
**ANNUAL REPORT
OF
CEHAT**

2010-2011

I. RESEARCH

Mapping of health facilities in cities of Maharashtra:

The current development pattern is increasing the shift of population from metro cities to small cities and towns. There is a dearth of information on health services and health status of those living there. There has been little research on the growth of health services in these towns. Maharashtra is the second most urbanised state in India with 42% of its population residing in urban areas. Over the years, the growth in public health sector has not kept pace with the growth in increase of urban population. The present study examined the spatial growth of public and registered private health facilities in selected cities of Maharashtra. The mapping method used in the study has been really useful in highlighting the availability of private/public facilities in these cities. We found clusters of private hospitals in the city centres, with the urban poor completely excluded. The private health sector has been growing without any kind of regulation. Unlike education where schools cannot be set up in an area where a school already exists, the health sector does not have any such norms. The growth of private hospitals is determined not by need but by the market, thus leading to high concentration zones within the city. The study highlights an urgent need for a norm for location / distribution of private hospitals within the city to facilitate a more equitable distribution of health services.

The use of Geographical Information System (GIS) in the field of health research is increasingly becoming important. GIS can be effectively used as locational technique for analysis for decision making in relation to optimum gainful utilization of available medical resources. Having embarked on the use of geographical method for health research, it prompted us to organize a seminar in collaboration with the Department of Geography; University of Mumbai titled "Spatial Dimensions on health care- Use of GIS in health studies". The aim of this seminar was to discuss the prospects and future development of GIS in spatial health and health care management. Six papers were presented at the seminar from use of GIS for mapping HIV/AIDS facilities in Maharashtra to effective management of sanitation facilities in Chennai slums to using it in post flood epidemic in Mumbai. The findings from the CEHAT study too were presented. A paper reflecting on concepts and relevant techniques in health was presented too followed by a panel discussion on future prospects of GIS in health studies.

We hope that the findings of the study would be useful in making key recommendations for regulation of private sector, especially for equalizing accessibility/distribution of private establishments. The methodology could be used for other states experiencing rapid growth in urban centres.

Health Status of Prawn Harvesters from the Little Rann of Kutch: An Exploratory Study

Prawn harvesters from the Little Rann of Kutch, Gujarat, largely members of the Miyana community, are seasonal migrants from along the coastal areas of Gujarat. Unlike the salt pan workers with whom they share the geographical area, the prawn harvesters remain to be a relatively poorly documented group. This study conducted by CEHAT in collaboration with ANANDI which has a strong presence among the prawn harvesters; is an attempt to document the socio-economic and health condition of the prawn harvesters at temporary settlements along the coast. The study was conducted in 13 temporary settlements spread across Rajkot and Surendranagar districts along the coast of the western Indian state of Gujarat.

Temporary settlements do not have toilets and facilities for management of solid and liquid waste and they dispose waste from prawn processing in the open leading to unhygienic environment, breeding of flies and mosquitoes. All basic amenities are practically inaccessible to the prawn harvesters at temporary settlements. Residents of temporary settlements travel 5km - 60 km to market place or grocery shops; the nearest PDS shop was reported to be at a distance of 5 km - 33 km from the temporary settlements. Distance to public sector health care facilities ranged from 5 km - 76km and only one of the 13 settlements reported services from the ANM, ASHA, MPW and gramsevak at the temporary settlement. Sixteen percent of the households (45/288) did not have a ration-card and of the rest, 56% (135/243) reported having a below-poverty line ration-card. Child-earners were reported in 85/288 households; of these 34 households reported male child earners while 63 households reported female child earners.

Almost one-fourth (24%, 481/2017) of the sample reported being ill at least once during the 15 days preceding the day of interview (acute illnesses). Eleven percent (11%, 43/402) of the persons who reported illness during the 15 days preceding the survey needed hospitalisation. More than ten percent (17%, 347/2017) of the prawn harvesters surveyed reported one or more chronic illnesses. Reproductive health problems accounted for 81% (188/231) of the chronic illnesses among women in the 17-50 year age group. Lower backache (37%, 65/177), excessive vaginal discharge (24%, 42/177) and pain in the lower abdomen (10%, 18/177) were the most reported conditions. One third of the respondents who reported one or more chronic conditions had not sought treatment at base village and at temporary settlements. Migration had more severe impact on women's access to health care.

Eighty-four (29%) of the 288 respondents reported having lost one or more children. Only one woman had received IFA tablets and TT injection during pregnancy at the temporary settlement. Only one third (32%, 14/44) of the births took place in a hospital and four of these were instrument assisted deliveries. Of the 30 deliveries that took place at home, only four (13%) were attended to by a trained *dai* (ASHA worker) and the rest were assisted by untrained *dais* or women from the family. The component of post-partum care was found to be totally lacking at the temporary settlement. Group discussions and key informant interviews highlighted apathetic

attitude of public sector health care providers. Women narrated instances of the ANM refusing to visit temporary settlements to conduct deliveries, and 108 ambulances refusing to collect patients from temporary settlements sighting poor road conditions as a reason.

The study highlights the lack of access to basic amenities such as potable water, sanitation, health care, transportation, education and public distribution system for the prawn harvesters from the LRK. The poorest are the worst affected from general deprivation - they rely more on poor quality water from the ditch, spend larger portions of their earnings on meeting needs of daily lives such as purchase of drinking water and engage in additional hardships of gathering firewood. Morbidity rates are higher than other tribal populations from the state probably as a result of combined effect of harsh environmental and work conditions, unhygienic living conditions and poor access to health care facilities. At temporary settlements, the women bear the double burden of household chores, and back-breaking work related to prawn harvesting which also keeps them in direct contact with prawns for long durations. These work conditions and prolonged contact with sea-food are known risk factors for health conditions including asthma, skin conditions and poor obstetric outcomes.

The study findings point towards the urgent need for provision of basic amenities including drinking water, PDS shops, health care, sanitation and education at temporary settlements. Mobile schools and mobile health care vans can be arranged for the prawn harvester residents at the temporary settlements. Social mobilisation and strengthening of cooperative societies could help the prawn harvesters gain the essential power to negotiate market rates. Appropriate investigations should be carried out to assess the impact of various environmental and occupational risk factors on prawn harvesters' health.

Implementation of User fees in a public hospital

User fee was introduced in India in the 1990s as part of Health Sector Reforms and many studies, including NSSO data show that levying user fee in public health facilities is an important factor that has contributed to the decrease in the utilisation of public health facilities over the last two decades. The broad objective of this study is to map the flow of user fee from collection, deposition, and expenditure of the funds generated by levying user fee in the Municipal hospitals of Mumbai, and understand the process of exemption from user fee and provision of Poor Box Funds to the needy. There have been many studies on user fee, indicating that the average hospital receipts forms a negligible percentage of the total hospital expenditure and if the administrative costs are deducted, the recovery is meagre.

The Primary data was collected by conducting semi-structured interview with the clinical and administrative staff involved in the implementation of user fee in a municipal hospital. Secondary data was collected from Accounts and the Medical Records Departments of the selected facility. The proportion of patients who are accessing waivers and exemptions was also looked at, using available data from the facility.

The preliminary study findings were shared in National Bioethics Conference held on 18-20th November 2010 in New Delhi. The draft final report of the study was submitted to the PDC for review on the 23rd May 2011. The review process is ongoing.

This study will help in examining the contribution of user fee in cost recovery. It will also try to elicit if the cost recovered from user fee forms a substantial part of the recurrent expenditure or not. The study will exhibit the percentage utilisation of funds collected by levying user fee in quality improvement of the services at that particular facility, as this was the justification behind introducing user fee in public health facilities. Another important finding will be to identify the process of user fee exemption for the needy and utilisation of poor box funds. The staff (at different levels) decides on the criteria for executing implementation, and this process will be explored as part of understanding the exemption process. The findings of the study will be used as evidence to lobby with the policy makers and bureaucrats to re-examine the implementation of user fee and ensure that this cost recovery mechanism does not act as a barrier, but is efficacious and offers the needy equitable access to healthcare.

