ANNUAL REPORT

OF

CEHAT

2012-2013

DETAILED REPORT FOR THE FINANCIAL YEAR 2012 - 13

I. RESEARCH

Charitable trust hospitals study

Charitable Trust Hospitals are one of the oldest forms of public private partnerships in the country. These hospitals get various benefits from the government such as land, electricity at subsidised rates, concessions on import duty and income tax, in return for which they are expected to provide free treatment to a certain number of indigent patients. In 2004, a Public Interest Litigation was filed in the High Court of Mumbai, challenging the hospitals that were not providing free treatment to poor and weaker sections. A scheme was instituted by the high court formalising the 20 per cent beds set aside for free and concessional treatment. In Mumbai, these hospitals have a combined capacity of more than 1600 beds. However, it has been brought to light both by the government and the media that these hospitals routinely flout their legal obligations. Considering that charitable hospitals are key resources for provisioning of health services to an already strained public health system it is vital to ensure their accountability.

This study by CEHAT intended to look at the literature on the history of state aided charitable hospitals in Maharashtra, with special focus on Mumbai, and appraise the nature of engagement between the private sector and the state aided hospitals. It critically reviewed the data submitted by the state aided charitable hospitals of Mumbai to the Charity Commissioner on free and subsidised patients, to estimate the degree of compliance to by the hospitals and also to monitor them. We hope that the findings of the study would be useful in making key recommendations for effective implementation of the high court scheme, especially for guaranteeing access to the poor to the 20% beds that are set aside.

Findings of the study:

- A substantial number of state aided charitable hospitals do not comply with the scheme and the degree of non compliance is quite high.
- Most state aided charitable hospitals never allotted the mandatory 20% beds for treating the poor and instead complained that they were treating too many patients.
- Data reported to the Charity Commission by the state aided charitable hospitals is inadequate, inconsistent and unsystematic. Many hospitals do not even submit the required data.
- Charitable hospitals predominantly treat indigent or weaker section patients at the outpatient level because outpatient (OP) admissions can be passed off as in patient (IP) admissions in the current scheme of things and frees an extra bed that can earn thousands of rupees per day.
- The Indigent Patients' Fund (IPF) is un-utilised by hospitals. It was seen that the IPF has always been in surplus, in fact, to the extent of crores of rupees.
- State aided charitable hospitals invariably underreported donations and bed numbers

at the office of the Charity Commissioner.

- No matter how serious the allegations were, no kind of penalties were levied on the offending hospitals. There was not a single instance where disciplinary action was taken against an offending hospital in Mumbai.

Publically Financed Health Insurance Schemes

Lately, a new crop of health insurance schemes funded by both Central and State Governments
have come into existence throughout India. Significantly high amount of public money is pumped to make these schemes operational. These schemes are designed for the poor masses and have resulted in increase of insured population from 5% in 2008-09 to a whopping 22% in 2010-
11.

An extensive review of literature on the Rashtriya Swastha Bima Yojna Scheme has been conducted. RSBY is a health insurance programme which intends to provide health assistance to people living Below Poverty line, with the technical assistance of agencies like the World Bank and GTZ. The beneficiaries are families of workers in the unorganized sector. The scheme provides cashless hospitalization benefit up to Rs 30000/- for most of the diseases that require hospitalization, in specified empanelled hospitals for a family of five members (with no age limit). As an insurance scheme for the poor based on the PPP model, it is hoped that the scheme will eventually make the geographical distribution of health care facilities more equitable vis-à- vis the rural-urban divide. Literature survey indicates that data on utilisation of services according to gender, age, location, type of insurance etc present patterns that need to be looked at closely at a more disaggregated level. Interestingly, the need to have private providers as a unit of analysis has not been addressed by existing studies on RSBY. While most of the studies identify cost-escalation as a great if not the greatest challenge to RSBY's future, this is one aspect that needs to be explored.

A study which aims to study the implementation of two publicly financed health insurance schemes in Maharashtra is planned. The two schemes being studied are the RSBY and the RJGAY (Rajiv Gandhi Jeevandayee Arogya Yojana). The study will enquire into healthcare availability in the district and its geographical distribution, type of procedures performed at public and private hospitals, utilization pattern and experiences of the beneficiaries.

Using the Public Expenditure Tracking Survey (PETS) for diagnostic purpose in Health Sector in Maharashtra

The Budget is an official policy document, which is indicative of the expenditure incurred and reflective of the policy priorities of the government. The budgetary processes in India are opaque and remain behind the extreme confidentiality of bureaucratic exercises. Even when accessed, the documents are not presented in a language and format that is user-friendly; the language used is too technical to understand making it difficult to comprehend. People, in general, consider the budget

highly technical and very difficult, and only a miniscule proportion of the population understands the technicalities involved. Besides, the most crucial stage of the budget process, that of budget preparation does not allow any kind of participation by civil society organisations. In order to be conducive to public involvement, public understanding and involvement in the budget process is critical for ensuring that the Government is accountable to the public. This Public Expenditure Tracking Survey, conducted in two districts in Maharashtra, explores the budget process through its various stages. The findings of the study outline budgetary processes; the range of issues discussed will help the reader understand all four stages of the budget process (formulation, approval, implementation and auditing).This information on the key actors in the system will not only hold them accountable, but will also help civil society organizations identify opportunities for civic participation. The findings were presented to key functionaries in the state.

