ANNUAL REPORT

PERIOD 1ST APRIL 2014 TO 31ST MARCH 2015

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. This centre began functioning from January 2005 in Mumbai. The Board of Trustees at a Special Meeting of the Trust held on May 11, 2013, decided to change the structure of CSER from an independent Centre to a programme, Research Programme on Ethics, directly under the Trust.

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 2014 - 15

I. RESEARCH (CEHAT)

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

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

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

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

small amounts of OOPs seriously. Only when large amounts are involved that they may report it or many might know about grievance redressal process. Even the RGJAY staff may tend to normalize the OOPs and may overlook the problem.

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

Study on Maternal Health

Maternal health concerns have consistently drawn the attention of successive governments and policy makers in India. To a large extent the public health system and its various mechanisms are devoted to provisioning of maternal health services across the country.

Despite the government's long term focus on maternal health care, bolstered by the globally applicable MDG of improved maternal health outcomes, many parts of the country continue to lag behind with abysmal maternal health indicators year after year. Against this backdrop, Oxfam India launched a multi-state[1] intervention project centred on improving the maternal health status. The study undertaken by CEHAT is part of this larger project.

As part of this project, CEHAT prepared policy documents for Odisha, Bihar, Jharkhand and India as a whole based on the primary data of the project and other secondary sources. Through the context specific strategies/recommendations in the papers, the aim is to set the wheels rolling towards achieving maternal health standards.

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

Unavailability of skilled human resources across all cadres is an issue universal to all the three states. The shortfall in human resource ranged from 28 percent to 90 percent across different health personnel in Jharkhand. Reasons for shortfall were similar across all three state and those

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

were usually high attrition due to low salaries, poor working conditions, absence of clear promotion policies, poor residential facilities and compromised security.
The quality of ANC and PNC service provision was not upto the mark in any of the states. Not all components of the ANC were offered to the women; measurement of Haemoglobin in blood, urine test was found to be the lowest across all states and the reason for the same was lack of necessary equipments/reagents to carry out those tests. PNC was mostly provided on the day of delivery and there after it gradually declined.

Budget of all the states showed that they relied heavily on incentive based schemes to address maternal health. The schemes failed largely in preventing out of pocket spending. Abortion facilities were largely missing to an extent that those were missing even from district hospitals in Bihar. Sterilization was the most promoted method of contraception and provisioning of temporary methods took a back seat in all three states.

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

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

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

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

model the screening and provision of empowerment counselling to pregnant women facing abuse while ensuring privacy and confidentiality of women.

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

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

Integrating Gender in Medical Education

Situation analysis of medical colleges

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

Only qualitative interviews conducted with faculty members for the purpose of analysis.

Some major findings:

- Most of the respondents confined teaching on Social Determinant of Health (SDH) and gender in general to PSM and were able to only vaguely remember the content on SDH in the MBBS curriculum. Apart from theoretical content, some practicals, history-taking, some theories in certain subjects like Psychiatry, clinical postings were reported by respondents as covering SDH.
- Many respondents spoke of changes in pattern of assessment – a shift to multiple choice questions – and increased emphasis on postgraduate entrance examinations today and lack of emphasis on practice being reflected in neglect of social aspects of health and promotion of a more scientific orientation towards health and medicine.
- About half of the respondents stated that gender issues were not taught in the MBBS curriculum. Respondents felt that issues arising out of gender discrimination, etc are not within the purview of medical education and that gender is too obvious a social phenomenon to be taught specifically in medical education.

- The respondents articulated an understanding of "gender" in terms of biological sex, issues of violence, prevalence/incidence of disease, and increasing presence of women in workforce is clearly indicative of a lack of a gender perspective in medical education.
- Respondents frequently expressed the idea that bringing in gender in medical education was a matter of improving communication between doctor and patient. Many hold gender stereotypical notions in causes of domestic and sexual violence, victim-blaming attitudes, assumptions on the basis of class and religion, etc.
- Some of the respondents were able to bring an understanding of gender as a social determinant of health in teaching their students about health seeking behaviour and disease incidence. Some respondents were able to identify vulnerabilities faced by women especially in case of spousal transmission of HIV and also the related stigma attached to an HIV positive woman or a woman suffering from TB which limits her access to treatment.
- Some of our respondents, who were able to identify gender-based discrimination, practices and power imbalances in society as a cause for adverse health consequences for women, expressed their limitations in terms of assisting their patients beyond the confines of the hospital. Reasons cited were heavy work load and the belief that the problem is social in origin and has to be tackled at the level of societal interventions and that there wasn't much that doctors could do about it.
- Some of the respondents spoke of practices being followed in their institutions in responding to sexual and domestic violence which are gender insensitive as the doctors do not take into account the trauma suffered by the woman and conduct the examination in a mechanical manner. In some cases, the doctors also tend to assume that most cases of sexual violence are that of consensual sex and thus show disbelief for the survivor's statement. Similarly, insensitive practices were also noted in carrying out abortion, especially in the second trimester.
- Some respondents held that social problems including gender are in the domain of family, society, etc and that as medical professionals, they cannot address these issues
- It was also held that the medical syllabus is already cumbersome and it is not possible to cover all relevant issues. Hence focus remains more on clinical aspects of medicine. Some of the respondents stated outright that learning about gender is not their concern as their duties are confined to examination of the case and giving treatment. But several other respondents agreed that it was necessary to integrate a gender perspective in medical education and also train medical professionals on the same.

Impact assessment research for GME

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

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

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

Evidence building on VAW

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

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

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

Data analysis on Sexual violence cases

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

Evidence on interventions in sexual violence

This paper is based on the results of establishing a comprehensive health sector response to sexual violence. Eliminating existing forensic biases to rape and neglect of health care needs of survivors, the model uses gender sensitive protocol for medico-legal documentation of sexual violence that focuses on informed consent, documentation of nature of sexual violence, collection of relevant forensic evidence, uses standard treatment guidelines for provision of

treatment and ensures provision of psycho-social support to survivor. This is supported by training of providers and setting standard operating procedures at facility level. The results indicate that a sensitive response by health professionals can play a crucial role in healing from sexual abuse.

Paper on Mandatory reporting:

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

a. A paper raising issues related to consequences of mandatory reporting, how it impinges on right to health care and the changes made in other countries has been written up. Paper submitted to British Medical Journal.

b. A briefing document was also prepared on the issue. This looked into the existing legal contradictions with regard to mandatory reporting of sexual violence to the police by health professionals, presented circumstances that act as barriers for survivors and their families in making immediate reporting and how it impinges on their access to health services.

Paper on legal outcomes:

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

Briefing documents:

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

Consultations:

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

Violence against Women in Conflict Affected Areas

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

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

CEHAT has committed to developing a volume on different practices related to violence against women and ways in which civil society organizations from across the country has engaged with it. A dialogue initiated with at least 9 organizations willing to contribute to this volume led to a study of the genesis of their work, the actual functioning, milestones achieved and challenges faced. Simultaneously, potential authors from respective organizations were contacted to contribute towards the making of this book and an outline for the case studies was developed and approved by all the contributors. Organizations including SAMA from Delhi, North-East Network from Shillong, Bhoomika and Anweshi from Kerala, Vimochana from Bangalore, Masum, Tathapi and SWATI from Pune, Sneha and Dilaasa from Mumbai will be contributing to the book. This volume would be the first effort in India to document the different forms of engagement with the health sector carried out by civil society vis-a-vis violence against women. The case studies will be presented at a national forum and ministries and civil society organizations will be invited for mutual sharing.

Formative research

A formative research was carried out at a government hospital in an Indian state with high prevalence of violence. The hospital has established a one-stop crisis centre in its premises to respond to survivors of violence. The objective of the research was to assess and understand the perception of the hospital staff regarding violence against women as a health issue and towards their own role in responding to women facing violence and to understand the role of the hospital

staff towards the one-stop crisis centre. A total of 31 semi-structured interviews were carried out with the staff of the hospital - doctors, nurses, sisters-in-charge, ward servants/ward guards and sweepers.

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

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

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

Study of police requisitions for sexual violence cases

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

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

Despite the expansion of the definition of rape under the Criminal Law Amendment 2013 and amendment in the Indian Evidence Act regarding not mentioning information related to past sexual history of the woman, questions posed by the police are heavily laden with gender insensitive questioning pertaining to the character of the woman emanating from a belief system that a sexually active woman cannot be raped. The data also indicates that police bring survivors for medical examination at odd hours through the night even in cases where there will be no

evidence due to passage of time since the incident, for e.g., when the survivor reports the assault after a week or month.

