
**ANNUAL REPORT
OF
CEHAT**

2014-2015

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I. RESEARCH

1. Research on implementation of targeted health insurance (RGJAY) in achieving universal health care for women and the marginalized

CEHAT commenced a study on evaluation of publically financed insurance schemes for the poor households in Maharashtra namely, RSBY and RGJAY to understand the workings of the scheme and relate with beneficiary experiences. Since the RSBY was stopped in 2012, RGJAY has been implemented in all the districts of Maharashtra. Hence, RGJAY has been studied in detail with a comparative aspect involving both the schemes. A detailed review was conducted based on various insurance schemes in India with a special focus on state level insurance schemes, critical analysis of the insurance schemes and policy level studies.

Secondary data collection involved the data from RGJAY website on empanelled hospitals, policy level documents including MOUs. The RGJAY society gave access to all the patient data (till August 2014) which had information on various aspects including preauthorization, claims, claim rejections etc. Primary data was collected from interviews with RGJAY society officials, program officers and district coordinators. Data was also collected from one empanelled public hospital and one empanelled private hospital which involved patient case studies, interviews with the RGJAY scheme staff, doctors and other staff involved in the scheme.

- Preliminary findings suggest that enrolment is low with merely 2.45% of total eligible families for RGJAY across Maharashtra as per the PDS data being enrolled and actually getting covered till now much lesser than the proportion covered through the previously running scheme.
- Nearly 83% of empanelled hospitals are in the private sector while region-wise the number of empanelled hospitals is highest in Vidarbha and Northern Maharashtra and lowest in Mumbai and Konkan. Yet Mumbai had more number of large multispecialty hospitals and the number of pre-authorization requests was also highest from Mumbai. Many patients travel to Mumbai from other districts for treatment and even though the empanelled hospitals are more in Vidarbha, many especially public hospitals do not have facilities to carry out all procedures. This suggests that actual availability of services may be lower than on paper.
- Enrolment of patients and the preauthorizations raised across hospitals indicate a tendency of the private sector to favour high end surgeries and procedures with higher package rates compared to those raised in the public sector.
- Within RGJAY, the process of claims to be carried out by hospitals is quite elaborate and majority of rejections of pre-authorizations by insurers is due reasons like improper documentation and wrong selection of package. Many a times, the problem of improper documentation is very trivial one like name not being properly displayed and usually due to procedure not being properly followed by the empanelled hospital and hence, when such pre-auth is rejected, the patient ends up being denied benefit of the scheme.
- Data on grievance redressal and case studies shows that despite the scheme being cashless, patients incur OOP and they may be often underreported as beneficiaries do not take small amounts of OOPs seriously. Only when large amounts are involved that they may report it or many might know about grievance redressal process. Even the RGJAY staff may tend to normalize the OOPs and may overlook the problem.

- In terms of scheme policy, many rules are unnecessarily rigid leading to beneficiary inconvenience like follow-up packages which are limited to certain procedures and can be availed only at the hospital where the procedure was done. Many patients travel considerable distances within and outside districts to access RGJAY and may not be able to return to the hospital farther away from home for follow-up services. It is evidently the reason why out of all the patients eligible for follow-up, only 21% cases availed the first follow-up, 7% availed the second follow-up, 2% availed the third follow-up and less than one percent of the patients came for the fourth follow up.
- Also like other existing schemes, the scheme does not provide comprehensive health care and concentrates on only tertiary level hospitalizations. Although the trend from the NSSO data from 1988 to 2004 clearly indicates increasing hospitalization, only 2.3% and 3.1% of rural and urban population (NSSO 2006) is hospitalized on an average while 8.8% and 9.9% of the population access outpatient coverage. The scheme has public-private partnerships such as private entities like TPAs and empanelled hospitals which perpetuate the interests of private health industry.

2. Study on Maternal Health

Maternal health concerns have consistently drawn the attention of successive governments and policy makers in India. To a large extent the public health system and its various mechanisms are devoted to provisioning of maternal health services across the country. Despite the government's long term focus on maternal health care, bolstered by the globally applicable MDG of improved maternal health outcomes, many parts of the country continue to lag behind with abysmal maternal health indicators year after year. Against this backdrop, Oxfam India launched a multi-state¹ intervention project centred on improving the maternal health status. The study undertaken by CEHAT is part of this larger project. As part of this project, CEHAT prepared policy documents for Odisha, Bihar, Jharkhand and India as a whole based on the primary data of the project and other secondary sources. Through the context specific strategies/recommendations in the papers, the aim is to set the wheels rolling towards achieving maternal health standards.

From the study it is evident that the infrastructure deficiency is common to Odisha, Bihar and Jharkhand and the existing set up is ill-equipped to provide quality maternal health services including normal delivery. In Bihar, Sub centres are short by 53 percent, Additional Primary Health Centres by 61 percent, Rural Hospitals by 92 percent and Sub divisional hospitals by 39 percent.

Unavailability of skilled human resources across all cadres is an issue universal to all the three states. The shortfall in human resource ranged from 28 percent to 90 percent across different health personnel in Jharkhand. Reasons for shortfall were similar across all three state and those were usually high attrition due to low salaries, poor working conditions, absence of clear promotion policies, poor residential facilities and compromised security.

The quality of ANC and PNC service provision was not upto the mark in any of the states. Not all components of the ANC were offered to the women; measurement of Haemoglobin in blood, urine test was found to be the lowest across all states and the reason for the same was lack of necessary equipments/reagents to carry out those tests. PNC was mostly provided on the day of delivery and there after it gradually declined.

Budget of all the states showed that they relied heavily on incentive based schemes to address maternal health. The schemes failed largely in preventing out of pocket spending. Abortion facilities were largely missing to an extent that those were missing even from district hospitals in Bihar. Sterilization was the

¹ Odisha, Bihar, Jharkhand, Maharashtra, Rajasthan and Chhattisgarh

most promoted method of contraception and provisioning of temporary methods took a back seat in all three states.

In Bihar, health indicators of Muslims starkly reflected their exclusion from health programmes. The proportion of medical facility in villages reduced as the share of Muslims in the village increased. In Jharkhand, the Particularly Vulnerable Tribal Groups did not have access to permanent methods of family planning and as a result of this denial, the women were subjected to unwanted pregnancies often complimented by poor health and nutritional conditions and limited access to services.

3. Assessment of effectiveness of a counselling intervention for women facing abuse in ANC setting

CEHAT is carrying out an intervention based research project which aims to assess the effectiveness of a counselling intervention for women facing abuse in Antenatal Care (ANC) setting. This project which is funded by MacArthur Foundation is based on the emerging evidence of high prevalence of violence during pregnancy and intersection of violence with adverse health outcomes. To achieve the objective, the project will use an evaluative research design. Pregnant women will be screened for violence with a standardized instrument and those women reporting experiences of partner violence will be referred to the crisis centre. They will be asked a series of questions about mental health, safety behaviours, self-efficacy and their experience of violence. At the crisis centre, the women will receive one session of "empowerment counselling" addressing partner violence and safety planning, as well as other information on various available services. All women will be followed up during their 6 week or other post-natal visit.

