

ANNUAL REPORT
PERIOD 1ST APRIL 2019 TO 31ST MARCH 2020
ANUSANDHAN TRUST

SUMMARY OF FUNCTIONING AND WORK OF ANUSANDHAN TRUST

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

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

The trust governs three institutions:

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

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

CSER (Centre for Studies in Ethics and Rights) The trust promoted work on bioethics/medical ethics from the very beginning. The work particularly on research in bioethics and ethics in social science research in health were further consolidated within CEHAT. Since there is a real national need to strengthen bioethics and also at the same time promote ethics in various professions, the Trust decided to establish a long-term focused programme on ethics under a separate centre. This centre began functioning from January 2005 in Mumbai. The Board of Trustees at a Special Meeting of the Trust held on May 11, 2013, decided to change the structure of CSER from an independent Centre to a programme, Research Programme on Ethics, directly under the Trust

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

DETAILED REPORT FOR THE FINANCIAL YEAR 2019-2020

CEHAT: - Centre for Enquiry into Health and Allied Themes: Research Centre of Anusandhan Trust

1. INTEGRATING GENDER SENSITIVITY IN HEALTH RESPONSE THROUGH ADDRESSING VAW AND VIOLENCE IN LABOUR ROOM AND RESEARCH ON IMPLEMENTATION OF TARGETED HEALTH INSURANCE IN ACHIEVING UNIVERSAL HEALTH CARE FOR WOMEN AND THE MARGINALISED

ACTIVITIES CONDUCTED

Training of healthcare providers: A curriculum to address intersectionalities in sexual and reproductive health

The project primarily aims to strengthen the health system response to VAW, and address the issue of labour room violence. However, these phenomena do not exist in isolation; many social factors intersect to moderate the intensity and the effects of violence against and abuse of women. VAW is being growingly recognized as a public health concern, the issue of disrespect and abuse of women in labour rooms of hospitals remains unacknowledged; the thrust on increasing the rates of institutional births is also exacerbating the issue, and not translating into quality care for the woman.

Adverse behaviours in labour rooms stem from deep-seated attitudinal biases against various populations of the society. Hence, it became important for the training to address these root causes of mistreatment of women. The needs of doctors and nurses with regard to the training would be different; hence two different trainings were conducted, one for nurses and one for doctors. A training for 34 nurses from MCGM hospital was conducted on 21st and 22nd August 2019. Similarly, another training for 24 doctors from all over India, was conducted on 20th and 21st September 2019, in Mumbai.

The trainings covered the following topics:

- Sexual and reproductive rights of women/ girls belonging to sexual minority communities, sex workers
- Accessing sexual and reproductive rights
- Physical disability – negotiating sexual and reproductive health rights
- Religion based discrimination and health rights
- Caste based discrimination and access to health care
- Preventing labour room violence

Participants reported that the trainings had indeed been useful in sensitizing them to the differing needs of populations which availed of their services, and had been novel information which they had not been exposed to before.

2. BUILDING EVIDENCE ON THE HEALTH NEEDS OF ADOLESCENTS AND YOUNG WOMEN

Collaborative initiative between CEHAT, Stree Mukti Sangathan, Jan Sahas and AALI

CEHAT was able to establish collaborations with three diverse organisations namely Stree Mukti Sangathan, Jan Sahas and AALI. The project entails building research capacities of CEHAT and other 3 organisations so that their rich data can be utilized effectively to influence policies, as well as inform their own interventions.

Efforts were made to strengthen its Management Information System (MIS) and develop a framework for analysis of service data pertaining to young girls and women. We have been able to generate evidence on three contentious issues: marital rape, barriers faced by young girls and women in accessing abortion services in public hospitals and stigma of consensual premarital sex among young girls and its implications for their sexual and reproductive health. The evidence on plight of young women and girls

who are routinely denied abortion services raises issues of conditional access, irrational practices amongst health providers and challenges with court approaches to abortion demands.

ACTIVITIES CONDUCTED

- **Visits to the organisation:**

A visit to all three organisations was made by CEHAT team to discuss the key variables in their data sets for analysis and also to build their capacity to enter and analyse the data. CEHAT supported Stree Mukti Sanghathan (SMS) to conduct a prospective study on understanding experiences of adolescents (11 to 17 years) in facing and/or witnessing domestic violence. This was a needs assessment study to identify kind of support services required by the adolescents and for development of an intervention. The findings of the study were presented by SMS team at Hinsa Mukti Parishad which is a network of grassroots organizations working to redress VAW in Maharashtra.

CEHAT team visited Jan Sahas to discuss key variables for analysis and guided them hands-on to enter and analyse their own case data on SPSS. During this visit, we supported them to develop a data entry format with the variables and codes. Jan Sahas team has compiled the data of all the districts in one SPSS file. Team is now working on coding and re-coding of data.

- **Trainings/ Meetings/ Workshops:**

A two day capacity building workshop was organised for AALI team members in Mumbai in month of March 2020. In this workshop, the AALI team generated tables using their data sets to generate evidence on stage at which a woman facing violence approaches an organisation providing legal services. This workshop also helped team in identifying gaps and strengthening documentation and MIS.

A one-day meeting cum training was conducted at SMS office in order to build the capacity of team to carry out primary study on understanding the impact of domestic violence on adolescents. In this training, participants were counsellors of all three counselling centers of SMS. This meeting was instrumental in developing the tool of the study, ethical considerations while conducting research were some of the points discussed with counsellors. After completion of data collection, SMS team was trained to develop an excel sheet for data entry and to conduct basic analysis. SMS completed data entry with help of interns from TISS. SMS team carried out descriptive analysis and CEHAT team helped them to interpret the findings in light of research questions.

1. On the basis of the findings of the primary study carried out by SMS, the organisation has decided to implement an intervention project “Jidnyasa” which means curiosity. Team has conceptualised to implement strategies on increasing awareness among adolescents about their rights, providing career counselling to adolescents, organising parenting session for survivors of domestic violence, and establishing a community resource centre for adolescents.
2. Based on our engagement, AALI and Jan Sahas have mobilised resources for carrying research using their service data. AALI has decided to dedicate a staff member specifically for the purpose of data entry and management. Similarly, Jan Sahas has brought new people on board to manage the data and conduct research.
3. An understanding of work of organisations have enabled us to learn how important it is to build collaboration between organisations and research community including universities as there are mutual benefits of this association. It can provide opportunity to organisations for strengthening their research capacity and also to produce rigorous evidence based on their work with community.

- **Research/ Papers submitted:**

A rigorous literature review was carried not only to sharpen our analysis but also to contextualise the findings emerging from our work. We reviewed various research studies exploring prevalence of marital rape, known risk factors, health consequences, legal frameworks available in various countries, attitude towards premarital sex and implementation status of health programs for adolescents. A considerable amount of time was also spent in data entry and the cleaning of data for the purpose of the analysis. One of the reasons was also that these are case records or service records and therefore written by counsellors. Hence an intensive data entry cleaning etc. is required to make the data available for analysis 3 potential papers were decided upon.

1. **Young girls and women and agency related to sexual and reproductive health:** This paper attempts to enhance our understanding of circumstances under which young girls engaging in consensual romantic relationships chose different pathways to achieve social acceptance and avoid stigma. This understanding is essential to develop a comprehensive health systems’ response to

needs of these young girls. This paper is based on analysis of service records of three public hospitals of Mumbai where crisis intervention services are provided to survivors of domestic and sexual violence by a team of interventionists.

2. **Marital rape in India a need to change law:** This paper focuses on the existing prevalence and health consequences of evidence of sexual violence within marriage in India, and presents an analysis of case records of hospital based crisis centre located in public hospitals in Mumbai. The data are compelling and raise important concerns regarding the exception to rape by husband in criminal law and available redressal mechanisms for survivors. This requires legal as well as procedural changes as offences covered under Section 376 are not being registered as rape due to attitudes of the police (apathy as well as normalization).
3. **Denial of safe abortion to survivors of Rape in India:** It was published in Health and Human Rights Journal in December 2019 which is an international peer reviewed journal, the paper, presents the experiences of 40 rape survivors, including two children, denied an abortion following rape. The cases were recorded by CEHAT in the course of building capacities of public hospitals to respond to violence against women in Mumbai, India, since 2000. We found that enormous damage is inflicted on women and girls by misinterpretation of the laws on abortion and rape, combined with a lack of understanding of the serious damage rape does, particularly repeated rape, and alongside other forms of assault and abuse. Domestic laws in India place a clear legal responsibility on health professionals to offer immediate care and treatment to rape survivors, including timely access to abortion. It is past due time for both the government and the courts to begin to hold themselves and health professionals accountable for ensuring this care is provided.

The evidence generated based on analysis of our service data was also presented in 16th Indian Association of Women Studies Conference January, 2020.

In December 2019, CEHAT became a part of National Coalition on Advocating Adolescent Concerns - (NCAAC) facilitated by Partners for Law in Development. CEHAT contributed in form of providing evidence in coalition's submission to Ministry of Woman and Child Development (MWCD) to consider adolescent concerns especially to sexuality. Recently, as a coalition we have made a submission to task force appointed by MWCD to look at raising the legal age of marriage for girls. CEHAT systematically put together the evidence on age at marriage and maternal and child health outcomes.

3. THE IMPACT OF MEDICO-LEGAL JUDGMENTS ON COURT TRIALS IN SEXUAL VIOLENCE

The present project by CEHAT proposed to carry out an empirical research on how courts understand and interpret medico-legal evidence in the context of changes in the rape laws and its impact on legal outcomes. Following were the objectives of the research.

1. To understand the role of medico-legal evidence in court judgements of survivors of sexual violence in the context of convictions and acquittals.

- a. A total of 110 judgements available on E-Court website were included for analysis. Later we segregated the data and found judgements related to elopement of young girls with their boyfriends. These were removed and hence a total of 96 judgements were analysed. The data was analysed and a draft report was developed. The analysis focusses on identifying factors that contribute to acquittal and conviction in cases of sexual violence and the role medicolegal documentation played in these.

FINDINGS

- In three fourth of the cases doctors had not been called as witnesses. However, proportion of convictions was higher when doctors deposed in the court.
- 84% of abusers were known to survivors of VAW
- All non- penetrative forms of sexual violence occurred in ages of 0-12 years and 13-17 age groups. These forms include making the child masturbate the abuser, sucking, licking of breasts/lips and touching/ rubbing of genitals of the accused on the survivors.
- Across the 3 age groups, 0-12, 13-17 and 18 years and above, (children, adolescents and adults) maximum convictions were seen in the youngest age group.

- 46 out of 96 suffered a health consequence in the form of unwanted pregnancies, injuries, pain in abdomen, infection and white discharge.
- Prosecution preparedness was assessed on the basis of bringing relevant witnesses, disallowing victim blaming questions, preparing witnesses for trial, bringing appropriate documents on court record and the like
- Sensitivity of the court/ judge towards the survivors is one of the important factors in the cases where abusers were convicted.
- No convictions were found in the category where a false promise of marriage was made to survivor. 11 such cases were found in the judgements.
- Other factors responsible for acquittals were; inability of the prosecution to recognise/ acknowledge health consequences of rape such as pain, tenderness, and failure to call the examining doctor as an expert witness to explain these has been one of the reasons in acquittals. The other reasons are inability to produce relevant witnesses for examination in the court, inability to prove that the survivor was a child under 18 years of age, inability to explain delay in filing FIR (even in cases where victims became pregnant after the rape).
- The study highlights the importance of doctors as witness to explain the presence/ absence of evidence, nature of health impact on the survivor as well as the need for sensitisation of the judiciary to the scope of medicolegal examination.
- The findings from the study were presented at the biannual conference held by the Hinsa Mukti Parishad – a network of NGOs and CBOs from Maharashtra working with women and various stake holders on issues related to violence against women.

The plan for dissemination of the report at a national conference on 26th March 2020 had to be deferred because of lockdown due to COVID 19 pandemic. The draft report is ready for dissemination and is published. A state level and national level dissemination of the findings was held

b. **Understanding experiences of doctors as expert witnesses in courts**

Doctors are called by courts as experts in cases of sexual violence trials. Hence, we felt that understanding their experiences regarding interactions with the judiciary were important as well. A simple set of questions was prepared to document their experiences. One challenge, encountered was getting doctors who have been called to the courts for deposition. This is telling of the long draw procedures as the time lag between a medical examination, and onset of the trial is very long, the data shows a gap of 2 years and it is quite possible that the doctor has been transferred to another hospital too. In fact we also found from some of the judgements that doctors were not even called by the prosecutor for a deposition.

It was proposed to interview 10 doctors from the Municipal secondary hospitals who had deposed in cases of sexual violence. However, only 5 could be interviewed despite repeated attempts. This was primarily due to high turnover of doctors in the municipal hospitals. Others who had once or twice been to the court could not remember the cases or their experience in the court. Attempts were made to explore the doctors' experiences regarding specific cases which did not yield results due to poor recall owing to long delays.

FINDINGS

- Often there is a long delay even up to two years since the doctors have seen the case/ examined the survivor. In this period the doctors who had examined the woman and filled in the proforma have often moved on from the hospital. Hence the senior members from the department answer the court calls. At times the courts are not agreeable to this.
- Even when the doctor who has carried out the medicolegal examination is available to attend the court call, he is likely to not remember the case. Public Prosecutor (PPs) do not help doctors prepare for the court hearing.
- In general, the doctors are treated with respect at the court. However, there are exceptional instances of experiences. At times the doctors believe that PPs do not even object to questions that are damaging to the woman's case. Sometimes even PP put allegation on doctor that since they have not commented on Hymen, case can lead to acquittal.

- The court still demands comments on hymen. Doctors from one of the hospitals especially mentioned insistence from the court on noting down the state of hymen – intact/ torn – despite their explaining the MoHFW guidelines. The doctors are often forced to respond in yes – no when they try to explain the status of injuries or presence/ absence of evidence.
 - It is demoralizing for doctors to see abusers being acquitted despite a clear history, documentation and explanation by doctors to the courts about medicolegal evidence.
2. **To analyse medico-legal documents pertaining to survivors of trafficking to understand the gaps in medico legal as well as therapeutic care.**

CEHAT in collaboration with Prerana, a Mumbai based organization that works with children of sex workers and also has its own shelter home to carry out a rapid assessment of the nature of examination and health care provided by doctors in government shelter homes to the girls rescued from trafficking. CEHAT provided guidance/ consultation for development of the interview guide and qualitative data collection. The team also participated in 4 out of the 8 interviews conducted. The study explored whether shelter homes/ institutions where these girls were housed had protocol for carrying out medical examination and what are the commonly faced health problems of these young girls.

