# ANNUAL REPORT

# PERIOD 1ST APRIL 2012 TO 31ST MARCH 2013

# 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 2012 - 13

## I. RESEARCH (CEHAT)

### Charitable trust hospitals study

Charitable Trust Hospitals are one of the oldest forms of public private partnerships in the country. These hospitals get various benefits from the government such as land, electricity at subsidised rates, concessions on import duty and income tax, in return for which they are expected to provide free treatment to a certain number of indigent patients. 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. In Mumbai, these hospitals have a combined capacity of more than 1600 beds. However, it has been brought to light both by the government and the media that these hospitals routinely flout their legal obligations. Considering that charitable hospitals are key resources for provisioning of health services to an already strained public health system it is vital to ensure their accountability.

This study by CEHAT intended to look at the literature on the history of state aided charitable hospitals in Maharashtra, with special focus on Mumbai, and appraise the nature of engagement between the private sector and the state aided hospitals. It critically reviewed the data submitted by the state aided charitable hospitals of Mumbai to the Charity Commissioner on free and subsidised patients, to estimate the degree of compliance to by the hospitals and also to monitor them. 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.

**Findings of the study**:

- A substantial number of state aided charitable hospitals do not comply with the scheme and the degree of non compliance is quite high.
- Most state aided charitable hospitals never allotted the mandatory 20% beds for treating the poor and instead complained that they were treating too many patients.
- Data reported to the Charity Commission by the state aided charitable hospitals is inadequate, inconsistent and unsystematic. Many hospitals do not even submit the required data.
- Charitable hospitals predominantly treat indigent or weaker section patients at the outpatient level because outpatient (OP) admissions can be passed off as in patient (IP) admissions in the current scheme of things and frees an extra bed that can earn thousands of rupees per day.
- The Indigent Patients' Fund (IPF) is un-utilised by hospitals. It was seen that the IPF has always been in surplus, in fact, to the extent of crores of rupees.
- State aided charitable hospitals invariably underreported donations and bed numbers at the office of the Charity Commissioner.

- No matter how serious the allegations were, no kind of penalties were levied on the offending hospitals. There was not a single instance where disciplinary action was taken against an offending hospital in Mumbai.

**Publically Financed Health Insurance Schemes**

Lately, a new crop of health insurance schemes funded by both Central and State Governments have come into existence throughout India. Significantly high amount of public money is pumped to make these schemes operational. These schemes are designed for the poor masses and have resulted in increase of insured population from 5% in 2008-09 to a whopping 22% in 2010-11.

An extensive review of literature on the Rashtriya Swastha Bima Yojna Scheme has been conducted. 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. 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.

A study which aims to study the implementation of two publicly financed health insurance schemes in Maharashtra is planned. The two schemes being studied are the RSBY and the RJGAY (Rajiv Gandhi Jeevandayee Arogya Yojana). The study will enquire into healthcare availability in the district and its geographical distribution, type of procedures performed at public and private hospitals, utilization pattern and experiences of the beneficiaries.

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

The Budget is an official policy document, which is indicative of the expenditure incurred and reflective of the policy priorities of the government. The budgetary processes in India are opaque and remain behind the extreme confidentiality of bureaucratic exercises. Even when accessed, the documents are not presented in a language and format that is user-friendly; the language used is too technical to understand making it difficult to comprehend. People, in general, consider the budget highly technical and very difficult, and only a miniscule proportion of the population understands the technicalities involved. Besides, the most crucial stage of the budget process, that of budget preparation does not allow any kind of participation by civil society organisations. In order to be conducive to public involvement, public understanding and involvement in the budget process is critical for ensuring that the Government is accountable to the public. This Public Expenditure Tracking Survey, conducted in two districts in Maharashtra, explores the

budget process through its various stages. The findings of the study outline budgetary processes; the range of issues discussed will help the reader understand all four stages of the budget process (formulation, approval, implementation and auditing).This information on the key actors in the system will not only hold them accountable, but will also help civil society organizations identify opportunities for civic participation. The findings were presented to key functionaries in the state.

**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. The paper also provides direction for more research on the issue of religious discrimination and its impact on health. The paper is published as chapter 7 of the Report on "Socio-economic and Educational Backwardness of Muslims in Maharashtra" published by the Government of Maharashtra

**Maharashtra Human Development Report**

The team from CEHAT prepared a background paper on Health and Health Care in Maharashtra, for the Human Development Report, being prepared by YASHADA. 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. Some of the key findings are as follows:

- 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%. 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.
- 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.

**Paper on role of private health sector**

The paper describes the changing political economy in India with a focus on the growth of the private health sector and provides a sound evidence-based critique of the existing situation. It looks at recent trends in growth of the private sector, especially during the last couple of decades. These years were characterized by liberalization of the Indian economy and the structural adjustment policies that followed. The new direction of health policy is towards reducing the role of government while increasing that of the private sector. The paper discusses various ways in which the state itself has provided direct and indirect support to the private sector - in medical education, in the form of concessions and subsidies to private medical professionals and hospitals, through PPPs, and lack of by lack of regulation. In short, the private sector in India has grown with the support of crutches from the state, which has led to its unprecedented boom. The paper also looks at PPP arrangements in health care critically and identifies policy gaps therein. The paper is particularly important as it raises issues of regulation of the private health care sector, which assumes greater significance in the context of the recommendations by the HLEG on UHC as well as the Steering Committee on Health for the Twelfth Five Year Plan. If UHC means contracting with private providers on an even larger scale without reining them in, it would inevitably result in cost-escalation, large scale corruption and eventual failure. The paper is published as
"Appropriate Role for the Private Sector in Health Care in India." Health for Millions. Oct-Dec 2012 Vol.38, No.4.

## Exploring Religious Discrimination Against Muslim Women at Health Facilities

During the past two decades, India has seen some of its worse communal conflicts with the rise in religious politics and the spaces for minorities have been shrinking steadily. Through this study, CEHAT sought to understand how this communalisation of both the State as well as civil society impacts women's health and access to health care in Mumbai. The study looks at the experiences of both Muslim and non-Muslim women's experience in accessing health care facility around their locality. The participants have been selected from the same area accessing the same health facilities. The socio-economic group has been controlled by choosing localities that have people of both religions living alongside, in similar conditions. Qualitative methodology using FGD's and in-depth interviews has been used for data collection.

Preliminary analysis of the data shows that both Muslim as non-Muslim women encounter rude behaviour by health care providers. However, Muslim women face an additional communal bias which is manifested in the verbal abuse, often with sexual intent, that they face. Muslim women reported being called by derogatory terms such as 'landiya baika', were taunted for wearing the burkha, encountered stereotypes of being dirty, uneducated, backward, and having too many children. Muslim women reported feeling humiliated, tried to withdraw from health facilities, but never complained or confronted a health care provider, for fear of retaliation. The analysis of the data also brought forth the disadvantage that women face due to their gender, in the form of restriction of mobility, poor access to resources and lack of decision making power in the household. The findings suggest that gender, class and religion all play a role in Muslim women's access to health services as well as the behaviour that is meted out to them there in.

## Gender in Medical Education

This project is aimed at the training of medical educators in state medical colleges in Maharashtra to incorporate a gender perspective in their teaching with a focus on issues of gender-based violence and discrimination. The need for this project stems from the key role that medical teachers can play in recognizing and addressing gender bias in medical education and practice, which often translates into poorer outcomes in health service delivery for women. Further, health care providers constitute the first point of contact for survivors of domestic and sexual violence. They can play a critical role not only in evidence collection and treatment, but also in identifying women who may be facing violence but may not report it. There is need for sensitization of the medical profession in understanding violence against women as a health issue and adequate training in addressing it.

In order that medicine becomes more gender sensitive, educating medical practitioners on gender issues and how gender interacts with other determinants of health is important. This is a crucial first step to change biases that exist in the field of medicine at different levels including research, service delivery, textbooks and teaching. This project aims to integrate gender perspectives in medical teaching and curriculum in Maharashtra by training faculty members of five disciplines, namely, Obstetrics/Gynaecology, Internal Medicine, Psychiatry, Preventive and Social Medicine and Forensic Medicine. The focus is on issues related to violence against women and sensitization of medical students and professionals.

A working group comprising of deans of participating colleges, representatives from DMER and MUHS, project faculty members as well as participating faculty members will be formed in order to advocate for integration of the project output in the medical curriculum in the state.

Participating colleges are: Government Medical College, Nagpur, Government Medical College, Aurangabad, Swami Ramanand Teerth Government Medical College, Ambejogai, Government Medical College, Miraj, Rajarshi Chhatrapati Shahu Maharaj Government Medical College, Kolhapur, Shri Bhausaheb Hire Government Medical College, Dhule, Mahatma Gandhi Mission's Medical College, Navi Mumbai. For more information on the project, please visit: www.gme-cehat.org

**Study on Response of Hospitals to the Terror Attacks**

Mass casualty incidents often put health systems under a tremendous resource crunch in terms of equipment, adequate staffing and resources. Documentation and research related to such events is critical in policy-making and planning of hospital preparedness. During the 2008 Mumbai Terror Attacks, which left 172 dead and 304 injured the hospitals that responded were the state-run JJ Hospital and its peripheral hospitals: G.T Hospital and St. George's Hospital. In addition the Cama and Albless Hospital itself was under attack, which created a challenging situation for the staff where they had to also ensure safety of patients and themselves. The unprecedented nature and the duration of the attacks further complicated the chaotic atmosphere in which the hospitals had to operate.

This study by CEHAT in collaboration with the Tata Institute of Social Sciences (TISS), Mumbai aimed to understand how these public hospitals responded to the attacks and assess the preparedness of the hospitals to deal with such a crisis from the healthcare providers' perspective. Moreover, it attempted to document lessons learnt and identified ways of improving the response based on experiences of the providers. The study used in-depth interviews of staff in the four hospitals present during attacks regarding detailed accounts of interaction within and outside the hospitals, constraints faced and recommendations for measures to be taken ensuring efficiency.

It is hoped that this study can be a key resource for policy makers and hospital administrators in the preparation and training of health care providers to respond to such events. It stresses for looking at medical interventions during emergencies in the Indian context so that best practices can be recognized and formed into new plans or codified into the existing plans. This study intends to enable the public health system to move from impulsive reaction to proactive response.

Findings

- The study showed that the existing emergency plans at the hospital and city-level were insufficient to meet with pressures and challenges of responding during the attack and should therefore these plans should be made more comprehensive by assessing vulnerabilities and preventive actions.

