One Stop
Crisis Centres

An Analysis by the Women Gaining Ground Consortium.

Women Gaining Ground

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Introduction

Violence against women is a widespread phenomenon in India, with a significant proportion of abuse and violence occurring within the family. It affects women and girls in multiple ways, leading to serious health complications. Violence against women and girls (VAWG) is recognized globally as a major public health concern and a violation of fundamental human rights. According to the World Health Organization, nearly one in three women worldwide have experienced physical and/or sexual violence, most often by an intimate partner comes from a report released in **2021**, using data collected between **2000-2018**[1] Gender-based violence (GBV) remains a leading cause of disability and death among women, with particularly severe consequences for their sexual and reproductive health. Intimate partner violence (IPV) during pregnancy is associated with preterm birth, low birth weight, fetal injury, miscarriage, and maternal mental health conditions such as depression, anxiety, and PTSD (CDC, 2023; PMC, 2023). These effects underscore GBV as not only a human rights issue but also a critical public health concern.

There is substantial evidence that survivors of GBV often engage with the health system, even when they do not seek legal help. A 2015 Lancet review emphasized the importance of a health systems approach to violence against women and girls (VAWG), highlighting the role of healthcare providers in early detection, documentation, and coordinated referrals (Lancet, 2015). More recent studies show that women facing abuse are significantly more likely to use health services than those who are not abused (UN Women, 2024). According to the National Family Health Survey-5 (2019–21), 29.3% of ever-married women aged 18–49 in India reported experiencing physical and/or sexual intimate partner violence, with many sustaining injuries that required medical attention (NFHS-5, 2021). Survivors were nearly twice as likely to seek healthcare compared to women not facing violence, yet only 14.2% sought help from formal sources such as health facilities, police, or legal aid (The Week, 2025). As one of the most consistent and early points of contact, healthcare providers are strategically placed to identify women facing violence, offer immediate medical and psychological care, document injuries, and make timely referrals that can mitigate long-term harm.

India's first hospital-based crisis centre, *Dilaasa* (meaning "reassurance"), was established in 2001 by the Centre for Enquiry into Health and Allied Themes (CEHAT) at KB Bhabha Hospital in Bandra, Mumbai. Widely recognized as the *Dilaasa Model*, this initiative laid the groundwork for the Ministry of Women and Child Development to establish *One Stop Crisis Centres* (OSCCs), also known as *Sakhi Centres,* across India in 2013–2014 to provide integrated support and assistance to women affected by violence, both in private and public spaces under a single roof. These Centres offer:

- **Medical assistance**
- **Police facilitation**
- **Legal aid and counseling**
- **Psychological support**
- **Temporary shelter (where needed)**

They are designed as a **convergent service model**, bringing together resources from the Ministry of Women & Child Development, Health, Police, and Legal Services Authority to

[1]https://www.who.int/news/item/09-03-2021-devastatingly-pervasive-1-in-3-women-globally-experience-violence

ensure survivors do not have to navigate multiple institutions.

As of March 2023, over 700 OSCs have been sanctioned across India, with varying levels of functionality across states. These centres are supported through the Central Government's *Nirbhaya Fund*, although their implementation is the responsibility of state governments.

Purpose of the Study

Women Gaining Ground (WGG) is a global consortium committed to addressing sexual and gender-based violence (SGBV) and promoting the political participation of young women and women with disabilities. India is a key participant in this initiative, where the program is implemented across four states: Uttar Pradesh, Bihar, Jharkhand, and West Bengal. CREA, based in New Delhi, serves as the national implementing partner, while the strategic state-level partners are Gramonnati Sansthan (Uttar Pradesh), Akanksha Seva Sadan (Bihar), YUVA (Jharkhand), and Sruti Disability Rights Centre (SDRC) (West Bengal).

In 2024 between August to October , the WGG India team undertook a study of a few selected OSCCs across the four states to strengthen and inform its advocacy efforts around GBV particularly to understand access and challenges. The primary objectives of the study were to examine:

1. Generating basic understanding on Resource allocations for the centres
2. Accessibility of these centres within hospital premises
3. Training of OSCC staff on GBV-related issues
4. The nature and availability of psychological support for survivors
5. Accessibility services for survivors with disabilities
6. The extent to which the centres are equipped to support young women and adolescent girls.

Overall, the purpose of this document is to assess the on-ground functionality, accessibility, and responsiveness of One Stop Crisis Centres (OSCCs) in selected districts across Uttar Pradesh, Bihar, Jharkhand, and West Bengal. It serves as an evidence-based input into ongoing advocacy efforts by civil society actors working on gender-based violence, disability rights, and health systems strengthening. The findings are meant to inform both local and national-level stakeholders, including women and child development departments, hospital authorities, police and legal service institutions, about persistent implementation gaps and the urgent need for systemic reform. This report documents how the OSCC model has been implemented, highlighting what has worked well and what requires improvement—particularly regarding accessibility for women with disabilities and convergence with key support services.

