



# Toolkit for Designing One-Stop Crisis Centres for Survivors of Gender-Based Violence: **Learnings from the Dilaasa Model**

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# Context



Photo: Ibrahim Rifath/Unsplash

## BACKGROUND

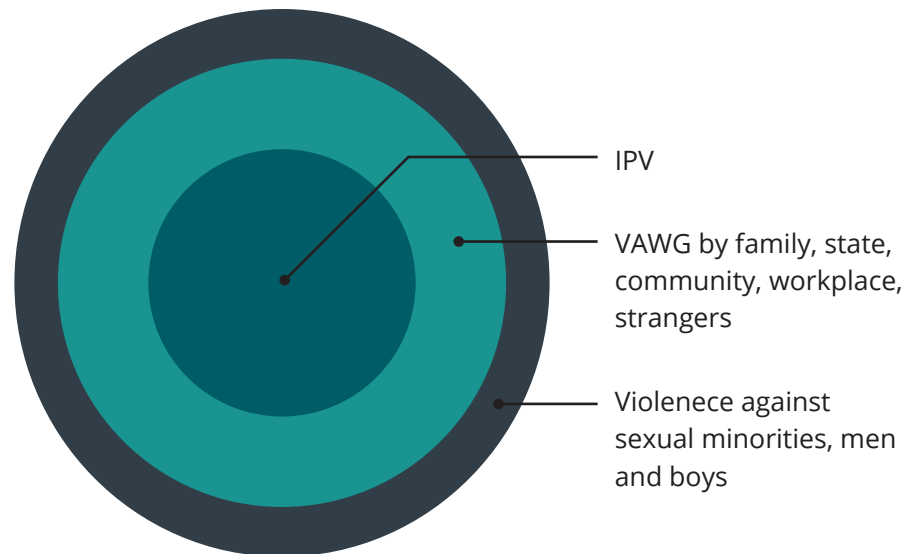
Globally, 30 percent of women in relationships experience physical and/or sexual violence from an intimate partner and seven percent of women have been sexually assaulted by someone other than a partner. This is highest in Africa, Eastern Mediterranean and South-East Asia, where approximately 37 percent of ever-partnered women report having experienced physical and/or sexual intimate partner violence (IPV) at some point in their lives. Exposure to violence is high among young women (ages 15–19 years), suggesting that violence starts early in women’s relationships and peaks between 40 and 44 years (WHO, 2013).

The vulnerabilities of female survivors of violence are multi-layered and defined by gendered realities and inequitable gender norms. Refer to Figure 1 on framing the research within the discourse of gender-based violence (GBV),<sup>2</sup> which depicts that the majority of GBV is directed against women and girls.

<sup>2</sup>Dr V Jithesh, Training of Health professionals, October 2019 Care India Bihar. Figure created for conceptual understanding of definitions of VAW and GBV. It is not as per measure of violence. The larger framing of the research for this project has been gender based violence, however since Dilaasa is based intrinsically within the discourse of violence against women, for the purposes of this Toolkit the authors have sometimes used the terms interchangeably however they are aware of the distinct differences.



**FIGURE 1: Gender-based violence and violence against women and girls**



Violence against women and girls (VAWG) is a significant public health issue and a violation of fundamental human rights. Research shows that GBV is a major cause of disability and death among women and has adverse consequences for women's sexual and reproductive health. Violence against pregnant women can cause serious harm to both the mother and fetus. Evidence points to a major impact on the health of GBV survivors; even when they do not seek legal services they may still visit and take advantage of health systems.

A comprehensive review published in the Lancet emphasizes the critical role of a health systems approach for responding to VAWG. This implies that health care providers can play a key role at the level of detection and provide immediate and long-term medical support, emotional support, and case documentation, as well as provide referrals for legal aid, counseling services, etc. Overall the systems approach broadly includes: improving health workers' understanding of legal provisions; supporting long-term efforts to sensitize and train health professionals on issues of GBV; incorporating routine screenings for violence ensuring the safety and security of the women

and monitoring and evaluating services to survivors in a sustained manner. The Dilaasa model has been touted as global evidence of the response of health systems to VAWG (Moreno et.al, 2015).



### Moroccan Context

Like in most parts of the world, GBV remains pervasive in Morocco, affecting all segments of the population irrespective of age, ethnicity, education level and economic status. The Minister of Family, Solidarity, Equality, and Social Development in Morocco released findings from a national survey on violence against women (VAW) in 2019, which stands at 54.4 percent nationwide, including 55.8 percent in urban areas and 51.6 percent in rural areas. However, the data on prevalence of VAW in public spaces show 19.6 percent in rural areas compared to 16 percent in urban areas. The most vulnerable women are ages 25-29 and marital VAW is highly prevalent. The survey findings also show that around 12.4 percent of Moroccan women 18-64 have suffered at least one case of violence in their lifetimes. Approximately 13.4 percent of women have been subject to online abuse (Morocco World News, 2019).

After five years of review and debate, the Law 103-13 on Violence Against Women in Morocco was passed by the House of Representatives on February 14, 2018. To investigate a multi-pronged strategy to build on these recent legislative and policy changes to effect positive and lasting change for GBV survivors from the grassroots level to the national level, the International Center for Research on Women (ICRW) is implementing the project titled “Combating Gender-Based Violence in Morocco-Promoting Best Practices in the State Response to Gender-Based Violence” in collaboration with Mobilising for Rights Associates (MRA), and Networks of Change with support from the US Department of State, Bureau of Democracy, Human Rights and Labor.

This project aims to strengthen the capacity of and coordination between local public institutions and civil society stakeholders to ensure that survivor-centred essential services and protections are available and accessible to GBV survivors in Morocco. The objectives are:

1. To enhance the capacity of health, justice, security & social service providers to establish effective



reporting mechanisms & deliver essential protections & services to GBV survivors;

2. To enhance the capacity of Non-Governmental Organizations (NGOs) to advocate for more effective protections & services for GBV survivors, & to monitor & document State action; and
3. To promote civil society collaboration with the media and build capacity of NGOs to increase access to information, build awareness on GBV protections and services for survivors and create public dialogue.

In response to the first objective, ICRW is closely working with four Moroccan NGO partners as well:

- ◆ Association Tahadi pour l'Égalité et la Citoyenneté
- ◆ Association Amal pour la Femme et le Développement
- ◆ Association Tafiil Al Moubadarat
- ◆ Association Anaouat pour femme et enfant

In September 2019, ICRW held several workshops in Morocco with the NGO partners and consequently developed a Best Practices Resource Guide,<sup>3</sup> which highlights evaluated models that have been exemplary in providing a roadmap for response mechanisms to bring all stakeholders on board while keeping the needs of GBV survivors at the centre of the intervention.

<sup>3</sup>link to the final document after that is uploaded in our website

Dilaasa was one of the models covered under this Guide.

The Guide used the following criteria to select and determine best practices:

- ◆ Use of survivor-centred approach;
- ◆ Focus on prevention and response;
- ◆ Engagement of multiple sectors;
- ◆ Participatory design and implementation principles;

## OBJECTIVES

The Toolkit highlights the context, background, philosophy and road map used for conceptualizing Dilaasa centres in India and its institutionalization and replication in several Indian states. It presents resources, materials, activities and information to support the development of a “one-stop shop” model (based on learnings from Dilaasa) for providing support to women survivors of GBV in Morocco.

The primary aim of this Toolkit is to build capacity of the NGO partners to develop Action Plans to conceptualize and implement “one-stop shops” (similar to the Dilaasa model) for survivors of GBV. These Action Plans will also facilitate advocacy-building around the need for such centres in the region. The Toolkit comprises case studies, tools and other relevant information on the Dilaasa model which will provide additional information for the NGO partners. The larger objective is for a wide range of audiences (civil society groups, NGOs, practitioners, advocates, etc.) to understand how such centres function for immediate medical care and access to justice.

This Toolkit can be used as a resource to train NGO staff and stakeholders including police, courts, NGOs, lawyers, Gendarmeries, Judicial Police, Public

- ◆ Rigorous measurements and evaluation;
- ◆ Mixed- methods data collection; and
- ◆ Replicability and sustainability.

Subsequently, in consultation with the NGO partners, ICRW identified Dilaasa as the model best suited for the Moroccan context. This Toolkit was conceptualized to facilitate adaptation of the model. While the focus here is on Morocco, the Toolkit can be used in other contexts as well.

Prosecutors, Committee members, Cell for countering VAW, shelter representatives, medical professionals, members of counselling and listening centres, members of hospital violence units, Police Commissioners and Chief Prosecutors working to address GBV. Although the Dilaasa model is based on a health systems response to GBV there are learnings in terms of coordination and multi-sectoral linkages with other stakeholders in India (such as the lawyers, Judges, Police, counsellors, legal aid professionals and NGOs) that point to the process of redressal for GBV survivors to be effective.

This Toolkit is available in English and Arabic. Since this document is meant for global access, any NGO/ practitioners/ advocates/ government officials working on this issue can use it to strategize on developing and replicating such models/ centres in their specific region.

Given stark differences in terms of economic, socio-political, legal and constitutional domains between India and Morocco, the authors are aware that some content presented may not resonate with the local realities of the Moroccan context. However, there is scope to understand how some learnings from the Dilaasa model can be used effectively in varied local contexts.

## SECTION 1 | BEST PRACTICES ON ADDRESSING GBV

### Understanding the One Stop Crisis Centre (OSCC) Model

One-Stop Crisis Centres (OSCC) as a method for responding to rape or domestic violence have been operational in the West since the 1970s and in South Asia for more than a decade. Several OSCC models in countries such as England and Wales, Rwanda, Zambia, Australia, South Africa, Malaysia, Philippines and Bangladesh have different histories and origins (Bhate-Deosthali and Rege 2018; Bairagi et.al 2006; Colombini et. Al 2012; Grisurapong 2007; WHO 2007).

- ♦ The Australian rape crisis centre was the outcome of the feminist movement and is based in a community set-up. This centre receives survivors who seek services for healing from the consequences of rape and for those who wish to engage in group therapy. The program is led by volunteers who undergo a six-week training.
- ♦ England and Wales run Sexual Assault Referral Centres (SARC) which provide emergency medico-legal services. In some SARCs, which are not equipped to provide medical treatment and care, survivors are referred to hospitals for treatment. After providing medico-legal services, SARCs refer cases for medical aid and psycho-social services elsewhere. The focus of these centres is on the

collection of forensic evidence in a sensitive manner but not treatment.

- ♦ The United States has models that include hospital-based services for survivors of domestic violence and rape through social workers at hospitals. A team of volunteers is trained to provide on-site support to rape survivors. When a rape survivor arrives at a hospital, the hospital calls a hotline number, upon which a volunteer is dispatched to facilitate the medical examination and provide basic support.
- ♦ OSCCs in South Africa are located within hospitals but linked to the Public Prosecutor's office and the focus is on judicial outcomes.
- ♦ OSCCs in Rwanda are located within police stations and the focus is on support for survivors through the judicial process.
- ♦ Malaysia, Philippines and Bangladesh set up OSCC models focused on training health professionals to identify patients who are survivors of violence and to carry out service provision to survivors. Many of these models are dependent on NGOs for providing counsellors and thus the quality and availability of services is subject to availability of NGO members. This dependence poses a barrier in integrating these into the existing health care services.



### EXERCISE

To understand the various elements of an OSCC model, we present a film clip and two case studies. Participants are requested to watch the film clip and form two groups. Each group will go through one case study and discuss the questions given after the description in their group. After a round of discussions within their respective groups they can present their reflections to the entire group for further discussions.



WATCH THE CLIP

ENGLISH

ARABIC

English: [youtu.be/KQegDASun1E](https://youtu.be/KQegDASun1E) | Arabic: [youtu.be/RmjSAzw-i7I](https://youtu.be/RmjSAzw-i7I)



## CASE STUDY 1

### The Thuthuza Care Centres

The Thuthuza Care Centres (TCC) in South Africa initiated by the National Prosecuting Agencies (NPA) and Sexual Offences and Community Affairs are one-stop centres for survivors of sexual violence that address the many complications of rape and attempt to streamline the process of rape care through integrated systems. TCCs provide survivors of domestic violence, sexual assault and child abuse with tests and treatment, medical advice, counselling, evidence collection (if the case will be reported to police), access to legal advocates, consultations with legal experts, etc. There are two NPA officials or staff members in each centre: a survivors' assistance officer and the site coordinator, whose task is to keep abreast of what is happening in the courts. At the court, a case manager appointed by NPA provides an update of the trial process and explains the outcomes to the survivors during the process. These services are available under one roof 24 hours per day and are free of charge. A TCC is located close to a public hospital in an area with high prevalence of sexual violence. These centres include an inter-departmental management team composed of representatives from the Departments of Health, Justice, Education, Treasury, Correctional Services, Police, Social Development and Civil Society. The centres are run by the Sexual Offences and Community Affairs unit, which has been working to develop best practices and policies to end victimization of women and children and improve prosecution of sexual offenses, maintenance, child justice and domestic violence. The goals of the centres are to reduce secondary victimization, increase conviction rate and reduce cycle time per case of violence.<sup>4</sup>

<sup>4</sup>For more information please visit: <https://www.gov.za/TCC>



## CASE STUDY 2

### Onieda Tribe

In the United States, the Oneida Tribe in Wisconsin faced a lack of coordination between justice and social services systems in responding to domestic violence. A Men's Re-Education Program for abusers had been developed, but was underused because there was no mechanism in place to enforce or monitor attendance or respond to noncompliance. In 1994, communities were required to construct a Coordinated Community Response (CCR) to continue receiving funding from the government, under the Violence Against Women Act (VAWA). The CCR team includes professionals from numerous tribal and non-tribal agencies who collaborate to share information more effectively, deliver services to survivors, ensure safety and promote offender accountability. Along with the philosophy of protecting the survivors of violence, the CCR team is mandated to hold domestic violence abusers accountable for their abusive behavior and for noncompliance with court mandates. One of the ways in which the CCR team ensures abusers accountability is by helping them complete the Men's Re-Education Program.

Internal stakeholders included tribal police, probation officers, members of court, housing, family and elderly service providers and behavioral health professionals. External stakeholders were state courts, county prosecutors, probation and parole officers, the State Department of Corrections and local Domestic Violence units. These partners worked together to define and understand their respective roles and drew up agreements with new written policies and Memoranda of Understanding (MOUs). For example, county and tribal police modified their internal protocols to allow effective access to important case information. The team meets once a month for about an hour to review cases, share information, modify protocols, and participate in cross-training events. The cross-training events are funded by the "Service Training for Officers and Prosecutors" (S.T.O.P.) grant from the Office on Violence Against Women. Additional funding has come from a variety of other sources including a Domestic Violence Prevention Enhancement & Leadership through Alliance (DELTA) grant from the federal Centers for Disease Control and Prevention, as well as state grants to develop educational and preventative strategies and to address sexual assault.<sup>5</sup>

<sup>5</sup>For more information please visit: <http://www.tribaljustice.org/places/domestic-violence-sexual-assault/mens-re-education-program/>





## CASE STUDY FOLLOW-UP



**Use the following questions to discuss features and relevance of the model your group is reviewing.**

1. What and how have the linkages been formed with various stakeholders?
2. How does each of the case studies ensure funding and accountability from the state machinery?
3. Please share your suggestions on positive outcomes, limitations, and challenges in these models from the perspective of the survivor of violence.
4. What are some of the challenges in working with abusers given the context of your work and experience on the issue?
5. In your local context which elements of the case study/studies are relevant towards your work?
6. How do you see the role of the laws for the protection from GBV (law 103-13 in case of Morocco) in your context for funding some of the ideas expressed in each of the models?