In India, we observe that user fees are never debated anymore and are being accepted as a norm in public hospitals. A policy brief, based on the review of existing evidence and also insights from the ongoing study was prepared to raise concerns. Examining evidence in the form of various published studies as well policy documents through a review of literature, the policy brief summarises available evidence and discusses various concerns from a low-income perspective. It looks at each of the objectives of the introduction of user fees and examines international experience with the help of published literature. It also looks at the impact of the introduction of user fees on access, in India and abroad. Experiences of some countries that managed to remove user fees and their impact vis-à-vis access will also be looked at. In a situation where various international agencies are openly advocating removal of user fees in the interest of healthcare access to a majority, it is hoped that this policy brief will have a positive impact on policy. The policy brief was released on the 25th March 2011 in a function held at SNDT University, Mumbai.

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

In the state of Maharashtra, CEHAT introduced Public expenditure tracking surveys (PETS) to clarify the flow of funds for health services, provide better public data about how these funds are allocated, and ensure that health funds, including the large funding provided by the National Rural Health Mission (NHRM), are used properly. Maharashtra is one of India's richest states, yet in spite of various government initiatives, many poor people rely on costly private services rather than use low-quality public services. The large number of different funds flowing into the health sector, Central and State government to district and to frontline service providers, makes it difficult to track funds. At the district level, there are several

parallel administrative systems and resource channels. The introduction of the NRHM seems to have exacerbated these problems, as new resources flow from the state to the districts outside of normal channels and without clear audit mechanisms. The complex layers of administration and financing at the district level create substantial potential for fund leakage. In order to ensure that financing is efficient and transparent, CEHAT is working to address the need for enhanced tracking of resource flows. The project uses the PETS diagnostic tool to build the evidence on institutional structures and administrative processes governing financial resources, flow of information and fund flow in practice, accounting and audit without necessarily examining the reason for their occurrence or potential solutions. This will involve qualitative research. The qualitative data will be collected through semi-structured interviews, in-depth interviews and the checklist with frontline service functionaries of the hospital, key officials at the block and district level of the relevant line departments, and state administrative officers.

Prior to designing the instruments, the team proceeded to do a rapid assessment of budget decision making and fund flow process and budget data management. This was done for two reasons - one, the team wanted to understand the structure of the system, identify different offices & their involvement in process of budget-formulation, finalization, vetting, approval and auditory mechanisms (internal / external audit). Secondly, to verify the availability of data and its specific characteristics (variables, length, etc.), and to verify the consistency of data reported across various administrative levels. It helped the team to understand and learn how to organize this uncoordinated and scattered data, the budget decision-making process and budget information. Based on proximity, Thane and Nashik districts were selected for rapid assessment. This process has helped the team to better understand the institutions that are shaper/makers, identify and build contacts with potential allies in the government setup. It also helped in identifying windows for intervening in the budget process itself.

Data collection of budget /expenditure at district level and analysis of the same is in process. Expenditure data have been received from the accountant General's office of Mumbai and Nagpur. These are the treasury district level actual expenditure data with detailed line items. This data does not have the budget estimate details, thus, to bridge this gap some data of estimates have been sought from the Health departments CAA wing, Pune. We are still in the process of getting the Budget estimate of some health variables from the regional health circle office of Dy, Director Health , Regional. Local Partners from Amravati and Solapur are in contact with some of the district and regional offices to collect the remaining documents. Based on the existing information, observation and probing questions are/will be incorporated to the protocol. Budget and expenditure profile of district/ appropriate material will be prepared for sharing some key issues with district level civil society organization to initiate advocacy activities like meetings and dialogue.

Study on response of hospitals to the terror Attacks study

After the terror attacks of 26/11/08 in Mumbai, we had proposed a study to document how public hospitals responded to these situations as they are the ones that are expected to bear the burden of care towards survivors of mass violence. An already strained public health system is pushed to its brink and its inadequacies are magnified because of the attention they receive during crisis. Such times offer the opportunity to assess the existing malaise and direct the government's attention to the need to equip hospitals and providers to respond to such emergencies. We felt that such an enquiry would help identify gaps in response, which could then be rectified so that providers feel more in control of the situation, should such an event occur again. The study is being conducted in partnership with the Tata Institute of Social Sciences. In depth interviews were conducted with 60 staff members including doctors, nurses, ward-boys, technicians and other support staff from the four hospitals that were first responders to the attacks - JJ, Cama, GT and St.George's Hospitals. Analysis of the data is currently underway.

Preliminary observations from the data show that most providers acted on their own individual judgment rather than as per a pre-decided plan. There was no clear definition of roles for each person, nor a clear chain of command. As a result, even though sufficient manpower was available, it was not always efficiently utilised. Smaller hospitals were the first responders and were equipped to handle a certain number of patients, however all cases were transferred to the larger hospital. This resulted in a needless extra load for the large hospital. Even in departments such as Forensic Medicine where the number of post-mortems required to be performed was staggering, cases were not referred to nearby Municipal Corporation hospitals to share the load. This caused delays and also resulted in tremendous fatigue for the staff. All staff were equipped with technical skills as far as their role in treating patients was concerned. The challenges that they reported were with respect to communicating with patients' relatives, maintaining records and dealing with the feeling of insecurity, given that a neighbouring hospital was under attack. The psychological impact of working in such an environment was also reported by providers, particularly those working in the Hospital that was attacked. As regards preparedness, while a Disaster Management Plan does exist for JJ hospital, none of the providers reported having received special training as per this plan. Some were aware that a plan was available, but they were unaware of their own role as per the plan. Most said that their prior experience of managing such emergencies had made equipped them to respond.

The findings of the study will be shared with the concerned hospitals and the health department. We hope that learnings from this study will contribute to strengthening the response of health systems during emergencies such as these

Exploring Religion based Discrimination 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, we aim 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 selected for data collection. Pilot study for the research has been completed and analysis is underway.

The draft report for the study has been completed submitted to the review committee. Feedback was attained and the report is presently under a second review to incorporate the feedback of the review committee. The sensitive nature of the study did not allow the women to open up as much as was expected in the in-depth interviews. A need was felt for the inclusion of community discussions where groups of women met randomly in the streets of the research area were spoken to; to get an in-depth view of the community and its relations with the public health service. The analysis of the report brought forth layers and layers of discrimination and their intersectionality with one another. Determining factors that could identify discrimination has always been a challenge of this study. Discrimination as a phenomenon will have to be read and understood within the preview of these layers.

Response to Sexual Assault at a Tertiary Care hospital in New Delhi

A study was conducted at a large tertiary care hospital in New Delhi in collaboration with SAMA, to look at the management of cases of sexual assault. In-depth interviews were conducted with key respondents to understand the process of seeking consent, history, medico-legal examination, forensic evidence collection, treatment and other aspects related to the role of health professionals in dealing with survivors of sexual assault. Findings suggest that there are no uniform protocols for seeking consent, history, conducting examinations and collecting evidence. This provides scope for biases of individual providers to creep in, often jeopardizing the survivor's rights. Evidence of coercion in obtaining informed consent is one such fall out which is of particular concern. Further, the manner of interpretation of examination findings indicates undue emphasis on the presence/absence of injuries and past sexual activity. Such stereotypical and restricted notions regarding sexual assault have serious implications. The study further shows that despite the fact that this is a large tertiary hospital, the care provided is inadequate as compared to guidelines provided by the WHO. There is no component of psychological support provided to survivors at all. Based on the learnings from this study, further intervention is being planned with the hospital to address gaps.

