MUKTHA PROGRAMME

Establishing a Health System Response to Violence Against Women

The Karnataka Experience

A Short Report

Cehat

A collaboration between CEHAT and NHM, Karnataka

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

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CEHAT in collabaration with NHM, Karnataka

&

1. Bowring & Lady Curzon Hospital
2. Gosha Hospital
3. Chikkaballapur District Hospital
4. Jayanagar General Hospital
5. KC General Hospital

Published in 2023

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Citation: Centre for Enquiry into Health and Allied Theme & National Health Mission, Karnataka. (2023). Muktha programme: Establishing a health systems response to violence against women: The Karnataka experience: A short report

This report pertains to the progress of 5 hospitals implementing Muktha – A health systems response to violence against women and girls. This is a dynamic report, as the endeavour progresses the report will be updated on the CEHAT website.

Designed & Printed by: Tymtix Solutions LLP

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Preface

Dr. Naveen Bhat Y. I.A.S.
Mission Director,
National Health Mission

Preface

Domestic violence and sexual violence are the most pervasive form of gender-based violence. The National Crime Records Bureau (NCRB) reports in India, a total of 4,28,278 cases of crime against women were registered in India during 2021, showing an increase of 15.3 per cent over 2020 (3,71,503 cases). Of these Rape – 31677, POCSO – 52,836, Kidnapping & abduction of women – 75,369, Assault on women with intent to outrage her modesty – 89,200 and Cruelty by husband or his relatives – 136,234. We know that this is only the tip of iceberg.

Studies across the world have found that women who had ever experienced intimate partner violence was significantly more likely to report poor health than were women who had never experienced domestic violence. It is against this backdrop that Karnataka has taken the initiative to strengthen the health care providers and health systems to proactively respond to survivors of violence by identifying signs and symptoms of violence as well as provide therapeutic and forensic care wherever required.

Starting out as a pilot, I am happy that we have been able to implement a health system response under the '**Muktha**' initiative for providing psycho social support to women and children in five hospitals of the state, with the technical assistance from CEHAT (Centre for Enquiry into Health & Allied Themes).

In the past fourteen months of the intervention, 2763 women and children were identified and offered first line support by the HCPs. I commend them for creating Standard Operating Procedures, adopt documentation formats and conduct capacity building of their peers. The monitoring committees are set up in the five hospitals to closely review quality of care received by women and girls reporting violence.

I congratulate the five hospitals for pioneering this initiative and keen to build on the work done and scale up the services to other hospitals of Karnataka and cover the entire health system of the state to offer services for Violence Against Women and Children (VAW/C).

Best Wishes,

(Dr. Naveen Bhat Y)

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Acknowledgement

At the outset we acknowledge the contribution of several individuals and agencies that enabled the initiation of comprehensive health care response to violence against women and girls (VAWG) for Bengaluru.

To begin with we would like to express our sincere thank you to Chief secretary Ms. Vandita Sharma, for her able guidance to create a response to VAWG by 5 public hospitals in Bengaluru. We also acknowledge the vision and leadership of Ms. Arundhati Chandrasekhar who ensured on ground implementation of this initiative across the selected hospitals. Ms. Rajani Parthasarathi as the Nodal officer of NHM guided CEHAT team and Health Care Providers (HCP) to navigate challenges encountered in different stages of the two-year project.

We thank Jagdeesh N Reddy, Kiran Bhatia, Shrinivas Gadappa, Sonali Deshpande, Mrudula Sawant and Padma Bhate-Desothali for in-depth training to the Master trainers of the five hospitals, even after the training they continued to support the teams of HCPs across five hospitals.

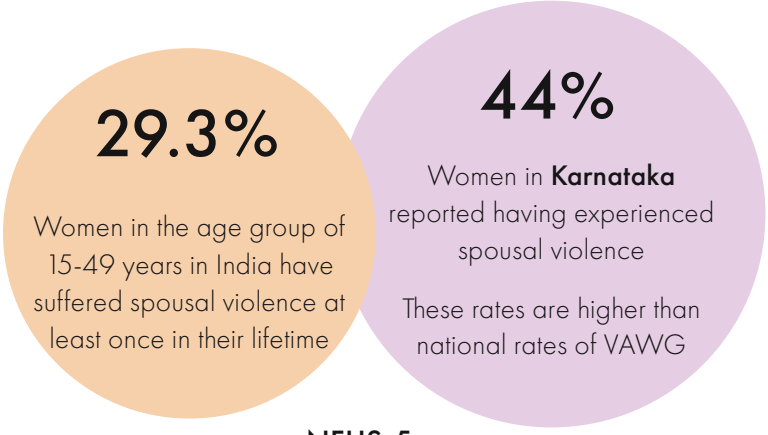
We would like to acknowledge Padma Prakash for her editorial support and Ashwini Chougule for proof reading and coordinating the printing of the report.

We also take this opportunity to acknowledge Sanjida Arora, Ajinkya Deshmukh, Swati Pereira and Pramila Naik who were involved at different stages of the project.

The aim of this report is to present the methodology adopted for creating a health system response to VAWG in five hospitals of Bengaluru and the preliminary learnings based on it. We therefore term it as a dynamic document. It will be updated to include new versions as the project moves to the stages of deepening the health care response to VAWG on the website.

Background

Violence against women and girls (VAWG) is a global issue that affects women physically, psychologically, sexually and economically. VAWG violate several fundamental human rights and negatively impacts women's health and wellbeing. It not only effects individual women and girls, but also their families, community and the country at large. The COVID-19 pandemic and associated lockdowns exacerbated violence against women and girls [1,2,3]. Domestic violence and sexual violence are the most pervasive form of VAWG.



NFHS-5

The National Health Policy 2017 regards the reduction of violence against women as a determinant of health. It recommends that women's access to health care be strengthened by making public hospitals more women friendly and ensure that the staff are orientated to gender sensitive issues. The policy notes with concern the serious and wide-ranging consequences of VAWG and recommends that the immediate health care to the survivors / victims be provided free of cost and with dignity in the public and private health sector.

Health Care Providers (HCPs) are in a unique position to address the health and psychosocial needs of women who are experiencing violence. Upon facing abuse, a woman is more likely to approach a HCP than go to the police [4]. Additionally, HCPs have also been assigned a legal responsibility under

1. EPW Engage. (2020, April 17). COVID-19, domestic abuse and violence: Where do Indian women stand? *EPW Engage*. https://www.epw.in/engage/article/covid-19-domestic-abuse-and-violence-where-do

2. Bose, A. (2020). India's domestic abuse survivors are in lockdown with their monsters, but helplines are not ringing. *News 18 Buzz*. https://www.news18.com/news/buzz/indias-domestic-abuse-survivors-are-in-lockdown-withtheir-monsters-but-the-helplines-are-not-ringing-2563955.html

3. Campbell, A. M. (2020). An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives. *Forensic Science International: Reports, 2*, 100089. https://doi.org/10.1016/j.fsir.2020.100089

4. Bhate-Deosthali, P., Rege, S., Pal, P. Nandi, S., Bhatla, N. & Kashyap, A. (2018). *Role of the health sector in addressing intimate partner violence in India: A synthesis report*. New Delhi: International Centre for Research on Women

laws such as Protection of Women from Domestic Violence (PWDVA); The Protection of Children from Sexual Offences (POCSO) and Criminal law amendment to rape (CLA). Their roles entails provision of therapeutic and forensic care wherever necessary. It is against this backdrop that HCPs and health systems have to be strengthened to proactively identify signs and symptoms of violence as well as provide therapeutic and forensic care wherever relevant for survivors of VAWG.

In India, the Dilaasa model is one of the first health system-based initiatives to address VAWG. It was set up by the Centre for Enquiry into Health and Allied Themes (CEHAT) and the Municipal Corporation of Greater Mumbai (MCGM) in 2000 at K. B. Bhabha Municipal Hospital in Mumbai through a collaborative effort. It was established as a hospital outpatient department (OPD) staffed with counsellors to provide crisis intervention services to women and children. The objective of establishing Dilaasa was to acknowledge VAW as a public health issue and create a health system response to it.