Information about health care provided to the girls at the shelter homes was explored from interviews with administrative heads of six institutions and in-house health care providers (one nurse and one doctor) from two institutions. Data from interviews with shelter home representatives were thematically analysed and a presentation was developed

FINDINGS

The shelter homes do not comply with the legal mandates. Only 1/8 shelter homes included in the study, which is a government run facility, had a Medical Examination Officer, 3 nurses (with one of them being present at night), and 5 counsellors; it also has 3 visiting doctors with one general physician visiting 4 times a week, a paediatrician visiting three times a 4 week, and a visiting psychiatrist. Three of the eight institutions had the facility for referral to external counsellors for “severe mental health symptoms”.

- Common health problems among residents, reported across all the three institutions, were: skin problems, anaemia, poor appetite, irregular menstrual cycles, and white discharge.
- Health examination and documentation at the time of admission did not adhere to the provisions/ mandates in the JJ Act. Examination within 24 hours by medical officer at the shelter home, a list of investigations to ascertain exposure to STIs and general health status were not carried out.
- Institutions relied on services of the nearest government hospitals for treatment of any illnesses the girls experienced. None of the Homes had a round-the-clock nurse or paramedic, a mandate of the Act.
- Only 2/8 institutions admits HIV positive children, and 2/8 admitted pregnant adolescents. Institutes relied on government hospitals for treatment. There was no clarity about special care needed by and provided to these groups.
- All institutions have some form of system for monitoring whether or not the girls menstruate regularly. Some carry out vaginal examinations by doctors, others ask girls to show swabs of vaginal blood and still others monitor disposal of used sanitary napkins. Respect for the girls’ dignity seems to be a low priority in many institutions.
- This study also pointed out the gaps in terms of guidance regarding health care provision in the JJ Act itself. There is a need to provide clear guidelines for care of/ protocol for girls rescued from trafficking, HIV positive children, ANC, intranatal, PNC care or MTP and post MTP care needed by pregnant adolescents. There is no mention of and therefore services for SRH education and contraceptive counselling.
- The findings from the present study indicate that the shelter homes are viewed by the authorities as a mere temporary accommodation for children, hence overlooking rights-based care provision and all-round development. This aspect stands out more starkly in the case of government shelter homes, which are especially disadvantaged due to infrastructural and human resource shortcomings.

Training of Child Welfare Committee (CWC) members:

Connected to the issue of medico legal response is the role of CWC is a quasi judiciary body that plays important role in children's rehabilitation in sexual violence cases. Having realised that personnel who run these institutions also have a limited understanding on the role of health care and services for young girls; we felt the need to organise training for CWC members from seven districts of the Konkan zone. CWC members operate under JJ act and hence interface with children who are in need of care and protection and those in conflict with the law. They also meet children who have been trafficked and hence we felt that if they are sensitised to the health needs of these diverse groups.

A two-day training was organized in December 2019 and was attended by chair-persons, members, DCPOs and OSCC representatives from Mumbai Suburbs, Palghar, Thane, Ratnagiri, Sindhudurg and Raigad districts.

Broad topics covered in the course of workshop were:

- Circumstances of sexual violence
- Understanding MTP act from a doctor's perspective
- Types of violence and its health impact
- MTP Act and POCSO – legal perspective

Participants appreciated the workshop contents and methods. This was the first ever orientation for many of the participants on health system perspective on sexual violence. They expressed a need for more decentralized workshops (at district levels) where all stake holders could participate. They also stated a need for working with the district level health system to ensure a comprehensive health response to child survivors of sexual violence.

A report of the workshop was developed and shared with the Office of the Regional Deputy Commissioner, Department of Women and Child Development.

4. ADVANCING HEALTH SECTOR RESPONSE TO VIOLENCE AGAINST WOMEN

The Dilaasa Crisis intervention centre for women and children was set up jointly by CEHAT and Municipal Corporation of Greater Mumbai (MCGM) in 2000. In 2005 CEHAT ensured that the crisis intervention services became an integral part of the health Service.

A concrete outcome of CEHAT advocacy on engaging the health sector to respond to VAW was the inclusion of Dilaasa centres in the Maharashtra National Health Mission (NHM) in 2016. This led to the setting up of 11 additional Dilaasa centres in hospitals of Mumbai. CEHAT's achievement has been the establishment of the Dilaasa blue print that comprises of a trained core group of health care providers (HCP) along with a trained crisis intervention team of counsellors. We have been brought on board by the Brihanmumbai Municipal Corporation (BMC) for technical support in the form of handholding teams and monitoring services. CEHAT is also on advisory board set up by BMC for the Dilaasa centres.

Crisis Intervention Activities of the project

- CEHAT is engaged in provision of crisis intervention services through Dilaasa in K B Bhabha Municipal Secondary Hospital at Bandra. The hospital based crisis centre at K B Bhabha hospital is managed for 4 days a week with the help of CEHAT team. This allows for senior counsellors in Bhabha Hospital to engage on issues related to management of 11 Dilaasa centres, discussion with counsellors and addressing their concerns. CEHAT counsellors at Dilaasa from K B Bhabha Hospital Bandra reached out to 777 women. 180 new cases of domestic violence (DV) and 73 new cases of sexual violence (SV) were registered at Dilaasa. Legal advice was arranged for 10 survivors with a senior lawyer. Additionally, health education in the form of health impact of domestic violence was provided to 290 women waiting in outpatient clinics as well as those admitted to ANC, PNC and female medical and surgical wards.
- CEHAT assisted Kurla Bhabha Municipal hospital in setting up of the crisis centres after it re-opened in September 2019, which was under renovation since 2015. Reorienting staff members of the hospital as there were new staff members too. The Dilaasa centre formally restarted since October 2019. In this period one case of SV and two new cases of DV were registered at this department and four follow ups were carried out.

- National Urban Health mission (NUHM) upscaled the Dilaasa centres in 11 hospitals of Mumbai since 2017 and agreed that CEHAT will provide technical support to the strengthening of the health system response to VAW. Each Dilaasa centres in 11 hospitals, is staffed with two counsellors, two auxiliary nurse midwives (ANMs) and one data entry operator. 1033 new DV cases and 564 new SV cases have been registered at these Dilaasa departments.
- CEHAT counsellors visit each of the 11 Dilaasa centres on a weekly basis to interact with the teams, learn about their challenges and assist them in difficult cases. CEHAT team has assisted in 32 cases of VAW across 11 centres. These interventions range from pressuring police for recording FIR and dealing with refusals by the police, helping teams to coordinate and present cases of child sexual abuse with CWC, and dealing with the hospital departments when they refuse to provide MTP services. Some efforts were also made to seek extension of hospital stay for safety of survivors of VAW when they did not have a place to go back to and when alternate arrangements were made. In addition, 9 cases were handled by CEHAT team in the 11 hospitals as first responders. These were complex cases involving sexual violence in cases of minors, where Dilaasa counsellors found the contexts challenging.
- Monthly case presentation meetings provide forum for ongoing capacity building of counsellors and ANMs from Dilaasa departments from 11 hospitals. These meetings also help CEHAT understand challenges faced by counsellors. One of the emerging concerns was related to the comprehensiveness of documentation and understanding intake forms. A specific session was carried out with all the counsellors to explain the rationale of the intake components as well as, do a hands on exercise of filling it up. Counsellors have also expressed need for inputs on reading medical papers, legal aspects etc for which sessions will be conducted. The counsellors now have clearer understanding of when and how to conduct joint meetings with survivor and abuser or other members of her family. Dilaasa teams' ability to interact with other resource agencies such as the police, the CWC, protection officers, judiciary has strengthened over the period. Counsellors acknowledge the benefits of case presentation meetings, especially the inputs from peers and experts.
- Dilaasa teams have been trained to understand sexual diversity and ways of responding to women/ girls belonging to LGBTIQ communities. This has enabled counsellors to reach out to young girls attempting suicide because of lack of acceptance about their sexuality by parents.

ADVOCACY EFFORTS

- CEHAT was approached by Ministry of Women and Child department (MWCD) to develop user manuals for all the 5 functionaries of the One stop centres (OSC) The functionaries include social workers, psychologists, police facilitation officers, paralegal workers and superintendents. This was in response to a rapid assessment commissioned by WHO on the functioning of existing OSCs in India. Gaps were found in perspectives of functionaries ranging from victim blaming to negotiating for upkeep of marriages and relationships at the cost of women's health and agency. CEHAT is being looked at as an expert organisation in developing training materials and facilitating them.
- Being engaged in direct interventions at the level of hospitals, CEHAT established new linkages with the deputy divisional commissioner to engage child welfare committees across Konkan region to enable an understanding on linkages related to health and violence faced by children. The Child welfare committees (CWC) despite having quasi judicial functions did not provide directions to hospitals for health care in child sexual abuse. Young children were often compelled to continue pregnancy resulting out of rape at the level of institutions as the option of medical termination of pregnancy was not thought of by CWC. Many expressed that they were unable to read the medical examination reports or interpret them which posed as obstacles in issuance of orders for future directions. The training helped build an understanding of the health effects of child sexual abuse, understanding of abortion laws in India as well as recognising scope and limitations of medical evidence. CEHAT is now collaborating with the CWCs in Maharashtra across other regions to facilitate such an understanding.

Activities related to Replication of Dilaasa model for Women Facing Violence in Other States

- **Haryana:** Meeting was held with Executive director (ED) of Haryana Health Resource centre (HSRRC) an apex technical body under the Health department providing technical support to execute functions of health and family welfare. The meeting was to propose formal collaboration for 3 years to handhold Sukoon centres established in hospitals inspired by Dilaasa model. Meeting with ED urged CEHAT to consider expanding the scope of support from 4 centres to 11 centres as Sukoon Centres have been

replicated additionally and there is a need to provide them with technical support. An outline for continual engagement was discussed with the nodal officer appointed by ED. Bi-monthly calls would be made to facilitate case presentation with the teams and difficulties and challenges would be discussed. A visit made to 3 centres of Panchkula, Ambala and Yamuna Nagar enabled an understanding that counsellors have been appointed in most centres and in others the existing counsellors have been charged with roles and responsibilities of the centres. This was a strategic entry for CEHAT to expand its support to additional centres and therefore we have gone ahead with this proposal and we have received a formal sanction for it.

A 2 days training of Health providers along with counsellors was carried out on 7-8 Nov 2019. 42 participants comprised of doctors, nurses, nodal officers and counsellors of 11 hospitals. Training focused on understanding the health consequences due to violence and the important concepts of sex, gender, patriarchy, power and intersectionality to understand the social reality relating to violence. The training concluded with demonstration of how can HCPs enquire about violence with a gender sensitive approach how they can provide first line support and psychological aid to survivors of violence through LIVES.

- **Goa:** Goa has two major district hospitals, one in South Goa and one in North Goa. Advocacy efforts were made with Directorate of health services (DHS) to appoint counsellors specifically to provide counselling services to women and children reporting violence and reaching public hospitals. Despite several follow ups, DHS did not appoint new counsellors. It was therefore decided that existing counsellors of different health programs of the government can be equipped in providing these services because they operate at the hospitals. Though they report to their program authorities, their administrative charge lies with the medical superintendent (MS) of the hospitals. Hence MS of both the hospitals issued directives for deputation of counsellors at the crisis centres. They have now allotted a room for the counselling in the main OPDs.

A day long training was conducted with both sets of counsellors in both hospitals in the month of June 2019. Training addressed the lethality of violence seen in survivors as they come with acute episodes of assaults, suicide attempts, rape amongst others. Training equipped the teams to understand addressing such intensity of violence, drawing up safety plans, dealing with abusive partners and linking up with additional resources. It was decided that a follow up of this training would be done after 3 months to understand uptake of services and nature of referrals. An training orientation for VAW for ½ day was conducted with 21 HCPs and 19 HCPs were oriented in Hospicio and Asilo hospitals respectively.

A second visit was carried out from 4th to 6th December; where 2 days were spent with the Hospicio team and 1 day was spent with the Asilo team. A case presentation was carried out in both the hospitals to understand successful cases and difficult cases. Steps on how to implement actions on the ground were discussed and a need was also felt to connect with local organisations for legal aid and other support services.

Each hospital has also appointed a nodal officer who is a doctor and the counselling team reports to the nodal officer.

- **Meghalaya:** NEN and CEHAT approached Neighrims medical college and hospital because it is the largest super specialty hospital in the north east region and because it has a wide range of staff as well as departments Establishing a hospital-based crisis centre in such a hospital would be a landmark for other larger hospitals to emulate this effort. Talks with the Neighrims medical college is under process, to review and assess the proposal and seek further directions.

NEN and CEHAT organised a 4 days training program for a mixed batch of HCPs, 49 HCPs from Neighrims and 35 HCPs from Ganesdas hospital attended the training. The expectation at the end of the referral was active case identification based on signs and symptoms of VAW and making referrals to the existing LHYONTI crisis centre in Ganesdas hospital.

- **Karnataka:** Karnataka has a state level scheme called Gelathi centres, which exists across each of the districts of Karnataka and are based in district hospitals. A one-day training, comprising of 90 counsellors from all Gelathi centres participated in this training. The purpose of the training was to enable an understanding amongst them on health consequences of violence, steps they need to take to

identify VAW survivors reaching hospitals, understanding how to read and decipher medical records of VAW survivors. Training was very well received and commissioner of Karnataka WCD also sought Dilaasa documentation format (intake form) to create a comprehensive documentation of counselling undertaken.

A meeting was held with Director and Secretary, Women & Child Development Department in Bangalore in September to seek approval for handholding of the project. While we had proposed hand holding for 2 hospitals but the secretary insisted that we should extend the support to at least 8 Gelathi Centres. The proposal was submitted in October 2019. With change in the state government, the state scheme Gelathi centres was discontinued with immediate effect in January 2020 and was replaced by national level scheme of ONE STOP CENTRES. Efforts are underway to establish collaboration with department to collaborate with OSCs to engage them on an understanding of violence against women as a health issue.

- **New Delhi:** A Series of conference calls and materials were shared with Medicine Sans Frontiers (MSF) team along with a proposal for three-way collaboration (MSF- CEHAT- Babu Jagjivan district hospital). CEHAT was invited for a round table meeting where MSF disseminated their research findings about community perceptions of VAW as well as HCPs perceptions of VAW. The latter indicated a need for training of providers because clearly HCPs were of the opinion that VAW is a law and order issue and they didn't have a role beyond medical treatment.
- **Maharashtra:** CEHAT carried out a series of meetings with the Akola hospital between 3-4 September, 2019 to understand the efforts made to date. The medical superintendent (MS) has sought a social worker, working with free legal aid to provide support services to women at the hospital currently. It was discussed that a need for training of HCPs at the hospital and also the need to include Akola medical college as it is in the same vicinity. The latter if trained can identify and start referring cases of VAW to the counsellors of the hospital.