The aim is to generate evidence for policymakers, funders, and administrators to help ensure that the commitments of the OSCC schemes are fully realized.

It is also intended to inspire more such audits and evaluations across regions and administrative levels in India, so that the implementation of the law can be continually monitored, made transparent, and ultimately strengthened.

Methodology

This was a qualitative exploratory study using a standardized assessment tool collaboratively developed by grassroots practitioners. In July 2023, all Women Gaining Ground (WGG) India partners came together in Ranchi, Jharkhand, for a two-day intensive workshop. This was a key moment for learning from each other and working together on the tool that is aimed at understanding the services of OSCC in terms of safeguards of GBV for women and young women including women with disabilities. The tool is attached as Annexure-I. The tool includes a mix of structured questions and open-ended observations on OSCC functioning. All data were

gathered through site visits, interviews with available staff, and physical inspection. While the study was not submitted for Institutional Review Board (IRB) clearance due to its non-interventional nature and absence of direct engagement with survivors, all ethical considerations such as confidentiality and non-disruption of services were followed.

The tool was designed based on the real-life experiences of practitioners working on the ground and aimed to address important gaps in knowledge about how One Stop Crisis Centres (OSCCs) function. The questions focused on practical aspects like infrastructure, services, coordination among departments, and the experience of survivors using these services.

After the workshop, each WGG partner carried out the study in their own state. They visited selected OSCCs and hospitals to conduct the assessments. These visits included talking and interviewing OSCC staff and hospital workers, reviewing documents, and observing how the centres work.

The OSSC centres visited in each state are listed below:

S.No	Block / District	State	Note
1	Lucknow	Uttar Pradesh	This is one of the model centres of the state of UP and has been recognised and rewarded by the Government. This centre was visited by surveying teams from all the WGG partners to understand what are some components and services are available in a well-functioning OSC centre
2	Mahoba	Uttar Pradesh	Surveyed and findings recorded by Gramonnati Sansthan
3	Chitrakoot	Uttar Pradesh	Surveyed and findings recorded by Gramonnati Sansthan
4	Patna	Bihar	Surveyed and findings recorded by Akanksha Seva Sadan
5	Muzaffarpur	Bihar	Surveyed and findings recorded by Akanksha Seva Sadan
6	Ranchi	Jharkhand	Surveyed and findings recorded by YUVA
7	Jamshedpur	Jharkhand	Surveyed and findings recorded by YUVA
8	North 24 Paragnas	West Bengal	Surveyed and findings recorded by Sruti Disability Right Centre

9	South 24 Paragnas	West Bengal	Surveyed and findings recorded by Sruti Disability Right Centre

The centres selected for this study were chosen based on two key factors. First, accessibility to the WGG India partners conducting the surveys. It was important to ensure that field visits could be carried out effectively and within the available time and resources. Second, the selection aimed to reflect a mix of urban and semi-urban settings, helping to capture a broader picture of how OSCCs are functioning across different contexts.

Scope and Limitations of the Study

While we believe this study offers valuable preliminary insights into recurring patterns and structural gaps in the implementation of the OSCC scheme, its scope is limited by geography, sample size, and available access. The centres were selected based on logistical feasibility and do not represent all districts or diverse regional contexts. Additionally, some data, particularly around budgets, survivor demographics, and inter-agency protocols, was either not accessible or inconsistently documented at the centres visited. Despite these limitations, the study highlights critical areas of concern, including the invisibility of OSCCs within hospitals, lack of trained staff, and the systemic exclusion of women with disabilities. We hope that this assessment will serve as both a prompt and a foundation for more expansive research across states and at the national level, contributing to a stronger evidence base that can drive accountability and reform in how OSCCs are resourced, monitored, and made accessible to all survivors of gender-based violence.

Additionally, despite the assessment tool developed for this study being fairly comprehensive, covering infrastructure, staffing, disability access, legal and psychosocial services, budget allocations, and more, not all data points could be captured during the field visits. In several centres, information related to budget allocations and financial records was either unavailable, inaccessible, or not transparently maintained. Similarly, the level of documentation and staff familiarity with the scheme varied widely, which made it difficult to gather consistent responses across sites. As a result, this report focuses on a subset of the findings that could be reliably verified and synthesized across states. We recognize the importance of aligning the study's objectives and tool with the reported findings and will work to address this gap in future iterations by expanding the scope and timeframe of fieldwork, deepening access to internal records, and ensuring that all sections of the tool are reflected in the analysis.

Overview of Key Findings

The assessment of One Stop Crisis Centres (OSCCs) across nine sites in Uttar Pradesh, Bihar, Jharkhand, and West Bengal indicates that while the scheme has been officially launched in all four states, its implementation varies significantly across locations. In many centres, only a few components of the intended service model were operational at the time of the visit. Common gaps included lack of signage, limited staff orientation, inadequate documentation, and weak inter-agency linkages.