The Dilaasa model aims to:

Institutionalize VAW as a public health issue by setting up a crisis intervention department providing psychological care to survivors on the premises of a public hospital

Train and build capacity of the hospital staff to recognise VAWG as a public health issue and integrate a response to survivors in clinical practice. The initiative was since 2006 has since been replicated at different levels of health facilities in several states including Kerala (Bhoomika), Haryana, Gujarat, Madhya Pradesh and Meghalaya.

Cehat

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service, welfare and advocacy on a variety of a public health issues. It was set up in 1994 and its objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programs to demonstrate how health services can be made accessible equitably and ethically. It has established evidence-based model for the health sector to effectively respond to survivors of Violence against women and children.

Backdrop to creating a health care response to VAW in Karnataka

In 2015, the Women and Children Welfare Department (WCD), the Legal Services Authority and the Police Department jointly started '*Gelathi* - special treatment cells*' for women and children who had faced violence. *Gelathi* centres were located in hospitals for responding to VAW in Karnataka. These centres provided counselling as well as legal support, health care and police assistance under one. By 2016-2017, Karnataka had successfully established at least one *Gelathi* centre in every district.

Since 2016, CEHAT has been making efforts to spark interest in other states for creating a response to VAWG in health settings. In this context CEHAT approached the Karnataka health department who referred the matter to WCD. It transpired that under the programme to end VAW the WCD had set up Gelathi centres in hospitals and had appointed counsellors in each of them across several districts.

Dr. Arundhati Chandrashekhar (former Mission Director, National Health Mission Karnataka), then the secretary of the Women and Child Department in Karnataka informed CEHAT that *Gelathi* centres are based on the Dilaasa -Mumbai model of which they had heard and read about, but not had an opportunity to visit. A visit was scheduled in 2017 for delegates of WCD and the health department. They were particularly impressed with the coordination of the counselling department with hospital departments and the ownership of it by Health Care Providers (HCP). They were also keen on implementing the documentation formats used by Dilaasa centres. Later, in 2018, CEHAT was invited to conduct a training of *Gelathi* counsellors on VAW and health.

Concurrently, the central government initiated the implementation of the One Stop Centre (OSC) programme in the aftermath of the brutal murder and sexual assault on a young medical student in Delhi. The OSC scheme was envisaged to provide women centered care to women and children facing domestic violence and sexual violence in all districts of India. The first OSC in Karnataka was set up in Udupi district in 2016, and by the end of the year, eight other districts in Karnataka had OSCs. By 2018-2019, the number of districts with OSCs increased to approximately 30. The *Gelati* centres were discontinued in favour of the One Stop Centres in 2020, coinciding with the expansion of the OSC.

Later Dr. Arundhati took charge as Mission Director of National Health Mission Karnataka. CEHAT approached her with a request to collaborate with the Government of Karnataka and create a roadmap to develop a "Health Sector Response to Violence against Women and girls". It is against this backdrop that the Karnataka National Health Mission (NHM) initiated a health system-based response to Violence Against Women and Girls (VAWG). The officials also felt that CEHATs expertise in this area would be beneficial to achieve this. **This initiative was called Muktha**. A Formal Memorandum of Understanding

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* *Gelathi*' means 'Sakhi' in Hindi and 'friend' in English.

(MoU) was signed between the National Health Mission, Karnataka and CEHAT to 'pilot a Health Systems Response to VAW' on 15th December 2020. Initially the MoU was in force for one year till 14th December 2021. After assessing one-year progress, NHM extended for 3 years effective from 15th December 2021 to 14th December 2024.

MoU Signed between CEHAT and NHM Karnataka (from left) Dr. Arundhati Chandrashekhar, Director, NHM Karnataka, Dr. Rajani, Deputy Director, State Mental Health Services and Prarthana, CEHAT Representative

Details of the Project are as Follows:

Goal

To establish a health system model to respond to survivors of violence against women and children at secondary level hospitals.

Specific Objectives of the Initiative

- To create a pool of Master trainers in all the five hospitals and support them to conduct training workshops of health workers of their respective hospitals to respond to VAWG.
- To onboard existing NHM counsellors of these hospitals and build their capacities to respond to survivors of VAWG and provide psychological support.
- To carry out health system strengthening activities to support healthcare providers to respond to survivors. These included creations of hospital monitoring committees, Standard Operating Procedures (SOP), documentation registers and case presentations at the level of hospitals.
- To establish a multi sectoral response by building linkages between and among the health system, community, police, women's groups and shelters for comprehensive response to women/girls.

Roles and Responsibilities of Stakeholders

National Health Mission (NHM)

- To notify five hospitals through a circular about the implementation of project for a minimum period of three years and appoint a nodal officer in charge at every hospital who would be responsible for the coordination of the project activities at the hospital level
- To oversee and monitor progress of the project by holding review meetings with nodal officers and seeking monthly reports

Hospitals

- To empower the nodal officers for oversight and implementation of the project
- To implement the protocol for medico-legal care for rape survivors as issued by Ministry of Health and Family Welfare in 2014
- To support and organise trainings at hospital level to identify and support VAWG survivors
- A core committee at the level of every hospital committee comprising the Medical Superintendent, ToT members, Medical Records officer was also set up to monitor the progress, adherence to SOPs and discuss challenges and improve delivery of services

CEHAT

- To provide all the technical support for the project including research and capacity building
- Organise monthly case presentation meeting with counsellors of 5 hospitals
- To provide a 24*7 helpline number that can be reached by all HCPs including counsellors when challenging case or difficulties are encountered
- To develop IEC material in local languages for publicising services to VAWG at hospitals so that patient population can avail maximum benefits of services
- To bear one time training expenses for conducting training of master trainers.

Design of the project

Five hospitals under the NHM viz. (I) District Hospital, Chikkaballapur (II) Bowring & Lady Curzon Hospital (III) Govt. HSIS Gosha Hospital (IV) Jayanagar General Hospital (V) KC General Hospital were selected as sites for the implementing the project.

	Number of Beds	Patient Load (OPD per day)	Deliveries per month
District Hospital, Chikkaballapur Secondary	205	800	300
Bowring & Lady Curzon Hospital Tertiary	750	1000 - 1200	220 - 250
Govt. HSIS Gosha Hospital Maternity Centre	120	150 - 200	450 - 500
Jayanagar General Hospital Secondary	300	800 - 900	350 - 400
KC General Hospital Secondary	300	800	300 - 330

All the five hospitals predominantly serve the economically marginalized sections in urban and semi urban Bengaluru, these comprise both local as well as migrant communities. The hospitals provide a range of services for women viz. antenatal and post natal care, deliveries and abortion services as well as immunization for children. The hospitals also have major departments such as medicine, ENT, orthopaedics, surgery amongst others. The project was initiated in four departments of each hospital viz. medicine, psychiatry, obstetrics and gynaecology and casualty as they receive the maximum load of women/girl patients.

The project from its outset sought to generate ownership of the initiative with the HCPs of the hospitals. So it comprised of creating a team of master trainers within the hospital, appointing nodal officers who took the responsibility of coordinating VAW response activities and designate a team to provide comprehensive psychosocial services within the hospital once a survivor of VAWG has been identified. CEHAT discussed with the National Health Mission (NHM) the need to appoint additional counsellors for this purpose. But NHM suggested that existing counsellors of the vertical programs be trained to offer this service.

The initiation of Muktha programme was inspired from WHO Miraj and Aurangabad model [5]. This model entailed creating a pool of master trainers at the hospital to equip their peers as well as co-workers to recognise and respond to VAWG. The project involved system strengthening activities such as creation of standard operating procedures to support HCPs, introduced documentation registers to record cases of VAWG and aggregate number of survivors supported as well as monitor quality of care offered by the HCPs. The core committee assigned to monitor the quality would meet on a bimonthly basis. Based on the outputs and learning outcomes from this initiative, CEHAT decided to replicate and adapt this intervention at tertiary care hospitals in Bengaluru. The new component in Karnataka initiative was designation of NHM counsellors to provide first line care that include psychosocial services at the hospital level and be equipped to make referrals which would enable a comprehensive response to VAWG.

