ANNUAL REPORT

PERIOD 1ST APRIL 2011 TO 31ST MARCH 2012

ANUSANDHAN TRUST

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 2011 - 12

RESEARCH (CEHAT)

Maharashtra Human Development Report (2012)

The team from CEHAT prepared a background paper on health which was accepted by YASHADA for the Human Development Report on Health after peer review. The background paper explored health disparities within the state and between districts. It found that the level of inequalities persistent within Maharashtra is unacceptably high. Most public as well as private hospitals are in the cities and in 1991 urban areas had 8 times more hospitals and 13 times more beds than rural areas. However, in 2005 this disparity worsened to 13 times more hospitals and 19 times more beds. In Maharashtra, only 37.5% villages have a Sub-Centre, only 11.4% villages have a PHC, only 42.6% Villages have a health facility, and only 38.9% Villages have a doctor. Data from health programmes indicate that Malaria and TB are emerging as two major threats- Malarial deaths have quadrupled over the last ten years, and urban TB, mostly drug resistant, is on the rise. Nutritional indicators from the state do not paint a promising picture either. In a way this is a reflection of low budgetary priority given to health and nutrition. When taken as the proportion of SDP, Maharashtra is one of the lowest public health spenders in the country at 0.5%. In Maharashtra, variation in infant mortality between districts seem to be associated with the districts economic development. While the central government is giving more budgetary resources to the state, the state government is not reciprocating to the extent necessary, but abdicating its role of contributing more. State Budgets need to be augmented substantially to fully realise health outcomes. For this the state health sector budget needs to be increased substantially. The paper also draws attention to the fact that Maharashtra has one of the largest private health sectors in the country, with which the state is forging partnerships in the form of PPPs. Yet, there is no regulation of the sector. Further, Charitable hospitals who are expected to provide services to the poor too are not doing so. The paper calls for the government to take regulatory action in this regard.

The HDR chapter that deals with health has been finalized and the report will be printed this year (2012). It is hoped that the publication will reorient the health policy in particular and social sector policy in general of the state towards better equity.

Charitable Trust Hospitals Study

Mumbai is a city where partnerships between the public and the private sector have existed in the health sector for a long time, in the form of contracting in facilities. In view of the large concessions and subsidies given to private hospitals run by “State Aided Public Trusts", and in order to formalise already existing loose arrangements, the Bombay Public Trusts (BPT) Act, 1950 in its Section 41AA mandated the Charitable Trust Hospitals to earmark 20 per cent of their operational beds for free and concessional treatment of the poor. Over the last few decades, the nature of Charitable hospitals have undergone tremendous change. Many such hospitals have allied with the private sector and in some cases global healthcare chains. In such a situation, the exclusive purpose of "medical relief" has come under attack, and there has been understandable reluctance on part of the hospital managements to comply with the conditions that earmarked beds for treatment of the poor.

In 2004, a Public Interest Litigation was filed in the High Court of Mumbai, challenging the hospitals that were not providing free treatment to poor and weaker sections. A scheme was instituted by the high court formalising the 20 per cent beds set aside for free and concessional treatment. The ongoing study uses the

data being submitted by hospitals to the charity commissioner's office to assess the level of compliance. The study also tries to find the geographical distribution of these free beds in Mumbai and prepare a typology of charitable hospitals in Mumbai. We hope that the findings of the study would be useful in making key recommendations for effective implementation of the high court scheme, especially for guaranteeing access to the poor to the 20% beds that are set aside.

Study on Rashtriya Swasthya Bima Yojana

RSBY is a health insurance programme which intends to provide health assistance to people living Below Poverty line, with the technical assistance of agencies like the World Bank and GTZ. The beneficiaries are families of workers in the unorganized sector. The scheme provides cashless hospitalization benefit up to Rs 30000/- for most of the diseases that require hospitalization, in specified empanelled hospitals for a family of five members (with no age limit). As an insurance scheme for the poor based on the PPP model, it is hoped that the scheme will eventually make the geographical distribution of health care facilities more equitable vis-à-vis the rural-urban divide. It is visualized that the scope for making profits will make the private sector set up hospitals even in the interior rural areas. Enrolment of beneficiaries as well as empanelment of public and private hospitals is underway. Till date, of the identified 51373696 Below Poverty Line (BPL) families, 21146656 have been enrolled. All BPL families are expected to be covered by 2012. Likewise, across 388 districts of 29 states and union territories, 6148 private hospitals and 2538 public hospitals have been empanelled by various insurance companies taking part in the scheme. 2,354,959 hospitalization cases have been reported across the country, as per the RSBY data management system.

Literature survey indicates that data on utilisation of services according to gender, age, location, type of insurance etc present patterns that need to be looked at closely at a more disaggregated level. Interestingly, the need to have private providers as a unit of analysis has not been addressed by existing studies on RSBY. While most of the studies identify cost-escalation as a great if not the greatest challenge to RSBY’s future, this is one aspect that needs to be explored. The proposed study plans to conduct a review of the scheme which would, at least partially, address these issues. Comparing three states (Kerala, Maharashtra and Chhattisgarh) selected according to different degrees of participation of private providers and comparing utilization, rejection ratios, etc across categories like gender, age, location, type of insurance etc will throw up interesting insights into the working of the scheme, yet unexplored.It is hoped that the outputs of the study will provide evidence that will help the scheme to adapt over time, as is its stated principle.

Health of Muslims in Maharashtra

This project is an attempt to understand the health status of Muslims in Maharashtra, through review of existing studies and analysis of secondary data sources. It seeks to understand the health status of Muslims in terms of morbidity reported by them, utilization of health facilities and cost of health care. Muslims comprise about 10% of Maharashtra’s population and approximately 70% of them reside in urban areas. Within these urban areas, the feeling of extreme insecurity due to growing communalism has resulted in the exodus of Muslims from mixed communities into homogenous ghettoes. The studies conducted by the minorities commission show that living conditions in the ghettoes are abominable, leading to several communicable diseases. The areas seem to be neglected by the municipal corporations - access to clean drinking water and sanitation is extremely poor. There is a dearth of public health facilities in some ghettoes such as Mumbra and Bhiwandi. Where available, the quality of public health facilities is poor and so people prefer to access private health care. However, as the population is largely economically deprived, they cannot afford to access private health care and there is no option but to utilize poor quality public facilities. On the whole in Maharashtra, Muslims fare better than other groups in terms of child mortality rates, but this is because they are largely concentrated in urban areas. Within urban areas, however, they do not fare as well and the IMR is actually higher than other groups. Similarly, most deliveries take place in institutions because of the urban location, but it is important to note that

home deliveries among Muslims do occur even in urban areas. The paper also discusses the behaviour of health professionals in public health facilities that reflect communal stereotypes and biases.
It is hoped that the findings of this paper will provide direction to the Government of Maharashtra's efforts in addressing the needs of this minority population.

Using the Public Expenditure Tracking Survey (PETS) for diagnostic purpose in Health Sector in Maharashtra
The study diagnoses institutional structures and administrative processes pertaining to the budgetary processes in health. This involves determining how the public hierarchy is structured, the roles and responsibilities of various administrative units, the processes of budget planning and implementation, the allocation rules used at the various levels, and the nature of information flows including accounting, reporting and monitoring procedures etc. The study used tracking survey of the frontline service provider and Programmes whose are specifically placed under the Directorate of Health Services (DHS), Government of Maharashtra, such as budget head which includes both curative and preventive care i.e., hospitals (District hospital, sub-district and rural hospital) and primary health care (PHC) under the ZillaParishad. Through semi structured primary data was collected through interview in two districts of Maharashtra.

During the reporting period, fieldwork- primary data collection for the study was conducted in two districts in a phase manner. First phase of data was collected in the month of February-march and May-June 2011, for PHCs, Hospitals, health and other officials of district and below . The remaining data was collected from the two regional health officials and various officials at different level of hierarchy of planning department, Finance,health department after completing the district fieldwork, in the month of August – November 2011. The data collected from the interviews were translated and transcribed followed by manually coding under broad themes using MS word. After the data had been arranged into different relevant themes, analysis of broader institutional and administrative structure guiding the health sector in the state was prepared. This section specifically brings out the context in which the study is placed under the larger head of health budget processes was shared with the IBP,TA for their comments.

During the reporting period, Cehat IBP team held two separate meetings, one with advocacy TA Amitabh Behar and the other with research TA Aaron Katz to discuss issues identified from the study and plan for the extension phase. The field experiences and the findings of the study were discussed with the mentors and experts from IBP which eventually helped to zero-down on the advocacy areas. Advocacy activities have been planned on specific findings emerging from the study. Advocacy outputs in the form of notes/pamphlets/flowcharts have been planned. A summary report in Marathi has also been planned along with two regional level capacity building workshops and engagement with different official for changes.

Intervention research on Sexual assault
CEHAT has been providing crisis intervention services to survivors of sexual assault and training to doctors and nurses at three public hospitals in Mumbai, since 2008. So far, over 100 survivors have been attended to at these hospitals. Data from the case records has been entered into an MIS and analysed to understand the profile of survivors, nature of assault, pathways of reporting to the health facility, factors leading to loss of evidence, relevant examination findings, health consequences of the assault. This is the only evidence of its kind available in India vis-a-vis sexual assault. A report documenting the setting up of the comprehensive health care response has been written up. The data show that a large majority of survivors of sexual assault reporting to the hospital are children below the age of 12 years. The assailant in most cases was a known person, usually a trusted person such as the child's own father, uncle, or neighbour. Often children were lured with promise of chocolates, toys, money or just an offer to play, suggesting that the act was planned and not impulsive as is often understood. It is important to note that a range of different types of assaults was noted - less than half of the cases (45%) reported with completed peno-vaginal penetration (rape). Other forms include fingering, masturbation, attempted penetration, anal

penetration, touching of chest etc.Physical force was seen to be used more commonly among adolescents and adults, rather than children and consequently bodily injuries too were seen more often in these age groups. With regard to medical evidence of sexual assault, it is important to note that only 18 of the 94 (19%) survivors reported bodily/physical injuries and only 36 of the 94 (38%) survivors presented genital injuries. A greater proportion of children (29 out of 51) presented with genital injuries. In contrast, only 5 out of 12 adolescents and 2 out of 16 adults sustained genital injuries.61.8% of survivors had changed clothes, 50% had bathed, 36.8% had douched, 88.2% had urinated and 52.9% defecated. In these cases, even if the survivor had reached the hospital within 24 hours, the chances of finding evidence may have reduced drastically. These findings call for a re-assessment of how medical evidence is interpreted by the judicial system.

An interesting finding that emerged was that in a large percentage of cases, a health complaint resulting from the assault – such as pain in the abdomen, burning micturation, etc, - prompted disclosure. Almost half of the survivors reported to the hospital directly for treatment while the rest of them went first to the police to file a complaint. This underscores the need to recognize voluntary reporting to the health facility, as well as treatment for health consequences. 61 of the 94 survivors reported with some physical health consequence including injuries, infections, unwanted pregnancies. Some had even gone to other hospitals where evidence was collected but no treatment provided. These findings underscore the need to emphasize the role of the health system in providing treatment and psychosocial support to survivors reporting sexual assault. The study shows that with the implementation of the comprehensive health care response at these hospitals, the various components of the health system's role have been operationalised. Specific informed consent has been sought for various procedures, history documentation is thorough, examination focuses on findings related to the assault (rather than recording irrelevant information such as size of the introitus or old tears of the hymen), evidence collection is informed by history, a reasoned medical opinion, based on history and examination findingsis formulated for each case, copies of documentation are provided to the survivor and every survivor receives complete medical treatment and psychosocial support from a social worker.

The findings from this intervention research project will be crucial in advocating for such health system models for response to sexual assault, to be adopted by other health facilities as well. It also points to the need for developing standard operating procedures for health systems as well as other agencies such as law enforcement.

Management Information System for Dilaasa

In order to enable easy, periodic analysis of cases being handled at Dilaasa Mumbai as well as other replication sites, a management information system has been developed. This MIS records 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. In the reporting year, data from the Dilaasa Indore crisis center in MY Hospital was analysed and was included in the report on 'Establishing Dilaasa Indore'. This report documented the entire process of establishment of the crisis center in Dilaasa, challenges faced in setting it up and sustaining it. In the reporting year, case records from 2007 to 2011 have been entered in the MIS. The data is currently being cleaned and will be analysed over the next six months. Research papers on specific themes have been planned, such as looking at pathways through which women access the crisis center, the health system's role in early identification of domestic abuse among women, violence faced by women during pregnancy and women attempting suicide.

Violence against women health workers

The health system has a large number of women employees working in various capacities including nurses, doctors and ayabais. There is evidence from other countries as well as anecdotal evidence that nurses face abuse in the workplace because of their disadvantaged position as well as the nature of their

work. As with any other sector, the Vishakha Guidelines on addressing sexual harassment at the workplace are applicable to health facilities as well, and it is imperative for health administrations to understand and address the abuse faced by women working in their facilities. This study was undertaken with the objective of mapping the different kinds of abuse faced by women health workers within the hospital as well as in their personal lives, to understand the avenues accessed by them to address this abuse, and the barriers faced therein. Focus Group Discussion were held with women workers at different levels including doctors, sister-in-charges, staff nurses, ayabais and maitranis. The findings from the study have been published in the book "In Sexual harassment at workplace" edited by Deepti Deshpande and Nikhil Bhagwat. Nashik: Home Science Faculty of Gokhale Education Society's SMRK-BK-AK-Mahila Mahavidyalaya.

Various types of abuse, particularly sexual abuse were reported by all categories of health workers. Abuse by senior doctors and peers included passing lewd remarks, making sexist jokes, coming drunk to work, asking personal questions about childbirth and sexuality, passing comments on appearance. Nurses reported that labour staff often refused to follow instructions from a woman and would come to the workplace drunk. All categories of health workers also reported facing abuse from patients. They stated that patients would stare at them, undress in front of them to embarrass them, refuse to accept advise from female doctors etc. With regard to reactions and perceptions about the violence faced, the study found that women health workers perceived the violence to be a result of unequal status of men and women within the health system. No matter how educated they were, they felt like they were treated as objects and men wanted to be at the top of the hierarchy. There was also a fear among the respondents that if they complained about the behaviour they would be labelled as intolerant or their evaluation would suffer. So they felt that it was more appropriate to ignore the abuse. Often they did not speak to anyone about the abuse at all. While nurses were reluctant to make use of formal redress mechanisms, they did state that they discussed the abuse with colleagues. Among doctors however, there was no such forum. They were completely unaware of sexual harassment committees that are established in the hospitals.

The study points to the need to for greater awareness among both men and women health workers on forms of sexual violence and women's rights in this regard. Redress mechanisms must be made more responsive and swift.

Development of ethical guidelines for domestic violence counselling:

While several counselling centres are functioning in India and providing services to survivors of domestic violence, there has been no endeavour to evolve guidelines for counselling in DV.After the publication of counselling ethics case book, CEHAT felt the need to take a step forward from the ethics casebook, and began the process of developing ethical guidelines in domestic violence counselling. The aim of these guidelines was to cultivate good practice in domestic violence counselling and educate counsellors on the discourse in counselling ethics. CEHAT invited experts from the field of psychology, social sciences, counsellors, psychiatry and ethicist and formed a committee. The committee consists of : Amar Jesani, Anuradha Kapoor, Jaya Sagade, Manisha Gupte, Prabha Nagaraja, Soumitra Pathare, U. Vindhya, A draft of the ethical guidelines was prepared based on the review of International codes of ethics and our experience of domestic violence counselling at the crisis centre. The guidelines presented the principles and values of feminist counselling and steps in applying the ethics frame work while counselling. In its first meeting held on 24th May 2011, the guidelines, its purpose, objectives and content was discussed threadbare. The committee gave detailed feedback on the draft guidelines. They were revised substantially and presented to the committee again on 4th November 2011. At the meeting there was a debate on whether these should be termed as 'guidelines' or they should be termed 'ethical standards', but it was concluded that as India doesn't have a regulatory body for counselling per se, and adherence to 'standards' cannot be enforced, they should be called 'guidelines'. Individual practitioners and organizations practicing DV counseling need to embrace such guidelines in order to ensure good

Feedback was also received on the structure of the guidelines which are currently being revised. The final consultation for finalizing them would be held in June 2012.

