Begin a New - Comprehensive care

1st October 2019 to 30th September 2022

PCVC UNTF Evaluation Report

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Disclaimer

This Report has been developed by an independent evaluator. The analysis presented in this report reflects the views of the author and may not necessarily represent those of PCVC, its partners or the UN Trust Fund.

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Vidiyal - Begin Anew (2019 to 2022)

This report presents the end-of-project evaluation undertaken for the UNTF PCVC Project "Vidiyal - Begin Anew" between 1st October 2019 to 30th September 2022.

The evaluation report is divided into nine sections covering three parts of the evaluation process: introduction, evaluation analysis, and findings.

Sections I and II introduces PCVC and the project, including objectives, services, and the impact of COVID. They also cover the evaluation methodology: the purpose of the evaluation, its specific objectives, rationale for using Classical Grounded Theory, sampling, data collection methods, analysis and report writing.

Sections III to V present the evaluation analysis covering the context and issues of PCVC's clients, the recovery path for burn and DV survivors, and PCVC service provision approaches. PCVC service provision includes services provided to clients and stakeholders/partners.

Sections VI to VIII present key findings along the following aspects: Gender equality (including PCVC's unique approach), Project Performance (efficacy, efficiency, relevance, impact and sustainability, and Knowledge Generation (key areas of learning from PCVC's work that may apply elsewhere).

Section I: Introduction

1. About PCVC

The International Foundation for Crime Prevention and Victim Care (PCVC) was founded in 2001 in Chennai, Tamil Nadu. It creates and extends services for two kinds of survivors: women burn victims and victims of domestic and interpersonal violence, particularly women and queers. Its services include emergency support and long-term rehabilitation aimed at supporting survivors recover from being victims to becoming thrivers.

These services are aimed to be client centred and comprehensive. They range from trauma-centred services (including interface with law and order and medical care), information for decision-making, housing and shelter (including emergency and long-term needs), psychotherapy, strength-based capacity building, family counselling, nutrition and sanitation care, skill building and employment opportunities, and special services for children of survivors.

PCVC delivers these services through its team of social workers, psychologists and welfare officers. In addition, it has also enrolled a wide variety of partners and stakeholders who provide services for survivors in their local contexts.

PCVC is also working with preventive aspects of violence, including enrollment and support of changemakers working towards a healthy society that treats all individuals equally and is free of violence. These preventive efforts focus on empowering and enrolling individuals who are part of colleges, community organisations, workplaces, etc. These individuals work as change makers creating gender equality in their contexts: gender role division within homes, prevention of sexual harassment at the workplace, countering the normalisation of violence against women in communities, etc.

2. UNTF Project Objectives

The project has two broad outcomes: (i) an increase in services to survivors (burn and DV victims); and (ii) an increase in multistakeholder service provision.

The first outcome is related to increasing services to DV and burn survivors, including the following kinds of services/outputs: physical services, including shelter and physiotherapy; trauma-informed support services; psycho-social responses by support systems and stakeholders; and information dissemination and capacity building.

The second outcome is aimed at enabling an increase in services provided by multiple stakeholders with the following outputs: an increase in participation of stakeholders/ partners; changes in their behaviour (approach, techniques and practices); increased alignment between the various kinds of services provided by stakeholders; and development of synergetic partnerships based on principles at multiple levels.

3. UNTF Project Services

The UNTF Programme covered four distinct aspects of PCVC's services to survivors: Vidiyal for Burn Care Survivors; Dhwani Hotline for Domestic Violence Survivors (women and queer individuals); Astitva Shelter for survivors of burns and domestic violence; and Outreach services for external partners, stakeholders, and changemakers.

Briefly, the Vidiyal project planned to work closely with hospitals in 11 districts of Tamil Nadu to provide services to women survivors. It primarily worked with burn survivors admitted into government hospitals. Its range of services included (i) physical services, including nutrition, medical support, sanitation support, physiotherapy through its RHC centre, shelter and clothing, etc.); and (ii) psycho-social services, including psychotherapy, family counselling, legal services, child care, economic empowerment including vocational training and job referrals, etc.

Besides offering phone counselling, the 24-hour Dhwani Hotline was the first point of contact for women victims of violence across the country. Clients approaching the hotline were provided with other services (in-house and in partnership with other like-minded organisations).

Astitva acted as an emergency shelter for DV survivors at risk of continued violence. This shelter was equipped to protect them and attend to their various physical and psychosocial needs.

Both Dhwani Hotline and Astiva Shelter were integrally supported by a psycho-social central team that ensured clients could access PCVC's various services appropriately. This psychosocial team provided access to extended services such as long-term psychotherapy, legal counsel, long-term housing needs, etc. The fifth key aspect of PCVC's work is Smiles for children of survivors. This aspect was not covered in the UNTF project.

Besides these direct services for women, PCVC had also instituted outreach services spread over Tamil Nadu and the rest of the country for burn and DV survivors. These services enrolled two critical kinds of actors: partners/stakeholders who could provide quality services to survivors in their contexts; and change makers who were committed to gender equality.

4. Impact of COVID

COVID significantly affected the project internally and externally.

Externally, COVID restrictions caused significant challenges in engaging with partners and stakeholders, particularly those interactions requiring trust and capacity building. Thus, the deployment of staff in hospitals and their mobility, provision of on-site care in hospitals and homes, in-house physiotherapy, etc., became challenging. To begin with, hospitals reshuffled their wards (including burns wards) to accommodate pandemic needs. Further, respondents in hospitals reported a reduction in burn incidents arising from domestic violence for reasons such as a reduction in alcohol consumption. Even as

the number of burn survivors in hospitals decreased, there was a substantive increase in DV victims reaching out for remote help.

In response, PCVC shifted their strategy, focussing on continuing to deliver services possible through new ways of working: online awareness sessions (video calls, physiotherapy exercises and wound care methods), provision of nutrition at doorsteps, etc. It suspended activities with government officials and medical staff that required intensive in-person engagement. Instead, it focussed on CSOs and civil society actors who could be accessed remotely.

Hospitals in 10 districts were contacted in the first six months, including the following: Chennai, Vellore, Madurai, Trichy, Salem, Thiruvarur, Thanjavur, Chengalpet, Kanyakumari, and Tirunelveli. In the second year, PCVC maintained contact with seven hospitals providing burn survivor support, including Chennai, Madurai, Chengalpet, Thiruvarur, Trichy, Vellore and Salem. By the third year, PCVC signed MoUs with five hospitals, including the following: Chennai, Chengalpet, Madurai, Thiruvarur and Vellore.

Internally, COVID disrupted the regular recruitment and orientation of project staff and increased demands on the psychological resources of the current teams. A few staff faced personal losses because of the pandemic, with PCVC supporting their recovery. However, because of restrictions, regular recreational and capacity-building activities were suspended.

Remote deployment of staff in hospitals during the pandemic was challenging. Instead, PCVC enrolled local CSOs as nodal organisations to provide essential services such as nutrition, medical care, etc. This creative solution opened the possibility of authentic decentralised partnerships. With the lifting of the pandemic restrictions in the last year, the organisation has resumed planned activities such as ongoing contact with partner hospitals and capacity building of health professionals and government officials.

Astitiva remained open during COVID, while almost all other shelters shut down. It re-organised its shelter to meet two needs: (i) COVID testing, specialised care for COVID+ women, and prevention of contamination to other sections of the shelter; (ii) Transitory sections where women who had to go out to work could do so.

During this time, PCVC increased its outreach activities, reaching out to women in remote and isolated contexts. This is one reason for the substantial increase in Dhwani calls (besides the general increase in reports of DV and burns). Further, the clients were not just from Tamil Nadu but also from other parts of the country. In response, PCVC instituted a multi-lingual team and consolidated its referral services to reach women in their local contexts.

Finally, it built a robust Change Maker programme that includes already identified sectors such as hospitals, government and CSOs. This initiative also enrols members from other communities, such as students and local communities.

5. PCVC Organisation Map

PCVC has grown over the last two decades through iterative refining and expansion of its services to burns and domestic violence survivors. In this sense, the institution is growing along the lines of building the ship while sailing it: serving clients directly while simultaneously improving existing services and developing new ones. This practice has resulted in a rich institutional growth of multiple relations based on shared principles.

PCVC has more than doubled its staff and services, particularly in the areas of shelter provision, hotline and outreach services in the last five years. In one of the early interviews, a senior staff member said that PCVC had been a small organisation devoted

to providing quality services for a long time. This was a critical reason for its credibility. COVID and its restrictions on mobility created opportunities for PCVC to move creatively and naturally from this identity to broadening its scope and kind of work. PCVC expanded its work significantly in increasing civil society capacity through its outreach programmes and strengthening local decentralised services available to survivors through partnerships with nodal CSOs.

PCVC has a loosely defined senior management team of directors and project leads. These included the President, Executive Director, Director (MIS, Finance, and HR), Senior Director (Client Services and Networking) and Associate Director. They directly and/or collectively supervised specific projects/functions. Project teams included the Dhwani Team, Vidiyal Team, Astiva Team (also Prem Vihar), Outreach Team, Psycho-Social Team, and Smiles Team. Functional teams included the following: MIS, Finance and Operations.

Project/Function based teams regularly engaged with the senior management in fixing their specific goals and targets, facing issues, and using resources. Inter-team communication was restricted to protect the confidentiality of the survivors concerned. Irresponsible communication amongst staff members about survivors is inimical to their safety. PCVC's teams were dedicated, specialised and competent. Members clearly understood goals, roles and responsibilities to fulfil key functions and deliver projects. PCVC also has well-defined accountability structures, including performance reviews of the staff, clear reporting structures, and real-time reporting of activities.

Most team members were women with significantly different social identities and expertise. These diverse teams had the capacity/creativity to provide holistic functional solutions that address client needs. The culture of participatory decision-making enabled team autonomy. For instance, the finance and operations team was considering a shift in the organisation of their filing systems, which is currently donor based, to one that is activity/day based.

Teams are involved in the planning processes right from the beginning and autonomously decide the utilisation of the resources available for optimum results. Thus, teams know the activities they must carry out and the resources available in the project for their work at any given time. This transparency evoked responsibility in individual team members to use these resources in the best possible way. The usual hierarchy that results from control of finances was significantly reduced without concurrent loss of accountability.

The definition of roles and responsibilities emphasised individual initiative and accountability amongst team members. This definition also increased the effectiveness of participation, where team members felt free to express their dissent to their colleagues and superiors. The organisation pursues an open-door policy, where individual staff members feel safe to take their concerns to senior management. For instance, one of the team members had a grievance about not being selected for a training programme. She directly approached the leader of the respective function with her complaint. This leader explained the rationale behind choosing members for the current training and subsequently supported her in attending courses of her choice.

Section II. Study Design and Methodology

1. Purpose of the Evaluation

The overall purpose of the final evaluation is to ascertain results (output, outcome and goal) and assess the five standard criteria ((impact, effectiveness, efficiency, relevance and sustainability. The review will establish the extent to which the overall program goal and specific objectives were achieved, identify the implementation challenges, and make recommendations for future implementation of similar projects.

2. Specific Objectives of evaluation

- ✓ To measure the quantitative and qualitative project indicators and substantiate project convergence or deviations, if any.
- ✓ To document the success practices, performance and transformation potential of PCVC in the domain of burn survivors and women victims of domestic violence, which would help disseminate good practices.
- ✓ To assess the operational and institutional challenges encountered by the PCVC staff team while implementing the project in various districts, especially during and after the COVID-19 pandemic.
- ✓ To review the convening role of PCVC in multi-stakeholder coalitions at both state and district levels in addressing gender-based violence.
- ✓ To analyse the overall programmatic focus and operational effectiveness contributing to transforming social inequalities and gender equality.
- ✓ To derive concrete recommendations that will help PCVC to redefine/reformulate new strategies based on lessons learnt about violence against women and other sexual minorities.
- ✓ To identify key lessons and promising/emerging good practices in ending violence against women and girls for learning purposes.

3. Evaluation Research Approach and Principles

The evaluation used the Classical Grounded Theory (abbreviated to CGT) approach. This approach focuses on developing knowledge from the key stakeholders/communities experiencing a particular phenomenon in life and at work. It foregrounds the voices of all project members, mainly the clients, in understanding what happened.

3.1. Rationale

The evaluator's intuitive choice of CGT as a methodology arises from her activist orientation. It is based on the researcher's experience in social movements, where collecting primary data around sensitive issues like violence and poverty requires spaces of free and safe expression, particularly to surface the wisdom of marginalised people.

One of the critical determinants of CGT's success is the usability of its findings - the maxim that the proof of the pudding is in the eating. Grounded Theory generally lends itself to the purpose of future action in the communities studied. It generates concepts and abstractions using the participants' language and is available for their scrutiny and use (Glaser and Strauss, 1967; Cresswell, 2007).

Previous application of CGT for experiences for understanding experiences of violence and poverty resulted in complex insights that reflected underlying concepts of participant

realities (multiple roles that silence played when women negotiated violence; or the reduction of agency to the labouring body of people experiencing poverty). Various stakeholders reported these insights as contributing directly to action on the ground. Thus, CGT as a methodology is uniquely suited for evaluations that focus on project performance; and are also concerned about areas of creativity, growth and learning.

GT's enquiry process accounts for emergence from the ground, allowing new insights to occur. Its maxim that the data on the ground lead theorising allowed the evaluation to remain sensitive to the reality of the clients of PCVC. During data collection, this approach allowed the researcher to "listen" to the narration of complex experiences without excessive abstraction, to see from the participant's worldview rather than "fit" them into existing theoretical frameworks. Instead, it was possible to use concepts to serve the data from the ground.

3.2. Steps of Classical Grounded Theory

Classical Grounded Theory adopts a series of inductive and abductive steps that are iteratively and/or progressively undertaken to arrive at crucial research findings. These steps include the following: (1) approach to research questions as a "blank slate", "All is data", and theoretical sampling; (2) iterative data collection and analysis through the generation of ongoing memos (3) Analysis through a free process of open coding and constant comparison, including correction of researcher bias; (4) theoretical saturation and abstraction to arrive upon core category and related concepts; (5) Selective coding around core category and concepts to render conceptual density including secondary empirical literature; and (6) theoretical coding of the emerging hypothesis including extant formal theory.

Each step unfolds into the next, though some also co-occur. Further, these steps do not conform to the phases of conventional research that focus on validation and description: Introduction; Literature review about Context and Background, Theoretical Framework and Methodology; Research Objectives; Scope, Sampling Frame and Size, and Research methods; Analysis; and Findings. For instance, the literature review is undertaken during selective and theoretical coding: towards the end of the research rather than the beginning).

3.3. Theoretical Sampling

Classical Grounded Theory uses theoretical sampling in the discovery of the results. It occurs in two parts. One, all kinds of data are collected and analysed around broad concepts and coded into categories through a process of constant comparison till they reach theoretical saturation. It prepares the ground for the emergence of the core category and related concepts. Two, selective sampling and theoretical coding are undertaken after the emergence of the core category, wherein data is collected selectively to render conceptual density to the emergent ideas.

The sampling frame and size are very different in theoretical sampling compared to conventional research. For example, conventional qualitative research using purposive sampling defines sample size, participant profile, etc., before undertaking data collection. However, theoretical sampling co-occurs with the various steps of data collection, open coding and analysis by constant comparison, and selective sampling and theoretical coding.

3.4. Data collection

Qualitative data was collected. Respondents for primary data collection included PCVC staff, partners and stakeholders, clients and caregivers. As part of primary data

collection, 18 in-depth, open-ended interviews, 9 Focus Group Discussions, six site visits and 85 self-administered questionnaires were completed. Interviews were about two hours long, while FGDs usually were two to four hours long. Site visits included hospitals and partner organisations. They provided rich observational data about various aspects of the evaluation questions: context, status and relations.

The self-administered open interview schedules were collected for the following participants: (1) PCVC Team Members (including leadership and project staff), (2) change makers, (3) external stakeholders/partners, and (4) and self-nominated women survivors.

Secondary data collection included a detailed review of the existing organisation and project documentation: Research, Financial Documentation; MIS qualitative data; MIS quantitive reports and proposals; Information Dissemination and Educational Material (including audio-visual); and Case Studies.

3.5. Data Analysis

Data collection and analysis were simultaneous and iterative, as outlined in the steps above. Broadly two rounds of data collection and two rounds of analyses were undertaken. The first round of data collection informed the inception report and the data sources for the second round of data collection. The inception report indicated a rich, complex growth; standards of excellence in service provision; detailed and robust client-based MIS; and changes in key outputs because of the Pandemic.

The second data collection and analysis round involved various sources based on their availability around the broad evaluation questions. This data was analysed through open coding and constant comparison to generate and populate emerging categories. At a certain point, after the site visits were completed, the theoretical saturation of most categories was achieved. The process of constant comparison also resulted in correcting initial researcher biases.

At this point, a leap of abduction was made, with the core category and its related concepts emerging clearly. Subsequent data collection and analysis focussed on selective coding. This involved questions that render density to the core concepts related to evaluation questions. This included new empirical data and extant formal theories.

3.6. Report Writing

Report writing was undertaken in two steps. In the first iteration of the report, findings were presented first to fulfil the formal requirements of project performance evaluations.

According to the CGT approach, the research findings were shared with the UNTF portfolio manager and five key members of PCVC for validation. For this purpose, one in-depth interview and two small group discussions were conducted.

These validation processes looked at the following aspects: What questions emerged from the evaluation findings? Did the findings resonate with the respondents' ideas of the project? Were they relevant and applicable to future action?

Participants in this process indicated that the findings closely corresponded with their ideas. A critical emergent topic of discussion was the advantages of using Classical Grounded Theory in evaluations because of its roots in client centredness.

Based on the feedback received, the second draft of the report was organised along the lines of traditional research, including introduction, methodology, analysis, and findings.

Section III. Context and Issues

PCVC services reach two different but intersecting clientele: burn victims and domestic violence survivors. There were some commonalities and differences in the causes, contexts and paths of recovery for these two categories of survivors.

1. About Burn Survivors

Burn Victims remain largely invisible to the government and civil society organisations. The pain and suffering endured by burn survivors is a silent tragedy. PCVC is one of the few organisations exclusively focused on women burn survivors.

1.1. Physical Impact of Burns

Physically, burns remain a significant cause of death for women. According to one of PCVC's staff, most women burn victims die on admission to the hospital. Usually, the recovery for burns that are over 45% is challenging. Besides the percentage of the surface area damaged by burns, their depth also decided the prognosis for survival. Other factors included concomitant medical conditions such as diabetes that hindered the recovery of tissues.

Often, doctors claimed that it was possible to predict cases of survival based on the degree of burns. Burns involving more than 65% of skin surface area were seen as fatal. Thus, according to one of the doctors, an accident resulted in more than 80% burns for 11 out of the 12 patients. The 12th had 45% burns. As predicted, 11 died while the 12th survived.

In addition to the severity of physical damage that burns could directly cause, they also caused a series of bodily shocks. The first was cardiac shock from the severity of pain from exposed nerves. This shock was usually immediate. This was followed by the shock to the system caused by the loss of fluid evaporating from open wounds, particularly in the initial period. Hence, maintaining fluid levels (more than ten times the average intake, according to one doctor) was critical. The third kind of shock was because of septicaemia. This risk was aggravated, not just in the open wounds but also in internal organs that are sometimes difficult to detect. The infection risk remains active well into two or three weeks of hospitalisation.

Besides the medical risks to life, physical recovery depends on two other critical factors: nutrition and physiotherapy. Burn survivors require substantive physical reserves in the body to rebuild lost tissues. Nutrition with high protein levels plays a significant part in the recovery process.

Since burns significantly impair muscle and tendons, recovery involves rebuilding tissue without contracture, which can increase disability. This rebuilding requires reconstructive surgery (such as skin grafts and correction of fused tissues) and daily physiotherapy. Corrective surgery for contracted/fused tissues could be avoided by specialised physiotherapy that distinguishes and works with the various tissues and their contracture in differing stages of recovery.

Overall, just the physical survival and recovery of burn victims places a very high cost on healthcare systems. The survival of patients depends on the quality of doctors. It also sets very high demands on monitoring, nursing and care-taking. Nurses have to monitor patients continuously and provide specialised care, including administering pain medication, replacing lost fluids, and preventing attendant illnesses such as bed sores. In addition, given that burns cause psychological shock, trauma and suffering, psychiatric care may be needed. Finally, burn care requires diligent care, including maintaining hygiene, providing regular nutrition, and supporting the daily functions of immobile patients.

Thus, one of the doctors commented that private hospitals rarely take burn victims. Besides the legal complications arising from burn incidents and the real risk of death, actual burn care is costly.

Finally, burns and pain are integrally linked. Pain is evident in all aspects: exposed nerves, essential practices such as debridement to remove dead cells, physiotherapy that puts stress on recovering tissues to ensure their health, etc. This integral link between burns and pain forms the basis of the ongoing suffering by the patients and, by extension, caretakers and family members. Burn care was often seen as equivalent to paediatric care because of the helplessness caregivers encountered when faced with real pain and suffering.

Given the very high levels of mortality in the case of burn victims, one senior doctor had learnt to find delight, even in the face of death. Another said that her faith supported her since life and death were ultimately in the hands of the Divine.

1.2. Hospitals and Burns

Currently, the primary service providers working with the physical recovery of burns survivors are public hospitals, which are often associated with Post Graduate teaching programmes. As discussed earlier, burn care is expensive and private hospitals are reluctant to take in burn patients.

Dedicated burn wards were not present in all hospitals. Often, burn victims were treated under emergency care and placed in ICUs in severe cases. They were then referred to other hospitals with required specialised care and infrastructure. In Tamil Nadu, the KMC hospital was seen as the most equipped to care for burn victims, with hospitals across the state referring patients to this unit.

Medically, burn care was classified along with plastic/reconstructive surgery. Further, children were often admitted into the paediatric wings directly. Two of the three hospitals visited had separate burn wards with their own ICU and ward facilities. Patients requiring long-term care were usually admitted into these wards. The third hospital's construction of a burn care ward was almost completed, with its own ICU and other specialised facilities for burns.

According to medical staff, setting up burn care wards was challenged by the kinds and methods of public health funding available. Two senior doctors described the challenges in the types of funding made available for burn care. A significant portion of the resources went into hospital infrastructure development since these were tangible and had populist appeal. For instance, in one hospital, several lakhs had been invested in laying down flooring using high-quality materials, ostensibly to reduce infection. Politicians with great pomp and fare inaugurated this floor. Instead, these resources should have been used to address the problems caused by the clogging of the drain pipes under the floor, creating leakage and causing significant risks of infection.

Again after an accident that claimed several rights, local politicians lobbied to install a burns ward in one hospital. Though its construction was almost complete, its opening was indefinitely postponed. There was an acute shortage of qualified nurses who could consistently monitor the new ward. The two nurses in the plastic surgery wards were taking day and night shifts. They were already significantly overburdened, and there was no budget to hire new nurses.

Shortages of nursing staff and hospital attendants were reported in two hospitals. In the third hospital, student nurses filled the gap to some extent. Noticeably, none of the hospitals reported a shortage of doctors. Given that these hospitals were teaching hospitals, there was a continuous deployment of post-graduate medical students who saw the opportunity to work with burn wards as increasing their skills.

Currently, medical staff reported that the recruitment of hospital attendance is outsourced to a company that employs them as contract workers at meagre wages. This had a detrimental effect on their performance since they often used their positions to get money from the patients.

