Centre for Enquiry into Health and Allied Themes (CEHAT)

ANNUAL REPORT
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ABBREVIATIONS

ANC: Antenatal Care

BMC: Brihanmumbai Municipal Corporation

CEHAT: Centre for Enquiry into Health and Allied Themes

CWC: Child Welfare Committee

DCPO: District Child Protection Officer

DMER: Directorate of Medical Education and Research

GMC: Government Medical College

GME: Gender in Medical Education

HCP: Health Care Providers

IEC: Institutional Ethics Committee

KEM: King Edward Memorial Hospital

LGBTQI: Lesbian, Gay, Bisexual, Transgender, Questioning (or: queer), Intersex

LIVES: Listen, Validate, Enhanced Safety and Support

MARD: Maharashtra Association of Resident Doctors

MBBS: Bachelor of Medicine and Bachelor of Surgery

MCGM: Municipal Corporation of Greater Mumbai

MIS: Management Information System

MoHFW: Ministry of Health and Family Welfare

MTP: Medical Termination of Prgnancy

MUHS: Maharashtra University of Health Sciences

MWCD: Ministry for Women and Child Development

NHM: National Health Mission

NUHM: National Urban Health Mission

OB GYN: Obstetrics and Gynaecology

OSCC: One Stop Crisis Centre

PNC: Postnatal Care

POCSO: Protection of Children from Sexual Offences

VAW: Violence against Women

WHO: World Health Organization

1. INTEGRATING GENDER SENSITIVITY IN HEALTH RESPONSE THROUGH ADDRESSING VAW AND VIOLENCE IN LABOUR ROOM AND RESEARCH ON IMPLEMENTATION OF TARGETED HEALTH INSURANCE IN ACHIEVING UNIVERSAL HEALTH CARE FOR WOMEN AND THE MARGINALISED

ACTIVITIES CONDUCTED

Training of healthcare providers: A curriculum to address intersectionalities in sexual and reproductive health

The project primarily aims to strengthen the health system response to VAW, and address the issue of labour room violence. However, these phenomena do not exist in isolation; many social factors intersect to moderate the intensity and the effects of violence against and abuse of women. VAW is being growingly recognized as a public health concern, the issue of disrespect and abuse of women in labour rooms of hospitals remains unacknowledged; the thrust on increasing the rates of institutional births is also exacerbating the issue, and not translating into quality care for the woman.

Adverse behaviours in labour rooms stem from deep-seated attitudinal biases against various populations of the society. Hence, it became important for the training to address these root causes of mistreatment of women. The needs of doctors and nurses with regard to the training would be different; hence two different trainings were conducted, one for nurses and one for doctors. A training for 34 nurses from MCGM hospital was conducted on 21st and 22nd August 2019. Similarly, another training for 24 doctors from all over India, was conducted on 20th and 21st September 2019, in Mumbai.

The trainings covered the following topics:

- Sexual and reproductive rights of women/ girls belonging to sexual minority communities, sex workers
- Accessing sexual and reproductive rights
- Physical disability – negotiating sexual and reproductive health rights
- Religion based discrimination and health rights
- Caste based discrimination and access to health care
- Preventing labour room violence

Participants reported that the trainings had indeed been useful in sensitizing them to the differing needs of populations which availed of their services, and had been novel information which they had not been exposed to before.

2. BUILDING EVIDENCE ON THE HEALTH NEEDS OF ADOLESCENTS AND YOUNG WOMEN

Collaborative initiative between CEHAT, Stree Mukiti Sangathan, Jan Sahas and AALI

CEHAT was able to establish collaborations with three diverse organisations namely Stree Mukti Sangathan, Jan Sahas and AALI. The project entails building research capacities of CEHAT and other 3 organisations so that their rich data can be utilized effectively to influence policies, as well as inform their own interventions.

Efforts were made to strengthen its Management Information System (MIS) and develop a framework for analysis of service data pertaining to young girls and women. We have been able to generate evidence on three contentious issues: marital rape, barriers faced by young girls and women in accessing abortion services in public hospitals and stigma of consensual premarital sex among young girls and its implications for their sexual and reproductive health. The evidence on plight of young women and girls who are routinely denied abortion services raises issues of conditional access, irrational practices amongst health providers and challenges with court approaches to abortion demands.

ACTIVITIES CONDUCTED

- **Visits to the organisation:**

  A visit to all three organisations was made by CEHAT team to discuss the key variables in their data sets for analysis and also to build their capacity to enter and analyse the data. CEHAT supported Stree Mukti Sanghathan (SMS) to conduct a prospective study on understanding experiences of adolescents (11 to 17 years) in facing and/or witnessing domestic violence. This was a needs assessment study to identify kind of support services required by the adolescents and for development of an intervention. The findings of the study were presented by SMS team at Hinsa Mukti Parishad which is a network of grassroots organizations working to redress VAW in Maharashtra.

  CEHAT team visited Jan Sahas to discuss key variables for analysis and guided them hands-on to enter and analyse their own case data on SPSS. During this visit, we supported them to develop a data entry format with the variables and codes. Jan Sahas team has compiled the data of all the districts in one SPSS file. Team is now working on coding and re-coding of data.

- **Trainings/ Meetings/ Workshops:**

  A two day capacity building workshop was organised for AALI team members in Mumbai in month of March 2020. In this workshop, the AALI team generated tables using their data sets to generate evidence on stage at which a woman facing violence approaches an organisation providing legal services. This workshop also helped team in identifying gaps and strengthening documentation and MIS.

  A one-day meeting cum training was conducted at SMS office in order to build the capacity of team to carry out primary study on understanding the impact of domestic violence on adolescents. In this

training, participants were counsellors of all three counselling centers of SMS. This meeting was instrumental in developing the tool of the study, ethical considerations while conducting research were some of the points discussed with counsellors. After completion of data collection, SMS team was trained to develop an excel sheet for data entry and to conduct basic analysis. SMS completed data entry with help of interns from TISS. SMS team carried out descriptive analysis and CEHAT team helped them to interpret the findings in light of research questions.

1. On the basis of the findings of the primary study carried out by SMS, the organisation has decided to implement an intervention project "Jidnyasa" which means curiosity. Team has conceptualised to implement strategies on increasing awareness among adolescents about their rights, providing career counselling to adolescents, organising parenting session for survivors of domestic violence, and establishing a community resource centre for adolescents.
2. Based on our engagement, AALI and Jan Sahas have mobilised resources for carrying research using their service data. AALI has decided to dedicate a staff member specifically for the purpose of data entry and management. Similarly, Jan Sahas has brought new people on board to manage the data and conduct research.
3. An understanding of work of organisations have enabled us to learn how important it is to build collaboration between organisations and research community including universities as there are mutual benefits of this association. It can provide opportunity to organisations for strengthening their research capacity and also to produce rigorous evidence based on their work with community.

- **Research/ Papers submitted:**

A rigorous literature review was carried not only to sharpen our analysis but also to contextualise the findings emerging from our work. We reviewed various research studies exploring prevalence of marital rape, known risk factors, health consequences, legal frameworks available in various countries, attitude towards premarital sex and implementation status of health programs for adolescents. A considerable amount of time was also spent in data entry and the cleaning of data for the purpose of the analysis. One of the reasons was also that these are case records or service records and therefore written by counsellors. Hence an intensive data entry cleaning etc. is required to make the data available for analysis 3 potential papers were decided upon.

