
**ANNUAL REPORT
OF
CEHAT**

2009-2010

RESEARCH

I. Health Services

1. Mapping of Urban Health Facilities in Maharashtra

Maharashtra is the second most urbanised state in India with 42% of its population residing in urban areas. Between 1991 and 2001 urban population in Maharashtra grew by 31% and the growth in proportion of poor for the same period was disproportionately high. Over the years the growth in public health sector has not kept pace with the growth in increase of urban population. Distribution of primary health centres in urban and rural areas is disproportionate to the distribution of poor over urban and rural areas. In absence of accessible public sector health services, the poor and the lower middle class in urban areas depend on private sector health care providers including the ones without legitimate qualifications. And still, access to these private providers is not easy for the poor and the lower-middle-class population. The present study examined quantitative and spatial growth of public and registered private health facilities in the context of growth in the population for the selected cities Aurangabad, Nashik, Nagpur and Solapur.

Findings - Aurangabad

Aurangabad is the fifth largest city from the state. Public sector health facilities consist of health centres, municipal hospitals, government medical college hospital, civil hospital and one ESIS hospital. Primary care is provided through health centres and five municipal hospitals. Municipal hospitals also provide secondary level care and tertiary care is provided by the teaching hospital and the civil hospital. Aurangabad experienced a 52.34% population growth in the period of 1991 to 2001. For the same period health centres increased by 186% (from seven in 1991 to 20 in 2001), public hospitals by 33% (three in 1991 to four in 2001) and registered private hospitals showed a growth rate of 88% (98 in 1994 to 184 in 2001). The skewed growth pattern is reflected in the bed to population ratio of 1:268 for private hospitals and 1:724 for public hospitals.

Spatial examination showed that even though the private sector showed a large growth, all parts (electoral wards) of the city had not benefited equally from this expansion. Analysis showed that the increase in number of private sector facilities was predominantly limited to three areas, two located near the city centre and one to the northern part of the city. These areas already had a higher than average number of private health facilities. The first two areas also happened to be the areas inhabited by middle and higher income population who can afford the prices charged by these services and thus avail of them. The third area showed increase number of health care facilities due to road connectivity north of the city and also catered to a lower socio-economic group from nearby localities.

Accessibility was observed to be another criterion that promoted growth of private hospitals in the city. Areas on the either side of highway that connects Aurangabad to neighbouring towns have seen an increase in number of private hospitals and clinics. It was noted that women from neighbouring areas outside the municipal corporation limits seek maternity services within the city thus the

city has reported a CBR that is higher than that for urban Maharashtra and national average.

The increase in the number of health care facilities has had limited benefits for the marginalised communities from the city. Aurangabad, because of the stage of development that it is in is experiencing a large influx of migrants. These include unskilled and semi-skilled workers who seek employment in the industrial zones developing at the periphery of the city, students drawn by the professional colleges, and elderly - the retired persons who have opted to make the city their home. All these groups have specific vulnerabilities. Impact of growth of health services needs to be explored for each of these groups.

Nasik

Over the period of 1991 to 2001, Nashik saw a slightly different pattern in the growth of health care facilities. The population growth rate was 64% for this period; in the public sector the primary care centres grew by 18% (11 in 1991 to 13 in 2001) and public hospitals grew by 100% (7 in 1991 to 14 in 2001). This increase however is likely to have limited impact in terms of increased access as only five of 18 urban health centres are located as independent facilities and the rest are housed within public sector hospitals. Private hospitals experienced a huge growth of more than 300% over the period of 2001 and 2009. The pattern of distribution of private hospitals within the city was similar to that noticed in Aurangabad, where wards with large number of health facilities close to the city centre, witnessing further increase in number of private hospitals.

This study highlights an urgent need for a norm for location / distribution of private hospitals within the city to facilitate equitable distribution of health services. Data analysis for two other cities- Solapur and Nagpur is underway. A comparative analysis of data from the four selected studies along with data on access (distances, time spent, expenses incurred) and utilisation of services by the marginalised groups is underway.

2. Seasonal Migration and its Impact on Health-A Case Study of Prawn Harvesters in Gujarat

CEHAT and ANANDI undertook a study on the fish prawn workers in Gujarat. It is known that most of the seasonal migrants face many issues. Among these, the most serious being the lack of basic services as food, health and education, particularly children among the migrants miss education and immunization. Fishing is a traditional livelihood activity of these prawn harvest communities largely concentrated in two blocks Maliya and Halvad in Gujarat. Salination of land, polluted water, scarce monsoon and poor irrigation schemes and government apathy towards farmers aggravated the condition over a period of time. That is why they migrate to the temporary settlements for the prawn harvest as their main occupation. The findings show that they can not save money from prawn harvest when they return to the base village after the season even though since 100 years they continue to migrate to the settlement because during the season at least they get some money to survive. Prawn catching is comparatively good remunerative business in good season.

The data also shows that these migrants face several health problems and have reported highest morbidity due to their living condition and involvement in the prawn harvest during their stay at settlement. Fever has been reported by 68 percent people due to weather, work pattern and living condition at the settlement. Women are most affected with reproductive health problems like white discharge, low backache, pregnancy induced and abdominal pain due to involvement in the prawn harvest/nature of work. Even though they have no provision of health care services at the settlement for the treatment of disease, ANC and PNC care for pregnant women, treatment for chronic illness like (T.B, reproductive illness, accidents, aches and pains, skin disease and respiratory problem etc.), schools for children and PDC services.

The study proves the exclusion of these seasonal or temporary migrants. There is complete absence of any government schemes or provisions (universal) benefiting these migrants in the place of migration. The key findings of the study have been shared with ANANDI and scientific review committee. The data collection and analysis has been completed. Key findings of all the chapters have been finished; few chapters' draft report is ready. Findings have been given to ANANDI for the presentation to the departments of Health and Family Welfare Department, Water and sanitation and Fisheries Dept- for shelter, worksite facilities, and education to make them accountable for the betterment of the living condition and provision of essential services to the prawn harvesters.