The observations of the data bring forth the need to sensitize the police and address misconceptions. It also highlights the need to draft model police requisitions to the hospital for medical examination. Often, police requisitions mention sections under which the case has been registered and request the doctor to conduct medical examination accordingly, which underscores the need to train doctors on various laws pertaining to sexual assault.

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

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

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

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

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

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

1. ***Needs Assessment for understanding the current response to survivors of violence against women and children:*** Needs assessment at the hospital level was done and the situation of current health services and an understanding of spread of health services were undertaken. It was noted that Goa has only one tertiary care hospital which has 950 cases and is responsible for doing a large amount of medico legal work. Besides this hospital, 2 other district hospitals namely Asilo and Hospicio are also present. A brief analysis of the medico legal work showed that there is no specific protocol that is being followed for MLC cases neither are the patients being given MLC documentation. It was also found out that at one of the district hospital, care services were available only for children facing sexual abuse, however, the same needs to be extended to women facing domestic violence and sexual violence.

2. A study was carried out focusing on the health and healthcare in the state to give a comprehensive understanding of the health system in terms of tracing its development through the years leading up to its current situation. The study is based on mainly secondary data from survey reports, government reports and statistical documents, research studies and primary data from key informant interviews with various stakeholders like government officials, public providers and civil society.

- The study found that public healthcare infrastructure as well as the private health sector is extensive in the state and well connected. But there is still some rural-urban disparity especially with shortage of health personnel in rural areas. Utilization studies have indicated a greater dependency on private sector which has grown tremendously.
- Goa has achieved a high level of coverage in maternal health and child immunization and yet there has been a drop in coverage of services in recent years. Nutritional status among children is also an issue with considerable prevalence of wasting, stunting and underweight children and high anaemia among children. Anaemia among women is high as well. Family planning uptake is low in the state and unmet need high with already low fertility rates. These changes may be due to increasing migrant population and lack of health coverage for them.
- The mortality trends clearly show that the state has epidemiologically transitioned with greater prevalence of non-communicable diseases and diseases of the aged. Although efforts have been made by the state to tackle these diseases, these have been more of piece-meal approaches.
- State's share of public spending is much greater than the central government share which shows high priority given to health sector. But this spending is disproportionately concentrated on tertiary care in urban areas and lower spending on primary healthcare, preventive and promotive health. In comparison, the private expenditure is much higher than public expenditure on health. Thus, the system seems inefficient and one can conclude the actual costs of achieving the best indicators in health have been much higher than the public health spending figures.

Development in Goa terms of health has been more due to socio-economic progress than a good public health system till now. In fact, this socio-economic progress and public focus on social sectors have contributed to a well-developed public health system. But unchecked growth of the private health sector, rising cost of healthcare and greater burden on individual households would negatively affect the health status of Goan population.

II. Research (SATHI)

Project – Maharashtra Health Equity and rights watch II (2011-2015)

Project Framework

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. **Concretizing models and shaping opinion towards options for a system for Universal Health care, as a key strategy for reduction of health inequities in Maharashtra**
   - During the period under reporting, several rounds of discussions were held to finalize framework for system of universal healthcare in Maharashtra and to get feedback for the policy document.

2. **Various consultations and dissemination workshops for concretizing models and shaping opinion towards options for a system for Universal Health care**
   - Given the state assembly elections conducted in the month of October 2014, we considerably modified and expanded our strategy for advocacy related to UHC in Maharashtra. This included both the sharing of UHC framework for Maharashtra state with academics and civil society and also dialogue with state level decision makers in the new government.
   - As part of the modified advocacy strategy in addition to state and national level consultations a series of workshops/advocacy events are planned so as to create discourse about the UHC framework in Maharashtra with various stakeholders.
   - **Release of the policy brief on "Universal Health Care in Maharashtra"**

Mr P. Sainath the well-known senior journalist was the chief guest for this Program. About 50 social – **health Activists, Academicians**, **Political party members**, were present for this day long program. A press conference was organized for the **media persons** on this occasion about 40 media persons participated in this press conference. During the programme, the representatives of political parties have shown willingness to include some of the policy recommendations of the UHC framework in to their party manifesto for upcoming state assembles elections.

- **A Consultation with Public health experts -** Going ahead with creating a discourse, SATHI had organized a consultation involving public health experts from Maharashtra and a few national level experts at Tata Institute of Social Sciences, Mumbai on 18th Oct 2014.
- **Regional interactions / workshops**- As part of the modified advocacy strategy in addition to state consultations a series of regional level interactions were planned so as to create discourse about the UHC framework across Maharashtra within various stakeholders mainly healthcare providers and CSOs and NGOs

In Pune, two meetings of this forum have already been conducted till 31st Jan 2105 where the group discussed intricacies of Maharashtra clinical establishments act. The meetings and concept of UHC have been widely covered by the local print media.

3. **Evaluation –** Each of the major components of the project was evaluated separately.

- **"**Concretising models and shaping public opinion and policy towards a regulated system for Universal Access to Health care".
- Primary as well as secondary research undertaken as part of the project activities
- Capacity building of young professionals- Fellowship program

4. Project outputs and dissemination

Sr. No	Format	Language	Title	Date of publication
1.	Conference presentations	English	Are women breaking free from the 'Culture of Silence'?	7th Asia Pacific Conference on Reproductive and Sexual Health Rights, held in January 2014 in Manila
2.	Seminar presentation	English	'Changing Paradigms of Women's Access to Healthcare- Role of Private Health Sector'	National Seminar on Maternal-Neonatal Health and Safe Abortion: Opportunities and Challenges organized by CommonHealth in Hyderabad on April 24-25, 2014
3.	Research Paper	English	Why do women accept hysterectomy? Findings from a study in Maharashtra'	International Journal of Innovation and Applied Studies, Vol. 8 No. 2 Sep. 2014, pp. 579-585
4.	Policy Brief	English Marathi	We need a system of Universal Health Care for Maharashtra	September 2014
5.	Research Paper	English	Hysterectomy among premenopausal women-	5th National Bioethics Conference (NBC)

			how informed is the decision to undergo hysterectomy?	Bangalore- 11th to 14th December 2014
6.	Policy paper	English	Moving towards Health and Health care for all!-	January 2015
7.	Research Paper	English	Hysterectomy among premenopausal women and its' impact on their life- Findings from a study in rural parts of India	International Research Journal of Social Sciences Paper to be published in March 2015 issue
8.	Policy Brief	Marathi	A policy brief on 5 immediate action points for moving towards UHC in Marathi	January 2015
9.	Article	Marathi	Two Articles on answers to current crisis of healthcare is 'UHC' in news papers, which are widely appreciated and followed by community	September and Oct 2014
10.	Films-	Marathi with English subtitles	An Animation film on Clinical Establishment Act with Rate Regulation	
11.		Marathi	A film on Community Based Monitoring an important component to move towards UHC in Maharashtra	
12.		Marathi	A film on Universal Health Care easy to understand by community	

III. ADVOCACY (CEHAT)

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

An SLP was filed in the Supreme Court in June 2014 with legal counsel from Lawyers' collective. Despite the fact that the MOHFW (Union government) has already circulated comprehensive guidelines for medico-legal care in sexual violence, Maharashtra state continues to use its obsolete and unscientific guidelines. Supreme Court was approached as the CEHAT Intervention in an ongoing PIL which did not receive a favourable response. The court took the side of Maharashtra Government despite presence of gender insensitive aspects in the protocol

and lack of therapeutic care. Supreme Court admitted the SLP and the long-awaited hearing finally took place on 27th March 2015 where Ms. Indira Jaising, senior advocate, Supreme Court represented CEHAT as its legal counsel. She presented the different challenges that survivors of sexual violence face, bringing up issues such as gaps in the health system, non-utilisation of the Nirbhaya funds and the like. The court appointed Ms. Jaising as Amicus Curiae to assist the court in dealing with the entire pending writ petitions related to sexual violence against women and children. The next hearing is on 10th July 2015.

