

ANNUAL REPORT OF ANUSANDHAN TRUST
Period: April 2010 – March 2011

I. RESEARCH (CEHAT)

Mapping of health facilities in cities of Maharashtra:

The current development pattern is increasing the shift of population from metro cities to small cities and towns. There is a dearth of information on health services and health status of those living there. There has been little research on the growth of health services in these towns. Maharashtra is the second most urbanised state in India with 42% of its population residing in urban areas. Over the years, the growth in public health sector has not kept pace with the growth in increase of urban population. The present study examined the spatial growth of public and registered private health facilities in selected cities of Maharashtra. The mapping method used in the study has been really useful in highlighting the availability of private/public facilities in these cities. We found clusters of private hospitals in the city centres, with the urban poor completely excluded. The private health sector has been growing without any kind of regulation. Unlike education where schools cannot be set up in an area where a school already exists, the health sector does not have any such norms. The growth of private hospitals is determined not by need but by the market, thus leading to high concentration zones within the city. The study highlights an urgent need for a norm for location / distribution of private hospitals within the city to facilitate a more equitable distribution of health services.

The use of Geographical Information System (GIS) in the field of health research is increasingly becoming important. GIS can be effectively used as locational technique for analysis for decision making in relation to optimum gainful utilization of available medical resources. Having embarked on the use of geographical method for health research, it prompted us to organize a seminar in collaboration with the Department of Geography; University of Mumbai titled “Spatial Dimensions on health care- Use of GIS in health studies”. The aim of this seminar was to discuss the prospects and future development of GIS in spatial health and health care management. Six papers were presented at the seminar from use of GIS for mapping HIV/AIDS facilities in Maharashtra to effective management of sanitation facilities in Chennai slums to using it in post flood epidemic in Mumbai. The findings from the CEHAT study too were presented. A paper reflecting on concepts and relevant techniques in health was presented too followed by a panel discussion on future prospects of GIS in health studies.

We hope that the findings of the study would be useful in making key recommendations for regulation of private sector, especially for equalizing accessibility/distribution of private establishments. The methodology could be used for other states experiencing rapid growth in urban centres.

Health Status of Prawn Harvesters from the Little Rann of Kutch: An Exploratory Study

Prawn harvesters from the Little Rann of Kutch, Gujarat, largely members of the Miyana community, are seasonal migrants from along the coastal areas of Gujarat. Unlike the salt pan workers with whom they share the geographical area, the prawn harvesters remain to be a relatively poorly documented group. This study conducted by CEHAT in collaboration with ANANDI which has a strong presence among the prawn harvesters; is an attempt to document the socio-economic and health condition of the prawn harvesters at temporary settlements along the coast. The study was conducted in 13 temporary settlements spread across Rajkot and Surendranagar districts along the coast of the western Indian state of Gujarat.

Temporary settlements do not have toilets and facilities for management of solid and liquid waste and they dispose waste from prawn processing in the open leading to unhygienic environment, breeding of flies and mosquitoes. All basic amenities are practically inaccessible to the prawn harvesters at temporary settlements. Residents of temporary settlements travel 5km – 60 km to market place or grocery shops; the nearest PDS shop was reported to be at a distance of 5 km – 33 km from the temporary settlements. Distance to public sector health care facilities ranged from 5 km – 76km and only one of the 13 settlements reported services from the ANM, ASHA, MPW and gramsevak at the temporary settlement. Sixteen percent of the households (45/288) did not have a ration-card and of the rest, 56% (135/243) reported having a below-poverty line ration-card. Child-earners were reported in 85/288 households; of these 34 households reported male child earners while 63 households reported female child earners.

Almost one-fourth (24%, 481/2017) of the sample reported being ill at least once during the 15 days preceding the day of interview (acute illnesses). Eleven percent (11%, 43/402) of the persons who reported illness during the 15 days preceding the survey needed hospitalisation. More than ten percent (17%, 347/2017) of the prawn harvesters surveyed reported one or more chronic illnesses. Reproductive health problems accounted for 81% (188/231) of the chronic illnesses among women in the 17-50 year age group. Lower backache (37%, 65/177), excessive vaginal discharge (24%, 42/177) and pain in the lower abdomen (10%, 18/177) were the most reported conditions. One third of the respondents who reported one or more chronic conditions had not sought treatment at base village and at temporary settlements. Migration had more severe impact on women's access to health care.

Eighty-four (29%) of the 288 respondents reported having lost one or more children. Only one woman had received IFA tablets and TT injection during pregnancy at the temporary settlement. Only one third (32%, 14/44) of the births took place in a hospital and four of these were instrument assisted deliveries. Of the 30 deliveries that took place at home, only four (13%) were attended to by a trained *dai* (ASHA worker) and the rest were assisted by untrained *dais* or women from the family. The component of post-partum care was found to be totally lacking at the temporary settlement. Group discussions and key informant interviews highlighted apathetic attitude of public sector health care providers. Women narrated instances of the ANM refusing to visit temporary settlements to conduct deliveries, and 108 ambulances refusing to collect patients from temporary settlements sighting poor road conditions as a reason.

The study highlights the lack of access to basic amenities such as potable water, sanitation, health care, transportation, education and public distribution system for the prawn harvesters from the LRK. The poorest are the worst affected from general deprivation – they rely more on poor quality water from the ditch, spend larger portions of their earnings on meeting needs of daily lives such as purchase of drinking water and engage in additional hardships of gathering firewood. Morbidity rates are higher than other tribal populations from the state probably as a result of combined effect of harsh environmental and work conditions, unhygienic living conditions and poor access to health care facilities. At temporary settlements, the women bear the double burden of household chores, and back-breaking work related to prawn harvesting which also keeps them in direct contact with prawns for long durations. These work conditions and prolonged contact with sea-food are known risk factors for health conditions including asthma, skin conditions and poor obstetric outcomes.

The study findings point towards the urgent need for provision of basic amenities including drinking water, PDS shops, health care, sanitation and education at temporary settlements. Mobile schools and mobile health care vans can be arranged for the prawn harvester residents at the temporary settlements. Social mobilisation and strengthening of cooperative societies could help the prawn harvesters gain the essential power to negotiate market rates. Appropriate investigations should be carried out to assess the impact of various environmental and occupational risk factors on prawn harvesters' health.

Implementation of User fees in a public hospital

User fee was introduced in India in the 1990s as part of Health Sector Reforms and many studies, including NSSO data show that levying user fee in public health facilities is an important factor that has contributed to the decrease in the utilisation of public health facilities over the last two decades. The broad objective of this study is to map the flow of user fee from collection, deposition, and expenditure of the funds generated by levying user fee in the Municipal hospitals of Mumbai, and understand the process of exemption from user fee and provision of Poor Box Funds to the needy. There have been many studies on user fee, indicating that the average hospital receipts forms a negligible percentage of the total hospital expenditure and if the administrative costs are deducted, the recovery is meagre.

The Primary data was collected by conducting semi-structured interview with the clinical and administrative staff involved in the implementation of user fee in a municipal hospital. Secondary data was collected from Accounts and the Medical Records Departments of the selected facility. The proportion of patients who are accessing waivers and exemptions was also looked at, using available data from the facility.

The preliminary study findings were shared in National Bioethics Conference held on 18-20th November 2010 in New Delhi. The draft final report of the study was submitted to the PDC for review on the 23rd May 2011. The review process is ongoing.

This study will help in examining the contribution of user fee in cost recovery. It will also try to elicit if the cost recovered from user fee forms a substantial part of the recurrent expenditure or not. The study will exhibit the percentage utilisation of funds collected by levying user fee in

quality improvement of the services at that particular facility, as this was the justification behind introducing user fee in public health facilities. Another important finding will be to identify the process of user fee exemption for the needy and utilisation of poor box funds. The staff (at different levels) decides on the criteria for executing implementation, and this process will be explored as part of understanding the exemption process. The findings of the study will be used as evidence to lobby with the policy makers and bureaucrats to re-examine the implementation of user fee and ensure that this cost recovery mechanism does not act as a barrier, but is efficacious and offers the needy equitable access to healthcare.

In India, we observe that user fees are never debated anymore and are being accepted as a norm in public hospitals. A policy brief, based on the review of existing evidence and also insights from the ongoing study was prepared to raise concerns. Examining evidence in the form of various published studies as well policy documents through a review of literature, the policy brief summarises available evidence and discusses various concerns from a low-income perspective. It looks at each of the objectives of the introduction of user fees and examines international experience with the help of published literature. It also looks at the impact of the introduction of user fees on access, in India and abroad. Experiences of some countries that managed to remove user fees and their impact vis-à-vis access will also be looked at. In a situation where various international agencies are openly advocating removal of user fees in the interest of healthcare access to a majority, it is hoped that this policy brief will have a positive impact on policy. The policy brief was released on the 25th March 2011 in a function held at SNDT University, Mumbai.

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

In the state of Maharashtra, CEHAT introduced Public expenditure tracking surveys (PETS) to clarify the flow of funds for health services, provide better public data about how these funds are allocated, and ensure that health funds, including the large funding provided by the National Rural Health Mission (NHRM), are used properly. Maharashtra is one of India's richest states, yet in spite of various government initiatives, many poor people rely on costly private services rather than use low-quality public services. The large number of different funds flowing into the health sector, Central and State government to district and to frontline service providers, makes it difficult to track funds. At the district level, there are several parallel administrative systems and resource channels. The introduction of the NRHM seems to have exacerbated these problems, as new resources flow from the state to the districts outside of normal channels and without clear audit mechanisms. The complex layers of administration and financing at the district level create substantial potential for fund leakage. In order to ensure that financing is efficient and transparent, CEHAT is working to address the need for enhanced tracking of resource flows. The project uses the PETS diagnostic tool to build the evidence on institutional structures and administrative processes governing financial resources, flow of information and fund flow in practice, accounting and audit without necessarily examining the reason for their occurrence or potential solutions. This will involve qualitative research. The qualitative data will be collected through semi-structured interviews, in-depth interviews and the checklist with frontline service functionaries of the hospital, key officials at the block and district level of the relevant line departments, and state administrative officers.

Prior to designing the instruments, the team proceeded to do a rapid assessment of budget decision making and fund flow process and budget data management. This was done for two reasons - one, the team wanted to understand the structure of the system, identify different offices & their involvement in process of budget- formulation, finalization, vetting, approval and auditory mechanisms (internal / external audit). Secondly, to verify the availability of data and its specific characteristics (variables, length, etc.), and to verify the consistency of data reported across various administrative levels. It helped the team to understand and learn how to organize this uncoordinated and scattered data, the budget decision-making process and budget information. Based on proximity, Thane and Nashik districts were selected for rapid assessment. This process has helped the team to better understand the institutions that are shaper/makers, identify and build contacts with potential allies in the government setup. It also helped in identifying windows for intervening in the budget process itself.

Data collection of budget /expenditure at district level and analysis of the same is in process. Expenditure data have been received from the accountant General's office of Mumbai and Nagpur. These are the treasury district level actual expenditure data with detailed line items. This data does not have the budget estimate details, thus, to bridge this gap some data of estimates have been sought from the Health departments CAA wing, Pune. We are still in the process of getting the Budget estimate of some health variables from the regional health circle office of Dy, Director Health , Regional. Local Partners from Amravati and Solapur are in contact with some of the district and regional offices to collect the remaining documents. Based on the existing information, observation and probing questions are/will be incorporated to the protocol. Budget and expenditure profile of district/ appropriate material will be prepared for sharing some key issues with district level civil society organization to initiate advocacy activities like meetings and dialogue.

Study on response of hospitals to the terror Attacks study

After the terror attacks of 26/11/08 in Mumbai, we had proposed a study to document how public hospitals responded to these situations as they are the ones that are expected to bear the burden of care towards survivors of mass violence. An already strained public health system is pushed to its brink and its inadequacies are magnified because of the attention they receive during crisis. Such times offer the opportunity to assess the existing malaise and direct the government's attention to the need to equip hospitals and providers to respond to such emergencies. We felt that such an enquiry would help identify gaps in response, which could then be rectified so that providers feel more in control of the situation, should such an event occur again. The study is being conducted in partnership with the Tata Institute of Social Sciences. In depth interviews were conducted with 60 staff members including doctors, nurses, ward-boys, technicians and other support staff from the four hospitals that were first responders to the attacks – JJ, Cama, GT and St.George's Hospitals. Analysis of the data is currently underway.

Preliminary observations from the data show that most providers acted on their own individual judgment rather than as per a pre-decided plan. There was no clear definition of roles for each person, nor a clear chain of command. As a result, even though sufficient manpower was available, it was not always efficiently utilised. Smaller hospitals were the first responders and

were equipped to handle a certain number of patients, however all cases were transferred to the larger hospital. This resulted in a needless extra load for the large hospital. Even in departments such as Forensic Medicine where the number of post-mortems required to be performed was staggering, cases were not referred to nearby Municipal Corporation hospitals to share the load. This caused delays and also resulted in tremendous fatigue for the staff. All staff were equipped with technical skills as far as their role in treating patients was concerned. The challenges that they reported were with respect to communicating with patients' relatives, maintaining records and dealing with the feeling of insecurity, given that a neighbouring hospital was under attack. The psychological impact of working in such an environment was also reported by providers, particularly those working in the Hospital that was attacked. As regards preparedness, while a Disaster Management Plan does exist for JJ hospital, none of the providers reported having received special training as per this plan. Some were aware that a plan was available, but they were unaware of their own role as per the plan. Most said that their prior experience of managing such emergencies had made equipped them to respond.

The findings of the study will be shared with the concerned hospitals and the health department. We hope that learnings from this study will contribute to strengthening the response of health systems during emergencies such as these

Exploring Religion based Discrimination at Health Facilities

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

The draft report for the study has been completed submitted to the review committee. Feedback was attained and the report is presently under a second review to incorporate the feedback of the review committee. The sensitive nature of the study did not allow the women to open up as much as was expected in the in-depth interviews. A need was felt for the inclusion of community discussions where groups of women met randomly in the streets of the research area were spoken to; to get an in-depth view of the community and its relations with the public health service. The analysis of the report brought forth layers and layers of discrimination and their inter-sectionality with one another. Determining factors that could identify discrimination has always been a challenge of this study. Discrimination as a phenomenon will have to be read and understood within the preview of these layers.