Health of Muslims in Maharashtra

This project is an attempt to understand the health status of Muslims in Maharashtra, through review of existing studies and analysis of secondary data sources. It seeks to understand the health status of Muslims in terms of morbidity reported by them, utilization of health facilities and cost of health care. Muslims comprise about 10% of Maharashtra's population and approximately 70% of them reside in urban areas. Within these urban areas, the feeling of extreme insecurity due to growing communalism has resulted in the exodus of Muslims from mixed communities into homogenous ghettoes. The studies conducted by the minorities commission show that living conditions in the ghettoes are abominable, leading to several communicable diseases. The areas seem to be neglected by the municipal corporations - access to clean drinking water and sanitation is extremely poor. There is a dearth of public health facilities in some ghettoes such as Mumbra and Bhiwandi. Where available, the quality of public health facilities is poor and so people prefer to access private health care. However, as the population is largely economically deprived, they cannot afford to access private health care and there is no option but to utilize poor quality public facilities. On the whole in Maharashtra, Muslims fare better than other groups in terms of child mortality rates, but this is because they are largely concentrated in urban areas. Within urban areas, however, they do not fare as well and the IMR is actually higher than other groups. Similarly, most deliveries take place in institutions because of the urban location, but it is important to note that home deliveries among Muslims do occur even in urban areas. The paper also discusses the behaviour of health professionals in public health facilities that reflect communal stereotypes and biases.

It is hoped that the findings of this paper will provide direction to the Government of Maharashtra's efforts in addressing the needs of this minority population. The paper also provides direction for more research on the issue of religious discrimination and its impact on health. The paper is published as chapter 7 of the Report on "Socio-economic and Educational Backwardness of Muslims in Maharashtra" published by the Government of Maharashtra

Maharashtra Human Development Report

The team from CEHAT prepared a background paper on Health and Health Care in Maharashtra, for the Human Development Report, being prepared by YASHADA. The background paper explored health disparities within the state and between districts. It found that the level of inequalities persistent within Maharashtra is unacceptably high. Some of the key findings are as follows:

- Most public as well as private hospitals are in the cities and in 1991 urban areas had 8 times more hospitals and 13 times more beds than rural areas. However, in 2005 this disparity worsened to 13 times more hospitals and 19 times more beds.
- In Maharashtra, only 37.5% villages have a Sub-Centre, only 11.4% villages have a PHC, only 42.6% Villages have a health facility, and only 38.9% Villages have a doctor.
- Data from health programmes indicate that Malaria and TB are emerging as two major threats- Malarial deaths have quadrupled over the last ten years, and urban TB, mostly drug resistant, is on the rise.
- Nutritional indicators from the state do not paint a promising picture either. In a way this is a reflection of low budgetary priority given to health and nutrition.
- When taken as the proportion of SDP, Maharashtra is one of the lowest public health spenders in the country at 0.5%. While the central government is giving more budgetary resources to the state, the state government is not reciprocating to the extent necessary, but abdicating its role of contributing more. State Budgets need to be augmented substantially to fully realise health outcomes. For this the state health sector budget needs to be increased substantially.
- Maharashtra has one of the largest private health sectors in the country, with which the state is forging partnerships in the form of PPPs. Yet, there is no regulation of the sector. Further, Charitable hospitals who are expected to provide services to the poor too are not doing so. The paper calls for the government to take regulatory action in this regard.

The HDR chapter that deals with health has been finalized and the report will be printed this year (2012). It is hoped that the publication will reorient the health policy in particular and social sector policy in general of the state towards better equity.

Paper on role of private health sector

The paper describes the changing political economy in India with a focus on the growth of the private health sector and provides a sound evidence-based critique of the existing situation. It looks at recent trends in growth of the private sector, especially during the last couple of decades. These years were characterized by liberalization of the Indian economy and the structural adjustment policies that followed. The new direction of health policy is towards reducing the role of government while increasing that of the private sector. The paper discusses various ways in which the state itself has provided direct and indirect support to the private sector - in medical education, in the form of concessions and subsidies to private medical professionals and

hospitals, through PPPs, and lack of by lack of regulation. In short, the private sector in India has grown with the support of crutches from the state, which has led to its unprecedented boom. The paper also looks at PPP arrangements in health care critically and identifies policy gaps therein. The paper is particularly important as it raises issues of regulation of the private health care sector, which assumes greater significance in the context of the recommendations by the HLEG on UHC as well as the Steering Committee on Health for the Twelfth Five Year Plan. If UHC means contracting with private providers on an even larger scale without reining them in, it would inevitably result in cost-escalation, large scale corruption and eventual failure. The paper is published as "Appropriate Role for the Private Sector in Health Care in India." Health for Millions. Oct-Dec 2012 Vol.38, No.4.

Exploring Religious Discrimination Against Muslim Women at Health Facilities

During the past two decades, India has seen some of its worse communal conflicts with the rise in religious politics and the spaces for minorities have been shrinking steadily. Through this study, CEHAT sought to understand how this communalisation of both the State as well as civil society impacts women's health and access to health care in Mumbai. The study looks at the experiences of both Muslim and non-Muslim women's experience in accessing health care facility around their locality. The participants have been selected from the same area accessing the same health facilities. The socio-economic group has been controlled by choosing localities that have people of both religions living alongside, in similar conditions. Qualitative methodology using FGD's and in-depth interviews has been used for data collection.