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

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

Despite CEHAT's consistent engagement with the MCGM and SPGRC (gender resource centre of the MCGM) concerning the protocols, the MCGM teaching hospitals approached the AMC, Assistant Municipal Commissioner for the implementation of Maharashtra medico legal protocols. CEHAT made oral and written submissions against the move but they did not yield results. A written submission was also made to the Chief medical superintendent in order to deal with the pressure on the hospitals implementing the central govt protocols. CEHAT again wrote to experts from across the country to appeal to the Maharashtra health department to not implement such protocols. At the level of Maharashtra too, Sampark Samiti (a network of organizations working on issues affecting women) was approached and written submission was made to them. CEHAT representative also spoke at Masum initiated Maharashtra Stree Hinsa Mukti Parishad forum and discussed concerns with the implementation of such a practice. Signatures were also sought on the letter raising concerns about the protocols.

CEHAT will continue its untiring efforts in this direction by reaching out to the Chief Minister and gathering evidence from the practices in other states. The lawyers collective will be assisted in the compilation of the responses of each state and central department about the steps that they

have taken based on changes in the new law. The compilation would be filed pre 15th July in the court.

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

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

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

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

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

circulated to enable a decision on the issue by the committee. We successfully brought in "informed refusal" as a concept in the national policy directive. A legal opinion on the matter has been sought and the MoHFW will release the final protocol and guidelines early December 2013. The experts were contacted and the project commitments were explained to them. All of them agreed to participate and the task force has therefore been formed. The first meeting of the task force was kept on hold until the new government came in power in order to have more stability in terms of the interactions with the ministries. Other research work that has been commenced is the compilation and analysis of police requisitions in cases of sexual violence. This will form basis of the guidelines for police as per the MoHFW guidelines.

Integrating Gender in Medical Education

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

Patients Rights Web Portal

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

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

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

IV. Advocacy (SATHI)

I.a Community Based Monitoring and Planning on Health Services in Maharashtra

Community based monitoring and Planning of health Services, has been implemented in 14 districts (including the new Palghar district), 32 blocks, 125 PHCs and 860 villages of Maharashtra, through the involvement of 25 Civil Society Organisations functioning as Block and District Nodal organizations. SATHI has been functioning as the state nodal organization for this process.

Following is a brief overview of the activities facilitated by SATHI to take the CBMP process forward at block and district levels and to resolve emerging issues:-

1. **State level review and planning meetings with CBMP partners –** 3 such meetings were conducted during the year with the involvement of all the CSOs involved in the CBMP process. In the first meeting held on 21 to 24 May 2014, planning of all villages to district kevel activities was done with the organizations. Planning for transition policy implementation in the 5 older districts was undertaken.

   In the next assessment meeting conducted in November 2014, the completed activities were reviewed and further planning was done. It was seen that activities of several organizations were pending due to lack of funds, and hence

   Certain activities were reorganized and the important ones were planned for the next part, with priority.

   The last meeting, held in March 2015, all organizations made presentations of the activities conducted during the year, focusing on the indicators decided in the first meeting.

2. **State level dialogue between State level officials and district level Health officials, CBMP partners through Video conference –** A state level video conference was organized on 15 December 2015, at Arogya Bhavan Mumbai, as a part of state culmination workshop, to take a stock of the district level issues that had emerged in the CBMP process.

3. **Review of CBMP process by AGCA members –** Meeting for Maharashtra state level review of CBMP activities with the members of the national level AGCA, was held on 9th February 2015. For this meeting, Dr. Thelma Narayan, Member of AGCA, representatives from AGCA National Secretariat were participated.

4. **State level orientation workshop for Accountants** – A training workshop was conducted for the accountants of all CSOs was conducted on 22-23 May 2014, and in preparation of this workshop, some admin team members from SATHI, who actively handle accounts, made visits to some organizations to actually see their accounts handling system.

Key processes conducted as part of transition phase for moving towards a sustainable and generalized model-

Beside coordination and facilitation of routine CBMP activities in field areas, SATHI has played significant role in conceptualizing, developing and facilitation of field level processes in collaboration with CBMP partners.

The processes are- Expansion of lower intensity, voluntary CBMP processes to nine new districts, Federations of monitoring committees, Community Action Resource Units (CARU), Grievance Redressal Cells – innovative mechanisms to ensure sustainable Community action for health

1. Expansion of lower intensity, voluntary CBMP processes to nine new districts-

The experience of implementing CBMP in 13 districts in an intensive project mode so far has been very important to demonstrate the feasibility and effectiveness of this process. However, driven by the conviction that CBMP based on community accountability and participation is a principle which needs to expand far beyond selected areas in these 13 districts, SATHI has worked towards developing a somewhat less intensive model of CBMP, which could be spread to many other districts and blocks in Maharashtra. After an extensive process based on publishing a state level advertisement inviting all civil society organisations interested in implementing CBMP on voluntary basis, since February 2014, 33 new organizations have implemented community based monitoring in 25 blocks of 9 new districts. One of the key achievements of the CBMP process in these new areas has been the remarkable Jan samvads. Other than routine Jan Sunwais in CBMP project areas, in 2014-15, total 30 block level Jan Sanvad were conducted under this process.

2. Federations of community monitoring committees at block level-

Since community based monitoring in select districts of Maharashtra has shown significant positive results, the need now is social expansion and organizational sustainability of CBMP, moving beyond the project mode. For further strengthening and expansion of the CBMP process, and to explore the potential for implementing CBM related to other social services like ICDS, PDS, water supply - the need was felt to establish a comprehensive, participatory forum at the block level. This led to the idea of developing a "Federation of Monitoring Committees".

Currently, such federations have been initiated in the five pilot phase districts. They have been formed at Pune (in Junnar, Purandar and Velhe blocks) and in Amaravati (Dharani block).

3. Grievance Redressal Facilitation Cell at block level-

The government has set up a Grievance Redressal system, which functions at the regional level, in various regions of the state. But this is an entirely departmental and formalistic mechanism which is not sufficient to reach out to the people. If a grievance redressal cell is established at block level, the regional grievance redressal system can be strengthened.

Block GRFCs have been set up currently as per plan in Dharani block of Amravati, Velhe block of Pune and Murbad block of Thane. The GRFC in the Dharani block have also been able to resolve some long standing issues.

4. CARU – Community Action Resource Unit

The evaluation process of CBMP indicated a need to move from the current relatively intensive model of CBMP towards a more generalized but less intensive one, with wider community outreach. Other similar efforts of community accountability, with wider generalisation were examined. It is known that as part of the process of social audit of NREGA undertaken in Andhra

Pradesh, resource units have been established at state, district and block levels. Subsequently, the idea came up that a similar Block Resource unit might help to generalise CBMP also.

CARUs have been initiated in Dhadgaon block of Nandurbar district and Purandar block of Pune district. In Nandurbar district 20 young volunteers selected in co-ordination with the Narmada Bachao Andolan, took the CBMP process to 60 new villages. In Purandar, 10 volunteers took the process to 30 new villages.

Innovative programmes conducted under CBMP in this year

1. ***Arogya Abhiyan 2015 -To ensure Guaranteed health services***

With NRHM (now NHM) completing 10 years, community based monitoring of health services has also reached a milestone of 7 years in some blocks and 3-5 years in others. ***This is an appropriate time to take stock of the positive impacts of NRHM and CBMP;*** there have been improvements in several aspects over the years – for instance increase in institutional deliveries, more regular village visits by health workers, improved behavior towards patients, availability of timely referral services, reduction in prescribing outside medicines, etc. These are crucial developments which need to be publicly recognised.

At the same time, certain unresolved issues remain, and specific local and policy level gaps need to be addressed. Hence to ensure positive response from responsible health authorities, to strengthen both local social-political will and administrative commitment to resolve key unresolved issues that have emerged from the CBMP process, the coalition of civil society organisations involved in this process launched the state level campaign-***'Arogya Abhiyan 2015 -To ensure Guaranteed health services.'***

This Abhiyan began with a unique Arogya Yatra on 24th February 2015, with the message – "Let us create change". As a part of the yatra, two teams travelled to Aurangabad, Beed, Osmanabad, Pune, Raigad and Thane between 24th and 28th of February. Medical students, journalists and activists were a part of this yatra and their itinerary included visits to health institutions, participation in village meetings and Jan Arogya Sansad (Jan Sunwais) at block/district level in above 6 districts. They interacted with members of monitoring committees, medical officers, health workers and people's representatives through interviews and through the jan samvads and the effort was to understand the perspective of stakeholders towards the CBMP process.