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5. World Health Organization, Centre for Enquiry into Health and Allied Themes, Human Reproduction Programme. (2021). *Scaling up the health system response to violence against women: lessons from hospital interventions in Maharashtra, India: Research brief.* New Delhi: World Health Organization.

Preparatory Phase

Efforts to Understand Existing Response to VAW within the Hospitals

Before initiating any interventions, it was essential for CEHAT to gain an understanding of the hospital procedures employed in cases of women reporting any form of violence. What was the existing case load related to VAWG; knowledge of providers regarding health consequences of VAWG as well as the perceptions of the hospital staff towards setting up a health care response to VAWG. Senior medical officers were interviewed per hospital for this purpose. They belonged to the departments of obstetrics & Gynaecology, General Medicine and Casualty/ Emergency. These departments were chosen as they were likely to see a large number of women and children with signs of violence. The interview consisted of two main components – in-depth interviews with senior doctors and direct observations.

Findings

a. Domestic Violence

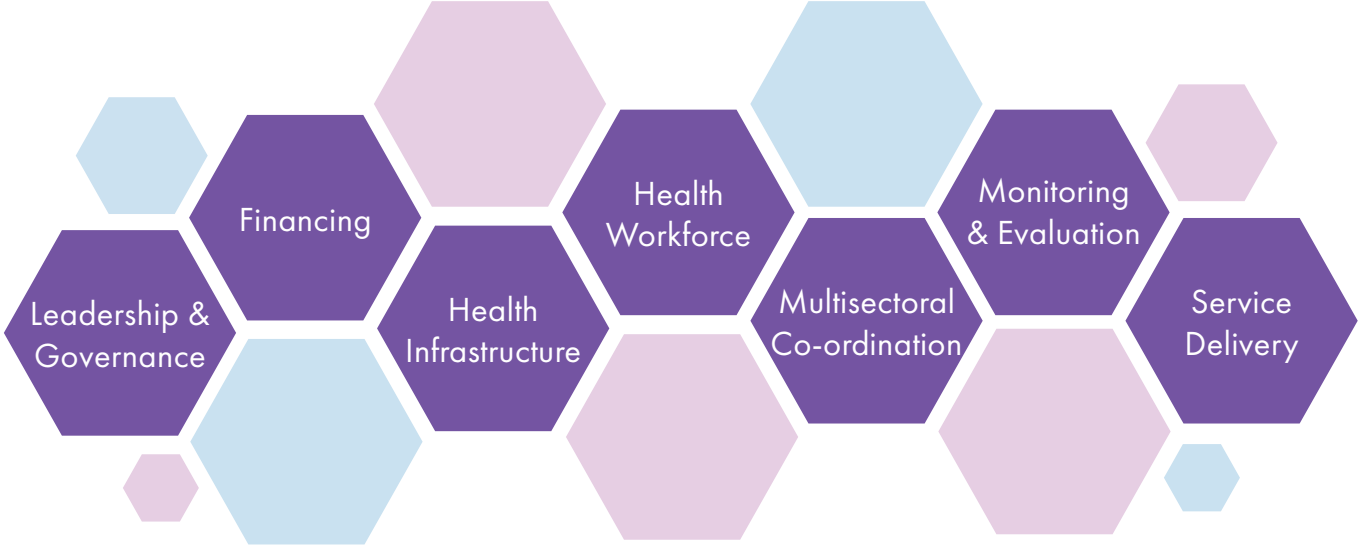
- None of the hospitals had mechanism in place to identify or respond to domestic violence cases.
- There were no activities related to creating awareness amongst staff about VAW and its health consequences.
- HCPs lacked clarity about filing Medico Legal Cases related to any form of VAW.
- There was no scope for temporary shelter/ admission for women in the five hospitals if women perceived their homes to be unsafe to return.
- Hospitals were seeking husband's consent for providing abortions.

b. Sexual Violence

- Hospitals were conducting virginity test on insistence of parents.
- Examination of rape survivors were relegated to female gynaecologists leading to delays in their absence.
- None of the hospitals were implementing the protocol for medico legal care in rape as issued by MoHFW in 2014.
- There was no recognition that survivors of rape could approach hospitals by themselves and not necessarily with the police.

Implementation Phase

The implementation activities related to setting up a health system response to VAW are described using the building blocks of the health systems designed by the World Health Organization (WHO). The core elements of building blocks include:



I. Leadership and Governance

NHM Leadership

In order to effectively manage the implementation of the intervention and facilitate collaboration between healthcare facilities, the state NHM department designated Dr. Rajani Parthasarathi, Nodal Officer who held the position of Deputy Director for State Mental Health Services. She was given the responsibility of overseeing the intervention activities and facilitating communication between the involved parties. To streamline communication and information sharing, whatsapp groups were established that included nodal officers and CEHAT team. Regular meetings with the leadership, including the Medical Superintendents and members of the training-of-trainers (ToT) team from each hospital, were held to report progress on VAW response activities and ensure its progress. In addition to these efforts, a monthly online meeting was scheduled between the Nodal Officer and CEHAT, while every third Saturday was allotted for an online meeting with the Mission Director and Nodal Officers to discuss the progress related to the activities of the initiative. As the project coincided with COVID 19 pandemic, monitoring committee meetings were held online in the initial stages.

Deputation of Nodal Officer for Each Hospital

To lead the activities of the project, a Nodal Officer was appointed at the level of every hospital. Nodal officers were selected from among health service administrative heads and senior clinicians based on the criteria of having supervisory and mentoring role, decision making responsibilities within the health facilities. The Nodal officer offered oversight and supported implementation of the project and liaisons activities between the various departments. They would reach out for trouble shooting to the nodal officer appointed at the level of NHM.

Setting Up of Core/Monitoring Committee at Each Hospital

A core/monitoring committee was set up at the level of each hospital. It comprised of the Medical Superintendent, nodal officers, master trainers (equipped to orient staff to VAW issues in the hospital) and Medical Records officer. The committee had the responsibility of monitoring the progress related to trainings, adherence to SOPs and discuss challenges and improve delivery of services. These meetings discussed the number of women/girls identified at each department, the nature of health complaints and the form of support offered.

Deputation of NHM Counsellors

The role of doctors and nurses was to provide initial support/ psychological first aid to women and children who have experienced violence. After which they would inform women and girls about availability of counselling services and would refer them to NHM counsellors for psychosocial counselling and support. Each hospital also earmarked a small private space for counselling women/girls. The NHM counsellors work on a rotating roster basis for one day a week.

Counsellors belonged to different vertical programs of the NHM; such as Maternal and Child Health, HIV, Breastfeeding, Special New-born Care Unit, Integrated Counselling and Testing Centre, or Antiretroviral Therapy. In those hospitals where these NHM counsellor positions were vacant, the District Mental Health Programme (DMHP) counsellors were deployed for one day a week. It should be noted that the number of counsellors was not consistent across all hospitals, with some experiencing significant shortages.

II. Financing

Budgeting Arrangements

CEHAT covered the initial one-time expense for providing technical support, this included provision of resource persons for capacity building, resource materials, documentation register formats, and Informational, Educational and Communication (IEC) materials. On the other hand, the National Health Mission (NHM) supported the training by providing the necessary venues as well as the catering services for the participants.

Post the five-day training of master trainers, orientation trainings conducted at the level of each hospital

was supported through the hospital funds. The creation of a separate space for counselling and provision of basic infrastructure such as table, chairs for provision of services and basic stationary was provided by the hospitals.

III. Health Infrastructure

Creation of Safe and Private Space for Psychosocial Services

The hospital was expected to allocate exclusive space for the delivery of psychosocial services to survivors of violence. The NHM counsellors would provide counselling to women and girls in this space. They are conveniently situated in the OPDs or near the emergency departments, with a focus on maintaining privacy for survivors.