3. Health Budget Inequities In Maharashtra

CEHAT (Centre for Enquiry into Health and Allied Themes) in collaboration with SATHI (Support for Advocacy and training into Health Initiatives) and TISS (Tata Institute of Social Sciences) has undertaken a project, "Maharashtra Health Equity and Rights Watch" to study inequities in health status and access to healthcare services. This was to support advocacy for equity-oriented health sector reform and health rights. One component of the project which CEHAT undertook was "Analyzing district Health budgets/expenditure of districts in Maharashtra". The research aims to:

- examine the trends of the total budget allocation and expenditure of select districts in Maharashtra;
- document the proportion of the health allocation and expenditure to the total expenditure in the budget;
- measure the budget's impact by linking budget expenditure with health care utilization data;
- compare health facilities across the state; and
- study health budget expenditure inequities between districts.

Administrative and financial information at the district and facility level was gathered and cross-checked with data from the Office of the Accountant General in Maharashtra and other state offices. Data from performance budgets (e.g., the Public Health Department and the Medical Education and Drugs Department), Zilla Parishad (ZP) budget documents, ZP annual account

documents, district progress reports, and annual district plans were compiled and analyzed, as well. The key findings include:

Per Capita Expenditure on Social Services at District Level -

Districts in less-developed areas of Maharashtra have higher per capita expenditure on social services than those in developed areas. This can be because less-developed districts receive additional funds under programs such as the Tribal Sub Plan. In addition, more-developed districts spend considerable funds from the municipal budgets that are not reflected in the state budget. Although the per capita spending is higher in the less-developed districts, these expenses have not translated into better social sector services. In fact these districts have higher infant and maternal mortality rates.

Total Expenditure on Public Sector Health Care -

Although government spending has increased in real terms from 2001-2007, the health budget has declined from 4 percent in 2001-2002 to 3.6 percent in 2007-2008. This may be connected to the National Rural Health Mission (NRHM) program launched in 2005 by the central government that allocated funds to health care services in the state. Half of these funds are off-budget and not accounted for in the state budget. This shows that although the NRHM aimed to improve health services the state government reduced its expenditure.

District Variation in Per Capita Health Expenditure -

Districts in less-developed areas of Maharashtra have higher health per capita expenditure than those in more-developed areas. This could be the result of high population density in developed districts and the recent increase in investments in less-developed districts. Such additional investments are allocated under programs like the Tribal Sub Plan and are sometimes made through the central government - often on the capital account - although the major share is borne by state government.

Rural-Urban Differences in Health Expenditures -

In the rural-urban distribution of health expenditures most districts show higher per capita spending in urban areas. At the state level urban areas have higher per capita health care expenditures. However, there are districts with higher expenditures in rural areas. These are mostly districts without government medical colleges and tertiary facilities with higher urban than rural expenditures (except for Pune). This means two things: 1) medical college and hospitals absorb a substantial portion of the public health budget, and 2) the public health budget is more proportionately distributed as per the population ratio of that district and even more generously distributed in rural areas.

Inequities in District Hospital Expenditure and Efficiency of Utilization -

In an overwhelming majority of hospitals the Bed Occupancy Ratio (BOR) has declined between 1998 and 2007. There are fewer hospitals with BOR greater than 80. The poor services provided by public health institutions declines its utilization. Surveys conducted by the National Sample Survey Organization also support this. Hence the urgent need to invest resources in the public health system to revive the existing services with adequate human resources.

Team Members: Prashant Raymus, from CEHAT and Abhay Shukla, and Nilangi Sardeshpande from Sathi , Consultant: Ravi Duggal

4. User fees in Municipal Hospitals in Mumbai

The research consisted of review of available literature on implementation of user fees and impact on access to health care, and a proposal to explore mechanisms related to implementation of user fees in a municipal hospital in Mumbai. The annotated bibliography covers both empirical evidence as well as conceptual papers related to user fees in health care. The presented scenario were evaluated by the purposes for which the user fees were levied, whether their stated objectives were achieved over the study period and potential of user fees to be an alternative health financing mechanism.

Literature provides evidence that user fees do not substantially contribute to the revenue and hence cannot be considered as alternate ways of health financing. Levying of user fees was noted to affect health care utilisation of the poor, the urban and the users of outpatient services. Research also suggests that unless appropriate exemptions were introduced the user fees negatively influenced the poor people's access to health care. However, it is also stressed by the researchers that utilisation of health care is a result of complex interplay between a number of social, cultural and economic determinants and conclusion that introduction of user fees alone being responsible for reduction in utilisation may be inaccurate. Studies (some from India) have highlighted the problems in implementing exemptions - that are crucial to maintain equitable access to health care - and its negative impact on the poor. The review points towards need for abolition of user fees as it is a regressive mechanisms for health financing.

To address this gap in the existing knowledge, CEHAT proposed an exploration of user fees in municipal hospitals in Mumbai. The study aims to map the flow of user fees from collection, deposition to expenditure of funds generated by user fee in municipal hospitals in Mumbai. The study will also document the health providers' role in the process of granting exemptions from user fees and provision of poor box funds to the needy. The proposed study will be carried out in one public hospital and primary data will be collected through semi-structured interviews with 24 (7 administrative staff and 17 clinicians) staff at the selected hospital. Secondary data on revenue, expenditure, patient turnover etc will be collected from medical records department of the hospital as well as from the MCGM headquarters. CEHAT proposes to use findings from the study to get policy makers and bureaucrats to re-examine the system and ensure equitable access to public health care services.

II. Conflict and Health

1. 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 the 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. While the proposal for the study was prepared and reviewed in early 2009, getting permissions for the study took a long time and it was cleared by the Directorate of Medical Education and Research only in February of 2010. Data collection is currently underway.

Team members: Padma Deosthali, Sana Contractor, Nidhi Sharma and Rashmi Divekar.

2. Communalism in "peacetime"

The Review of literature and methodology for the peacetime communalism study has been completed. The proposal development took considerable time as it is a challenging subject to study. The team received several inputs from a wide range of researchers/activists. It was finally conceptualised a study that captures women's' perceptions of experiences of discrimination at the health facilities- those related to gender, class and religion. For this FGDs was concluded as a useful tool and sample would consist of Muslim and Non-Muslim women from a community that had a similar economic background so as to control effects of class on experiences of discrimination. The study is titled "Exploring religious discrimination at health facilities". The data collection for the study has begun. Two pilot FGD's have been conducted and the analysis for the same has been completed.