After the presentations by each group, the facilitator can ask the participants to list the similarities and differences between the Dilaasa model and the other two models discussed in the case studies.



**Here the facilitator should:**

- ♦ Be knowledgeable on issues on GBV, VAWG and the local context, including having experience and expertise conducting trainings on gender issues using participatory methodology;
- ♦ Treat all participants with respect and provide a safe space for sharing experiences;
- ♦ Be effective learning and sharing knowledge and experiences on specific issues;
- ♦ Engage in active listening;
- ♦ Encourage participants to be vocal and keep a non-judgmental attitude.





## KEY TAKEAWAYS

### Prototypes of One Stop Crisis Centres (OSCCs):

OSCCs across the globe are of various kinds:

#### 1. NGO-run OSCCs

These are OSCCs that may be located within hospitals but are run by NGOs. The NGO staff brings experience and expertise and therefore quality of services is good. However, they are not sustainable and depend on the NGOs to garner funding as well as for other functions.

#### 2. Standalone OSCCs

These are OSCCs that are set up within a community and not institutionalized in any system such as health, police, or court (which are accessed by survivors for specific services). The number of women reaching these may be low and immediate medical care might be challenging.

#### 3. Hospital based OSCCs

These are mostly located in tertiary hospitals, are resource-intensive, are accessible to all populations, have provisions for immediate medical care and allow for multisectoral collaboration.

### Advantages/Disadvantages of an OSCC Model<sup>6</sup>

#### Advantages:

- ♦ More efficient and coordinated services
- ♦ Full range of services (sometimes including police, prosecutors, social workers, counsellors, psychological support) for survivors
- ♦ Reduces number of times survivors must repeat their story and amount of time they spend in seeking services

#### Disadvantages:

- ♦ More space and resources required
- ♦ Client load may be small (in rural areas, for example), raising cost concerns
- ♦ May draw staff and resources out of other services
- ♦ May not be fully integrated into general health services
- ♦ If administered by the judicial system, may focus too much on prosecution and not on women's health and wellbeing
- ♦ Resource-intensive

These important takeaways will help participants understand the best way to implement OSCCs that resonate with local contexts and local political will. The role of multi-stakeholders and keeping survivors at the centre of the mechanism are some of the key elements to keep in mind for ensuring an OSCC model in regional advocacy efforts.

<sup>6</sup>Refer to WHO Clinical and Policy Guidelines, 2013 – <https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>

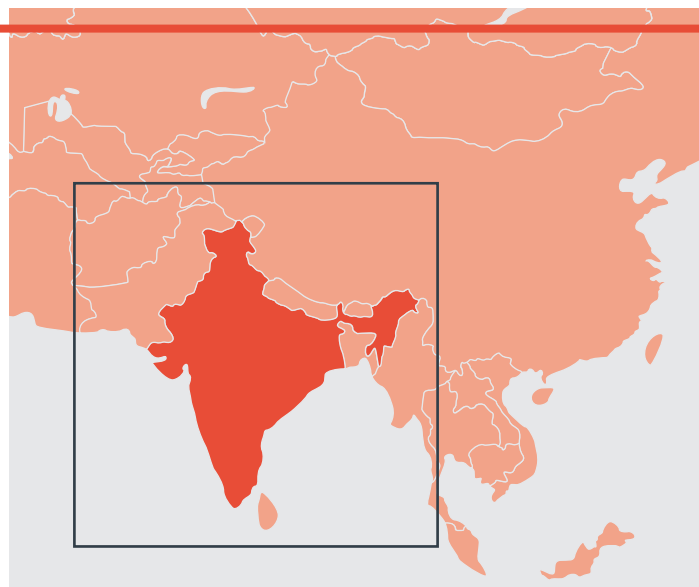
# Introduction to the Dilaasa Model

## SECTION 2 | BEGINNINGS

The Dilaasa model is a joint initiative of the Municipal Corporation of Greater Mumbai (MCGM) and CEHAT.<sup>7</sup> It is a redesigned OSCC adapted to the country context. The genesis, role of the partners, trajectory and the key elements of the model are presented here.

### 2.1 CONTEXT IN INDIA

In India, there was no recognition of domestic violence as a public health issue in 1998. However, the women's movement had brought up VAW as an issue into the public domain in the late 1970s. The movement was galvanized by the brutal rape of a tribal girl by policemen inside a police station. It brought into the public domain the question of patriarchal GBV for the first time in India in addition to the class and caste violence that had long been highlighted. Around the same time, many women were coming forward with stories of domestic abuse. The feminist principle 'the personal is political' was successful in demystifying 'private' and making domestic violence a public and political issue. The women's movement has been consistent in demanding justice and several changes in laws related to VAWG were brought about between the 1980s and 1990s, such as custodial rape, Supreme Court guidelines for sexual harassment in the workplace and the introduction of the law criminalizing sex-determination tests.



The women's movement asserted that all women have the right to violence-free lives and that domestic violence inhibits women from realizing their rights and full potential in all other aspects of their lives – social, economic and political. It also established infrastructure and services to care for survivors and provide support to female survivors of violence. The state responded by establishing free legal cells, shelters and counseling centres.

<sup>7</sup>CEHAT is the research centre of Anusandhan Trust set up in 1994. It works on health and human rights issues through research, policy advocacy and interventions. For more information visit: <http://www.cehat.org/>

Landmark legislation on domestic violence, the Protection of Women from Domestic Violence Act (PWDVA),<sup>8</sup> was enacted in 2005, which included violence by intimate partner (husband or live in partner) and members of marital or natal/parental family. The civil remedies included emergency relief for the survivors, protection order, residence order, maintenance and custody. The legislation recognized public health facilities as service providers and mandated that all women reporting cases of domestic violence must receive free treatment and information as well as appropriate referral to protection officers. In 2013, after a massive campaign against sexual violence following the rape and murder of a young professional, the legal definition of rape was changed to include all forms of sexual violence, including vaginal, anal and oral sexual violence. Recognizing the right to health care for survivors of sexual violence, the law made it mandatory for all public and private hospitals to provide immediate treatment.

## 2.2 GENESIS OF THE DILAASA MODEL

The idea of setting up a public hospital-based service for survivors of domestic violence emerged in 1998 during a meeting organized by the Ford Foundation for its grantees in India. At this meeting, a successful initiative from Malaysia to set up OSCCs in government hospitals, was presented. These centres were set up in collaboration with local NGOs and provided multiple services under one roof. The idea was to provide immediate medical care, counselling, police and legal support in one place. This was a new concept for the region and no such effort had been made in India at that time. CEHAT, an organization engaged in health and human rights work, was one of the grantees at this meeting, thought this concept sounded challenging and exciting.

### Approaching the government health officials

The concept, including the critical role of health professionals and health systems, was presented to health officials of the MCGM. The idea appealed to them, but they were not confident that a hospital could respond to domestic violence, which had until

then been seen as an issue for the police to address and investigate. After several rounds of discussion, CEHAT and MCGM agreed that such a project could be undertaken as a joint collaboration.

### Health system context

When a woman who has suffered domestic violence approaches the health care system, her physical injuries are treated by health professionals, but she is not provided with any emotional support or information on how to stop violence in her life. While many organizations provide counselling services to women facing domestic violence, there had been no systematic or formal efforts to sensitize health care professionals to the issue of domestic violence and the critical role they can play in the identification, documentation, treatment and referral for survivors. Deep-rooted biases in forensic medical practice are reflected in the medico-legal examination of cases of sexual violence as seen in two-finger tests, preoccupation with hymenal status and other unscientific procedures.

### Study tour to Malaysia and Philippines for senior health officials of the MCGM

It was deemed necessary that the MCGM health officials learn from other countries to garner support for the idea of public hospital-based services for domestic violence. In 1999, after significant research and planning, a team of health officials went on a study tour to Malaysia and Philippines. The team met government officials who had initiated OSCCs in the two countries and visited OSCCs to understand the pathway of a survivor from the time she enters the hospital to her exit. The team also met NGOs in the two countries to understand their experience with the OSCC. This visit was an eye opener of sorts, and the visitors developed an understanding of the roles of various hospital departments, service providers and NGOs.

### The following insights were gleaned from the study tour:

- ♦ A hospital provides an excellent site for intervention and support work for women facing domestic violence.

<sup>8</sup>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 a list acts of violence that constitute physical, sexual, emotional, and financial violence. It is significant as it allows women to approach the state directly and get a protection order to stop violence in the home without having to put the husband in prison or have to leave her abusive home.



- ♦ A proper room and space must be created within the hospital for the Centre.
- ♦ The Centre should be near and on the same floor as the Casualty Department so that women do not get lost or have to spend time finding their way to the Centre. The pathway from the Casualty Department to the Centre should not be intimidating or frightening in any way.
- ♦ The Centre should not be too close to the Casualty Department to be disturbed by the hustle and bustle there; there should be some distance between the two.
- ♦ There should be a good referral system in the hospital. The staff must be sensitized to the issue of domestic violence as well as their respective roles in addressing it.
- ♦ The method of feminist counselling—to which participants were exposed during their visit to a crisis centre in the Philippines—was deemed beneficial for women survivors.

### Adapting the model to the India context

The contours of an OSCC in India were thus laid down. It was evident from the experiences of women's groups and NGOs that the current response of hospital staff to VAW was poor, as evidenced by the lack of documentation of domestic violence in health settings and insensitive practices such as two-finger test for rape examination. CEHAT's own work on right to health care and that of other groups in India highlighted other challenges at the level of hospital such as overcrowding,

insensitivity of staff, lack of privacy, poor infrastructure in terms of human and other resources. This meant that the main thrust of any effort would have to be towards sensitizing and capacity building of the hospital staff. The goals that were thus set for the Dilaasa model (CEHAT, 2005):

- ♦ Institutionalize domestic violence (and more broadly, VAW) as a legitimate and critical public health concern within the government hospital system
- ♦ Build capacity of hospital staff and systems to sensitively respond to the health needs of the survivors of domestic violence

### 2.3 NON-GOVERNMENT ORGANIZATION AND GOVERNMENT PARTNERSHIPS

At this stage, there was no scope for this initiative to be funded by the government, but the Ford Foundation agreed to fund the pilot project. It was to be set up as a joint initiative of MCGM and CEHAT. The ground rules needed to be clearly laid down. There was a tendency for the government system to contract services and hand them over to NGOs, and it was decided that this project would be time-bound and handed over to the government to run the services. A Memorandum of Understanding (MoU) was signed between the parties, listing the roles and responsibilities of each party.

#### Principles of partnership

It was agreed that the pilot would be a partnership between a public (MCGM) and private non-profit organization (CEHAT). The ownership would remain that of the MCGM and the pilot would draw on the resources of both MCGM and CEHAT.

It was agreed that all decisions would be taken together with consensus. The scientific and ethics review processes would be followed per CEHAT norms. The Project Director was the medical superintendent of the hospital, and the team comprised CEHAT staff as well as deputed staff from the hospital. An advisory committee was set up with experts from different fields as well as senior government officials who were to meet twice per year to take stock of the project activities. This was to also support advocacy and visibility of the pilot. A consultant group included experts who guided the project in all its activities- research, training and service provision.



The partnership and joint ownership between an NGO and a government agency ensured the full involvement and ownership of the hospital staff and it was not identified as an NGO-initiative/CEHAT cell. It was mutually decided that the project would be called 'Dilaasa,' which means "empathetic support" in Hindustani and was recognized by all communities in India.

### Role of each partner

The MoU listed the role of each partner. Each partner brought its own expertise. CEHAT had demonstrated commitment and expertise on gender, health and human rights, while the public hospital had the capacity to provide a safe and accessible space to respond to survivors' needs with greater reach. CEHAT was responsible for providing trained staff and technical assistance, including setting up and running the centre, training hospital staff, documentation and research. The funds were to be secured by CEHAT.

The role of the MCGM was to provide the following:



**Space:** Three large rooms were provided free of charge. These were used for counselling, legal consultation, small group training and meetings.



**Shelter:** The MoU had mentioned creating a ward of 10 beds as shelter for survivors, but the system was not able to take responsibility for such a service. There were pertinent concerns about who would be in charge, provide childcare, dealing with suicide attempts and attempted entry by an abuser. It was also deemed unsustainable to have such a ward as 'shelter' in an overcrowded public hospital. The hospital therefore agreed to provide emergency shelter for women for 24 hours.



**Staff:** The hospital was to designate staff to provide crisis intervention services and train the trainers, as well as ensure that all staff

completed the training course, provide free medical care, foster formal collaborations with other sectors such as police, child welfare committees, shelters and other institutions.

## 2.4 SETTING UP AND RUNNING DILAASA

### Formative research

To understand the current hospital structure and procedures, the team carried out various small studies as formative research. The team tried to understand administrative structure, allocation of beds, departments (outpatient and inpatient), other services, caseload of various departments and services for which hospitals referred patients elsewhere.

An observation study at the Casualty department was carried out for 15 days to understand how staff responded to women reporting violence or suspected of facing violence. The roles of various actors at the departments were observed. In-depth interviews with hospital staff were conducted to understand their perceptions of domestic violence as a public health issue, forms and consequences of domestic violence and their response to setting up Dilaasa.

These studies were critical as they revealed the service providers' negative attitudes towards understanding domestic violence, non-recognition of the issue, non-cognizant behavior towards signs of violence, perceptions that responding to domestic violence was not their job but that of the police, and prevalence of victim-blaming. The analysis of medico-legal records provided critical insights into the profile of men and women coming to the hospital with health complaints that needed investigation by the police. The gendered differences in the nature of complaint and pattern of injury were revealing and clearly demonstrated that assaults at home and accidental consumption of poison were being reported mostly by women and were not picked up as domestic violence. All studies at the hospital level highlighted gaps in the current response in terms of documentation, procedure, perceptions and attitudes.

**FIGURE 2: Various functions of the project**

### Training and capacity building

Medical education follows a biomedical approach with little space for social determinants. For this reason, medical staff in hospitals are neither equipped to deal with nor sensitized to domestic violence. Therefore, sensitization of all 882 hospital staff prior to setting up and implementing services at Dilaasa was identified as a critical step during the project planning stages. This was deemed necessary to garner support at the hospital for the Centre, ensure referrals, increase awareness among staff and help staff recognize and identify Dilaasa as an integral part of the hospital.

