Addressing Right to Health by Promoting Greater Government Accountability for Safeguarding People's Right to Access to Essential Medicines

Access to essential and life saving medicines is a huge challenge for about two third citizens of India. This is in spite of the fact that India is the third largest producer of low cost generic medicines which are exported to about 200 countries of the world. India's drug production is a complex maze of system. Medicines are sold in market by more than sixty thousand different names. A majority of them are multi ingredient drugs popularly called fixed dose combinations (FDCs). All the FDCs are for domestic sale while the medicines exported are single ingredient except those which are part of the WHO's list of essential medicines – such medicines are less than twenty five only. There are certain medicines which are part of national list of essential medicines under price control through Drug Price Control Order issued by the National Pharmaceutical Pricing Authority (NPPA) under the department of pharmaceuticals of the Govt. of India. Currently there are about 700 medicines under price control which cater to about 15% of the total drug consumption of India. To avoid the It indicates that most of the medicines prescribed in India are out of price control and manufacturer of these are at liberty to fix any price. The profit margins in medicines goes up to 4000% making majority of the medicines unaffordable to majority of the patients. Most recent all India data reveal that the out of pocket spending in medical is about 70% of the total expenditure and 70% of it is on purchase of medicines and investigations. Out of pocket expenses in health care is the major reason to push families in poverty in India which can be addressed by offering free distribution of all life saving and essential medicines and investigations. This can be first initiated from the publicly owned hospitals as have been done by some of the states. Tamilnadu started a scheme of free medicines in 1995, Rajasthan in 2011 and then few other states have announced and have partially started free distribution. Another very important reason for which gratis distribution of medicines is essential is to curb the practice of unnecessary and unreasonable medication. The practice of over medication through prescription of irrational medicines is a common medical practice which happens through unethical promotion mostly of unnecessary drugs by the pharmaceutical companies through inducement of medical professionals through graft. This practice could only be curbed through supply of free medicines and investigations which breaks the nexus between pharmaceutical companies, medical providers and private chemists

The project "Addressing Right to Health by Promoting Greater Government Accountability for Safeguarding People's Right to Access to Essential Medicines" was conceived to attain people's right to health through universal access to essential and life saving medicines by advocating for systems, policies, legal and regulatory

frameworks which contribute towards increasing assurance to rational therapeutics and investigations.

Under the project, opinion and action of stakeholders were mobilized to assure universal access to essential and life saving medicines initially through the public health system with four states identified for intensive action. The project followed following key approaches to meet the goal:

- Promote knowledge on the concept of rational therapeutics and people's right to free essential and life saving medicines through organization of evidence based public events, regular policy and system analysis and by monitoring the status of access to medicines.
- Initiate engagement of stakeholders in constructive deliberations and activities to evolve demand for right to free provisioning of medicines.
- Advocacy for policy and systemic changes within government system for enhancing access to medicines.
- Assist and cooperate with government system in evolving effective systems and mechanisms to increase people's access to medicines.

For this, the project aimed to create background of policy advocacy for higher accountability of the national and state governments especially in the states of Rajasthan, Madhya Pradesh, Odisha and Uttarakhand to make it possible for people to have access to essential medicines as a significant and necessary component of the universal health care. All these four states at the time of initiation of the project were at different stages with respect to implementation of any scheme by the government for free medicines. While Rajasthan had an established scheme for free medicines to all called *"Mukhya Mantri Nishulk Dawa Yojana"* initiated since October 2011 and was doing fairly well, Madhya Pradesh which initiated a similar scheme by the name *"Vallabh Bhai Patel Nishulk Dava Yojana"* in late 2012 was struggling to streamline systems for procurement, supplies and maintaining quality of drugs. In Odisha, the state government had proposed to initiate free medicines scheme three years back, but there was no significant progress in terms of its execution. Uttarakhand portrayed a very ambiguous picture. During the period when the project was being framed there were reports of some discussions going on in the state about introducing provisions for free medicines, but no concrete decisions were taken by the state till the start of the project. Although the project activities would focus on four states, the advocacy at state and national level was expected to have a much wider impact.

State Forums with CSOs on Access to Essential and Life Saving Medicines:

Two days state forum for CSOs on access to medicines were held in all the four states. The forums were organized in collaboration with the JSA state chapters. The initial planning meeting of the CSOs/alliance that was to be organized in the initial phase of

the project was also merged with the forum itself. The common objectives of the forum in all the states were to orient the group of CSOs on various dimensions of access to medicines and to create a pool of organizations which are well equipped to coordinate right to free medicines campaign in the states.

However, since all the states varied in terms of government provisions for ensuring free medicines through public health facilities, hence the discussions varied slightly. While in Madhya Pradesh discussions were more around the already functional free medicines scheme and the issues and gaps within it, in Uttarakhand the deliberations were largely around Rajasthan model of free medicines and how the same could be replicated in the state. In Odisha the discussion was concentrated more around how the already announced free medicines scheme needs to be rolled out fast. The format of the forum although was quite similar in all the states with the first day spent on understanding issues for monitoring of medicine status at health facilities and mobilising more CSOs to join hands in the advocacy and campaign and dynamics of access to medicines, policies, pharma market, state provisions and guidelines for drug procurement, supplies and distribution etc. The second day was largely spent on identifying state issues and carving out CSO strategy

Formation of "People's Alliance for Right to Free Medicines"

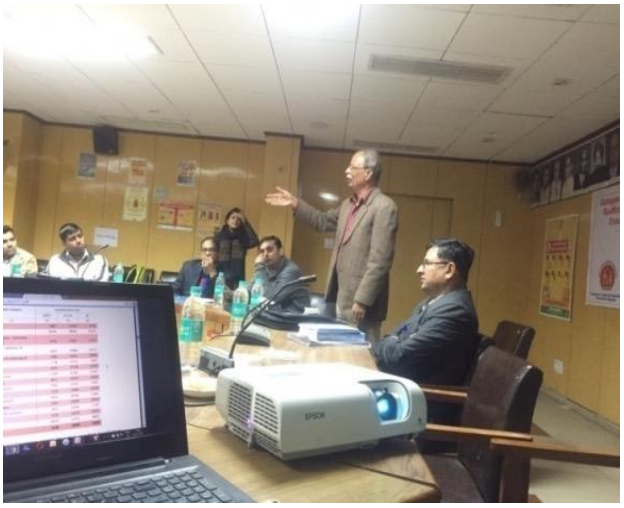
In order to forge advocacy and regular monitoring around access to medicines in the states, it was important to have a network of organizations which were sensitized towards the subject and were inclined to get engaged in activities to improve and strengthen access to medicines situation. There was therefore a felt need to form a wide network of CSOs in the states that was aware and sensitive towards the subject. It was envisaged that the alliance/network so formed would further act as an advocacy and watch group effectively calling for and demanding access to free medicines as a matter of people's right. The state forum with CSOs was used as a platform to launch this alliance/network. The significance of forming the alliance and its probable roles

were shared with the participants and their suggestions were sought on how to go about it. However, as a major consensus the state representatives suggested that it would be more appropriate to strengthen and widen the already existing JSA networks within the states rather than forming a separate alliance or network. It was thus decided that the JSA state chapters would also serve as the "people's alliance for right to free medicines" and would undertake required interventions and advocacy around issues related to access to medicines in their respective states. In each state a core group of 10-12 members was formed within the JSA chapters to categorically take care of issues related to access to medicines and to coordinate campaign and activities around the same. The functions of the core group were defined as:

- To mentor and guide the alliance in its functions.
- Hold interactions with the departments, legislatures and other stakeholders at the state capital.
- Coordination of activities which are to be carried out at the state level.

