Centre for Enquiry into Health and Allied Themes (CEHAT)

ANNUAL REPORT

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Abbreviations:

AMCHSS: AchuthaMenon Centre for Health Science Studies

CEHAT: Centre for Enquiry into Health and Allied Themes

DMER: Directorate of Medical Education and Research

GMC: Government Medical College

GME: Gender in Medical Education

IEC: Institutional Ethics Committee

KEM: King Edward Memorial Hospital

MARD: Maharashtra Association of Resident Doctors

MBBS: Bachelor of Medicine and Bachelor of Surgery

MCGM: Municipal Corporation of Greater Mumbai

MoHFW: Ministry of Health and Family Welfare

MSF: MédecinsSansFrontières /Doctors Without Borders

MUHS: Maharashtra University of Health Sciences

MWCD: Ministry for Women and Child Development

NUHM: National Urban Health Mission

OB GYN: Obstetrics and Gynaecology

PSM: Preventive and Social Medicine

RGJAY: Rajiv Gandhi JeevandayeeArogyaYojana

RMNCHA: Reproductive, Maternal, Neonatal, Child and Adolescent Health

UNFPA: United Nations Population Fund

VAW: Violence against Women

WHO: World Health Organization

1. INTEGRATING GENDER IN MEDICAL EDUCATION

Collaborative initiative between DMER, MUHS and UNFPA

'Integration of Gender in Medical Education' was initiated in Maharashtra in the year 2013. CEHATinitiated this project, with the support of UNFPA, DMER and MUHS. The strategies of the project are:

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1. Build capacity of medical faculty on gender perspectives and women's health issues through the training of trainers' [TOT] programme.

2. Facilitate teaching of gender perspectives to MBBS students by trained medical faculty.

3. Advocate for policy inclusion of modules integrating gender perspectives in MBBS curriculum by assessing the impact of this programme.

The project aims to integrate a perspective on gender in medical curriculum and teaching through five disciplines of medicine – Preventive and Social Medicine, Internal Medicine, Obstetrics and Gynaecology, Forensic Medicine and Toxicology and Psychiatry. The activities undertaken in the year 2017 and 2018 involved expanding this initiative to medical educators, and including GME modules in Maharashtra's MBBS curriculum.

ACTIVITIES CONDUCTED

Presentation of GME in all deans' meeting

CEHAT presented the GME project at the Deans' meeting at DMER held on 27th April 2017. The presentation intended to create awareness about GME among the deans of all medical colleges. Another objective in conducting this meeting was to bring the deans of three medical colleges (GMC Aurangabad, GMC Ambejogai, GMC Miraj) on board to conduct further trainings of the faculty belonging to all five disciplines. In order to continue and scale up the activity, it was important to expand the pool of GME trained faculty. The deans agreed and committed to start the training after the summer vacations.

Academic Council's approval to inclusion of modules in medical curriculum

The Academic Council's meeting on October 26, 2017 took the decision to include Gender Integrated modules in medical curriculum for the upcoming academic year, beginning June 2018. The decision was also tabled in the minutes of the meeting.

Workshop on Evidence Based Clinical Practices

A preparatory meeting was held at CEHAT office regarding organization of Evidence Based Clinical Practice Workshop. UNFPA representatives, CEHAT staff, GME mentors and GME educators were present for this meeting. A plan was charted out to execute the 1.5 day workshop. It was decided to seek a formal collaboration with DMER and KEM hospital and to request for deputations of medical educators from all five disciplines from medical

colleges across Maharashtra. The topic for 1.5 day's consultation, names of the speakers and clinical checklists to ensure gender sensitive approach were finalised in this meeting. Initially the meeting was scheduled on September 22-23, 2017, which was rescheduled to November 24-25, 2017.

The 1.5 day workshop made an attempt to introduce the medical educators across Maharashtra with the initiative of gender sensitization of medical curriculum, and also to make them aware of formal inclusion of the GME modules. The workshop was attended by almost all the collaborators of GME project - DMER, UNFPA, KEM hospital, GME and CEHAT team and around 35-40 medical educators across Maharashtra.