To achieve this, a group of 40 hospital staff were identified for the training of the trainers. This was a 10-day training focused on knowledge, skills and attitudes. The staff could come for one day of training per month, so this took almost a year. Once trained, they were requested to volunteer to train the rest of the staff. Twelve of these staff members volunteered

and formed the core group of trainers. This facilitated recognition by hospital staff of Dilaasa as their own programme, not as an NGO activity foisted from outside. The core group was encouraged to become an in-house team with ownership of the project. They had internalized the perspective of the project, acted as advocates within and outside the hospital and were responsible for preparing training modules and training all hospital staff. Active participation of male doctors was important in ensuring that VAW not be classified as a 'women's activity' but be acknowledged as a public health concern.

Dilaasa training modules were designed to build the capacity of hospital staff and systems to sensitively respond to the health needs of survivors of domestic violence. Formative research helped define the content and each module included content on perspective, concepts, definition and data on VAW along with practice sessions on how to respond to various scenarios.



## TRAINING MODULE

### A three-hour training module developed by trained hospital staff

#### Session 1 (45 min)

The facilitator (a trained hospital staff) reads out routine situations at the hospital, such as a patient reaching the registration counter after the time is up and being shouted at, a patient coming at night to Emergency with history of temperature scolded for coming in so late, a patient complaining of 'consumption of half a bottle of insecticide,' 'being told that, insecticides don't kill anyone,' and other examples where staff may 'shout at' or 'abuse' patients. Through this exercise, these incidents are deconstructed to explain the difference in power between the health provider and patient and how the one who has power is seen to inflict violence on the less powerful individual, knowing that the weaker one cannot retaliate. The definition of violence is thus introduced to the group. Violence is a systematic use of force or power by a stronger person on the weaker one to exercise control over him/her.

#### Session 2 (45 min)

This is followed by group work. The participants are divided into three groups and each group is given a case study. The groups have to read the case study and identify forms of violence and health consequences. The group work is summed up through a presentation by the facilitator on prevalence, forms, and consequences of VAW. This session is aimed at building participants' knowledge/perspective on VAW.

#### Lunch Break (30 min)

#### Session 3 (60 min)

The next session focuses on building skills through role plays. To begin with, the facilitator makes a presentation on how to approach survivors of violence, on how to identify violence, what to ask, how to listen, how to validate, provide support and refer to Dilaasa. The participants are again divided into three groups and each group is given one case profile. They are asked to demonstrate how they will respond to the woman. The three case profiles:

- ♦ A 23-years old woman comes to the hospital, repeatedly complaining of body pains.
- ♦ A 30-year-old married girl was brought to the hospital on Saturday night at 1.30 a.m. by two men, as she had consumed rat poison.
- ♦ A 35-year-old mother of three was brought to the hospital with burns due to stove blast, accompanied by two neighboring women.

To conclude, the facilitator sums up by saying that these three could be three different women or the same woman who may come to hospital through different stages of violence. This is to emphasize on the need for early intervention to prevent reoccurrence of violence.

The module for orientation of all hospital staff, developed by the core group, has similar objectives and topics as the core group 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. Subsequently, follow-up training sessions were conducted to build skills for screening and gain deeper understanding of domestic violence and its causes. Inclusion of various cadres of hospital staff in the core group is an imperative and we aim for 100 percent coverage among hospital staff.

As soon as the centre was established, a core group of trainers was trained from other hospitals of the MCGM. They also attended 10 days of training. The curriculum for training hospital staff has been published and made available for practitioners.<sup>9</sup> Steps have been taken to institutionalize training through the formation of a training cell for MCGM, 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.

**FIGURE 3: Dilaasa's training model**



### Counselling

Dilaasa provides psychosocial services based on feminist principles of counselling. This model 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 take more control of their situation. It provides a larger picture of how the woman's problems, fears, insecurities, and negative self-cognitions are rooted in gender roles and patriarchal values. This awareness allows women to locate the source of their distress not within themselves, but in the social context. In addition,

the feminist counseling practice makes connections between the personal and the political and creates a space where women can be heard with respect, sensitivity and genuineness, and without being blamed. Feminist interventions locate the root of VAW within structures and institutions that are gender unequal. They question abuse and place the onus of abuse on the perpetrator, not the survivor. The principles of work therefore need to be integrated into the ethos of the OSCC- clearly stated in Standard Operating Procedures (SOPs) so that there is accountability in the redressal process. The counselling and support services

<sup>9</sup>More details can be found here: <http://www.cehat.org/uploads/files/VAW%20and%20HCP%20Training%20Curriculum.pdf>.



must agree that “there is no excuse for domestic violence.” The focus cannot be on ‘preserving marriage’, ‘reconciliation’, compromise, but on putting an end to violence.

A woman visiting 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 longer. Their follow-up depends on their first contact with the centre.

Safety assessment and planning form essential components of counselling for women facing domestic violence. This is done by assessing the increase in severity (from verbal to physical, from slaps to kicks and bites to use of instruments) and intensity of violence (from once in few months to once a month to once a week to daily), the potential threat to a survivor's life, or a threat to throw her out of the house and the impact of violence on her mental health (tendency of suicidal ideation or self-harm behavior). If the woman is unsafe, a safety plan is prepared with her that is practical and relevant in her circumstances. In addition, efforts to provide multiple sources in consonance with women's needs are made; for instance, there are provisions for medical referrals, medico-legal case registration and police complaint if needed. Women who are afraid of returning home because of the 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 to a shelter or finding a safe space with relatives/friends etc. Extending a woman's stay at the hospital also provides her necessary time and space to decide what she wants.

Quality control measures put in place for counselling included case reviews and presentations on a regular basis in the presence of an expert. The needs of the survivor are at the centre of the functioning of the crisis centre. Utmost importance is given to ensure the safety of the woman, to her healing process and adhering to the principle above all to do no harm.

### **Strategies used at implementation level to integrate project/issue into the system**

- ♦ Dilaasa has been established as a department of the hospital to ensure it can create its own relational and functional space and establish links to other departments and staff. This also means that this department is on par with other hospital departments.
- ♦ Conscious effort was taken to ensure all correspondence and liaising was done in the name of Dilaasa. This was followed both within the hospital and with outside organizations and agencies. This helped Dilaasa develop its own identity. Although the members of the team were from CEHAT and the MCGM, all policies and rules for the centre were developed together.

### **Strategies to increase visibility of domestic violence as a health issue**

- ♦ A pamphlet providing information about the Centre (Annexure 1) was developed, translated into local languages and made available at the hospital's Registration Desk, outpatient departments, inpatient departments and the Casualty Department.
- ♦ Posters (Annexure 2), calendars and referral slips were placed in all the departments of the hospital.
- ♦ A placard was developed for doctors in each of the outpatient departments, listing the signs for identifying cases of domestic violence.
- ♦ The hospital's case paper was modified to include a column entitled ‘Referred to Dilaasa’. The hospital's Management Information System was modified to include a field in which Casualty Department medical officers keep a daily record of the number of women referred to Dilaasa for services reported to the medical superintendent.
- ♦ In all meetings with senior doctors, consultants, local government representatives, members of the Public Health Committee and union representatives, the medical superintendent spoke about the need for the Centre, and encouraged them to visit. This helped reduce resistance and ensure collaboration from all stakeholders.



## 2.5 REPLICATION OF DILAASA

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 doctors', nurses' and social workers' roles. Within a few years, once the concept had been demonstrated and administrators and health providers were convinced that domestic violence was an important public health issue, the health system developed an enhanced sense of project ownership. This attitude is best illustrated by the fact that a core group of trainers from another

hospital replicated the project out of a sense of concern for women reporting violence there. Another hospital's core group of trainers went further and identified poor management of sexual assault cases and demanded support from CEHAT to improve their response (Ravindran and Vindhya 2010). The first replication of Dilaasa was carried out by MCGM in a Mumbai public hospital in 2005. The experience was reassuring and confirmed the essential elements of the model. See Figure 4 below.

**FIGURE 4: The Dilaasa Model**



The training cell of the MCGM also sensitized other hospitals to respond to domestic violence and refer survivors to Dilaasa. A group of trained doctors began raising concerns with current practices related to medico-legal procedures in cases of sexual violence. As the hospital where Dilaasa has been set up did not receive rape cases, this aspect of the health system response had not become a part of Dilaasa intervention.

In 2008, the Chief Medical Superintendent agreed to implement a uniform method for medico-legal examination for rape cases in three hospitals. CEHAT had developed a SAFE kit in 1998 modelled on the kits

used by Canadian police. There had been consistent advocacy with doctors to use these kits for examining rape cases, it had not been implemented. Within a couple of months, implementation revealed gaps in practice and procedures, which then informed the development of a doctors' manual that provided step-by-step guidance on comprehensive care for survivors of sexual violence. Key components of this comprehensive care included informed consent, history documentation, relevant evidence collection, treatment and chain of custody. This model was implemented in three hospitals and the experience informed submissions to the Justice Verma Committee<sup>10</sup> and later the Ministry of Health and Family Welfare "Guidelines

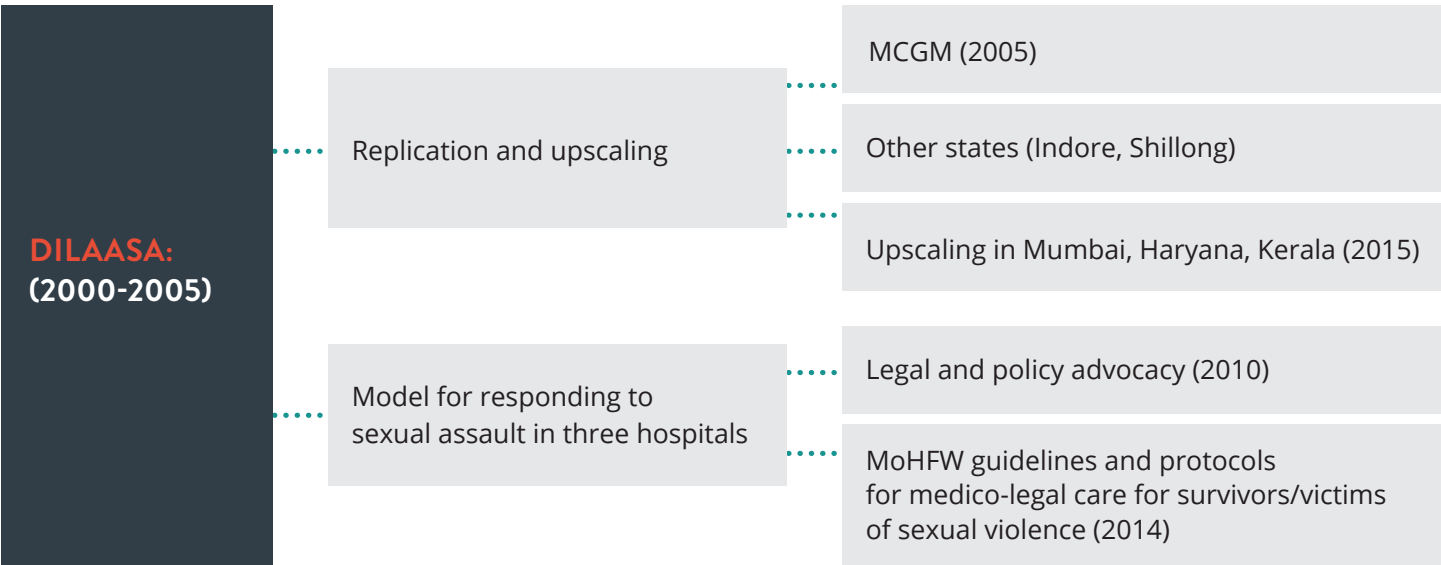
<sup>9</sup>The Justice Verma Committee (JVC) was set up in 2013 after the campaign demanding action against sexual violence. The committee sought inputs from multiple stakeholders and activists. The Dilaasa model for responding to sexual violence was submitted to JVC. The report recommended the CEHAT-Dilaasa manual for medicolegal care.

and Protocols for Medico-legal Care for Survivors/ Victims of Sexual Violence” published in 2014.<sup>11</sup> Dilaasa was also replicated in three hospitals in other states in India and upscaled as part of National Health Mission in Mumbai and Haryana.

In summary, Dilaasa is a redesigned OSCC model in India, that has trained existing hospital staff to respond to and integrate VAW in their roles and responsibilities. This is more sustainable than a traditional OSCC recruiting specialists brought into the hospital setting.

The first Dilaasa crisis centre was established in 2001 in the Bandra Bhabha Hospital in Mumbai as a joint project between an NGO and a government-run hospital. Since 2006, the centre in Mumbai has been functioning as a part of the public hospital. By 2018, the Dilaasa model had been adopted in 11 hospitals across three states in India. It is now entirely in the hands of the government, giving it significant political backing and sustainability (Annexure 6). The following illustrates Dilaasa’s journey:

FIGURE 5: Dilaasa’s Trajectory



<sup>11</sup>Can be retrieved from <https://main.mohfw.gov.in/sites/default/files/953522324.pdf>



## EXERCISE

Two case studies are presented below. The participants are requested to divide themselves into two sub-groups and discuss (suggested questions after explanation of the case studies). After a round of discussion, participants present their observations to the larger group for further discussion.

1. **Country A** has set up an OSCC in a hospital. Every woman identified as a survivor of violence in any of the hospital departments (emergency, out-patient or in-patient) is referred to the OSCC. The woman is received by the OSCC staff and given medical treatment there. The family or those accompanying her know that she has not been treated or admitted in the regular ward but taken elsewhere. The OSCC has doctors, police and counsellors and is located in the tertiary hospital. For women needing specialized medical care, wait times are often long as doctors must make a special visit to the OSCC after their regular duty is over. They provide all necessary support services to the survivor. The centre receives one or two cases daily. The hospital staff and the police department have raised concerns over the waste of human resources.
2. **Country B** has an OSCC in the hospital that is tied to an NGO. The hospital has provided space on campus for the NGO. NGO staff come daily and provide counselling services. They have established formal collaboration with the police department for delegation of police personnel. The police are able to send only a police constable – the lowest ranking member of the police hierarchy, who is not entitled to record formal police complaints. A woman therefore must go to the nearest police station to record a complaint. The OSCC has established referral mechanisms with other sectors such as public prosecutor's office and social justice institutions. They have all agreed to provide necessary support, but do not attend monitoring committee meetings, which are seen as an NGO service not taken seriously. Over the last month, the NGO has not been able to send staff due to turnover. The hospital brought in another NGO and the services worked normally for six months, but later there was a funding crisis in the NGO.



### Suggested questions for group discussion:

- ♦ What are the strengths and weaknesses of each model?
- ♦ Who should provide services in a hospital-based crisis centre?
- ♦ Do you think having full-time personnel from police at the centre is practical in your settings?
- ♦ What is the OSCC that you envisage in your setting?



## KEY TAKEAWAYS

Due diligence is necessary to set up any model. Visits to similar settings to understand how these have been set up are useful and in-depth understanding of the local context (through formative research, needs assessments and baseline surveys) is highly recommended. The key is to institutionalize service to ensure ownership by the system for sustainability of the redressal mechanism for the survivors.

