SUMMARY OF FUNCTIONING AND WORK OF ANUSANDHAN TRUST

Anusandhan Trust (AT) was established in 1991 to establish and run democratically managed Institutions to undertake research on health and allied themes; provide education and training, and initiate and participate in advocacy efforts on relevant issues concerned with the well being of the disadvantaged and the poor in collaboration with organizations and individuals working with and for such people.

Social relevance, ethics, democracy and accountability are the four operative principles that drive and underpin the activities of Anusandhan Trust's institutions with high professional standards and commitment to underprivileged people and their organizations. The institutions of the Trust are organised around either specific activity (research, action, services and /or advocacy) or theme (health services and financing, ethics, primary healthcare, women and health, etc.); and each institution has its specific goal and set of activities to advance the vision of the Trust.

The trust governs three institutions:
CEHAT (Centre for Enquiry into Health and Allied Themes) the earliest of the three institutions established in 1994 concentrates or focuses on its core area of strength – social and public health research and policy advocacy.

SATHI (Support for Advocacy and Training in Health Initiatives) The Pune-based centre of Anusandhan Trust has been undertaking work at the community level in Maharashtra and Madhya Pradesh, and also facilitates a national campaign on Right to Health and other related issues.

CSER (Centre for Studies in Ethics and Rights) The trust promoted work on bioethics/medical ethics from the very beginning. The work particularly on research in bioethics and ethics in social science research in health were further consolidated within CEHAT. Since there is a real national need to strengthen bioethics and also at the same time promote ethics in various professions, the Trust decided to establish a long-term focused programme on ethics under a separate centre.

The Trustees of the Anusandhan Trust constitute the Governing Board for all institutions established by the Trust. Presently there are eight trustees, each institution is headed by a Coordinator appointed by the Trust and the institution functions autonomously within the framework of the founding principles laid down by Anusandhan Trust. Each institution is free to work out its own organizational and management arrangements. However the Trust has set up two structures, independent of its institutions, which protect and help facilitate the implementation of its founding principles: The Social Accountability Group which periodically conducts a social audit and the Ethics Committee responsible for ethics review of all work carried out by institutions of the Trust. The Secretariat looks at the financial management of AT and its institutions.

DETAILED REPORT FOR THE FINANCIAL YEAR 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 Heath 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 too 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 s 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. Form 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.

I a. Maharashtra Health Equity and Rights Watch project

Project period- 15th November 2005 to 14th November 2008, extended up to 30th September 2009

The formal project period ended in September 2009, however some of the dissemination activities were conducted after September 2009. In this report, we are giving information about the overall achievements of the project as well as the specific activities that were conducted in the period from April 09 to March 2010.

In 2005, SATHI undertook this project with the overall aim of monitoring **the gaps in access to health care, particularly with a focus on women's access to health care** in Maharashtra state for supporting equity-oriented health sector reform and advocacy for health rights.

Specific objectives of this project were

1. To document existing inequities in access to health care with special focus on caste, tribe, class, gender, rural-urban and regional disparities
2. To monitor trends regarding key process indicators responsible for such inequities and to widely disseminate the findings
3. To support state-level advocacy for reduction of inequities in health care and to strengthen initiatives to establish the Right to health and health care

4. To sensitize decision makers and health advocacy groups in other Indian states, by regular dissemination of the reports and activities of the Health Equity watch
5. To explore the possibility and lay the groundwork for an All-India Health Equity Watch

In these four years, SATHI accomplished various research activities under this project to achieve the objectives. The research activities entailed analysis of existing data with an equity lens as well as primary research.
Important research activities accomplished during April 2009 to March 2010 are as follows:

1. **A report on Nutritional Crisis in Maharashtra -** This report is based on analysis of secondary data from the National Family Health Survey and the NSSO pertaining to the state of Maharashtra, as well as data from a survey carried out for the 'Right to Food campaign' in the state and other sources. This report is an attempt to study undernutrition in the context of socio-economic inequities, food security and various programmes undertaken to address this problem in Maharashtra. A concise report in Marathi summarizing key findings of this report has also been printed and has been widely disseminated in the Right to Food network organisations.

On August 29th, 2009 SATHI organised a day long discussion on the major themes emerging from this report. The main issues discussed in the meeting were inequities in food intake, issues regarding current poverty line and targeted approach to PDS, contentious policy issues relating to nutritional supplementation for children, and role of health care system in dealing with malnutrition. This programme was attended by around 30 activists and resource persons mainly from Maharashtra and also from other parts of India, which included right to Food campaign activists, health activists, nutritionists as well as economists. The deliberations highlighted mainly issues concerning undernutrition in Maharashtra and possible strategies to overcome the problem.

Subsequently, on 3rd February 2010, SATHI in collaboration with the Karve Institute of Social Sciences organised a discussion programme to disseminate the findings of this report. This programme was attended by students doing MSW course in Karve Institute as well as colleagues from other NGOs in Pune. Dr. Vandana Prasad and Ms. Kiran Moghe were main speakers for this programme.

The major findings of this report were covered by print media as well as electronic media.

2. **A report on Health Inequities in Maharashtra-** key findings of this report have been translated into Marathi and have been published in form of a report in May 2009.
3. **Household survey on inequities and barriers to Health care access -** One of the important research components of this project has been a detailed household survey covering 1650 households from 10 districts of Maharashtra. This household survey has collected information about:

a. Healthcare sought for the illnesses treated on OPD basis in 15 days prior to the day of interview
b. Hospitalisations during last one year
c. Deliveries in last 2 years and women's reproductive health problems in last 3 months

After the preliminary analysis of the household survey data, an expert discussion programme was organised in Pune in September 2009. Major findings of the survey were presented to the consultant's group which comprised of researchers from different organisations. The report is being finalised in the light of the comments received in this meeting.