III. Women and health

Paper on 'Abortion and Sex Selection - Redefining Concepts'

The paper attempts to examine two extremely contentious issues related to the reproductive rights of women, abortion and sex selection that have been the subject of endless debates. Paper highlights the challenges for the campaign in future and need for redefining the two through the prism of human rights, medical ethics and women's rights. While abortion was legalized in India well over three decades ago the unceasing debates and contradictions regarding abortion seem to have come full circle with some of the ongoing protests against pre natal sex determination leading to sex selective abortions being misinterpreted as opposed to the right to abortion itself. An over-emphasis on preventing sex-selective abortions also threatens to jeopardize the right to abortion that women have achieved even if access to it may not be universal in nature. It is this anomaly of pitting one right against another that needs to be changed by identifying the real issues and reorienting the debate on abortion and sex selection.

The paper is divided into an introduction which discusses women's reproductive health as a backdrop for the ensuing discussion on the concepts of abortion and sex-selection. This is followed by a brief

history of how the Medical Termination of Pregnancy Act and the Prevention of Misuse of Preconception and Prenatal Diagnostic Technology Act came into existence and the lacunae and obstacles in their implementation. It ends with a mention of the recommendations and amendments that have been tabled in relation with the above acts and a proposal for the way forward.

III. Violence against Women

1. Casebook on counselling ethics:

Counselling ethics is a well developed theme in the west but at a nascent stage in India. In the course of familiarising ourselves with the various models used in order to resolve ethical dilemmas, the need to develop ethical guidelines in counselling women facing Domestic violence was realized. These dilemmas and challenges have been documented in the form of a casebook, which has been published. The aim is to disseminate the case book and encourage Domestic violence counsellors to look at the discourse on counselling ethics in DV.

2. 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 kit was revised along with experts and a consultation was held on 30th September to get feedback and endorsement. After the consultation, the new kit was finalized. Along with a kit for examination of survivor of sexual assault, we also developed a kit for examination of accused of sexual assault, which was also presented at the consultation. Since January 2010, the revised protocols and manuals are being used by the examining physicians. The new manual is a guide for doctors that provides them step by step instructions for collecting evidence and providing care.

3. Observation study at Public hospital on management of sexual assault:

A formative observation study was conducted in Nagpada Police Hospital, where maximum number of sexual assault cases are examined in Mumbai. The findings threw up several issues related to procedure and attitudes of hospital staff in dealing with sexual assault cases. Some of the areas of concern were that history of assault was sought in the presence of police, consent was sought by the clerk, no treatment was provided to survivors at all at the hospital and there was no consistency in the medical evidence collected. From the perspective of "comprehensive response to sexual assault" this hospital fails on all levels. It focuses only on evidence collection in cases of sexual assault as if that is the only need of the survivor. Survivors are only referred to other

hospital for reported symptoms, with no advice on follow up and possible symptoms that may surface later. The report of this study was presented to the Police Surgeon, who expressed a willingness to change procedures as well as initiate a crisis centre to respond to sexual assault survivors in the hospital. This was an excellent opportunity since the Police Hospital receives the maximum number of sexual assault cases in Mumbai. We have drawn up a proposal for work with the Police hospital, which we will be presenting to the home department. As per this proposal, CEHAT will be providing capacity building to the hospital staff to respond to cases of sexual assault in a sensitive manner and will provide SAFE kits for examination and evidence collection.

4. Formative research on management of sexual assault:

In an attempt to set up crisis intervention services at hospital in Delhi, a needs assessment study has been conceptualised and is underway. This includes key informant interviews with various players involved in responding to sexual assault cases. The data collection for this study is underway. Based on the learnings from the study, an appropriate intervention will be designed to address gaps in the system.

5. Management Information System for Dilaasa

An information system is being developed to enable easy periodic analysis of cases being handled at Dilaasa. 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. 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. The variables for the MIS are being finalized in consultation with the counsellors and software for its operationalisation is being prepared. The counsellors would have to be trained to enter this information into the MIS on a regular basis.

6. Study of cases of attempted suicides reported at public hospitals

Large number of women report to public hospitals after an attempt to suicide which is not even recorded as one. It is recorded as "accidental consumption of poison" On the basis of experience at Dilaasa, it was realized that many women who are survivors of domestic violence are forced to take this step as a consequence of ongoing experience of abuse. A need was felt to understand the profile of such suspected and reported cases of attempted suicides in public hospitals in Mumbai and study the current treatment model. A sample of 12 target public and peripheral hospitals has been identified and A 'Data Input Sheet' has been drafted for collecting data during the visits to health facilities to understand the current treatment practices for attempted suicide victims. On the basis of feedback, a pilot run for the interview guide was conducted in two public hospitals and scope of the project was extended from qualitative to include quantitative data as well. The findings of the pilot run have been put into a report. Dr. Shubhangi Parkar, HOD of Psychiatry, KEM hospital has agreed to be a consultant on this initiative.

ADVOCACY

1. Public Private Partnerships

Public-Private Partnerships (PPP) have been in existence for some time in India. Recent years have seen promotion of PPPs through NRHM to meet public health goals. However, in a country with a vast, largely unregulated private sector there is limited information on mechanisms for implementation of these partnerships as well as their impact on utilisation and access to health care for especially the poor. Information on effectiveness of these partnerships in meeting their stated goals has also not been well documented.

A national conference “Emerging health care models: Engaging the private sector”. was organized where 15 papers were presented and various experts including Dr Rama Baru, Dr Venkat Raman, Sunil Nandraj, Dr Amarjeet Singh and Dr Gita Sen spoke on challenges in partnering with the private health sector.

The key themes for the conference were -

1. PPPs as emerging models in health sector: benefits and issues of concern
2. Role of the state in PPPs and related reforms in policy and legislation
3. Lack of regulation in the private sector and its impact on such partnerships
4. State of patients' rights in the midst of emerging health sector models (role of non-state sectors - private organisations, international agencies, civil society, media etc)
5. PPP and universal access to health care facilities and equity in health

And it sought to generate debate on -

- Within these newly emerging health models how does one safe-guard right to health?
- How does the public as well as private sector synergise in working towards national health goals through these partnerships?
- How does one ensure quality and efficiency of the health services? If through regulatory mechanisms, what would these be?