- There is a need to create standardised protocols and procedures to be followed by the various responding agencies during mass emergency to prevent duplication of resources and time delays.
- The study highlighted that conducting regular trainings and drills of the hospital staff co-ordinating both within and outside the hospital and between agencies can streamline the process of responding to emergencies.
- The provision of systematic psychosocial support for those affected including healthcare providers working during emergencies is an area that needs to be critically looked at.
- There is a need for better communication and co-ordination between hospitals and various agencies like the government, police, media and voluntary organizations to minimize gaps and respond to terrorist-attacks during mass-emergencies.
- The study emphasizes that mass casualties maybe unpredictable but good planning that allows scaling up and incorporates multi-sectoral involvement can drastically improve the response.

**Intervention research based on service records**

Report on establishing comprehensive health sector response to sexual assault published. This report is based on the experience of establishing a comprehensive health care response to sexual assault at three public hospitals in Mumbai, in collaboration with the Municipal Corporation of Greater Mumbai. CEHAT is the first institution in India to have directly engaged with the public health sector to develop a model to respond to sexual assault. The model includes development and implementation of a gender sensitive examination proforma, operationalization of informed consent and provision of medical care along with crisis intervention services. The report presents ways in which such a model can be run within the existing resources of the hospital.

The report presents ways in which health professionals were equipped to provide emergency health care, recognize voluntary reporting by survivors to hospitals and document sexual assault related findings sensitively. The model also empowered health providers to formulate medical opinion and interpret negative medical findings. The report also presents profile of survivors and challenges faced by them in reporting sexual assault. Analysis of case records and medical records of survivors throws light on the dynamics of sexual violence, nature of health consequences and limitations of medical evidence - which have not been studied to a great extent in the Indian context. Specific recommendations for different agencies such as child welfare institutions, police machinery, community based organisations and so on are discussed in order to create a multipronged approach to respond to sexual assault.

**Policy Research on Maternal Health**

Globally, every year over 500,000 women die of pregnancy related causes and 99 percent of these occur in developing countries. The Millennium Development Goals (MDG) of the United Nations has set the target of achieving 200 maternal deaths per lakh of live births by 2007 and 109 per lakh of live births by 2015. India as a whole and most states within it lag behind this target considerably. India has a fragmented and myopic approach to addressing maternal health, which is a part of the problem. Through this project, CEHAT has been attempting to highlight

the gaps in maternal health related policies and programs in India and make a case for a broader, more comprehensive and rights-based approach to addressing the issue of maternal health.

A national level review on policies related to maternal health was carried out, which threw light on the many lacunae both at policy and implementation levels. The review found that India's policies focus very narrowly on reducing maternal mortality, while overlooking the broader framework of sexual and reproductive rights. As a result, several important issues affecting the health of women are not even addressed. Abortion as a right finds no place in policy and efforts of the government to improve maternal health do not take into consideration ensuring right to abortion services. Prevention of unwanted pregnancies is an integral part of sexual and reproductive rights, but our programs continue to push female sterilization as the only method of contraception, without providing women with other options. Similarly, domestic violence which is known to have an impact on women's control over their fertility, as well as pre and post partum health of mothers is not even addressed as an issue of concern. Policy and programs continue to focus their attention solely on ensuring institutional deliveries, but issues such as violence faced by women during childbirth at the hands of health professionals remains unacknowledged. Post-natal care, the review finds, is extremely poor, and not much effort is being made to improve it. Awareness and access to safe and legal abortion services too is poor. These are serious blind spots at the policy level. In terms of provision of services, the review found an overwhelming presence of the private sector in this regard. Public-Private Partnerships to encourage institutional deliveries have been implemented without any sort of regulation of the private partners. This has implications for quality of services as well as equity in access. Even apart from the PPPS, the overwhelming majority of services such as ANC are accessed from the private sector where its presence is great. In terms of access to services too, the review found stark inequalities based on class, caste, religion, urban/rural location in access to services.

**Armed Conflict and Health**

Currently in India several states are ridden with low-intensity conflicts. The state of Jammu and Kashmir, the states in the North East and recently Chhattisgarh have been witnessing an extremely complex insurgency as well as several years of civil strife. There is limited documentation or study of the effects on the health and the health system and the challenges of the health system in responding. Violence against women in such contexts is often not recognised but rather it is systematic used as tool by the state – police and army- as well as the militants or insurgents to silence and terrorize communities.

For the past four years, CEHAT has been engaging with various organizations as well as the State in an effort to address violence in conflict and facilitate an understanding and recognition of it as a public-health issue. The first consultation was held in Srinagar, in collaboration with the J&K State Commission for Women in September 2009, which threw up the need to conduct training programs with health care providers so that they may be able to recognize and respond to the effects of violence specifically against women. Subsequently, in December 2010 and April 2011 with training initiatives were organized in Delhi and Mumbai with participants together from different states in the country, including Jammu and Kashmir, Manipur, Jharkhand, Chhattisgarh and Maharashtra to engage with the issue of violence in conflict situations. As part of future planning, the participants of these trainings identified a need to form a support group that will work towards addressing issues that emerged, such as initiating

counselling services, training of health care providers on the issue of VAW and training for conducting autopsy and act as a lobby to provide protection to health professionals from external pressures/politics. They would form a critical mass for bringing about the required changes in the system for sensitising it and for raising the issue of right to health care in armed conflict.

CEHAT was also part of the symposium held by Women Against Sexual Violence and State Repression (WSS) which highlighted the need to develop protocols that would include sexual assault examinations as part of autopsies in areas of conflict, developing a protocol for investigating cases of custodial rape, training of health professionals as well as the police and judiciary to understand the limitations of medical evidence, evolving a way to enable unbiased investigation of cases of sexual assault specific problems related to chain of custody and neutrality of health professionals in situations of conflict.

Currently, CEHAT is in the process of conducting a study the public health profile in conflict regions of Chhattisgarh in collaboration with local health organizations. This study will look at status of the health system in these areas and the effect of violence on the system and document the experiences and difficulties faced by healthcare providers in working in these areas.

**Research (SATHI)**

**MAHARASHTRA HEALTH EQUITY AND RIGHTS WATCH PROJECT -II**
**Project Reporting Period: April 2012 to March 2013**

**Synthesis:**
Work undertaken as part of this project is based on, three complementary approaches of health equity in the state, they are as follows:

1. Additional specific research to deepen our understanding regarding certain irrational practices by the private health sector (esp. in context of women's health) as they accentuate 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 larger pool of professionals working on Health rights issues with an equity perspective

Detailed account of activities accomplished during the reporting period is given below-

1. **Studying women's access to health care taking hysterectomy as an illustration**
   This study exclusively focuses on women who have undergone hysterectomy to decipher the reasons behind acceptance of hysterectomy as a treatment.
   Some of the important research questions that this study would attempt to address are-
   - 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?
   - How do women's perceptions about menstruation and reproductive health influence the acknowledgement of need for treatment?

- How do women negotiate in the family to seek health care?
- What role the family members play, at the time of decision making for hysterectomy?
- How do women overcome the information asymmetry between them and the health care provider at the time of decision-making before undergoing hysterectomy?
- How do women take decisions regarding health care expenditure for treatment of their gynaecological problems?
- What are the consequences (short term as well as long term) of surgery on the physical health of women?
- What were the consequences of the surgery on their marital life?

This primary research activity is also part of the PhD degree of the team members.

**Status:-**

This study is part of PhD of one of the team members. The proposal was presented to the Doctoral Advisory Committee and it is approved, the proposal is also approved by the ethics committee. Field work has been initiated in this period. Visits to all the three study blocks have been conducted. In two of the blocks, local NGO has been contacted to seek their help in identifying eligible participants. It is expected that the interviews would be completed in coming months. Simultaneously, analysis of the interviews would be started.

2. **In depth analysis of first phase household data on Health inequities with a focus on quality of maternal health services**

**Background** - Understanding gender dimensions of health care access have been one of the thrust areas in health research in last few decades. Given the culture of silence, women seldom talk about their reproductive health problems, further, it is seen that health care access is difficult without familial permission. Lack of availability of appropriate health services was also among major barriers described. However, recently there is definite improvement in availability of health care services in certain parts of the country albeit mostly in private health sector, which is inadequately regulated. Several news reports and few research studies show that irrational practices such as unnecessary caesarean sections and hysterectomies are prevalent in private sector.

This paper is based on a study undertaken to understand how women overcome the barriers in accessing healthcare taking hysterectomy as an illustration. The study reveals that women were breaking the cultural silence around reproductive health problems, as they thought that the delay in treatment can lead to cancer and ignorance can be life threatening. This paper highlights the important findings related to the interactions of respondents with private providers, mainly about the information given by providers regarding the nature of illness, its severity and such. Several women have reported that the doctors told them that their condition may lead to cancer. It was seen that doctors did not conduct appropriate pathological investigations before making such statements. The study findings underscore the prevalence of irrational practices in the health sector and highlight the ways in which women are misguided to accept surgery taking advantage of their fear of cancer and lack of body literacy.

**a)** A paper on ‘Access to postnatal care (PNC) as determined by socio-demographic factors: A study in Maharashtra’

**Status -** The article 'Access to postnatal care (PNC) as determined by socio-demographic factors: A study in Maharashtra' was sent to the Indian Journal of Public Health (IJPH) in September 2012. After several rounds of editorial and peer review, we received a feedback on 2nd March 2013 stating that they are unable to accept the manuscript for publication in IJPH.

We have now modified the contents of the article to suit to the requirements of another journal dedicated to issues on maternal and child health, Indian Journal of Maternal and Child Health (IJMCH).

**b) A paper on the basis of analysis of NFHS 3 data pertaining to Maharashtra focusing on Increasing numbers of Caesarean sections reflecting irrationality of delivery care**

An outline of the article based on analysis of NFHS 3 data has been prepared. The article would be sent for publication to the Journal of Biosocial Sciences (JBS). Instead of focusing only on Maharashtra, the article would focus on analysis at an all India level with a focus on three states- Kerala, Maharashtra and Bihar (one state each from three groups formed based on c-section rates in these states). Based on the national level dataset (NFHS III, 2005-06), the article will delve into two areas-

- Need for c-section/ indicated c-section Vs c-section rates at an all India level and in 3 selected states based on development indicators
- Background characteristics leading to unindicted c-sections / increased c-section rate in these areas

**Status:-**

Team would send the article for publication in 'Journal of Biosocial Sciences', a peer reviewed international journal.

**3. Concretizing models and shaping opinion towards options for a system for Universal Access to Health care, as a key strategy for reduction of health inequities in Maharashtra**

**'Regional Consultation on Policy Options for Universal Health Coverage'**

The regional consultation on 'Emerging policy options for UHC' was co-organized by SATHI (Support for Advocacy and Training to Health Initiatives), PHFI's Secretariat for High Level Expert Group (HLEG) and Tata Institute of Social Sciences (TISS) on 10th and 11th May, 2012.