Preliminary analysis of the data shows that both Muslim as non-Muslim women encounter rude behaviour by health care providers. However, Muslim women face an additional communal bias which is manifested in the verbal abuse, often with sexual intent, that they face. Muslim women reported being called by derogatory terms such as 'landiya baika', were taunted for wearing the burkha, encountered stereotypes of being dirty, uneducated, backward, and having too many children. Muslim women reported feeling humiliated, tried to withdraw from health facilities, but never complained or confronted a health care provider, for fear of retaliation. The analysis of the data also brought forth the disadvantage that women face due to their gender, in the form of restriction of mobility, poor access to resources and lack of decision making power in the household. The findings suggest that gender, class and religion all play a role in Muslim women's access to health services as well as the behaviour that is meted out to them there in.

Gender in Medical Education

This project is aimed at the training of medical educators in state medical colleges in Maharashtra to incorporate a gender perspective in their teaching with a focus on issues of gender-based violence and discrimination. The need for this project stems from the key role that medical teachers can play in recognizing and addressing gender bias in medical education and practice, which often translates into poorer outcomes in health service delivery for women. Further, health care providers constitute the first point of contact for survivors of domestic and sexual violence. They can play a critical role not only in evidence collection and treatment, but also in identifying women who may be facing violence but may not report it. There is need for sensitization of the medical profession in understanding violence against women as a health issue and adequate training in addressing it.

In order that medicine becomes more gender sensitive, educating medical practitioners on gender issues and how gender interacts with other determinants of health is important. This is a crucial first step to change biases that exist in the field of medicine at different levels including research, service delivery, textbooks and teaching. This project aims to integrate gender perspectives in medical teaching and curriculum in

Maharashtra by training faculty members of five disciplines, namely, Obstetrics/Gynaecology, Internal Medicine, Psychiatry, Preventive and Social Medicine and Forensic Medicine. The focus is on issues related to violence against women and sensitization of medical students and professionals.

A working group comprising of deans of participating colleges, representatives from DMER and MUHS, project faculty members as well as participating faculty members will be formed in order to advocate for integration of the project output in the medical curriculum in the state.

Participating colleges are: Government Medical College, Nagpur, Government Medical College, Aurangabad, Swami Ramanand Teerth Government Medical College, Ambejogai, Government Medical College, Miraj, Rajarshi Chhatrapati Shahu Maharaj Government Medical College, Kolhapur, Shri Bhausaheb Hire Government Medical College, Dhule, Mahatma Gandhi Mission's Medical College, Navi Mumbai. For more information on the project, please visit: www.gme-cehat.org

Study on Response of Hospitals to the Terror Attacks

Mass casualty incidents often put health systems under a tremendous resource crunch in terms of equipment, adequate staffing and resources. Documentation and research related to such events is critical in policy-making and planning of hospital preparedness. During the 2008 Mumbai Terror Attacks, which left 172 dead and 304 injured the hospitals that responded were the state- run JJ Hospital and its peripheral hospitals: G.T Hospital and St. George's Hospital. In addition the Cama and Albless Hospital itself was under attack, which created a challenging situation for the staff where they had to also ensure safety of patients and themselves. The unprecedented nature and the duration of the attacks further complicated the chaotic atmosphere in which the hospitals had to operate.

This study by CEHAT in collaboration with the Tata Institute of Social Sciences (TISS), Mumbai aimed to understand how these public hospitals responded to the attacks and assess the preparedness of the hospitals to deal with such a crisis from the healthcare providers' perspective. Moreover, it attempted to document lessons learnt and identified ways of improving the response based on experiences of the providers. The study used in-depth interviews of staff in the four hospitals present during attacks regarding detailed accounts of interaction within and outside the hospitals, constraints faced and recommendations for measures to be taken ensuring efficiency.

It is hoped that this study can be a key resource for policy makers and hospital administrators in the preparation and training of health care providers to respond to such events. It stresses for looking at medical interventions during emergencies in the Indian context so that best practices can be recognized and formed into new plans or codified into the existing plans. This study intends to enable the public health system to move from impulsive reaction to proactive response.

Findings

- The study showed that the existing emergency plans at the hospital and city-level were insufficient to meet with pressures and challenges of responding during the attack and should therefore these plans should be made more comprehensive by assessing vulnerabilities and preventive actions.
- There is a need to create standardised protocols and procedures to be followed by the various responding agencies during mass emergency to prevent duplication of resources and time delays.
- The study highlighted that conducting regular trainings and drills of the hospital staff co- ordinating both within and outside the hospital and between agencies can streamline the process of responding to emergencies.
- The provision of systematic psychosocial support for those affected including healthcare providers working during emergencies is an area that needs to be critically looked at.
- There is a need for better communication and co-ordination between hospitals and various agencies like the government, police, media and voluntary organizations to minimize gaps and respond to terrorist-attacks during mass-emergencies.
- The study emphasizes that mass casualties maybe unpredictable but good planning that allows scaling up and incorporates multi-sectoral involvement can drastically improve the response.

Intervention research based on service records

Report on establishing comprehensive health sector response to sexual assault published. This report is based on the experience of establishing a comprehensive health care response to sexual assault at three public hospitals in Mumbai, in collaboration with the Municipal Corporation of Greater Mumbai. CEHAT is the first institution in India to have directly engaged with the public health sector to develop a model to respond to sexual assault. The model includes development and implementation of a gender sensitive examination proforma, operationalization of informed consent and provision of medical care along with crisis intervention services. The report presents ways in which such a model can be run within the existing resources of the hospital.