The study derives much of its methodological design from understanding the functioning of the Dilaasa crisis centre, reviewing service records, and studying the data related to women reporting violence during pregnancy to understand their profile, help seeking, specific circumstances and narrations. To ensure the replicability of this model in other healthcare settings, a rigorous review of existing literature and observation in hospital settings was carried out to decide on who should screen and at what point the screening should be done. Based on that it was decided that screening will be carried out at ICTC by a trained professional as every ANC facility is equipped with a facility of blood testing for pregnant women. Observation of study settings also helped to model the screening and provision of empowerment counselling to pregnant women facing abuse while ensuring privacy and confidentiality of women.

A screening instrument adapted to Indian settings which not only helps in identification of women facing violence but is also easy to administer was developed after studying various screening tools used in earlier studies and WHO guidelines in screening women facing violence in healthcare setting.

To determine the impact of empowerment counselling, tools were developed for measuring constructs like outcome of pregnancy, attitude towards child, coping behaviour, physical and mental health of women. A pilot study has been planned for 1 week in two selected hospitals after incorporating the inputs of scientific review committee. A paper based on the review of literature conducted for the project will be published.

Integrating Gender in Medical Education

Situation analysis of medical colleges

In order to better implement the next training session, a situation analysis of participating medical colleges was carried out and a team of researchers visited each of the colleges and interviewing participants and at least one other mid or senior-level faculty member from selected five departments (Obstetrics and Gynaecology, Medicine, Psychiatry, Forensic Medicine and Preventive and Social Medicine) to get an idea of the current curriculum, teaching and practice of their subject as well as get their perspective and inputs on the project. For this purpose, 96 interviews for medical teachers, librarians (related to resources available in the library) and students (related to activities undertaken by students in the college) and a questionnaire for administrative representatives for information on the hospital (patient intake, services and facilities, availability of staff, etc) and college (total student intake-UG and PG, faculty strength – permanent/temporary/ bonded in each department) were conducted. Only qualitative interviews conducted with faculty members for the purpose of analysis.

Some major findings:

- Most of the respondents confined teaching on Social Determinant of Health (SDH) and gender in general to PSM and were able to only vaguely remember the content on SDH in the MBBS curriculum. Apart from theoretical content, some practicals, history-taking, some theories in certain subjects like Psychiatry, clinical postings were reported by respondents as covering SDH.
- Many respondents spoke of changes in pattern of assessment – a shift to multiple choice questions – and increased emphasis on postgraduate entrance examinations today and lack of emphasis on practice being reflected in neglect of social aspects of health and promotion of a more scientific orientation towards health and medicine.
- About half of the respondents stated that gender issues were not taught in the MBBS curriculum. Respondents felt that issues arising out of gender discrimination, etc are not within the purview of medical education and that gender is too obvious a social phenomenon to be taught specifically in medical education.
- The respondents articulated an understanding of “gender” in terms of biological sex, issues of violence, prevalence/incidence of disease, and increasing presence of women in workforce is clearly indicative of a lack of a gender perspective in medical education.
- Respondents frequently expressed the idea that bringing in gender in medical education was a matter of improving communication between doctor and patient. Many hold gender stereotypical notions in causes of domestic and sexual violence, victim-blaming attitudes, assumptions on the basis of class and religion, etc.
- Some of the respondents were able to bring an understanding of gender as a social determinant of health in teaching their students about health seeking behaviour and disease incidence. Some respondents were able to identify vulnerabilities faced by women especially in case of spousal transmission of HIV and also the related stigma attached to an HIV positive woman or a woman suffering from TB which limits her access to treatment.
- Some of our respondents, who were able to identify gender-based discrimination, practices and power imbalances in society as a cause for adverse health consequences for women, expressed their limitations in terms of assisting their patients beyond the confines of the hospital. Reasons cited were heavy work load and the belief that the problem is social in origin and has to be tackled at the level of societal interventions and that there wasn't much that doctors could do about it.

- Some of the respondents spoke of practices being followed in their institutions in responding to sexual and domestic violence which are gender insensitive as the doctors do not take into account the trauma suffered by the woman and conduct the examination in a mechanical manner. In some cases, the doctors also tend to assume that most cases of sexual violence are that of consensual sex and thus show disbelief for the survivor's statement. Similarly, insensitive practices were also noted in carrying out abortion, especially in the second trimester.
- Some respondents held that social problems including gender are in the domain of family, society, etc and that as medical professionals, they cannot address these issues
- It was also held that the medical syllabus is already cumbersome and it is not possible to cover all relevant issues. Hence focus remains more on clinical aspects of medicine. Some of the respondents stated outright that learning about gender is not their concern as their duties are confined to examination of the case and giving treatment. But several other respondents agreed that it was necessary to integrate a gender perspective in medical education and also train medical professionals on the same.

Impact assessment research for GME

Based on findings from the situation analysis, a tool has been prepared to conduct baseline evaluation of MBBS students for testing knowledge and sensitivity to gender issues in medical education. This study will be carried out after the second training phase is over and before the trained faculty members begin introducing gender sensitive modules in classroom teaching.

Curriculum modules to be implemented by project participants are being developed with the help of resource persons from the five medical subjects. Resource persons including mentors will undertake a short review of medical textbooks based on the EPW 2005 series to assess the changes made in the textbooks in the last nine years.

Based on the plan for implementation of gender-integrated modules, the impact assessment study with students will be conducted through self-administered quantitative assessment questionnaires for testing knowledge, attitudes and skills of the students. There will also be qualitative interviews with teachers to understand their experiences of implementing the modules.

4. Evidence building on VAW

Dilaasa case records were evaluated primarily to inform evidence-based decision making in public health. An analysis of service records showing the reluctance of women to register a police complaint was carried out to provide evidence against alleged misuse of section 498A. Out of 2146 women registered at Dilaasa from 2001 to 2010, a total of 1675 married women were considered for this analysis. The findings were illuminating as only 47% of women had sought police support before coming to Dilaasa and out of these merely 2% had filled a FIR while rest registered NC. This was published in a paper by Indira Jaising for the Economic and Political Weekly.

Another analysis which looked at facilitating and constraining factors for follow-up at crisis centre among women facing domestic violence was conducted. The rationale for this analysis was to identify the population at risk of loss to follow-up and to help the interventionists to devise special measures for this vulnerable population. Women with attempted suicide and poor mental health status were found to be less likely to come for follow-up. In terms of socio-economic characteristics, women who are illiterate, unemployed and got married at an early age were found to be vulnerable.