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 participated in this consultation.

**State level workshop on Rajiv Gandhi Jeevandayee Arogya Yojana and Universal Healthcare in the context of Maharashtra' on 25 June 2012 in Mumbai**

On 25th June 2012, a day-long state level meeting of health activists and health sector professionals was organised at Mumbai, to analyse and critique the emerging '*Rajiv Gandhi Jeevandayi Arogya Yojana*' (RGJAY) being launched by the Government of Maharashtra. This scheme is closely modelled on the existing '*Arogyasri*' scheme in Andhra Pradesh (A.P.), wherein 972 tertiary health care procedures would be provided by empanelled large hospitals (private or public) to persons with annual income less than 1 lakh, this would be funded by the

State government and finances would be managed by National Insurance company. Annual reimbursement for selected tertiary care services upto Rs. 1.5 lakh per family would be made available, presently the scheme is being launched in eight districts including Mumbai city, and would be progressively rolled out to cover the entire state.

**Jan Swasthya Abhiyan had conducted National Convention on Universalizing Healthcare** for All on 28th and 29th November 2012 in Delhi. Many civil society organizations, academicians and health activists across the country participated in this convention. On behalf of SATHI, Dr. Abhay Shukla and Dr. Abhijit More participated in this convention. Dr. Shukla made a presentation on 'the role of the community in accountability and planning of health services in the context of ongoing debate about Universalizing Healthcare for All' and Dr. Abhijit More made a presentation on 'issues related with the role of private healthcare sector in UHC and its regulatory framework'. Senior officials from Union Health Ministry and many trade union and political party representatives also participated in this convention.

**4. Fellowship programme for capacity building of young professionals**
**Fellowship program**

Fellowship program have started with an objective to build the capacities of young health and social professionals around the themes of health rights and health equity approach. This was achieved through three ways firstly sharing information by experts in the field of public health secondly through developing health rights perspective thirdly by enhancing skills in documentation and action linked research.

**Design of the program**

This program has designed in a way so that fellows get exposure of conceptual aspect of health rights, health equity, community health and related documentation-research. The program has been engineered so that education and application of information will go hand in hand. Field exposure is a highlight of this program. This program is more of collaborative learning than a self learning program.

**Status: -** In the reporting period first batch of fellowship was successfully completed and we have started with the second batch in September 2012.

Contact session for the second batch of fellowship programme was completed in month of November 2012. During this reporting period, fellows completed their first phase of field placement.

**A STUDY OF PATTERN OF UTILIZATION OF FLEXIBLE FUNDS IN SELECT VHSCs AND PHCs FROM PUNE DISTRICT OF MAHARASHTRA**

**Project period-** August 2011-December 2012

**Team Members-** Dr. Nilangi Sardeshpande, Shweta Marathe and Deepali Yakkundi

**Background**

Government of India has launched the National Rural Health Mission (NRHM) since year 2005. The main objective behind NRHM is to ensure accessible and effective healthcare for the rural population of India. To strengthen the health Institutions, NRHM has made available flexible funds for local level health institutions. Untied fund is provided to VHSCs from villages while RKS-Rugn Kalyan Samiti (Patient welfare committee) of various health institutions receives three types of funds i.e. annual maintenance grant, RKS fund (annual corpus grant) and untied fund.

During the fourth phase of Community Based Monitoring **(April 2010 to March 2011)** in Maharashtra, information was gathered regarding utilization of untied funds, Annual maintenance grant and RKS funds in over50 PHCs. The data were gathered for year 2009-10. The findings revealed that, these funds are often being utilized on items, which are not permitted as per the guidelines. The study revealed poor management of funds as well as poor reporting systems.

In the present study, this expenditure of these untied funds would be systematically tracked in selected facilities / villages.

**Project objectives**

To ensure effective utilization and improve transparency regarding utilization of flexible funds received by the PHCs and VHSCs.

**Key research areas in this project are**

- **To study pattern of utilization of flexible funds** by tracking its expenditure in selected PHCs and VHSCs.
- To **enhance capacity** of civil society members Community monitoring of health services, district monitoring and planning committee members implementing CBM regarding monitoring utilization of untied funds received by the PHCs and VHSCs as well as medicines availability.
- **To advocate for transparency** in utilization of flexible funds and in budget information about medicines at the district and facility level.

**Activities**

- Monitoring and tracking expenditure using PETS for untied funds at select PHC level and village level
- Develop advocacy and campaign material regarding utilization of untied fund, RKS funds and medicine
- Capacity building of the civil society organizations for monitoring flexible funds received at local level health institutions and assessing the availability of medicines in the PHCs.

**Following activities are accomplished during the period of reporting**

- **Data collection of RKS and untied fund study-** Completed data collection for monitoring utilization of RKS and untied funds in selected PHCs and VHSCs respectively.
- **Data analysis -**Analysis of the data collected for monitoring utilization of RKS and untied funds in selected PHCs and VHSCs respectively.
- **Study report** -Prepared report of the above study
- **Policy brief-**Prepared policy brief highlighting important findings from the study
- **Short booklet for RKS members-** which is to be disseminated to RKS members, planning and monitoring committee members from 13 districts.
- **Capacity building workshops-** Five capacity building workshops were conducted in five districts implementing CBMP, with civil society members Community monitoring of health services and district monitoring and planning committee members.
- **Reading material for workshops-** Notes and documents were prepared for capacity building workshop such as notes on guidelines regarding use of RKS and untied funds, booklet power point presentations etc.

**Accomplished activities pertaining to Medicine related work**

- **Report on medicine study-** Prepared report of study on medicine availability, procurement and budgetary allocations
- **Pictorial booklet on the issue of medicine shortages** -Pictorial booklet in Marathi on the issue of medicine shortages in public health facilities.

**ADVOCACY (CEHAT)**

**Right to health care for survivors of sexual violence-PIL**

CEHAT has been intervening in a Public Interest Litigation in the Nagpur Bench of the Bombay High Court since September 2010. The demands of the intervention petition are to ensure right to comprehensive treatment and care for survivors of sexual violence, and to develop gender sensitive protocols for medical examination in cases of sexual assault. The protocols developed by the committee appointed by Government of Maharashtra (GoM) in response to the petition are not gender sensitive and we have been engaging with the committee in this regard. In the month of June 2012, a hearing was held wherein CEHAT submitted an affidavit to the High Court highlighting the problems in the proformas. One of the significant issues highlighted was that of mandatory reporting – the manual and proforma created by the GoM did not seek consent from the survivor for reporting the case to the police, although mandatory reporting to police is not mandated by law. The court ordered that the Government appointed committee meet with the interveners to address these issues. A meeting was organized by the Government of Maharashtra on 3rd November 2012. The persisting issues with the proforma were discussed. These included the overemphasis on injuries, noting status of the hymen even when irrelevant, inclusion of height and weight as parameters for examination, among others. A detailed note on these issues is available at (http://www.cehat.org/go/uploads/SexualViolence/Issues%20for%20discussion%203rd%20Nov%202012.pdf). However, the committee argued that these were important aspects and must be

retained in the proforma. Subsequently an affidavit was submitted to the high court reiterating the problems and the resistance of the committee to accept changes.

**Policy Advocacy for implementation of comprehensive and gender sensitive protocols for responding to sexual violence**

Having worked with the health sector for 6 years, establishing a comprehensive health system response to sexual violence, which has produced evidence that the health system can indeed be sensitised to provide good services to survivors, CEHAT has been advocating for implementation of gender sensitive protocols across the health sector in India. As part of this effort, we have made submissions to various State governments (link to Delhi Advocacy Page) as well as the Central Government and are part of a committee constituted by the Central Health Ministry to formulate such protocols for the entire nation. CEHAT's effort has been to ensure that the protocols are comprehensive as well as gender sensitive, and that they give adequate attention to healing from trauma, facilitation of which is the main responsibility of the health system.

CEHAT has also made written and oral submissions to the Justice Verma Committee following the Nirbhaya Rape Case in Delhi in November 2012. The outcome of this engagement is the inclusion of the manual in the final report of the Commission in the chapter on Medico legal care, Annexure 6 on psychosocial support and Annexure 7 on guidelines for developing protocol.

We have also taken the legal route by filing an intervention application in the Nagpur bench of the Bombay High Court, demanding implementation of gender sensitive protocols for responding to survivors of sexual violence, and ensuring their right to treatment.

**Media Advocacy: Engagement with media on sexual violence and role of the health sector**

After the 16th December 2012 incident in Delhi, the media has been consistently reporting on issues related to sexual assault. There has been consistent involvement on this front and our work has been covered by several newspapers- English and Marathi. While most of the media reporting was around gaps in various response systems to sexual assault, we attempted to focus on the good practice that CEHAT and the Municipal Corporation have been able to establish. We also tried to include concerns with setting up of services for healing and rehabilitation of survivors of sexual assault along with changes in the criminal justice system. NDTV, The Week, Hindu have covered specific articles on work of CEHAT. Links to key articles are given below:

Another ordeal begins after rape
http://www.thehindu.com/news/national/other-states/another-ordeal-begins-after-rape/article4302508.ece

Sexual assault medical examination medical evidemce
http://articles.timesofindia.indiatimes.com/2013-01-04/mumbai/36148439_1_sexual-assault-medical-examination-medical-evidence

Rape more than a battle or justice

http://www.ndtv.com/video/player/india-matters/rape-more-than-a-battle-for-justice/261525

FAQs http://www.cehat.org/go/uploads/SexualViolence/FAQ.pdf

**ABORTION AND SEX SELECTION**

CommonHealth- Coalition for Maternal-Neonatal Health and Safe Abortion, and Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai organized on 27 February, 2013, a day-long dialogue aimed at creating common ground between those working to prevent sex-selection and those committed to promote women's access to safe abortion. The Dialogue was attended by 30 participants including seven persons from the host organisations.

The dialogue intended to cover the following areas –

- the situation with respect to access to safe abortion services in India today, barriers to safe-abortion access, groups most affected, likely health consequences
- situation with respect to declining sex ratios: extent of the problem, causes, strategies adopted to reverse the trend; policies and interventions through which the campaign against sex-selection seeks to prevent the selective abortion of female foetuses
- Ways in which both groups can work together to promote gender equality, prevent sex-selection and promote access to safe abortion

The participants recommended the following on "*what are the steps that we can take to work on preventing sex selection without compromising on women's access to safe abortion services"* Give below is the list way forward.