The report presents ways in which health professionals were equipped to provide emergency health care, recognize voluntary reporting by survivors to hospitals and document sexual assault related findings sensitively. The model also empowered health providers to formulate medical opinion and interpret negative medical findings. The report also presents profile of survivors and challenges faced by them in reporting sexual assault. Analysis of case records and medical records of survivors throws light on the dynamics of sexual violence, nature of health consequences and limitations of medical evidence - which have not been studied to a great extent in the Indian context. Specific recommendations for different agencies such as child welfare institutions, police machinery, community based organisations and so on are discussed in order to create a multipronged approach to respond to sexual assault.

Policy Research on Maternal Health

Globally, every year over 500,000 women die of pregnancy related causes and 99 percent of these occur in developing countries. The Millennium Development Goals (MDG) of the United Nations has set the target of achieving 200 maternal deaths per lakh of live births by 2007 and
109 per lakh of live births by 2015. India as a whole and most states within it lag behind this target considerably. India has a fragmented and myopic approach to addressing maternal health, which is a part of the problem. Through this project, CEHAT has been attempting to highlight the gaps in maternal health related policies and programs in India and make a case for a broader, more comprehensive and rights-based approach to addressing the issue of maternal health.

A national level review on policies related to maternal health was carried out, which threw light on the many lacunae both at policy and implementation levels. The review found that India's policies focus very narrowly on reducing maternal mortality, while overlooking the broader framework of sexual and reproductive rights. As a result, several important issues affecting the health of women are not even addressed. Abortion as a right finds no place in policy and efforts of the government to improve maternal health do not take into consideration ensuring right to abortion services. Prevention of unwanted pregnancies is an integral part of sexual and reproductive rights, but our programs continue to push female sterilization as the only method of contraception, without providing women with other options. Similarly, domestic violence which is known to have an impact on women's control over their fertility, as well as pre and post partum health of mothers is not even addressed as an issue of concern. Policy and programs continue to focus their attention solely on ensuring institutional deliveries, but issues such as violence faced by women during childbirth at the hands of health professionals remains unacknowledged. Post-natal care, the review finds, is extremely poor, and not much effort is being made to improve it. Awareness and access to safe and legal abortion services too is poor. These are serious blind spots at the policy level. In terms of provision of services, the review found an overwhelming presence of the private sector in this regard. Public-Private Partnerships to encourage institutional deliveries have been implemented without any sort of regulation of the private partners. This has implications for quality of services as well as equity in access. Even apart from the PPPS, the overwhelming majority of services such as ANC are accessed from the private sector where its presence is great. In terms of access to services too, the review found stark inequalities based on class, caste, religion, urban/rural location in access to services.

Armed Conflict and Health

Currently in India several states are ridden with low-intensity conflicts. The state of Jammu and Kashmir, the states in the North East and recently Chhattisgarh have been witnessing an extremely complex insurgency as well as several years of civil strife. There is limited documentation or study of the effects on the health and the health system and the challenges of the health system in responding. Violence against women in such contexts is often not recognised but rather it is systematic used as

tool by the state – police and army- as well as the militants or insurgents to silence and terrorize communities.
For the past four years, CEHAT has been engaging with various organizations as well as the State in an effort to address violence in conflict and facilitate an understanding and recognition of it as a public-health issue. The first consultation was held in Srinagar, in collaboration with the J&K State Commission for Women in September 2009, which threw up the need to conduct training programs with health care providers so that they may be able to recognize and respond to the effects of violence specifically against women. Subsequently, in December 2010 and April 2011 with training initiatives were organized in Delhi and Mumbai with participants together from different states in the country, including Jammu and Kashmir, Manipur, Jharkhand, Chhattisgarh and Maharashtra to engage with the issue of violence in conflict situations. As part of future planning, the participants of these trainings identified a need to form a support group that will work towards addressing issues that emerged, such as initiating counselling services, training of health care providers on the issue of VAW and training for conducting autopsy and act as a lobby to provide protection to health professionals from external pressures/politics. They would form a critical mass for bringing about the required changes in the system for sensitising it and for raising the issue of right to health care in armed conflict.

CEHAT was also part of the symposium held by Women Against Sexual Violence and State Repression (WSS) which highlighted the need to develop protocols that would include sexual assault examinations as part of autopsies in areas of conflict, developing a protocol for investigating cases of custodial rape, training of health professionals as well as the police and judiciary to understand the limitations of medical evidence, evolving a way to enable unbiased investigation of cases of sexual assault specific problems related to chain of custody and neutrality of health professionals in situations of conflict.

Currently, CEHAT is in the process of conducting a study the public health profile in conflict regions of Chhattisgarh in collaboration with local health organizations. This study will look at status of the health system in these areas and the effect of violence on the system and document the experiences and difficulties faced by healthcare providers in working in these areas.