As a preparation for the yatra, report cards for these districts were prepared based on 15 key and primary, village, Sub-Centre and PHC level health service guarantees. These report cards formed the basis for the Jan Arogya Sansad (5 at block level and 1 at Pune district level) which were attended by District and Block level people's representatives, health officials and workers, members of Monitoring and Planning Committees, local journalists etc. Around 100 to 300 people were present for each of the jan arogya sansad.

The assessment indicated that within village level services, 115 out of 158 villages (73%) reported that the condition of referral services for women in labour and for serious patients as well as village visits of health workers and immunisation is good (68%). Regarding PHC level

services, the figures show that out of 23 PHCs, 100 % do not prescribe medicines from outside, while in 89% of the PHCs, illegal charging beyond the price of the case-paper, has been stopped.

However, for residential facilities for doctors and staff and the issue of doctors reporting to work regularly and punctually, the good response was only 56%.

In terms of sub-centre services, among 67 sub-centres in 5 blocks, 78% of the sub-centres show good immunisation services. But in the sub-centres of **6 blocks, the situation of staff residing at the centre (45%), regular cleanliness (43%), availability of round the clock (24 hours) normal delivery in the sub-centre(34%) and sub-centre being accessible to the people (52%), all these are in a serious condition.**

The culmination programme of this Arogya Yatra was conducted in Pune on 2nd March 2015. Senior health activist, Dr. Anant Phadke was present for this culmination programme as the Chief Guest. Dr. Abhay Shukla, Member, Advisory Group on Community Action, NHM, Dr. Nitin Jadhav, state coordinator, CBMP, Maharashtra, students of B.J. Medical College, who were a part of the Arogya Yatra, and representatives of Civil Society organisations involved in the Monitoring process, were also present.

At the end of the yatra, a letter with the following demands, and endorsed by people's signatures, was sent to the Health Minister.

- The NRHM has resulted in important improvements in health services in the rural areas. Hence instead of reducing funds for public health services, necessary increase should be made and human resources should also be increased.
- District and state level issues which have emerged from the CBMP process, but are as of now unresolved, should be resolved with priority.
- Considering the fact that community monitoring of health services has led to several positive changes, this process should be replicated all over Maharashtra**.**

Mahila Arogya Abhiyan – Taking into account the occasion of the International Women's Day on 8th March, the Health Department undertook a Mahila Arogya Abhiyan in all districts, from 26th February to 12th March 2015. Contribution of SATHI in strengthening CBMP process at national level-

Some of the SATHI team members were involved and contributed in CBMP process at national level process. One of the team members of SATHI is a member of Advisory Group for Community Action (AGCA) which is constituted under NHM. He has participated in AGCA meetings and has given inputs in CBMP process at national level. The some of the examples are given below where SATHI team member presented various processes of Maharashtra CBMP at national level -

1. Presented CBMP process in the workshop on strengthening CBM in Delhi especially in urban area, organized by VHAI.
2. Presented and shared experiences of CBMP Maharashtra in National level consultation on Community Action organized by AGCA secretariat.

3. **Inputs to Mizoram state for strengthening CBMP processes**
4. **Exposure visit to Nagaland state for understanding Communitization process**
5. **Exposure visit to CBMP areas of Maharashtra of activists who are working on Community Based accountability processes in other states –** Activists from the COPASAH network, from different states in India, made a 2 day visit to CBMP areas in Maharashtra, on 18 and 19 of September 2014. The processes at the district and state level were presented by SATHI team members.

Contribution in writing paper and articles on CBMP process-

SATHI has written following articles and paper on CBMP in 2014-15.

- MSP paper " Occasional Paper Reclaiming Public Health through CBM Case Maharashtra India"
- Innovative strategies for Community Based Monitoring of Health services – Insights from experiences in Maharashtra, India- written by Dr. Nitin Jadhav and published in COPASAH newsletter.
- Articles were written on various issues related to Public Health system such as gaps in construction of buildings and basic facilities in Public Health Institutions, Seva Hami kayada, problems which are facing by Health functionaries etc in popular newspapers like Loksatta, Lokmat, Sakal.

List of Publications published under CBMP process-

No	Publication
Tools & Report card	
1.	Village level
2.	Sub-Centre level
3.	Primary Health Centre level
4.	Rural Hospital
Short Tools & Report Card for Regional level activities	
5.	Village level
6.	Primary Health Centre level
Reprinting of various booklets	
7.	Role and Responsibility of VHNS Committee at Village level
8.	Role and Responsibility of PHC level Monitoring and Planning Committee
9.	Role and Responsibility of Rugna Kalyan Samittee
10.	Re-printing of posters on Health Services entitlements declared by NHM for awareness
11.	Sarkari Davakhana Hotoy Janatecha!
12.	People are reclaiming the Public Health System!
13.	**Published a guidebook for Health officials-orientation about CBMP process**
14.	**Davandi –** Tri-monthly Newsletter

1.b. 'Promoting a comprehensive and rights based approach to address malnutrition in Maharashtra'

A: Activities and advocacy

A: Monitoring of field activities: Concerned Action team members visited field frequently to ensure/ hand hold/ review and plan the proposed activities in the field:	
Awareness in villages	*On going in all villages and Vasties throughout the year.* *After the training in December 2014, Messages are being given in all intervention villages for supplementary food for children of age 6 months to 3 years.*
Mata gat meetings undertaken	*In every field mata gat members are part of the village committee monitoring the ICDS services*
Vasti level/ village level committee formation and meetings	*All committees at Village and Vasti level are formed and regular meetings are being conducted at village/vasti level.*
BLOCK LEVEL committees formed and meetings undertaken	*All Block level committees are formed and meetings are being conducted in every block/Vasti*
District level mentoring committee formation and meetings	*District level mentoring committees are formed and functional in all districts except Mumbai, Khoj.*
Three rounds of data collection	*Three rounds of data collection are over in all blocks as well as in Vasties of urban areas.* *The fourth round has begun in March 2015.* *The fourth round will end by April 2015.*
Action points formulated and acted upon	*Done everywhere for round one, two and for the Third round.*
AW and Supervisor level discussions and solving local issues	*Done everywhere for first three rounds*
Block level meetings	*Done everywhere for first three rounds*
District level meeting	*Done everywhere for first three rounds*
Jan Sunwai / Samwad	*Done everywhere for all three round. data is being analyzed. The fourth round began in March 2015*
B: State level Review and Planning meetings with partner organisations	
• Two rounds of data collection (Third and fourth rounds) were to be done in this financial year. The third round of data collection was delayed and hence the first state level review and planning meeting was conducted in Pune on 20th November 2014 to 22 November 2014. The fourth round of data collection is being done in the months of March 2015 and April 2015 and hence the state level review and planning meeting for this round of data will be done in the month of June 2015. • The proposed state level review and planning meeting for finalization of proposal and	

budget for the year 15-16 which was to be held in March 2015 got delayed and was postponed in the first week of April 2015.

C: State level advocacy meeting with WCD officials, state level mentoring committee meetings

- *Many issues raised in state level mentoring committee meeting held on 7th August 2014 Rigorous follow up is being done to get finalized minutes from WCD.*
- *The minutes of the meeting submitted to W&CD and got finalized minutes after intensive follow up with Pune office*
- *The GR has expired in June 2014. Advocacy is on to get extension. Many visits, emails and calls have been done to Mumbai to meet first Mr. Uke. Principal Secretary. Mrs Usha of (ISSNIP) World Bank project.*
- *Visit to NSF regarding review meeting and also visit to Mr. Uke's office to discuss WCD proposal with him: 17 June 2014*
- *Visit to WCD for meeting with Mr. Uke regarding discussion on WCD proposal: 2 July 2014*
- *Meeting with WCD Commissioner Mr. Rajendra Chavan for state level issues raised through CBMA of ICDS services*
- *Participation in State level workshop organized by Jijau Mission and Khoj regarding reducing malnutrition from Melghat on 4th and 5th June 2014. We made impactful presentation on successes of CBMA ICDS. We could get due attention to our project in the W&CD bureaucracy and among the top officials of UNICEF.*
- *Participation in 5th National Conference of Right to Food campaign- Ahmadabad – participated in 5th National Conference of Right to Food campaign and presented our work in one session on the process of Community based Monitoring and Action related to ICDS services.*
- *Participated in the meeting organized by Supreme court Advisors office at TISS for submission of our demands related to policy level issues about ICDS services. (10th Jan 2015).*
- *In month of March 2015 visit to Mumbai to meet Commissioner ICDS Mrs. Vinita Singal, Commissioner ICDS and Mrs Vandana Krishna Commissioner Jijau Mission. With the help of Mrs. Vandana Krishna, we got appointment of Mr. Sanjeev Kumar, new Principal Secretary ICDS. He signed the GR for permission of CBMA in 20 more blocks with existent area of intervention. The GR is now in the office of Minister W&CD. We hope that after assembly session it would be released.*
- *Prepared a note on policy level issues related to ICDS services and Health services and submitted to Supreme Court Advisors office at TISS in the month of February 2015*
- *Attempted to meet previous Minister of state for Health ministry Fouziya Khan at least for 3 to 4 times in this year to address issues regarding integration between Health and ICDS*
- *One article in Marathi news paper on successes of CBMA ICDS.*
- *Article published in Davandi Special issue regarding CBMA of ICDS services.*
- *Published several news items in Davandi regarding CBMA of ICDS services.*