Evolving 'good practice' for responding to attempted suicide at the hospital
Dilaasa's experience has demonstrated that there is a close correlation between attempted suicide and domestic abuse. Several women are admitted to the hospital every month reporting 'accidental consumption of poison', which is actually an attempt to end their lives. Screening of such patients by counsellors has often identified abuse as an underlying trigger for attempting suicide. Based on this experience, Dilaasa evolved a counselling strategy to these clients. This counselling strategy is operational in 2 hospitals in Mumbai where Dilaasa is located. A study was undertaken to understand the existing psychiatric models of response to attempted suicide at other public hospitals in Mumbai. The study was conducted in collaboration with the department of Psychiatry at KEM hospital, to understand the psychiatric response to attempted suicides amongst women facing domestic violence. Interviews were conducted with Associate professors, resident medical officers and heads of the department from JJ, KEM and Rajawadi psychiatry departments on the response of their respective departments to women attempting suicide. The interviews with the psychiatrists clearly brought out that most psychiatrists identify that women attempting to end their lives are facing abuse in their families. However their psychiatric training made them label such women as 'impulsive', 'malingering' and 'attention seeking' without making any connection to the social factors that allow abuse against women. The focus in the diagnosis was always on the woman's capacity to cope or not cope, but never on her stressful and abusive living environment. Most psychiatrists identified that women require counselling services, but felt that it is beyond the role of a psychiatrist to do so.

These findings are to be shared with a consultative group of senior psychiatrists, psychologists and social workers, working on the issue of violence and mental health. The aim of the consultation would be to develop a uniform protocol for responding to attempted suicides amongst women facing abuse. The consultation is due to be held in end of April 2012.

Study on response of hospitals to Terror Attacks
After the terror attacks of 26/11/08 in Mumbai, we had proposed a study to document how public hospitals responded to these situations as they are the ones that are expected to bear the burden of care towards survivors of mass violence. The study is being conducted in collaboration with theCenter for Disaster Management, Tata Institute of Social Sciences.Interviews were conducted with 54 health care providers across the 4 hospitals that responded to the attacks. In this year, the data obtained as part of the study was analysed. Preliminary findings suggest that the response to the attacks did not follow any pre-determined plan. There was no clear definition of roles and providers acted based on their experience. There was little or no awareness of about existence of a disaster management plan, or each providers' role in it. This was true both of hospitals who received victims of the attacks, as well as the hospital that itself was attacked. The preliminary analysis of data has been completed and findings of the study are ready. They were presented to the PDC as well as to consultants at the Center for Disaster Management, TISS. Report writing is under way. The findings of the study will be shared with the concerned hospitals and the health department. We hope that learnings from this study will contribute to strengthening the response of health systems during emergencies such as these.

Research (SATHI)

Project: Maharashtra Health Equity and Rights Watch, Phase – II
Funding agency: IDRC
Team Members- Abhijit More, Nilangi Sardeshpande, Rashmi Padhye and Deepali Yakkundi

The research conducted by SATHI in the first phase of Maharashtra Health Equity and Rights Watch had

brought out certain important findings regarding irrationalities in the private sector such as overuse of injections and high rates of hysterectomies and caesarean sections. Hence, the research undertaken as part of the second phase delves into causations of these trends. Considering that it is not just enough to describe the problems plaguing the current health system in Maharashtra, the second phase activities also include working on solutions towards ensuring equitable access to health care services for the population. Thus, in the second phase we are intertwining research on specific aspects of health care access (including misguided access or irrational care) with policy research on working out and proposing a system for Universal Access to Health Care in Maharashtra, which could be an option to minimise the inequities in access to care and to reduce irrational care.

The three complementary approaches taken in this second phase in order to develop the work on health equity in the state are as follows:

1. Specific research to deepen understanding regarding certain irrational practices by the private health sector (esp. in context of women's health) as they accentuate the health inequities,
2. Concretising models and shaping public opinion and policy towards a regulated system for Universal Access to Health care, as a key strategy for reduction of health inequities and reduction of irrational health care expenditure
3. Capacity building of younger health professionals to create a pool of professionals working on Health rights issues with an equity perspective

Activities:

1. **A qualitative study investigating the phenomenon of 'misguided' access to health care services for women, taking 'hysterectomy' as an illustration of misguided access**

   This primary research activity is also part of the PhD degree of the PI of this project. In the first year of the project, following activities are accomplished.

   i. Literature review on the issue,

   ii. Proposal presentation before the Doctoral Advisory Committee (DAC). On the basis of the feedback received during the discussion, the proposal is being appropriately modified.

Abstract

Gender inequities in access to health care are one of the important concerns in India. Given the biological and social vulnerabilities, women face higher load of morbidities than men. (Sen, Iyer, George 2002; Wingard 1984) This disparity stems in part from the greater vulnerability of the female reproductive tract to infection and the risks associated with childbearing, but is also linked to widespread gender discrimination, especially in South Asian countries (Grown, Gupta and Pande 2005). It is also well known that in India women's illnesses go untreated more often than men's (Madhiwala, Nandraj and Sinha 2000), and that poorer, rural, and lower caste women get sicker more often and receive less treatment than wealthier, urban and higher caste women (Iyer, 2005).

Studies, which have looked into lower utilization of health services by women, have shown that women face various barriers in accessing health services, such as cultural barriers as women feel shy to talk about their reproductive problems (Gittelsohn et. al, 1994) financial barriers as they seldom can decide about spending money for their needs. (Iyer, 2005)

Acknowledgment of women's illnesses by women themselves as well as their family members is one of the first hurdles that need to be overcome in order to get proper treatment for seeking health care for health problems. (Chatterjee M. 1990) Majority of women silently bear the load of reproductive morbidity as they are socially trained to be secretive about the matters related to reproductive organs and at the same time their health needs are ignored by the family members as well. (Das Gupta, Chen, Krishnan, 1995)

In this milieu of lack of access to health care for several women in India, the problem of over-medicalization of different reproductive events of women's lives has also started emerging. Increasing

number of caesarean sections is an important indicator of this trend. NFHS 3 data has shown that one in four women in the highest wealth index group was delivered by caesarean. (IIPS, 2007) With the advent in medical technologies, India is now also becoming a hub for Assisted Reproductive Technologies. (Sama, 2010)

Another such area where surgical interventions are on rise is the treatment of reproductive tract infections. Different studies (Desai, Sinha & Mahal 2011; Kameswari & Vinjamuri 2007; Gopinathan 2006) and some of the news reports are indicating that the number of hysterectomies is increasing in recent years.

Conceptual framework

Present study focuses on understanding women's access to health care taking hysterectomy as an illustration. Till date, various studies have brought out important aspects of women's access to health care such as women's perceptions about illnesses (Unnithan-Kumar, 1999) need for probing in case of morbidity studies understanding women's morbidities (Madhiwalla, Nandraj & Sinha, 2000) and various barriers to health care access faced by women. In India, presently health care is sought mainly from the private health sector and health care expenses are mostly in the form of out of pocket expenditures (NSSO, 2004).

The conceptual framework for the present study would be a combination of the framework proposed by Chatterjee (1988) and the 'access' as concept of fit model proposed by Penchansky (1981). The rationale for combining these two is that Chatterjee's framework would help in understanding the demand side factors which determine women's access to health services such as the need, acknowledgement of need and permission for seeking care. However, in terms of understanding the supply side factors that are the characteristics of the health care system, Chatterjee's framework only uses availability of health services as the indicator. Studying only availability of health services may not give complete understanding of the reasons for which women accessed or did not access a particular facility. Hence, the dimensions of accessibility and acceptability of health services would be added to the Chatterjee framework.

Rationale of the study

The literature review reveals that there are very few studies, which have explored the social aspects of hysterectomy in Indian context. The medical literature points towards the grave consequences of hysterectomy especially if it is accompanied with removal of ovaries. Though there is anecdotal information about the reasons for rising numbers of hysterectomies, there isn't adequate scientific evidence to explain the exact reasons for which women undergo hysterectomy at an early age and whether these decisions are informed decisions based on information regarding the short term as well as long-term consequences of the surgery. In this context, this study is aimed at providing explanations to these questions with in the broader framework of women's access to health care.

Some of the important research questions that this study would attempt to address are-

1. How and when do women acknowledge the need for treatment for the gynaecological morbidities? What are the factors that encourage women to talk about their health needs?
2. How do women's perceptions about menstruation and reproductive health influence the acknowledgement of need for treatment?
3. How do women negotiate in the family to seek health care?
4. What role the family members play, at the time of decision making for hysterectomy?
5. How do women overcome the information asymmetry between them and the health care provider at the time of decision-making before undergoing hysterectomy?
6. How do women take decisions regarding health care expenditure for treatment of their gynaecological problems?
7. What are the consequences (short term as well as long term) of surgery on the physical health of women?
8. What were the consequences of the surgery on their marital life?

Scope of the study

This study exclusively focuses on women who have undergone hysterectomy to decipher the reasons behind acceptance of hysterectomy as a treatment. To understand the phenomenon of hysterectomy in a holistic manner, it would be desirable to include the perspectives of health care providers in the study because to understand the issues related to access to health care services, it is essential to consider demand side factors as well as supply side factors. However, it is practically difficult to incorporate both these aspects in a single study. Hence, for the sake of practicality, currently the study would delimit itself to understanding demand side factors in case of hysterectomy.

Methodology adopted for this study and its justification

This study would be conducted using feminist methodology. Given the topic of research, which is trying to understand how women overcome cultural and financial barriers to seek hysterectomy, this research tries to address the gender relations in the family, taking health care access as the event to understand these relations.

Use of feminist methodology would enable the researcher to understand the gender aspects of access in this case. It would help in understanding how women negotiate within the family despite the low social status accorded to them and seek hysterectomy. The power hierarchy also exists between the health care provider and the recipient of care. Hence, feminist methodology would also be useful in explicating this hierarchical relationship between care provider and care seeker.

In- depth interviews would be conducted as a method for data gathering.

2. **In depth analysis of first phase data to understand:**
   The quality of maternal health services and key related gaps and barriers in context of Maharashtra
   A draft article 'Access to postnatal care (PNC) as determined by socio-demographic factors: A study in Maharashtra' is ready and is being reviewed internally.

Abstract:

Background: India is failing to reach even near to achieving fifth Millennium Development Goal (MDG 5) by lowering number of maternal deaths. An important reason for maternal deaths is infections in the postnatal period. Thus, postnatal care (PNC) is of utmost importance for a woman's health and well being.

Objective: To document differential access in postnatal care across social, economic and regional groups in Maharashtra.

Methods: This study takes into consideration information collected through interviews with 285 women who have delivered in a reference period of two years from 1659 households across ten districts and Mumbai city in Maharashtra.

Results: The percentage of women receiving postnatal care (33 %) is a matter of concern. Out of those who received PNC, differences across demographic and social groups are notable. There are significant differences in percentage of women receiving PNC across rural- urban areas, caste groups and household asset index based groups. Further, age wise and parity wise differences were also seen.

Conclusions: In the study population, socio-demographic factors largely affect women's access to PNC services.

3. **Regional consultation on 'Universal Access to Health Care'**

A High-Level Expert Group (HLEG) on Universal Health Coverage (UHC), appointed by the Government of India in October 2010, provided with the mandate of developing a framework for

providing easily accessible and affordable health care to all Indians. The HLEG officially submitted its report to the Planning Commission of India in November, 2011.

The submission of the recommendations for health care reform came at a time of historically unprecedented opportunity for advancing people's health through the introduction and effective implementation of UHC. There is clearly articulated governmental intent to increase public financing of health to 2.5% of India's GDP as reflected in the Prime Minister's Independence Day address on August 15, 2011, that health would be accorded the highest priority in the 12th Five Year Plan.

As a crucial next step in advancing the agenda of UHC in India, SATHI-CEHAT, PHFI and Tata Institute of Social Sciences has planned to jointly organize a two-day regional workshop on 'Emerging Policy Options for Universal Health Care', on the 10-11th May, 2012 at Tata Institute of Social Sciences, Mumbai, India.

The workshop will be devoted to the HLEG report, along with the related section on UHC in the Planning Commission's steering committee report, and will focus on the possible models/ options and considerations for implementing UHC in various states with specific participation of State public health officials and a wide range of civil society stakeholders.

Preparatory activities for this consultation are going on. Members and Chairman of High Level Expert Group on Universal Health Coverage (appointed by Planning Commission), senior health officials, activists and representatives of civil society organizations from Maharashtra, Karnataka and Gujarat are expected to participate in this consultation. In this consultation, various emerging options for Universal Health Coverage in India would be discussed in detail.

Project: Availability of essential medicines in Maharashtra
Funding agency: IBP initiative of CBPP
Team Members- Nilangi Sardeshpande, Shweta Marathe and Deepali Yakkundi

The work in pilot phase focused on understanding the medicine procurement as well as distribution process in the state of Maharashtra, calculating the budgetary provisions for essential medicines at district level and assessing the overall availability of essential medicines in selected PHCs. Pune district was selected as study area for this project. The main objective of the research activities undertaken as part of this project was to provide evidence regarding the flaws in current drug procurement and distribution system, to support the ongoing advocacy initiatives in order to improve the availability of essential medicines in the Primary health centers in Maharashtra.

Activities:

1. **Assessment of availability of essential medicines in two PHCs from Pune district of Maharashtra**
   67 select medicines were regularly monitored in two select PHCs from Pune district of Maharashtra. Total 6 rounds of monitoring were completed during this period. This regular monitoring exercise revealed that 35% to 40% of essential medicines were completely unavailable in the studied PHCs. Only 25% of medicines were available in satisfactory quantity, whereas overstocking was found for around 10% medicines. It was also found that a significant number of (11 out of 67 selected for the study) essential medicines were never supplied to PHCs. Despite the supply of medicines to the PHCs from multiple sources, some of the medicines such as Inj. Oxytocin, Inj. Phenargan, Inj. Adrenaline and Inj. Methargin were NIL in stock. Due to arbitrary supply from the Zilla Parishad (ZP – District elected body), lack of monitoring mechanisms by ZP, and accepting stock with short expiry from the manufactures, there were

medicines in the stock which had crossed the expiry date. Gross discrepancy between actual stock and stock in register was also observed, which reveals poor documentation, poor record keeping, and lethargic, apathetic attitude of the pharmacists towards management of medicine stock. Subsequently in the month of October and November 2011, a follow up study was conducted in the same PHCs to find out if there is any improvement in the stock of medicines.

2. **Review of prescriptions given in the PHC**
   Case papers of 122 patients who visited PHCs during the period when the availability of medicines was being monitored, were reviewed. To assess the rationality of medicines prescribed, the symptoms reported by the patients were also noted down. Dosage of the medicines was not mentioned in any of the prescriptions. Medicines were being given for only three days as standard practice. In more than 50% of the cases, four to five different medicines were given to the patients and in six cases, two or more than two analgesics were prescribed to the patients which reveals over use of analgesics. Also, Tab. Chloroquine was being prescribed to all the patients who reported fever irrespective of other symptoms.

3. **Exit interviews of patients focused on whether the patients received all prescribed medicines from PHC or were asked to buy it from outside and if any extra charges were taken from patients**
   Around 48 exit interviews were conducted from both the PHCs. The interview focused on whether the patients received all prescribed medicines from PHC or were asked to buy it from outside and if any extra charges were taken from patients. In Malshiras PHC (14 interviews), all the patients were given medicines from the PHC itself. Whereas in Nasarapur PHC (34 interviews), 30% of the patients were asked to bring medicines from outside. Majority of them had to buy needles for injections from outside.

4. **Study of the procurement and distribution system in Maharashtra as well as successful models of Tamil Nadu model, Kerala model, and Chittorgarh (Rajasthan) model**
   The objective of this study was to understand key gaps, bottlenecks and areas of delay in the existing medicine procurement as well as distribution system. Along with understanding the system of Maharashtra, we have reviewed Tamil Nadu model, Kerala model, and Chittorgarh (Rajasthan) model which are considered as successful models of procurement. Information regarding the system in Maharashtra was gathered through review of existing literature and interviews of key informants such as health officials who are currently working in the public health system, as well as former officials at state and district level.

5. **Study of per capita allocations and expenditures for essential medicines in the district and PHCs under study**
   The study attempted to calculate the budgetary allocations for medicines at PHC as well as district and state level, and propose the required budget (per capita drug expenditure) for fulfilling present need and do advocacy for transparent budgetary mechanisms. Access to information regarding budgets for medicines was a major challenge in this study. Some of the important findings that emerged from the analysis of budgets is as follows:
   - In Maharashtra, 11% of total public health care expenditure was on medicines, whereas in Tamil Nadu, it is 15% and in Kerala, it is 17%.
   - At state level, the budget for medicines is around Rs. 27 per capita in the year 2011-12. In Tamil Nadu, the budget is same, however, the prices at which TNMSC procures medicines is significantly lower than in Maharashtra, hence the former can provide free medicines to all the patients who seek treatment from public health system.

   Analysis of information related to budgets at the district level revealed that there are multiple sources for purchase of medicines at the district level. Dr. Anant Phadke, who is senior advisor at

SATHI was appointed as a member of the working group on Drugs and Food Regulation for giving inputs for 12th Five Year Plan. As one of the inputs to this working group, he prepared a note which specifies calculations for per capita budget requirements for providing free of cost medicines in public health facilities. Various budget related exercises done by the team were helpful in preparing this note.