Regular meetings of the core group and other JSA members have been organized in all the four states. Three meetings of JSA members around access to medicines were held in each of the states during the course of one year. During the meetings deliberations revolved around status of access to medicines and implementation of free medicines scheme in the state, major gaps and lacunae identified, exploring urgent areas for advocacy and developing future plan of action.

Monitoring of Access to Medicines in the states:



An important component of the project was to initiate process of monitoring of access to medicines situation in the states through the voluntary participation of CSOs. It was envisaged that the "People's Alliance for Right to Free Medicines" (the JSA network) would serve as a group of CSOs effectively engaged in regular monitoring of access to medicines situation. The whole idea was that the CSOs will be oriented and equipped with tools for the assessment of medicines availability and prescription practices and they would then carry out periodic assessments of health facilities voluntarily. Based on the assessments carried out by the CSO members reports were to be generated highlighting the status of access to medicines in the states. The report was to be widely shared with CSOs and the government and used as a significant base for further advocacy.

Policy Dialogues with State Planners and Service Providers :

Regular engagement and interactions with policy planners and medical practitioners can go a long way in paving way in promoting rational use of drugs and enhancing access to free medicines from public health facilities. Their engagement and participation in processes directed towards strengthening systems for ensuring availability of free medicines and rational use of drugs can help bring about better results in terms of adherence to norms and guidelines and improvement in prescription behavior and skills thus leading to increased access to medicines and better quality of health care.

WHO defines rational use of drug as: *"Rational use of drugs requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements for an adequate period of time, and the lowest cost to them and their community."* In simplest words, rational use means prescribing right drug, in adequate dose for the sufficient duration and appropriate to the clinical need of the patient at lowest cost. Common types of irrational use of medicines include: use of too many medicines per patient ("poly-pharmacy"); inappropriate use of antimicrobials, often in inadequate dosage, for non-bacterial infections; overuse of injections when oral formulations would be more appropriate; failure to prescribe in accordance with clinical guidelines; inappropriate self medication, often of prescription-only medicines; non-adherence to dosing regimes. Such irrational prescription practices have been found to be very rampant in India across both public and private medical practitioners and there are ample of factors which promote such prescribing behaviors among doctors.

Multi-state Action Research Study on Access to Medicines :

In order to explore current status of accessibility of drugs in public healthcare facilities in different states of India, a study was set to be carried out in five geographically spread out states. While selection of some of the states was based on the continuing work under the project, others were chosen based on their geographical locations. These states were :

1. Uttarakhand (northern India)
2. Odisha (eastern India)
3. Madhya Pradesh (central India)
4. Andhra Pradesh (southern India)
5. Bihar (eastern India)

The broad objectives of the study were:

- Study state policies/provisions and budgetary allocation for ensuring access to essential medicines.

- Examine status of availability and stock-outs of essential medicines at public health facilities.
- Study mechanisms for supply chain management, procurement and distribution of drugs at various levels of health facilities.
- Study prescription writing practices across different states.
- Assess current status of out of pocket expenditure on medicines.
- Identify gaps and challenges in ensuring universal access to free essential medicines in the states.

Advocacy and campaign :

Rajasthan's campaign to save free medicines and diagnostics schemes and protect people's health rights :

The free medicines scheme of Rajasthan despite being one of the most successful models of free drug distribution through public health facilities in the country has been under pressure especially since the change in the state governance. There have been efforts to water down the scheme, although not very explicitly. At one point of time, there was a plan to make the scheme targeted only for families covered under the National Food Security Act. However, the timely advocacy efforts prevented this attempt. There have been plans by the State to create pathways for increasing private health sector participation. Schemes such as "Run a PHC" is one such scheme and for this they have been incessantly going for handing over of public health care facilities to private players to run the health facilities under public private partnership (PPP) mode. There are two modes of hand over happening in the state. One is where if any private sector organization is willing to provide these services without any government support, then without following any tender process, health facilities would be handed over to them by simply signing MoU with these private sector organizations. The other process of handing over these facilities is through tendering process under which any not for profit, profit making, any individual MBBS doctor or any other competent entity can bid for the tender.

Charging the poor for health care services in the public healthcare system is violation of the fundamental rights of the citizens.

A delegation of five persons of Jan Swasthya Abhiyan Rajasthan met with the Health Minister Rajasthan during the ongoing assembly session to discuss on its concerns and

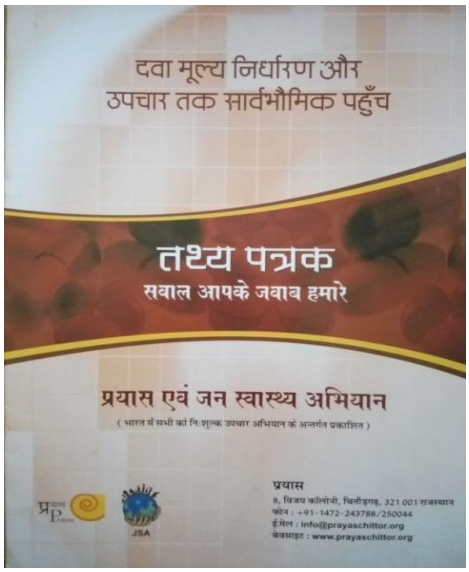
JSA Rajasthan members gathered outside legislative assembly on 22nd September 2015 with demands.

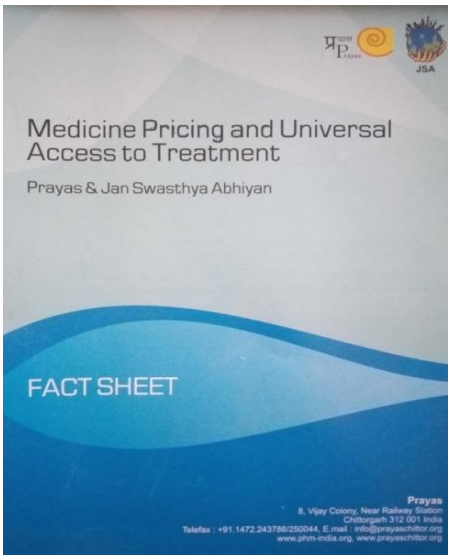
Demands and related issues were discussed thoroughly with the Minister and senior health department officials including the Additional Mission Director, National Health Mission Rajasthan and an agreement reached on

- The government admitted that the list of 300 PHCs issued under call for proposals for handing over of PHCs to private bodies has serious anomalies and that the PHCs enlisted therein do not meet the criteria of being remote and backward. The list therefore will not be considered and a more rational list of backward and remote PHCs will be developed.
- The government would experiment with PPP in PHCs with a smaller number of backward PHCs first and would escalate the idea only after evaluating its outcomes at the end of a year. Thus, PPP would not be implemented in 300 PHCs but only a handful to begin with.
- The clause in the RFP wherein the private operators were given the liberty of providing additional services to the patients apart from those which are mandated under Indian Public Health Standards (IPHS) will be removed completely. The clause was dangerous as this would have opened doors for the private operators to make huge money by exploiting patients by prescribing unnecessary tests and diagnostics.
- The government agreed that any health facility which registers protest by the local community on handing over to private bodies will not be considered for privatization.

