

Hospital based Crisis Centre for Domestic Violence: THE DILAASA MODEL

2011

Executive Summary

Domestic violence is pervasive across all countries, cultures and societies. Across the world, between a quarter and one half of all women have faced abuse by intimate partners and 40% to 70% of female victims have been killed by their intimate partners. Victims of domestic violence are abused inside what should be the most secure environment – their own homes.

In the Indian context, the National Family Health Survey (NFHS) – III has reported 33% women facing some form of physical violence, while 10% reporting sexual violence and 16% reporting parental abuse. One percent of never married women reported being sexually abused by someone. Of these, 27% reported that the abuser was a relative.¹ There were about 8000 cases of dowry deaths -women killed within their marital homes. More than 75,000 cases were registered of cruelty by husbands and relatives.²

The Protection of Women from Domestic Violence Act, 2005 defines Domestic violence as any act, its commission or omission that harms, injures or endangers the health, safety, life, limb, or well-being both mental and physical, of the aggrieved person. The law also offers several types of relief orders for women ranging from compensation order, protection order to residency order.

For the first time “Medical facilities” have been identified as “Service Providers” in the implementation of this act. The first and foremost responsibility of medical institutions is that they cannot refuse treatment to the aggrieved woman under any circumstances. Besides provision of medical treatment the person in charge of the medical facility will be required to counsel the woman and inform her about reliefs under this law.

This policy brief is addressed to all those individuals and groups who are in a position to influence policies and programmes at local, organizational as well as national level. The brief is based on the experience and the success of a hospital based Crisis Centres for women facing domestic violence in Mumbai - Dilaasa. It is a joint initiative of the MCGM and CEHAT, established to sensitise Health care providers and train them to understand domestic violence as a health issue. Besides training of Health care providers, the key function of Dilaasa is provision of psycho social support to women facing domestic violence. It has also received recognition from the United Nations Development Program (UNDP) as one of the best practices in Gender Mainstreaming. We hope that this document will inspire the promotion, replication and implementation of the Dilaasa model – a strategy that has been found to work.

¹ International Institute for Population Sciences (IIPS) and ORC Macro. *National Family Health Survey (NFHS-3): 2004-05: India, Mumbai, IIPS, 2008.*

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

Domestic violence is a public health issue of epidemic proportions

“Victims of domestic violence are abused inside what should be the most secure environment—their own homes—and usually by the persons they trust most”.³ Domestic violence is a public health issue of epidemic proportions. It is pervasive across all countries, cultures and economic classes. Acts of abuse include hitting, kicking, forced sexual intercourse, and psychological abuse (such as intimidation and humiliation),⁴ etc. The abuse can often escalate and lead to repeated and serious physical injury. Women are particularly vulnerable in societies where there is marked gender discrimination and cultural norms that make women the subordinate and submissive partners with rigid gender roles.⁵ Obviously this makes women in India highly vulnerable.

The National Family Health Survey 3 (2005 – 06) reveals that, one third of all women between the ages of 15 – 49 years have experienced violence at least once. Of this, almost half (45%) belong to the lower wealth quintile. A whopping 85% of women who have experienced domestic violence and have been ever married had been subjected to violence by their husbands.⁶ Worldwide, between one-quarter and one half of all women have faced abuse by intimate partners and 40% to 70% of female murder victims have been killed by their intimate partners.⁷

There are a large number of studies which have established that domestic violence can lead to physical, psychological and sexual health problems. Psychological consequences of abuse in fact go unnoticed and unaddressed. These include depression, anxiety disorders, post-traumatic stress disorder, suicidal tendencies and chronic pain complaints (such as backaches – which can be psychological fallout of repeated abuse). Domestic violence is also a risk factor in poor health outcomes and burden of disease. It is 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 generations thereafter, with serious effects on health, education, employment, crime and economic well being of individuals, families, communities and society as a whole.⁸

A comprehensive law on domestic violence, “Protection of Women from Domestic Violence Act 2005 (PWDVA, 2005)” took effect as recently as in 2006. Its implementation

³ National Family Health Survey 3 (2005 – 06): *Domestic Violence*, downloaded from [http://www.nfhsindia.org/NFHS-3%20Data/VOL-1/Chapter%2015%20-%20Domestic%20Violence%20\(468K\).pdf](http://www.nfhsindia.org/NFHS-3%20Data/VOL-1/Chapter%2015%20-%20Domestic%20Violence%20(468K).pdf) on 9/10/10.