A two-day training for HCPs was conducted at the Nursing College in Akola, and attended by 33 doctors and few nurses from the Ladyharding District Womens Hospital and Akola, Government Medical College. The main objective of the training was to sensitise health care providers about violence as a public health issue, the health consequences faced by the survivors and the support that can be provided to them in a gender sensitive way. A team of four resource persons; from CEHAT interacted with the participants to equip them with skills to identify signs and symptoms and also understand the challenges they face in doing the same.

Post training, we felt that a separate session with existing counsellors (HIV & RMCHA) programmes also need to be oriented to provide counselling services to women. Documentation formats currently being used are sketchy and does not capture details of violence faced and nature of support offered. CEHAT is in talks with the MS to seek permission for such a hand holding of the counsellors.

- **Tamil Nadu:** CEHAT plans to work with 2 hospitals to enable them in developing a comprehensive health care response to VAW. OSC scheme by Women and child department is a central government scheme. Though the scheme expects that the OSCs will be located in the vicinity of the hospitals, there has not been much success by both WCD and Health departments to foster convergence. CEHAT proposes to identify local partner NGO for the purpose of the project and also to ensure handholding of these hospitals at the local level.

RUWSEC has been identified as a local partner because this is a women's health rights based organisation with a strong presence in the region run by community women but also has doctors as a part of their organisation. They have experience of collaborating with the health department for reproductive health programs (not VAW) we seek to build on their local presence as well as their experience of having worked with the health department. The collaboration talks are under process.

TRAINING ACTIVITIES

- **Training Core Groups of HCPs (doctors & nurses) in 13 hospitals on responding to VAW:** One of the core activities of the Dilaasa centre is to ensure that VAW is recognised as a health issue. This requires that Health care providers (HCP) recognise signs and symptoms in their patients on violence against women. Hence orientation trainings of 3 hours were planned in each of these hospitals.

While each of the hospitals have appointed a doctor as a nodal person of Dilaasa, they required to be oriented to VAW issues. These trainings are carried out by CEHAT and Dilaasa counsellors along with some of the core group members of the Dilaasa. Core group of the Hospital comprises of interested doctors and nurses who support the activities of Dilaasa centres.

Ten trainings for doctors and nurses from 11 hospitals and 2 trainings for Bandra Bhabha Hospital have been conducted. Through these trainings CEHAT reached out to 319 health care providers across eight hospitals. Training participants included 118 doctors, 134 nurses and 67 representatives of other cadres of health care providers/hospital functionaries such as laboratory technicians, medical social workers, security guards, clerical staff, cleaners etc.

- **Training of data entry operators from 11 hospitals**

An important activity committed by CEHAT is to equip data entry operators from all 11 Dilaasa centres to enter information from the Dilaasa intake forms into a MIS system. This is critical to generate evidence about profile of Dilaasa users, nature of health complaints faced by women, intensity of violence and expectation of women from these centres. A day long training of data entry operators was conducted to explain the formats better. Upon follow up visits to the Dilaasa centres, we saw that gaps existed in the filling of MIS and this was to do with the manner in which counsellors were inputting information in intake and follow up forms. Part of the issues were addressed during the discussions on how to fill the intake forms in case presentation meetings attended by the counselors and ANMs. A second training cum meeting was to take a stock of the extent of data entered and tables generated so that a report can be developed on it.

- **Training of team from Jan Sahas:**

A training was requested by Jan Sahas, Madhya Pradesh to familiarise their grassroots teams to concepts of violence against women, violence as a health issue, role of health system towards survivors of violence, provisions in MTP act, POCSO. Over 50 representatives of Jan Sahas teams from three districts of Madhya Pradesh attended the training on 13th to 15th June 2019.

OTHER ACTIVITIES

- **Monitoring visits to 13 hospitals to carry out review of Dilaasa activities with teams on a quarterly basis:**

Under this activity, 54 visits were made to 11 hospitals. In these visits 52 DV cases and 23 SV cases were discussed with the teams. Documentation of case identification interactions too were read and discussed with Dilaasa team members. During the visits feedback is provided to counsellors and included in documentation. Assistance was also provided in classification of women and girls coming in touch with the Dilaasa teams. These visits by CEHAT counsellors provide an opportunity to interact with hospital level nodal officer as well as other doctors and nurses who play a key role in providing comprehensive health care to a survivor of violence against women.

- **Monitoring committee meetings**

The forum of monitoring committee was established in 2012 for assessing comprehensive health care response to sexual violence. Since the Dilaasa NUHM were set up in 2016-2017, we felt that it is important for each of the hospitals where Dilaasa is located monitoring committee be established. This is one step towards institutionalising the centres as monitoring committees of the hospital would eventually take charge for smooth functioning of Dilaasa. Three hospitals have set up monitoring committees (Govandi Shatabdi, BDBA Kandivali, HBT Jogeshwari) whereas three monitoring committees (Bhabha Hospital, Cooper hospital and Rajawadi hospital) existed. A total of 6 monitoring committee meetings took place. The process of initiating these committees in 5 other hospitals is underway. These committees consist of nodal officer for the hospital, senior representatives from departments of gynaecology, surgery, paediatrics, representatives of medical records department, police constable on duty at the casualty, Dilaasa counsellors and representatives of CEHAT. WhatsApp groups were initiated by each hospitals, have formed forums for regular discussion between counsellors and other members of the monitoring committee.

Issues addressed during monitoring committee meetings

- Delays in discharge of survivors of sexual violence due to memo or signature from police.
- Court insists that doctor who conducted the medico legal examination appear as witness.
- Sending sample from product of conception to FSL – what kind of sample, disposal of remainder of biological material.

- Procedures regarding samples not collected by police
 - Procedures regarding sealing of samples
 - Role of nurses during medico-legal examination
 - Role of doctors in provision of psychosocial support
 - Role of medical records officer in cases of survivors of sexual and domestic violence
- **Establishing evidence on health sector response to VAW by developing protocols**
A literature review of existing protocols and procedures across different countries for responding to domestic violence is currently being undertaken. This is crucial to do in order to understand the efforts made and what can be learnt from them. It is peculiar to note that all the literature that exists globally focuses on Intimate partner violence (IPV). In the Indian context IPV forms a subset of domestic violence and hence this literature also needs to be contextualised. We plan to establish an expert group comprising of civil society members as well as lawyers and health officials from Ministry of health and family welfare to review the literature and present a draft protocol.
 - **Workshop with members of Child Welfare Committees (CWC):**
A one and half day long workshop was organized on role of health system in responding to survivors of sexual violence for members of CWCs from Greater Mumbai and neighbouring districts from Konkan region. The workshop was attended by 21 CWC members. Participants were oriented to concepts of violence, health impacts of violence, circumstances of sexual violence, medico-legal evidence and its scope, MTP act and implications for girls under 18 years of age, POCSO – role of health system, challenges in interactions between CWC and health system and how to address these. Feedback from participants suggests that this topic had never been discussed with the members of CWC and inputs were appreciated. Participants said similar trainings should be conducted for members of CWCs across the state.
 - **Hinsamukti Parishad:** A state level forum for NGOs and CBOs working at grassroots on issues related VAW. CEHAT is one of the organisers of the Hinsamukti Parishad and CEHAT representative participated in meetings for deciding agenda of the biannual conference. This provides the organisation an opportunity to raise issues related to comprehensive health response on wider fora. CEHAT also made presentations based on work in Mumbai. Two counsellors from Dilaasa from peripheral municipal hospitals too attended the conference organised in December 2019.
 - **AMAN Network:** A national forum for NGOs and CBOs working on violence against women; CEHAT representative gave a presentation on need for and impact of MIS (management information system) for those providing counselling services to survivors of violence. Usefulness of such data for continuity of care, monitoring as well as advocacy was discussed.
 - **Association with Rotary Club:** CEHAT's efforts in establishing a health care model for responding to VAW has been recognised globally as well as in India. We are being called upon by private medical associations as well as Rotary clubs to present these models and gains from it. CEHAT was invited to one such panel discussion titled "Women empowerment: From awareness to accountability" by Rotary Club of Mumbai and attended by private medical practitioners, adolescent girls and young women as well as members of community. CEHAT presented the Dilaasa model, services provided and learnings from it.

5. DEVELOPMENT OF TRAINING MODULES FOR FUNCTIONARIES OF ONE STOP CENTRES IN COLLABORATION WITH WHO-INDIA

A systematic review of existing materials on existing guidelines along with the standard operating procedures issued by MWCD was carried out to ensure that the training modules for the five functionaries are developed in a context specific manner. WHO's rapid assessment of the OSC's established in different states was carried out to understand the gains and challenges faced by OSC teams in responding to the issue of Violence against women/ Girls (VAW/G). These reports offered a backdrop of the context of these OSCs and expectations from the roles of Medical superintendents, para medical officers, counsellors, caseworkers, para legal workers and police facilitation officers.

Existing guidelines for women centred counselling practices by UNFPA, WHO were also reviewed along with CEHAT's existing evidence based counselling guidelines and ethical guidelines for responding to VAW. Medico legal guidelines for sexual violence care issued by MoHFW in 2014 were adapted to the context in which the functionaries carry out their duties.

A first draft was developed and submitted on 31st October 2019, to WHO and MWCD teams for their review. The document was reviewed and found suitable to carry out a pretesting of the modules with a set of select OSCs in India. A training calendar was submitted and 4 senior master trainers were contacted. A daylong meeting was carried out with the 4 trainers to discuss the training modules, methodology and expected outcome. Two sets of training dates were submitted to WHO and MWCD for undertaking the same.

6. IMPLEMENTATION OF GENDER IN MEDICAL EDUCATION FOR SENSITIVE HEALTH CARE SERVICES TO PERSONS BELONGING TO LGBTQI COMMUNITIES; AND FACILITATING GENDER SENSITIVE SERVICES IN THE PSYCHIATRY DEPARTMENT OF 3 MEDICAL COLLEGES.

The project sought to collaborate with The Department of Medical Education and Research (DMER) with aim of contacting medical colleges for the implementation of the project. The process for establishing the same entailed site visits and physical meetings with each college and interactions with different ranks of medical professionals. The colleges contacted were Nair Medical College (Mumbai), Grant Medical College (Mumbai), B. J. Medical College (Pune), Government Medical College (Akola), and Government Medical College (Dhule). The end outcome was that we had 5 medical colleges instead of the committed 3 medical colleges to deepen GME.

Technical Advisory Committee: A Technical Advisory Committee (TAC) was formed. The objective of the committee was to:

- Critical review of research methods and tools for the formative phase of the project.
- Assessment and approval of the content of the curriculum for a 3-day residential training of medical educators.
- Conduct sessions with medical educators on subjects of expertise.
- Engagement with site visits when feasible.
- Review of and inputs on the gender-sensitive clinical protocol for the department of psychiatry.
- Review of the clinical protocol implementation plan and evaluation tools.
- Critical appraisal of the implementation evaluation and project reports.

ACTIVITIES CONDUCTED

- 1) Understanding health care needs, existing responses of health practitioners towards persons from LGBTQI communities when they access health institutions.
 - a. Collaborations with medical colleges were pursued simultaneously with seeking permissions from DMER.
 - **B. J. Medical College (Pune):** An initial meeting was held in Pune with an Associate Professor of Psychiatry from B.J. Medical College (B.J.M.C.), which helped acquaint him about the project objectives, outcomes, and roles and responsibilities of the collaborating medical colleges and CEHAT. In this meeting, it was also established that the number of residents in B. J. Medical College were very few for participation in the GME project. In lieu of that, the professor appraised CEHAT of the Maharashtra Institute of Mental Health (MIMH) which has been developed along the lines of NIMHANS and is under the charge of the Dean of B.J.M.C. Professor suggested that a role for the students of MIMH, which is a research-oriented institute, can be designed within the project and this would be beneficial for both CEHAT, as well B.J.M.C. A second meeting was conducted with the Associate Professor of Psychiatry, along with the coordinator of Nursing Psychiatry, to understand the Nursing curriculum and scope for integration of GME.
 - **Government Medical College (Akola):** A visit was made to Akola to meet the Dean of GMC at a time when medical educators from the institute were attending a training organised by CEHAT in Akola. CEHAT team was introduced to the UG Medical Education Coordinator at GMC, Akola, who took interest in understanding the GME modules and the purpose of the project. He asked for more detailed documentation and physical copies of the modules which he would present at the upcoming departmental meeting with HODs of all five relevant departments.

- **Nair Medical College (Mumbai):** A meeting was arranged for the CEHAT team with the Dean. In this subsequent meeting with the Dean, he approved the project for collaboration with Nair and asked the Associate Professor to act as the nodal person and facilitate meetings with HODs of all five departments. Post this meeting, CEHAT wrote a proposal to Nair MC for collaboration outlining the efforts and outcomes of the past GME project, objectives of the current project, roles and responsibilities of all those involved, and the expected outcomes of the project.
 - **Grant Medical College (Mumbai):** Dean approved the project for collaboration and referred the team to the coordinator of UG Medical Education, who was also the HOD of the Department of Anatomy. In a meeting with him, the HOD recommended that CEHAT talk to a medical educator from one of the disciplines which are a part of GME and referred us to the HOD of Forensic Medicine and Toxicology. The latter was keen to collaborate on the project and asked for letters addressed to HODs of the other four departments, which were shared ahead of his departmental meeting.
 - **Government Medical College (Dhule):** One of the faculty members of Psychiatry from the college was a collaborator on the GME module for this subject. The Associate Professor facilitated a meeting with the Dean, where he also invited HODs of all the five departments. This was the only college where the CEHAT staff was given the chance to interact with all HODs together. After the Dean's approval, a smaller meeting was held with HODs where the course of action was decided and contributions expected from the departments were noted.
- b. A global literature review was carried out on providers' knowledge, attitude, and practice towards LGBTQI persons accessing the health system. This was presented by project staff to the CEHAT team. Based on it, a comparative analysis of the MCI and MUHS curricula was done by juxtaposing the findings in a box and identifying opportunities for gender sensitisation. In the MUHS curriculum, the content is divided into knowledge, skills and attitude, with attitude calling for humanistic and empathetic relationship. Similarly, in the MCI curriculum, subject specific competencies are divided into the three domains of cognitive, affective and psychomotor. The affective domain calls for the student to adopt ethical principles and maintain proper etiquette, while demonstrating respect for the rights of the patient. These mentions in the MCI and MUHS curricula present opportunities for aligning the deepening of GME with the mandate of medical education in colleges.
 - c. Discussions with medical educators about health problems faced by LGBTQI communities, which built upon responses recorded in CEHAT's past implementation of GME. Through these interactions, it was found that knowledge about LGBTQI communities is limited and their health concerns are deemed restricted to sexual and reproductive health, particularly STIs. This prompted a change in strategy from situation analysis, to a new strategy of witness seminar.
 - d. The methodology of witness seminar was introduced as a means of chronicling and archiving queer history in India in the context of health care. Witness seminar was chosen as a method because a need was identified to document the experience of activists and service providers in the evolution of the LGBTQI movement in India and its linkages with health and human rights. The purpose of the witness seminar proposed for this project was two-fold: (1) tracing the historical evolution of the needs and rights of sexual and gender minorities through activists, civil society members and service providers, and (2) understanding participants' experience of treatment of sexual and gender minorities within the health system. Specifically, what are their health concerns, the commonly encountered challenges in providing care for them, and what are the suggestions going forward to promote gender-sensitive service delivery for them.