This workshop provided a platform for the release of Gender Integrated Modules of five disciplines by Dr Shingare, Director of DMER. The GME educator Dr PriyaPrabhu briefly described GME project and presented the 'Action Research' that had been carried out at three government college of Maharashtra (Aurangabad, Ambejogai, Miraj). Other sessions facilitated discussion on consent, communication strategies, issues of privacy and confidentiality and violence against women. Participants' comments suggested that the topics discussed during the workshop were helpful to deal with day-to-day cases in the clinical settings. It succeeded in giving the participants insights on ethics in medical practice. The workshop also highlighted medical educators' need to undergo detailed training on concepts of 'gender' and 'patriarchy.'

Training on Gender Integrated Modules for medical educators

The Gender Integrated Modules will be included in the MBBS curriculum from upcoming academic year from June 2018. But with the approval of MUHS Academic Council, it has become mandatory to incorporate them in the syllabi. Efforts are being made to train the medical educators from 22 medical colleges of Maharashtra. It has been proposed to conduct these training sessions across Maharashtra after receiving permissions from DMER.

2. RESPONDING TO VIOLENCE AGAINST WOMEN THROUGH ENGAGING THE HEALTH SECTOR

Advancing health sector response to Violence against Women

The Dilaasa Crisis intervention centre for women and children was set up jointly by CEHAT and Municipal Corporation of Greater Mumbai (MCGM) in 2000. In 2005 CEHAT ensured that the crisis intervention services became an integral part of the health Service. CEHAT retained the role of technical advisors to the MCGM for training, research and monitoring support. In 2014, the MoHFW (Ministry of health and Family Welfare) issued guidelines for medico legal care to sexual violence survivors. These guidelines and the protocol are based on the comprehensive health care model developed by CEHAT in collaboration with the Municipal Corporation of Greater Mumbai.

Legal Advocacy

The Government of Maharashtra passed a resolution for all hospitals to use the protocols and guidelines issued by the Ministry of Health and Family Welfare. This acceptance has come after a seven year long struggle with the Department of Health, Maharashtra.

The PIL is pending in the Supreme Court of India based on other prayers. Following developments were shared in the Supreme Court of India by Ms. Indira Jaising in the capacity of Amicus Curiae:

- Ministry of women and child department (MWCD) decided to launch a toll free national help line 181 across all the states of India. The purpose of the help line was to reach out to women and girls facing any form of violence and / or distress
- Further the MWCD also launched the OSCC, one stop crisis centre program for each state recently and funds for it have been allocated by the Union govt Finance ministry to MWCD
- Nirbhaya funds which were to the tune of 1000 crores in 2013 received fresh allocation of 1000 crores in 2014. The ministry of finance has transferred the amount of the Nirbhaya funds to the MWCD
- Legal services authority decided to place a lawyer in every police station across the country, which was a demand from the petition of the Delhi domestic working women's forum vs Union of India (1994)
- Ministry of health and family welfare (MOHFW) drafted comprehensive and gender sensitive medico legal guidelines to respond to survivors reporting sexual violence.
- Ms. Jaising submitted before the court that most ministries have been responsive and have provided an update of the steps taken by them. Despite progress made on different fronts, some contentious issues require the attention of the honourable judges.
- The concern related to marital rape and lack of registration of such an offence was raised. Evidence related to survivors reporting to hospitals and wanting to seek legal redress was presented. But due to the lack of provision in the CLA 2013 for registering such an offence police file it under Sec 377, which is dangerous. It was suggested that the exception in the Rape law needs to be struck down for married and separated women to file marital rape under Sec 376.
- The issue of age of consent was also raised. Adolescents in the ages between 16 to 18 years may be involved in relationships which are consensual, however under POCSCO 2012 any sexual activity under 18 years is forbidden. This poses a grave danger to adolescents in consensual relationships.
- One stop crisis centres are being established at the tune of 1 per state, but these are not adequate and such centres be set in each hospital of the country. There is a need to upscale these efforts
- The need for reparation for survivors of sexual violence was mentioned. Even in situations where the perpetrator of the act is not found, once an FIR is in place such compensation must be offered.