In addition to the above research activities, one of the team members presented concerning the Maharashtra Health Equity and Rights Watch in the **5th International Conference of International Society for Equity in Health** (ISEqH), held during June 9 to 11, 2009 at Crete, Greece.

I b. Assessment of budget, procurement and supply of essential medicines in Maharashtra

Project period August 2009- July 2011

Background

Non-availability of essential medicines in public health facilities is one of the major problems hampering the quality of treatment in the public health system.

SATHI has been looking at this aspect of the public health system through its activities such as the household survey and the facility survey conducted as part of 'Maharashtra Health Equity and Rights Watch' and the facility survey conducted as part of Community based monitoring in five districts of Maharashtra. CBM has revealed the problems related to mismanaged drug distribution system, since often for the same medicine there is deficient supply in one PHC whereas it is oversupplied in a neighbouring PHC.

In the household survey, information regarding the episodes of illnesses treated on OPD basis as well as the hospitalizations was gathered from 1659 households. One of the sections in the questionnaire was pertaining to the perceptions of the respondents regarding quality of health care provided by the public health system. *More than half of the respondents (55%) complained about the quality and availability of the medicines* provided by the public health facilities; they cited this as one of the main reasons for not seeking treatment from the public health system.

Information from all the different sources confirms that the deficiencies related to availability and distribution of medicines are important problems in the public health system. Right to essential medicines is one of the important parts of Right to health. Given this context, SATHI has initiated a project which is studying the procurement and distribution system of drugs in Maharashtra and the budgetary allocations for the same.

The overall objective to undertake this project is to improve the availability of essential medicines in primary health centres.

The short term objectives are:-

1. To understand the procurement and distribution process in the state of Maharashtra
2. To develop tools for monitoring the procurement and distribution of medicines in the state of Maharashtra

Key areas of research in this project are-

- The budgetary allocations for essential medicines at state level in Maharashtra
- The procurement and distribution system of essential medicines in Maharashtra with a view of understanding key gaps, bottlenecks and areas of delay
- Actual availability of various essential medicines with reference to standard norms at select PHCs in Pune district

The objectives mentioned above are being achieved through following activities:-

1. Expenditure tracking for the select medicines purchased at the state level
2. Documenting the process of procurement for select medicines in the state of Maharashtra
3. Periodical assessment of availability of selected medicines in two PHCs in Pune district
4. Analysis of health budgets to understand per capita allocations for essential medicines

The period under reporting was the initial phase of the project. In the initial phase of the project, the methodology of the project was refined in consultation with the IBP-PI technical advisors. Along with the consultations, the project team also attended training for 10 days on 'Health and Budgets'. One of the staff members visited the Philippines to learn from the experience of organisations involved in monitoring procurement such as Procurement Watch Inc, Government Watch etc.

Besides capacity building of the staff members to undertake work on health budgets, in the first phase of the project, the team focussed on discussions with senior level health officials to understand the current system of procurement of medicines that is being followed in the state. Similarly, literature related to the Tamil Nadu procurement system (TNMSC model) was studied considering that it is one of the model systems of drug procurement in India. To understand the problems in existing procurement system, other reports such as the CAG report and few other studies have been referred to.

On the basis of the literature review, tools for monitoring the procurement system and monitoring actual availability of medicines in the PHC have been developed. Pune district has been finalised for monitoring the availability of medicines.

As mentioned earlier, availability of essential medicines in PHCs has also been raised as one of the important advocacy issues in different public hearings organised as part of CBM. This issue was also raised in the state level programme of CBM where most of the senior officials from the health department were present.

Thus overall in this project, we are trying to link the research and advocacy for right to essential medicines by undertaking a study on procurement, distribution

and availability of essential medicines and disseminating the research findings through the existing community monitoring framework under NRHM.

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 though 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.

II a. Partnerships for Community Health and Health Rights

Project period: July 2007 to March 2010

This project was initiated in mid-2007, the overall objective of this project has been to contribute to the strengthening and accountability of Public Health services and regulation of Private medical sector based on partnerships with selected grassroots organisations.

The year 2009-10 was quite demanding for SATHI team since the process of community based monitoring of health services was evolving in pilot areas of Maharashtra, and significant technical inputs were required for consolidation of the CBM model. Along with developments in Maharashtra, the SATHI team was actively involved in supporting assertions of Health rights in Barwani district of Madhya Pradesh.

Specific objectives of the SATHI partnerships for community health and health rights were as follows-

1) Creation of an appropriate niche for less educated/functionally literate women as ASHAs in specified remote areas of Maharashtra and MP.

2) Consolidation of the gains in National health policy, related to institutionalizing citizen's health rights, service guarantees and accountability/monitoring mechanisms in the context of NRHM.

3) Establishment of demonstrative examples in certain areas in Maharashtra, Madhya Pradesh, of implementation of the Community based monitoring framework envisaged in the National Rural Health Mission.

4) Initiation of demonstrative examples of civil society activation in certain areas in Maharashtra, for implementation of the new rules framed under the amended Bombay Nursing Home Registration Act (BNHRA), especially the provision relating to Patients' Rights including the rights of HIV positive persons.