A draft research proposal with tools and informed consent form was developed for review by the IEC after the methodology had been reviewed by the PDC and TAC.

- e. A preliminary presentation was made to the IEC, ahead of the TAC meeting, on 20th December 2019. The purpose of this presentation was to appraise the IEC member about the project and its objectives such that a more detailed research proposal could be submitted for review after feedback from the PDC and TAC. In this presentation, linkages of the current project with outcomes of the previous GME were explained to IEC members. The roles and responsibilities of the medical colleges and CEHAT were delineated along with a short brief about the programmatic

and research components achieved so far in the project. The presentation concluded with the following expected outcomes:

- Availability of gender-sensitive medical faculty.
 - Session plans made available for gender-integrated teaching at the MBBS level.
 - Evidence on feasibility of implementing a gender-sensitive psychiatry protocol.
 - Joint publications emerging from development of the psychiatry clinical protocol and its implementation.
 - Publication of the exploratory research on the evolution of current knowledge, attitudes, and practice among medical professionals towards LGBTQI persons accessing the health system.
- 2) A 3-day curriculum has been developed building upon relevant topics culled out from previous trainings under GME, which focuses on understanding of gender and sex, intersectionality, discrimination, physical and psychological health consequences and building skills to respond to the unique needs of the community.
 - 3) To conduct 3-day residential trainings covering a batch of 20 medical educators in each batch comprising of medicine, psychiatry, gynaecology, forensics, community medicine.

7. UPSCALING EVIDENCE BASED HEALTH SYSTEMS RESPONSE TO VIOLENCE AGAINST WOMEN AND CHILDREN IN ELEVEN PUBLIC HOSPITALS IN MUMBAI: REVIEW OF ITS IMPLEMENTATION

The study attempts to contribute to building evidence for health systems response to violence against women (VAW) by -

- i. Assessing the extent to which various components of the Dilaasa model have been replicated in 11 peripheral Municipal hospitals of Mumbai.
- ii. Documenting the problems (if any), encountered by 11 hospitals in establishing a health sector response; the strategies adopted by them in overcoming problems and the processes adopted to make the model functional on a day-to-day basis.
- iii. Identifying the strategies that played a role in scaling up of the Dilaasa model in 11 Municipal hospitals.

ACTIVITIES CONDUCTED

- **Seeking approvals from Municipal authorities:** Dilaasa Crisis centres are integrated into the government's National Urban Health Mission (NUHM 2015 - 2016) in Maharashtra and are now in the process of being scaled up in 11 public hospitals in Mumbai by the Municipal Corporation of Greater Mumbai (MCGM). Any research on Dilaasa centres requires permission from the Deputy Executive Health Officer (DEHO) of the NUHM. The proposal, objectives, relevance of such a research study, expected outcomes and policy implications were presented to the authorities followed by submission of tools, consent forms and protocols for research as well as ethics approval procedures. A review of these documents was deemed satisfactory and CEHAT received the permission to go ahead with the research. The 2nd stage included seeking approvals from the respective hospitals and that too was completed successfully.
- **Sampling:** Since the project has a mixed-methods approach, efforts were made to identify the sampling frame and sample size for each method. We also had to be mindful of the fact that resident medical officers are transferred every 6 months and hence the design of the survey and a post-survey at 3 months' follow-up had to be developed to capture their knowledge, attitudes and practices (KAP) related to VAW response. The survey will be administered by researchers and the information will be taken from the health care providers (HCPs) (doctors and nurses) and Dilaasa counsellors.
 - To review the health sector response to VAW in 11 peripheral hospitals, a survey will be carried out covering the essential components of the Dilaasa model. This will use the indicators laid down by WHO (2017) on strengthening health systems response. In addition to these indicators, some context-specific qualitative strategic components in the form of vignettes will also be included in survey.
 - The sampling frame consisted of 1 counsellor and 13-15 providers at each of the 11 facilities. We identified the sample of counsellors (1 from each facility), who will be identified based on the higher number of years of experience. Since providers are not always available to participate, we over-sampled to accommodate non-response from some of the HCPs.

- In-depth interviews with survivors receiving services from 11 Dilaasa centers will be conducted. This is essential to document the extent to which such a health systems response is acceptable, beneficial and meeting the needs of women. The sample size is 22 (2 from each facility) and we will use purposive sampling to identify participants whose experience of Dilaasa will be best suited to enhance our understanding.
- In-depth interviews with counsellors of the Dilaasa centres will be conducted to understand the day-to-day functioning of the centre in the context of problems faced and strategies developed to overcome them.
- **Visit to OSC centre:** A study visit was organised by CEHAT team, to the OSC centre at KEM hospital in Mumbai which became functional in November 2019 under a scheme of the Ministry of Women and Child Development (WCD), Government of India. This was done to learn from their experience of being a hospital-based centre like Dilaasa. The team found that the implementing agency is an NGO called SNEHA in Mumbai. The guidelines require a team of 14 people at each OSC and SNEHA's HR manages recruitment and duty hours which currently runs on a rotation. They get cases referred from KEM, Police and a pre-existing SNEHA helpline which is still functional even though the physical station at KEM has been discontinued.
- **Finalising tools and consent forms:** CEHAT has submitted the research proposal to its Institutional Ethics Committee (IEC) and obtained feedback. The tools and consent forms have been approved with minor changes. Translation of tools was undertaken and these were approved by the IEC

FUTURE PLANS

The data collection was to be initiated by March 2020 but given the COVID situation and the subsequent nation-wide lockdown, data collection could not be initiated. So, we have now adapted to the context and are prioritising other elements of the research study – qualitative aspects such as interviews of One Stop Crisis (OSC) centre teams, documenting and analysing the role they played in VAW and analysis of the aggregated data of these centres.

8. STRENGTHENING HEALTH SYSTEMS' RESPONSE TO VIOLENCE AGAINST WOMEN BY IMPLEMENTING WHO CLINICAL AND POLICY GUIDELINES

CEHAT's decade long work on advancing the health sector response to VAW contributed in development of WHO's clinical and policy guidelines on "Responding to intimate partner violence and sexual violence against women" for low and middle income countries in 2013. These guidelines provide evidence based guidance to equip healthcare providers (HCPs) in providing care to survivors especially in LMICs. However, there are several gaps in understanding how low middle income countries like India can implement these guidelines. Considering our work on VAW, WHO Geneva approached CEHAT to test approaches to roll out these guidelines in two tertiary hospitals of Maharashtra, India. This collaboration provided a strong base to negotiate with medical colleges for implementation of the project.

This project aims to establish how systems approach which is about creating a supportive ecosystem within the health facility can enable HCPs to identify and provide first line support to women facing violence. The strategies that were used to create an enabling environment include addressing barriers faced by HCPs, building capacity of HCPs, and establishing protocols for care. The project was carried out in two tertiary hospitals of Maharashtra, India.

The intervention included training of healthcare providers and introduction of system level changes like establishing standard operating procedures, models of care, introducing documentation registers etc. The research component comprised an assessment of knowledge, attitude and practice (KAP) of providers through a survey administered at pre, post and post – 6 months training.

ACTIVITIES CONDUCTED

- **Follow-up training of HCPs:** The follow-up trainings were organized 6 months post two day training, from February 2019. These were half day trainings where post – 6 months knowledge, attitude and practice (KAP) tool was administered to participants. The tool was administered before the initiation of follow-up training. The

content of the refresher training was developed based on preliminary findings of KAP survey of pre and post-training and analysis of documentation of cases of violence. CEHAT team found that there is less change in knowledge and attitude of providers on issue of sexual violence. Also, we found that trainees were identifying the most obvious health complaints of VAW such as assaults, attempt to suicide, rape and are missing out covert signs of VAW. Hence, the follow up training at 6 months was primarily focused on myths related to sexual violence, legal mandate of healthcare providers, detecting covert signs of VAW and hands-on documenting cases of violence. These trainings were conducted by selected healthcare providers who were trained as trainers.

Out of 220 providers who responded to KAP survey during pre and post-training, 201 were there for post – 6 month KAP survey. Thus, there was a loss to follow-up of 19 providers at post – 6 months assessment. Transfer of providers from one health facility to other was the most common reason for loss to follow-up.

- **Qualitative data collection:**

The qualitative data collection was completed in month of November and December 2019. A total of 28 in-depth interviews and 2 focus group discussions with providers were done in this period. Additionally, 10 survivors who received support from healthcare providers were also interviewed. For in-depth interviews with healthcare providers, stratified sampling was used to have equal representation of HCPs of different departments, age group, cadre, designation, and years of experience. A list of providers was prepared based on this stratification and appointments were sought for interview. In case of survivors, a list was prepared by CEHAT team where safe contact details were available. This list was given to social worker of each health facility to make first telephonic contact for study and seek oral consent. The second telephonic contact was made by CEHAT staff to schedule interview with the survivors.

Several mock interviews were conducted to practice interview guide before formal data collection. It helped to develop skills to frame questions clearly and efficiently considering time constraints of providers. Research team faced challenges in organizing interviews with women survivors. The safe contact details were available for only 50% of documented cases. Further, most of phone numbers were either switched off or out of service. The research team contacted about 150 women to arrange interview with 10 women.

As a best practice, we decided to transcribe all the interviews in original language and then translate into English. At present, team is involved in transcribing, translating interviews and checking of transcripts. The codebook development, generation of query reports and discussion of the structuring of findings will be done by April.

- **Video documentation of the project:**

Under this project, we planned to commission a 3 to 4-minute video telling narrative story of why health sector response to domestic violence in Indian hospitals is needed, what training was conducted, what changes are being observed in the practices and attitudes of providers and any changes in the hospital facilities to be able to provide better services to survivors of domestic violence.

The video was conceived with purpose of informing policy makers, Ministry of Health, Women and Child Development, donors/ UN agencies in India as well as globally, other NGOs including international NGOs operating in India and globally such as CARE, Gates Foundation, FPAP, IPPF as well as national and local community based NGOs providing health and other services to women affected by violence.

CEHAT invited bids from experts and based on expertise and experience of working on issue of VAW, we contracted this project. CEHAT team-oriented expert about project and briefed about expectations from the assignment. Meetings were organized with expert team to develop a story board of what the narrative will convey, develop a list of stakeholders to be interviewed on video, and develop an interview guide.

The finalized video was featured as a web story on WHO website on the occasion of the International day on the Elimination of Violence Against Women (<https://www.who.int/news-room/feature-stories/detail/indian-health-workers-transform-care-for-women-survivors-of-violence>). Further, we are

planning to use this video for dissemination of project in various forums.

- **Data analysis of KAP survey:**

A considerable amount of time was spent on analysis of KAP data. Reverse coding of some items was carried out according to desired responses. Normal distribution was also checked to determine the statistical test for analysis. Test like McNemar and Wilcoxon signed ranked test were used to measure the change in KAP of proportion of participants at different points of time. Paired sample t- test was also done to analyse the change in mean score domain wise as well as question wise. A multivariate Generalised Estimating equation Model was also created to measure change in KAP by taking into account age, sex, cadre, site and designation of providers. At present, team is working on a manuscript based on KAP data.

- **Manuscripts writing workshop:**

A three-day manuscript writing workshop was organized in Mumbai in month of September. The purpose of this workshop was to discuss and review process for manuscript development and submission for peer-reviewed publication. In this workshop, selected trainers from both the sites also participate in addition to CEHAT and WHO team members. We analysed sample publications (qualitative, quantitative and mixed methods) to inform development of manuscripts for this project. The workshop was instrumental in mapping out three publication from this project. We discussed target journals, outlined the manuscripts, assigned responsibilities and decided timelines.

- **Conferences:**

In October, 2019, we presented our experience of implementing this project in Sexual Violence Research Initiative Forum, Cape Town. Trainers from both the hospitals along with CEHAT and WHO team got opportunity to share learnings from this project in panel on “Gender based violence care and support”.

Recently, we contributed an abstract in an organised session on “Innovations in strengthening health systems preparedness to address violence against women – learnings from providing accessible, quality, and gender-responsive services” proposed by WHO for upcoming Global Symposium on Health Systems Research. The abstract for organised session has been accepted and this will be a good opportunity for us to bring the issue of violence against women on health systems agenda.

An abstract based on analysis of cases documented by healthcare providers has been submitted in Federation of Gynecology and Obstetrics (FIGO) regional conference. The abstract informs the presenting signs and symptoms of women indicating violence and various support services provided by providers.

FINDINGS

The analysis of KAP survey has shown a significant increase in mean scores of knowledge, attitude and practice of providers at post- training. A decrease in KAP scores was found at 6-months post- training which was not significant. At 6 months post-training, 72.1% of HCPs identified at least one survivor of violence in last 3 months, compared to 48.8% in the pre- training. A significant number of HCPs referred survivors to external support services at 6 months post- training as compared to 51% before training.

The trained HCPs were able to identify and respond to 531 women facing violence in a period of 9 months. In 53.9% of cases, providers proactively asked women about violence. One-third of cases came in OBGY with primary complaint of pain in abdomen. Majority of women presented with complaints of suicide attempt (33.3%) and injuries (32.2%). Women reported emotional as the most common form of violence (73.6%). The first line support which includes listen, inquire, validate, enhanced safety and support (LIVES) was provided to women in 26.9% of cases while in rest providers only listened and inquire about violence.

The GEE model indicated that change in scores from pre training to post training was significant for Knowledge, Attitude, and Practice, and this change was sustained over 6 months for all three measures. Significantly lower KAP scores were observed for medicine department and older age groups relative to Gynecology department and less than 25 years age group respectively.