Response to Sexual Assault at a Tertiary Care hospital in New Delhi

A study was conducted at a large tertiary care hospital in New Delhi in collaboration with SAMA, to look at the management of cases of sexual assault. In-depth interviews were

conducted with key respondents to understand the process of seeking consent, history, medico-legal examination, forensic evidence collection, treatment and other aspects related to the role of health professionals in dealing with survivors of sexual assault. Findings suggest that there are no uniform protocols for seeking consent, history, conducting examinations and collecting evidence. This provides scope for biases of individual providers to creep in, often jeopardizing the survivor's rights. Evidence of coercion in obtaining informed consent is one such fall out which is of particular concern. Further, the manner of interpretation of examination findings indicates undue emphasis on the presence/absence of injuries and past sexual activity. Such stereotypical and restricted notions regarding sexual assault have serious implications. The study further shows that despite the fact that this is a large tertiary hospital, the care provided is inadequate as compared to guidelines provided by the WHO. There is no component of psychological support provided to survivors at all. Based on the learnings from this study, further intervention is being planned with the hospital to address gaps.

Study on burns reported by women at a medical college

Cases of severe burns have been known to be caused by domestic violence. There have also been reports of women burning themselves as a result of torture faced in the marital home. In most cases, the burns are extremely severe and the victims do not survive. When death is imminent, a 'dying declaration' is recorded by the police in the hospital. Here, women are not able to reveal the cause of burns because of pressure from the marital family and concern of the future of their children, should they implicate the marital family in their death. In the first year of having provided counselling services at MY hospital Indore, 133 cases of burns were screened by Dilaasa counsellors. An observation that was reported by the counsellors was that several of these cases come across as 'suspicious' cases, in that they may be homicidal or suicidal. However, all of them are registered as 'accidental' burns in the hospital. In some cases, Dilaasa counsellors had been able to elicit a history of homicide or suicide, even though the hospital records had registered it as 'accidental'. This prompted us to undertake an analysis of burns cases at the hospital, with the objective of comparing the profile of men and women reporting burns at the hospital and to identify gaps in recording these cases at the hospital.

We found that of the 580 cases of burns reported at the hospital between October 2008 and September 2009, 70% of them were women, most of who were below the age of 30 years. The extent of burns was much greater among women than men, and they were also more likely to die as a result of the burns. Among the 133 cases screened by Dilaasa counselors, it was found that 90% were married. 76% said the incident occurred at home, most common cause of burn being a *chimney* (small lantern) and stove burst. On screening, 8 were found to be suicidal, 15 homicidal, and only 27 were clearly possibly accidental. A large number (75) were suspected to be non-accidental; all of these had been recorded as 'accidental' in the hospital records. This suggests that there is a discrepancy in recording of burns cases in the hospital, which needs to be addressed. It highlights the need for standard protocols for documentation and management of burns cases. The findings of the study were presented at a National conference organised by Vimochana on the issue.

Intervention research on Sexual assault

CEHAT had been implementing the SAFE kit, training of hospital staff on the issue of sexual violence as well as providing services to survivors of sexual assault at two municipal hospitals – Rajawadi Hospital and Oshiwara Maternity home. Learnings from this pilot project were incorporated into the development of a model comprehensive health sector response to sexual assault. Based on the results of piloting the SAFE kit in two hospitals in Mumbai in the year 2008-2009, we felt the need to revise the kit. The kit needed to be modified so that the manual is more detailed and the proforma less lengthy.

The pilot implementation of a comprehensive health care response clearly demonstrated that just a “kit” cannot ensure holistic health care for survivors. Health providers were unable to respond to several issues whether it was about operationalising consent for examination, or it was collecting evidence based on history. Further most providers would also carry biases and stereotypes about the sexually assaulted people reporting at the hospital. This prompted CEHAT to develop a manual which provides a step by step approach to Health providers about seeking consent, conducting examination, collecting evidence, following treatment protocols and ensuring psychosocial support. The manual seeks to educate health providers about their dual role, which is therapeutic and medico legal in nature. The manual and revised proforma were reviewed by experts from the discipline of forensic medicine, gynecology, psychiatry and law. The manual was also endorsed by the IFFHRO and WHO and published in 2010 . CEHAT team aims to publicize the manual to aid health providers in the examination and treatment of sexual assault and reduce the over reliance on the “ kit” , as such kits contain all the basic paraphernalia required for conducting such examinations and therefore can be easily assembled by individual hospitals.

Analysis of sexual assault case records:

CEHAT has been providing crisis intervention services to survivors of sexual assault and training to doctors and nurses at three public hospitals in Mumbai. So far, 65 cases have been attended to. The records have been analysed to understand the profile of survivors, nature of assault, pathways of reporting to the health facility, factors leading to loss of evidence, relevant examination findings, health consequences of the assault and legal outcomes. This is the only evidence of its kind available in India vis-a-vis sexual assault. Evidence from this data set is being used to support a Public Interest Litigation in the Nagpur High Court, which seeks to ensure uniform, sensitive protocols and provision of comprehensive health care to survivors of sexual assault. CEHAT is an intervener in the matter.

Management Information System for Dilaasa

In order to enable easy, periodic analysis of cases being handled at Dilaasa Mumbai as well as other replication sites, a management information system is being developed. This MIS would record information about the socio-demographic profile of women visiting the department, the nature of violence faced by them, health consequences and the nature of intervention provided by Dilaasa. It would also help to record cases that are being screened, whether they are facing DV or not and whether the ones facing DV are being registered at the centre. We hope that the MIS

will enable us to generate reports on the profile of women coming to the centre and the services that the centre provides. It would also enable monitoring of the services being provided by the centre, the pattern of referrals and the gaps therein. The variables for the MIS have been finalized and data entry is underway. The analysis of the case records for the period 2001-2006 highlighted several aspects related to effectiveness of a public hospital based crisis centre and challenges in responding to survivors of domestic violence. A large number of women coming to Dilaasa report within 1- 2 years of facing abuse. This is critical as it provides an opportunity for intervention at earlier stage of abuse. Again, majority of women coming to Dilaasa have never reported abuse to any formal agency thus underscoring the early detection of abuse. The patterns of abuse reported by women also demonstrate the various forms of abuse that women endure. Lastly, the data has been useful in dispelling several myths related to addiction and violence, unemployment and violence, dowry as the only form of abuse and so on.

A Study on Understanding the Experience of the Training Cell

In the past eight years that *Dilaasa* has been functioning, health professionals have been closely involved with the venture and have been the driving force in making it a success. They have participated in *Dilaasa's* activities in addition to their routine responsibilities. Given the apathetic attitude of the medical and nursing professions towards violence, we think it is commendable that so many health care providers have taken such a keen interest in *Dilaasa's* work, even though they receive no additional compensation for it. This study will help us gain an insight into what motivates health care providers to play such an active role and what they think they have gained from being associated with such a venture. What is the impact of being part of the training cell on the professional lives of these healthcare workers, is another area that was studied. At a point when *Dilaasa* is being replicated at several other sites and similar training cells are likely to be formed, such an analysis will provide valuable testimonies which can motivate other health projects. The results of the study will modify the functioning of the training cell based on the barriers faced by health care providers while being part of such a venture.

Evolving 'good practice' for responding to attempted suicide at the hospital

Dilaasa's experience has demonstrated that women admitted in public hospitals for accidental consumption of poison are often related to an attempt to end one's life. The underlying reason being that they are unable to bear the abuse at home. Based on this experience, Dilaasa evolved a suicide prevention counselling strategy. This counselling strategy is operational in 2 hospitals in Mumbai where Dilaasa is located. In order to broad base this model and encourage other hospitals to respond to this issue CEHAT called for a meeting of different departments of psychiatry from public hospitals as well as psychologists and civil society activists. After a detailed discussion on the Dilaasa suicide prevention model, some of the public hospital social workers and psychologists opined that they too have a frame work of counselling such women. In order to understand these existing psychiatric models, CEHAT decided to undertake an exercise of understanding the suicide prevention models of these hospitals. A study is being conducted in collaboration with the KEM hospital to understand the psychiatric response to attempted suicides amongst women facing domestic violence. Following this, a 'consultative group' of mental health professionals will be formed who will jointly be able to develop a comprehensive care model on responding to attempted suicides.

RESEARCH (SATHI)

Project Title: An assessment of availability, budgetary provision, procurement and supply system concerning essential medicines in select districts of Maharashtra

Project period- August 2009- July 2011

(Period under reporting –April 2010 to March 2011)

Funding agency: International Budget Partnership

Team Members- Nilangi Sardeshpande, Shweta Marathe and Deepali Yakkundi

Background

Availability of essential medicines in public health facilities is one of the serious concerns regarding the quality of health care services. This is also one of the major reasons for lower utilisation of the public health system. The proportion of expenditure on medicines to total expenditure is higher in the public health facilities as compared to private health facilities. Thus to get better understanding of the problem of medicine availability, SATHI has undertaken a project, which looks into the overall availability of essential medicines in PHCs from Pune district of Maharashtra, medicine procurement as well as distribution process and the budgetary allocations for the same.

Key areas of the research in this project were:-

- Actual availability of various essential medicines with reference to standard norms in selected PHCs of Pune District
- The procurement system of essential medicines at district as well as state level to understand key gaps, bottlenecks and areas of delay
- The budgetary allocations for essential medicines at district level in Maharashtra

The aim of the project was to provide evidence regarding the current drug procurement and distribution system to the ongoing advocacy initiatives in order to improve the availability of essential medicines in the primary health centres in Maharashtra

To fulfil the objectives of the project following activities were undertaken-

1. Checking actual availability of select medicines in two PHCs from Pune district
2. Calculations regarding per capita allocations and expenditures for essential medicines in the districts/ PHCs under study
3. Documenting the process of procurement for select medicines in the state of Maharashtra

The present report summarises overall progress about the project activities undertaken during the year 2010-2011. Besides planned activities, a few activities were performed beyond the plan as well.

The following activities were carried out during the period of reporting:

1. Assessment of availability of essential medicines in two PHCs from Pune district of Maharashtra.

64 medicines were selected from the list of around 112 essential medicines for PHC prepared by Directorate of Health Services. Two PHCs, one from Velhe and other from Purandar block in Pune district were selected for study on the basis of criteria such as location of the PHC, its accessibility, patients flow, if any other health centre is available nearby to this PHC, and overall its suitability for the study. 6 rounds of data collection were completed in both the PHCs during

April 2010 to September 2010. Information such as stock in register, stock in actual storage, expiry date of medicines, lists of supply and indent and local purchase was collected during the monitoring visits. Data was analysed quantitatively as well as qualitatively on the basis of different parameters set for the analysis.

2. Understanding procurement and distribution system

Another important component of the project was to develop understanding about the medicine procurement and distribution system. Meeting and interviews with Govt. health officials were the key source for understanding procurement and distribution. The information was gathered by thorough review of available literature and conducting interviews of key informants such as health officials who are currently working in the public health system as well as former officials from state and district level. Data collection regarding procurement system was delayed a bit because of government's attempt to revamp the whole procurement system of the state. This change had taken place during April 2010 to July 2010, during which period officials were not ready to share any information about existing or proposed system.

Along with understanding system of Maharashtra, we have reviewed the Tamil Nadu model, Kerala model, and Chittorgarh model which are considered as successful models to improve medicine availability. With the help of reviewing available literature we have prepared tools for assessment of the procurement cycle.

3. Budgetary allocations

In the present project we have attempted to examine the budgetary allocations towards medicines for SC and PHC from district and state level, also to derive budget requirement (per capita drug expenditure) for fulfilling present medicine need in SC and PHC and to do advocacy for transparent budgetary mechanisms. It was quite challenging to obtain budgetary data. Access to any budgetary data was limited. We are still in process of obtaining some of the essential budgetary data.

Besides all these project activities, two of the members working on project, attended third meeting of IBP Partnership Initiative held in Cambodia in month of June 2010. In the month of November, two of the team members had an opportunity to attend 5 days Advocacy workshop.

Impact achieved through the project-

- 1. The issue of medicine non-availability was presented in State culmination workshop as part of CBM-** on 28th April 2010, state level dissemination meeting for Community Based Monitoring was organized in Arogya Bhavan in Mumbai. Most of the middle to senior state level health officers were present in this meeting. Besides other important findings related to the functioning of the public health system, the data regarding availability of select medicines in all the five districts under CBM was presented during this meeting. Along with the data, some of the suggestions regarding purchase and distribution of the medicines in Maharashtra were also put forth in this meeting. In the meeting, the officials committed that the information regarding medicine purchase, distribution and availability would be displayed on DoH website. This issue is being followed up as part of advocacy under Community Based Monitoring programme.

2. **Jan Arogya Abhiyan (JSA-Maharashtra)** had organised a **State Health rights convention** on 5-6 March 2011 in Pune. Over 160 representatives from health sector and social organisations drawn from 27 districts across Maharashtra attended the convention. Our findings from the study on availability of essential medicines in select 10 PHCs and 5 RHs from 5 other districts of Maharashtra were shared during the convention. The same report has been posted on website of JSA as well. In this convention, it was decided to launch a State level signature campaign addressed to Chief Minister demanding urgent *reversal of sharp hike in user fees* at Medical college hospitals, and basic overhaul in medicine procurement and distribution policy to ensure *guaranteed availability of all essential medicines* in all public health facilities.
3. **The issue of shortage of medicines was also raised in NRHM Common Review Mission (CRM).** One of the SATHI team members was part of the Common Review Mission team constituted by Government to review the progress of NRHM in the state of Maharashtra. Kolhapur district was one of the districts which the team visited. Since SATHI had done the assessment of availability of medicines in this district, the findings of this study were inputted to the CRM report. In addition, the problems related to the overall procurement system were also raised in this CRM report.
4. **Media advocacy-** As decided in the JAA convention, a press release was issued on the occasion of World Health Day. Through the press release, the demand for providing free health care and adequate medicines in PHCs and RHs was put forth. In this press release, the findings of the survey conducted as part of the IBP supported project, where medicine availability was studied in five districts were used. The survey had revealed that out of a small list of most common, essential medicines that should certainly be available in these facilities, 50 to 70% of medicines were out of stock. The other important demands were to double the budget for medicines immediately and citizens to be involved the monitoring of this system of purchase and distribution of medicines.