An expenditure tracking exercise in Pune district for untied funds

Building evidence for need for transparency in the fund utilization had been one of the areas of focus in the pilot phase of the project. In continuation with this focus, in the next phase, SATHI has undertaken expenditure tracking of the flexible funds received under NRHM.

One of the specificities of NRHM is that it has made available flexible funds for local level health institutions. At the PHC level, these untied grants are of three different types such as untied funds, Annual Maintenance Grant (AMG) and Rogi Kalyan Samiti (RKS) funds. During the fourth phase of Community Based Monitoring (April 2010 to March, 2011) in Maharashtra, information was gathered for utilization of untied funds in 52 PHCs, utilization of Annual maintenance grant in 50 PHCs and utilization of RKS funds in 52 PHCs. Analysis of this information revealed that untied funds are often being utilized on items which are not allowed as per the guidelines. A considerable amount of expenditure from all the three funds has been spent on miscellaneous and 'combined' expenses which reflects poor reporting and perhaps in some cases inappropriate spending.

The NRHM funds are not routed through the budget of the Health department, instead they are directly transferred from centre to the State health society and from there to the District health societies. Hence they bypass the regular channels of account scrutiny and audit. In these circumstances, it is essential that the civil society is well equipped to monitor the expenditures done using the flexible funds. Otherwise these flexible funds would become one more area for corruption. Hence, in addition to building capacity of the local organisations for monitoring district level procurements, it is essential to develop tools for monitoring of the untied funds. In this phase, we are systematically tracking these expenditures in selected facilities / villages and study the patterns of utilization.

This study is undertaken in Pune district. There are total 75 VHSCs and 15 PHCs covered by CBM in this district. The pattern of utilization was studied in details in a total of 15 VHSCs and 5 PHCs and tracking of funds was attempted in 5 VHSCs and 2 PHCs.

RESEARCH (CSER)

The Practice of Obstetric Care in Mumbai, an ethical analysis

This study was designed to understand what obstetric service providers understand as medical ethics, what they understand as ethical dilemmas and how they negotiate with the same. The study was conducted in 6 hospitals in the cities of Mumbai and Navi Mumbai, across the categories of public teaching hospital, private teaching hospital, corporation hospital, Trust-run, no-profit hospital, and smaller, private maternity homes. The reason for spreading the study across different types of institutions was the assumption that what providers think as ethical issues, what occupy their attention and concern as providers, how they shape their practice and engage with their patients are informed a lot by the type of institution they are working in and the rules and protocols followed by the institution. An important part of this study was to understand how individuals who are responsible for caring for patients, arrive at decisions in the face of constraints and dilemmas.

The study went for a six-month extension in September 2011 and finally got over in March 2012. A total of 62 respondents had been mapped for the study. Coding of data and preliminary analysis was completed by October 2011 and in end September 2011 some of the findings were presented as working papers at

the 12th Asian Bioethics Conference at Taiwan. One of these papers was written up in its final form and submitted to the *Journal of Medical Ethics and History of Medicine*. At the moment of writing the annual report, the paper has been sent out for external peer review by the journal. The study also had its third and final International Advisory Committee meeting over three days in November 2011. The findings of the study were presented to the committee and feedback obtained from them. The study will have two more papers written from the data over the current year. As another output of the study, a one-day case seminar on clinical ethics was organized with some of the respondents of the study at BARC Hospital auditorium. The case presentations and discussions of the seminar are being edited as a book which will get published in the coming year. The network established and developed by the study has been sustained and a couple of follow-up projects are already in the line to be finalized and implemented.
Team Members: Amar Jesani, Neha Madhiwala, Rakhi Ghoshal, Sweta Surve

Biomedical and Health Experimentation in South Asia: critical perspectives on collaboration, governance and competition (BHESA)
South Asia, especially India has become a favourite destination for Biomedical and health experimentation. In this study, we are aiming to explore the relationships between experimental scientific enquiries in medicine and public health, the pharmaceutical industry, the CRO sector and developmental programmes, to assess their impact in South Asia. Using case studies of experimental projects in India, Nepal and Sri Lanka such as research collaborations that connect international researchers with local institutions, personnel and populations, we aim to analyse the networks through ethical, socio-anthropological, political and economic frames.

This project is funded by Economic and Social research council, UK (ESRC). This project is international research collaboration between CSER, University of Edinburgh (UK), University of Durham (UK), University of Tufts (US), University of Colombo (Sri Lanka), and Social Science BAHA (Nepal).
In October 2010, there was an inception workshop held in Mumbai. Team members from the collaborating countries and key stake holders from the clinical research industry, policy makers & regulators, activists were invited for this meeting. Current issues in the field was discussed which led to decisions regarding the objective of the study. Later, the CTR-I database was restructured and used to identify various institutions where a large number of clinical trials are happening.

In February 2011, the team again met to decide on the sampling criteria and the strategy to be followed during the course of research. The project is on-going.

Team- Deapica Ravindran, Anand Kumar, Chitra Borkar, Girish Ingle, Amar Jesani

Clinical trials watch
The CTR-I has been a one point registration for the clinical trials in India. Since June 2009, registration of all trials in India in CTR-I was made mandatory. There has been a leap in the number of trials on CTR-I since then. CSER has maintained a manual database where all the trials on CTR-I were downloaded on a spreadsheet and analysed .The emerging trends are published as Clinical trials watch in the *Indian journal of medical ethics*. So far 3 factsheets have been published. In January 2011, the CTR-I was revamped and hence we had to change our entire database based on this. Thus our latest factsheet, the fourth clinical trials watch, speaks only about the current on-going trials in India.
Team: Chitra Borkar, Deapica Ravindran, Vivian David Jacob

Study of the experiences of professionals and NGOs in implementing monitoring and evaluation and the effects of capacity building of professionals in monitoring and evaluation.
CSER has been working in the field of monitoring and evaluation to build the capacity of non governmental organisations in the field of reproductive health and has been working with Mac Arthur grantees from 2005 onwards. Our close association with the teams in the field and experience of working

with them for designing their projects and monitoring and evaluation systems combined with our interest in the field of public health ethics spurred us to undertake a study reviewing the experience of NGOs and professionals of implementing and institutionalising M&E. The objective of the research study was to understand the experiences of NGOs and NGO professionals who have been training and doing capacity building in M & E for other organisations as well as the experiences of the community based organisations who are actually implementing programmes and those who were trained in M&E for that purpose. The study explored the real-life picture of what works, what does not and what are issues that must be tackled and dealt with in the process. The research also aimed to put in perspective, the cost and gains to the organisation in the process. This study extended much beyond our own work as we were looking at the experiences of organisations from across the country. We strived to ensure a wide enough sample to ensure confidentiality and at the same time generalisability to the findings.

The study started in January 2011 after obtaining Institutional Ethics Committee clearance from Anusandhan Trust IEC. We contacted more than 35 organisations from across the country and finally got approval and consent for participation from professionals from 24 organisations from the 9 states of Maharashtra, Goa, Karnataka, Bihar, Jharkhand, Gujarat, Rajasthan, West Bengal and the national capital Delhi. Data collection was completed in September 2011 and the final report has been submitted to the Mac Arthur foundation in February 2012. The report of the study is to be published by CSER. Papers based on the study will be published. A follow up meeting of the study is planned in June 2012.

The Role of Non-Health System Stakeholders in the Management of Government Run Child Health Programmes through Village Health Sanitation and Nutrition Committees (VHSNC): A Situational Analysis from Gujarat and Jharkhand.

Community participation and ownership are important factors for effective delivery of health services. To ensure community participation, government has constituted Village Health Sanitation and Nutrition Committees at the village level with representatives from health system, Panchayati Raj Institutions and representatives from marginalised sections of the community. The present study conducted in the States of Jharkhand and Gujarat explores the role of the non health system stakeholders in the functioning of the VHSNCs. The study funded by the Indian Council of Medical Research specifically looks at the their role in the implementation of child health programmes. The findings of the study will help in the better implementation of child health programmes through VHSNCs and in developing strategies for community participation.

The study was approved by the Indian Council of Medical Research in November 2011. A provisional approval was obtained from the Anusandhan Trust Institutional Ethics Committee in July 2011 for the study. A detailed proposal has been submitted to the Anusandhan Trust IEC for the final ethical clearance. The study which is of 18 months duration is expected to be completed by September 2013.

ADVOCACY (CEHAT)

Budget Advocacy:

Alliances with the local budget partners, KHOJ and Astitva Sanstha, from Amravati and Solapur districts was developed and strengthened. The partners in both the districts were involved in the research and accompanied researchers for primary data collection and acquiring local budgets. During this process they were able to familiarize themselves with the different offices and the relevant budget documents which can be useful in future to build evidence around the issues/problem identified in these constituencies. Further, a one day orientation workshop was organized on 24 Sept. 2011 at the end of the field work wherein fieldwork observations were shared with the organizations. Around 11 members participated from the two partnering organization. The workshop was facilitated by three officials holding senior position from treasury, finance department and health department. Apart from sharing experiences, the

partners were trained in applying the budget in their activities as well as advocating for changes in allocation in their respective constituencies.

Providing Support to a PIL lodged in the Mumbai High Court by KHOJ

CEHAT has continued its support to KHOJ, the petitioner of the PIL (IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION WRIT PETITION NO.3278 OF 2010), on the issue of malnutrition, child death and livelihood opportunities in the tribal block of Amarati. During the reporting period there were 3 hearings wherein, it was brought to the notice of court about the huge under-utilization of the budget in the tribal department specifically in the ITDP project in Melghat blocks. The vacant sanctioned post of the nodal officer for the tribal block was brought to the attention of the court as well. The court in its order directed the State to appoint nodal officers to coordinate the activities of 6-7 department for the addressing the issues of malnutrition and child deaths. There were also issues related to inefficient functioning of the Public Distribution System.

Concerns raised about user fees in public hospitals

User fee was introduced in India in the 1990s as part of Health Sector Reforms and many studies, including NSSO data show that levying user fee in public health facilities is an important factor that has contributed to the decrease in the utilisation of public health facilities over the last two decades. The broad objective of this study is to map the flow of user fee from collection, deposition, and expenditure of the funds generated by levying user fee in the Municipal hospitals of Mumbai, and understand the process of exemption from user fee and provision of Poor Box Funds to the needy. The study found that a large majority of the poor patients do not access the waivers that are meant for them. The study also found that the decisions regarding user fees are taken arbitrarily, the costs of administration are very high, and long delays are involved in patients accessing care when payment becomes a constraint to access.

The final report was published and a dissemination workshop was organised at Mumbai University on September 7th 2011, where a research brief, based on the study results was presented. The workshop saw participation from civil society activists across Maharashtra involved in work on access rights, researchers, officials as well as people's representatives. The concerns raised in the report have been part of the media advocacy, whereby journalists interested in stories related to health equity and access were engaged and given inputs for their stories. The Report of the User Fee study , the press note and the policy brief that was prepared got prominent coverage in the press. CEHAT is part of the JSA campaign against privatization of public hospitals. CEHAT is invited to present two papers in the National seminar titled "User Charges, Public Health Facilities and Universal Access" organized by Centre for Women's Development Studies (CWDS) and JNU in New Delhi later in 2012.

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

The intervention filed by CEHAT in the PIL in Nagpur High Court, with the aim of ensuring comprehensive and sensitive provision of health care to survivors of sexual assault, continued for the second year. Revised proformas and guidelines for medical examination and treatment of sexual assault survivors were submitted to the court on 7th June 2011. In spite of such close engagement by CEHAT with the committee, theproformassubmitted are not as per the standards set by the WHO. Unfortunately the petitioners did not register any objections to these proformas and therefore the court came to the conclusion that the proformas be circulated for implementation all over Maharashtra hospitals and police stations. Disturbingly, the proformas lay emphasis on injures per se whether in penetrative sexual assault or non penetrative sexual assault. This would provide absolutely wrong directions to a doctor while conducting examinations; thereby it would be interpreted as "no injuries would mean no sexual assault". Analysis of sexual assault cases handled by CEHAT and responded to at the three hospitals implementing the comprehensive health care response to sexual assault dispels the myths around injuries completely. Further the guidelines don't even mention the nature of therapeutic care required by survivors of sexual assault. CEHAT, in response to the court order, filed a review application to draw attention of the

judiciary to the fact that the proformas submitted by the committee do not follow the WHO standards and are also in contradiction with the Indian law. Several efforts were taken to build opinion amongst health professionals, NGOs and civil society on the problems with the state proforma, in the form of consultations. Since the proformas were not on par with the international standards established by the WHO for health care response, CEHAT sought a WHO technical opinion on these proformas and manual and submitted it to the GoM. Efforts were made to involve experts from the field of Medicine, women's rights activists, lawyers, social workers to discuss ways of getting the GoM to understand the problems. A state level consultation was organized at the DHS office on 6 August 2011. Simultaneously a response was filed in Nagpur court citing opinions from Indian experts, civil society, and CEHAT's data on Sexual assault as well as the WHO technical opinion. Despite the agreements arrived upon during the 6 august meeting, the revised proforma and manual submitted to the court prior to the October hearing were unacceptable on the same grounds. Further, unscientific reasons were provided for not incorporating the changes. Petitioners also filed an affidavit levying baseless allegations against CEHAT.

CEHAT filed a response to GoM and petitioner affidavits pointing out gaps in the GOM manual and refuting baseless allegations made by the petitioners. The division bench of judges heard the matter and asked that the GOM to call a meeting with the Intervenors and Petitioners to discuss these differences and arrive at an agreeable proforma for examination and treatment of survivors. The meeting was held in the month of November2011. However until April 2012, no revised proformas have been received from the government.

Abortion and sex-selection

This year saw a series of knee jerk reactions by the GoM as a response to the rising pressure to curb sex selection. The Census 2011 found that the sex ratios have further declined both nationally as well as at the state level. In Maharashtra, the sex ratios have declined in almost all districts making it a state issue and not a regional matter anymore. CEHAT staff has been involved in many ways in responding to these proposals from writing letters to the officials, issuing press statements, working with journalists, amongst others. From proposing that abortion should be considered as murder, to replicating a bizarre scheme like 'Silent Observer' that tracks all pregnancies through software in the ultrasound machines, to seeking permissions for every abortion from municipal commissioner of the city are some examples of such responses. A lot of effort and time was spent by the CEHAT in coordination with the media, civil society representatives to ensure that a strong resistance was built. In September 2011, a committee for 'control of unauthorized abortions' was appointed under the chairmanship of Dr.Sanjay Oak (Dean, KEMH), by the Health Minister. Padma Deosthali from CEHAT was appointed on the committee along with several others including a representative of FOGSI and UNFPA. While most of the recommendations were positive - about increasing awareness of and access to abortion services - there were voices that felt that in the context of falling sex ratios, there should be more stringent monitoring of abortions. Two recommendations were made by the committee in this light – one to preserve photographic evidence of every second-trimester abortus, and the second to make medical abortion pills available only with service providers registered under MTP. Six out of the nine members vehemently opposed these recommendations arguing that it would reduce access to abortion but the Chairperson insisted on making it a recommendation along with dissenting note. A letter signed by all the six members was submitted to the health minister expressing concern over these suggestions. The latest proposal by the GoM is to designate senior police officers as nodal officers at district level for implementation of the MTP and PCPNDT Acts. Both the laws have absolutely no role for the police, the monitoring mechanisms under both the acts are clearly defined. CEHAT staff participated as resource persons for training of the police on these acts and deliberated upon the salient features of the act and emphasized issues such as confidentiality of MTP records, right to abortion for women, barriers in seeking safe abortion, reasons for delay in seeking abortions indicating vulnerability of women. The need for privacy and confidentiality as core to abortion services was underscored.

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

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

As the Asia Regional Focal Point of the IFHHRO, CEHAT has been actively participating in all its activities. IFHHRO, OSI and other NGOs have launched a campaign in 2010 to address certain key issues of human rights violations in health care settings. One of the issues being addressed through the campaign is that of forced and coerced sterilization. In the context of India, it was felt that there is a need to deliberate upon the existing guidelines for sterilizations, particularly to address issues of quality of care and consent. A working group for evaluation of existing guidelines on sterilization was constituted, comprising of gynaecologists, representatives of professional associations (FOGSI), and policy groups working on the issue of family planning in India. Dr. Nikhil Datar(R.N.Cooper Hospital and FOGSI), Dr.Abhijit Das (Center for Health and Social Justice), Dr. Surekha Mehta (Ex-Quality Assurance Committee Convener, MCGM), Dr. SuchitraDalvie (CommonHealth), Dr.P.K.Shah(President, FOGSI), Dr.M.C.Patel (Medico-legal Cell, FOGSI), Dr. Subha Sri (RUWSEC) were invited to be members of the working group in addition to three CEHAT representatives.