While examining the reasons for the acute shortage of nursing staff, respondents pointed out the current method of resourcing based on national (previously state) insurance policies earmarked for poor people. Notably, the money allocated to this insurance is not directly provided to the beneficiaries. Instead, it is routed through a private insurance company that reimburses public hospitals based on their claims.

When hospitals admit patients, they submit claims to the insurance company, which vets these claims and disburses the money. According to one of the senior doctors, the staff of this insurance company was not medically trained. Thus, when he recommended medical procedures, the insurance company downplayed their nature and significance and disbursed much smaller amounts of money.

Senior doctors in two hospitals said that of the money set aside for the beneficiary scheme, the beneficiary does not receive any cash disbursals. Of the funds disbursed, a portion is retained by the insurance company for its operational needs. Of the remaining money, hospitals retain a certain percentage for central maintenance and regular supplies. Finally, a small portion (around 20%, according to one doctor) reaches the burn ward to cover patient expenses incurred in the unit, including specific medical supplies and equipment, staffing, operations, etc. Nurses in one hospital claimed that their ward made the most persistent demands for hospital administration. The paediatric wards were the only other ward to make such concerted demands on their central hospital administration.

In one of the hospitals, a staff member, a trained software professional, was explicitly hired to ensure that the financial disbursements were appropriately sourced. This staff member said that accessing resources through the insurance scheme was challenging. Some of these patients were not registered in the system in the first place. In these instances, the staff helped them to register online and submit appropriate documents.

Further, many patients and caregivers viewed access to free health services by these hospitals as their right. They demanded reasons to comply with this scheme when they received no overt or direct benefit. Understandably, they needed help following the complicated links between their insurance, the insurance company, the hospital and the ward. As a result, they became angry and frustrated. Noticeably, all three hospitals said they did not turn any patients away because they could not pay and were not registered under the insurance policy.

Besides the shortage of funds, there was a freeze in submitting demands to hire personnel in older hospitals (three decades or more). Thus, retired permanent employees in old hospitals were no longer replaced. Further, such hospitals have expanded the kind and scope of their services considerably, including constructing physical infrastructure. However, new proposals for hiring staff commensurate with this growth were discouraged.

Even though resourcing for nursing staff was a key challenge across hospitals, doctors reported that they had yet to make concerted efforts to remedy the problems across the institutions. While there were conferences on burn care (the last one being in the previous year, as reported by one doctor), these focussed more on the medical aspects of care rather than issues related to access and quality.

1.3. Identifying Causes of Burns

Causes of burns are four: accidents, suicide, abetment to suicide and homicide. All burn patients are reported as medico-legal cases, including those registered as accidents,

requiring police to do documented enquiries and file cases. To avoid legal complications, for the most part, these cases were recorded as accidents.

PCVC and hospital staff that it was possible to discover the difference between accidents, suicide and homicide from the nature of the burn patterns. For instance, self-immolation likely involved burns on the face and neck, while accidents usually involved the legs. Again, burns in homicides were likely to be on the back of the survivor. The kind of fuel used also indicated the causes of the burns. Women were more likely to use kerosene, while men tended to use petrol/diesel/alcohol. In addition, the behaviour of caregivers and family members also provided some understanding of the causes of the burns. However, hospital staff claimed that they deliberately stayed out of the police investigations of such cases. The police essentially interviewed the concerned people independently.

PCVC staff, while discussing the various causes of burns, said that most women often disclosed what happened only after they came to terms with their situation and after the staff had built trust with them. Thus, there were marked differences in the reasons for the burns in the hospital intake between hospital intake forms and the case histories of clients recorded over time.

1.3.1. Accidental Burns

Men and children were more likely to suffer from actual accidents. One of the doctors claimed that several such accidents amongst men occurred amongst migrant communities engaged in construction work. Further, these burns were caused by electricity rather than fires. Electricity burns caused deeper inner tissue and bone damage that could result in gangrene and amputation. In the case of children, burn accidents were almost always accidental, caused by children playing in groups using fast-burning fuel such as petrol and kerosene. The parents seemed deeply affected by shame and guilt for their perceived negligence in these instances.

According to almost all respondents, official reporting on these various categories for causes of burns for women was unreliable. Mostly, women categorise their burns as accidental (more than 80%, according to one of the medical staff). Given that women undertake the cooking function in most homes as part of their reproductive roles, it seems plausible that women are more likely to suffer from burns than men. Underneath this apparent picture, more gender-related complexities emerge. Women burn survivors face more significant risks (self-immolation and homicide) than men because of inequality in social and economic status based on gender.

1.3.2. Self-immolation

According to hospital staff, while men and women immolate themselves, the number of women is more significant (3/4th of women burn victims compared to 1/4th of men burn victims). Self-immolation in children was rarely reported, though present. Children as young as ten years old undertook these acts. In one instance, the child tried to immolate himself because his parents failed to get him a geometry box for school.

1.3.2.1. Suicidal Ideation and Self-Immolation

Suicidal ideation that leads to self-immolation is related to persistent and/or acute thoughts of self-harm. Such self-harm results from the ongoing erosion of self because of indifference and violence, psychiatric illness, and acute psychological distress (acts of passion). To some extent, the nature of suicidal ideation, in general, is still being explored. For instance, it is well known that the nature and specificity of suicidal ideation indicate significant risks to survivors. Thus suicide call lines emphasise greater

attention to such callers to reduce their sense of isolation. However, this risk assessment is rarely undertaken for two reasons: (i) survivors find it shameful to discuss their ideas of self-harm, and (ii) threats to commit suicide are dismissed as emotional outbursts.

While discussing the self-immolation of her daughter, one of the caretakers shared that this was not the first attempt. Her daughter had earlier tried to commit suicide by taking sleeping pills because of the persistent violence that she faced from her husband. The couple were separated for two months and then reconciled. However, the violence persisted, resulting in the woman setting herself on fire to commit suicide for the second time.

Burns themselves may lead to suicidal ideation. For instance, one of the women in her 60s had extensive burns because of a cooking accident. She had lost the desire to live. Her two sons had already died. Though she did have three daughters, she did not want to burden them. Interestingly, all three daughters and her grandchildren took care of this elderly woman. Further, she was a much sought-after astrologer with many grateful clients genuinely concerned for her well-being.

1.3.2.2. Sexual Purity and Self-immolation

According to participants (medical staff, PCVC staff and survivor), a significant reason for self-immolation in the case of women (and sometimes men) is non-marital sexual relations (extra-marital relations, rejection by intimate partners, queer relationships etc.). Such associations often face social issues of stigma, ostracisation, and accompanying psychological problems such as shame, rage and betrayal. For instance, according to a nurse, one of the male patients had two wives. When the second wife came to know about the first wife, she doused the man with kerosene and set fire to him. Another critical reason for self-immolation found in men was alcohol consumption. After drinking, men would fight with their wives, douse themselves with alcohol, and set themselves on fire.

According to a respondent, women (and men) often douse themselves in fast-burning fuels and threaten to burn themselves in times of passion. In these instances, they do not intend actually to die. However, they underestimate the swiftness with which fire travels and often end up losing their lives or disabling themselves.

Cultural reasons for committing suicide by women through self-immolation require more enquiry, particularly the relations between sexual purity and fire. Being accused of infidelity was a key reason for women to immolate themselves. Thus, one of the caregivers in the hospital claimed that her daughter's husband accused her daughter of infidelity. To prove her character, she tried to immolate herself.

The relationship between religious beliefs about purity and fire was evidenced by women burn victims who engaged in the "fire bathing" ritual, categorised as accidental. Hospital and PCVC staff reported an increase in such cases during the Tamil month of "Aadi" (July/August). During this time, women walk over a bed of hot coals in a ritual consecrated to the Goddess. According to one of the nurses, this ritual is undertaken in large groups, and there was jostling in the group that led to such accidents.

This tendency to self-immolation fostered by the local culture is often aggravated by stereotypes in cinema, where women assert their purity (or punish its lack) by self-immolation. In these movies, the women die or emerge whole magically. What these movies do not show is the experience of severe pain, suffering, disability, and the long process of recovery that awaits those who survive in real life.

1.3.3. Domestic Violence, Abetment to Suicide and Homicide

Often, women immolate themselves when they find themselves in violent situations (persistent/acute acts of violation, isolation, control and indifference). Acute and persistent violence (verbal, physical, emotional, and mental) often strips victims of their dignity. Their sense of innate significance is eroded in acute psychological distress. Intimate partners and families deny their power/agency. At these moments of risk, they burn themselves.

Often, women's attempts to commit suicide are incited by family members, including intimate partners and family members. Active abetment to suicide includes overt actions, such as challenging women to make real their threats of suicide and covert actions, such as neglecting/isolating them. Thus, the gradations between suicide (intended and threatened) and abetment to suicide are blurred.

Many women had no option but to continue living with their perpetrators after their hospital release. Given this, the under-reporting of violence by women survivors is not surprising. In such cases, where survivors return to their violent contexts, suicidal ideation often remains. Thus, one of the doctors shared that women who have immolated themselves did not do so again because of the suffering involved in this manner of death. However, they still used other means, such as hanging, poisons, and drugs.

Homicide was rarely reported, usually in final statements by dying women. This is not to say that such cases did not occur. However, as with suicide that has formal legal implications, it was under-reported. There were differences in reporting of dowry-related incidents over time. PCVC, OSC and hospital staff said there were very few dowry-related cases in the current context. In one hospital, it was reported that the primary caretakers were mothers-in-law. While in some instances, these were inspired by authentic compassion, in other cases, in-laws took extra care to avoid getting involved in legal complications arising from the possible death of the victim.

This is not to say that dowry did not remain a key concern. An OSC staff claimed that the forms of dowry had now changed, with families of women condoning this practice through lavish gifts for their daughters. Again, one of the CSO staff working with violence against women in rural Tamil Nadu claimed that significant dowry-related violence continued to exist.

2. Survivors of Domestic Violence

A feminist perspective of violence understands such acts as being contoured fundamentally by structural inequality of power, not just psychological factors. Violence persists because of the power of individuals to instil fear, constrict freedom, and violate the boundaries of others because of structural/social norms, conventions and practices.

A key reason for gender inequality is the lack of distinction between sex and gender and the classification of women as essentially other (and less) than men. Thus, many change makers and partners pointed out physical characteristics while discussing the differences between men and women. Only a few respondents distinguished physical differences from psychological differences (such as intelligence, equanimity, etc.).

This is even though sex itself may be seen as a social construction, with individuals showing clusters of different physical characteristics, such as the presence of XXY chromosomes leading to the concurrent existence of both sex organs, men with breasts, hairy women, etc. Given this, it is unsurprising that psychological attributes such as courage, nurturance, etc., are not determined by sex. Gender role divisions based on essentialist differences around sex play a critical role in defining the contours of power.

Even in relatively egalitarian subsistence economies, where men and women were treated on par, for the most part, essentialist gender roles discriminate against women in subtle ways. For instance, women are seen as symbols of land and home and men as symbols of the sea and work among marine fishers of Tamil Nadu. While seemingly equal, men

assumed a tacit superior status in a culture that views life from the indivisible and free sea to the fragmented, bounded land.

Most societies and families are based on patriarchal norms that view women as less significant/powerful than men. Therefore, it is unsurprising that women encounter significantly more violence than men across all socio-economic groups. Thus, domestic violence that women face remains a silent pandemic even now.

Even as more women are coming forward to take action against violence and to restore their dignity and equality, the more pervasive and intersectional aspects are yet to be significantly impacted. These include the most vulnerable sections of women most prone to control and violence, including the poor, unemployed, those with different abilities, single, queer, etc.

For instance, one of the OSC officers discussed the following example of a survivor with speaking and hearing impairments. She married a man who also had speaking impairments for seven months. In these months, she was repeatedly sexually assaulted, not just by her husband but also by her father-in-law. Her marital family also subjected her to various forms of physical torture. Finally, she sought the support of her natal family, who realised that their daughter was traumatised. This woman was very courageous. With the help of her family and the OSC, she confronted her husband and in-laws directly and filed cases against them. Her one desire to slap her husband came true in the police station, with the police and her family cheering her on.

Along with women, violence towards children is also coming to the fore now. This includes children of both genders, posing new challenges around questions of violence boys and men encounter. For instance, one of the PCVC's CSO partners discussed cases registered under child sex protection laws. Most of these cases involved teens (sometimes as young as 15 years of age) who had consensual sex. In some instances, such couples were separated. In others, the families waited till they reached the legal age and married them off. Reporting of rape of minors and incest still remained very low.

Men are now speaking about their rights to violence-free lives in intimate partner relationships, though such incidents are rare. This may be because their occurrence may be less than those of women and also because of masculinisation that shames men who speak about their experiences of abuse and powerlessness.

2.1. Gendered Violence

Research on the violence against lesbian and bisexual women indicated that breach of confidentiality is the first violation in abusive relationships. This is when perpetrators access information about women's sexuality/actions/thoughts/feelings without their victim's consent (reading letters and journals, accessing their mobile and online data, overhearing their conversations, stalking them, etc.).

Defining violence itself is challenging in that overt actions of verbal and physical violence usually indicate the tip of the iceberg. In many instances, violence also includes pervasive sexual abuse that is under-reported and indirect emotional and mental acts that form the bedrock of the exertion of power over women. Finally, the most pervasive and silent form of violence was close family members severed relations with the survivors and subjected them to silence, indifference and social isolation.

The distinction between arguments, conflicts and violence as concepts often overlap in lived experience. While examining the nature of conflict and diversity, Lewis classifies arguments as mental differences, while conflicts have heavy emotions attached to these differing viewpoints. Markedly, conflict could arise between two or more people; and also within oneself, where one aspect of the personality resists another.

Usually, conflicts in groups (families, teams, communities) arise when dominant perspectives, including social ones such as majoritarianism, patriarchy, racism,

casteism, etc., suppress individual expression. The more extensive this suppression, the more emotional intensity the conflict gains. It finally ends in violence, fragmentation and separation.

While they may be effective in the short run, negotiations do not address the deep emotions with which different viewpoints remain. To transcend the conflict, it was essential to express the conflicting views safely and move to an internal location deeper/ wider. From this new perspective, it was possible to hold both viewpoints without losing their innate and unique wisdom.

To be alive is to express oneself. Violence is closely related to silence and constriction of expression. While it is easier to see when others silence survivors, it is more challenging to see where survivors silence themselves. They suppressed their expressions and denied their thoughts and feelings because of their internal, idealised norms: psychological (recoil from adverse emotions such as fear, shame, anger, etc.) and social (woman, wife, heterosexual, etc.). This self-censure often results in increasing their isolation and stunting their growth.

The impact of violence also depended on how acute, pervasive and persistent it was. In some instances, survivors reported constriction and infringement in all aspects of their lives: sexual, physical, emotional and mental. In other cases, violations were more singular. However, these incidents occurred in deeply trusted relations (such as child sexual abuse). Thus, the impact of violence could not be assessed by external parameters alone. It varied based on factors such as the psychological and material resources of the survivor and their depth of relations.

PCVC worked with predominantly women clients and children who were associated with them. Most of these cases are related to intimate partner violence. By and large, the cyclical nature of domestic violence in intimate partnerships is somewhat well understood. Typically, violent cycles involve the following episodes: appeasing the victim, escalating aggression, precipitating the violent attack, and returning to appeasement.

According to PCVC staff, a new category of older women survivors is also emerging. These include (i) women who have been in long-term abusive marriages that they had tolerated for an extended period and (ii) those that face intergenerational violence from their children. However, the number of such women reaching out to access PCVC services is relatively small. For instance, they discussed a client whose daughter physically attacked her. The daughter had a romantic relationship with a young man, and the mother disapproved of him. Therefore the daughter set fire to her mother. However, such clients were few.

While OSC officers did not comment on violence against the elderly, they discussed in detail the abuse of the rights of the elderly to secure their property. Often elderly parents were coerced by their children/ caretakers to write their property to them. OSC intervened in these instances by revoking the legal writs and drawing up new ones based on the needs of the elderly. This was a new area of work, and there was scope for many errors. In one such instance, the OSC officer revoked a written writ of an elderly woman that conferred her considerable property on her children. This woman had complained that she had been coerced to produce this writ by her children. The very next day, she rewrote her will conferring her property to two church members. It then came to light that these members had influenced her to disinherit her children so they could usurp her property.

2.2. Sexual Orientation/Identity

Queer and non-hetero-normative women were a silent category of DV victims for a long time in the country. In recent times, with the decriminalisation of homosexuality in India, such individuals are coming forward to seek help more and more.

Broadly, various categories of individuals exist outside heteronormative experiences broadly classified as queer. These include lesbians, gay men, bisexual men and women, men who have sex with men, and transgender people. The decriminalisation of homosexuality in the country and awarding of rights to transgender people in Tamil Nadu has gone a considerable way in allowing queer people to access various kinds of services. Thus, PCVC hotline staff reported that around 40% of the calls they received on the Dhwani hotline were from queer survivors.

The experience of violence in these various categories of queer individuals is very different. Women (lesbians, bisexual women and trans men) are most likely to experience violence in the private domains of family. One of the silent tragedies remains suicides committed by young couples in their early 20s because of the violence and social stigma they face. In contrast, men (and boys) are more likely to experience violence in public domains such as schools, toilets, parks, etc.

For instance, one of the nodal CSO staff working closely on transgender rights and an OSC officer claimed that the trans women were highly organised. The OSC member went on to say that they accessed their welfare services successfully. Competent community members who could navigate the government welfare systems supported others, such as the registration as the third gender.

The CSO nodal officer, discussing trans women in communities, said they were organised in reconstituted families based on sexual identity. Trans women approached other trans women who became members of such institutions. These tightly-knit groups ensured that their concerns were heard. Their members were often drawn into semi-legal activities that put them at risk for violence. Sometimes, they, too, engaged in petty crime, complicating situations.

He went on to say that in contrast to trans women, trans men were likely to be publicly invisible and less troublesome. Once they stepped out of their neighbourhoods, they were indistinguishable from men and made no efforts to draw attention to themselves. Thus, they were less likely to need support.

Further, there are significant differences between lesbians and trans women. Trans women usually report experiences of being a man in a woman’s body. Lesbians, on the other hand, do not do so in all instances. In fact, a key concern for lesbians is the pressure to recast their intimate relations along the same norms of gender performance found in heteronormative relations. Thus, one partner is expected to play the man's role while the other has to play the woman's role (butch/femme). Relations that transcend gender binaries remain challenging to conceive/realise for the most part.

The extent of violence faced by lesbians, bisexual women and trans men is still shrouded, for the most part, in silence. Intractable positions around essentialist gender binaries, religious edicts, etc., challenge acceptance of queer relations by close family members. Often, families use corporal punishments such as beating and incarceration, control over mobility/communication, isolation and severance of ties to suppress such orientations/relations. Further, queer individuals also face pernicious discrimination and silencing in their social circles (extended networks and communities). Thus, it is unsurprising that they remain at high risk.

For instance, a couple who were PCVC clients had to be rescued from their families and shifted in secrecy to prevent their families from further assaulting them. In another example, a queer couple had run away from their violent families in a nearby city and was housed in PCVC’s shelter. The couple's families came to the shelter and convinced them they would change their attitude and help them set up their home in their native city. On reaching their city, the couple was separated. One of these women was subjected to repeated violence and reached out to PCVC for support to trace her partner. The partner, however, was shifted out of her address and could not be traced.

2.3. Normalisation and Reconciliation

Several actors play a critical role in the degree of normalisation/condoning of violence. To begin with, this normalisation often leads to incorrect identification of abuse. Thus, PCVC staff reported that external actors (including families, police, and communities) regularly normalised sexual harassment as part of eve-teasing based on essentialist gender roles of men and women.

Further, there were different operational definitions of what constituted violence. OSC officers claimed that most women who came to their centre made fraudulent complaints of marital violence for two reasons.

Some women felt entitled to use the justice system to serve their agendas, such as settling scores with their spouses. Underlining this point, one of the OSC officers narrated the following instance. A young woman had the support of her wealthy parents and wanted to divorce her husband. She tried to use legal processes to exploit him. Instead of counselling her to reconcile with her husband, her parents gave in to her demands and spoiled her.

Two, women viewed the OSC as a mediator to resolve their marital conflict and engender reconciliation. They often saw the OSCs as “Katta Panchayats” (Kangaroo courts) that would force their husbands to comply with their terms. One officer went on to say that their services did not reach the real victims of domestic violence, who were poor and uneducated. Filing official complaints and undertaking legal action required education and resources.

Different external actors condoned daily violence to varying degrees and often were unaware of the very real psychological damages caused by acts of violence. Further, they only intervened when the behaviour could not be condoned morally/socially. Thus, marital rape is rarely reported and addressed because it does not challenge families' morals or social status.

Intervention by external actors often took the form of rough and ready corporal punishment used to discipline the perpetrator and indicate their disapproval. Thus, when family members, communities, and police intervened, they physically punished the perpetrator: threatening their physical safety, beating them up, incarcerating them, etc. One of the elderly caretakers illustrated this phenomenon. Her daughter had been instigated to immolate herself by her husband and suffered extensive burns. When this came to light, she and several men from her extended family and community beat up the perpetrator.

Further, most external actors advocate reconciliation in marriage and families for two reasons: (i) to secure the woman socially and (ii) to avoid the social stigma associated with separation and divorce. Often, such advocacy for reconciliation does not consider the real damage incurred by the survivors.

In many instances, they are actively counter-productive. Victims of domestic violence forced to reconcile with their spouses experienced a greater sense of isolation. This further decreased the possibility of them seeking outside help. In the case of the elderly caretaker discussed above, her daughter had already attempted suicide by consuming poison two years ago because she could not bear her husband’s abuse. At that time, the mother and other families warned the husband to stop such behaviour. However, they also persuaded the survivor to return to her marital home. Unable to escape from the violence, her daughter set herself on fire in a second attempt to commit suicide, this time with far more adverse consequences.

Section IV: Recovery Path for Survivors

While burn and DV survivors faced distinct challenges in their recovery paths, some were common to both. Both created shock and trauma, contracture and disability (overtly physical in the case of burn survivors and covertly psychological coercion in the case of DV survivors), etc. Thus, there were some commonalities in PCVC's psycho-social services provided to the two categories of survivors and their corresponding projects: dignity, "here and now" responsiveness, etc.

1. Recovery Path for Women Burn Survivors

PCVC is unique in addressing a wide variety of needs of women burn survivors. As seen above, the severity of pain in burns causes great suffering to the women and their caretakers. Burns result in a series of life-threatening shocks to victims' physical and psychological systems, resulting in death in many patients. Providing care includes both urgent and critical services to the clients. PCVC has well-developed methods and approaches to burn care enabling women's recovery. It demonstrates an extraordinary commitment to attending to individual survivor needs to the best extent possible.

Services to burn survivors through the Vidiyal Project and its RHC are on three fronts: physical recovery, psycho-social recovery, and relations with caretakers. The Vidiyal team embodies all the aspects of client-centred burn care, including the following: nursing and provision of medical and nutritional support (including special needs to improve preoperative blood count rates), social work, psychological counselling, and physiotherapy. In addition, burn survivors avail of the shelter facilities for several reasons: (i) to recover in secure environments, particularly clients who have attempted to immolate themselves or faced DV; (ii) to recover from severe damages that require intensive physiotherapy; (iii) to recover from reconstructive surgeries, etc.

1.1. Physical Recovery

As discussed, the physical recovery for women burn survivors is long, painful and arduous. Besides the medical aspects of shock and infection, nutrition and physiotherapy play a critical role. In recovering from burns, the body uses existing resources to rebuild tissues: muscles and skin. Lack of adequate nutritional supplements, particularly protein and haemoglobin, inhibits growth severely. For instance, one of the burn victims was skeletally thin, probably because of the demands of recovery placed on an already malnourished body.