⁴ WHO (2002): *World Report on violence and Health - summary*, downloaded from http://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf on 9/10/10

⁵ Ibid 2.

⁶ The Advocates for Human Rights (2006): *Prevalence of Domestic Violence*, downloaded from http://www.stopvaw.org/Prevalence_of_Domestic_Violence.html on 9/10/10.

⁷ Ibid 4.

⁸ WHO (2010): *Preventing Intimate Partner and Sexual Violence against women – taking action and generating evidence*, downloaded from http://www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf on 9/10/10.

is in its embryonic stage. Interventions for provision of services and care for women experiencing domestic violence are almost non-existent in our country. Various national policies give varied importance to domestic violence.

Domestic Violence: the policy scenario

Internationally, the Fourth Population Conference (UN ICPD, Cairo, 1994), asserted the need for *“eliminating all practices that discriminate against women; assisting women to establish and realize their rights, including those that relate to reproductive and sexual health”* and to eliminate violence against women.⁹ Reproductive rights essentially include women’s decision making right in planning and spacing pregnancies, prevention of unwanted pregnancies, access to contraceptives, etc.

In India, the National Policy for the Empowerment of Women (2001)¹⁰ prescribed that the legal and judicial system should be made more responsive and gender sensitive to women’s needs, especially in cases of domestic violence. The policy laid down that *“all forms of violence against women, physical and mental, whether at domestic or societal levels, including those arising from customs, traditions or accepted practices shall be dealt with effectively with a view to eliminate its incidence. Institutions and mechanisms/schemes for assistance will be created and strengthened for prevention of such violence, including sexual harassment at work place and customs like dowry; for the rehabilitation of the victims of violence and for taking effective action against the perpetrators of such violence.”* The Policy asserted the need for strengthening institutional mechanisms in order to promote the advancement of women as well as make available resources – financial, human and market – for the implementation of the policy.

This commitment has been reaffirmed in the Eleventh Five Year Plan which proposes for the plan period a fivefold agenda for gender equity. These are economic empowerment; social empowerment; political empowerment; strengthening mechanisms for effective implementation of women-related legislations; and augmenting delivery mechanisms for mainstreaming gender.¹¹ Of critical importance is the assertion by the 11th Plan that *violence is a public health issue* and its call for the *“training of medical personnel at all levels of the health care system to recognize and report violence against women and children”*. The Plan recognizes that any approach towards ensuring gender equity has to be multipronged and should (amongst other things), *“ensure an environment free from all forms of violence against women)—physical, economic, social, psychological etc., strengthen existing institutional mechanisms and create new ones for gender main-streaming and effective policy*

⁹ UN ICPD (1994): Programme of Action of the UN ICPD, downloaded from <http://www.iisd.ca/Cairo/program/p04003.html> on 10/1/11.

¹⁰ Ministry of Women and Child Development (2001). National Policy for the Empowerment of Women, 2001, WCD, New Delhi: Government of India.

¹¹ Planning Commission (2008). *Eleventh Five Year Plan – Inclusive Growth (2007 – 2012)*, Vol. 1, New Delhi: Government of India.

implementation".¹² The need for training and sensitizing medical students has also been spelt out by the Plan given that medical and health establishments are often the first point of contact for women experiencing domestic violence. The Eleventh Five-year Plan provides for budgetary allocations for the implementation of all such acts that promote and protect the rights of women.

The strategies laid down by the Planning Commission and in The National Policy for the Empowerment of Women (2001) are *undoubtedly* the way forward. The existence of models such as *Dilaasa* for successful intervention is a major facilitating factor making the task relatively easier. *We need to act now.*

Dilaasa

Dilaasa is a joint initiative of the Centre for enquiry Health and Allied Themes (CEHAT) and the Municipal Corporation of Greater Mumbai (MCGM).