### **Fostering collaboration with the health system**

Efforts must be made to build awareness with decision-makers in the health system and ministry on the need for the health system to respond to VAW in a sensitive way. We emphasize the following points:

- ♦ Prevalence and forms of violence using DHS, community-based studies, police records. Globally one woman in every 3 has experienced physical and/or sexual violence (World Health Organization, 2013).
- ♦ Direct and indirect consequences on health.
- ♦ Pathways for survivors of violence within the health facility – survivors either report violence spontaneously or in response to questions from health care providers prompted by signs and symptoms presented in the outpatient or inpatient consultation.
- ♦ Health facilities can play a critical role by identifying VAWG, providing treatment, encouraging access to support services, documenting incidents of violence and participating in a multi-sectoral response to VAWG.



## SECTION 3 | ROLE OF HEALTH SYSTEMS

The section details prevalence, forms and consequences of VAW and the critical role of health systems and professionals. It highlights the current evidence on the subject and recommended clinical practice (Bhate-Deosthali, 2013).

### 3.1 UNDERSTANDING VIOLENCE AGAINST WOMEN

VAW is a worldwide issue, with physical and/or sexual IPV affecting one in three women, which leads to substantial health effects that are determinants of morbidity and mortality. The prevalence is highest in Africa, the Eastern Mediterranean and Southeast Asia (WHO, 2013). Domestic violence is also a risk factor with adverse health outcomes, known to affect children's education and growth and employment opportunities. There are serious economic consequences as well. In short, the harm caused by such violence can last a lifetime for a woman, affecting her directly and future generations, with serious effects on health, education, employment, crime and economic well-being of individuals, families, communities and society as a whole.

Violence results in injuries, bruises, fractures, burns, vaginal tears, psychiatric problems, miscarriages and others. Health effects range from low birthweight of babies to anemia, from depression to suicide, from vague bodily complaints to severe illnesses such as pelvic inflammatory diseases, from repeated abortions to chronic pain syndromes, from unwanted pregnancies and unsafe abortions to HIV/AIDS, from pregnancy complications to maternal mortality, from memory loss to heightened anxiety, from fear of sexuality to low self-esteem. Psychological consequences of abuse may go unnoticed and unaddressed, including depression, anxiety disorders, post-traumatic stress disorder, suicidal tendencies, and chronic pain complaints (such as backaches – which can be psychological fallout of repeated abuse).

The relationship between domestic violence and health is dynamic– certain health conditions may trigger violence in women's lives, which in turn may deteriorate her health. For example, women who suffer from mental health problems, TB and HIV/AIDS may face ridicule, desertion, denial of treatment and isolation, and their condition may worsen in the absence of

support. If a woman has white discharge, she may be accused of sleeping with other men; if she repeatedly becomes sick, she may not receive medical attention. This, in turn, increases the probability of violence in their lives. A vicious circle is thus set in motion.

### 3.2 WHY THE HEALTH SYSTEM

To obtain treatment for the health complaints and injuries caused by violence, women approach the health facility. It is well-documented that women who face abuse are more likely to use health services than other women. According to a multi-site study performed in seven cities in India, almost half (45.3%) of women who faced violence reported injuries requiring treatment (INCLEN, 2000).

Another study, which examines cases of women recorded in the Emergency Police Register of the Casualty Department in an urban, government-run hospital in Mumbai, found that two-thirds of the women over 15 years of age (66.7% or 497/745) were definitely or possibly cases of domestic violence (Daga et. al, 1999).

Health professionals are therefore in a strategic position to reach women facing violence, as one of the most certain and earliest contacts for a survivor of violence. Early identification of women facing violence and appropriate intervention by healthcare providers can prevent the more severe health consequences that she will face if she continues to be abused.

Documentation of health complaints resulting from abuse can be done at health facilities. Such documentation can be used by the survivor in court as evidence, if she chooses to pursue legal action. Details of documentation are below.

### 3.3 ROLE OF HEALTH SYSTEM

Healthcare professionals have an obligation to maintain the health of patients and provide care. This goes beyond treating physical injuries and includes

identification of the root cause of ill-health, provision of psychosocial care and, in cases of violence, referral to appropriate agencies. Medical training enables providers to distinguish between a health complaint due to a medical condition and a complaint resulting from violence. An appropriate and ethical response of healthcare providers to violence includes identifying women who are survivors of domestic violence, providing psychological support, referring them to appropriate services, and following the legal mandate, in addition to providing the necessary medical treatment.

Healthcare providers need to reorient their positions in treating women facing violence, with the understanding that:

- ♦ Domestic violence is a public health issue and not a private matter.
- ♦ Domestic violence is a matter of power and control by men in a patriarchal society, not a matter of strain in a relationship. The issue must be responded to in providing holistic healthcare to the woman facing violence.
- ♦ A pure biomedical approach will not be sufficient for redressing issues of survivors of violence.
- ♦ VAW affects one in three women globally (World Health Organization, 2013).

### **The WHO Clinical and Policy Guidelines 2013 recommend that the care and health services for women survivors of violence should be women-centred**

Women who disclose any form of violence by an intimate partner or other family member or sexual assault by any perpetrator should be offered immediate support. Healthcare providers should offer first-line support when women disclose violence.

#### **First-line support includes:**

- ♦ Being non-judgmental and supportive and validating what the woman says
- ♦ Providing practical care and support that responds to her concerns, but does not intrude asking about her history of violence; Listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved)

- ♦ Helping her access information about resources, including legal and other services she might find helpful
- ♦ Assisting her to increase safety for herself and her children, where needed

#### **Providing or mobilizing social support**

- ♦ Providers should ensure:
- ♦ Privacy of the consultation;
- ♦ Confidentiality, while informing women of the limits of confidentiality (i.e., mandatory reporting)
- ♦ If healthcare providers are unable to provide first-line support, they should ensure someone else (within their healthcare setting or another that is easily accessible) is immediately available to do so.

#### **Demystifying common myths around VAW**

Health professionals are not immune from the same unconscious biases and views on VAW as the communities they represent. It is important to take this into account when looking at the differences in interaction and range of victim-blaming vs. survivor-centered attitudes. It is necessary to debunk these myths to enable a sensitive and respectful response towards survivors of violence.





## EXERCISE

### MYTHS AND FACTS ABOUT VAW

The facilitator can begin reading out the statements as commonly held perceptions in society and ask the group to state whether they agree or disagree with them, and why. A debate on each can be encouraged and summed up with the facts.

#### **Gender-based violence only happens to a certain “type” of person**

**FACT:** Studies show that gender-based violence can happen among people of all caste, class, religion, region, gender, sexuality etc.

#### **Sexual violence is mostly perpetrated by strangers**

**FACT:** Studies consistently show that most women who experience sexual violence have been abused by a known person.

#### **Rape always leaves sign of injuries**

**FACT:** Only one-third of women who have been raped may show any sign of injury on their body

#### **Men are naturally violent and cannot help themselves**

**FACT:** Violence is a learned behavior. It is encouraged in men by gender norms that support aggression and dominance in men. Men are often able to control their violence in certain settings, such as at work, while choosing to be violent at home.

#### **Women who experience violence at the hands of their partners “deserve” it. If she had acted differently, it would not have happened.**

**FACT:** It is never the victim’s fault. Violence cannot be justified for any reason. As health providers, it is important to examine our values and beliefs about gender roles.

#### **“Violence against women is a private matter.”**

**FACT:** Violence is not a household’s or a woman’s issue, but a public/social issue.

#### **“He loves me, that is why he hits me.”**

**FACT:** This myth has an element of ‘possessiveness’- that woman is a property of man, especially her husband. Possessiveness is manifested in ways such as telling her not to take up a job, not to pursue education. Women feel this is out of sheer love and affection. If the abuse is physical it is apparent, but when it appears in such subtle forms of ‘possessiveness’ it becomes more complex. A closer look at the cyclic episodes of violence points out that he hits her, but he also dresses the wound, apologizes, thus making her feel that he loves her.

#### **“He hits only when he is drunk.”**

**FACT:** Even if he is drunk, he hits only his wife; not his boss or neighbors. He uses it as an excuse to abuse.



## EXERCISE

**“The man is sad or mad rather than bad. He is emotionally disturbed, so he is not responsible for his actions.”**

**FACT:** Men in our societies are not socialized to handle emotion, sadness, and stress. It is not considered acceptable for a man to cry. Hence it is believed that he relieves his stress by beating his wife. Rather than disapproval, he gets sympathy. There is also a notion that if a man is abusive, he may be mentally ill. However, it is important to note that most mentally ill persons are not violent.

**“It cannot be that bad, or she would have left the man.”**

**FACT:** There are several reasons for why women do not leave their abusive homes. Many of them feel the need to keep their homes intact for the sake of their children. Also, the stigma associated with being a separated or deserted woman in society is too great for most to handle. Several women have no other means of support and are economically dependent on their husbands. In most cases, the woman does not even get support from her natal family. This does not negate the fact that the woman is being abused. It just means that she has no choice but to stay on.



## KEY TAKEAWAYS

### **What to do if a healthcare professional suspects violence:**

- ♦ Do not pressure women to disclose that she is living in an abusive relationship.
- ♦ Share information about services that are available if she chooses to use them.
- ♦ Offer information on the effects of violence on the health and of women and their children's.
- ♦ Offer a follow-up visit.



# Integrative Response to GBV

## SECTION 4 | ROLE OF OTHER STAKEHOLDERS: LESSONS IN MULTISECTORAL APPROACH

Given the emphasis on the multi-stakeholder approach in responding effectively to GBV survivors, effective linkages need to be forged and roles and responsibilities of each stakeholder should be clarified. Depending on where an OSCC is based (e.g. hospital facility, courts, police stations, separate facility, etc.), these roles and functions are defined and coordinated in a process which is sensitive to the needs of the survivor. The ultimate goal is to provide all services under one roof. While this is often not possible as resources cannot be pulled from each system, the aim of OSCCs is to ensure that the survivor gets a quick and sensitive response when referred to these services.

This section discusses the nuances of Dilassa's multi-stakeholder approach and those of in other institutions to understand the differences and processes involved in keeping the needs of the survivor at the centre of the service-providing mechanism.

### 4.1 INTERFACE OF A SURVIVOR WITH FORMAL AND INFORMAL SYSTEM

The following is an exercise that can be conducted to describe the role of formal and informal systems in a survivor's access to justice:





## EXERCISE

The session starts with a play that brings out the response of various stakeholders to survivors of sexual violence and the impact of the response on the survivor. The facilitator will ask for 9 volunteers who would play different characters in Maya's life – husband, mother, friend, doctor, police, local community leader, co-worker, social worker and public prosecutor. One participant will play the role of Maya and will be seated on a chair in the centre of the room. The others will be asked to stand in a circle around her. The facilitator must also have 9 sheets of cloth or newspaper to be used as blankets.<sup>12</sup>

Maya is a 30-year-old woman. She has been married for 10 years. She has two children ages nine and seven. She works at a garment factory while her husband is a taxi driver. The company's contractor is known to make lewd comments at women in the factory. Maya has discussed this with her friends at the factory who in turn suggested that it is best to ignore him. He came to know about it. Maya was returning from work at her usual time, the contractor summoned her back to the factory stating that her husband had called up and had an urgent message for her. As soon as Maya entered the contractor's office, he mugged her and threatened to kill her if she did not comply with whatever he asked her to do. He had forced peno-vaginal sex. He threatened her with dire consequences if she revealed the episode and stated that she would lose her job. Maya decided to take some steps against the contractor. She approached friends, family, health system, police and community.

After this, read out the response of each of the characters whom Maya approached for help. After the response is read out, the character puts a blanket/sheet on Maya.

### 1. Friend

Maya confided in her closest friend, Anita about the abuse. "Are you sure that you want to even reveal this to anyone? Just forget the entire episode and pretend that it never happened? Do you think anyone will believe that you were raped by our contractor? He is such an affluent man! Also come to think of it, you may lose your job!"

### 2. Mother

Maya visits her mother's house and confides in her: "I had told you not to speak against him, Oh god, such shame on our family! Maya do not even think of telling this to your husband, what if he throws you out? Who will look after you and your children?"

### 3. Co-worker

Maya is desperate and finally speaks to the other worker at the factory, she had also told her about the lewd comments in the past. "I had asked you to ignore

<sup>12</sup> If blankets or sheets are not available, newspaper sheets can be used too.



## EXERCISE

the comments, other women have been talking about you; they say that you had gone with him on your own and now you are accusing the contractor. Maya, think of it, he has such a good reputation why would he do this to a poor worker like you?"

### 4. Maya's husband

He has been depending on Maya's income as his taxi business is not doing well at all. He does not do much at home and does not help with children's studies at all. "Maya, I feel so disgusted with you, I have been suspecting as to why you have been coming home late. Is he your new boyfriend? Is that why you refuse to have sex with me? Get out, just go to your mother's place, I do not want to see you again."

### 5. Doctor

Maya goes to the doctor who says "If you were raped, have you made a police complaint? How come you don't have a single injury?" Doctor speaks to her colleague in English "How is it possible for an adult woman to be raped and not have a single injury?"

### 6. Local Community leader

The Local community leader come to know about Maya's story: "Contractor is an important member of the community; he was the one who set up this factory 10 years ago and provided an income source to so many women. Do you want to threaten his reputation? Maya, you have no shame, spoiling his and our name like that."

### 7. Police

Maya finally decided to make a police complaint against the contractor about the sexual assault. "Oh lady, now you say your employer has raped you, these women are always tarnishing the image of well-to-do men. Do you think you will get money by threatening him like that? Anyway, the police procedure is long, and you will have to come here every day."

### 8. Public Prosecutor

"Maya how much money have you got? I have so many cases like this. To tell you frankly, your case is weak, nothing much can happen! The contractor is powerful. Anyway, there were no eyewitnesses to your case."

### 9. Social worker at Shelter Home

"Maya, we do not keep raped women here, you know with the police coming and all, our residents will get disturbed. I think it is best for you to stay with your husband."

Narrator asks Maya: "Why do you put up with all this? Why don't you speak out against rape?"





## EXERCISE

After this, participants are asked if there are any other negative statements that they hear people say to women who have been sexually assaulted. Responses must be noted. Encourage participants to share phrases, comments and expressions commonly used in their context. After this, the facilitator should explain that the characters will now change their behavior and say positive things to Maya. The responses of each of the characters should be read out and as it is done, the character should go close to Maya and remove one sheet.

### 1. Doctor

Maya, I am your doctor. I understand that coming to the hospital for reporting the incident must have been difficult for you. I will be there to assist you in your treatment and will also explain procedures related to examination.

### 2. Social worker

Maya, you have shown a lot of courage. Please let me know in what way I can assist you. I also feel that you need to share all your pain and anger about the episode, this will help you feel lighter.

### 3. Police

Maya, we will help you to make a First Information Report and will also explain the investigation procedure.

### 4. Local Community leader

As a governing body of our community, I condemn the behavior of the contractor. It is not you but he who should be ashamed of his behavior.