In **Uttar Pradesh**, the OSCCs in Mahoba and Chitrakoot had limited visibility and infrastructure. Both the buildings were newly constructed. In Mahoba, the Centre has signage but lacks key elements such as trained staff ,referral forms, or accessibility support for persons with disability. In Chitrakoot, there was

no designated staff, and were not formally informed about the centre's functioning. In both districts. The team found the referral was done but not as per mandate whereas Mahoba district had a better referral system. At Chitrakoot no formal referral pathways or linkages with legal, shelter, or mental health services were identified on the documents.

In **Bihar**, the OSCC in Patna had a visible room and a basic case register maintained by a counselor appointed by Mahila Thana. Patna centre had a 24x7 facility available but the centre was running in the office of land registry. However, trained counsellors and legal aid providers were not present, and coordination with other departments was informal. In Muzaffarpur, there was an assigned centre manager, with clear signage and dedicated space within the premises of the Sadar Hospital There was nothing mentioned about training spaces for both the places. In Muzaffarpur proper documentation and follow up for survivors were available. However, the same was unavailable in Patna. The trained counsellor was not available at both the centres with basic knowledge of GBV and support system required.

In **Jharkhand**, the OSCCs in Ranchi and Jamshedpur had clearer signage and dedicated rooms. Case documentation and some form of survivor follow-up were observed, particularly in Ranchi. The Ranchi centre was in the premises of the mental health hospital of Kanke and Jamshedpur was on the third floor of the red cross building without any lift or any other accessibility support system. However, neither centre had trauma-informed professionals, and accessibility features were minimal. While some coordination with the District Legal Service Authority (DLSA) was reported, regular interactions with police, Protection Officers, or mental health professionals were inconsistent.

In **West Bengal**, the centres in North and South 24 Parganas had low visibility and limited operations. In North 24 Parganas, the OSCC space was locked during the visit, and there was no signage or designated staff present. In South 24 Parganas, staff were difficult to reach and shelter services were reportedly not functioning due to staffing shortages. Accessibility provisions were not observed in either location, and service availability could not be confirmed through staff or public authorities.

A more detailed, site-wise account of these findings is available in Annexure 2- Summary of State Findings, which documents specific observations from each OSCC visited during the assessment.

Limited Implementation & Systematic Gaps

Across all four states, certain patterns were consistently observed. None of the OSCCs visited had infrastructure to support women with disabilities. Basic accessibility features, such as ramps, handrails, accessible toilets, adjustable seating, or signage in Braille or local languages, were entirely absent. Privacy and confidentiality were compromised in nearly every site due to the lack of partitions, soundproofing, or private consultation spaces. No Centre offered integrated legal, medical, and psychosocial support under one roof, as envisaged in the scheme design. Instead, services were either absent, informally outsourced, or provided on a part-time basis without supervision or protocols. Referral mechanisms and survivor follow-up systems were universally weak or missing, and in many centres, hospital staff were unaware of the OSCC's mandate or role. There was no system in place for orientation, in-service training, or convergence meetings with police, legal aid authorities, or shelter homes.

Disconnect between Policy and Practice

However, the overall picture that emerges is one of significant divergence between policy and practice. This fragmented and inconsistent implementation stands in clear gaps of the standards set by law and policy. The One Stop Centre Scheme Guidelines (2015, revised 2017) mandate the co-location of medical, legal, psychosocial, and police facilitation services, round-the-clock availability, and full accessibility

for women with disabilities. These obligations are reinforced by the Protection of Women from Domestic Violence Act, 2005, which requires timely and coordinated support services for survivors, and the Rights of Persons with Disabilities Act, 2016, which guarantees access to public services, including crisis response systems, for persons with disabilities. The near-total absence of trained personnel, inter-agency convergence, and accessible infrastructure at most OSCCs indicates not just weak implementation, but a systemic failure to comply with these legal and policy frameworks. What exists on paper has not translated into meaningful protection or support on the ground. Without immediate and systemic corrective measures, these centres risk becoming symbolic placeholders, rather than meaningful access points for survivors seeking justice, care, and protection.

An Isolated Innovations: A Fragmented Landscape

Innovations are few and far between look like with a political will, inter-departmental coordination, and trained human resources .Despite these widespread deficiencies, a few local innovations and adaptive practices did stand out. In certain districts of Jharkhand, the presence of NGO partners helped foster more survivor-sensitive spaces and enabled limited but meaningful collaboration with health and legal systems. In Patna, Bihar, staff made efforts to redirect survivors to better-functioning One Stop Centres managed by the Department of Women and Child Development for counselling and shelter, although these efforts remained informal and poorly coordinated. In sharp contrast, the Lucknow OSCC, referenced in internal discussions and state-level observations, had a visible entrance, full-time multidisciplinary staff, clear record-keeping, and formalized links with hospital and protection systems. While not meeting all standards, it demonstrated what a functional OSCC can look like.