FUTURE PLANS

Based on finding that majority of healthcare providers were not able to do safety assessment, planning and provide support services to women, one of the implications is to have a separate cadre or train nurses or social workers in hospital to provide counselling services to women. Further, during qualitative data

collection nurses suggested to train few selected nurses who are willing to provide counselling to women. Considering this, we have planned a two day training of nurses in Mumbai in March on providing counselling to women. This training of nurses will ensure that survivors get all support services before leaving health facility. The sessions which are planned for this two day training include principles of counselling, understanding social structures, safety assessment, planning, and response in specific case examples with medical complaints indicating violence.

We are planning to organize dissemination workshop of the project at national and state level in month of June. A research brief based on this project will be released during these workshops to engage with government officials, healthcare providers, international organizations and non- government organizations working on issue of violence against women.

PUBLICATIONS APRIL 2019 – MARCH 2020

Papers/ Articles:

Mistreatment of women in the labour rooms of India: A call to action. By Vernekar, Durga & Rege, Sangeeta. Medico Friend Circle Bulletin, 382, February 2020, pp. 56-58

<http://www.cehat.org/uploads/files/Mistreatment%20of%20Women%20in%20the%20Labour%20Room%20of%20India%20A%20Call%20to%20Action.pdf>

Denial of safe abortion to the survivors of rape in India. By Rege, Sangeeta & Bhate-Deosthali, Padma. Health and Human Rights Journal, 21(2), December 2019, pp. 189 – 198

<http://www.cehat.org/uploads/files/Denial%20of%20Safe%20Abortion%20to%20Survivors%20of%20Rape%20in%20India.pdf>

Effectiveness of a counselling intervention implemented in antenatal setting for pregnant women facing domestic violence: a pre-experimental study. By Arora, Sanjida, Bhate-Deosthali, Padma & Rege, Sangeeta. British Journal of Obstetrics and Gynaecology, August 2019, pp. 1–8.

<http://www.cehat.org/uploads/files/Effectiveness%20of%20a%20counselling%20intervention%20implemented%20in%20antenatal%20setting%20for%20pregnant%20women%20facing%20domestic%20violence%20a%20preexperimental%20study%281%29.pdf>

Integrating gender perspectives in gynecology and obstetrics: Engaging medical colleges in Maharashtra, India. By Rege, Sangeeta, Bhate-Deosthali, Padma, Shingare, Pravin, Gadappa, Srinivas, Deshpande, Sonali, Gaikwad, Nandkishore & Vaidya, Shailesh. International Journal of Gynecology and Obstetrics, 145, May 2019, pp. 253–257.

<http://www.cehat.org/uploads/files/Integrating%20gender%20perspectives%20in%20gynecology%20and%20obstetrics.pdf>

Books/ Reports:

Understanding fate of institutions: Grand Medical College and Sir Jamsetjee Jejeebhoy Hospital Foundation, renown and decline. Anusandhan Trust's Ninth Krishna Raj Memorial lecture on contemporary issues in health and social sciences. By Pandya, Sunil K. May 2019, CEHAT, eSocial Sciences, Department of Medical Humanities, Seth GSMC, KEM and FMES, vii, 19 p.

<http://www.cehat.org/uploads/files/KR%209th%20final.pdf>

Disrespect and abuse during childbirth: An annotated bibliography. By Vernekar, Durga, September 2019, CEHAT, vii, 59 p.

<http://www.cehat.org/uploads/files/Disrespect%20and%20abuse%20during%20childbirth:%20An%20annotated%20bibliography.pdf>

Violence against resident doctors in Maharashtra: Their perspective on occurrence, consequences and redressal mechanisms. By Barai-Jaitly, Tejal; Bhate, Kamaxi; Kabra, Yashowardhan & Katre, Rajesh September 2019, CEHAT, KEM and MARD, xiii, 94 p.

<http://www.cehat.org/uploads/files/Violence%20Against%20Resident%20Doctors%20in%20Maharashtra%20Their%20Perspective%20on%20Occurrence%20Consequences%20and%20Redressal%20Mechanisms.pdf>

Mistreatment of women in labour – Perceptions of Health care providers. September 2019, CEHAT
<http://www.cehat.org/publications/indexlist/1/Books/Reports>

Chapter in a Book:

Nature of services available to women survivors: One Stop Crisis Centers - Review and Recommendations. By Bhate-Deosthali, Padma and Rege, Sangeeta In Conflict in the shared household: Domestic violence and the Law in India By Indira Jaising and Pinki Mathur Anurag (Eds.), Oxford University Press, May 2019, pp. 342-360.

<http://www.cehat.org/uploads/files/Nature%20of%20Services%20Available%20to%20Women%20Survivors%20one%20Stop%20Crisis%20Centres-%20Review%20and%20Recommendations.pdf>

Media coverage:

GMCH module on gender perspective wins top award.

Author(s): Sharad, Arpita | Date: 2019, May 1 | Source: The Times of India

<https://timesofindia.indiatimes.com/city/aurangabad/gmch-module-on-gender-perspective-wins-top-award/articleshow/69119691.cms>

„2-finger virginity test“ to be erased from Maharashtra syllabus.

Author(s): Debroy, Sumitra | Date: 2019, May 8 | Source: The Times of India

<https://timesofindia.indiatimes.com/city/mumbai/2-finger-virginity-test-to-be-erased-from-maharashtra-syllabus/articleshow/69226324.cms>

60% of doctors in Maharashtra hospitals have faced violence: Study

Author(s): Iyer, Malathy | Date: 2019, June 18 | Source: The Times of India

<https://timesofindia.indiatimes.com/city/mumbai/60-of-doctors-in-maharashtra-hospitals-have-faced-violence-study/articleshow/69834444.cms>

What hospitals can do to curb attacks on resident Doctors

Author(s): Barai - Jaitly, Tejal | Date: 2019, June 17 | Source: TheWire.in

<https://thewire.in/health/kolkata-doctors-attack-protests>

PMJAY scheme in Maharashtra: 10 lakh families issued e-cards, fewer hospitals empanelled in remote areas

Author(s): Barnagarwala, Tabassum | Date: 2019, August 2 | Source: The Indian Express

<https://indianexpress.com/article/india/pmjay-scheme-10-lakh-families-issued-e-cards-fewer-hospitals-empanelled-in-remote-areas-5871222/>

Suicides are preventable if a Multi-sectoral strategy is evolved

Author(s): Pathare, Soumitra; Kalha, Jasmine | Date: 2019, September 10 | Source: The Wire.in

<https://thewire.in/health/suicide-prevention-mental-health-intervention>

Indian health workers transform care for women survivors of violence

Author(s): | Date: 2019, November 25 | Source: World Health Organization

<https://www.who.int/news-room/feature-stories/detail/indian-health-workers-transform-care-for-women-survivors-of-violence>

Find a better alternative

Author(s): Majumdar, Swapna | Date: 2020, January 10 | Source: The Pioneer

<https://www.dailypioneer.com/2020/columnists/find-a-better-alternative.html>

The reasons why 63 Indian housewives killed themselves every day in 2018

Author(s): Kajal, Kapil | Date: 2020, February 19 | Source: Scroll.in

<https://scroll.in/article/953545/the-reasons-why-63-indian-housewives-killed-themselves-every-day-in-2018>

Other Materials:

Counsellor Diary in English (Reprint) – September 2019

Dilaasa visiting cards with 13 hospitals address – January 2020

YouTube Links:

Strengthening health systems response to violence against women in Indian hospitals. 2019, November 18, By World Health Organization

<https://www.youtube.com/watch?v=GaMx1O4qrEs&feature=youtu.be>

Submissions to international institutes:

Submission for call by UN Special Rapporteur on Violence Against Women. Submitted to United Nations Human Rights Office of the High Commissioner. CEHAT, May 2019, 7 p.

<http://www.cehat.org/uploads/files/UN%20Special%20Rapporteur%20Call%20for%20submissions%20Mistreatment%20and%20violence%20against%20women%20during%20reproductive%20healthcare%20with%20a%20focus%20on%20childbirth.%281%29.pdf>

SATHI: - Support for Advocacy and Training to Health Initiatives: Action Centre of Anusandhan Trust

1. RESEARCH

Project Title - Building Evidence, Strengthening Action for a Sustainable and Generalisable Model of Community Accountability of Health Systems in Maharashtra, India

Funding Agency: Accountability Research Centre

Reporting period- April 2019 to August 2019

Goal: Building evidence, strengthening action for a sustainable and generalisable model of Community accountability of Health systems in Maharashtra, India

Component 1: Research- Measuring and Explaining Outcomes in Public Healthcare Provision

Objective 1: To undertake study for assessing and explaining the impact of CBMP across multiple contexts in the state of Maharashtra

Key activities

- Primary data collection for CBMP study completed on 14th May 2019
- Data entry and transcription for entire data has been completed by end of May 2019
- Preliminary analysis of RKS and VHSNC survey data was conducted for the presentation in session at COPASAH, October 2019 at Delhi, on multi-stakeholder bodies
- Research brief was prepared and disseminated in state level workshop in February 2020, key findings were also made during the same workshop. The workshop was attended by key officials, CSOs implementing CBMP, some block level officials as well as some experts from national level

Project Title - Practices, regulation and accountability in the evolving private healthcare sector: lessons from Maharashtra State, India

Funding Agency: Medical Research Council

Reporting period- April 19 to June 2019 (3 months)

Goal: Understanding transformation of evolving private healthcare sector in last two decades and impacts for the medical sector in Maharashtra, India

Key activities

1. Dissemination of work- two team members attended the conference at Oxford
2. Meeting at KCL regarding project closure
3. Working in progress for two research papers
4. Data storage was accomplished
5. Reports to KCL were prepared for funder

2. INTERVENTION AND SERVICE PROVISION

Project title- Community based monitoring and planning process

Funding Agency – National Health Mission (NHM), Maharashtra

Reporting period: April 2019 to March 2020

Project Area: Implementation of CBMP process in existing 886 villages, 180/189 PHCs, 28 blocks, 13 Districts with 23 organisations in Maharashtra.

Key Interventions-

- Participatory audit and planning (PAP) of RKS funds was undertaken in 180 PHCs from 13 districts where all PHCs from each existing block.
- Focus for the entire year was on improving indicators: High risk ANC mother tracking till her delivery; VHSC strengthening with the focused programs in the village.

- After data collection it was used for Local advocacy, consensus building for problem solving related to local bodies like VHNSC and RKS.
- One specific area of action Improvement in the ANC related services and verification of JSY and PMMVY by VHNSC.

Major activities done in FY2019-2020:

- 2 State level review and planning meetings with all field partners.
- 1 State level workshop on strengthening documentation of field partner organizations.
- Capacity Building workshop for field level accountants.
- Participation and presentation of CBMP activities in State Mentoring committee (SMC)
- State level workshop on Community Action for Health (CAH)
- Regular and continuous supportive supervision through field visits by SATHI team members in CBMP covered areas.
- Publications – Two CBMP update and Reprint of awareness material for partners.
- Developed draft proposal as – Proposed framework for community accountability and action ensuring Health care and Health promotion under Ayushman Bharat programme.

Documentation and reports published

- Report on interventions related to Arogyasabha in the CBMP field.
- Collection of case stories from various districts, blocks and PHC's.
- Various key reports on e.g. workshops, TOT, state level review and planning meeting,
- Report on the status of HWCs gathered through Google doc.

Project title- Building evidence, strengthening action for a sustainable and generalisable model of Community accountability of Health systems in Maharashtra, India

Funding Agency – Accountability Research Centre

Reporting period: April 2019 to March 2020

Key activities -

Block level activities-

- Completed preparatory work for conduction of Multi-sectoral Social Audit process-
 1. Conduction of village meetings for consolidating Social Audit Facilitation Group (SAFG) in 30 intervention villages.
 2. Orientation to SAFG on Multi-sectoral Social Audit process.
 3. Collection of information related to various social schemes under Health, Nutrition and Education for social audit.
- Field level interventions were completed in 3 districts where village and block level public dialogues were conducted between various stakeholders.

State level activities

- Field visits done and inputs were given to partner organizations during preparatory phase and conduction of the social audit processes.
- The SATHI action team provided support in the form of building capacities, developing formats and have had a supportive supervision for taking forward SA process at field level.
- The SATHI action team participated in capacity building workshops; visited each field area during trainings of SAFG; with focus on physical verification and public dialogue.
- SATHI team completed multi-sectoral SA- related documentation process in all field area.

Publication output-

1. **Training module on Social Audit** for local activists
2. Flex posters exhibition on **understanding the concept of social Audit**
3. Flex posters exhibition on **entitlements related to Public Distribution System**
4. Flex posters exhibition on **entitlements related to nutrition scheme**
5. Flex posters exhibition on **entitlements related to Right to Education**

6. Flex posters exhibition on **entitlements related to Panchayats**
7. Initiated preparing a **compiled booklet on list of entitlements and formats for obtaining data from service providers in 12 social schemes under 5 sectors** such as Health, Education, Nutrition, Tribal development and Rural Development.
8. Block wise flyer on SA process documentation for three blocks.
9. State level flyer on learnings and challenges of SA process.

Project title- Integrating social mobilisation with budget work to strengthen Health and Nutrition entitlements for tribal communities in Maharashtra.

Funding Agency -International Budget Partnership

Reporting period: November 2019 to March 2020

Objective 1 – Unpacking the Public Finance Management Issues underlying Service Delivery Gaps of AAY

Key activities-

- With the involvement of key representatives from the agency groups (CBOs and Anganwadi), SATHI and NRC member organizations developed a framework for the documentation needed to unpack public finance management issues. SATHI team developed a list of the key stakeholders to be interviewed at district, block, bit and villages level. The designed documentation template was used for unpacking critical issues and challenges of the service delivery and PFM, AAY.
- SATHI gathered information from across 3 tribal districts (3 blocks; each consisting of 9-15 villages and 18-30 anganwadis) in Maharashtra.
- Interviews were conducted with nodal government officials, VNC members, Anganwadi workers, PRI members.
- Based on this documentation a state level flyer was developed.