The working group met in August 2011 and discussed the existing policies and problems with the guidelines for sterilization. Prior to the meeting, CEHAT analyzed the various circulars on sterilization received from the State government, against national as well as international guidelines such as the FIGO ones. Under the national population program, there is a clear emphasis on female sterilization as a method of contraception, as against other reversible methods or even male sterilization. This raises several issues regarding women's contraceptive choices and the potential for coercion. Analysis of circulars also found that there are discrepancies between the circulars issued by the State, the National guidelines on sterilization, and those of FIGO. Based on this analysis, several issues related to informed consent, case selection, sterilization concurrent with abortion, standards of care, functioning of quality assurance committees and the need for review of guidelines for sterilization were discussed at length in the first meeting. As a first step it was discussed that the FIGO guidelines which addressed some of these issues in a progressive manner should be modified to bring in the Indian context and presented to the FOGSI for endorsement as a policy statement. The FIGO guidelines were reviewed and amendments made, contextual to the Indian scenario. The statement was sent to FOGSI for endorsement. It was reviewed by the FOGSI managing committee and revisions suggested. It has now been resubmitted to them for the next meeting to be held in September 2012.

Advocacy (SATHI)

Project title - Consolidating health rights activities and Community based health capacities (Health rights partnership project)

Funding agency – Oxfam India
Period under reporting- April 2011 to March 2012
Team Members- Dhananjay Kakade, Trupti Joshi, Shailesh Dikhale, Shakuntala Bhalerao, Nitin Jadhav, Bhausaheb Aher, Hemraj Patil, Ajay Viswakarma & Arun Gadre

Project Summary

A. Capacity building and support to selected partner organisations to work as district resource cells on health rights
B. Promoting activities for patient's rights by building a critical mass around this issue in the state

C. Value addition to Community Based Monitoring (CBM) in Maharashtra and promoting processes for wider recognition and support to CBM
D. Developing relevant awareness material and new editions of key publications of SATHI

In the last quarter, following key activities took place under the project- 'State Health Rights Resource Centre -Promoting Actions for Health Rights'.

I. Health Rights activities in collaboration with partner organisations

Partner organizations have conducted following key health rights activities with the guidance and support from SATHI.

1) MASUM- District Pune-

Conducted Arogya Hakka Yatra in 10 villages in Daund and Purandar taluka- 5000 people participated in this Arogya Yatra

MASUM thinks that if rural youth is sensitised and activated towards health rights issues then the process of communitisation of health rights can move forward significantly. With this perspective, MASUM made efforts to tap the youth potential and channelise it for realization of health rights. Yuva Arogya Mandal was formed for this purpose. In order ensure participation of youth in health rights action, MASUM tried to make health rights action more attractive to youth. Thus, idea of Community Video emerged and it clicked well with the youth.

SN	Month	Health rights activity	Process
1	Jan 2012 - March 2012	Organization of youth convention for health rights in Purandar block	*Yuva Arogya Mandal* was formed in Purandar block. MASUM facilitated this process. Subsequently, '*Arogya Hakkasathi Yuva* Melawa' (Convention of Youth for Health Rights) were organised at Saswad and Taloda in the same block.
2	Jan 2012 - March 2012	Development of health rights material in the form of community video, with youth participation in Purandar block	Idea of community health video emerged during Convention of Youth for Health Rights. Bhausaheb Aaher from SATHI oriented these youths about video making. Afterwards with the help of MASUM, young 'activists' recorded interviews of those people whom healthcare services were denied by PHCs. A twenty minute video was prepared and it was used as video evidence during block level Jansunwai organised at Saswad on 27th march 2012.
3	August 2011	Health Awareness rallies in the field areas of MASUM- This was held in three villages of the Malshiras block. In total around 500 people have participated in these rallies.	Objective of these rallies was to make community members aware about their entitlements in the tertiary care public hospitals like Sassoon Hospital in Pune and other facilities like Rural Hospital. Besides awareness about the entitlement in the public health system, range of issues afflicting women's health was also discussed with the community members.

SN	Month	Health rights activity	Process
4	August 2011	Orientation of the media persons regarding community based monitoring of health services took place in Dhalewadi, Waghapur and Pimpari villages of the Saswad block , this was organised by Masum.	For highlighting findings of the CBM process orientation of the media persons was organised by Masum

2) Amhi Amchya Arogyasathi, District- Gadchiroli

SN	Month	Health rights activity	Process
		Two block level Jan Samvad (public dialogue with public health officials) were organised for resolution of public healthcare related issues	1) Nagbheed Block Jansamwad- 24 January, 2012 2) Korchi Block Jansamvad – 16 March, 2012 Information about status of public healthcare services in concerned health centres was gathered. This information was analysed and issues for resolution through public dialogues were identified. Jan samvads i.e. public dialogues with PHC health officials were organised at above mentioned places. **Following key issues were raised during these dialogue processes :-** 1) Gross shortage of essential medicines in all PHCs in the block 2) Vacant posts of ANMs and MPWs 3) Denial of maternal health services especially delivery care in PHCs 4) Non-functional ambulance 5) Improper behavior with patients 6) Absence of staff quarters 7) Absence of ramp and western style toilets in rural hospital for physically challenged patients
2	Jan 2012 - March 2012	PHC level dialogues to resolve problems faced by ASHAs	Four PHC level dialogues (at Botekasa PHC, Kotgul PHC, Deulgaon PHC and Malewada PHC) were organized to resolve problems faced by ASHAs
3	Jan 2012 - March 2012	Monitoring over public healthcare services	Regular monitoring on Vadasa RH & Korchi RH were done by women's self-help group federation i.e. Parisar Sangh
4	May 2011	Village level meetings for review of the expenditure of the untied fund (6 villages)	Social audit of the untied fund- Expenditure of the untied fund was discussed with the community members and issues like transparency and appropriateness of the expenditure was discussed with the community members
5	June 2011	Instances of denial of health care were discussed with the PHC doctors and DHO	

1) Rachana Samajik Punarbandhani Samstha, District- Pune

SN	Month	Health rights activity	Process

1	Jan 2012 - March 2012	Stakeholder’s workshop on Health Rights and CBM	Multi- stakeholder’s workshop on health rights and CBM was organised in Pune on 11th Feb 2012. Representatives from civil society organisations, media persons, activists, public health officials, private medical practitioners, committee members in CBM process and people’s representatives from four blocks of Pune district participated in this workshop. In this workshop, role of various stakeholders in the context of health rights, malnutrition, and community based monitoring and accountability of public health system was discussed. Along with that, discussion was also focused on how to resolve unsolved systemic issues of public health and voluntary replication of CBM process in non-CBM areas.
2	Jan 2012 - March 2012	Dialogue with private medical practitioners on Patients Rights	Dialogue meeting with private medical practitioners was organised at Pirangut on 19th March 2012. Issues like patients’ rights, universal access to healthcare, malpractices in medical profession were discussed with doctors from Mulashi Medical Association. It was decided in this meeting to form a joint forum for patients and doctors. It was also decided to conduct public dialogue programmes to increase communication between medical community and people.
3		Meeting with PHC doctors and ANMs	Meeting with PHC doctors and ANMs for improvement in the PHC services Demanded details about the expenditure of the VHSC untied fund from Sarpanch, Anganwadi worker from 20 villages
	April 2011 to September 2011	Demanded details about the expenditure of the untied fund from Sarpanch, Anganwadi worker from 20 villages.	Since the untied fund is an important resource available at the community level for planning of the health related activities keeping in view local priorities objective was to make untied fund more accessible for ordinary community members and bring transparency in the overall utilisation of the untied fund. A meeting was held in respective villages in which Sarpanch and AWW have participated.

3) Janarth Adivasi Vikas Samstha, District- Nandurbar

Janarth Adivasi Vikas Samstha is active in forming various groups around issue of patient’s rights in Nandurbar district. This organisation was, and continues to be so, initiator as well as moving force behind Shahada Rugna Hakka Samiti(Shahada Patient’s Rights Committee). After Shahada, organisation decided to focus its attention on district headquarter i.e. Nandurbar city. Here also, Janarth is prime facilitator as well as initiator of patient’s rights committee.

SN	**Month**	**Health rights activity**	**Process**
1	Jan 2012 - March 2012	Activities concerning patient’s rights in Nadurabar city	1)Poster exhibition on patient’s rights were displayed in 7 different areas in the Nandurbar city
			2) Visited 10 private practitioners (doctors) in Nandurbar city and had dialogue with them regarding patient’s rights issue**.**

SN	Month	Health rights activity	Process
			3) Organized a meeting with civil society organizations, activists and citizens from Nandurbar city to brief them about patient's rights and to initiate the process of formation of Rugna Hakka Samiti. Subsequently, a training session was conducted for this newly formed Nandurbar Rugna Hakka Samiti, on 26th February 2012. Private practitioners, civil society representatives, reporters, representatives of anti superstition movement- ANS, representatives from Dalit rights groups from the Nandurbar city participated in the training session.
			4) Public meeting was organised by Nandurbar Rugna Hakka Samiti at Nandurbar on 25th march 2012. Issues like patient's rights, universal access to healthcare; irrational medical practice and problems faced by patients in civil hospital as well as private hospital were discussed in the meeting. It was decided that, this Samiti would raise some issues about civil hospital in 27th March Jan sunwai. Possible future course of action was decided in this meeting.

4) Lok Sangharsh Morcha (LSM), Akkalkuwa, District- Nandurbar

SN	Month	Health rights activity	Process
1	Jan 2012 - March 2012	Block level youth convention regarding health rights and community based monitoring	Akkalkuwa block level youth convention on health rights and community based monitoring was organised on 26th March 2012. Youths were sensitised regarding health rights issues, CBM process. Health related problems faced by Ashram- shala were discussed.
2	August and September 2011	Loksamanway Pratishthan has completed review of the ongoing calendar programme in 3 PHCs of the Akkalkuwa block of the Nandurbar District. In this review range of issues that have emerged in the calendar programme were discussed in detail and some of the critical findings regarding regularity of the outreach services was shared with the PHC doctors. During the reporting period health rights awareness campaigns were held in 20 villages of the Akkalkuwa block.	• ANM, MPW, Asha and Anganwadi workers narrated their duties in the village level meetings. • In the 20 villages where health rights awareness campaigns took place issues entitlements mentioned in the NRHM framework were widely discussed with the community members and innovative methods like street play and songs were used to convey health rights messages.

District Hospital Jansunwai by Lok Sangharsh Morcha (LSM) and Janarth Adivasi Vikas Samstha at Nandurbar

For the first time, District Hospital Jansunwai was conducted in Maharashtra. Organisation of district hospital Jansunwai in itself is a challenging task. It requires data collection from multiple

departments, meticulous data analysis and collecting testimonies of denial of healthcare. Based on this groundwork, public health issues were raised. People participated in this Jansunwai in large numbers and put forward their difficulties. Media covered this event quite extensively. On the whole, this Jansunwai was successful in bringing out various loop-holes in the administration of Nandurabar District Hospital in public domain.

SN	Month	Health rights activity	Process
1	Jan 2012 - March 12	District Hospital Jansunwai	**Following key issues were raised during Jansunwai :-** 1)Gross shortage of essential medicines 2)Vacant posts 3)Denial of health services 4)Unhygienic wards in the hospital 5)Improper behaviour with patients 6) Compelling patients to buy medicines from outside 7) Compelling patients to do X-ray, ultra-sound sonography from outside 8) No separate, isolated room for autopsy 9) Demanding money from patients/ their relatives for referral services.

Patient's rights activities - Patients Rights workshop was organized in Nagpur on 16th December 2011, in conjunction with State level protest to demand enactment of BNHRA rules

- SATHI conducted sessions during State level workshop organised on 23 December 2011 by Movement for Peace and Justice regarding patient's rights, private sector regulation and universal health care
- Specific patients rights activities organised in Nandurbar, Akkalkuwa and Rachana trust area in Pune district

II. State level convention against privatisation of key public healthcare services in Maharashtra

Maharashtra Government has proposed privatisation of CT scan, MRI facilities and laboratory services in hospitals associated with 14 Government Medical Colleges as well as privatisation of radiology services in all government run district hospitals in Maharashtra. In order to denounce this disastrous and anti-people move, a 'state level convention against privatisation of key public healthcare services in Maharashtra' was organised in Mumbai on 17th March 2012. Wide spectrum of public health activists, social organisations, doctors and representatives of radiology and lab technician union, labour unions, nurse's federation participated in this convention in large numbers. With the initiative of Jan Arogya Abhiyan, a preparatory meeting was organised for this convention in Mumbai on 19th February 2012. SATHI contributed to the whole process and participated in both these meetings.

--

Name of programme - State convention on accountability of Health and social services
Funding agency – Narottam Sekhsaria Foundation

On 22nd and 23rd November 2011 in a vibrant atmosphere and with a shared vision to ensure accountability of the social sector, over 270 delegates from more than 23 districts across Maharashtra participated in the State convention on accountability of Health & Social services which was organised at Tata Institute of Social Sciences, Mumbai. The convention was co-organised by People's Health Movement-Maharashtra (known as Jan Arogya Abhiyan, state unit of PHM-India), Centre for Rights and Governance, School for Rural Development, Tata Institute of Social Sciences and organisations implementing Community based monitoring of health services across Maharashtra state. The key theme discussed was how to ensure accountability of social services like health care, education, food security,

water supply, nutritional services. The positive experiences emerging from Community monitoring of health services, being implemented as part of the National Rural Health Mission in Maharashtra since 2007, were a key reference point in the presentations and discussions, in which national and state level resource persons participated along with Panchayat members, representatives of Health sector employees unions and civil society organisations.
The SATHI team was centrally involved in the conceptualization, planning and organisation of this convention including managing various aspects of financial management and logistics.

- **Key speakers-** Medha Patkar, NAPM, Aruna Roy and Nikhil De, MKSS, Sowmya Kidambi, Social audit – A.P., Prof. Yesudian, Dean, Department of Health System Studies, TISS and Pradip Prabhu, Dean, Admiral Vishnu Bhagwat, Retd. Chief of Naval Staff, Abhijit Das, Member of NRHM Advisory Group for Community Action; Rakhal Gaitonde, State coordinator – Community monitoring and planning, NRHM Tamil Nadu, Health sector trade union leaders and Panchayat representatives

--

Project title – 'Resource Centre on Maternal Health Rights - Barwani, MP'
Funding agency – AID
Period under reporting- April 2011 to March 2012
Team Members- Dhananjay Kakade, Nitin Jadhav, Ajay Viswakarma, Rakesh Sahu.

Project Summary

Some of the main objectives of the sanctioned project were to work in collaboration with grassroots NGOs and people's organizations, in selected areas like --

- Creating awareness regarding maternal health services and related rights among community members and activists of grassroots organizations.
- Advocating for improved maternal health services and safe delivery care as part of basic health services with reasonable quality, in local public health institutions.
- Influencing health care providers involved in providing maternal health services to improve their behavior and communication with people accessing care, as well as improving delivery of basic health services in selected areas.
- Surveys and Data Collection: Partner organizations would carry out collection of information in their areas regarding the existing status of availability of maternal health services. In these surveys the focus would be on state of actual availability of various services, facilities for patients including investigation facilities, state of delivery related care, availability of specialist doctors, medical officers, nurses, staff and medicines etc.

In the year April 2011 to March 2012, following key activities took place under the project- 'Resource Centre on Maternal Health Rights - Barwani, MP'

1. **Health Rights activities in collaboration with partner organisations.** SATHI **h**as provided Technical support to local Partner Organization Jagrit Adivasi Dalit Sangathan (JADS) in Dist Barwani. Day to day support was given for advocacy at District Hospital, Barwani. Individual cases are looked in to. The activities were mainly in three areas.

A. **<u>At the District Hospital level following activities were conducted</u>**
   1. ***Helped JADS collecting information on-***
      a. Availability of essential medicines in the District Hospital (DH) and in the Female ward.

b. Quality of health services in the Female ward of DH
c. Maternal deaths and their necessary documentation.

2. **Capacity building for** running a help desk at DH. Due to resistance from Government authorities the help desk run by SATHI was withdrawn. Now the helpdesk is run by DH but is just an information center and not really a help desk.
3. **Feeding back the collected information:** Information collected was fed back in to the awareness of the activists and local community pressure was thus enhanced. This helped in improvement in the services to some extent.

B. <u>CHC Pati and Palsud:</u>

At CHC level the activities conducted were in the following areas:

A. Collecting Information on Drug availability.
B. Investigating Maternal and infant deaths and monthly review of the referrals.
C. Facilitating monitoring of the CHC Pati, Palsud and PHCs by capacity building of village level activists through training, and periodic reviews.