1. **Young girls and women and agency related to sexual and reproductive health:** This paper attempts to enhance our understanding of circumstances under which young girls engaging in consensual romantic relationships chose different pathways to achieve social acceptance and avoid stigma. This understanding is essential to develop a comprehensive health systems' response to needs of these young girls. This paper is based on analysis of service records of three public hospitals of Mumbai where crisis intervention services are provided to survivors of domestic and sexual violence by a team of interventionists.

2. **Marital rape in India a ned to change law:** This paper focuses on the existing prevalence and health consequences of evidence of sexual violence within marriage in India, and presents an analysis of case records of hospital based crisis centre located in public hospitals in Mumbai. The data are compelling and raise important concerns regarding the exception to rape by husband in criminal law and available redressal mechanisms for survivors. This requires legal as well as procedural changes as offences covered under Section 376 are not being registered as rape due to attitudes of the police (apathy as well as normalization).
3. **Denial of safe abortion to survivors of Rape in India:** It was published in Health and Human Rights Journal in December 2019 which is an international peer reviewed journal, the paper, presents the experiences of 40 rape survivors, including two children, denied an abortion following rape. The cases were recorded by CEHAT in the course of building capacities of public hospitals to respond to violence against women in Mumbai, India, since 2000. We found that enormous damage is inflicted on women and girls by misinterpretation of the laws on abortion and rape, combined with a lack of understanding of the serious damage rape does, particularly repeated rape, and alongside other forms of assault and abuse. Domestic laws in India place a clear legal responsibility on health professionals to offer immediate care and treatment to rape survivors, including timely access to abortion. It is past due time for both the government and the courts to begin to hold themselves and health professionals accountable for ensuring this care is provided.

The evidence generated based on analysis of our service data was also presented in 16th Indian Association of Women Studies Conference January, 2020.

In December 2019, CEHAT became a part of National Coalition on Advocating Adolescent Concerns - (NCAAC) facilitated by Partners for Law in Development. CEHAT contributed in form of providing evidence in coalition's submission to Ministry of Woman and Child Development (MWCD) to consider adolescent concerns especially to sexuality. Recently, as a coalition we have made a submission to task force appointed by MWCD to look at raising the legal age of marriage for girls. CEHAT systematically put together the evidence on age at marriage and maternal and child health outcomes.

3. THE IMPACT OF MEDICO-LEGAL JUDGMENTS ON COURT TRIALS IN SEXUAL VIOLENCE

The present project by CEHAT proposed to carry out an empirical research on how courts understand and interpret medico-legal evidence in the context of changes in the rape laws and its impact on legal outcomes. Following were the objectives of the research.

1. **To understand the role of medico-legal evidence in court judgements of survivors of sexual violence in the context of convictions and acquittals.**

a. A total of 110 judgements available on E-Court website were included for analysis. Later we segregated the data and found judgements related to elopement of young girls with their boyfriends. These were removed and hence a total of 96 judgements were analysed. The data was analysed and a draft report was developed. The analysis focusses on identifying factors that contribute to acquittal and conviction in cases of sexual violence and the role medicolegal documentation played in these.

FINDINGS

- In three fourth of the cases doctors had not been called as witnesses. However, proportion of convictions was higher when doctors deposed in the court.
- 84% of abusers were known to survivors of VAW
- All non- penetrative forms of sexual violence occurred in ages of 0-12 years and 13-17 age groups. These forms include making the child masturbate the abuser, sucking, licking of breasts/lips and touching/ rubbing of genitals of the accused on the survivors.
- Across the 3 age groups, 0-12, 13-17 and 18 years and above, (children, adolescents and adults) maximum convictions were seen in the youngest age group.
- 46 out of 96 suffered a health consequence in the form of unwanted pregnancies, injuries, pain in abdomen, infection and white discharge.
- Prosecution preparedness was assessed on the basis of bringing relevant witnesses, disallowing victim blaming questions, preparing witnesses for trial, bringing appropriate documents on court record and the like
- Sensitivity of the court/ judge towards the survivors is one of the important factors in the cases where abusers were convicted.
- No convictions were found in the category where a false promise of marriage was made to survivor. 11 such cases were found in the judgements.
- Other factors responsible for acquittals were; inability of the prosecution to recognise/ acknowledge health consequences of rape such as pain, tenderness, and failure to call the examining doctor as an expert witness to explain these has been one of the reasons in acquittals. The other reasons are inability to produce relevant witnesses for examination in the court, inability to prove that the survivor was a child under 18 years of age, inability to explain delay in filing FIR (even in cases where victims became pregnant after the rape).
- The study highlights the importance of doctors as witness to explain the presence/ absence of evidence, nature of health impact on the survivor as well as the need for sensitisation of the judiciary to the scope of medicolegal examination.

- The findings from the study were presented at the biannual conference held by the Hinsa Mukti Parishad – a network of NGOs and CBOs from Maharashtra working with women and various stake holders on issues related to violence against women.

The plan for dissemination of the report at a national conference on 26th March 2020 had to be deferred because of lockdown due to COVID 19 pandemic. The draft report is ready for dissemination and is published. A state level and national level dissemination of the findings was held

b. **Understanding experiences of doctors as expert witnesses in courts**

Doctors are called by courts as experts in cases of sexual violence trials. Hence, we felt that understanding their experiences regarding interactions with the judiciary were important as well. A simple set of questions was prepared to document their experiences. One challenge, encountered was getting doctors who have been called to the courts for deposition. This is telling of the long draw procedures as the time lag between a medical examination, and onset of the trial is very long, the data shows a gap of 2 years and it is quite possible that the doctor has been transferred to another hospital too. In fact we also found from some of the judgements that doctors were not even called by the prosecutor for a deposition.

It was proposed to interview 10 doctors from the Municipal secondary hospitals who had deposed in cases of sexual violence. However, only 5 could be interviewed despite repeated attempts. This was primarily due to high turnover of doctors in the municipal hospitals. Others who had once or twice been to the court could not remember the cases or their experience in the court. Attempts were made to explore the doctors' experiences regarding specific cases which did not yield results due to poor recall owing to long delays.

FINDINGS

- Often there is a long delay even up to two years since the doctors have seen the case/ examined the survivor**.** In this period the doctors who had examined the woman and filled in the proforma have often moved on from the hospital**.** Hence the senior members from the department answer the court calls**.** At times the courts are not agreeable to this**.**
- Even when the doctor who has carried out the medicolegal examination is available to attend the court call, he is likely to not remember the case**.** Public Prosecutor **(**PPs) do not help doctors prepare for the court hearing**.**
- In general, the doctors are treated with respect at the court**.** However, there are exceptional instances of experiences**.** At times the doctors believe that PPs do not even object to questions that are damaging to the woman**'**s case**.** Sometimes even PP put allegation on doctor that since they have not commented on Hymen, case can lead to acquittal.

- The court still demands comments on hymen. Doctors from one of the hospitals especially mentioned insistence from the court on noting down the state of hymen – intact/ torn – despite their explaining the MoHFW guidelines. The doctors are often forced to respond in yes – no when they try to explain the status of injuries or presence/ absence of evidence.
- It is demoralizing for doctors to see abusers being acquitted despite a clear history, documentation and explanation by doctors to the courts about medicolegal evidence.

2. **To analyse medico-legal documents pertaining to survivors of trafficking to understand the gaps in medico legal as well as therapeutic care**.

CEHAT in collaboration with Prerana, a Mumbai based organization that works with children of sex workers and also has its own shelter home to carry out a a rapid assessment of the nature of examination and health care provided by doctors in government shelter homes to the girls rescued from trafficking. CEHAT provided guidance/ consultation for development of the interview guide and qualitative data collection. The team also participated in 4 out of the 8 interviews conducted. The study explored whether shelter homes/ institutions where these girls were housed had protocol for carrying out medical examination and what are the commonly faced health problems of these young girls.