D: Consultation with experts and partner organizations on innovative strategies to improve child nutrition

- *Visit to TISS regarding preparating meeting on seminar of democratization and accountability of social services including ICDS services on 26 June 2014*
- *Organized State level consultation on Democratization and accountability of social services 25th and 26th July 2014*
- *Consultation was organized with Dr Vandana Prasad in Pune on 31st July 2014*
- *Organized consultation for brainstorming meeting on key issues and strategy to address malnutrition in Maharashtra on 15th Jan 2015.*
- *Participated in the meeting organized by NSF on 15th Jan. 2015 on paper presentations by Ravi, Shrijit etc.*

E: Training

Prepared training manual and IEC material, took trainings of FFs and BC on three key messages for supplementary food for the children of age group 6 months to 3 years
Trainings of Field Facilitators and Block Coordinators was conducted on 8th to 10th December 2014 regarding three key messages for supplementary food for the children of age group 6 months to 3 years.

F: Publications

Proposed and accomplished:

- *Guidebook*
- *Training manual and IEC material.*
- *Stories of change through CBMA ICDS process: 'Jevha Anganwadila Jag Yete'*
- *(Not proposed but published) - English Flyer of CBMA ICDS*
- *Report on study of THR utilization after implementation of new GR*

G: State level workshop for advocacy related to sustaining and generalising CBM approach in social sector

The workshop/Convention could not be conducted this year. The pace of bringing various concerned forums mainly like Anna Adhikar Abhiyan, TISS and others was slower than we expected. And also due to engagement of various organizations in their own priority areas, this workshop could not be held as expected.
But in the brainstorming meeting held on 15th Jan. 2015 at Mumbai, it was decided to hold the preparatory meeting for the proposed workshop/convention in the month of March 2015. Finally a meeting took place in Mumbai on 27th March 2015 attended by many key organizations like Aanna Adhikar Abhiayn, various organizations working on nutrition etc. It has been now decided to hold this state level convention on malnutrition around June end 2015. This workshop would be organized by Aanna Adhikar Abhiyan, JAA, TISS and Poshan Hakka Gat.

H: New CBM blocks Jan Samwad to Institutionalise CBM of ICDS

The activity did not happen. The proposed scaled up GR could not be extended and hence the obstacle.

B: Research component:

1. **Understanding current pattern of utilization of THR packets after implementation of new GR**

   After completing data collection, data coding and data entry in the month of November 2014, data analysis and report writing have been completed subsequently. Report has been prepared in Marathi. Marathi report has been published. Additionally we are also translating this Marathi report into English for wider use.

2. **Documenting role of ICDS and public health system in preventing malnourishment in children aged 1 to 3 years.**

   After receiving comments from external panel for ethical review of the study, tool was modified accordingly. Tool was field tested in the month of January. In the meantime Investigator was selected. We faced quite difficulties in getting investigators for small period jobs. That is the reason of delay. Actual data collection started from the 1st week of February2015. Flyer is prepared for this study

3. **Documentation of Complementary Feeding practices among mothers of under children in the age group of 6 to 18 months**

   After selection of investigator, data collection for this study was started from the 1st week of February2015. We faced quite difficulties in getting investigators for small period jobs. That is the reason of delay. Report is completed for this study

1.c. 'Advocacy for social accountability and regulation of private medical sector in India'

Objective- Promoting awareness and advocacy on 'participatory, accountable regulation of private healthcare sector in India' at both national and state levels.

This would be furthered by the following areas of activity:

- Capacity building of civil society activists towards demanding social accountability of private healthcare sector, providing guidance and helping rights based civil society organisations in strategising advocacy on social accountability of private healthcare sector in selected states.
- Developing quality information material on contemporary issues related to regulation of private medical sector for civil society activists, at national level and in pilot state.
- Conducting multi-stakeholder meetings on private medical sector regulation in the pilot state
- Bringing private healthcare related issues under public scrutiny by documenting and publicizing major problematic experiences of patients and testimonies of doctors.

Outcomes / Key Result

Planned activity	Output
National level advocacy in the next year for appropriate standards in central CEA: We would be focusing on inclusion of Patients' rights in the standards related to central CEA, and also trying to ensure provisions that	• SATHI coordinated with other civil society organisations to give feedbacks on the revised draft of standards under CEA. Now draft standards include charter of patient's rights and responsibilities.

would take into account constraints faced by health care institutions working in remote and vulnerable areas, mostly on not-for-profit basis.	• Dr Arun Gadre has been appointed as chair person of sub group of the committee formed under National Council for Clinical Establishment at central level to come out with methodology of standardization of rates. • Dr Arun Gadre has evolved a first draft of methodology of standardization of rates. • National Workshops for developing strategy related to CEA was conducted on 26th Feb 2015 in AIIMS, New Delhi. The doctors who had come to Delhi from all over INDIA gathered in the morning at AIIMS to brainstorm over the formation of the national Network of doctors to fight commercialization of health care and medical malpractices. Many aspects of commercialization and ways to go ahead, including issue of Clinical Establishment Act, were discussed. It was decided to float a forum named "Doctors for de-commercialised, rational and ethical care". A rough draft of an appeal to doctors of India from this group was circulated
Improved awareness regarding need for accountability and regulation of Private healthcare providers among CSO activists in UP and CG. Some significant cases of denial of patients' rights have been gathered, analysed and presented to important key stakeholders.	• Dr Arun Gadre visited Raipur to attend one and a half day workshop on CG Nursing Home Act arranged by PHRN on 23rd and 24th September 2014. Nearly 33 activists from all across the state participated in it.. • Dr Abhijit More visited Chhattisgarh as a resource person for two district level workshops on 'CG Nursing Home Regulation Act and Patient's Rights' arranged by Sulakshana of PHRN on 18th and 19th February 2015. • Besides that Dr Abhijit More also participated in CG state level culmination workshop on 'CG Nursing Home Regulation Act and Patient's Rights' in Raipur on 30th, 31st March 2015. • CSOs in Bengaluru had organised a panel discussion on 'Rational prescriptions for the private health sector: How to achieve ethical, accountable, quality health care in India'. Dr Arun Gadre was one of the main speakers in this event which was conducted on 28th