The provision of nutritious food was one of PCVC's significant services. For instance, hospital staff claimed that PCVC filled the gaps in their services for burn patients. While the hospital did provide basic meals, burn care required additional supplements, particularly proteins, beyond the scope of its policies. PCVC's provision of regular protein-rich nutrition (protein powders, eggs, nuts, fruits, etc.) was critical to patient recovery.

PCVC staff said they regularly monitored the patients' food needs in their hospitals and provided nutrition based on individual requirements. For instance, while all the clients were given two eggs as part of their daily diet, in some instances, this number was increased when needed. In cases of indigent clients who did not have access to good food when discharged, PCVC staff continued to provide regular nutrition supplies through home visits (and various package delivery services, particularly during COVID) to aid their recovery.

Intake of nutritious food went beyond the availability of adequate nutrition. Often burn survivors reported a consistent loss of appetite and resisted eating for several reasons. To

begin with, because of the pain they were in, they did not feel like eating. Further, they were traumatised by their open wounds and the decaying flesh they smelled. Women also refused to eat because they were immobile and wanted to restrict their excretory functions. Thus, one of the caretakers claimed that her daughter, with severe burns on her face and neck, could only eat liquid food. Getting her to eat regularly was very difficult. Although food and fluid intake were critical for recovery, burn survivors struggled to eat and drink. In these instances, PCVC staff spent considerable time with patients to coax them to eat the required amount of food.

Hygiene and sanitation remained central concerns. Sepsis/infection remained a critical risk to survival and required special provisions such as bedding, hospital gowns, masks, etc. Further, bathing and debridement were crucial to recovery. Often burn victims refused to take baths because washing with soap was painful and because they feared the dead flesh that sloughed off. In these instances, PCVC staff educated survivors and caretakers about the importance of hygiene. In addition, PCVC also provided psychological counselling to caretakers. In cases where clients did not have any caretakers/family support, PCVC hired specific personnel for this support.

PCVC also followed up with women consistently after discharge to support their recovery. For instance, PCVC staff could not maintain regular telephonic conversations with a particular client. They then undertook a home visit, where it was revealed that the client refused to leave her bed and had extensive sores. She had refused to take a bath because she feared the pain and ugliness of sloughed flesh. In this instance, the staff stepped in and helped her bathe. They also ensured she received medical care to recover from her bed sores. Subsequently, the client recovered from her burns and became an active household member.

Survivors also have to come to terms with very real disabilities that result from burns. They often could not do routine tasks that they took for granted in the past. Thus, in one instance, the greatest source of psychological distress for the survivor was her inability to hold her infant.

Physiotherapy played a critical role in the integration of skin grafts and the reduction of disability. Contracture and fusing of tissues are crucial risks to burn recovery. Often the new tissue that grows follows the contours of the injury. If not adequately stretched and used, these tissues often fuse. Prevention/reduction of disability requires specialised attention to particular tissue to maintain the balance between stretching and using the new, regenerating tissues without risking their healing and growth. These exercises are often painful and tedious.

PCVC emphasised the importance of physiotherapy and exercising right from the beginning. They provided vital information about the criticality of long-term routine exercises to clients and their caretakers to prevent contracture of the body caused by burns and recovery from progressive reconstructive surgeries.

PCVC provides physiotherapy in hospitals and their RHC. On discharge, PCVC identified support for clients that they could avail in their homes/localities. In addition, PCVC also provided physiotherapy support through its in-house specialist and its RHC in the long term. Clients who used the shelter services and RHC often engaged in physiotherapy for eight hours daily (including evening rehabilitation exercises). The RHC staff regularly monitored individual client progress over time and tailored various physiotherapy exercises based on their specific requirements.

Besides physical and technical support, PCVC staff also reported providing psychological support for burn survivors to pursue routine, painful and/or tedious exercises. Often, women did not want to do these exercises for various reasons such as resignation about their disability, lack of motivation, etc. In these instances, PCVC staff created activities aligned with the individual client's aspirations. For example, one of the clients had

extensive burns on her hands. She had lost the functionality of the tendons of her hands, and her fingers started contracting. She felt very sad because she could no longer hold her eight month baby and cook for her family. Her physiotherapy exercises were tailored around the various cooking activities, such as kneading dough. Over time, she recovered the use of her hands to cook for her family on her own. More importantly, she could pick up her child and play with her.

In addition, PCVC also provided shelter facilities for burn survivors for various reasons, including lack of caretakers, lack of adequate hygiene, victims of domestic violence, and intensive medical and physiotherapy needs.

For instance, one of the burn survivors had tried to immolate herself because of the violence in her marital home. She had been discharged from the hospital but was not in regular contact with PCVC staff. She did not have a phone. The only means of contact was through her brother and sister-in-law, who lived in the neighbouring houses.

The staff then visited the client's home with the external evaluator. This survivor was supported by her elderly mother and lived in an asbestos shack with rudimentary amenities. While she was no longer in contact with her in-laws, her husband was in touch with her and provided her with some support. Noticeably, the houses surrounding the shack were all well-constructed.

The PCVC physio-therapist undertook a detailed examination of the physical areas of the burns, including measurements of grafts and contractures and those for pressure garments. She also recommended some simple exercises that would prevent contraction. As soon as the team arrived at the client's house, the client's sister-in-law also came with her child. She said most people did not come near the shack because they avoided the client and her disfigurements.

The PCVC team urged the client to come to the Shelter and avail of the RHC facilities. Contractures were setting in, and these could result in permanent disfigurement. The client seemed hesitant to leave her elderly mother and travel to a new city. At this point, the sister-in-law urged the client to go. When asked about this enthusiasm, PCVC staff shared that the well-constructed houses in the surrounding area belonged to the client's natal family members. Her brother was employed in the government and was well-off. They were looking to get rid of their responsibility towards the client.

PCVC's attention to detail and persistence in fulfilling physical needs tangibly formed a critical base of trust between the organisation and its clients. From this base, PCVC provided various psycho-social services for burn victims.

1.2. Psycho-Social Recovery

Burns constitute a series of severe shocks to the system. They mark a threshold event in the psychology of burn survivors. Survivors require considerable resilience to recover from these experiences. In some instances, surviving burns often were accompanied by post-traumatic stress disorders, including flashbacks, nightmares, anxiety and depression. This could be caused by the burn incident in and of itself. It could also be caused by concurrent domestic violence leading to suicide and homicide.

Most hospitals reported that burn patients could avail of psychiatric care. Thus, medical staff said that psychiatrists visited their patients and provided psycho-active medication to deal with the severe pain, anxiety, depression and shock. However, PCVC staff reported that the medicalisation of psychology created iatrogenic challenges such as inhibiting food intake and movement, deterring recovery and increasing risks of drug dependency.

PCVC staff regularly counselled burn victims during their hospitalisation and afterwards. A critical aspect of this counselling was to listen to the survivors. For instance, one of the clients reported an increased sense of well-being in the very first session because she

could freely share her emotions. Listening to clients in these counselling sessions allowed them to surface their immediate needs that informed PCVC's actions. PCVC's responsiveness to these needs was vital in evoking trust in clients and their caretakers. These counselling sessions also focussed on providing information to alleviate fear and doubt and take the right action at the right time. For instance, one of the burn clients reported that she was worried about her fever. PCVC staff assured them this was normal in burn recovery, and she did not have to feel apprehensive.

Encouraging women to adopt good self-care practices was a critical focus of psychosocial services. Often burn survivors could not see the significance of their survival and recovery. They felt they had no hope, were insignificant, and/or a burden to others. PCVC staff reported that only consistent care worked in these instances. PCVC team members who were also survivors were particularly important in inspiring such clients to take proactive action for their well-being.

For instance, the Vidiyal team members said they maintained constant contact with burn survivors discharged from the hospitals through telephone calls and home visits. At the very time of intake in the hospital, PCVC staff recorded the contact numbers of burn survivors and their caretakers. Often burn survivors could not access telephones. In other instances, they isolated themselves because of their suffering and circumstances and did not respond. In these instances, PCVC staff repeatedly initiated contact until they successfully reached out to the clients. This persistence conveyed sincerity in the offering of services.

Burn survivors face considerable psycho-social challenges in their recovery. Burns radically alter the survivors' perception of their bodies, wholeness and attractiveness. This is particularly true for those who suffer damage to body parts not covered by clothes. Thus, seeing the changes in their appearance and flesh often is distressing. Others also recoil from their appearance, resulting in survivors isolating themselves, adding to their misery. Even deciding to step out of their rooms and homes and move into public spaces requires much courage.

Some of this distress was alleviated by two factors: (i) the recovery of normal relations with others (including the resumption of conjugal relations and functions such as cooking associated with cleanliness) and (ii) the discovery of personhood that was larger than external appearances. For instance, a burn survivor claimed that accepting her disfigurements also led to a larger acceptance of the self, including her innate beauty. Finding freedom from others' reactions to her appearance freed her expression - in terms of the clothes she chose and her movement in the world. Again, in another instance, a burn survivor was employed successfully as a receptionist. This allowed her to transcend her ideas of beauty and allowed others to do the same.

1.3. Engagement with Caretakers

A critical service that PCVC provided was to ensure adequate conditions for physical and psychosocial recovery, including relations with caretakers. They worked with clients to select their context for healing: natal family, marital family, extended family, hospitalisation and external shelters, etc. Often, the women survivors had to identify where the optimum conditions for their recovery would be met. In these instances, PCVC staff worked with the survivors and their families, including evocation of empathy and support.

Optimistic caretakers played a critical role in the nature and extent of recovery. Women burn victims are less likely to receive care simply because the nursing role is traditionally assigned to women. Further, burns placed arduous demands not only on the physical and psychological resources of the clients but also on the caretakers. In general, there was very little acknowledgement of the challenges that caretakers face. Mothers and sisters usually took care of burn care victims in the hospitals visited.

For instance, one of the burn victims felt that she was a burden to others and felt deeply upset when her caretaker was abrupt with her. PCVC staff encouraged her to see from the caretaker's point of view. They often had to spend long hours in the hospital, and becoming irritable was not unusual in these circumstances. From the new viewpoint, the client reported that her distress about her caretaker's irritability was reduced substantially.

In another instance, one of the caretakers reported to the PCVC staff that the client was shouting at him because of her pain. PCVC staff encouraged him to see the burn victim's real distress. They also enabled him to see the toll his responsibilities took on his psychological resources.

In instances of neglect, abetment to suicide and homicide, the perpetrators were likely to be in positions of power/primary caretakers. In some cases, perpetrators realised the gravity of the damage they had caused and undertook sincere efforts to make amends. PCVC team members reported instances of husbands whose wives immolated themselves because of domestic conflict. The damage caused by burns surprised such men, who often changed their behaviour subsequently. In one such instance, the husband showed consistent devotion to the care of his wife, which was a key reason for her successful recovery.

However, in many other instances, this behaviour change was not evident. In such cases, women continued to face indifference, negligence, and/or various degrees of violence. This not only made self-care more challenging but also increased risks in recovery considerably. In such instances, PCVC staff counselled significant caretakers to overcome guilt, shame, indifference, hostility, etc.

For instance, one of the survivors was in love with a man, but their families disapproved of this relationship. Both got married to others, but her lover persuaded her to leave her husband and live with him. At this time, she was three months pregnant. Given that both of them were married to other people, their relationship faced community disapproval. As a result, the client started living with her parents with her infant son. During this time, her lover, along with this wife, doused her with petrol and set her on fire. In the hospital, her primary caretakers remained her parents, who disapproved vehemently of her conduct and felt that she deserved her suffering. PCVC counselled her parents to stop blaming their daughter, and her father eventually apologised to the client for emotionally and verbally abusing her.

2. Recovery Path for Domestic Violence Survivors

PCVC addresses the needs of a wide variety of survivors of domestic violence. It addresses violence in natal and marital families, intimate relations, inter-generational conflict, and discrimination based on sexual identity and orientation. Many survivors face violence in their intimate partnerships/marriages, including abetment to suicide by immolation and homicide in the case of burn victims.

While the Vidiyal project attended to burn survivors, including those who are victims of domestic conflict and violence, PCVC provided three kinds of different services to the survivors of Domestic Violence, including queer individuals as a category: (i) Dhwani: First Responder Call Line that operates 24/7; (ii) Astitva: Emergency Shelter Services for women undergoing trauma (Violence and Burns); and (iii) psycho-social support including long-term holistic care. While Dhwani reached out to women, including those in acute and violent crises, Astitva protected such women. Both these functions were supported by long-term psychosocial services that address a range of services, including therapy, legal and medical support, economic empowerment, children's schooling, etc.

PCVC also offered another shelter for survivors in partnership with a local NGO (beyond the scope of the UNTF project) that served as a halfway home. Survivors not at risk and

capable of pursuing their regular life in the outside world availed of this secondary shelter. In addition, PCVC also supported clients in finding independent and affordable housing (by themselves or with other survivors).

2.1. Evocation of Agency

The path to recovery for DV survivors was long and arduous. To begin with, survivors required considerable courage and resilience to accept their reality and transform their relations with themselves, others and their contexts. Thus, many change makers and stakeholders note these qualities as inspirational.

On their growth path because of the support extended by PCVC, survivors reported two simultaneous movements: inward in terms of locus of control and agency; and outwards in terms of power to act decisively in various domains of life. Thus, they began redefining their identity, success and health based on their inner needs and aspirations; and experienced greater freedom in matters such as wearing certain clothes, choosing their work area, selecting their partners, etc. Their engagements with PCVC allowed them to make decisions critical to their growth in a safe and supportive context.

A significant aspect of PCVCs' support was to enable survivors to see their reality as it is. Based on this acceptance and acknowledgement, they unlearn and relearn new perspectives and behaviour. For instance, one survivor noted that her family's act of violence radically transformed her view of the world in negative and positive ways. Amongst the adverse reactions was a loss of trust in others and relations taken for granted previously. This loss of faith was also accompanied by much smaller circles of trusted family members and friends. However, the greater discernment in relations was a great benefit, wherein they could identify unhealthy patterns early and make appropriate choices to change them.

A vital aspect of the recovery process was the resolution of violent relations with perpetrators. Typically, perpetrators control/constrict their victims to assert their power over them. Seeing this reality as is and discerning the nature of relations with perpetrators was a long process in many instances.

Clients did not always view violence objectively because of the internal normalisation of gender inequality. Thus, PCVC staff claimed that women did not always perceive covert acts of violence as such. For instance, male perpetrators often tracked women's phones, monitored their mobility, and/or regularly invaded their privacy. However, women often viewed this as an aspect of "caring". Again, perpetrators expressed remorse and charmed clients to reconcile with them. However, this expression of guilt was not accompanied by evidence of tangible amends/change in perspective/behaviour. Despite this, clients would believe that the perpetrators would stop their violent acts and return to their homes.

Further, seeing reality only sometimes resulted in beneficial action. Thinking about taking action and taking action were two distinct steps of recovery. For instance, two OSC officers claimed they had a policy of counselling a survivor only once. Subsequently, the survivor could approach them only when they had decided to take formal/legal action and were prepared with the required documentation. Only then could the officers entertain them.

A considerable aspect of PCVC's services was to support clients in bridging this gap between thinking/feeling and taking decisive action that was beneficial to their well-being. Staff said that some clients often cycled/oscillated between reconciliation, punishment, separation, etc., over long periods. These cyclical processes were based on very real material concerns for their survival (and those of their dependents, particularly children).

Risky premature reconciliation also occurred because of psychological codependency in the client's relations with perpetrators. As discussed earlier, domestic violence has an inherent cyclical nature consisting of the following phases: perpetrators erupt into violence, express remorse and please the victim, escalate conflict progressively, and burst into violence again. Each recurring cycle usually results in the intensity and frequency of violent acts. Over time, survivors often found themselves in less credible positions than earlier while seeking help.

PCVC staff were well aware of the risks of premature reconciliation arising from such codependency. They conducted detailed risk assessments in reconciliation to facilitate clients to make informed decisions. However, clients decided whether to reconcile/ separate. Thus, staff reported that many clients went back to their homes and came back. Clients were free to choose their course of action and pace of change.

PCVC staff reported various wellness interventions they undertook with clients to increase their agency and recover from their violence. Self-care was critical to recovery. Clients had to embrace the significance of the self, moving beyond previously constricting experiences. Thus, several survivors claimed that they were exposed to better self-care practices due to their engagements with PCVC ranging from eating better to doing work that makes them happy. As a result, they were more responsive to their own needs.

To some extent, the very interpersonal nature of violence obfuscates the articulation of individual psychological struggles, particularly suicidal ideation, self-harm, depression and negligence of the self. Thus, survivors often internalised the punitiveness of perpetrators leading to self-harm and harm to others.

PCVC staff admitted that the shelter clients did invade each other's boundaries leading to everyday conflicts. In these instances, the team applied the principle of mutual respect, structuring client engagements in a way that impartially protected the dignity of everyone involved.

Self-harm was also a key risk. Repeated exposure to violent acts/trauma decreases survivors' significance and constricts their expression, often resulting in despair. Thus, survivors reported that they experienced the feeling that they did not want to live anymore at some point in the recovery.

The presence of suicidal ideation is a critical part of risk assessment in the path to recovery. As with burn victims, suicide and suicidal ideation were also held with a degree of shame amongst DV survivors. Some clients did struggle with ideas of self-harm and suicide that persisted even with increased agency. For instance, one of the DV survivors claimed that even after 13 years, she struggled with thoughts and feelings about the futility of her life. However, she overcame these adverse ideas because of her two children. Again, PCVC staff said that some of their clients reported self-mutilation (cutting, burning, etc.) that was associated with intense feelings arising from reliving the experiences of violence.

2.2. Freeing Agency

A critical aspect of freeing clients' agency was facilitating their freedom of expression and decision-making, particularly in relations with their families and communities.

PCVC staff said they were alert to the consequences of clients expressing their agency and taking tangible action. Often, such clients face the risk of further violence and/or indifference. Perpetrators often saw such self-assertion as challenging/dishonouring them. They responded in two ways: escalating the force they used or severing relations. In both instances, the client has little say in the consequences. Thus, a critical part of PCVC's services is to support clients through such adverse experiences and retain their significance/autonomy.

For instance, the mother of a shelter client arrived with a group of supporters at the shelter's gates. She did not want her daughter to stay there. The mother threatened to immolate herself if the client refused to return home with her. In this instance, PCVC staff spoke to the mother, reassured her of her daughter's well-being, and de-escalated the conflict between her and her daughter. The daughter continued to stay in the shelter. In other instances, the results were not so salubrious. In one example, the parents of the survivor, who were extensively politically connected, were still hunting for their daughter. In this instance, the survivor had to go into hiding.

On their path to recovery, engaging with perpetrators becomes inevitable for some survivors. Thus, even when survivors leave their homes and reach the shelter, they may still be required to make statements about their choices in the presence of law enforcement personnel and the perpetrators.

These encounters with violent perpetrators are likely to be traumatic. Illustrating this, PCVC staff discussed the experience of one of their clients. This client had to meet her violent family members and inform them that she had chosen to stay in the shelter to avoid future legal complications. Staff had arranged for the family members to come down to the shelter. Further, they were in the constant company of the survivor. Despite these various safety measures, the survivor suffered a panic attack that immobilised her and prevented her from entering the room where her family members were seated.

Sometimes, survivors wanted to reconcile their relations with their families/perpetrators. Such efforts met with differing results. In cases in which survivors wished to reconcile with their perpetrators, PCVC's principles of mutual respect allowed staff to approach perpetrators as persons with innate dignity, however condemnable their actions may be. While relating to perpetrators, this plasticity is a crucial feature of PCVC's approach to justice. It allowed PCVC to balance its rights-based approach with the needs and aspirations of the survivors.

In some instances, survivors severed their relations with the perpetrators in the future for several reasons, including the fear of slipping back into past patterns of victimhood and conscious decisions to move away from violent individuals.

Choosing to sever relations with perpetrators resulted in adverse social consequences. External actors exerted considerable pressure on such survivors not to do so. For instance, the police generally discouraged survivors from filing DV complaints and advised them to reconcile with their perpetrators/return to their families. This pressure to reconcile with perpetrators did not adequately acknowledge the effect of the violence on the clients and increased the risks they faced.

Survivors faced considerable stigma and ridicule for severing relations with their perpetrators (natal and marital families, intimate partners). For instance, one of the women wanted to divorce her husband. When she returned to her natal family, her parents coerced her violently to reconcile with her husband. As a result, she was forced to leave both homes. This was when she began the actual process of discovering who she was. She could redefine her identity beyond her marriage and family as an individual in her own right.

Again, survivors had to file timely complaints at police stations to deter future episodes of violence. In one such instance, the client encountered the hostility of the police, who ridiculed her. She was a young woman who wanted to file a domestic violence complaint with the police. She was accompanied by a PCVC staff member who was only slightly older. In the station, the police abused the client verbally and cast aspersions on her character. They then confiscated her phone, read her texts, and ridiculed her about their contents. At this point, the staff member stepped in and stopped this assault. This act was deeply evocative of dignity, not just for the client but also for the staff member.

Standing with clients for dignity also posed risks to PCVC staff. In one instance, a violent perpetrator stalked a client and came to know the shelter's location. PCVC team moved

her to another safe place. Frustrated with this, the perpetrator started abusing PCVC staff verbally and physically. He called at all times, stalked the shelter premises, threatened PCVC staff with physical assault, and injured a service provider exiting the shelter gates. Initial appeals to police by staff to restrain him had limited results, with the police expressing their helplessness in dealing with him.

To some extent, this abuse of PCVC staff by perpetrators was not an isolated case. Team members said that verbal abuse by perpetrators was common. These included casting aspersions on their character, cursing them, and threatening them and their families with future harm.

Staff went on to say that this aggression was one kind of response. Perpetrators also attempted to collude with them by pleasing the team and slandering the survivors. These perpetrators would try to speak pleasantly and reasonably with staff for several reasons: damaging the client's relationship with PCVC, encouraging PCVC staff to violate client confidentiality, reducing their vigilance to client risk, etc.

In some instances, survivors who had transcended the immediate violent relations may be required to encounter their perpetrators (psychologically and/or materially). Thus, in cases of marital violence involving children, some form of future relations may be inevitable. In these instances, recovery meant that clients actively decided the extent, frequency and nature of these engagements. Further, these decisions had to respect the dignity of the children involved while protecting them simultaneously, including their right to pursue relationships with their fathers/perpetrators.

For instance, one client said she did not want to be in contact with her husband. She also wanted her children to avoid getting in touch with their father. However, PCVC staff counselled her to consider her children's needs. Thus, she allowed visitation rights to the children under monitored conditions. She did not meet him, however. When the children became older, they stopped reaching out to him too.

Even amongst clients who had severed relationships with perpetrators completely, there were differences in how they reached inner psychological reconciliation with themselves and their past association with perpetrators. A critical aspect of this was forgiveness in its right understanding. Forgiveness is about the individual and not the violent act and does not condone such actions.

Survivors ranged in their responses to the idea of forgiveness. In some instances, survivors could not forgive the perpetrators. In other cases, they had already forgiven them because they believed being human meant making mistakes. One survivor said she had forgiven the perpetrator, not because she justified his actions, but to find peace for herself. This authentic movement towards forgiveness in survivors arose when they accepted their reality "as is", distinguishing the person from the act of violence while remaining fully cognizant of the damages they incurred. Further, forgiving perpetrators did not mean survivors resumed material relations with perpetrators. Instead, it allowed them to find peace and grow.