5) Enhanced capacity and activity of civil society organisations in certain pilot areas, concerning right to essential medicines, including medications for HIV positive people, as part of the overall campaign for increasing access to health care

Progress of activities in this context in the year 2009- 2010 have been as follows-

A. Mainstreaming SATHI's training methodology-

Inputs for ASHA training in Maharashtra- SATHI had taken the initiative in forming a consortium of experienced NGOs working in various adivasi areas for training less educated ASHAs. This involved coordinating, in collaboration with partner organisations, the training and capacity building of 250 ASHAs in five adivasi districts of Maharashtra- Thane, Nandurbar, Nashik, Amravati and Gadchiroli. This project to conduct demonstrative ASHA training in 5 tribal districts of Maharashtra in collaboration with partner NGOs in these districts, was funded by the State Health Dept with value addition support from Association for India's Development (AID). The SATHI team, with help of other experts, has developed pictorial manuals I to V for ASHA training in Maharashtra for less educated ASHAs. These manuals were accepted by the State NRHM Directorate as official complementary manuals for training ASHAs, and 9000 copies of each of these 5 volumes of SATHI manuals have been printed for the ASHAs in tribal areas. In this

phase SATHI and seven partner organisations in five districts, have completed training of 228 ASHAs.

ASHA related developments in Barwani, Madhya Pradesh- SATHI's Marathi manuals were converted into user friendly, pictorial Hindi volumes by the SATHI team and used extensively during the training of less educated ASHAs in Pati block of Barwani District. Hindi training modules were shared with all higher officials in the MP Health Department. The present model of ASHA that is evolving in Pati block of Barwani district is definitely influenced by the perspective of 'ASHA as an activist' compared to the official model of ASHA. In Pati block total 54 ASHAs have been trained till volume IV by the SATHI team.

B. Collaboration with selected partner organisations for strengthening of Health rights in the State of Maharashtra and Madhya Pradesh-

In order to ensure a critical mass around health rights issues, SATHI has been involved in partnerships with effective grassroots organizations working in various regions of the State. Names of these organizations are as follows-

In the state of Maharashtra – MASUM, Aamhi Amchya Arogyasathi, Lok Samanvay Pratishthan, Rachana Trust, Janarth, Jan Arogya Samiti- Aajara

In the state of Madhya Pradesh - Jagrit Adivasi Dalit Sangathan (JADS)

These organizations have been active on health rights issues even prior to this partnership, however as part of the partnership they have receiving regular technical inputs and related support from SATHI. This has led to promotion of health rights in specific areas where idea of health rights has been communitised and people have become more aware about their entitlements, especially in the public health system. From each of these organizations, about 10-15 activists were trained on health rights, who have played a key role in community interventions in the areas of respective partner organisations. After the partnership now some of the partner organizations are independently leading health rights activities at the block level and in some places even at the district level. Typical health rights activities conducted by these partner organizations are as follows-

a. *'Jan samvad', 'Jan sunwai'* or other forms of dialogue on health rights with the local Health functionaries in all areas
b. Continued intensive community monitoring of selected health facilities and mass rallies or other programmes for improvement in the public health facilities
c. Trainings on the calendar programme and introduction of this programme at the community level in two field areas
d. Village level awareness meetings with the help of posters and other media, on guaranteed health services and functions of the health functionaries
e. Periodic follow up of mass events like Jan Samvad and Jan Sunwai to ensure improvements in services

Some examples of innovative health rights activities conducted in the year 2009-10 by partner organizations with technical inputs from SATHI are as follows-

In Maharashtra –

• **Survey and Press conference on availability of essential medicines by Lok Sangarsh Morcha in Nandurbar District -** In March 09 with the help of checklists prepared by the SATHI team, Lok Sangarsh Morcha surveyed seven PHCs and one Rural Hospital in Akkalkua taluka to assess the ***availability of 67 essential, routinely required medicines*** in PHCs and RH. This information was analyzed by SATHI. The main finding was gross shortage of these essential medicines across these health facilities. On 25th March 09, a press conference was organized in Nandurbar, the district town, to draw the attention of the people and the press towards this continuing shortage of essential medicines even after three years of NRHM. This press conference was very well covered in the local press. Lok Sangharsh Morcha is following-up this matter systematically with the concerned officials.

• **Health Rights Convention and Jan Sunwai** was organized by Lok Sangarsh Morcha (LSM) on issues like availability of essential medicines in 7 PHCs (comparative survey); honorarium of ASHAs; support given to pregnant women through JSY and Matrutwa Anudan Yojana etc. LSM activists carried out a comparative survey in 7 PHCs of Akkalkuwa and Taloda Block. This convention and Jan Sunwai was organized on 19th August 09 in Nandurbar, in which 550 people from different parts of Akkalkuwa and Taloda block have participated, among whom more than half were women. For this programme MOs from all the PHCs including Shahada block were present and responded to various issues raised by the people in the audience. This event was also attended by the Civil Surgeon and DHO of Nandurbar who have responded on several issues. Adv. Brian Lobo, Dr. Shyam Ashtekar and Dr. Dhananjay Kakade were present in this Jan Sunwai as panel members. This convention and Jan Sunwai was very well covered by all the news papers.

• **Amhi Amchya Arogyasathi, District Gadchiroli** organised social audit of VHSC (Village Health and Sanitation Committee) activities in Salhe village, Tal-Korchi, Dist-Gadchiroli. This audit conducted by village activists focused on utilisation of untied funds and delivery of village level healthcare services. After discussion with community members regarding the functioning of VHSC, a social audit report was prepared. This process has led to range of positive changes in the functioning of the VHSC, Amhi Amchya Arogyasathi is planning to replicate it in other villages of the district**.**

• **Rachana trust in Pune district** has conducted a range of health rights activities like Jan Sunwai, open letter to private doctors to avoid misuse of injection and saline, mass awareness programmes on the issues like Anemia, reproductive health, pregnancy delivery etc. Linked with these, in the area covered by Rachana trust, a range of improvements in form of better availability of medicines, display of Citizens health charter in various public health facilities and filling up of vacant posts have taken place in last one year.