Information about health care provided to the girls at the shelter homes was explored from interviews with administrative heads of six institutions and in-house health care providers (one nurse and one doctor) from two institutions. Data from interviews with shelter home representatives were thematically analysed and a presentation was developed

FINDINGS

The shelter homes do not comply with the legal mandates. Only 1/8 shelter homes included in the study, which is a government run facility, had a Medical Examination Officer, 3 nurses (with one of them being present at night), and 5 counsellors; it also has 3 visiting doctors with one general physician visiting 4 times a week, a paediatrician visiting three times a 4 week, and a visiting psychiatrist. Three of the eight institutions had the facility for referral to external counsellors for "severe mental health symptoms".

- Common health problems among residents, reported across all the three institutions, were: skin problems, anaemia, poor appetite, irregular menstrual cycles, and white discharge.
- Health examination and documentation at the time of admission did not adhere to the provisions/ mandates in the JJ Act. Examination within 24 hours by medical officer at the shelter home, a list of investigations to ascertain exposure to STIs and general health status were not carried out.
- Institutions relied on services of the nearest government hospitals for treatment of any illnesses the girls experienced. None of the Homes had a round-the-clock nurse or paramedic, a mandate of the Act.

- Only 2/8 institutions admits HIV positive children, and 2/8 admitted pregnant adolescents. Institutes relied on government hospitals for treatment. There was no clarity about special care needed by and provided to these groups.
- All institutions have some form of system for monitoring whether or not the girls menstruate regularly. Some carry out vaginal examinations by doctors, others ask girls to show swabs of vaginal blood and still others monitor disposal of used sanitary napkins. Respect for the girls' dignity seems to be a low priority in many institutions.
- This study also pointed out the gaps in terms of guidance regarding health care provision in the JJ Act itself. There is a need to provide clear guidelines for care of/ protocol for girls rescued from trafficking, HIV positive children, ANC, intranatal, PNC care or MTP and post MTP care needed by pregnant adolescents. There is no mention of and therefore services for SRH education and contraceptive counselling.
- The findings from the present study indicate that the shelter homes are viewed by the authorities as a mere temporary accommodation for children, hence overlooking rights-based care provision and all-round development. This aspect stands out more starkly in the case of government shelter homes, which are especially disadvantaged due to infrastructural and human resource shortcomings.

Training of Child Welfare Committee (CWC) members:

Connected to the issue of medico legal response is the role of CWC is a quasi judiciary body that plays important role in children's rehabilitation in sexual violence cases. Having realised that personnel who run these institutions also have a limited understanding on the role of health care and services for young girls; we felt the need to organise training for CWC members from seven districts of the Konkan zone. CWC members operate under JJ act and hence interface with children who are in need of care and protection and those in conflict with the law. They also meet children who have been trafficked and hence we felt that if they are senistised to the health needs of these diverse groups.

A two-day training was organized in December 2019 and was attended by chair-persons, members, DCPOs and OSCC representatives from Mumbai Suburbs, Palghar, Thane, Ratnagiri, Sindhudurg and Raigad districts.

Broad topics covered in the course of workshop were:

- Circumstances of sexual violence
- Understanding MTP act from a doctor's perspective
- Types of violence and its health impact
- MTP Act and POCSO – legal perspective

Participants appreciated the workshop contents and methods. This was the first ever orientation for many of the participants on health system perspective on sexual violence. They expressed a need for more decentralized workshops (at district levels) where all stake holders could participate. They also

stated a need for working with the district level health system to ensure a comprehensive health response to child survivors of sexual violence.

A report of the workshop was developed and shared with the Office of the Regional Deputy Commissioner, Department of Women and Child Development**.**

4. 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.

A concrete outcome of CEHAT advocacy on engaging the health sector to respond to VAW was the inclusion of Dilaasa centres in the Maharashtra National Health Mission (NHM) in 2016. This led to the setting up of 11 additional Dilaasa centres in hospitals of Mumbai. CEHAT's achievement has been the establishment of the Dilaasa blue print that comprises of a trained core group of health care providers (HCP) along with a trained crisis intervention team of counsellors. We have been brought on board by the Brihanmumbai Municipal Corporation (BMC) for technical support in the form of handholding teams and monitoring services. CEHAT is also on advisory board set up by BMC for the Dilaasa centres.

Crisis Intervention Activities of the project

- CEHAT is engaged in provision of crisis intervention services through Dilaasa in K B Bhabha Municipal Secondary Hospital at Bandra. The hospital based crisis centre at K B Bhabha hospital is managed for 4 days a week with the help of CEHAT team. This allows for senior counsellors in Bhabha Hospital to engage on issues related to management of 11 Dilaasa centres, discussion with counsellors and addressing their concerns. CEHAT counsellors at Dilaasa from K B Bhabha Hospital Bandra reached out to 777 women. 180 new cases of domestic violence (DV) and 73 new cases of sexual violence (SV) were registered at Dilaasa. Legal advice was arranged for 10 survivors with a senior lawyer. Additionally, health education in the form of health impact of domestic violence was provided to 290 women waiting in outpatient clinics as well as those admitted to ANC, PNC and female medical and surgical wards.
- CEHAT assisted Kurla Bhabha Municipal hospital in setting up of the crisis centres after it re-opened in September 2019, which was under renovation since 2015. Reorienting staff members of the hospital as there were new staff members too. The Dilaasa centre formally restarted since October 2019. In this period one case of SV and two new cases of DV were registered at this department and four follow ups were carried out.
- National Urban Health mission (NUHM) upscaled the Dilaasa centres in 11 hospitals of Mumbai since 2017 and agreed that CEHAT will provide technical support to the strengthening of the health system response to VAW. Each Dilaasa centres in 11 hospitals, is staffed with two counsellors, two auxiliary

nurse midwives (ANMs) and one data entry operator. 1033 new DV cases and 564 new SV cases have been registered at these Dilaasa departments.

- CEHAT counsellors visit each of the 11 Dilaasa centres on a weekly basis to interact with the teams, learn about their challenges and assist them in difficult cases. CEHAT team has assisted in 32 cases of VAW across 11 centres. These interventions range from pressuring police for recording FIR and dealing with refusals by the police, helping teams to coordinate and present cases of child sexual abuse with CWC, and dealing with the hospital departments when they refuse to provide MTP services. Some efforts were also made to seek extension of hospital stay for safety of survivors of VAW when they did not have a place to go back to and when alternate arrangements were made. In addition, 9 cases were handled by CEHAT team in the 11 hospitals as first responders. These were complex cases involving sexual violence in cases of minors, where Dilaasa counsellors found the contexts challenging.
- Monthly case presentation meetings provide forum for ongoing capacity building of counsellors and ANMs from Dilaasa departments from 11 hospitals. These meetings also help CEHAT understand challenges faced by counsellors. One of the emerging concerns was related to the comprehensiveness of documentation and understanding intake forms. A specific session was carried out with all the counsellors to explain the rationale of the intake components as well as, do a hands on exercise of filling it up. Counsellors have also expressed need for inputs on reading medical papers, legal aspects etc for which sessions will be conducted. The counsellors now have clearer understanding of when and how to conduct joint meetings with survivor and abuser or other members of her family. Dilaasa teams' ability to interact with other resource agencies such as the police, the CWC, protection officers, judiciary has strengthened over the period. Counsellors acknowledge the benefits of case presentation meetings, especially the inputs from peers and experts.
- Dilaasa teams have been trained to understand sexual diversity and ways of responding to women/ girls belonging to LGBTQI communities. This has enabled counsellors to reach out to young girls attempting suicide because of lack of acceptance about their sexuality by parents.