	March 2015.
Passing of Maharashtra CEA in Vidhan Sabha (State Assembly) with inclusion of provisions for patients' rights.	• SATHI was involved actively in coordinating and collecting feedbacks from many civil society organisations across the state on draft Maharashtra CEA published on government's website. SATHI also communicated its demand to CEA Bill drafting committee members. • The committee appointed by the previous health minister of Maharashtra has submitted its draft of Maharashtra Clinical Establishment Act to the Government on June 4. • SATHI representative as a part of larger health right coalition delegation met Principal Secretary (Health), Maharashtra, in February 2015, to demand few changes in draft Maharashtra CEA and to hold public consultations on key demands of rate standardization and grievance redressal mechanism for patients. • Jan Arogya Abhiyan organized a consultation on 7th February 2015 at Patrakar bhavan, Pune on the theme 'Need and methods to standardize rates in Private hospitals'. Dr Arun Gadre from SATHI made a presentation on rate standardization methodology invented by him.
Publication and dissemination of testimonies of rational private doctors.	• Testimonies of rational doctors were compiled, analyzed and converted into a Marathi Book named 'Kaifiyat'. On 28th September 2014, dissemination workshop and publication ceremony of the Marathi book took place. Nearly 140 people attended with the chief guest, Dr Prakash Amte, a noted social worker from Maharashtra. Media covered this event very well. • After publishing Kaifiyat Marathi edition, additional meetings are being conducted in various cities of Maharashtra. Following meetings took place till Dec end. o 29th November – Pune (around 45 participants with 4 doctors) o 6th December – Nashik (around 50 participants with 30 doctors) o 16th December – Nagpur (around 40

	participants, none from medical fraternity) The outcome at Pune is formation of – Doctors-Patients Forum. The second meeting took place voluntarily on 20th December. Third meeting of this Pune group is scheduled on 10th Jan 2015. The book titled 'Voices of Conscience from Medical Profession' written by Dr Arun Gadre and Dr Abhay Shukla got published at the hands of Shri S.C. Sinha, Member, National Human Rights Commission On 26th Feb 2015 in AIIMS, New Delhi. Dr M C Misra-Director of AIIMS, Dr C S Pandav from Centre of Community Medicine in AIIMS, senior surgeon Dr. Samiran Nundy, some of the senior rational doctors from various parts of India who have given testimonies, senior doctors from AIIMS and health activists were present in large numbers in this event. media covered this event quite well • An article in British Medical Journal (BMJ) by Dr. Gadre has been published recently which has led to significant number of comments and further internet based media coverage.
At least two hundred survey questionnaires ('People's perception of private healthcare sector') are filled, analyzed and documented in the pilot state	• 651 survey questionnaires ('People's perception of private healthcare sector') are filled, analyzed and documented in the Maharashtra. Report is prepared
Promotion of the web site: 'privatehospitalswatch.org'	• Website is functional

1.d. Promoting participatory action on local Health budgets and medicine distribution in Maharashtra

Following activities have been completed during the reporting period

1. **State level orientation workshop** -A two days state level orientation workshop was organized by SATHI on 26th and 27th August at Pune. Six civil society organizations were invited for the workshop, in collaboration with whom, project activities would be undertaken. This workshop was organized with the objective of discussing each activity in detail and preparing detailed plan for its execution.

2. **Participatory Audit and Planning (PAP) of Rogi Kalyan Samiti (RKS) funds**

- As a part of IBP project a series of participatory audits were conducted to ensure better planning and utilization of these. This process involves three main steps viz, understanding pattern of expenditure of RKS funds in the previous year, verification of various records such as bills, receipts, quotations, minutes of the meeting etc., physical verification of the same (basically a proper audit process), and then using the findings to discuss and plan expenses under the RKS for the coming year.

This process has been undertaken in three districts – Thane, Nandurbar and Raigad, during November and December 2014. In each district, 2 PHCs and 1 RH/SDH were covered, thus a total of 9 institutions were covered in this process. In the PAP process RKS and Monitoring Committee members, district and state level officials local PRI members and CBMP implementing CSOs were involved As a preparation for this, the details of expenses of the RKS funds in these institutions were sought from the MOs, and this information was analysed to understand the pattern of expenditure. All this was displayed on a poster and presented to RKS and Monitoring committee members in a specially organized PAP meeting. As the state nodal agency, a representative of SATHI was present during each of these audits. Post the audit, meetings were held with members of the RKS to discuss issues which came up.

3. **Theory of change**- Apart from the field level activities, Theory of change for activities written in the project proposal were also developed with the valuable inputs from Ravi.

V. TRANINGS & EDUCATION (CEHAT)

A total of 5 trainings were conducted where healthcare providers were trained at the 3 hospitals on providing comprehensive healthcare in responding to sexual violence including taking consent, conducting examinations and collecting evidence, and providing a reasoned medical opinion. Fifty two new Resident Medical Officers were also given an orientation on responding to violence against women.

A monitoring committee was held at Rajawadi Hospital with a group of 8 doctors who examine survivors. The current practices, gaps in responses and challenges faced by healthcare providers were addressed to ensure quality of care for the survivors.

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

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

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

CAPACITY BUILDING OF PARTNER ORGANISATIONS:

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

1. Post the training on establishing and running of hospital based crisis centre, many organizations as well as government health institutions have made efforts to engage health providers on the issue of violence against women and role of health care providers (HCP). The South Kolkatta Saniddhya group from Kolkata conducted a seminar on the need for a health care response to violence against women. Key stake holders such as the Chairperson of state women's commission and delegates from the health department were invited with the aim to engage higher health care officials in initiating capacity building programs for medical and paramedical staff in screening, responding and supporting women and children facing violence. CEHAT has been working with this organization in order to carry out a state wide workshop on the issue of VAW and the role of health sector. However the state is still not open to conduct such workshops and the process of understanding VAW as a health issue has been a slow process. At the same time CEHAT has also been in talks with Swayam – a women's counselling centre for domestic violence to carry out a needs assessment at the level of hospital to understand the profile of violence faced by women, nature of health complaints reported by them and current procedures at the hospital to deal with the issue. However permissions are still awaited.

2. *One day Training in Bhopal at JP Hospital* – J.P. hospital collaborated with Action Aid to establish services for survivors of violence against women at a centre called 'Gauravi' and CEHAT has been closely working with them since its inception. From the beginning, the crisis centre has been inundated with survivors. However, it did not have any link with the hospital at all except for the space allocated for provision of services because of the way it was advertised. Hence, it was pertinent for Gauravi centre to position itself as a hospital based department and understand the linkages of violence against women, health consequences and the role of the health sector in mitigating it. A one day meeting was organized at the level of the hospital with key health professional to understand violence against women (VAW) as a public health issue. The Mumbai based Dilaasa model as a response to sexual and domestic violence was presented and its outcomes discussed at the meeting. Health professionals were also invited to Mumbai to interact with the health professionals who screen women to identify cases of violence against women, provide psychological first aid as well as build capacities of their fellow health providers on this issue.

3. *Three day residential training on feminist counselling to respond to VAW* – Based on the earlier engagement, Action Aid also felt a need to equip counselling organisations from

all over Madhya Pradesh with feminist counselling skills as implemented in the Dilaasa crisis centre to work with survivors of domestic and sexual violence. A three day training course was conducted for more than 40 counsellors and lawyers on the issue of feminist counselling to respond to violence against women. The program was dedicated to understanding the role of the women's movement in bringing forth the issue of VAW, understanding the role of the health sector vis-a-vis VAW, creating awareness on the medico legal issues in domestic and sexual violence as well as practicing skills in crisis intervention. A day was also dedicated to understanding changes in the rape law, understanding criminal and civil procedures vis-a-vis domestic violence, steps in using the DV law and steps in engaging multiple stake holders such as CWC, courts, judiciary, police and the health sector so that a comprehensive response to VAW can be built. The training had an overwhelmingly positive response.

4. CEHAT has been invited to conduct trainings of health providers and counsellors of Bhoomika, a Gender based Violence Management Centre under NRHM Kerala in order to address sexual violence concerns, both therapeutic and medico legal. Besides the training, engagement with the NRHM department officials has been to create comprehensive services at the level of Bhoomika where presently only 1 counsellor mans the centre. However, there is no structure in place where by health providers screen women and refer them to counsellors, they do not have emergency shelter and a concern is that it is not integrated in to the hospitals as a department and it is largely one person centred. Recently the NRHM decided to prepare a set of standard operating procedures (SOP) for all the Bhoomika centres. CEHAT shared the SOPs prepared at the level of the Municipal hospitals for sexual assault health care response as well as the MOHFW (Union Government guidelines for medico legal care in sexual assault). The Kerala medico legal authorities have also created guidelines and a form for medical examination to be used across Kerala hospitals. However, analysis of these guidelines showed deep rooted biases and unscientific comments, besides not being in tune with the changes in the Rape law. The document was reviewed and changes suggested along with the rationale for it. Efforts are being made to push for the implementation of the MOHFW guidelines which are comprehensive, scientific and gender sensitive.