ADVOCACY (CEHAT)

Right to health care for survivors of sexual violence-PIL

CEHAT has been intervening in a Public Interest Litigation in the Nagpur Bench of the Bombay High Court since September 2010. The demands of the intervention petition are to ensure right to comprehensive treatment and care for survivors of sexual violence, and to develop gender sensitive protocols for medical examination in cases of sexual assault. The protocols developed by the committee appointed by Government of Maharashtra (GoM) in response to the petition are not gender sensitive and we have been engaging with the committee in this regard. In the

month of June 2012, a hearing was held wherein CEHAT submitted an affidavit to the High Court highlighting the problems in the proformas. One of the significant issues highlighted was that of mandatory reporting – the manual and proforma created by the GoM did not seek consent from the survivor for reporting the case to the police, although mandatory reporting to police is not mandated by law. The court ordered that the Government appointed committee meet with the interveners to address these issues. A meeting was organized by the Government of Maharashtra on 3rd November 2012. The persisting issues with the proforma were discussed. These included the overemphasis on injuries, noting status of the hymen even when irrelevant, inclusion of height and weight as parameters for examination, among others. A detailed note on these issues is available at (http://www.cehat.org/go/uploads/SexualViolence/Issues%20for%20discussion%203rd%20Nov%202012.pdf). However, the committee argued that these were important aspects and must be retained in the proforma. Subsequently an affidavit was submitted to the high court reiterating the problems and the resistance of the committee to accept changes.

Policy Advocacy for implementation of comprehensive and gender sensitive protocols for responding to sexual violence

Having worked with the health sector for 6 years, establishing a comprehensive health system response to sexual violence, which has produced evidence that the health system can indeed be sensitised to provide good services to survivors, CEHAT has been advocating for implementation of gender sensitive protocols across the health sector in India. As part of this effort, we have made submissions to various State governments (link to Delhi Advocacy Page) as well as the Central Government and are part of a committee constituted by the Central Health Ministry to formulate such protocols for the entire nation. CEHAT's effort has been to ensure that the protocols are comprehensive as well as gender sensitive, and that they give adequate attention to healing from trauma, facilitation of which is the main responsibility of the health system.

CEHAT has also made written and oral submissions to the Justice Verma Committee following the Nirbhaya Rape Case in Delhi in November 2012. The outcome of this engagement is the inclusion of the manual in the final report of the Commission in the chapter on Medico legal care, Annexure 6 on psychosocial support and Annexure 7 on guidelines for developing protocol.

We have also taken the legal route by filing an intervention application in the Nagpur bench of the Bombay High Court, demanding implementation of gender sensitive protocols for responding to survivors of sexual violence, and ensuring their right to treatment.

Media Advocacy: Engagement with media on sexual violence and role of the health sector

After the 16th December 2012 incident in Delhi, the media has been consistently reporting on issues related to sexual assault. There has been consistent involvement on this front and our work has been covered by several newspapers- English and Marathi. While most of the media reporting was around gaps in various response systems to sexual assault, we attempted to focus on the good practice that CEHAT and the Municipal Corporation have been able to establish. We also tried to include concerns with setting up of services for healing and rehabilitation of survivors of sexual assault along with changes in the criminal justice system. NDTV, The Week, Hindu have covered specific articles on work of CEHAT. Links to key articles are given below:

Another ordeal begins after rape
http://www.thehindu.com/news/national/other-states/another-ordeal-begins-after-rape/article4302508.ece

Sexual assault medical examination medical evidemce
http://articles.timesofindia.indiatimes.com/2013-01-04/mumbai/36148439_1_sexual-assault- medical-examination-medical-evidence

Rape more than a battle or justicehttp://www.ndtv.com/video/player/india-matters/rape-more-than-a-battle-for-justice/261525

FAQs http://www.cehat.org/go/uploads/SexualViolence/FAQ.pdf

ABORTION AND SEX SELECTION

CommonHealth- Coalition for Maternal-Neonatal Health and Safe Abortion, and Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai organized on 27 February, 2013, a day-long dialogue aimed at creating common ground between those working to prevent sex- selection and those committed to promote women's access to safe abortion. The Dialogue was attended by 30 participants including seven persons from the host organisations.

The dialogue intended to cover the following areas –

- the situation with respect to access to safe abortion services in India today, barriers to safe-abortion access, groups most affected, likely health consequences
- situation with respect to declining sex ratios: extent of the problem, causes, strategies adopted to reverse the trend; policies and interventions through which the campaign against sex-selection seeks to prevent the selective abortion of female foetuses
- Ways in which both groups can work together to promote gender equality, prevent sex-selection and promote access to safe abortion

The participants recommended the following on "*what are the steps that we can take*

to work on preventing sex selection without compromising on women's access to safe abortion services" Give below is the list way forward.

- The "Anti-Sex-Selection Campaign" and the "Right to Abortion Campaign" are not on opposite sides. Both are deeply concerned about gender discrimination and committed to promoting women's rights. In fact, many individuals and organizations are active in both campaigns. This meeting has been another step forward towards working together to maximise our synergies.
- Each one of the organizations present may disseminate widely the action points from this meeting in any forums, workshops, meetings and trainings that they organize or participate in. Online forums such as the http://fassmumbai.wordpress.com/ need to be more active on the issue.
- There is need to document discussions held during such meetings on abortion in order to disseminate the information to other partners in the campaign.
- CommonHealth's website http://www.commonhealth.in/ provides access to a large number of reports and the latest data on reproductive and sexual health, including data needed for advocacy against sex-selection and safe abortion. Participants may please send CommonHealth resources that they have produced on these topics, to help build a pool of resources for both advocacy and for developing IEC materials for public education.
- Organizations and activists as they come across public personas and spokespersons of the cause of women's rights and health rights should educate them on the right terminologies to be used – for example, never to use the term 'foeticide' which has the connotation that an abortion is "murder of the foetus" and is therefore anti-abortion language. It is important that a culture of appropriate terminologies and concepts develops within the campaigns for prevention of sex selection and promotion of access to safe abortion.