ADVOCACY EFFORTS

- CEHAT was approached by Ministry of Women and Child department (MWCD) to develop user manuals for all the 5 functionaries of the One stop centres (OSC) The functionaries include social workers, psychologists, police facilitation officers, paralegal workers and superintendents. This was in response to a rapid assessment commissioned by WHO on the functioning of existing OSCs in India. Gaps were found in perspectives of functionaries ranging from victim blaming to negotiating for upkeep of marriages and relationships at the cost of women's health and agency. CEHAT is being looked at as an expert organisation in developing training materials and facilitating them.
- Being engaged in direct interventions at the level of hospitals, CEHAT established new linkages with the deputy divisional commissioner to engage child welfare committees across Konkan region to enable

an understanding on linkages related to health and violence faced by children. The Child welfare committees (CWC) despite having quasi judicial functions did not provide directions to hospitals for health care in child sexual abuse. Young children were often compelled to continue pregnancy resulting out of rape at the level of institutions as the option of medical termination of pregnancy was not thought of by CWC. Many expressed that they were unable to read the medical examination reports or interpret them which posed as obstacles in issuance of orders for future directions. The training helped build an understanding of the health effects of child sexual abuse, understanding of abortion laws in India as well as recognising scope and limitations of medical evidence. CEHAT is now collaborating with the CWCs in Maharashtra across other regions to facilitate such an understanding.

Activities related to Replication of Dilaasa model for Women Facing Violence in Other States

- **Haryana:** Meeting was held with Executive director (ED) of Haryana Health Resource centre (HSHRC) an apex technical body under the Health department providing technical support to execute functions of health and family welfare. The meeting was to propose formal collaboration for 3 years to handhold Sukoon centres established in hospitals inspired by Dilaasa model. Meeting with ED urged CEHAT to consider expanding the scope of support from 4 centres to 11 centres as Sukoon Centres have been replicated additionally and there is a need to provide them with technical support. An outline for continual engagement was discussed with the nodal officer appointed by ED. Bi-monthly calls would be made to facilitate case presentation with the teams and difficulties and challenges would be discussed.

  A visit made to 3 centres of Panchkula, Ambala and Yamuna Nagar enabled an understanding that counsellors have been appointed in most centres and in others the existing counsellors have been charged with roles and responsibilities of the centres. This was a strategic entry for CEHAT to expand its support to additional centres and therefore we have gone ahead with this proposal and we have received a formal sanction for it.

  A 2 days training of Health providers along with counsellors was carried out on 7-8 Nov 2019. 42 participants comprised of doctors, nurses, nodal officers and counsellors of 11 hospitals. Training focused on understanding the health consequences due to violence and the important concepts of sex, gender, patriarchy, power and intersectionality to understand the social reality relating to violence. The training concluded with demonstration of how can HCPs enquire about violence with a gender sensitive approach how they can provide first line support and psychological aid to survivors of violence through LIVES.
- **Goa:** Goa has two major district hospitals, one in South Goa and one in North Goa. Advocacy efforts were made with Directorate of health services (DHS) to appoint counsellors specifically to provide counselling services to women and children reporting violence and reaching public hospitals. Despite several follow ups, DHS did not appoint new counsellors. It was therefore decided that existing counsellors of different health programs of the government can be equipped in providing these services

because they operate at the hospitals. Though they report to their program authorities, their administrative charge lies with the medical superintendent (MS) of the hospitals. Hence MS of both the hospitals issued directives for deputation of counsellors at the crisis centres. They have now allotted a room for the counselling in the main OPDs.

A day long training was conducted with both sets of counsellors in both hospitals in the month of June 2019. Training addressed the lethality of violence seen in survivors as they come with acute episodes of assaults, suicide attempts, rape amongst others. Training equipped the teams to understand addressing such intensity of violence, drawing up safety plans, dealing with abusive partners and linking up with additional resources. It was decided that a follow up of this training would be done after 3 months to understand uptake of services and nature of referrals. An training orientation for VAW for ½ day was conducted with 21 HCPs and 19 HCPs were oriented in Hospicio and Asilo hospitals respectively.

A second visit was carried out from 4th to 6th December; where 2 days were spent with the Hospicio team and 1 day was spent with the Asilo team. A case presentation was carried out in both the hospitals to understand successful cases and difficult cases. Steps on how to implement actions on the ground were discussed and a need was also felt to connect with local organisations for legal aid and other support services.

Each hospital has also appointed a nodal officer who is a doctor and the counselling team reports to the nodal officer.

- **Meghalaya:** NEN and CEHAT approached Neighrims medical college and hospital because it is the largest super specialty hospital in the north east region and because it has a wide range of staff as well as departments Establishing a hospital-based crisis centre in such a hospital would be a landmark for other larger hospitals to emulate this effort. Talks with the Neighrims medical college is under process, to review and assess the proposal and seek further directions.

  NEN and CEHAT organised a 4 days training program for a mixed batch of HCPs, 49 HCPs from Neighrims and 35 HCPs from Ganesdas hospital attended the training. The expectation at the end of the referral was active case identification based on signs and symptoms of VAW and making referrals to the existing LHYONTI crisis centre in Ganesdas hospital.
- **Karnataka:** Karnataka has a state level scheme called Gelathi centres, which exists across each of the districts of Karnataka and are based in district hospitals. A one-day training, comprising of 90 counsellors from all Gelathi centres participated in this training. The purpose of the training was to enable an understanding amongst them on health consequences of violence, steps they need to take to identify VAW survivors reaching hospitals, understanding how to read and decipher medical records of VAW survivors. Training was very well received and commissioner of Karnataka WCD also sought Dilaasa documentation format (intake form) to create a comprehensive documentation of counselling undertaken.

  A meeting was held with Director and Secretary, Women & Child Development Department in Bangalore in September to seek approval for handholding of the project. While we had proposed hand

holding for 2 hospitals but the secretary insisted that we should extend the support to at least 8 Gelathi Centres. The proposal was submitted in October 2019. With change in the state government, the state scheme Gelathi centres was discontinued with immediate effect in January 2020 and was replaced by national level scheme of ONE STOP CENTRES. Efforts are underway to establish collaboration with department to collaborate with OSCs to engage them on an understanding of violence against women as a health issue.

- **New Delhi:** A Series of conference calls and materials were shared with Medicine Sans Frontiers (MSF) team along with a proposal for three-way collaboration (MSF- CEHAT- Babu Jagjivan district hospital). CEHAT was invited for a round table meeting where MSF disseminated their research findings about community perceptions of VAW as well as HCPs perceptions of VAW. The latter indicated a need for training of providers because clearly HCPs were of the opinion that VAW is a law and order issue and they didn't have a role beyond medical treatment.
- **Maharashtra:** CEHAT carried out a series of meetings with the Akola hospital between 3-4 September, 2019 to understand the efforts made to date. The medical superintendent (MS) has sought a social worker, working with free legal aid to provide support services to women at the hospital currently. It was discussed that a need for training of HCPs at the hospital and also the need to include Akola medical college as it is in the same vicinity. The latter if trained can identify and start referring cases of VAW to the counsellors of the hospital.