- The MOHFW has a comprehensive protocol in place and it has been issued to all the states for enabling health professionals to respond to sexual violence. But many states have not adopted it. The Federal system has specific portfolios under the state; health has also been considered a state subject, which has allowed for different protocols for medico legal work in rape across states. But the direction of the Honourable Supreme court can ensure that all states follow a gender sensitive medico legal protocol across the states of India. This can be done under Article 141/ 142 of the Constitution of India in the context that a direction from the Court in that regard will help with uniform implementation of the guidelines.

Lastly, the honourable Judges were provided with the Amicus brief and the same was shared with all the petitioners as well as with Additional solicitor General for states. Ms.Jaising requested the court to develop a road map for uptake of these contentious issues and resolve them systematically. A two-month period was granted to the ASG to respond to the brief and recommendations therein.

Capacity Building of Partner Organisations:

- UNFPA sought a technical partnership with CEHAT to carry out a series of capacity building workshops with civil surgeons across 23 districts Maharashtra on the implementation of MOHFW protocols for medico legal care.
- CEHAT initiated dialogue with key stakeholders involving Govt of India (MOHFW) as well as experts from fields of law, medicine, human rights, women rights and health activists towards developing medico legal examination protocol for suspect in cases of sexual violence.
- A one day workshop was held in collaboration with Aarambh initiative of Prerana (a Mumbai based organisation) on the role of health sector in responding to sexual violence. The workshop aimed at clarifying queries around navigating the health system, understanding the scope and limitations of medical evidence, pushing for therapeutic care in hospitals and ensuring respectful and sensitive communication with survivors. CEHAT is part of a working group towards ensuring uniformity in health systems response to children facing sexual violence in the POCSO on the Ground series anchored by Aarambh initiative in partnership with UNICEF.
- Jan Sahas, Madhya Pradesh approached CEHAT to conduct a workshop on feminist intervention skills to address VAW for their field workers across the state. The workshop was held over five days for 21 field workers to help them enhance their intervention when working with survivors of violence.

Study on impact of experiencing sexual violence on survivors and families:

The research study was built on a rigorous review of literature as this was a prospective study and we aim to contact all those rape survivors who had accessed our services over 9 years. The scientific review helped to finalise the study objectives and interview guide. After revisions, the study had to be reviewed by the IEC (Institutional Ethics Committee). A lot of

effort was made to convince the IEC for the need to carry out the study and finally the study was certified. This process went on for almost six months. The study required internal capacity building of even existing staff, as the research and intervention role could not be mixed yet both were required in the interviews. Consent forms and interview tool guides have been developed for the study and we have commenced the study.

On-going monitoring of crisis intervention services:

Dilaasa crisis intervention service involves direct engagement with survivors of violence offering counselling, helping them with medical care, providing legal counselling, assisting with filing police complaints and referral to other networks based on their requirement. While carrying out interventions, the team conducts case presentations; as such a forum is important for the counsellors to share their difficulties, challenges and also leads to learning from each other's experiences. While counselling, they have often subscribed to the discourse on counselling ethics and how to ensure that they utilize feminist and ethical counselling.

Replication/ Guidance for Hospital-based Crisis Centres for Women Facing Violence in Other States

The centre follows the Dilaasa model, an evidence-based model functioning in a peripheral hospital of Mumbai for the past 16 years, established as collaboration between MCGM and CEHAT and later integrated as a department of the hospital. CEHAT'S collaboration with the Ministry of women and Child Development (Union of India) had led to the setting up of Dilaasa centre inAsilo Hospital, a district hospital of North Goa. The centre has now been recognised as a department of the hospital. This is a major hospital receiving all referrals from across tehsils and talukas. A training of RMNCHA counsellors from the state was held from June 30 – July 2, 2017. It was geared towards an understanding of the link between violence and health and strengthening identification of survivors in their capacity of coming in contact with adolescents and young mothers.