TRANINGS & EDUCATION (CEHAT)

Second National course on Comprehensive health sector response to sexual assault

In collaboration with the Department of Forensic Medicine and Toxicology, Seth GS Medical College & KEM Hospital, Mumbai, we organized the second national course on comprehensive healthcare response to sexual assault survivors. The course, held in Mumbai on 31st March and 1st April 2012, received an exceptional response from doctors across Maharashtra. Teams comprising of a gynecologist, forensic medicine specialist, pediatrician and psychiatrist from

medical colleges across Maharashtra as well as senior health administrators from other states of India participated, with a total of 27 participants.

Led by national experts from the fields of gynecology, forensic medicine, law, and social sciences, the workshop was hugely successful in stimulating discussions vis-à-vis the therapeutic and evidentiary role of doctors in responding to survivors of sexual assault. Various methods such as role plays, film screening, case studies, and facilitated discussions were employed to build perspectives of doctors on sexual violence, and their ethical and legal responsibilities. It is expected that after this training delegates will devise and implement uniform, gender-sensitive protocols for sexual assault survivors in their respective health system. The course received CME accreditation from the Maharashtra Medical Council demonstrating its relevance to in-service training for post-graduate doctors as well as for incorporation into the medical curriculum for undergraduates.

Seminar On Gender Based Against Women- Role Of Healthcare Providers

A seminar on comprehensive response to gender-based violence was organized in collaboration
with the Department of Forensic Medicine and Toxicology, Seth GS Medical College and KEM Hospital, on 15th April, 2012. The seminar received an unprecedented response with over 200 registrations. Participants ranged from disciplines of gynecology, forensic medicine, surgery, pediatrics, psychiatry, internal medicine, orthopedics, preventive and social medicine, pathology, physiology, anatomy and pharmacology. These included medical students, resident doctors,
medical faculty, general practitioners, specialists/ consultants, hospital administrators, social workers and lawyers. While predominantly from government and private medical colleges and hospitals of Mumbai, there were representations from Pune, Nagpur, Pardi, Kamthi and Chandigarh as well.

National experts from the fields of gynecology, forensic medicine, community medicine, law, and social sciences led discussions with healthcare providers. Adv. Flavia Agnes delivered the keynote address highlighting responsibilities of doctors vis-à-vis the judicial frameworks governing domestic violence and sexual assault in India. Dr. Jagadeesh Reddy, Renu Khanna, Dr Sanjay Oak, Dr Kamakshi Bhate, Chitra Joshi, Sangeeta Rege and Dr Padmaja Sawant were other speakers at the semina, The Maharashtra Medical Council granted 2 CME credits to participants for attending this seminar. Participants expressed satisfaction with their learning through this seminar, and echoed the need for greater sensitization of health professionals on this issue through incorporation in MBBS curriculum.

Capacity Building Of Health Professionals In Delhi Hospitals

Following the Delhi High Court Order of 2009, the All India Institute of Medical Sciences
[AIIMS] in Delhi is in the process of implementing a similar sexual assault response model in their hospital. They had approached CEHAT to conduct trainings for resident doctors to equip them with necessary perspectives and skills in responding to survivors of sexual assault. Two half-day workshops were planned on the 26th and 27th of May, 2012 for doctors from the gynecology and forensic medicine departments at

AIIMS and Dadadev Hospital. The workshop was attended by 100 doctors and nurses from the departments of Gynaecology, Forensics, Emergency Medicine and Hospital Management. AIIMS is currently in the process of developing a protocol for medical examination in cases of sexual assault and in this light, the proforma for medical examination developed by CEHAT was discussed at length during the training. Possibilities of a follow up training were discussed as well as a joint intervention research project was discussed.

Training On Domestic Violence

Training was initiated in 2012-2013 at the five peripheral hospitals. There was one core group meeting held at KB Bhabha Bandra, two at KB Bhabha, Kurla, two at Cooper, two at Rajawadi and one at MT Agarwal hospital. At KB Bhabha Kurla and MT Agarwal hospitals, the film *At the Crossroads* was screened for the staff. It was mainly attended by the nurses at both hospitals. KB Bhabha Kurla had around 15 participants and at MT Agarwal 36 health care staff including nurses and technicians and support staff attended. After the film screening, there was a discussion for 1 hour on the issue of Domestic Violence. At Rajawadi, an orientation of the new staff about issue of Domestic Violence was facilitated by the core group members and Dilaasa team.

On 8th of March, International Women's Day was celebrated by organizing skits and a poster competition. This was done with a view to increase awareness and sensitivity of the women employees of the hospitals, to help them recognize and appreciate themselves as women and to emphasize the importance of reaching out to the patients during the OPD hours. The counsellors have also been involved in training and activities to create more awareness at community level. Such community awareness programs were held at Kurla, Chunabhati and Vikhroli areas. Chehak organization had invited Community Development Officer of KB Bhabha Hospital and the counsellors at Dilaasa centre for an interaction with the women in Goregaon centre to promote awareness about the issue of domestic violence. They were also invited to conduct training for the new appointed Community Development Officers at a hospital.

Training On Sexual Violence

With the change in the law for sexual assault (Criminal Amendment Act, 2013 and Protection of Children from Sexual Offences, 2012), the interventions and the trainings were made more robust to accommodate this change. A total of 86 doctors were trained in 6 trainings in the 3 hospitals. An additional 66 doctors and health care providers including nurses were trained in 2 other hospitals (Jaslok Hospital and Centenary Hospital, Govandi) that asked for the training. In this one year, there have 3 joint monitoring committee meeting with the members of the monitoring committees of all 3 hospitals with one monitoring committee meeting in each hospital every month. These monitoring committee meetings look at the issues in providing a comprehensive healthcare response to the survivor. These meeting provide a platform for the doctors, the nurses, the MO, the MS and the MRO to talk about the problems they face while providing services and try to come up with solutions to overcome these.