### 5. Public Prosecutor

Maya, I shall explain the court procedure to you; we should meet before every court hearing. Please feel free to ask me questions or share your doubts about the procedure - they can be long and tedious at times, but I will be there to guide you.

### 6. Co-worker

Maya let us go and report the contractor to the manager - do not worry, we are there with you. Other women will also have the courage to speak up.

### 7. Husband

I understand the trauma you have been through; I will stand by you through all the difficulties.

### 8. Mother

My dear Maya, you have always been a strong-willed person. I believe you.

### 9. Friend

Maya, I know how it feels, I am there for you always.



## EXERCISE



Once all the blankets are removed, the facilitator<sup>13</sup> will ask those who participated, to share their experience, starting with Maya. She is asked how she felt through the entire process. This is followed by each of the 9 volunteers being asked to narrate how they felt in their specific roles.

### Participants can be asked about:

- ♦ Barriers in reporting sexual assault, at the level of family and other institutions such as police, health, and judiciary
- ♦ Biases that exist against survivors of sexual assault such as doubts about her character
- ♦ Disbelief about the entire incident

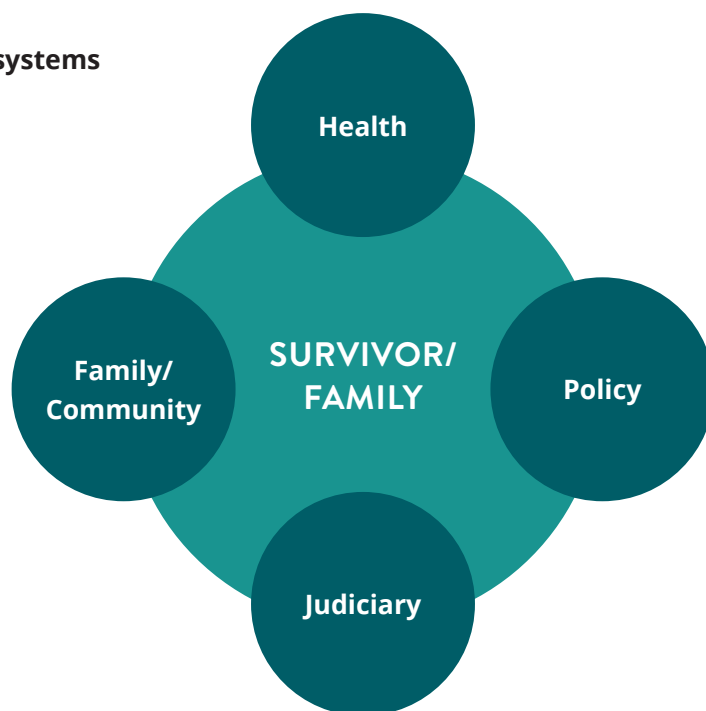


### Key points for discussion:

- ♦ The facilitator must draw attention to the fact that Maya had complained about other forms of sexual abuse but no action was taken, emphasize on the continuum within which sexual VAW takes place, explain the circumstances in which sexual violence takes place, efforts that a survivor has to report the offence, insensitive responses of the system that can weigh her down.
- ♦ The facilitator must stress the importance of looking at the person who has undergone rape as a survivor and not as a victim. Women's rights groups have consistently highlighted that even if a woman has been severely abused, she has agency, autonomy, and capacity to make decisions. In fact, the act of reporting the incident is one of courage and demonstrates her agency. The term 'survivor' respects this agency, while the term 'victim' denotes that she needs pity – the entire connotation is of us 'rescuing' women who have been sexually assaulted. On the contrary, the term 'survivor' suggests that she has struggled and is fighting against oppression.
- ♦ The facilitator must discuss the social scenario in which sexual assault occurs, the structures that enable it to happen, and the ones that women constantly deal with. Discuss how factors such as caste, class, community, sexual orientation, disability exacerbate the consequences of sexual violence. Migrant women experience unique challenges such as lack of essential documentation which may not allow them access to services. They may find it difficult to report abuse due to fear of police and concerns about being deported.

Refer to Annexure 3 on Medico-Legal Performa used at Dilaasa.

<sup>13</sup> The Facilitator should be pre-determined based on the criteria mentioned in [page 11](#)

**FIGURE 6: Role of various systems**

Rape is seen as a loss of honour and not as violence and violation of rights. A woman's character, her past relationships, whether she reported immediately, whether she had any marks of injury (indicating whether she struggled 'enough') and other such biases and prejudices are deeply entrenched in the way the society as well as institutions respond to her. Rape is not about sex. It is about displaying power.

The health system's response to sexual violence is insensitive in many countries. There is an inertia to respond because doctors do not want to testify in courts, which results in delays and long wait times for survivors. The medico-legal procedure is focused on evidence collection and signs of struggle, which ignores times women are threatened, numbed or intoxicated. The absence of physical injuries is often presumed to indicate a false complaint. Healthcare providers in many countries document the status of hymen and size of vaginal introitus to comment on virginity and/or sexual habitation. These are irrelevant, unscientific and insensitive. Gender-sensitive protocols must be made mandatory in all facilities.

Other institutions, namely the police and courts are also insensitive, and survivors are doubted at every step. Multiple visits and multiple sessions of questioning are painful and the road to justice is very long. The response of the informal system, such as community

and family, can also be insensitive, often characterized by victim-blaming and ostracization. In some instances, survivors have been forced to relocate.

The findings of the integration of response mechanisms by NGOs and the state in Morocco, and learnings of the Dilaasa model, presented in the following section, will shed light on the effectiveness of multi-sectoral approaches. This section presents one case study and one analysis piece for discussion and further clarity.

## 4.2 MULTI-SECTORAL COLLABORATION

Survivors of violence have multiple needs, which cannot all be addressed under one roof and survivors may have to be connected to other resources for safety and social and economic support. This section provides insights into principles of fostering collaborations with other services to ensure a coordinated response.

Survivors may also need to visit various institutions to access justice or other support. The OSCC team should be aware of police and legal procedures so they can guide the survivor.

Information on available helplines, OSCCs, mental health and counseling, legal aid, police and judicial institutions, local government, child protection, shelter and livelihoods services should be compiled. Whenever possible, implementers should conduct visits



to these centres to understand the procedures and nature of services. Referring a survivor may involve not merely giving her contact details but facilitating an appointment for her, providing written information and arranging for someone to accompany her on her first appointment.

The OSCC must create and maintain a resource directory with basic information about available vocational training, economic support, child care, shelters, legal support and other counselling centres such as child guidance clinics, addiction centres, psychologists, groups working with lesbian and bisexual women and support groups. This directory should be updated periodically.

**Medical centres should establish referral mechanisms:**

- ◆ Roles and responsibilities need to be stated clearly.
- ◆ Procedures for protecting confidentiality of information must be defined. Only relevant information should be shared when referring a woman to another agency.
- ◆ For core services, it is recommended that the OSCC develop partnerships with another agency. This can be done through formal or informal agreements. This lends credibility to such referrals and ensures that the agency is committed to the terms of the agreement. Women bestow a lot of faith in the counsellors and it is fair to provide them with authentic information. They should also know they can come back to the counsellor (and the centre) in case of any future problems.
- ◆ It is recommended that OSCCs organize a forum for reviewing referrals and learning from experience. Regular visits and contact with such agencies are important.

## CASE STUDY

### Dilaasa: Role of Multiple Stakeholders

Dilaasa has been set up as a department of the hospital and the OSCC must present aggregate data on the number of women and children who receive services monthly, the nature of health consequences, etc. A monitoring committee oversees the activities of the OSCC.

It has established strong linkages for ensuring:

- ◆ Police support by telephone calls to the police station if survivors want to register a complaint
- ◆ Social support such as shelters, children's institutions, hostels, financial aid, income generation and skills-building
- ◆ Legal support through voluntary lawyers, NGOs and State Legal Services Authority
- ◆ Support during court trials from Public Prosecutors
- ◆ Dedicated care for child survivors, through Child Welfare Committees

Plans for stakeholder engagements in Morocco for addressing of VAW were developed based on workshops in September<sup>14</sup> and social network analysis of interactions between four NGO partners and their stakeholders.<sup>15</sup> NGO partners in association with stakeholders and ICRW engaged in a participatory systems-analysis workshops in four regions in Morocco (Marrakech-Chichaoua, Meknes-El Hajeb, Taza, and Casablanca) to understand the role of multi-stakeholder response to GBV survivors and realities of survivors navigating systems to access justice. These workshops mapped the system of GBV response by identifying how different parts of the system work together and interact. Participants (NGOs and government stakeholders) charted the actual experience of women moving through this system, focusing discussions on layered identities of women (rural vs. urban, literate vs. illiterate, migrant vs. native born, physical vs. economic violence) and how their experiences differed by characteristics.

There were discussions regarding common issues while responding to violence under law 103-13 in Morocco:

- ◆ Some areas of confusion included whether or not medical professionals could issue a court admissible certificate.
- ◆ In all regions, coordination to meet the needs of an individual survivor is difficult because there is no secure, shared data system of service provision accessible to all actors.

<sup>14</sup> Refer to page 6.

<sup>15</sup> For more details please refer to [Annexure 7](#).



- ◆ In some regions, it has been easier to coordinate multi-sectoral responses than in other regions, and this seems to rely on the individuals and their relationships. Casablanca and Meknes show civil society at the centre and government at the periphery of the redressal mechanism with less diversity in types of government associations. Within more well-connected cities such as Taza and Marrakech, there is slightly more centrality of government actors. However, while in Taza there are multiple government actors as central figures, in Marrakech there is centrality of only a few key figures (primarily the chief prosecutor and vice prosecutor), which means the relationship between civil society and the government sectors is mediated by those individuals. This relationship can also be seen in Casablanca and Meknes. Even so, interactions with government actors are being initiated by civil society organization leaders, with government-initiated interactions being limited. Overall, the civil society organizations are well connected but lacking connections to government sectors, which are more connected with each other than to civil society. Various stakeholders and their connections determine the effectiveness of the process for the survivor.

A model like Dilaasa can help bridge this gap by providing multiple touch points for integration between governmental and non-governmental response systems. The following issues were of interest:

- ◆ Service provision under one roof
- ◆ Common protocols for all state and non-state responders to GBV to ensure women are referred to all steps in the response system
- ◆ Gender sensitization training for first receivers of survivors of violence (gendarmes, court guards, hospital reception, etc.) and protocols for how these people should respond to ease survivors' entry into the response system
- ◆ Reform of policy so medical professionals can issue court-admissible medical certificates and removal of barriers to issuance of these certificates





## EXERCISE



Based on the learnings of the coordinated and integrated response mechanism from Dilaasa and the findings of interactions of NGOs with the state in Morocco the participants can have a discussion based on the following suggested questions.

### Suggested questions for discussion:

- ♦ What are some of the ways in which interaction with key stakeholders can be more efficient?
- ♦ What are the advantages of establishing formal institutional ties between stakeholders for effective response to survivors of violence?
- ♦ How does one ensure accountability in terms of service provisioning from other stakeholders who are intrinsic parts of the OSCCs through the referral chain?
- ♦ What are some of the learnings from the Dilaasa model on multisectoral approach which can be used in your local context.



## KEY TAKEAWAYS

VAW is a complex phenomenon and survivors have multiple needs, including support and from individuals, family, neighborhood and the community and health, police, legal, social and financial services. All these cannot be provided under one roof, but must be facilitated through a strong coordinated response.

# Allocation of Resources and Documentation

This section focuses on the type of documentation required at the OSCC, the nature of data to be collected and analyzed as part of monitoring activities, the purpose of monitoring and evaluation and allocation of resources.

## SECTION 5 | REPORTING TOOL

It is essential that any health service manage data on VAW for planning provision of care. For women who seek legal recourse, medical documentation can be useful evidence in court. All facilities need to document the following in the **Medical Register**: Name, Age, Address, Type of Complaint, Form of Violence, Relationship with Abuser, Treatment provided, Referral etc.<sup>16</sup>

Data is also necessary for quality assurance at every level of the health system, to understand the current state of services and track progress (that is, monitoring and evaluation). At the national and subnational levels, public health surveillance on VAW provides crucial data.

These data can be used to create awareness and advocacy campaigns and guide development of response models. Similarly, monitoring and evaluation can contribute to evidence on what works and where improvement is needed.



Photo: CEHAT



Photo: CEHAT

<sup>16</sup> Refer to Annexure 4 – Intake Form – Dilaasa.



## EXERCISE

Review available data for your country (or region if country data are not available) and discuss the following. Country DHS data and crime records could be circulated for discussion.

- ♦ What does the data tell you about prevalence, forms, and consequences of VAW?
- ♦ What is missing in the existing data?
- ♦ What are the various sources of data on VAW? (list could include DHS, community-based studies, helpline, counselling centres, courts, police records)
- ♦ What is the scope and limitation of each of these data sources?
- ♦ What is known about attitudes towards domestic violence? What is the data source?
- ♦ What activities would you recommend for public awareness and influence public opinion to challenge the acceptability of violence against women?

From routinely collected service data at the OSCC, the number and type of cases can be aggregated per facility and included in **monthly or quarterly reporting**. These statistics can inform managers about the profile of survivors such as age, marital status, relationship with abuser, years of abuse, types of violence reported, consequences of violence, referrals from various departments and case load etc.

### Privacy and confidentiality in data collection, sharing and reporting

These are important principles for protecting the client from further harm in the form of stigma, discrimination and retaliation. Only aggregated analysis should be made public; if a case study is presented, the name must be changed and no identifiable information should be used. All records should be kept in safe custody.

- ♦ Do not write any indication of violence on the first page of a record that others who do not need to know can see (e.g. bed charts, x-rays).
- ♦ Ensure documents are always locked in the facility. At no point should they be left where other can see them.
- ♦ Protect records the woman may take home; inform her about keeping the documents safe if a medico-legal case has been or will be made.

### Documentation of counselling

The counselling centre must maintain documentation for every visitor. Counselors must explain the purpose of documentation and explain these will be kept confidential. Specify:

- ♦ Where and how information about violence should be recorded and stored
- ♦ What information will be shared and with whom (including chain of custody for forensics)
- ♦ How confidentiality is maintained and who has access
- ♦ What information will be compiled and reported and how frequently it will be updated





## EXERCISE

Documentation is an important aspect of any counselling centre's work, which clear protocols inclusive of intake procedures and registers. The staff also needs to be trained to understand the importance of documentation and skills to be able to complete required forms.

This documentation is crucial as it details the types of violence experienced, women's coping mechanisms and other information. The centre has a responsibility to enlighten society about various forms of VAW and their struggles to access justice. Case records are a good source of information on types of VAW within their families, individual responses to this violence, circumstances that prevent women from speaking out about in and the welfare consequences of living in abusive environments. There are various ways in which documentation can be helpful:

- ◇ Can be systematically analyzed and disseminated to society to build awareness on the issue and change people's attitudes.
- ◇ Sensitize other agencies and make them more responsive to the needs of the survivors of violence.
- ◇ Improve service quality.
- ◇ Examine current strategies adopted by the centre for improving referral services and training of care providers and the effectiveness of interventions.

