings and communicate the progress of the case to the woman from time to time.

Such an OSC has been established by the Delhi State Legal Services Authority (DLSA) and is functional since March of 2016 with one judicial assistant and one orderly posted in the Center. The centers can be part of a strong referral system so that women have multiple places to go to for support and counseling through their entire struggle for justice.

6 INTEGRATING THE HEALTH SYSTEMS RESPONSE TO IPV AT ALL LEVELS OF CARE – FINDINGS FROM FORMATIVE RESEARCH

Based on the findings from the report (CEHAT, 2015), 11 models other than the Dilaasa centers were identified, documented and analyzed. A summary of the findings from this analysis is given in the table below.

Table 1: Models at various levels of the health system:

Name of the CSO, Year of Program Initiation	Location of Intervention	Components	Staffing	Funding	Role of the Health System
PRIMARY					
Soukhya, 2011 Karnataka	Maternity hospitals- doctors, Auxiliary Nurse Midwife (ANMs[4]) and community workers, Bangalore	-Counselor on call for provision of crisis intervention services -Referral links established for all services -Training -Research	-Staff deputed for the project -Counselors hired under the project	Indian Council of Medical Research (ICMR)	-Deputation of staff -Space allocation
SWATI, 2017 Gujarat	Community Health Centre (CHC), ASHAs, Gujarat	Services at CHC -Community awareness and referral by ASHAs	-Staff appointed by SWATI	SWATI	-Deputation for training
SECONDARY					
Bhoomika, 2009 Kerala	21 centers across 21 district hospitals in the state	-Psychosocial and medical support to survivors of domestic violence and rape -Referral to state legal aid for legal services -Training of HPs	Social workers hired for the center	National Rural Health Mission (NRHM), Ministry of Health and Family Welfare (MoHFW)	-Funded by Govt Nodal officer -District level committees for monitoring services

[4] ANM is a village-level female health worker in India who is known as the first contact person between the community and the health services.

IOHLYNT, 2011 Meghalaya	Based in Shillong civil hospital	-Psychosocial and medical support to survivors of domestic violence and rape -Training of Health care professionals (HCP) -Training of Police personnel	Deputation of social worker from dept of social welfare	Department of Women and Child Development (DWCD), NRHM	-Provision of space -Deputation of staff Recognition by Ministry of Women and Child Development (MoWCD) Ministry of Health and Family Welfare (MoHFW) guidelines being followed
Sukoon, 2014 Haryana	Eight centers in district hospitals	-Psychosocial and medical support to survivors of domestic violence and rape -Referrals for other services -Training of hospital staff	Health resource center	NRHM and Directorate of Health Services (DHS)	-Fully funded Deputation of staff -Nodal officers -Monitoring of services and technical support by CEHAT -Builds convergence with other departments
Dilaasa Women's Crisis Center, 2014 Goa	1 crisis center in North Goa district hospital Plans for 1 crisis center in South Goa district hospital	-Psychosocial and medical support to survivors of domestic violence and rape –including children -Psychosocial support -Linkages with Protection Officer[5], legal aid -Training of Health care providers at the level of hospitals and community health centers -Awareness programs in communities	Supported by National Mission for Empowerment of Women (NMEW) and DHS	NMEW, WCD	-Fully funded -Deputation of staff -Nodal officers -Monitoring of services and technical support by CEHAT -Convergence with other departments

[5] Protection Officers are nominated by the state governments under the Protection of Women from Domestic Violence Act, 2005 for its implementation