Capacity Building On Role Of Health Professionals In Responding To VAW

In this period 3 trainings on comprehensive health care response to sexual

assault were conducted in these hospitals where 15 resident doctors and housemen participated. The components of the training were perspective building, importance of taking informed consent, eliciting detailed history, thorough examination, orientation to SAFE kit and how to use it to collect the different samples, importance of drafting the provisional opinion etc. Different case studies were used during the training to make them understand the model thoroughly. In addition to this, resource persons from CEHAT were also invited to other hospitals such as Sion Hospital and Thane Civil Hospital to conduct sessions on sexual assault examination and importance of the health system in responding to Violence Against Women.

Inclusion Of Training On Violence Against Women In The BMC-Training Cell

Since 2011, CEHAT has been advocating for inclusion of the trainings on domestic and sexual violence for health professionals, into the regular training sessions held by the municipal corporation of greater Mumbai. A proposal for this too was submitted to the CMS back in 2011 and was approved. The BMC's training cell conducts several trainings for staff on issues such as biomedical waste management, transfer protocols etc. Along with this, a 2 hour session on Violence Against Women as a Health issue was also included in the training. The session covered both sexual and domestic violence, the dynamics of violence, its health consequences, and the legal and ethical role of health professionals in responding to survivors of violence. Two such trainings were conducted in the reporting period – one with clinical and the other with non- clinical staff. In addition to this, a need was also expressed by the BMC to conduct specific trainings for doctors on Medico-legal Procedures and Mental Health. These have been planned in the forthcoming months.

Counselling Ethics Workshop

The ethical guidelines for Domestic Violence counseling which were published as part of the project were disseminated among NGOs at a workshop organized at the Savitribai Phule Gender Resource Center on 17th November 2012. The workshop was attended by a range of organizations providing services to survivors of DV. Some of the participants were trained counselors, while others were barefoot workers. The participants were provided with an overview of feminist counseling, after which they were asked to reflect on the principles outlined in the guidelines - against their own practice. The discussion that followed was extremely very insightful. Organizations spoke of the manner in which their practice sometimes jeopardized ethical principles. For instance, one organization spoke about how they were required to submit names and addresses of beneficiaries who sought counseling support, to the social welfare department. This was treated as a governmental requirement, without realizing the implications that it might have for the survivor's confidentiality. Similarly, one counselor from a telephone helpline spoke of how they mandatorily reported cases of all callers expressing thoughts of ending their lives, to the police. The implications of these for the client were discussed, as were ways in which they could operationalize the guidelines into their own counseling practice, in order to ensure that ethical principles were respected.

Feminist Counselling Course In Nirmala Niketan

Having conducted two courses on Feminist Counseling in Violence Against women in collaboration with the Tata Institute of Social Sciences, we were approached by Nirmala Niketan College of Social Work to conduct a session with their students. A day-long course for MSW (part 2) students was conducted in December 2012. The course was aimed at building a feminist perspective in counseling and imparting skills on feminist counseling in violence against women. Through interactive methods such as case studies and role plays, the course helped students understand the dynamics of domestic violence and the strategies that can be employed in counseling.

INTERVENTION AND SERVICE PROVISION (CEHAT) Crisis Intervention Services For

Survivors Of Sexual Violence

During the year, 61 cases of sexual violence were responded to. Counselling services continued

to be given to these survivors and their families. Through our intervention we have attempted to ensure that the medico-legal examination is sensitive and scientific, while also ensuring that the survivor gets comprehensive treatment and care while they were in the hospital. We have also helped survivors negotiate with the police and legal system. There have been several problems in dealing with the police in the recent past. At the 3 hospitals where the comprehensive health care response to sexual assault is being implemented by CEHAT, a need emerged for creating a group of health care providers in the hospital who would monitor the response to each case. It was decided in consultation with Dr Seema Malik (Chief Medical Superintendent) that a Monitoring Committee should be formed in each of these hospitals who will make sure that a comprehensive healthcare response to each sexual assault survivor in the hospital is operationalized. The Monitoring committee includes Medical Superintendent of the hospital, Medical Officer, Lecturer or Registar of each Gyneacology unit, sister in charge of Labour/ Gyneacology ward, Community Development Officer and Medical Records Officer of the hospital. During this period two Monitoring committee meetings were held. In the first meeting, purpose of forming this monitoring committee was explained to them, the components of the model and principles for intervention were presented. It was decided that detailed Standard Operating Protocols outlining role of each health care provider would be prepared which will help to ensure that each component of the model response is operationalized effectively. During this period there were also some concerns related to with the Forensic Science Laboratory. To deal with this, there was a felt need to have one meeting with FSL to understand the procedure of sending samples to FSL. At the second monitoring committee meeting held in December, Dr Desai from the FSL was invited to explain the requirements of the FSL and how samples should be packed, sealed and sent to FSL.