C. <u>At the community level-</u>

A. Training on Women's Health was conducted. (assisted by Dr Nilangi from Pune)
B. Village level monitoring of village health and nutrition days (VHND) helped not only for improving the facility, but was also used for disseminating information to the villagers about nutrition, anemia, and care during pregnancy.

2. **Follow up actions related to Barwani – AGCA visit and inputs for PIL.** After the death of Vepari bai, JADS organised major mass protests in Dec. 2010 and Jan. 2011, demanding tangible improvements in the functioning of public hospitals, particularly improved provision of maternal health care. The SATHI team facilitated visits to Barwani by a Jan Swasthya Abhiyan – CommonHealth - SAMA team as well as a team of NRHM-Advisory Group for Community Action (AGCA) members; both teams gave significant recommendations for health service improvement and accountability. Subsequently a Public interest litigation (PIL) was filed by JADS activists in Indore High court, which has further resulted in orders being issued by the court to the State government to draw up an action plan to implement the recommendations of the NRHM-AGCA team.

   SATHI resource team at Barwani followed up subsequent developments. Many gaps are noted in implementation of suggestions rendered by both teams and order executed by the high court. Consistent advocacy is being done to address these issues. The issues are,

   - No new gynecologists have been posted to Barwani District Hospital. Existing gynecologist Dr C K Gupta is still burdened with FP camp duties. One of the two existing pediatricians has been shifted out. No additional doctors have been posted to CHC Pati and now two of the three PHCs in Pati block have no doctor.
   - While the state level team was directed to make monthly visits to Barwani, none have taken place.
   - Order was issued to provide CEmONC services in Sendhwa CH by posting of EmOC trained MO, Anaesthetist and Gynaecologist. It has not started functioning as CEmONC.
   - Maternal death reviews have started. However, there is no involvement of community members.
   - Gross shortage of doctors and paramedical staff persists especially at peripheral facilities.
   - As directed, visits by Secretary and other senior officials every 2 months to ensure systems and processes get institutionalized, have not begun.
   - Some technical protocols for deliveries have been pasted on DH labour room wall. But they are not regularly followed.

- Maternal death reviews are conducted, but collector level review is not being done. No community involvement.
- Help desk is functional at DH but is more of an information center.

Summary of the key activities done in the reporting period are as follows-

In the year 2011-2012, the center at Barwani has emerged as a functional Resource center on maternal health rights. Community activists of JADS have been oriented to handle the emergency situations and to demand proper services with patients' rights perspective. In the last few months the SATHI resource persons needed to visit the District Hospital only occasionally, the JADS activists can manage on their own. The medical officers, the staff at district hospital have become more responsive to the local activists.

Project title- Community Based Monitoring and Planning of Health Services in Maharashtra
Funding agency- National Rural Health Mission, Maharashtra
Period under reporting- 1st April 2011 to 31st March 2012
Team members- Nitin Jadhav, Dhananjay Kakade, Shakuntala Bhalerao, Trupti Joshi, Bhausaheb Aher, Shailesh Dikhale

SATHI's role as State Nodal NGO in implementation of the project in the State of Maharashtra
Besides the existing five districts, in the second phase, the CbM process is now being expanded to eight new districts. SATHI has had a key role in initiating CBM in 8 new districts (Gadchiroli, Chandrapur, Raigad, Kolhapur, Nashik, Solapur, Aurangabad & Beed). Activities were carried out as mentioned in the proposal, in 7 out of the 8 districts (except Chandrapur District)

In Raigad district, the previously selected NGO has been not approved by the Executive Committee of State Health Society. It was decided that for Raigad district SATHI will take responsibility as a District nodal NGO, till the new District nodal NGO is selected.

In the reporting period following core activities have been conducted by SATHI, as the State nodal NGO-

1. State level activities-

1. **State level Training of Trainers** from 18th to 21st April 2011 was conducted in Pune. The representatives of District and Block Nodal NGOs participated in this TOT. After this TOT, the activities were started in 6 districts (except Chandrapur and Raigad).
2. **State level orientation workshop for Health officials from 8 new districts-** This orientation workshop was held on 30th April 2011 in Arogya Bhavan Mumbai. This workshop was attended by the State level officials from NRHM, the district level officials such as Civil Surgeon, District Health officers, representatives of District and Block nodal NGOs which are implementing CbM process. The main objective of this workshop was to give orientation regarding Community based Monitoring process to the district level officials, in order to ensure the active participation and cooperation from Health officials in the concerned districts.
3. **State level workshops for Accountants**- This activity was held twice in the reporting period. The first workshop was held on 7th and 8th June 2011 for the accountants from new 8 districts. The second workshop was conducted on 20th and 21st September 2012 for the accountants from 5 old districts. These workshops have been conducted in the context of maintaining accounts as well as administrative issues related to CBM project. These workshops and meetings helped the partner organisations in getting clarity regarding the requirement and transparency in the overall administrative and accounting requirements of the CBM project.
4. **State Mentoring Committee meeting-** The State Mentoring Committee meeting was held on 20th September 2011 at Arogya Bhavan in Mumbai. This is a forum to discuss issues about process of CBM with State level officials.

5. **State level orientation workshop for Civil Surgeons and RH superintendents**- The State level workshop was held on 22nd August 2011 at Arogya Bhavan in Mumbai. Dr. D.S. Dakhure, Director of Health Services, State level officials and Civil Surgeons and Health officials from 5 districts where Community based Monitoring and planning process is being implemented, participated in the workshop. The main objective of this workshop was to discuss unresolved issues related to the Rural Hospitals, as well as to ensure the participation and cooperation from Health officials especially Civil Surgeons and RH superintendents.
6. **Review and planning meeting with CBM Partner organizations**- It was reported earlier, that the Chief functionary of Anusandhan Trust and administrative staff of SATHI visited each organization to understand the accounts system of each CBM partner organization from 5 districts. In this visit administrative and accounts related concerns had emerged for a few organizations. So participatory review of programmatic activities of three organizations was conducted and the state level meeting was held on 7th July 2011, to discuss mechanisms for proper maintaining of accounts and organising activities.
7. **State level review of accounts and audit of partner organisation –** A total of 29 organisations are involved in the CBM project. During the period from January to March 2012, SATHI has done an audit and accounts review of 26 organisations. A total of 39 review meetings were held with the partner organizations in this regard.

2. Technical support and capacity building of the District and Block nodal NGOs at programmatic and administrative levels –

One of the key components of this project is 'trainings on CBM' at all levels of the monitoring committees in expansion areas of 12 districts. The capacity building process has been broadly at two levels - State level workshops and trainings 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 widely appreciated by the district implementing organizations.

Training - To initiate CBM activities in the new districts, activities taken up include - district workshop for district health officials, district TOT for CBM karyakartas, Block provider workshops in 5 new districts (Gadchiroli, Beed, Solapur, Nashik, Kolhapur). CBM activities in the new districts started in April 2011, and include - district workshop for district health officials in Raigad district and district TOT for CBM karyakartas, Block provider workshops were organised.

Arogya Yatra was held in 9 new districts (Thane, Pune, Nandurbar, Amravati, Osmanabad, Gadchiroli, Beed, Solapur, Nashik). A SATHI team member was involved in conceptualization and implementation.

Data Collection at various levels- Village, Sub center, PHC, RH level data collection was done in 5 old districts and 5 new districts. A SATHI team member was involved in designing of these various questionnaires.

Jansunwais – In the CBMP process after the data collection there is a continuous process, and the issues that come up in the data collection, are raised during Jansunwai. So the process of Jansunwai started from January 2012. 51 Jansunwais were organised in 10 districts in the period from January to March 2012.

SATHI team members were involved in these activities for technical support and capacity building of District and Block nodal NGO.

Project: Availability of essential medicines

Engaging intensively with public agencies to advocate for transparency in budget information at the district and facility level, especially disaggregated data on medicines and untied funds

Demand for transparency in budget information especially regarding the spending of untied funds and availability of medicines is being raised in the public hearings in different districts as part of CBM and in meetings with the NRHM state level officials.

Media advocacy

A press release was issued on the occasion of World Health Day. Through the press release, the demand for providing free health care and adequate medicines in PHCs and RH was put forth. It was demanded that the gross shortage of medicines in Government Hospitals and Dispensaries should be overcome; purchase and distribution of medicines should be radically improved. The flawed and non-transparent mechanism for the purchase and distribution of medicines in the government sector was stressed upon in the press release. The other important demands were to double the budget for medicines immediately and citizens to be involved the monitoring of this system of purchase and distribution of medicines.

National seminar on 'Models and methods for ensuring availability of essential medicines in public health facilities'

On 24th of June 2011, a daylong seminar was organised by SATHI, on 'Models and methods for ensuring availability of essential medicines in Public health facilities'. The seminar was attended by senior level Government officials, health professionals as well as members of civil society organisations from different states. In this seminar, following issues were discussed at length-

A. Drug procurement and distribution systems in different states such as Maharashtra, Tamil Nadu, Rajasthan and Karnataka

B. Per capita budget requirements for adequate medicine availability in public health facilities

III. EDUCATION AND TRAINING (CEHAT)

Course on Health and Human Rights:

The 9th International Post Graduate Certificate course in Health and Human Rights was organised from 23rd Jan to 1st Feb, 2012, at the University of Mumbai. Like previous years this year also the course attracted a large number of professionals and researchers from various parts of India and abroad. The intensive course covered various aspects of human rights and its linkage with health, providing participants in depth knowledge about the various concepts and their practical applications.

Advocate Mihir Desai was the Chief Guest for the Inaugural session. Advocate Desai stressed the need and importance of human rights and how health is an integral part of the entire human rights discourse. He briefly spoke about the history of human rights, UDHR and various conventions. He laid special emphasis on the human rights violations of the vulnerable groups and also spoke about various landmark judgments that have shaped the course of various laws and legislature in the country. He also emphasised the need for such courses and how they develop various skills of the participants.

The faculty for the course was internationally known professionals with vast experience in their respective fields. The methodology for the course was participatory and was highly appreciated by the participants. Apart from various sessions on different topics there was also a field visit to a one stop crisis centre, Dilaasa. It is one of its kind in India which is situated in a public hospital and provides medical,

legal and psychological help to victims of violence (women). The field trip was very well received by the participants and many felt that they could do something similar in and around their work place.

Course on Feminist Counselling:

Feminist counselling as a technique for responding to survivors of domestic violence and sexual violence although found to be effective remains out of the purview of mainstream mental health practice. Therefore, a course on responding to violence against women through Feminist Counselling was developed and run by CEHAT in collaboration with TISS for the first time in April 2011. It was attended by practising clinical psychologists, social workers and educators from all over the country. Adv.Flavia Agnes was invited for the valedictory programme and she gave an inspiring talk. The 2nd course, held in November 2011, was modified based on the feedback from the participants, faculty and course coordinators. 19 participants were enrolled in the 5-day course starting 25th - 29th November 2011 in collaboration with TISS. The course threw up challenges vis a vis engagement with professionals belonging to the discipline of psychology, as it challenged the value-neutral aspects of mainstream psychology and urged the participants to place the onus of abuse on the social environment rather than intra-pyschic features of individual women. The overwhelming majority of participants did see the need for such a course in the graduate and post graduate psychology as well as social work schools.

We are now attempting to see ways and means by which TISS, our collaborative partner can incorporate the 5 day course content into their curriculum. We also aim to write a paper based on the execution of feminist counselling course.

Training on sexual violence:

Hospital based trainings-

CEHAT is engaged in implementing a comprehensive health care response to sexual assault since April 2008. Regular trainings are a key component of our engagement with the 3 hospitals (Rajawadi Hospital, Oshiwara Maternity Home, Bandra Bhabha Hospital) implementing the comprehensive response to sexual assault. Every six months new resident medical officers get posted in the hospitals while the trained ones get posted elsewhere, therefore trainings are critical to induct new health care providers into the components of the sexual assault response. These trainings comprise of understanding forms of sexual violence, health consequences of the same on women and children as well as their role in responding to them. Emphasis is laid on therapeutic role of the HCP's as often their focus is restricted to medico legal evidence collection only.

In the year 2011-12, 5 trainings were conducted at the three hospitals – Rajawadi, Oshiwara Maternity Home and Bandra Bhabha hospital. 63 health care providers were trained in these. An additional joint training was conducted by Dr ShoibaSaldanah who has set up an organisation called Enfold in Bangalore, to deal with the issue of child sexual abuse. The training was aimed at providing health care providers with information and communication skills to dialogue with child survivors of sexual abuse. 26 Health care providers participated in this training program, including lecturers, medical officers, resident medical officers, house officers, and nurses.

National Course on Comprehensive Health Sector Response to Sexual Assault-

In the past year, CEHAT has held two 2-day courses on "Comprehensive Healthcare Response to Survivors of Sexual Assault." The first course, organized in collaboration with Safdarjung Hospital and Sama, was held in Delhi on 1st and 2nd October, 2011. It was attended by 35 participants selected from Delhi and other parts of India. Participants included heads of department, senior specialists, and residents from gynecology and forensic medicine; nurses, lawyers, health administrators, psychologists and social workers. The second, organized in Mumbai in March 2012, was held in collaboration with the Department of Forensic Medicine and Toxicology, Seth GS Medical College and KEM Hospital. The course received an exceptional response from doctors across Maharashtra. Teams comprising of a

gynecologist, forensic medicine specialist, pediatrician and psychiatrist from medical colleges across Maharashtra as well as senior health administrators from other states of India participated, with a total of 27 participants.

The goal of these courses has been to equip healthcare professionals with perspectives and skills to adopt a comprehensive and sensitive approach in responding to sexual assault survivors. They focused on building perspectives and skills amongst healthcare providers on sexual violence, therapeutic role of doctors, dealing with ethical obligations and legal responsibilities, and deposition in court as medical experts. Experts in the fields of gynecology, forensic medicine, law and women's health served as faculty. Through hands-on methods such as role play, live demonstration, case studies and facilitated discussions, participants were equipped with skills for responding to sexual assault. At the culmination of the course, participants shared feeling more equipped in medical examination of sexual assault as well as having developed a richer understanding of legal aspects pertaining to sexual assault. It is expected that after this training delegates will devise and implement uniform, gender-sensitive protocols for sexual assault survivors in their respective health system.

Both the courses received CME accreditation from the Maharashtra and Delhi Medical Councils respectively, demonstrating their relevance to in-service training for post-graduate doctors as well as for incorporation into the medical curriculum for undergraduates.

Training of Health Professionals in New Delhi

Following the 1st National Course on 'Comprehensive Healthcare Response to Sexual Assault Survivors', participants from Dadadev Hospital, Delhi were enthusiastic to implement the SAFE Kit protocol at their hospital and requested CEHAT to provide technical support and guidance.

Following the Delhi High Court Order of 2009, the All India Institute of Medical Sciences [AIIMS] in Delhi is in the process of implementing a similar sexual assault response model in their hospital. They had approached CEHAT to conduct trainings for resident doctors to equip them with necessary perspectives and skills in responding to survivors of sexual assault. Two half-day workshops were planned on the 26th and 27th of May, 2012 for doctors from the gynecology and forensic medicine departments at AIIMS and Dadadev Hospital. The workshop was attended by 100 doctors and nurses from the departments of Gynaecology, Forensics, Emergency Medicine and Hospital Management. AIIMS is currently in the process of developing a protocol for medical examination in cases of sexual assault and in this light, the proforma for medical examination developed by CEHAT was discussed at length during the training. Possibilities of a follow up training were discussed.

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

Revision of the Manual for Medical Examination of Sexual Assault

The manual for medical examination was revised, and new learnings from the past three years were incorporated. In particular, an annexure of data from the implementation of project in the three hospitals was included in the manual. It highlights some of the key findings relating to the large number of survivors reporting voluntarily to the hospital, the range of sexual acts that have been reported, the nature of health consequences etc. The data is useful in dispelling certain myths that health care providers carry. For instance, there is a widely prevalent myth that if the case is 'genuine' then injuries must be present. Data from CEHAT's intervention shows that more than half of survivors do not show genital injuries and 80 percent do not show physical injuries. Other additions to the manual include a pamphlet for health care providers that would help them to provide certain positive messages and address psychological consequences of the assault.

Capacity building on domestic violence

The current team of Training Cell (2011-2012) comprises 68 health professionals which include 10 Doctors, 43 nurses, 2 matrons, and 6 Community Development Officers of hospitals, 2 Ayabais, 2 ward boys, 1 from electric department and 1 is occupational therapist, 1 ICTC counselor.The Training cell has been in existence since the past 6 years and a growing number of Health care providers associating themselves with it. The core groups have been conducting training in their respective hospitals, 1 training on domestic and sexual violence was conducted for the nurses in Bandra Bhabha where nurses were oriented to their role in responding to women facing violence. A similar training was also conducted at Oshiwara maternity home for the nurses. In Cooper hospital, a screening of the film on Dilaasa 'At the Crossroads' was organized by the core group.