Dilaasa-NHM, 2014 Maharashtra	11 peripheral hospitals in Mumbai	- Psychosocial and medical support to survivors of domestic violence and rape – women and children -Referral for social, legal and police -Training of health professionals police and counselors	-Social workers deputed to the center or hired for the center	National Health Mission (NHM), Ministry of Health	-Funded by Brihanmumbai Municipal Corporation -Nodal officer appointed -Technical support for training from CEHAT -Advisory committee -MoHFW guidelines
TERTIARY					
Vimochana, 1998 Karnataka	Burns Unit Victoria Hospital	-Counseling and legal services to burn victims -Advocacy for improving medical care for burn victims	Social workers from Vimochana	Vimochana	-Provision of space -Increased budget for improving burn care
SNEHA, 2001 Maharashtra	Three medical colleges in Mumbai and one district hospital in Kalwa	-Psychosocial and medical support to survivors of domestic violence and rape -Referral for legal and social services Training of Health Practitioners (HPs)	Social workers from SNEHA	SNEHA	-Provision of space -Deputation of staff for training and as core group
ANWESHI, 2011 Kerala	Link with medical college Calicut	-Referrals to Anweshi counseling center -Sensitization of staff and awareness of services provided by ANWESHI	--	ANWESHI	-Deputation for training
SWATI, 2012 Gujarat	Medical college in Gujarat	-Psychosocial and medical support to survivors of domestic violence -Referrals for other services Training of HPs	Counselors appointed by SWATI	SWATI	-Provision of space -Deputation of staff for training

Drawing on the Dilaasa model and the learning from the aforementioned models (Table 1), Box 2 (see Page 23) highlights the essential elements to a health systems response to VAW, including IPV.

Box 2. Essentials of a Public Hospital-based Crisis Center

1. Centers should respond to all forms of violence against women.
2. Centers should be integrated into the existing health services rather than standalone services.
3. Responding to gender-based violence must be integrated into the roles and responsibilities of the existing hospital staff as that is more sustainable than recruiting project-based staff in hospitals.
4. Crisis centers should be set up as a department of the hospital.
5. Training of providers should be on-going.
6. Appointment of nodal officer and core group at hospital level for training, monitoring and supervision is needed.

Recommended Center Operations:

- Survivors of violence either report violence directly to the health providers or are identified by trained health providers based on signs and symptoms presented in the outpatient or inpatient consultation.
- Once identified, the survivors should be provided medical treatment, medico-legal care where appropriate and informed about the crisis intervention department.
- Crisis intervention services: The centre should have protocols for documentation of the abuse, its severity, for assessment of safety, mental health impact and development of a safety plan. An empowerment model should be followed for crisis intervention as it questions power within relationships and helps women locate the source of their distress in the larger social context of power and control and enables them to resist systemic oppression. This can be done through questioning common notions about violence and dealing with the fear, anxiety and shame that keeps violence under cover.
- Protocols developed by the MoHFW for sexual violence should be implemented, including:
  - Seeking informed consent of survivor for examination, treatment, evidence collection and informing the police
  - Gender-sensitive proforma that does not record status and type of hymen or measure the size of the vaginal opening or make any comment on sexual habits of the survivor
  - Chain of custody for management of evidence collected
  - Immediate first aid such as pain relief, emergency contraception and prophylaxis for sexually transmitted infections and follow up care
- Doctors should provide reasoned medical opinion and explanation that the absence of injuries and/or absence of forensic evidence is common, which can help survivors in court.

The public health model places utmost importance on the prevention of injury and ill health (primary level intervention), on harm reduction (secondary level intervention) and treatment and rehabilitation (tertiary level intervention). In addition to primary prevention efforts, one cannot ignore the fact that a large number of women are already accessing the health care system for complaints arising from violence. There is therefore also a need to plan and implement programs within the health care system that provide the much-needed social and psychological support required by women in crises and to reduce harm caused by the violence. In addition to prevention of violence, public health efforts must focus its strategies on harm reduction (secondary-level intervention) and treatment and rehabilitation (tertiary-level intervention).

Primary Prevention: Provide Training and Education Materials to Frontline Workers

Primary prevention strategies refer to those efforts that can prevent violence from occurring in the first place. Although prevention is a well-established concept in the field of public health, theories and programming for primary prevention are relatively new in the field of violence against women and girls. (Garcia, C et al., 2015)

The health system can raise awareness about the need to address violence against women by reporting and publicizing data for the prevalence, health burden and costs of violence and contribute to efforts to counter the acceptability of such violence. However, evidence to guide healthcare organizations in primary prevention activities is scarce. Lori Michau and others have reviewed existing evidence and note that most primary prevention involves actions outside of the health sector (Michau, et al., 2015).

