A rapid assessment of the responses to address GBV during and immediately following the lockdown in India.

Conducted during October 2020- March 2021, with NGOs, OSCs, frontline healthcare providers in Madhya Pradesh and Rajasthan

We are under lockdown; GBV is Not.

Assessment brief

Sama Resource Group for Women and Health

Acknowledgements

We acknowledge all the organisations, one stop centres and community frontline healthcare providers who agreed to be part of this assessment despite the extremely challenging context. We thank them for their time, insights and suggestions that have contributed to the understanding of the realities of the pandemic, the response to GBV as well as gaps in response.

We also thank UNFPA for their support.

For feedback and queries, please write to sama.womenshealth@gmail.com

Sama Team

Introduction

"We are under lockdown; GBV is Not" is a brief based on a rapid assessment conducted by Sama Resource Group for Women and Health during the period October 2020 – March 2021. The assessment was carried out with organisations, one stop centres (OSCs) and community based frontline healthcare providers in the states of Madhya Pradesh (MP) and Rajasthan (RJ).

The assessment findings, the issues and concerns that it flagged have contributed and are expected to continue to contribute to evidence for policy advocacy and programming to address gender-based violence (GBV) in the context of the Covid-19 pandemic and beyond it.

The assessment sought to understand the following:

- Manifestation of GBV in the pandemic context
- Access to support and care in the context of lockdown and restrictions and the post lockdown challenges
- Health system response to GBV

A total of 23 interviews were conducted, 10 from Rajasthan and 13 from Madhya Pradesh. All interviews were conducted virtually, using the zoom platform or over phone calls when access to internet was unavailable. A letter about the purpose of the assessment was sent to about 43 organisations. Apart from these, some OSCs and healthcare providers were also contacted to participate in the assessment process.

Assessment Participants	Rajasthan (RJ)	Madhya Pradesh (MP)	Total
Organisations	5	6	11
Health care providers	3	5	08
One Stop Centers	2	2	04
Total	**10**	**13**	**23**

Of those who were contacted, 23 consented to participate in the assessment. A consent format was shared with the willing participants over email, to seek their informed consent.

Limitations / challenges

Mobilising participation in the assessment was challenging; organisations expressed being overwhelmed by work as well as personal commitments. As mentioned previously, merely a half of the potential participants who were contacted agreed. Amongst healthcare providers, 7 out of 8 participants

were community-based providers such as ASHAs and ANMs. They agreed to be interviewed for a very short duration due to their work commitments.

Overall, the availability of the participants and adequate time for the interviews was a challenge; repeated cancellations and rescheduling took place. Apart from this, poor connectivity was a hinderance. Nevertheless, the interviews were scheduled and conducted as per the convenience of the participants.

The assessment period October 2020 – March 2021 was after the lockdown had ended. But the shadow of the lockdown and its impact extended to this period. The fear of Covid-19 infection and its consequences, concerns about transmission, access to diagnostics / testing, medicines, health care were palpable in the conversations with the participants. The loss of employment, hunger, closure of educational institutions, lack of access to transportation continued to be serious concerns for them as service providers as well as for the survivors. For several participants, these experiences overlapped as they identified being from the same communities that they supported. In the case of OSCs and healthcare providers, the limited availability and access toother referral services as well as health care beyond Covid-19 as well as the additional responsibilities of Covid 19 prevention and treatment on the already weak public health system, had a serious impact.

Key Issues and Concerns

The findings from this assessment provide important insights to the collective understanding and analysis of the interlinkages between GBV and the pandemic. Several analyses of challenges, gaps in the implementation and barriers faced by survivors, many of which are long-standing analyses and recommendation have been raised by women's groups, organizations/CSOs even prior to COVID19. These remain central to understanding and analysing the emergent issues and concerns. The pandemic has reiterated the need to address these issues and concerns towards equitable, quality and accountable systems to respond to GBV.[1]

Interlinkages between the pandemic and GBV

❖ The experiences of aggravated GBV were closely linked to the social and economic consequences that the pandemic had unleashed. The pandemic responses such as lockdowns and restrictions had an impact on people and communities at a scale that was unprecedented. The aggravation of GBV was perceived as a direct consequence of the lockdown, restrictions that were responses to the pandemic.