Study on burns reported by women at a medical college

Cases of severe burns have been known to be caused by domestic violence. There have also been reports of women burning themselves as a result of torture faced in the marital home. In most cases, the burns are extremely severe and the victims do not survive. When death is imminent, a 'dying declaration' is recorded by the police in the hospital. Here, women are not able to reveal the cause of burns because of pressure from the marital family and concern of the future of their children, should they implicate the marital family in their death. In the first year of having provided counselling services at MY hospital Indore, 133 cases of burns were screened by Dilaasa counsellors. An observation that was reported by the counsellors was that several of these cases come across as 'suspicious' cases, in that they may be homicidal or suicidal. However, all of them are registered as 'accidental' burns in the hospital. In some cases, Dilaasa counsellors had been able to elicit a history of homicide or suicide, even though the hospital records had registered it as 'accidental'. This prompted us to undertake an analysis of burns cases at the hospital, with the objective of comparing the profile of men and women reporting burns at the hospital and to identify gaps in recording these cases at the hospital.

We found that of the 580 cases of burns reported at the hospital between October 2008 and September 2009, 70% of them were women, most of who were below the age of 30 years. The extent of burns was much greater among women than men, and they were also more likely to die as a result of the burns. Among the 133 cases screened by Dilaasa counselors, it was found that 90% were married. 76% said the incident occurred at home, most common cause of burn being a *chimney* (small lantern) and stove burst. On screening, 8 were found to be suicidal, 15 homicidal, and only 27 were clearly possibly accidental. A large number (75) were suspected to be non-accidental; all of these had been recorded as 'accidental' in the hospital records. This suggests that there is a discrepancy in recording of burns cases in the hospital, which needs to be addressed. It highlights the need for standard protocols for documentation and management of burns cases. The findings of the study were presented at a National conference organised by Vimochana on the issue.

Intervention research on Sexual assault

CEHAT had been implementing the SAFE kit, training of hospital staff on the issue of sexual violence as well as providing services to survivors of sexual assault at two municipal hospitals - Rajawadi Hospital and Oshiwara Maternity home. Learnings from this pilot project were incorporated into the development of a model comprehensive health sector response to sexual assault. Based on the results of piloting the SAFE kit in two hospitals in Mumbai in the year 2008-2009, we felt the need to revise the kit. The kit needed to be modified so that the manual is more detailed and the proforma less lengthy.

The pilot implementation of a comprehensive health care response clearly demonstrated that just a "kit" cannot ensure holistic health care for survivors. Health providers were unable to respond to several issues whether it was about

operationalising consent for examination, or it was collecting evidence based on history. Further most providers would also carry biases and stereotypes about the sexually assaulted people reporting at the hospital. This prompted CEHAT to develop a manual which provides a step by step approach to Health providers about seeking consent, conducting examination, collecting evidence, following treatment protocols and ensuring psychosocial support. The manual seeks to educate health providers about their dual role, which is therapeutic and medico legal in nature. The manual and revised proforma were reviewed by experts from the discipline of forensic medicine, gynecology, psychiatry and law. The manual was also endorsed by the IFFHRO and WHO and published in 2010 . CEHAT team aims to publicize the manual to aid health providers in the examination and treatment of sexual assault and reduce the over reliance on the “ kit” , as such kits contain all the basic paraphernalia required for conducting such examinations and therefore can be easily assembled by individual hospitals.

Analysis of sexual assault case records:

CEHAT has been providing crisis intervention services to survivors of sexual assault and training to doctors and nurses at three public hospitals in Mumbai. So far, 65 cases have been attended to. The records have been analysed to understand the profile of survivors, nature of assault, pathways of reporting to the health facility, factors leading to loss of evidence, relevant examination findings, health consequences of the assault and legal outcomes. This is the only evidence of its kind available in India vis-a-vis sexual assault. Evidence from this data set is being used to support a Public Interest Litigation in the Nagpur High Court, which seeks to ensure uniform, sensitive protocols and provision of comprehensive health care to survivors of sexual assault. CEHAT is an intervener in the matter.

Management Information System for Dilaasa

In order to enable easy, periodic analysis of cases being handled at Dilaasa Mumbai as well as other replication sites, a management information system is being developed. This MIS would record information about the socio-demographic profile of women visiting the department, the nature of violence faced by them, health consequences and the nature of intervention provided by Dilaasa. It would also help to record cases that are being screened, whether they are facing DV or not and whether the ones facing DV are being registered at the centre. We hope that the MIS will enable us to generate reports on the profile of women coming to the centre and the services that the centre provides. It would also enable monitoring of the services being provided by the centre, the pattern of referrals and the gaps therein. The variables for the MIS have been finalized and data entry is underway. The analysis of the case records for the period 2001-2006 highlighted several aspects related to effectiveness of a public hospital based crisis centre and challenges in responding to survivors of domestic violence. A large number of women coming to Dilaasa report within 1- 2 years of facing abuse. This is critical as it provides an opportunity for intervention at earlier stage of abuse. Again, majority of women coming to Dilaasa have never reported abuse to any formal agency thus underscoring the early detection of abuse. The

patterns of abuse reported by women also demonstrate the various forms of abuse that women endure. Lastly, the data has been useful in dispelling several myths related to addiction and violence, unemployment and violence, dowry as the only form of abuse and so on.

A Study on Understanding the Experience of the Training Cell

In the past eight years that *Dilaasa* has been functioning, health professionals have been closely involved with the venture and have been the driving force in making it a success. They have participated in *Dilaasa's* activities in addition to their routine responsibilities. Given the apathetic attitude of the medical and nursing professions towards violence, we think it is commendable that so many health care providers have taken such a keen interest in *Dilaasa's* work, even though they receive no additional compensation for it. This study will help us gain an insight into what motivates health care providers to play such an active role and what they think they have gained from being associated with such a venture. What is the impact of being part of the training cell on the professional lives of these healthcare workers, is another area that was studied. At a point when *Dilaasa* is being replicated at several other sites and similar training cells are likely to be formed, such an analysis will provide valuable testimonies which can motivate other health projects. The results of the study will modify the functioning of the training cell based on the barriers faced by health care providers while being part of such a venture.

Evolving 'good practice' for responding to attempted suicide at the hospital

Dilaasa's experience has demonstrated that women admitted in public hospitals for accidental consumption of poison are often related to an attempt to end one's life. The underlying reason being that they are unable to bear the abuse at home. Based on this experience, *Dilaasa* evolved a suicide prevention counselling strategy. This counselling strategy is operational in 2 hospitals in Mumbai where *Dilaasa* is located. In order to broad base this model and encourage other hospitals to respond to this issue CEHAT called for a meeting of different departments of psychiatry from public hospitals as well as psychologists and civil society activists. After a detailed discussion on the *Dilaasa* suicide prevention model, some of the public hospital social workers and psychologists opined that they too have a frame work of counselling such women. In order to understand these existing psychiatric models, CEHAT decided to undertake an exercise of understanding the suicide prevention models of these hospitals. A study is being conducted in collaboration with the KEM hospital to understand the psychiatric response to attempted suicides amongst women facing domestic violence. Following this, a 'consultative group' of mental health professionals will be formed who will jointly be able to develop a comprehensive care model on responding to attempted suicides.