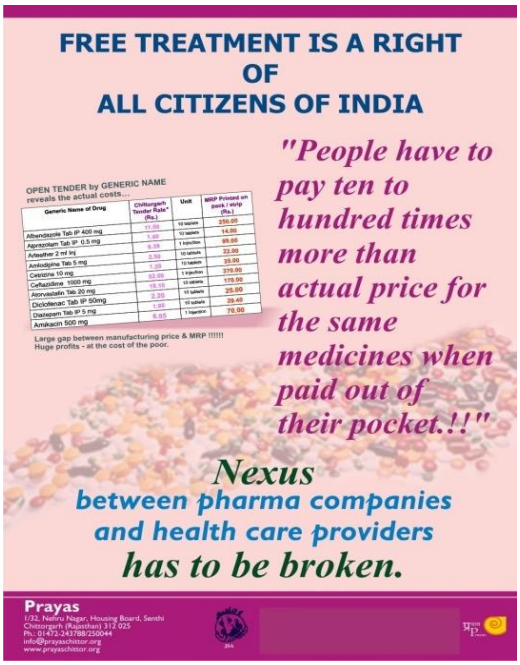
Printing and Publications of Advocacy Material:

A series of posters and leaflets were published for promotion of the concept of Right to Universal Free Essential and Life Saving Medicines. Prayas has published a fact sheet on free medicines and pricing in the year 2009 which was very well received by different section of stake holders. A new version of it was published with added and latest data. Besides the fact sheet which was published in English and Hindi has been translated in





Factsheets on "Medicine Pricing and Universal Access to Treatment" in Hindi and English



Some other India languages by the JSA chapters of Odisha and Andhra Pradesh states.

Participation in national and international events:

Dr. Narendra attended the annual conference organized by MEZIS (a membership organization of doctors in Germany) held from 20th to 22nd March 2015 in Leipzig, Germany. MEZIS leads the popular campaign called "No Free Lunch" which indicates that doctors who are part of this movement neither accept any freebies or lavishing tours nor do they attend any conferences etc organized by pharmaceutical companies in lieu to promote the products produced by them. About 600 doctors are part of No Free Lunch campaign. The campaign is led by Dr. Christiane Fisher who invited Dr. Narendra Gupta to the convention to share his experience from India. Dr. Gupta spoke about the work Prayas has been doing around the issues of access to medicines and the emerging challenges in different parts of India.

Dr. Narendra also held meetings with the members of the Buko Pharma Campaign in Bielefeld. The 30 years old campaign essentially monitors the actions of pharmaceutical companies' role in developing countries of the world. One of its famous campaigns was against Bayer Company's tonic popularly known as Bayer tonic. Dr. Narendra Gupta interacted with the Buko Pharma staff and faculty members where he also shared his experience from India on related issues

Issues & Challenges

- High cost of medicines.
- Proliferation of irrational drugs and FDCs.
- Unethical promotion of medicines.
- Over, under and unscientific prescriptions.

- Ensuring quality medicines.
- How to make the correct medicine available at the right time, when a patient needs it and at affordable prices.
- And if it were a government facility, how to ensure that the patient does not have to pay anything.
- Even though the “Niramaya” scheme has been launched number of times still it has not fully implemented.
- Lobbies of medical practitioners and chemists.
- Disinformation about the quality of medicines and creating doubts in the minds of the people.
- Low acceptance on the part of the public.
- Lack of rational use of medicine.
- Poor prescription by doctors.
- Doctors do not prescribe in generic name.
- Doctors prescribe unnecessary medicine and follow unethical practice.
- No training / sensitizing program planned.
- Unavailability of all the essential medicine at all the public facilities.
- All the support staffs are not placed in the distribution centre.
- Software is not functional and not installed in all the facilities.
- All the 570 declared essential medicines are not procured, only 97 are procured and 369 are put in tender process.
- There is no proper ethical protocol for prescription.
- Use of too many medicines per patient.
- Inappropriate use of antimicrobials, often inadequate dosage for non-bacterial infections.
- Overuse of injections when oral formulations would be more appropriate.
- Failure to prescribe in accordance with clinical guidelines.
- Inappropriate self medication.
- Secure universal access to quality essential medicines and diagnostic services in all public health facilities free of charge

Recommendations:

- Generic prescriptions to be made compulsory in all health facilities.
- Display of availability of “Free Medicines” and its uses in all public health centres.
- Promote the rational use of drugs and diagnostics and reduce the consumption of unnecessary, unscientific and hazardous medicines.
- Promote drug safety and prescription audit. Five percent Prescription must be audited through an independent body.
- Private medicine shops must be closed within the hospital premises.
- Development of ‘Adverse Drugs’ Reaction’ monitoring cell.

- Monitor and address the misuse of antibiotics.
- Doctors should write prescription on self carbonated prescription slips with Generic / Salt names out of Essential Drug List and follow standard treatment guidelines.
- Generalize Community based monitoring and planning of public health services to ensure the accountability and responsiveness of public health services.
- Institute medical pluralism in public health facilities so that people have a choice to access non-allopathic care. Substantial encouragement must be given to research and documentation to pave the way towards integrated health care.
- Government needs to set up its own mechanism of collecting data on the market for medicines.
- Government must constitution of Drug and Therapeutics Committee (DTC). Monitoring of entire therapeutic category need to monitor therapeutic segment of price controlled drug.
- Monitoring the school health program and free distribution of medicine in school.
- Ban all irrational medicines and irrational combinations.
- Establish drug distribution center in all villages.
- Sensitization and orientation about rational use of drugs (RUD).
- All the drug distribution centre must be attached with a patient counselling on medicine.
- Protect the poor from the high and increasing cost of essential drugs and medical supplies and essential diagnostics.
- Bring all medicines under a cost-based price-control regime.
- Enact a Right to health act, which ensures universal access to good quality and comprehensive health care including the entire range of primary, secondary and tertiary services.
- Eliminate corruption in the Public Health System through transparent policies for appointments, promotions, transfers, procurement of goods and services and infrastructure development through a transparent act and institute robust grievance redress systems which are adequately financed and managed with some degree of autonomy from the management.
- Ceiling price should be fixed for all drugs under price control based on existing prices and ‘fair’ drug prices can be determined by their price in the market

Expanding Access to Reproductive Rights: Using the Law to Guarantee Reproductive Health and Rights in India

There has been marked improvement in the health indicators of the country over the years. However, the pace of improvement has not matched with many other countries of the world which had similar health status. Women's health is still an issue to be addressed. Maternal mortality Ratio of India is 178 per one hundred thousand live births as per data of 2012. This indicates that around 50,000 women are dying annually during pregnancy, labour or within 42 days after delivery. Most of the causes of deaths are preventable. Earlier majority of the causes of deaths were related to the shortcomings at the level of families viz. not going to health care providers for check up, counseling and vaccination; not seeking for hospital based deliveries. But, since the National Rural Health Mission has been launched in the country, institutional deliveries have steadily increased owing Janani Suraksha Yojna (JSY) and later Janani Shishu Suraksha Karyakram (JSSK) and most of the deaths are happening in medical institutions because of the non-availability of required treatment at the health facility and then they are referred to other hospitals. Maternal morbidities and deaths are a major area of concern. One of the other areas relating to women's health is their reproductive and sexual health. These include services relating to prevention of reproductive and sexually transmitted morbidities, reproductive hygiene and adolescent health. Non-availability of reproductive health services or their denial is violation of Right to Health Care which is an integral part of Right to Life and Liberty under the Article 21 of the constitution of India through many judicial orders. The High Courts and the Supreme Court of India have authority to pass appropriate orders in this regard. However the knowledge among citizens about use of judicial process to realize the reproductive health rights is very little. This project essentially aims to create awareness on reproductive health rights and facilitate litigation in the instances of denial of services. Prayas carried out following activities under the project:

State Consultations: These were held in the states of Arunachal Pradesh, Bihar, Chhatisgarh, M.P., Odisha and Rajasthan. Representatives of civil society organizations, legal activists, officials from the state governments and academia participated in it. Issues relating to maternal, sexual, abortion and contraception rights along with sex based harassment and discrimination were discussed through many panel discussions and group work. These consultations built networks

of health and legal activists to work on the subject women's health.