The ideological position of *Dilaasa* can be described as:¹³

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

With this in mind, *Dilaasa* was established as a public hospital-based crisis centre to address the psychosocial needs of women facing domestic violence. It was established at Bandra Bhabha Hospital, Mumbai, India, in 2001. It essentially follows the principles of Feminist Counselling. Accordingly, domestic violence is understood as a result of patriarchal structure and a tool to maintain status quo within a relationship. Feminist counselling in *Dilaasa* aims to make women survivors feel that they were not responsible for the violence that they had faced and addresses their fears, anxieties and needs. The ultimate objective is to empower the woman to make decisions on how to stop domestic violence.

Needs of the woman is at the core of the functioning of *Dilaasa*. Utmost importance is given to ensure the safety of the woman and to enable her to heal from abuse and take control of her life. *Dilaasa* also provides emergency shelter and legal counselling and this makes the service more comprehensive.¹⁴ So far, *Dilaasa* has been able to help more than a 2000 women. This is an achievement in itself.

Training of the hospital staff – both medical and paramedical – to be sensitive and responsive to the issue of domestic violence formed the pivotal thrust of the department.

¹² Ibid 7.

¹³ Ravindran, Sundari TK and Undurti, V. (2010). *Dilaasa* Evaluation Report, Mumbai: CEHAT.

¹⁴ Ibid 14.

A well-designed and pragmatic training prototype has been created by *Dilaasa*, which has successfully built “the capacity of hospital staff and systems to adequately, sensitively and appropriately respond to the health needs of victims and survivors of domestic violence.”¹⁵

Core groups of trainers have since been formed in five hospitals and a second crisis centre intervention department has been set up in another public hospital, the Kurla Bhabha Hospital. A Training Cell of key trainers from among staff of the five hospitals has also been created. The departments were formally handed over to the staff of the MCGM in 2006. Since then, CEHAT has been providing mainly technical support, and *Dilaasa* has been functioning as a project of MCGM.

Thus, *Dilaasa* has filled a major gap in the public health system and provides excellent gender representation through its approach towards domestic violence. Based on ten years of experience in offering effective services to women experiencing domestic violence within a public hospital setting, *Dilaasa* offers a prototype for successful replication in public hospital settings elsewhere in India. Moreover, the PWDVA has opened up a major window of opportunity for garnering political support within the health system for domestic violence interventions.

The Dilaasa model

Locating a crisis centre within a public hospital

Rationale

- The PWDVA (2005) has identified health professionals as service providers in responding to women facing domestic violence. This means that they are expected to not only provide the necessary information about such an act to a victim but also fill a Domestic Incident Report.
- Evidence shows that in general victims of domestic violence and / or sexual violence visit hospitals, particularly the emergency departments more frequently, than those without a history of abuse.¹⁶ In fact, it is possible that healthcare professionals (HCP) may be seeing more cases of domestic violence than the police.¹⁷ Locating a crisis centre within a public hospital therefore offers an opportunity for women experiencing violence to seek specialized services.
- Public hospitals are used by a large number of women from marginalised sections of society.

¹⁵ Ibid 14.

¹⁶ Ibid 2.

¹⁷ Krimm J. and Heinzer M. (2002). “Domestic Violence Screening in the Emergency Department of an Urban Hospital”, *Journal of National Medical Association*, 94(6), June 2002.

- Women who suffer serious injury can be immediately helped, because they would almost always appear at the casualty department. Good documentation of the case history can also be an important basis on which the woman could seek legal recourse if she chooses to.
- Health care professionals who have been trained in recognizing signs and symptoms of domestic violence are in a good position to differentiate between inflicted injuries and an “accidental fall” (as might be reported by the patient) and sensitively probe to ascertain cases of abuse. They are in a position to break to cycle of domestic violence, before it escalates with disastrous consequences.
- The age group that is most affected by domestic violence comes to the hospital for pregnancy, delivery and contraceptive services and for health care for their children. If there is routine screening and referral of *all women* who attend the hospital, there is scope for reaching out to women at a much earlier stage of the onset of violence than would be possible through a stand-alone crisis centre which women have to voluntarily come to.
- Women who are afraid of returning home because of threat of violence can be admitted “under observation” for a period of 24 hours, which allows time for working out the next steps: referring her to a shelter or findings a safe space with relatives/friends.
- Users as well as staff of crisis centre can be assured of safety from potential threats from the perpetrators, because the hospital has a security system and can also immediately refer the matter to the police.
- Many hospitals have a social work department and can depute social workers to work in the crisis centre.