  A two-day training for HCPs was conducted at the Nursing College in Akola, and attended by 33 doctors and few nurses from the Ladyharding District Womens Hospital and Akola, Government Medical College. The main objective of the training was to sensitise health care providers about violence as a public health issue, the health consequences faced by the survivors and the support that can be provided to them in a gender sensitive way. A team of four resource persons; from CEHAT interacted with the participants to equip them with skills to identify signs and symptoms and also understand the challenges they face in doing the same.

  Post training, we felt that a separate session with existing counsellors (HIV & RMCHA) programmes also need to be oriented to provide counselling services to women. Documentation formats currently being used are sketchy and does not capture details of violence faced and nature of support offered. CEHAT is in talks with the MS to seek permission for such a hand holding of the counsellors.
- **Tamil Nadu:** CEHAT plans to work with 2 hospitals to enable them in developing a comprehensive health care response to VAW. OSC scheme by Women and child department is a central government scheme. Though the scheme expects that the OSCs will be located in the vicinity of the hospitals, there has not been much success by both WCD and Health departments to foster convergence. CEHAT proposes to identify local partner NGO for the purpose of the project and also to ensure handholding of these hospitals at the local level.

RUWSEC has been identified as a local partner because this is a women's health rights based organisation with a strong presence in the region run by community women but also has doctors as a part of their organisation. They have experience of collaborating with the health department for reproductive health programs (not VAW) we seek to build on their local presence as well as their experience of having worked with the health department. The collaboration talks are under process.

TRAINING ACTIVITIES

- **Training Core Groups of HCPs (doctors & nurses) in 13 hospitals on responding to VAW:**

  One of the core activities of the Dilaasa centre is to ensure that VAW is recognised as a health issue. This requires that Health care providers (HCP) recognise signs and symptoms in their patients on violence against women. Hence orientation trainings of 3 hours were planned in each of these hospitals. While each of the hospitals have appointed a doctor as a nodal person of Dilaasa, they required to be oriented to VAW issues. These trainings are carried out by CEHAT and Dilaasa counsellors along with some of the core group members of the Dilaasa. Core group of the Hospital comprises of interested doctors and nurses who support the activities of Dilaasa centres.

  Ten trainings for doctors and nurses from 11 hospitals and 2 trainings for Bandra Bhabha Hospital have been conducted. Through these trainings CEHAT reached out to 319 health care providers across eight hospitals. Training participants included 118 doctors, 134 nurses and 67 representatives of other cadres of health care providers/hospital functionaries such as laboratory technicians, medical social workers, security guards, clerical staff, cleaners etc.

- **Training of data entry operators from 11 hospitals**

  An important activity committed by CEHAT is to equip data entry operators from all 11 Dilaasa centres to enter information from the Dilaasa intake forms in to a MIS system. This is critical to generate evidence about profile of Dilaasa users, nature of health complaints faced by women, intensity of violence and expectation of women from these centres. A day long training of data entry operators was conducted to explain the formats better. Upon follow up visits to the Dilaasa centres, we saw that gaps existed in the filling of MIS and this was to also do with the manner in which counsellors were inputting information in intake and follow up forms. Part of the issues were addressed during the discussions on how to fill the intake forms in case presentation meetings attended by the counselors and ANMs. A second training cum meeting was to take a stock of the extent of data entered and tables generated so that a report can be developed on it.

- **Training of team from Jan Sahas**:

  A training was requested by Jan Sahas, Madhya Pradesh to familiarise their grassroots teams to concepts of violence against women, violence as a health issue, role of health system towards survivors of violence, provisions in MTP act, POCSO. Over 50 representatives of Jan Sahas teams from three districts of Madhya Pradesh attended the training on 13th to 15th June 2019.

OTHER ACTIVITIES

- **Monitoring visits to 13 hospitals to carry out review of Dilaasa activities with teams on a quarterly basis:**

  Under this activity, 54 visits were made to 11 hospitals. In these visits 52 DV cases and 23 SV cases were discussed with the teams. Documentation of case identification interactions too were read and discussed with Dilaasa team members. During the visits feedback is provided to counsellors and included in documentation. Assistance was also provided in classification of women and girls coming in touch with the Dilaasa teams. These visits by CEHAT counsellors provide an opportunity to interact with hospital level nodal officer as well as other doctors and nurses who play a key role in providing comprehensive health care to a survivor of violence against women.

- **Monitoring committee meetings**

  The forum of monitoring committee was established in 2012 for assessing comprehensive health care response to sexual violence. Since the Dilaasa NUHM were set up in 2016-2017, we felt that it is important for each of the hospitals where Dilaasa is located monitoring committee be established. This is one step towards institutionalising the centres as monitoring committees of the hospital would eventually take charge for smooth functioning of Dilaasa. Three hospitals have set up monitoring committees (Govandi Shatabdi, BDBA Kandivali, HBT Jogeshwari) whereas three monitoring committees (Bhabha Hospital, Cooper hospital and Rajawadi hospital) existed. A total of 6 monitoring committee meetings took place. The process of initiating these committees in 5 other hospitals is underway. These committees consist of nodal officer for the hospital, senior representatives from departments of gynaecology, surgery, paediatrics, representatives of medical records department, police constable on duty at the casualty, Dilaasa counsellors and representatives of CEHAT. WhatsApp groups were initiated by each hospitals, have formed forums for regular discussion between counsellors and other members of the monitoring committee.

  Issues addressed during monitoring committee meetings

  - Delays in discharge of survivors of sexual violence due to memo or signature from police.
  - Court insists that doctor who conducted the medico legal examination appear as witness.
  - Sending sample from product of conception to FSL – what kind of sample, disposal of remainder of biological material.
  - Procedures regarding samples not collected by police
  - Procedures regarding sealing of samples
  - Role of nurses during medico-legal examination
  - Role of doctors in provision of psychosocial support
  - Role of medical records officer in cases of survivors of sexual and domestic violence

- **Establishing evidence on health sector response to VAW by developing protocols**

A literature review of existing protocols and procedures across different countries for responding to domestic violence is currently being undertaken. This is crucial to do in order to understand the efforts made and what can be learnt from them. It is peculiar to note that all the literature that exists globally focuses on Intimate partner violence (IPV). In the Indian context IPV forms a subset of domestic violence and hence this literature also needs to be contextualised. We plan to establish an expert group comprising of civil society members as well as lawyers and health officials from Ministry of health and family welfare to review the literature and present a draft protocol.

- **Workshop with members of Child Welfare Committees (CWC):**
  A one and half day long workshop was organized on role of health system in responding to survivors of sexual violence for members of CWCs from Greater Mumbai and neighbouring districts from Konkan region. The workshop was attended by 21 CWC members. Participants were oriented to concepts of violence, health impacts of violence, circumstances of sexual violence, medico-legal evidence and its scope, MTP act and implications for girls under 18 years of age, POCSO – role of health system, challenges in interactions between CWC and health system and how to address these. Feedback from participants suggests that this topic had never been discussed with the members of CWC and inputs were appreciated. Participants said similar trainings should be conducted for members of CWCs across the state.
- **Hinsamukti Parishad:** A state level forum for NGOs and CBOs working at grassroots on issues related VAW. CEHAT is one of the organisers of the Hinsamukti Parishad and CEHAT representative participated in meetings for deciding agenda of the biannual conference. This provides the organisation an opportunity to raise issues related to comprehensive health response on wider fora. CEHAT also made presentations based on work in Mumbai. Two counsellors from Dilaasa from peripheral municipal hospitals too attended the conference organised in December 2019.
- **AMAN Network**: A national forum for NGOs and CBOs working on violence against women; CEHAT representative gave a presentation on need for and impact of MIS (management information system) for those providing counselling services to survivors of violence. Usefulness of such data for continuity of care, monitoring as well as advocacy was discussed.
- **Association with Rotary Club**: CEHAT's efforts in establishing a health care model for responding to VAW has been recognised globally as well as in India. We are being called upon by private medical associations as well as Rotary clubs to present these models and gains from it. CEHAT was invited to one such panel discussion titled "Women empowerment: From awareness to accountability" by Rotary Club of Mumbai and attended by private medical practitioners, adolescent girls and young women as well as members of community. CEHAT presented the Dilaasa model, services provided and learnings from it.