II. ADVOCACY

Budget Advocacy:

On 25th March 2011 CEHAT along KHOJ, Amravati (Quest for Knowledge, Hope, Opportunity, and Justice); Department of Economics, University of Mumbai; PG Department of Economics, SNDT; Tata Institute of Social Sciences organized a Seminar on *"Maharashtra's Budget: A Scrutiny of Development Discourse"*. The seminar was organized at the time when the legislature was discussing departmental budget of the state. The focus of the seminar was on social sector provisions in the state budget, and patterns of general government spending with specific reference to dalits, tribals, children and women and use of budget analysis as a tool to monitor the government's commitment to social sector. The inaugural session started with the release of policy brief on the practice of levying user charges in government hospitals, prepared by CEHAT's research team. The brief, titled *"Punishing the Poor? A Look at Evidence and Action Regarding User Fees in Health Care"* presents evidence from across the world regarding its practice. The sessions include presentations by, Prof. Anita Rath from Tata Institute of Social Sciences, on *"Maharashtra's Social and Health Sector Budget: A Note on Emerging Characteristic and Trends"*, from CEHAT by Prashant Raymus on *"Public Health Sector in Maharashtra: A Macro Perspective"*; Surekha Dalavi from Shramik Kranti Sangathanaribal on *"Tribal Sub Plan in Maharashtra"*, Pravin More from Alliance for Dalit Rights on titled *"Scheduled Castes- Special Component Plan (SCSP) in Maharashtra"*, by Vibhuti Patel, Director, P.G.S.R. Prof. & HOD, Department of Economics, SNDT Women's University on paper titled *"Gender Audit of Maharashtra Budget Statement 2010-11"*. Denny John, Director - Health Programmes, of Center for the Study of Social Change (CSSC) Mumbai presented on *"Child Budget Planning in Maharashtra and India"*. The seminar had case studies presentations on exploring Realities and Myths of State Development by CEHAT on *"User Fees in Maharashtra: a Discussion and Preliminary Evidence from a study"* and by Khoj, Amravati on *"Health Budget and Plans - Challenges and Experiences from Amravati District."*

The seminar was attended by 100 participants including students, researchers, academicians and activists. The presentation and discussion raised several issues and concerns based on a succinct analysis of the state budget and critique of the overall governance in the state and lack of transparency in budget making process. Key recommendations that emerged from the seminar were circulated widely.

Monitoring budgets:

As part of the expenditure tracking being carried out in two districts of Maharashtra, a process has been set in motion for enhancing the capacity of the local budget partner in observing and monitoring fund flow, processes and institutional structures. Local Budget Partners from Amravati and Solapur District have been identified. They

are involved in advocating for strengthening the budgetary support for the various programs within their constituencies at the local level. The partnering team is part of the research process as they can familiarize themselves the different offices and the relevant budget documents which can be useful in future to build an argument around the issues/problem identified in these constituencies. The partner from Amravati organized one day meeting, wherein around 7-8 organization from the district participated. It was conducted with the purpose of generating awareness and identifying concerns on budget matters within the local constituency with the objective of politicizing the budget.

Concerns raised about user fees in public hospitals

The Government of Maharashtra hiked User Fees in public hospitals through a Government Resolution ([GR MIC-2006/305/CR-33/06/Administration-2 dated 30 December, 2010](#)) December 2010. CEHAT has been corresponding with the Department of Medical Education and Research regarding the problems with such policy, in the context of an underfunded healthcare system, which serves a lot of poor patients. The two Government Resolutions from [2001](#) and [2010](#) show the quantum of hike in user fees charged at the hospitals.

Right to health care for survivors of sexual assault: Public interest litigation

CEHAT filed an intervention petition in the Nagpur High Court on 9th Sept 2010 in a Public interest litigation (PIL) filed by Dr.Ranjana Pardhi and others against Union of India in 2009. The Lawyers Collective is representing CEHAT for this petition. The PIL by Ranjana Pardhi and others seeks to streamline the medico legal response to sexual assault. As a response to this, the central and state governments submitted proforma for medical examination of sexual assault survivors. These proformas are archaic and not in accordance with the international standards or existing laws in the country. The first prayer demanded that the state government should stop the use of their archaic proforma with immediate effect and replace it. The second prayer asked the state government to ensure the provision of immediate medical treatment along with psychosocial services at the hospital level.

The court appointed a committee to look in to the proformas and manual submitted by the petitioners as well as CEHAT (intervenors) and submit a proforma and manual to the court. However the committee set up comprised of only forensic doctors, these doctors don't conduct sexual assault examinations at all, therefore our legal counsel argued on 2nd February 2011 that the committee should be broad based to include doctors who were instrumental in implementing the comprehensive health care response in Mumbai hospitals. 2 experts from the discipline of gynecology were appointed by the court on this committee. CEHAT also demanded that those involved in drafting such a proforma ought to visit the 3 hospitals where such a comprehensive model is being implemented; this would give the committee members an opportunity to speak to the doctors and nurse about the model, visit the hospital and look at the records. Meetings were organised at 3 sites and the committee was invited to interact with the staff. After reviewing CEHAT's manual and proformas, guidelines as well as

paying visits to these hospitals, the committee submitted their revised proformas and guidelines to the court on 7th June 2011. In spite of such close engagement with the committee, the proformas submitted are not as per the standards set by the WHO. Unfortunately the petitioners did not register any objections to these proformas and therefore the court came to the conclusion that the proformas be circulated for implementation all over Maharashtra hospitals and police stations. Disturbingly, the proformas lay emphasis on injuries per se whether in penetrative sexual assault or non penetrative sexual assault. This would provide absolutely wrong directions to a doctor while conducting examinations; thereby it would be interpreted as "no injuries would mean no sexual assault". Analysis of CEHAT record pertaining to sexual assault dispel the myths around injuries completely. Further the guidelines don't even mention the nature of therapeutic care required by survivors of sexual assault. CEHAT in response to the court order has filed a review application to draw attention of the judiciary to the fact that the proformas submitted by the committee do not follow the WHO standards and are also in contradiction with the Indian law. Currently efforts are underway to build an opinion amongst health professionals, NGOs and civil society on the problems with the state proforma.

Campaigning against the use of two-finger test in examination of sexual assault survivors:

Taking forward its commitment towards making the health sector response more gender sensitive, CEHAT worked closely with the Human Rights Watch on its report "Dignity on Trial: India's Need for Sound Standards for Conducting and Interpreting Forensic Examinations of Rape Survivors". A press conference was held on 6th Sept 2010 asking the Indian government to ban the "Two finger test" commonly used in examining women and children reporting sexual assault. The HRW appealed to the government to ban such a test and develop sound standards for conducting forensic examinations based on international standards, one such example is that of the WHO. The report refers to one such good practice model evolved by CEHAT in collaboration with the Brihanmumbai Municipal Corporation (BMC) in India. CEHAT's released its Manual for Medical Examination of Sexual Assault at the press conference.

Development of ethical guidelines for domestic violence counselling:

After the publication of counselling ethics case book, CEHAT felt the need to take a step forward from the ethics casebook, and began the process of developing ethical guidelines in domestic violence counselling. The aim of these guidelines was to cultivate good practice in domestic violence counselling and educate counsellors on the discourse in counselling ethics. CEHAT invited experts from the field of psychology, social sciences, counsellors, psychiatry and ethicist and formed a committee. The committee consists of : Amar Jesani, Anuradha Kapoor, Jaya Sagde, Manisha Gupte, Prabha Chandra, Soumitra Pathare, U. Vindhya, Vanita Mukherjee, A draft of the ethical guidelines was prepared based on the review of International codes of ethics and our experience of domestic violence counselling at the crisis centre. The guidelines presented the principles and values of feminist counselling and steps in applying the ethics frame work while counselling. In its first meeting held on

24th May 2011, the guidelines, its purpose, objectives and content was discussed threadbare. The committee gave detailed feedback on the draft guidelines. Currently the team is working towards revising the guidelines and resubmitting it to the committee for a discussion. The committee strongly felt that these guidelines should be used at the Dilaasa crisis centres first and then advocate for its use by other organisations. Those involved in domestic violence counselling could adapt them as per their context. While several counselling centres are functioning in India, this is the first such endeavour to evolve guidelines for counselling in DV.