In addition to this, the linkages between domestic violence and suicide attempts amongst women were explored. Out of 2146 women, about 24% (511) were found to have suicidal thoughts while 16% registered after an attempt to end their lives. All those women who attempted suicide (335) were admitted in hospital with the complaint of accidental poisoning. The results indicate that women who are young, unmarried, facing abuse for less than 2 years and natal family as abuser are more likely to show suicidal behaviour. This investigation informs the gap in the current psychiatric interventions for this vulnerable population.

Data analysis on Sexual violence cases

Sexual assault cases from 2008 to March 2013 were analysed to suggest that the elopement cases and false promise of marriage do not constitute the bulk of rape cases. Out of 306 cases that got registered with intervention hospitals, only 4% of cases were that of elopement while false promise of marriage constitutes a low of 6%. This analysis also challenged the recent hype about juveniles as prime perpetrators of sexual assault cases as only 13% of accused were found to be below 18 years of age.

Evidence on interventions in sexual violence

This paper is based on the results of establishing a comprehensive health sector response to sexual violence. Eliminating existing forensic biases to rape and neglect of health care needs of survivors, the model uses gender sensitive protocol for medico-legal documentation of sexual violence that focuses on informed consent, documentation of nature of sexual violence, collection of relevant forensic evidence, uses standard treatment guidelines for provision of treatment and ensures provision of psycho-social support to survivor. This is supported by training of providers and setting standard operating procedures at facility level. The results indicate that a sensitive response by health professionals can play a crucial role in healing from sexual abuse.

Paper on Mandatory reporting:

One of the issues that emerged after the POCSO 2012 and CLA 2013 was mandatory reporting by health professionals to the police. Even in the absence of this clear legal obligation, the health professionals have always disregarded informed consent procedures. CEHAT has been advocating for the right to health care of survivors of sexual violence and for essential elements of a health sector response as informed consent, standard treatment protocols, relevant forensic evidence collection, chain of custody and psychosocial services. Considering this situation, an extensive review of literature on the subject was carried out. Several presentations on the issue were made to policy makers and opinion makers.

- a. A paper raising issues related to consequences of mandatory reporting, how it impinges on right to health care and the changes made in other countries has been written up. Paper submitted to British Medical Journal.
- b. A briefing document was also prepared on the issue. This looked into the existing legal contradictions with regard to mandatory reporting of sexual violence to the police by health professionals, presented circumstances that act as barriers for survivors and their families in making immediate reporting and how it impinges on their access to health services.

Paper on legal outcomes:

Analysis of factors leading to conviction or acquittal in cases of sexual violence has been completed based on the judgements procured. The analysis includes the presentation of medical evidence in courts, its interpretation by the courts and the available intervention data in each of the cases.

Briefing documents:

- A briefing document on violence against adolescents and their right to sexual and reproductive health was circulated at the national launch of the Government of India's National Programme on Sexual and Reproductive Health Rights of adolescents.
- A briefing document for the Ministry of Health and Family Welfare on Violence Against women as Public Health Issue. This was evidence based position that the Ministry took at the World Health Assembly in 2013.

Consultations:

Several consultations with experts such as lawyers, child rights activists, those working with persons with disability, LGBT groups and so on were organised to seek inputs and build consensus on the MoHFW national protocol and guidelines. An entire new section on responding to sexual violence reported by persons belonging to marginalised groups was written up, feedback sought from experts and now forms part of the final document. Oral and written submissions were made to the WCD and Health Departments of the Government of Maharashtra on the serious lacunae in the GoM protocol and manual.

5. Violence against Women in Conflict Affected Areas

A proposal on studying violence against women in conflict-affected areas developed earlier and the tools shared with groups in Chattisgarh and Kashmir could only be conducted in Kashmir due feasibility issues. This is an in-depth qualitative study looking at the perspectives of health professionals on impact of armed conflict on health systems. The in-depth interviews range from practicing doctors to doctors who were students of the Government medical college at that time to HOD's of departments and Principal of the Medical College. Most of these practitioners are practicing in the state even today and stand as the pillar behind the medical system. The Government Medical College was inaugurated in the late 50's and grew in reputation and prestige very quickly. By late 80's it was ranked in the top 5 colleges of the country. Early 90's witnessed the collapse of all systems in the state including the medical system. In this environment how did the college and the associated hospitals function? What was the effect of the conflict on them, their lives and their profession? How did the system function in-spite of all adversaries' to sustain the workload of a conflict zone and to produce good quality doctors. Many doctors after completing their basic education left the state for safer and better opportunities' yet returned the minute they felt it was safe to come back. What brought these doctors back to the conflict zone and what kept the innumerable doctors in the state in spite of all the problems. The research looks at some of these questions to explore how a system that should be neutral during the phase of armed conflict is not allowed medical neutrality and is targeted equally or more as medical facilities are a necessity for one and all. The data analysis was done to understand the impact of conflict on health systems from the perspective of health professionals.

6. Documentation of Existing Practice in India Working On Violence and Health System:

CEHAT has committed to developing a volume on different practices related to violence against women and ways in which civil society organizations from across the country has engaged with it. A dialogue initiated with at least 9 organizations willing to contribute to this volume led to a study of the genesis of

their work, the actual functioning, milestones achieved and challenges faced. Simultaneously, potential authors from respective organizations were contacted to contribute towards the making of this book and an outline for the case studies was developed and approved by all the contributors. Organizations including SAMA from Delhi, North-East Network from Shillong, Bhoomika and Anweshi from Kerala, Vimochana from Bangalore, Masum, Tathapi and SWATI from Pune, Sneha and Dilaasa from Mumbai will be contributing to the book. This volume would be the first effort in India to document the different forms of engagement with the health sector carried out by civil society vis-a-vis violence against women. The case studies will be presented at a national forum and ministries and civil society organizations will be invited for mutual sharing.

7. Formative research

A formative research was carried out at a government hospital in an Indian state with high prevalence of violence. The hospital has established a one-stop crisis centre in its premises to respond to survivors of violence. The objective of the research was to assess and understand the perception of the hospital staff regarding violence against women as a health issue and towards their own role in responding to women facing violence and to understand the role of the hospital staff towards the one-stop crisis centre. A total of 31 semi-structured interviews were carried out with the staff of the hospital - doctors, nurses, sisters-in-charge, ward servants/ward guards and sweepers.

The findings from the formative research indicate that health care providers come in contact with women who experience violence; they also recognise such cases based on the symptoms and health complaints that women report with. While most providers were able to list health complaints related to violence, including the mental health effects, many of them did not view violence as a health issue, categorising it as a social issue. They perceived their role as being limited to treatment of symptoms. Moreover, violence was understood in terms of severity of injuries. The woman was seen as being responsible for the violence, pushing the burden of stopping violence on the woman.

Despite the presence of an OSCC in the hospital and the centre being viewed as a positive initiative by most providers, they did not see their role as a stakeholder in responding to violence. This also brings out the need for the OSCC to actively engage with the hospital staff to increase identification and referral and harness its potential as a hospital-based crisis centre.