Profile and options suited for locating Crisis centres in public hospitals

- Crisis centres are ideally located within secondary hospitals (200 plus beds) with a casualty department. Hospitals of this size are large enough to have a sufficient number of women experiencing violence seeking help to justify the allocation of staff and resources for housing the department. This is the best way to integrate the crisis centre within the hospital structure and ensure its sustainability.
- No more than four to five crisis centres would be needed even for a city like Mumbai. Other hospitals can be trained to screen and refer women to these crisis centres. No more than one crisis centre may be needed within a district.
- Hospitals that have nursing schools attached to them would also be an excellent option. Nurses, in fact, have a huge potential and a lot to contribute. Their formal training as nurses provides them with skills that can be used to the optimum, provided they are allowed to do so. This is not the case at present because our

healthcare model is doctor centric. In *Dilaasa*, however, nurses and other staff contribute in a big way. Nurses have been officially deputed to provide counselling services and they are doing very well.

- If it is not feasible to have a separate department, it may be placed under the social work department or the nursing department, both of which have a caring function within a health facility. Locating it as part of a clinical department could medicalise the issue of domestic violence, and can eventually lead to the withdrawal of psychosocial support essential for recovery of women affected by domestic violence.
- The department of Obstetrics and Gynaecology is another possible site to locate it as last option, given that a large number of women experiencing domestic violence are likely to approach this centre for their reproductive health needs.

Training

In order to have a sustained successful health systems response, Training and Counselling form the major components of the entire initiative.

Training and sensitisation of hospital staff is required in order to enable them to identify domestic violence as a public health issue. Unfortunately, health care professionals are not trained to ask questions pertaining to “symptoms” of domestic violence, and nothing beyond the medical aspects of the problem gets recorded, much to the disadvantage of the patients in case legal proceedings need to be initiated. Most health professionals do not even recognize this as part of their professional duty – a major lacuna in medical education system. Detection of injuries arising from domestic violence against a woman patient, providing treatment with a gendered understanding in view, and providing referrals to other related services such as counselling, legal aid etc. are all steps that need to be undertaken by medical staff but are seldom done in view of the dominant perception of domestic violence as a ‘personal issue’, not within the domain of health and illness.

Initiation of a crisis centre in a hospital to deal with violence against women clearly necessitates a complete shift in conventional perspectives and duties of the staff of the hospital. For this it is essential that they (i.e. the hospital staff, including medical officers, nurses, para-medical staff, even resident medical officers, etc) undergo training. The purpose is awareness building and sensitization of the staff towards the issue of domestic violence. Training is also essential so as to build a cadre of trained personnel who will serve as “change agents” and can generate and sustain the interest of other health care professionals. Here are some lessons learned from the training component of the *Dilaasa* initiative:

- Training of staff cannot be seen as a one-time activity. Hospitals have a huge turn over of staff, resulting in trained staff constantly moving out and new, untrained staff replacing them. Sufficient human and financial resources need to be earmarked to

have a sustained and ongoing capacity building on domestic violence as an ongoing activity of the hospital.