Within the Indian health care setting, the health workers at the community level such as the ASHAs, Auxiliary Midwives and Nurses (ANMs), Integrated Child Development Services (ICDS)[6] Anganwadi workers (AWW), can be instrumental in carrying out tasks at primary prevention. One concern is burdening ASHA workers to address VAW. ASHA workers are voluntary workers who are undervalued, underpaid and are unprotected. There have been many instances where ASHA workers themselves faced violence and the governance system was not able to look after them in those circumstances. However, they can play an important role as part of an upward referral system as seen in Gujarat, Maharashtra and Kerala where services for responding to violence have been established at health facility level. A range of government and non-governmental programs such as MASUM, Mitanin (of Government of Chhattisgarh), SNEHA, Soukhya, SWATI are examples of initiatives where frontline workers such as ANMs, ASHA workers and community mobilizers have been trained to

[6] The Integrated Child Development Services (ICDS) Scheme is one of the flagship programmes of the Government of India which looks at early childhood care and development. It was launched in 1975 as a response to the challenge of providing pre-school non-formal education and to address malnutrition, morbidity, reduced learning capacity and mortality amongst children in the age group of 0-6 years, pregnant women and lactating mothers (Source: http://www.icds-wcd.nic.in/icds.aspx)

create awareness about forms of violence and refer women experiencing violence to the crisis intervention services set up in their nearby hospital/s. This approach does not put them at risk at the community level. Masum and SNEHA have also worked with community women to set up support groups that can create a zero tolerance to violence at the community level and contribute to preventing violence by raising the issue at the local governance level.

Evidence from the formative study by ICRW in two districts (Benaras and Pratapgarh) in Uttar Pradesh shows large numbers of women, particularly from lower socioeconomic classes, access health systems; for many this is the first place where they are disclosing violence. There have been continuous engagements of ASHA workers with women and survivors confiding in them if they are facing physical violence to share their grief; without the intention of seeking help.

The formative study also highlights several challenges in engaging ASHAs, AWWs and ANMs in addressing VAW. ASHA, AWW and ANMs attitude towards IPV is similar to the communities they live in. Being women from the communities sometimes they hesitate to take up issues of violence. They also lack knowledge, capacity and support for addressing IPV at times. Many of the ASHAs and AWWs were themselves survivors of violence. Survivors interviewed voiced that FLHWs often lack awareness and information about methods of redressal but should raise consciousness/ awareness about IPV within the community. Responding to violence has put some of the FLHWs at risk of violence.

The primary health workers could, therefore, be engaged in the following:

- Recognition, voicing and awareness-building activities for girls and women in the communities on forms of violence and consequences of the same. These activities should increase their knowledge about their rights, increase their understanding of what constitutes a healthy relationship, increase their self-esteem and the belief that they do not deserve to be abused.
- Male health workers can be trained to organize and implement educational and awareness-building activities for adolescent boys and men on gender inequality, positive gender roles and healthy relationships.
- Information, education and communication material on the subject can be printed and posted at all levels of public health system. Such posters and other material send an important message that VAW is a public health issue and that women and girls can report violence to public health facilities.

Secondary Prevention: Provide Healthcare Provider Training on Standard Woman-Centered Protocols

Secondary prevention strategies involve efforts to minimize harm already done and to prevent further injury from occurring. Within the health care setting, both health care and social service providers can play important roles in facilitating women's reporting of the abuses they are facing and in educating women about available medical and social services.

Identification of women and girls who are, or have been, subjected to violence is a prerequisite for appropriate treatment and care and referral to specialized services where these exist. The experience from the various models that have been studied, indicate that identifying violence requires training of health-care providers in understanding the signs and symptoms associated with violence, know-how to ask about violence and respond. Providers also need to be trained to carry out proper and thorough documentation of recent incidents of abuse, the resulting injuries and the history of violence and to subsequently make referrals to the appropriate agency or department for further care and emotional and social support.