A total of 49 abstracts were received and after a careful review 18 papers were invited, 13 of which were compiled in a volume. The papers presented at the conference consisted of presentation of NGOs' work through PPP, those that evaluated some key PPPs, and some that presented the governments' perspective on PPPs and one paper that presented the international evidence regarding PPPs. In addition, some eminent scholars were invited to share their perspective at the conference.

The presentations at the conference generated discussion on theoretical issues around PPPs primarily the definition of what should or should not be termed as PPP. Lack of regulatory mechanisms for monitoring and accrediting private sector in India (that often results in less than desired quality of care) were noted as the primary concern for involving private sector in the process of reaching public health goals. Need for separate treatment to for-profit and not-

for-profit private sectors while considering PPPs was also discussed. Another area that received lot of time at the conference was various models of PPP and their merits and demerits. Whether PPM is a guise for privatisation and the role of the state in PPM were discussed at the conference and the working paper goes on to conclude that PPM is not a way of privatisation and that government is not trying to shirk its responsibilities towards provision of services to the poor/ most needy by engaging in partnership with private / non-government sectors.

The issue on roles and responsibilities of both partners and the role of 'contract between the partners' has been extensively discussed in the context of various models of PPP. The point about 'mutually consented arrangements being more successful than partnerships involving competitively selected partners' needs further exploration. There is little discussion however on the evidence pertaining to impact of these PPPs on access to health care for the poor. Wherever such evidence exists (papers from the compiled volume), it points towards benefits of PPPs though with limitations - even when these include involvement of non-formal care providers to provide a suitable level of care. The draft working paper is useful in that it presents discussion on a number of issues around PPPs - especially under NRHM and in the area of RCH. There is a compelling need to design research exploring impact of PPP on access to health care and equity.

2. CEHAT's Budget Initiative

CEHAT intended to expand its work related to budget training and advocacy to other two states- Orissa and Madhya Pradesh as well as continue with its activities in Maharashtra.

Orissa and Madhya Pradesh

- Local partners (individuals, organisations, networks and institutions) were identified in both states
- Brainstorming, sharing of experience for internal capacity building carried out in MP
- Support provided to local partners in terms of compilation of facts to strengthen their activities
- Follow up of orientation training
- Gram panchayat budgets collected by a local partner, analysis submitted to panchayat samiti

In June 2009, a state level convention on health sector budget in Orissa was organised. A civil society charter of demands on health budget in Orissa was finalised at this convention. A background note consisting of four presentations - that gave readers a comprehensive picture of health budgets and civil society budget work in India, an analysis of health budgets as well as health expenditure in Orissa and role of JSA Orissa in advocacy for a health charter in Orissa. This note was published in a booklet form. The state level convention was followed up with a two days state level training workshop on 'Health budget analysis at district level governance' in December 2009. This was

attended by 46 participants (including representatives of CEHAT and partner organisations). The first part of the workshop focussed on thematic issues related to macro-economics of the state and civil society's perspective of holding state accountable towards budgetary promises. This part familiarised the participants to common terms used, federal structure and fund flow mechanisms across different levels of government and programme implementing bodies. The second part of the workshop involved analysis of data for three selected districts and helped clarify the participants' doubts regarding district budgets. The last part of the training focussed on charting out a plan of action for strategic intervention in budget work in Orissa. A number of action steps were listed and a list of documents and data sources was prepared.

3. Armed conflict and women

A consultation was held in Srinagar in the month of September'09 with medical professionals, academicians, lawyers, police and judiciary and NGO's to look at the issue of VAW in an armed conflict situation, the role of the state and the response of health sector to VAW. The consultation closed with the participants expressing a desire to initiating training where Para counsellors could be trained to identify and work with cases of VAW. A need for a screening cum treatment clinic exclusively for women in Srinagar was also felt where cases from the entire state could be referred to. This would be a multi sectoral clinic offering services to women. A need was expressed for documenting cases of violence and generating awareness in communities on DV. It was felt that many victims were not aware of what constituted DV and hence it was not reported. Documentation process has been initiated in the state of Jammu and Kashmir and in North East India. Efforts are being made to document cases in Chattisgarh as well. CEHAT was invited to ICPD 20+ in Shillong (NE India) to bring forth the problems of Women in Armed Conflict zones especially in Kashmir. The team held a comparative session for North East India and Kashmir highlighting the problems of VAW in the two areas. The need for documentation was further reiterated in this seminar. A Working paper on Armed Conflict - "Right to health care in Armed conflict" looking at the effects on Health Systems and Women and the Role of Health Care Practitioners in the Armed Conflict is being written.

4. Promoting a comprehensive health care response to Sexual assault.

As a response to the Delhi high Court and a PIL filed in Nagpur, 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. It is important to note here that: a. health facilities across the country do not have a uniform protocol and procedure for responding to sexual assault, b. the forensic role (evidence collection) always takes precedence to the health care/medical role (treatment). It is a shame that the government should develop a form for the first time sans any reference to existing laws and WHO guidelines on the subject. Apart from several issues related to consent and history taking, these

protocols ask doctors to conduct two-finger test and comment on past sexual history of the survivor.

CEHAT has submitted its objections to the respective ministries and asked them to repeal them. However, no action has been taken till date. Several meetings with the DGHS Delhi and Mumbai have been held but the protocols have not been withdrawn. We are considering legal intervention so that we can introduce a comprehensive health sector response to sexual assault that includes evidence collection, documentation, treatment and psychosocial services.

TRAINING AND EDUCATION

1.National course on VAW and role of Health Care Providers:

The fourth national course was conducted from 14th to 22nd September 2009, it comprised of 23 participants, all of them were nursing principals from different parts of Maharashtra. Being academically inclined, all the participants were very involved in the course and prepared excellent slides, charts and visual media for their presentations, there was a unanimous agreement that contents of this course have to be included in all the nursing courses both ANM and GNM. The course had full support from the nursing council and was also inaugurated by Dr Bansode, Assistant Director (Nursing, Govt. of Maharashtra). At the valedictory session, Dr Potdar Deputy Director (Nursing, Govt. of Maharashtra). assured that he will ensure that the course gets integrated in the regular nursing curricula. After the course the nursing department shared the framework in which they would like us to put our course contents and efforts are being made to integrate it.