Objective 2: Generating Evidence and Feedback on AAY using the CBMP Approach

Key activities-

- **Training of Trainers:** A state level training of trainers was conducted with participants from local civil society organizations actively involved in the NRC from three selected intervention districts. The training was focussed on AAY entitlements, service delivery and Public Finance Management (PFM of AAY).
- The trainers from the local CSO partner played a critical role for strengthening the capacities of members of CBOs and anganwadi workers at the village level. Selected CBOs being NRC member organizations with grounded presence in the intervention areas they conducted responsibility of facilitating the process in villages.
- SATHI worked with NRC member organizations at the block level.
- Three block level trainings were organised for CBOs and Anganwadis with the support from block level trainers. Main focus of the training was on the AAY programs entitlements for tribal women (pregnant and lactating) and children, how these entitlements are delivered and realized, and what could be AAY's service delivery and budgets issues. The trainings were to build capacities of the agency groups, and to support tribal communities to gain awareness about their entitlements so that they are able to mobilize to claim these entitlements under AAY.
- Adopting the CBMP Approach, SATHI collaborated with CBOs and other NRC member organizations to spread awareness on AAY entitlements among the tribal communities, particularly focusing on empowering the VNCs and anganwadi across 30 villages in three districts.

Objective 3: Analysing and disseminating Findings to the Community to Inform Social Action.

Key activities

SATHI has developed a state and three district level flyers based on the information. Issues related to AAY were shared with state and district level officials through district CBOs and agency group.

Project Title - Continuation of State and sub-national level capacity building initiatives for Mass Organizations towards building and strengthening Health Rights action in Maharashtra and Bihar

Funding Agency - Association for India's Development (AID)

Reporting period- April 2019 to March 2020

Goal: Enabled creation of a new team of grassroots CSO activists, and the Health Rights work initiated in their field areas.

Objectives:

- Providing technical and strategic inputs to mass organizations working in Maharashtra, focusing on continuation of ongoing health rights activities with exploring advance strategies and mechanisms towards deepening and expanding community accountability processes in Maharashtra
- Enhancing capacities of activists of JJSS in addressing more complex health system issues which require multi-level advocacy skills, including engaging exiting democratic bodies and institutions.

Key activities

1. **Capacity building workshops/meetings of activists** for understanding concept of multi-sectoral monitoring and evolving methods/mechanisms for the same were conducted in two districts i.e. Thane & Palghar.
2. **The process of Multi-Sectoral Social Audit process has been started with identification of village level groups for implementation of SA process** on selected schemes under various social services like **Health, Education, and Nutrition. Van Niketan** focussed on health (Pradhan Mantri Matrutv Vandana Yojana and Janani Surksha Yojana), Nutrition (Amrut Aahar Yojana) and Education (Sarv Shiksha Abhiyan). **Arohen** focussed on Health and Nutrition.
3. **Mass awareness activities** for orientating community and various local key stakeholders about multi-sectoral monitoring and planning process were conducted
4. **One round of activities was conducted related to multi-sectoral monitoring and planning process** which include mass awareness; evidence collection of issues/gaps and Public dialogue between community and key concerned officials.
5. The **information from service providers** was mainly in the form of **number and name of beneficiaries, kind of benefits given, period of benefits given** etc.
6. After receiving information, it was verified by **village level SA group where group had conducted interviews of beneficiaries; Focal Group Discussion and visit to public institution** etc.

The issues were emerged from the physical verification were raised in the village level dialogue between community including beneficiaries and services providers.

Project Title: Community Action for Nutrition, supported by Tribal Development Department

Funding Agency: Tribal Development Department, Maharashtra

Reporting period: April 2019 to March 2020

Goal: Ensuring a positive situation in tribal communities of Maharashtra, where nutrition related awareness, linkage of communities with health and nutrition services based on participation and accountability processes, and household nutrition practices are optimally developed, to minimize child malnutrition and its consequences.

Scope of the project – 10 tribal blocks in Maharashtra, 420 habitations,

Estimated tribal children monitored – Around 22000

Objective 1: Community Action for Nutrition (CAN) Project will spread awareness about the Bharat Ratna Dr. A.P.J Abdul Kalam Amrut Aahar Yojana. For the implementation of the Amrut Aahar Yojana in the project area, Rural Health, Nutrition, Water Supply and Sanitation Committee, Nutrition Committee and Mata Samiti will be made active.

Key activities:

- Awareness campaigns for community's awareness regarding rights and entitlements related to nutrition were conducted in 420 tribal villages using large printed flex of growth charts through Poshan Hakka Gat at village level with members of VHNSC, Mata Samiti and Ahaar Samiti. Community members identify gaps and try to address them through dialogue with concerned authorities. It results in better quality and regularity of food, and its higher utilisation in various schemes.
- Monitoring of the functioning of the nutrition & AAY services through Village Level Poshan Hakka Gat.

Objective 2: During this project the number of children with severe child malnutrition and moderate

child malnutrition will be reduced by up to 20%. The prevalence of growth faltering will be reduced by up to 25% in children below the age of 6 years. The improvement rate in the children in the severe and moderate category will be increased by up to 25%. Malnutrition related child deaths will be reduced by up to 15%.

Key activities:

- Monthly anthropometry of all the children under six years of age is being conducted regularly in all the 10 blocks. Based on these anthropometric measurements malnourished and growth faltered children have been identified and their follow up has been done on regular basis.
- As a result, among many other areas of improvement, the number of children receiving referral service, has increased by up to 50%.

Outcome: Positive changes achieved:

- From June, 2019 to March, 2020, the percentage of SAM children reduced from 5.2% to 2.5% (52.2% reduction) and the percentage of MAM children reduced from 14.3% to 8.3%. (41.7% reduction)
- From June, 2019 to March, 2020, the percentage of SUW children reduced from 14.1% to 8.9% (36.9% reduction) in SUW children has been observed.

Objective 3: The number of pregnant women, lactating mothers and children registered under Amrut Aahar Yojana will be increased up to 90% and the consumption of the meals will be increased up to 80%. In order to understand the current situation of this service, a data compilation model will be developed based on public participation. On this basis the information about the beneficiaries of the Amrut Aahar Yojana will be made available, according to the villages, to the Tribal Development Department. After the completion of the process, this model can be made universal in all the tribal districts

Outcome, positive changes achieved in Bharat Ratna Dr. APJ Abdul Kalam Amrut Ahaar Yojana (AAY)

- Despite some funds related issues, AAY has been functional for mothers on average in 400 village/habitations. Whereas, AAY has been functional for children on average in 392 habitations.
- Pregnant and lactating women were not consuming AAY in the Anganwadi, but now they come to the Anganwadi every day.
- The quality of AAY has improved. Instead of only rice and vegetables, women now receive the full meal regularly in Junnar, Karjat, Armori, Kurkheda, Jawhar, Mokhada, Shahada, Dhadgaon, Tyambakeshwar.
- Due to regularisation of AAY, children are now receiving eggs regularly.
- In the area of CAN process, AAY has been functional for mothers in 400 village/habitations. Whereas, AAY has been functional for children in 392 villages/habitations. Quality of AAY meal has been improved. Pregnant and lactating women started eating AAY meal in Anganwadi.
- Total 8368 issues regarding Nutrition services (AAY and ICDS) emerged through CAN process. Out of these 5465 issues i.e. two third (65.3%) issues got resolved through local coordination.

Objective 4: The process will also identify severe stunting (Low height for age, below -3 z score) and moderate stunting (Low height for age, between -2 z and -3 z score) and provide counselling to prevent it.

Outcome, positive changes achieved in Bharat Ratna Dr. APJ Abdul Kalam Amrut Ahaar Yojana

- CAN process ensures that all the children under the age of 6 years in the habitation are registered and hence the attendance is maximized at Anganwadi while reaching out to migrant, remote, marginalized households.
- ASHA is trained and involved for *weekly visits to each and every malnourished child*, counselling mothers for improved household nutrition
- Monthly anthropometry of all children is carried out *in presence of mothers / parents* and their nutrition status is accurately rated, reported while *eliminating any under-reporting of malnutrition*.
- *Intensive follow up of malnourished children through ASHA has been done on regular basis*, including referral of severely malnourished children for treatment has also been done.
 - **Follow up of high-risk pregnant mother** - Follow up of 4200 episodes of pregnant women out of total number of episodes 6247 has been done during Dec 19 to March 2020. Referral has been given in 2690 episodes. Out of which 828 episodes were high risk mothers. Due to CAN process average 200 plus high-risk mothers have been ensured for required health services.

Documentation and reports:

- Poshan Kuposhanache „SAKAS“ Samvad Patra - We regularly publish one newsletter for CAN process. Previously title of this news letter was „We CAN Poshan Nirdhar Manthan“ since November 2019 it has been changed and currently it is „Poshan Kuposhanache „SAKAS“ Samvad Patra“. The first issue has been published which contains positive stories of change for the month of April, 2019. „Total 9 issues of the newsletters have been released.

Project Title - Building Community Awareness and Action to Improve Child Nutrition Practices and Services in Selected Tribal, Rural and Urban areas of Maharashtra (From April 2019 to August 2019)

Funding Agency: Bajaj Holdings Investments Limited (Bajaj CSR)

Reporting period: April 2019 to March 2020

Objective wise output, key successes achieved in this year.

Objective 1: Enhanced capacity development of 120 ASHAs/Poshan Sakhi, around 120 Anganwadi workers, 20 block facilitators and coordinators in project areas.

Key activities:

- Regional Training of Trainers (TOT) has been conducted with the level of knowledge was measured to increase from 54.4% prior to training to 80% after the training.
- The block level training of the ASHA/Poshan Sakhi and Anganwadi workers has been completed
- Mobile app related orientation and training of all field facilitator and block has been completed.

Objective 2: The overall percentage of severe under nutrition would be reduced by up to 6%, among under 6 children in project areas.

Key activities:

- Anthropometry is being conducted monthly with the follow up of malnourished children in the Bhor, Velhe and Dharni blocks. **(91% till date).**
- As per the reports received in the month of August-September, 70 SAM children, 389 MAM children, 489 SUW children and 1266 MUW children have been identified and their follow up is currently in progress.
- During these follow ups, counselling of the family of the child is done with demonstrations of nutritious recipes. If the child needs medical care, the child is referred to the Nutrition Rehabilitation Centre (NRC) or the nearest healthcare facility.
- The block wise details of the number of malnourished children identified and followed up are given in the table below.

Outcome, key positive changes:

- The percentage of malnourished children has been reduced from 9.9% (October 2019) to 4.8% (February 2020) --- (51.5% reduction in malnutrition)
- The percentage of underweight children has been reduced from 30.4% to 23.4% showing (23% reduction)

- **Objective 3: Prevalence of growth faltering will be identified and appropriate action will be taken.**

Key activities:

- Regular Anthropometry has been completed and the follow up of malnourished children has been done in the Bhor, Velhe and Dharni blocks. As per the reports received so far, 758 children have been identified as growth faltered in the month of October and November 2019. The follow up for these children has been done and out of these children status of 423 children has been improved.
- In December 2019 and January 2020 total 493 have been identified as growth faltered. The follow up for these children has been done and out of these children status of 270 children has been improved.

Objective 4: In project areas, activity of key grassroots stakeholders [Village Health, Nutrition, Water Supply and Sanitation Committee members / Mothers committee members [Under WCD] and PRI representatives towards improving nutrition services and entitlements in their habitations would be significantly increased. In 30% villages of the project area the committees

will be activated.

Key activities:

- „Poshan Hakk Gat“ has been formed in all the 120 habitations of Dharni, Bhor and Velhe blocks. Regular meetings for these Gats are going on regularly on monthly basis.
- Meetings have been conducted with the PRI members of the Bhor and Velhe blocks. PRI members“ workshop has been conducted in the Bhor block as well as in Velhe block. To increase participation of PRI members including various community members at village level for resolving nutrition service and household nutrition practice related issues, workshop has been conducted in the Dharni block.
- To increase community participation, community awareness and education as part of the process of strengthening nutrition services prepared big size flex growth chart to use it in the community level campaign twice.
- In Dharni block, the village of Gaulandoh has taken an initiative to make their village malnutrition free. In order to achieve this goal, the Sarpanch of the village also joins Asha worker during some of the follow up visits to the families of malnourished children.

Objective 5: Improved quality of supplementary feeding by Anganwadi for 3 to 6 years old children, with up to 10% caretakers reporting improvement in following intervention.

Key activities:

- Total 201 cases of improvement in the of supplementary feeding by Anganwadi for 3 to 6 years old children have been reported from all three blocks during September 2019 to February 2020.
- In all 120 habitations supplementary food has been served twice a day in all the anganwadi centres.
- Irregularity in distribution of eggs (Under AAY) to pregnant women, lactating mothers and children under six year of age have been corrected due to intervention of B-CAN process at 40 villages of Dharni block.
- Previously pregnant and lactating mothers usually did not eat AAY meal in Anganwadi. Now due to B-CAN process awareness all pregnant and lactating mothers have started eating their AAY meal in Angnawadi.
- Previously groundnut Chikki was distributed to children under „Dr. APJ Abdul Kalam Amrut Aahar Yojana“ and due to hardness, the children were not able to eat it. This issue was discussed with AWW across 40 villages and also discussed in the Gabha samiti which was held on 11th Sept. 19 now AWW has started distributing groundnut Shengdana Lado in all 40 habitations of Dharni of B-CAN.
- Rotten 30 eggs (under AAY Scheme) have been observed during the visit of B-CAN karykarta to Bhandlum village of Dharni block. This issue has been communicated to Sarpanch of Bhandlum as well as Additional CEO of Amravati. Through Addl. CEO“s intervention and Sarpanch“s instructions, action has been taken and eggs have been now replaced.
- The person appointed to cook the food for the Bharat Ratna Dr. APJ Abdul Kalam Amrut Ahaar Yojana is supposed to receive Rs. 1000 remuneration. The ladies preparing the food do not receive the payment on time. Furthermore, the honorarium of the meal helpers has not been received for the past 3 months. However, the Samiti regularly followed up with this issue, and as a result, all the honorariums and payments have been done at Dharni block.
- In Bhor and Velhe block concept of Matka Fridge has been implemented in 31 villages. (Bhor-10 and Velhe 21)

Objective 6: Improved nutrition practices among parents/caregivers of under 6 children in project area, with upto 10% caretakers demonstrating such improved practices.

Key activities:

- Total 419 Nutritional recipes demonstrations have been completed from September 2019 to February 2020 in all 3 blocks. Due to which people started preparing food or recipes accordingly at various places.
- Parents of 234 children have reported improved nutrition practices across all the three blocks due to follow up through B-CAN during September 2019 to February 2020.
- Follow up of undernourished children has been done for 2517 children in the month of October 2019 and 2318 children in the month of November 2019. Recipes demonstration has been given to these children“s family members.