> This is also something you are faced with – having to choose or prioritize, for e.g., with regard to food and violence. A woman survivor began a small business but once Covid lockdown started, her business collapsed. She was not able to earn and did not have any savings. It was a challenge for the woman to access food for herself and her family. At the time that was her sole focus. (Organisation, MP)

❖ The loss of employment, aggravation of poverty, hunger, isolation, lack of transport, shutting of educational institutions, increase in gendered surveillance and control of mobility, lack of access to health care, were some of the consequences evidenced.

❖ These consequences resulted in multiple vulnerabilities that forced survivors to prioritise and address other needs over addressing violence.

❖ The socio-economic consequences of the pandemic and aggravation of GBV were disproportionately experienced by the marginalised – for example, girls and women from Dalit and tribal communities, girls and women with

[1]The issues presented in this section are drawn mainly from the assessment, as well as from Sama's interface with organisations through other initiatives during this period. Relevant policies, guidelines that were emerged during this period have also been referred to.

disabilities, sex workers, domestic workers, children, HIV positive women, Trans* communities.

❖ The experience of GBV intensified due to the lack of availability and accessibility of support services for survivors. In some of the areas where such services continued to be available, the lack of information about their availability and the absence of transportation or inability to afford transport, posed barriers to access. Inequities in access to services for GBV survivors have persisted long before the pandemic but were exacerbated during this period causing immense distress and vulnerability.

> Due to containment zones, restrictions on entry into containment zones, we faced major challenges to reach the communities that required support. (Organisation, MP)

❖ Health care for health concerns other than Covid-19, including for GBV, were not provided or only to a limited extent. This was evident at all levels of the health system – from community level healthcare to tertiary level facilities.

❖ Organisations involved in service provision were also affected by the lockdown and other restrictions such as "work from home", "not permitted to travel without a pass", which posed serious barriers in responding to situations of GBV and in the provision of support and care to survivors.

❖ Nevertheless, good practices, new approaches were initiated by organisations to navigate the situation amidst the restrictions to enable better access to care and support for survivors. Some examples are provision of ration along with services for GBV, cycles to facilitate mobility, shift of outreach and counselling to online platforms and phones, use of volunteers, urgent health care, for e.g., support in self-managed abortions, care and medicines for non-Covid healthcare.

> Our LGBTQ community was completely under stress as they faced loss of earnings. Transgender persons who were staying on rent faced a lot of abuse. Unfortunately, in our community, everyone faces violence even otherwise, which continued during Covid. But most of the transgenders didn't share about violence that occurred during the lockdown. The main reason was because we know that no one is going to take any action. The fear of being excluded from our own LGBTQ community is also (Trans activist, MP)

❖ The pandemic consequences wreaked havoc and distress for survivors as well as service provider organisations, even as the normalisation of GBV as "a private problem" was apparent in policy directions and their

implementation. For example, in several instances, police and other State officers, agencies, refused to provide any support / aid for GBV survivors calling it a "private issue". Moreover, the assumption of the home as a "safe space" mirrored and reinforced the power and gender inequalities, aggravating GBV. Covid-19 policies and guidelines thus reinforced these deeply entrenched, gender unjust perspectives.

> It was very difficult for women survivors to reach out.
> The amount of data that even we are showing, the cases were 10 times more than that. The reason we know this is that the moment lockdown was over sometime in July (2020), there was a rush of women reaching out to us. The number increased drastically. We were flooded with cases. Women were facing a lot of violence for a long time (during lockdown). (One stop centre (OSC), MP)

❖ The policies did not adequately acknowledge and prioritise GBV as a public health issue, a human rights concern adequately. This led to gaps in necessary information, messaging about services, support networks that could be accessed.

❖ Services for Covid 19 were prioritised over all else; services for other health needs including for maternal health care, abortion care, contraception needs, cancer, HIV, TB, etc. were unavailable or in a very limited manner.

❖ New forms and locations of GBV were also reported. Complaints of GBV in pandemic specific spaces such as quarantine centres, isolation wards in health facilities emerged. Almost all migrant workers returning from the cities to their homes in rural locations had to quarantine in the centres. They lacked privacy; women and girls reported to helplines and organisations about being concerned and fearful of staying in these spaces.

> …..We received calls from women who stayed in these quarantine centers. They told us about the lack of basic facilities. Privacy and fear were big concerns. (Organisation, MP)

Services for addressing GBV and for supporting survivors as "essential"

The absence of guidelines or protocols dedicated to addressing GBV, provision of support and care resulted in non-availability of services for survivors, including healthcare, shelter, police, legal services, psychosocial counselling, etc. Most of the services for GBV were not mandated as "essential".