Asia Regional Focal Point of the IFHHRO (International Federation of health and human rights organisations)

Campaign against Forced and Coerced Sterilization and Denial of Access to Pain Relief

As the Asia Regional Focal Point of the IFHHRO, CEHAT has been actively participating in all its activities. IFHHRO, OSI and other NGOs have launched a campaign in 2010 to address certain key issues of human rights violations in health care settings. One of the issues being addressed through the campaign is that of forced and coerced sterilization. As part of this, a representative and nominee from CEHAT attended the seminar on Forced and Coerced Sterilization held in Salzburg in December 2010. In the context of India, it was felt that there is a need to deliberate upon the existing guidelines for sterilizations, particularly to address issues of quality of care and consent. As a follow up of Salzburg, a working group consisting of experts has been constituted, that would consider and if required, draft alternate guidelines for this purpose. Professional organizations like the Forum of the Obstetricians and Gynecologists Society of India (FOGSI) would be approached for endorsement of these guidelines. A second key issue that is being addressed through IFHHRO's campaign is that of lack of access to pain relief. A representative of CEHAT attended a 2-day workshop on Pain Relief as a Human Right organized by IFHHRO and OSI.

Health and Human Rights Wikipedia

IFHHRO has also created a 'Health and Human Rights Wikipedia' to provide concise and precise information about human rights issues for health professionals. The wiki looks at providing information by issue as well as information about specific countries. The section on Domestic Violence was added to the HHR Wikipedia by CEHAT this year. Two interns from the Tata Institute of Social Sciences were involved in collating and summarizing literature on the issue.

Disseminating Information

By way of increasing visibility of the ARFP, brochures highlighting the main activities of the ARFP were printed and are being disseminated at key events. We have also been updating the ARFP news section on the website to keep people informed of various activities involving health professionals and human rights from the region.

Statement on death penalty:

A press conference was organized in Mumbai in April 2011 to address the issue of use of Indian drugs in executions in the United States. It was organized by Reprieve, a US-based legal action charity providing legal services to prisoners who cannot afford to pay. As ARFP, CEHAT was invited to present its work and perspectives on human rights violation and death penalty. A statement opposing the death penalty was issued by IFHHRO which was shared at this press conference.

III. TRAINING AND EDUCATION

Course on Health and Human Rights:

The course was organised in January 2011 in collaboration with the Department of Civil and Politics, Mumbai University. Justice(Retd) Sujata Manohar spoke at the inaugural function and underscored the importance of Human Rights education for health professionals. Twenty two participants from all parts of the country participated in this course. These were mostly middle level professionals from various civil society groups and those from the state governments. The revised course was received well, the reading material too was updated. The chief guest for the valedictory function was Justice (retd) Vyas, Chairperson, State Human Rights Commission. He congratulated the Mumbai University for offering this course.

Course on Feminist Counselling:

Feminist counselling as a technique for responding to survivors of domestic violence and sexual violence although found to be effective remains out of the purview of mainstream mental health practice. Therefore, a course on responding to violence against women through Feminist Counselling was developed and run by CEHAT in collaboration with TISS for the first time in April this year. It was attended by practising clinical psychologists, social workers and educators from all over the country. Adv Flavia Agnes was invited for the valedictory programme and she gave an inspiring talk.

Responding to Violence against women in Conflict:

Responding to the needs that emerged through review and consultations on the issue of conflict, violence and health, a three day training curricula was developed based on the National course on VAW and role of HCPs. The training was opened to the different states of India affected by armed conflict. Twenty five participants from Kashmir, Jharkhand, Chattisgarh, Gadchiroli and Manipur attended the training. It gave opportunity for people of the different regions of India to interact with each other, share their experiences and their coping mechanisms. It was an opportunity for people living and working in different parts of the country to realise that their battle was not in isolation and what they are going through is what millions of people in the country are also going through. Participants shared the need for measures for sensitization and training at different levels, along with attempts at inter-sectoral coordination to address the issue of VAW in a holistic manner. As a feedback, most participants expressed the need to conduct such training programmes at national as well as state levels.

Participants also expressed the need to visit the Mumbai based crisis centre Dilaasa. A 3 day interactive consultation “Armed Conflict, Violence Against Women And Right To Health” was organised for health professionals and civil society members was organised in April’11 in Mumbai for the participants from Kashmir. The consultation took forward from the Delhi training and focussed on armed conflict, Human Rights and Ethics. An interactive session was organised with the team of Dilaasa. Overall, this programme allowed for diverse issues and concerns surrounding right to health in an armed conflict, to be heard, discussed and debated. Through such an interaction the sense of injustice that participants had experienced and witnessed in their professional and personal lives, could be seen as channelizing towards action. As part of future planning, they 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.

Training on sexual violence:

Hospital based trainings-

CEHAT is engaged in implementing a comprehensive health care response to sexual assault since April 2008. In the endeavour of ensuring a comprehensive health care response to sexual assault, periodic orientation trainings are conducted at the level of 3 hospitals, K B Bhabha Bandra west, Rajawadi Ghatkopar east and Oshiwara maternity home. These trainings comprise of understanding forms of sexual violence, health consequences of the same on women and children as well as their role in responding to them. Emphasis is laid on therapeutic role of the HCP’s as often their focus is restricted to medico legal evidence collection only. A total of 9 trainings were conducted comprising of 150 doctors. These trainings are attended by lecturers and resident medical officers.

Community awareness trainings-

While working with the health systems, we also realize that there is a need to create awareness about the issue of sexual violence and also dispel myths about sexual violence. We approached CORO as they have a large community set up and respond to several issues impacting lives of women. A module for helping CORO volunteers to understand the issue of sexual violence, role of health care providers as well as basic counselling skills was conducted. The skill building workshop would enable them to increase awareness in the communities that they work in and also make civil society aware of the role of the health systems. One such training was conducted for 40 CORO volunteers. This was followed up by training as CORO wanted CEHAT to train their staff in counselling skills. The second training was conducted on 21st April 2011 for 35 participants.

Police trainings -

A training programme for 65 sub inspectors on 7th June 2010 and involved doctors in the same. The aim of conducting these workshops with the police is to encourage a

multisectoral response to sexual violence and create awareness on the role of health providers. This was also an attempt to inform the police about the model set up in three municipal hospitals of Mumbai so that they could refer cases of sexual assault to these hospitals.

Training of Health Professionals in New Delhi

CEHAT collaborated with SAMA to establish a model akin to the one in Mumbai on responding to sexual assault. Such an initiative was undertaken in response to a Delhi high court order of April 2009 directing health department, home department as well as institutions to develop guidelines to respond to sexual assault against women. We seized this opportunity to present the sexual assault response model of Mumbai and conducted trainings of health professionals from Safdarjung hospital on how health professionals should respond to sexual assault. We conducted two such trainings. In the course of our work in the hospital, the DG office issued a protocol for examination of sexual assault. However this protocol was completely regressive as it overly relied on evidence such as signs of force, built of the woman, status of the hymen and the 2 finger test. These methods have been considered redundant and have been abolished in most parts of the world. WHO guidelines have not been followed at all. This prompted CEHAT and SAMA to dialogue with the central health office in New Delhi and put on record concerns vis a vis the protocols. After much engagement with the DG office, they withdrew this protocol and deleted the 2 finger test. Yet many regressive aspects of the protocol continue. We are currently engaged in a dialogue with the central health department to replace their protocol.

Capacity building for the BMC:

This was the 11th year of collaboration with the Bombay Municipal Corporation. The Training cell has been in existence since the past 6 years and a growing number of Health care providers associating themselves with it. The aim has been to dialogue with the officials to direct funds towards the running of the Training cell as well as to formalise the roles of its members. The current team of Training Cell (2009-2011) comprises 68 health professionals which include 10 Doctors, 43 nurses, 2 matrons, and 6 Community Development Officers of hospitals, 2 Ayabais, 2 ward boys, 1 from electric department and 1 is occupational therapist, 1 ICTC counselor.