2.Course on Health and Human Rights:

After the fifth course, a need was felt for reviewing the curriculum and a meeting for the same was organised on 27th April 2009. This one day meeting was attended by Coordinator, CEHAT, 3 members from the core faculty and members from the coordination team. One of the members who could not attend the meeting had send his comments via email. After the meeting certain changes were suggested in the structure and content of the sessions. This also led to reducing the duration of the course by three days. The sixth course, with the suggested changes, was organised from 18th January to 27th January, 2010. Like every year the course attracted a large number of participants both from India and abroad. One of the changes made, was for vulnerable groups and their human rights violation, we had organised a panel discussions. This was very well received by the participants.

We have also been approached by Department of Civil and Politics Mumbai University, who are very keen to collaborate with us on this course.

3.Capacity Building of Providers on the issue of violence against women and Role of Health care Providers

The team conducted group meetings with the batches of 20 nurses stating the relevance of the Dilaasa crisis centre, the impact on health due to domestic violence and the role that they can play in responding to such women. Nurses participated in the Dilaasa activities such as poster exhibitions, pamphlet distributions in the hospital wards and referring women who were facing abuse. Dilaasa has been receiving attention from other district hospitals, whereby a demand was made to conduct awareness programs for Doctors. The team conducted 2 such district level trainings comprising of a group of more than 80 people and 50 people respectively. Both trainings were conducted in month of September 2009. The team also conducted urban community level training to

increase awareness of Dilaasa centre activities so that more women can avail of these services. Three trainings were organised in the month of July, August and September 2009 for women from 3 different urban communities and 190 women participated in these trainings.

A two-day state level consultation on Domestic Violence and the role of the health care providers was organized in January this year by the Public Health Institute in Nagpur. . This was done with the objective of raising awareness about the role of health professionals in responding to violence under the PWDVA. 60 Doctors from various district hospitals in Maharashtra participated in this consultation. The response was very positive and in the future, we plan to follow up with them so that they can conduct such trainings at their hospitals as well.

4. Capacity building for the BMC:

Training Cell (TC)

We plan to formalise the training cell of the BMC. The TC is aimed at looking at issues related to not just domestic violence, but also training the HCP's to understand the issue of sexual harassment at work place, encouraging the HCP's to attend trainings related to clinical ethics and moving towards a patient friendly atmosphere in hospitals.

A training program was organised to present the work undertaken by the Jan Swasthya Abhiyan. The meeting was attended by 40 TC members; Dr. Dhanajay Kakkade from SATHI was invited to undertake the training. He presented the rationale for a health movement, and the way in which it was able to pressurise the government to take cognizance of the health rights of the underprivileged people, he went on to speak about the NRHM and community based monitoring work being undertaken by SATHI. There was a lot of discussions on the privatisation of the health sector, and the national health policy. The talk enthused the training cell members and also helped them understand the complexities associated with the health system in India. TC members also raised several crucial issues related to the concept of public- private partnerships in the sector.

The TC also undertook an exercise of documenting the problems faced by each hospital in discharging their duties, whether it was related to the lack of medicines, linen, and staff or otherwise.

Sensitisation across 5 peripheral hospitals in the Bombay Municipal Corporation:

Several short meetings and orientation programs were conducted with new entrants so that they could get familiar with the core issues such as domestic violence as a health issue, role of HCPs in responding to women, skills required for screening women and the like. 5 orientation programs were conducted in Bandra Bhabha hospital covering a total of 88 HCP's. These were targeted towards Doctors to address the issue of non referrals to the Dilaasa crisis centres. Similarly 4 trainings were organised in Kurla Bhabha hospital with 60

HCP's, similarly 1 training was conducted in Cooper and 2 in Rajawadi comprising of 50 HCP's.

Capacity Building of Health Care Providers on developing a Comprehensive healthcare response

We felt that it was crucial for the Health Professionals to undergo a systematic training on how to fill up the performa, seek consent from the survivor of sexual assault and collect evidence. It was pertinent for them to understand the issue of sexual violence before proceeding with the protocol. We developed a half day training program that looked at the definition of Rape and problems with it , myths and facts related to sexual assault and a hands on training with the use of the protocol along with case studies. We realised that these trainings helped the HCP's to come forward and ask their doubts as well as express their fears about the court and legal proceedings. We took this opportunity to present the different laws that govern the health system and the professionals. Two such training programs in Rajawadi hospital and Oshiwara maternity home were conducted on this issue comprising of a total of 63 HCP's in the reporting period.

A day long training with the police on the several impediments faced by women reporting sexual assault, the role of medical evidence, and women's expectations from the police. Sixty two police officials attended the program. An over whelming number of police also expressed that such trainings should be conducted with women police constables as they often accompany the survivor of sexual assault.

5. Training of trainers in Shillong and Delhi:

A 3 day intensive training program was conducted with 23 Health care providers (HCP) where in the training consisted of understanding the link between violence against women and health , different types of health consequences , forms of violence and counselling skills in supporting such women. The training session ended with participants forming specific groups of nurses, doctors and counsellors and conducting a dummy training session on the same issue. Participants received certificates for completing the course successfully and were quite keen to implement the learnings back in the hospital. As NEN would be collaborating with Ganesadas hospital, we are looking forward to enhancing the feminist counselling skills of NEN and staff of the hospital to equip them in running the crisis centre. This activity would be undertaken once HCP's are formally deputed to work in the crisis centre.

Safdarjung hospital in New Delhi has shown keen interest in training their staff on the issue of violence against women. Based on the preliminary meetings, we realised that the staff was very keen to know about the new law on Domestic violence and their role vis a vis it. This prompted us to collaborate with the founders of this law, The Lawyers collective, WRIC unit. Adv Indira Jaising addressed the group of 40 Doctors from several departments on their role vis a vis the law, Participants received insights in to how they can play an important role by documenting the health consequences reported by women and the importance it has in the court of law as well as how it can help the woman to seek compensation order under the law. Though we started with the issue of

Domestic violence and the health sector response, we slowly expanded the scope of our work to include sexual violence, there were primarily 2 reasons one was the Delhi high court order mandating all the hospitals to use the SAFE kit and two, the readiness of the Gynaecology department to implement such a response. Based on our past experience with the hospital, we invited the senior HCP's comprising of the Heads of the department of gynaecology, forensic medicine as well as associate professors to visit CEHAT. The study tour comprised of providing them an exposure to the functioning of the Dilaasa crisis centre as well as an interaction with the physicians implementing the comprehensive response to survivors of sexual assault, classroom sessions on understating sexual violence as well as the proforma and method of evidence collection. Equipped with the necessary perspective and skills, these physicians have planned to start the implementation of a model response. We would collaborate with the hospital to equip them with technical expertise to start such implementation.