❖ Organisations, OSCs who were involved in providing services directly to communities and survivors were unable to continue their work due to the severe lockdown and restrictions. They were able to provide only a few services and mostly through helplines, WhatsApp and other ICT (information communication technology) platforms, during the lockdown. This impaired access for a large number of girls and women who did not have access to ICT or were in situations where access was controlled.

> There was no transportation during lockdown, which was a major issue. Our work area is in the midst of mountains and forests. We have a very poor network there. It was very challenging to reach out to the tribal and rural communities from these areas. And we could not go there either in person due to the lockdown and non-availability of transport. (Organisation, MP)

Provision and access to services for survivors

HELPLINES

Helplines were the only available mechanism for survivors and service providers to connect with each other for most parts of the lockdown.

> During the lockdown, we were making a lot of follow up calls, but most phones of women were switched off. Majority did not have any balance of phone charge. They could not afford it. They were not able to contact us or anyone else for help. We did a lot of phone recharges during that time. …Especially in those cases where we were aware that the woman is likely to be in trouble (facing violence). It was very difficult for us to reach out to the women during this time. You can imagine, if we were not able to reach out to them what could be the situation for them. (One Stop Centre, MP)

- Organisations and OSCs stated that during the early part of the lockdown, however, they received fewer calls on average than they would otherwise.
- The gender gap with respect to access to phones, to internet / emails in the communities that they engage with, is substantial. This pre-existing gender gap in access was compounded by aggravation of other social and economic inequities during this period. Most of the women working on daily wages were unable to recharge their mobiles due to financial constraints.
- Even where girls and women had access to mobiles, the constant surveillance and restricted mobility in the households did not provide any opportunities to make a call, seek help or support.

Helpline staff in some places did not have access to software or infrastructure to continue their work from home. Nor could they travel to the OSCs or helpline centres due to the lack of access to transport as well as to emergency passes.

> In the case of girls and young women, between 15 and 24 years of age, we observed a different type of problem during lockdown. Strict surveillance of parents over girls increased in such a way that the mobiles of girls were taken away by parents. We have conducted a small study in which we observed that the mobile phones of 56 girls were forcefully taken by their parents. Girls even faced physical violence due to mobile phones. (Organization, RJ)

- Helplines dedicated to GBV response were tasked with Covid-19 information dissemination and follow ups during the pandemic. Lines were constantly engaged and several survivors were unable to access the helplines.

> We were receiving a lot of calls (Covid related) during that time and our team was working from home; we were also tying up with the NHM, we were helping in running the Covid Helpline. The role of OSCs changed. We had to be in the field a lot to follow up on Covid related issues. (One stop centre, RJ)

- Helplines are important for survivors to seek support and for service providers to become aware of the violence and respond to it. They, however, must be supplemented with other services. Organisations and OSCs observed that in the absence of transport, "stay at home" orders, the unavailability of the supplementary referral services as they were not recognised as "essential", neither they nor survivors were able to move ahead from the situation. In some situations, they were able to organise transport, or passes albeit extremely delayed.

PROTECTION OFFICERS (POs)

Protection officers were envisaged by the Protection of Women from Domestic Violence Act (PWDVA) as a crucial link between survivors and support services such as the shelters, counsellors, courts, police, lawyers and others.

- The institution of the PO has had serious gaps even prior to the pandemic, including the non-appointment of POs, poor resource allocation,

> It is difficult to access the PO. Women are waiting for the PO's next visit to the villages. Unfortunately, many of the POs are unaware about the law. They don't know about the DIR. There is a lot of evidence regarding this. Recently, for example, when our counsellor interacted with a PO, they refused to fill the DIR and said they would follow the Court's orders and not of any organization. (Organization, RJ)

lack of convergence of services, and limited capacities of POs. These impacted access to POs and their functioning during the pandemic too.

- POs did not receive clear directions or protocols to enable them to adequately support survivors. Non-availability of other services such as legal support, access to Courts during the lockdown also posed barriers to their functioning.

SHELTERS

A number of survivors were forced to stay in violent homes as alternative safe spaces, shelters or means to reach them were not available, affordable or accessible to them. This was also true in situations of child abuse, when children were unable to access any support to move from violent homes. The closure of schools, hostels enforced children to be in violent homes, without any access to care or support.