The National Consultation: It was held on 3rd, 4th and 5th December 2015 in Jaipur. Approximately 220 persons belonging to civil societies, advocates and academia from ten project states participated in it. The consultation was attended by many experts who took part in different panel discussions.

Fact Findings: Denial of quality maternal and other women's health related services is quite common in different categories of health institutions. These denials cause adverse effects physically, financially, mentally and socially. Losses bring in hardships to all family members in majority of the instances. Prayas carried out fact findings in more than 200 such instances of denial of health services. These included instances of maternal mortality, failures of sterilization leading to pregnancy, non-availability of safe abortion services, infertility etc. In few of the instances, fact findings were also carried out at health institutions where mandated services were not available for a long period of time causing great difficulties to the citizens of the region.

Filing of writ petitions and Public Interest Litigations: Based on the fact findings, representations were made to appropriate authorities for rectification or resolution of the issue and in the instance of non-response or adverse response, public interest litigations and individual writ petitions were filed in the state high courts under the Article 21 of Indian constitution. In the year 2015, more than 200 writ petitions and/or PILs were filed in the states of Arunchal Pradesh, Bihar, M.P. and Rajasthan.

Sensitisation of health and legal activists: During the year 2015, more than 1250 partners throughout the country including NGOs, lawyers, paralegals, etc. were sensitized and trained around SRHR and using law as a tool to increase access to those rights. During these workshops major issues related to SRH among different districts and states were discussed and action plan was developed. These action plans were followed up and appropriate actions are being taken to convert them into well drafted writ petitions and public interest litigations.

Focused group discussions and interviews were conducted during fact findings and through this effective demands have been placed for their entitlements. Over 200 people have agreed to become petitioner to claim their health rights after made aware of their entitlements.

Result 1: Positive orders in 60% of cases will result in improved access to reproductive health care for 30% of the population in the state.

Result 2: Action by the State taken in a timely manner to implement court orders on reproductive and sexual health matters.

Result 3: Orders of Supreme Court and State High Courts are increasingly progressive in guaranteeing reproductive rights and access to health care.

Result 4: At least 30% increase in the number of legal interventions on reproductive and sexual health rights filed by NGOs and individuals throughout the country.

Result 5: Women and marginalized communities will demand their sexual and reproductive rights through legal interventions independent of SLIC's direct intervention.

Result 6: Women have improved and increased access to reproductive and sexual health care services in project intervention areas.

Result 7: Increased engagement of Civil Society Organizations in monitoring and planning of the Government health schemes and delivery services related to reproductive and sexual health through identification of policy gaps.

Reducing child labour in brick kilns of Ajmer – Bhilwara districts of Rajasthan


There are more than 2000 brick kiln in Rajasthan. Every year thousands of children migrate to brick kiln with their families in Rajasthan. The brick kiln workers come from Central Rajasthan, Uttar Pradesh, Bihar, Chhattisgarh and Jharkhand. Children migrate with their families and assist their families in brick making work. Child labor is a major social problem in brick kiln. The Government Education System does not provide any schooling to the children on the brick kilns across Rajasthan. The Education Department has policy provisions /schemes that cater to the migratory children like migratory hostel and non Residential Bridge Course (NRBC). But these schemes do not get implemented as the Department has no systematic data base on migrant children and the staff is not motivated to provide services to these communities that lie at the bottom of the socio economic hierarchy. The Right to Education Act promises education for all children. This right is violated everywhere in brick kilns. The children suffer critical conditions in brick kiln sites.

Interventions

Prayas started interventions both in source and destinations area of Ajmer, Bhilwara and Nagaur districts with brick kiln workers community. It focused on migratory children of brick kiln workers in Bhilwara , Ajmer and Nagaur district of Rajasthan. Most of these children are dropout, non-school going and working children. The age group of children is between 6 to14 years. Sarv Shiksha Abhiyan(SSA), the Central Government program for universalisation of primary education has schemes for this category of children referred to above viz. Migratory Hostel (MH) and Non Residential Bridge Course (NRBC). The migratory hostels are opened in source areas where families that migrate can leave their children behind. The NRBCs are opened at the brick kilns for children who have migrated with their families. These facilities are managed by the School Management Committee (SMC) under whose jurisdiction the area falls.

Children's Mapping in Source Area for Migratory Hostel : Prayas conducted a mapping of migrant children during 11 to 26 August in pockets of three blocks of Ajmer and Nagaur. The areas with intensive migration were covered. After the mapping it gave a memorandum including list of children to related State, District and Block level educational official to open migratory hostel in source area. The table below contains the results of the mapping exercise carried out in different blocks:

Table 1: Details of Migrant Children in Source Area

S. No	District	Block	Number of Children
1	Ajmer	Kishangarh	206
2	Ajmer	Masuda	78
3	Nagour	Parbatsar	315
Total			599

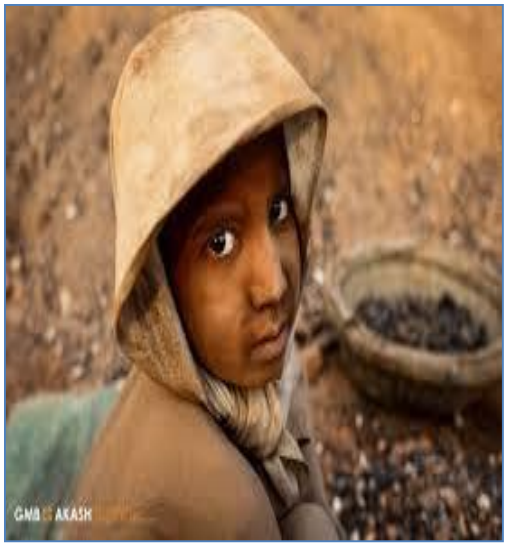
Children's Mapping in Brick Kilns for NRBC : Prayas conducted mapping of migrant children on brick kilns of Bhilwara and Ajmer in the month of November and December. After the mapping, it prepared a proposal for NRBC. It gave a memorandum including children's list to related SMC and other district and block level educational authority to open NRBCs on brick kilns. The table below gives result of mapping exercise carried out on brick kilns.

Table 2: Details of Children in Brick Kilns

SI.No	District	No. of Brick kilns	Number of Children
1	Bhilwara	12	393
2	Ajmer	9	192
Total		21	585

Liaison work/meetings with Government officer/Authority: All along the project period, the Prayas team continued to meet government officials to ensure educational services for migratory children of brick kiln workers. For this, it met with the Commissioner and Dy. Commissioner Primary Education Department of the Govt. of Rajasthan and the District Magistrate, District Education Officer, Block Education Officer, Addl. District Project Coordinator SSA and many other officials of Bhilwara and Ajmer districts.