The following activities were carried out beyond the plan:

1. **Monitoring availability of essential medicines in select PHCs and RHs from 5 other districts of Maharashtra.**

Due to the impending change in the procurement policy in the year 2010, all the procurements were brought to a halt by the Health department. Hence this led to severe crisis in availability of medicines in the rural public health facilities. It was important to bring this situation to the notice of the health department and to oblige them to take immediate action to remedy the situation. Hence we expanded the data collection and monitoring activity in other 5 districts of Maharashtra (Kolhapur, Amravati, Nandurbar, Thane and Osmanabad) in addition to Pune district. A field researcher was appointed for this additional data collection. Analysis of the data revealed that 35 to 65% medicines were completely unavailable in both PHCs and RHs. Findings from the study were subsequently discussed in JAA state convention and JAA decided to take up this issue as one of the important issues of campaign. This issue of medicine shortage was broadly covered by almost all local newspapers.

2. Analysis of case papers

Besides monitoring of medicine stock, data regarding medicines prescribed in the PHCs for 122 patients was noted. To assess the rationality of medicines prescribed, the symptoms reported by the patients were also noted down. Since, the data regarding availability of medicines for the same period is available; an attempt would be made to see if there is any discrepancy in the illness of the patients and medicines prescribed to the patient.

Monitoring of medicine stock was done for the period April 2010 to September 2010. In order to get representative data, we have noted information from 10 to 15 prescriptions each month issued in the same span. Date, age, symptoms of the patient and list of medicines prescribed were noted from the prescription paper.

Analysis of the data revealed that the diagnosis of the illness as well as duration of medicine was not mentioned on any prescription that was studied. The pharmacist informed that as a standard practice, medicines are given in the quantities that would suffice for 3 days. Though it is not written by MO on the prescription, this is explained to the patient while issuing medicines. Data from prescriptions was analyzed using following parameters-

- Irrational prescriptions
- Over prescription
- Over use of analgesics
- Unnecessary use of injections

3. Exit interviews of patients

Rationale for conducting the exit interviews was to know patients' actual experience and perceptions about medicine availability in the PHCs. The exit interviews were conducted using a short questionnaire. The interview focused on whether the patients received all prescribed medicines from PHC or were asked to buy it from outside and if any extra charges were taken from patients.

We made a single visit in both the PHCs and interviewed patients who visited the PHC on that day. Around 48 exit interviews were conducted from both the PHCs. Presently we are in the process of writing report and obtaining some of the remaining budgetary information. Report of the present study would be completed shortly.

RESEARCH (CSER)

A. Practice of Obstetric Care in Mumbai, an ethical analysis

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

Detailed institutional profiles of each of the six hospitals were drawn up; a map of their structure, system, personnel, hierarchy, and so on was made. The research team then conducted sustained, in-depth interviews with the providers. Between April 2010 and March 2011, the team completed 58 of the scheduled 60 interviews. The purpose of the study is to document and analyse and probably come up with a theory of how larger political economy and institutional-sociological flows inform and constitute notions of ethics, morality and shape the logic of practice and of service provision of the individuals.

Team Members: Amar Jesani, Neha Madhiwala, Supriya Bandekar, Sweta Surve, Rakhi Ghoshal

B. Promoting Discourse on Ethics and Human Rights amongst Health Professionals

In another development related to clinical ethics, we are working towards developing an action research project with the Dept. of Surgery at the BARC hospital, which has been organising a support group of breast cancer survivors treated at the hospital for the past 8 years. This team has done some research on the quality of life of survivors over a period of years. CSER will be collaborating with the BARC team to undertake an ethnographic study to understand several aspects of women's concerns and their coping strategies which affect their treatment and rehabilitation. This study will guide the process of facilitating members of the support group to develop relevant patient education material which addresses the concerns and needs of women seeking treatment for breast cancer and also long-term survivors, from their own perspective. This initiative will help to both document a best-practice as well as develop learning/educational material for providers and patients beyond the hospital as well. Till date, the CSER team has attended four support group meetings, done some pilot interviews with a few survivors, extensively documented the experience of the surgeons on this team, completed a literature review and drawn up the research plan. The study will commence following approval from the faculty and ethics committee.

Team Members: Girish Ingle, Rakhi Ghosal, Neha Madhiwalla

C. Biomedical and Health Experimentation in South Asia: critical perspectives on collaboration, governance and competition (BHESA)

South Asia, especially India has become a favourite destination for Biomedical and health experimentation. In this study, we are aiming to explore the relationships between experimental scientific enquiries in medicine and public health, the pharmaceutical industry, the CRO sector and developmental programmes, to assess their impact in South Asia. Using case studies of experimental projects in India, Nepal and Sri Lanka such as research collaborations that connect international researchers with local institutions, personnel and populations, we aim to analyse the networks through ethical, socio-anthropological, political and economic frames. This project is funded by Economic and Social research council, UK (ESRC). This project is international research collaboration between CSER, University of Edinburgh (UK), University of Durham (UK), University of Tufts (US), University of Colombo (Sri Lanka), and Social Science BAHA (Nepal).

In October 2010, an inception workshop was held in Mumbai. Team members from the collaborating countries and key stake holders from the clinical research industry, policy makers & regulators, activists were invited for this meeting. Current issues in the field was discussed which led to decisions regarding the objective of the study. Later, the Clinical Trials Registry-

India database was restructured and used to identify various institutions where a large number of clinical trials are happening.

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

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

D. Clinical trials watch

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

Team: Chitra Borkar, Deapica Ravindran, Vivian David Jacob.

E. Study of the experiences of professionals and NGOs in implementing monitoring and evaluation and the effects of capacity building of professionals in monitoring and evaluation

CSER had been undertaking capacity building for Monitoring & Evaluation for Non Governmental Organisations from 2005 onwards. The research study aims at understanding the experiences of NGOs and NGO professionals who have been trained in Monitoring and Evaluation. Understanding the practical difficulties and hurdles in implementing a monitoring and evaluation programme will be crucial in evidence based practice. The findings from the study can be used towards developing a better understanding of M&E and will also help in better implementation of monitoring and evaluation component. We are also exploring the ethical dimensions of implementing monitoring and evaluation programmes especially in interventional programmes and research.

The research proposal based on the recommendations from Mac Arthur foundation was finalised in November 2010. The proposal was submitted to the Anusandhan Trust IEC in the December 2010 meeting. Approval was granted to the proposal conditional to some clarifications. Revisions were made in the proposal as directed by the IEC and final approval has been granted by the IEC for conducting the study. A detailed literature review was conducted to aid in developing a basic understanding about the field. Data collection for the study began in the month of March 2011. Organisations from the states of Jharkhand, Gujarat, Maharashtra, Tamil Nadu, Rajasthan, Bihar, Goa and Karnataka were contacted for participation in the study. The team visited organisations in Goa and Jharkhand for interviewing professionals from the organisations located there. The study will be completed by December 2011.

Team members: Divya Bhagianadh, Mahua Ray, Vijaya Saraogi.

F. Collaboration with Mahila SEWA trust, Ahmedabad

CSER is collaborating with Mahila SEWA trust, Ahmedabad for conducting a needs assessment study of the their project- Yuva Swasthya (Securing Young People's Health). The needs assessment study was carried out from 7th April – 11th April'11. The study was done in Seven villages across four Talukas of Ahmedabad district – Dholka, Daskoi, Sanand and Viramgam. Focus Group Discussions were help with young adolescent girls of 12-17 years, young adolescent boys of 18-24 years and the members of the Village Health and Sanitation Committee. We also carried out indepth interviews with Anganwari and Aageywan workers.

Team members: Neha Madhiwalla, Sanjay Singh

Promoting Discourse on Ethics and Human Rights amongst Health Professionals

G. Bioethics case-books

Following the decision to develop a text-book on bioethics, we had further consultations and discussion with potential writers and authors. After much discussion, it was felt that it may be more feasible to begin with a set of case-study books, which could serve as useful teaching material and help to bring in more Indian material into the ethics curriculum. Existing text-books or case-books are largely based on Western experiences. There are also a few notable case-books which are based on the experience of international research – involving collaboration between Western and developing country research teams or Western research teams conducting research in developing country settings. However, none of these books addressed several of the concerns of the Indian researchers who are working in their own country and negotiating India's complex social and political system. The combination of a democratic system and a poor society creates a very challenging and unique research context. Also, most of the case-books emerging from the Western countries are preoccupied with the researchers' concerns – whether ethical, organisational or political, which are often not shared by the participant communities. In contract, Indian researchers are an integral part of the same society in which their participants live and may have several shared histories, shared interests and concerns. For the past five years, a national faculty has been conducting training on research ethics and has been developing and using several case studies in its workshops. These case studies are based on their own experiences, documented historical events and contributions from other peers. An editorial group was set up to bring together all this material, develop additional material and write introductory sections, which would support the case-studies as well as provide more inputs to the readers. This group consists of Amar Jesani and Neha Madhiwalla (CSER), Mala Ramnathan (Sri Chitra Tirunal Institute), Suneeta Krishnan (St. John's Research Institute) and Sunita Bandewar (Joint-Centre for Bioethics, Toronto). This group met once in December 2010 to discuss the outline of the book, the necessary revisions required, the additional material to be developed and the writing of the introductory sections. The work on the case-book is in progress and should be completed by June 2011.

While there is quite a lot of material of research ethics, the clinical ethics or ethics of healthcare practice has got very little attention till date. Additionally, unlike research ethics, where organisations such as the ICMR and CSER have been conducting regular training workshops and programmes, there is no significant training programme on clinical ethics which has been organised on a regular basis. Thus, we do not even have a core faculty or teaching material in this subject.

Thus, in order to begin the process of develop a case-study book on clinical ethics, we fell back on available material from other sources such as articles or case-studies published in Indian journals such as the Indian Journal of Medical Ethics, National Medical Journal of India and other medical journals. We realised that the material was not entirely suitable for developing a case-study book as the case-studies presented were often too brief, details were lacking and they were in the nature of analysis and reflection rather than simply a narration of events. On the other hand, several of the case studies were not discussing ethical problems as much as legal or institutional problems such as overcrowding, lack of protocols, ambiguity in legal provisions, criminal acts or gross negligence. These cases were not suitable for training as they were too one-sided, posed no dilemma and had no alternative solutions.

As a second stage of this process, we visited several institutions which provide medical or public health services and met some key individuals in these institutions who are active in the field of ethics. The institutions which were visited include St. John's Institute and NIMHANS in Bangalore, Swami Vivekananda Youth Movement in Mysore district and Sri Chitra Tirunal Institute in Trivandrum. CSER researcher interacted with individual professionals in each of these institutions and documented 30 case studies from various aspects of clinical work such as NICU care, intensive care, maternal health, community health and psychiatry. The cases focussed on different aspects such as informed consent, confidentiality, equity, conflict of interest and truth-telling. The themes of cultural difference, varied value systems, the effect of poverty on health-seeking and institutional environments' influence on decision-making emerged in the case studies.

Following this, an editorial group consisting of D Richard Cash, Public Health Foundation of India, New Delhi, Dr Sridevi Seetharam, SVYM, Mysore and Tejal Barai, Mumbai was formed for the development of the case-book. In addition, staff from CSER will contribute to case-studies from their research projects and also correspond with different clinicians, in order to develop more case-studies. It is expected that this case-book will be ready by the end of 2011.

II. ADVOCACY (CEHAT)

Budget Advocacy:

On 25th March 2011 CEHAT along KHOJ, Amravati (Quest for Knowledge, Hope, Opportunity, and Justice); Department of Economics, University of Mumbai; PG Department of Economics, SNDT; Tata Institute of Social Sciences organized a Seminar on "*Maharashtra's Budget: A Scrutiny of Development Discourse*". The seminar was organized at the time when the legislature was discussing departmental budget of the state. The focus of the seminar was on social sector provisions in the state budget, and patterns of general government spending with specific reference to dalits, tribals, children and women and use of budget analysis as a tool to monitor the government's commitment to social sector. The inaugural session started with the release of policy brief on the practice of levying user charges in government hospitals, prepared by CEHAT's research team. The brief, titled "*Punishing the Poor? A Look at Evidence and Action Regarding User Fees in Health Care*" presents evidence from across the world regarding its practice. The sessions include presentations by, Prof. Anita Rath from Tata Institute of Social

Sciences, on “*Maharashtra’s Social and Health Sector Budget: A Note on Emerging Characteristic and Trends*”, from CEHAT by Prashant Raymus on “Public Health Sector in Maharashtra: A Macro Perspective”; Surekha Dalavi from Shramik Kranti Sangathanaribal on “*Tribal Sub Plan in Maharashtra*”, Pravin More from Alliance for Dalit Rights on titled “*Scheduled Castes- Special Component Plan (SCSP) in Maharashtra*”, by Vibhuti Patel, Director, P.G.S.R. Prof. & HOD, Department of Economics, SNDT Women’s University on paper titled “*Gender Audit of Maharashtra Budget Statement 2010-11*”. Denny John, Director - Health Programmes, of Center for the Study of Social Change (CSSC) Mumbai presented on “*Child Budget Planning in Maharashtra and India*”. The seminar had case studies presentations on exploring Realities and Myths of State Development by CEHAT on “*User Fees in Maharashtra: a Discussion and Preliminary Evidence from a study*” and by Khoj, Amravati on “*Health Budget and Plans – Challenges and Experiences from Amravati District.*”

The seminar was attended by 100 participants including students, researchers, academicians and activists. The presentation and discussion raised several issues and concerns based on a succinct analysis of the state budget and critique of the overall governance in the state and lack of transparency in budget making process. Key recommendations that emerged from the seminar were circulated widely.