Centre-wise Findings During the Study:

Features/ Services	Mahoba	Chitrakoot	Patna	Muzaffarpur	Ranchi	Jamshedpur	North 24 Parganas	South 24 Parganas	Total (Yes / 6)
Accessibility									
Ramp for wheelchair users	No	No	No	Yes	Yes	No	No	No	0/8
Accessible toilet	No	Yes	No	Yes	No	No	No	No	0/8
Braille signage or audio info	No	No	No	No	No	No	No	No	0/8
Signboard for OSCC	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes (partial)	4/8 (1 partial)
Location easy to access	No	No	Partial	Yes	No	Partial	No	No	2/8 (2 partial)

IEC material in local languages	Yes	Yes	No	Yes	Yes	Yes	No	No	0/8
Services Provided									
Psychosocial counselling	Yes	Yes	No	No	Yes	Yes	N/A[2]	N/A	2/6 (1 partial)
Legal aid services	Yes	Yes	Yes	Yes	Yes	Yes	No	N/A	0/7
Case intake register	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	4/7 (1 partial)
Referral to Protection Officer	Yes	Yes	Partial	Yes	Partial	Partial	N/A	No	3/7 (3 partial)
Survivor follow-up system	Yes	Yes	Yes	Yes	Yes	Yes	N/A	No	0/7
Linkage to a shelter home	No	No	No	No	no	Partial	No	No	3/8 (3 partial)
Emergency medical care (within the hospital)	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	6/7 (1 partial)
Infrastructure and Systems									
Dedicated room	Yes	Yes	Yes	Yes	Yes	Yes	No	No	3/8
Dedicated staff for OSCC	Yes	No	Partial	partial	Partial	Partial	Partial	Partial	5/8 (5 partial)
24x7 availability	Yes	No	No	No	No	No	No	No	0/8
SOPs/Protocols displayed	No	No	No	No	Yes	No	No	No	0/8
Stakeholder coordination (DCPU, DLSA, PO)	Yes	No	Yes	Yes	Yes	Partial	No	No	3/8 (3 partial)
Regular review meetings	Yes	No	No	Yes	Yes	Partial	N/A	N/A	0/6

[2] "N/A" (Not Applicable) has been used where information could not be gathered during the visit. These entries are excluded from the total count to avoid skewing the overall analysis.

Staff received orientation/training	Yes	Yes	Yes	No	No	No	No	No	2/8
Referral directory (PO, shelter, DLSA, NGOs)	No	No	No	No	No	No	No	No	0/8
Internal documentation of protocols	No	No	No	No	No	No	No	No	0/8
Cross-Cutting Issues and Institutional Integration									
Awareness among hospital staff	No	No	No	No	No	No	No	No	0/8
OSCC visible in hospital layout / flow	No	No	No	Yes	Yes	No	No	No	3/8 (3 Partial)
Police coordination (formal)	No	No	No	No	No	No	No	No	0/8
NGO / CSO linkage (documented)	No	No	No	No	No	No	No	No	2/8 (2 Partial)

Key Recommendations:

Key Issues	Findings	Recommendations
Difficulty in Accessing OSCCs	OSCCs are located at the district level, making access difficult for rural survivors. Public transport is inadequate, and social stigma deters urban survivors.	• Coordinate with the District Legal Services Authority's Legal Clinics at the rural level. • Provide transportation support to ensure accessibility.
Lack of Resources	OSCCs lack sufficient staff for psychological counseling, legal aid, and medical assistance. Overburdened staff cause delays in survivor support.	• Strengthen partnerships with local women's organizations. • Assign dedicated support persons for survivors.

Lack of Awareness	Given the lack of signage, information materials, and routine awareness drives, it is likely that many women, especially those from rural or marginalized communities, may be unaware of the services they offer.	• Conduct awareness campaigns via social media and newspapers, especially on key occasions. • Organize outreach programs in marginalized communities.
Limited Understanding of Gender & Disability Issues	OSCC staff lack training in feminist issues, disability rights, and legal frameworks. Awareness of the Disability Board (Mission Power Board) is low.	• Provide comprehensive training on feminist issues, disability rights (RPD Act), and survivor support. • Train staff on engaging special educators and supporting LGBTQ+ survivors.
Poor Centre Conditions	Staff are overworked, leading to insensitivity toward survivors. Security personnel are often missing. Staff juggle multiple responsibilities.	• Appoint staff as per government guidelines. • Provide mental health support and sensitivity training for staff.
Inadequate Infrastructure & Basic Facilities	Many centres lack essentials like drinking water, functional toilets, and 24x7 availability. Some are in unsuitable locations (e.g., upper floors without elevators).	• Relocate centres to better-equipped locations, preferably within hospitals. • Ensure 24x7 operations with proper facilities.
Lack of Accessibility for Disabled Women	Many OSCCs lack ramps, wheelchair access, elevators, sign language interpreters, and communication aids.	• Equip centres with ramps, wheelchairs, and elevators. • Maintain a directory of certified sign language interpreters.
Job Insecurity for OSCC Workers	Staff fear job loss at any time, particularly those aged 40–45, affecting morale and commitment.	• Retain experienced staff and provide job security policies. • Offer retraining and professional development.
Poor Coordination with Other Departments	OSCCs lack effective cooperation with police, medical services, and legal authorities, leading to case delays.	• Conduct quarterly coordination meetings with key departments (Police, DLSA, Social Welfare, Medical Services).
Lack of Mental Health Support	OSCCs do not have adequate mental health counseling for trauma survivors.	• Connect OSCCs with the National Mental Health Helpline to offer psychological support.