In spite of advance notice and no action was taken by the state education authorities including DEEO, BEEO, RP-SSA regarding the migratory hostel in Parbatsar. In the meantime, the migration season started in November and most of the children migrated to brick kiln with their families. In this situation, Prayas team again started mapping of children's for the MH and identified 45 children in brick kilns of Ajmer. Prayas prepared nomination/ application forms and submitted 65 children application forms to ADPC office at Nagaur. All the applications were certified by the local authority of government officials. A completed list of children's and decided proposal was also sent to ADPC office at Nagaur to open MH in Pilwa. The main resistance to opening the Migrant Hostel in Pilwa came from the very person who was responsible for the hostel in Pilwa. The teacher in the Upper Primary School of Pilwa, P.S. Parbatsar was not allowing a migrant hostel to be opened as this would disturb her daily commute from Ajmer 65 kms away. Pilwa and its neighboring villages have a large population of the Bavri community that belongs to Scheduled Caste. The main source of livelihood for this community is seasonal migration to brick kilns of district Ajmer. The families migrate with their children who then drop out from school. Prayas survey showed that 92 percent children in the 6-14 year age group migrate with their parents. Following the survey, the brick kiln workers applied for opening of a migrant hostel that is provided for under the Sarva Shiksha Abhiyan. Prayas team along with the worker's representatives met the Additional District Project Coordinator (ADPC) Nagaur, Block Education Officer (BEO) Parbatsar, and the Deputy Commissioner SSA Jaipur. All the officials supported the application. However the school can be only opened if the School Management Committee (SMC) moves the



application. The School Teacher is the Secretary of the SMC and controls it. She refused to move the application. The main reason seemed to be that she commutes daily from Ajmer to Pilwa some 65 kms away. When the Prayas representative met her, she openly said that she will not allow the hostel to be opened under her jurisdiction. The teacher even brought political pressure on the local officials. The irony of the situation is that the very people tasked with ensuring schooling for children are the ones obstructing it.

However Prayas team continued to apply the pressure. It even considered legal options like moving the High Court to file a Public Interest Litigation (PIL). The Education Department officials were told that they will have to answer in Court if they do not open a Migratory Hostel. Finally the ADPC issued the order at his level. This order is included as an Annexure to the report. Finally the hostel was opened. While some of the prospective children to be enrolled had stayed back, others had migrated with their parents. Prayas team assisted in getting back these children and enrolling them in schools. The hostel is running now. It has 44 children that include 25 boys and 19 girls.

Achievements:

- Prayas identified 1184 children who are out of school at the time of mapping of source and destination of brick kiln workers community. This is not a 100 percent mapping. This is only sample of selected villages/brick kilns in source and destination area.
- The Bhilwara district authority of primary education department and SSA **opened 39 NRBC centers in brick kiln and enrolled 1170 children's of brick kiln workers** community. These all children are migratory.
- A Migratory Hostel has been opened at Pilwa for the first time for the children of migrant brick kiln workers. It has 44 children that include 25 boys and 19 girls.

Challenges:

- The Nagaur district authority of primary education did not take any action at right time regarding to migratory hostel. Prayas submitted a list of migratory children at starting of September but the officers have not taken seriously the migratory children issue.
- The school principle at Pilwa did not support at all the process of opening the migratory hostel. She ignored the team all time.
- Transfer of officials: In Ajmer the key official tasked with opening the NRBCs at brick kilns was transferred at a critical juncture. The previous official had promised that the schools will be opened after the annual winter break. But he was

transferred. The new official took time in joining and the whole process got derailed.

- The lower level officials do not want to take additional responsibility of work. They feel that it is additional burden.

Lessons Learnt :

The forms for migrant hostel should be filled when the parents are at home. Prayas team did not do this but only gave list of migrant children to the Government. This was clearly not sufficient.

Prayas should consider the option of legal intervention to ensure that the bureaucracy is more responsive. The present mode of meeting officers and giving memorandum did produce results but very slowly and sometimes failed also as happened in case of Ajmer NRBCs and almost happened in case of Pilwa MH. If backed up by threat of judicial strictures, the officials would have been more responsive.

Community Based Enquiries of health services in Pratapgarh and Chittorgarh districts

Prayas carried out community based enquiries of health services in Pratapgarh block of Pratapgarh district to understand the availability of services with specific to the tribal families living in Chiklad, Punga Talab, Adavella, Khuntgarh, Jolar, Kotwal, Dharni, Gamet, Magri, Kamlagudi, Devgarh, Samli Pathar, Pyarji ka Pathar,Baari, Hathnikudi, Lalpura, Kesarpura, Ranpur, Bordi, Peepli kheda and Phulda villages. It was found that villagers of these villages experience tremendous difficulties in accessing medical services even for minor ailments and suffer very adversely in instances of medical emergencies. As a result of sustained advocacy, opening of three new PHCs at Hathni Kundi, Peepli Kheda and Adawela were announced during 2015 and buildings of two of the PHCs are under construction. Land for Hathni Kundi PHC has been identified and proposal for same is sent to higher authorities.

During the course enquiries untied fund status of Village Health, Sanitation and Nutrition Committees of the 21 villages were examined and found that these VHSNCs did not receive any funds. It was only after state level advocacy funds were released of 21 VHSNCs and materials were purchased to strengthen MCHN days of the villages.

It was also found out that the local bank has charged some amount in the name of service charges from the accounts of VHSNCs which was settled after the intervention at state level and block level. The VHSNCs of Magri & Pyarji pathar were not functioning properly because of election of new chairman. These were strengthened through regular meeting with increasing involvement of newly elected members. Pyarji Pathar, Dharni, Chiklad and Hathni Kudi were facing problem of opening bank account due to lack of required documents and election of new chairman which was resolved with active participation of all the stakeholders. Proposal for setting of new anganwadi at Jolar Village Panchayat got approved and it is scheduled to start during this year(2016).

In some VHSNC bank accounts there were some bank cheques in favor of VHSNCs duly signed by the medical officer and Sarpanch but they did not match with the bank records as it was signed by previous medical officer in charge and the Sarpanch. These issues were resolved with intervention of Prayas staff.

During the celebration of International Women's Day on 8th March 2015 in Pratapgarh, case studies of six families who did not receive benefits of Shubh Laxmi Scheme were presented. Some families also shared that they did not receive assured five kilos of desi ghee. Community based enquiries alerted the health staff and as a result, monthly organization of MCHN (Mother Child Health Nutrition) days have begun regularly in Dhawda, Kalakhet and other villages.

Community based health enquiries were conducted in Chittorgarh district as well. The health institutions covered were District Hospital, Chittorgarh, Community Health Centres Bhadesar and Gangrar, Primary Health Centres – Kannauj, Bansen, Putholi and Borda and Sub Health Centres – Panch Devla, Nahargarh, Kanthariya. These enquries both the positive and negative features of the public health services.

Hard work for soft fibres - Labour law violations in Indian ginning factories

Introduction: India is one of the world's leading producers of textiles and clothing. Approximately 35 million Indian citizens are directly employed and a further 45 million are indirectly employed in this sector. This means that the textile industry is the second largest employment sector in India after agriculture accounting for 18 per cent of industrial jobs (cf. IndiaMART 2012; CCI 2014, 2). Because of the high national and international importance of the Indian textile and clothing production sector, India is the focus of attention when it comes to making social and environmental improvements in the global supply chain for clothing. In the course of the appraisal of the causes of the collapse of Rana Plaza in Bangladesh in the spring of 2013, the German Partnership for Sustainable Textiles was established in Berlin in October 2014. Since then, the debate between all involved players from the world of politics, business, trade unions, and civil society has intensified in Germany and reached a new level. Unfortunately, however, this debate all too frequently focuses on Bangladesh and the issue of safety at work. Although it is certainly true that Bangladesh is an important supplier country for clothing with highly precarious working conditions, and although (a lack of) safety at work is a matter of life and death, it is essential not to lose sight of other supplier countries of textiles and clothing and other key labour law violations.
This study would like to make a contribution to this debate by providing an overview of work processes and working conditions in the various textile-processing stages in the Indian state of Gujarat. Of all the processes involved in textile production, the main focus of this study is on ginning, a process that is largely unknown in Germany, but without which no cotton fibres can be used for spinning. The results of this study are based on three sources: following a comprehensive study of relevant literature in 2014, one of the authors – S. Ferenschild - undertook a study trip to Gujarat as part of the Clean Clothes Campaign (CCC) in January 2015.