The possibility to replicate OSCs in the state of **Telangana** was explored in collaboration with TISS. A study visit was initiated in Mumbai on May 2-3, 2017, with the Director and Joint Director of DWCD, Program Officer on Child Health under NHM, Program Officer on Maternal health under HFW, and two senior lady IPS officers.

A meeting was held on May 16 followed by a study visit in Mumbai on June 13-14, 2017, with the Deputy Director from DME, head of departments of OBGY, Paediatrics, Nursing and Assistant Director of Social Welfare from the state of **Tamil Nadu**.Discussions were also held with **Karnataka** state to replicate OSCs. It was decided to conduct trainings for healthcare providers in both the states.

Trainings were conducted in the state of **Haryana** as part of the state's initiative to replicate the Dilaasa model. Joint trainings were conducted for Yamuna Nagar District Hospital and Ambala hospital on August 2nd and 4th, 2017. Both hospitals currently follow the Dilaasa model under the name 'Sukoon'.

Due to CEHAT's engagement with the Delhi High Court and the Director of health services, a government order for implementation for MoHFW protocols was issued in November 2017 in **Delhi NCR**.

Madhya Pradesh has already set up Gauravi centre (by Action aid) as well as has a government order for implementation of MoHFW protocols.CEHAT participated in a 1.5 day workshop on June 19-20 in Bhopal, **Madhya Pradesh**, for 35 healthcare officials. Additionally, 18 OSC counsellors were trained at a 5 day course organized in collaboration with PSI from May 9-13, 2017.

A three-day training workshop was conducted in collaboration with the Gender Resource Centre of the state of **Gujarat** for participants from OSCs and helpline counsellors for a three day training held from September 14-16, 2017.

3. GOVERNMENT FUNDED HEALTH INSURANCE SCHEME IN MAHARASHTRA: RAJIV GANDHI JEEVANDAYEE AAROGYA YOJANA

The report on Maharashtra's RGJAY scheme analyses two years of implementation, and raises several concerns as well as loopholes in the scheme. A mixed -methods approach was taken for a holistic understanding of the scheme implementation. Qualitative methods were used to study one empanelled public hospital study and one empanelled private hospital and the RGJAY staff, TPA doctors, patients to get a multiple stakeholder perspective on the scheme functioning.

The findings of the study revealed that despite such a large empanelment of the private sector, the scheme has not been able to reach rural population and remote districts which was a crucial goal of the scheme, to cover majority of the state population. The disparity in terms of the service availability across districts continues to exist, forcing patients to travel to other districts to avail health care. Besides lack of awareness about the scheme, the beneficiaries accessing the scheme faced barriers like problems with medical documentation, unavailability of services, etc. Out-of- pocket expenditure was one of the major grievances even as many times it went unreported. Many patients were satisfied even though they had incurred some out-of- pocket expenses. Poor accountability and overall lack of adequate monitoring mechanisms prevent efficient execution of the scheme.

The new National Health Policy (NHP) was also introduced in 2017. A key objective of the NHP is to align the private sector towards public health goals. Its main strategy is to ensure free comprehensive primary care provision by the public sector, supplemented by strategic purchase of secondary care hospitalization and tertiary care services from both public and non-government sector to fill critical gaps. The key mechanism of strategic purchasing is insurance schemes. Thus in the larger context of ensuring Universal Health Coverage (UHC), government funded health insurance schemes seek to play a very large role.

In this context, critical questions need to be asked such as: What have been the various bottlenecks, successes and failures of the existing national and state level insurance schemes? What are the lessons learnt so far for these to be scaled up? What have been the experiences

of the users? What has been the experience of for-profit private health sector? What are the pros and cons for adopting the insurance approach to realise the goal of Universal Health Care? What are the crucial gaps that need to be addressed for health systems strengthening for UHC and how?