• **<u>In Madhya Pradesh</u>**

District level protest organized by Jagrit Adivasi Dalit Sangathan on the issue of non functioning of Deendayal Upadhyay Scheme in Barwani district hospital- This scheme has provision for free medical treatment and investigation up to a limit of Rs. 20000/- per family per annum, concerning treatment and investigation in all government health facilities. However the Deendayal Upadhyay Scheme was not functioning in Barwani district hospital since 10 months due to various malpractices, forcing poor patients to undergo catastrophic expenditures. In order to protest against

non- functioning of this scheme a rally was organised by the people's organisation JADS (Jagrit Adivasi Dalit Sangathan), in which around 1000 people participated. SATHI team members obtained information regarding the functioning of the scheme and analysed this in form of a critical report as an input to this activity. Finally after intervention by the State Health commissioner this scheme has now been restarted.

Community initiative in deciding utilization of village untied funds - In 6 villages of Pati block of Barwani, in a genuine spirit of community participation, community members associated with JADS took active initiative in deciding about utilisation of the village untied fund. Some activities organised by the community by utilising these funds include - Hamlet level health check up camps, constructing soak pits around the water sources, preparation of nutritious food for children in the village etc.

C. Value addition to Community based monitoring of health services in Maharashtra

As mentioned in the separate section on Community based monitoring in this report, apart from the existing 5 districts where the community based monitoring (CBM) project was initiated on a pilot basis, CBM activities are now being initiated in 8 new districts of Maharashtra. SATHI has continued as State nodal NGO to facilitate implementation of the process, in the PIP phase, for the period from April 09 to March 2010.

In addition to the dedicated CBM team, several other SATHI team members involved in the '**Partnerships for Community Health and Health Rights'** project have added value to the CBM process in the following forms:

Value addition by SATHI team to NRHM supported CBM process

- Some of the Health rights awareness material conceptualised and developed by the SATHI team was widely used at the Community level, while implementing CBM activities.
- In the official plan of implementation of CBM, all district level activities were supposed to be autonomously conducted by District and block level implementing organisations. However considering the need for further capacity building of the implementing organisations, SATHI team members have made significant contributions at the district level too.
- SATHI team members have contributed to data analysis, documentation and preparation of reports for CBM.

(A compiled report of Community based monitoring of health services under NRHM in Maharashtra during 2007-2010 may be accessed at www.sathicehat.org)

D. Capacity building of 15-20 civil society organisations to sustain Maharashtra state level advocacy-

This process was specifically undertaken to increase awareness and capacity building amongst 15-20 civil society organizations about the right to essential drugs in general and health rights of people living with HIV/AIDS, including right to medicines specifically required for people living with HIV/AIDS.

Monitoring availability of essential medicines-

- Maharashtra Health department has passed a GR mentioning roles and responsibilities of the monitoring committees at PHC, Block and District levels. *Monitoring of availability of essential medicines as a component of Community monitoring of Health services is now included as one of the roles of these committees*. Based on this decision, SATHI has initiated monitoring of availability of essential medicines (including medicines required for care of persons living with HIV-AIDS) as a component of Community monitoring of Health services in selected districts of Maharashtra.
- It was decided that wherever Health rights partners are involved in CBM, they would specifically monitor in detailed manner, the availability of Essential Medicines in respective districts. Monitoring would also include medicines required to treat opportunistic infections among persons living with HIV/AIDS. Some of our partners have collected such data which has been used for advocacy.

E. <u>Sustained National level advocacy</u>

a. The SATHI team, particularly one SATHI team member who is part of the national Advisory Group for Community Action (AGCA), and another who is part of the Technical Advisory Group (TAG), have continued to contribute to planning and development of the national process for Community based monitoring of Health services.
b. A SATHI team representative was part of the task force to draft the **National Health Bill** – which contains extensive provisions to operationalise the Right to health and health care. Various sections were contributed and inputs were given based on experience of drafting the Gujarat public health act. The demand for such a National Health Act has been included in Jan Swasthya Abhiyan's People's Health manifesto.
c. JSA organized a national workshop on the National Health Bill in November 09, a SATHI team member circulated a note and made a presentation at this workshop regarding various changes required and issues to be addressed in the National Health bill.

Overall, SATHI's role as a 'local to national' resource centre for People's Health rights has been consolidated during this one year.

II b. Community based monitoring and planning of health services

Activity initiated since June 2007; current phase of activity supported by NRHM April 2009- March 2010

Introduction:

To ensure that health services reach all those in the community who require services, NRHM has proposed an intensive accountability framework that includes Community-based Monitoring as one of its key strategies. The NRHM Framework for Implementation outlines the composition and broad roles of monitoring and planning committees at various levels. As per the guidelines of Advisory Group for

Community Action (AGCA), community based monitoring of Health services is being organized in Maharashtra since mid-2007 and has been developed further in 2009-10.

The objectives Community based Monitoring are as follows:

- It will provide regular and systematic information about community needs, which will be used to guide the health planning process appropriately
- It will provide feedback according to the locally developed yardsticks, as well as on some key health service indicators.
- It will provide feedback on the status of fulfilment of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.
- It will enable the community and community-based organizations to become equal partners in the health planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system.

SATHI's role as a State Nodal NGO in implementation of the process in the State of Maharashtra

In Maharashtra a process was conceptualized and implemented in the following five districts, in five different regions of the State - Nandurbar, Amaravati, Osmanabad, Pune and Thane. In each district three blocks, in each block three PHCs and under each PHC five villages were selected for implementation of the project. (Thus 15 Blocks, 45 PHCs and 225 Villages were selected in first phase.) The work of Community based monitoring has now been expanded in these 5 districts with addition of 8 new blocks, 33 new PHCs and 275 new villages.

In the second phase, the CbM process is being expanded to eight new districts. SATHI had a key role to play in operationalising the selection process of district and block nodal NGOs. Selection of district and block nodal NGOs has been completed in all districts (Gadchiroli, Chandrapur, Raigad, Kolhapur, Nashik, Solapur, Aurangabad & Beed). In these eight districts, a total of additional 60 PHCs would be covered and under each PHC five villages i.e. additional 300 villages would be covered.