The textile production chain in India, using the example of Gujarat: The Indian textile production sector is very diverse. It ranges from the production of numerous natural fibres (such as cotton, silk, wool, or jute) and man-made fibres to all the different processing stages, including tailoring. It is dominated by small and micro enterprises (cf. CCI 2014, 2; IndiaMART 2012). Indian enterprises in the textile industry are not generally integrated, in other words, most companies have specialized in a specific stage of processing and do not cover several processes under one roof. Productivity is generally low and production, while not capital intensive is very labour intensive (cf. GTAI 2013). However, the majority of workers in the textile sector are casual labourers. Moreover, a high proportion of them hail from 6 marginalized social groups. About 60 per cent of workers are women, whereby the proportion of men in the workforce is higher in northern India. In southern India, however, the proportion of women in the workforce is higher (cf. FWF 2012a, 12). The textile sector in Gujarat is also dominated by labour-intensive forms of production. The main reason for this is that since India gained

independence, the Indian government has supported smaller enterprises and labour-intensive production methods while at the same time restricting modern technologies (cf. Dun & Bradstreet India, n.d.). The following sections will provide an overview of the consequences of this policy for the individual stages of production.

Working conditions in ginning factories in Gujarat: Cotton ginning is a processing stage in the cotton production process that is relatively unknown in Germany. It is generally done in close proximity to the cotton growing areas, which is why the most important cotton-growing regions are also the regions with a high concentration of ginning factories. In recent years, several studies on the poor social conditions in Indian ginning factories have been published (*cf*. Patel **2011**; Prayas **2012**; Prayas, *n.d.*). For this present report, four case studies in Gujarat were used to determine how the sometimes extremely precarious working conditions have developed since the publication of these studies. In November 2014, SÜDWIND's Indian partner, the PRAYAS Center for Labour Research and Action, conducted a survey of workers in four ginning factories and compiled the evaluated results in a report. The findings of this report are summarized below

List of cotton-ginning factories in Gujarat

S. No.	District	Number of factories
1	Ahmedabad	*77*
2	Patan	*27*
3	Mehsana	137
4	Vadodara	40
5	Sabarkantha	33
6	Amreli	28
7	Bhavnagar	*47*
8	Junagadh	*92*
9	Rajkot	*144*
10	Bharuch	24
11	Surendranagar	*72*
12	Other districts	*41*

In Indian society, which is still heavily shaped by the caste system, the majority of ginning factory owners in Gujarat comes from the Patel community or caste .India is one of the largest cotton-exporting nations in the world. It exports to over 50 countries worldwide. The exportation of cotton has risen in recent decades. Cotton is mainly exported to the countries of South Asia and China.

Workers and work processes: There is no reliable data on the number of people working in ginning factories in Gujarat. Official records are not a sufficiently reliable source of information for the simple reason that many of those employed in this sector are casual workers, i.e. they do not appear in official records or duty rosters, etc. However, if one assumes that the smallest ginning factory, which operates 10–12 *charkhas* (gins), employs 50–60 workers and larger factories operate 36–40 *charkhas* and employ 125–130 workers, and considering that 70 per cent of ginning factories are small and 30 per cent are large, one can assume that about 55,000 people work in this sector. This constitutes a very large workforce. Work in ginning factories comprises three main processes: the unloading of trucks and the spreading/mixing of raw cotton in the factory's storage area, the operation of the gins, an. the operation of the pressing machine and the removal of the pressed cotton bales.

Case example: Manisha from Kadi / Gujarat

Manisha is 18 years old and throughout the 2014/15 season she worked in one of the ginning factories surveyed (unit C). She comes from a rural family living in South Rajasthan, she is illiterate and unmarried. She has three brothers and one sister. Her parents work in agriculture, two brothers work as construction workers in Gujarat,her thirteen-year-old sister and her twenty-year-old brother are still in training. Like her brother Prakash and her parents, Manisha has never gone to school, whereas her brother Chetan, one of the construction workers, has attended school at least for five years. With the money she earns in the ginning factory, Manisha supports her family as the family income is quite low. In the ginning factory she works in shifts and sometimes she even works the night shift. The work is very difficult for her because of the noise, and because of the cotton dust flying around she has breathing problems. The workplace is lit up but there is no drinking water or protective clothing such as a breathing mask for example.Manisha lives in an accommodation provided by the factory owner. She lives in a room of only 10 square metres which she shares with two and sometimes even with five other workers. Though the room has electricity, there is no fan. Cooking is done outside the room for which Manisha is provided oil and wood by the factory owner. Manisha has one day off per week, and she loves to go to the market that day. The biggest problem for her is that she cannot find a job near her hometown. So she has to work far away from home. In addition, the employment in the ginning factory is limited to four months only. Afterwards she has to look for a new job. She does not want to work so far away from home any longer.

participants seemed to be younger than 18 years. But as they and their labour contractors present are well aware of the fact that employment of people under 18 in ginning factories is illegal, they are “very careful” in reporting their age.

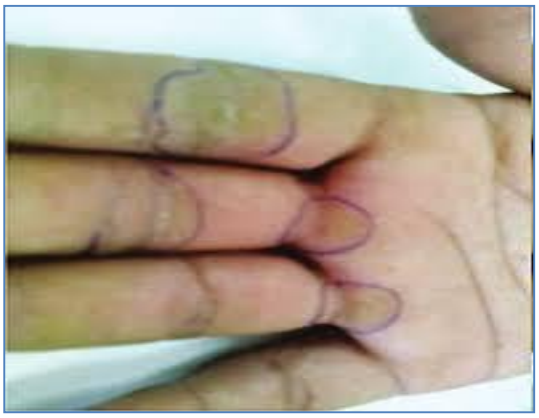
(d) Discrimination: No discrimination was reported except for the case of pregnancies: Pregnant women are not entitled to special working conditions or leave. They have to do the same work as all other workers. If they stop working around the time of the birth they have to take unpaid leave

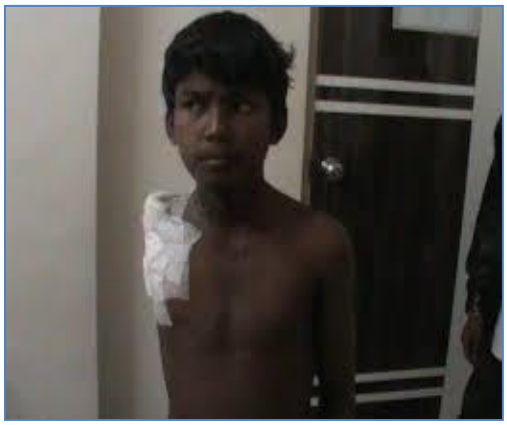
(e) Freedom of association: There is no union activity in any of the factories surveyed. The workers very clearly stated that the factory management will not permit any union activity. There are no collective agreements in any of the factories. In two of the factories surveyed there have been initiatives to form a trade union. These were prevented by the management. However, some labour contractors further try to support trade unions. Some of the persons interviewed in the two factories where there have not yet been any trade union initiatives said they would appreciate the formation of a trade union to support their interests.

(f) Wages: As in many other sectors, the wage situation in ginning industry is very problematic: None of the persons interviewed who are all unskilled workers has ever received a pay slip. Their daily wages range from 150 Rupees (1.95 Euros) to 190 Rupees (2.47Euros). Only one factory, which in addition to ginning has further production stages, reported higher wages. So the wages paid are far below the statutory minimum wages for unskilled workers in Gujarat, which in 2014 amounted to 229 Rupees (2.97 Euros) or, since the end of December 2014, to 276 Rupees (3.58 Euros) for an eight hour day (see Government of Gujarat 2014: 2).The wages are paid fortnightly or monthly. None of the four factories seems to pay bonuses or extra payments, although the information received varied. Some workers said that they got some bonus while others, working in the same factory, had never heard of bonuses. One worker said that he once got an annual bonus of 1,800 Rupees (23.37 Euros). Others reported that they sometimes receive gifts in kind of sweets or clothes. On the whole, the criteria for bonus payments, if there are any bonuses paid, seem to be very unclear to the workers. All respondents said that the wages are insufficient to meet their basic needs. To meet these needs the wages were to increase between 18 and 75 percent they said. One respondent considered it necessary to increase the daily wage to 500 Rupees (6.49 Euros).