- A two-pronged training strategy is to be adopted, involving intensive training for a “core group” within each hospital; and coverage of all hospital staff with a more basic orientation to domestic violence as a gender and public health issue and on the role of health provider.
- The core group should essentially be a pool of trainers comprising of a mixed cadre of health care professionals that take the responsibility of integrating *Dilaasa* within the hospital. The core group is encouraged to become an in-house team that owns the project, has imbibed the perspective of the project, acts as advocates within and outside the hospital for the project and is responsible for preparing training modules and training of all hospital staff. Active participation of male doctors as core group members and key trainers is an important ingredient in the success of the training. Gender-based violence does not get relegated as “women’s activity”, but gets acknowledged as a public health concern because of the participation of male professionals.
- 100% coverage of all hospital staff with orientation training is to be aimed for. The training content is to be packaged to fit into the busy schedule of the public hospital without compromising on quality and weakening its impact on trainees. Careful planning of the training process and content needs to happen, with a view to perspective-building, as well as developing knowledge and skills for screening women experiencing domestic violence and for counselling.
- The entire training for the core group has to take place before the crisis centre is set up.
- A large enough number of members are selected to participate in the core group’s training to allow for a substantial loss due to transfer or work load. In *Dilaasa*, over 40 core group members were trained and the project was ultimately left with about 12 core group members. A core group within a hospital should have at least 12 members to be effective.
- Ongoing orientation training for all hospital staff is a challenge and may not be sustainable unless institutionalised. Formation of a Training Cell, with experienced members from core groups of different hospitals would be an important step towards institutionalising training. The Training Cell would eventually be responsible for planning and running regular training sessions for orientation and for updating knowledge and skills.
- Moreover, the current Training Cell could become a valuable resource for training other health department staff. People from health departments are likely to be more receptive to hear from their own ilk. It is the *moral and professional duty* of every health care professional to be a part of, or contribute towards the functioning of the centre.

Counselling

The success of centre depends almost entirely on the quality of counselling and support provided to the women. *Dilaasa's* experience has established the pivotal role of feminist counselling in the recovery, rehabilitation and empowerment of women survivors of violence.

- A public-hospital based crisis centre needs to depute its social workers or nursing staff as counsellors. The person so chosen needs to be interested and committed to this task. An ideal staffing pattern would be to have a full time social worker, a part time doctor and at least two nurses deputed by the hospital.
- The counsellors need to be trained and skilled in feminist counselling. Such counselling will aim at making the affected woman believe that violence is not “normal”, that it is unacceptable and something can be done to stop the abuse.¹⁸
- A counsellor has to validate a woman’s experience, help make the connections with the social context and be non-judgmental in approach. It is essential that crisis centre is a space where women can be heard with respect and sensitivity in a non-threatening atmosphere.¹⁹ The eventual course of action taken by the woman is a decision that only she can make.
- Referral to other organisations for legal counselling and for shelters makes the service more comprehensive. The hospital information system should also build a record of the details of women referred from each department to the crisis centre. This helps build systemic accountability.²⁰
- Capacity building of the entire team of counsellors should be a constant ongoing activity.²¹
- An experienced counsellor – possibly an external consultant – needs to oversee the counselling process and provide ongoing feedback, guidance and support to the counsellors.
- Quality control measures need to be put in place. These include case reviews on a regular basis in the presence of the expert. The review should monitor whether the needs of the woman is at the core of the functioning of the centre. Utmost importance is to be given to ensure the safety of the woman and to her healing, and to “*above all, doing no harm*”.

¹⁸ Barai-Jaitly, T. (2010). *Dilaasa: Crisis Intervention Department for women – A Report*, Mumbai: CEHAT and Dilaasa.

¹⁹ Ibid 20.

²⁰ Ibid 14.

²¹ Ibid 20.

Putting in place systems within and outside the public hospital for effective functioning of crisis centres

- Women can be referred to the crisis centre from any other department of the hospital including the casualty, out-patient department, in-patient departments (such as the gynecology department) and also from other hospitals or community centers.
- There should be an integrated system of screening and referral. At the primary care level, health workers (such as auxiliary nurse midwives, etc) and medical officers may be trained to screen and refer; at the secondary level, counselling services as well as referral to legal and other resources may be provided. Medical colleges and nursing colleges could play a significant role in training pre-service health professionals on domestic violence as a public health issue.²²
- Medical personnel in the hospital with a crisis centre are to be trained to ask screening questions (a tool comprising of signs and symptoms has been prepared by *Dilaasa*), identify women facing domestic violence, and provide medical support. If a woman has been identified in any of the other departments or wards, then she needs to be referred to the casualty in order to undertake detailed documentation of the case. The patients are then either referred to the crisis centre or the counsellors visit the ward, as required.
- In addition, the crisis centre staff may be directed to visit the Casualty Department everyday to make sure that all cases of women registered as medico-legal cases can be offered help by the crisis centre.
- All women admitted following suicide attempts are to be screened for domestic violence and provided relevant counselling. The hospital case sheet needs to be modified in order to identify referred women. This can be done simply by stamping “referred to crisis centre”.
- In order to have efficiency of record keeping, it is also essential that the Management Information System of the Hospital is changed to include a field to mark referrals to be entered by the casualty medical officers.