- Follow up of undernourished children has been done for 2212 children in the month of December 2019 and 2156 children in the month of January 2020. Recipes demonstration has been given to these children's family members.
- In Bhore and Velhe block concept of Bal Kopalra has been implemented in total number of 191 villages (Bhore 80 villages and Velhe 111 villages)

Objective 7: Five Case studies will be documented

Key activities:

- Mission Poshan: Seven issues of newsletter „Mission Poshan“ of B-CAN process including these case studies have been published. These newsletters covered the stories of positive changes observed in the B-CAN area. The newsletters also included various types of articles related to nutrition in order to provide different types of information to the facilitators, Anganwadi worker and Asha worker of B-CAN in easy to understand language.
- Around 15 to 20 draft case studies have been received yet and 13 case studies have been successfully documented from the Bhore, Velhe and Dharni blocks. Dahinda Anganwadi story of Dharni block, Bhaginghar Kurkure Band story of Velhe block, Garodar va Stanyada Maata AAY Aahar story Dharni, Cleft Lip story Bhore total 4 case studies have been successfully documented.
- Two short films, namely, “Ahaar Vividhata” and “Utsav Vajan Vadhicha... Gaon Kuposhan Mukticha”, were filmed in the Dharni block and completed during December-January.
- The short film on Food Diversity was selected for screening at the Maha Arogya Film Festival organised by Public Health Department, Government of Maharashtra. The film festival was organised in order to make people aware regarding health-related issues as well as health related various schemes provided by the government.
- The screening of this film on Food Diversity was done on 29th February, 2020 at the Film and Television Institute of India (FTII) in Pune. The film was awarded Rs. 2000 cash prize as well as a certificate after the screening.
- Published flyer based on recent data of Building Community action for nutrition process (B-CAN) in the Month of March 2020.

Objective 8: To improve knowledge of Asha/Poshan Sakhi in intervention habitations, building capacities of 120 ASHA/Poshan Sakhi to facilitate community meetings regarding nutrition services, messages and counselling, follow up and health care support...

Key activities:

- The block level training of the ASHA/Poshan Sakhi was completed in the Bhore, Velhe & Dharni block during May to June 2019.

Objective 9: Mobile APP and portal regarding CAN process will be developed during implementation of first year of project.

Key activities:

- Mobile APP related to follow up of undernourished children has been developed recently and now it is functional. Mobile APP for collecting periodic data related to Nutrition services such as ICDS services and Bharatratna Dr. APJ Abdul Kalam Amrut Aahar Yojana has also been developed and functional.

Objective 10: Community sensitization on Nutrition issues in 120 habitations, series of monthly awareness building activities related to nutritional services and practices, conducted regularly over one year, across 120 habitations.

Key activities:

- Poshan Hakk Gat has been formed in all the 40 habitations of Dharni and Bhore blocks and in 40 habitations of Velhe block.
- Monthly meetings are being carried out regularly of this Poshan Hakk Gat during which discussions regarding nutritional services and practices are held regularly. During these discussions, the members are made aware of their entitlements, various nutrition specific schemes as well as ways to improve household nutrition. Community level issues regarding the nutrition services are also discussed during these meetings.
- Growth Chart campaign to create awareness about nutrition of under six children, first 1000 days and nutrition of Pregnant and lactating women has been done in 50% habitations of all three blocks.

Objective 11: Dialogue at block and district level with systematic community inputs on quarterly basis in 2 districts. Quarterly block and district level nutrition review meetings conducted with systematic community inputs.

Key activities

- One round of dialogue regarding nutrition services related issue is completed in Bhor, Velhe and Dharni block and some issues like vacant post of Anganwadi worker, repair work related to AWC, construction of new AWC, payment of Anganwadi worker related to AAY, distribution of new THR these issues were discussed and some of these issues get resolved in the block level dialogue.
- In Dharni block 7 meetings at block level with various officials including ICDS and Health has been conducted and 3 Gabha Committee meetings has been conducted yet. On July 6th Meeting regarding nutrition related issues was held with ICDS and Health officials such CDPO of ICDS, Health MS, and THO.
- Meeting regarding need for developing convergence and synergy between line departments such as ICDS and Health in presence of BDO, CDPO, THO, Anganwadi supervisor, RBSK team, PHC medical officer and ANM has been conducted to address an important issue of Malnutrition in Bhor block of Pune district.
- To develop synergy and convergence between ICDS and Health department of Velhe block, block level meeting with BDO, CDPO, THO, Anganwadi supervisor, RBSK team, PHC medical officer has been conducted.
- In Bhor, Velhe and Dharni block, block level dialogue at each block has been conducted. Dialogue with Block Level officials regarding ICDS services and Amrut Aahar Yojana in Dharni block.

Objective 12: Developed tools and report cards for documenting community feedback on nutrition and related health services tools and report cards developed and used for documenting community feedback on nutrition and related health services 240 tools and report cards will be generated.

Key activities:

- An innovative pictorial tool regarding nutrition services such as ICDS and Amrut Aahar Yojana have been developed including innovative report card regarding the same has been developed.
- Issues emerged through B-CAN process regarding nutrition services has been addressed during various meetings at village level as well as block level meetings at Bhor, Velhe and Dharni block.

Objective 13: Strengthening capacity of 120 AWWs regarding overall community nutrition and regularly communicating nutrition messages at household level, 3 training workshops at block level (1 per block) will be conducted.

Key activities:

- The block level training of the Anganwadi workers regarding overall community nutrition and household nutrition practices has been conducted during 28th and 29th June, 2019 in the Bhor block.
- The block level training of the AWW regarding overall community nutrition and household nutrition practices has been conducted at Velhe, Bhor & Dharni block during 10th July, 2019 to 20th August, 2019.

Objective 14: Report cards generated through CAN process, with common and systemic issues identified and discussed at Block level and District level nutrition review meetings, six monthly Anganwadi report cards prepared for 120 habitations.

Key activities:

- Two round of biannual data collection process regarding nutrition services has been completed and issues emerged through this were discussed at village and block level dialogue. Report card preparation and discussion at various levels is in process.

Objective 15: A mass dialogue will be organized at block level annually which will felicitate the key members responsible for reducing malnutrition. A dialogue with officials related to nutrition services will also be conducted.

Progress:

- A mass dialogue was organised at the block level in Dharni block on 28th February, 2020 at the Panchayat Samiti Auditorium. This mass dialogue was inaugurated by Deputy CEO and Project Officer, Melghat, Dr. Mittali Sethi and District Health Officer Dr. Dilip Ranmale was the Chairman for the same. The Child Development Project Officer, Taluka Medical Officer and Medical Superintendent of Dharni block were also present for this dialogue along with many social activists.

Objective 16: Cluster level Health Check-up camps will be held to assess nutritional status of under 6 children annually.

Key activities:

- Cluster level Health Check-up camps were organised in the Bhor, Velhe and Dharni blocks at cluster level/ PHC level.

- Health check-up of total 210 children (Bhor, Velhe and Dhrani) was done through these camps and the children in need to treatment were referred to NRC or CTC. The MOs also counselled the parents of the malnourished children regarding their diet and nutrition.

3. ADVOCACY

Project Title - Promoting accountability of the private healthcare sector and patient's rights in India

Funding Agency: Azim Premji Philanthropic Initiative

Reporting Period: April 19 to August 19

Goal: Promoting accountability of the private healthcare sector and implementation of patients' rights in India, with a focus on the city of Pune.

Objective 1: To develop networking among medical professionals by expanding Alliance of

Doctors for Ethical Healthcare.

Key activities:

Meetings of doctors were conducted across India to expand ADEH in cities like Indore, Belgaon, Bijnor, Kozhikode, Panjim. A regional meeting in Bhopal was attended by 45 doctors. One Newsletter published and disseminated through ADEH what's up group and emails. We approached young medicos of Medical colleges in Belgaon, Kolhapur, Miraj, Bharati medical college Pune, B J Medical college Pune.

Objective 2: To develop a state level campaign in Maharashtra, for ensuring accountability and regulation of the private medical sector, focused on protection of patients' rights.

Key activities:

A folk drama - Bharud was performed at various places for depicting the fallout of keeping Healthcare in Market in Nashik, Sangali, Pune Patrakar Bhavan and J P Naik centre, Pune. We conducted Awareness meetings regarding failing public healthcare and rights of the patients in private healthcare sector at - Kashewadi vasti, with NMP plus in a joint meeting by Smile Foundation and Pune Municipal Corporation at PMC Auditorium, Koregaon Park and at Ram tekadi organised with the help of Deepagruha. We organised core team meetings for patients' rights campaign in Nanded, Parabhani and Sangli. We conducted a Patients' rights State level workshop at Pune.

Objective 3: To initiate / foster citizen action groups or Citizen-Doctor forums in six major cities of Maharashtra, to develop awareness and local dialogue on key health advocacy issues

Key activities:

Various public lectures by eminent doctors were organised for educating masses on Dengue by Dr Purandare and Dr Bhondwe, on - Mobile addiction by Dr Shukla and on Ergonomics of body pain by Dr Vaze. We had two Facebook live for e sakal.

Objective 4: To finalize the rate calculator for determination of rates of any procedure

Key activities:

The rate calculator was finalised

Objective 5: Finalizing study on marketing practices in the pharmaceutical industry in India, and documenting patients' rights denial cases

The research was completed, published its findings and a film is released based on quotes from the research. Film – Ek MR ki mout. The report achieved a great impact with very high TRP by print as well as TV media and PMO took note of it.

C2:

Project Title: Ensuring social accountability and multi - stakeholder regulation for advancing Universal Health Coverage in India,

Funding Agency: WHO, India Office.

Duration: 16th September, 2019 to 17th December 2019

Reporting Period: September 19 to December 19

Goal: To discuss inclusive approaches and develop consensus and engagement amongst diverse

stakeholder groups around concrete proposals to strengthen social accountability and multi-stakeholder regulation focussed on the private healthcare sector in India, as part of the process of moving towards a system for Universal Health Care, through a series of two workshops.

Objective 1: Organization of satellite session “Including the Excluded”:

Key activities:

The imperative of involving multi-stakeholder forums to ensure responsive governance of health systems in the Movement towards UHC in India”, during the COPASAH Global Symposium in New Delhi on 15th October 2019.

Attended by more than 50 delegates from India, Nepal, Sri Lanka, Bangladesh, Uganda, Kenya, South Africa, United Kingdom and USA, the 90-minute workshop was divided into two parts, covering issues related to multi stakeholder representation for social regulation of private and public health systems in India, through presentations and panel discussions.

Chaired by Prof Jonathan Fox, Accountability Research Centre, USA, the session included presentations focused on the state of grievance redressal in the private health sector and the role of state medical councils, along with the General medical Council model of the NHS in the UK, which integrates patient perspectives in regulation.

SATHI research team presented their study findings on multi-stakeholder committees as spaces for promoting community participation in the public health system.

Objective 2:

Organization of the second national workshop: “Ensuring Social accountability and Responsiveness of the Private Healthcare sector for Moving Towards UHC”, in New Delhi on 26-27 November, 2019.

Key activities:

The two-day workshop was organized in collaboration with the Jan Swasthya Abhiyan and was attended by over 70 people. Participants were representatives from the government and policy makers (Dr Vinod K Paul from NITI Aayog, senior officials from the NHSRC), WHO India country office representatives, Alliance of Doctors for Ethical Healthcare, Healthcare Workers associations, Health Rights networks such as Jan Swasthya Abhiyan, Healthwatch forum, SAMA, Patient Rights Groups, legal experts, Policy researchers and other relevant stakeholders.

Over two days, sessions were held on key components of such social accountability and regulation – observance of Patients’ rights, grievance redressal, Clinical Establishment Act, Regulation of Rates and of publicly funded health insurance schemes, minimum standards, and treatment protocols to ensure quality and rationality of care. Each theme started with an update on status of current mechanisms, followed by detailed discussions on effective implementation of existing positive provisions, correction of gaps and deficiencies in the current regulatory framework, and recommendations on future policy direction.

A report on the workshop was published in the IJME and circulated amongst all participants. Discussions and conclusions arising from the two workshops are being used to inform further actions in the movement for accountability of the private healthcare sector.

4. DOCUMENTATION AND PUBLICATION

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

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

1. Audio Visual Health Awareness Material –165
2. TV News & interviews- 18
3. Documentation of Jansunwais- 15
4. CBM Film (English & Marathi)

5. Periodicals- Marathi-4, English-6 = 14
6. Books- 3499
7. Bound Volumes- 200
8. Reference Books- 130

PUBLICATIONS APRIL 2019 – MARCH 2020

- Sarvajanic Sevanche Samajik Ankeshan Margadarshak Pustika, April 2019
- SAM MAM Gradation Chart, April 2019
- Child Health Card, April 2019
- Growth Chart (Girl & Boy) Mulgi Vayanusar Vajan (Janma te 5 Varshe) for CAN, April 2019
- Flip book- Adivasi Vikas Vibhag Antargat Community Action For Nutrition Prakriya_ Asha/Gaon Karykartisathi Flipbook Prashikshan Pustika, April 2019
- Asha/Gaon Karykartisathi Prashikshan Pustika_ Adivasi Vikas Vibhag Antargat Community Action For Nutrition Prakriyesathi, April 2019
- Asha/Gaon Karykartisathi Protocol_ Adivasi Vikas Vibhag Antargat Community Action For Nutrition Prakriyesathi, April 2019
- We CAN - Poshan Nirdhar Manthan Ank (Adivasi Vikas Vibhag Antargat Community Action For Nutrition (CAN) Prakalpache Varthapatra), April 2019
- Pesa Nidhi, Amrut Ahar Yojana, Shikshan Hakka Kayada 2009 (Shala Samiti), Ration Card – Yellow, Orange, White Ration Card - Flex Posters, April 2019
- Report_ Witness Seminar on Private Healthcare Sector in Pune and Mumbai since the 1980s Held on 24th June 2018, Mumbai, June 2019
- Sarvajanic Sevanvar Samajik Anekshan – Shaskiya Yojana va tya sambandhit mahiti gola karnayache arakhade, June,2019
- Kotumbik Mahiti, Balkachi Prathmik Mahiti, Balkachi Masik Nondvahi, Balkachya Pathpuravachya Nondi, Amrut Ahar Yojana- Garodar Mata va Stanada Mata -Registration Forms for CAN, June 2019.
- Witness Seminar on Regulation of formal private healthcare providers in Maharashtra Journey of Bombay Nursing Homes Registration Act and the Clinical Establishments Act AND Journey of Pre-Conception and Pre-Natal Diagnostics Techniques (Prohibition of Sex Selection) Act, 1994), June 2019.
- Garodar /Stnada Mata-Amrut Ahar Yojana Labharthi; Gavatil 6 Varshaparyantchi Balke - Amrut Ahar Yojana Labharthi – Anukramanika (Registration Form), June 2019.
- Growing Corporatisation of Private Healthcare in India and its Implications Key insights from a collaborative study conducted by SATHI, Pune, India and King’s College, London, June 2019.
- Arogya Kendramadhil Manushyabal / Karmachari Uplabdhta - Sarvekshan Ahaval 2018-19, July 2019.
- Growth Chart (Girl & boy) Mulgi Vayanusar Vajan (Janma te 5 Varshe) for BCAN, July 2019.