The core groups have been conducting training in their respective hospitals, 4 trainings in Kurla Bhabha hospitals comprising of 30 HCPs, 2 trainings in Rajawadi Hospital comprising of 25 HCPs in each group, 1 training was conducted in M.T Agarwal comprising of 13 HCPs and 1 training of 25 HCPs in Cooper hospital. As the Dilaasa film was released around the same time, TC members decided to screen the film as it brings forth the issue of Domestic violence, health consequences as well as the role of a health care provider in responding to it. CEHAT members conducted meetings with core group members to equip them with skills and information required to facilitate a discussion on the film. At least 5 screenings of the film were done across these hospitals covering 130 HCP's. The film was very well received and generated a lot of discussion on the role of HCP's as well as on the issue of VAW. Core

groups across 5 hospitals were keen to organize activities on the occasion of International Women's Day. These ranged from showing spots called '*Bol*' followed with a guided discussion, poster exhibitions based on VAW, slogan competition and a talk on child sexual abuse, highlighting aspects of awareness and prevention. One of the core groups also appointed a senior doctor to judge the write up competition on 'What women want'.

Violence against women health workers

A study conducted by CEHAT on understanding violence faced by women health workers in 2009 threw up several issues related to the nature of harassment and particularly sexual harassment at work place by male colleagues/ juniors/ seniors and patients. In the light of this finding, we felt that it was pertinent to conduct training on understanding the redressal mechanism for sexual harassment at work place as well as understanding what constitutes sexual harassment. A one day workshop was conducted by Adv Ujwala Kadrekar from Lawyers Collective. 23 participated in the training. Concepts related to sexuality, personal boundaries and comfort zone were discussed to enable the group to understand the background of how sexual harassment at work place gets defined. The definition on sexual harassment and the Vishakha guidelines led to a lot of discussion and sharing of experiences related to harassment. Nurses stated that they felt more enabled to now approach the committee for redressal as they understood the redressal mechanism better.

IV. INTERVENTION AND SERVICE PROVISION

Crisis intervention services for survivors of sexual assault :

51 survivors of sexual assault reported to the 3 public hospitals where CEHAT has set up a comprehensive health sector response to sexual assault. 29 of them were under 16 years and within that, a large majority was under 12 years of age. It was seen that most often the nature of sexual assault was a combination of non penetrative assaults such as fingering, forced masturbation and peno vaginal sex. Often the parents and relatives on approaching the hospital are completely overwhelmed with the hospital procedures and protocols, along with that they are often grappling with feelings of shame. The survivor also finds herself lost amongst hospital procedures and demands from family. A large part of the first contact intervention is about ensuring that the survivor and their families understand the procedures of the hospital, the importance of body evidence collection and the like. Secondly the emphasis is on ensuring that she receives treatment completely free from the hospital and also avail of counselling services. In case of children the counselling is often aimed at enabling the child to verbalise and demonstrate her emotions and feelings. Once that is done efforts are made to engage with the child in relation to ways in which physical pain and discomfort would subside with medicines. A large part of the dialogue is with the family and that too with the mothers as they are often ridden with guilt of having not been able to take care of the child. Efforts are made to help the mothers deal with their emotions and are explained the importance of ensuring that the child be allowed to lead a normal life, go to school and play with her friends. Interventionists also plan strategies to enable the parents to deal with comments from the community, neighbours etc. We have collaborated with Majlis in March 2011 to enable families of survivors to receive legal aid and understand the legal procedures entailed in the case. Follow up has been a challenge with the survivors as most often they don't want to return to the hospital even though they have health needs. In response to this home visits has been thought of as an alternate strategy. The aim of follow up has been to assist the survivors in the process of healing and respond to their emotional needs

Dilaasa, Crisis Intervention Department at Bhabha hospital, Bandra

The centre received 196 new women, 300 women followed up for counselling services, where as 47 women came for legal follow ups. 16 case presentations took place. It was observed that young women and girls have started narrating natal family abuse and pressure to marry against their wishes; this is true of young girls attempting suicide. Counsellors are faced with the challenge of getting the girls to follow up for counselling so that they feel more equipped to deal with the abuse. Similarly more and more young women are facing desertion or that their partners refuse to provide any economic support to them. This has led the counsellors to conduct a dialogue with the abusive partners vis a vis joint meetings. The entire objective of the joint meeting to ask the abuser to take responsibility of the relationship and stop abuse. The crisis centre continues to counsel women, who have consumed poison and deny a

suicide attempt, they maintain that this was accidental. However counsellors make efforts to strike a dialogue about the impact of such consumption on their health and try and make efforts so that such women in denial come back to seek support. A total of 58 such women were counselled but not registered. The crisis centre in charge is also involved in counselling women reporting sexual assault not just at her hospital, but also extends support to other Municipal hospitals receiving sexual; assault cases. Thus the crisis centre has now started responding to the issue of not just domestic violence but also sexual violence. At least 7 cases of sexual assault were responded to at the level of Dilaasa in Bhabha hospital Bandra.

Dilaasa, Crisis Intervention Department at Bhabha hospital, Kurla

This year 57 women registered at the counselling centre. There were 50 follow up counselling sessions and an additional of 7 legal counselling sessions. The case load has dropped significantly. A major reason that can be attributed is that certain major departments such as paediatric OPD, paediatric ward as well as minor operation theatre have been closed for the past 5 months. This has led to lesser patient population coming to the hospital in general. Further the hospital is also going through a medicine crunch. This has invited a lot of anger from the patients in general. Therefore we see more and more referrals happening to Sion hospital which is a tertiary care hospital. The social worker and nurse deputed at the department have therefore started engaging in outreach activities. In the past year they have conducted at least 2 workshops with the CHVs and ANMs at the ward level to increase awareness about Dilaasa activities. The centre in charge was responsible to get 2 slots of interviews on the channel Care TV for presenting the Dilaasa initiative and creating awareness on role of health systems in domestic violence cases.

Replication of Dilaasa in Shillong, Meghalaya

CEHAT collaborated with the North east network (NEN) to undertake the setting up of a hospital based crisis centre in Shillong. Through this partnership, efforts were made to build a relationship with the directorate of health services in Shillong and dialogue about the importance of setting up a crisis centre in a public hospital. CEHAT assisted the NEN to develop the proposal and dialogue with the health system for the same. Before the setting up of such a hospital based crisis centre, it was imperative that the Health care providers (HCP) be trained to understand the issue of Violence against women, its link to health consequences and enable them to impart trainings to their peers on this issue. A Training of trainers (TOT) was thought to be most effective method for it. CEHAT conducted a Training of trainers of 23 HCP's on the issue of Violence against women. Post an intensive training, specific groups of counsellors, doctors and nurses emerged and were keen to develop short modules for their peers on VAW and role of the health system. NEN has been provided a room designated for setting up the crisis centre at the civil hospital in shilling and a clinical psychologist was deputed to provide the required services to women survivors of violence. CEHAT dialogued with the NEN to depute staff from both the hospital as well as NEN to participate in the national course on Feminist counselling to respond to the issue of Violence against women. One member from NEN and 1 counsellor from Ganeshdas hospital participated in the 5 day intensive course on feminist counselling, which was aimed at building an understanding on the issue of violence against women and

understanding concepts linked to violence such as patriarchy , gender and others and finally actual hands on counselling sessions.

DOCUMENTATION AND PUBLICATION (CEHAT)

The main focus in the last years was on editing fields in the SLIM Library software in order to add missing or incomplete data. The unit has along started bar coding the resources in the unit. The documentary section was editing and a short abstract of the documentaries and other documentary details were added to the section. In the reference and e-document sections links are given to the soft copies either on the web or in-house resources. This year Stock taking of the library was done with a detailed documentation of the process involved. We have also done a documentation of the SLIM data entry module. The main focus this year was in promotion of the resources and the website.