Monitoring budgets:

As part of the expenditure tracking being carried out in two districts of Maharashtra, a process has been set in motion for enhancing the capacity of the local budget partner in observing and monitoring fund flow, processes and institutional structures. Local Budget Partners from Amravati and Solapur District have been identified. They are involved in advocating for strengthening the budgetary support for the various programs within their constituencies at the local level. The partnering team is part of the research process as they can familiarize themselves the different offices and the relevant budget documents which can be useful in future to build an argument around the issues/problem identified in these constituencies. The partner from Amravati organized one day meeting, wherein around 7-8 organization from the district participated. It was conducted with the purpose of generating awareness and identifying concerns on budget matters within the local constituency with the objective of politicizing the budget.

Concerns raised about user fees in public hospitals

The Government of Maharashtra hiked User Fees in public hospitals through a Government Resolution ([GR MIC-2006/305/CR-33/06/Administration-2 dated 30 December, 2010](#)) December 2010. CEHAT has been corresponding with the Department of Medical Education and Research regarding the problems with such policy, in the context of an underfunded healthcare system, which serves a lot of poor patients. The two Government Resolutions from [2001](#) and [2010](#) show the quantum of hike in user fees charged at the hospitals.

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

CEHAT filed an intervention petition in the Nagpur High Court on 9th Sept 2010 in a Public interest litigation (PIL) filed by Dr.Ranjana Pardhi and others against Union of India in 2009.

The Lawyers Collective is representing CEHAT for this petition. The PIL by Ranjana Pardhi and others seeks to streamline the medico legal response to sexual assault. As a response to this, the central and state governments submitted proforma for medical examination of sexual assault survivors. These proformas are archaic and not in accordance with the international standards or existing laws in the country. The first prayer demanded that the state government should stop the use of their archaic proforma with immediate effect and replace it. The second prayer asked the state government to ensure the provision of immediate medical treatment along with psychosocial services at the hospital level.

The court appointed a committee to look in to the proformas and manual submitted by the petitioners as well as CEHAT (intervenors) and submit a proforma and manual to the court. However the committee set up comprised of only forensic doctors, these doctors don't conduct sexual assault examinations at all, therefore our legal counsel argued on 2nd February 2011 that the committee should be broad based to include doctors who were instrumental in implementing the comprehensive health care response in Mumbai hospitals. 2 experts from the discipline of gynecology were appointed by the court on this committee. CEHAT also demanded that those involved in drafting such a proforma ought to visit the 3 hospitals where such a comprehensive model is being implemented; this would give the committee members an opportunity to speak to the doctors and nurse about the model, visit the hospital and look at the records. Meetings were organised at 3 sites and the committee was invited to interact with the staff. After reviewing CEHAT's manual and proformas, guidelines as well as paying visits to these hospitals, the committee submitted their revised proformas and guidelines to the court on 7th June 2011. In spite of such close engagement with the committee, the proformas submitted are not as per the standards set by the WHO. Unfortunately the petitioners did not register any objections to these proformas and therefore the court came to the conclusion that the proformas be circulated for implementation all over Maharashtra hospitals and police stations. Disturbingly, the proformas lay emphasis on injures per se whether in penetrative sexual assault or non penetrative sexual assault. This would provide absolutely wrong directions to a doctor while conducting examinations; thereby it would be interpreted as "no injuries would mean no sexual assault". Analysis of CEHAT record pertaining to sexual assault dispel the myths around injuries completely. Further the guidelines don't even mention the nature of therapeutic care required y survivors of sexual assault. CEHAT in response to the court order has filed a review application to draw attention of the judiciary to the fact that the proformas submitted by the committee do not follow the WHO standards and are also in contradiction with the Indian law. Currently efforts are underway to build an opinion amongst health professionals, NGOs and civil society on the problems with the state proforma.

Campaigning against the use of two-finger test in examination of sexual assault survivors:

Taking forward its commitment towards making the health sector response more gender sensitive, CEHAT worked closely with the Human Rights Watch on its report "Dignity on Trial: India's Need for Sound Standards for Conducting and Interpreting Forensic Examinations of Rape Survivors". A press conference was held on 6th Sept 2010 asking the Indian government to ban the "Two finger test" commonly used in examining women and children reporting sexual assault. The HRW appealed to the government to ban such a test and develop sound standards for conducting forensic examinations based on international standards, one such example is that

of the WHO. The report refers to one such good practice model evolved by CEHAT in collaboration with the Brihanmumbai Municipal Corporation (BMC) in India. CEHAT's released its Manual for Medical Examination of Sexual Assault at the press conference.

Development of ethical guidelines for domestic violence counselling:

After the publication of counselling ethics case book, CEHAT felt the need to take a step forward from the ethics casebook, and began the process of developing ethical guidelines in domestic violence counselling. The aim of these guidelines was to cultivate good practice in domestic violence counselling and educate counsellors on the discourse in counselling ethics. CEHAT invited experts from the field of psychology, social sciences, counsellors, psychiatry and ethicist and formed a committee. The committee consists of : Amar Jesani, Anuradha Kapoor, Jaya Sagde, Manisha Gupte, Prabha Chandra, Soumitra Pathare, U. Vindhya, Vanita Mukherjee, A draft of the ethical guidelines was prepared based on the review of International codes of ethics and our experience of domestic violence counselling at the crisis centre. The guidelines presented the principles and values of feminist counselling and steps in applying the ethics frame work while counselling. In its first meeting held on 24th May 2011, the guidelines, its purpose, objectives and content was discussed threadbare. The committee gave detailed feedback on the draft guidelines. Currently the team is working towards revising the guidelines and resubmitting it to the committee for a discussion. The committee strongly felt that these guidelines should be used at the Dilaasa crisis centres first and then advocate for its use by other organisations. Those involved in domestic violence counselling could adapt them as per their context. While several counselling centres are functioning in India, this is the first such endeavour to evolve guidelines for counselling in DV.

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

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

As the Asia Regional Focal Point of the IFHHRO, CEHAT has been actively participating in all its activities. IFHHRO, OSI and other NGOs have launched a campaign in 2010 to address certain key issues of human rights violations in health care settings. One of the issues being addressed through the campaign is that of forced and coerced sterilization. As part of this, a representative and nominee from CEHAT attended the seminar on Forced and Coerced Sterilization held in Salzburg in December 2010. In the context of India, it was felt that there is a need to deliberate upon the existing guidelines for sterilizations, particularly to address issues of quality of care and consent. As a follow up of Salzburg, a working group consisting of experts has been constituted, that would consider and if required, draft alternate guidelines for this purpose. Professional organizations like the Forum of the Obstetricians and Gynecologists Society of India (FOGSI) would be approached for endorsement of these guidelines. A second key issue that is being addressed through IFHHRO's campaign is that of lack of access to pain relief. A representative of CEHAT attended a 2-day workshop on Pain Relief as a Human Right organized by IFHHRO and OSI.

Health and Human Rights Wikipedia

IFHHRO has also created a 'Health and Human Rights Wikipedia' to provide concise and precise information about human rights issues for health professionals. The wiki looks at providing information by issue as well as information about specific countries. The section on Domestic Violence was added to the HHR Wikipedia by CEHAT this year. Two interns from the Tata Institute of Social Sciences were involved in collating and summarizing literature on the issue.

Disseminating Information

By way of increasing visibility of the ARFP, brochures highlighting the main activities of the ARFP were printed and are being disseminated at key events. We have also been updating the ARFP news section on the website to keep people informed of various activities involving health professionals and human rights from the region.

Statement on death penalty:

A press conference was organized in Mumbai in April 2011 to address the issue of use of Indian drugs in executions in the United States. It was organized by Reprieve, a US-based legal action charity providing legal services to prisoners who cannot afford to pay. As ARFP, CEHAT was invited to present its work and perspectives on human rights violation and death penalty. A statement opposing the death penalty was issued by IFHHRO which was shared at this press conference.

ADVOCACY (SATHI)

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

Funding agency – Oxfam India

Period under reporting- April 2010 to March 2011

Team Members- Dhananjay Kakade, Bhagyashri Khaire, Abhijit More, Trupti Joshi, Shailesh Dikhale, Shakuntala Bhalerao, Nitin Jadhav, Sant Mahato, Ajay Viswakarma, Rakesh Sahu

Background of the project- The overall aim of the project was to consolidate health rights activities and community based health capacities in areas covered by SATHI in Maharashtra and Western Madhya Pradesh. This was achieved by further development of the Health rights partnerships with existing partner organisations in defined areas, value addition to Community based monitoring, strengthening social support to selected ASHAs who were trained by SATHI and partner NGOs, and supporting advocacy especially on Patient's rights.

Specific objectives of this project were as follows-

- 1) Consolidation of health rights activities being done by partner organisations by continued development of grassroots work and alliance building at district level.
- 2) Generalised implementation of Community Monitoring in further districts of Maharashtra with value addition by SATHI team members; orientation of certain large networks regarding community based monitoring
- 3) Strengthened Health system and community support for selected NGO trained ASHAs

- 4) Orientation of activists in a few areas of Maharashtra regarding Patient's rights in the private sector and regulation of the private sector.
- 5) Strengthened pro-people advocacy (in collaborative manner) on specific national health issues.

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

A. Consolidation of Health rights activities in multiple areas of Maharashtra and Madhya Pradesh by partner organisations-

In the context of SATHI's health rights partnership with six organizations in the state of Maharashtra and one organization in the state of Madhya Pradesh, for each partner organisation one SATHI action team member was designated to give regular strategic inputs and support to key health rights events.

Following are highlights of health rights activities that were conducted by the partner organizations in their respective field areas in the reporting period.

In the State of Maharashtra-

I. Janarth Adivasi Vikas Sanstha, Shahada, District- Nandurbar.

Community action and advocacy for improvement in the municipal hospital- Members of the Patients rights committee had a dialogue with the municipal officials to point out various deficiencies (e.g. non-appointment of medical doctor, shortage of medicines etc.) seen in the Shahada Municipal Hospital. Besides dialogue, delegates submitted a memorandum stating that Shahada Municipal hospital should be upgraded to a Rural hospital. As a result of this dialogue, temporarily one doctor has been given the charge of the Shahada hospital and now at least, it has become functional. Health rights & patients rights poster exhibitions were conducted in three localities of Shahada town. Signature campaign was also conducted to increase community awareness regarding poor condition of the Shahada Municipal hospital and to generate popular support for its improvement.

Activities done by the Patient's Rights Committee, Shahada- This committee now meets every month and is often attended by around 15 to 20 people. Due to the efforts of various members of this committee, Private doctors in Shahada have agreed to co-host the proposed Patient's Rights Convention.

II. Lok Sangharsh Morcha (LSM), Akkalkuwa, Nandurbar

Village Health Calendar Programme was launched in seven villages of Akkalkuwa block. This programme was planned for improvement in the regularity and quality of outreach services in the mentioned seven blocks. Besides launching the calendar programme, information regarding entitlements in the JSY and Matrutwa Anudan Yojana, Aanganwadis was regularly shared with the community. For the first time in this area, the forum of Mahila Gram Sabhas was used innovatively to raise women's health issues in a systematic way. As a result of the calendar programme outreach services are showing

significant improvements in the areas where presently the calendar programme is being implemented.

III. Rachana Samajik Punarbandhani Sanstha, Pune-

More than 600 school students (10 to 14 years age group), from Rachana trust's intervention area wrote a letter to the NRHM- Mission Director demanding representation of school children in the Village Health and Sanitation Committee (VHSC) so that their health issues are addressed. Bal Gram sabha was conducted in Kondgaon village on 14th August 2010. The Block Panchayat Sabhapati (PRI Member) presided over the sabha. 60 students from surrounding four villages came together for the Bal gram-sabha and pointed out a range of deficiencies seen in the local public health system and demanded their urgent solution.

Dialogue with the private health sector- Rachana Trust representatives had a meeting with nine private medical practitioners from Mulshi block, to orient them about patient's rights issues, BNHRA rules.

IV. Amhi Amchya Arogyasathi (AAA), Kurkheda, Dist-Gadchiroli-

Submission of memorandum, regarding use of various health funds, to District Guardian Minister – A delegation of activists from women's self-help groups (SHGs) federation submitted a memorandum to District Guardian Minister R.R. Patil and discussed with him issues of non-availability of VHSC untied fund, lack of JSY benefits, poor quality of healthcare services etc. It has resulted in number of qualitative improvements in local health care services.

Data collection from 3 PHCs, about status of availability of 57 essential medicines- After capacity building activists from AAA and other organisations collected data regarding availability of 57 essential medicines from 3 PHCs. Findings were subsequently widely reported in the media and were also presented in the Jan Samwad.

Women's SHG federation had a dialogue with health care providers in five PHCs of the area where they have pointed out a range of women's health linked deficiencies in the public health system, it has resulted in certain local improvements.

V. Mahila Sarvangeen Utkarsh Mandal (MASUM), Dist-Pune

'Arogya Yatra' in 15 villages- Arogya yatras were conducted in 15 villages to create awareness about health rights. Various tools like street play, songs & poster exhibition were used to make it attractive.

Meetings & discussion with villagers, VHSC members, women's self-help groups etc.- Out of 15 villages under this project, village level meetings were conducted in 5 villages (113 villagers participated) to create awareness about health rights, features of public and private healthcare systems.

Activists from Masum held separate discussions with VHSC members from 14 villages (198 participants) to inform them about their role and responsibilities. After training on health rights, '*Sadaphulis*' (MASUM village health workers - activists) have found out

that there are some factual errors in the ANC card which are filled by the ANMs during ANC check up. To verify the noting in the ANC card, *Sadaphulis* themselves have checked Blood pressure, weight, Hb% of pregnant women. This was followed by a dialogue with the health care provider regarding the gaps found. Women from 9 villages participated in the dialogue.

Besides above mentioned activities, a range of public dialogues with the health functionaries were organised in the PHCs and the Rural Hospital.

VI. Shramik Mukti Dal (Lokshahiwadi)-SMD - Ajara, Kolhapur District

Grievance registration mechanism for patients- SMD displayed a board in front of Gadhinglaj sub-district hospital (which gives contact details of Sanghatana members) for patients to register their complaints, grievances against that sub-district hospital. This has helped the organisation to collect patient's grievances and address them during periodic meetings with hospitals or in some cases urgently. At the same time, it has benefited patients also. Patients have started using this board and till date 12 grievances have been raised during dialogue with health officials /settled with the intervention of Sanghatana.