With the objective in mind, and in the context of the findings of the study, we approached the Tata Institute of Social Sciences, Prof T. Sundararaman, Dean - School of Health Systems Studies and Dr.SoumitraGhosh, Assistant Professor, School of Health Systems Studies; for the purpose of collaboration for a national level conference. They readily agreed and extended full co-operation and support. A national level conference was thus organized in collaboration with Tata Institution of Social Sciences (TISS) on October 13-14, 2017.

Abstracts on the above themes were invited from research scholars, academicians, independent researchers and practitioners engaged in research on health insurance and allied fields of public health in India. All abstracts received were reviewed by a joint Technical Advisory Committee (TAC) of CEHAT and TISS. The members of the TAC included Dr Padma Prakash, Mr. Sunil Nandraj, Dr. Padma Bhate – Deosthali and Dr SoumitraGhosh. Shortlisted abstracts were sent comments by the TAC, with a request to review for presentation in the conference. Some senior experts in the field were also invited to share their experiences and evidence. These were Dr SakhtivelSelvaraj, Dr. V.R Muraleedharan, Ms.Sulakshna Nandi and Dr. Nishant Jain. Thus the conference had a fair balance of expert views as well as gave opportunity to young researchers to share their findings.

The last session comprised of a round table do discussions where in the core findings and recommendations emerging from the conference were discussed and eventually finalized over email. The core findings document is also uploaded on the CEHAT website and findings themselves have been shared across several forums, along with the findings of the CEHAT RGJAY study for the purpose of discussion and debate (The core findings can be read here: http://www.cehat.org/announcement/1518674992).

These forums / submissions include Call For Evidence UN Secretary-General's Independent Accountability Panel: 2018 Report On Private Sector Accountability, For Women's, Children's And Adolescents' Health; Submission to RajyaSabha MP, Shri. Jairam Ramesh (Jointly with others); article in the Wire Submission, to the EPW ; Presentation by CEHAT (Presentation made by Dr. Padma Deosthali and prepared jointly) For Redefining The "Public Good": Exploring The Conceptual Contours Of Public Good In The Context Of "Public-Private Partnerships" In The Delivery Of Public Services Co-Organized by: School of Habitat Studies, Tata Institute of Social Sciences, Mumbai Zakir Husain Center for Educational Studies, Jawaharlal Nehru University, New Delhi (with EQUIPPPS network) and a training for community health workers of AIDWA, Maharashtra.

4. PERCEPTIONS OF BEHAVIOUR: HEALTH CARE PROVIDERS AND VIOLENCE IN LABOUR ROOMS

Collaborative Initiative: CEHAT, Aurangabad Medical College and Dilaasa, KB Bhabha Hospital, Bandra (West)

Though studies on the topic use varying terms such as ‘disrespect and abuse’ and mistreatment during facility-based childbirth’, the present report shall use the term ‘obstetric violence’, a commonly used term globally (Savage & Castro, 2017), to refer to maltreatment of women during childbirth. In 2007, Venezuela became the first country to formally define obstetric violence (through the Organic Law on the Right of Women to a Life Free of Violence, 2007) as: the appropriation of women’s body and reproductive processes by health personnel, which is expressed by a dehumanising treatment, an abuse of medicalisation and pathologisation of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life.

Bowser and Hill (2010) operationalized the term further so as to include one or more of the following aspects:

i. Physical abuse (e.g. pushing on a woman‘s abdomen to try to force the baby out)

ii. Non-consented care (e.g. performing a Caesarean section without the woman’s consent)

iii. Non-confidential care and denial of privacy (e.g. being forced to deliver in public view)

iv. Non-dignified care (e.g. humiliating, blaming or scolding the woman in labour)

v. Discrimination based on specific attributes (e.g. being insulting towards teenage mothers)

vi. Abandonment and neglect and refusal to grant assistance (e.g. staff not attending to an emergency delivery)

vii. Detention in services (e.g. detaining the woman and her baby in the health facility owing to her inability to pay the fee)

Through its work at Dilaasa, women have confided to counsellors about mistreatment they have suffered at the hands of healthcare providers during childbirth. CEHAT has embarked upon a study to explore this phenomenon. As a first step, a compilation of annotated bibliographies on obstetric violence is being worked upon, which in the process of finalization. The findings and emerging gaps from the annotated bibliographies will feed into the primary study.