The core responsibilities of SATHI, as the State nodal NGO, have been as follows–

1. Liaison with government officials as well as district and block implementing organizations to coordinate the activity

This project has been a unique social experiment in Maharashtra. Such community accountability, feedback and dialogue mechanisms in the health sector were to be systematically implemented on a significant scale. The challenge has been to manage a wide range of activities in a limited timeframe, through a chain of collaboration stretching from the national AGCA, State Government to the block level NGO and to ensure that these activities lead to concrete improvements to maintain the momentum of the process. Another daunting task was to liaison with government officials, and dealing with potential conflicts in a sensitive manner.

2. Technical support and capacity building of the District and Block nodal NGOs

One of the key components of the project is 'trainings on CBM' at all levels of the monitoring committees in expansion areas of 5 districts. The capacity building process by SATHI was broadly at two levels- State level workshops and training at the district level. Block coordinators and block facilitators, who were also expected to act as master trainers in respective districts, were trained in the skills and tools that would be required in CBM. SATHI's contribution in these key processes has been appreciated by the district implementing organizations and tools that were developed became a reference for CBM in other states.

3. Conceptual and practical support to interventions

Some of the core strategies of monitoring processes like preparation of the report cards, public hearings, Jan Samvad were shaped by SATHI's previous experience of working with the grass root organisations; SATHI's perspective about monitoring had a significant impact on the monitoring processes that unfolded at the community level. SATHI's team members also gave inputs as panelists at PHC and District level Jan sunwais. Similarly SATHI supported whichever innovations were being introduced by the partner organisations.

4. Publication of orientation and awareness material

SATHI has published a wide range of awareness and orientation material regarding community based monitoring of the health services during implementation of the project. This includes-

- Especially designed pictorial VHSC as well as RH, PHC level tools. These tools were initially used in Thane, Nandurbar and Amravati districts keeping in mind the adivasi population and lower literacy levels. This tool helped non-literate or functionally literate persons to understand the monitoring questions.
- Village, PHC and RH level report cards have been published in poster format for public display.
- Village health services calendar was designed at state level and was used in selected villages of 5 districts.
- A range of posters regarding the service guarantees mentioned in the NRHM were published and widely disseminated.
- 'Dawandi' is a newsletter of approximately 24 pages which is published quarterly by SATHI. Dawandi is circulated across Maharashtra, reaching various stakeholders from Village health committees to State health officials.
- SATHI has published and disseminated a 'Compiled Report of CBM in Maharashtra' for the period (2007-2010) in English
- Booklets on Village Health, Water supply, Nutrition and Sanitation Committee and PHC Monitoring and Planning Committee – these booklets consist of information regarding constitution, information regarding untied funds and also roles and responsibilities of the committees.

- **Progress of Community Based Monitoring Process in Maharashtra**

1) Maharashtra was the first state of the country to include Community Based Monitoring of the Health services in its State Project Implementation Plan (PIP).

2) In this year (2009-10) approximately 80 news items were published in leading state level news papers concerning community based monitoring of the health

services in Maharashtra. Similarly, events like Jan Sunwais and the state review workshop were significantly reported in the electronic media.

3) At the National level, the model of CBM that has evolved in Maharashtra has been recognized as one of the examples of a credible model of Community Based Monitoring of Health services.

4) A large number of instances have been documented which point towards definite change in the attitude of health functionaries and improvement in regularity of services.

- **Overall key changes due to Community monitoring process**
  1. Improved dialogue between frontline Health care providers and community
  2. Improved attendance at public health facilities in some areas
  3. Greater frequency of visits by ANMs, MPWs to villages and better cooperation from community
  4. Check on illegal charging, irregularities in JSY payments
  5. More responsive attitude of PHC doctors and staff, improved services in many areas
  6. Mutual suspicion, lack of understanding has been replaced by better understanding of problems of Health care providers and positive interaction
  7. Practice of prescribing medicine from private shops has totally stopped in many areas; some required medicines which are not available, are now purchased from the RKS funds.
  8. Boards regarding Citizen's health charter and availability of medicines have been displayed

SATHI is continuing to play the role of State Nodal Agency to anchor the process of Community Based Monitoring in Maharashtra, for the period of 2010 – 2011.

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 Maharshtra). At the valedictory session, Dr Potdar Deputy Director (Nursing, Govt. of Maharshtra). 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 1training 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 a 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 gyanecology, 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.

III. Demonstrative ASHA training by consortium of NGOs supported by NRHM

Project period: April 2008 – March 2010

Background

It is a widely accepted principle that the Community Health Worker (CHW) is an essential part of Primary Health Care. CHWs are very much required in villages, especially in remote areas and in particular tribal areas, where no other resident health care provider is available. Prompt treatment of minor conditions at an early stage; early detection and initial treatment of some serious conditions like dehydration, pneumonia with timely referral when necessary; advice and guidance regarding care are amongst the key roles that the CHWs can play, to help to reduce infant and child mortality.

Given this context, it is a significant development that as a component of the National Rural Health Mission, the nationwide ASHA programme has been launched, covering high focus states as well as tribal districts in non-focus states like Maharashtra. SATHI has had certain reservations about the conceptualization and design of the national ASHA programme, yet SATHI decided to get involved in the training of ASHAs in certain areas in Maharashtra as well as in its state level mentoring. This is an attempt to shape it to a certain extent in a pro-people direction.