5. A one day CME accredited course was organized by AIIMS, Bhubaneswar, Odisha and CEHAT was invited to conduct the same. AIIMS institute organized this training based on directions received from the Union of India, Ministry of health and family welfare (MOHFW) for implementation of medico legal guidelines issued by them. Participants comprised of 53 senior forensic doctors as well as gynaecologists from reputed medical institutions. Dr C Mahapatra, ex FOGSI president and currently professor obgyn, from SCB medical college and hospital, Director of AIIMS, Dr. A K Mahapatra and Dr AK Mohanty HOD, forensic medicine. The focus of the training was to equip health professionals to carry out therapeutic and forensic responsibilities vis-a-vis skill building exercises through case studies, role plays and group discussions. Several discussions were held pertaining to the new laws, medical opinion, documentation of findings and court trials and debates were held on tricky areas pertaining to informed and specific consent, mandatory reporting. The AIIMS is in a process of implementing the MOHFW union Govt protocol.

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

7. SWATI, an Ahmadabad based organization had participated in CEHAT's capacity building workshop on setting the OSCC models and developing a health care response to VAW. SWATI has already collaborated with a civil hospital in Dhangadra area. They needed technical support in understanding how to develop training module for Health professionals and how to build their own team to engage with the hospital staff. A 2 day program was carried out at Dhangadra to equip the staff of the crisis centre in understanding health consequences of VAW, steps in orienting HCPs to VAW and methods of screening women and children for abuse on 24th and 25th Dec 2014.

8. UP state government was very keen to replicate the Dilaasa crisis centre in their districts. Based on their study visit to CEHAT and Dilaasa, we were requested to develop SOPs for the establishing of these crisis centres and linking them to the existing schemes of the MWCD in the state of Maharashtra. CEHAT along with TISS has developed SOPs for the establishing of the Asha Jyoti Kendras (AJK) in 23 districts of UP and submitted a joint draft. Later on, consultations were done with the civil society organizations to seek feedback on the draft protocols. These were also sent for review to the concerned departments who would come in touch with survivors of VAW. The state health department has also adopted the central government protocol for medico-legal care for sexual violence. CEHAT along with TISS will also conduct capacity building workshops of UP AJK centres.

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

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

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

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

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

Integrating Gender in Medical Education: Training of Trainers Workshops

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

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

VI. INTERVENTION AND SERVICE PROVISION (CEHAT)

Building Evidence on the Health Sector Response to Violence Against Women

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

i. Domestic Violence

May 2014 – April 2015

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

From May 2014 to March 2015, 216 new cases of domestic violence have been registered at Dilaasa, Bandra Bhabha and 71 at Kurla Bhaba. During this period, 333 follow-up sessions were conducted at Bandra Bhabha and 39 at Kurla Bhabha. An additional 73 women were screened for domestic violence and offered suicide prevention counselling after having attempted suicide at Bandra and 20 at Kurla Bhabha. Twenty two women came in for legal follow-up.
Referrals take place from various departments of the hospital such as the Casualty department, Female medical and surgical wards and trauma ward of the hospital. There were 109 such women were referred from the hospital to Dilaasa. Sixteen women came to the centre after seeing the posters. Ninety two women were referred by other sources such as ex-clients, other hospitals, organizations and communities.

During the process of counselling, if the woman expresses interest in seeking legal redress, support is provided through consultations with lawyers from Majlis. Twenty two women received legal consultation at Dilaasa. When the woman needed urgent assistance, an appointment was sought from the lawyer and the woman was directly referred either to the Protection Officer or to the Majlis office.

The counsellors interact with the patients in the ward on a regular basis, informing them about the services of the centre. This encourages them to access the service when required and helps spread the word in their community. There is ongoing engagement with the doctors to ensure identification of women facing violence and their referral to the centre.

ii. Sexual Violence

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

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

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

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

Approval for setting up a hospital based crisis centre responding to women and children facing violence in Goa was received from the Ministry of health and family welfare (MOHFW) as well as Ministry of women and child, (MWCD) Goa. Departments of Health, Women and Child Development, Panchayats, Forensics department at Goa Medical College and Hospital, representatives of District Legal Services Authorities were all approached and explained the purpose of the project. Their cooperation was sought in an effort to develop a convergence model.

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

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

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

women facing violence. Therefore, this could a reason why these women still wanted some time to think of what services they wanted from the centre

Visits to the Dilaasa centre:

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

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

Conferences and Presentations

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

VII. 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-7, English-8 = 15
6. Books- 3299
7. Bound Volumes- 196
8. Reference Books- 130

The publications in Marathi & English brought out during April 2014 to March 2015 are as follows

No	Particulars of Publication	Date of Publication
1.	'Dawandi'- News Letter published quarterly	June, 2014 to March, 2015
2.	Pictorial VHSC Tools for 1 year and 3 years (Gaon Patilvar Milnaraya Aarogya Sevanbaddlchya Mahitisathi Prashnavali)	September, 2014
3.	Pictorial VHSC Report Card for 1 year and 3 years (Aplya Gavatil Aarogya Sevanche Pragatipatrak)	September, 2014
4.	Pictorial PHC Report Card (Aplya Prathmik Aarogya Kendratil Aarogya Sevanche Pragatipatrak) for 3 years	September, 2014
5.	Pictorial PHC Tool (Prathmik Aarogya Sevanchi Prashnavali) for 3 years	September, 2014
6.	Pictorial RH Tools (Gramin Rugnalaya)	September, 2014
7.	Pictorial RH Report Card (Gramin Rugnalaya)	September, 2014
8.	Anganwadi Tool_Anganwadimadhye Milnaraya Sevanchaya Mahitisathi Prashnavali	September, 2014
9.	Anganwadi Report Card_Anganwadimadhye Milnaraya Sevanche Pragatipatrak	September, 2014
10.	Training Manual Book for Trainers _ 6 to 3 yrs. Vayogatatil Mulanchaya Poshanabaddal Samudayala Sandesh Denyasathi	December, 2014
11.	Ekatmik Bal Vikas Sevanvar Lokadharit Dekhrekh va Kruti (Guide Book)	December, 2014
12.	Ekatmik Bal Vikas Sevanvar Lokadharit Dekhrekh va Kruti _ Sandesh Cards	December, 2014
13.	Balachaya Vadhicha Chart _Flex poster	December, 2014
14.	Universal Health Care_ English brochure (We need a system for Universal Health Care!)	January, 2015
15.	Universal Health Care_Marathi brochure (Aarogya Sevechya	January, 2015

No	Particulars of Publication	Date of Publication
	Sadhyachaya Arajkteltn Baher Padnayasathi Maharashtrat 'Sarvansathi Aarogya sevechi Vyvashta Nirman Karane Avashyak Ahe)	
16.	Hoy, He Sahaj Shakya Ahe!! Rajyatil Aarogyaseva Sudharnyasathi 5 Prabhavi, Kami Kharchik va twarit Karnyajoge Upay (Policy brief Marathi)	January, 2015
17.	Sarvansathi Mofat Aargoya Seva (UHC booklet)	January, 2015
18.	Moving towards Health and Health care for all Framework for a Public-centred Universal Health Care system in Maharashtra (UHC document)	January, 2015
19.	Rashtriya Gramin Aarogya Missionchaya Lokavloknasathi Rajyavyapi Aarogya Yatra, Aarogya Abhiyan Yatra-2015- Flex, Patrak	February, 2015
20.	Aarogya Sevancha Hakka - 5 types posters	February, 2015
21.	Gaon Aargoya Poshan, Pani Purvatha Swachhata Samiti (VHSC Patrak)	February, 2015
22.	CBMP Posters Chala Chala, Aarogya Sevanvar Dekhrekh Karu ya! Aple Aarogya Hakka Milvu ya!!	March, 2015
23.	Aarogya Kendra Dekhrekh va Niyogen Samiti (PHC_Patrak)	March, 2015
24.	Community Based Monitoring and Planning in Maharashtra Supported by NHM, (CBMP policy brief)	March, 2015
25.	CBMP Update English	March, 2015
26.	Paule Chalati Badalanchi Vat	March, 2015
27.	Adhikari va karmchari yanche interview book	March, 2015
28.	Ashi Hot Ahe aarogya Sevevar Dekhrekh (CBMP Marathi Brochure)	March, 2015
29.	CBM Stickers _ Aarogya Sevanvar Lokadharit Dekhrekh va Niyogen (8 strips)	March, 2015
30.	CBM Stickers _ Toll Free & Janani Shishu Suraksha Karyakram (JSSK)	March, 2015
31.	Nivadnuk Jinkali, Ata Pudhe Kaya?	March, 2015
32.	Lokadharit Dekhrekh va Niyogen Prakriya (CBMP Marathi Flyer) - 13 dist	March, 2015
33.	ICDS Policy Brief_ Community Based Monitoring and Action (CBMA) to strengthen ICDS services in Maharashtra	March, 2015
34.	SAM Study Report	March, 2015
35.	Anganwadila jevha jag yete (Success stories in ICDs)	March, 2015
36.	Weaning policy brief	March, 2015
37.	Anganwadila Jevha Jag Yete (Success stories in ICDS)	March, 2015
38.	‘Rugna Kalayan Nidhi’, ‘Rugna Kalyana’sathi Kasa Kharcha Karava? (RKS Booklet)	March, 2015
39.	THR Brochure (THR chi pakite kiti Upyogi, Kiti Poshak)	March, 2015
40.	Charter of Patient's Rights and Responsibilities	March, 2015
41.	Voices of Conscience from the Medical Profession	March, 2015