Training and Education (SATHI)

Project title- Developing capacities for using community oriented evidence towards strengthening district health planning in Maharashtra state, India
Funding agency- World Health Organisation (WHO)
Period under reporting- 1st April 2011 to March 2012
Team members- Nitin Jadhav, Dhananjay Kakade, Hemraj Patil, Sachin Sathe and Abhay Shukla

The project was started in the month of August 2010 with an aim to build the capacity of members of Block and District monitoring and planning committees including health officials towards facilitating their use of evidence for decentralized health planning in three districts namely Pune, Nandurbar and Amaravati.

Strategies employed in three intervention districts in this project are as follows-

- 'Structured learning course on Health planning', for District and block health officials and civil society representatives from the select districts
- At District and Block levels, practical capacity building of members of District and Block monitoring and planning committees
- Facilitation of processes for inclusion of community based evidence in the district health plan and activation of the District health monitoring and planning committee.

The following activities were carried out in this project in the period April 2011 to March 2012:
I. Commencement (First and second contact sessions) of the structured learning course on evidence based decentralized planning of health services-

- **1st contact session-**

  The first contact session of the course was held in Pune during 26th to 28th of July 2011. Resource persons were invited to orient and carry out perspective building of participants on the

issues like Health Rights, Equity and Gender. Participants were also oriented regarding the existing structure and functioning of the public health system. Besides explaining official structure of the public health system, specific problems and deficiencies afflicting the public health system in the state of Maharashtra and possible mechanisms to remedy the situation were discussed in detail.

- **2nd contact session-**

The second contact session of the course was held in Pune during 8th to 10th of November 2011. The main objectives of this contact session were to build on the first session and to provide orientation about-

- Information related to sources of data which would be utilized in the planning process of health services.
- Detailed information about various flexible funds related to NRHM and guidelines for their utilization.
- Process of preparation of Programme Implementation Plans (PIPs)
- Present issues related to utilization of NRHM flexible funds and preparation of PIPs; to overcome current gaps, what would be the possible role of various stakeholders like health providers, PRI members, civil society organizations, members of Monitoring and Planning committees and Rugna Kalyan Samittee (RKS) members etc.

❖ **Developing Modules for the course on evidence based decentralised planning of health services**

As a part of the course, the following six modules have been developed.

Module 1- Introduction to Public Health Systems
Module 2 - Perspective building and issues of Governance and Health Sector Reform
Module 3 - Social Determinants of Health
Module 4- Community Action for health
Module 5 - Use of evidence for decentralised health planning
Module 6 - District Health Planning

❖ **Study tour to Kerala for the participants of structured learning course-**

As a part of capacity building of the participants of structured learning course, study tour to Kerala was organized from 8 to 18 April 2012. The objective of study tour was to enable Health activist involved in community planning to understand decentralized Health planning in Kerala. A total of 21 course participants participated in this study tour.

II. Capacity building activities and orientation of District and Block Monitoring and Planning Committee members for evidence based health planning

The overall approach of SATHI has been to build capacity of the block and district nodal NGOs to use community level evidence generated through the process of Community Based Monitoring (CBM) of health services. In the same context, a series of block level workshops have been conducted in Amaravati, Nandurbar and Pune Districts. Total 9 Block level orientation workshops/meetings for RKS members and Monitoring and Planning Committee members regarding utilization of NRHM flexible funds at different levels

In these Block level workshops, VHSC members (especially Sarpanches and Anganwadi workers) and non-official RKS members were invited. In these workshops information related to different types of funds, guidelines for utilization and present gaps in utilisation, as well as what could be the role of committee members in strengthening decision making towards appropriate utilization of funds to ensure clear benefit to patients (‘Rogi Kalyan’) was discussed.

III. Facilitation of processes for inclusion of community based evidence in District health plans

Various steps were taken in order to facilitate community based inputs during the preparation of Program Implementation Plans (PIP) under NRHM in specific districts.

The steps were as follows-

1. Identification of issues emerging from Community based monitoring process as an input to preparation of proposals for PIP for coming year. Key issues were identified based on CbMP processes such as data collection, preparation of report cards, Jan Sunwais and CbMP committee meetings etc.

2. Total eight **One day capacity building workshops** were conducted in six intervention blocks from Nandurbar, Amaravati and Pune districts under the WHO supported project on capacity building for decentralised health planning. The main objective of these workshops/meetings has been to share information related to the process of preparation of PIPs under NRHM, and to discuss what could be the role of VHSC members in the different planning processes such as preparation of PIP. In these workshops, there was active participation of PRI members like Sarpanches (village elected representative), office bearers of Panchayat Samiti and Zilla Parishad (block and district elected local government bodies) etc. as well as members of RKS committees, CbMP committees.

IV. State level advocacy workshop with state level officials, resource persons and civil society representatives

In order to facilitate the community participation in decentralised planning of health services, following State level events were organized by SATHI-

- A State level advocacy workshop in Mumbai on 3rd August 2011. In this workshop two National Rural Health Mission - Advisory Group for Community Action (AGCA) members from national level were invited to review the CBMP process in the State of Maharashtra and also interact with State level officials, to emphasis the need for inclusion of community based evidence in the District health plans. District and block coordinators from five districts were also invited for this workshop. Various strategies for inclusion of the community level evidence in the preparation of the official health plans were discussed in this workshop.

- A State level consultation on Decentralised health planning was organised on 19th January 2012 in Arogya Bhavan, Mumbai. The objectives were to discuss national experiences about decentralised health planning, and in this light to discuss with State level Health officials the draft proposals submitted in respective districts by the representatives of civil society organizations. In this consultation, Dr. T. Sundararaman, Director, National Health System Resource Centre presented an overview of concepts and experiences regarding decentralised health planning from various states. Representatives of civil society organizations implementing CBMP in 5 districts and State level NRHM officials, Mr. G. Bhalerao and Dr. S. Pawar, (both Joint Directors, NRHM, Maharashtra) participated in the discussions.

- **Linked with the Community based planning process, meetings have been organised by SATHI with the State Health department / NRHM to enlarge and ensure spaces for decentralized planning-** State level meetings were conducted with State NRHM officials, involving representatives of civil society organizations who are implementing the CbM process. The main objective of these meetings was to understand the process of PIP and steps in the preparation of PIPs, and to discuss what could be the spaces for participation in the present context of planning process. Some letters were issued by State level officials to facilitate processes at local level, including a ***State level circular specifying that a representative of CbMP committee should be invited for meetings of the RKS at PHC and CHC levels***.

Project: Maharashtra Health Equity and Rights Watch, Phase – II

Activity: Capacity building of young professionals through a fellowship programme on Health rights with an equity perspective

The objective of the fellowship programme is to build the capacity of young social sector professionals around themes of community health with health rights and health equity approach, enhancing skills for action linked research, documentation, community action and advocacy in Maharashtra. This comprehensive programme is aimed at providing both conceptual and practical learning experience for people who are exploring opportunities to work in the field of activism and social change.

The content of the Fellowship Programme was delineated after referring to some of the existing fellowship programmes in other parts of the country like the 'Community health fellowship' programme conducted by the Community Health Cell, Bangalore. The reading material included some of the existing material related to community health and health rights. Some new material was prepared and some was translated into Marathi. Selected reading material has been collated for the fellowship programme.

Six fellows were selected out of total 23 applicants for the first batch of fellowship programme. The selection process included a written examination, personal interview and a group discussion. Of the six fellows, three women and three men of age group between 23-26 years were selected. Five out of six fellows were postgraduates in Social work and one was a medical graduate with Public health training. Apart from the six fellows, an additional two candidates (one male and another female) were also selected under special consideration. They both hailed from tribal and disadvantaged communities and had significant field experience but lacked academic grounding. They were selected only to participate in the classroom sessions for about 1.5 months. The field experience of these senior fellows along with academic background of younger fellows was considered a good platform to share their respective perspectives. The training of first batch of fellows started on 6th September, 2011.

The outline of the classroom schedule was prepared according to the objectives of the fellowship programme. For the fellowship programme, resource persons from Pune, Nashik, Thane, Mumbai, Bangalore and Delhi were invited.

On parallel lines, an e-mail was sent to the field based partner organisations[1] explaining to them about the Fellowship Programme, and about the placement of fellows with their organization and the role of Mentorship in the fellowship programme. The details were discussed in a meeting held subsequently. After 6 weeks of contact learning, the fellows finished their first field placement of three months (November 2011 to January 2012). The second phase of fieldwork started in mid-February 2012 and is planned to conclude in May 2012.

Education and training (CSER)

Thematic workshops

i. The Sixth Krishna Raj Memorial Lecture on Contemporary Issues in Health and Social Sciences was organized by Anusandhan Trust with its centers, CSER, CEHAT, Mumbai and, SATHI, Pune and Tata Institute of Social Sciences on 'An ethics for public health in India' by Dr Yogesh Jain (Jan Swasthya Sahayog, , Chhattisgarh), 3rd March 2012 at Tata Institute of Social Sciences. The lecture focused on the public healthcare intervention and the ethical barriers in its implementation. This lecture was attended by nearly 80 participants from different walks of life from the city. This lecture

[1] As part of Health Rights work, SATHI has developed regular partnership with around 6 to 8 organizations who are working on health issues in different parts of Maharashtra.

was video-graphed and has been made available on youtube. The lecture transcript has also been converted into a written report and will be published.

The speaker focused on the seamless connection between the ethics of medical practice and public health. Speaking from his experience of working in one of the poorest, most backward areas of the country, he illustrated the impact that callous policy-making and programme planning and implementation had on the lives of the poor communities in rural Chattisgarh. Using examples from nutrition, tuberculosis control and malaria, he graphically brought out the extent to which policies and programmes had ignored the realities of people's lives and also violated the principles of good science. He raised a larger moral question about the legitimacy of a system where those who are not connected in any way to the reality of these communities and who have never had the experience of poverty and hunger make all the decisions about where resources should be allocated and what kinds of strategies should be employed. He called for an ethics of public health which would be centred on the rights of the people and the moral obligation for caring for the patient that is central to medical ethics.

The lecture was attended by about 80 participants, which included students, health activists and health professionals from different parts of Mumbai. The lecture was followed by open forum, where participants were able to interact with the speaker.

ii. A one day case seminar was organised in collaboration with the ICMR-NIH Bioethics Programme and BARC hospital on 25th March 2012. 14 practicing doctors from different specialties and with different levels of experience presented cases which posed ethical dilemmas from their own practice. They were drawn from a range of institutions including AIIMS, St John's Hospital, Bangalore, Manipal Hospital, BARC Hospital, Bhopal Memorial Hospital, BARC Hospital, D.Y.Patil Hospital and Kamlesh Hospital. This event was organized at the BARC Hospital, Mumbai. This was also an opportunity for resident students at the BARC hospital to participate in the event. In all, there were 25 participants. The case seminar was extremely successful. There was very rich discussion with diverse viewpoints being expressed and argued upon. The entire event was audio-taped and transcribed. Upon reading the transcript of the seminar, it was felt that there was actually there was enough material to produce a case book. We contacted an experienced editor for this task. She was of the opinion that, in order to convert these seminar proceedings into a case book, certain cases would have to be re-reviewed by experts and commentaries obtained from them. This task will be undertaken upon availability of additional funds.

The seminar was unique, in many ways, because of the diversity of the participants and the range of ethical dilemmas that were discussed. The participants came from the fields of gastroenterology, pediatrics, obstetrics and gynecology, oncology, anesthesia, general surgery and public health. They were also diverse in age and experience, including heads of departments, senior consultants, researchers and students. Consequently, the range of issues that were discussed was also extremely diverse. They include the dilemmas of communicating poor prognosis to relatives, dilemmas related to obtaining and executing 'do-not-resuscitate' orders, dilemmas related to proxy decision-making, dilemmas related to routine use of pre-natal diagnostic tests v/s cost containment, medical teachers' concerns about allowing surgical residents to operate independently, concerns related to treatment of multi-drug resistant tuberculosis among chronic defaulters, the ethical problems related to 'cut practice' and the dilemmas of providing palliative treatment to patients with terminal cancer.

The seminar was also unique for the environment of candour and co-operation that it generated. Usually, clinical ethics meetings tend to focus on scandalous violations or on defending the medical profession. The discussion is often too general and rarely focuses on the substantial issues at hand. In this meeting, it was remarkable to see that presentations made by heads of departments and by

medical residents were given equal attention and that attention remained focused on the issue rather than the presenter. As the participants were also themselves presenting cases, there was a unique mutual respect between presenters and audience. It was very heartening to see that the seniors did not talk down to the students, just as the audience did not hesitate from commenting on cases presented by them. One case study presented by the BARC residents was based on the history of a patient currently admitted in the hospital. They had brought this to the seminar to ask for suggestion on the line of treatment that they should adopt. The senior doctors in the audience dealt with this case study discussion with a unique sensitivity. This seminar also included two case studies from the realm of public health, specifically dealing with the interface between medicine and public health. Such discussions are usually absent in medical meetings. The kind of cases presented (one on MDR TB and the other on 'cut practice') helped to broaden our understanding of the clinical ethics case study. The fact that clinicians could appreciate the ethical content of these cases and relate them to their everyday practice was revealing.

Training programmes

i. CSER researchers also participated in a theater workshop organized by Ms. Radha Ramaswamy from the Centre for Community Diaglogue and Change, for students and faculty of KEM hospital, other professionals from the Brihanmumbai Municipal Corporation and other institutions. Two researchers from CSER attended a week long training-of-trainers workshop being organized by the same group in early June. This came about due to our continuous interaction with the Mumbai Medical Humanities Group, which is an informal network of interested medical teachers, students and other professionals, which is making efforts to initiate a medical humanities programme in Mumbai. This interaction has been quite fruitful as the group includes several faculty, ex faculty and students of KEM hospital, where a formal medical humanities cell has been instituted.

   A group of trainer/facilitators based in Mumbai has been formed. They meet regularly every month and organize short training sessions for different groups. This group has planned to institute a regular programme using the 'theatre of the oppressed' (a specific methodology based on the work of Paulo Friere and Alberto Boal) to explore ethical and social concerns with medical students in different teaching hospitals in Mumbai.

Bioethics case-books

i. A manuscript of the research ethics case book with 57 case studies is ready. These case study book has been co-edited by Amar Jesani, Mala Ramnathan and others. Seven writers have contributed cases to this book. These case studies are enriched by the fact that they are based in real-life incidents, most of them drawn from the writers' own research experience. This is the first book of its kind to emerge from India, which takes into account the peculiarities of ethical problems in this cultural and social context.

   We approached a publisher Byword Publications and have finalised an agreement for publication. This case-book has also been peer-reviewed. We expect that it will be released by December this year after the publisher has been handed over the manuscript. The case book has been divided into different sections thematically. Each case is cross-referenced so that users may use the same case in different contexts. For e.g. a single case may be used to discuss ethical dilemmas in research on women, HIV/AIDS and in qualitative research, depending on the context.

ii. As discussed above, a case-book on clinical ethics is being developed from the transcript of the clinical ethics case seminar. A professional editor has been contacted to undertake the editing of the material, inviting reviews/comments as required and prepare the clinical ethics case-book.

Training manuals and patient education material on breast cancer

i. Nishu Singh Goel was awarded a Senior Fellowship to develop a self-help manual for survivors of breast cancer, their care givers and healthcare professionals. The CSER team initiated this project by undertaking formative research on the copings and concerns of women surviving breast cancer in collaboration with the Department of Surgery, BARC Hospital. The formative research formed the basis for developing the manual, so that it incorporates the views and experiences of women themselves and is not simply based on expert knowledge. In order to develop this manual, members of the support group for breast cancer survivors at BARC Hospital were approached. Those who volunteered to participate in this process were contacted and they interacted with Nishu Goel and the CSER team. In addition to them, the team also interacted with patients and healthcare providers in other hospitals. A summary of the research process is given below:

The manual is divided into 5 sections, which deal with different aspects of breast cancer. This includes an information section, a section on dealing with diagnosis and treatment, a section on effective coping strategies and rehabilitation (finding the X factor), a section for caregivers (husband, children, relatives and friends), a section on dealing with relapse, recurrence and death and a section on reaching out to others in need of support. The process of development of the manual was very unique in that it involved survivors themselves, their caregivers and also the medical professionals involved in cancer care. There was a very intensive discussion on the approach to be adopted in the manual, its audience and its objective. This experiment of bringing lay and professional perspectives and the patients and providers concerns together was very educative and insightful.