- The "Anti-Sex-Selection Campaign" and the "Right to Abortion Campaign" are not on opposite sides. Both are deeply concerned about gender discrimination and committed to promoting women's rights. In fact, many individuals and organizations are active in both campaigns. This meeting has been another step forward towards working together to maximise our synergies.
- Each one of the organizations present may disseminate widely the action points from this meeting in any forums, workshops, meetings and trainings that they organize or participate in. Online forums such as the http://fassmumbai.wordpress.com/ need to be more active on the issue.
- There is need to document discussions held during such meetings on abortion in order to disseminate the information to other partners in the campaign.
- CommonHealth's website http://www.commonhealth.in/ provides access to a large number of reports and the latest data on reproductive and sexual health, including data needed for advocacy against sex-selection and safe abortion. Participants may please send CommonHealth resources that they have produced on these topics, to help build a pool of resources for both advocacy and for developing IEC materials for public education.
- Organizations and activists as they come across public personas and spokespersons of the cause of women's rights and health rights should educate them on the right terminologies to be used – for example, never to use the term 'foeticide' which has the connotation that an abortion is "murder of the foetus" and is therefore anti-abortion language. It is

important that a culture of appropriate terminologies and concepts develops within the campaigns for prevention of sex selection and promotion of access to safe abortion.

**Advocacy (SATHI)**

**COMMUNITY BASED MONITORING AND PLANNING ON HEALTH SERVICES IN MAHARASHTRA**

**Project reporting period – April 2012 to March 2013**

*CBM continued full-fledged in the first 5 pilot districts (Thane, Pune, Amravati, Nandurbar, Osmanabad). As the state nodal organization, SATHI gave strategic inputs and was involved in most of the activities undertaken as part of CBMP in these 5 districts.*

Activities undertaken :-

Ensuring the functioning of the CBMP mechanism across the various levels

Training workshops were held for members of the Village Heath committee members to appraise them of their roles and responsibilities. Regular meetings were conducted of the PHC monitoring and planning committees to take stock of issues, mark those still unresolved to be followed up at a higher level. Similarly meetings were also held at the taluka level with the taluka monitoring and planning Committee. Several awareness programmes were organized by the committees and the CSOs, many in creative ways, to drive home right to health care and need for monitoring.

Information collection

As part of CBMP, data is collected at various levels including, village, PHC, Sub centre and Rural Hospital levels, regarding the availability of health services and the quality of the same. SATHI has prepared the tools for this data collection, modified them as per the experiences on field, trained the members of committees as well as CSOs for their utilization. The collation and analysis of the data was done by SATHI.

Jansunwais

Regular jansunwais were held at various levels, PHC, taluka and even at the district levels. SATHI along with has been involved in all the preparatory activities for the jansunwais and also the follow-up of issues raised.

PIP related work

With the inclusion of the planning component, workshops were held at the taluka levels to understand planning as a process, and then several meetings were held for the finalization of the PIP- Plan Implementation Programme

*New 8 districts*

Since 2011, the CBMP process was expanded to 8 new districts – Gadchiroli, Kolhapur, Beed, Raigad, Aurangabad, Nashik, Solapur and Chandrapur). The first phase yearly activities could not be completed in 2011-12 due to insufficient time. Hence some of these spilled over into the next year that is 2012-13. A remarkable change in attitude took place as people were enlightened that health care services are not a charity doled out, rather the public health system is established

with people's money and hence health care service is the right of people. Several positive changes were seen in these districts due to the initiation of the CBMP process. Each district identified issues through the process of data collection and jansunwais and regular meetings. Some of these were resolved and others were flagged for resolution at a higher level.

A unique sms survey was conducted to check on two important aspects regarding health care – availability of essential medicines, and availability of 24by 7 health services. The availability of 10 essential medicines was checked through an sms survey on 5th December 2012, and it covered 36 PHCs in 12 districts of Maharashtra. Similarly information on the availability of doctors and nurses was sought from 25 PHCs in 12 districts of Maharashtra. All these had a 24 x 7 status as per information on the Maharashtra Government website.(as per the website, 397 out of 1809 PHCs have a 24 x 7 status.) Information was also sought from 24 other PHCs which did not have the 24 x 7 status. A policy brief with the findings was published in Marathi based on this survey.

## PROMOTING A COMPREHENSIVE AND RIGHTS BASED APPROACH TO ADDRESS MALNUTRITION IN MAHARASHTRA

**Project Reporting Period - First Phase- Nov. 2012- March 2013**

### A) Implementation of community based monitoring and action processes concerning nutrition related programmes in selected areas:

Currently CBMA – ICDS is being implemented on a pilot basis in 5 rural blocks and 2 urban areas of Maharashtra, which includes selected rural areas in Amaravati (2 blocks), Nandurbar, Gadchiroli, and Pune (one block each) and selected urban areas of Nagpur and Mumbai. So far this activity has been proceeding with sanction from the government, but financial support from Narotam Sekhsaria Foundation. SATHI has been involved in coordinating CBMA- ICDS in Maharashtra for the last two years.

### Organizational framework

This project is multi-dimensional in nature, spread over six geographically dispersed districts and cities, for addressing the complex problem of malnutrition. The activities involved encompass promoting of community action and accountability, research and knowledge generation contextualised in the socio-economic setting of malnutrition, and advocacy esp. with Department of Women & Child Development of Maharashtra to create spaces for accountability and posing issues at policy level.

Considering the complexities of these activities, instead of any one organization taking the entire responsibility of coordinating the project, this would be managed by a consortium of collaborating civil society organisations.

The roles defined for each activity are as follows.
For community action – SATHI and Amhi Amchya Arogyasathi
For advocacy – SATHI and KHOJ
For research – NSF will be taking main responsibility for coordination. SATHI would coordinate the situational analysis & nutrition status survey and analysis of community based data. Other organisations will be coordinating specific activities as decided.

For field level activities the organisations and blocks for each one are as follows.

| **Location** | **Blocks / Localities** | **Nodal organisation** |
|---|---|---|
| ***Rural – districts*** | | |
| Pune | Velhe | Rachana |
| Amaravati | Dharani and Chikhaldara | Khoj |
| Gadchiroli | Kurkheda | Amhi Amchya Arogyasathi |
| Nandurbar | Dhadgaon | Janarth |
| ***Urban – cities*** | | |
| Nagpur | Low income communities in Nagpur | Amhi Amchya Arogyasathi |

**State level activities-**

i. State level mentoring committee meeting took place on 8th November 2013. Mr. Uke, Principal Secretary, W&CD Department; Mr. Rajendra Chavan Commissioner ICDS participated. Various issues were discussed. The issues have been sent to ICDS for action.
ii. To follow up the state level meeting, a meeting was held with Mr. Rajendra Chavan, commissioner, ICDS at Pune on 10th March 2014. It was decided that WCD will arrange quarterly review meeting in future.

In the first year the focus was on groundwork (e.g. preparation of tools, workshops), Training of trainers and block level trainings, awareness generation. Initially it was proposed that the first round of data collection in eight blocks / areas would be initiated. Since there is delay in initiating the project, it began in Nov 2012, many proposed activities were pushed in the second year including round of data collection.

**Status of the key activities for community accountability and action planned in the first year is as follows:**

| |
|---|
| **Anaganwadi And VCDC tools**: Preparation of tools, Field testing. Preparing Final tool Finalized, tested in TOT of block coordinators and field facilitators in Nagpur on 29th to 31st Jan 2013, field tested in Velhe in March 13 now will be printed by May end |
| **Flex posters story on malnutrition**<br>Preparation is being done. Will be prepared in second quarter of year 13-14 |
| **State level workshop for TOT of Field facilitators**<br>Conducted on 28 to 30th Jan 2013 |
| **Village level Training and Mobilization for community action - of the committees and PRI members** |

| |
|---|
| Began in all rural districts. At that time, both cities were in the last phase of situational analysis, there was a resistance from local authorities in Mumbai and Nagpur. After completing situational analysis on 20th March in Mumbai, in both cities Vasti level rapport building began. We are also waiting for the release of Government circular empowering the local organizations to conduct community based monitoring of ICDS services.<br>**Velhe: Pune: Rachana:** Village level training started. Committees strengthened, A responsive providers' workshop took place with robust participation from PRI members.<br>**Nandurbar, Janarth:** Village level training started. Committees strengthened, A responsive providers' workshop took place but though CDPO and AWW were present, participation from PRI members was not much. Meeting will be conducted with concerned PRI members along with CDPO in May 13.<br>**Dharani, Chikhaldara: Khoj: Amarawati:** Village level training started. Committees strengthened, A responsive providers' workshop took place with robust participation from PRI members.<br>**Kurkheda: Amhi Amachya Arogyasathi: Kurkheda:** Village level training started. Committees strengthened, A responsive providers' workshop took place with robust participation from PRI members. |
| **Block level meetings**<br>Happened in Dharani, Chikhaldara on 20, 21st March and at Velhe on 21st March other areas will start the same in April 2013. |
| **Report card filling and base line data collection**<br>Since the situational analysis was over in March, there is no circular by Government authorities even in March the activity is being pushed in April 2013. |
| **Advocacy** |
| **State level workshop for advocacy with WCD Dept. -** Done |
| **State level convention in collaboration with Right to food campaign**<br>Is postponed in the next year |
| **To get a circular/ GR**<br>Final GR (Combined for Rural and Urban) prepared and sent to Chief secretary Mr. Uke. A lot of efforts are being done so as to make WCD Department release a circular allowing the pilot project to run. Hope to get it by end of March 2013 |
| **Research** |
| **Baseline analysis (Situational analysis**<br>Baseline analysis (Situational analysis) was over on the field on 20th March. Data is now being entered and analyzed. The report will be published by June 2013 |
| **CBMP public health system** |
| **Block level and District level events will be conducted for building up the pressure to resolve the long standing issues in PHCs and Rural Hospitals**<br>Not accomplished in this year as the activities started in November |

**PROMOTING HEALTH RIGHTS, COMMUNITY MONITORING AND PRIVATE SECTOR REGULATION IN MAHARASHTRA**

**Project Reporting Period - 1st April 2012 to 31st March 2013**

**Advocacy on Patient's Rights and Standardization / Regulation of Private medical sector**

Objective- **The overall aim of the project was to consolidate and expand health rights and community monitoring activities related to public health system with focus on promotion of maternal health rights, while enlarging advocacy for regulation of the private medical sector, in Maharashtra.**

Theme of project- **Health Rights Resource Centre - Promoting Actions for Health Rights**

Geographical coverage- **Promotion of health rights activities (including community based monitoring) with focus on maternal health, in four districts of Maharashtra, value addition for community based monitoring as well as state level advocacy for patient's rights at state level and expansion of CBM activities in two new districts of Maharashtra**

**Budget- Budget for activities planned in this proposal during the period of April 2012 to March 2013 would be Rs. 24,99,065.**

**Goal and Outcomes for the year 2012-13**

**A) Promotion of health rights activities with focus on maternal health in collaboration with selected partner organizations in four districts of Maharashtra**

- Organisation of capacity building workshops on health rights and community based monitoring for PRI members, civil society organizations and other social actors by partner organizations with the objective of mobilizing them for resolution of unresolved and outstanding public health issues.
- Organisation of health rights events / campaigns / public programmes / press conferences /conventions to press for resolution of unresolved public healthcare issues with wider participation of social actors including PRI members.
- Facilitation of collection of information on maternal health services (at District hospital / CHC / PHC levels) along with documentation of selected cases of denial of maternal health services in these areas.