The findings indicate the need for awareness and sensitisation on violence against women as a health issue and the need for ongoing training health care providers to play an active role in responding to abused women as mandated by the law. The role of nurses can especially be tapped upon as most of them did not identify violence as a cause of women's health complaints. Given the training, they would better be able to identify and respond sensitively to women facing violence.

8. Study of police requisitions for sexual violence cases

Another analytical study was carried out to critically look at the police requisitions given to the doctor by the police officials when they bring a survivor of sexual violence to the hospital. The analysis looked at police requisitions in 53 cases of sexual assault from January to August 2014 sent by different police stations to three peripheral hospitals in Mumbai. Based on this analysis, case studies were made which included other issues with the police that had emerged during intervention.

Findings indicate that largely there is no connection between the nature of assault and the questions asked by the police. Their questions focus on the use of force and marks of injuries on the body of the woman, bringing to the fore the lack of understanding amongst the police, of reasons for absence of injuries and the limitations of medical evidence.

Despite the expansion of the definition of rape under the Criminal Law Amendment 2013 and amendment in the Indian Evidence Act regarding not mentioning information related to past sexual history of the woman, questions posed by the police are heavily laden with gender insensitive questioning pertaining to the character of the woman emanating from a belief system that a sexually active woman cannot be raped. The data also indicates that police bring survivors for medical examination at odd hours through the night even in cases where there will be no evidence due to passage of time since the incident, for e.g., when the survivor reports the assault after a week or month. The observations of the data bring forth the need to sensitize the police and address misconceptions. It also highlights the need to draft model police requisitions to the hospital for medical examination. Often, police requisitions mention sections under which the case has been registered and request the doctor to conduct medical examination accordingly, which underscores the need to train doctors on various laws pertaining to sexual assault.

9. Responding to Violence Against Women through Engaging the Health Sector: Replication of a Hospital Based Crisis Centre for Women Facing Violence in Goa

Proposal for setting up a hospital based crisis centre in Goa was backed up with an analysis of secondary data such as NCRB, NFHS-3 as well as studies on violence against women and health consequences studies in Goa and study of the profile of the state. This information was presented to the health officials to convince them for a health sector response to violence against women and children.

A preliminary report of Goa's situation vis-a-vis violence against women and children has been prepared which maps the existing services in the state. Following are some of the major findings:

According to NFHS-3 fourteen percent of women aged 15-49 in Goa have ever experienced physical violence and 2 percent have ever experienced sexual violence. Overall, 17 percent of ever-married women have experienced spousal physical or sexual violence from their current husband or if currently not married, their most recent husband. Twelve percent report having ever experienced spousal emotional violence. The prevalence among some groups of women is quite high as 36 percent of those uneducated and 33-39 percent of those in two lowest wealth quintiles report ever having experienced spousal physical or sexual violence. More than one-half (54%) of women whose husbands consume alcohol and get drunk experience spousal violence, compared with 8 percent of women whose husbands do not consume alcohol.

Though general access to health care services is high and there are several organisations that work to help women who experience violence, only 28 percent of women who have ever experienced violence have sought help to end the violence (NFHS-3). Women who do go for health care services often do not inform the doctors about DV. Many women facing domestic violence do not go to healthcare providers for minor injuries, depression, anxiety or other mental health issues. No counselling services are provided to women facing violence at any point. There are no systems to monitor the functioning of the healthcare system vis-a-vis the DV Act.

Although there are laws to protect women and children for these violent acts, the issue still remains a major concern. There is a hugely active Civil Society that is assisting the government in tackling domestic violence. But there are no mechanisms to monitor the functioning of the agencies/ individuals notified under the DV Act. In many DV cases – as reported by many service providers – physical violence is minimal and therefore cases do not access medical facilities. Violence is more psychological, financial, emotional and sexual, which do not get recorded at healthcare centres.

1. ***Needs Assessment for understanding the current response to survivors of violence against women and children:*** Needs assessment at the hospital level was done and the situation of current health services and an understanding of spread of health services were undertaken. It was noted that Goa has only one tertiary care hospital which has 950 cases and is responsible for doing a large amount of medico legal work. Besides this hospital, 2 other district hospitals namely Asilo and Hospicio are also present. A brief analysis of the medico legal work showed that there is no specific protocol that is being followed for MLC cases neither are the patients being given MLC documentation. It was also found out that at one of the district hospital, care services were available only for children facing sexual abuse, however, the same needs to be extended to women facing domestic violence and sexual violence.
2. A study was carried out focusing on the health and healthcare in the state to give a comprehensive understanding of the health system in terms of tracing its development through the years leading up to its current situation. The study is based on mainly secondary data from survey reports, government reports and statistical documents, research studies and primary data from key informant interviews with various stakeholders like government officials, public providers and civil society.
 - The study found that public healthcare infrastructure as well as the private health sector is extensive in the state and well connected. But there is still some rural-urban disparity especially with shortage of health personnel in rural areas. Utilization studies have indicated a greater dependency on private sector which has grown tremendously.
 - Goa has achieved a high level of coverage in maternal health and child immunization and yet there has been a drop in coverage of services in recent years. Nutritional status among children is also an issue with considerable prevalence of wasting, stunting and underweight children and high anaemia among children. Anaemia among women is high as well. Family planning uptake is low in the state and unmet need high with already low fertility rates. These changes may be due to increasing migrant population and lack of health coverage for them.
 - The mortality trends clearly show that the state has epidemiologically transitioned with greater prevalence of non-communicable diseases and diseases of the aged. Although efforts have been made by the state to tackle these diseases, these have been more of piece-meal approaches.
 - State's share of public spending is much greater than the central government share which shows high priority given to health sector. But this spending is disproportionately concentrated on tertiary care in urban areas and lower spending on primary healthcare, preventive and promotive health. In comparison, the private expenditure is much higher than public expenditure on health. Thus, the system seems inefficient and one can conclude the actual costs of achieving the best indicators in health have been much higher than the public health spending figures.
 - Development in Goa terms of health has been more due to socio-economic progress than a good public health system till now. In fact, this socio-economic progress and public focus on social sectors have contributed to a well-developed public health system. But unchecked growth

of the private health sector, rising cost of healthcare and greater burden on individual households would negatively affect the health status of Goan population.

II. ADVOCACY

Building Evidence on the Health Sector Response to Violence Against Women : LEGAL ADVOCACY

An SLP was filed in the Supreme Court in June 2014 with legal counsel from Lawyers' collective. Despite the fact that the MOHFW (Union government) has already circulated comprehensive guidelines for medico-legal care in sexual violence, Maharashtra state continues to use its obsolete and unscientific guidelines. Supreme Court was approached as the CEHAT Intervention in an ongoing PIL which did not receive a favourable response. The court took the side of Maharashtra Government despite presence of gender insensitive aspects in the protocol and lack of therapeutic care. Supreme Court admitted the SLP and the long-awaited hearing finally took place on 27th March 2015 where Ms. Indira Jaising, senior advocate, Supreme Court represented CEHAT as its legal counsel. She presented the different challenges that survivors of sexual violence face, bringing up issues such as gaps in the health system, non-utilisation of the Nirbhaya funds and the like. The court appointed Ms. Jaising as Amicus Curiae to assist the court in dealing with the entire pending writ petitions related to sexual violence against women and children. The next hearing is on 10th July 2015.