The minimum requirements for asking about partner violence include a protocol/standard operating procedure, training on how to ask, minimum response or beyond, a private setting, confidentiality ensured and a system for referral in place.

WHO guidelines recommend that all health-care providers be trained in women-centered first-line support, to respect a woman's right to decide on her own pathway to safety. This approach is consistent with so-called psychological first aid, a first response to individuals undergoing traumatic events. A supportive response from a well-trained provider can act as a turning point on the pathway to safety and healing.

Tertiary Prevention: Provide Social Services Such as Counseling, Advocacy and Legal Services

Tertiary prevention efforts refer to strategies aimed at addressing previous exposures to physical, emotional, sexual violence and their consequences. Within the public health framework, such strategies would involve the delivery of services such as counseling, advocacy, referrals to other needed social services (such as shelter, legal aid, educational and job training programs and medical services) and assistance in negotiating and accessing these various and often fragmented, service systems. The long-term impact of experiencing violence may require mental health services that are gender-sensitive and these must be made available at the tertiary level.

Healthcare providers – particularly doctors – are in a unique position to identify victims of violence. In addition to the fact that they are often the first contact for victims seeking treatment, they are highly regarded and seen as neutral entities to whom patients can easily confide. This unique position affords doctors the ability to enquire into the current (or most recent) episode of violence, as well as the history of abuse by creating safe environment and providing privacy. Furthermore, within the public health system, doctors are the only individuals with the authority to register medico-legal cases, conduct autopsies, collect important forensic evidence and carry out post mortem examinations. All these procedures are necessary to prove the incidence of violence and punish the perpetrator.

Box 3 highlights the recommendations for health sector responses resulting from the formative research with frontline health workers.

Box 3. Recommended Health Systems Response

Level	Response
Primary	• Create community awareness of the types of violence against women, particularly IPV; the health consequences of violence; legal rights and services available • Create awareness and provide information about crisis intervention services at the secondary and tertiary hospitals and other services available such as livelihood, shelters, etc. • Ensure trained staff to provide first-line psychological support to women reporting violence • Set up a referral mechanism • Medical Officers and ANMs at the Public Health Center level, should be trained to provide first-line treatment to women who may access services for violence-related problems
Secondary	• Identification and reporting of violence • Provision of clinical and forensic care and linkages with legal, police and social support services • Provision of crisis intervention services through a dedicated department or designated trained staff • Crisis intervention departments could also be set up
Tertiary	• Identification, provision of clinical and forensic care • Setting up of crisis intervention departments • Trained personnel for provision of crisis intervention, rehabilitation and long-term care • Medical colleges should include training on VAW in their curriculum • Role of convergence of health with education departments on initiative of adolescence education and prevention of violence

7 CONSIDERATIONS FOR SCALING UP SUCCESSFUL IPV PROGRAMMING

This review has identified promising models in health services for women subjected to violence. These have functioned in various settings and at different scales. Each of these has identified gaps in current response to survivors of domestic and sexual violence, trained health care providers and provided services either through training of existing staff, appointment of NGO staff or referral to existing services.

The World Health Organization/Expandnet defines scale-up as "deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and programme development on a lasting basis" (WHO/Expandnet, 2010, p. 2). The WHO manual for health managers provides direction for assessing scalability (WHO, 2017), noting that the expansion of appropriate health services for women subjected to violence can proceed in various directions – for example:

- From a select set of interventions implemented in a pilot area to addition of new interventions;
- From pilot-test areas to other, similar communities;
- From one province to other provinces;
- From urban or densely populated areas to rural or less densely populated areas;
- From higher to lower levels of the health system (for example, from referral/tertiary hospitals to primary health clinics);
- From the NGO sector to the public sector.

The current review of various models of responding to VAW in the health sector have shown that the Dilaasa model – a redesigned OSC – has been replicated and adapted in various settings and has also been scaled up to 11 hospitals under the NHM. The Dilaasa model was replicated by the government of Kerala and Haryana in multiple sites namely district hospitals under their NHM budgets.