For compiling annotated bibliographies, a desk review of secondary literature was undertaken which comprised primary studies on obstetric violence. A list of studies on obstetric violence was populated through an internet search using the search terms obstetric violence’, ‘disrespect and abuse during childbirth’, ‘respectful care during childbirth’, and ‘labour room violence’. Titles of the studies thus obtained were screened for relevance. 52 studies were thus shortlisted. These studies were then subjected to the following inclusion criteria:

i. Must be primary studies

ii. Must be published in a peer-reviewed journal

25 of the 52 studies met the inclusion criteria. A final list of 25 studies (out of which 6 were conducted in India) was included in the present review of literature.

Following the compilation of the annotated bibliographies, a review was conducted of the studies selected, wherein trends in studies such as the time period of the studies, country locations, objectives of the studies, settings, and key findings were studied. The findings were organized according to themes, and thus presented.

A vast majority of the studies had been conducted in the years following the WHO statement on prevention and elimination of disrespect and abuse during facility-based childbirth in 2014. Studies were mainly exploratory in nature exploring perceptions of mistreatment during childbirth. Prevalence studies, largely undertaken in African countries, revealed varying rates of obstetric violence, ranging from 5% to 83% in some settings. Behaviours such as scolding or slapping women during childbirth were seen as normative or even necessary by both, healthcare providers as well as women, for the better outcome of the baby. Higher rates of obstetric violence were reported among women hailing from social minorities, lower socioeconomic strata, those having greater parity, or having HIV positive status. Interventions at health facility level to prevent and eliminate disrespectful practices during childbirth were seen to be hindered by excessive workload of healthcare providers and lack of basic infrastructural facilities. Hence, an urgent need for programs addressing obstetric violence through a comprehensive social-behavioural approach, working from the individual to the policy levels, and at both, the health provider and the client sides, was identified.

This compilation of annotated bibliographies and the analysis of studies were presented before the Programme Development Committee on April 6, 2018. The document is currently being worked upon based on the feedback received from the committee members, and is undergoing finalization following which it shall be sent for publication.

5. VIOLENCE FACED BY RESIDENT DOCTORS IN PUBLIC HOSPITALS OF MAHARASHTRA BY PATIENT/S AND / OR RELATIVE/ S AND / OR ESCORT/ S

Collaboration between CEHAT, KEM and Maharashtra Association of Resident Doctors

Studies conducted globally have revealed the phenomenon of violence being inflicted on doctors, nurses and other healthcare providers. Studies have indicated that the factors leading up to this violence can be organizational, societal or individual; relatives of patients were most commonly found to be the perpetrators. Violence against healthcare providers impacts their physical and psychosocial health adversely; some studies even indicate signs of post-traumatic stress disorders in doctors who had faced violence.

Resident doctors form the backbone of the Indian public health system. Recently, there have been numerous cases of attacks on resident doctors in Maharashtra perpetuated mainly by caregivers of the patient, and the issue has gained national importance. CEHAT, in

collaboration with KEM hospital and the Maharashtra Association of Resident Doctors (MARD), has initiated a study which explores resident doctors' perceptions of violence. The study uses the quantitative approach, and shall collect data using an online survey questionnaire. The study has been cleared by the IEC committee of CEHAT as well as KEM.

The survey comprises of questions for doctors who have not only faced violence, but also those who have witnessed violence or have neither faced nor witnessed violence, but have an opinion to share. The survey seeks information not only on perceptions of violence, but also on recommendations which resident doctors feel shall improve and make safer their working conditions.