Efforts made in Maharashtra: CEHAT was invited to a meeting organized by the Gender resource centre, SPGRC of the BMC to discuss the implementation of Maharashtra medico legal examination protocol. When no one else challenged these protocols, CEHAT raised concerns over the problematic protocols and issues with formulation of one stop crisis centres for rape through a written submission to SPGRC. These crisis centres will cater to a limited section of vulnerable women when evidence from India clearly shows that those facing domestic violence also reach hospitals for health consequences arising out of abuse. Hence while establishing a hospital based crisis centre, domestic violence survivors must also be included in their ambit and not just sexual assault survivors. The discussions highlighted the existing 14-year old hospital based crisis centre in BMC which is a thoroughly evaluated evidence based model. Hence, it is best that efforts be made to replicate such an evidence - based model.

Efforts were also made to meet the health secretary of Maharashtra, health department. A comparative analysis of Maharashtra and Union govt protocol was presented and an appeal was made to the health secretary to direct the state to implement the MOHFW protocol. CEHAT also engaged with several organizations in Maharashtra through written submissions about this issue and called on the civil society to unite and bring pressure on the government to stop implementing these regressive medical procedures. The inability of NGO sector to present a common voice against these regressive protocols is a growing concern as some of them have even promoted their implementation.

Despite CEHAT's consistent engagement with the MCGM and SPGRC (gender resource centre of the MCGM) concerning the protocols, the MCGM teaching hospitals approached the AMC, Assistant Municipal Commissioner for the implementation of Maharashtra medico legal protocols. CEHAT made oral and written submissions against the move but they did not yield results. A written submission was also made to the Chief medical superintendent in order to deal with the pressure on the hospitals implementing the central govt protocols. CEHAT again wrote to experts from across the country to appeal to the Maharashtra health department to not implement such protocols. At the level of

Maharashtra too, Sampark Samiti (a network of organizations working on issues affecting women) was approached and written submission was made to them. CEHAT representative also spoke at Masum initiated Maharashtra Stree Hinsa Mukti Parishad forum and discussed concerns with the implementation of such a practice. Signatures were also sought on the letter raising concerns about the protocols.

CEHAT will continue its untiring efforts in this direction by reaching out to the Chief Minister and gathering evidence from the practices in other states. The lawyers collective will be assisted in the compilation of the responses of each state and central department about the steps that they have taken based on changes in the new law. The compilation would be filed pre 15th July in the court.

Up scaling the Dilaasa model and designing a training institute on SRHR and Gender Based Violence:

CEHAT has been constantly involved with the National Mission on Empowerment of Women (NMEW) for up scaling the Dilaasa model all over the country. NMEW was in consultation with CEHAT to publish all the guidelines, posters, intake sheets and training curricula jointly and NMEW Director committed that various states proposing to set up hospital based crisis centres will be informed that their teams should participate in the capacity building courses being organised by CEHAT. The WCD initiative in Rajasthan was referred to us and the team from there participated in our three day workshop too. However, with the change in government, several proposals were left hanging and when the new ministry was formed under the new government there was a draft scheme for setting up OSCCs which was ill-conceived. A critique was sent across and efforts were made internationally too through UN agencies and the WHO to critique this proposed scheme. The NMEW director tried hard to include most of Dilaasa material as Annexure to the scheme. The idea was to at least build pressure for ensuring high quality services even when the proposed set up was highly problematic. Currently everything is in limbo with regard to the crisis centre scheme. However, the Ministry of Health has issued national protocol and guidelines and there is a huge demand for training across the country. We are in the process of developing a course along those lines. CEHAT developed technical know-how for up scaling of the Dilaasa model in 100 sites for the Government of India which ensures that a gender sensitive space is created in these hospitals where survivors receive care and are able to heal from trauma caused due to abuse. CEHAT has also developed curriculum, protocols, templates developed in various languages for education of health care providers on understanding GBV as a public health issue which are evidence based instead of each hospital having to reinvent the wheel.

Policy Advocacy Including Inter-ministerial Work on Violence Against Women (VAW) And Health

The Purpose of the project is to prepare policy guidelines for the police, public prosecutors and judiciary for interfacing with the health sector on sexual violence and to prepare guidelines for health sector to respond to VAW, to organize inter ministerial meetings for consensus building and development of these guidelines, to develop a clear policy directive on Health sector response to VAW.

The MoHFW set up a committee for developing national protocol and guidelines for health sector to respond to sexual violence in April 2013. CEHAT has been part of this process and the committee has finalized the documents in its meeting held on 1 Nov 2013. One issue is related to mandatory reporting and there was a consensus that health care must not be compromised at any cost. So an analysis of all cases from the service records where survivors did not want to report to the police but only wanted health care was completed and these narratives were shared with the policy makers. An ethicist and lawyer were brought in to explain the various contradictions that mandatory reporting brings in with existing laws. A briefing document was prepared and circulated to enable a decision on the issue by the

committee. We successfully brought in "informed refusal" as a concept in the national policy directive. A legal opinion on the matter has been sought and the MoHFW will release the final protocol and guidelines early December 2013.

The experts were contacted and the project commitments were explained to them. All of them agreed to participate and the task force has therefore been formed. The first meeting of the task force was kept on hold until the new government came in power in order to have more stability in terms of the interactions with the ministries. Other research work that has been commenced is the compilation and analysis of police requisitions in cases of sexual violence. This will form basis of the guidelines for police as per the MoHFW guidelines.

Integrating Gender in Medical Education

A website developed with eSocial Sciences (eSS) was launched during the first training in February 2014 as a virtual resource centre for the project participants. It contains teaching material and readings, and is periodically updated with relevant news and research papers. Also, it can serve as an interactive forum to encourage discussion on issues of gender among students and teachers.

Patients Rights Web Portal

CEHAT in collaboration with IKF (Iris Knowledge Foundation) launched a web portal related to patients' rights on World Health Day, 7th April, 2015. This portal is an informative and interactive platform for patients and general public seeking information related to patients' rights and wanting to share their experiences with the health care and health insurance providers.

The aim is to empower people with the knowledge of their rights as health seekers vis-a-vis fair access to quality health care with an assurance of their confidentiality and a safe clinical environment along with participation in decisions regarding their treatment. Website contains information related to various Indian laws and regulations which protect their rights as patients and ensure their access to quality health care and seek grievance redressal. Research and reports around patients' rights and latest news and issues will be updated periodically on the website.