The medico-legal response model based on guidelines issued by WHO as implemented in three Mumbai-based hospitals has been translated into guidelines and protocols by the MoHFW for responding to survivors of sexual violence. These components will be essential in bringing IPV programming to scale.

Systems responsiveness checklist as recommended in the WHO Manual 2017 with observations from models is discussed in Box 4. Based on this analysis further review will be needed on these models to determine which, if any of these models, are ready for scale-up.

Box 4: Systems responsiveness checklist as per WHO Manual 2017 with observations from models discussed above:

Is there a gap that needs to be addressed (for example, a gap in the coverage of available services)?	No, the practices cover all levels of health system and range of providers
Is input about the scaling-up of services/ interventions being sought from a range of stakeholders (for example, policy-makers, health-care providers, NGOs)?	Yes - from NGOs, health providers, policy makers, counselors of crisis centers, administrators
Do key stakeholders understand the importance of having evidence on the feasibility and outcomes of the pilot intervention before scaling up?	The scaling up will be done by MoHFW which does need evidence on feasibility
Has the intervention/service been pilot-tested in the variety of socio-cultural and ...geographic settings?	Yes, it has, with rural, urban women from different class, caste and religious backgrounds
Has the socio-cultural and geographic context been taken into account in the scaling-up plan?	Yes, it has been
Is there a need to make changes in policies, protocols and tools?	Polices, protocols need to be developed for responding to DV
Is there readiness to support scaling up services in the sites selected?	Except for training and appointment of counselors there is no other input required
Will adequate human, technical and financial resources be available during scale-up?	The doctors and nurses will integrate this as part of their work; counselors will have to be appointed if not available; and role of frontline workers will have to be strategically thought through based on evidence from the ground. Technical resources will have to be made available.
Is there engagement with funders and technical partners to build a broad base of financial and technical support for scale-up?	Needs to be done as done in Maharashtra, Haryana and Kerala.
Is there a plan and mechanisms (for example, indicators and health information systems) to monitor and evaluate progress and improve quality during the scaling-up process?	Yes, these have been done and can be scaled up.

8 RECOMMENDATIONS

After reviewing the programming models in this synthesis it's clear that large numbers of women are accessing health services. For many – particularly the most marginalized women in lower socioeconomic classes – these public health facilities are the first place where they are disclosing violence. But the challenges faced in India are similar to those elsewhere: the predominant biomedical model does not help with the disclosure or enable an appropriate response from providers; violence against women is not seen as a clinical or public health issue and health care providers may share the predominant socio-cultural norms of disrespect and abuse of women, especially in reproductive health services.

The programs highlighted here have some common features: on-going training; core groups of trainers at the facility level who are responsible for training and monitoring; one nodal officer in charge of the center to liaise with departments and other sectors; and some integration within the health system to provide medical and social support to survivors of violence.

In India, as in other low- and middle-income countries where resources are limited, there is a tendency to depend on NGOs, which can be challenging. Evidence from the Philippines and Malaysia experiences where NGOS were hired but could not provide long-term sustainable services illustrate that NGOs and CSOs can partner in service provision as demonstration, training, technical support, capacity building, research, monitoring and evaluation, but direction and organization should be centralized within the country's health systems.

Furthermore, key lessons from global evidence suggests that committed leadership and organic growth from bottom up, regular and mandatory training of Health Care Professionals (HCPs), creation of pool of trainers for sustainability, development of clear referral pathways are critical to ensure a health systems response, these were found to be similar from the evidence in India.

The following are policy and operational recommendations for improving the health systems response to IPV, drawn from this synthesis of programming, along with formative research with frontline health workers and in-depth interviews with key informants that have been validated at the National Consultation held in New Delhi in June 2018.