The Mukhta Centre is open from 10 AM to 4 PM from Monday to Saturday, except on the second and fourth Saturdays and government holidays.

Development of IEC Material

Information, Communication and Education (IEC) material was adapted from existing CEHAT-Dilaasa materials. All the IEC materials were printed in local language by NHM. These were displayed on the walls of the facility to inform patients and relatives about Muktha program for responding to VAWG. Common areas such as OPD waiting rooms where there is likely to be high exposure for the IEC material were selected for displaying them. Similarly IEC material was also developed to target HCPs and reiterate their roles and responsibilities in responding to violence against women and girls.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Cehat
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ಚಿಕಿತ್ಸೆ ಆರೈಕೆಯಲ್ಲಿ
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ಕಾರ್ಯಕರ್ತರಾಗಿ ನಿಮ್ಮೊಡನೆ ಯಾರಾದರೂ ಬಂದು ತಮ್ಮ ಮೇಲಿನ ಕೌಟುಂಬಿಕ ಅಥವಾ ಲೈಂಗಿಕ ದೌರ್ಜನ್ಯ ಕುರಿತಂತೆ ಹೇಳಿಕೊಂಡಾಗ ನೊಂದವರ ಘನತೆ, ಸುರಕ್ಷತೆ ಹಾಗೂ ಯೋಗಕ್ಷೇಮವನ್ನು ನೀವು ಕಾಪಾಡಬೇಕು.
ಗೌಪ್ಯತೆಯನ್ನು ಖಚಿತ ಪಡಿಸಿ
ಮೊದಲಿಗೆ ಸುರಕ್ಷ ವಾತಾವರಣವನ್ನು ಒದಗಿಸಿರಿ. ನಂತರ ಆಕೆ ಹೇಳಿಕೊಂಡ ವಿಷಯಗಳನ್ನು ಬೇರೊಬ್ಬ ಸಹಭಾಗಿ ಅಥವಾ ಕಾರ್ಯಕರ್ತರೊಂದಿಗೆ ಹಂಚಿಕೊಳ್ಳುವ ಮೊದಲು ಆಕೆಗೆ ತಿಳಿಸಿ ಆಕೆಯ ಒಪ್ಪಿಗೆ ಪಡೆದು ಮುಂದುವರಿಯಿರಿ.
ಸೂಕ್ಷ ಗ್ರಾಹಿಯಾಗಿ ಆಲಿಸಿ, ಹಾಗೂ ಕಣ್ಣಲ್ಲಿ ಕಣ್ಣಿಟ್ಟು ಆಲಿಸಿರಿ.
ವಿಚಾರಣೆ
ಹಿಂಸೆಯ ವಿಷಯ ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಿ ಹಿಂಸೆ ಮಿತಿಮೀರಿದ ಬಗ್ಗೆ ವಿಚಾರಿಸಿರಿ.
ಆಕೆ ಹೇಳಿಕೊಂಡ ವಿಚಾರಗಳನ್ನು ಸಂಕ್ಷಿಪ್ತವಾಗಿ ಹೇಳಿರಿ.
ಸುರಕ್ಷತೆಯನ್ನು ನಿರ್ಣಯಿಸಿ
(ಭೌತಿಕ ಹಾಗೂ ಮಾನಸಿಕ)
ಆಯ್ಕೆ ರೂಪದಲ್ಲಿ ಆಸ್ಪತ್ರೆಗೆ ಅಡ್ಮಿಟ್ ಆಗಿರಿ ಎಂಬ ಸಲಹೆಯನ್ನು ಮುಂದಿಡಿರಿ. ಯಾವಾಗಲಾದರೂ ಆತ್ಮಹತ್ಯೆ ಪ್ರಯತ್ನ ಅಥವಾ ಮಾಡಿಕೊಳ್ಳುವಂತಹ ಯೋಜನೆ ಮಾಡಿದ್ದೀರಾ ಎಂದು ವಿಚಾರಿಸಿರಿ.
ಬೆಂಬಲ ಸೇವೆಗಳನ್ನು ಕುರಿತಂತೆ ಮಾಹಿತಿ ಒದಗಿಸಿ
PWDVA ಅಡಿಯಲ್ಲಿ ಬರುವ ಪ್ರೊಟೆಕ್ಷನ್ ಆಫೀಸರ್‌ಗಳು, CWC ಮೆಂಬರ್‌ಗಳು ಹಾಗೂ ಬೆಂಬಲ ಒದಗಿಸುವ ಇತರೆ ಸಂಘ ಸಂಸ್ಥೆಗಳ ಸಂಪರ್ಕ ವಿವರಗಳನ್ನೊಳಗೊಂದ ಒಂದು ಪಟ್ಟಿಯನ್ನು ತಯಾರಿಸಿ ಇಟ್ಟುಕೊಳ್ಳಿರಿ.
ಫಾಲೋ ಅಪ್‌ನ ಮಹತ್ವದ ಬಗ್ಗೆ ಒತ್ತು ನೀಡಿರಿ
ಚಿಕಿತ್ಸೆ, ಆರೈಕೆ ಹಾಗೂ ಅಭಿಪ್ರಾಯ ಹಾಗೂ ಹೆಚ್ಚುವರಿ ಸಹಾಯಕ್ಕೆ ಸಂಬಂಧಿಸಿದ್ದು.
ನಿಮ್ಮ ಅಭಿಪ್ರಾಯ -ದೃಷ್ಟಿಕೋನಗಳನ್ನು ಆಕೆಯ ಮೇಲೆ ಹೇರಬೇಡಿರಿ. ನೊಂದವರ ಹೇಳಿಕೆಗಳನ್ನು ಅನುಮಾನಿಸದಿರಿ.
Developed by :
Cehat
ಹೆಚ್ಚಿನ ಮಾಹಿತಿಗಾಗಿ ಸಂಪರ್ಕಿಸಿ :
ಸ್ಥಳೀಯ ಡಾಕ್ಟರ್‌ಗಳು ಅಥವಾ ನರ್ಸ್ ಗಳು
: ಮುಕ್ತ ಸೆಂಟರ್ ವಿಳಾಸ :
ಪ್ರಕಟಣೆ : ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ


ನೀವು ಮನೆಯಲ್ಲಿ ದೌರ್ಜನ್ಯ ಅನುಭವಿಸುತ್ತಿದ್ದು
ತುರ್ತಾಗಿ ಮನೆ ಬಿಡಬೇಕಾಗಿ ಬಂದಲ್ಲಿ
ನಿಮ್ಮ ಮತ್ತು ನಿಮ್ಮ ಮಕ್ಕಳ ಸುರಕ್ಷತೆಗಾಗಿ
ಯೋಜನೆಯನ್ನು ಮಾಡಿಕೊಳ್ಳಿ
ಗುರುತಿಸಿಕೊಳ್ಳಿ
ಸ್ನೇಹಿತರು, ನೆರೆಹೊರೆಯವರು, ಸಂಬಂಧಿಕರು ಅಥವಾ ಆಶ್ರಯ ಗೃಹ
ಯೋಜನೆ
ಅಲ್ಲಿಗೆ ಹೇಗೆ ಹೋಗಬೇಕೆಂಬ ಯೋಜನೆ
ಸಿದ್ಧತೆ
ನಿಮ್ಮ ವೈಯಕ್ತಿಕ ಅಗತ್ಯ ವಸ್ತುಗಳನ್ನು ತೆಗೆದುಕೊಂಡು ಹೋಗುವ ಸಿದ್ಧತೆ ಮಾಡಿಕೊಳ್ಳಿ
ಹೆಚ್ಚಿನ ಮಾಹಿತಿಗಾಗಿ ಸಂಪರ್ಕಿಸಿ :
ಸ್ಥಳೀಯ ಡಾಕ್ಟರ್‌ಗಳು ಅಥವಾ ನರ್ಸ್ ಗಳು
ಪ್ರಕಟಣೆ :
ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ
World Health Organization
human reproduction programme
hrp
research for impact
: ಮುಕ್ತ ಸೆಂಟರ್ ವಿಳಾಸ :

IV. Health Workforce

Training of Master Trainers (ToT)

A training of trainers' approach was adopted to train the middle-to-senior level doctors and nurses who would in turn conduct orientation programmes for the rest of the staff of their own hospitals. Such a method can sustain the on-going training as well as develop ownership towards the effort to respond to VAW as a public health issue [6]. The HCPs for this training were deputed from four departments viz. Obstetrics and Gynaecology, General Medicine, Psychiatry and Casualty, all of which have a routine interface with women patients.