Patients/Users can participate by contributing their experiences with health care providers and health insurance agencies and help others become aware of the unfair practices in the healthcare system and how they can be tackled by an informed health seeker.

III. TRAINING

A total of 5 trainings were conducted where healthcare providers were trained at the 3 hospitals on providing comprehensive healthcare in responding to sexual violence including taking consent, conducting examinations and collecting evidence, and providing a reasoned medical opinion. Fifty two new Resident Medical Officers were also given an orientation on responding to violence against women. A monitoring committee was held at Rajawadi Hospital with a group of 8 doctors who examine survivors. The current practices, gaps in responses and challenges faced by healthcare providers were addressed to ensure quality of care for the survivors.

Training was held for the nurses and representatives of the Medical Records Office at Dr. Babasaheb Ambedkar Hospital, Kandivali in order to facilitate the making of SAFE kit at the hospital. This training was also attended by staff nurses from V.N Desai Hospital, Santacruz.

Similarly the comprehensive healthcare response to sexual assault training was conducted at the Hindu Hruday Samrat Balasaheb Thackerey Trauma Care Municipal Hospital for 34 health care providers. The training challenged the notions that mentally ill people commit crimes and that the role of the doctors was limited to the forensic aspects of examination. The training examined the components of a comprehensive response to sexual assault while focusing on the therapeutic role of the healthcare provider.

The intervention team was a part of the workshop organized by Masum, Pune on the issue of taking the work forward by the organizations working for women. The team presented CEHAT's work and gained insights of various other projects in Maharashtra. The need to work collectively on the grassroots emerged very prominently from this workshop. Follow-up workshop involved planning for a summit where different organizations working at the grassroots level would present their work in the form of a research paper which is critically reviewed and analysed.

CAPACITY BUILDING OF PARTNER ORGANISATIONS:

Engagement with civil society organizations on VAW as a public health issue -

1. Post the training on establishing and running of hospital based crisis centre, many organizations as well as government health institutions have made efforts to engage health providers on the issue of violence against women and role of health care providers (HCP). The South Kolkatta Saniddhya group from Kolkatta conducted a seminar on the need for a health care response to violence against women. Key stake holders such as the Chairperson of state women's commission and delegates from the health department were invited with the aim to engage higher health care officials in initiating capacity building programs for medical and paramedical staff in screening, responding and supporting women and children facing violence. CEHAT has been working with this organization in order to carry out a state wide workshop on the issue of VAW and the role of health sector. However the state is still not open to conduct such workshops and the process of understanding VAW as a health issue has been a slow process. At the same time CEHAT has also been in talks with Swayam – a women's counselling centre for domestic violence to carry out a needs assessment at the level of hospital to understand the profile of violence faced by women, nature of health complaints reported by them and current procedures at the hospital to deal with the issue. However permissions are still awaited.
2. *One day Training in Bhopal at JP Hospital* – J.P. hospital collaborated with Action Aid to establish services for survivors of violence against women at a centre called 'Gauravi' and CEHAT has been closely working with them since its inception. From the beginning, the crisis centre has been inundated with survivors. However, it did not have any link with the hospital at all except for the space allocated for provision of services because of the way it was advertised. Hence, it was pertinent for Gauravi centre to position itself as a hospital based department and understand the linkages of violence against women, health consequences and the role of the health sector in mitigating it. A one day meeting was organized at the level of the hospital with key health professional to understand violence against women (VAW) as a public health issue. The Mumbai based Dilaasa model as a response to sexual and domestic violence was presented and its outcomes discussed at the meeting. Health professionals were also invited to Mumbai to interact with the health professionals who screen women to identify cases of violence against women, provide psychological first aid as well as build capacities of their fellow health providers on this issue.

3. *Three day residential training on feminist counselling to respond to VAW* – Based on the earlier engagement, Action Aid also felt a need to equip counselling organisations from all over Madhya Pradesh with feminist counselling skills as implemented in the Dilaasa crisis centre to work with survivors of domestic and sexual violence. A three day training course was conducted for more than 40 counsellors and lawyers on the issue of feminist counselling to respond to violence against women. The program was dedicated to understanding the role of the women's movement in bringing forth the issue of VAW, understanding the role of the health sector vis-a-vis VAW, creating awareness on the medico legal issues in domestic and sexual violence as well as practicing skills in crisis intervention. A day was also dedicated to understanding changes in the rape law, understanding criminal and civil procedures vis-a-vis domestic violence, steps in using the DV law and steps in engaging multiple stake holders such as CWC, courts, judiciary, police and the health sector so that a comprehensive response to VAW can be built. The training had an overwhelmingly positive response.
4. CEHAT has been invited to conduct trainings of health providers and counsellors of Bhoomika, a Gender based Violence Management Centre under NRHM Kerala in order to address sexual violence concerns, both therapeutic and medico legal. Besides the training, engagement with the NRHM department officials has been to create comprehensive services at the level of Bhoomika where presently only 1 counsellor mans the centre. However, there is no structure in place where by health providers screen women and refer them to counsellors, they do not have emergency shelter and a concern is that it is not integrated in to the hospitals as a department and it is largely one person centred. Recently the NRHM decided to prepare a set of standard operating procedures (SOP) for all the Bhoomika centres. CEHAT shared the SOPs prepared at the level of the Municipal hospitals for sexual assault health care response as well as the MOHFW (Union Government guidelines for medico legal care in sexual assault). The Kerala medico legal authorities have also created guidelines and a form for medical examination to be used across Kerala hospitals. However, analysis of these guidelines showed deep rooted biases and unscientific comments, besides not being in tune with the changes in the Rape law. The document was reviewed and changes suggested along with the rationale for it. Efforts are being made to push for the implementation of the MOHFW guidelines which are comprehensive, scientific and gender sensitive.
5. A one day CME accredited course was organized by AIIMS, Bhubaneswar, Odisha and CEHAT was invited to conduct the same. AIIMS institute organized this training based on directions received from the Union of India, Ministry of health and family welfare (MOHFW) for implementation of medico legal guidelines issued by them. Participants comprised of 53 senior forensic doctors as well as gynaecologists from reputed medical institutions. Dr C Mahapatra, ex FOGSI president and currently professor obgyn, from SCB medical college and hospital, Director of AIIMS, Dr. A K Mahapatra and Dr AK Mohanty HOD, forensic medicine. The focus of the training was to equip health professionals to carry out therapeutic and forensic responsibilities vis-a-vis skill building exercises through case studies, role plays and group discussions. Several discussions were held pertaining to the new laws, medical opinion, documentation of findings and court trials and debates were held on tricky areas pertaining to informed and specific consent, mandatory reporting. The AIIMS is in a process of implementing the MOHFW union Govt protocol.
6. Based on the study tour, Jan Sahas approached CEHAT to orient their lawyers and paralegal workers to understand the role of medico legal are in sexual assault. A one-day consultation was

held with a team of lawyers from Jan Sahas, Devas, Madhya Pradesh, followed by a training of 40 community workers and lawyers on the health response to sexual violence in Bhopal. Post this training, the in charge was keen to also implement a psycho social care element to their current interventions in the legal system. However she stated that there is a gap in the understanding of their team members and requested that CEHAT provide support to them. It was discussed that a 5 day training program on Feminist intervention skills can be held in order to address the issue of VAW.