Dilaasa carried out such an analysis in the first year managing the centre. Analysis indicated that many women were referred only after a suicide attempt. This prompted the team to train counsellors in suicide prevention and related medico-legal issues.

### **Ethical issues**

To protect women's right to privacy and confidentiality, the analysis must only present aggregate analysis and patterns. Identifiable information should never be presented in any report or paper.

OSCCs could follow this procedure in collaboration with research institutions or appoint an independent researcher to ensure ethical, thorough analysis and produce scientific evidence.

### **Evaluation**

Evaluation involves periodic and in-depth assessment of performance and progress toward objectives, either of the programme as a whole or of a major aspect of the programme. It can answer questions about service quality, intervention impact, compliance with standards, assessment of gaps and steps that could be taken to improve the programme. Dilaasa was evaluated by an external panel to assess achievement toward its goal of setting up a hospital-based crisis intervention service and determine replicability.



## EXERCISE

Evaluation may be conducted to answer questions such as

- ♦ What is progress made towards the stated objectives?
- ♦ Have the objectives of the project been achieved?
- ♦ What are the steps required to be taken to improve quality of services?
- ♦ Has the OSCC been able to adequately reach out to survivors?
- ♦ How is the health system contributing to an effective response to VAW?

**Monitoring and evaluation data should be used to review and track health system performance and make improvements in service delivery as follows:**

- ♦ Revise or adjust planning for existing services or inform plans for expanding services.
- ♦ Provide feedback to staff on monitoring findings and discuss ways to improve service quality.
- ♦ Share or disseminate findings in the community and discuss how to make quality improvements with community members, including local women's organizations, service organizations in other sectors and community leaders.
- ♦ Refine protocols or standard operating procedures.
- ♦ Provide additional training to healthcare providers.
- ♦ Improve infrastructure for service delivery and strengthen referral pathways.

Example: Under the support of the Lawyers Collective that drafted the bill on the Protection of Women from Domestic Violence in 2005 in India, implementation of the law has been monitored annually since it was passed. Attention has consistently been drawn to continuing challenges such as scarce budgets, appointment of protection officers under the law (contractual vs regular, independent charge vs additional charge) and lack of training of police and judges on the law.<sup>17</sup>



## KEY TAKEAWAYS

Documentation is important and cannot be left to individuals. It must be planned, and clear formats for documenting services should be developed and implemented. The documentation in cases of VAW is sensitive and therefore utmost care must be taken to follow procedure to maintain privacy and confidentiality.

<sup>17</sup> For more details refer to: <http://www.lawyerscollective.org/wp-content/uploads/2012/07/Manual-on-Best-Practices-under-PWDVA.pdf>; <https://www.lawyerscollective.org/wp-content/uploads/2012/07/Resource-Tool-for-Monitoring-Evaluation-of-PWDVA.pdf>; <http://www.lawyerscollective.org/wp-content/uploads/2012/07/Staying-Alive-Evaluating-Court-Orders.pdf>

## SECTION 6 | BUDGET TOOL

In most countries, the health budget does not include allocations for VAW services. Any initiative to set up services for VAW must list the various costs and ensure there is funding available. It is important these be included in existing budgets for health programmes (Bhate-Deosthali et. al, 2013).

### Core elements of what constitutes comprehensive response to VAW:

- ♦ Identification of women survivors of violence
- ♦ Immediate treatment for health complaints such as injuries, infections, unwanted pregnancies and others

- ♦ Provision of first-line support including listening, validation, safety planning and facilitating social support and legal services
- ♦ Documentation of violence and collection of evidence in cases of survivors of sexual violence
- ♦ Clarification of chain of custody for preservation of evidence

In several countries, VAW services are financed or supported by UN agencies or NGOs. It is important that funds be made available in national health budgets. It is important that a specific budget line item be included for VAW services, which shows the government's commitment and ensures accountability.



### EXERCISE

Ask participants to develop a plan for setting up OSCC and list costs involved in setting up the centre.

#### Estimating the costs of providing services:<sup>18</sup>

- ♦ Staff (number of staff and hours of human resources for providing comprehensive care): Have an estimate of the number of women likely to come for counselling; 2 counsellors at minimum for OSCCs.
- ♦ Meetings with various stakeholders for planning, coordination, and monitoring: These include meeting with department heads within the hospital, representatives of other support agencies and sectors. The frequency of the meetings is to be mutually decided.
- ♦ Infrastructure and equipment for setting up space to ensure privacy: Cupboards, tables, chairs, computers and other communication costs
- ♦ Essential medical supplies: Drugs, emergency contraception, post-exposure prophylaxis (PEP), amongst others, which may be included as part of hospital inventory or listed separately.
- ♦ Development of protocols and procedures for running OSCC
- ♦ Documentation: Finalizing formats for documentation of VAW by providers and by OSCC staff
- ♦ Training of staff: Consider number of training days, staff strength, cost of venue, food, material, faculty time
- ♦ Advocacy and outreach efforts: Meetings with front-line workers, local government, community leaders and schools to spread awareness about existing services
- ♦ Information, education and communication materials and dissemination: Posters, pamphlets, cards, etc. for creating awareness of VAW and OSCC services
- ♦ Research cost: Collection of monitoring and evaluation data, analysis and writing.

<sup>18</sup> Refer to [Annexure 5- Costing of Dilaasa centres](#) and [Annexure 6 – Programme implementation Plan 2013-14](#), Ministry of Health and Family Welfare, Government of India - Budget head for Dilaasa.





### KEY TAKEAWAYS

The planning for required cost for setting up OSCC must be done systematically. This must consider the cost of setting up the centre which may include some one-time costs and the cost of running the centre which are recurring costs.



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# Annexures

## ANNEXURE 1 | DILAASA PAMPHLET



### DILAASA - Crisis Intervention Department for Women

Sometimes, we visit the hospital for treating various complaints, such as injuries, aches and pains or serious injuries like burns. At times, there is no physical illness, but we feel stressed due to financial problems at home, or when our family members mistreat us. These worries lead to health complaints like sleeplessness, headaches, frequent dizziness, and problems related to menstruation. The pressure may mount to such an extent that we feel like ending our lives.

When we visit the hospital for treating any of these complaints, healthcare providers ask us to specify reasons while filling case papers. Some of us are able to say that we were hit by our husband; some of us may have even have filed a complaint with the police before visiting the hospital. But most of us often hesitate to say that our husband, parents or close relatives have beaten us. It is not easy to admit that our in-laws or parents make us feel oppressed. We say instead, that we were hurt in an accident.

At Dilaasa, we offer women the space to talk about difficulties under the assurance of confidentiality – the information will not be shared with others. This centre has been set up as a joint initiative of the MCGM and Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai. There are trained, sensitized professionals to confide in and help find a way out of the difficult situation. Women can seek advice, avail of legal redress, police intervention, temporary shelter for one or two days in situations of emergency, and get current information on new laws passed by the government through this department.

In order to put an end to the violence that women and girls face at home from their family members, the Government of India enacted the **Protection of Women from Domestic Violence Act, 2005**. Under this Act, women are entitled to protection irrespective of caste or religion. Whether you are facing violence from in-laws, parents or any other relative, you can avail of help under this law. If there are difficulties that prevent you from seeking legal remedies by yourself, this law makes it possible for another person to do so on your behalf. We often fear that by speaking out against violence, we may stand to lose the roof over our heads. However, with the help of this law, it is possible to continue living in the same house and resisting violence. This law aims to empower women.

Each one of us wishes to live in a home free from violence; Dilaasa is making an effort towards this, guided by the motto that 'No one has the right to inflict violence on another person'. Dilaasa is committed to working with women to reduce loneliness and instil greater confidence.



### DILAASA - Crisis Intervention Department for Women

**Bandra:** Dept. No. 101, Gynec OPD, K. B. Bhabha Hospital, R. K. Patkar Marg, Bandra (W), Mumbai - 50  
Time: Mon To Fri - 9:00 a.m. to 4:00 p.m. / Sat. - 9:00 a.m. to 12:00 noon  
Phone: Direct 26400229 / Bhabha - 26422775 / 26422541 Ext. 4376, Email: dilaasamumbai@gmail.com  
**Kurla:** K. B. Bhabha Hospital, Belgrami Road, Kurla (W), Mumbai - 70  
Phone: 26500241 Extn. 212 Time: Wed. & Thu. - 9:00 a.m. to 4:00 pm.



## ANNEXURE 2 | POSTER FOR HEALTH CARE PROFESSIONALS

# First-line Support is an important aspect of Therapeutic Care

As a Health Care Provider, when someone discloses domestic or sexual violence, you need to protect dignity, safety and well-being of the survivor



## ENSURE CONFIDENTIALITY

Provide a safe space, seek informed consent before disclosing information about the survivor to any other stakeholder or caregiver

## LISTEN ACTIVELY

and maintain eye contact



## INQUIRE

Ask open ended questions, inquire about escalation of violence, summarise what the survivor has expressed

## ASSESS SAFETY

(PHYSICAL and PSYCHOLOGICAL)

Offer admission to the hospital as an option, ask whether she has attempted suicide or is thinking about it



## PROVIDE INFORMATION TO SUPPORT SERVICES

Maintain a list of contact details of Protection Officers under PWDVA, CWC Members, organizations that provide support

## EMPHASISE THE IMPORTANCE OF FOLLOW UP

for treatment and care, feedback on referral services



## DO NOT IMPOSE YOUR VIEWS DO NOT DOUBT THE SURVIVOR'S NARRATIVE



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### Contact Us:

CEHAT, Survey No. 2804 & 2805,  
Aaram Society Road, Vakola, Santacruz East,  
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## ANNEXURE 3 | MEDICO-LEGAL PERFORMA - DILAASA

## MEDICO-LEGAL EXAMINATION REPORT OF SEXUAL VIOLENCE

1. Name of the Hospital ..... OPD No. .... Inpatient No .....
2. Name ..... D/o or S/o (where known).....
3. Address.....
4. Age (as reported) ..... Date of Birth (if known).....
5. Sex (M/F/Others) .....
6. Date and Time of arrival in the hospital .....
7. Date and Time of commencement of examination.....
8. Brought by..... (Name & signatures)
9. MLC No. .... Police Station.....
10. Whether conscious, oriented in time and place and person.....
11. Any physical/intellectual/psychosocial disability .....  
(Interpreters or special educators will be needed where the survivor has special needs such as hearing/speech disability, language barriers, intellectual or psychosocial disability.)
12. Informed Consent/refusal  
I..... D/o or S/o.....

hereby give my consent for:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a) medical examination for treatment                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) this medico legal examination                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) sample collection for clinical & forensic examination | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

I also understand that as per law the hospital is required to inform police and this has been explained to me.

I want the information to be revealed to the police Yes ☐ No ☐

I have understood the purpose and the procedure of the examination including the risk and benefit, explained to me by the examining doctor. My right to refuse the examination at any stage and the consequence of such refusal, including that my medical treatment will not be affected by my refusal, has also been explained and may be recorded. Contents of the above have been explained to me in ..... language with the help of a special educator/interpreter/support person (circle as appropriate) .....

If special educator/interpreter/support person has helped, then his/her name and signature.....

Name & signature/thumb impression of Witness

.....

With Date, time and place

Name & signature of survivor or parent/Guardian/person in whom the child reposes trust in case of child (<12 yrs)

.....

With date, time & place

13. Marks of identification (Any scar/mole)

(1) .....

(2) .....

Left Thumb impression

14. Relevant Medical/Surgical history

Onset of menarche (in case of girls) Yes <input type="checkbox"/> No <input type="checkbox"/> Age of onset.....
Menstrual history – Cycle length and duration ..... Last menstrual period.....
Menstruation at the time of incident -Yes <input type="checkbox"/> / No <input type="checkbox"/> , Menstruation at the time of examination - Yes <input type="checkbox"/> / No <input type="checkbox"/>
Was the survivor pregnant at time of incident - Yes/No, If yes duration of pregnancy .....weeks
Contraception use: Yes <input type="checkbox"/> / No <input type="checkbox"/> If yes – method used: .....
Vaccination status – Tetanus ( <input type="checkbox"/> vaccinated / <input type="checkbox"/> not vaccinated ), Hepatitis B ( <input type="checkbox"/> vaccinated / <input type="checkbox"/> not vaccinated )

[illegible]

Hit with (Hand, fist, blunt object, sharp object)	Burned with
Biting	Kicking
Pinching	Pulling Hair
Violent shaking	Banging head
Dragging	Any other

- i. Emotional abuse or violence if any (insulting, cursing, belittling, terrorizing).....
- ii. Use of restraints if any .....
- iii. Used or threatened the use of weapon(s) or objects if any.....
- iv. Verbal threats (for example, threats of killing or hurting survivor or any other person in whom the survivor is interested; use of photographs for blackmailing, etc.) if any:.....
- v. Luring (sweets, chocolates, money, job) if any: .....
- vi. Any other:.....

i. Any H/O drug/alcohol intoxication:.....

ii. Whether sleeping or unconscious at the time of the incident: .....

This proforma contains 4 copies of each sheet. Sheets are to be distributed as follows:  
Pink - For the patient. Yellow - For the police. Blue - for the FSL. White - for the hospital

**15 F. Details regarding sexual violence:**

*Was penetration by penis, fingers or object or other body parts (Write Y=Yes, N=No, DNK=Don't know) Mention and describe body part/s and/or object/s used for penetration.*

	Penetration			Emission of Semen		
Orifice of Victim	By Penis	By body part of self or assailant or third party (finger, tongue or any other)	By Object	Yes	NO	Don't know
Genitalia (Vagina and/or urethra)						
Anus						
Mouth						

Oral sex performed by assailant on survivor	Y	N	DNK
Forced Masturbation of self by survivor	Y	N	DNK
Masturbation of Assailant by Survivor, Forced Manipulation of genitals of assailant by survivor	Y	N	DNK
Exhibitionism (perpetrator displaying genitals)	Y	N	DNK
Did ejaculation occur outside body orifice(vagina/anus/mouth/urethra)?	Y	N	DNK
If yes, describe where on the body			
Kissing, licking or sucking any part of survivor's body	Y	N	If Yes, describe
Touching/Fondling	Y	N	If Yes, describe
Condom used*	Y	N	DNK
If yes status of condom	Y	N	DNK
Lubricant used*	Y	N	DNK
If yes, describe kind of lubricant used			
If object used, describe object:			
Any other forms of sexual violence			

*\* Explain what condom and lubricant is to the survivor*

Post incident has the survivor	Yes/No/DoNot know	Remarks
Changed clothes		
Changed undergarments		
Cleaned/washed clothes		
Cleaned/washed undergarments		
Bathed		
Douched		
Passed urine		
Passed stools		
Rinsing of mouth/Brushing/ Vomiting(Circle any or all as appropriate)		

Time since incident.....

H/o vaginal/anal/oral bleeding/discharge prior to the incident of sexual violence.....

H/o vaginal/anal/oral bleeding/discharge since the incident of sexual violence.....