- Survivors struggled to leave spaces of violence; due to the lockdown, many of them were unable to leave due to the lack of transport and passes. Some of the women survivors who had reached out to organisations, OSCs, for help were forced to leave to escape the violence and seek shelter, due to these delays. Others were asked to leave their homes, walked long distances (sometimes with children) before they received some help. Some survivors paid substantial amounts for vehicles and travelled at great risks to themselves in the absence of passes, to access shelter.
- The organisations and OSCs experienced delays or were unable to organise transport, shelter and passes to support survivors in leaving and finding alternative spaces.
- Organisations tried to get the support of the police to help survivors in dire situations, with limited outcomes. Police apathy as well as additional responsibilities to implement pandemic measures posed barriers.
- Survivors were unable to seek help from their community, family and friends who they usually went to for immediate relief or shelter. This was due to the restrictions on movement, fear of the infection, absence of transport, and the overall socio-economic effect of the pandemic on survivors and those that would have reached out to.
- Even before the pandemic, shelter homes were inadequate, most of them overcrowded with abysmal living conditions. Many shelter homes continued to function during the pandemic, but did not admit any survivors due to the lack of space or infrastructure or due to the fear of Covid

> Transportation to shelters was usually managed through government vehicles like police van, or through the One Stop Crisis Centre rescue vehicle. But, during Covid, this required a lot of negotiation and push, as it was not laid down as part of any guideline. (OSC MP)

transmission. Some shelter homes asked residents to leave, forcing many to try and seek alternative shelter, or return to spaces of violence.

- Some shelters made testing and a negative result mandatory for admission of survivors. This caused delays in admission, and for survivors who could not afford or access the tests, the shelter was inaccessible.
- There were no clear-cut pandemic related advisory/protocol/directives for shelter home admissions, shelter home responses were varied.
- Shelter homes were not designated as "essential services" and transportation to shelter homes was also a challenge given restricted public transport facilities.
- In the context of children, the violence prevalent in shelter homes has been a critical concern. This was reinforced during the pandemic lockdown. Reports of violence against children in shelters, child sexual abuse, assault were received by organisations.

> In case of sexual abuse faced by children in JJ homes which are monitored by the Collector, WCD officers. Unfortunately, sexual abuse is an issue in most of the ST/SC hostels, shelter homes/hostels for children with disabilities. (Organisation, MP)

ONE STOP CENTRES

- During the pandemic, OSCs were open and functioning. They were able to provide services, although in a limited manner.
- Some of the OSCs were engaged primarily in Covid management. This affected their work in supporting survivors.
- OSCs also grappled with the lack of transport and passes for their staff during this period.
- OSCs that were open had to navigate the situation so that staff that lived closer to the OSC could take turns at the centre.
- Survivors were unable to, in most instances, reach OSCs. OSCs that on an average receive two or more complaints over the phone and survivors every day, reported very few calls and almost no survivors during the lockdown. Even those who did, could receive only minimal services as a lot of the referral support was unavailable or it was challenging to reach them.

> We had no time to think about anything else (except Covid). During the time, the rehabilitation work stopped completely. …….Cases of rape, abuse were very much there. But everyone, even ASHA and Anganwadi workers who were the persons who connected those facing violence with support services, had to engage only in the Covid work. (OSC, RJ)

- OSCs were able to coordinate with the health facility where they were located for healthcare services.

> Some of our older cases required intervention and support during this time. The husband was back home. There was loss of job, lack of money, hunger, alcohol, etc. But there were no vehicles running. Even if the woman wanted to reach the centre (OSC), how could she? Sometimes we took the police's help, sometimes we counselled the husband over the phone or we asked the area affiliated police station to intervene. (OSC, RJ)

POLICE AND COURTS

- Inordinate delays in recording survivors' statements were also experienced during this time, resulting in discrepancies in the FIR were reported by organisations. Delays in filing FIRs were also common which caused delays in survivors' access to care, medico-legal examination, etc.
- The police explained the delay as a result of pandemic management.
- Refusal to register cases by the police is not specific to the pandemic period. Survivors or their relatives undertook substantial risks to reach the police during the lockdown seeking urgent help, which was denied or delayed.
- All court work was delayed; some courts were being conducted online but there were many delays.