The draft of the manual is ready. The design of the manual has also been finalized with an evocative cover and section seperators. The content has been peer-reviewed by doctors from BARC hospital, Tata Memorial Hospital and Nanavati Hospital as well as a spectrum of women who are breast cancer survivors. Both the above hospitals have expressed interest in reproducing the manual and using it in their hospitals. In order to ensure the accuracy of information as well as relevance to women and their caregivers, before bringing out the final edition of the manual, one more round of peer-review and copy-editing will be undertaken.

Fellowships in bioethics

i. As reported earlier, a senior fellowship was awarded to Nishu Singh Goel for development on patient education material and caregivers' manual on breast cancer. Ms. Goel is a counsellor affiliated to the Tata Memorial Hospital and Nanavati Hospital. She is also a yoga teacher. She has vast experience of counselling, particularly for cancer survivors. She has been involved in research on the therapeutic effects of yoga for cancer patients at the Tata Memorial Hospital. The work that she did as part of the fellowship is described above. Nishu was awarded a fellowship from march to June 2012. However, she began discussions and preliminary work on this project late last year. She attended support group meeting, consulted various medical professionals and patients and also held extensive discussions with the CSER team as a preparatory work for the fellowship. Her ideas for the structure of the manual were based on these discussions. During the fellowship period, she interacted with patients, their caregivers and providers with a specific focus on the sections of the manual.

ii. We announced a fellowship for production of audio-visual material in December 2012. We received 17 applications. A two member jury consisting of Amar Jesani, editor, Indian Journal of Medical Ethics and Urmila Thatte, head of department, Clinical Pharmacology, KEM Hospital was appointed to review the applications. Following a two stage selection process, the fellowship was awarded to Khushbu Ranka for making a film on clinical ethics. While Khushbu and her team were accomplished film-makers, they did not have an extensive knowledge of clinical ethics or the nuances of the issues. Thus, we facilitated their interaction with a large number of doctors, health activists and others over the period from February to June. They went through a multi-stage process of finalising a story idea,

developing a story board/script and, finally, shooting and editing the film. They were closely mentored by Dr Nobhojit Roy, practicing surgeon and palliative care specialist. The decided to focus on the complex issues involved in intensive care. The 18 minute film titled 'On Certain Days' describes the dilemmas faced an intensive care specialist working in a govt. Hospital ICU. It explores various other issues such as torture in police custody, gender-based violence and proxy decision-making. The film has an ensemble cast of trained actors and doctors/nurses/residents and has been shot on location in a government hospital. The format of the film has been designed to facilitate the use of the film for training purposes. This film will uploaded online and would be available as a free download. We also intend to use the film with real-life audiences to assess its utility as a training tool.

iii. A group fellowship (junior) was awarded to 8 M.D. students of the G.S.Medical College (KEM Hospital) to conduct a study on undergraduate and post-graduate students of their institute to elicit their views about medical humanities (appropriateness, modality of teaching, duration of curriculum and present involvement in the arts and other cultural activities). These students belong to the preventive and social medicine and psychiatry departments. As this was designed as a formal research study, it was reviewed by the multi-institutional ethics committee for Anusandhan Trust as well as the research ethics committee of KEM Hospital. Medical humanities is a compulsory subject in medical education in most developed countries. Its objective is to sensitise medical students through the use of arts, social sciences and philosophy. This course gives them a better understanding of society and culture, betters skills for expressing their feelings and communicating with patients. It teaches them empathy and lays the foundation for ethical professional behaviour. These students will be conducting the study under the guidance of Dr. Padmaja Mavani, Associate Professor, Dept. Of Gynecology and Obstetrics, K.E.M Hospital. The start of the study was delayed due to the fact that KEM ethics committee did not meet as scheduled. The CSER team mentored these students, helped them to develop the research tool, helped them to plan the fieldwork and in data analysis. This fellowship serves a dual purpose of generating much needed evidence on students' views on medical education and the need for medical humanities and also of providing the necessary background information to KEM hospital to design its own medical humanities curriculum. G.S. Medical College has set up a medical humanities cell, of which Dr Padmaja is a member. The decision to plan this as a formal study and go through an institutional process of obtaining ethical approval and departmental permission was laborious and delayed the study further. However, the students have completed 60 percent of the fieldwork and have begun the process of data-entry and editing.

iv. Maithreyi M.R., who was awarded a senior fellowship has submitted her report documenting the history of the bioethics movement in India. The report has been peer-reviewed and prepared for publication. She has also obtained the necessary permissions from participants for using segments from their interviews. The report is an oral history account of the different strands within the health field which have contributed to the development of bioethics in India. It covers various institutions, networks and individuals' work. It is titled "Towards a History of Bioethics in India; Mapping the Field"

Secretariat of the Anusandhan Trust Ethics Committee

CSER serves as the secretariat of the Anusandhan Trust Ethics Committee. During this year, in a significant development, the ethics committee became multi-institutional with two health organisations, SNEHA and Sewa Rural seeking affiliation. During the year, apart from organizing the reviews of applications, the IEC Secretariat worked on the revision of Standard Operating Procedures and Checklists. It also facilitated discussion among the organisations seeking affiliation on the terms of reference and organizational arrangements. The procedures of the IEC were also made more systematic with revision of the certificate formats, minute-keeping formats and the drawing up of an annual calendar. In the coming year, the IEC will be formally become a multi-institutional ethics committee. We are also

pursuing the process of seeking accreditation with FERCI, which is a regional federation of ethics committee members.
IEC Secretariat: Neha Madhiwalla, Chitra Borkar

INTERVENTION AND SERVICE PROVISION (CEHAT)

Crisis intervention services for survivors of sexual assault

We responded to 29 new cases in the reporting period, of which more than half were children. Crisis intervention services including psychological support to the client and her parents, safety assessment, interfacing with the police, etc have been provided to all clients. We have also continued to assist doctors in conducting the examination and provide support to survivors. Particularly, during this period, we have started receiving more number of FSL reports and doctors have been provided inputs in drafting final opinions. We have also secured conviction in one case that we received in October last year. In this case we were able to provide the survivor whatever support she required in order to pursue the case, including helping her move to another locality due to threats from the abuser. We prepared her to depose in the court and also dialogued with the PP regarding her case. We also worked with the doctor to ensure that he was able to testify and explain the medical evidence properly in her case. All of these factors helped in securing conviction.

One of the challenges to sexual assault has been that women do not follow up. After examination and treatment at the hospital level, most survivors are unable to come for follow up counselling. This is especially true when it comes to parents of sexually abused children. Often this has to do with their economic conditions. Some cannot afford the cost of travel. Coming for counselling also means that they would have to accompany the child; this would therefore mean loss of daily wages. Parents are not extremely comfortable with home visits as they fear that neighbours who may be unaware of the incident would enquire as to why the hospital people came to their residence. This often restricts our communication to telephone communication. Information is provided to parents about ways of dealing and comforting the abused child, the fact that she may have certain physical symptoms such as pain in urination, defecation and how to manage those, feelings of anxiety, sleeplessness, fear of being left alone, remarks from peers or community and how to enable the child to overcome them. However the recently declared compensation scheme for survivors of rape has enabled at least a few survivors to follow up with us. One of the reasons is that the economic compensation can offer them concrete support to relocate to another place, seek medical help from other sources, and enroll in to skill building program. The scheme is only valid for rape survivors of 2011. We have filed 6 such claims and submitted them to the women and child department.

Specific challenges have been faced with police during this period, particularly with filing of cases. Police have refused to file FIR under section 376, have detained survivors for hours at the police station before filing an FIR, have insisted on multiple examinations and the like. Our interventionists have had to help the survivor negotiate these problems at every step. This callousness of the police is a cause of concern and we have letter stating the problems has been sent to the DCP to take action. This requires some action from the higher authorities and points to the need to develop standard operating procedures for the police as well.

Standard Operating Procedures (SOP) for Sexual Assault Response at Hospitals

At the 3 hospitals where the comprehensive health care response to sexual assault is being implemented by CEHAT, a need emerged for standard operating procedures to guide hospital administrators and examining doctors in managing care for survivors of sexual assault. In response to difficulties that survivors encountered at these hospitals, which sometimes resulted in examination/treatment being delayed or denied, draft guidelines were prepared by CEHAT. The guidelines encompass provisions

related to treatment, admission, free care, informed consent, police intimation and so forth. These will aid providers to adequately address the needs of survivors as well as meet procedural requirements. Feedback received from doctors in the SAFE Kit trainings reiterated the need for such guidelines.

The Savitribai Phule Gender Resource Center (SPGRC), a BMC initiative is established to address violence against women. A draft SOP was prepared by the team and shared the Savitribai Phule Gender Resource Center to assess the feasibility of implementing these in all MCGM hospitals of Mumbai. A presentation on the SOP was made to the SPGRC who endorsed it. They approached the Additional Municipal Commissioner (AMC) for its implementation. The AMC (City) approved the SOP and it is ready for implementation. This SOP will hopefully bring in uniform protocol in responding to Sexual Assault cases in at least the Municipal Corporation hospitals.

Dilaasa, Crisis Intervention Department

The Dilaasa department in Bandra Bhabha Hospital has successfully completed 11 years. In the year April 2011 to March 2012, 201 new cases were registered in the centre. The proportion of cases referred from the hospital has reduced and this points to the need for continued capacity building training in the hospitals so that health care providers refer women facing abuse to the centre. 352 follow ups and 68 legal consultations were provided as well. In Kurla Bhabha hospital, 74 new cases were registered, there were 49 follow ups and 15 legal consultations. The crisis centre also continues to counsel women, who have consumed poison and deny a suicide attempt, they maintain that this was accidental. However counsellors make efforts to strike a dialogue about the impact of such consumption on their health and try and make efforts so that such women in denial come back to seek support. A total of 96 such women were counselled but not registered. The Dilaasa crisis centre continues to receive students and visitors from the discipline of social work, psychology and also nursing schools. Students from SNDT and TISS have been posted as interns at the centre. The Bhakti Vedanta College of Nursing also organized a field visit for their students to the Dilaasa crisis centre, in order to provide them exposure to the issue of VAW as a public health issue. The centre also received other forms of recognition this year. It was featured by Futures Without Violence as a model for responding to DV through the health system, during the 16 days of activism in November 2011. It was also featured in the television program Satyameva Jayate where in the project director spoke about the health consequences of domestic violence and the health system as a site for intervention.

Replication of Dilaasa in Shillong, Meghalaya

CEHAT collaborated with the North east network (NEN) to undertake the setting up of a hospital based crisis centre in Shillong. The centre has started functioning and NEN has been provided a room designated for setting up the crisis centre at the civil hospital in Shillong and a clinical psychologist was deputed to provide the required services to women survivors of violence. CEHAT dialogued with the NEN to depute staff from both the hospital as well as NEN to participate in the national course on feminist counselling to respond to the issue of Violence against women. One member from NEN and 1 counsellor from Ganeshdas hospital participated in the 5 day intensive course on feminist counselling, which was aimed at building an understanding on the issue of violence against women and understanding concepts linked to violence such as patriarchy , gender and others and finally actual hands on counselling sessions. Following this, two more trainings were held on counselling women facing violence, for a group of 20 clinical psychologists and social workers from all over Shillong. These were three day trainings that addressed concepts related to gender and violence as well as built skills for responding to survivors of domestic and sexual abuse through use of methods such as case discussions and role plays.

Collaboration and Networking (SATHI)

As indicated in the various project related reports, SATHI is involved in a wide range of collaborations as part of its work. Some of the major collaborations are as follows:

- **Community based monitoring** – SATHI is partnering with 14 district and block nodal NGOs in the 5 pilot phase districts. Similarly there are 17 organisations in the 8 new CBM districts where SATHI has initiated partnerships.
- **Health rights partnerships** – As mentioned, SATHI is partnering with 6 organisations in Maharashtra and one organisation in Western M.P. as part of this project.
  Further SATHI is collaborating with 3 organisations for ASHA support and advocacy activities.
- **Decentralised health planning** – SATHI is collaborating with 6 organisations across three districts for capacity building related to decentralised health planning activities.

SATHI continues to be an active constituent of Jan Arogya Abhiyan (JAA) and SATHI team members contribute to JAA activities outside their project work. A SATHI team member is one of the co-convenors of JAA.
SATHI also continuously involved with Sasoon Bachao Samittee with various other activists in Pune city.
A SATHI team member continues to be one of the national joint convenors of Jan Swasthya Abhiyan.
A SATHI team member is a part of the NRHM Advisory Group for Community Action (AGCA) which includes prominent Community health activists from different parts of the country, this forum provides regular opportunities for exchange and networking with various health activists as well as interaction with NRHM at national level.

DOCUMENTATION AND PUBLICATION (CEHAT)

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

Promoting the Library and Documentation Unit Collection : This year we have put in efforts to promote the collection of the Library and Documentation that includes Online catalogue, research studies/resources available on CEHAT website to others organizations, individuals, students, institutes and academics apart from the old contacts through e-bulletin, group mails to target audience and other web-based tools.

The research area webpage was revamped so that the user can access the resources at one glance. If a user is looking for material on specific Research area it is easier to get all research project listed under that area with links to all the publications i.e. reports, paper/articles and resources material developed under that research area. http://www.cehat.org/go/ResearchAreas/HealthServicesandFinancing. A webpage on Domestic Violence (http://www.cehat.org/go/DomesticViolence/Home) was developed which gives details about the work done by CEHAT in this area and links to various resources.
E-bulletin: We have put together two e-bulletin one on Domestic violence http://www.cehat.org/go/uploads/Library/ebulletinAugOct10.pdf) and Health budget. The domestic violence e-bulletin is published and circulated to target audience and the health budget bulletin is ready for dissemination.

Literature Lists: Literature lists on Health Economic and Financing, Research Methodology and Public private partnership were put together and circulated to the internal staff whi9ch are now available in the unit.

Publications

Reports

1. Kurian, Oommen C.; Wagle, Suchitra and Raymus, Prashant. Mapping the flow of user fees in a public hospital. Mumbai: CEHAT, 82 p., 2011 [ISBN : 978-81-89042-58-5]
2. Contractor, S., Venkatachalam D, Keni Y, Mukadam R. Responding to sexual assault: A study of practices of health professionals in a public hospital. Mumbai: CEHAT and New Delhi: SAMA, 58 p., 2011 [ISBN: 978-81-89042-57-8]
3. Manual for medical examination of sexual assault. Revised edition. Mumbai: CEHAT, x,64 p., 2012 [ISBN: 978-81-89042-59-2]
4. Pradhan, Anagha and Shaikh, Tayyaba. Living on the Margins: Prawn Harvesters from Little Rann of Kutch (An Exploratory Study of Health Status). Gujarat: Anandi and Mumbai: CEHAT, 114 p., 2011 [ISBN: 978-81-89042-56-1].

Articles

1. Kurian, Oommen C. "Charitable Hospitals: Charity at Market Rate" Economic and Political Weekly, 47(39) September 29, 2012, pp. 23-25
2. Deosthali, Padma and Rege, Sangeeta. :Violence faced by women health workers" In Sexual harassment at workplace edited by Deepti Deshpande and Nikhil Bhagwat. Nashik: Home Science Faculty of Gokhale Education Society's SMRK-BK-AK-Mahila Mahavidyalaya, 2012, pp. 104-112.
3. Bhate-Deosthali, Padma; T K Sundari Ravindran and Vindhya, U. "Addressing domestic violence within healthcare settings: The Dilaasa model" Economic and Political Weekly, 47(17) April 21 - April 27, 2012, pp. 66-75
4. Contractor, Sana. "Abortion and sex selection: Contentious issues in the campaign against sex selection" The Urban World, Special issue on sex selection and PCPNDT act. 4(3), July-Sep 2011, pp. 13-17
5. Contractor, Sana. "Reflections on the high court's dismissal of the 'TISS rape case'" Indian Journal of Medical Ethics, VII(4), Oct-Dec 2011, pp. 246-247
6. Rege, Sangeeta. "Medico-legal cases across various hospitals - A review & understanding of procedures" Medico-Legal Update, 11(2), 2011, pp. 67-69

Poster Presentations

1. Contractor, Sana and V. Deepa "Interrogating the Health Sector Response to Sexual Assault: Findings from a Tertiary Care Hospital in India" Presented at the SVRI Forum 2011, October 11-13, Cape Town, South Africa.