(g) Infrastructure, Health and Security : Three of the four factories have canteens on their premises. However, only the management and supervisory staff have access to them. The workers do not eat there. All four factories surveyed comply with Article 19 of the Factories Act insofar as They have toilets on the premises. In two of the four factories the workers reported to have access to the toilets. In the remaining two

factories, the workers are not allowed to use the toilets on the factory premises. In fact, in these factories the workers are mostly seasonal migrants living inside the factory premises. Nevertheless, they do not have any toilets even in their living quarters. They have to resort to open defecation. In the group discussion the workers complained about this because this situation causes them major problems. None of the factories surveyed had care facilities for children under the age of six years as they are obliged to under Article 48 of the Factories Act if more than 30 women are employed.





One of the four factories surveyed employed more than 30 female workers. None of the persons interviewed reported that safety equipment is provided or used. Even in the factory visited there was no evidence of safety equipment available.
The responses to the question whether there is sufficient medical care in the factories varied. Some answered the question in the affirmative while others answered in the negative. Asked about the kind of medical care, the workers reported that there is a medicine cabinet.27 None of the persons interviewed has suffered an accident in the factory. In three factories, however, major accidents in the recent past were reported. One of these was so serious that the worker died. In two other incidents the workers suffered serious injuries and had to be hospitalized. Information on compensation received was available only in the case of the fatal accident where the family received half of the statutory compensation after negotiations. In the two other cases there was no information on compensation, only that the management paid for the hospitalization costs. The persons interviewed did not suffer from occupational diseases an did not report of any illness. However, further investigations will be required to gather information about the prevalence of occupational diseases, particularly about Byssinosis

Byssinosis – also called brown lung disease or Monday fever – is an occupational lung disease caused by exposure to cotton dust in inadequately ventilated working environments. Depending on the prevailing conditions it can also occur in ginning factories. To date, no case is known in the factories surveyed / in the region what might be due to the high turnover (seasonal work) of the employees. Other possible diseases

relate to difficulty breathing and skin rashes. A recent study of ginning factories in Maharashtra State suggests that long-term exposure to cotton dust can result in reduced lung volume (cf. Dube et.al. 2013). Concerning the social security of the workers, the persons interviewed did not report of contributions to any social security scheme of the government.

(h) Employment contract and contract work: None of the persons interviewed had a written employment contract with the factory. They all were recruited by so-called „labour contractors. Neither the factories nor the labour contractors are registered in accordance to Article 6 of the ‚Interstate Migrant Workers Act'.6 And none of the migrants did receive the 'displacement allowance' equal to 50 percent of the monthly wage or at least 75 Rupees (0.97 Euros) as required by Article 14 of this Act. Workers from three of the four factories reported that they are paid only one way travel expenses (either from their place of residence to the place of work or the way back), though Article 14 of the above mentioned act stipulates that expenses for the outward and return travel shall be paid by the contractors and that the travel time shall be considered as normal work time The majority of the workers is recruited through labour contractors for fixed-term, seasonal activity in the factories and has no access to social security. However, it is possible that there are some permanent workers who have access to social security. The major violations of labour laws in ginning and pressing are:
1. All factories are forcing workers to overtime which is in contravention to the provisions of the Factories Act.. The wages are below the statutory minimum wages per eight-hour day. Taking into account the daily overtime, the payment is almost only one third of the statutory rates. Elementary sanitary facilities such as toilets are not provided in two of the four factories surveyed, though the Factories Act prescribes that the employer has to ensure the provision of sanitary facilities. No safety equipment is provided by any of the factories. The reported serious accidents in three of the four factories surveyed showed that if an accident occurs, the victims are not compensated according to the requirements of the Workmen's Compensation Act.

Results and Recommendations:

The number of accidents in ginning factories must be reduced, and safety must be improved. **Further efforts to increase wages need to be made.** The current wage rate is far below the statutory minimum wage.

It is necessary to create transparency in the cotton value chain. Up to now it is very difficult to follow the way of cotton after ginning. It is hardly possible to verify what cotton is exported and what cotton is processed locally. Transparency in the supply chain can contribute to link precarious working conditions at the beginning of the supply chain with the clothing retailers at the end of the chain and to undertake advocacy work with them.

The organization of employees must be further developed. This is the most important task. Organized labour can best fight against the violation of labour rights at various different levels. Political advocacy work will not be successful without pressure from the workers. But this is not easy.

Joint action and activities of labour rights organizations must be promoted. The cotton value chain is long. Many organisations and activists at different levels work to improve the workers' situation. Their activities should be networked, possibly by establishing a central coordinating body which monitors the whole chain and brings together people working at and on different levels of the value chain.

Working conditions along the entire value chain require further studies. The present study focuses only on one part of the value chain – the ginning factories. Similar studies of other stages of the value chain, which were only roughly outlined in chapter two of this study, could help to get an overall picture of the workers' situation in the textiles sector.

Additional studies should focus for example on GOTS or BCI certified cotton processors. The fact that ginning factories affiliate with Standards Organisations like GOTS or BCI is good news. This increases transparency and the possibility to gain an insight into the factories not only through audit visits. However it is surprising that working conditions in the GOTS-certified factories surveyed were only slightly different from other, conventional factories. Therefore it is appropriate to investigate the standards, to carry out a study of other certified factories and to do advocacy work with Standards Organisations in order to ensure that labour rights are not only included in every standard but also implemented in the factories.

In view of the labour rights violations in Indian ginning factories, GOTS should conduct a separate study of the situation in this production process. It is to be welcomed that GOTS has included the ginning process in its certification system. However, this sector is different from other production processes because of its seasonal character. Therefore GOTS should ensure that audits are conducted only during the season. In addition, the certifying organisations should have special qualifications concerning labour rights in seasonal and migrant labour or be trained in this respect

Study to Understanding Barriers to ANC, Institutional Delivery and high prevalence of Anaemia in Rajsamand District

A study was conducted in two blocks of Rajsamand district to understand barriers in antenatal care, reasons for home delivery, factors influencing delivery outside of institutions/home deliveries and perceptions about how those factors could be addressed among community members and healthcare providers. It also looked into the barriers in prevention and treatment of anaemia during pregnancy and to assess coverage of preventive iron-folic acid - distribution and compliance among pregnant women. The study used mixed method, a quantitative survey which includes women who delivered in the last 1 year (age group 18-45 years), focus groups with ASHAs, traditional birth attendants, religious leaders and mother-in-law and key informant interviews with health service providers.

Kumbhalgarh and Bhim blocks were selected for the sampling frame as they have a high proportion of tribal population and highest number of reported home deliveries compared to other blocks being 834 and 713 respectively the total for Rajsamand being 33793. They contribute to almost 50% of home deliveries for the whole block. Over 50% of public health facilities are understaffed. Access to health facilities in these blocks is also difficult and not easy for all users of the health system, given the hilly terrain and hard-to-reach areas in these blocks.

A comprehensive questionnaire was designed that covered respondent and household background information, ANC services undertaken, iron folic acid consumption and delivery information. The questionnaire was translated in Hindi and piloted in the field by Prayas, Chittorgarh who supported Earth Institute for this study for various aspects. The survey team from Prayas was trained to administer the interview based questionnaire at a household level.