5. DEVELOPMENT OF TRAINING MODULES FOR FUNCTIONARIES OF ONE STOP CENTRES IN COLLABORATION WITH WHO-INDIA

A systematic review of existing materials on existing guidelines along with the standard operating procedures issued by MWCD was carried out to ensure that the training modules for the five functionaries are developed in a context specific manner. WHO's rapid assessment of the OSC's established in different states was carried out to understand the gains and challenges faced by OSC teams in responding to the issue of Violence against women/ Girls (VAW/G). These reports offered a backdrop of the context of these OSCs and expectations from the roles of Medical superintendents, para medical officers, counsellors, caseworkers, para legal workers and police facilitation officers.

Existing guidelines for women centred counselling practices by UNFPA, WHO were also reviewed along with CEHAT's existing evidence based counselling guidelines and ethical guidelines for responding to VAW. Medico legal guidelines for sexual violence care issued by MoHFW in 2014 were adapted to the context in which the functionaries carry out their duties.

A first draft was developed and submitted on 31st October 2019, to WHO and MWCD teams for their review. The document was reviewed and found suitable to carry out a pretesting of the modules with a set of select OSCs in India. A training calendar was submitted and 4 senior master trainers were contacted. A daylong meeting was carried out with the 4 trainers to discuss the training modules, methodology and expected outcome. Two sets of training dates were submitted to WHO and MWCD for undertaking the same.

6. IMPLEMENTATION OF GENDER IN MEDICAL EDUCATION FOR SENSITIVE HEALTH CARE SERVICES TO PERSONS BELONGING TO LGBTQI COMMUNITIES; AND FACILITATING GENDER SENSITIVE SERVICES IN THE PSYCHIATRY DEPARTMENT OF 3 MEDICAL COLLEGES.

The project sought to collaborate with The Department of Medical Education and Research (DMER) with aim of contacting medical colleges for the implementation of the project. The process for establishing the same entailed site visits and physical meetings with each college and interactions with different ranks of medical professionals. The colleges contacted were Nair Medical College (Mumbai), Grant Medical College (Mumbai), B. J. Medical College (Pune), Government Medical College (Akola), and Government Medical College (Dhule). The end outcome was that we had 5 medical colleges instead of the committed 3 medical colleges to deepen GME.

Technical Advisory Committee: A Technical Advisory Committee (TAC) was formed. The objective of the committee was to:

- Critical review of research methods and tools for the formative phase of the project.
- Assessment and approval of the content of the curriculum for a 3-day residential training of medical educators.
- Conduct sessions with medical educators on subjects of expertise.
- Engagement with site visits when feasible.
- Review of and inputs on the gender-sensitive clinical protocol for the department of psychiatry.
- Review of the clinical protocol implementation plan and evaluation tools.
- Critical appraisal of the implementation evaluation and project reports.

ACTIVITIES CONDUCTED

1) Understanding health care needs, existing responses of health practitioners towards persons from LGBTQI communities when they access health institutions.

a. Collaborations with medical colleges were pursued simultaneously with seeking permissions from DMER.

- **B. J. Medical College (Pune)**: An initial meeting was held in Pune with an Associate Professor of Psychiatry from B.J. Medical College (B.J.M.C.), which helped acquaint him about the project objectives, outcomes, and roles and responsibilities of the collaborating medical colleges and CEHAT. In this meeting, it was also established that the number of residents in B. J. Medical College were very few for participation in the GME project. In lieu of that, the professor appraised CEHAT of the Maharashtra Institute of Mental Health (MIMH) which has been developed along the lines of NIMHANS and is under the charge of the Dean of B.J.M.C. Professor suggested that a role for the students of MIMH, which is a research-oriented institute, can be designed within the project and this would be beneficial for both CEHAT, as well B.J.M.C. A second meeting was conducted with the Associate Professor of Psychiatry, along with the coordinator of Nursing Psychiatry, to understand the Nursing curriculum and scope for integration of GME.
- **Government Medical College (Akola):** A visit was made to Akola to meet the Dean of GMC at a time when medical educators from the institute were attending a training organised by CEHAT in Akola. CEHAT team was introduced to the UG Medical Education Coordinator at GMC, Akola, who took interest in understanding the GME modules and the purpose of the project. He asked for more detailed documentation and physical copies of the modules which he would present at the upcoming departmental meeting with HODs of all five relevant departments.
- **Nair Medical College (Mumbai):** A meeting was arranged for the CEHAT team with the Dean. In this subsequent meeting with the Dean, he approved the project for collaboration with Nair and asked the Associate Professor to act as the nodal person and facilitate meetings with HODs of all five departments. Post this meeting, CEHAT wrote a proposal to Nair MC for collaboration

outlining the efforts and outcomes of the past GME project, objectives of the current project, roles and responsibilities of all those involved, and the expected outcomes of the project.

- **Grant Medical College (Mumbai):** Dean approved the project for collaboration and referred the team to the coordinator of UG Medical Education, who was also the HOD of the Department of Anatomy. In a meeting with him, the HOD recommended that CEHAT talk to a medical educator from one of the disciplines which are a part of GME and referred us to the HOD of Forensic Medicine and Toxicology. The latter was keen to collaborate on the project and asked for letters addressed to HODs of the other four departments, which were shared ahead of his departmental meeting.
- **Government Medical College (Dhule):** One of the faculty members of Psychiatry from the college was a collaborator on the GME module for this subject. The Associate Professor facilitated a meeting with the Dean, where he also invited HODs of all the five departments. This was the only college where the CEHAT staff was given the chance to interact with all HODs together. After the Dean's approval, a smaller meeting was held with HODs where the course of action was decided and contributions expected from the departments were noted.

b. A global literature review was carried out on providers' knowledge, attitude, and practice towards LGBTQI persons accessing the health system. This was presented by project staff to the CEHAT team. Based on it, a comparative analysis of the MCI and MUHS curricula was done by juxtaposing the findings in a box and identifying opportunities for gender sensitisation. In the MUHS curriculum, the content is divided into knowledge, skills and attitude, with attitude calling for humanistic and empathetic relationship. Similarly, in the MCI curriculum, subject specific competencies are divided into the three domains of cognitive, affective and psychomotor. The affective domain calls for the student to adopt ethical principles and maintain proper etiquette, while demonstrating respect for the rights of the patient. These mentions in the MCI and MUHS curricula present opportunities for aligning the deepening of GME with the mandate of medical education in colleges.

c. Discussions with medical educators about health problems faced by LGBTQI communities, which built upon responses recorded in CEHAT's past implementation of GME. Through these interactions, it was found that knowledge about LGBTQI communities is limited and their health concerns are deemed restricted to sexual and reproductive health, particularly STIs. This prompted a change in strategy from situation analysis, to a new strategy of witness seminar.

d. The methodology of witness seminar was introduced as a means of chronicling and archiving queer history in India in the context of health care. Witness seminar was chosen as a method because a need was identified to document the experience of activists and service providers in the evolution of the LGBTQI movement in India and its linkages with health and human rights. The purpose of the witness seminar proposed for this project was two-fold: (1) tracing the

historical evolution of the needs and rights of sexual and gender minorities through activists, civil society members and service providers, and (2) understanding participants' experience of treatment of sexual and gender minorities within the health system. Specifically, what are their health concerns, the commonly encountered challenges in providing care for them, and what are the suggestions going forward to promote gender-sensitive service delivery for them.