The actual working of the crisis centre

- Woman comes to the crisis centre, she is informed of the services offered, the work done by the crisis centre and the kind of help – emotional, psychological, social and legal, that women are provided free of cost.
- Once it is ascertained that the woman concerned is interested in availing help from the crisis centre, an *intake* form is filled up with her consent. There is a recording of the latest episode of violence along with the history of violence. Referral for medical help, a medico-legal statement and registering of a police statement if desired by the woman is done at this stage.

²² Ibid 14.

- This is followed by a counselling session. The session starts with establishing goals of counselling based on the expectations of the woman. Following the counselling, a safety plan is also devised if her circumstances come across as threatening or escalation of violence is anticipated. The safety plan may include provision of temporary shelter at the hospital. Follow up counselling sessions are held at the convenience, need and consent of the woman.

Counselling ethics

Women coming to the department are in a very vulnerable state, and adherence to counselling ethics is vital.²³

- Beneficence and non-maleficence are the backbone of the ethical principles on which the department should work. Protection and promotion of their rights and dignity is of utmost priority.
- Informed and voluntary consent to avail the services is essential. The woman should also be informed about details of the services and that she has the freedom to decide if she would like to avail these services.²⁴
- During the entire course of interaction, the woman experiencing domestic violence needs to be assured privacy and confidentiality.
- This also means that after counselling the course of action selected by a woman might prove to be frustrating for the counsellor, but it has to be remembered, that ultimately, the woman has to be the decision maker.

Concluding Remarks

Women facing domestic violence in India have very little in terms of formal support. Hospitals with appropriate support through capacity building and with constant improvisation through research, can have Crisis Intervention Departments as an integral part of their services *without* any additional burden on resources – both human resources and financial.²⁵

It is time that we start *accepting* domestic violence as a serious public health issue. Successful replication or adaptation of the *Dilaasa* model across hospitals in the country will constitute a big step towards an adequate response to the health consequences of domestic violence by the public health system. It is up to all of us, to promote better, more responsive, more responsible and more inclusive systems and processes to deal with domestic violence.

²³ CEHAT is in the process of formulating ethical guidelines for domestic violence counselling through a national level consultative process. The guidelines are to be imbibed by all counsellors and they should be a part of their routine training. They can also be applied in cases of ethical dilemmas and conflicts. They are expected to be published by 2012.

²⁴ CEHAT is in the process of evolving ethical guidelines for counselling women facing domestic violence. These would be evolved through a consultative process. Like – minded organizations can endorse the same and use them in their work. We believe that their endorsement would go a long way in enhancing the credibility of their work.

²⁵ Ibid 14.

Acknowledgements

The policy brief is based on External Evaluation of Dilaasa conducted by TK Sundari Ravindran and Vindhya Undurti. Tejal Barai – Jaitly wrote the policy brief. We are grateful to Dr Sundari Ravindran for finalising the brief.

Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing, (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Investigation and Treatment of Psycho-Social Trauma.

DILAASA

Dilaasa, India's first hospital based crisis centre was established at K.B. Bhabha Hospital, Bandra to make the public health care system accountable to the issue of domestic violence. It was set up in 2001 as a collaboration of the public health department of the MCGM (Municipal Corporation of Greater Mumbai) and CEHAT (the research centre of the Anusandhan Trust). Another such department was initiated at Kurla Bhabha Hospital in the year 2006. The strategic location of *Dilaasa* in a hospital has helped around 2000 women facing domestic violence in accessing services easily.

Dilaasa means "reassurance" and it seeks to provide psycho-social support to women survivors of domestic violence.

A joint initiative of Municipal Corporation Greater Mumbai

And



Centre for Enquiry Into Health And Allied Themes