6. Engagement with the Private health sector

A half day consultation was held with the Indian Medical Association (Juhu branch) on the PWDV Act and the role of the health care providers in its implementation. Given the fact that a lot of women seek services at private health facilities, we felt that it is imperative to dialogue with health care providers from this sector as well. It was felt that to sensitize the private practitioners on the issue of Domestic violence and the role of the health care providers in context of PWDV Act, such a consultation must be held. Around 50 private practitioners attended the consultation. The participants acknowledged that they do see such cases in the course of their practice but they are at a loss regarding what they can do to help them. The training was hence useful for them.

7. Training of ICTC counselling providing PPTCT services

A two day residential participatory training was organised for the counsellors from various Integrated Counselling and Testing Centres managed by MADACS. Thirty counsellors attended the training. Objective of the training session was to sensitise ICTC counsellors to the concepts of gender, sexuality, violence against women and counselling. The expected outcomes of the training were:-

1. The counsellors will get an in-depth understanding of concepts related to gender, patriarchy and violence against women
2. The counsellors will understand the linkages between gender VAW and HIV/AIDS
3. The counsellors will develop skills and techniques to address issues from women's perspective

The module for training was developed after careful review of existing pre- and post-test counseling modules as well as review of existing training modules used to train the counselors. The training curricula for the ICTC counselors was found to be grossly lacking in content on gender, patriarchy or violence. To bridge the gap a two day module developed for training of counsellors and a training was carried out in collaboration with MDACS. Thirty counsellors attended the training.

This training was an important step in improving quality of counselling services provided through the ICTCs and a valuable contribution to the field of

counselling training. Self evaluation by the team mentions improvement in quality of counselling of 16 counsellors from 16 municipal hospitals. This is a commendable achievement as is convincing MADACS of the need to address violence as an issue during ICTC counselling.

The first few sessions explored the counsellors' training, nature of activities and challenges faced in the course of their work as ICTC counsellors. Subsequent sessions explored importance of gender sensitivity in counselling, patriarchy, sexuality, principles of counselling, history of feminist movement and domestic violence. Discussions on relevant movies, group work and case studies were used in the training. The questions raised by the participants reflect their lack of awareness as well as desire to know more about gender, violence and counselling.

INTERVENTION AND SERVICE PROVISION

'Dilaasa' counselling centers at Mumbai and Indore

Counselling at Bandra Bhabha hospital:

The centre received 187 new women, with 260 women who followed up and an additional 48 women came for legal follow ups. There were 61 women who were counselled but did not register with Dilaasa. This was a concern for the counselling centre as this number has been on the rise. This prompted CEHAT to undertake analyzing the profile of these women, their socio economic status and their marital status and the reason that kept them away from getting registered at the counselling centre. The analysis brought out that often this category included women who had attempted suicides but were in a state of denial that they were facing abuse, in such situations the counsellors made all the efforts in building rapport and requested them to come to the centre again, in some cases, it came to light that the counsellors were unable to explore why women were denying that they were facing abuse. This analysis brought to light that it cannot be taken for granted that counsellors would be able to present these difficulties in their own, this led CEHAT to put in stringent monitoring mechanism in place. The monitoring entails a one to one meeting with individual counsellors to take in to account their difficulties and challenges that they faced in counselling.

Counselling at Kurla Bhabha hospital:

This year only 48 women registered at the counselling centre. There are several reasons for such a low registration as against 90 women last year. To begin with , the hospital underwent a huge amount of renovation, this put the Dilaasa department out of action for at least 3 months, where in the counselling had to be done in a make shift arrangement. Women also found it difficult to reach the counselling centre as the venue of the department was shifted at least twice. Adding to these problems the hospital too had registered an over all low patient number as basic departments such as psychiatry and surgery had become almost non functional. This year too most women were referred from the hospital itself, the kurla centre received 117 women for follow up and another 25 women for legal follow up. Counselling services and information was also provided to another 22 women, but were not registered with Dilaasa, as it was often relatives of an abused women seeking legal advice, or information about a property dispute and the like.

Counselling at MY hospital Indore: The counselling centre registered 104 women and counselled 56 follow-ups. About half of the women registered (54 women) were in the age group of 16-25 years followed by those in the age group of 26-35 years (25 women). 91 women were married while 13 were unmarried girls. 34 women came after an episode of poisoning and 35 after an assault - these were the most common complaints reported. A considerable number (19) were cases of burns while others were of mental torture (11) and rape (3). Most cases come in contact with Dilaasa through the effort of counsellors who go to the wards and casualty, screening women who have been admitted. 73 cases of the 104 have reached Dilaasa in this manner. Of the remaining 31 who have

been referred to Dilaasa, only 16 have been referred from the hospital (13 by the CMO and 3 from wards). Others have come through having seen Dilaasa posters, other organizations or from the community.

Challenges to counselling:

- In cases of burns, providing counselling proves to be a challenge as they are not able to speak and they do not reveal domestic violence. Also, a lot of the cases are those of severe burns that don't survive and hence there is only limited support that can be provided by way of counselling.
- Among cases of poisoning, although screening is carried out routinely, several cases are missed because they leave the hospital against medical advice before they can come in contact with the counsellor.
- Similarly, a lot of cases of assault are also missed; only the few who are referred from the CMO receive counselling. This is because since the staff of casualty is not trained, they often do not refer cases.
- The reference from wards is also less. In order to address this problem, a Dilaasa seal has been kept in both OPD and wards so that referral is easier. An intercom is also being installed to facilitate referral; however this will take some time due to paper-work.