Conclusion

This assessment shows that OSCCs across the eight districts are falling short of what they are meant to provide, safe, accessible, and coordinated support for survivors of gender-based violence. Physical access is one of the biggest gaps. Most centres have no ramps, no accessible toilets, and no signs to guide people. For women with disabilities (WWD), this creates an almost total barrier to entry. When a center is not physically accessible, it sends a clear message: you are not expected here. This exclusion is not just about infrastructure; it reflects deeper systemic neglect.

Beyond physical access, the lack of trained staff, proper systems, and formal services means that even survivors who do manage to reach an OSCC often face delays, confusion, or are turned away. Services like counseling, legal aid, and follow-ups exist on paper but are missing or informal in practice. Without strong referral networks or regular coordination among key agencies, such as the police, hospitals, and NGOs, survivors are left to navigate complex systems on their own.

At the same time, this study makes it clear that these gaps can be addressed. While budget allocation was a stated objective, the study team was unable to access official OSCC budgets or disaggregated financial information during the field visits. This represents a significant gap, underscoring the need for improved transparency and data access to assess the adequacy and utilisation of funds. The OSCC scheme suffers from budget unpredictability, lack of ring-fenced funds for staffing and infrastructure upgrades, and poor transparency in expenditure tracking. Policy-wise, convergence mandates remain weak, with no inter-ministerial oversight mechanism to ensure implementation fidelity.

We need physical spaces that are inclusive, staff who are trained and present, and systems that are survivor-centred. Districts already taking small steps, like partnering with NGOs or setting up informal linkages, show that progress is possible.

The recommendations emerging from this study are directed at multiple institutions, reflecting the intersectoral design of the One Stop Centre (OSC) Scheme. The primary responsibility for implementing and managing OSCs lies with the Department of Women and Child Development (WCD) at both state and district levels. This includes recruitment of staff, inter-agency coordination, monitoring, and use of scheme funds under the Nirbhaya Fund. Hospitals, under the Department of Health and Family Welfare, are tasked with housing the centres, offering emergency medical care, and ensuring frontline staff are sensitised to gender-based violence (GBV) and referral protocols. The District Legal Services Authorities (DLSAs) are responsible for ensuring legal aid services are available through OSCs, and the police are expected to cooperate through designated officers for survivor assistance and FIR support.
In addition, the Social Justice and Empowerment Departments and State Commissioners for Persons with Disabilities have an obligation, under the Rights of Persons with Disabilities Act, 2016, to ensure all public services including OSCs,are accessible and inclusive of women with disabilities. This includes the provision of physical infrastructure (e.g., ramps, accessible toilets), communication support (e.g., sign language interpreters, easy-to-read materials), and trained personnel.

The issues documented here are not just technical problems; they are questions of justice, dignity, and basic human rights. OSCCs were created to respond to violence with compassion, speed, and structure. That vision is still achievable, but only if there is political will, sustained investment, and clear accountability. Survivors, especially the most marginalized among them, cannot afford to wait.

Similar accessibility and service audits must be carried out across all OSCCs in India to understand the full scope of the challenge. States should take up the findings from such studies and translate them into real improvements on the ground, starting with the basic, doable steps recommended here. By acting now, governments and stakeholders can begin to close the gap between policy and reality, and finally deliver on the promise of OSCCs as safe, inclusive, and effective spaces for all survivors. Also there should be intentional and mindful interdepartmental and NGOs collaboration needs to be done to improve the awareness in the community and access to the services.