Policy Directives, Planning, Budgeting and Convergence

a. MoHFW to establish a national directive on addressing domestic/intimate partner violence (alongside sexual violence). This must be first step for operationalizing the NHP commitment to the issue. This must be integrated in all relevant components of the National Health Mission, including guidelines for State Program Implementation Plans.

b. The national directive must be supported with adequate provisioning of financial resources for training of health professionals at all levels and for appointment of counselors for provision of services in health facilities. This can be done in a phased manner starting with district hospitals as done in Haryana, Kerala and Maharashtra.

c. More comprehensive costing studies need to be generated for policy uptake and scaling up initiatives for the government, for the facility itself, it is recommended that within the infrastructure, five people are vital to the support of the delivery of services and they are two counselors, two health workers and one legal consultant. The institutionalized and evaluated model of Dilaasa costs 3 million INR per year estimated in 2012. This including costs for infrastructure, training, running costs and salaries (for social workers, health workers and counselors).

d. There is serious concern about stand-alone one stop crisis centers under the OSC scheme and their expansion in the face of concerns about their effectiveness. Several are located in hospitals with no coordination with hospital authorities. The Ministry of Health /Department of Health needs to take cognizance of this and collaborate and converge efforts with the OSCs so that more women can access comprehensive services.

e. Mechanisms for multisectoral collaboration and coordination to prevent and respond to violence against women should be developed and monitored by a committee of Secretaries of relevant ministries such as Ministry of Health and Family Welfare, Ministry of Women and Child Development and Ministry of Home. Civil Society Organizations and womens rights groups must be involved and brought on board for technical support, research, monitoring of services.

f. Integration of health systems response to domestic violence and sexual violence should be included in the appraisal process and criteria of the State Program Implementation Plans by the National Program Coordination Committee (NPCC) of the National Health Mission and all participants in the appraisal process should be sensitized on the issue.

g. Ensure mechanism for States to implement directives to address domestic violence and sexual violence against women.

h. MoHFW should adapt the WHO clinical handbook to develop a national protocol on intimate partner violence, incorporating the lessons learned from existing models. This should identify the specific actions for different levels of the health system and different cadres of health providers, including doctors, nurses and paramedical workers.

i. Efforts to integrate violence against women in medical, nursing and midwifery curricula should be developed.

j. Specifically, efforts across the Ministry of Human Resources Development (MHRD) and Ministry of Health and Family Welfare (MoHFW) should be converged to include sensitization and capacity building of adolescents to recognize violence through the education curriculum to change social norms, as part of primary prevention of violence.

Operationalization of Policies and Programs

k. Crisis intervention and support departments should be ideally located within hospitals with a casualty department. Such hospitals are large enough to have sufficient workload. These should be created as separate departments within a hospital setting.

l. Training of in-service personnel in domestic violence (and other issues) should become part of the health system functions, recognized as a vital activity, have dedicated staff and an adequate budget and carried out in a systematic and methodical manner. All health care providers should be trained to be aware of the impact of violence on women's health and to know how to identify and provide minimum first line support and referral to other services where these exist. This should include frontline workers as well with the understanding that they are volunteers but are closely interacting with women in the community.

m. Since women experiencing domestic violence may access a public health facility at any level, there should be an integrated system of identification and referral. At the primary care level, ANMs and medical officers may be trained to recognize, identity and refer cases. At the primary level, ASHA workers and their potential to play an important role in awareness generation and forward and backward referrals need to be explored. At the secondary level, counselling services as well as referral to legal and other resources may be provided. Initiatives to address domestic violence within health care settings would therefore have to systematically engage with different levels of the health care system.

n. Institute system level changes to ensure privacy and confidentiality, setting up of standard operating procedures, systematic documentation, monitoring and supervision must be set up.

o. Injury surveillance systems must include domestic violence especially in cases of burn injury registry.

9 CONCLUSION

India has made some efforts towards making health systems responsive to violence against women, but it is not sufficient to address the magnitude of the issue. There is a lack of national strategy and plan by the MoHFW to respond to violence against women generally or IPV specifically. There is no directive for allocating resources for training of health professionals and for setting up services by the central government. Barring a few states such as Haryana, Kerala and Maharashtra, where resources have been allocated for setting up services the rest have made no such effort. Promising programs do exist, however.

This review has highlighted challenges and shortcomings in India's health systems response to violence against women and identified promising models with potential for scale-up. The recommendations here provide a vital next step in further entrenching comprehensive VAW and IPV programming within those systems.

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