During the project under reporting, a range of village level meetings were conducted, in these meetings issues like village level healthcare services, irregularities in functioning of PHCs, nurse's behavior with patients, status of sub-centre building, denial of services, demand for new PHC, reorganization of villages under PHCs were discussed. Key observations of the community members regarding functioning of the public health system were shared with the local health authorities.

In the State of Madhya Pradesh-

During the reporting period, the following activities took place in the area of JADS (Jagrit Adivasi Dalit Sangathan) in Barwani District as part of the Health rights partnership project.

1. On 14th and 15th June 2010 a joint *workshop of VHSC members and ASHAs* was held in Bokrata village in Pati block (District- Barwani) this meeting was attended by 55 VHSC members and 10 ASHAs. In this two day meeting following points were discussed-
 - a) Role of ASHA as an activist and specific aspects on which ASHA would require support from VHSC members.
 - b) An issue like regular filling up of ASHA's medicine kit was also discussed and it was decided that VHSC members and ASHAs would have dialogue with ANM and PHC Doctor to ensure regularity in medicine supply.
2. '*Jan Jagaran Swasthya Yatra*' was organized in ten villages of Pati block in Barwani District. Five members from each village health committee participated in this yatra. Notably information regarding misuse of saline-injections, water purification, hospital related information, helping sick patients etc. was shared by VHC members than SATHI team members.
3. '*Swasthya shivir*' was organized in Bokrata village of Pati block. Around 180 people participated in this shivir including village health committee members, ASHAs, and activists from the people's organisation. ASHAs and village health committee members shared their work experiences as well as work done by them.

4. Healthcare services in Bokrata Primary Health Centre were *continuously monitored* by village health committee members from 10 villages for two months.
5. Some of the community based village health committees have become non-functional. So the situation was analyzed and *VHCs were reorganized. Identity cards were issued* to health committee members from 10 villages which are proving to be beneficial for members while dialoguing with health officials, starting from PHC to the district hospital.
6. *Pictorial survey format* was designed so that uneducated/less educated VHC members could conduct survey about ANM visits to village, immunization, check-up of pregnant women, functioning of anganwadi etc. After coming to know about the survey findings, VHC members undertook many activities like *dialogue with ANM for regular visit to village, monitoring on anganwadi, re-opening of one closed sub-centre* etc.
7. In three villages (out of 10 villages), VHC members have been *monitoring functioning of the Anganwadi*, especially provision of nutritional food to children and pregnant women. As a result, these services are showing qualitative improvement.
8. VHC members have so far *helped 475 villagers (from 10 villages) in getting Deendayal Cards* under Deen-Dayal Antyodaya Upachar Yojana. The scheme provides free treatment and investigation facility to patients belonging to BPL families who are hospitalized in govt. hospitals.

B. Value addition and replication of Community Based Monitoring –

In the area of MASUM which is one of SATHI's partner organisations, CBM rights based methodology has now been used in a broader manner for accountability of food security schemes. MASUM activists have raised the issue of poor quality mid-day meal in schools, in one of the PHC committee meetings. They have strongly argued that there has to be a mechanism for quality check of the mid day meal scheme implemented in the area of the PHC. Following this committee members visited 9 schools, during which they came to conclusion that out of these 9 schools, in only 3 schools quality of mid day meal was satisfactory. Actual food samples from 4 schools were handed over to the Medical Officer and subsequently were sent for the lab examination.

C. Strengthening ASHA programme in selected areas –

In Gadchiroli district two workshops were conducted at Kurkheda (26th August 2010) and Korchi (28th August 2010) for ASHAs and VHSC (village health & sanitation committee) members (total 50 participants). This workshop was organized to increase the cooperation, synergy between ASHAs and VHSC members. Major themes were ASHA as active member of VHSC; support of VHSC members to ASHA, utilization of VHSC untied fund etc. A pictorial poster exhibition was designed by SATHI on these themes. The methodology of the workshop included group work and discussions on the poster exhibition by VSHC members & ASHAs.

D. Orientation of activists in Maharashtra regarding Patient's Rights-

Orientation meeting was held in Satara town on 25th August 2010 which was attended by 10-12 prominent social activists. A group of these activists have shown keen interest in forming Rugna

Hakka Samiti (Patient's Rights Forum) in Satara, similar to the Forum in Pune City. In the context of Patient's Rights a range of posters, pamphlets, slide shows etc have been provided to this group in Satara. Notably all preparatory activities in Satara were through voluntary efforts of the activists in Satara. Similar efforts have been initiated in Sangli and Nashik, where similar orientation meetings on patient's rights have been conducted.

E. Inputs to National level advocacy:

With inputs from a SATHI team member, NRHM's national Advisory Group on Community Action has nominated two members to monitor the communitisation components of the State PIP in the state of Maharashtra. One of these nominated persons is a SATHI team member. Now these two AGCA members (Dr. Dileep Mavalankar and Dr. Abhay Shukla) have initiated a process of tracking and monitoring implementation of various community oriented components of NRHM in Maharashtra including Community monitoring, formation and training of VHCs, functioning of Rogi Kalyan Samitis and ASHA programme. One round of review was conducted by both the members and a meeting was held with the State NRHM Mission director on 26th August 2010 to discuss various delays, bottlenecks and critical issues in development of communitisation elements of NRHM. Based on this a set of action points has been submitted to the Director NRHM Maharashtra for further action. These activities have been reported in the national AGCA and form an input for similar reviews in other states. The suggestion of integrated community based monitoring of various social services has also been presented in the national AGCA in its recent most meeting in September 2010.

Another important emerging sphere of national advocacy is the area of 'Universal access to health care'. Since today 70-80% of health care is being given by the private medical sector, and nearly 90% of doctors are in the private sector, in order to achieve universal health care it would be necessary, besides strengthening the public health system, to regulate sections of the private medical sector and involve them in providing rationalized care to people, which would be free of charge at point of service. Funds for such a system would need to be raised through enhanced tax funding as well as some for of social health insurance, keeping in mind the experiences of Brazil, Thailand and other countries which have achieved such universal access. It may also be kept in mind that the very large section of unorganised sector workers today does not have access to quality health care, and this could become a critical social force in demanding a universal access system.

Keeping this context in mind, in the period under reporting SATHI had organized a meeting titled 'Options for universal health coverage of workers particularly in unorganized sector'. The objective of this meeting was to involve trade unions and workers health activists in the emerging discussions on the issue of universal access to health care, while exploring the possibility of wider mobilization based on unorganised sector unions. This meeting was held in Pune on 25th Sept. 2010. In this meeting a range of schemes like ESI, CGHS, RSBY etc. were critically analysed and key constraints and limitations of these schemes were thoroughly discussed. To build a critical mass around this demand, representatives of the national trade unions NTUI and SEWA, and representatives of the unorganised workers unions were invited for this meeting. A background paper for this meeting was prepared by SATHI's research consultant, who was supported from this project.

F. Publications- Patient's Rights booklet - The Patient's rights booklet draft underwent several revisions following which it has been published and disseminated.

Manual for ASHA trainers – Systematic inputs from ASHA trainers have been taken for the manual for ASHA trainers. Based on this feedback some revisions in the manual were made and overall drafting was done by a senior training resource person (Dr. Mohan Deshpande), following which it was finalized and published.

Project title- SATHI Resource Center for training and support to Community health rights activities in Madhya Pradesh

Funding agency- AID

Team Members- Sant kumar Mahto, Ajay Vishwakarma, Rakesh Sahu, Dhananjay Kakade

This small project was undertaken for complementary support health rights activities in Madhya Pradesh, specifically in Barwani. In terms of financial support and proposed activities overall scope of this project has been modest. Key health rights activities carried out under this project in the reporting period are as follows, it may be noted that most of these activities have been conducted in collaboration with Jagrit Adivasi Dalit Sangathan (JADS) -

1. Community level trainings were conducted in 15 villages where people were made aware regarding health entitlements in the District Hospital.
2. In order to curb medical practice by quacks, community action took place in Pati block of the Barwani district. Subsequently the appropriate local authority was involved in the process and police complaint was lodged against unqualified doctors.
3. In order to assist patients who come to the District Hospital, a Help Desk facility was initiated. The person running a Help Desk was oriented about service availability and entitlements of the patients in the District Hospital
4. In the reporting period SATHI team members have gathered information on Maternal deaths, RKS funds, availability of essential drugs in CHC and the District Hospital. This information was subsequently analysed and used during the local campaigns and community actions by the Sangathan.
5. Following death of a young woman during delivery in the District Hospital, massive rally was held in Barwani town by the partner people's organisation JADS, SATHI team members assisted in information gathering, preparing press releases etc.
6. Beyond Barwani SATHI team members have conducted trainings of activists of other organisations in Madhya Pradesh (Sendhwa, Sihore) on the issue of health rights.

Project title- Community Based Monitoring and Planning of Health Services in Maharashtra

Funding agency- National Rural Health Mission, Maharashtra

Period under reporting- 1st August 2010 to 31st March 2011

Team members- Nitin Jadhav, Abhay Shukla, Dhananjay Kakade, Shakuntala Bhalerao, Trupti Joshi, Bhausahab Aher, Shailesh Dikhale

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

Besides the existing five districts, in the second phase, the CbM process is now being expanded to eight new districts. SATHI had a key role to play in the selection process of district and block nodal NGOs. Selection of district and block nodal NGOs has been completed in March 2010 in all districts (Gadchiroli, Chandrapur, Raigad, Kolhapur, Nashik, Solapur, Aurangabad & Beed). Out of 8 districts in the 7 districts (except Raigad District) the earlier selected organizations have finally been approved by the Executive Committee of State Health Society in its meeting on 25 Jan. 2011. After approval following activities have been conducted in 7 new districts-

1. **State level Training of Trainers** from 1st to 3rd March 2011 was conducted in Pune.

In these eight districts, a total of additional 17 blocks, 51 PHCs would be covered and under each PHC five villages i.e. additional 255 villages would be covered.

In the period under reporting the core responsibilities of SATHI, as the State nodal NGO, have been as follows-

1. Liaison with government officials as well as district and block implementing organizations to coordinate various activities

2. Technical support and capacity building of the District and Block nodal NGOs at programmatic as well as administrative level

One of the key components of the project is 'trainings on CBM' at all levels of the monitoring committees in expansion areas of 12 districts. The capacity building process was broadly at two levels - State level workshops and trainings at the district level. Block coordinators and block facilitators, who were also expected to act as master trainers in respective districts, were trained in the skills and tools that would be required in CBM. SATHI's contribution in these key processes has been widely appreciated by the district implementing organizations and also became reference point for CBM in other states.

At administrative level, capacity building of District and Block nodal NGOs has been done through workshops and meetings with accountants. These workshops have been conducted in the context of maintaining accounts as well as administrative issues related to CBM project. These workshops and meetings helped the partner organisations in getting clarity regarding the requirement and transparency in the overall administrative and accounting requirements of the CBM project.

As a part of this capacity building at administrative level, a team which consisted of Chief functionary of Anusandhan Trust and administrative staff of SATHI visited each organization to understand the account system of each CBM partner organization from 5 districts. This team has given inputs wherever the gaps were found in the maintaining of accounts. These visits helped to understand the account systems of various partners as well gaps in systems of some of these organisations.

3. Conceptual and practical support to interventions

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

4. Publication of orientation material and monitoring tools

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

- Specially designed pictorial VHSC as well as RH, PHC level tools were modified and some additional issues were included in each tool for monitoring. In addition, this year we developed tools on Anganwadi, Sub centre to enable their monitoring.
- Village, Anganwadi, Sub centre, PHC and RH level report cards have been printed in poster format and disseminated.
- Village health services calendar was reprinted at state level and was used in selected villages of 5 districts.
- A range of posters regarding the service guarantees mentioned in the NRHM were reprinted and widely disseminated.
- 'Dawandi' is the CBM newsletter of approximately 24 pages which is published quarterly by SATHI. Dawandi is circulated widely across Maharashtra, reaching various stakeholders from Village health committees to State health officials.
- Booklets on Village Health, Water supply, Nutrition and Sanitation Committee and PHC Monitoring and Planning Committee were reprinted. These booklets consist of information regarding constitution, information regarding untied funds and also roles and responsibilities of the committees.
- Marathi and English flyers were published which present in brief form the main features of the CBM experience in 5 districts of Maharashtra.

Progress of Community Based Monitoring Process in Maharashtra

1. In the period January to March 2011, Jan sunwais in 5 districts were organised at PHC, Block and District levels. ***70 PHC level Jan sunwais, 16 Block level Jan sunwais and 4 District Jan sunwais were organised in this period.***
2. At the National level, the model of CBM that has evolved in Maharashtra has been widely recognized as an example of an effective model of Community Based Monitoring of Health services.
3. A number of instances were documented by implementing organizations which point towards definite change in the attitude of health functionaries and increase in regularity of services.
4. ***Developing community based planning-*** The CBM coalition has regularly interacted with state level officials to ensure that the health planning process in districts is made more participatory and is genuinely decentralized. Related suggestions were regularly presented to the state level authorities. These efforts have yielded following enabling steps at the State level-
 - A) To ensure participation of Community based monitoring and planning committee members in the finalization of PIP at district and block level, a letter was issued by Mission Director, NRHM Maharashtra to all the concerned officials, making CBM civil society implementing organisations and committee members stakeholders in the process of decentralised planning.
 - B) A letter was issued by the Mission Director, NRHM, Maharashtra to all concerned Govt. officials, and instructed that PHC and Block nodal NGO representatives should be regularly invited to Rugna Kalyan Samiti (RKS) meetings at all levels.

C) Earlier the annual village untied fund (Rs 10,000), which should ideally be utilised for issues identified by the VHSC, was in many villages being spent by Anganwadi worker (AWW) exclusively on Anganwadi related expenses. Due to continued advocacy with the state authorities, a letter was issued by the Mission Director that this fund should be utilized for health issues of the village as decided by VHSC members, and VHSC should have the sole mandate to prepare a plan for it.