Annexure 1: Sample Assessment Tool Developed for the Study

A) Information about the centre

- Name of the Centre:
- Address & Location:
- Contact Details:
- Operational Status / Year of Establishment:
- Managing Body (Government / Non-Government):
- If Non-Government, Name of the Organization Running the Centre:
- If the Centre is Not Located Within the Government Hospital Premises, Please Specify the Reason:

B) Information about staff

Post / Designation	No. of Sanctioned Posts	No. of Posts Filled	Name(s) of Incumbent(s)	Gender (M/F/TG)	Qualification	As per Scheme Norms (Yes/No)	Working Hours / Shifts
Centre Administrator							
Case Worker							
Police Facilitation Officer							
Para Legal Personnel / Lawyer							
Para Medical Personnel							
Psychologist / Counsellor							
IT Staff							
Multipurpose Helper							
Guard / Watchman							

Any Other (Please Specify							

C) Functioning of the centre

- Average Number of Cases Registered Per Month:
- Trend in Case Numbers Over the Last 3 Years (Increasing / Decreasing):
- Types of Violence Reported:
- Age Group of Survivors:
    A. Below 18
    B. Above 18
    C. Married
    D. Unmarried
- Cases Referred by Police Stations (Number and Types of Cases):
- Transport Facilities from the Centre to Other Support Services:

D) Disability-Specific information

- Disability-Specific Information
- Number of Cases Involving Women with Disabilities (WWDs):
- Types of Violence Faced by WWDs:
- Categories of Disabilities Represented:
- Number of Cases Where Disability Was a Result of Violence:

Accessibility for WWDs:

- Is the Centre Physically Accessible (e.g., Ramp, Wheelchair Availability)?
- Are Accessible Washrooms Available?
- Do You Have a List of Sign Language Interpreters?
- How Do You Support Women with Intellectual or Psychosocial Disabilities?
- Is the Counsellor Trauma-Informed?
- What Protocols Are in Place for Supporting Women Who Are Suicidal?
- Do You Have a List of Special Educators Who Can Support Girls/Women with Intellectual Disabilities?
- How Do You Address Cases Involving Pregnant Survivors of Violence?
- What Infrastructure Exists for Women Accompanied by Children?
- If a Woman Comes with a Disabled Child, Are You Linked with Services for Children with Special Needs?

E) Services provided by OSCC

Serial No.	Indicators	Drop box/ mark ✓ which is applicable
1	Integration with 118 Women Helpline	• Yes/No • Functional/Non-functional • Active 24*7 [ ] • Active for a stipulated time(specify period)
2	Emergency Response and Rescue Services	Linkages developed with • National Health Mission (NHM) [ ] • 108 service [ ]

		• Police-PCR Van [ ]
3	Shelter	• For a period of 05 days [ ] • • For a period less than 05 days [ ] • • For a period beyond 05 days [ ] • • Maximum 05 Woman at a time [ ] • • Beyond 05 Woman at a time [
4	Medical assistance	• Available 24*7 [ ] • Available during fixed Hours [ ]
5	Assistance to women in lodging FIR/ NCR/DIR	
6	Psycho-social support/ counselling	• Counselor is appointed on a full-time basis [ ] • Services of the counselor are provided part-time [ ] • Only need-based counseling is available [ ] • Counseling is given only at the time of admission [ ]
7.	Legal aid and counseling	• Services of advocates made available by DLSA [ ] • Services of an advocate are provided by OSC in i. Selected cases [ ] ii. In all cases [ ]
8.	Video Conferencing Facility	• Available [ ] • Not available [ ]
9.	Beds	• Separate bed for each woman [ ] • Beds are shared by women [ ] • Accommodated on the floor [ ] • Any other specify Condition of beds Good [ ] Bad [ ]
10.	Mattresses	• Provided on all beds [ ] • Provided on floor [ ]
11.	Clothing	• Provided with one set of clothing [ ] • Provided with two sets of clothing [ ] • One set of undergarments is provided [ ] • Two sets of undergarments are provided [ ]
12	Basic Kit	• A separate kit provided to each woman [ ] • Common facility to all women [ ] • Sanitary pads [ ] • Tooth brush [ ] • Toothpaste [ ]

		• Soap [ ] • Shampoo [ ] • Hair Oil [ ] • Comb [ ]

E) Case Follow-Ups and FIRs

- Number of Cases Registered at the OSCC (Last 6 Months):
- Number of FIRs Filed from the OSCC (Last 6 Months):
- What Actions Has the Centre Taken as a Follow-up for Counselling Cases?
- What Follow-up Is Done in FIR Cases?

F) Awareness

- What Steps Does the Centre Take to Raise Awareness About OSCC Services in the District?
- Is there a clearly visible signboard for the centre?
- Does the Centre Have Awareness or IEC (Information, Education, Communication) Materials?
- If yes, what type (e.g., pamphlets, posters, videos)?
    - What language(s) are used?
    - Are materials available in regional languages?
    - Are materials accessible in Sign Language?

G) Helpline and Related Linkages

- Does the Centre Operate a Separate Helpline?
- Is the Centre Connected to Any Existing Helpline Services?
    - If yes, which ones?
- Is the Centre Linked with ChildLine?
- Is the Centre Connected to the National Disability Helpline 'Kiran'?