**B) Advocacy on Patient's Rights**

Organization of two state level multi-stakeholder meetings on Standardization and Regulation of Private Healthcare Sector including Patient's Rights, particularly in the context of newly launched Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) in Maharashtra and emerging proposals for Universal health care.

**C) Value addition to Community based monitoring of health services and state level advocacy**

1. Information about some of the CBM linked accountability processes is widely disseminated and some of these processes are adopted even in non CBM areas.
2. As a result of wider advocacy for CBM as an accountability principle, some number of civil society organisations, activists, public health professionals and PRI members publicly support CBM process as a principle.

**D) Publications**

Booklet for PRI members regarding community based monitoring, ASHA, untied fund, guaranteed health services etc.
Publication of report of 'participatory review of community based monitoring of health services in Maharashtra'
Publication of modified patient's rights policy brief in the context of RGJAY.

**Status of the Activities/ output In the year 12-13**

**Activities/ output expected: Organisation of capacity building workshops on health rights and community based monitoring for PRI members, civil society organizations and other social actors by partner organizations with the objective of mobilizing them for resolution of unresolved public health issues:**

**Khoj** arranged the workshop of stake holders on 29th December 2012.
**Janarth** arranged a training workshop for Panchayat Raj Institution members of ten Gram Panchayat on unresolved health rights issues. Similarly it arranged a workshop for teachers' organization on patients' rights on 31st Dec 2012. **Amhi Amachya Arogyasathi: Stake holders Workshop** was conducted in Kurkheda on 13th Sept, 2012.

**Activities/ output expected: Organisation of health rights event/ campaign/public programme / press conference/convention to resolve unresolved public healthcare issues with wider participation of social actors.**

**Convention to resolve unresolved public healthcare issues with wider participation of social actors.**

A Dharane Andolan was undertaken on 10th December 2012 i.e. the Human Rights Day, at Gadchiroli to demand resolution of many unresolved healthcare issues.

**Patients' rights events:**

**Nagpur: Within assembly session:**

On 18th and 19th December 2012 amidst the assembly session at Nagpur, partner organizations and civil society organizations met various press reporters, MLAs to demand rectification of gaps in the central CEA.
**Khoj:** A stake holder workshop was organised in Amarawati to discuss lacunae in government hospitals

**Masum** organised a Taluka level meeting of stakeholders to present the data. Deputy Director Health, Taluka medical officer, Panchayat Raj members and some patients who had to face denial of services participated in this meeting.

**At Pune,** many organizations gathered at Lokayat on 1st Feb 2013 for discussing the emerging issue of Clinical Establishment Act. (CEA) Nearly 60 people participated from different districts of Maharashtra including Nandurbar.

**Maharashtra state health ministry came out with intent to adopt Central Clinical Establishments Act (CEA) 2010 as it is.** This posed a sort of opportunity to use CEA to spread awareness for some kind of regulation of private health providers, and also as a challenge because the Central CEA has some serious gaps for its successful ground level implementation and in patients' rights perspective. These gaps need to be rectified.

In response to this change in context, we organised a workshop in Pune, involving members of JSA and many other social organizations to inform the activists about the welcome steps incorporated in CEA and also about the major deficiencies in it.

We also interacted with IMA branches in Pune, Mumbai and Nashik.

CEA provided a pivot for engaging various organizations of private practitioners like Association of Medical consultants in Mumbai in constructive dialogue for social regulation of private healthcare providers.

No changes were required in proposal design per say to respond to the challenge of CEA but the activities for advocacy for patients' rights were focused more on CEA.

**Activities/ output expected: Collection of information on maternal health services (at District hospital / CHC / PHC levels)along with documentation of selected cases of denial of maternal health services:**

**1) JSSK related training of activists** was taken in Khoj, (Date: 4th Sept) Janarth,(Date: 12th Sept) and in Masum, (Date: 19th Sept ) by Dr Arun Gadre. Shakuntala Bhalerao had a dialogue with activists of Amhi Amachya Arogyasathi on 11th Sept 2012.

**2) All four partners, Khoj, Amhi Amachya Arogyasathi, Janarth and Masum collected data of denial of services under JSSK programme.**

**Nandurbar: Janarth:**

A workshop was taken for volunteers. JSSK was monitored in 30 villages.

All organizations are going to present the data in district event of coming CBM.

**Activities/ output expected: Organization of state level multi -stakeholder meetings on Standardization of Private Healthcare Sector and Patient's Rights in the context of Rajiv Gandhi Jeevandayee Arogya Yojana in Maharashtra**

The workshop on 'Rajiv Gandhi Jeevandayee Arogya Yojana' was conducted on 25th June 2012 in Mumbai. The meeting was attended by about 50 participants from different parts of Maharashtra. Dr Rajan Shukla from IIPH, Hyderabad, presented detailed analysis and critique of the 'Arogyasri' scheme in A.P. This was followed by a comparison of the Arogyasri scheme in A.P. and emerging Jeevandayee scheme in Maharashtra by Dr Abhijit More from SATHI.

Press conference on this issue was held the next day i.e. 26th June 2012.

Another workshop was conducted on 'Clinical Establishment Act and regulation of private hospitals' in Pune on 1st March 2013. About 50 activists participated in the workshop.

**Masum** arranged a workshop at Parinche Tal: Saswad, on the subject: Patients' rights. Dr Arun Gadre from SATHI presented the concept of health rights in general and patient's rights in specific. Many PRI members, representatives form the civil societies, teachers and students participated. The very concept that even private medical person is accountable to the patients was intriguing. A lot of discussion ensued

with active participation from PRI members and teachers.

**Activities/ output expected: Dissemination of CBM related processes like data collection, community level health rights dialogue. Replication of these processes in some non-CBM areas**

A) The CBMP process was disseminated in two districts of Marathwada- Nanded and Latur. Jansanwad took place in three PHCs (Malakoli, Barul) in district Nanded on 2nd, 5th and 8th June 2012 respectively

B) With the help of partner organization (PO),' Astitwa Samaj Vikas Wa Sanshodhan Sanstha'; the CBMP process was disseminated in, Taluka Sangola, district Solapur.Health rights Jansamwad took place at Sangola, district Solapur on 18th Sept 2012.

In Latur district- Jan sunwai was organised in Ausa(in collaboration with Rationing Kruti Samitee), Renapur (in collaboration with Mahila Rajasatta Andolan) and Ahmadpur (in collaboration with Kalapandhari) on 26th Feb, 25th feb and 24th Feb 2013 respectively

C) At Chiplun: on 16th March 2013 three PHC level Jan sunwai were conducted by Partner Organization 'Samwad'. The PHCs which were monitored were Kapare, Rampur and Kharawate. Chiplun is not covered under NRHM CBMP. Over all though the higher health authorities did not attend, the Jansunwai was successful in giving a sense of public accountability of Government Health Services to the partner organization and villagers.

**Activities/ output expected: Preparatory activities and facilitation of intensive participatory review of community based monitoring of health services in Maharashtra (2007-2012),**

CBM evaluation is complete. Mrs. Renu Khanna, and Mrs. Anagha Pradhan completed collection of the data from the field, its analysis and have come out with a draft report.

**Activities/ output expected: Organization of state level multi stakeholder (which includes civil society, media, academicians and policy decision makers) consultation to disseminate findings of this review process**

Debriefing of the report was done to the implementing partner organizations on 26th March 2013.
Dissemination of the CBM evaluation report will be done in Mumbai on 25th May 2013 with multi stake holders.

**Activities/ output expected: Publications:**

**Publication of modified patient's rights policy brief in the context of RGJAY-** Published.

**Booklet for PRI members regarding community based monitoring -**Published

**Film on CBM -** Done

## RESOURCE CENTRE ON MATERNAL HEALTH RIGHTS - BARWANI, MP

**Project Reporting Period:** April 2012 to March 2013

### I. Background

The record of the Health system in India towards providing adequate and quality health services to ordinary people residing in rural and urban parts of India has been exceptionally poor. With the advent of neo-liberal policies from the 1990s and consistent stagnation or reduction in real

terms in the Government's spending on health care, public health services in India have been weakened further.
Presently the Health Sector in India is undergoing significant policy changes, particularly after the launch of the National Rural Health Mission which is a mixed package. Some initiatives like increased public health funding, promise of guaranteed health services at all levels of the public health system, institutional recognition to Community based monitoring of health services, clearly delineated IPHS (Indian Public Health Standards) are welcome steps laid down in the framework of NRHM. On the other hand, introduction of questionable Public Private Partnerships (PPPs), problematic incentive based schemes like JSY (Janani Suraksha Yojana) focused on promoting institutional deliveries etc. are some of the contentious issues. Recently JSSK (Janani Shishu Suraksha Yojana) has been launched. JSSK is definitely a game changing entitlement as it excludes none, (it is not only for BPL families) it guarantees free transport to and fro for a pregnant woman for her delivery, promises free medicines/diet/ delivery services and Caesarian section to woman, offers free treatment, transport for new born. While problematic aspects of Public health policy like those mentioned above would need to be modified through social pressure, the promises and guarantees made under NRHM like JSSK can be actualized at the ground level only through sustained public mobilisation and popular pressure for accountability.

Within this broader setting, Maternal health services have emerged as an important focus area both at policy level, as well as among civil society organisations. The official focus on reduction of maternal mortality has led to introduction of schemes like JSY which have induced larger numbers of women to seek institutional deliveries, without the required upgradation of services in health facilities. This is leading to a situation where increasing numbers of women are seeking institutional delivery care, often being forced to travel long distances to public hospitals for the same, but are being denied quality services, with serious consequences. Madhya Pradesh is one of the states with an already high maternal mortality ratio (335 as per SRS, 2009) where such developments are *raising a serious question as to whether 'institutional delivery' necessarily means 'safe delivery'*.