> Women were going to police stations but they didn't receive sufficient and satisfactory response. For example, one girl was missing and her mother was going everyday to the police station to register a case but police didn't take any action. In some cases, the police scolded the women, asking them why they had come to the police station in the lockdown period and sent them back home without listening to them. (Organisation, MP)

> We have observed a delay of 6-7 days in getting a copy of the FIR report from the police as well as medical examination reports from the public hospital. This led to increased pressure on the survivor and her relatives by others to such an extent that the survivor changed her statement. Many times, due to this pressure, we found major discrepancies in the FIR compared with the statement given by the survivor. (Organisation, RJ)

- Most courts were not functioning during the lockdown and survivors were unable to attend courts. Even after lockdown had been relaxed, courts were not back to functioning fully.
- Legal aid authorities were shut, which meant that survivors could not receive timely response for their cases.
- All this caused substantial delays in compensation/maintenance for survivors; women had to wait for over months to be granted relief in cases of domestic violence. In some instances, partners of survivors against whom cases had been filed and relief had to be sought, went missing to avoid penalties and relief to the survivors.

> We, transgender, interact with the police for registering cases of violence. Even in non-Covid situations, they are not cooperative. Unfortunately, Covid has given them a big excuse to not listen or cooperate with us. Even when we struggled and managed to file the FIR, they tricked us by filing the incorrect penal code or favoring the opponent. (Organisation, RJ)

HEALTH SYSTEM

- Public health system's priority was control of the Covid infection. All other healthcare needs were mostly neglected. People also avoided going to clinics or hospitals for minor illnesses as they also feared getting infected. They were also hesitant due to mandatory testing.

> During lockdown, due to non-availability of public abortion facilities, we had to facilitate access to information about self-managed abortion to girls, women, including GBV survivors. During the lockdown, on the one hand, there was non-availability of contraceptives, or they were inaccessible. (ORG RJ)

- There were delays in conduct of medico-legal examination for survivors of sexual violence. Many of the health facilities had stopped conducting examinations and providing healthcare for survivors.

- Immunization and other community level services such as Anganwadi, antenatal care (ANC), postnatal care (PNC), etc. were stopped during the lockdown period.
- In the absence of services, organisations had to provide or facilitate urgent essential services that would otherwise have been available through referral support. For example, access to information and the abortion pill to facilitate self-managed abortions.

> Health services during the lockdown were almost completely halted. If a woman was pregnant she was not even looked at and was immediately referred to other hospitals. There were many women who were pregnant and the private clinics were shut. It was very hard for pregnant women, young girls who conceived, as abortions were not being conducted. (Organisation, RJ)

- Healthcare providers, especially frontline healthcare providers struggled during the lockdown. There was a shortage of PPE kits, face shields, they had to conduct household surveys. The burden of work increased manifold.

> During the lockdown, and after that, cases of violence increased in India against women. But I feel reporting of such cases has not happened. But slowly when the lockdown was not there, women started visiting our hospital and our department too. I must say if there were two reporting of domestic violence cases before, during the covid-19 situation, it doubled. We have faced a shortage of gloves and sanitizers during the lockdown and even in the hospital. We had to manage and buy these using our own money. (Nurse RJ)

> The challenges are not new while dealing with the cases of violence during the lockdown or after that. The main challenge is the increased workload of Covid-19 related work. Along with this, transport was a major issue. We, ASHAs, were asked to do house visits, monitoring of Covid-19 cases. But we did not receive adequate number of safety kits and other essentials. (ASHA MP)

This assessment brief presents key issues and challenges in the context of the pandemic, particularly during the lockdown and its immediate aftermath.

Although the context is specific, the responses of the participants indicate the need for strengthened, sustained, equitable, accessible and quality systems to address GBV beyond the pandemic context. The pandemic context has raised specific concerns in addition to the need for a well-resourced, well-functioning system for the prevention and response to GBV. The following part of the brief presents the recommendations to the pandemic specific context and beyond.

Recommendations

The recommendations below have emerged from the issues and concerns raised in the previous sections of this assessment brief. They raise issues that were most pertinent at the time that the assessment was conducted and provide insights for similar contexts of health crises. Several recommendations are also relevant to address GBV and respond to GBV survivors beyond the pandemic context.

The following is a consolidated list of recommendations for the various duty-bearers - police, OSC, Shelters, Courts, health systems, State Ministries, departments, etc.:

Acknowledge the aggravation of GBV in the context of the current pandemic, and other public health and humanitarian crises.

° Recognize that GBV is a gross violation of human rights, health rights and commit to its prevention and response through immediate and long-term action.

° Recognize that gender-based violence (GBV) and healthcare as well as other socio-economic determinants for survival and wellbeing are deeply connected.

° Ensure that GBV is addressed through quality multisectoral services (psychosocial, legal, shelter, livelihoods, information, health care, education, etc.) that respond to the multiple needs of survivors.