- Formats - Balkachya Kutumbachi Mahiti; Balkachi Prathmik Mahiti; Balkachi Masik Nondvahi; Balkachya Pathpuravachya Nondi; Garodar Mahilecha Pathpurava for BCAN, July 2019.
- Balkachi; Garodar -Stnada Matechi Anukramanika Registration forms for BCAN, July 2019.
- Identity Card for Karyakarta for CAN, August 2019.
- Growth Chart (Girl/Boy) Mulgi Vayanusar Vajan (Janma te 5 Varshe) for BCAN, August 2019.
- Anganwaditil 5 Varshakahlil Balkachi Poshan Sthiti-Chart, August 2019.
- Anganwadimadhye Milnarya Sevanche Pragati Patrak (Report card), August 2019.
- Balkache Arogya Card, August 2019.
- Poshan Seva Prashnavali (Ekatmik Bal Vikas Seva Yojanechi Sarvasadharan Mahiti va Soyi Suvridha), August 2019.
- Balkache Lambi va Unchinusar Vajan (SAM MAM Gradation Chart) BCAN, August 2019.
- When People Unite for Children's Nutrition... (Community Action for Nutrition (CA) Process under Tribal Development Department)-Brochure, August 2019.
- Jevha Lok Balakanchya Poshanasathi Ektra Yetat. Brochure, August 2019.
- When People act for Child Nutrition: Building Community Action for Nutrition. (B- CAN Brochure English), August 2019.
- Promotional Practices of the Pharmaceutical Industry and Implementation Status of Related Regulatory Codes in India - Study Report, August 2019.
- Alliance of Doctors for Ethical Healthcare – Brochure, August 2019.
- PCDF Brochure – Vaidyak Kshetratil Vivekachi Hak, August 2019.
- Asha, Poshan Sakhi va Poshan Hakka Gat Karyakartyansathi Prashikshan Pustika_Bajaj CSR Antargat Building Community Action for Nutrition Prakriyetil, September 2019.
- Asha, Karyakarti/ Poshan Sakhi Sathi Poshan Samvad Pustika_ Bajaj CSR Antargat Building Community Action for Nutrition Prakriyetil, September 2019.
- Bajaj CSR Antargat Building Community Action for Nutrition Prakriyetil Asha, Karyakarti/ Poshan Sakhi va Poshan Hakka Gat Karyakartyansathi Prakriya Ammalbajavani Tasech Balkanchya Pathpuravyasathiche Protocol va Margdarshak Suchana, September 2019.
- Samajik Sevanche Uttardayitav - Sadyasthiti v Disha, September 2019.
- Samajik Sevanche Samajik Anekshan - Shaskiya Yatrana Uttardai Karnyasathi Gaongatani Uchalele Ek Thos Paul... Marathi Brochure, September 2019.
- Social Audit of Public Services People's Initiative to Make Public Systems Accountable' Brochure, September 2019.

- Diary_Rashtriya Arogya Abhiyan - Arogyasevanvar "Lokadharit Dekhrehk va Niyogen Prakriya' Diary, September 2019.
- Community based monitoring and planning in Maharashtra Supported by NHM Supported by NHM - Governments Clinics are turning into people's clinics. (CBM Policy brief), September 2019.
- Lekhajokha_CBMP update policy brief marathi - Rashtriya Arogya Abhiyan Antargat Arogya Sevanvar Lokadharit Dekhrehk v Niyogen Prakriya – Maharashtraatil Lokadharit Dekhrehk va Niyogen Prakriya – April 2019 –August 2019, September 2019.
- GR Book - Lokadharit Dekhrehk va Niyogen prakriyesathi sambandhit Avashyak Shasan Nirnaya, Paripatrake, September 2019.
- Let us Demand Speedy Adoption & Implementation of Patients' Rights Charter in all Public & Private Hospitals in all State/UTs Letter by Union Ministry of Health & Family Welfare, November 2019.
- "Rugna Kalyana Nidhi' Rugna Kalyanasathi Kasa Kharch Karava? (Rugna Kalyan Samiti Sadyansathi Margadarshak Pustika), December 2019.
- Sarvajanik Sevanchi Samajik Ankekshan Prakriya- Ambejogai Talukyatil Yantrana Uttardai Karnyasathichi Navinyapurna Prakriya- Brochure, December 2019.
- Guide book for Government Officers- Lokadharit Dekhrehk Prakriyet Sahbhagi Adhikaryansathi Margdarshak Pustika, December 2019.
- Certificate: Pramanpatra – Sarvajanik Sevanvar Samajik Ankekshan prakriyet Sahabhagi Zalyabaddal (Manavlok Sanstha, Astitav Samaj Vikas va Sanshodhan Sanstha), December 2019.
- Nivadnuk Jinkali Ata Pudhe Kay?, December 2019.
- Sarvajanik Sevanchi Samajik Ankekshan Prakriya- Lokdekhrehkitun Shaskiya Yantrana Uttardai- Brochure, December 2019.
- Mishan Poshan – Kuposhan Nirmulanasathi Samvadpatra, December 2019.
- Rugna Hakkanchi Sanad, December 2019.
- Bharatratna Dr. APJ Abdul Kalam Amrut Ahar Yojana Poster, January 2020.
- Samajik Ankekshan (Social Audit) Mhnaje Kay? – Flex Posters. January 2020.
- Bharatratna Dr. Abdul Kalam Amrut Ahar Yojnecha Hetu – Poster, January 2020.
- Aplya Anganwaditil Seva – Poster, January 2020.
- Research brief on Study on assessing the impact of Community Based Monitoring and planning process across multiple contexts in the state of Maharashtra, February 2020.
- Social audit and participatory planning process (SAPP) for Rogi Kalyan Samiti (RKS) funds in Maharashtra, February 2020.

- Prathmik Arogya Kendra Dekhrehk va Niyogen Samiti (Samitibaddal Mahiti Denari Pustika) (PHC booklet), March 2020.
- ArogyaKendrankadun "Arogyavardhini" Kendrakde Lokadharit Dekharekhichi Vatcahl', March 2020
- Building Community Action for Nutrition (B-CAN) when people act for child nutrition – Brochure, March 2020.
- Building Community Action for Nutrition (CAN) - Brochure, March 2020.

5. COLLABORATION AND NETWORKING

SATHI is involved in a wide range of collaborations as part of its work, in 13 District and 29 blocks of Maharashtra and works with 22 NGOs/ Organisations.

SATHI continues to be an active constituent of Jan Arogya Abhiyan (JAA) in Maharashtra and SATHI team and members contribute to JAA activities outside their project work.

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

A SATHI member is also a member of Health chapter of National Human Rights Commission

A SATHI member is a founder member of nationwide network that is active in reforms of private healthcare sector– „Alliance of doctors for ethical healthcare“.

STAFF DETAILS AS ON 31ST MARCH 2020

Sr No.	Employee Name	Designation	Gross salary	Name of institute/Centre
1	Samma Mathew	Chief Functionary	1,39,420.00	AT
2	Arun Gadre	Coordinator-SATHI	87,732.00	AT
3	Sangeeta Rege	Coordinator-CEHAT	1,19,068.00	AT
4	Monika Renni	Executive Secretary/Assistant	43,910.00	AT
5	Archana Diwate	Research Officer	46,297.00	SATHI
6	Jessy Jacob	Administrative Officer	43,897.00	SATHI
7	Meena Indapurkar	Office Assistant	12,211.00	SATHI
8	Ravindra Mandekar	Office Secretary	33,255.00	SATHI
9	Shweta Marathe	Senior Research Officer	25,516.00	SATHI
10	Tushar Khaire	Administrative Assistant	34,852.00	SATHI
11	Urmila Dikhale	Senior Administrative Officer	51,032.00	SATHI
12	Vinod Shende	Project Officer	25,618.00	SATHI
13	Abhay Shukla	Senior Programme Coordinator	92,692.00	SATHI
14	Bhauasheb Aher	Senior Project Officer	48,932.00	SATHI
15	Deepali Yakkundi	Research Officer	43,897.00	SATHI
16	Hemraj Patil	Project Officer	43,897.00	SATHI
17	Nitin Jadhav	Senior Project Coordinator	55,766.00	SATHI
18	Ramdas Shinde	Administrative Assistant	40,297.00	SATHI
19	Shailesh Dikhale	Senior Project Officer	46,832.00	SATHI
20	Shakuntala Bhalerao	Project Officer	43,897.00	SATHI
21	Sharda Mahalle	Junior Administrative Officer	43,897.00	SATHI

22	Trupti Moreshwar Malti	Senior Project Officer	46,832.00	SATHI
23	Manasi Shrouti	Project Associate	34,852.00	SATHI
24	Nitin Ghatge	Project Officer	41,497.00	SATHI
25	Sachin Sathe	Project Officer	42,697.00	SATHI
26	Jyoti Shelke	Project Assistant	30,495.00	SATHI
27	Dilip Harmale	Office Secretary	30,495.00	SATHI
28	Krishna Bajare	Project Associate	36,412.00	SATHI
29	Shankar Shirke	Project Associate	34,852.00	SATHI
30	Swapnil Vyavhare	Project Associate	34,852.00	SATHI
31	Shobha Kamble	Office Assistant	27,393.00	CEHAT
32	Pramila Naik	Administrative officer	70,712.00	CEHAT
34	Rajeeta G. Chavan	Research Associate	43,894.00	CEHAT
35	Radha Pandey	Secretary	36,236.00	CEHAT
36	Sudhakar Manjrekar	Office Assistant	27,393.00	CEHAT
37	Dilip Jadhav	Secretary	35,711.00	CEHAT
38	Anupriya Singh	Research Associate	52,663.00	CEHAT
40	Sujata S. Ayarkar	Senior Research Associate	53,488.00	CEHAT
41	Sanjida Arora	Research Officer	70,062.00	CEHAT
42	Olinda D'souza	Secretary	36,411.00	CEHAT
43	Swati S. Pereira	Administrative Assistant	44,344.00	CEHAT
44	Durga Vernekar	Research Associate	44,569.00	CEHAT
46	Sarita Patel	Secretary	35,361.00	CEHAT
48	Koyeli Bhattacharjee	Research Officer	71,037.00	CEHAT
49	Angha Pradhan	Senior Research Officer	85,566.00	CEHAT
50	Surbhi Srivastava	Senior Research Associate	52,663.00	CEHAT
51	Arunita Lahiri	Research Associate	22,060.00	CEHAT

Slabs of gross monthly salary including benefits	Female	Male	Total Staff
<5000	0	0	0
5001-10000	0	0	0
10001-25000	1	0	1
25001-50000	15	18	33
50001-100000	8	3	11
>100000	2	0	2
Total	26	21	47

Sr.No.	Name of the Board Members	Position on the Board	Remuneration
1	Dhruv Mankad	Managing Trustee	0
2	Jaya Sagade	Trustee	0
3	Mohan Deshpande	Trustee	62,400.00
4	Padma Prakash	Trustee	35,000.00
5	Padmini Swaminathan	Trustee	7,500.00

6	Raghav Rajagopalan	Trustee	0
7	Rakhal Gaitonde	Trustee	0
8	Ravinder Singh Duggal	Trustee	0
9	Vibhuti Patel	Trustee	0

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

Name of the Public Trust:
ABRIDGED BALANCE SHEET AS AT:

ANUSANDHAN TRUST
31st MARCH, 2020

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

FUNDS & LIABILITIES	RS.	RS.	PROPERTIES & ASSETS	RS.	RS.
Trust Fund or Corpus		30,055.00			
Reserve Fund		-	Immov. Properties Book value of immovable property as on 31st March 2020		12,46,226.23
Employee Social Security and Welfare Fund		70,73,670.66			
Research & Education Fund		1,13,24,966.67	Moveable Properties Book value of moveable property as on 31st March 2020		17,93,306.43
Maintenance & Overheads Fund		27,75,246.92			
Building Fund		1,22,22,307.42	Advances		
Earnest Money Deposit		-	Tax deducted at source	20,96,160.00	
			Deposits	1,88,983.00	
			Employees	-	
		5,05,000.00	Contractors	30,72,340.00	
Liabilities for sundry credit balances			Advance for purchase of immovable assets	52,64,647.00	
Earmarked Grants			Balance with GST Authorities	1,01,575.00	1,07,23,705.00
Income & Expenditure Account			Outstanding Income (Accrued Interest)		2,48,005.97
Balance as per last balance sheet	7,22,27,923.30				
Add: Surplus as per Income & Expenditure Account	1,69,66,957.97		Cash & Bank Balances		
		5,52,60,965.33	Bank balances	2,55,75,092.15	
			Fixed Deposits with Banks	4,95,55,571.01	
			Cash & Cheque in hand	50,304.00	7,51,80,967.16
TOTAL		8,91,92,212.00	TOTAL		8,91,92,212.00

Place: Mumbai
Dated: 26th October 2020

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

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

ANUSANDHAN TRUST
31ST MARCH 2020

Name of the Public Trust:
ABRIDGED INCOME & EXPENDITURE ACCOUNT FOR THE YEAR ENDED

EXPENDITURE	RS.	RS.	INCOME	RS.	RS.
To Expenditure in respect of properties			By Interest earned	6,12,327.00	39,02,098.00
To Establishment expenses			By Grants	2,28,619.00	7,00,58,485.00
To Depreciation			By Donation	5,32,316.32	54,000.00
To Amount Written off			By Grants administration income	-	-
To Loss on Sale of Asset			By Profit on Sale of Asset	39,482.07	-
To Amount transferred to reserve or Specific funds			By Income from other sources		
To Expenses towards objects of the Trust			Contribution to publication & database	60,18,777.03	13,203.00
			Consultancy Fees		32,50,085.00
			IEC Review Charges	8,69,02,956.55	10,000.00
			Award Money		75,000.00
			Royalty		4,649.00
Surplus carried to Balance Sheet			Deficit Carried over to Balance sheet		1,69,66,957.97
TOTAL		9,43,34,477.97	TOTAL	9,43,34,477.97	9,43,34,477.97

41

Place: Mumbai
Dated: 26th October 2020