The questionnaire is being administered online using Google forms (developed with the help of IKF Foundation). It was pilot tested and revised. It was then sent to various WhatsApp groups of resident doctors across hospitals in Maharashtra. WhatsApp plays an important role in connecting and mobilizing various Maharashtra Association of Resident Doctors (MARD) heads of hospitals, core group members and members. The questionnaire was first circulated on the night of March 22, 2018. It will remain open to response for two months.

6. PATIENTS' RIGHTS WEBSITE

CEHAT and Iris Knowledge Foundation have collaborated to create a website (http://www.patientsrights.in/pr/AboutPR/About_Us.aspx). It aims to equip patients with information that make them aware of their rights as patients, asking for these rights when they are denied the same, and making informed decisions. A framework for the website has been created, wherein information shall be added under various tabs. The proposed tabs are:

i. About the website – relevance (why such a website), what information and help the users can get from it and so on.

ii. About Patients' Rights and Patient responsibilities - overview of what rights patients are entitled to and their responsibilities towards the hospital and physician.

iii. Resource material – includes relevant legislations and guidelines with brief covering note wherein the content is simplified for the website user. It will also include links to various other relevant websites and relevant CEHAT studies/papers.

iv. Filing a complaint - When can you file a complaint, procedure of filing a complaint, important considerations while filing a complaint

v. Discussion threads/Share your story and talk to experts (optional for users)

vi. Case examples – cases filed in courts along with a brief synthesis of information that can help users understand the cases better along with an overview / analysis of cases in India pertaining to violation of patients' rights.

vii. News – links to relevant articles – to be updated every week.

The process of developing the content which shall be added under each of the tabs is on-going. Some of the content shall have to be vetted by experts before final addition to the website.

7. ASSESSING THE EFFECTIVENESS OF A COUNSELLING INTERVENTION FOR WOMEN FACING ABUSE IN ANTENATAL CARE

This research project is aimedat assessing the effectiveness of a counselling intervention in antenatal care setting for pregnant women facing domestic violence. Another goal was to train healthcare providers (HCPs) and equip them with skills to routinely screen pregnant women for violence.

The period from April 2016 to March 2017 was primarily dedicated to data collection of research study accompanied by activities ensuring review, verification and validation.The findings were as follows:

From the women whoparticipated in the study, 155 (68%) women sought support from counselors out of 229 who reported facing violence during thatparticular pregnancy. It was found that women did not cite pregnancy as the starting point of this violence. They reported the violence even before pregnancy. This demonstrates that the pregnancy doesn't act as a protective or triggering factor for women facing domestic violence. Majority of women who didn't seek counseling were not able to make any subsequent visit in hospital.

Women came in contact	**Consented to participate**	**Women facing violence during pregnancy**	**Faced violence in past**	**Suspected**	**Non-realization**	**Sought services**
2778	2515 (90.5%)	229 (9.1%)	83 (3.3%)	113 (4.5%)	96 (3.8%)	155 (67.8%)

About 47% of the women were in the age group of 18 to 24 years and another 43% were in the age group 25 to 31 years. Further, about 70% of women were in their first five years of marriage. Almost 68 % of these women were educated up to secondary level, but were unemployed. About 27% of these women reported filing non-cognizable complaint against the abuser in the past. Nearly half of the women got registered in the hospital in second trimester and about half of these women reported violence as the reason for delay in seeking antenatal care. Interestingly, about one fourth of the women reported the present pregnancy as unwanted. Majority of the women reported facing violence since marriage and the emotional violence was the most common form of violence reported by women during pregnancy.

Physical and reproductive health problems due to violence in lifetime were reported by 41% and 21% of women respectively. The study also found a profound impact of violence on

emotional well-being as almost all the women reported emotional health problems. Suicidal ideation during pregnancy was reported by about 29% of women. During the course of study, some unscientific and unlawful actions by the hospital staff also came to light. Two most common problems faced by women were access to abortion and abusive and rude behaviour of healthcare providers.