2.3. Agency and Autonomy

Notably, PCVC supports women to become autonomous without creating undue dependencies. PCVC takes active steps to inform clients about various aspects: assessment of risks, multiple aspects of recovery, and the specific services it provides. For instance, PCVC staff said that clients availing of their services knew what they might expect from the organisation (kind, duration, scope, etc.). They are also informed about PCVC's conditions for support, such as mutual respect (with PCVC staff and other clients) and safety precautions (such as not disclosing their intimate details with other clients that may lead to future risks).

For instance, different clients avail shelter services for varying periods based on their specific needs. According to staff, most women see the shelter as a temporary measure rather than a fixed entitlement because they know the exact services that PCVC offers right from the beginning. They know about the purpose of the shelter, its various amenities, and the duration of such support. Thus very few clients want to continue staying in the shelter. Once gainfully employed, they found other places to stay, including PCVC's Prem Vihar shelter and joint housing with other clients.

In a rare instance where the client wanted to stay on in the shelter, PCVC staff addressed her various concerns and supported her to shift out. This client had availed of the shelter services for herself and her two children. PCVC helped her recover from her violent experiences, gain meaningful employment, and secure good schools for her children nearby. Since this arrangement was comfortable, she did not want to leave. PCVC staff found her suitable and affordable housing close to the school so she could move out.

Similarly, PCVC had a graduated policy of transport support, of which the client was informed. Initially, clients used the organisation's vehicle to attend to urgent needs such as visits to the police stations and courts. Over time, staff booked cabs/autos for survivors to travel safely. As clients became more confident, they were encouraged to use public transportation. Through each of these graduated steps, the clients gained greater confidence in their capacities and came to terms with the reality of their circumstances.

Again, providing counselling services to clients followed this pattern of increasing autonomy. Thus, PCVC staff initiated regular contact to monitor the client's well-being during the initial phase until trust was built. The intensity and frequency of communication in this phase depended on the urgency of the needs of the survivors. This urgency reduced as more and more of their essential needs were met. For instance, domestic violence survivors would want to speak for several hours a week or even in a session initially. Subsequently, staff maintained regular bi-weekly/weekly contact with their clients.

As clients progressed in their recovery, their need for PCVC's services decreased. PCVC staff continued to initiate contact at greater intervals and stopped when clients said they were doing well consistently (at least three times).

Clients remained free to contact PCVC. To enable their long-term needs, PCVC organised regular survivor meetings. According to staff, many old clients attended these meetings to stay in touch, learn from their peers, reflect on their growth and seek support for their current needs.

Section V: PCVC Service Provision

PCVC services may be broadly categorised into client and partner/stakeholder services. Client services include physical and psycho-social services, while partner/stakeholder services include information dissemination, education, capacity building and networking.

1. Client Services

Generally, a vast rubric of practices is covered in the domain of psycho-social methods ranging from advice to specialised trauma care. Remarkably, PCVC's services to domestic violence survivors were authentically client-centred and holistic, supporting women to exert their agency in all domains of life, including fulfilling physical, psychological and social needs to survive and grow.

PCVC's services can be categorised into the following four kinds: (i) trauma-centred interventions that include physical and psychological care, (ii) client-centred services that focus on progressive support for clients to exert their agency; (iii) strength-based capacity building that concentrates on positive psychological growth including gender equality, inner wisdom and creativity, psychological integration, resilience, etc.; and (iv) resource support including a wide variety of unique and tangible needs including medical needs, shelter, child care, legal support, employment opportunities, etc.

This classification sees survivors as unique individuals embedded within specific ecosystems of family, community and society moving through various aspects of recovery in the physical and social world. This categorisation is instrumental in increasing the efficacy of services provided to women and the education of external partners and stakeholders, including healthcare workers, CSOs, communities and government officials.

For instance, one of PCVC's clients was a 22-year-old woman who was sexually assaulted, raped and financially exploited by her classmate (to the tune of Rs. 1,40,000/-) for four years. She finally mustered the courage to approach her college management and family for justice. Her parents were not supportive, and the college could not take any action because of the pandemic. She reached out to PCVC seeking support to recover from the trauma and get closure.

PCVC provided her with several services, including psychosocial counselling by the Dhwani team and online psychotherapy sessions with a psychologist. Dhwani's team members contacted the college to initiate action against the perpetrator. This resulted in the perpetrator giving an apology letter, acknowledging the amount of money he had extracted from her. The client reported that she had moved forward and was concentrating on her career. The psychosocial team maintained regular contact with her to continue the recovery process.

1.1. Trauma Centred Care

A significant portion of the PCVC services is focused on providing trauma-centred care that includes biological and psychological aspects. These ranged from providing nutrition, essential hygiene and medical products, and provision of support, including support for nursing care. Burns and violence are often accompanied by significant physical and psychological trauma, pain and suffering.

A critical aspect of trauma care for survivors was their rescue from violent contexts and fulfilling essential needs of clothing, shelter and food. For instance, a queer couple faced consistent violence from their families. They were rescued and shifted to an interim

shelter for a night, where they could hide from their families. They were then moved to the PCVC shelter without leaving a trail by which the perpetrators could pursue them.

Trauma survivors often face psychological distress related to PTSD, including the following: sleeplessness, forgetfulness, persistent anxiety and depression, panic attacks, unexpected "flashbacks" and nightmares that trigger the memory of the trauma/violence, somatisation of violence, and addiction to psychoactive substances. This is particularly true for sexual abuse. The impact of sexual violence is aggravated by the profound silence about real experiences of sexuality: freedoms, risks and responsibilities. Further recovery from trauma does not follow predictable paths, with psycho-somatic symptoms recurring suddenly.

The long-term psychological causes and effects of trauma are often difficult to determine without trust building over time. This long-term relationship of trust allows clients to overcome their fear, shame, guilt, etc. The effects of trauma may present themselves as various psychotic symptoms (usually associated with depression). For instance, one of the clients availed psychiatric care from a reputed civil society organisation that partnered with PCVC. This client reported that she had persistent experiences of feeling that her bed was on fire when she tried to sleep. The psychiatrist seemed to have diagnosed her symptoms as schizophrenia, based on hallucinations rather than psycho-somatic flashbacks characteristic of PTSD.

The somatisation of various kinds of violence (not just physical) is critical to trauma care. Just as burns cause contracture of the biological tissues, persistent/acute psychological trauma causes psychological contractions that survivors embody, sometimes for several years. Without seeing these contractures and releasing them consciously, the impact of the violence remains coded in the body, reducing the capacity for self-care and recovery. Psychological approaches focussing on the body, such as relaxation therapy, body-based theatre and dance therapy, mediation and dream journalling, allow the embodied memories of these extreme experiences to surface and be released in safe contexts.

Trauma also involved a high degree of vigilance on the part of the caretakers. For instance, self-harm in high risk clients was a real risk. PCVC adopted sound methods to prevent such harm, the foremost of which is continued contact, alerting caretakers, and encouraging women to express their negative feelings of fear, anger, shame, etc., without judgement. For instance, a queer partner of one of the shelter clients committed suicide outside. The client in the shelter was in considerable distress. PCVC team kept close contact with her until the acuity of her distress passed.

1.2. Client-Centred Services

Remarkably, PCVC's services to domestic violence and burn survivors are authentically client-centred and holistic, supporting women to exert their agency in all domains of life, including fulfilling physical and psychological needs to survive and grow. From the beginning, PCVC encourages clients to independently define their goals and purpose, the kinds of relations they wish to have, and the work they want to do. These goals were short and long-term (three and six months). They were reviewed regularly so clients could see their progress and change course when necessary.

Principally, PCVC focuses on the significance of survivors first in its approach to services related to recovery and empowerment. Clients progressively decide their future actions and relations with their families and communities. PCVC treats survivors as intelligent and equal individuals capable of steering their lives well. Its client-centred services (including psychotherapy) differ distinctly from advice/guidance.

Client-centred therapy remains the core of the psychological services provided by PCVC. This approach is invaluable in demonstrating respect for the client's personhood. PCVC discussed two kinds of psycho-therapy: counselling and art therapy. PCVC staff

discussed their role in offering space and time for clients to explore and reflect on their experiences to see them in new ways. This focus on unconditional listening has been thoroughly integrated into PCVC practices, evidenced in its last-mile approach to recovery, where women make a series of decisions with PCVC's support for their well-being over time.

PCVC views informed decision-making as critical to survivor agency. It is premised on the fact that with the right information, survivors will make decisions with the best possible outcomes for their recovery. PCVC's client-centred therapy and informed decision-making significantly differed from most psycho-social services available.

Most actors used their experiences and frameworks to determine survivors' psychological and social needs. They conflate information sharing, advice/guidance and psychotherapy. They often characterise survivors as ignorant and seek to change their viewpoints based on partial and idealised frameworks. Such advice is often prescriptive rather than expansive. It assumes that service providers know better what survivors need than the survivors themselves. Thus, such services often remain irrelevant or counterproductive (such as the normalisation of violence and forced reconciliation).

PCVC's client-centred approach enabled self-reflection in team members. For instance, when questioned about how PCVC defines violence, one of the senior members claimed that this is a difficult task. Rather than looking at theoretical (external and possibly rigid) definitions of violence, PCVC encouraged women to define violence as they saw it in the "here and now". Often, survivors refined these definitions over time as they recovered and gained greater insight into the nature of inequality.

Supporting clients' decision-making was not without its challenges. This was particularly true when their actions put them at risk for further violence. For instance, when clients decided to return to their violent contexts, PCVC staff often conducted risk assessments with them. This allowed the clients to see reality as is, at least partially. Further, the team also maintained regular contact and closely monitored such clients.

The client-centred approach was reflected, not just in the client engagements, but in the organisation's very orientation, ranging from strategy to daily practice. For instance, the project strategy begins with the needs of the survivors and then builds concurrent elements such as communication and media, partnerships and advocacy.

Internally, organisational functions are tailored to this client-centred approach. PCVC's map of service functions is comprehensive and responsive to survivors' needs. Different programmatic and management functions within the organisation cater to clients' specific concerns. For instance, the most well-developed parts of the MIS focus on the core function of real-time response to individual clients.

1.3. Strength Based Capacity Building

Trauma care and client-centred services focus on the needs of individual clients so that they can recover from their traumatic/violent experiences and begin to lead healthy daily lives. As such, they are therapeutic and aim to reduce psychological distress/illnesses. The relationship between the care provider/therapist and the client is hierarchical, however participatory it may be.

Strength-based capacity building locates itself firmly in the domain of sourcing inner power (power within and with) to initiate action (power over and to). Its fundamental aim is not to relieve psychological distress but to discover and realise inner potential. In this sense, it views power as generative and synergistic.

Strength-based capacity-building programmes reduce the hierarchical gap between care provider and client. The responsibility for the growth of the clients is vested in their actions as equal members of the human experience. Here the facilitator's authority is much less when compared to the therapist. For instance, self-disclosure is critical in the

contouring hierarchy in relationships. While self-disclosure by therapists/trauma care workers is discouraged, in strength-based capacity building, self-disclosure by facilitators is an essential part of the process.

Unlike therapy, strength-based approaches do not focus on specific outcomes such as alleviating psychological distress arising from past experiences or increasing productivity. When successfully employed, these consequences do occur. Instead, they focus on the discovery of potential and future possibilities. Unlike trauma and client-centred approaches that centre individuals, strength-based capacity building approaches hold individual and mutual growth together.

Critical thinking is a vital aspect of strength-based capacity building. It expands individualistic perspectives to structural causes of discrimination, inequality and violence. Developing critical thinking freed survivors to pursue their dreams and goals. Thus, PCVC works with women actively to explore the constrictions of prescribed gender roles to reclaim their power as individuals and equal members of society.

Besides structural aspects of empowerment, strength-based capacity building also includes psychological elements. PCVC does focus on individual growth aspects such as the discovery of self beyond current identities (such as women, victims, patients, etc.), the realisation of individual aspirations for self and others, and self-initiative and responsibility. These support survivors' movement from being dependents needing therapeutic care to thrivers focussing on the growth of self and others.

For instance, PCVC staff discussed the contents of their work with shelter clients while providing psychological support. Much of this work was based on strength-based approaches that evoke aliveness and encourage clients to work from their power. To begin with, the caretakers in the shelters had deep wisdom that arose from their experiences of violence and recovery. By their very presence, they embodied the possibility of healing and restored the sense of self among survivors. This was particularly relevant given that the recovery path is long and sometimes seems futile.

Further, staff conducted regular group work with the clients using a set of seemingly simple exercises aimed at identifying strengths and articulating them to others. One such exercise was the identification of positive qualities of individuals by group members on paper. Staff reported that some clients found this exercise deeply inspirational and retained their papers from this exercise for a long time. Another exercise focussed on identifying areas of pride amongst clients.

These exercises had two beneficial effects. It allowed clients to source their inner psychological resources such as wisdom, power and love. It also created a mutual culture of encouragement, where clients felt supported to face their challenges. The staff, however, did not classify this group work as a strength-based capacity building but instead as therapy (similar to the art therapy made available to clients).

Significant advances in Applied Behavioural Sciences have occurred in the last few decades. These may sharpen PCVC's strength-based capacity building, such as Process Work, Non-Violent Communication, Appreciative Enquiry, Restorative Justice Circles, Deep Democracy, etc. All these have excellent methods that contribute to self and collective growth. They do not see the individual as ill/disabled/abnormal. Instead, they focus on self-discovery. Further, they view experiences of adversity - loss, conflict, etc. - as sites of rich and diverse growth and expansion.

Of particular interest are the advances made in conflict resolution. Most survivors of violence have challenging relations with conflicts. They either induce them to exert some control on their circumstances (if only that of time and place) or avoid them at considerable costs to their expression and well-being. Understanding the nature of conflicts and experiencing and resolving disputes in safe spaces allow survivors to reduce their reactivity and engage with diversity in richer ways.

1.4. Resource Based Support

A significant portion of PCVC's support is providing physical services to address several survivor needs. These include food, clothing, shelter and hygiene requirements. They also include housing and employment opportunities in the external world. PCVC also provides nutritional support to survivors, including grocery support (particularly during COVID) for poor clients.

As discussed before, grounding needs in material realities is a critical aspect of trust-building with clients. It also acts as an equaliser in providing services for poor clients, where PCVC attends to basic needs without compromising client dignity. For instance, the Astitva team said that a welcome kit was part of the protocols of the shelter. This welcome kit included two pairs of good quality clothes and sanitation products such as toothpaste, soap, etc. At-risk clients who were rescued often needed these essential supplies.

In addition to material support, PCVC provides various services that ensure survivor recovery. Legal support for clients is provided by PCVC's network of lawyers and law firms that support clients in their legal challenges: advice, filing of cases, and addressing courts.

PCVC also provides support to the dependents of survivors, particularly children. The needs and rights of such children are secured through multiple ways: counselling for mothers to decide the role of fathers/perpetrators; development and recreational needs such as school attendance and nearby play areas; supporting single parents to find safe housing; etc. For instance, staff listed three schools with whom PCVC had ongoing relations where children of survivors could avail of education without interruption.

Another small but essential support included the provision of grocery kits and necessary items to set up new homes. Nool (thrift store) is one such effort wherein survivors may choose various items, including festive and everyday clothes, toys, furnishings, utensils and kitchenware, etc. To some extent, the Nool initiative embodies the principles of PCVC's resource-based support: clients choose the resources they need with dignity, rather than PCVC giving what it thinks is best for them.

A key element of recovery for survivors was financial autonomy. Many survivors noted that financial independence was a critical milestone in their recovery path. This financial independence meant several things to them: freedom from external demands, increased significance because of productive work engagement, and opportunities to grow in new, unanticipated directions.

PCVC ensured that survivors had access to work in keeping with their capacities. (including remote work that they could do from the shelter itself). In one instance, the survivor was successfully employed by an international company and was entirely financially independent. In another example, a survivor with software skills was employed in a small company but could not retain the job. She retrained as a nurse and was now gainfully employed.

As survivors sought financial autonomy, they were encouraged to save to support themselves. Thus, clients who were employed outside and could autonomously move around were shifted to the secondary PCVC shelter set up on the premises of a local NGO in Chennai. This shelter also provided free food as part of its canteen services. Women could focus on their savings to move into independent homes with greater security.

2. Multi-Stakeholder Engagement

Besides providing direct services to victims, PCVC also undertakes considerable action to increase multi-sectoral services for burn and DV survivors. However, the increase in such services is determined mainly by macro-structural factors such as high infrastructure investment without concurrent personnel investment.

There was an acute staff shortage in both hospitals and OSCs, particularly among those involved in nursing, shelter caretakers, etc. Noticeably, almost all existing employees (OSC, Nursing Staff) were women. For instance, while the OSC centres have been mandated by policy, not all are staffed as planned/needed. Two OSC centres in one city had two shelters. One of these had been constructed recently for populist reasons but was empty. Both OSC centres had one staff each, who attended to the various requirements of rescuing women, supporting their legal action, etc. The mandated number was seven per OSC. 12 of the 14 positions were not filled since the services required night shifts, and staff were unwilling to work these shifts.

In the domain of domestic violence, various stakeholders hold diverse perspectives on the causes of violence, gender equality and psychological well-being. These ranged from providing welfare services to rights-based advocacy. The Government remains the key stakeholder with several laws, policies and schemes for addressing the needs of domestic violence survivors. These services are spread across diverse departments and functions in overlapping and/or dissonant ways. Besides the government, CSOs are critical in providing services for women survivors. As with the government, they too ranged in the kinds and quality of services.

The overlaps and dissonances in the various services provided to DV survivors by multiple stakeholders are particularly evident in psycho-social services covered under the broad term of counselling. This service category included a wide range of very different activities: psychotherapy, legal counselling, information sharing, advice and guidance, etc.

Besides the kind of services offered, there was some uncertainty about the exact nature of services available on the ground, even amongst well intentioned partners and stakeholders. Thus, many of the partners said that a critical insight from PCVC's multistakeholder engagements and training was the identification of the nature of the services available for DV survivors in the state: gender sensitivity, trauma care, psychotherapy, social work, legal support, shelter services, etc. For instance, one of the government officials shared that psychotherapy was offered as a service in hospitals for patients who were suicidal or violated. Most other government officials and CSO members seemed unaware of this service.

PCVC has an extensive network formed over the years that is strategically sound, based on the understanding that realising a violence free society requires many individuals and organisations to work together. To fulfil client needs, these partners/stakeholders are selected through "here and now" engagements. Thus, PCVC's extensive network is live and responsive, maintaining regular contact with individuals and organisations to fulfil client needs and provide services. This has catalysed participation and action amongst its stakeholders and partners, resulting in changes in their perspectives, methods and practices.

A significant reason for the quality of enrolment of various partners arises from PCVC's commitment to the care of survivors. By demonstrating integrity and commitment around specific results, partnerships are built on trust and credibility. For instance, PCVC identified one of its nodal partners because of the authentic commitment shown by the latter's staff in attending to the needs of survivors. The senior member of this CSO was evoked to provide support beyond the contractual obligations of PCVC in response to the conditions of the survivor.

This emphasis on commitment and integrity creates real possibilities for synergistic action in partnerships. Thus, another nodal CSO identified by PCVC had a robust rights-

based approach to violence within local communities. It facilitated the organisation of several Violence Against Women groups in local communities in the district where it works. These groups were federated into an autonomous institution that could intervene effectively in individual communities. While this nodal CSO supported PCVC in delivering services in their district, PCVC provided the CSOs opportunities to access larger state and national fora for learning and advocacy.

Key partnership strategies embedded in the PCVC approach to increase Multi-sectoral services were the following:

(1) Direct work in hospitals to provide services to burn survivors.

(2) Development of extensive referral services to provide services to clients in their local contexts

(3) Partnership with key stakeholders to increase the quality and quantity of services provided to survivors of DV.

(4) Enrolment of gender equality advocates through its Change Maker programme

2.1. Working with Government District Hospitals

The Vidiyal project deploys PCVC staff in Chennai and Chengalpet hospitals. For its two hospital partners in Madurai and Vellore, it has enrolled nodal CSOs who depute staff to provide similar services in their localities. While PCVC planned to recruit and deploy its staff, circumstances caused by COVID caused it to change its approach to a more locally responsive one. Thus, it enrolled local nodal CSOs to support burn victims in their partner district hospitals. PCVC does build the ongoing capacity of the CSOs and staff recruited to provide this support. It also gives physical resources to clients through these partners, such as nutrition, medical supplies, grocery support etc.

In addition to providing direct support to clients and caretakers through their staff and their nodal CSO partners, PCVC also informed and educated various hospital staff about the multiple aspects of burn care for patients and their caregivers as part of their regular interactions. The organisation has started administering capacity-building sessions to educate healthcare professionals and government officials on gender-sensitive approaches in the last year. Participants in these training reported shifts in individual viewpoints (to be less judgemental, in one case) and the importance of seeing structural aspects such as gender beyond the client's medical condition (to see how the patient's context determined her recovery in another).

Hospital staff asserted that PCVC's work with them has enabled patient recovery significantly. In one of the hospitals, where the medical staff had given up, PCVC's team saved the woman's life, and she is on the path to recovery. In another hospital, medical personnel commended PCVC staff for their exemplary integrity and consistent professionalism and wished that more such people would join their department.

2.2. Development of Referral Services

PCVC's network of partners/stakeholders aims to provide decentralised services to survivors. Over the years, PCVC has developed extensive referral services that support survivors to seek support close to home. Faced with the challenges of COVID and the increase of calls from across the country from women on its hotline, PCVC has extended its referral services, not just within Tamil Nadu but across the country. A key aspect of this networking is to assess the kinds and quality of services through appropriate due diligence processes.

The intuitive movement of decentralising services through partners to take care of survivors in their communities demonstrates the development of synergistic partnerships

based on shared principles. This emerging network has the potential to be genuinely polycentric, where scale in support of women is not achieved through mechanised mental models but through sincere individuals and organisations that provide specific services to survivors and enable a violence-free society.

2.3. Partnerships with Government and CSOs

PCVC has partnered with One Stop Centres (government OSCs) and CSOs across Tamil Nadu. It also works with the police informally, including filing legal cases and providing protection for clients. These partnerships are based on well-evolved maps of stakeholders providing specific services for specific categories of DV survivors.

A vital aspect of these partnerships was to build capacities of partners through the following ways: (i) ongoing relations over a period of time, working together to provide services to survivors; and (ii) training and sensitivity sessions that explore gender equality, particularly as it applies to survivors.

PCVC has well-developed information and educational material (Handbooks, PPTs, short films, brochures, social media posts, etc.) that adhere to the principle of simplicity. This simplicity in communication reflects the organisational principles of dignity arising from committed work that puts survivors first. In newly emerging domains, PCVC is developing communication material that attends to survivor needs, including sensitive and pioneering areas such as intimate partner violence in queer relationships.

PCVC has undertaken capacity-building exercises for government officials and CSOs intending to shift participants' viewpoints to more gender-sensitive positions. A vital part of these sessions is to bring various stakeholders into the same room where they gain more expansive ideas, not just about gender and DV, but also about the kinds and nature of services needed/available for DV survivors.

By building capacities of partners and stakeholders such as the government and CSO staff, PCVC is enrolling individuals who can make changes within their systems/ contexts. For instance, one of the OSC officers said that their training with PCVC opened the possibility of identifying and collaborating with several institutions working in the area of domestic violence. This exposure has increased her capacity to deliver real help to survivors in her organisation.