Several NGOs working in tribal areas of Maharashtra have demonstrated the definite potential of well-trained CHWs (especially women) in tribal areas, who are able to provide basic health services at the hamlet level, in an accessible and affordable manner. Thus on the one hand there is a national CHW scheme being launched and operationalised, and on the other hand there is the positive NGO experience of upgraded training to village health workers in various tribal areas of Maharashtra. This is the logical backdrop to the suggestion given by SATHI that in

some areas ASHAs be given upgraded training by experienced Health NGOs with support and collaboration with the State Health department.

SATHI could convince the concerned officials in the health department that certain experienced NGOs would conduct demonstrative trainings of 50 ASHAs in each of the 5 selected 'predominantly tribal' districts. The trainers from the health department were expected to be involved in this training so that later on they can use the methods employed by NGOs in the training of other ASHAs. SATHI decided to play a leading and facilitating role in this process of conducting demonstrative training. The objectives of this on going project supported by NRHM, with value addition support by AID are -

Objectives

1. Training and capacity building of several batches of ASHAs by a consortium of experienced NGOs using innovative methodology and material, in five districts of Maharashtra which have a high proportion of tribal population – Thane, Nandurbar, Nashik, Amravati and Gadchiroli
2. Methodology for training less educated ASHAs to be refined, standardised and implemented on a significant scale to serve as a model for training of less educated ASHAs in the state
3. Trainers from the State Health department in respective districts and blocks to be oriented with respect to the innovative methodology.

Institutional mechanisms

As mentioned above, SATHI has taken responsibility to work as the ***state level training resource agency*** for this project, providing basic training material for ASHAs (mainly pictorial manuals), training of trainers and guidebooks for them and state level coordination and monitoring for the activities.

A ***state level training resource pool*** has been formed consisting of senior trainers from various experienced NGOs such as SATHI, The Foundation for Research in Community Health (FRCH) and ABHA and some of the Block training resource agencies. These resource persons have been giving inputs for training of trainers of the seven NGOs and also in various blocks as required. In various blocks in the five selected districts, specific NGOs have taken responsibility for conduction of activities. The following seven organizations are working as district training resource agencies in respective districts-

1) Thane – BAIF / MITRA
2) Nashik – VACHAN
3) Amravati – Apeksha Homeo Society and Khoj- Melghat
4) Gadchiroli – Amhi Amchya Arogyasathi
5) Nandurbar – Janarth and Lok Samanvay Pratishthan

Progress of activities (April 09 to March 10)

- **Mid term review:** Before conducting rounds IV and V of the ASHA training project, it was considered appropriate for SATHI to gather feedback from various stakeholders in the form of a mid-term review. This mid-term review helped to identify problems and limitations of the current ASHA training process and day-to-day functioning of ASHAs, so that these issues could be improved upon before embarking on training phases IV and V of the project.

- **Review and planning meeting:** The review and planning meeting with heads of partner organisations involved in ASHA training Programme was held in May 09. Issues identified in these review meetings were collated and presented in the ASHA state mentoring meeting. Following this some corrective actions were taken by the State Government to rectify identified problems.
- **Training of trainers:** For the trainers in these five districts, a Training of Trainers workshop was organized in Pune from 14th to 17th September 2009, covering Vol. IV and V. The main objectives of this workshop were to evolve a common methodology for training of these volumes in the five tribal areas of Maharashtra.
- **Evaluation of ASHA training:** SATHI's evaluation sought to assess the ASHA program in key areas of Maharashtra in three ways. First, it compared NGO ASHAs and government ASHAs, asking whether SATHI's training methodology is producing ASHAs with the same or better knowledge and functionality as the government's training methodology. Second, it assessed the overall amount of support provided by the government for ASHAs, both NGO and government. It examined whether ASHAs are receiving two such government supports: regular re-supply of drug kits and proper reimbursement for their work. Third, it sought to understand how households in villages with ASHAs are engaging with their ASHAs, and whether there is a different level and type of engagement for villages with NGO ASHAs and government ASHAs.
- **Publication of ASHA pictorial manual IV and V:** We have printed pictorial manual IV, V and supplied 9000 (each vol.) copies to NRHM. We have also prepared Guidebook no. 4 and 5 for trainers.
- **Completion of ASHA training Vol. IV and V:** The training of ten batches of 223 ASHAs with Vol. IV and V has been completed by the NGOs in respective districts, as planned by March 2010. The training was greatly facilitated by the availability of the pictorial training manuals prepared by SATHI. Although these manuals were prepared specifically keeping in mind the needs of ASHAs who are less educated than the stipulated 8th standard criterion, it was also a major help in the training even of those who fulfilled the 8th pass criterion, as it had been a long time since these women had left school. In addition to the manual the training process was facilitated for the ASHAs due to the use of various methods like group discussions, posters, role plays, video films, songs etc. After each day's training, a revision session was held to enable retention of the knowledge gained. Oral and written examinations were also taken to assess the actual gain in knowledge. The use of interactive methodology for training, and the maintenance of an informal and friendly atmosphere in the training sessions also ensured that the ASHAs gained required knowledge and skills while enjoying the training.

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.

CAMPAIGNS

IV. Contribution to campaign on Patient's Rights

SATHI has continued to be a leading element in the advocacy for finalization and implementation of Bombay Nursing Home Registration Act (BNHRA) rules, individually as well as a part of Jan Arogya Abhiyan (JSA-Maharashtra, a coalition of progressive NGOs, organisations working in the sphere of health), contributing to the following activities:

- SATHI team members along with partner organisations organised **dialogues with association of private doctors (IMA) on issue of Patients Rights** in places like **Pune, Amaravati and Shahada** in collaboration with partner organisations during 2009.
- SATHI as a part of Jan Arogya Abhiyan in collaboration with Association for India's Development (AID) organized an **e-petition campaign** in mid-2009 appealing to the Health Minister of Maharashtra to adopt the Standard charter of Patient's Rights under BNHRA Rules 2006.
- SATHI actively contributed to Jan Arogya Abhiyan's conduction of **a State level consultation on Patients Rights** on 24 February 2010. Hon'ble Member of NHRC- Shri P.C. Sharma was chief guest. Activists from different parts of Maharashtra presented patients rights violation cases before him. Shri Sharma supported the JAA demand for legal protection to Patients Rights. Joint Charity Commissioner-Mumbai was also present. Activists drew his attention towards rampant violation of Mumbai High Court's order of reserving 20% beds for poor and economically weaker sections of society in Trust Hospitals. Joint director of Health services was present and promised to convey to higher authorities the activists' demand for prompt approval to BNHRA rules. The event was followed up by a press conference and media coverage.
- As part of Jan Arogya Abhiyan, SATHI team members tried to meet the new Health Minister, and discuss with him the issue of Patient's rights and BNHRA rules, but despite several efforts this has not materialized till date.

Activities beyond the project: SATHI's contribution to 'Patient's Rights Forum, Pune'

SATHI team has actively contributed to the formation of a broad citizen based Patients' Rights forum in Pune. **Rugna Hakka Samiti (Patients' Rights Forum)** is a voluntary body of Pune citizens, formed in April'09, to create awareness and to ensure protection of patients' rights in city hospitals. The Forum is has established a dialogue with representatives of private doctors, charitable hospitals with the aim of protecting and promoting patient's rights. SATHI team has been active member of this forum.

Keeping in view SATHI's larger aim of strengthening health rights activities and moving towards the larger objective of universal access to health care, the team has continued its partnerships with like minded organizations in the states of Maharashtra and Madhya Pradesh. Similarly involvement of SATHI in networks like Jan Swasthya Abhiyan, at the national and state levels has continued. In the context of Community

based monitoring of health services, SATHI has been involved in a range of diverse collaborations with stakeholders like NRHM Maharashtra, NRHM Advisory Group for Community Action (AGCA) and various district and block nodal NGOs.

This section reflects the highly collaborative nature of SATHI's work, and invaluable contributions that our partners have made in strengthening health rights and accountability framework for the health system. The very brief notes below focus only on the collaborative activities done with SATHI in the last one year, and naturally do not attempt to describe the much broader range of activities being done by each organisation.

1. SATHI's partners in the Health rights partnership programme

In Maharashtra-

i. Janarth

Janarth is an NGO working in Shahada block of Nandurbar District since 1996. Janarth has been in the forefront of raising various health issues, particularly the problem of sickle cell anaemia concerning the tribal population of Nandurbar district. In the last one year, they have conducted a range of health rights related actions like dialogue with private practitioners regarding patient's rights and misuse of injection and saline. They have also conducted effective community level dialogue with the Public health functionaries on health rights issues.

ii. Rachana Trust

Rachana Trust has been working in Haveli block of Pune District since last 17 years. Their main areas of work are awareness about child rights, public health system and related community entitlements. Key health rights activities that they have organized in last one year include 'Jan Aarogya Samvad' for improvement of the Public Health Services organized in four PHCs, generating awareness on health rights issues through posters exhibition in village meetings, and survey regarding essential medicines in 6 PHCs followed by dialogue with District health officials.

iii. Loksamanway Pratishthan

While Loksamanway Pratishthan is an NGO, it has developed from Lok Sangharsh Morcha, which is a people's organisation which has primarily worked on the issue of rehabilitation and compensation to the people affected by Sardar Sarovar Project. Loksamanway Pratishthan has been working on the issue of malnutrition amongst the tribal children for last more than five years. With inputs from SATHI they have carried out a large campaign to raise awareness about unnecessary use of injections and saline. The also organized a survey and press conference on availability of essential medicines in PHCs, followed by a Jan Sunwai on issues related to functioning of the local public health system.

iv. Amhi Amchya Arogyasathi

Amhi Amchya Arogyasathi (AAA) is an organisation working in the tribal district of Gadchiroli since last 25 years. They have considerable experience of working on herbal medicines, woman's health issues, running community

health worker programmes, organizing self- help groups and village level micro planning. In last one year, with inputs from SATHI, Amhi Amchya Aarogyasathi organized Jan Samvad related to health in various villages where it is active.

v. Shramik Mukti Dal-

Shramik Mukti Dal (SMD) has been working in Ajara block of Kolhapur district since nearly last 15 years. SMD has led numerous people's struggles on rehabilitation of dam oustees in south Maharashtra, along with demanding measures to overcome drought and to ensure equitable water distribution. In the last one year Shramik Mukti Dal organized effective campaigns like a demonstration to highlight improper functioning of the sub-divisional Hospital in Gadhinglaj. Similarly they have also organized a Dharna at the block headquarter, demanding that the Health minister should immediately give final sanction to the draft BNHRA rules including patients rights, which have been awaiting for final official approval since July 2006.

vi. MASUM

MASUM (Mahila Sarvangin Utkarsha Mandal) works in 18 villages in Purandar block of Pune District. MASUM focuses on women's health concerns with a feminist perspective and works with a rights based approach to health and health care. During last one year, as part of health rights activities in their area, Gram Sabhas were especially organized to discuss village health issues. MASUM has also organized effective health rights awareness programmes on service guarantees in the NRHM and women's health issues.

In Madhya Pradesh-

Jagrit Adivasi Dalit Sangathan (JADS) is a mass organisation which has been working in Barwani district since more than last 14 years mainly on the issue of forest rights, employment rights and implementation of NREGA, food security and PDS, and also health rights. Over the last one decade, with inputs from SATHI team members based in Barwani, JADS has organized a wide range of community actions related to health. In the last one year, among other actions they organized a large protest to demand resumption of Deendayal Upadhyay Scheme (to ensure free health services and medicines), while community members associated with JADS organized village level programmes to ensure creative utilisation of the village untied fund.