Given this larger context, since over the last one decade, SATHI along with various organisations have taken a 'Right to Health' approach and are specifically involved in asserting the demand for the Right to health care. Fostering health movements in collaboration with people's organisations and other like minded grassroots NGOs has been one of the key themes adopted by the SATHI team since the inception of its health rights work in Maharashtra and Barwani district of M.P. The SATHI team has been collaborating with the people' organisation Jagrit Adivasi Dalit Sangathan (JADS) in Barwani since the year 2000, supporting training of women community health workers as well as assisting development of community pressure for improved functioning of public health services.

In the last one year SATHI team at Badwani has identified two like minded NGOs interested in activities with a health rights perspective. These are Sanjeevani at Amarawada in Dist. Chindwada and Gram Seva Samitee, at Rohana, in Dist. Hoshangabad. Two more NGOs, Parath and Satyakam have also been identified for giving technical inputs on health rights issues.

Keeping this entire background in mind, the SATHI team based in Barwani is planning to give further focused inputs on the issue of maternal health rights to the selected organisations in western / central M.P.

## II. Objectives

The main objectives of the resource centre to be achieved in collaboration with grassroots NGOs and people's organizations, in selected areas are as follows:

- Creating awareness regarding maternal health services and related rights among community members and activists of grassroots organizations.
- Advocating in selected districts 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 behaviour and communication with people accessing care, as well as improving delivery of basic health services in selected areas
- Promoting maternal death reviews by district maternal death review committees, as well as building capacity for community maternal health audit among involved civil society organizations.

**Proposed:** It is proposed that focused activities would be carried out in Barwani district along with areas of two more partner organisations, Sanjeevani at Amarawada in Dist. Chindwada and Gram Seva Samitee, at Rohana, in Dist. Hoshangabad. Two more NGOs, Pararth and Satyakam from same districts will be provided technical assistance for their Maternal health activities.
The time frame proposed is one year (April 2012 to March 2013).

**Status:** All above mentioned NGOs were contacted/ contracted, supported and the outcome was dialogue between the communities and health officials on various gaps identified in Chindwada and Hoshangabad.

## Main activities

A. **Awareness building, information collection and analysis, inputs for community oriented review of health services in Chindwada (working with Sanjeevani), and Hoshangabad (working with Gram Sewa Samitee)**

C1) For the activists of **Sanjeevani, Chindwada, and Gram Sewa Samitee, Hoshangabad** trainings of the activists and facilitators was conducted. Further follow up trainings as per need will also be undertaken. The focus of these trainings was on, data collection from Primary health centers and CHCs, with a health rights perspective, monitoring of Village Health Nutrition Day (VHND) where the Ante- Natal Check up is conducted by ANMs. For other two NGOs, Pararth and Satyakam, technical assistance was provided for similar trainings of the activists of these NGOs to enable them to carry out health rights activities with focus on maternal health.

### C2) Community and local level training and orientation

**Village health groups** – partner organizations organized orientations of active village community members in their area of work on key issues including public health system entitlements, duties of public health providers, community based monitoring etc. Action plans based on local health priorities at the community level would also be developed based in such village meetings.

### C4) Surveys and data collection

Partner organizations were helped to carry out collection of information in their areas regarding the existing status of availability of maternal health services

**C5) Dialogue with local health officials (Jan Samwad):** After analyzing the data collected from PHCs and CHCs, issues of denial of services were raised in a local block level dialogue with health officials. The Jan Samwad was conducted in Amarawada on 30th October 2012 and in Hoshangabad in November 2012.

### B. State level workshops

A state level preparatory workshop was organized on 11th and 12th February 2013 with participation of representatives of various grassroots organizations from different districts of M.P. During this workshop participants were informed about various maternal health related schemes and facilities expected to be provided as entitlements, the status of maternal deaths in various districts, methodology of community audit of maternal deaths, and methods of information collection and analysis regarding maternal health services. A group was formed – 'Mahila Swasthya Adhikar Manch, MP' to coordinate activities in 13 districts. After three-four months and data collection at local level, a State level dissemination workshop would be organised, where the grassroots organizations would present the collected data and advocacy and media coverage would be undertaken concerning the issues raised.

### C. Support for information collection and analysis, inputs for health rights activities in Barwani (working with JADS)

Keeping in mind the ongoing issues being raised by the People's organisation JADS regarding maternal health services in the district, as well as the ongoing PIL on maternal deaths and positive orders issued in this case, inputs for various further health rights activities were given in Barwani district as per need expressed by the people's organisation. This included organising awareness camps on maternal health entitlements in various blocks, accessing relevant information and analyzing this in context of further follow up for the PIL.

## TRANINGS & EDUCATION (CEHAT)

### Second National course on Comprehensive health sector response to sexual assault

In collaboration with the Department of Forensic Medicine and Toxicology, Seth GS Medical College & KEM Hospital, Mumbai, we organized the second national course on comprehensive healthcare response to sexual assault survivors. The course, held in Mumbai on 31st March and 1st April 2012, 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.

Led by national experts from the fields of gynecology, forensic medicine, law, and social sciences, the workshop was hugely successful in stimulating discussions vis-à-vis the therapeutic and evidentiary role of doctors in responding to survivors of sexual assault. Various methods such as role plays, film screening, case studies, and facilitated discussions were employed to build perspectives of doctors on sexual violence, and their ethical and legal responsibilities. 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. The course received CME accreditation from the Maharashtra Medical Council demonstrating its relevance to in-service training for post-graduate doctors as well as for incorporation into the medical curriculum for undergraduates.

**Seminar On Gender Based Against Women- Role Of Healthcare Providers**

A seminar on comprehensive response to gender-based violence was organized in collaboration with the Department of Forensic Medicine and Toxicology, Seth GS Medical College and KEM Hospital, on 15th April, 2012. The seminar received an unprecedented response with over 200 registrations. Participants ranged from disciplines of gynecology, forensic medicine, surgery, pediatrics, psychiatry, internal medicine, orthopedics, preventive and social medicine, pathology, physiology, anatomy and pharmacology. These included medical students, resident doctors, medical faculty, general practitioners, specialists/ consultants, hospital administrators, social workers and lawyers. While predominantly from government and private medical colleges and hospitals of Mumbai, there were representations from Pune, Nagpur, Pardi, Kamthi and Chandigarh as well.

National experts from the fields of gynecology, forensic medicine, community medicine, law, and social sciences led discussions with healthcare providers. Adv. Flavia Agnes delivered the keynote address highlighting responsibilities of doctors vis-à-vis the judicial frameworks governing domestic violence and sexual assault in India. Dr. Jagadeesh Reddy, Renu Khanna, Dr Sanjay Oak, Dr Kamakshi Bhate, Chitra Joshi, Sangeeta Rege and Dr Padmaja Sawant were other speakers at the semina, The Maharashtra Medical Council granted 2 CME credits to participants for attending this seminar. Participants expressed satisfaction with their learning through this seminar, and echoed the need for greater sensitization of health professionals on this issue through incorporation in MBBS curriculum.

**Capacity Building Of Health Professionals In Delhi Hospitals**

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 as well as a joint intervention research project was discussed.

**Training On Domestic Violence**

Training was initiated in 2012-2013 at the five peripheral hospitals. There was one core group meeting held at KB Bhabha Bandra, two at KB Bhabha, Kurla, two at Cooper, two at Rajawadi and one at MT Agarwal hospital. At KB Bhabha Kurla and MT Agarwal hospitals, the film *At the Crossroads* was screened for the staff. It was mainly attended by the nurses at both hospitals. KB Bhabha Kurla had around 15 participants and at MT Agarwal 36 health care staff including nurses and technicians and support staff attended. After the film screening, there was a discussion for 1 hour on the issue of Domestic Violence. At Rajawadi, an orientation of the new staff about issue of Domestic Violence was facilitated by the core group members and Dilaasa team.

On 8$^{th}$ of March, International Women's Day was celebrated by organizing skits and a poster competition. This was done with a view to increase awareness and sensitivity of the women employees of the hospitals, to help them recognize and appreciate themselves as women and to emphasize the importance of reaching out to the patients during the OPD hours. The counsellors have also been involved in training and activities to create more awareness at community level. Such community awareness programs were held at Kurla, Chunabhati and Vikhroli areas. Chehak organization had invited Community Development Officer of KB Bhabha Hospital and the counsellors at Dilaasa centre for an interaction with the women in Goregaon centre to promote awareness about the issue of domestic violence. They were also invited to conduct training for the new appointed Community Development Officers at a hospital.

**Training On Sexual Violence**

With the change in the law for sexual assault (Criminal Amendment Act, 2013 and Protection of Children from Sexual Offences, 2012), the interventions and the trainings were made more robust to accommodate this change. A total of 86 doctors were trained in 6 trainings in the 3 hospitals. An additional 66 doctors and health care providers including nurses were trained in 2 other hospitals (Jaslok Hospital and Centenary Hospital, Govandi) that asked for the training. In this one year, there have 3 joint monitoring committee meeting with the members of the monitoring committees of all 3 hospitals with one monitoring committee meeting in each hospital every month. These monitoring committee meetings look at the issues in providing a comprehensive healthcare response to the survivor. These meeting provide a platform for the doctors, the nurses, the MO, the MS and the MRO to talk about the problems they face while providing services and try to come up with solutions to overcome these.

**Capacity Building On Role Of Health Professionals In Responding To VAW**

In this period 3 trainings on comprehensive health care response to sexual assault were conducted in these hospitals where 15 resident doctors and housemen participated. The components of the training were perspective building, importance of taking informed consent, eliciting detailed history, thorough examination, orientation to SAFE kit and how to use it to collect the different samples, importance of drafting the provisional opinion etc. Different case studies were used during the training to make them understand the model thoroughly. In addition

to this, resource persons from CEHAT were also invited to other hospitals such as Sion Hospital and Thane Civil Hospital to conduct sessions on sexual assault examination and importance of the health system in responding to Violence Against Women.

**Inclusion Of Training On Violence Against Women In The BMC-Training Cell**

Since 2011, CEHAT has been advocating for inclusion of the trainings on domestic and sexual violence for health professionals, into the regular training sessions held by the municipal corporation of greater Mumbai. A proposal for this too was submitted to the CMS back in 2011 and was approved. The BMC's training cell conducts several trainings for staff on issues such as biomedical waste management, transfer protocols etc. Along with this, a 2 hour session on Violence Against Women as a Health issue was also included in the training. The session covered both sexual and domestic violence, the dynamics of violence, its health consequences, and the legal and ethical role of health professionals in responding to survivors of violence. Two such trainings were conducted in the reporting period – one with clinical and the other with non-clinical staff. In addition to this, a need was also expressed by the BMC to conduct specific trainings for doctors on Medico-legal Procedures and Mental Health. These have been planned in the forthcoming months.