6) ***Organizing visit of Dr. Syeda Hameed, Member, Planning commission and team to Maharashtra-***

A Planning Commission team led by Member, Dr. Syeda Hameed visited Maharashtra during 5 to 8 October 2010 to understand the process of 'Community based monitoring of Health services' (CBM). This is a positive indicator of the Commission's interest in promoting accountability processes in the social sector. The impact and potential of CBM as a recently emerged initiative, in making local health services accountable, and improving the delivery of these services, has been appreciated by the Planning Commission team which visited villages, PHCs and CHCs in two districts (Thane and Pune) and interacted with community members as well as health care providers, and subsequently prepared an extremely appreciative report.

7) ***Meeting with Chief Minister, Maharashtra for generalization of Community based Monitoring and extending the CBM approach to other social services-***

Based on positive experiences during her visit to observe CBM in Maharashtra, Dr. Syeda Hameed, Member, Planning commission took the initiative to organise a meeting with the Chief Minister of Maharashtra, Shri Prithviraj Chavan on 13th March 2011 at Mumbai to discuss strengthening of CBM of Health services, and to explore multi-sectoral community monitoring of various social services on a pilot basis two districts of Maharashtra: Gadchiroli and Thane. This meeting was facilitated by the SATHI team and was attended by a SATHI team member, as an important advocacy initiative.

III. EDUCATION AND TRAINING (CEHAT)

Course on Health and Human Rights:

The course was organised in January 2011 in collaboration with the Department of Civil and Politics, Mumbai University. Justice (Retd) Sujata Manohar spoke at the inaugural function and underscored the importance of Human Rights education for health professionals. Twenty two participants from all parts of the country participated in this course. These were mostly middle level professionals from various civil society groups and those from the state governments. The revised course was received well, the reading material too was updated. The chief guest for the valedictory function was Justice (retd) Vyas, Chairperson, State Human Rights Commission. He congratulated the Mumbai University for offering this course.

Course on Feminist Counselling:

Feminist counselling as a technique for responding to survivors of domestic violence and sexual violence although found to be effective remains out of the purview of mainstream mental health practice. Therefore, a course on responding to violence against women through Feminist Counselling was developed and run by CEHAT in collaboration with TISS for the first time in

April this year. It was attended by practising clinical psychologists, social workers and educators from all over the country. Adv Flavia Agnes was invited for the valedictory programme and she gave an inspiring talk.

Responding to Violence against women in Conflict:

Responding to the needs that emerged through review and consultations on the issue of conflict, violence and health, a three day training curricula was developed based on the National course on VAW and role of HCPs. The training was opened to the different states of India affected by armed conflict. Twenty five participants from Kashmir, Jharkhand, Chattisgarh, Gadchiroli and Manipur attended the training. It gave opportunity for people of the different regions of India to interact with each other, share their experiences and their coping mechanisms. It was an opportunity for people living and working in different parts of the country to realise that their battle was not in isolation and what they are going through is what millions of people in the country are also going through. Participants shared the need for measures for sensitization and training at different levels, along with attempts at inter-sectoral coordination to address the issue of VAW in a holistic manner. As a feedback, most participants expressed the need to conduct such training programmes at national as well as state levels.

Participants also expressed the need to visit the Mumbai based crisis centre Dilaasa. A 3 day interactive consultation “Armed Conflict, Violence Against Women And Right To Health” was organised for health professionals and civil society members was organised in April’11 in Mumbai for the participants from Kashmir. The consultation took forward from the Delhi training and focussed on armed conflict, Human Rights and Ethics. An interactive session was organised with the team of Dilaasa. Overall, this programme allowed for diverse issues and concerns surrounding right to health in an armed conflict, to be heard, discussed and debated. Through such an interaction the sense of injustice that participants had experienced and witnessed in their professional and personal lives, could be seen as channelizing towards action. As part of future planning, they identified a need to form a support group that will work towards addressing issues that emerged, such as initiating counselling services, training of health care providers on the issue of VAW and training for conducting autopsy and act as a lobby to provide protection to health professionals from external pressures/politics.

Training on sexual violence:

Hospital based trainings-

CEHAT is engaged in implementing a comprehensive health care response to sexual assault since April 2008. In the endeavour of ensuring a comprehensive health care response to sexual assault, periodic orientation trainings are conducted at the level of 3 hospitals , K B Bhabha Bandra west, Rajawadi Ghatkopar east and Oshiwara maternity home. These trainings comprise of comprise of understanding forms of sexual violence, health consequences of the same on women and children as well as their role in responding to them. Emphasis is laid on therapeutic role of the HCP’s as often their focus is restricted to medico legal evidence collection only. A total of 9 trainings were conducted comprising of 150 doctors. These trainings are attended by lecturers and resident medical officers.

Community awareness trainings-

While working with the health systems, we also realize that there is a need to create awareness about the issue of sexual violence and also dispel myths about sexual violence. We approached CORO as they have a large community set up and respond to several issues impacting lives of women. A module for helping CORO volunteers to understand the issue of sexual violence, role of health care providers as well as basic counselling skills was conducted. The skill building workshop would enable them to increase awareness in the communities that they work in and also make civil society aware of the role of the health systems. One such training was conducted for 40 CORO volunteers. This was followed up by training as CORO wanted CEHAT to train their staff in counselling skills. The second training was conducted on 21st April 2011 for 35 participants.

Police trainings –

A training programme for 65 sub inspectors on 7th June 2010 and involved doctors in the same. The aim of conducting these workshops with the police is to encourage a multisectoral response to sexual violence and create awareness on the role of health providers. This was also an attempt to inform the police about the model set up in three municipal hospitals of Mumbai so that they could refer cases of sexual assault to these hospitals.

Training of Health Professionals in New Delhi

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

Capacity building for the BMC:

This was the 11th year of collaboration with the Bombay Municipal Corporation. The Training cell has been in existence since the past 6 years and a growing number of Health care providers associating themselves with it. The aim has been to dialogue with the officials to direct funds towards the running of the Training cell as well as to formalise the roles of its members. The current team of Training Cell (2009-2011) comprises 68 health professionals which include 10

Doctors, 43 nurses, 2 matrons, and 6 Community Development Officers of hospitals, 2 Ayabais, 2 ward boys, 1 from electric department and 1 is occupational therapist, 1 ICTC counselor.

The core groups have been conducting training in their respective hospitals, 4 trainings in Kurla Bhabha hospitals comprising of 30 HCPs, 2 trainings in Rajawadi Hospital comprising of 25 HCPs in each group, 1 training was conducted in M.T Agarwal comprising of 13 HCPs and 1 training of 25 HCPs in Cooper hospital. As the Dilaasa film was released around the same time, TC members decided to screen the film as it brings forth the issue of Domestic violence, health consequences as well as the role of a health care provider in responding to it. CEHAT members conducted meetings with core group members to equip them with skills and information required to facilitate a discussion on the film. At least 5 screenings of the film were done across these hospitals covering 130 HCP's. The film was very well received and generated a lot of discussion on the role of HCP's as well as on the issue of VAW. Core groups across 5 hospitals were keen to organize activities on the occasion of International Women's Day. These ranged from showing spots called '*Bol*' followed with a guided discussion, poster exhibitions based on VAW, slogan competition and a talk on child sexual abuse, highlighting aspects of awareness and prevention. One of the core groups also appointed a senior doctor to judge the write up competition on 'What women want'.

Violence against women health workers

A study conducted by CEHAT on understanding violence faced by women health workers in 2009 threw up several issues related to the nature of harassment and particularly sexual harassment at work place by male colleagues/ juniors/ seniors and patients. In the light of this finding, we felt that it was pertinent to conduct training on understanding the redressal mechanism for sexual harassment at work place as well as understanding what constitutes sexual harassment. A one day workshop was conducted by Adv Ujwala Kadrekar from Lawyers Collective. 23 participated in the training. Concepts related to sexuality, personal boundaries and comfort zone were discussed to enable the group to understand the background of how sexual harassment at work place gets defined. The definition on sexual harassment and the Vishakha guidelines led to a lot of discussion and sharing of experiences related to harassment. Nurses stated that they felt more enabled to now approach the committee for redressal as they understood the redressal mechanism better.

EDUCATION AND TRAINING (SATHI)

Various training activities have been carried out under action projects like Community based monitoring of health services, which are mentioned in respective project reports. Further, one of SATHI's projects is primarily focused on capacity building and training, whose report is given in this section below.

Project title- Developing capacities for using community oriented evidence towards strengthening district health planning in Maharashtra state, India

Funding agency- World Health Organisation (WHO)

Period under reporting- 1st August 2010 to 31st March 2011

Team members- Dr. Yogendra Ghorpade, Dr. Nitin Jadhav, Dr. Abhay Shukla, Dr. Dhananjay Kakade

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

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

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

The following activities were carried out in this project in the period August 2010 to March 2011:

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

As part of the project, SATHI along with the State Health Systems Resource Center, Maharashtra (SHSRC) had organized a two day **state level workshop on use of evidence for decentralised health planning at YMCA, Mumbai on October 19th and 20th 2010.**

The main objective of the workshop was to orient various stakeholders of the Community based monitoring and planning (CBMP) process which including Government officials as well as NGO representatives from the districts where community based monitoring (CBM) is being implemented. National experts with experience in decentralised planning made presentations as resource persons. Representatives of District nodal NGOs from five districts namely Amaravati, Nandurbar, Thane, Pune and Osmanabad where CBM is being implemented for last 3 years were present along with representatives of Block nodal NGOs from the respective districts. Among the Government health officials- State level officials involved in the planning process along with District programme managers of NRHM and the Block Medical officers were also present from the same districts. There were a total 58 participants in the workshop.

There were a wide range of presentations and participatory discussions, panel discussions among experts over two days outlining the perspective and experiences of evidence based decentralised planning. Subsequently the participants of the workshop participated in group work. Groups were created according to the levels of decentralised planning such as Village and Sub center level, PHC and Rural Hospital level, and Block level planning. Each group discussed and presented the draft planning model for their respective level which would be the basis for further work within their respective areas.

II. Structured learning course on evidence base decentralized health planning

This course would be of **one year duration which includes four contact sessions and assignments as well as field work.** Participants would be **Govt. Officials** such as Medical Officers from PHCs, Block Medical Officers and District Programme Managers and **Civil society representatives** involved in Community Based Monitoring and Planning programme. For this course 25 to 30 participants would be selected from 5 selected districts where CBM is

being implemented. This course would be of **one year duration which includes four contact sessions and assignments as well as field work**. Meanwhile, application forms have been sent to the offices of DHOs in the districts under CBM and also to the district and block level NGOs, to identify the prospective candidates. Filled application forms were expected to get the by end of March or early April 2011.

Six modules for the course have been finalised in detailed outline form as follows:

Module 1- Introduction to Public Health Systems

Module 2 - Perspective building and issues of Governance and Health Sector Reform

Module 3 - Social Determinants of Health

Module 4- Community Action for health

Module 5 - Use of evidence for decentralised health planning

Module 6 - District Health Planning

Out of these modules, substantial work has been done towards preparation of the first two modules, which would be required for the first contact training and initiation of the course.

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

In the period under reporting, the overall approach of SATHI was to build capacity of the block and district nodal NGOs to use community level evidence generated through Community Based Monitoring (CBM) of health services. For this district level workshops were conducted in Osmanabad, Thane and Pune Districts. In addition, a capacity building workshop for representatives from Amaravati and Nandurbar districts was organised in Pune.

In these workshops, the overall processes of PIP (Project implementation plan) preparation at various levels was explained, participants were oriented about availability of flexible funds at each level of the public health system, and emergent spaces for civil society organisations to intervene in planning utilisation of these funds were pointed out. In some of these workshops, issues were prioritised and accordingly a draft list of planning suggestions for inclusion at various levels of the public health system was prepared.

These workshops taken together were attended by over 80 members of the block and district nodal organisations.

IV. Facilitation of processes for inclusion of evidence based, community oriented proposals in health plans

The SATHI team carried out state level advocacy to ensure inclusion of evidence based, community oriented proposals in the District and other local health plans. Related suggestions were regularly presented to the state level authorities.

Based on these efforts, a letter was issued by Mission Director, NRHM, Maharashtra to all the concerned officials to ensure participation of Community based monitoring and planning committee members in the finalization of PIP at district and block level. Also a letter was issued by the Mission Director to all concerned Govt. officials, instructing that Rugna Kalyan Samiti (RKS) – Hospital Development Committee members should be involved in the RKS planning meetings at all levels. State authorities further issued a letter stating that the Village Health Committee would have the sole mandate to prepare the Village health plan and approve the use of related funds.

Following the district level workshops on decentralised planning of health services, the district and block nodal NGOs in five districts of the state PIP carried out a range of planning related activities in their areas. This included organising discussions and promoting development of planning related proposals and suggestions at Village, PHC, Block and District levels.

Based on these processes, the implementing organisations have prepared an alternative planning proposal in each of the five districts district with clearly spelt out planning suggestions. These were submitted to the district level authorities for inclusion in the respective district PIPs for the coming year 2011-12.

TRAINING AND EDUCATION (CSER)

CSER organised a number of trainings for the capacity building of staff in the field ethics and health research.

- Training workshop on Qualitative Research Methodology, August 2010;
- Workshop on Ethics in Health Research, September 2010;
- Rakhi Ghoshal attended a ten day residential workshop conducted by CEHAT and Mumbai University on Public Health and Human Rights, January 2011;
- Workshop on Qualitative data collection and analysis in February 2011.

Promoting Discourse on Ethics and Human Rights amongst Health Professionals

Thematic workshops

A workshop was organised on ethical issues in health research in India for researchers of five different organisations conducting health research – CEHAT, CSER, SATHI, SEWA –Rural and SNEHA from August . These five organisations have come together to establish a single ethics review committee. Thus, this training was organised to orient their key staff to the ethics of research and health interventions. The resource persons for this training included Gracy Andrew (SANGATH, Goa), Mala Ramnathan (Sri Chitra Tirunal Institute, Trivandrum), Amar Jesani and Neha Madhiwalla (CSER). The curriculum of the workshop was based on the profile of research conducted by these organisations, which ranges from health system studies, community based interventions, epidemiological studies and field trials of various drugs and devices. In addition to discussing the basic issues in health research such as informed consent, privacy and confidentiality, this workshop also dealt with the specificities of conducting research in institutions and in communities. These settings pose different challenges to researchers in terms of the power structures that must be negotiated, the complexity of relationships involved and the legal/institutional rules which are applicable to research. The workshop also looked at issues of justice and equity in research, which is a foremost concern for researchers. Finally, the workshop also dealt with the problems of ethics in multi-disciplinary research where the professional guidelines, norms, traditions and standards may differ greatly and even contradict each other.