H/o painful urination/ painful defecation/ fissures abdominal pain/pain in genitals or any other part since the incident of sexual violence .....

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**16. General Physical Examination-**

- i. Is this the first examination.....
- ii. Pulse..... BP .....
- iii. Temp..... Resp. Rate.....
- iv. Pupils .....
- v. Any observation in terms of general physical wellbeing of the survivor.....

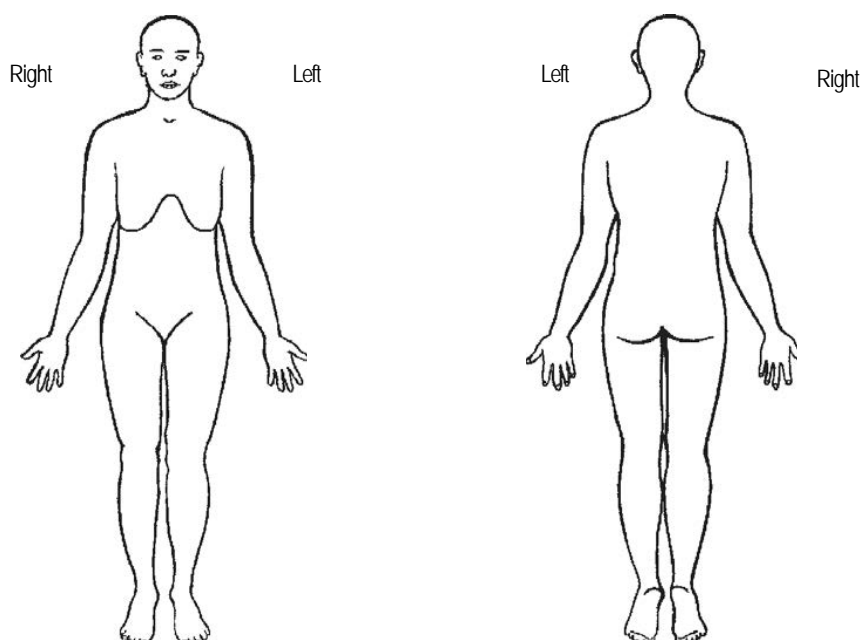
**17. Examination for injuries on the body if any**

The pattern of injuries sustained during an incident of sexual violence may show considerable variation. This may range from complete absence of injuries (more frequently) to grievous injuries (very rare).

*(Look for bruises, physical torture injuries, nail abrasions, teeth bite marks, cuts, lacerations, fracture, tenderness, any other injury, boils, lesions, discharge specially on the scalp, face, neck, shoulders, breast, wrists, forearms, medial aspect of upper arms, thighs and buttocks)*

*Note the Injury type, site, size, shape, colour, swelling signs of healing simple/grievous, dimensions.)*

Scalp examination for areas of tenderness(if hair pulled out/ dragged by hair)	
Facial bone injury: orbital blackening, tenderness	
Petechial haemorrhage in eyes and other places	
Lips and Buccal Mucosa / Gums	
Behind the ears	
Ear drum	
Neck, Shoulders and Breast	
Upper limb	
Inner aspect of upper arms	
Inner aspect of thighs	
Lower limb	
Buttocks	
Other, please specify	



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## 18. Local examination of genital parts/other orifices\*:

## A. External Genitalia: Record findings and state NA where not applicable.

Body parts to be examined	Findings
Urethral meatus & vestibule	
Labia majora	
Labia minora	
Fourchette & Introitus	
Hymen	
Perineum	
External Urethral Meatus	
Penis	
Scrotum	
Testes	
Clitoropenis	
Labioscrotum	
Any Other	

\* Per/Vaginum /Per Speculum examination should not be done unless required for detection of injuries or for medical treatment.

P/S findings if performed .....

P/V findings if performed .....

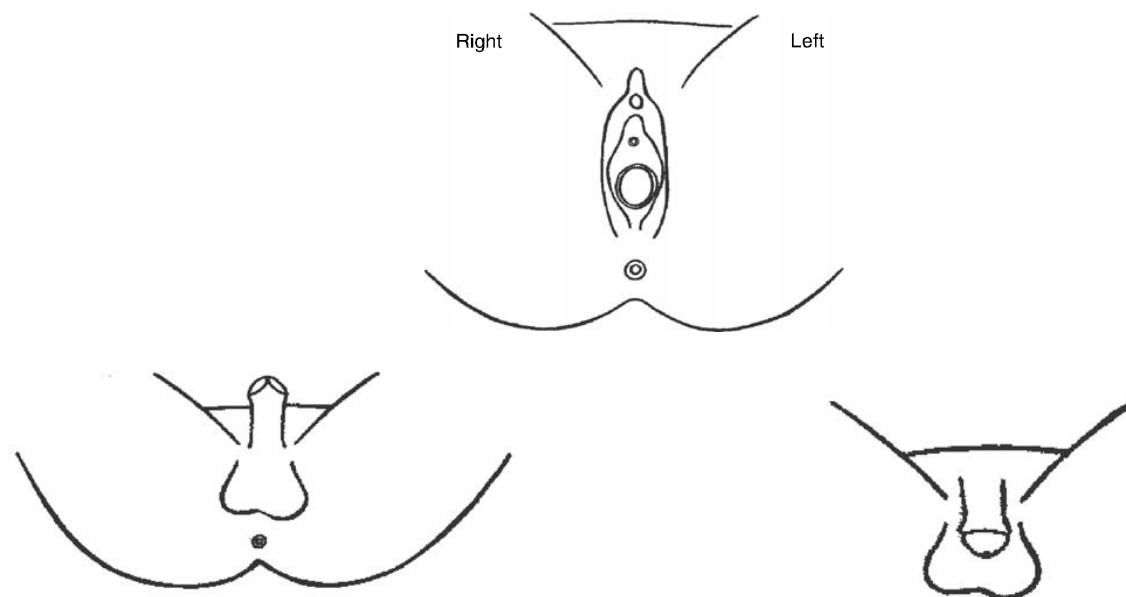
Record reasons if P/V or P/S examination performed .....

## C. Anus and Rectum (encircle the relevant)

Bleeding/ tear/ discharge/ oedema/ tenderness .....

## D. Oral Cavity - (encircle the relevant)

Bleeding/ discharge/ tear/oedema/ tenderness .....



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**19. Systemic examination: .**

- 1) Central Nervous System: .....
- 2) Cardio Vascular System: .....
- 3) Respiratory System: .....
- 4) Chest: .....
- 5) Abdomen: .....

**20. Sample collection/investigations for hospital laboratory/ Clinical laboratory**

- 1) Blood for HIV, VDRL, HbsAg .....
- 2) Urine test for Pregnancy/ .....
- 3) Ultrasound for pregnancy/internal injury .....
- 4) X-ray for Injury .....

**21. Samples Collection for Central/ State Forensic Science Laboratory**

- 1) Debris collection paper .....
- 2) Clothing evidence where available – (to be packed in separate paper bags after air drying) .....

List and Details of clothing worn by the survivor at time of incident of sexual violence

**3) Body evidence samples as appropriate (duly labeled and packed separately)**

	Collected/Not Collected	Reason for not collecting
Swabs from Stains on the body (blood, semen, foreign material, others)		
Scalp hair (10-15 strands)		
Head hair combing		
Nail scrapings (both hands separately)		
Nail clippings (both hands separately)		
Oral swab		
Blood for grouping, testing drug/alcohol intoxication (plain vial)		
Blood for alcohol levels(Sodium fluoride vial)		
Blood for DNA analysis(EDTA vial)		
Urine (drug testing)		
Any other (tampon/sanitary napkin/condom/object)		

**4) Genital and Anal evidence** (Each sample to be packed, sealed, and labeled separately-to be placed in a bag)

\* Swab sticks for collecting samples should be moistened with distilled water provided.

	Collected/Not Collected	Reason for not collecting
Matted pubic hair		
Pubic hair combing (mention if shaved)		
Cutting of pubic hair (mention if shaved)		
Two Vulval swabs (for semen examination and DNA testing)		
Two Vaginal swabs (for semen examination and DNA testing)		
Two Anal swabs (for semen examination and DNA testing)		
Vaginal smear (air-dried) for semen examination		
Vaginal washing		
Urethral swab		
Swab from glans of penis/clitoropenis		

\*Samples to be preserved as directed till handed over to police along with duly attested sample seal.

**22. Provisional medical opinion**

I have examined (name of survivor).....M/F/Other.....aged..... reporting (type of sexual violence and circumstances)..... days/ hours after the incident, after having (bathed/douched etc)..... My findings are as follows:

- Samples collected (for FSL), awaiting reports .....
- Samples collected (for hospital laboratory) .....
- Clinical findings .....
- Additional observations (if any) .....

**23. Treatment prescribed:**

Treatment	Yes	NO	Type and comments
STI prevention treatment			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Post exposure prophylaxis for HIV			
Counselling			
Other			

**24. Date and time of completion of examination** .....  
This report contains ..... number of sheets and .....  
number of envelopes.

Signature of Examining Doctor

Name of Examining Doctor

Place:

Seal

**25. Final Opinion** (After receiving Lab reports)

**Findings in support of the above opinion**, taking into account the history, clinical examination findings and Laboratory reports of ..... bearing identification marks described above, ..... hours/ days after the incident of sexual violence, I am of the opinion that: .....

Signature of Examining Doctor

Name of Examining Doctor

Place:

Seal

**COPY OF THE ENTIRE MEDICAL REPORT MUST BE GIVEN TO THE SURVIVOR / VICTIM FREE OF COST IMMEDIATELY**

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**ANNEXURE 4 | INTAKE FORM - DILAASA**

DV	SV	Counsellor
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**DILAASA: CRISIS CENTRE FORM WOMEN INTAKE FORM**  
(FORM FOR SEXUAL VIOLENCE & DOMESTIC VIOLENCE)

**SECTION 1**

(NO FIELDS SHOULD BE LEFT BLANK)

Reg No:	Date:
Time interview started:	Time interview ended:
Referred by:	Date of MLC (whethere done from Dilaasa):
Name:	Age (DOB):

<b>Religion:</b>	Muslim	Christian	Hindu	Buddhist	Other
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**Medical Treatment: If referred from the hospital record the following from the case paper**

What was found in the examination?	What is the treatment prescribed?							
Pregnancy status:	Yes	Months	No	NA				
Marital Status:	Single	Married (1 <sup>st</sup> /2 <sup>nd</sup> wife)	Seperated	Widowed	Deserted	Divorced	Others	NA

**Number of years of marriage/ Date of marriage:****Name and address of a "safe" contact person:**

(Specify the relation – Natal Family, Marital Family, Employers, Neighbors/Friends, Others)

Present address (mention landmark):	Safe address (mention landmark):
Phone no.: (home/self)	Phone no.: (home/self)
C/O Workplace:	C/O Workplace:

**Can we get in touch with the woman? If so, how?**

By Phone	By Letter	Cannot get in touch
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**Education**

Illiterate	Primary	Secondary	Post graduate	Vocation Course	Other
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**Occupation**

Not employed	Domestic worker	Homemaker	Formal sector	Self-employed	Informal sector (specify)	Other
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**Financial Status:**

Husband's income ( Daily/Weekly/Monthly wages):

Woman's income ( Daily/Weekly/Monthly wages):

Family income ( Daily/Weekly/Monthly wages):

Do you have any assets in your name?	Movable	Immovable
--------------------------------------	---------	-----------

**Do you have any important documents with you?**

Marriage certificate	
Marriage Photo	
Birth Certificate of children	
Ration card	
List of streedhan/gifts given at the time of marriage	
Receipts of jewelry	
Investments in your name	
Voter card	
Health reports	
Academic certificates	
Property Paper	
Bank Accounts	
Any other	
Passport	

**Information about children**

Name:	Sex:	Age:	Any other information:
Her relationship to the abuser? Husband/ Marital family (specify), Natal family (specify), Children			
Name of the Abuser?			
Address and Telephone number of workplace?			
Police Station nearest to residence?			
Police Station nearest to incidence?			
Date:		NC/FIR no:	

**SECTION 2 | HISTORY OF VIOLENCE****Details of present/recent incident of violence****History of violence:**

Number of years you have experienced violence:

Whether faced violence in pregnancy:

### Type of Violence Faced

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

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

**Narrate incidence of violence and her life story:**



### What do you do after the incidence of violence?

(Cry, sit in a corner, leave the house, go to your natal home, talk to the children, go to sleep, nothing, carry on with work, make a police complaint, suicidal ideation)

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

### Are there other family members affected by violence?

Name:	Age:	Sex:	Type of violence & its effect

### Safety Assessment

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

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

### Safety Plan

**Safety plan discussed with woman** (physical and Psychological):

**Expectations from the centre** (In the woman's words)

### SECTION 3 | INTERVENTION

(DISCUSSION WITH THE WOMAN)

**Registration of complaints** (MLC, Police complaint):

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

**Emotional Support** (Reassure her that violence is not her fault; share with her that she is not alone; share coping mechanisms such as attending women's meetings, engaging in paid work, skill building etc.; stress her strengths; help her to understand the pattern of abuse and link it to a larger oppressive structure in which we live and how violence against women happens most of the time.)

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

**Shelter:**

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

**Legal Counselling** (her rights, procedure for injunction, PWDVA, stay order, maintenance, divorce)

**Impression** Woman's perception about her situation (a more holistic picture about her life)

## Counsellor's analysis of the woman's situation

### Future plan discussed with woman

Reg. of complaints:

Medical:

Emotional Support:

Social Support:

Safety/Shelter:

Police:

Legal Aid:

How do you feel after the counselling session? (Ask this question to the woman after counselling session)

Date:

Feedback from the team:

## ANNEXURE 5 | COSTING FOR DILAASA CENTRES

### Estimated Costs of a Dilaasa Crisis Centre per year in INR<sup>19</sup> (2012)

**Initial cost** of training of counsellors and health care providers and some infrastructural cost

- ♦ Training of trainers; 9 days
- ♦ Training of counsellors; 5 days
- ♦ Training of hospital staff; minimum 3 training modules of 3 hours each
- ♦ Meeting expenses for Case presentation
- ♦ Monitoring committee meetings

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**Human resources:**

One full time and one part time social worker, one part time nurse, one part time physiotherapist.

- ♦ At least two counsellors
- ♦ One data entry counsellor
- ♦ ANM

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**The running cost** of the crisis centre includes expenses for telephone, photocopying, travel with survivors, supervision, and monitoring of quality of services, data management

- ♦ Infrastructure – tables, chairs, curtains, cupboards, filing cabinet, computer, printer, fax, telephone
- ♦ Paper and other material cost

The Dilaasa crisis centre is in Bandra (West), an administrative unit within Mumbai with a population of 3,37,000. The total female population is 1,55,200. The overall cost of setting up and running a unit is INR 3,000,000 annually in Bandra (West), Mumbai. This indicates that in Bandra an average of Indian Rupees 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 Indian Rupees 14,00,000 that is Rs 9 per woman as the existing staff of the hospital has been restrained and deputed to manage the crisis centre (Deosthali, et al 2018).