Provision of services to cases of sexual assault reporting at the two hospitals:

We responded to 12 cases in all of sexual assault at Rajawadi and Oshiwara hospitals where the SAFE kit is being used, and 1 from V.N Desai hospital from where a case was referred to us, but the kit is not being used. 4 of these cases were of adult women and 3 were of children. Nature of support provided varied from case to case based on the need of the survivor. Emotional support was provided to all survivors, including addressing issues of self-blame. When the SAFE kit was used, we also provided inputs to doctors in the course of examination. In some cases, there was a need to intervene with hospital authorities in order that the woman/child was given the required services free of charge. We helped survivors to get FIR and also arranged for a shelter for one woman. In case of children, parents were spoken to as well. The importance of not restricting the child's activities after the assault, and providing information about 'good touch' and 'bad touch' was provided. A lot of efforts are made to counsel the parents and especially the mother as often women are blamed for the sexual assault.

Based on the hospital documentation, we have traced the police stations where these cases have been filed so that we come to know the legal status. In a case of gang rape, there was conviction of 2 people and were given a sentence of 4 years. However this work is in progress. Due to the fact that CEHAT is the only organisation providing intervention services to survivors of sexual assault, we have been receiving requests from other hospitals as well as CBO's to speak to the survivors of sexual assault that have reached their organisations. We feel that this is a good opportunity for CEHAT to establish its expertise in crisis

intervention and expand the efforts in other hospitals as well to provide comprehensive health care response to survivors of sexual assault.

Coordination with other systems for ensuring the chain of custody: The implementation of the SAFE kit threw up several issues with regard to the lack of protocols for responding the survivors. One such problem was the absence of a proper chain of custody for preservation of the collected evidence. We explained that because there were multiple players and no one person was accountable, each felt that the other was responsible for the chain of custody. Certain key issues related to the standard operating procedures were designed along with stakeholders present. It was decided that the responsibility for the entire case would lie upon the examining physician who is a senior gynaecologist. Therefore even if there are several players, this person would be responsible for ensuring all the steps related to the submission of the evidence collected to the police. A note to this effect was prepared and circulated to both the hospital authorities.

DOCUMENTATION AND PUBLICATION

CEHAT's collection has grown from books to various other resources like reprints, reference materials, CDs, VCDs, posters etc. This involved preparing standardized databases and merging them. The entire collection has been given Key Words and Subject Index. The main focus in the last two years was on preparing a centralised catalogue of various print and non- print resources. CEHAT along with other centres of AT has purchased a commercial Library Software Slim 21. This software has many features like Cataloguing system Acquisition system, Circulation System, Serials Control System and WebOPAC. The data from the old software was transferred into SLIM 21. The entire collection of the Library and Documentation Unit is online with key words and subject Index for easy search and users can now access the catalogue through the WebOPAC link that is on the CEHAT website.

With the new system (SLIM 21) users can now have access to wide library collection of books, publications, reference books, Periodicals, Thesis and Dissertations, Documentary and Films, Data Cd's, Posters, Reprints including access to full text articles, Organisational Repositories (reports and articles) and other resource material available in the unit. The catalogue can be searched in simple and advanced mode using Boolean Operators. Advanced searches can be made including fields like Author, Subject, Title, Year, Publisher, among others. The Web OPAC's also provide facilities like personalized on screen display, save options, etc. *CEHAT Library Catalogue* <http://59.181.133.21/w27>.

Books on Approval Basis: The system that was put in place for getting books on Health studies has been very useful and this year too many books have been added to the collection.

E-bulletin: The quarterly e-bulletin which updates information related to broad thematic area of CEHAT's work along with updates about the new services that are introduced in Library and Documentation Unit. The earlier e-bulletin was circulated to only internal staff members this year the efforts were made to develop e-bulletin on specific areas of CEHAT's work and were circulated to wider audiences. The following e-bulletin were prepared and circulated widely Private health sector, Abortion, Domestic Violence.

Literature on Specific Issues: The unit which began this activity of collecting literature on specific issues has continued and has collected literature on following topics.

- Health Financing and budget
- User Fees
- Sexual and Reproductive Health
- Private Health Sector

Few of these could be developed into annotated bibliographies or literature lists.

Contact List: In order to Network and collaborate with organisations / libraries / institutes to develop and support initiatives and dissemination of publication a category specific contact list have been prepared. Although most of the CEHAT's work on each of the Thematic areas is available on the website in order

to reach out to people we have identified broad subjects and have developed webpages with specific information about work done by CEHAT in specific areas along with links to various past and present studies and resources available at CEHAT and other related links and updates on recent development in those areas. This is being widely dissemination through the e-bulletin.

Webpages that were developed were :

- Private Health Sector
<http://www.cehat.org/go/PrivateHealthSector/Home>
- Abortion <http://www.cehat.org/go/Abortion1/Home>

Database:

The main focus has been to develop a Client Module. This module is mainly for dissemination of data. It gives the trends that can compare the situation across states, variable-wise and year-wise. The output can be transferred in excel so that the user can draw area graphs, line graphs, and bar charts for meaningful, attractive presentation. The output can be saved in pdf, html formats. The client module is presently being reviewed for bugs in the data as well as program. The definitions, sources and notes are also added for the existing as well as for the new data in the module. Once the module is reviewed it would be finalized and would be disseminated.

Developing IEC Materials

Poster:

A poster was developed targeted towards health care providers. The poster prompted providers to look beyond injuries and screen patients for abuse. It also outlined the role of health care providers under the PWDVA.

Film:

A film to highlight the experience of Dilaasa and impress upon providers and policy makers, the importance of role of health care providers in responding to abused women is being made. The film adopts a semi-fictional approach to demonstrate how the health system can intervene in cases of violence and the services that can be provided at the level of the health system. The film is being made in collaboration with Point of View and the script was reviewed by the CEHAT team. The film has been shot and is currently in the post-production stage.

Publication List for the year 2009-2010

2009

आरोग्य आणि कुटुंब कल्याण मंत्रालय, भारत सरकार, सेहत आणि यु.एन.एफ.पी.ए गर्भधारणापूर्व आणि प्रसवपूर्व निदान तंत्र (लिंग निवडीवर प्रतिबंध) कायदा, १९९४: माहिती पुस्तिका, जुलाई २००९, प.४०

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Patel, Divya, Chaudhari, Leni, Mhatre, Ujjwala, वैद्यकीय गर्भपात कायदा: महाराष्ट्रातील सेवा पुरवठादारांकारिता मार्गदर्शिका. 2009. 19 p.