IEC Material

1. Dilaasa Calendar 2012: Looking Beyond Symptoms

Press coverage: 2011

- http://www.dnaindia.com/mumbai/report_treatment-for-poor-not-free-study_1639386
- http://www.moneylife.in/article/needy-patients-get-nothing-while-charity-funds-earn-interest/23333.html
- http://www.moneylife.in/article/user-fee-keeps-poor-away-from-using-public-healthcare-facilities/21673.html
- http://www.hindu.com/2011/04/13/stories/2011041363640900.htm

- http://epaper.lokmat.com/newsview.aspx?eddate=04/03/2012&pageno=2&edition=41&prntid=2674&bxid=25869308&pgno=2
- http://articles.timesofindia.indiatimes.com/2012-04-01/mumbai/31270138_1_counsel-victims-sexual-assault-doctors
- http://fpj.co.in/news/57398-City-doctors-being-trained-to-examine-victims-alt39objectivelyalt39.html

Documentation and Publication (SATHI)

CBM publications:
SATHI has published a wide range of awareness and orientation material regarding community based monitoring of the health services during implementation of the project. Publications in 2011-12 include-

- A Marathi booklet ***'Aata sarakari davakhana hotoy janatecha'*** which documents positive experiences of CBM processes in Maharashtra in the form of feedbacks given by different stakeholders, in the year 2011. Currently, the process of translating this booklet into English, is on. This booklet would be named as ***'People are reclaiming the public health system…'***. Key positive experiences and feedback about community based monitoring of public healthcare services in Maharashtra will be shared at national level through this booklet.
- Specially designed pictorial VHSC as well as RH, PHC level tools were modified and reprinted.
- Village, Anganwadi, Sub centre, PHC and RH level report cards have been reprinted in poster format and disseminated.
- Updated CBM brochure in Marathi including information on 8 new districts reprinted during this period.
- 'Dawandi' is the CBM newsletter of approximately 24 pages which is published quarterly by SATHI. Dawandi is circulated widely across Maharashtra, reaching various stakeholders from Village health committees to State health officials. During the reporting period, 4 issues were published and circulated.
- Booklets on Village Health, Water supply, Nutrition and Sanitation Committee and PHC Monitoring and Planning Committee were reprinted. These booklets consist of information regarding constitution, information regarding untied funds and also roles and responsibilities of the committees.
- Guide book of Community based monitoring committee was reprinted for new 8 districts.
- Booklet on RKS (Rugna Kalyan Samittee) - This booklet includes information regarding untied fund, information about decision making of committee, roles and responsibilities of the committees.
- Poster on RKS fund and Information was printed during the period.
- A collage of the stories of change related to the CBMP process over the last five years, was printed in form of a book titled "Paule Chalati Badalachi Wat" in this period.

Film on CBM processes- In order to create more awareness about the process of CBM, SATHI is trying to use different mediums of communication. A film on CBM process is a part of that endeavor. Key CBM processes especially Jansunwais are currently going on. So it will take more time to complete the film. It is expected to be completed by November 2012. There have also been some technical reasons for delay.

Publication related to project on availability of essential medicines:
A report of the National seminar on 'Models and methods for ensuring availability of essential medicines in public health facilities' was finalized and sent to the participants of the seminar.

Health equity and rights watch publications:

- Review of existing Standard Treatment Guidelines at national as well as international level and the status of implementation of these STGs[2]

The need for regulation of health care providers has been generally recognized as an important component of any publicly funded and managed UHC system. In this context, given the currently widespread irrational practices, excessive interventions and related high costs associated with the private medical sector in India, regulation of the *content of health care* becomes quite important. This is necessary both to contain excessive costs (which are expected to further spiral in an inadequately regulated UHC system) and to ensure good quality, rational care to all those accessing the UHC system. In this setting, Standard treatment guidelines (STGs) have played a significant role in standardizing and rationalizing treatment practices across the world.

In January 2011, a discussion was jointly organized by SATHI and the High Level Expert Group (HLEG[3]) which is a group constituted by the Planning Commission to work out a proposal for Universal Health Coverage in India. The discussion focused on the need for regulation of Private Health Sector in context of UHC. In continuation of this meeting SATHI undertook work on review of existing STGs at national and international levels. This review was done by Dr. Sujata Deshpande with inputs from SATHI team members. Dr. Deshpande is a pediatrician and neonatologist who has worked both in India and in the universal health care system in Australia, and has a special interest in rational health care. The objective of this review document has been to understand how these STGs might be drawn upon for a future UHC system in India.

- A popular awareness document in form of FAQs on 'Universal Health Care'

One of the important areas of this phase focuses on concretising models and shaping public opinion and policy towards a regulated system for Universal Access to Health Care, as a key strategy for reduction of health inequities and reduction of irrational health care expenditure. For shaping public opinion on the issue of Universal Access to Health Care, it is essential to disseminate information on various aspects of UHC. Keeping this in mind, a document in the form of FAQs on UHC has been prepared.

This booklet is meant to-

- Clarify some key concepts around 'Universal Health Care' (UHC)
- Discuss briefly where and how these concepts have been put into practice
- Examine the tangible benefits of such a system
- Discuss whether we could develop such a system in India; look at the legal and policy framework and financial commitments required for this

The readership for this booklet is anyone who is interested in making health care accessible and affordable to all, including social activists and health professionals. The booklet unfolds in the form of answers to some frequently asked questions.

--

SATHI continues to maintain the ***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

[2] Standard Treatment Guidelines (STGs) or Clinical Practice Guidelines (CPGs) are systematically developed statements that assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. (Field and Lohr, Institute of Medicine, 1990)

[3] With the aim of incorporating a comprehensive plan for health within the 12th Five-Year Plan, the Planning Commission, under approval by the Prime Minister, constituted a High Level Expert Group (HLEG) on Universal Health Coverage (UHC), which has been assigned the task of reviewing the experience of India's health sector and suggesting a 10-year strategy going forward.

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. Audio Visual Health Awareness Material –155
2. TV News & interviews- 18
3. Documentation of Jansunwais- 15
4. CBM Film (English & Marathi)
5. Periodicals- Marathi-6, English-11 = 17
6. Books- 3244
7. Bound Volumes- 186
8. Reference Books- 130

The publications brought out during April 11 to March 12 are as follows

Publications in Marathi

No	Particulars of Publication	Date of Publication
1.	'Dawandi'- News Letter published quarterly	
2.	Swasthya Sathi Part-1 (Reprint)	May, 2011
3.	PHC Monitoring and Planning Committee Booklet (PHC Booklet)	August, 2011
4.	Sarvajanik Aarogya Sevanvar Lokadharit Dekhrekh Prakriya (Guide Book)	August, 2011
5.	Ashi Hot Ahe Aarogya Sevevar Lokanchi Dekhrekh (CBM_Marathi Brochure)	August, 2011
6.	Pictorial VHSC Tools	August, 2011
7.	Pictorial PHC Tools	August, 2011
8.	Pictorial RH Tools	September, 2011
9.	Pictorial Anganwadi Tools	September, 2011
10.	Ata Sarkari Davakhana Hotoya Jantecha (Marathi CBM Book)	December, 2011
11.	‘Rugna Kalayan Nidhi’, ‘Rugna Kalyana’sathi Kasa Kharcha Karava? (RKS Booklet)	December, 2011
12.	Rugna Hakka Brochure	December, 2011
13.	Jan Aarogya Abhiyan Brochure	December, 2011
14.	Medicine brochure	December, 2011
15.	Aarogya Sevanvar Dekhrekh Niyojan- Gaon Aarogya, Poshan, Pani Purvatha va Swachata Samiti, I-Card	January, 2012
16.	‘Rugna Kalayan Nidhi’, ‘Rugna Kalyana’sathi Kasa Kharcha Karava? (RKS Booklet) – (Reprint)	January, 2012
17.	Jan Aarogya Abhiyan Brochure (Reprint)	February, 2012
18.	Ashi Hot Ahe Aarogya Sevevar Lokanchi Dekhrekh (CBM_Marathi Brochure)	March, 2012
19.	Paule Chalati Badlanchi Vat	March, 2012
20.	SATHI Voucher	March, 2012
21.	Nav Kshitij Navi Aavahan	March, 2012
22.	Universal Health Care	March, 2012
23.	People are reclaiming the public health system	March, 2012

- **Report Card Published in the Community Based Monitoring Project**
  1) Village, RH and Anganwadi level report cards (All in two color) (August-September, 2011)
  2) Village level report cards (All in two color) Reprint for 8 new districts (December, 2011)

- **Posters published in the Community Based Monitoring Project**
    1) Asa Vaparuya Aaplya Sarkari Davakhanyacha Rugna Kalyan Nidhi (two color) (March, 2012)
- **Flex Poster Exhibitions (1.5 x 2 sq. ft., 4 color)**
    1) Saline & Injection Poster, 10 posters*
    2) Anaemia, 26 posters*
    3) Health Rights, 32 posters *
    4) Darubandi Posters, 18 Posters*
    5) Asha Ani Gaon Aarogya Samiti, 11 Poster
    6) Patients' Rights, 15 Posters*
    7) Tambakhu Posters, 14 Posters*
    8) Women's Reproductive Health, 72 Posters*
    9) Women's Reproductive Health, 72 Posters (Hindi)
    10) Stree-Aarogya Garbha Kal ke Darun Khatare- 8 Posters (Hindi)

    * (Available in Hindi)

DOCUMENTATION AND PUBLICATION (CSER)

Maithreyi, M. R. 2012. Towards a history of bioethics in India: mapping the field. A preliminary report.Centre for Studies in Ethics and Rights; Mumbai

'Hands on Learning' in Medicine: Who Benefits?
Ghoshal, R. Economic Political Weekly , Oct 2011;Vol XLVI (42)

Reproduction: The overdetermined space of the colonial and the contemporary
Ghoshal, R. in Pradip Basu (Ed.) Colonial Modernity: Indian Prespectives; Setu Prakashani, Kolkata. 2011: 144-157

Borkar C, David Jacob V, Ravindran D. Clinical Trials Watch, Indian J Med Ethics. 2011 Jul-Sep;8(3):197.

STAFF PROFILE

List of CEHAT Staff as on 31st March 2012

Employee Name	Designation	Male/Female
Anandi Dantas	Research Officer	Female
Anita Jain	Research Officer	Female
Anjali Kadam	Secretary	Female
Arvind Harekar	Secretary	Male
Deepmala Patel	Research Associate	Female
Dilip Jadhav	Office Assistant	Male
Dinali Hataskar	Admin Assistant	Female
Jasmine Kalha	Research Associate	Female
Margaret Rodrigues	Research Officer	Female
Meghna Jethava	Sr. Research Associate	Female
Oommen C. Kurian	Research Officer	Male
Prachi Avalaskar	Sr. Research Associate	Female
Prashant Raymus	Research Officer	Male
Pramila Naik	Jr. Administrative Officer	Female
Priyanka Shukla	Sr. Research Associate	Female

Rahul Sapkal	Sr. Research Associate	Male
Ramdas Marathe	Office Assistant	Male
Sana Contractor	Research Officer	Female
Sangeeta Rege	Sr. Research Officer	Female
Shobha Kamble	Office Assistant	Female
Sonal Sheth	Sr. Research Associate	Female
Suchitra Wagale	Sr. Research Associate	Female
Sudhakar Manjrekar	Office Assistant	Male
Sushma Patil	Jr. Account Officer	Female
Tayyaba Khatoon	Research Officer	Female
Ujwala Kadrekar	Sr. Research Officer	Female
Vijay Sawant	Secretary	Male
Yavnika Tanwar	Sr. Research Associate	Female
Zamrooda Khanday	Sr. Research Officer	Female

List of SATHI Staff as on 31st March 2012

Employee Name	**Designation**	**Male/Female**
Abhijit More	Junior Project Officer	Male
Ajaylal Vishwakarma	Junior Project Officer	Male
Ashwini Devane	Junior Research Officer	Female
Bhausaheb Aher	Junior Project Officer	Male
Deepali Yakundi	Research Associate	Female
Gajanan Londhe	Office Assistant	Male
Hemraj Patil	Project Associate	Male
Jessy Jacob	Administrative Assistant	Female
Kiran Mandekar	Junior Administrative Officer	Male
Meena Indapurkar	Office Assistant	Female
Nilangi Sardeshpande	Senior Project Officer	Female
Nitin Jadhav	Project Officer	Male
Rakesh Sahu	Project Associate	Male
Ramdas Shinde	Office Secretary	Male
Ravindra Mandekar	Office Secretary	Male
Rashmi Padhye	Junior Project Officer	Female
Sachin Sathe	Project Associate	Male
Shailesh Dikhale	Junior Project Officer	Male
Shakuntala Bhalerao	Junior Project Officer	Female
Sharada Mahalle	Administrative Assistant	Female
Shweta Marathe	Junior Research Officer	Female
Trupti Joshi	Junior Project Officer	Female
Urmila Dikhale	Administrative Assistant	Female

List of CSER Staff as on 31st March 2012

Employee Name	Designation	Male/Female
Divya Bhagianadh	Assoicate Coordinator	Female
Mahendra Shinde	Jr. Admin Officer	Male
Chitra Pandit	Jr. Programme Officer	Female
Bhushan Parkar	Office Assistant	Male
Deapica Ravindran	Jr. Programme Officer	Female
Bhasyati Sinha	Sr. Research Assistant	Female
Sweta Surve	Jr. Programme Officer	Female
Rakhi Ghoshal	Sr. Programme Officer	Female
Kinjal Ved	Office Assistant	Female
Sanna Meherally	Jr. Programme Officer	Female
Vivan David Jacob	Jr. Programme Officer	Male
Arpan Tulsyan	Sr. Programme Officer	Female

List of Anusandhan Trust staff as on 31st March 2012

Employee Name	Designation	Male/Female
Abhay Shukla	Coordinator - SATHI	Male
Neha Madhiwalla	Coordinator - CSER	Female
Padma Deosthali	Coordinator - CEHAT	Female
Saramma Mathew	Chief Finance & Admin Officer	Female

THE BOMBAY PUBLIC TRUST ACT, 1950
SCHEDULE : VII [Vide Rule 17(1)] Regn. NO.E-13480, dt.30-08-91(Mumbai)

Name of the Public Trust: ANUSANDHAN TRUST
BALANCE SHEET AS AT: 31st MARCH, 2012

FUNDS & LIABLITIES	RS.	RS.	PROPERTIES & ASSETS	RS.	RS.
Trust Fund or Corpus		30,055.00			
Reserve Fund		-	**Immov. Properties**		
			Book value of immoveable property		
Employee Social Security and Welfare Fund		2,525,265.73	as on 31st March 2012		2,895,054.42
Research & Education Fund		2,002,008.33	**Moveable Properties**		
			Book value of moveable property		
Maintainence & Overheads Fund		2,449,600.60	as on 31st March 2012		2,197,760.87
Building Fund		8,075,397.97	Income Tax to be recovered	270.00	
			Tax deducted at source	557,190.00	
			Deposits	835,545.00	1,393,005.00
Earmarked Grants (Refer Note c in Notes to Accounts)			**Outstanding Income (Accrued Interest)**		170,303.00
Opening balance as per last balance sheet	24,692,313.17				
Add: Opening balance of Grants to be disbursed	146,700.00		**Cash & Bank Balances**		
Add: Grants received during the year	37,658,807.69		Bank balances	17,423,026.82	
Add: Transfers during the year	303,184.00		Fixed Deposits with Banks	13,214,066.88	
Add: Interest earned during the year	398,007.47		Cash & Cheque in hand	25,410.00	30,662,503.70
Less: Grants disbursed during the year	12,333,607.00				
Less: Transfers to various funds	990,353.00				
Less: Expenses incurred during the year	36,874,065.85	13,000,986.48			
Income & Expenditure Account					
Balance as per last balance sheet	7,240,366.23				
Add: Surplus as per Income & Expenditure Account	1,994,946.65	9,235,312.88			
TOTAL		**37,318,626.99**	**TOTAL**		**37,318,626.99**

-

Place: Mumbai
Dated: 16th September 2012

THE BOMBAY PUBLIC TRUST ACT, 1950
SCHEDULE : VII [Vide Rule 17(1)]

Regn. NO.E-13480, dt.30-08-91 (Mumbai)

Name of the Public Trust: **ANUSANDHAN TRUST**
INCOME & EXPENDITURE ACCOUNT FOR THE YEAR ENDED: **31ST MARCH 2012**

EXPENDITURE	RS	RS.	INCOME	RS.	RS.
To Establishment expenses		15,962.50	**By Grants administration income**		1,172,000.00
To Depreciation		19,112.85	**By Interest (not allocated to any project or specific fund**		207,835.00
			By Donation		20,000.00
To Expenses towards objects of the Trust (Expenses over and above those booked under the Earmarked Funds)			**By Income from other sources**		
			Contribution to publication & database	40,838.00	
			Miscellaneous Receipts	20,148.00	
			Training fees	52,000.00	
			Registration fees	75,000.00	
			Other income	2,200.00	190,186.00
Surplus carried to Balance Sheet		1,554,945.65			
TOTAL		**1,590,021.00**	**TOTAL**		**1,590,021.00**

Place: Mumbai
Dated: 16th September 2012