2.4. Enrolment of Changemakers

A critical effort is the Change Maker initiative. This initiative focuses on informing a wide section of people and enrolling those concerned about gender inequality as change-makers. Through this Change Maker programme, PCVC is investing in the capacities of a range of actors who can promote gender equality in their contexts. These change-makers include students, professionals, community members, CSO staff, etc. They commit to advocating for violence-free societies amongst their peers and in their contexts to reduce gender equality.

Not only do these diverse change makers work on different systems that perpetuate violence, but they also address the various aspects of these systems from within them. Some change makers discussed the shifts that they were creating in their micro-systems. One young woman said she had intervened in her family to address gender inequalities between her and her brother. As a result, both shared household chores, which were earlier designated as her work. In other instances, community leaders organised activities focussing on violence free societies.

PCVC is to be commended for its intuitive capacity-building strategy recognising individual commitment to change and sourcing their inner power/agency as

foundational to impact. It has grasped the right levers to impact complex systems perpetuating gender-based violence.

Currently, PCVC has started exploring volunteering possibilities systematically through its Nool initiative. Some other ideas that emerged were a small library in the shelter and a toy bank with different age-appropriate toys for paediatric burn survivors in the KMC hospital.

Further, it does invite interns and volunteers to work with it. Developing a formal volunteer/internship programme may be effective. Some change makers indicated that they would like to associate with PCVC more. Further, given the highly specialised quality of care provided by PCVC, it offers rich possibilities for learning. One such possibility is internships for physiotherapists who want to acquire knowledge and practice in burn care.

2.5. Partnering For Impact

PCVC has positioned itself to disseminate information and educate professionals and civil society actors about gender equality and violence-free life. This is a sound beginning in partnership building. However, this approach may need to be reviewed in the long run. It runs the risk where partners start viewing PCVC as the providers of resources. Thus, partners in two hospitals and one CSO wanted PCVC to provide more money to hire staff/shoulder expenses involved in delivering services in their wards/localities.

Currently, information and education needs among various stakeholders are varied. In the case of hospitals, medical staff were already aware of the consequences of burns on women victims to a great extent. In fact, many of the medical staff interviewed showed a nuanced understanding of burn clients' needs and circumstances. All the senior doctors that PCVC has enrolled are exceptional, given that they have pursued this hard work over decades. They were closely acquainted with the public hospital systems and had considerable wisdom about the structural gaps in service provision to burn patients.

Given the tremendous potential for real and rich mutuality, PCVC may consider deepening these partnerships on two fronts: (i) information sharing (rather than just giving information but also receiving it) through various joint research and reflective efforts; and (ii) facilitation of generative dialogues based on strength-based capacity building.

Generative dialogues begin with the premise that the members engaged in the process are equal participants who bring their wisdom/power to identify and resolve issues collectively. For instance, as discussed, hospital staff reported an acute shortage of nurses and nursing attendants resulting from larger health policy changes. Three doctors had worked in burn care for over 20 to 30 years and were deeply aware of survivors' needs and systemic challenges. Bringing such doctors and medical staff together and working on this issue may result in new ways of looking at the problems and solving them collectively.

Such dialogues use strength-based approaches to partnership building that have the potential to transcend contentious relations. For instance, in a multi-stakeholder meeting organised by PCVC, government officials felt that CSO criticisms were often biased. They did not acknowledge the sincere efforts of government officials. CSOs felt that government officials must accept and acknowledge their feedback as constructive arising from their commitment to survivors. These apparent contentions obfuscated the genuine effort made by the government officials and CSO to come together to provide better services to women. Using strengths-based approaches more proactively in these dialogues can deepen conversations beyond the apparent contradictions and move towards harmonious alignment in work.

Section VI: Gender Equality

PCVC bases its services on a robust rights-based approach, beginning with the understanding that rights are not a privilege but are inalienable to personhood.

PCVC identifies violence as an outcome of politics. It examines distinctions of three aspects of power: "power within", "power to" (self-initiation and responsibility), and "power over". Structurally, PCVC focuses on gender inequality as critical to creating violence. Ideas around critical thinking about "power over" concerning patriarchy, gender-based discrimination and violence are significantly evolved. Evidence of this is seen in all aspects of its work, from the selection of its clientele to its daily practices, such as securing privacy, assessing risks, and prioritising survivor voice and agency.

The principles of gender equality are clearly embodied in the practices of PCVC. This is evident in the selection of its clientele. PCVC locates itself clearly as a women-centric organisation. Most of its leadership and staff are women. In working with clients, it is particularly conscious of gender inequality that is part of survivors' realities.

For instance, while explaining the rationale for providing services to women burn survivors of burns, PCVC staff pointed out that gender played a critical role in determining burn incidents for women. This resulted from overt violence and covert indifference that increased women's risks. Even when the burn incidents were accidental, women face greater challenges in their recovery. They had less access to resources for recovery, including nutrition, nursing care, physiotherapy medical supplies.

PCVC enabled clients to see gender equality as an inalienable right rather than favours conferred by others. Most of the staff are actively critically thinking about gender discrimination and violence, patriarchy and the nature of power over women's bodies. For instance, the PCVC team members discussed the reality of women perpetrators and toxic intimate partner relations where both partners are violent to each other. However, compared to male perpetrators, women who inflicted violence were more likely to face quicker and more intense social criticism, disapproval and punishment.

PCVC facilitated clients to unlearn constricting gender roles and discover new potential and possibilities. For instance, one of the clients claimed that she had found the inherent gender inequality that was the cause of the violence she faced. She shifted the locus of control from the external structure (serving her family at the cost of her well-being because of social role expectations) to prioritising her internal growth aspirations. In another instance, the client did not overtly express structural violence as a reason for the violence she faced. Instead, she saw it as a consequence of her individuality - her boldness in pursuing her dreams and ambitions that resulted in her family's disapproval and violence.

Noticeably, this critical thinking was applied to clients and the self - the axiom "personal is political". For instance, one of the staff members discussed the nature of her relations with her family. Her family sometimes shared jokes on WhatsApp that ridiculed a particular section of people (such as using poor English). While they saw these jokes as trivial, she could not accept them in the same way. She then requested her family not to share such messages with her as they were disrespectful. While this led to some friction within the family, she believed that expressing her viewpoints based on principles of universal dignity was important.

Another staff member, while examining the relationship between experiences of violence by men and women, said her two young boys were exposed to abusive sexual contact by an outsider recently. The children did not seem significantly affected by it as they narrated the incident. However, she realised that she must talk to them about "safe

touch" despite their gender and what to do when they feel unsafe (including letting her know immediately).

The balance between an idealistic rights-based approach and a pragmatic service provision is unique to PCVC's work. This balance is based on principles of dignity, "here and now" responsiveness and restorative justice. Thus, the principles of equality are not merely pedagogic but pragmatic and embodied in lived reality. This has resulted in PCVC addressing hard questions in their work with survivors: agency in reconciliation/ separation in violent relations; the dignity of the perpetrator; the use of prescriptive authority in service provision, particularly in high-risk situations, etc.

In the current context, there is increasing recognition that critical thinking about gender equality and human rights is essential for real progress. However, for real change to occur, individuals must embody this equality beyond mental frameworks. While the axiom "personal is political" is well known now, PCVC addresses the very real differences in how individual women define their personal and political experiences by beginning from where they are, how they see the world, and how they would like to grow.

This tempering of gender frameworks with client wisdom allowed clients to define gender equality as it applied to them in their current reality rather than an idealistic, prescriptive notion. It allowed them to make progressive small and big life decisions based on their current needs and aspirations. This unique "here and now" approach has the potential to address cutting-edge work with gender and violence that moves beyond rhetoric to holistic change.

Three fundamental principles inform this integral approach: (i) being respectful and embodiment of dignity, (ii) "here and now" orientation resulting in real-time responsiveness and last-mile delivery, and (iii) restorative justice that prioritises victim needs.

1. Being Respectful

PCVC's institutional identity and culture are firmly rooted in the principle of dignity. This is a crucial reason for the relevance of its services. Dignity is translated to the everyday practice of respect (self and other) and significance. Innate dignity means that PCVC sees its services as rights exercised by survivors rather than just being recipients of support. PCVC team treats each client as unique and begins from their needs and aspirations. Its foremost principle is "do no harm". Thus, it starts with clients' needs and progresses as the relationship grows.

Across the board, client confidentiality and self-disclosure were treated with care. Clients' right to privacy was seen as critical to their dignity. Role requirements include structured access to client information. Team members were discouraged from gossiping about clients.

Commitment to embodying the principle of dignity amongst staff members is remarkable. Thus, almost all staff members discussed the importance of respect for each other and their clients in their engagements. They were acutely aware of the distinction between the rhetoric of dignity and the embodiment of it. Many used nuanced illustrations of learning and unlearning while asked to describe the nature of dignity, the foremost of which was the emphasis on the client's decision making capacity for their own lives. Their embodiment of this principle often catalysed survivors to recognise their significance and discover new possibilities.

Staff discussed not just offering respect but also receiving consideration. For instance, one of the key roles that PCVC plays is supporting clients to engage with perpetrators. With violent perpetrators/clients' families/external stakeholders, PCVC often drew and demonstrated boundaries to ensure mutual respect.

Within the institution, team members reported very few conflicts between them. A key reason for the norm is that members address each other respectfully. In times of conflict, when the principle of respect was foregrounded, it created opportunities to move beyond conflicting points of view to more harmonious ones. This emphasis on respect was also evident in relations with the partners that PCVC works with. During site visits, the staff showed great sensitivity to partner realities, including their time availability and space usage.

Translation of the principle of dignity into practice was sometimes challenging. For instance, the organisation has a "zero tolerance" policy towards all forms of discrimination. Staff members discussed the dismissal of one of their team members that resulted from enforcing this policy.

As mentioned earlier, the queer partner of a shelter client living outside committed suicide. This came as a shock to the client and the teams. One of the staff members ridiculed her at this time, causing red flags to go up. Further enquiry revealed that this staff member had rigid ideas about homosexuality based on her religious beliefs. She had camouflaged these ideas during the selection process. Senior team leaders made multiple efforts to make her see how her rigidity impinged on the right to dignity of the queer client. However, these efforts failed, and the staff member had to be let go.

2. "Here and Now"

PCVC's "here and now" approach is a significant reason for its real-time responsiveness and last-mile approach. Several partners said they trusted PCVC because it responded immediately to distressed survivors. For instance, doctors commended PCVC's services to an extensively injured burn survivor. The prognosis for her was very bleak, and she had no caretaker. The PCVC team moved swiftly to employ a caretaker in the hospital and then shift her to its shelter for detailed support in recovery.

Responsiveness in trauma-informed services is particularly significant, given that PCVC intervenes in highly volatile and risky solutions that require urgent responses. Failure to respond to immediate needs can escalate survivors' psychological and physical distress and recovery (particularly burns).

This responsiveness is embedded in PCVC's daily practice, organisational orientation, and functions. Real-time responses require a high degree of alertness. The security measures for the shelter may illustrate this. At least two to four designated staff and leaders monitored the shelter remotely through the night at different times.

A key challenge was the alertness of the security staff. Unlike most urban residential pockets in Chennai, the security staff had to be alert to threats and strict about sharing information about the team and clients with people approaching them (including officials like the police). Thus, there were instances when security inadvertently shared personal communication details with individuals linked to perpetrators. Through a careful selection process, one of the contracted staff, who showed this alertness, was appointed to oversee the shelter's security and orient other contract staff.

Besides daily practices such as alertness, real-time responsiveness was also systemically embedded in the various physical and psychosocial services. Women could approach the services through several communication channels: the Dhwani hotline, the mobile number on the organisation's website, and online chats. Clear team members were designated for each of these interfaces so the services could remain operational around the clock.

PCVC's operating and finance systems are geared toward real-time response. The MIS centres survivors and tracks them with unique codes. Data into the MIS is fed daily and weekly so that staff are regularly updated about client progress and can provide timely support. For instance, delays in assistance related to wound care, nutrition and

physiotherapy could considerably increase disability in burn survivors. The MIS client data ensures that this timely support is possible.

Similarly, the finance systems are set up to respond to staff needs for cash flow without administrative lags. A key feature is the debit cards of the organisation that are carried by senior team members that allow cash fluidity during urgent (and planned requirements). When staff travel out of Chennai for rescue, home visits, hospital visits, etc., their financial needs may be somewhat unpredictable. In such instances, a certain amount based on estimated expenses is transferred to their cards (processed within one day). Immediate cash transfers are also done for even more urgent requirements, where the money is transferred to staff accounts.

Underpinning this principle of "here and now" responsiveness was PCVC's commitment to treat individual survivors as unique and attend to their specific needs. In this sense, it transcended existing frameworks, such as gender rights, service provision models, etc. In doing so, it has intuitively created sound foundations for work that may cause long-term impact.

The "here and now" approach also was integral to PCVC's capacities to meet the emergent needs of survivors over the long haul. This last mile effort, unique to PCVC, was evident in its tangible and holistic results, where clients move from being victims to becoming thrivers. From the time of contact to functional recovery, PCVC retained close and regular contact with its clients, getting to know their essential needs as they arose and found the means to fulfil them: physical and psychosocial needs, legal support, child care, economic sufficiency, housing needs, grocery support, etc.

Last not but not least, PCVC is in the process of building relations with various partners based on this "here and now" approach in providing timely services through its referral systems. For instance, a nodal organisation leader discussed an urgent rescue effort of which she was a part in her district. In this instance, the survivor was rescued overnight. She stayed in the shelter provided by the CSO for a day so that her pursuers lost track of her. She was then shifted to the PCVC shelter. Staff also discussed cases where survivors stayed briefly in the OSC centres proximal to them in similar rescue efforts.

This approach to partnership building accounts for the phenomenon of emergence in programme planning and strategy. For instance, the outreach team discussed their awareness and changemaker session schedules. They said that they did set yearly targets. However, the scheduling of these programmes was based significantly on the invitations they received from various stakeholders. Thus, during some parts of the year, they were very busy, while their schedules were more relaxed at other times.

3. Restorative Justice

Because of its principles of dignity and "here and now" approach that balance idealism and pragmatism, PCVC has intuitively integrated restorative justice principles in its rights-based approach. Many of these principles were seen in PCVC's work: prioritising survivors' agency, the interconnected nature of violence, and the attitude of mutual respect, including perpetrators. For instance, many survivors want to resolve their issues without being involved in punitive and formal legal processes. Instead, they focussed on recovering physically and psychologically, regaining their capacity to make independent decisions and determine the kinds of relations they wished to have.

For the most part, rights-based approaches and modern legal structures (OSCs, courts, police, etc.) are conflated because of the common goals of justice. However, the principles of the restorative justice systems that PCVC intuitively adopts are markedly different from ideas of modern justice. Howard Zehr's work on Restorative Justice was particularly relevant while articulating PCVC's intuitive view of justice. His work was based on traditional justice systems in relatively egalitarian indigenous communities. The key

elements of his model that addressed harms, needs and causes of violence included the following features: prioritisation of victim support, offender responsibility, inter-relatedness of human relations, and respectful dialogue.

The shift to restorative justice perspectives from modern justice systems requires a corresponding movement from punishing the perpetrator for revenge to restoring damages incurred by the victims. Both justice systems identified violence (at least physical acts) in the same manner for the most part. Both used punishment as a deterrent. However, from this point, their worldviews and actions varied significantly.

Restorative justice aims to restitute damages incurred by the victim foremost. It empowers victims by actively involving them in informed decision-making and privileging their views and expressions. Victims determined the nature of the violence, the damages they incurred, and the needs and obligations of perpetrators/communities to restore these damages. The role of the victim was far more significant than that of a (biassed) witness, usually evident in modern systems.

With perpetrators, the goal of restorative justice was not punitive. Without condoning the violence or minimising the damages caused, justice focussed on expressing authentic remorse by perpetrators and sincere efforts to restore damages through a series of liabilities and responsibilities. It recognised that the act of violence also damaged the latter. Further, perpetrators who felt remorse for their actions and took active measures to restore damages were less likely to engage in violent behaviour in future. Thus, such an approach had a more substantial preventive effect than just punitive measures.

For instance, the aggression of the perpetrator, who was stalking the PCVC shelter, was aggravated by the punitive measures undertaken by the police. He was jailed for a month because his wife filed a legal complaint against him. He associated with various criminals during this incarceration who now supported him. One of the PCVC staff said there had been a slim chance of avoiding this escalation if they had counselled him in the early stages of contact. He was a victim of profound childhood abuse himself and was under considerable psychological distress. PCVC staff did attempt to counsel him after his incarceration, even to the point of speaking to him for hours at night. However, this only provided temporary alleviation and deterrence.

Besides addressing the concerns of victims and offenders, restorative justice principles also address the issues families and communities face. Violence did not just rupture relations between the victims and perpetrators but also the mutual relations in the context in which such acts were embedded. Zehr and Mika point out that restorative justice systems view the interconnectedness of the community through a web of relations. This web of connections affected violent acts and was influenced by them. Thus, communities/societies were also obligated to address the well-being of the offenders and others indirectly affected by the crime.

One key difference in community-based restorative justice systems compared to modern ones was the emphasis on restoring the mutuality of relations between victims and perpetrators. For the most part, modern legal systems did not address the connections between victims and perpetrators, and their actions often led to irreconcilable separation. Restorative justice systems emphasise mutuality and reconciliation.

However, this authentic reconciliation does not condone the violent act/behaviour and defines damages based on the victim's needs and perceptions. Further, it requires the perpetrators to admit their transgression, express remorse and take concrete actions to make amends. Perpetrators must display real and consistent changes in behaviour over time. Further, families/communities/justice systems also had to take responsibility for perpetuating/allowing the violence to occur and take action to prevent such incidents. Without these elements, reconciliation only provides a reprieve to the women, while at deeper levels, violent cycles persist and gain momentum, increasing the risks to women's safety, as discussed elsewhere.

PCVC did not emphasise reconciliation (as with community restorative justice) over separation (as with modern justice systems). Survivors choose to reconcile/separate based on various factors, including economic dependence, psychological co-dependence, self-worth, concurrent responsibilities such as child care, etc.

Section VII. Project Performance

This section examines the five elements of project performance: efficacy (did the planned output and activity have the intended result?), efficiency (did the project use resources optimally?), relevance (did the work reach the right people?), impact (did the work creating lasting change?), and sustainability (can the work be continued in future?).

Efficacy and Impact centre around Outcomes in the Results Framework and are closely linked. The section on Efficacy examines the activities and outputs undertaken to achieve a particular change that is tangible. The section on Impact examines the sustainability of the outcome.

1. Project Efficacy

PCVC has contributed to the availability of physical and psycho-social services to (i) women burn victims and (ii) women and queer survivors of domestic violence. The project performance against the output indicators mentioned in the Results Framework is satisfactory. In many activities, the organisation showed exemplary performance. These activities have contributed effectively to reaching the outcome of the project.

PCVC's principles of dignity, "here and now" responsiveness and restorative justice pay commendable attention to fulfilling unique survivor needs. In doing so, it engages with grave issues related to life and death without causing harm. Notably, most clients report an increase in overall well-being.

PCVC's map of service functions is comprehensive and responsive to survivors' needs. While physical needs are easier to arrive at, psycho-social support is more challenging to define and categorise. PCVC's different but interrelated services are remarkably integrated and holistic: trauma-informed care, client-centred services, empowerment/ strength-based capacity building, and resource support.

The interventions designed under the programme are appropriate in choice and quantity and enough to reach its objectives. Variations between planned and implemented inputs were recorded only because of the worldwide COVID pandemic. The Revised Results Framework accurately represents the output and activities of the project. This results framework is coherent regarding principles, strategy, action and outcome. It is structured to handle the challenges of complex systems.

The effectiveness of most of the outputs was high, particularly those related to direct services for women. This was because of its real-time responsiveness, particularly relevant in the high-risk issues with which it works. This approach has ensured that women's urgent and essential needs are addressed promptly and appropriately. Besides effective services, newly evolving outcomes such as catalysing multi-stakeholder networks are beginning to show results.

PCVC has accurately analysed assumptions, risks and conditions in developing its outputs. Trauma-informed care is, by definition, high-risk, and PCVC has ongoing real-time risk assessments to ensure that its activities meet the needs of the women. There were no differences in the targeted and planned outputs that were not contingent on COVID. There were no outstanding unintended results on clients. PCVC's "last mile" approach ensures that the organisation regularly monitors their contexts and progress and addresses the various obstacles to recovery in the short and long term.

The project has two broad outcomes: An increase in services to survivors (burn and DV victims); and an increase in multistakeholder service provision.

1.1. Increase in Services to Survivors

Increase in services to DV and burn survivors include the following services/outputs: Physical services, including shelter and physiotherapy; trauma-informed support services; psycho-social responses by support systems and stakeholders; information dissemination; and capacity building.

1.1.1. Burn Survivors

PCVC's contribution to the availability of services to Burn Care victims is unique. The severity of pain in burns causes great pain and suffering to not just the women but also their caretakers. Burns result in a series of life-threatening shocks to victims' physical and psychological systems, resulting in death in many patients. Providing care includes both urgent and critical services to the clients. PCVC has well-developed methods and approaches to burn care enabling women's recovery. It demonstrates an extraordinary commitment to attending to individual survivor needs to the best extent possible.

The Vidiyal Team has three kinds of psycho-social care: psychological, psycho-social, and physical (including nursing support and provision of food and groceries). This three-pronged approach addresses the various aspects of burn care holistically and comprehensively. Notably, these services were tailored to the unique needs of individual clients.

Burn Survivors in Vidiyal	Year 1	Year 2	Year 3	Total
Vidiyal (hospital intakes of Survivors)	230	205	279	714
Vidiyal Follow up calls (Survivors)	1264	3546	11145	15955
Vidiyal Caregivers	230	205	279	714
RHC members	114	144	194	452

1.1.1.1. Physical Recovery

There has been an increase in the physical recovery of burn survivors. PCVC services include nutrition, essential medical supplies and regular physiotherapy. A key aspect of the services includes supporting the clients in taking care of themselves, including eating well, exercising, etc.

Burn care victims availed of the long-term support of physiotherapy provided by the RHC for recovery from reconstructive surgery and contracture of the body caused by burns. PCVC promoted many measures to recover ability, including yoga and intensive physiotherapy sessions.

Physical inputs also required meeting the shelter needs of burn victims for various purposes: violent/apathetic caretakers, recovery from intensive surgery, etc. Staying in the shelter was particularly critical for women who did not have significant caretakers and required prolonged physiotherapy (sometimes for over eight hours a day) to ensure recovery.

1.1.1.2. Psycho-Social Needs

Burn victims are regularly contacted by PCVC members to check on their well-being on being discharged and are encouraged to use counselling/shelter/RHC/referral services

as needed. This care adopts the "last mile" approach that tracks survivors from the time of contact to when they return to everyday life. PCVC has shown outstanding perseverance in supporting burn victims through their physical, psychological, and social challenges.

1.1.1.3. Caretaker Relations

There is an increase in the support provided by caretakers. PCVC regularly interact with families and caretakers of burn victims to share information, educate them, and monitor their aid in survivors' recovery. Caretakers feel empowered to perform their duties with greater understanding and support through this regular contact. Thus, survivors receive the help they need. While engaging with clients embedded in violent relations, PCVC support survivors to autonomously decide their relations with perpetrators (overt violence and tacit support) as part of their recovery path (reconciliation, separation, etc.).

1.1.2. Domestic Violence

PCVC addresses the needs of a wide variety of survivors of domestic violence. It addresses violence in natal and marital families, intimate relations, inter-generational conflict, and discrimination based on sexual identity and orientation. Many survivors face violence in their intimate partnerships/marriages, including abetment to suicide by immolation and homicide in the case of burn victims.