7. SWATI, an Ahmadabad based organization had participated in CEHAT's capacity building workshop on setting the OSCC models and developing a health care response to VAW. SWATI has already collaborated with a civil hospital in Dhangadra area. They needed technical support in understanding how to develop training module for Health professionals and how to build their own team to engage with the hospital staff. A 2 day program was carried out at Dhangadra to equip the staff of the crisis centre in understanding health consequences of VAW, steps in orienting HCPs to VAW and methods of screening women and children for abuse on 24th and 25th Dec 2014.
8. UP state government was very keen to replicate the Dilaasa crisis centre in their districts. Based on their study visit to CEHAT and Dilaasa, we were requested to develop SOPs for the establishing of these crisis centres and linking them to the existing schemes of the MWCD in the state of Maharashtra. CEHAT along with TISS has developed SOPs for the establishing of the Asha Jyoti Kendras (AJK) in 23 districts of UP and submitted a joint draft. Later on, consultations were done with the civil society organizations to seek feedback on the draft protocols. These were also sent for review to the concerned departments who would come in touch with survivors of VAW. The state health department has also adopted the central government protocol for medico-legal care for sexual violence. CEHAT along with TISS will also conduct capacity building workshops of UP AJK centres.

Responding to Violence Against Women through Engaging the Health Sector: Replication of a Hospital Based Crisis Centre for Women Facing Violence in Goa

Following the approval of setting up a hospital based crisis centre for women and children facing violence, a one-day state level workshop was held by CEHAT in association with the Goa Medical Cell, Goa Medical College on 24th September 2014. Participants numbered at 55 including clinical practitioners and health administrators from the disciplines of forensic medicine, gynaecology, psychiatry, paediatrics and surgery from the Goa Medical College and Hospital as well as Directorate of Health Services, Goa. The objectives were sensitization and training of health professionals in responding to sexual violence and domestic violence and develop an understanding of the national and international clinical guidelines. The workshop was well received by the participants and the MoHFW guidelines for medico-legal care issued by the GoI were discussed at length.

Later, a core group of the Asilo Hospital participated in a three day workshop facilitated by Sujata Warriar an international trainer on the issue of violence against women and role of the health sector in collaboration with CEHAT in Dec 2014. The training included perspective building on concepts such as gender, patriarchy, intersectionality to understanding dynamic of violence against women and its consequences on them. Sessions on understanding VAW as a public health issue, role of health professionals in responding to VAW were also held. A practice session on how to conduct training for peers in their hospital was also held.

Subsequently, to commemorate International women’s day, formal inauguration of Crisis Intervention Centre for Women was held by Mr Rajiv Gawas, Chief Officer MMC, Mapusa; and Director of Administration, Directorate of Health Services, Panaji. The Asilo Hospital Mapusa organized daylong activities for nurses, doctors and supportive staff, a workshop on Crisis Intervention Centre for Women on domestic violence and women in collaboration with CEHAT on 10th March 2015. This included three orientation trainings for nurses, doctors support staff over two days at Asilo Hospital on the subject of violence against women, health consequences of violence and operationalization of Crisis Intervention Centre for Women at the hospital and its role in responding to violence against women.

The fourth orientation training programme under the banner of Crisis Intervention centre for Women was organized on 8th May 2015 at Asilo Hospital for 26 participants including PRO (Public Relation Officers) Asilo, Sangath social worker & Matruchaya Social worker, pharmacy & registration counter staff, Asilo social worker and breast feeding counsellor. The training consisted of sessions on Violence Against women, VAW as a health concern, what can the health care provider do, viewing of a video clip and role play by participants.

Integrating Gender in Medical Education: Training of Trainers Workshops

In continuation with last year’s first training of trainers (ToT) workshop for the Integrating Gender in Medical Education project, this year another ToT was carried out on 14th and 15th November, 2014. The short training was held at YMCA, Mumbai Central, with a total of 13 participants from 5 colleges. Participants from RCSMGMC Kolhapur and GMC Nagpur did not attend in spite of having been deputed by their colleges. The training was a condensed version of the first 5 days training held in Feb, 2014.

The second five days training programme was held from 10th – 14th February, 2015 at Hotel West End, Marine Lines, with 20 participants from seven participating colleges. This workshop included sessions on revision of basic concepts, abortion and sex selection, gendered nature of health care settings, gender mainstreaming in medical education, panel discussion, field visit to Dilaasa centre, and group-work with subject mentors.

IV. INTERVENTION AND SERVICES

Building Evidence on the Health Sector Response to Violence Against Women

The intervention includes technical support to Dilaasa crisis centres located at two public hospitals in Mumbai and providing round the clock intervention to survivors of sexual violence reporting to three public hospitals in Mumbai.

i. Domestic Violence

May 2014 – April 2015

	Bandra Bhabha Hospital	Kurla Bhabha Hospital
Screening	73	20
New registrations	216	71
Follow-up sessions	333	39
Legal consultation	22	-

From May 2014 to March 2015, 216 new cases of domestic violence have been registered at Dilaasa, Bandra Bhabha and 71 at Kurla Bhabha. During this period, 333 follow-up sessions were conducted at Bandra Bhabha and 39 at Kurla Bhabha. An additional 73 women were screened for domestic violence

and offered suicide prevention counselling after having attempted suicide at Bandra and 20 at Kurla Bhabha. Twenty two women came in for legal follow-up.

Referrals take place from various departments of the hospital such as the Casualty department, Female medical and surgical wards and trauma ward of the hospital. There were 109 such women were referred from the hospital to Dilaasa. Sixteen women came to the centre after seeing the posters. Ninety two women were referred by other sources such as ex-clients, other hospitals, organizations and communities.

During the process of counselling, if the woman expresses interest in seeking legal redress, support is provided through consultations with lawyers from Majlis. Twenty two women received legal consultation at Dilaasa. When the woman needed urgent assistance, an appointment was sought from the lawyer and the woman was directly referred either to the Protection Officer or to the Majlis office. The counsellors interact with the patients in the ward on a regular basis, informing them about the services of the centre. This encourages them to access the service when required and helps spread the word in their community. There is ongoing engagement with the doctors to ensure identification of women facing violence and their referral to the centre.

ii. Sexual Violence

From May 2014 to April 2015, intervention was carried out in 277 cases of sexual violence reported at the three hospitals. The survivors both women and children were given emotional support, informed about medico-legal procedures, treatment and were referred for counselling. If required, the women were referred to the shelter to ensure their safety. Similarly, the counsellors coordinate with the Child Welfare Committee and the police regarding the cases. Under the Juvenile Justice Act of 2000, the child welfare committee can intervene in any case that involves a child. The committee has the same powers as a metropolitan magistrate or a judicial magistrate of the first class. A child can be presented to the committee by a police officer, any public servant, any social worker or public spirited citizen, or by the child himself/herself. Coordination with the committee ensures that the child is presented in front of the committee and a shelter provided if needed. Similarly, when the police inform the caregivers about presenting the child, they are not intimidated. A statement in front of the committee ensures that rights of the child are safeguarded. Such cases were followed up in several instances and legal intervention was carried out in nine instances.