A draft research proposal with tools and informed consent form was developed for review by the IEC after the methodology had been reviewed by the PDC and TAC.

e. A preliminary presentation was made to the IEC, ahead of the TAC meeting, on 20th December 2019. The purpose of this presentation was to appraise the IEC member about the project and its objectives such that a more detailed research proposal could be submitted for review after feedback from the PDC and TAC. In this presentation, linkages of the current project with outcomes of the previous GME were explained to IEC members. The roles and responsibilities of the medical colleges and CEHAT were delineated along with a short brief about the programmatic and research components achieved so far in the project. The presentation concluded with the following expected outcomes:

- Availability of gender-sensitive medical faculty.
- Session plans made available for gender-integrated teaching at the MBBS level.
- Evidence on feasibility of implementing a gender-sensitive psychiatry protocol.
- Joint publications emerging from development of the psychiatry clinical protocol and its implementation.
- Publication of the exploratory research on the evolution of current knowledge, attitudes, and practice among medical professionals towards LGBTQI persons accessing the health system.

2) A 3-day curriculum has been developed building upon relevant topics culled out from previous trainings under GME, which focuses on understanding of gender and sex, intersectionality, discrimination, physical and psychological health consequences and building skills to respond to the unique needs of the community.

3) To conduct 3-day residential trainings covering a batch of 20 medical educators in each batch comprising of medicine, psychiatry, gynaecology, forensics, community medicine.

7. UPSCALING EVIDENCE BASED HEALTH SYSTEMS RESPONSE TO VIOLENCE AGAINST WOMEN AND CHILDREN IN ELEVEN PUBLIC HOSPITALS IN MUMBAI: REVIEW OF ITS IMPLEMENTATION

The study attempts to contribute to building evidence for health systems response to violence against women (VAW) by -

i. Assessing the extent to which various components of the Dilaasa model have been replicated in 11 peripheral Municipal hospitals of Mumbai**.**

ii. Documenting the problems **(**if any**)**, encountered by 11 hospitals in establishing a health sector response; the strategies adopted by them in overcoming problems and the processes adopted to make the model functional on a day-to-day basis**.**

iii. Identifying the strategies that played a role in scaling up of the Dilaasa model in 11 Municipal hospitals**.**

ACTIVITIES CONDUCTED

- **Seeking approvals from Municipal authorities:** Dilaasa Crisis centres are integrated into the government's National Urban Health Mission (NUHM 2015 - 2016) in Maharashtra and are now in the process of being scaled up in 11 public hospitals in Mumbai by the Municipal Corporation of Greater Mumbai (MCGM). Any research on Dilaasa centres requires permission from the Deputy Executive Health Officer (DEHO) of the NUHM. The proposal, objectives, relevance of such a research study, expected outcomes and policy implications were presented to the authorities followed by submission of tools, consent forms and protocols for research as well as ethics approval procedures. A review of these documents was deemed satisfactory and CEHAT received the permission to go ahead with the research. The 2nd stage included seeking approvals from the respective hospitals and that too was completed successfully.
- **Sampling:** Since the project has a mixed-methods approach, efforts were made to identify the sampling frame and sample size for each method. We also had to be mindful of the fact that resident medical officers are transferred every 6 months and hence the design of the survey and a post-survey at 3 months' follow-up had to be developed to capture their knowledge, attitudes and practices (KAP) related to VAW response. The survey will be administered by researchers and the information will be taken from the health care providers (HCPs) (doctors and nurses) and Dilaasa counsellors.

➢ To review the health sector response to VAW in 11 peripheral hospitals, a survey will be carried out covering the essential components of the Dilaasa model. This will use the indicators laid down by WHO (2017) on strengthening health systems response. In addition to these indicators, some context-specific qualitative strategic components in the form of vignettes will also be included in survey.

➢ The sampling frame consisted of 1 counsellor and 13-15 providers at each of the 11 facilities. We identified the sample of counsellors (1 from each facility), who will be identified based on the higher number of years of experience. Since providers are not always available to participate, we over-sampled to accommodate non-response from some of the HCPs.

➢ In-depth interviews with survivors receiving services from 11 Dilaasa centers will be conducted. This is essential to document the extent to which such a health systems response is acceptable, beneficial and meeting the needs of women. The sample size is 22 (2 from each facility) and we will use purposive sampling to identify participants whose experience of Dilaasa will be best suited to enhance our understanding.

- In-depth interviews with counsellors of the Dilaasa centres will be conducted to understand the day-to-day functioning of the centre in the context of problems faced and strategies developed to overcome them.

- **Visit to OSC centre:** A study visit was organised by CEHAT team, to the OSC centre at KEM hospital in Mumbai which became functional in November 2019 under a scheme of the Ministry of Women and Child Development (WCD), Government of India. This was done to learn from their experience of being a hospital-based centre like Dilaasa. The team found that the implementing agency is an NGO called SNEHA in Mumbai. The guidelines require a team of 14 people at each OSC and SNEHA's HR manages recruitment and duty hours which currently runs on a rotation. They get cases referred from KEM, Police and a pre-existing SNEHA helpline which is still functional even though the physical station at KEM has been discontinued.
- **Finalising tools and consent forms:** CEHAT has submitted the research proposal to its Institutional Ethics Committee (IEC) and obtained feedback. The tools and consent forms have been approved with minor changes. Translation of tools was undertaken and these were approved by the IEC

FUTURE PLANS

The data collection was to be initiated by March 2020 but given the COVID situation and the subsequent nation-wide lockdown, data collection could not be initiated. So, we have now adapted to the context and are prioritising other elements of the research study – qualitive aspects such as interviews of One Stop Crisis (OSC) centre teams, documenting and analysing the role they played in VAW and analysis of the aggregated data of these centres.

8. STRENGTHENING HEALTH SYSTEMS' RESPONSE TO VIOLENCE AGAINST WOMEN BY IMPLEMENTING WHO CLINICAL AND POLICY GUIDELINES

CEHAT's decade long work on advancing the health sector response to VAW contributed in development of WHO's clinical and policy guidelines on "Responding to intimate partner violence and sexual violence against women" for low and middle income countries in 2013. These guidelines provide evidence based guidance to equip healthcare providers (HCPs) in providing care to survivors especially in LMICs. However, there are several gaps in understanding how low middle income countries like India can implement these guidelines. Considering our work on VAW, WHO Geneva approached CEHAT to test approaches to roll out these guidelines in two tertiary hospitals of Maharashtra, India. This collaboration provided a strong base to negotiate with medical colleges for implementation of the project.

This project aims to establish how systems approach which is about creating a supportive ecosystem within the health facility can enable HCPs to identify and provide first line support to women facing

violence. The strategies that were used to create an enabling environment include addressing barriers faced by HCPs, building capacity of HCPs, and establishing protocols for care. The project was carried out in two tertiary hospitals of Maharashtra, India.

The intervention included training of healthcare providers and introduction of system level changes like establishing standard operating procedures, models of care, introducing documentation registers etc. The research component comprised an assessment of knowledge, attitude and practice (KAP) of providers through a survey administered at pre, post and post – 6 months training.