The findings from the study contributed towards filling a gap in the literature by providing detailed information about the phenomenon of violence during pregnancy in the Indian context and the impact of a screening and counseling intervention. Evidence on the issue of verbal abuse by HCPs with pregnant women has helped CEHAT in conceptualizing an intervention research in one of the study hospitals.

Research on violence during pregnancy enabled to present the importance of routine screening and it has been institutionalized in two study hospitals. Two refresher trainings of HCPs were carried out during data collection to inform doctors and nurses about the progress of the study, preliminary findings and the problems faced by women at the level of hospital in accessing the healthcare. Further, under National Urban Health Mission (NUHM), hospital-based crisis centres have been started in the 11 peripheral hospitals of Mumbai. CEHAT was involved in providing technical assistance in establishing these crisis centres. The training of healthcare providers in these hospitals emphasized on routine enquiry of violence during pregnancy and referring women to counselors for support services. Efforts are being made to institutionalize the process of screening and responding to violence during pregnancy.

Events:

- CEHAT was one of the collaborators for the sixth National Bio Ethics Conference organized in January 2017. The theme was response of the health system to intimate partner violence within marriage as well as out of wedlock. The coordinator of CEHAT was invited as the chairperson for this theme and shared the experience of working in this field and addressing this issue by building capacity of health system.

8. IMPLEMENTATION RESEARCH TO TEST APPROACHES TO ROLLING OUT WHO GUIDELINES AND TOOLS FOR THE HEALTH SECTOR RESPONSE TO VIOLENCE AGAINST WOMEN

In 2013, the World Health Organisation (WHO) developed clinical and policy guidelines on ‘Responding to intimate partner violence and sexual violence against women,’ for low and middle income countries. India had expressed commitment to the Global Plan of Action agreed upon at the 67th World Health Assembly to develop comprehensive mechanisms to respond to different forms of violence in 2014.

Through this study, CEHAT seeks to implement these guidelines, generate evidence on feasibility of implementation, and also the possibility of developing a model health care response in tertiary medical setup. This project is in collaboration with the WHO, which has undertaken similar initiatives in Afghanistan, Pakistan and some parts of Africa.

Subsequently these guidelines were also developed into a handbook for health care providers for responding to intimate partner violence (IPV) and sexual violence.

This will be a two-phase project. Phase 1 will include formative research to bring in perspectives from women users of public health services as well as providers perspective on offering services. The needs of healthcare providers and barriers faced by them in providing care for survivors of violence will also be assessed. Phase 2 involves implementation of a package of activities such as training, hand holding etc. based on the clinical handbook and the manual for health managers. It will also assess improvements on health care provider performance. The project duration is from March 2018 to February 2020. At the end of this study, a report on implementation of the project and learning based on trainings will be released.

Collaboration has been established with the Directorate of Medical Education and Research (DMER). Two medical colleges in the state of Maharashtra (GMC Aurangabad and GMC Miraj) have been identified for the purpose of rolling out the guidelines. These colleges are already involved in the implementation of integrating Gender in Medical Education (GME) initiative of DMER and CEHAT.

A training of researchers was conducted where research principles, how to seek informed consent, how to conduct a focus group discussions and in-depth interviews, discussion over handling practical issues which might come while conducting research etc. were discussed. A two day stakeholder meeting was held on March 26-27, 2018 in Mumbai. The meeting was aimed at making participants aware of violence against women as a public health issue and efforts taken by CEHAT and WHO towards addressing it. The meeting included several interactive exercises and discussions. The two medical colleges are going to implement this project in their colleges from June 2018, when they are expected to train all the faculty, resident doctors, nurses and support staff on clinical handbook and managers' manual published by WHO and bringing it into the practices.

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Calendar:

Universal Health Care (UHC) Calendar 2018

Report:

RGJAY Report (Government Funded Health Insurance Scheme in Maharashtra: Study of Rajiv Gandhi JeevandayeeAarigyaYojana by SuchitraWagle&Nehal Shah, April 2017, xix, 135 p.
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