Standard Operating Procedures (SOP) for Sexual Assault Response at Hospitals

At the 3 hospitals where the comprehensive health care response to sexual assault is being

implemented by CEHAT, a need emerged for standard operating procedures to guide hospital administrators and examining doctors in managing care for survivors of sexual assault. In response to difficulties that survivors encountered at these hospitals, which sometimes resulted in examination/treatment being delayed or denied, draft guidelines were prepared by CEHAT. The guidelines encompass provisions related to treatment,

admission, free care, informed consent, police intimation and so forth. These will aid providers to adequately address the needs of survivors as well as meet procedural requirements. Feedback received from doctors in the SAFE Kit trainings reiterated the need for such guidelines.

The Savitribai Phule Gender Resource Center (SPGRC) is a BMC initiative for fostering work related to gender, health and VAW. A draft SOP was prepared by the team and shared the Savitribai Phule Gender Resource Center to assess the feasibility of implementing these in all MCGM hospitals of Mumbai. A presentation on the SOP was made to the SPGRC who endorsed it. They approached the Additional Municipal Commissioner (AMC) for its implementation. The AMC (City) approved the SOP and it is ready for implementation. This SOP will hopefully bring in uniform protocol in responding to Sexual Assault cases in at least the Municipal Corporation hospitals.

DILAASA

There were 209 new cases registered at KB Bhabha, Bandra during the period April 2012 to
March 2013. While at KB Bhabha, Kurla, the number of new cases registered was around 56. There were243 follow-up interventions carried out at KB Bhabha Bandra and 29 at KB Bhabha, Kurla. These cases are referred from the health system (doctors, nurses, and support staff), from the community, from ex clients and other such sources. There are weekly meetings held at the Dilaasa Centre, Bandra where cases are discussed with the other members of the team. Around
35 such case presentations have been held in this period. These case presentations involved in depth discussions on documentations, safety planning exercises, understanding of alcoholic addiction and safety planning for women, discussion on intake sheet other than discussing cases of the counsellors. The topics for these discussions are based on the experiences and comments shared by the team which led to planning of themes for the CPs. A system of telephonic follow ups was put in place through discussions in case presentation.

Whenever the woman needed legal help, she was provided with it with the help of the lawyers from Majlis who visit the centre. When the woman needed urgent assistance, an appointment was sought from the lawyer and the woman was directly referred. Under the provision of PWDV Act, women can be directly referred to the Protection Officers for filing of DIR so that the matter comes on board faster. Hence, in some cases, the counsellor directly referred a woman to the Protection Officer. This decision of referring the woman to the Protection Officer was made based on the specific need. At KB Bhabha, Bandra, counsellors interact with the health care professionals of the hospital on a regular basis. A system of maintaining a register has been in place recently to assess the overall interaction and its impact. Counsellors found that when there was such regular interface with the doctor at the casualty, the number of referrals increased by that particular doctor. Counsellors also regularly visit the wards and talk to the patients, the nurses and provide information about Dilaasa and its services.

DOCUMENTATION AND PUBLICATION (CEHAT)

Review was conducted and changes for missing or incomplete data in SLIM Library software was completed in 2012. The entire library collection is bar coded. The editing work for documentary films is completed. Short abstract of the documentaries and other documentary details were added to the section till 2012. E-document sections links are given to the soft copies either on the web or in-house resources.

The Stock taking of the library was done with a detailed documentation process. In which transfer of books from CEHAT library to CSER library was done and same was updated on SLIM. The locations of the books which are under SATHI library are changed and they are now reflecting under SATHI and not CEHAT. As an ongoing process website is updated on regular basis with Publications, Articles, Reports, Press coverage, events. We are regularly posting news on Face book page.

Promoting the Library and Documentation Unit Collection : Our main focus still remains on promoting the collection of the Library and Documentation that includes Online catalogue, research studies/resources available on CEHAT website to others organizations, individuals, students, institutes and academics apart from the old contacts through e-bulletin, group mails to target audience, and other web-based tools. Publications are displayed in various events.

News alert are send regarding the relevant projects to relevant teams as a ongoing process.

The research area webpage is user friendly that the information which is required by the user is accessible at one glance.

Details about each project, research are easily located under the links to all the publications i.e. reports, paper/articles and resources material developed under that research area. For example: http://www.cehat.org/go/ResearchAreas/HealthServicesandFinancing. A webpage on Domestic Violence (http://www.cehat.org/go/DomesticViolence/Home) was developed which gives details about the work done by CEHAT in this area and links to various resources.

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STAFF DETAILS AS ON 31ST MARCH 2013

Name of the Staff	Designation	Gross salary	Centre
Dinali Hataskar	Research Associate	11,426.00	CEHAT
Shobha Kamble	Office Assistant	14,641.00	CEHAT
Vidya Todankar	Secretary	15,217.00	CEHAT
Anjali Kadam	Secretary	18,671.00	CEHAT
Bhavna Lalwani	Senior Research Associate	26,883.00	CEHAT
Prachi Avalaskar	Senior Research Associate	27,983.00	CEHAT
Pramila Naik	Senior Research Associate	28,258.00	CEHAT
Sana Contractor	Research Officer	41,919.00	CEHAT
Padma Deosthali	Coordinator - CEHAT	80,685.00	AT
Ramdas Marathe	Office Assistant	14,191.00	CEHAT
Sudhakar Manjrekar	Office Assistant	14,641.00	CEHAT
Dilip Jadhav	Office Assistant	14,641.00	CEHAT
Vijay Sawant	Secretary	19,196.00	CEHAT
Siddharth David	Senior Research Associate	26,883.00	CEHAT
Oommen Kurian	Senior Research Officer	43,011.00	CEHAT