° Prioritise its prevention, as well as care and support for survivors in health and humanitarian crises. GBV is exacerbated in such crises with dire socio-economic and health consequences for survivors.

° Policy response in the context of pandemics must be cognizant of the implications for GBV due to lockdowns and restrictions on mobility.

° Classify/recognise GBV as a public health issue in the policy documents, post pandemic/recovery plan; and ensure wider dissemination of this mandate at varied levels of the health systems.

° Ensure that State institutional responses to GBV are coordinated and available, accessible even in pandemic, epidemic and other health and humanitarian crises.

° Ensure adequate availability of good quality masks, PPEs, regular testing, quarantine facilities, health care and adequate remuneration and social security, etc. for healthcare and other frontline service providers so that they are able to provide requisite quality services.

° Ensure that the national women's helpline 181 is operational and linked to survivor support services including provision of transport.

° All Courts including fast track and virtual courts must function to pass emergency orders of protection, residence, and maintenance and child custody without delays. District Legal Service Authorities (DLSAs) should remain functional

pursuant to the National Legal Service Authority Scheme for Legal Services to the Victims of Disaster.

- One Stop Centres (OSCs) should not be diverted to other crises management that prevents them from implementing services for GBV survivors, which is their primary role.

- Issue protocols for provision of all services to address GBV in pandemic and humanitarian crises.

- Ensure public dissemination of information on helplines, WhatsApp numbers, OSCs and all other survivor support services through multiple platforms, formats to ensure accessibility by all service providers, persons and survivors.

- Collate, analyse innovative / good practices by organisations, service providers, governments in addressing GBV during the pandemic. Enable resources and the sustained implementation of innovations that strengthen initiatives to address GBV.

Recognise as "essential" and implement all services necessary to address GBV in health, humanitarian crises

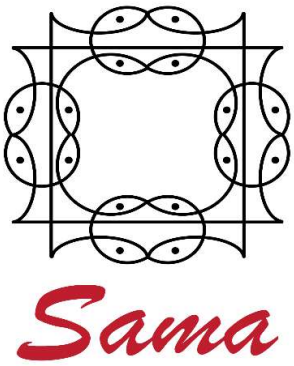
- Ensure that health care, including timely access to abortion, contraception and other sexual and reproductive health services, psychosocial care for GBV is included as "essential services" in all guidelines.
- Ensure functioning of all services for quality care and support for survivors and prevention of violence.
- Ensure requisite permissions, passes for service providers to enable them to continue provision of care and support.
- Ensure requisite permissions, emergency transportation for survivors so that they can access services, care and support.
- Ensure that all institutions, organizations, agencies, including the police, courts, health systems, OSCs, shelters, protection officers, etc. that are essential for a multisectoral response to GBV and support survivors are deemed "essential services".

Strengthen Systems and Responses to GBV overall, that have implications for services in the current pandemic and other health humanitarian crises contexts

- Ensure that these services are available to ALL the survivors of GBV, including trans persons and persons identifying as non-binary gender identities and varied sexual orientations (LBTQI), sex workers, adolescent girls, single women, women with disability, women and girls from marginalized caste, tribe etc. Guidelines/directives should state this clearly.

- Commit adequate financial, infrastructural and skilled human resources towards creation of support and care networks to respond to GBV.

- Enable communities' and civil society organisations' provisions of critical support services through facilitation of their access to various infrastructural, human and other resources.
- Ensure widespread dissemination of information about various services for survivors of GBV. The dissemination platforms, formats, languages must be varied to enable access to information for survivors from different social and geographical locations and their needs.
- Implement the PWDVA in its entirety, including appointment and accountability of POs, service providers, protection orders to address domestic violence.
- Allocate adequate financial, infrastructural and knowledge resources to ensure its effective and sustained implementation of the PWDVA.
- Ensure the protection of healthcare providers, especially frontline workers, ensure fair working conditions, just remuneration, training and social security benefits.
- Collect and analyse disaggregated data from various sources such as helplines, shelters, OSCs, health system, police, etc. on various dimensions of GBV, including in the pandemic recovery period, to inform future policy and implementation preparedness.



SAMA – RESOURCE GROUP FOR WOMEN AND HEALTH

B-45, SECOND FLOOR

SHIVALIK MAIN ROAD

MALVIYA NAGAR

NEW DELHI – 110017

PHONE: 91-011-26692730

E-MAIL: SAMA.WOMENSHEALTH@GMAIL.COM

WEBSITE: WWW.SAMAWOMENSHEALTH.IN/