Additional Questions for Internal Observation:

- **Location** – Where is the centre located? Is it isolated or situated within a populated area? Is it near any political party offices? How accessible is it?
- **Management** – If the centre is not run by the government, who is responsible for its operations?
- **Staff** – Are the staff members permanent or contractual? Have they received training, and do they demonstrate a feminist understanding? Are salaries paid regularly? What is the workload like? Does the administrator need to support the staff? What are the staff's attitudes,are they survivor-friendly? Are there sufficient resources available for the staff? How is the internal coordination among staff members?
- **Survivor Demographics** – What are the caste, religion, and other social identities of the survivors accessing the centre?
- **Infrastructure** – Is there adequate electricity? Is the infrastructure spacious, well-lit, and airy? Is there privacy for survivors? Are the toilets and shower areas properly clean, separate, and hygienic?

Annexure: Summary of State Findings

Uttar Pradesh

The assessment in Uttar Pradesh covered two OSCCs , one each in Chitrakoot and Mahoba Districts. Both centres were found to be severely underdeveloped, with very little in place for the building. At Mahoba 9 staff were appointed and in Chitrakoot there was no Centre Manager found.

The Chitrakut Centre was not inside the premises of the Hospital and was located a bit off the city centre, There was signage and properly marked rooms by which rooms can be recognised. The cases which were coming from the Child Welfare Committee (CWS) were registered at OSCC. In Mahoba and Chitrakoot basic office running materials were available such as furniture , files, registers and forms etc. The nurse assigned to Chitrakut at OSCC had not received any training and described her appointment as a verbal order from hospital administration without guidance on what her role entailed. There were records of the cases and it was documented too but they refused to show it. The nurse reported that if a survivor did approach, they would typically be referred informally to police or protection officers, but this had not happened in practice, as the direct cases are not coming to the centre, but 30 to 40 cases are coming from the CWC and the police station in a month.

A counselor and a DLSA employee were appointed at the center though the study team didn't find any information if an external counsellor was invited for the survivor counseling process. The referrals were made at Naari Niketan or the survivors were sent to their own homes.The hospital staff showed no awareness of the OSCC's intended purpose, and no convergence meetings or planning had taken place as per her sharing during the visit. There were IEC materials found at the centre printed in Hindi but lack of awareness posters, or any effort to inform the community or hospital visitors about the existence of the OSCC. In terms of accessibility, there were ramps at the centre , accessible toilets were made and personal use items for the survivors were available, but the technical understanding of inclusive accessibility was completely missing like asking on braille signage the nurse couldn't answer anything.

In Mahoba, a Display Board of the Sakhi One Stop Centre was installed on the building. The manager assigned to the OSCC duties shared that got training from the department but not on intersectional gender based violence issues. There are separate rooms in the centre, but they are small. The team found that the centre manager closely worked with police and legal aid services and records were also maintained for the cases. The cases were coming from CWC mostly. No monthly reporting, coordination, or reviews were being carried out as an interdepartmental meeting. The protection officer and DLSA had not interacted with the hospital on OSCC work and there was a weak linkage with the health department. There were accessible toilets, but no ramps or wheelchairs were found at the centres.

In both centres, it was clear that the OSCC existed only as infrastructure without any deep thought of constant improvement in the services and support to the survivors of GBV. The access to survivors of disability was missing in the entire understanding of the people who were assigned for the service delivery and in the infrastructure itself.

Jharkhand

The assessment team visited OSCCs in Ranchi and Jamshedpur, where the initiative showed marginally better visibility and infrastructure than in Uttar Pradesh and Bihar. However, even in these centres, critical service gaps remained in terms of counselling, legal aid, coordination with other stakeholders, and survivor-centric functioning.

In Ranchi, the OSCC was located within the RIMS (Rajendra Institute of Medical Sciences) hospital campus and had a clearly demarcated room with a board identifying it as an OSCC. There was a dedicated room, with basic furniture, including a table, chairs, and a fan. The OSCC was being operated by the DCPO, who has been appointed by the government and the staff maintained a register of survivor cases. Some records of survivors were available, and the staff appeared familiar with handling GBV cases. The OSCC had a case intake register, referral register, and a

basic filing system. There was a list of helpline numbers and contact details of other service providers displayed on the wall.

Despite this, the centre was still under-functioning. There was no 24x7 availability and the centre operated only during the daytime. Medical staff within the hospital were not fully sensitized to the role or importance of the OSCC, and referrals from the emergency ward or other hospital departments were infrequent. Legal services were available, and the staff formally referred to the Protection Officer or DLSA. The formal system of operation was followed up but the staff indicated that many survivors were reluctant to return or continue services after the first visit. There was a dedicated ambulance or vehicle for transportation of the survivors but there was no disability-friendly infrastructure, such as ramps, handrails, or accessible toilets etc were available. IECs available in Hindi though the awareness about the centre within the hospital and among the public was still low.

In Jamshedpur, OSCC is located inside the Red Cross Building not in a government hospital. The centre was located on the third floor of the building. The centre had a table and chairs, and two officials from the Social Security Department at the time of the visit. The OSCC had a register of survivors, and the staff was on psychosocial first aid and handling of GBV cases.