Promoting the Library and Documentation Unit Collection : This year we have put in efforts to promote 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.

The research area webpage was revamped so that the user can access the resources at one glance. If a user is looking for material on specific Research area it is easier to get all research project listed under that area with links to all the publications i.e. reports, paper/articles and resources material developed under that research area. <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.

E-bulletin: We have put together two e-bulletin one on Domestic violence (<http://www.cehat.org/go/uploads/Library/ebulletinAugOct10.pdf>) and Health budget. The domestic violence e-bulletin is published and circulated to target audience and the health budget bulletin is ready for dissemination.

Literature Lists: Literature lists on Health Economic and Financing, Research Methodology and Public private partnership were put together and circulated to the internal staff which are now available in the unit.

V. LIBRARY DOCUMENTATION AND PUBLICATION

- 80. Pradhan, Anagha. Migration Report. CEHAT and ANANDI Publications, 2011
- 2011
- 79. Dantas, Anandi. Mapping of Urban Health Facilities in Maharashtra. Mumbai: CEHAT, 74 p., 2011 [ISBN: 978-81-89042-55-4]
- 78. Bhate-Deosthali, Padma and Khatri, Ritu. **Healthcare in the Private Sector: A Study of Private Hospitals in Maharashtra**. Mumbai: CEHAT, xv,136 p., 2011 [ISBN: 978-81-89042-54-7] [Download full report...](#)
- 2010
- 77. Deosthali, Padma and Rege, Sangeeta. **Feminist Reponse to Attempted Suicide: A Model for Public Health Intervention**. Working Paper No. 2. Mumbai: CEHAT, 36 p., 2010 [ISBN: 978-81-89042-53-0] [Download](#)
- 76. Rege, Sangeeta. **Guidelines for Counselling Women Facing Violence**. Mumbai: CEHAT, 48 p., 2010 [Download Report](#)
- 75. Barai - Jaitly, Tejal. **National conference report: Emerging Health Care Models: Engaging the Private Health Sector'**, 25th - 26th September 2009 YMCA. Mumbai: CEHAT, vi,42 p., 2010
- 74. **Dilaasa crisis intervention department for women: a report**. Mumbai: CEHAT, 14 p., 2010 [Download Full Report](#)
- 73. **Manual for medical examination of sexual assault**. Mumbai: CEHAT, x,58 p., 2010 [ISBN: 978-81-89-042-51-6] [Download Report](#)
- 72. Jagadish, N.; Deosthali, Padma; Contractor, Sana; Rege, Sangeeta and Malik, Seema. **Comprehensive health sector response to sexual assault does the Delhi high court judgment pave the way?** Working Paper No. 1. Mumbai: CEHAT, 16 p., 2010 [ISBN:978-81-89042-50-9] [Also listed in SVRI (Sexual Violence Research Initiative) Online Publications/Resource Section, July 2010][Download](#)
- 71. Rege, Sangeeta; Deosthali, Padma and Contractor, Qudsiya. **Challenges in domestic violence counseling**. Mumbai: CEHAT, viii, 40 p. , 2010 [ISBN: 978-81-89042-53-0] [Download full report...](#)
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- Articles
- 2011
- A 305. Bhate-Deosthali, Padma; Khatri, Ritu and Wagle, Suchitra. **Poor standards of care in small, private hospitals in Maharashtra, India: Implications for public-private partnerships for maternity care**. *Reproductive Health Matters*, 19 (37), 2011, pp. 32-41 [Fulltext](#)
- A 304. Dantas, Anandi. **Mapping of Urban Health Facilities in Maharashtra**. Paper presented in *Eight Conference of Indian Association for Social Sciences and Health on Health, Environment and Sustainability*. Organised by Department of Population Studies and Social Work, Sri Venkateswara University, Tirupati, February 11-13, 2011

- A. 303. Dantas, Anandi. **Mapping of Urban Health Facilities in Maharashtra.** Paper presented in the *National Seminar on Delivery of Health care for the Urban Poor-Convergence Approach*. Organised by Regional Centre for Urban and Environmental Studies of All India Institute of Local Self Government (AIIILSG), Mumbai and Ministry of Housing & Urban Poverty Alleviation, Government of India. January 6-7, 2011
- 2010
- A 302. Dantas, Anandi. **Mapping of Urban Health Facilities in Maharashtra.** Paper presented in *Seminar on Spatial Dimensions on Health Care use of GIS in Health Studies*. Organised by CEHAT and Department of Geography, University of Mumbai, 24th September 2010
- A 301. Dantas, Anandi. **Mapping of health facilities in Aurangabad.** *Health Action*, August 2010, 23(8), pp.34-36
- A 300. Deosthali, Padma and Khatri, Ritu. **Violating the law, yet thriving: study of private hospitals in Maharashtra.** *Medico Friend Circle Bulletin*, February - March 2010, No.339, pp.1-10
- A 299. Deosthali, Padma and Rege, Sangeeta. **A study to understand violence faced by female health workers: a need to develop hospital based response.** In *Second International Conference on Violence in the Health Sector*, Congress Centre "De Meervaart" Meer en Vaart 300,1068 LE Amsterdam, The Netherlands. October 27 - 29, 2010, 249 p. (Poster)
- A 298. Rege, Sangeeta and Deosthali, Padma. **Dealing with spousal violence.** *Indian Journal of Medical Ethics*, October-December 2010, VII(4), pp.246-248
- A 297. Wagle, Suchitra. **The third party in decision making: the role of web based medical facilitators in medical tourism.** Paper presented in *National Bioethics Conference*, New Delhi, 2010.
- A 296. Kurian, Oommen C.; Raymus, Prashant and Ranade-Sathe, Jui. **Equity through exemptions? User fees in a municipal hospital in Maharashtra.** Paper presented in *National Bioethics Conference*, New Delhi, 2010. (PPT)
- A. 295. Gupta, Rupali and Rege, Sangeeta. **Challenges and dilemmas in institutionalising a crisis centre for women facing domestic violence in the public health system.** Paper presented in *National Bioethics Conference*, New Delhi, 2010.
- A 294. Sana Contractor and Sangeeta Rege. **Need for better governance in responding to cases of sexual assault in the health sector.** Paper presented in *National Bioethics Conference*, New Delhi, 2010.

Newsletter:

The Training cell and its increasing membership prompted CEHAT to develop a newsletter to increase communication amongst different hospitals about the nature of efforts undertaken vis a vis this issue. We also thought that it was pertinent that HCP's feel rewarded if they are positively reinforced by sharing their screening tips, or how they made a difference to a woman's life. This was an activity supported by Point of View but the team was involved in developing structure, facilitating discussions and finalizing the product. Currently the news letter is in 2 languages Marathi and English.

Film:

A film "At the cross roads" was made and released on 16th February 2011. The film was aimed at highlighting the role of health care providers in responding to abused women. It was also aimed at showcasing the Dilaasa model and promotes its replication in other parts of the country. The release function saw more than 170 people, Health care providers, activists, organisations and the like. The film was highly appreciated and was also followed by a lively discussion on the issue of violence against women. The film and the newsletter were inaugurated by Dr Seema Malik, the Chief medical superintendent of peripheral hospitals. Post this function, several demands are being made for the film copies and the film is being used to discuss the issue of domestic violence in groups of professionals as well as at the level of community.

Poster Presentations :

1. Contractor, Sana and Rege, Sangeeta (2010). Implementing a Comprehensive Health Sector Response to Sexual Assault. Poster Presentation in *First Global Symposium on Health Systems Research*, 16-19 November 2010 - Montreux Switzerland.
2. Deosthali, Padma and Khatri, Ritu (2010). Engaging the Private Health Sector for Universal Access : Issues of Concern. Poster Presentation in *First Global Symposium on Health Systems Research*, 16-19 November 2010 - Montreux Switzerland.
3. Dantas, Anandi (2010). Mapping of Urban Health Facilities in the Evolving City of Aurangabad, Maharashtra, India. Poster Presentation in *First Global Symposium on Health Systems Research*, 16-19 November 2010 - Montreux Switzerland.
4. Rege, Snageeta (2010). Understanding Violence faced by Women Health Workers: A Need to Develop Hospital Based Response. *Poster Presented in Violence in the health sector Amsterdam*.