No	Particulars of Publication	Date of Publication
42.	Brief Report on People's perceptions regarding private healthcare services in selected parts of Maharashtra (Policy brief)	March, 2015

STAFF DETAILS AS ON 31ST MARCH 2015

Sr. No	Name of the Staff	Designation	Gross salary	Centre
1.	Abhijit More	Project Officer	26,960.00	SATHI
2.	Arun Gadre	Senior Scientist	55,647.00	SATHI
3.	Ashwini Devane	Junior Research Officer	30,287.00	SATHI
4.	Bhausaheb Aher	Junior Project Officer	31,147.00	SATHI
5.	Deepali Yakundi	Junior Research Officer	28,567.00	SATHI
6.	Gajanan Londhe	Office Secretary	22,594.00	SATHI
7.	Hemraj Patil	Project Associate	26,927.00	SATHI
8.	Jessy Jacob	Junior Administrative Officer	28,997.00	SATHI
9.	Kiran Mandekar	Junior Administrative Officer	30,287.00	SATHI
10.	Meena Indapurkar	Office Assistant	8,641.00	SATHI
11.	Nitin Jadhav	Project Officer	40,200.00	SATHI
12.	Ramdas Shinde	Administrative Assistant	24,707.00	SATHI
13.	Ravindra Mandekar	Office Secretary	22,919.00	SATHI
14.	Shailesh Dikhale	Junior Project Officer	31,147.00	SATHI
15.	Shakuntala Bhalerao	Junior Project Officer	31,147.00	SATHI
16.	Sharada Mahalle	Junior Administrative Officer	28,567.00	SATHI
17.	Shweta Marathe	Junior Research Officer	35,147.00	SATHI
18.	Trupti Joshi	Junior Project Officer	31,147.00	SATHI
19.	Tushar Khaire	Office Secretary	22,269.00	SATHI
20.	Urmila Dikhale	Administrative Officer	33,700.00	SATHI
21.	Vinod Shende	Project Assistant	21,619.00	SATHI
22.	Anjali Kadam	Secretary	22,656.00	CEHAT
23.	Radha Pandey	Secretary	21,956.00	CEHAT
24.	Pramila Naik	Junior Admin Officer	34,178.00	CEHAT
25.	Shobha Kamble	Office Assistant	17,464.00	CEHAT
26.	Sudhakar Manjrekar	Office Assistant	17,464.00	CEHAT
27.	Dilip Jadhav	Office Assistant	17,464.00	CEHAT
28.	Vijay Sawant	Secretary	23,006.00	CEHAT
29.	Sonal Vasanthan	Admin Assistant	27,285.00	CEHAT
30.	Jasmin Chembiparambil	Admin Assistant	27,960.00	CEHAT
31.	Rashi Vidyasagar	Research Associate	27,960.00	CEHAT
32.	Asilata Karandikar	Research Associate	28,185.00	CEHAT
33.	Sumeet Pokharnikar	Senior Research Associate	33,628.00	CEHAT
34.	Suchitra Wagle	Research Officer	26,054.00	CEHAT
35.	Sanjida Arora	Senior Research Associate	32,803.00	CEHAT
36.	Sujata Ayarkar	Research Associate	27,960.00	CEHAT
37.	Nehal Shah	Senior Research Associate	16,402.00	CEHAT
38.	Shreya Sen	Senior Research Associate	32,528.00	CEHAT
39.	Aafrin Ansari	Junior Admin Officer	20,012.00	CEHAT

40.	Aarthi Chandrasekhar	Research Officer	43,099.00	CEHAT
41.	Sangeeta Rege	Senior Research Officer	54,143.00	CEHAT
42.	Abhay Shukla	Coordinator- SATHI	66,599.00	AT
43.	Padma Deosthali	Coordinator- CEHAT	98,136.00	AT
44.	Saramma Mathew	Chief Finance & Admin Officer	74,386.00	AT
45.	Richa Honavar	Accounts & Admin Officer	43,099.00	AT

Slabs of gross monthly salary including benefits paid	**Female**	**Male**	**Total staff**
< 5000	0	0	0
5001 – 10000	1	0	1
10001 – 25000	5	8	13
25001 – 50000	19	7	26
50001 – 100000	3	2	5
> 100000	0	0	0
Total	**28**	**17**	**45**

Sr.No.	**Name of the Board Members**	**Position in the Board**	**Remuneration**
1	Dhruv Mankad	Managing Trustee	NIL
2	Padma Prakash	Trustee	
3	Amar Jesani	Trustee	
4	Ravinder Singh Duggal	Trustee	
5	Vibhuti Patel	Trustee	
6	Mohan Deshpande	Trustee	
7	Nobhojit Roy	Trustee	
8	Padmini Swaminathan	Trustee	

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, 2015**

FUNDS & LIABLITIES	RS.	RS.	PROPERTIES & ASSETS	RS.	RS.
Trust Fund or Corpus		30,055.00			
Reserve Fund		-	**Immov. Properties**		
			Book value of immoveable property		
Employee Social Security and Welfare Fund		2,583,550.08	as on 31st March 2015		2,110,494.72
Research & Education Fund		3,141,307.69	**Moveable Properties**		
			Book value of moveable property		
Maintainence & Overheads Fund		1,906,003.57	as on 31st March 2015		1,970,424.51
Building Fund		9,692,354.04			
			Tax deducted at source	662,869.00	
Earnest Money Deposit		500,000.00	Deposits	171,845.00	834,714.00
Liabilities for expenses		8,820.00			
Earmarked Grants (Refer Note c in Notes to Accounts)			**Outstanding Income (Accrued Interest)**		18,282.97
Opening balance as per last balance sheet	10,133,182.81				
Add: Opening balance of Grants to be disbursed	146,700.00		**Cash & Bank Balances**		
Add: Grants received during the year	61,906,377.86		Bank balances	38,103,572.86	
Add: Transfers during the year	12,903.12		Fixed Deposits with Banks	8,429,290.01	
Add: Interest earned during the year	518,837.96		Cash & Cheque in hand	54,730.00	46,587,592.87
Less: Grants disbursed during the year	15,391,742.00				
Less: Transfers to various funds	2,045,549.02				
Less: Expenses incurred during the year	34,629,328.01	20,651,382.69			
Income & Expenditure Account					
Balance as per last balance sheet	10,497,463.73				
Add: Interest of previous year	12,163.97				
Add: Surplus as per Income & Expenditure Account	2,498,408.48	13,008,036.18			
TOTAL		**51,521,509.25**	**TOTAL**		**51,521,509.25**

Place: Mumbai
Dated: 6th September, 2015

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 ENDE 31ST MARCH 2015

EXPENDITURE	RS	RS.	INCOME	RS.	RS.
To Establishment expenses		177,627.06	**By Grants administration income**		1,085,000.00
To Loss on assets scrapped		2,405.52	**By Interest (not allocated to any project or specific fund**		559,482.00
To Depreciation		24,912.25			
			By Donation		284,475.61
To Expenses towards objects of the Trust (Expenses over and above those booked under the Earmarked Funds)		166,374.00	**By Income from other sources**		
			Contribution to publication & database	19,407.00	
			Miscellaneous Receipts	18,824.70	
			Consultancy received	897,391.00	
			Royalty	5,147.00	940,769.70
Surplus carried to Balance Sheet		2,498,408.48			
TOTAL		**2,869,727.31**	**TOTAL**		**2,869,727.31**

Place: Mumbai
Dated: 6th September, 2015