In the last few years, there has been a substantial increase in queer clients, who are a high risk category facing severe violence within families and pervasive social discrimination. Another new category of clients includes older women facing intergenerational conflict or in long-term abusive marriages.

Women and Queer Survivors of Domestic Violence in Vidiyal, Dhwani and Shelter	Year 1	Year 2	Year 3	Total
Astitva (Shelter needs)	80	89	143	312
Dhwani				
Dhwani First Time calls	646	1085	713	2444
Psycho Social Support Follow-up calls	1524	13373	18744	33641
Referrals to other services of PCVC (shelter, legal, mental health, OSC, employment, NGO/ CSO and Special Cell)	205	508	499	1007

1.1.2.1 Psycho-Social Services

PCVC has increased the availability of psychosocial services to DV survivors of various kinds through Dhwani, its First Responder Call Line, and Astitva, its Emergency Shelter. While Dhwani reaches out to women, including those in acute and violent crises, Astitva protects such women. Both these functions are supported by common long-term psychosocial services that address a range of services, including therapy, legal and medical support, child care etc.

Remarkably, these services are authentically client-centred and holistic, supporting women to exert their agency in all domains of life, including fulfilling physical and psychological needs to survive and grow. PCVC has to be commended for its consistency in providing services. This is evidenced by their continuation during the pandemic, altering their forms to suit women's changing needs arising from their current conditions and constraints.

1.1.2.2. Information Needs of Survivors, Families and Caregivers

There is increased information amongst women and their caregivers about burn care, VAW and rights. Team members closely interact with women, caregivers and families to share information. PCVC has well-developed communication material that covers critical information about burn care recovery, the nature of DV, etc.

1.1.2.3. Client Capacity Building

There is an increase in survivors' abilities in burn care to counter violence and exercise their rights. Clients reported adopting good physical and psychosocial care practices because of their engagement with PCVC and its training/capacity-building sessions. In the case of burn victims, there is a substantive reduction of physical disability hindering routine movements.

PCVC supports women to progressively build their capacities to exercise their agency and make informed decisions: goal setting, individual counselling, art therapy, group work for growth, support in asserting themselves with their families, travelling to meet other actors (courts, government, etc.), travelling together, skill training for employability, etc.

1.1.2.4. Caretakers and service provider support

There is an increase in the support provided to burn survivors by hospitals with which PCVC interacts. PCVC staff deployed in the hospitals engage with various hospital staff to provide information and education about multiple aspects of burn care for patients and their caregivers. Hospital staff asserted that PCVC's work with them has enabled patient recovery significantly.

There is an increase in the well-being reported by DV survivors (including many burn victims) arising from resolving their relations with their families (however painful this was in some instances). PCVC has detailed risk assessment processes to ensure that survivors are informed and as safe as possible. PCVC's intuitive restorative justice principles that extended respect to perpetrators without condoning their actions have resulted in tangible changes in their behaviour. In most instances, this attitude of mutual respect has facilitated clients to see their reality and determine the kind of relations with their families.

1.2. Increase in Multi-Sectoral Services

Outcome 2 focussed on enabling an increase in services provided by multiple stakeholders. Several actors provide services to women survivors. Of particular note are the services provided by government hospitals, Welfare departments and OSC centres, CSOs, police, and legal services. Key outputs included increased participation, behavioural change, increased alignment and synergistic partnerships.

Multi-Stakeholder Outreach	Year 1	Year 2	Year 3	Total
Health Care Professionals				

First level Meetings with Health Professionals	76	13	4	93
Health Professionals Trained	0	0	73	
Government Officials (OSC, District Officials, CWC, police, etc)				
Number of Government Officials Contacted	33	9	230	272
Number of government officials trained	0	0	236	236
CSOs				
Number of CSOs contacted in Tamil Nadu	338	146	52	536
Number of CSOs collaborated in Tamil Nadu	47	107	64	218
Number of CSOs identified/collaborated in 6 States (Kerala, Karnataka, Tamil Nadu, Maharashtra, Andhra Pradesh, and Telangana)				74
Number of CSO members provided with capacity building	28	102	85	215
Change Makers				
Awareness Sessions	575	5147	8078	13800
Number of Change Makers enrolled (out of the targeted 450)	203	709	1346	2258

1.2.1. Increase in Multi-stakeholder Participation

There has been some increase in multi-sectoral support services because of PCVCs' persistent trust-building over the long term with specific and key service providers, including hospitals, OSCs, and Nodal CSOs.

PCVC has established partnerships with One Stop Centres (government OSCs) and CSOs across Tamil Nadu. These service providers are selected through interactions over time. PCVC is consolidating its extensive referral network within Tamil Nadu and across the country to respond to the increase of its clients availing of its hotline services.

This network is live and responsive for several reasons: (i) a fundamental commitment to survivor well-being; (ii) regular engagement with individuals and organisations through information dissemination, education and training; and (iii) due diligence processes that focus on the quality and kind of specific services provided by network members. Many partners reported beneficial consequences in the quality of their service provider because of their partnership with PCVC.

Further, this network is decentralised, providing services to survivors close to their homes. This emerging synergistic network has the potential to be authentically polycentric, where scale in support of women is not achieved through mechanised mental models but through sincere individuals and organisations working together for a violence-free society to provide specific services to survivors.

1.2.2. Increase in Multi-stakeholder Knowledge

There is increased knowledge among stakeholders on the effects of burns and domestic violence on survivors. PCVC has well-evolved outreach activities to increase the understanding of stakeholders. It also has well-evolved maps of stakeholders involved with particular categories of clients and specific services. Information dissemination is simple, even while it covers complex issues such as gender binaries, body and sexuality, etc. This simplicity reflects the organisational learning arising from a detailed focus on client well-being. PCVC is also developing information and education material on sensitive and pioneering areas such as intimate partner violence in queer relations and online digital privacy.

1.2.3. Increase in Multi-stakeholder Capacity

There is some increase in the capacities of stakeholders, particularly medical personnel and government officials working with DV. PCVC's capacity building has two interrelated components: (i) ongoing "learning by doing" approach wherein stakeholders collaborate in providing services to survivors and learn in the process; (ii) and training sessions that focus on specific issues such as post-traumatic services for survivors for medical staff. PCVC has maintained ongoing contact with key CSOs professionals and government officials through this inter-related engagement.

The Changemaker initiative is a critical step that evolved out of the needs of COVID. It enrols individuals (students, professionals, community members, etc.) as changemakers committed to a violence-free society. They advocate for gender equality in their contexts, amongst their families, peers, organisations and communities.

PCVC is to be commended for its capacity-building strategy that recognises individual potential in bringing about transformative structural change and shifting complex systems that perpetuate violence.

2. Efficiency in Management

PCVC has well-worked out management functions providing efficient and interrelated service to survivors. The following key functions are deployed: (i) programmatic functions related to Vidiyal (Burn Survivors), Dhwani (hotline), Astiva (shelter) (Domestic Violence), Psychosocial Team and Outreach Team. Other management functions include HR, MIS, and Finance and Operations.

2.1. Human Resources

PCVC adopts a two-tier recruitment policy, recruiting members as consultants, who become organisational staff, usually after a year. Recruitment is through word of mouth and association with the organisation in various capacities over time. The organisation has increased its team strength from around 19 to 46 in the last three years.

PCVC has recruited staff members from diverse backgrounds, including social work, psychology, social sciences, etc. It pays particular attention to the capacities of individual staff and encourages them to fill positions suited to their abilities.

PCVC maintains long-term relations with its staff, with some members returning to the organisation to take on critical roles after pursuing other interests, such as higher education. In other instances, clients associated with the organisation are encouraged to become its staff over time. Such staff have invaluable experiential wisdom that catalysis survivors in their path to recovery.

PCVC's HR policy that pays particular attention (provision of PPF and medical insurance) to its lowest-paid employees is commendable. Resources of the organisation are

dedicated to the less resourced employees. For instance, the senior management does not purchase their computers from project funding.

2.2. Management of Information Systems (MIS)

PCVC's MIS systems are commendable for their elegant simplicity. The chosen indicators for project monitoring are appropriate and collected in real-time with high accuracy. The information collected by the MIS is treated with responsibility, with several checks and balances that ensure that the information about survivors, partners and stakeholders is not mishandled/misused.

The current MIS collects and organises various documentation, including detailed information about individual clients and the activities that PCVC undertakes with them. It is designed to provide real-time information about the specific services offered to individual women to increase PCVC's effectiveness. The current MIS has been developed iteratively based on the emergent nature of the PCVC's practice.

The MIS tracks primary burns and domestic violence beneficiaries, including survivors and caregivers. It organises this information based on unique codes linked to individual clients who avail of various physical and psychosocial services: nutrition, physiotherapy, counselling, legal advice, shelter needs, etc.

The MIS system is being integrated on two fronts: with the cloud-based platform used by the hotline and the app-based user interface of staff members. Currently, staff post WhatsApp updates that are transferred in real-time to the MIS database.

2.3. Finance and Operations

The resources allocated to the project were used strategically to achieve particular outcomes. PCVC's financial systems are sound and innovative, based on real-time budgeting and disbursal. It has adopted financial mechanisms that record cash disbursals immediately through online transactions and debit cards that senior staff members operate. This method of cash disbursal has several advantages: ready resources in high-risk situations, avoidance of the use of personal accounts of staff members for advances, and reduction in delay in receiving reimbursements of expenses incurred.

Financial accountability within teams and across the organisation is clearly outlined. Thus, in consultation with their team, team leaders identify the required resources and are accountable for their use with integrity. Depending on the kind of expense incurred (routine, fixed vendors) and the volume of the cost, diverse financial protocols for sanction are established.

3. Relevance of Work

PCVC has consistently supported women despite their age, educational identity, class, rural/urban contexts, etc. Survivors, partners and stakeholders recognise the relevance of its service.

PCVC has an ongoing and living analysis of socio-cultural and institutional factors seen through the lens of survivors. This analysis informs the strategic choices of the PCVC. Emphasis on emergence in responsive strategy is a crucial reason for the relevance of PCVC's work. Clients availing PCVC's services reported not only recovery from violence but also an increase in inner power and agency and increased psychological health in general.,

The “here and now” approach of PCVC ensures that it is responsive to the specific needs of its clients. Clients continuously engage with staff to give feedback about the kind and quality of services provided, even the simplest aspects, such as the choice of snacks.

Further, PCVC engages with survivors, partners and stakeholders regularly, who provide feedback about its services and their relevance in specific contexts. For instance, during her interview, one of the OSC officials gave inputs to the accompanying PCVC staff about limitations in OSC services. While referring their clients to the government department, she wanted to ensure that PCVC does not create unrealistic expectations. PCVC clients expected the same support quality, including therapy and marital counselling, from other stakeholders. As a regulatory body, the OSC could only intervene in cases of women who wanted to undertake formal action. They could not undertake marital counselling.

Domestic violence as a category affects all classes of women, and reaching out to the most vulnerable (poor and uneducated) remained a challenge. Thus, PCVC staff said that the survivors who accessed their emergency shelter were often from the middle/lower middle class. Since it was an emergency shelter, there were very few well-off women. The shelter itself was equipped to address the needs of very poor women. However, such women very rarely reached out to PCVC. It was now working with partner organisations that organised local women living within communities so that information about their services reached the most vulnerable survivors.

PCVC uses several methods to identify clients who need their services the most: direct work in government hospitals, referrals, hotline, and communication and media strategy. It has consistently supported its poorer and more vulnerable clients through concrete resource support, particularly evident in its work on burn and queer (a silent category of victims) survivors. Clients in government hospitals are often poor and educated, embedded in violent or indifferent contexts. Staff members said they paid particular attention to clients’ needs from impoverished families by providing long-term nutritional support, pressure garments, physiotherapy, etc.

Clients availing of Dhwani and Shelter services would likely be more educated/ resourceful (moderately poor). Impoverished survivors often do not have the resources to reach even the actively inclusive, friendly services of PCVC. This economic inequality is more evident in the case of government services. Thus, one of the OSC members reported that very few poor/illiterate women availed of their services. The documentation and legal processes involved required resources that are out of reach of such women. Most women who did reach out for their services were educated and sought mediation in domestic conflict rather than undertaking legal action against violence.

In response, PCVC, through its multi-stakeholder strategy, has attempted to reach services to women in their contexts. Thus, it has mobilised and engaged with local partners/stakeholders to provide emergency and long-term support to women in remote locations/high-risk situations who reach out to it. PCVC’s understanding of the strengths and gaps in partners/stakeholders is practice-based and sound, leading to aligned action. This enrolment of partners over time and across locations arising from the common purpose of fulfilling client needs is particularly appropriate in ensuring the relevance of PCVC’s approach and services.

4. Impact

Examining the project performance, its impact may be seen at three levels: individual clients who report tangible improvement in their well-being in the long-term, such as the recovery of physical ability after burns through physiotherapy; micro-systems such as hospitals that incorporate better burn care practices in their daily work; and systemic impact on structural issues such recognition of the needs of burn and DV survivors that fundamentally shifts worldviews on gender equality and creates sustainable change.

Impact as a concept is often confused with various results aspects, such as activities, outputs and outcomes. It is integrally related to sustainability in terms of long-term shifts in complex systems that create the condition of domestic violence. Impacting complex and pervasive systems such as patriarchy requires many individuals and diverse organisations to work synergistically on different aspects for decades. Further, while outcomes (shifts in micro-systems that still need to be sustainable on their own) start becoming evident in three years, long-term impact minimally requires at least ten years.

PCVC is poised to make a real impact towards a violence-free society. To begin with, there are very few organisations that work with women burn victims directly and systematically. Given that women burn survivors face severe obstacles in their survival and recovery, PCVCs work is critical in making visible a key group of survivors that have been almost entirely invisible till now. This is a significant shift that directly impacts burn survivors as a category.

Broadly its two outcomes of client services and multi-stakeholder engagement are strategically sound in generating long-term impact. PCVC is making a noticeable difference in the lives of its clients, their families, and their societies. In addition, it has also enrolled key partners and stakeholders, who are essential to shift complex systems sustainably.

PCVC's operational strategy is intuitively oriented towards shifting complex systems and integrates individual potential, systems thinking and tangible results. This strategy begins with individual wisdom and power, mutual respect, and investment in the growth of self and others. This is evident in the engagements with survivors and those with its staff, partners and stakeholders. In doing so, it has intuitively avoided the fundamental error of beginning with mental models (such as particular aspects of feminism, therapy, etc.) that most scaling approaches adopt.

While writing on complex systems, Meadows identifies expansive worldviews and principled individuals as key to creating systemic impact. Power, rules and information are all critical factors. However, they were secondary to the people who constitute these systems and their worldviews. Sharma, building on Meadows's views on leverage points in complex systems, identifies the following elements needed to create sustainable and just impact: (i) enrolment, capacity building and championship of principled individuals embedded in various systems and structures; (ii) mutual information sharing to enable informed decision-making; (iii) robust partnerships that are aligned/synergistic; (iv) public communication and media strategies that aim at shifting social perceptions such as the normalisation of violence; and (v) government advocacy to ensure inalienable rights.

Viewed along these parameters, PCVC's emerging scaling strategy is robust and effective. It is already adopting the approach of investing with individuals, who are committed to the welfare/rights of survivors first and foremost, embedded in various complex systems to create change. This is evident in the deployment of its staff within the KMC. The long-term presence of individual PCVC staff in the hospital is a crucial aspect of trust and credibility in the partnership. Medical staff reported on the integrity, care and professionalism of PCVC staff as exemplary. PCVC has scaled this deployment in other districts by enrolling and building nodal CSOs as partners. While the CSOs identify the personnel deployed in hospitals, PCVC staff train these CSO team members.

PCVC's enrolment of partners and stakeholders is sound and based on fundamental principles of transparency. Thus, PCVC consistently informs partners and stakeholders about the specific services it provides, their possibilities and limitations. This partner/ stakeholder engagement approach creates the potential for synergistic action to shift complex systems. It evokes partners/stakeholders to reflect on their services and the various commonalities and alignments with PCVC and each other.

PCVC has adopted a robust communication and media strategy carried out by its outreach team to share information. The foundations of this information and education content lie in the detailed and nuanced understanding of patriarchy and gender equality. Further, this communication material addresses emerging needs such as online digital security.

PCVC has well-developed information-dissemination mechanisms reaching out to its clients, key partners and stakeholders, including health professionals, government officials, and CSOs. Thus, PCVC's outreach team regularly conducts awareness sessions that reach out to large groups disseminating information about gender inequality and violence. PCVC also actively uses multiple social media platforms and public media (including innovative methods such as community radio) to communicate to civil society about gender-based violence.

This robust information dissemination is a key reason for the increase in survivors contacting PCVC. For instance, PCVC staff said that when they conducted awareness sessions for students, community members, etc., the results of such sessions took time to be evident. Individual survivors who had participated in these sessions approached them a few days later to avail of PCVC services and/or associate with it as change makers.

PCVC has undertaken robust advocacy with the government for policy change. It has close working relationships with state government agencies, particularly the welfare department and the police, to serve burn victims. This working relationship is based on a nitty-gritty understanding of these systems. Thus, PCVC's capacity building modules with government officials are well-received. It also has credible ties with senior professionals in various sectors who champion risk-takers when necessary and advocate for a violence free society.

5. Sustainability

Overall, PCVC has shown commendable resilience in delivering its services through support through the means available. This resilience is a testament to the integrity between foundational organisational principles, sound project strategy, planned activities and expected outcomes. It is also a testament to the organisation's commitment to serving survivors.

Client dependency is one of the core challenges in sustainability. PCVC's understanding of dependency creation is well-evolved. Thus, survivors, partners and stakeholders are informed about what they may expect from the organisation right from the beginning. Services are geared towards increasing their power and autonomy, including economic independence.

PCVC has pursued donor diversity as part of its funding strategy. Thus, core services and staff are secured through several kinds of funds. Further, PCVC has a prudent resource policy based on accurate estimates of what is available and what it can provide in real-time. It is now attempting to secure funds to continue its activities, particularly related to multi-stakeholder relations.

PCVC is already addressing the "next step" of scaling that can impact the lives of survivors tangibly based on sound principles of decentralised action and local responsiveness. It engages actively with the complexity of various contexts and systems that ensure sustainable change in behaviour practice.

PCVC's scaling effort is atypical and commendable from the view of sustainability. It invests in individuals and institutions to discover their perspectives and shift them towards realising a violence-free society. Thus, various stakeholders internalise knowledge and practice in the "here and now" that increases their agency for sustainable

action in their contexts. This scale modelling is inherently transferable to different geographical areas and complex systems.

PCVC has delineated the various functions in scaling services for burn and domestic violence victims. Rather than attempting to increase its services by concurrently expanding organisational membership and activities, PCVC multi-stakeholder engagement creates sustainable possibilities wherein multiple service providers generate resources for their work.

Individual staff are already empowered to make decisions related to their roles and use their creativity to achieve effective results. Internally, sustaining psychological resources to provide continuous high-risk services by PCVC may pose severe challenges in the long term. The demands on time and resources of programme staff as providers of trauma-informed care are very high. They encounter high-risk situations (such as threats and abuse by perpetrators), acute suffering, and loss that require alertness over sustained periods. In the face of this, the staff's consistent commitment to survivors' well-being is laudable.

However, sustaining this commitment has its challenges. For instance, one of the staff members said that her father had noticed a marked change in her behaviour. She had become more withdrawn over time. According to her, after listening to clients the whole day, she had little energy to call her parents and speak with them. She was also less outgoing than she used to be in social gatherings. Most people did not understand the gravity of the issues that she was dealing with.

Most staff members said they coped with the psychological consequences of their work individually. In some instances, this was through solid family support. In other cases, staff shared their feelings with friends and pursued recreational activities with them. One of the staff members actively engaged in self-work through therapy. This self work is foundational to developing long-term resilience.

PCVC is aware of the risks to psychological well-being in undertaking such work, such as burnout, social isolation from family and peers, etc. Thus, staff members reported that the organisation pays attention to their needs for rest, recreation and recovery where necessary, including the provision of holidays and flexibility in time. For instance, one of the staff members said that she had lost her father during the second wave of COVID. PCVC supported her for three months by reducing her workload and providing her access to therapy.

PCVC also has various activities that promote individual staff members' growth, including access to therapy (confidentiality), deputation to multiple programmes that increase professional competence, and capacity-building workshops. For instance, one staff member claimed she selected and attended courses that she felt would help her grow with PCVC’s support.

Institutionally, PCVC has adopted the “learning by doing” approach to learning and development. This is particularly suited for its “here and now” principle. A critical aspect of this approach is the creation of safe spaces for individuals to unlearn old views and behaviour and learn new ones through experience. For instance, some staff discussed the safety they felt in exploring issues related to sexuality, particularly in the context of queer clients. They encountered such clients for the first time and had to unlearn some of their old attitudes towards sexual orientation and choice. This approach has created strong foundations in deep experiential wisdom allowing rich growth.

However, to some extent, the external focus on efficacy and impact - the foregrounding of survivor well-being has obfuscated the inward gaze of inner growth and resilience.

For instance, the organisation has concrete, discrete functions with clearly defined roles that directly or indirectly serve women. This precise articulation is critical to providing safe, effective, timely services. Simultaneously, team members have started to relate

regularly with each other within and across teams only within the confines of their service role requirements. This constriction had been aggravated by COVID, where regular in-person meetings/training/workshops were challenging to organise.

This strict confinement to roles and activities may inhibit peer and cross-functional learning needed for institutional resilience. Thus, at the end of the four-hour in-depth and in-person FGDs, team members said this was a new experience where the focus of discussion was not just the survivors but also themselves and their relations as a team. They learnt a lot from each other. Again, different team members ranged in their knowledge about key aspects of survivor recovery, such as risk assessments for suicides and the somatisation of PTSD.

PCVC staff did say they participated in regular recreational activities (team dinners, picnics, etc.) as part of team building. Recreation and self-work are very different in their purpose and nature. Entertainment does provide much-needed rest and play. In this sense, it is easy and pleasant, but its effects will likely be transient. Dedicated learning and development require persistent effort (including discovering the self and mutuality of growth, developing competencies and skills, etc.).

PCVC did conduct a staff capacity building session in the past year with its staff that explored various lived experiences of gender amongst the staff. Investing in a dedicated learning and development function based on strength-based capacity building that supports institutional, team, and partner growth is critical to resilience. This learning and development function is closely related to knowledge generation (and research). While the learning and development function focuses on pedagogy, knowledge generation focuses on content. PCVC is already aware of this gap. Thus, right at the outset of the evaluation, a senior team member said this was a critical focus of the coming planning period.

A critical aspect of this learning development function is the periodic internal/peer reviews and reflections about their individual growth, work, and challenges. PCVC has a live real-time feedback loop to fulfil client needs across teams and reporting structures. Extending this feedback loop to look at staff progress would create a source of rich experiential knowledge. A robust learning and development programme that emphasises peer learning and cross-functional work has the potential to energise individual team members and teams, various projects, and the institution as a whole.

Section VIII. Knowledge Generation

PCVC has primarily focussed on providing services to survivors and catalysing key partners/stakeholders to extend their services. This focus on experiential wisdom from direct and detailed interactions with survivors has resulted in unique approaches and services. In this sense, PCVC has not imposed external frameworks on its growth or work. PCVC's grounding in the principles of dignity, "here and now" responsiveness and restorative justice have resulted in painstaking cutting-edge work.