Since it was not possible to get five free days in a week, to conduct training without interrupting the duties of the HCPs in the hospital, the training was spread across two months. The COVID 19 situation in the state contributed to this state of affairs. The first phase of training was conducted between 21st to 23rd January 2021 and the second, between 19th to 20th February 2021.

> I used to get angry at the patient; especially these young unmarried girls would come up with pregnancy, now after the training, it's changed my perspective. I think what might have been the unfavourable circumstances that got into the girl in this situation. Lack of attention in the family is a major reason for teenage pregnancy.
>
> - A Senior Doctor

Selection of senior to middle level doctors and nurses for the ToT was done in consultation with the senior hospital authorities. HCPs underwent 5 days training programme that covered a range of topics from understanding concepts of Gender, Sex, patriarchy, intersectionality and its linkages to power and

6. Centre for Enquiry into Health and Allied Themes. (2018). *Violence against women and role of health professionals: A training curriculum.*

control which lead to VAWG. The next segment focused on creating an understanding on violence as a public health issue which entailed steps to identify signs of violence, direct and indirect ways of asking questions to women about violence and steps in provision of basic psychosocial support. For this purpose LIVES concept was used in the training. The concept of LIVES is developed by WHO as first line care for women and girls reporting violence. The acronym includes – Listening without judging, inquiry related to violence, validate the survivors feeling, enquire about safety issues and finally connect women and girls with social support systems. After the conceptual aspects of training, skills to become trainers were also included in the training program. The ToT members were trained on adult learning and participatory methods and oriented to a pre-tested package of training adopted from the WHO CEHAT training course [7]

> “I want to set an example to others by implementing all that I can do for a woman when she comes to hospital and we get to know that she is facing violence.
>
> - Nursing Officer

A total of 46 HCPs (25 doctors and 21 nurses) were part of the five-day training held in Arogya Soudha.

Orientation to Hospital Staff by Master Trainers within their Hospitals

After the five-day training, Master Trainers from these hospitals initiated orientation sessions for the HCPs of their hospitals, focusing on the four departments as per the design, viz., Casualty, General Medicine, Psychiatry and Obstetrics & Gynaecology.

These members divided the content and took responsibility of delivering their part through the two days

7. World Health Organization. (2017). *Strengthening health systems to respond to women subjected to intimate partner violence: A manual for health managers.*

of training. A minimum two-day training package was mandated for HCPs of these departments at the hospital level. To equip Master trainers, CEHAT conducted a series of virtual and physical meetings to familiarise them with participatory exercises, steps to conduct games / group discussions / role plays and presentations. CEHAT personnel were also present in the initial roll out for the first training across five hospitals, which enabled trainers to feel confident and supported.

Participation of nodal officers in organising and mobilising HCPs enabled the smooth delivery of training with good technical support and assured attendance in coordination with the Medical Superintendent. Hospitals were requested not to depute more than 25 HCPs per batch, for ease of management. The intimation to attend the training had to come from the Medical Superintendent office for active participation of the staff. While the majority of the trainers used the PPTs shared by CEHAT, one hospital developed its own slides to deliver the content.

In most hospitals a mix of nursing staff and doctors of four departments conducted the training so that duties did not get affected.

However, this had to be paused after the first round of training across the five hospitals as deputations for two full days was not possible due to COVID surge. Additionally, Covid 19 protocols prevented the assembly of 25 persons in one place. The capacity building activity was therefore shifted to virtual mode so as to ensure that there was no break in the program activities and the issue of VAWG continued to stay visible through this medium. Despite these challenges, master trainers with support from nodal officers were able to complete orientation of 727 staff members across 5 hospitals in one year.

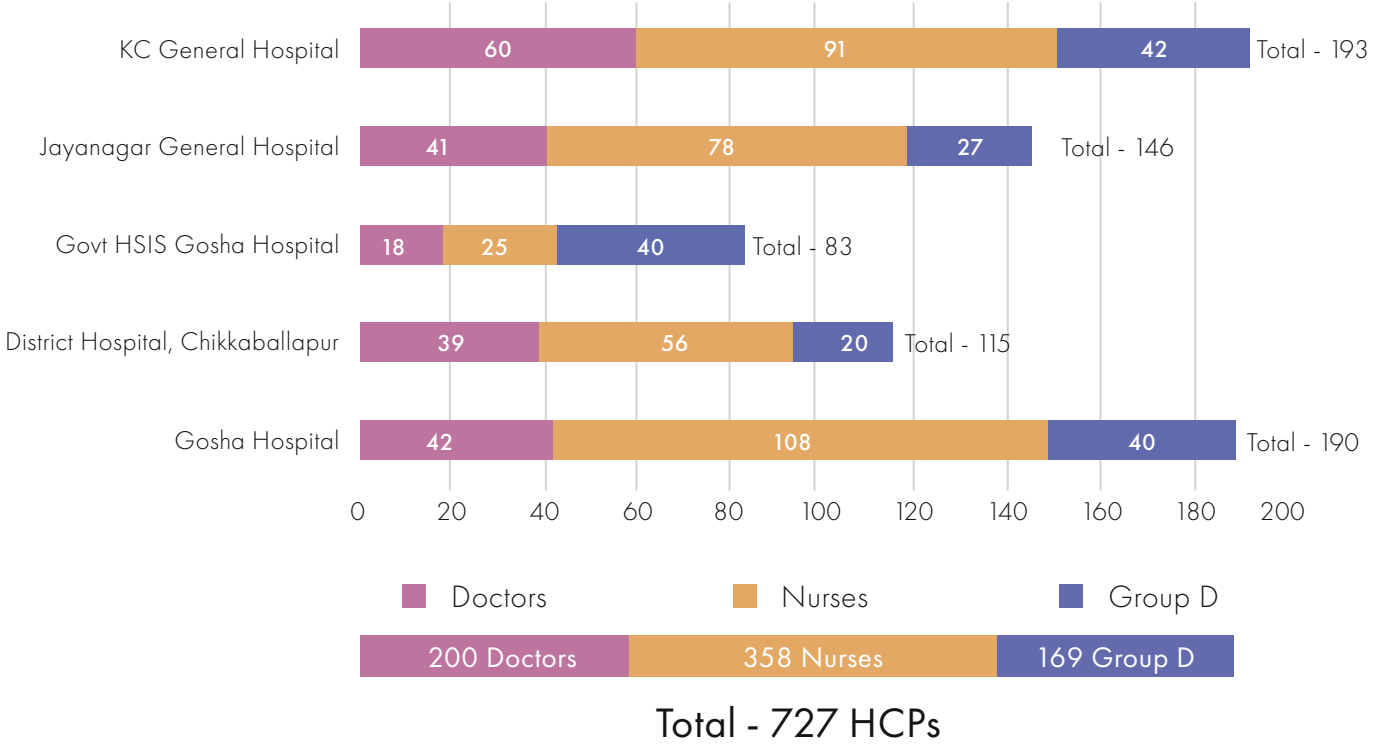
> “Training was very good. We gained knowledge. Before this training I thought somebody else will take care of the woman who is reporting violence. But after this training realised I am also responsible to respond to women experiencing violence.
>
> - Middle level doctor

Training of Group D Workers

Group D workers, including ambulance drivers and security guards, were sensitised by master trainers to the issue of VAW and the newly established response system in their hospitals through a comprehensive two-hour training programme.