**Counselling Ethics Workshop**

The ethical guidelines for Domestic Violence counseling which were published as part of the project were disseminated among NGOs at a workshop organized at the Savitribai Phule Gender Resource Center on 17th November 2012. The workshop was attended by a range of organizations providing services to survivors of DV. Some of the participants were trained counselors, while others were barefoot workers. The participants were provided with an overview of feminist counseling, after which they were asked to reflect on the principles outlined in the guidelines - against their own practice. The discussion that followed was extremely very insightful. Organizations spoke of the manner in which their practice sometimes jeopardized ethical principles. For instance, one organization spoke about how they were required to submit names and addresses of beneficiaries who sought counseling support, to the social welfare department. This was treated as a governmental requirement, without realizing the implications that it might have for the survivor's confidentiality. Similarly, one counselor from a telephone helpline spoke of how they mandatorily reported cases of all callers expressing thoughts of ending their lives, to the police. The implications of these for the client were discussed, as were ways in which they could operationalize the guidelines into their own counseling practice, in order to ensure that ethical principles were respected.

**Feminist Counselling Course In Nirmala Niketan**

Having conducted two courses on Feminist Counseling in Violence Against women in collaboration with the Tata Institute of Social Sciences, we were approached by Nirmala Niketan College of Social Work to conduct a session with their students. A day-long course for MSW (part 2) students was conducted in December 2012. The course was aimed at building a feminist perspective in counseling and imparting skills on feminist counseling in violence against women. Through interactive methods such as case studies and role plays, the course helped students

understand the dynamics of domestic violence and the strategies that can be employed in counseling.

## INTERVENTION AND SERVICE PROVISION (CEHAT)

### Crisis Intervention Services For Survivors Of Sexual Violence

During the year, 61 cases of sexual violence were responded to. Counselling services continued to be given to these survivors and their families. Through our intervention we have attempted to ensure that the medico-legal examination is sensitive and scientific, while also ensuring that the survivor gets comprehensive treatment and care while they were in the hospital. We have also helped survivors negotiate with the police and legal system. There have been several problems in dealing with the police in the recent past. At the 3 hospitals where the comprehensive health care response to sexual assault is being implemented by CEHAT, a need emerged for creating a group of health care providers in the hospital who would monitor the response to each case. It was decided in consultation with Dr Seema Malik (Chief Medical Superintendent) that a Monitoring Committee should be formed in each of these hospitals who will make sure that a comprehensive healthcare response to each sexual assault survivor in the hospital is operationalized. The Monitoring committee includes Medical Superintendent of the hospital, Medical Officer, Lecturer or Registar of each Gyneacology unit, sister in charge of Labour/ Gyneacology ward, Community Development Officer and Medical Records Officer of the hospital. During this period two Monitoring committee meetings were held. In the first meeting, purpose of forming this monitoring committee was explained to them, the components of the model and principles for intervention were presented. It was decided that detailed Standard Operating Protocols outlining role of each health care provider would be prepared which will help to ensure that each component of the model response is operationalized effectively. During this period there were also some concerns related to with the Forensic Science Laboratory. To deal with this, there was a felt need to have one meeting with FSL to understand the procedure of sending samples to FSL. At the second monitoring committee meeting held in December, Dr Desai from the FSL was invited to explain the requirements of the FSL and how samples should be packed, sealed and sent to FSL.

### 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) is a BMC initiative for fostering work related to gender, health and VAW. 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**

There were 209 new cases registered at KB Bhabha, Bandra during the period April 2012 to March 2013. While at KB Bhabha, Kurla, the number of new cases registered was around 56. There were243 follow-up interventions carried out at KB Bhabha Bandra and 29 at KB Bhabha, Kurla. These cases are referred from the health system (doctors, nurses, and support staff), from the community, from ex clients and other such sources. There are weekly meetings held at the Dilaasa Centre, Bandra where cases are discussed with the other members of the team. Around 35 such case presentations have been held in this period. These case presentations involved in depth discussions on documentations, safety planning exercises, understanding of alcoholic addiction and safety planning for women, discussion on intake sheet other than discussing cases of the counsellors. The topics for these discussions are based on the experiences and comments shared by the team which led to planning of themes for the CPs. A system of telephonic follow ups was put in place through discussions in case presentation.

Whenever the woman needed legal help, she was provided with it with the help of the lawyers from Majlis who visit the centre. When the woman needed urgent assistance, an appointment was sought from the lawyer and the woman was directly referred. Under the provision of PWDV Act, women can be directly referred to the Protection Officers for filing of DIR so that the matter comes on board faster. Hence, in some cases, the counsellor directly referred a woman to the Protection Officer. This decision of referring the woman to the Protection Officer was made based on the specific need. At KB Bhabha, Bandra, counsellors interact with the health care professionals of the hospital on a regular basis. A system of maintaining a register has been in place recently to assess the overall interaction and its impact. Counsellors found that when there was such regular interface with the doctor at the casualty, the number of referrals increased by that particular doctor. Counsellors also regularly visit the wards and talk to the patients, the nurses and provide information about Dilaasa and its services.

**DOCUMENTATION AND PUBLICATION (CEHAT)**

Review was conducted and changes for missing or incomplete data in SLIM Library software was completed in 2012. The entire library collection is bar coded. The editing work for documentary films is completed. Short abstract of the documentaries and other documentary details were added to the section till 2012. E-document sections links are given to the soft copies either on the web or in-house resources.

The Stock taking of the library was done with a detailed documentation process. In which transfer of books from CEHAT library to CSER library was done and same was updated on SLIM. The locations of the books which are under SATHI library are changed and they are now reflecting under SATHI and not CEHAT. As an ongoing process website is updated on regular basis with Publications, Articles, Reports, Press coverage, events. We are regularly posting news on Face book page.

Promoting the Library and Documentation Unit Collection : Our main focus still remains on promoting 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. Publications are displayed in various events.

News alert are send regarding the relevant projects to relevant teams as a ongoing process.

The research area webpage is user friendly that the information which is required by the user is accessible at one glance.

Details about each project, research are easily located under the links to all the publications i.e. reports, paper/articles and resources material developed under that research area. For example: 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.

**Publications**
**Book:**

- Feminist Counselling and Domestic Violence in India/ Edited by Padma Bhate-Deosthali, Sangeeta Rege, Padma Prakash. Routledge India – 2013 – 352 pages.

**Reports**

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- Establishing a Comprehensive Health Sector Response to Sexual Assault. Mumbai: CEHAT, 77 p., 2012 [ISBN: 978-81-89042-63-9]
- Raymus, Prashant. Mapping Budget Processes in the Public Health Sector in Maharashtra. Mumbai: CEHAT, 163 p., 2012 [ISBN: 978-81-89042-62-2]
- Ethical Guidelines for Counseling Women Facing Domestic Violence. Mumbai: CEHAT, 32 p., 2012 [ISBN: 978-81-89042-60-8]
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**Press coverage: 2012 & 2013**

**2013**

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http://www.thehindu.com/news/national/many-rape-survivors-wipe-off-evidence-study/article5113801.ece

http://archive.indianexpress.com/news/panel-drafts-guidelines-for-better-healthcare-to-sex-abuse-victims/1160992/

http://epaper.timesofindia.com/Default/Scripting/ArticleWin.asp?From=Archive&Source=Page&Skin=TOINEW&BaseHref=TOIM/2013/08/26&PageLabel=1&EntityId=Ar00102&ViewMode=HTML

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http://archive.indianexpress.com/news/maharashtra-rape-examination-norms-fall-short/1114982/

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+Times+City&title=Poor+education%2C+job+opportunities+fuel+%E2%80%98internal+brain+drain%E2%80%99+in+India&edname=&publabel=TOI

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http://timesofindia.indiatimes.com/city/mumbai/One-in-two-people-dont-know-abortions-are-legal-says-survey/articleshow/19027358.cms

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http://www.dnaindia.com/mumbai/report-treatment-for-poor-not-free-study-1639386

**Documentation and Publication (SATHI)**

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 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-9, English-11
6. Books- 3269
7. Bound Volumes- 186
8. Reference Books- 130

**The publications brought out during April 2012 to March 2013 are as follows**

| No | Particulars of Publication | Date of Publication |
|---|---|---|
| 1 | 'Dawandi'- News Letter published quarterly | April , 2012 to March, 2013 |
| 2 | PIP Flyer Capacity Building to Promote Commnutity Based Health Planning in Maharashtra | September, 2012 |
| 3 | Pictorial VHSC Report Card (Aplya Gavatil Aarogya Sevanche Pragatipatrak) | October, 2012 |
| 4 | Pictorial PHC Report Card (Aplya Prathmik Aarogya Kendratil Aarogya | October, 2012 |

| No | Particulars of Publication | Date of Publication |
|---|---|---|
| | Sevanche Pragatipatrak) | |
| 5 | Pictorial PHC Tool (Prathmik Aarogya Sevanchi Prashnavali) | October, 2012 |
| 6 | Pictorial VHSC Tool (Gaon Patilvar Milnaraya Aarogya Sevanbaddlchya Mahitisathi Prashnavali) | October, 2012 |
| 7 | Certificate_Aarogya Sevanvar Vikendrit Niyojan Prashikshan Pramanpatra | October, 2012 |
| 8 | Pictorial Subcentre Report Card | October, 2012 |
| 9 | Pictorial Subcentre Tool | October, 2012 |
| 10 | Medicine Tool_Dekrekh Karu Ya Aushadhanchya Kharedi-Vitran Prakriyevar Ani Uplabadhatevar | November, 2012 |
| 11 | Sarvansathi Mofat Aarogya Seva (Universal Health Care Booklet in Marathi) | November, 2012 |
| 12 | Ashi Hot Ahe Aarogya Sevevar Lokanchi Dekhrekh (CBM_Marathi Brochure) | November, 2012 |
| 13 | Aarogya Kendratil Aushdhanchi Uplabhadata Ani Kharedi-Vitaran Prakriya (Report on availability of Medicine) | November, 2012 |
| 14 | SATHI Brochure | December, 2012 |
| 15 | Government Clinics are turning into people's Clinics (Brochure) | December, 2012 |
| 16 | Chala Aapli Gaon Aarogya Samiti Balkat Karu ya! (VHSC_Booklet) | December, 2012 |
| 17 | Sarvajanik Aarogya Sevanvar Lokadharit Dekhrekh Prakriya (Guide Book) | December, 2012 |
| 18 | Aarogya Sevanche Posters (5 types posters) | December, 2012 |
| 19 | ‘Rugna Kalayan Nidhi’, ‘Rugna Kalyana’sathi Kasa Kharcha Karava? (RKS Guide Booklet) | January, 2013 |
| 20 | State level Community monitoring survey (based on SMS) regarding Availability of essential medicines in PHCs of Maharashtra (Aushadh Tutvadaycha Prashna Sutena, Marg Asun Gadi Pudhe Jaina) | January, 2013 |
| 21 | Kasa Kharch Kela Jato Gaon Aarogya Samitila va Rugna Kalayan Samitila Milnara Nidhi (Brochure) | January, 2013 |