The workshop was thoroughly evaluated with each session being graded by the participants accompanied by qualitative comments. This workshop was also a step towards developing a short-course on research ethics that CSER aims to do in coming time. The workshop was held at the Western Regional Centre of the ICSSR in the Kalina campus of the University of Mumbai. The workshop was attended by 20 participants.

Fellowships

One senior and one junior fellowship was awarded in this period. The senior fellowship was awarded to Maithreyi M.R. who is a senior journalist and editor for developing a history of bioethics in India, based on review of documentary material and oral history. The junior fellowship was awarded to Vivian David Jacob for a study on the profile and history of clinical researchers in the states of Tamil Nadu and Maharashtra based on the information available on the Clinical Trials Registry of India.

IV. INTERVENTION AND SERVICE PROVISION (CEHAT)

Crisis intervention services for survivors of sexual assault

51 survivors of sexual assault reported to the 3 public hospitals where CEHAT has set up a comprehensive health sector response to sexual assault. 29 of them were under 16 years and within that, a large majority was under 12 years of age. It was seen that most often the nature of sexual assault was a combination of non penetrative assaults such as fingering, forced masturbation and peno vaginal sex. Often the parents and relatives on approaching the hospital are completely overwhelmed with the hospital procedures and protocols, along with that they are often grappling with feelings of shame. The survivor also finds herself lost amongst hospital procedures and demands from family. A large part of the first contact intervention is about ensuring that the survivor and their families understand the procedures of the hospital, the importance of body evidence collection and the like. Secondly the emphasis is on ensuring that she receives treatment completely free from the hospital and also avail of counselling services. In case of children the counselling is often aimed at enabling the child to verbalise and demonstrate her emotions and feelings. Once that is done efforts are made to engage with the child in relation to ways in which physical pain and discomfort would subside with medicines. A large part of the dialogue is with the family and that too with the mothers as they are often ridden with guilt of having not been able to take care of the child. Efforts are made to help the mothers deal with their emotions and are explained the importance of ensuring that the child be allowed to lead a normal life, go to school and play with her friends. Interventionists also plan strategies to enable the parents to deal with comments from the community, neighbours etc. We have collaborated with Majlis in March 2011 to enable families of survivors to receive legal aid and understand the legal procedures entailed in the case. Follow up has been a challenge with the survivors as most often they don't want to return to the hospital even though they have health needs. In response to this home visits has been thought of as an alternate strategy. The aim of follow up has been to assist the survivors in the process of healing and respond to their emotional needs

Dilaasa, Crisis Intervention Department at Bhabha hospital, Bandra

The centre received 196 new women, 300 women followed up for counselling services, where as 47 women came for legal follow ups. 16 case presentations took place. It was observed that young women and girls have started narrating natal family abuse and pressure to marry against their wishes; this is true of young girls attempting suicide. Counsellors are faced with the challenge of getting the girls to follow up for counselling so that they feel more equipped to deal with the abuse. Similarly more and more young women are facing desertion or that their partners refuse to provide any economic support to them. This has led the counsellors to conduct a dialogue with the abusive partners vis a vis joint meetings. The entire objective of the joint meeting to ask the abuser to take responsibility of the relationship and stop abuse. The crisis

centre continues to counsel women, who have consumed poison and deny a suicide attempt, they maintain that this was accidental. However counsellors make efforts to strike a dialogue about the impact of such consumption on their health and try and make efforts so that such women in denial come back to seek support. A total of 58 such women were counselled but not registered. The crisis centre in charge is also involved in counselling women reporting sexual assault not just at her hospital, but also extends support to other Municipal hospitals receiving sexual; assault cases. Thus the crisis centre has now started responding to the issue of not just domestic violence but also sexual violence. At least 7 cases of sexual assault were responded to at the level of Dilaasa in Bhabha hospital Bandra.

Dilaasa, Crisis Intervention Department at Bhabha hospital, Kurla

This year 57 women registered at the counselling centre. There were 50 follow up counselling sessions and an additional of 7 legal counselling sessions. The case load has dropped significantly. A major reason that can be attributed is that certain major departments such as paediatric OPD, paediatric ward as well as minor operation theatre have been closed for the past 5 months. This has led to lesser patient population coming to the hospital in general. Further the hospital is also going through a medicine crunch. This has invited a lot of anger from the patients in general. Therefore we see more and more referrals happening to Sion hospital which is a tertiary care hospital. The social worker and nurse deputed at the department have therefore started engaging in outreach activities. In the past year they have conducted at least 2 workshops with the CHVs and ANMs at the ward level to increase awareness about Dilaasa activities. The centre in charge was responsible to get 2 slots of interviews on the channel Care TV for presenting the Dilaasa initiative and creating awareness on role of health systems in domestic violence cases.

Replication of Dilaasa in Shillong, Meghalaya

CEHAT collaborated with the North east network (NEN) to undertake the setting up of a hospital based crisis centre in Shillong. Through this partnership, efforts were made to build a relationship with the directorate of health services in Shillong and dialogue about the importance of setting up a crisis centre in a public hospital. CEHAT assisted the NEN to develop the proposal and dialogue with the health system for the same. Before the setting up of such a hospital based crisis centre, it was imperative that the Health care providers (HCP) be trained to understand the issue of Violence against women, its link to health consequences and enable them to impart trainings to their peers on this issue. A Training of trainers (TOT) was thought to be most effective method for it. CEHAT conducted a Training of trainers of 23 HCP's on the issue of Violence against women. Post an intensive training, specific groups of counsellors, doctors and nurses emerged and were keen to develop short modules for their peers on VAW and role of the health system. NEN has been provided a room designated for setting up the crisis centre at the civil hospital in shilling and a clinical psychologist was deputed to provide the required services to women survivors of violence. CEHAT dialogued with the NEN to depute staff from both the hospital as well as NEN to participate in the national course on Feminist counselling to respond to the issue of Violence against women. One member from NEN and 1 counsellor from Ganeshdas hospital participated in the 5 day intensive course on feminist counselling, which was aimed at building an understanding on the issue of violence against women and understanding concepts linked to violence such as patriarchy , gender and others and finally actual hands on counselling sessions.

COLLABORATION AND NETWORKING (SATHI)

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

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

SATHI continues to be an active constituent of Jan Arogya Abhiyan (JAA) and SATHI team members contribute to JAA activities outside their project work. A SATHI team member is one of the co-convenors of JAA. In March 2011, JAA organised a State level convention in Pune attended by over 160 activists from 27 districts of Maharashtra; SATHI team members along with many other activists contributed to organising this convention.

A SATHI team member continues to be one of the national joint convenors of Jan Swasthya Abhiyan.

A SATHI team member is a part of the NRHM Advisory Group for Community Action (AGCA) which includes prominent Community health activists from different parts of the country, this forum provides regular opportunities for exchange and networking with various health activists as well as interaction with NRHM at national level.

DOCUMENTATION AND PUBLICATION (CEHAT)

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

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

The research area webpage was revamped so that the user can access the resources at one glance. If a user is looking for material on specific Research area it is easier to get all research project listed under that area with links to all the publications i.e. reports, paper/articles and resources material developed under that research area. <http://www.cehat.org/go/ResearchAreas/HealthServicesandFinancing>. A webpage on Domestic Violence (<http://www.cehat.org/go/DomesticViolence/Home>) was developed which gives details about the work done by CEHAT in this area and links to various resources.

E-bulletin: We have put together two e-bulletin one on Domestic violence (<http://www.cehat.org/go/uploads/Library/ebulletinAugOct10.pdf>) and Health budget. The domestic violence e-bulletin is published and circulated to target audience and the health budget bulletin is ready for dissemination.

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

Publications

80. Pradhan, Anagha. Migration Report. CEHAT and ANANDI Publications, 2011

2011

79. Dantas, Anandi. **Mapping of Urban Health Facilities in Maharashtra**. Mumbai: CEHAT, 74 p., 2011 [ISBN: 978-81-89042-55-4]

78. Bhate-Deosthali, Padma and Khatri, Ritu. **Healthcare in the Private Sector: A Study of Private Hospitals in Maharashtra**. Mumbai: CEHAT, xv,136 p., 2011 [ISBN: 978-81-89042-54-7] [Download full report...](#)

2010

77. Deosthali, Padma and Rege, Sangeeta. **Feminist Reponse to Attempted Suicide: A Model for Public Health Intervention**. Working Paper No. 2. Mumbai: CEHAT, 36 p., 2010 [ISBN: 978-81-89042-53-0] [Download](#)

76. Rege, Sangeeta. **Guidelines for Counselling Women Facing Violence**. Mumbai: CEHAT, 48 p., 2010 [Download Report](#)

75. Barai – Jaitly, Tejal. **National conference report: Emerging Health Care Models: Engaging the Private Health Sector', 25th – 26th September 2009 YMCA**. Mumbai: CEHAT, vi,42 p., 2010

74. **Dilaasa crisis intervention department for women: a report**. Mumbai: CEHAT, 14 p., 2010 [Download Full Report](#)

73. **Manual for medical examination of sexual assault**. Mumbai: CEHAT, x,58 p., 2010 [ISBN: 978-81-89-042-51-6] [Download Report](#)

72. Jagadish, N.; Deosthali, Padma; Contractor, Sana; Rege, Sangeeta and Malik, Seema. **Comprehensive health sector response to sexual assault does the Delhi high court judgment pave the way?** Working Paper No. 1. Mumbai: CEHAT, 16 p., 2010 [ISBN:978-81-89042-50-9] [Also listed in SVRI (Sexual Violence Research Initiative) Online Publications/Resource Section, July 2010][Download](#)

71. Rege, Sangeeta; Deosthali, Padma and Contractor, Qudsiya. **Challenges in domestic violence counseling**. Mumbai: CEHAT, viii, 40 p. , 2010 [ISBN: 978-81-89042-53-0] [Download full report...](#)

Articles

2011

A 305. Bhate-Deosthali, Padma; Khatri, Ritu and Wagle, Suchitra. **Poor standards of care in small, private hospitals in Maharashtra, India: Implications for public-private partnerships for maternity care.** *Reproductive Health Matters*, 19 (37), 2011, pp. 32-41
[Fulltext](#)

A 304. Dantas, Anandi. **Mapping of Urban Health Facilities in Maharashtra.** Paper presented in *Eight Conference of Indian Association for Social Sciences and Health on Health, Environment and Sustainability*. Organised by Department of Population Studies and Social Work, Sri Venkateswara University, Tirupati, February 11-13, 2011

A. 303. Dantas, Anandi. **Mapping of Urban Health Facilities in Maharashtra.** Paper presented in the *National Seminar on Delivery of Health care for the Urban Poor-Convergence Approach*. Organised by Regional Centre for Urban and Environmental Studies of All India Institute of Local Self Government (AIILSG), Mumbai and Ministry of Housing & Urban Poverty Alleviation, Government of India. January 6-7, 2011

2010

A 302. Dantas, Anandi. **Mapping of Urban Health Facilities in Maharashtra.** Paper presented in *Seminar on Spatial Dimensions on Health Care use of GIS in Health Studies*. Organised by CEHAT and Department of Geography, University of Mumbai, 24th September 2010

A 301. Dantas, Anandi. **Mapping of health facilities in Aurangabad.** *Health Action*, August 2010, 23(8), pp.34-36

A 300. Deosthali, Padma and Khatri, Ritu. **Violating the law, yet thriving: study of private hospitals in Maharashtra.** *Medico Friend Circle Bulletin*, February – March 2010, No.339, pp.1-10

A 299. Deosthali, Padma and Rege, Sangeeta. **A study to understand violence faced by female health workers: a need to develop hospital based response.** In *Second International Conference on Violence in the Health Sector*, Congress Centre”De Meervaart”Meer en Vaart 300,1068 LE Amsterdam, The Netherlands. October 27 – 29, 2010, 249 p. (Poster)

A 298. Rege, Sangeeta and Deosthali, Padma. **Dealing with spousal violence.** *Indian Journal of Medical Ethics*, October-December 2010, VII(4), pp.246-248

A 297. Wagle, Suchitra. **The third party in decision making: the role of web based medical facilitators in medical tourism.** Paper presented in *National Bioethics Conference*, New Delhi, 2010.

A 296. Kurian, Oommen C.; Raymus, Prashant and Ranade-Sathe, Jui. **Equity through exemptions? User fees in a municipal hospital in Maharashtra.** Paper presented in *National Bioethics Conference*, New Delhi, 2010. (PPT)

A. 295. Gupta, Rupali and Rege, Sangeeta. **Challenges and dilemmas in institutionalising a crisis centre for women facing domestic violence in the public health system.** Paper presented in *National Bioethics Conference*, New Delhi, 2010.

A 294. Sana Contractor and Sangeeta Rege. **Need for better governance in responding to cases of sexual assault in the health sector.** Paper presented in *National Bioethics Conference*, New Delhi, 2010.

Newsletter:

The Training cell and its increasing membership prompted CEHAT to develop a newsletter to increase communication amongst different hospitals about the nature of efforts undertaken vis a vis this issue. We also thought that it was pertinent that HCP’s feel rewarded if they are

positively reinforced by sharing their screening tips, or how they made a difference to a woman's life. This was an activity supported by Point of View but the team was involved in developing structure, facilitating discussions and finalizing the product. Currently the news letter is in 2 languages Marathi and English.

Film:

A film "At the cross roads" was made and released on 16th February 2011. The film was aimed at highlighting the role of health care providers in responding to abused women. It was also aimed at showcasing the Dilaasa model and promotes its replication in other parts of the country. The release function saw more than 170 people, Health care providers, activists, organisations and the like. The film was highly appreciated and was also followed by a lively discussion on the issue of violence against women. The film and the newsletter were inaugurated by Dr Seema Malik, the Chief medical superintendent of peripheral hospitals. Post this function, several demands are being made for the film copies and the film is being used to discuss the issue of domestic violence in groups of professionals as well as at the level of community.