The training aimed to raise awareness among the Group D workers about the prevalence of violence against women and children and their role in responding to such incidents. Training equipped the Group D workers with the knowledge and skills necessary to effectively respond to VAW cases in a timely and compassionate manner.

Total HCPs trained in 5 hospitals



Total - 727 HCPs

Initiating a Comprehensive Health Care Response to Rape Survivors

The implementation of the rape care protocols issued by the Ministry of Health and Family Welfare (MoHFW 2014) was a key aspect of the initiative. All hospitals involved in the project received additional day long in -person training to implement these protocols. This was over and above the five-day training received by them. The components included perspective building on the issue of sexual violence and circumstances surrounding it, myths and facts related to rape, communication skills to seek informed consent, sensitive enquiry in to forms of sexual violence, gender sensitive medico legal examination, gender sensitive documentation and drafting a medical opinion. After the training, nodal officers coordinated the printing of the rape examination proformas and ensured their availability for examining doctors of the gynaecology and obstetrics.

Refresher Trainings

It is a known fact that one-time training is inadequate to sustain learnings, hence refresher trainings were held to reinforce the roles of HCPs in responding to health consequences of violence. This was done for master trainers who were ToT members. The refresher training for doctors was conducted online during COVID 19 pandemic, with department-specific sessions (General Medicine, Casualty, Obstetrics and Gynaecology, and Psychiatry), featuring trainers from other hospitals that offer such services. It also included a hands-on training on identification of covert signs of violence, steps involved in implementation of psychological first aid and steps to record in the documentation register. Nurses spend more time in patient care in both OPD and ward settings, but there was initial hesitation in asking women about violence and the referrals from nurses were very low. Hence a refresher training series specifically for nurses was also carried out.

Training of Counsellors at Mukta Centres

Forty-four NHM counsellors were identified from NHM vertical programmes running at the hospitals. Each hospital created a roster system for the counsellors, and they had to report to Nodal Officers about their counselling activities. These counsellors were trained for two days to familiarise them with concepts such as gender, sex, patriarchy, intersectionality, impact of violence on health and women centered crisis intervention services. They were provided with resource directory to create linkages to the additional services required by women such as legal aid, shelter support, community-based organisations supporting women and the like. After one year of training, an incremental training session was conducted for the same cohort. This session aimed to refresh and build upon the knowledge and skills previously acquired. As these counsellors were posted only once a week, they were also encouraged to assess for signs and consequences of violence on women in their department -be it antenatal settings/ HIV testing/ adolescent services/ TB care and the like.

NHM counsellors found it challenging to manage their duties and provide psychosocial services to survivors of VAW. Despite being deputed only once a week, they reported excessive workload in their primary departments. As a common minimum response each hospital attempted to designate at least one person to provide psychosocial services to women and girls facing violence. For example in Gosha Hospital it is a senior nurse, in Jaya Nagar a district mental health program counsellor (DMHP) in Chikballapur, an Integrated Counselling and Testing Centre (ICTC) counsellor, in KC general hospital Special Neonatal Care Unit (SNCU) counsellor and lastly in Bowring Hospital a nursing officer.

Few other hospitals ingeniously utilised existing resources available within hospital. In Jayanagar hospital and Bowring hospital, the Critical Care Respose Unit (CCRU)[+] counsellors provide police aid, legal support and additional support services required, whereas Chikballapur hospital has an OSC in its premises and so makes referrals to the centre for similar services.

Evolving Standard Operating Procedures for Comprehensive Care

Trained HCPs along with nodal officer developed Standard Operating Procedures (SoPs) for their respective hospitals to enable uniformity in response. The SOPs focused on sensitive medical care, basic infrastructure to maintain privacy for psychosocial support, confidentiality of records and documentation, clearly drawing the roles and responsibilities of HCP within the hospital set up. These SOPs are adapted from the Dilaasa centres and the BMC Hospitals [8,9].

As a part of the SOP, all hospitals decided to implement medico legal guidelines and protocols for the care to victims/survivors of sexual violence in 2014.

[+]Critical Care Response Unit (CCRU) has been introduced by Bengaluru police, a system wherein women subjected to different types of crimes can find medical and legal facilities under one roof.

8. Centre for Enquiry into Health and Allied Themes. (2022). *Standard operating procedures for responding to violence against women/girls for healthcare settings* . Retrieved from: https://www.cehat.org/uploads/files/SOP_for_Hospital_OSCs.pdf

9. Centre for Enquiry into Health and Allied Themes. (2022). *Standard operating procedures for responding to violence against women/girls for hospital based counselling departments.* Retrieved from: https://www.cehat.org/uploads/files/SOP_for_Dilaasa_centres.pdf

Challenges

- Though a group of 46 HCPs were trained as Master trainers, all did not take up the responsibility of conducting the training, some took up the charge of coordinating trainings, ensuring deputations of staff members amongst others. Nurses did not feel confident of conducting trainings, so a separate dialogue was carried out and they were encouraged to take on small roles in the delivery of trainings to build their confidence.

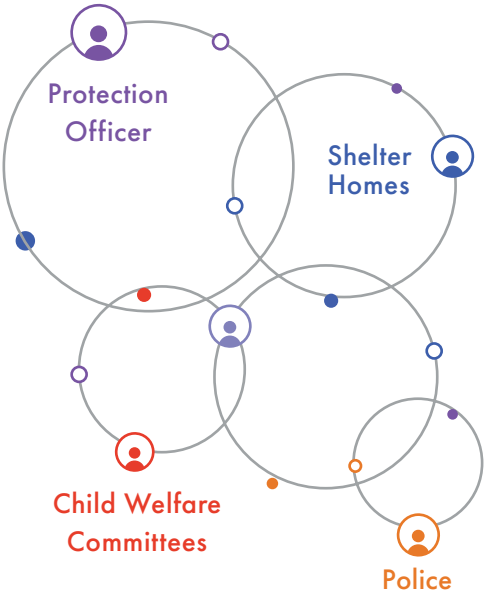
- Nodal officers were middle level doctors and faced resistance from some senior doctors. They did not attend these trainings. Nodal officers had to be supported by accompanying them to MS/Dean office and seek solutions. The MD, NHM had to be approached to intervene in the matter. The resistance to implement any activities to respond and prevent VAW is still not seen as a health priority issue.

- In the initial stage of the project, even trained HCPs found it tedious to identify women/girls facing violence citing busy work schedules. Once identified and supported there was hesitation to document in the registers. This issue was tackled by consistent dialogue, engagement and visits to discuss role of documentation registers. A preliminary analysis of the same was also presented to them (it is presented in forthcoming sections). This enabled them to understand that the most obvious signs of violence in the form of assaults, poisoning and rape were being identified but covert signs of violence and impact on health were being missed out. An experiential workshop along with HCPs from other sites who have been doing it for the last several years helped in dealing with their concerns and led to experiential learnings.

V. Multi-Sectoral Co-ordination

Referrals and Liaison with Other Resource Agencies

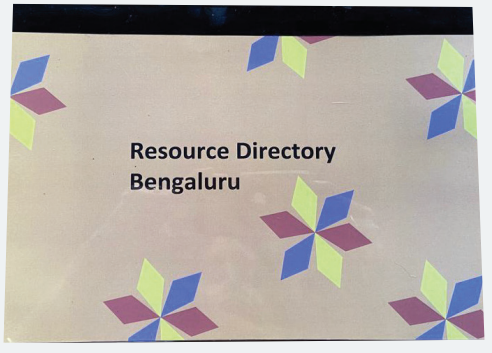
Violence against women is a multidimensional issue. No single agency can provide all the required services. A comprehensive response requires Mukhta project to establish links with agencies outside the hospital setting. Mukhta offers referral services to agencies such as the police, child welfare committees, protection officer, shelter homes, all of which provide support and services beyond the scope of health system. Survivors may need information, guidance and assistance in reaching out to these agencies. NHM Counsellors provide basic psychological support and make an informed referral to other services. For holistic service provision to survivors, effective referral network was developed by CEHAT. Various public and private organisations that offer services like shelter homes, legal aid, vocational training for income generation were



contacted that were in the vicinity of the hospital. For comprehensive support for women identified with violence from the health system, a directory comprising of close to 35 organisations was developed. It comprised of details related to helpline numbers for additional help such as shelter homes, legal help, protection officers, Swadhar Kendras and vocational, etc. was developed for easy referral.