PCVC's current practice models have significant potential to create a sustainable impact towards a violence free society. They meet high standards of excellence worthy of replication in several ways. For instance, PCVC has an extensive database tracking thousands of survivors in great detail. Just a simple content analysis of this data would provide valuable knowledge inputs in the domain of service provision to burn and DV survivors.

Despite this, its knowledge generation remains somewhat confined to information dissemination and the creation of educational materials around broad issues such as gender, albeit of excellent standards. PCVC has recognised this gap and has taken steps to create a clear research function.

As with the learning and development function, the focus on tangible results for clients has obfuscated the significant knowledge contributions that PCVC can make to its peers and partners. Much of this knowledge is yet to be synthesised and articulated, even internally. Iterative synthesis and articulation may be undertaken based on the existing expertise and emergent needs, beginning with strengthening internal capacities and extending to partners and stakeholders.

PCVC's detailed practice to meet survivor needs has valuable insights and reflections that form the basis of excellent standards for the sector. PCVC has documented a few Standard Operating Protocols, such as risk assessment. It may be helpful to develop similar SoPs (internal to begin with), such as those related to shelter services, hotline services, etc. Besides articulating good practices, these protocols may provide the basis for checklists to assess the quality of services offered to survivors by external actors.

Besides providing data for valuable research on gender and violence, periodic reviews of MIS data (that tracks critical impact and operational indicators) may provide valuable insights into measuring the results of services to survivors in general. This potential is particularly true, given the rich primary data the MIS collects.

Again, individual staff have extensive experiential knowledge arising from years of dedicated practice that is virtually untapped. For instance, the PCVC staff, while reviewing a booklet produced by a senior nurse who was doing her doctorate on burn patients, gave key inputs. These inputs were based on working with hundreds of such victims over two decades. These considerable intellectual resources of staff members have yet to be tapped. Developing enquiry and research capacities through micro-researches would help staff grow intellectually and allow staff to devote time to specific interest areas in their work.

PCVC has developed key competencies in addressing burn survivors based on sound and innovative principles. Currently, there is a significant gap in such competencies in the sector as a whole. For instance, PCVC has a highly specialised understanding of burn care survivors' physiotherapy and nursing needs. Carving out professional courses that augment the skills of various service providers is a critical contribution that PCVC may make.

Thus, one of the suggestions to the physiotherapist who wanted feedback on her professional growth was to start a course on "physio-therapy for burn care". Students of this course would include students of physiotherapy and practitioners who wanted to

augment their skills. Not only would she contribute to the capacities of others, but she would also discover new aspects of her discipline that she had not considered before.

Section IX: Recommendations

The vision of a violence-free society that PCVC's work evokes, where dignity is embodied universally, is inspiring. This work has several notable aspects: commitment to the dignity of survivors first and foremost, its unique "here and now" approach, its restorative justice principles, the culture of learning and unlearning that sources experiential wisdom, strong organisational features including functional and role clarity, robust participatory mechanisms, and a strong and intuitive strategic outlook based on investing in individuals and institutions and mutual partnerships based on shared principles.

PCVC's work represents cutting-edge work in gendered violence, moving beyond rhetoric to real change. It tempers rights-based idealism with the lived experiences of women and queer survivors. It addresses hard questions: agency in reconciliation/separation in violent relations; the dignity of the perpetrator; and the use of prescriptive authority in service provision, particularly in high-risk situations. As such, this work must continue and grow.

1. Recommendations for Efficacy

Broadly, the project's outputs focussed on increasing services to survivors directly and through supporting partners and stakeholders.

1.1. Outcome 1: Client services

PCVC's work provides effective physical and psychosocial services to burn and DV survivors, which are exemplary and must continue.

PCVC may consider deepening its capacities in three psychological phenomena that are found along with burn and domestic violence survival: (i) Post-Traumatic Stress Disorder, including symptoms such as anxiety and panic attacks, somatisation of violence, loss of memory and flashbacks; (ii) self-harm including suicidal ideation, self-mutilation, addiction, and lack of physical and psychological self-care; and (iii) conflict resolution capacities including the discovery of the creative potential of conflicts and the criticality of addressing dissent without suppressing it or scapegoating individuals.

PCVC already works extensively with caregivers to ensure women survivors' safety, recovery and growth. In addition, examination of the long-term impact of nurturance/ caregiving at various levels may be considered: families, peers, professionals, etc. This may be particularly relevant given that caregiving and nurturance are seen as women's work.

PCVC intuitively engages with families using restorative justice principles. However, this pioneering approach may be clearly articulated so that it becomes part of regular practice.

1.2. Outcome 2: Multi Stakeholder Engagement

PCVC's success in communicating complex issues simply in its information dissemination and education activities is laudable. This is because of the continuous engagement of creativity, putting women first and must continue.

While effective, the focus on information dissemination and education risks being one-sided and prescriptive. To avoid this, PCVC may strengthen the mutuality of

communications by regularly receiving inputs from their partners on shared purpose, principles and activities.

PCVC's capacity building to key stakeholders, including medical staff, government officials, and CSOs, is critical and must continue. Its partnership/stakeholder model is intuitively designed to work in complex systems. It recognises the simultaneity of individual change and structural transformation and must continue.

PCVC's approach of catalysing decentralised service provision proximal to women through partners and stakeholders must continue. So too, must its efforts to establish synergistic partnerships with various service providers, keeping the women at the centre.

PCVC's capacity building of partners/stakeholders may be oriented towards strength-based approaches. Such capacity-building sources individuals' inner wisdom and power and establishes equality and mutuality. It has the potential to deepen mutual growth and open new and creative ways of working together beyond information dissemination and education. In doing so, PCVC may avoid being categorised as a resource provider alone. The potential of innovative and impactful action in these partnerships is high, given that current individuals/partners are selected based on their integrity, commitment to women's well-being and effectiveness.

2. Recommendations for Efficiency

PCVC's current management systems are well-developed and robust.

While teamwork in results-based activities is remarkably high, PCVC may focus on generative forms of engagement that promote mutual learning and development within and across teams without compromising survivor confidentiality. This may be particularly important given the increased staff in the last few years and the isolation engendered by the pandemic.

PCVC's attention to the less privileged members of its staff in its HR policies is laudable and must continue. PCVC may consider supporting single women/queer individuals amongst its staff since such members will likely face higher pressures. They are not socially secured by the institution of marriage and often bear significant caregiving burdens for the elderly and children.

The iterative process of MIS design and implementation is to be commended for its simplicity in that it captures essential information to serve survivors while minimising the demands on the programme staff. This is unusual and must continue.

PCVC may consider adding to the current MIS systems (i) to track HR, including staff growth and performance review; (ii) stakeholders/partners, including those contacted and trained (iii) Change makers.

Besides research, PCVC may also consider using the rich MIS data for periodic reviews that result in feedback looks that inform (i) strategy and (ii) learning and development.

3. Recommendations for relevance

PCVC's relevance is very high for burn and domestic violence survivors and must continue.

PCVC has systematically attempted to reach out to the most vulnerable among survivors and is exploring community based interventions in partnership with CSOs. This is based on its understanding that communities are usually the first responders in rural and remote contexts. Exploring this aspect of work along the lines of prevention and service provision may result in new approaches while engaging with survivors.

To some extent, PCVC sees its relevance only with respect to clients and needs to see its significance to partners/stakeholders/sectors fully. While the underlying modesty is laudable, it does not recognise PCVC's potential to lead multi stakeholder action: (i) setting standards of excellence in service provision that reach out to the most vulnerable/at-risk survivors, (ii) bringing together diverse stakeholders because of its credibility to engage in generative and complex dialogues, etc. PCVC may consider taking slow and steady steps in this direction proactively.

4. Recommendations for Impact

PCVC's services have a clear impact on survivor well-being and must continue.

Currently, PCVC's strategy centring survivors is intuitive and remarkably integral. It includes capacity building, information sharing, communication and media, advocacy and partnerships. These outputs have the potential to leverage complex systems. PCVC may consider articulating each of these elements more clearly.

PCVC's intuitive investment in individuals - clients, staff, partners/stakeholders, and change makers - to shift complex systems that perpetuate violence must continue.

PCVC's information dissemination, education and communication strategy about burn care, gender and violence is sound and must continue. It may consider including communication material to peers (journal articles, standards of practice, etc.)

PCVC's enrolment of partners and stakeholders, as a poly-centric network, has real potential to create an impact. For this, PCVC must embrace its leadership potential in creating relations of mutuality.

PCVC has established close relations with government officials at various levels and regions and actively engages in ongoing advocacy. This must continue.

PCVC may review and articulate its scaling strategy from the view of mutuality in partnerships that support sustainability. For instance, generative dialogues between committed individuals from various sectors based on equality and mutuality can catalyse creative action in the "here and now".

5. Recommendations for sustainability

PCVC's "here and now" approach increases the possibilities of sustainable changes in clients and must continue.

PCVC's intuitive approach to sustainable scaling is laudable, and it is poised to make a real difference in the movement towards a violence-free society and must continue.

Providing consistent trauma-informed services takes a heavy toll on the psychological resources of the professionals involved. PCVC may consider developing a dedicated learning and development function based on strength-based capacity building for its

staff and key partners. Such a learning and development function would include self-discovery, peer learning, and reflection, enabling individual and collective growth.

6. Recommendations for Knowledge Generation

PCVC's holistic approach demonstrates in detail critical elements of physical and psycho-social requirements of DV and burns survivors, including food, clothes, shelter, income and psycho-social support. These learnings and insights may inform standards of excellence that inform multiple stakeholders in (i) burn care; (ii) trauma-informed support services for domestic violence survivors.

PCVC may consider strengthening the interrelated functions of research and periodic reviews (that track tangible project performance in terms of efficacy and efficiency and the more intangible aspects of individual and institutional growth). PCVC is aware of this gap and has already taken the first steps in this direction by clearly outlining a research function.

PCVC has detailed and invaluable records based on survivor-centred practice over decades that can support micro and macro research with the potential for tremendous sectoral wisdom.

PCVC may consider adopting action research approaches since they create possibilities for sharing information mutually around critical issues of common interest to various partners/stakeholders.

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Appendices

Appendix I. Questions for Evaluation of Project Performance

The evaluation questions focus on two areas: Programme Achievements and Organisational Management.

Programme Achievements examines the results chain, including impact, outcome, outputs and activities. Organisational Management examines the project's principles, strategy, governance and management.

The questions listed are comprehensive. Not all are required in all interviews, and many need very short answers. However, they provide the broad strokes of the evaluation projects.

1. Project Efficacy

Are the interventions planned under the program appropriate and enough to reach the objectives set in the program?

Were inputs appropriate in choice and quantity? What were the variations between planned and implemented inputs?

Is the available version of the Results Framework an accurate representation of the project?

Has the RF changed during the course of the project? What are these changes?

How has COVID affected the plans and outcomes?

What is the organisation's performance against the output indicators mentioned in the project's Results Framework? Were there any differences in the targeted and planned outputs and activities?

What are the possibilities and challenges in translating the results chain on the ground?

Has the implementation strategy (activities, outputs), as envisaged at the start of the project, been successful in contributing effectively to reaching the outcomes of the project? If not, what could have been done better?

Were assumptions, risks and conditions accurately analysed and chosen in the logical framework? What were the unanticipated risks and partial assumptions?

Were the activities that were identified most effective?

What specific activities/outputs/outcomes were not achieved and why?

Has the project achieved any unintended outcomes? What are these outcomes?

Were external relations developed at different levels according to the principles of collaboration and transparency?

What are the key capacity-building efforts at various levels (information, education, behavioural change, etc.)

What are the key advocacy efforts of the project? What are the results of such advocacy?

What communication and media strategies are in place to disseminate information and engage with various clients, partners, stakeholders, communities, and civil societies to shift perceptions of women?

Who were the critical partners enrolled to protect women at risk?

What are the critical research areas that inform action on the ground?

What are the key Champions enrolled to reduce the risk of change-makers/women?

2. Project Management and Efficiency

2.1. Organisational Profile

What is the Organogram (Authority, Accountability, Functions and Roles)?

What is the Staff Profile of the organisation?

Are management capacities adequate?

Do implementing staff understand programme outcomes and outputs?

What are the organogram, essential functions, and roles and responsibilities?

What are the organisational authority and reporting structures?

What are the regular planning cycles? Who is involved in the planning processes at various levels?

Who are the accountability holders at various levels (including sanction of financial decisions)?

What are the mechanisms (including information-sharing platforms) of participation and decision-making at the Board, Central, Project Team, and Beneficiary levels?

What accountability/responsibility mechanisms are used to arrive at a specific decision (Dialogue, Voting, Negotiation, Silent consent, etc.)

What were quality control measures taken at various levels?

2.2. HR and Team Building

What are the HR policies to ensure timely recruitment, staff retention, professional growth, etc.?

Are the key HR processes in place to support the successful and effective implementation of the project? What are these?

What is the staff profile regarding educational background, functional and subject expertise, and work experience?

What are the key elements in the relations with organisational and project teams (regular capacity building and decision-making platforms, mobility between projects, etc.)?

Are the roles and functions of staff members clearly defined? What are the strengths and challenges related to various roles and functions?

What are the principles behind team building and management?

What are the key insights and reflections in deploying/playing roles (narrate three incidents)

What are the strengths of the project team?

What are the challenges in team building and management?

What are the areas of future investment for team building?

2.3. MIS

List the indicators regularly tracked: primary beneficiaries (women), secondary beneficiaries (family caregivers, health professionals, government officials and civil society actors).

Are the chosen indicators for project monitoring of outputs and activities appropriate and easy to collect?

What is the degree of accuracy, efficacy and efficiency of the MIS to ensure the delivery of quality services?

Does the MIS capture information on various aspects of project management: procurement, reporting of activities mapped against outputs, finance management, etc.?

Was information accurately collected, stored and treated by the project management ethically and strategically?

Is monitoring data used as a feedback loop to ensure learning for future implementation? If yes, how? Please elaborate

2.4. Resource Utilisation

What are the various resources utilised/generated in the project (funds, human resources, time, expertise, etc.)

Were these resources being allocated strategically to accomplish particular outcomes?

Have grant disbursals occurred as planned and promptly? If there are variations, please specify.

Is project management efficient and effective in budget management and adaptation to external changes?

What are the discrepancies under key budget heads from the original plan? What are the reasons for these discrepancies (including internal factors such as poor planning and external factors such as elections)?

What is the budget utilisation review against each project's outcomes? (An individual assessment of each of the results against the given budget has to be carried out)

What active measures of cost-effectiveness did the project pursue? Are possible new areas of cost-effectiveness being identified?

3. Relevance

Was the project responsive to the different identities of its clients: age, education, caste, clan, religion, employment status, rural/urban, distance from service providers, etc.?

Were project beneficiaries and stakeholders identified using appropriate methodologies for various project activities?

To what extent does the project's design respond to the needs of beneficiaries with different profiles (age, educational, social, rural/urban, gender, class, religion)?

Were beneficiaries and partners actively involved in the design and implementation of the project?

Do target beneficiaries and stakeholders see the project's activities as relevant and appropriate to their specific contexts?

Are beneficiaries and public partners in agreement about the definition of the philosophy, the objectives and the implementation of the project?

Before making strategic choices, did the project analyse sociocultural matters and the institutional environment?

How well does the programme understand and build on existing strengths and capacities of the stakeholders to respond to felt and emerging needs?

Are stakeholders and representatives of the beneficiaries and technical services involved and informed in the design and preparation of the project?

Were vulnerable and excluded social groups encouraged to participate in project activities and be represented in newly created networks?

Do participants and organisations involved in the capacity building report an increase in inner power, competencies and skills?

How appropriate is the capacity building based on the participant's educational background, age, role in the community, etc.?

4. Way Forward/Sustainability

What are the critical lesson learned and the recommendations for promising or emerging good practices in good governance?

What are the future aspirations of the organisation?

What are the measures to ensure integrity between organisational principles, strategies and implementation in future?

What would change in 10 years in PCVC: people, work, locations, etc

Is a 'model' in place or emerging that can suggest systematic learning and future scale-up?

What would be the logical 'next steps' in project design of similar projects?

What are the recommendations for effective organisational/institutional development, project design and delivery of future programmes for women?

To what degree have the stakeholders understood and actively taken up the project programming precepts, tools and mechanisms?

Does the project provide sufficient follow-up activities to avoid distortion from the original objective?

Are the products and services of the project financially and economically sustainable?

What are the mechanisms for Donor diversity that are being pursued?

How effective will the program be in another geography?

What activities/elements ensure the sustainability of outcomes (E.g., institution building/Partnership, local cadre, etc.)?

Appendix II. Some Ethical Guidelines for Data Collection

1. Have a beginner's mind. There is always something new to learn from the people you speak with.

2. Learn to listen. This means listening to the voices in one's head and learning to mute them to listen to the other person.

3. Be precise and specific. Encourage participants also to be so. Insights and reflections are in the details - illustrations and incidents: where, what, how, when.

4. Follow the participant's thinking. Being open to learning often means that the participant will lead you into areas of conversation that offer insights you have not considered before.

5. Seek informed consent about the use of their data. Inform the participants clearly about the purpose behind your enquiry. Ensure their anonymity in public reports.

6. Ensure privacy, consent, and confidentiality. Often in interviews, participants give details of their personal lives and contexts out of a degree of trust in you. Ensure that the data collected is treated with appropriate integrity.

6. Be sensitive and respectful. However right or wrong the participants may be perceived, their dignity is inviolable.

7. Remember that you receive their generosity - time, hospitality, information, etc. Remain humble.

8. Be prepared. As part of this preparation, examine your biases and prejudices - psychological, social, cultural, economic, etc.

9. Encourage storytelling that is empowering. Our conversations are filled with stories. Our stories allow us to be the protagonists in our own eyes.

10. Do not force answers. Participants often are reticent in discussing specific solutions in detail, particularly related to sensitive questions about violence and conflict.

11. Seek insights and reflections along with data. Often the perception of the same data is informed by different worldviews.

12. Be sensitive to regional and community contexts. Do not present yourself in a way that distracts from the work together.

13. Be responsive to participants' queries. Commit to finding answers to their questions or redirecting these to appropriate responders.

Appendix III: Using Classical Grounded Theory

This Appendix examines Grounded Classical Theory as a methodology contrasting it with conventional research, outlines the nature of researcher objectivity, and outlines the primary data collection approach and respondent profiles. It also examines data collection and analysis based on the iterative steps of grounded theory in detail.

1. Conventional Research and Classical Grounded Theory

According to Glaser and Strauss, social science enquiry has focused on validating and invalidating existing grand theories. However, Social Science as a discipline was still emerging. Given this, ways to evolve new social science theories beyond empirical conclusions were essential.

Classical Grounded Theory (abbreviated to CGT) is counter-intuitive to conventional research. Conventional researches emphasise validation and description of existing theories. While CGT includes these two research elements, it primarily aims to arrive at concepts about a phenomenon close to the respondent's view of the world. In this sense, the findings focus on conceptual insights.

Further conventional researches require a clear disciplinary focus and theoretical map based on a secondary literature review. However, CGT counterintuitively holds that these conventional research steps, particularly premature literature review and peer feedback, are inimical to theoretical sensitivity in the free induction and abduction process (Glaser, 2012). Rather than beginning with researcher frameworks, it starts with respondent ideas. Review of formal theory and empirical research is usually undertaken later when the core category and related concepts have already begun to emerge.

Ontologically, CGT requires an intuitive, multi-disciplinary approach encompassing a wide-ranging literature review across the broad research area to sharpen theoretical sensitivity. Further, the final ontological findings may differ significantly from those initially considered before abstraction. Thus, while the study results are expressed through ideas close to the respondent's language, they do not directly correspond to their concepts (or the researcher's). Glaser does not specify the content and methods of ontological data collection and instead recommends iterative data collection using diverse methods: narratives, quantitative data, articles, secondary literature etc.

Epistemologically, CGT may be examined through three aspects: the nature of truth, the relation between the researcher and the participant, and the nature of reasoning[1]. It does not focus on verification (objective approach using deduction) or description (subjective approach)[2]. Instead, it examines underlying patterns to abstract its findings. This is not to say that data collection and analysis are not rigorous. Indeed, triangulation

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[1] This research emphasises the relation of "empathic neutrality" where the researcher is transparent about the reasons for doing this research and the way these assumptions have influenced the research process. The research is "pragmatic" (Biddle and Schafft, 2014) in the sense that it aims to generate knowledge that will support action on the ground: "which rests on the premise that an interpretation is true if it leads to, or provides assistance to take, actions that produce the desired or predicted results" (P27, Ritchie and Lewis). The conceptual frameworks developed are to support action on the ground as much as to develop a theoritical framework.

[2] For the most part, conventional research is seen as broadly having verificatory or descriptive aims. Verification focusses on proving/disproving a particular formal theory applicable to an ontological category within specific disciplines through rational application of logic based on a specific methodology. Description develops a theoretical conceptual map to describe the phenomenon as accurately as possible through interpretative epistemologies. In either case, a clear definition around the ontology and epistemology of the research and its disciplinary foci, based on a thorough understanding of existing and relevant theories, is seen as essential preparation to undertake the research enquiry.

of data, wherein the answers to the same question are collected from multiple sources, is fundamental to open coding and constant comparison used to develop and populate key categories. However, findings are not statistically relevant (even when numeric data is used) and suggest causality rather than establish it.

2. Objectivity in Classical Grounded Theory

The evaluator was clearly positioned as a "neutral outsider" who was "listening" to the "stories" of the participants to understand their "truth". During data collection, she did not attempt to adopt dialogic processes of constructing meanings, concepts and theories. For instance, participants defined power in very different ways. One participant described the kinds of power that PCVC works with: "Power Within", "Power To", and "Power Over". Interestingly "Power with" was the most covertly and intuitively held concept.

This contrasts with most qualitative research approaches, where researchers surface their biases/construct their perspectives and concepts openly. In this sense, they actively co-create the research findings with the participants. Glaser, arguing against this dialogic approach, claims it places undue importance on researcher views. Instead, suspending all such researcher frameworks during the data collection and analysis is better. Inherently, open coding and constant comparison surface and rectify underlying bias, if any. Further, Glaser recommended the maintenance of an objective distance from the empirical data to make the intuitive leap, which is essential for the abstraction's explanatory power (Glaser, 2012).

Despite its strong positivist tonalities, CGT's objective distance differs from most positivist deductive research. Lars-Johan Age (2011), examining the nature of objectivity in CGT, claims that the approach may not be easily classifiable as either positivist or interpretative. Instead, he explores its epistemology by examining its premises along three axes constituting science: correspondence, hermeneutic dialogue, and pragmatism.

He points out that the focus on the emergence of a single, new and unifying concept is similar to Popper's theory on correspondence. Meaning-making in CGT does not use the usual dialogic construction used by hermeneutic phenomenology. However, it prioritises the element of understandability by the layperson as analytical and sensitisation functions. Further, its conceptual findings use the language of participants rather than abstractions of pure theory. The third element of usefulness is evident in its purpose, as stated above. Thus, the successful discovery of findings provides solutions to the problems encountered and allows participants to regain some degree of agency in the context within which they are working.

3. Primary Data Collection Approach

While detailed questions were developed around initial broad themes based on the evaluation objectives for collecting primary data, the research process was open-ended. Thus the questions asked were modified iteratively to follow insights and reflections that emerged from the ground.

Primary data collection was undertaken in a spirit of free enquiry, focussing on stories, insights and reflections. The focus was on listening to participants to understand their worldviews. Participants were encouraged to focus on what was important to them. They were also encouraged to give specific instances/incidents/stories to illustrate their points. This focus on narrativisation recognised the participants' agency and took their point of view.