At Ranchi the hospital authorities were aware of the OSCC's presence, and there was at least some informal coordination with the DCPU and police. Survivors who approached the centre were either supported with medical care or referred to the Protection Officer, and a case registered was maintained by the staff in charge.

At Jamshedpur there were clearly limitations of accessibility at the centre. Counselling services were inconsistent, and the NGO staff did not have clinical counselling training. Legal services were linked with the centre provided on-site, and linkages to the DLSA remained formal. While the staff maintained registers, there was no electronic data system or regular reporting to district authorities. Though the IEC materials were displayed, there had been no community outreach or campaigns to promote awareness of the OSCC. The centre had no infrastructure that supported women with disabilities, and privacy for survivors was difficult to maintain due to the layout of the rooms.

Across both sites in Jharkhand, it was evident that some structural elements were in place including dedicated rooms, signage, and partial documentation, but the functioning of the OSCCs remained uneven and under-resourced. While the presence of NGO staff and case registers marked an improvement over Uttar Pradesh and Bihar, the centres lacked trained multidisciplinary teams and understanding on handling GBV cases. Inter-agency coordination was ad hoc, and accessibility and survivor-friendly infrastructure continued to be a major gap.

Bihar

The team visited OSCCs in Patna and Muzaffarpur, where some elements of infrastructure and documentation were present, but functionality and inter-departmental coordination remained extremely weak.

It was located in the campus of the Chhajju Bagh Registration Office in Patna. There were separate rooms for each type of work, in which proper arrangements of electricity were made. There was a big signboard that was easily visible to everyone. To handle the cases, the responsibility of the centre's administrator was given to the counselor from the Women's Police Station. A register of cases was maintained at the centre, and some survivors had availed of the services. However, only a few cases came in over several months, and referral slips were available. The room had chairs and a table, and for confidential counseling, there was a partitioned space in a separate room, creating an appropriate environment for sensitive

conversations. The centre also provided on-site counseling services, and legal aid was available as well.

The centre functioned only during the day, with no 24/7 availability of the services. Medical support was available, but it depended on the responsiveness of hospital staff. The centre administrator shared that survivors were sometimes referred to protection officers or short-stay homes, but these referrals were tracked and records were kept by the centre administrator. There was no formal convergence mechanism with police, DCPU, or DLSA, and follow up procedures were being followed. There were no printed IEC materials, no outreach, and no disability-friendly infrastructures were found. Coordination with the hospital administration existed only nominally, and there was no system of monitoring or feedback.

In Muzaffarpur, the OSCC was located within the District Hospital, but had very good-functionality. A nurse was assigned to the OSCC, she had received any training. The OSCC ——has a dedicated room –. There was - signage, and the location was - known to-hospital staff members.

In Muzaffarpur, the OSCC was located in the district hospital, and its functioning capacity was very good. The OSCC was overseen by an appointed centre administrator, who was highly experienced and trained. The infrastructure of the OSCC building was well developed, with separate rooms designated for different services. Each room had its purpose clearly labelled, and a large signboard outside made the centre visible from a distance. The hospital staff were also aware of this facility.

Counseling, legal aid, and medical assistance services were available here. According to the Centre administrator, whenever a survivor arrived, formal assistance and guidance were provided by both the centre administrator and the case worker. Every case was documented properly through survivor files and a structured follow-up process.

West Bengal

The team visited OSCCs in North 24 Parganas and South 24 Parganas, both of which were found to be severely under-functioning, with striking gaps in visibility, staffing, accessibility, and survivor services.
In North 24 Parganas, the OSCC was situated within one of the most crowded government medical colleges in the district. However, there was no signboard indicating its location, and it was not marked on the hospital's internal directory. Hospital staff, including security guards and support personnel, were largely unaware of the centre's presence. The OSCC itself was a temporary cubicle—partitioned using makeshift materials—located behind a collapsible gate in a shared hospital area. At the time of the visit, the centre was locked, and no staff were present despite it being a regular working day. A security guard reported that only two female staff members occasionally visited the centre for short durations (typically 3–3.5 hours), but their roles were unclear, and their visits were irregular. There was no signage in local languages or Braille, no disability-accessible infrastructure, and no clarity on whether any survivors had accessed services. No documentation, registers, or case protocols were visible, and there was no indication of counselling, legal aid, or police facilitation services being available.

In South 24 Parganas, the OSCC was located on the periphery of Kolkata district, in a state general hospital that appeared largely deserted and poorly maintained. Although a signboard was present at the centre, the hospital staff were unaware of its existence, and the facility's location within the hospital was isolated and difficult to access. Only one staff member—a data entry operator—was present during the visit. The Centre Administrator was reachable only by phone and confirmed that four staff were officially appointed (including an

Women Gaining Ground

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