Interface with Police for VAW Survivors

HCPs encountered a significant challenge as police officers would often pressure medical providers to give their "opinions" on sexual abuse cases. The set of questions sent to them did not have scientific base. These ranged from whether a survivor was capable of sexual intercourse, if her hymen was intact, what were the nature of vaginal injuries and the like. These questions were not in consonance with the revised and expanded definition of rape/sexual violence.



A dialogue was carried out with senior police officials in Bengaluru to discuss concerns with the set of questions sent to examining doctors and the fact that they were not in consonance with the role of the doctors or the revised definitions of sexual violence. CEHAT engaged along with NHM officials to request the police to withdraw irrelevant question formats issued to HCPs. Consequently, an order was issued by the Assistant Commissioner of Police directing all police officers to cease seeking these unscientific queries. Instead, the MoHFW was designated as the official document to be referred by the police for their investigation.

Intersectoral Meeting with Line Departments for Mutual Referral and Support

The NHM director under the leadership of Additional Chief Secretary (ACS) invited officials from Women & Child welfare, social welfare, Home department, Karnataka legal services authority and Police department to seek their cooperation in getting together other government departments focusing on women's safety and well-being. The meeting chaired by the then ACS & Development Commissioner Ms. Vandita Sharma discussed the need for a convergent response to the issue of violence against women and children. During the meeting the nodal officer of Muktha programme presented the one year progress report of the project since its inception. ACS applauded hospitals for implementing health.

sector response to VAW despite raging Covid-19 pandemic and utilisation of existing human resources for the same. ACS recommended that both the police and WCD be part of an exclusive virtual training to orient the HCPs of Karnataka on the MoHFW proforma and other related information.

Coordinated Services Delivery with Existing Services by Police Department

The Bengaluru Police have established a CCRU as part of the Safe City project. The CCRU is operational in three of the five hospitals where Muktha project was initiated. The aim of CCRU team is to support women and child survivors of violence. Their role is to enable survivors to seek police and legal aid once they enter the healthcare system. The hospitals where Muktha program is established, collaborated with CCRU team effectively by leveraging the resources available within the hospital. Hospital counsellors from Mukta are skilled in identifying the signs of violence in women approaching their departments, after which they provide psychological support and explain the impact of violence on women's health. From there CCRU unit takes up the case and assists survivor in making a police complaint and also handle legal aspects if the survivor so wishes.

VI. Monitoring and Evaluation

Monitoring and evaluation strengthens the health system's response to VAWG by providing information on the training needs and data on what works and what does not in the given context. This mechanism promotes accountability for quality service from stakeholders and implementers. Case presentations are used for monitoring and evaluation.

Case Presentations

The core group of five hospitals, held bi-monthly/quarterly case presentations with CEHAT. From April 2021 to June 2022, seven virtual case presentations were conducted.

These case presentations provided an opportunity for doctors and counsellors to discuss the challenges they faced and learn from each other's experiences. For instance, doctors encountered difficulties while completing the Ministry of Health and Family Welfare proforma for sexual violence cases, and the counsellors lacked training in detecting violence among women visiting their Outpatient Departments. The case presentations also allowed CEHAT to assess the delivery of services and identify training gaps for both doctors and counsellors.

During the presentations, the counsellors presented one successful and one challenging case, providing a platform for incremental learning and receiving feedback from experts who moderated the session. The discussions also helped CEHAT to identify future training needs for the counsellors. Based on the insights gained, in-person training on specific topics such as joint meetings for prevention of VAWG with family members and the Protection of Women from Domestic Violence Act was conducted.

Additionally, the presentations served as a platform for the team to address administrative challenges, including concerns about the demanding responsibilities of their primary department, which interfered with their ability to be housed at the Mukta Centre even for a day during the week.

Documentation

As part of the initiative, documentation registers based on the WHO format were introduced in five departments at the Outpatient (OPD) and Inpatient (IPD) levels. The purpose of these registers was to capture the signs and health consequences of VAW by trained HCPs, the nature of support provided, and the number of referrals made to Muktha Centres.

A Nodal Officer was assigned the responsibility of developing monthly progress report on the number of women and girls identified based on signs and symptoms, the type of support provided, and the challenges faced. The reports also included data on the number of HCPs oriented to the issue of VAW.

When the Muktha initiative was introduced, none of the hospitals were aware of the protocol and guidelines for medico-legal care in survivors of sexual violence by the Ministry of Health and Family Welfare (MoHFW). However, post-training, the NHM Director played a decisive role in ensuring the implementation of these protocols in the hospitals. This provided an important foundation for delivering comprehensive and effective support to survivors of VAW.

At the end of one year, CEHAT interviewed the same set of senior personnel to understand the extent of preparedness on the part of the hospitals to respond to VAW. Four senior administrators across hospitals were interviewed for this purpose. The findings are mentioned below.

Findings

a. Domestic Violence

- Since the setting up of Muktha project, all the 5 hospitals mentioned having a mechanism in place to identify domestic violence cases. If a HCP finds signs or symptoms suggestive of violence, they inquire about it. They mentioned that if a woman/girl confirms that she is facing violence they provide basic support and also connect her to NHM counsellor for additional psychosocial support. They enter the information about it in documentation registers.
- The hospitals have initiated periodic training sessions to increase awareness among staff regarding VAW and its adverse health outcomes. These range from being bi-monthly to a quarter across hospitals. They are yet to put in place a mechanism to train post graduate resident doctors posted for a short duration at the hospitals.
- HCPs suggested that they have an enhanced understanding of the legal role played by them in supporting survivors of VAW than they had at the inception of the project. They mentioned knowing about appropriate procedures to file Medico Legal Cases (MLCs) when such incidents are reported by women and described procedure for examination, collection of evidence and maintaining the chain of custody to ensure that the evidence collected is admissible in court.
- Hospitals mentioned that they had earmarked two beds in the hospitals in case a survivor needs temporary shelter/ admission. In the meantime the NHM counsellor is called to make arrangements to other shelter homes if the woman requires prolonged stay.

b. Sexual Violence

- All the hospitals have initiated the implementation of rape protocol for medico legal care in rape as issued by MoHFW in 2014. Physical copies of the same are available in each hospital.
- HCPs explained that they have learnt to respect the survivor's consent about various components of medico-legal examination, evidence collection, treatment and informing police.
- HCPs categorically stated that they do not perform two-finger test.
- HCPs acknowledge that rape survivor could approach hospitals by themselves and not necessarily with the police.
- Many HCPs are concerned about the examination of adolescent girls where they disclose that they had consensual sexual relationship and do not want to get examined or file a case. Medical providers stated that this is a huge dilemma for them as POCSO makes it mandatory for the hospitals to report the adolescent person to the police.

VII. Service Delivery

Number of Women and Children Receiving Care

Despite the challenges posed by the COVID-19 pandemic and lockdowns, HCPs were able to provide support to 2763# survivors of VAW between December 2021 and February 2023. This statistic is significant as it highlights that despite the fear and disruption caused by COVID-19, women and children still sought medical help due to incidents of violence.

HCPs ensured that all women facing violence receive immediate and primary medical treatment. In all cases of violence, HCPs inform survivors about psychosocial services and availability of NHM counsellors for the same. NHM counsellors have also developed skills to identify signs of violence among their patients/ primary departments (ICTC, ART, SNCU, Breast feeding, psychiatry to name a few). Some have been actively following up with survivors and refer them to additional services, such as those provided by local NGOs and OSCs. In the primary department, the NHM counsellors create awareness about the health impacts of violence and encourage them to seek support.