| No | Particulars of Publication | Date of Publication |
|---|---|---|
| 22 | Rugna Kalayan Nidhi _Report (Gaon Aargoya Samitila va Rugna Kalayan Samitila Milnaraya Nidhicha Vapar) | January, 2013 |
| 23 | IDPMS Booklet on medicine availability_Marathi | January, 2013 |
| 24 | Catalogue of SATHI Publication (booklet) | January, 2013 |
| 25 | Kahi Muddyanvar Samadhan.... Barech Prashna Baki (Lokadharait Dekrekh Prakriya Culmination Marathi Flier) | January, 2013 |
| 26 | Thodkyat Davandi book | March, 2013 |
| 27 | PHC Monitoring and Planning Committee Booklet (PHC Booklet) | March, 2013 |
| 28 | Rajiv Gandhi Jivandai Yojana policy brief | March, 2013 |
| 29 | Lokadharit Dekhrek Prakriya single Poster in 4 color | March, 2013 |
| 30 | 24 x 7 PHC in Maharashtra_ Flier | March, 2013 |
| 31 | Nivdnuka Jinklya, Ata Pudhe Kay? (PRI Members booklet) | March, 2013 |
| 32 | Aarogya sevanvar Lokadharit Dekhrekh v a Niyogen _ Stickers | March, 2013 |
| 33 | Aarogya Seva Aapla Hakka Calendar January 2013-March 14, | March, 2013 |
| 34 | Report of Evaluation of Community based Monitoring & Planning in Maharashtra | March, 2013 |
| 35 | Report of Evaluation of Community based Monitoring & Planning in Maharashtra in mahrathi ( Maharashtra Lokadharit Dekhrekh Prakriyachya Mulmapnacha Ahaval | March, 2013 |

## STAFF DETAILS AS ON 31ST MARCH 2013

| Sr. No | Name of the Staff | Designation | Gross salary | Centre |
|---|---|---|---|---|
| 1 | Meena Indapurkar | Office Assistant | 7,220.00 | SATHI |
| 2 | Dinali Hataskar | Research Associate | 11,426.00 | CEHAT |
| 3 | Kinjal Ved | Office Assistant | 12,250.00 | CSER |
| 4 | Shobha Kamble | Office Assistant | 14,641.00 | CEHAT |
| 5 | Vidya Todankar | Secretary | 15,217.00 | CEHAT |
| 6 | Anjali Kadam | Secretary | 18,671.00 | CEHAT |
| 7 | Sharda Mahalle | Administrative Assistant | 21,536.00 | SATHI |
| 8 | Jessy Jacob | Administrative Assistant | 21,536.00 | SATHI |
| 9 | Deepali Yakkundi | Project Associate | 22,466.00 | SATHI |
| 10 | Urmila Dikhale | Junior Administrative Officer | 23,826.00 | SATHI |
| 11 | Ashwini Devane | Junior Project Officer | 24,186.00 | SATHI |
| 12 | Shweta Marathe | Junior Project Officer | 24,906.00 | SATHI |
| 13 | Shakuntala Bhalerao | Junior Project Officer | 25,626.00 | SATHI |
| 14 | Trupti Joshi | Junior Project Officer | 25,626.00 | SATHI |
| 15 | Rashmi Padhye | Junior Project Officer | 25,986.00 | SATHI |
| 16 | Bhavna Lalwani | Senior Research Associate | 26,883.00 | CEHAT |
| 17 | Prachi Avalaskar | Senior Research Associate | 27,983.00 | CEHAT |
| 18 | Pramila Naik | Senior Research Associate | 28,258.00 | CEHAT |
| 19 | Sumita Bohra | Junior Admin & Accounts Officer | 28,258.00 | AT |
| 20 | Sanna Meherally | Junior Programme Officer | 29,975.00 | CSER |
| 21 | Deapica Ravindran | Junior Research Officer | 31,075.00 | CSER |

| | | | | |
|---|---|---|---|---|
| 22 | Nilangi Sardeshpande | Senior Project Officer | 38,454.00 | SATHI |
| 23 | Arpan Tulsyan | Senior Research Officer | 36,100.00 | CSER |
| 24 | Sana Contractor | Research Officer | 41,919.00 | CEHAT |
| 25 | Divya Bhagianadh | Junior Programme Director | 42,150.00 | CSER |
| 26 | Neha Madhiwalla | Coordinator - CSER | 70,000.00 | AT |
| 27 | Saramma Mathew | Chief Finance & Admin Officer | 61,285.00 | AT |
| 28 | Padma Deosthali | Coordinator - CEHAT | 80,685.00 | AT |
| 29 | Ramdas Marathe | Office Assistant | 14,191.00 | CEHAT |
| 30 | Sudhakar Manjrekar | Office Assistant | 14,641.00 | CEHAT |
| 31 | Dilip Jadhav | Office Assistant | 14,641.00 | CEHAT |
| 32 | Santosh Trilotkar | Office Secretary | 15,300.00 | CSER |
| 33 | Abhijit More | Junior Project Officer | 15,592.00 | SATHI |
| 34 | Gajanan Londe | Office Secretary | 18,031.00 | SATHI |
| 35 | Ravindra Mandekar | Office Secretary | 18,301.00 | SATHI |
| 36 | Ramdas Shinde | Office Secretary | 18,301.00 | SATHI |
| 37 | Vijay Sawant | Secretary | 19,196.00 | CEHAT |
| 38 | Hemraj Patil | Project Associate | 21,536.00 | SATHI |
| 39 | Rakesh Sahu | Project Associate | 21,846.00 | SATHI |
| 40 | Mahendra Shinde | Junior Administrative Officer | 22,183.00 | CSER |
| 41 | Kiran Mandekar | Junior Administrative Officer | 24,186.00 | SATHI |
| 42 | Ajaylal Vishwakarma | Junior Project Officer | 24,186.00 | SATHI |
| 43 | Bhausaheb Aher | Junior Project Officer | 25,266.00 | SATHI |
| 44 | Shailesh Dikhale | Junior Project Officer | 25,626.00 | SATHI |

| | | | | |
|---|---|---|---|---|
| 45 | Siddharth David | Senior Research Associate | 26,883.00 | CEHAT |
| 46 | Nitin Jadhav | Project Officer | 28,105.00 | SATHI |
| 47 | Vaibhao Ambhore | Senior Research Officer | 35,200.00 | CSER |
| 48 | Arun Gadre | Programme Coordinator | 41,051.00 | SATHI |
| 49 | Oommen Kurian | Senior Research Officer | 43,011.00 | CEHAT |
| 50 | Abhay Shukla | Coordinator- SATHI | 62,320.00 | AT |

| **Slabs of gross monthly salary (Rs) plus benefits paid to staff** | **Female staff** | **Male staff** | **Total staff** |
|---|---|---|---|
| | | | |
| < 5000 | 0 | 0 | 0 |
| 5001 – 10000 | 1 | 0 | 1 |
| 10001 – 25000 | 11 | 14 | 25 |
| 25001 – 50000 | 13 | 7 | 20 |
| 50001 – 100000 | 3 | 1 | 4 |
| > 100000 | 0 | 0 | 0 |
| **Total** | **28** | **22** | **50** |

**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**

**ABRIDGED BALANCE SHEET AS AT:** **31st MARCH, 2013**

| 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** | | 1,852,459.72 | as on 31st March 2013 | | 2,605,549.06 |
| **Research & Education Fund** | | 1,933,189.33 | **Moveable Properties** | | |
| | | | Book value of moveable property | | |
| **Maintainence & Overheads Fund** | | 1,686,625.60 | as on 31st March 2013 | | 1,956,147.82 |
| **Building Fund** | | 8,721,426.97 | | | |
| | | | Tax deducted at source | 610,787.00 | |
| | | | Deposits | 375,545.00 | 986,332.00 |
| **Earmarked Grants (Refer Note c in Notes** | | | | | |
| **to Accounts)** | | | **Outstanding Income (Accrued Interest)** | | 48,655.97 |
| Opening balance as per last balance sheet | 12,854,286.48 | | | | |
| Add: Opening balance of Grants to be disbursed | 146,700.00 | | **Cash & Bank Balances** | | |
| Add: Grants received during the year | 48,555,567.14 | | Bank balances | 20,520,675.07 | |
| Add: Transfers during the year | - | | Fixed Deposits with Banks | 11,731,576.00 | |
| Add: Interest earned during the year | 253,720.00 | | Cash & Cheque in hand | 5,260.00 | 32,257,511.07 |
| Less: Grants disbursed during the year | 12,538,868.00 | | | | |
| Less: Transfers to various funds | 377,146.00 | | | | |
| Less: Expenses incurred during the year | 34,776,093.18 | 14,118,166.44 | | | |
| **Income & Expenditure Account** | | | | | |
| Balance as per last balance sheet | 9,235,312.88 | | | | |
| Add: Surplus as per Income & Expenditure Account | 276,959.80 | 9,512,272.68 | | | |
| **TOTAL** | | **37,854,195.74** | **TOTAL** | | **37,854,195.74** |

Place: Mumbai
Dated: 1st September 2013

**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**
**ABRIDGED INCOME & EXPENDITURE ACCOUNT FOR THE YEAR ENDED: 31ST MARCH 2013**

| EXPENDITURE | RS | RS. | INCOME | RS. | RS. |
|---|---|---|---|---|---|
| **To Establishment expenses** | | 363.00 | **By Grants administration income** | | 595,000.00 |
| | | | **By Interest (not allocated to any project or specific fund** | | 365,510.00 |
| **To Depreciation** | | 16,548.16 | | | |
| | | | **By Donation** | | 640.00 |
| **To Expenses towards objects of the Trust (Expenses over and above those booked under the Earmarked Funds)** | | 2,229,816.04 | **By Income from other sources** | | |
| | | | Contribution to publication & database | 60,617.00 | |
| | | | Miscellaneous Receipts | 5,000.00 | |
| | | | Consultancy received | 1,453,145.00 | |
| | | | Registration fees | 40,000.00 | |
| | | | Insurance claim received | 3,775.00 | 1,562,537.00 |
| **Surplus carried to Balance Sheet** | | 276,959.80 | | | |
| **TOTAL** | | **2,523,687.00** | **TOTAL** | | **2,523,687.00** |

Place: Mumbai
Dated: 1st September 2013