Given that this evaluation was a temporary engagement with an "outsider", these engagements were based on the "do no harm" principle. Reflectiveness in primary data collection kept the growth of survivors in front and centre. To this end, it encouraged all

the participants to step back and see where they are with regard to this purpose in a spirit of mutual learning. The focus of this data was the expression of participant agency: their insights, wisdom, strengths, things going well, etc., where possible.

A key concern was the intrusion into clients' lives and contexts that usual primary data collection involves. For instance, one of the caretakers cried through the FGD while talking about her small daughter, who had suffered extensive burns. Since the CGT approach is based on the principle of "All is Data", it was possible to collect information about survivor realities from multiple less intrusive sources: self-administered survey forms, staff sharing, case studies, site visits, and MIS documentation.

Fundamental principles of confidentiality, transparency, accountability, and mutuality were also prioritised, given the sensitivity and gravity of the issues that PCVC works with. These principles ensure the safety of participants based on the principle of no harm and secure the equality and rights of the participants.

Primary Data Collection Details

Method	Respondents	Numbers	Description
In-depth Interviews	PCVC Staff	7	Executive Director, Senior Director, Associate Director, Director (HR, Finance and Operations), MIS Officer, Operations Officer, PCVC deputed CSO officer
	Hospital Staff	7	3 Doctors, 1 Nurse, 1 female ward security member, 1 external senior PhD researcher from a local nursing college, and 1 hospital MIS officer
	Government Officials	2	OSC officers
	CSOs	2	CSO Heads
Focused Group Discussions	PCVC Staff	6	Vidiyal (Burn Care), Astiva (Shelter), Dhwani (First Responder Call Line), Outreach Team, Psychosocial Team, and Finance and Operations Team.
	Caretakers	1	6 Caretakers
	Hospital Staff	1	Nurses
	CSOs	1	Head and 4 member Team working with Domestic Violence
Site Visits		6	3 Hospitals, 2 CSOs, RHC
Self Administered Questionnaires	Change Makers Questionnaires	20	
	Partners	4	
	Survivors	18	
	Staff	43	

4. Applying the Steps of Classical Grounded Theory

As discussed earlier, the steps in Classical Grounded Theory include the following: (1) approach to research question as a "blank slate", "All is data"; (2) iterative data collection and analysis and the generation of ongoing memos (3) Analysis through a free process of open coding and constant comparison, including correction of researcher bias; (4) Theoretical saturation of key categories and abduction/emergence of the core category and related concepts; and (5) Selective and theoretical coding around core category and concepts to render conceptual density including secondary empirical literature.

4.1. Inception Report

The researcher approached the evaluation as a "Blank Slate" to prepare the inception report. She collected information and memoed data to gain a broad understanding of the project, its activities, and the organisation in general. This phase informed the inception report and the various methods and tools for data collection.

It focussed on detailed, in-depth interviews with key leaders of the project and the MIS Officer, an FGD with eight members of the "Vidiyal" team along with the Senior Manager (operations) and a site visit to the RHC. In addition, secondary data, including reports, case studies, MIS templates, etc., were scanned.

This data collection and preliminary analysis resulted in the following initial insights. The organisation seemed to reflect organic, robust and rich growth resulting in complex inter-related action. The initially planned in-depth interviews would be too thin to understand this complexity.

This project spanned the COVID pandemic. While the outputs mainly remained the same, there were variations in the intensity with which these were pursued. Further, new inputs, such as the change maker initiative, were designed and followed. To some extent, this broadened the lens and complexity of the study.

Initial scrutiny of the reporting and MIS systems reveals detailed secondary documentation on the various aspects of working with women at different levels: intake forms, call/client tracking, etc. Given this, primary data collection with clients may be restricted to mostly observation and self-nominated respondents.

4.2. Data Set 1 and Open coding.

The key concepts that emerged from the inception study informed the next rounds of iterative data collection (communities selected, tools used, etc.). Initial data were collected and analysed from a wide variety of sources based on their availability and the broad evaluation questions. These were analysed through a method of constant comparison till key categories emerged, and theoretical saturation was reached.

The broad category of themes initially explored based on the inception report included (i) gender equality, (ii) conflict and violence, (ii) survivors' experience, (iii) kinds and quality of services, etc. This data was broadly categorised using constant comparison. The lens through which these categories were developed was survivor well-being.

For instance, the evaluation examined the increase in physical, psychological and social services for survivors. The category of "increase" was expanded in the initial data collection stage from multiple sources such as staff interviews, client reports, medical reports, MIS, etc. This data was simultaneously coded into open categories through constant comparison.

As data collection and analysis progressed, more and more categories emerged. So did greater complexities within categories till they became saturated. This saturation was usually through a process of triangulation where the same concepts were evident in three or more data sources.

Thus, in the first set of interviews and FGDs about the increase in services provided to burn survivors, a PCVC staff showed photographic evidence of improved mobility. This led to a series of explorations around the impact of contracture in the case of burn victims in general (gathered through interviews with medical professionals), the specific services that PCVC provides (collected through the detailed RHC client records that reflected the progressive recovery of individual survivors), and the experience of the burn survivors (case reports outlining the path, challenges and strengths in recovery).

Again, the category of agency and its underlying principle of dignity became evident right in the beginning. Almost all clients discussed psychological recovery as the reclamation of their decision-making power/their agency/their dignity. The concept of agency was viewed through multiple lenses: (i) interviews with PCVC staff around their interventions with clients in high risk situations, (ii) reports of survivors indicating an increase in confidence to exert their "power to" in various contexts, including pursuing careers, making their homes, and even choosing clothes that they find comfortable, and (iii) MIS documentation wherein clients reported a series of expansive decisions to grow as an individual.

While some of these categories emerged easily, such as effectiveness, more complex, underlying categories, such as PCVC's unique principles that explained the nature and reasons for increased services to survivors, were only partially evident.

The process of open coding and constant comparison was integral to addressing researcher bias, as outlined by Glaser. One such bias was the focus on the quality of PCVC services. Thus, almost all the data from clients, stakeholders, and staff indicated that PCVC's service provision was effective and often met high standards of excellence. Further, PCVC had a robust MIS system that tracked physical and psycho-social micro-data of various kinds, including detailed intake/progress sheets (hospital, Astiva, Vidiyal, RHC, and Dhwani) and staff activity reports. Presenting its achievements would not be a challenge.

Yet there was no documentation that reflected on the reasons for these tangible successes in delivering project outputs. Following this line of enquiry led to the fact that PCVC did not have a well-articulated research, learning and development function. While PCVC delivered good quality services to clients effectively and efficiently, it rarely reviewed and reflected on its success/gaps regularly to grow sustainably. The lack of a systematic Learning and Development function also resulted in the absence/inconsistent articulation of key concepts and principles held intuitively as part of the organisation's approach, such as PTSD, suicidal ideation, strength-based capacity building, restorative justice, etc.

4.3. Emergence of Core Category and Related Concepts

The emergence of the core category and related concepts was an intuitive abduction[3]. To some extent, the abductive process is unique to CGT. In such an abductive approach, the emerging concepts do not directly relate to the researcher's or respondents' ideas.

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[3] Glaser writes that emergence of the core category and its related concepts is an intuitive attribute of the researcher called theoretical sensitivity that allows the researcher to recognise substantive concepts and make the leap in abstraction from being immersed in the empirical data through a process of open coding and constant comparison. She makes a leap of intuitive abstraction from existing categories to arrive upon a single core category and its related concept. This core category is distinct from the categories developed through the open coding process. It has the elements of multi-variant integrated theory, which is quite different from the initial meanings attributed by the participant and the researcher. The emergence of the core concept is directly related to its "slipperiness", essential to the emergence of abstracted theory. Slipperiness refers to the adaptability of the core category in various contexts with multiple meanings accomplished through intuitive leaps of abstraction.

It was evident right from the beginning that dignity was a key underlying principle of PCVC's work. Many respondents, including staff and clients, discussed dignity, respect (self and mutual) and autonomy. In daily practice, clients reported being treated with dignity in their engagements with PCVC, which was a key reason for their recovery. At the level of innovation, dignity was reflected in services provided with challenging stakeholders such as perpetrators and enablers of violence. In practice, dignity was reflected through respectful behaviour within the organisation, with stakeholders/ partners and civil society.

Two other critical interrelated concepts emerged across all the categories: real-time responsiveness (particularly evident in trauma centre care) and the last mile approach (physical services PCVC provides to burn care victims, addressing long-term systemic/ contextual factors that impact survivor recovery), etc. From this, a leap of abstraction was made to the core category of the "here and now" principle that underpinned all of PCVC's work and the relation of this principle to those of dignity and restorative justice. Notably, the core category and related concepts were quite different from respondent ideas and concepts. Thus, none of the respondents discussed the "here and now" principle or the restorative justice approaches.

When applied to the various aspects of PCVC work, these principles gained conceptual density. For instance, exploring the principles of individual freedom and mutuality that underpin restorative justice and the "here and now" approach opened new views into the nature and quality of PCVC partners and networks at the levels of commonalities, alignments and synergies. Again, the "here and now" approach explained PCVC's firm grounding in physical support of various kinds that form the basis of trust building with clients to address more complex psycho-social aspects of their recovery.

4.4. Selective Sampling and Theoretical Coding (Data Set 3).

Subsequent primary and secondary data collection and interviews were aimed at selective sampling and theoretical coding. Selective sampling (part of theoretical sampling) refers to the process of rendering conceptual density and complexity to the abstracted core category and its related concepts.

Data related to the emergent key concepts were collected, and their significance was outlined. For instance, agency as "power to" clearly emerged as a clear concept related to the core category of dignity and agency. In this sampling stage, the focus of the data collection examined the psychological distinctions between the agency of a survivor (power to) from that of a thriver (integrating power to, power over, power within, and power with). This exploration led to the nature of the strength-based capacity building that PCVC undertakes, moving beyond client-centred therapy. This expansive view has significant implications, not just for clients but also stakeholders and staff.

As selective coding of primary and secondary data rendered density to the core category and related concepts, critical corresponding formal theories were also included for theoretical coding. Theoretical coding involves pursuing extant formal theories to sharpen definitional clarity and render density to emerging concepts. These included concepts from secondary literature such as Butler's deconstruction of sex and gender, Lorde's essays addressing gender binaries and sexuality, Zehr's restorative justice systems and Meadow's leverage points in complex systems.

5. Some Challenges

There were some challenges in applying classical grounded theory in the evaluation, given that it is markedly significant in approach, objectivity, etc., from conventional research. To some extent, this raised questions about the process of data collection, analysis, and findings. The open-ended nature of data collection that ranged over broad

topics resulted in some confusion, as the questions asked did not directly relate to particular outputs evaluated directly. Thus, a common question at the end of interviews and FGDs was about the range of questions asked and how these questions would serve the evaluation objectives.

Further, the presentation of the emerging category, though highly relevant, raised issues related to rigour. A key reason was the difference between conventional research and CGT. Conventional research presents a concept map (outlined by research objectives) and validates/describes this concept map in its findings by citing data sources and quoting participants. CGT begins with a wide-ranging set of questions and arrives upon a concise concept map that explains the various aspects considered.

Appendix IV: List of Documents Reviewed

Project Documents

Proposal

Results Chain

Revised Results Chain

PCVC Mid-Term Evaluation Methodology, Draft Report and Final Report

Annual Reports

Progress Report Year 1

Annual Activity Report Year 1

Progress Report Year 2

Annual Activity Report Year 2

Progress Report Year 2

Awareness Session Reports

Intensive Change Makers Session Reports

Survivor Network Meeting Reports

Outreach Activity Report

Financial Documents

Budget Utilisation Certificate Year 1

Budget Utilisation Certificate Year 1

Budget Utilisation Certificate Year 1

Narrative Financial Reports for reallocation of resources including COVID

Expenditure MIS Sheet

Procurement Form

Tender Document

Project Management and MIS

OzoneTel Design Sheet.

Burns Victim Client Interaction MIS Templates

Burns Victim Client Hospital Interaction: Filled Sample

Burns Victim Month and Year wise Activity Numerical Report (MIS Aggregated Reports Sample)

Domestic Violence Victims (Dhwani) Client Interaction Template

Domestic Violence Victims (Dhwani) MIS Sample

Domestic Violence Month and Year Wise Activity Numerical Reports (MIS Aggregated Reports)

HR Policies

Case Studies

Case Studies - Burns Survivors

Case Studies - Domestic Violence Survivors

PCVC Stories of Change: One sample received

Burn Care Communication Material

Burns Communication handbook

KMC Workbook

Health Care Professional Training PPT

Hospital Professional Training Report Samples

New Hospital Intake form (2) (1)

Pressure Garment Measurement (2)

RHC Intake Form (1)

Wound record form (1)

Domestic Violence

Survivor network meeting reports

Risk Assessment Checklist and Standard Operating Protocols for Domestic Violence Victims

PSYCHO-SOCIAL APPROACHES – A HANDBOOK outline - UN Trust Fund

Psychosocial Approaches Document: Outline of the four approaches to psychosocial care, including trauma, strength based capacity building, client centred therapy, and

Outreach Services Communication Material

Sample Newsletters; Received 7

Vidiyal Brochure

Dhwani Brochure

Dhwani Awareness PPT

Digital Safety PPT for Survivors

Outreach Services Awareness and Training Sessions Sample Reports

Insights from Change Makers Engagement Reports

Intensive Change Maker's Session Training Reports

Outreach Report

Contracts and MoUs

MoU with Tamil Nadu Social Welfare Department

MoU/Contract with CSO Nodal Organisations

MoU with Hospitals

Other Organisation Documents

Meeting Minutes _State level information sharing meeting_PCVC UN Women Research

Nool Concept Note

Writer's Cafe

CLAPP-Handbook

Appendix V. Self Administered Tools

V.I. Respondent Informed Consent Sheet

About the Study

PCVC has appointed an external professional, Gomathy Balasubramanian, to evaluate its performance of the project on physical and psycho-social care of women survivors of violence with UNTF between 2019 to 2022.

This self-administered questionnaire aims to collect knowledge from you to understand PCVC's work in caring for women (and queer individuals) who are burn victims and survivors of domestic violence.

About the Questionnaire

The questionnaire is meant to be reflective. The questions asked mostly focus on your insights in the care of women.

These questions are open-ended. Please try and answer them in detail, including giving examples and describing incidents. This will give valuable insights to improve the work of PCVC in the care of women survivors.

Please try to answer these questions in solitude. There are no right and wrong answers to them. Instead, they focus on understanding your perspective.

The sets of questions explore both positive and negative aspects of an experience. Usually, we tend to focus on the gaps rather than the strengths. Please first specify strengths without qualifying them first before examining gaps.

Confidentiality

The information shared by you will be available only to the external evaluator. It will be used for the sole purpose of writing the evaluation report. The data collected will not be used by an external evaluator for any other purpose.

The information shared will be kept confidential. Individual respondents will not be identified by name and social identity (gender, education, age, etc.) in the evaluation report. Any data used will be presented to ensure respondent anonymity.

Clarifications

Please get in touch with Gomathy at 99200 23203/gomathynb@gmail.com for clarifications/questions.

V.2. PCVC Domestic Violence Clients' Questionnaire

1. Profile

What is your age?

What is your sexual orientation?

What is your marital/relationship status?

Do you live alone? With natal family? With marital family?

2. Aliveness

When do you feel alive?

What does being alive mean to you on your path to recovery?

What are three qualities in yourself of which you are proud?

How is your life significant to others? Give examples.

According to you, what are the key transformative incidents that impacted you deeply? How have you perceived yourself differently as a result of these incidents (as a woman/ victim/survivor)? Describe these incidents in detail.

What inspired you on the path to recovery? Give an example.

What new areas of life have opened to you on the path to recovery?

What are your accomplishments on the path to recovery? Give an example of an incident.

How did COVID influence your feelings and thoughts about yourself? Did it shift your perspectives about life?

Do you feel empowered to initiate actions for your well-being? Give examples.

How has your image of yourself changed over time? What parts of yourself are you proud/ashamed of?

What does personal dignity mean to you now? Give examples.

How are you supporting others around you to grow?

3. Physical Health

How would you characterise your health?

What are the signs of good health? Describe in detail.

What are the illnesses you have?

Has your perception of your body and health changed in your path to recovery?

Have your eating habits changed on the path to recovery?

4. Relatedness

What is the reason for your encountering violence/harm?

Do you feel that you were forced to inflict harm on your self because of your circumstances?

Who is responsible for the harm you have encountered?

Would you like to remain related to the persons who have harmed you? If so, what would you like to see different in your relations with them?

Could you forgive the people responsible for the violence? What does forgiveness mean to you?

Do you see other people in your life differently now? Describe these differences with examples.

How have relations changed between you and others? Give examples.

Have some relations deepened? Give examples.

Did COVID have a role to play in the change in your relations with others?

Do you feel isolated? Who do you turn to in these moments?

Do you believe in spiritual growth? If so, How have your relations changed in your path to peace/progress?

Who is the person(s?) who supported you most after the violence? Narrate an incident of support.

Have you formed new relations/friendships in your path of recovery? How do these relations differ from earlier ones? Give examples.

5. Social Perception

Did people blame you for the harm you have encountered? Who are these people?

Do you face stigma? Give examples.

Do you continue to participate in social festivals and family celebrations as before? If there are changes, what are these?

Are there differences in your appearance, dress, jewellery, etc.?

Do these changes reflect shifts in inner expressions, or are they aimed at managing external expectations?

6. Productiveness

How would you characterise your economic status - income and property ownership?

How has the nature of work changed in your path to recovery?

What have you discovered about your work on your path to recovery?

Are you employed? Do you feel that you can get employment?

What are skills you would like to acquire in future?

7. Psychosocial Context

Has your view of society changed now? Narrate an example.

Has your view of gender changed in your path to recovery? Narrate an example.

Did you feel that there is an essential difference between men and women? If so, what is this difference? Could you give an example? If not, why?

In your experience, how much of gender results from learned social norms and conventions?

How does your gender define you in your daily life now? Give examples.

How did your gender affect you during the COVID pandemic? Give examples.

Has your view of the institution of marriage and family changed? How do you now view these aspects?

8. Future Aspirations

What are your future aspirations? Give a picture of yourself ten years from now.

What are the areas of self-growth you have identified?

What strengths and opportunities have you identified to grow as a person?

What support would you like to fulfil your future aspirations?

How would you like to support the growth of those close to you?

V.3. PCVC Staff Questionnaire

1. Introduction to Self

What are your age and gender?

What is your educational and work background?

2. Socio-economic Context

What is your view on violence?

What do you see as the difference between ordinary everyday conflict and violence?

What are the differences in the experience of violence between men and women (physical, psychological, social)?

What is the relation between burn victims, suicide and homicide?

How do burn incidents, sexuality, intimate partner violence, self-inflicted harm and suicide intersect on the ground?

What is your view of the women survivors? How has this view changed over the course of your work? Describe in detail.

What are their aspirations (psychological, relational, social and economic aspirations)?

What are some of your insights about the nature of dignity and violence arising from your engagement with women survivors? Describe these insights in detail.

3. PCVC

What drew you to PCVC in the first place?

How long have you been associated with PCVC?

What has surprised you about your work with PCVC?

What are its key embodied principles? How do these relate to your individual values?

4. Strategy

What system do you regularly work with (hospitals, Families, etc.)?

What was the effect of COVID on these systems? Describe in detail.

How did you navigate these shifts during the COVID pandemic in these systems?

Have there been any shifts in the perception/action of these systems? Narrate an incident that stands out to you about this shift.

5. Activities

What are the activities that you undertake with clients?

What are the opportunities/possibilities in working with clients?

What are the three things that you have learnt from clients?

What are the challenges in working with clients?

6. Organisational Role

What is the relevance of your work to clients and society?

What is your role? Do you understand your role clearly?

What are the key outputs/functions for which you are accountable?

How did the COVID Pandemic affect your role?

What were the challenges you faced in playing your role?

What are the new ways of working that you discovered?

What support have you received in playing your role?

6. Organisational Management

What is leadership according to you? Give an instance of good leadership in the organisation.

To whom do you report directly (individuals and teams)? What is the frequency of this reporting?

What are you accountable for? What are your signatory functions, including recruitment and finance)

What are quality control measures that you take in various aspects of your work? Describe these measures.

How do you plan your activities (individual plans, team plans, organisational events/ tasks)?

When did you have to change your course of action and undertake unplanned activities? How frequent were these changes? Give examples.

10. Team Building

What are the principles behind team building and management, according to you?

What are the key team interactions: capacity building, decision-making, movement between projects, etc.?

According to you, what are the strengths of your team?

What are the challenges in team building and management?

11. Individual Growth

How is PCVC supporting your growth as an individual and a professional?

How do you contribute to the growth of others: team, clients, partners, etc.? Give Examples

V.4. PCVC Partner/Stakeholder Questionnaire

1. Introduction to Self

What is your educational and work background?

What is the vision and mission of your organisation?

What is your role in your organisation? Describe some key responsibilities of your position.

2. Socio-economic Context

What is your view on Gender?

Did you feel that there is a fundamental difference between men and women by their very nature? If so, what is this difference? **Could you give an example?**

In your experience, how much of gender results from social norms and conventions?

What is your view on violence?

What do you see as the difference between ordinary everyday conflict and violence?

What are some of your insights about gender roles arising from your experience in the COVID pandemic?

3. Women Survivors

What is your view of the women survivors?

What are their aspirations (psychological, social, economic)?

What are some of your insights about the nature of dignity and violence arising from your engagement with women survivors? Describe these insights in detail.

3. About PCVC

What drew you to PCVC in the first place?

Is there one incident that strikes you as being unique to PCVC?

What has surprised you about your work with PCVC?

What are the strengths/challenges that you see in PCVC?

4. Relations with PCVC

How long have you been associated with PCVC? What are the outputs on which you have worked together?

According to you, what are the key principles of PCVC's work? Which of these are important to your organisation also?

How would you characterise your collaboration with PCVC? Describe in detail.

What are the common contextual issues that have emerged in your work together?

What have been the key strengths/gaps in the collaborative process?

What has changed in your perception about women survivors?

5. Future Aspirations

What are the mutually beneficial areas of future collaboration that you envisage?

How would you like your mutual relations to evolve in the future?

V.5. PCVC Change Maker Questionnaire

1. Introduction to Self

What is your educational and work background?

What inspired you to work with the issue of violence and women survivors? Describe the inspiring incident.

2. Being a Change Maker

What does being a change-maker mean to you?

Describe three actions you have undertaken to change gender/social relations in your context.

What have you learnt from your experiences of working with gender as a change-maker?

What areas have you grown as a person in your work as a change-maker?

What are the challenges that you have faced as a change maker?

3. Socio-economic Context

What is your view on Gender?

Did you feel that there is a fundamental difference between men and women by their very nature? If so, what is this difference? Could you give an example?

In your experience, how much of gender performance result from social norms and conventions?

What is your view on violence?

What do you see as the difference between ordinary everyday conflict and violence?

4. Women Survivors

What is your view of the women survivors?

What are their aspirations (psychological, social and economic)?

What have you learnt from the women with whom you interact? Give examples.

What are some of your insights about the nature of dignity and violence arising from your engagement with women survivors? Describe these insights in detail.

5. About PCVC

How long have you been associated with PCVC?

What drew you to PCVC in the first place?

What are the kinds of interactions that you have with PCVC? Describe these interactions.

Is there one incident that strikes you as being unique to PCVC?

What has surprised you about your work with PCVC?

How would you like to interact with PCVC in future?