Pitre, Amita and Pandey, Meenu, Response of health system to sexual violence: study of six health facilities in two districts of Maharashtra, 2009. x, 110 p.

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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?, 2010. 16 p.

CEHAT, Dilaasa crisis intervention department for women: a report, 2010. 14 p.

CEHAT, Manual for medical examination of sexual assault, 2010. x, 58 p.

CEHAT Staff Profile April 2009 to March 2010

Sr. No.	Name	Designation	Period	Qualification	Projects
1	Amarjit Singh	Sr. Administrative Officer	15/09/2008 to 14/09/2009	B. Com.	Administration-CEHAT
2	Anandi Dantas	Research Officer	17/02/2009 till date	M. Phil (M.A.)	Towards Strengthening Health & Health Care in India
3	Aneeha Rajan	Research Associate	01/09/2009 to 28/02/2009	Masters in Social Work	Pehel
4	Anjali Kadam	Office Secretary	27/07/2009 till date	H.S.C.	Data Entry Operator
5	Anuja Kastia	Research Officer	21/04/2009 to 09/10/2009	P.G. Diploma in Preventive & Promotive Health Care	Towards Strengthening Health & Health Care in India
6	Arti Kadam	Research Associate	05/11/2008 to 19/07/2009	Masters in Social Work	Pehel
7	Deepmala Patel	Research Associate	09/06/2008 till date	M.S.W. Community Development	Dilaasa-Indore
8	Devidas Jadhav	Office Secretary	06/07/1999 to 31/05/2010	SSC	Administration - CEHAT
9	Dilip Jadhav	Office Assistant	01/11/2004 till date	HSC	Administration - CEHAT
10	Gajendra Dixit	Sr. Research Associate	08/02/2010 to 30/04/2010	M.A. in Social Work	Towards Strengthening Health & Health Care in India
11	Geeta Surve	Office Secretary	18/04/2008 to 31/08/2010	H.S.C.	Administration - Pehel, CEHAT
12	Hemlata Shedge	Sr. Research Associate	09/09/2008 to 28/09/2009	M.Sc. II/Anthropology	Pehel
13	Leni Chaudhuri	Sr. Research Officer	07/12/2004 to 08/04/2009	M.Phil	Public Health Report, Establishing Health as a Human Right, Prisoner's Study
14	Margaret Rodrigues	Research Officer	11/09/1997 till date	B.Sc., Diploma in systems Management	Library and Documentation Unit
15	Namitha George	Sr. Research Associate	05/08/2009 to 05/02/2010	M.S.W.	Pehel
16	Netralal Sharma	Office Assistant / Care Taker	01/01/2002 till date	S.S.C.	Administration - CEHAT
17	Nidhi Gupta	Research Officer	10/04/2009 to 26/05/2010	Master of Health Administration	Towards Strengthening Health & Health Care in India

18	Nidhi Sharma	Sr. Research Associate	01/03/2010 till date	M.A. in Psychology	Towards Strengthening Health & Health Care in India
19	Padma Deosthali	Co-ordinator	13/04/1998 till date	M.S.W., P.G. D.H.R.M.	Pehel, Abortion Advocacy
20	Pramila Naik	Jr. Administrative Officer	09/10/2000 till date	B.Com	Administration - CEHAT
21	Prashant Raymus	Research Officer	30/12/2003 till date	M.A.	Towards Strengthening Health & Health Care in India
22	Priyanka Josson	Sr. Research Associate	13/04/2009 to 04/06/2010	Masters in Social Work	Pehel, Conflict and Health
23	Priyanka Shukla	Jr. Research Officer	1/1/2008 till date	M.L.I.Sc.	Library and Documentation Unit
24	Ramdas Marathe	Office Assistant	11/7/2007 till date	H.S.C.	Administration - Dilaasa
25	Rashmi B. Divekar	Sr. Research Associate	17/01/2005 to 19/08/2010	B.A. pursuing LLB	Pehel
26	Reena George	Sr. Research Officer	1/11/2007 to 26/09/2009	M.S.W.	Prisoner's Study
27	Ritu Khatri	Sr. Research Officer	5/05/2008 to 31/08/2009	Masters in Community Health	Fostering Reforms in Private Health Sector
28	Rupali Gupta	Research Officer	09/11/2009 till date	DPSCDM, MCSA	Pehel
29	Sana Contractor	Research Officer	01/10/2008 till date	Masters in Public Health	Pehel
30	Sangeeta Rege	Sr. Research Officer	16/11/2006 till date	M.S.W.	Pehel, Dilaasa, SAFE Kit
31	Shobha Kamble	Office Assistant	14/12/1999 till date	Primary School	Administration - CEHAT
32	Snehal Velkar	Sr. Research Associate	02/02/2009 to 24/04/2009	M.A. in Social Work	Public Health Report, Safe Kit
33	Suchitra Desai	Jr. Research Officer	25/09/2006 to 24/9/2007	M.Sc. (Anthropology)	Fostering Reforms in Private Health Sector
34	Sudhakar Manjrekar	Office Assistant	15/11/2000 till date	Secondary School	Administration - Pehel
35	Sushma Gamre	Research Associate	15/06/2000 to 15/05/2009	B.A.	Fostering Reforms in Private Health Sector
36	Sushma Patil	Jr. Accounts Officer	07/04/2008 till date	B. Com.	Administration - CEHAT
37	Tayyaba Ahmed Shaikh	Research Officer	11/3/2008 till date	M.A. and MPS	Public Health Report, Towards Strengthening Health & Health Care in India

38	Vijay Sawant	Office Secretary	07/02/1995 till date	B.A.	Library and Documentation Unit
39	Viral Shah	Sr. Administrative Officer	23/06/2009 to 31/08/2009	M.D.B.A. (Finance)	Administration-CEHAT
40	Yashashree Keni	Research Officer	23/11/2009 till date	Postgraduate Diploma in Public Health	PeheI
41	Zamrooda Khanday	Sr. Research Officer	01/04/2009 till date	Masters in Social Work	Conflict and Health