HCPs identified a total of 2763 patients who have experienced some form of Violence and provided them with the initial form of support by delivering basic psychological support. One of the components of first line support is LIVES approach. LIVES is an acronym and stands for Listen, Inquire about violence in a non-judgmental manner, Validate the survivors experience, enhance their safety and provide/refer her to additional Support services.

Number of Survivors Responded to by the Hospitals (December 2021 to February 2023)

	Bowring	CDH	Gosha	JGH	KCH	Total
Casualty	221	636	NA	500	590	1947
ObGy	NA	84	321	5	62	472
Psychiatry	48	65	NA	5	70	188
General Medicine	47	2	NA	5	58	112
Other Departments	0	24	NA	20	0	44
Total	**316**	**811**	**321**	**535**	**780**	

Total - 2763 survivors

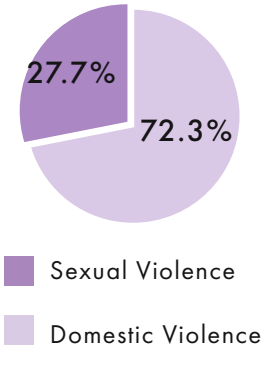
Snapshot of the Survivors Receiving Psychosocial Services from Counsellors January 2022 to December 2022

Of the 2763 survivors, 1223 women decided to seek psychosocial services from the counsellors. The charts presented below indicate the forms of violence and its impact on health. It is interesting to note that 2763 women were identified by HCPs and provided basic support and referred to NHM counsellors, but only 50% of them decided to seek counselling immediately. This underscores the importance of provision of basic psychlogical first aid by all HCPs as they are the first contact to a survivor.

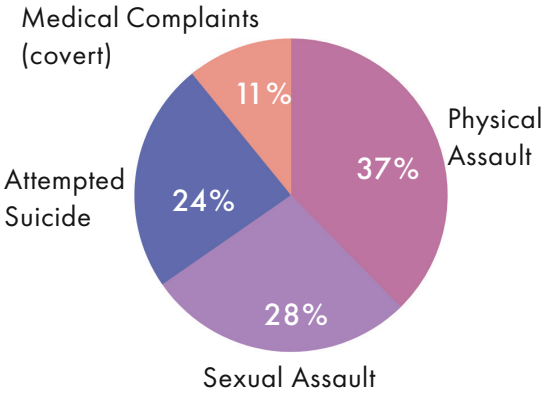
The detailed documentation enabled to understand the impact of violence on health of women and girls. Physical violence resulted in (46%) having cuts bruises, burns, fractures amongst others. Women reporting emotional violence faced consequences such as attempt to end their lives and dealing with depression. Owing to the training and consistent dialogue on VAWG covert signs of violence in the form of anaemia were also recorded and responded to.

Roughly, one in four women seeking counselling services were in the ages of 18 -25 years. This is an important finding as it indicates potential for early identification of violence in health settings and reduce intensity/ frequency of VAW if the woman is offered timely support.

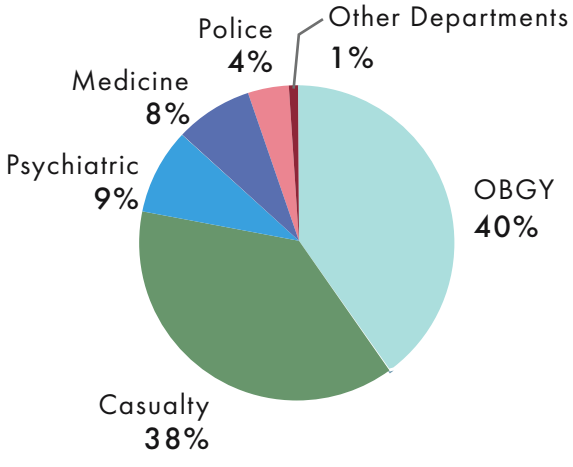
Type of cases



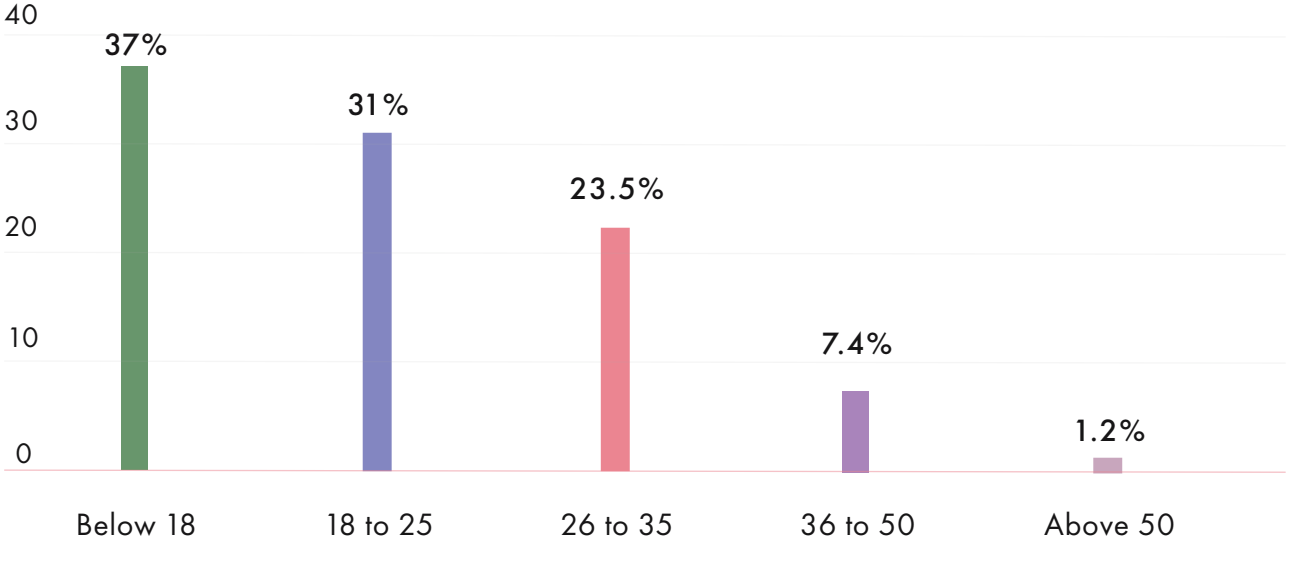
Presenting Health Complaints



Referral Data



Age of Survivors (Years)



Way Forward

The Muktha project has completed two years of initiating a health care response at the level of five hospitals. Despite being set up during COVID 19 pandemic, HCPs participated in trainings, build capacities of their peers and started responding to women and girls facing violence. As is evident that in a span of fourteen months, HCPs have responded to 2763 women which is a significant number. This initiative needs sustained effort from both NHM as well as five hospitals. Now that the program has been underway for some time, it is worthwhile to consider expanding the capacity building to additional hospital departments such as pediatrics, orthopedics, ENT to expand the reach of Muktha program within the hospital itself.

It would be important to create a dedicated team at hospital for psychosocial services. This period has indicated a large case load requiring at least one full time counsellor supported by designated NHM counsellors for provision of psychosocial services.

There is a need to keep up consistent dialogue with the Police and Prosecution authorities so that their support can be drawn for survivors of VAWG. There is an urgent need to initiate joint programs to build capacities of the police and public prosecutors to recognise the scope and role of medical evidence as well as the role of a medical providers in the court of law. It is also important to create a feedback mechanism between the Hospital and other stake holders for HCPs to understand services received by women once they were referred to police, shelter, protection officers, one stop centres to implement a coordinated services delivery in its spirit.

Last but not the least, it is important to incorporate the concept of violence against women as a health issue into Medical and nursing education so as to bolster sensitivity amongst young doctors and nurses from their training institutes itself. This can also promote a culture of zero tolerance to VAW at different fronts.

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

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Violence and Health.