Press coverage: 2011**Ultra sound & fury over girl child**

epaper.timesofindia.com/Repository/getFiles.asp?... - Cached

13 Jul 2011 - *Ultra sound & fury over girl child*. Malathy Iyer TNN Mumbai: The fight for the girl child is roiling the state like never before. ...

Mr Minister, heal thyself, say experts - The Times of India

timesofindia.indiatimes.com/.../Mr-Minister-heal-thyself-say-experts... - Cached

6 Jul 2011 - Union health *minister* Ghulam Nabi Azad must look as long back as the early twentieth century and read the views of Havelock Ellis and ...

Maha govt reformulates forensic test proforma for rape victims May 03,2011

<http://ibnlive.in.com/generalnewsfeed/news/maha-govt-reformulates-forensic-test-proforma-for-rape-victims/670168.html>

The Maharashtra government has re-formulated the entire proforma for forensic medical examination of sexually assaulted victims, the Bombay High Court bench here was informed. Government Pleader Bharati Dangare, last week submitted before the division bench of Justice D D Sinha and A P Bhangale here that it has prepared an instruction manual, age estimation proforma, requisition letter for chemical analysis,

and format for final opinion as per the suggestions for proper forensic medical examination of rape victims.

'Monitoring of abortion pill sales is regressive & intrusive ...

[articles.timesofindia.indiatimes.com > Collections > Unsafe Abortions](#) - [Cached](#)

13 Mar 2011 - MUMBAI: Social activists have slammed the state government's intentions to regulate the *sale of abortion pills* and to keep close tabs on ...

Budget allocation cuts relief for rape victims - Times Of India

[articles.timesofindia.indiatimes.com > Collections](#) - [Cached](#)

9 Mar 2011 - MUMBAI: After the celebrations for International Women's Day, here's some grim news. Despite the rising number of rapes in the country there ...

NGOs screen film on domestic violence, Dharavi women recount ...

[www.indianexpress.com/.../ngos-screen-film-on-domestic-violence-... - Cached](#)

16 Feb 2011 - NGOs screen film on domestic violence, Dharavi women recount experiences - Laying emphasis on the role of public health workers in ...

Hike in cost of med tests pinches pockets of poor - Times Of India

[articles.timesofindia.indiatimes.com > Collections](#) - [Cached](#)

14 Feb 2011 - MUMBAI: The government's decision to increase the *cost of tests* and services in its hospitals has come as rude shock to patients, ...

The poor have a bad year ahead for healthcare - Times Of India

[articles.timesofindia.indiatimes.com > Collections](#) - [Cached](#)

12 Feb 2011 - MUMBAI: The civic budget for health for the financial year 2011-12 looks exhaustive, with a huge amount being pumped in for the construction ...

Civil society cries regional imbalance in healthcare - Times Of India

[articles.timesofindia.indiatimes.com > Collections > Health](#) - [Cached](#)

8 Feb 2011 - Bhubaneswar: Members of *civil society* organizations on Monday urged the state government to take steps to remove *regional imbalances* while ...

Civil society bodies express apprehension about economic ...

[www.orissadiary.com > Orissa Events](#) - [Cached](#)

8 Feb 2011 - *Civil society bodies express apprehension about economic* governance in Orissa, Orissa Event Diary.

Odisha Budget Solidarity to organise a state level convention on ...

[www.orissadiary.com > Business News](#) - [Cached](#)

4 Feb 2011 - *Odisha Budget Solidarity to organise a state level convention on* Health sector Budget on 7th February, Orissa Business News.

File report on standard medical protocol for sexual assault victims

Law et al. News 03.02.2011 | 02:52 Nagpur RS Agrawal

The Nagpur bench of High Court of Bombay has asked a committee constituted by the government for examining all aspects in relation to protocols, proformas, and health care response to sexual assault victims, and submit its report to the court by March 10. The court also asked the committee to furnish a copy of the report to petitioner in the case Dr. Ranjana Pardhi and others as well as intervenors in the proceedings, Mumbai based NGO "CEHAT" - Centre for Inquiry into Health and Allied Themes.

State appoints panel to look into sexual assault protocol - Times ... Times of India

3 Feb 2011 - NAGPUR: The *state* government has *appointed* a committee to *look into* the *sexual assault* protocols and forms that should be utilized all over ...

VI. STAFF PROFILE

Staff Details for Year April 2010-March 2011

Sr. No.	Employee Name	Designation	Qualification
1	Anandi Dantas	Research Officer	M. Phil (M.A.)
2	Anupriya Ameya Sathe	Sr. Research Associate	MSc. Health Science
3	Anjali Kadam	Secretary	H.S.C.
4	Anita Jain	Research Officer	MHSA (Health Services Admi)
5	Deepmala Mahesh Patel	Research Associate	M.S.W. Community Development
6	Devidas Jadhav	Secretary	S.S.C.
7	Dilip Jadhav	Office Assistant	H.S.C.
8	Dinali Hataskar	Administrative Assistant	M.Com
9	Gajendra Dixit	Sr. Research Associate	M.A. in Social Work
10	Geeta Surve	Secretary	H.S.C.
11	Jasmine Kalha	Research Associate	M.S.W.
12	Komal Asrani	Administrative Assistant	T.Y.B.Com.
13	Margaret Rodrigues	Research Officer	B.Sc. Diploma in system Management
14	Meghna Jethva	Sr. Research Associate	M.A.
15	Netralal Sharma	Office Assistant	S.S.C.
16	Nidhi Gupta	Research Officer	Masters in Health Administration
17	Nidhi Sharma	Sr. Research Associate	M.A. in Psychology
18	Oommen Kurian	Research Officer	PhD
19	Prachi Avalaskar	Sr. Research Associate	M.S.H.S.
20	Pradnya Jadhav	Administrative Assistant	B. Com
21	Prashant Raymus	Research Officer	M.A.
22	Pramila Naik	Jr. Administrative Officer	B.Com
23	Priyanka Shukla	Sr. Research Associate	MLISC (Library Science)
24	Priyanka Josson	Sr. Research Associate	Masters in Social Work
25	Rahul Sapkal	Sr. Research Associate	M.A. in Development Studies
26	Ramdas Marathe	Office Assistant	H.S.C.
27	Rashmi Divekar	Sr. Research Associate	B.A. pursuing LLB
28	Rupali Gupta	Research Officer	DPSCDM
29	Sana Contractor	Research Officer	B.D.S, M.P.H.
30	Sangeeta Chatterji	Sr. Research Associate	M.S.W.

31	Sangeeta Rege	Sr. Research Officer	M.S.W.
32	Shobha Kamble	Office Assistant	Primary School
33	Suchitra Wagle	Sr. Research Associate	Ph.D. Sociology, MSc, Anthropology, Adv.cert.course-clinical research
34	Sushma Patil	Jr. Administrative Officer	B.Com
35	Sudhakar Manjrekar	Office Assistant	Secondary School
36	Tayyaba K. Shaikh	Research Officer	M.A. and MPS
37	Yamini Sonavane	Research Associate	B.H.M.S.
38	Yashashree S.Keni	Research Officer	PGDPH, MBBS
39	Yavnika Tanwar	Sr. Research Associate	Master of Arts in Disaster Management
40	Vijay Sawant	Secretary	B.A.
41	Zamrooda Khanday	Sr. Research Officer	Masters in Social Work