2. Partnerships in the context of community based monitoring of health services-

A. At the national level-

i. **Advisory Group on Community Action (AGCA):** AGCA, as a national group of experienced civil society representatives was specially constituted by the Union Health Ministry to obtain technical and other inputs for implementing community action components of NRHM. In the pilot phase, a SATHI team member who belongs to AGCA has shared insights from Maharashtra CBM model in the wider AGCA meetings. The SATHI team has

worked in close collaboration with PFI (Population Foundation of India) and CHSJ (Centre for Health and Social Justice). PFI has been hosting the National Secretariat of AGCA and CHSJ has been providing technical support to CBM implementation in nine pilot states of the country.

B. In the State of Maharashtra

i. NRHM -Maharashtra

Implementation of community based monitoring in the State of Maharashtra was mainly facilitated through partnership with the NRHM structure linked with the State Public health department. This has led to issuance of various Government circulars and guidelines pertaining to implementation of community based monitoring of health services, and also led to wider institutional support.

ii. Collaboration with District level nodal NGOs-

For implementation of Community based monitoring, SATHI has entered into formal partnerships with five District nodal NGOs. In the span of last one year SATHI team has given range of diverse technical inputs and also contributed to capacity building of District nodal NGOs to implement community based monitoring.

3. SATHI's involvement in Jan Swasthya Abhiyan at national and state levels

The SATHI team was managing the National secretariat of JSA until mid-2008, and one of the SATHI team members is a national joint convenor of JSA. With this context, the SATHI team actively contributes to JSA activities at the national level.

One of the SATHI team members is a co-convenor of Jan Arogya Abhiyan (JSA-Maharashtra) who is supported by other team members. In collaboration with other JAA organizers, the SATHI team contributes to state level coordination of Jan Arogya Abhiyan activities.

4. Collaborations regarding research

Research conducted as part of Health Equity and Rights Watch project was the major research activity of SATHI during period under reporting i.e. year 2009-10.

Establishment of interaction between Public Health experts, Social Scientists and health sector NGOs in the form of a 'Health Equity and Rights Watch' was one of the stated objectives of the project. To fulfill this objective, on one hand SATHI developed official collaborations with academic institutes such as Tata Institute of Social Sciences, Mumbai and on the other hand collaborated with 14 grass root level organisations spread across the entire state. In this way we have been able to inculcate both the academic as well as activist spirit in this project. Building alliances with experienced organisations in both these spheres has certainly enhanced the quality of research. In addition, various experts from the field of economics, gender studies, and

health research have been associated with different activities of this project and their expertise has been sought from time to time.

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 organsiations / 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

दिलासा इन्दौर **मध्यप्रदेश में महिलाओं के प्रति हिंसा और स्वास्थ्य समाधान की दिशा में एक पहल,** २००९, पन्ने.३१

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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.

CEHAT, National conference on emerging health care models: engaging the private health sector, 25 - 26th September 2009, 157 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.

SATHI continues to maintain its ***Library and Information Service*** through a small computerized library. The library contains basic documents, books on health and health care in India, especially related to Public Health; it also receives important reports, journals and magazines on health care. The library serves as a resource center for social activists, journalists, researchers.

The following is a categorization of the contents in the library:

1. Books- 2500
2. Bound Volumes- 186
3. Reference Books- 130
4. Audio Visual Health Awareness Material –121
5. TV News & interviews- 15
6. Periodicals- Marathi-6, English-10; total 16
7. Posters- 10
8. Flex poster exhibitions - 6

The publications brought out with inputs from SATHI during April 2009 to March 2010 are as follows -

Publications in Marathi

No.	Particulars of Publication	Date of Publication
1.	Summary of 'A Report on Health Inequities in Maharashtra' in Marathi	May, 2009
2.	Health Rights Training Manual	March, 2010
3.	Pictorial data collection tools for Village Health Committee	September, 2009

No.	Particulars of Publication	Date of Publication
4.	'Dawandi'- Newsletter published quarterly	Issues 1,2,3 in Sep. 09, Dec. 09 and Mar. 10
5.	Village Sanitation Committee Booklet	March, 2010
6.	PHC Monitoring and Planning Committee Booklet	March, 2010
7.	Health Rights Calendar 2009	May, 2009
8.	Village health services calendar - 2010	Jan, 2010
9.	Training Manual No. 4 for ASHAs (published for Government of Maharashtra under NRHM)	Nov. 2009
10.	Training Manual No. 5 for ASHAs	Mar.2010

- **Reprint of Posters Published for the Community Based Monitoring Project - Aug.09**
  1) Taking initiative on Health Rights
  2) Health Services to be available at the PHC
  3) Community Monitoring of Health Services at the Sub centre level
  4) Community Monitoring of Health Services at the Village level
  5) Key aspects of Public Health facilities to be monitored by Community
- **Reprint of Report Card Published in the Community Based Monitoring Project - Sept.09**
  Village, PHC and Rural Hospital level report cards (All in two color)
- **Flex Poster Exhibitions (each poster 1.5 x 2 sq. ft., 4 color, Marathi)**
  1) Health Rights, 32 posters *
  2) Issues regarding access to essential medicines, 19 posters
  3) Patients' Rights, 15 posters
  4) Anaemia, 26 posters
  5) Women's Reproductive Health, 72 posters

  * (Available in Hindi also)

Publications in English

No.	Particulars of Publication	Date of Publication
1.	Taking Shape – Report of founding years of SATHI	June, 2009
2.	A Report on Nutritional Crisis in Maharashtra	September, 2009
3.	A Report of National Seminar on Health Equity in India	September, 2009
4.	Compiled Report of Community Based Monitoring of Health Services Under NRHM in Maharashtra (2007-2010)	March, 2010