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<sup>19</sup> US Dollars (USD) to Indian Rupees (INR) exchange rate for October 1, 2012 1 USD = 52.38 INR



## ANNEXURE 6 | PROGRAMME IMPLEMENTATION PLAN 2013-14, MINISTRY OF HEALTH AND FAMILY WELFARE GOVERNMENT OF INDIA- BUDGET HEAD FOR DILAASA

Budget Head	Physical Target	Unit Cost (Rs in Lakhs)	Budget Proposed (Rs in Lakhs)	Budget Approved (Rs in Lakhs)	Special Remarks/Notes
<b>7.11 Dilaasa Project</b>			182.6	93.618	Approvals in accordance to separate proposal submitted by State on Dilaasa Project
<b>7.11.1 Civil Work and Furniture</b>	11	6	66	55	Approved @ Rs. 5 lakh per Centre as one-time expenditure for civil work and furniture at 11 MCGM peripheral hospitals
<b>7.11.2 Human Resources</b>					
Medical Social Worker	22	2.4	52.8	26.4	Approved 2 Medical Social Workers per Centre @ Rs. 20,000/ month for 3 months in the current year
Health Worker	22	1.2	26.4	6.6	Approved 2 Health Workers per Centre @ Rs. 10,000/ month for 3 months in the current year
DEO	11	1.2	13.2	3.17	Approved one Accountant cum DEO per centre @ Rs. 9,600/ month for 3 months in the current year
Coordinator Medical Officer	1	6	6	0	Not Approved
<b>7.11.4 Office Expense</b>	11	1.2	13.2	0.45	Approved @ Rs. 5000/ month / centre for 3 months
<b>7.11.3 Training of Health Professionals</b>	1	5	5	2	Approved Rs. 2 lakh for the current year

## ANNEXURE 7 | ROLE OF MULTI-STAKEHOLDERS IN MOROCCO USING SOCIAL NETWORK ANALYSIS

Led by ICRW team, the data for this Social Network Analysis was collected from sheets filled out by participants (all four NGO partners and stakeholders) during workshops held in Morocco in September 2019. The four cities that data was collected in were Marrakech, Meknes, Casablanca, and Taza. Each participant listed who they met with, and how many times they met with them in each month. This data was translated from French and Arabic into English, with the team consulting together to determine confusing areas and possible mistranslations. Data were entered and four different raw data files in NodeXL, one for each city.

### Method

To avoid repetition, a list was developed naming each person (by function) who was mentioned in the data collection sheets by city. When functional roles (e.g. chief prosecutor, hospital social worker, etc.) were mentioned multiple times, their titles were standardized, and their appearances on the list reduced to a maximum number of times that functional role appeared on a single sheet, regardless of the amount of time it appeared throughout the data. Data points were eliminated that were not applicable, or unclear. We then went back through and replaced titles with the standardized versions.

When the interaction frequency was unknown, it was shown as the average of the total sum of interactions minus the number of unknowns represented by \* or  $=\text{SUM}(D\alpha:D\beta) / (\text{Total interactions} - *)$ . The average was generally standard with it being 4 for Meknes, 5 for both Casablanca and Marrakech, but was 10 in Taza due to the disproportionate influence of the President of Activating initiatives, and the large number of unknown frequencies. This caused the average to skew higher, because the known values were based upon a smaller sample size of the more influential actors within the network.

The vertices were color-coded for seven sectors that appeared most frequently (**Table A**). Vertex shape represents function in government (solid squares), civil society (disks) or social workers (solid triangles). Lastly, vertices were sized at 2.5 for legibility.

For the edges, we altered the thickness to represent the frequency of a given interaction per month. For legibility, the frequency was scaled as shown in (**Table B**). The edges are directed with arrows to show who initiated interactions. The arrowheads were sized at 1.5. Lastly, the edge style represents the type of interaction held as shown in (**Table C**).

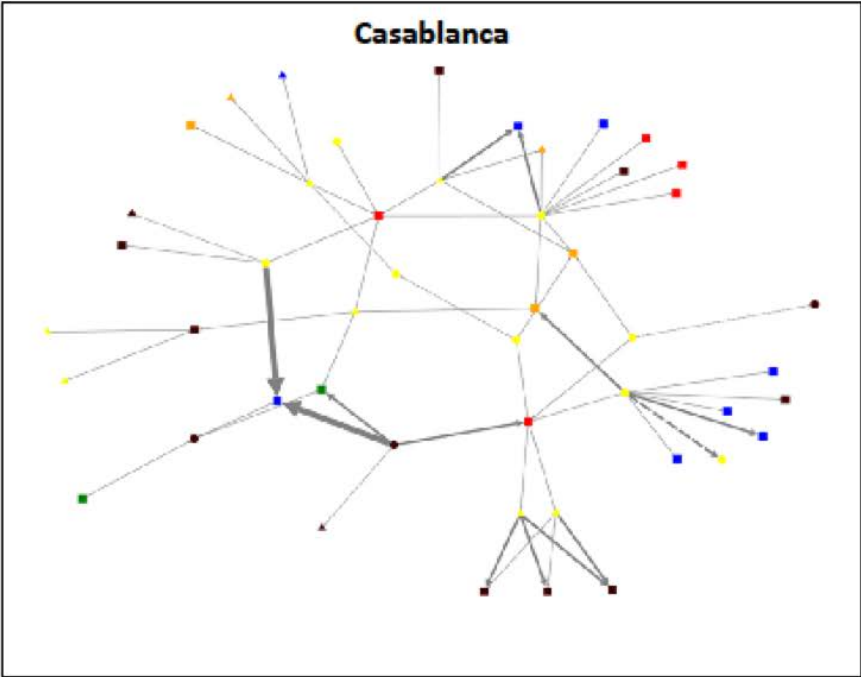


Table A: Vertex Color	
Sector	Color
Civil Society	Yellow
Prosecution	Green
Judiciary	Blue
Police/Gendarmerie	Red
Health	Orange
Media	Black
Other/Unknown	64,0,0

Table B: Edge Width Scale	
Interactions per month	Scaled number
1-5	1
6-10	2
11-15	3
16+	4

Table C: Edge Style	
Type of interaction	Edge Style
Government to NGO	Solid
NGO to NGO	Dash
Government to Government	Dot

**Casablanca** shows clear centrality of NGO presence including ATEC, the Association or Education and Social Solidarity as well as the Association Investissement Utile. For the state actors present on our map, the head of the hospital violence unit, the police commissioner, the chief prosecutor, and the head of the police department are those with whom individuals have the most contact. The lead with the state actors are generally initiated by the NGO and are not reciprocated. This type of interaction makes up 90% of the interactions mapped. The other 10% are civil society to civil society, and there is no government to government interaction mapped. Another important point is that no relationship mapped was reciprocated. Meaning the same party was reaching out to the other and never in the reverse. For the frequency of interactions within Casablanca the average is 1-5 times.

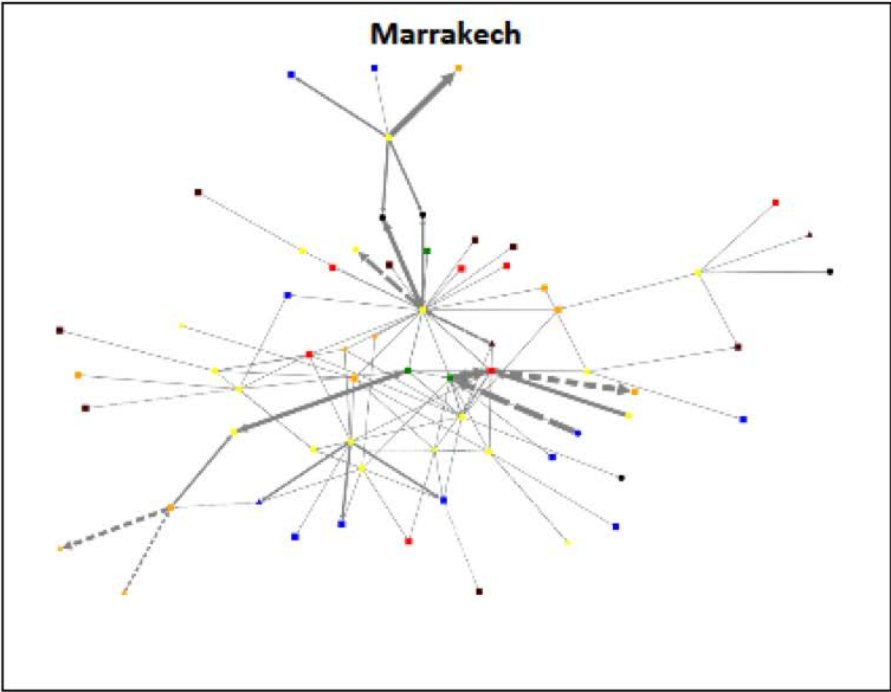


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NGO to NGO	Dash
Government to Government	Dot

**Marrakech** shows a more integrated system, but the general pattern still holds, with NGO presence being most central, and state actors being more peripheral. As a function of who we partnered with in Marrakech, Anaouat society shows the largest NGO presence and NGO centrality. For state actors the chief prosecutor, the head of the Gendarmerie and the Police Commissioner are most central in our mapping. 30% percent of edges are reciprocated. Of the reciprocated interactions they are primarily civil society to civil society or Government to Government. But together, these types of interactions equal 23% of total interactions. 77% of interactions are civil society to Government with few instances of reciprocation. The average frequency of interactions is 1-5 times.



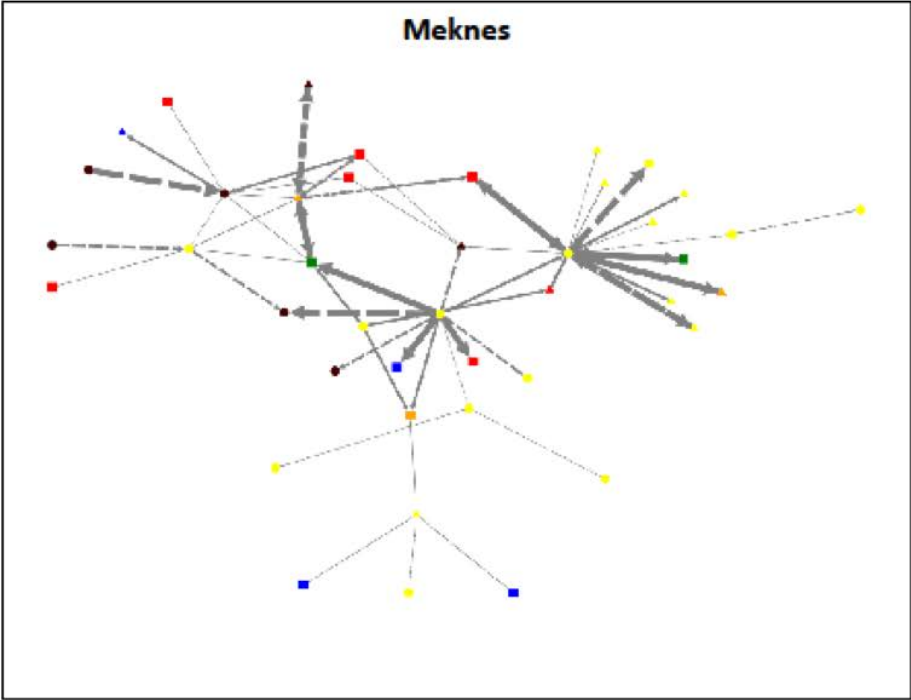


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NGO to NGO	Dash
Government to Government	Dot

In **Meknes**, the two most central figures are the President of Association Amal, and the Vice President of Aspirations Association. Of the state actors most central, those were the chief prosecutor and a social worker from the ministry of health. Of interactions held, 44% were reciprocated with the average frequency being 6-10 times. Overall, civil society to Government interactions were 47%, civil society to civil society were 44% and Government to Government were 11%. Despite there being less diversity of actors integrated, the frequency of interaction, and percent of reciprocation is higher on average than other cities.

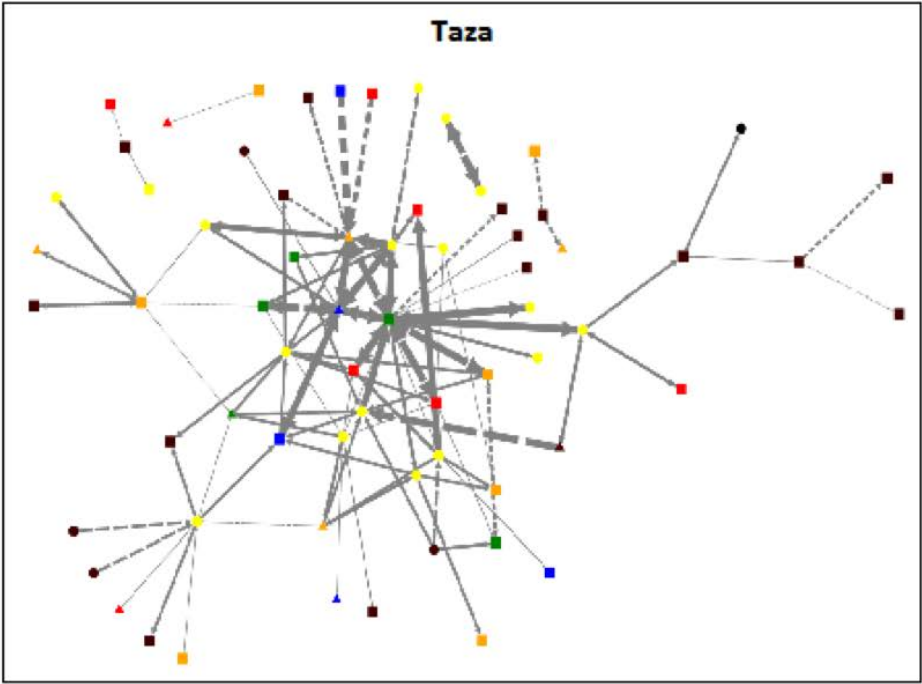


Table A: Vertex Color	
Sector	Color
Civil Society	Yellow
Prosecution	Green
Judiciary	Blue
Police/Gendarmerie	Red
Health	Orange
Media	Black
Other/Unknown	64,0,0

Table B: Edge Width Scale	
Interactions per month	Scaled number
1-5	1
6-10	2
11-15	3
16+	4

Table C: Edge Style	
Type of interaction	Edge Style
Government to NGO	Solid
NGO to NGO	Dash
Government to Government	Dot

**Taza** represents the most integrated system with the largest number of actors. We see the chief prosecutor showing a high degree of centrality along with the head social worker at the court violence unit. Despite the increased centrality of state actors in Taza, there is still relative NGO centrality, with the Association of Activating Initiatives, AFAK Association, and the Association for Those with Physical Disabilities- Taza being significant actors. For interactions held, the average frequency was 6-10 and 56% of interactions were reciprocated. Civil society to government interactions were 63%, civil society to civil society were 6% and Government to Government was 31%. These percentages show a shift in the types of interactions that is only seen in Taza.



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