Poster Presentations :

1. Contractor, Sana and Rege, Sangeeta (2010). Implementing a Comprehensive Health Sector Response to Sexual Assault. Poster Presentation in *First Global Symposium on Health Systems Research*, 16-19 November 2010 - Montreux Switzerland.
2. Deosthali, Padma and Khatri, Ritu (2010). Engaging the Private Health Sector for Universal Access : Issues of Concern. Poster Presentation in *First Global Symposium on Health Systems Research*, 16-19 November 2010 - Montreux Switzerland.
3. Dantas, Anandi (2010). Mapping of Urban Health Facilities in the Evolving City of Aurangabad, Maharashtra, India. Poster Presentation in *First Global Symposium on Health Systems Research*, 16-19 November 2010 - Montreux Switzerland.
4. Rege, Snageeta (2010). Understanding Violence faced by Women Health Workers: A Need to Develop Hospital Based Response. *Poster Presented in Violence in the health sector Amsterdam.*

Press coverage: 2011

Ultra sound & fury over girl child epaper.timesofindia.com/Repository/getFiles.asp?... - **Cached**
13 Jul 2011 – *Ultra sound & fury over girl child.* Malathy Iyer TNN Mumbai: The fight for the girl child is roiling the state like never before. ...

Mr Minister, heal thyself, say experts - The Times of India

timesofindia.indiatimes.com/.../Mr-Minister-heal-thyself-say-experts... - **Cached**

6 Jul 2011 – Union health *minister* Ghulam Nabi Azad must look as long back as the early twentieth century and read the views of Havelock Ellis and ...

Maha govt reformulates forensic test proforma for rape victims May 03,2011

<http://ibnlive.in.com/generalnewsfeed/news/maha-govt-reformulates-forensic-test-proforma-for-rape-victims/670168.html>

The Maharashtra government has re-formulated the entire proforma for forensic medical examination of sexually assaulted victims, the Bombay High Court bench here was informed. Government Pleader Bharati Dangare, last week submitted before the division bench of Justice D D Sinha and A P Bhangale here that it has prepared an instruction manual, age estimation proforma, requisition letter for chemical analysis, and format for final opinion as per the suggestions for proper forensic medical examination of rape victims.

'Monitoring of abortion pill sales is regressive & intrusive ...

articles.timesofindia.indiatimes.com › [Collections](#) › [Unsafe Abortions](#) - [Cached](#)

13 Mar 2011 – MUMBAI: Social activists have slammed the state government's intentions to regulate the *sale of abortion pills* and to keep close tabs on ...

Budget allocation cuts relief for rape victims - Times Of India

articles.timesofindia.indiatimes.com › [Collections](#) - [Cached](#)

9 Mar 2011 – MUMBAI: After the celebrations for International Women's Day, here's some grim news. Despite the rising number of rapes in the country there ...

NGOs screen film on domestic violence, Dharavi women recount ...

www.indianexpress.com/.../ngos-screen-film-on-domestic-violence-... - [Cached](#)

16 Feb 2011 – *NGOs screen film on domestic violence, Dharavi women recount* experiences - Laying emphasis on the role of public health workers in ...

Hike in cost of med tests pinches pockets of poor - Times Of India

articles.timesofindia.indiatimes.com › [Collections](#) - [Cached](#)

14 Feb 2011 – MUMBAI: The government's decision to increase the *cost of tests* and services in its hospitals has come as rude shock to patients, ...

The poor have a bad year ahead for healthcare - Times Of India

articles.timesofindia.indiatimes.com › [Collections](#) - [Cached](#)

12 Feb 2011 – MUMBAI: The civic budget for health for the financial year 2011-12 looks exhaustive, with a huge amount being pumped in for the construction ...

Civil society cries regional imbalance in healthcare - Times Of India

articles.timesofindia.indiatimes.com › [Collections](#) › [Health](#) - [Cached](#)

8 Feb 2011 – Bhubaneswar: Members of *civil society* organizations on Monday urged the state government to take steps to remove *regional imbalances* while ...

Civil society bodies express apprehension about economic ...

www.orissadiary.com › [Orissa Events](#) - [Cached](#)

8 Feb 2011 – *Civil society bodies express apprehension about economic* governance in Orissa, Orissa Event Diary.

Odisha Budget Solidarity to organise a state level convention on ...

www.orissadiary.com › [Business News](#) - [Cached](#)

4 Feb 2011 – *Odisha Budget Solidarity to organise a state level convention on* Health sector Budget on 7th February, Orissa Business News.

File report on standard medical protocol for sexual assault victims

Law et al. News 03.02.2011 | 02:52 Nagpur RS Agrawal

The Nagpur bench of High Court of Bombay has asked a committee constituted by the government for examining all aspects in relation to protocols, proformas, and health care response to sexual assault victims, and submit its report to the court by March 10. The court also asked the committee to furnish a copy of the report to petitioner in the case Dr. Ranjana Pardhi and others as well as intervenors in the proceedings, Mumbai based NGO "CEHAT" – Centre for Inquiry into Health and Allied Themes.

State appoints panel to look into sexual assault protocol - Times ... Times of India

3 Feb 2011 – NAGPUR: The *state* government has *appointed* a committee to *look into* the *sexual assault* protocols and forms that should be utilized all over ...

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. Books- 3169
2. Audio Visual Health Awareness Material –143
3. TV News & interviews- 18
4. Documentation of Jansunwais- 15
5. Periodicals- Marathi-6, English-10, total - 16
6. Bound Volumes- 186
7. Reference Books- 130

Publications brought out by SATHI during April 2010 to March 2011 are as follows:

Publications in Marathi

No	Particulars of Publication	Date of Publication
1.	'Dawandi'- News Letter published quarterly	Four issues in given period
2.	Information Brochure on Community Based Monitoring: Marathi Flyer	April, 2010
3.	Swayamsevi sansthani Prashikshna Dilelya ASHA Tyanche Kam Kase Challe Ahe? (Report on study on ASHA programme in Maharashtra)	May, 2010
4.	Pictorial VHSC Tools	September, 2010
5.	Pictorial Sub center Tools	September, 2010
6.	Pictorial PHC Tools	September, 2010
7.	Pictorial Anganwadi Tools	October, 2010
8.	Information Brochure on Community Based Monitoring: English Flyer	November, 2010
9.	Khazagi Aarogya Sevechi Dasha Ani Disha	December, 2010
10.	Poster 1- Rugna Hakkanche Palan, Changanlya Hospitalche Lakshan	December, 2010
11.	Poster 2- Mala Rugna Hakka Mahit Ahe	December, 2010
12.	Information Brochure on Community Based Monitoring: English Flier (Reprint)	January, 2011
13.	Village health services calendar 2011	March, 2011
14.	Saline & Injection Posters (single posters) (Reprint)	March, 2011
15.	Training Manual Guide Book for ASHAs	March, 2011
16.	Sarvajanik Aarogya Sevanvar Lokadharit Dekhrehk Prakriya (CBM Guide Book)	March, 2011
17.	Ashi Hot Ahe Aarogya Sevevar Lokanichi Dekhrehk (CBM Marathi	March, 2011

No	Particulars of Publication	Date of Publication
	Brochure)	
18.	Ata Sarkari Davakhana Hotoya Jantecha (Marathi CBM report)	March, 2011
19.	Health Rights Partnerships report	March, 2011

- **Report Cards Published in the Community Based Monitoring Project**

- 1) Anganwadi, Subcenter (All in two colours)
- 2) Village, PHC and RH level report cards (All in two colours) Reprint

- **Flex Poster Exhibitions (1.5 x 2 sq. ft., 4 color)**

- 1) Health Rights, 32 posters *
- 2) Injection & Saline Posters*
- 3) Anaemia, 26 posters*
- 4) Women's Reproductive Health, 72 Posters*
- 5) Patients' Rights, 15 Posters
- 6) Tambakhu Posters, 14 Posters*
- 7) Darubandi Posters, 18 Posters
- 8) Asha Ani Gaon Aarogya Samiti, 11 Posters
- 9) Asha Ani Gaon Aarogya Samiti, 1 Poster
- 10) District hospital, 23 (Hindi)

* (Available in Hindi)

STAFF MEMBERS (CEHAT)

Staff Details for Year April 2010-March 2011

Sr. No.	Employee Name	Designation	Qualification
1	Anandi Dantas	Research Officer	M. Phil (M.A.)
2	Anupriya Ameya Sathe	Sr. Research Associate	MSc. Health Science
3	Anjali Kadam	Secretary	H.S.C.
4	Anita Jain	Research Offider	MHSA (Health Services Admi) M.S.W. Community Development
5	Deepmala Mahesh Patel	Research Associate	Development
6	Devidas Jadhav	Secretary	S.S.C.
7	Dilip Jadhav	Office Assistant	H.S.C.
8	Dinali Hataskar	Administrative Assistant	M.Com
9	Gajendra Dixit	Sr. Research Associate	M.A. in Social Work
10	Geeta Surve	Secretary	H.S.C.
11	Jasmine Kalha	Research Associate	M.S.W.
12	Komal Asrani	Administrative Assistant	T.Y.B.Com. B.Sc. Diploma in system Management
13	Margaret Rodrigues	Research Officer	Management
14	Meghna Jethva	Sr. Research Associate	M.A.
15	Netralal Sharma	Office Assistant	S.S.C.
16	Nidhi Gupta	Research Officer	Masters in Health Administration
17	Nidhi Sharma	Sr. Research Associate	M.A. in Psychology

18	Oommen Kurian	Research Officer	PhD
19	Prachi Avalaskar	Sr. Research Associate	M.S.H.S.
20	Pradnya Jadhav	Administrative Assistant	B. Com
21	Prashant Raymus	Research Officer	M.A.
22	Pramila Naik	Jr. Administrative Officer	B.Com
23	Priyanka Shukla	Sr. Research Associate	MLISC (Library Science)
24	Priyanka Josson	Sr. Research Associate	Masters in Social Work
25	Rahul Sapkal	Sr. Research Associate	M.A. in Development Studies
26	Ramdas Marathe	Office Assistant	H.S.C.
27	Rashmi Divekar	Sr. Research Associate	B.A. pursuing LLB
28	Rupali Gupta	Research Officer	DPSCDM
29	Sana Contractor	Research Officer	B.D.S, M.P.H.
30	Sangeeta Chatterji	Sr. Research Associate	M.S.W.
31	Sangeeta Rege	Sr. Research Officer	M.S.W.
32	Shobha Kamble	Office Assistant	Primary School Ph.D. Sociology, MSc, Anthropology, Adv.cert.course- clinical research
33	Suchitra Wagle	Sr. Research Associate	B.Com
34	Sushma Patil	Jr. Administrative Officer	B.Com
35	Sudhakar Manjrekar	Office Assistant	Secondary School
36	Tayyaba K. Shaikh	Research Officer	M.A. and MPS
37	Yamini Sonavane	Research Associate	B.H.M.S.
38	Yashashree S.Keni	Research Officer	PGDPH, MBBS Master of Arts in Disaster Management
39	Yavnika Tanwar	Sr. Research Associate	B.A.
40	Vijay Sawant	Secretary	Masters in Social Work
41	Zamrooda Khanday	Sr. Research Officer	

STAFF MEMBERS (SATHI)

List of SATHI Staff Members during 1st April 2010 to 31st March 2011

Name	Designation	Period
Abhay Shukla	Coordinator	Since March 2009 (with SATHI team since October 1998)
Abhijit More	Junior Project Officer	From August 2008 to March 2011
Ajaylal Vishwakarma	Project Associate	Since December 2005
Ashwini Dorwat	Project Associate	From April 2010 to March 2011
Bhausahab Aher	Junior Project Officer	Since February 2011
Bhagyashree Khaire	Junior Project Officer	From April 2005 to March 2011

Deepali Yakundi	Research Associate	Since April 2007
Dhananjay Kakade	Project Officer	Since February 2004
Gajanan Londhe	Office Assistant	Since April 2010
Jessy Jacob	Office Secretary	Since January 2006
Kiran Mandekar	Administrative Assistant	Since July 1996
Meena Indapurkar	Office Assistant	Since October 2002
Nilangi Sardeshpande	Senior Project Officer	Since June 2002
Nitin Jadhav	Junior Project Officer	Since August 2007
Rakesh Sahu	Project Associate	Since April 2009
Ravindra Mandekar	Office Assistant	Since November 2000
Rashmi Padhye	Junior Project Officer	Since September 2010
Santkumar Mahto	Junior Project Officer	From April 2005 to March 2011
Shailesh Dikhale	Junior Project Officer	Since August 2000
Shakuntala Bhalerao	Junior Project Officer	Since March 2008
Sharada Mahalle	Administrative Assistant	Since October 2007
Shweta Marathe	Junior Research Officer	Since March 2010
Trupti Joshi	Junior Project Officer	Since November 2007
Urmila Dikhale	Administrative Assistant	Since September 2007
Yogendra Ghorpade	Project Officer	Since October 2010

STAFF MEMBERS (CSER)

Name	Designation	Qualification
Deepak Nikam	Office Assistant	B.Com
Chitra Borkar	Junior Programme Officer	B.Com
Deapica Ravindran	Junior Programme Officer	M.S.C. Biotechnology
Divya Bhagianadh	Associate Coordinator	BDS, MPH
Mahendra Shinde	Junior Administrative Officer	M.Com
Neha Mahiwalla	Coordinator	M.A. in Social Work
Sachin Nikarge	Junior Programme Officer	MA in Sociology
Sanjay Kumar Singh	Junior Programme Officer	Masters in Rural Development
Supriya Bandekar	Junior Programme Officer	MA in Sociology
Vijaya Saraogi	Junior Programme Officer	M.A. in Economics
Bhasyati Sinha	Senior Research Assistant	B.A in Economics,
Sweta Surve	Junior Programme Officer	M. A. Social Work

Rakhi Ghoshal	Junior Programme Officer	M. A. in English Literature
Anand Kumar	Junior Programme Officer	M. S.C in Clinical Research
Kumar Das	Junior Programme Officer	M.A. in development Studies
Mahua Ray	Senior Programme Officer	M. A. in Anthropology