The International Women's Day was celebrated at Kurla Bhabha Hospital in collaboration with a nursing college where the students performed a skit to create awareness on gender discrimination. The activities attracted a large crowd of patients and staff of the hospital.

Responding to Violence Against Women through Engaging the Health Sector: Replication of a Hospital Based Crisis Centre for Women Facing Violence in Goa : Counselling services

CEHAT won a grant for a proposal of a pilot crisis centre responding to violence against women and children in Goa hospital from National mission for empowerment of women (NMEW), a program under the Ministry of Women and Child Development (MWCD), Union of India. The model looked at working in the health system and then forming alliances through a convergence approach with police, legal aid authority, courts and so on. A rapid assessment of services in Goa was carried out to understand available resources.

Approval for setting up a hospital based crisis centre responding to women and children facing violence in Goa was received from the Ministry of health and family welfare (MOHFW) as well as Ministry of

women and child, (MWCD) Goa. Departments of Health, Women and Child Development, Panchayats, Forensics department at Goa Medical College and Hospital, representatives of District Legal Services Authorities were all approached and explained the purpose of the project. Their cooperation was sought in an effort to develop a convergence model.

As the medical college already has a special unit for child sexual abuse, the health department not wanting to duplicate efforts and granted permission for setting up the crisis centre at Asilo Hospital, North Goa. After orientation and three day capacity building workshop of selected staff in Mumbai coupled with a visit to Dilaasa crisis centre, the crisis centre was inaugurated in May, 2014.

Efforts were also made to coordinate with the PWDVA, Protection officer and we have him on board to provide legal and other required services to women facing domestic violence. This is critical as women need legal assistance too. Meetings with local NGOs were carried out to establish working equations with others NGOs providing services to women and children for referral and mutual support. They were informed about the project and most have agreed to provide services and act as referral points for women facing violence. These include shelter homes for women and children, organisations and individuals providing various services for women and children, counselling services, legal aid services, vocational training, etc. Counsellor at the Family Counselling Centre under the CSWB was contacted for scheme information and soliciting cooperation.

In the period between Jan 2015 to May 2015, 67 women were provided with in-depth counselling. Additionally, 252 women were identified as facing some or the other forms of distress and sought basic counselling after being identified as facing violence through screening process by Health providers and counsellors. It is hoped that these women come back for in-depth counselling. It is important to recognize that despite the presence of a hospital based crisis centre , women may not be immediately prepared to seek services , in fact its only when they are screened by HCPs and referred to the centre do they realize that the centre provides services for women facing violence. Therefore, this could a reason why these women still wanted some time to think of what services they wanted from the centre

Visits to the Dilaasa centre:

During the past year, several visitors and delegates have visited the crisis centre. This included an Officer on Special Duty from the Ministry of Health, government of India, a team of police officers from Telengana, a team of lawyers and activists from Jan Sahas, Bhopal, several members of the crisis center from Panchkula, Haryana as well as the counsellors from Gauravi Crisis Center, Bhopal. A delegation from Uttar Pradesh included the Principal Health Secretary and the director of the Forensic Laboratory along with a team of doctors. A member from the organization, Medicins Sans Frontieres as well as Population Services International (India) also visited the centre to understand the work. All these meetings and study tours were to understand the Dilaasa functioning and the methods and approaches of integrating the health care response to violence against women.

IPS Officers from the Telegana also paid a visit to the center to know the role of the police in helping women in crisis and violent situation. The centre was also visited by several students from Bhakti Vedant Nursing College and Nirmala Niketan College of Social Work for an orientation into the work of Dilaasa. The crisis center played host to a number of international visitors as well including 2 Korean members of Parliament and the team from Southall Black Sisters.

Conferences and Presentations

- Dilaasa case records from 2001 to 2011 were analysed. A paper titled 'Patterns of domestic violence and pathways to seek support by women registered with a hospital-based crisis centre: a descriptive study' was developed and presented at the South Asia conference on Gender, community and violence: Changing mindsets for empowering women of South Asia organized by Dr. K.R. Narayanan Centre for Dalit and Minorities Studies, Jamia Milia Islamia and South Asia Women's Network. The study which looked at 2032 case records revealed that 16% women reached the centre after having attempted suicide. Physical and sexual violence was reported by 84% and 48% of women respectively. More than half of the married women experienced sexual violence from the husband, reiterating the need to recognize marital rape as an offence. The study also substantiated the need for hospital-based services to enable early identification and comprehensive care for survivors of violence.
- Similarly, the intervention team presented the work at the Regional Symposium: 'Expanding the Canvas: Deepening the Dialogue', 2014, Pune organized by Forum for Engaging Men. The forum consists of various organizations working around the issues of masculinity and violence. The symposium was one of the several symposiums happening in India before the global symposium in November 2015. The intervention team spoke about their experiences of working with young boys who are survivors of violence as well as the limited experience with the husbands of survivors of domestic violence.

STAFF DETAILS AS ON 31ST MARCH 2015

Name of the Staff	Designation	Gross salary
Anjali Kadam	Secretary	22,656.00
Radha Pandey	Secretary	21,956.00
Pramila Naik	Junior Admin Officer	34,178.00
Shobha Kamble	Office Assistant	17,464.00
Sudhakar Manjrekar	Office Assistant	17,464.00
Dilip Jadhav	Office Assistant	17,464.00
Vijay Sawant	Secretary	23,006.00
Sonal Vasanthan	Admin Assistant	27,285.00
Jasmin Chembiparambil	Admin Assistant	27,960.00
Rashi Vidyasagar	Research Associate	27,960.00
Asilata Karandikar	Research Associate	28,185.00
Sumeet Pokharnikar	Senior Research Associate	33,628.00
Suchitra Wagle	Research Officer	26,054.00
Sanjida Arora	Senior Research Associate	32,803.00
Sujata Ayarkar	Research Associate	27,960.00
Nehal Shah	Senior Research Associate	16,402.00
Shreya Sen	Senior Research Associate	32,528.00
Aafrin Ansari	Junior Admin Officer	20,012.00
Aarthi Chandrasekhar	Research Officer	43,099.00
Sangeeta Rege	Senior Research Officer	54,143.00
Padma Deosthali	Coordinator- CEHAT	98,136.00