ACTIVITIES CONDUCTED

- **Follow-up training of HCPs:**

  The follow-up trainings were organized 6 months post two day training, from February 2019. These were half day trainings where post – 6 months knowledge, attitude and practice (KAP) tool was administered to participants. The tool was administered before the initiation of follow-up training. The content of the refresher training was developed based on preliminary findings of KAP survey of pre and post-training and analysis of documentation of cases of violence. CEHAT team found that there is less change in knowledge and attitude of providers on issue of sexual violence. Also, we found that trainees were identifying the most obvious health complaints of VAW such as assaults, attempt to suicide, rape and are missing out covert signs of VAW. Hence, the follow up training at 6 months was primarily focused on myths related to sexual violence, legal mandate of healthcare providers, detecting covert signs of VAW and hands-on documenting cases of violence. These trainings were conducted by selected healthcare providers who were trained as trainers.

  Out of 220 providers who responded to KAP survey during pre and post-training, 201 were there for post – 6 month KAP survey. Thus, there was a loss to follow-up of 19 providers at post – 6 months assessment. Transfer of providers from one health facility to other was the most common reason for loss to follow-up.

- **Qualitative data collection:**

  The qualitative data collection was completed in month of November and December 2019. A total of 28 in-depth interviews and 2 focus group discussions with providers were done in this period. Additionally, 10 survivors who received support from healthcare providers were also interviewed. For in-depth interviews with healthcare providers, stratified sampling was used to have equal representation of HCPs of different departments, age group, cadre, designation, and years of experience. A list of providers was prepared based on this stratification and appointments were sought for interview. In case of survivors, a list was prepared by CEHAT team where safe contact details were available. This list was given to social worker of each health facility to make first telephonic contact for study and seek oral consent. The second telephonic contact was made by CEHAT staff to schedule interview with the survivors.

Several mock interviews were conducted to practice interview guide before formal data collection. It helped to develop skills to frame questions clearly and efficiently considering time constraints of providers. Research team faced challenges in organizing interviews with women survivors. The safe contact details were available for only 50% of documented cases. Further, most of phone numbers were either switched off or out of service. The research team contacted about 150 women to arrange interview with 10 women.

As a best practice, we decided to transcribe all the interviews in original language and then translate into English. At present, team is involved in transcribing, translating interviews and checking of transcripts. The codebook development, generation of query reports and discussion of the structuring of findings will be done by April.

- **Video documentation of the project:**

  Under this project, we planned to commission a 3 to 4-minute video telling narrative story of why health sector response to domestic violence in Indian hospitals is needed, what training was conducted, what changes are being observed in the practices and attitudes of providers and any changes in the hospital facilities to be able to provide better services to survivors of domestic violence.

  The video was conceived with purpose of informing policy makers, Ministry of Health, Women and Child Development, donors/ UN agencies in India as well as globally, other NGOs including international NGOs operating in India and globally such as CARE, Gates Foundation, FPAP, IPPF as well as national and local community based NGOs providing health and other services to women affected by violence.

  CEHAT invited bids from experts and based on expertise and experience of working on issue of VAW, we contracted this project. CEHAT team-oriented expert about project and briefed about expectations from the assignment. Meetings were organized with expert team to develop a story board of what the narrative will convey, develop a list of stakeholders to be interviewed on video, and develop an interview guide.

  The finalized video was featured as a web story on WHO website on the occasion of the International day on the Elimination of Violence Against Women (https://www.who.int/news-room/feature-stories/detail/indian-health-workers-transform-care-for-women-survivors-of-violence). Further, we are planning to use this video for dissemination of project in various forums.

- **Data analysis of KAP survey:**

  A considerable amount of time was spent on analysis of KAP data. Reverse coding of some items was carried out according to desired responses. Normal distribution was also checked to determine the statistical test for analysis. Test like Mcnemar and Wilcoxan signed ranked test were used to measure the change in KAP of proportion of participants at different points of time. Paired sample t- test was also done to analyse the change in mean score domain wise as well as question wise. A multivariate Generalised Estimating equation Model was also created to measure change in KAP by taking into

account age, sex, cadre, site and designation of providers. At present, team is working on a manuscript based on KAP data.

Manuscripts writing workshop:

A three-day manuscript writing workshop was organized in Mumbai in month of September. The purpose of this workshop was to discuss and review process for manuscript development and submission for peer-reviewed publication. In this workshop, selected trainers from both the sites also participate in addition to CEHAT and WHO team members. We analysed sample publications (qualitative, quantitative and mixed methods) to inform development of manuscripts for this project. The workshop was instrumental in mapping out three publication from this project. We discussed target journals, outlined the manuscripts, assigned responsibilities and decided timelines.

- **Conferences:**

In October, 2019, we presented our experience of implementing this project in Sexual Violence Research Initiative Forum, Cape Town. Trainers from both the hospitals along with CEHAT and WHO team got opportunity to share learnings from this project in panel on "Gender based violence care and support".

Recently, we contributed an abstract in an organised session on "Innovations in strengthening health systems preparedness to address violence against women – learnings from providing accessible, quality, and gender-responsive services" proposed by WHO for upcoming Global Symposium on Health Systems Research. The abstract for organised session has been accepted and this will be a good opportunity for us to bring the issue of violence against women on health systems agenda.

An abstract based on analysis of cases documented by healthcare providers has been submitted in Federation of Gynecology and Obstetrics (FIGO) regional conference. The abstract informs the presenting signs and symptoms of women indicating violence and various support services provided by providers.

FINDINGS

The analysis of KAP survey has shown a significant increase in mean scores of knowledge, attitude and practice of providers at post- training. A decrease in KAP scores was found at 6-months post- training which was not significant. At 6 months post-training, 72.1% of HCPs identified at least one survivor of violence in last 3 months, compared to 48.8% in the pre- training. A significant number of HCPs referred survivors to external support services at 6 months post- training as compared to 51% before training.

The trained HCPs were able to identify and respond to 531 women facing violence in a period of 9 months. In 53.9% of cases, providers proactively asked women about violence. One-third of cases came in OBGY with primary complaint of pain in abdomen. Majority of women presented with complaints of suicide attempt (33.3%) and injuries (32.2%). Women reported emotional as the most common form of violence (73.6%). The first line support which includes listen, inquire, validate, enhanced safety and

support (LIVES) was provided to women in 26.9% of cases while in rest providers only listened and inquire about violence.

The GEE model indicated that change in scores from pre training to post training was significant for Knowledge, Attitude, and Practice, and this change was sustained over 6 months for all three measures. Significantly lower KAP scores were observed for medicine department and older age groups relative to Gynecology department and less than 25 years age group respectively.

FUTURE PLANS

Based on finding that majority of healthcare providers were not able to do safety assessment, planning and provide support services to women, one of the implications is to have a separate cadre or train nurses or social workers in hospital to provide counselling services to women. Further, during qualitative data collection nurses suggested to train few selected nurses who are willing to provide counselling to women. Considering this, we have planned a two day training of nurses in Mumbai in March on providing counselling to women. This training of nurses will ensure that survivors get all support services before leaving health facility. The sessions which are planned for this two day training include principles of counselling, understanding social structures, safety assessment, planning, and response in specific case examples with medical complaints indicating violence.

We are planning to organize dissemination workshop of the project at national and state level in month of June. A research brief based on this project will be released during these workshops to engage with government officials, healthcare providers, international organizations and non- government organizations working on issue of violence against women.

PUBLICATIONS APRIL 2019 – MARCH 2020

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