In total 422 women's surveys were analysed from the two blocks namely, Bhim and Kumbhalgarh in Rajsamand district. 208 women from the sample had undergone a home delivery for their last delivery. 48% of them belonged to Kumbhalgarh and 52% were from Bhim. 214 women from the sample had undergone institutional deliveries, 51% of them were from Kumbhalgarh and 49% from Bhim.

There is already an initiative towards community based management of malnutrition. However based on the data this program also needs to

a. IFA consumption is low and irregular mainly because women feel nauseous and sick. However if they were to more clearly understand the benefits, rather than just understanding how it benefits the "blood and delivery process" may be they would make a better effort for intake.

b. If community members instead of just the ASHA and ANM convince adolescent pregnant and lactating women to take iron supplementation and complement it with a balanced nutrition the level of acceptance will be better.

c. Based on the focus groups and interviews women stop taking buttermilk and ghee based products during pregnancy as the community believes it will accumulate on the head of the child make delivery difficult. These misconceptions prevent them from even consuming their normal diet let alone adopting a healthy diet.

d. Good nutrition is not a community norm and women do not understand the reason for increased requirements during pregnancy and lactation. They might not perceive this as important as they don't understand the developmental and cognitive effects it has on the child. Anemic women are at higher risk of giving birth to low birth weight babies. Poor nutrition affects development which affects the productivity of the generation. This vicious cycle continues. **Positive reinforcement via risk messaging** is a potential strategy for improved diet and community based management of prevention of malnutrition.

Community Involvement- Do not depend on ASHAs alone

It was apparent from the interviews of the ASHAs and mother-in laws that there is no one key person who influences decision making of the woman regarding her pregnancy care and delivery. When the ASHA alone tries to deal with difficult cases there is the attitude that "she is doing it for money" which also demotivates the ASHA to carry out her work. Involvement of more peer women, committees or groups and the Panchayat would help the ASHA and ANM in their work**.** Only when practices about good nutrition, ANC and institutional delivery become a norm in the community is acceptance better and it creates a demand from the consumer side to access the benefits of a public health system.

Building State's Accountability on Health Care Financing through Research, Advocacy and Community Engagement in Rajasthan

The goal of the project was to ensure that quality public health care services are available to all citizens of Rajasthan as a matter of their right. This was to ensure adequate public expenditure on health care in the state and greater transparency and accountability in its distribution and utilization, to develop systems and processes for public engagement in planning and monitoring of health care services to ensure appropriate use of health funds and to undertake systemic review and generate evidences to advocate for reforms in existing policies related to health and health care financing in the state.

In order to build strong evidences for advocacy around public health expenditure in the state and quality of health care services, a statewide study was conducted. The study attempted to analyze public expenditure on health care linking it with the state of health care services, infrastructure, human resources and availability of drugs and equipments at various points of service delivery right from the periphery to the top. The study also assessed out of pocket expenditure (OoPE) on health care especially in OPD with focus on medicines and diagnostics. This also provided significant information on the current scenario of free medicines and free diagnostics schemes in the state which have been operational since more than three years now but have been under the threat of getting downsized and distorted lately. The study would largely consist of three sections:

- analyzing trends in state health budget over the years by reviewing its various sources, allocation, distribution, utilization and mechanisms for transparency.
- undertaking health facility assessments to comprehend the state of budget utilization in terms of available infrastructure and services and the gaps that lay therein.
- conducting exit interviews with patients/beneficiaries to assess OoPE and their perception on quality of care.

The study to the best efforts would be carried out through randomized sampling methods to have representative data. It would be conducted in about eight districts of Rajasthan spread across different parts of the state in alliance with JSA colleagues. Standard methodologies for sampling would be applied and tools would be developed for the purpose of data collection. Collected data will be tabulated and analyzed by using standard statistical package and findings would be brought out in the form of a detailed report. Results of the study would be widely disseminated among various constituents such as govt. health officials, health service providers including frontline health workers, CSOs, policy makers, parliamentarians, legislatures, representatives of local bodies , media etc with the help of factsheets and other instructional material developed for the purpose. The findings will be extensively used to initiate advocacy for

better health care services, policies and programs and calling for reforms in the field of health care financing in the state. BARC would take the lead in conducting the study while JSA Rajasthan would take the lead in development of tools and questionnaires. Analysis and report development would be undertaken jointly.

ii) Policy briefs : Based on the findings from the above study as well as through review of existing policies, data and system frameworks, analytical policy briefs would be drafted and released on critical components of the state health system such as health care financing and human resource in health. These briefs would provide broad account of existing health care scenario with focus on these components and would attempt to identify gaps and challenges that lie therein and put across recommendations for further policy planning and action. These documents would be widely circulated among different constituents for fostering greater deliberations, reflections and necessary action to cover up those gaps. Both BARC and JSA Rajasthan would jointly share the responsibilities for developing these documents.

(iii) State level consultation and dissemination:

A state level consultation with legislatures, policy makers, executives, CSOs and other constituents will be organized for the dissemination of the results and findings of the study and to build up consensus around the issues and concerns so identified. The consultation would also aim to build upon a charter of demands for greater transparency and accountability of the government in planning, allocation, expenditure and monitoring of health funds. BARC would take the lead in organizing this consultation.

(iv) Capacity building workshop for CSOs

In order to build a wider pool of civil society members in the state who have considerable understanding on public health financing and are equipped with the mechanisms which may be used for the monitoring and tracking of the health budget, a capacity building orientation of CSOs will be conducted. The workshop would attempt to build the capacities of CSO members engaged in critical advocacy and accountability platforms to undertake health budget advocacy, foster greater collaboration to influence budget processes in the state, and to engage in development and implementation of budget monitoring and tracking processes. About 40 CSO members from across the state will be oriented through this workshop. BARC would take the lead in organizing this workshop while JSA would support by mobilizing participants

(v) Community engagement in health monitoring and advocacy:

Increased community participation in public decision making at the local level can help both the community and the government to understand the complex demands of the people better. This would lead to better coordination, transparency and accountability in action planning, priority setting, budget allocation and expenditure. Hence activities related to community engagement in health advocacy and monitoring would be undertaken. The activities would involve:

Awareness building: **Awareness will be raised amongst the communities, VHSCs, RKSs, Gram Panchayats on health rights** and they would be encouraged to plan, demand and monitor delivery of health care services and fund utilization. They would be made aware of the cost of infrastructure, services and the need for mobilization of resources and fair use of them for better delivery of health services. They would be oriented on and engaged in participatory processes of health planning, monitoring and budgeting.

Monitoring and generation of report cards : **Citizen's forums especially the VHSCs will be revamped and oriented to pro-actively monitor health care facilities, MCHN days and anganwadi centre's and engage in village health planning and appropriate expenditure of untied fund which it is annually entitled to.** They will use simple audit check-lists developed consultatively to score/rate these facilities and these audit reports will be used as system-input to strengthen the health system and demand accountability on budget allocations and expenditure.

Interactions with health officials and budget tracking: Greater community interactions with frontline health workers, health service providers at the facilities and block and district health officials will be fostered in order to build greater confidence in the public health system, make it reliable through accountability mechanisms and use the same for accessing health services. JSA and PBI partners would keep regular track of health budget allocations to the district and would keep a watch on its distribution and utilization. District level consultation would be organized with participants from different constituencies to share the findings from monitoring of health care services and tracking of budget. The project would focus on Devgarh PHC area of Pratapgarh district of Rajasthan for intensive work around community engagement for monitoring and advocacy of health care services and health budget in the first phase. Devgarh PHC consists of five sub-centre spread across 20 villages and three gram panchayats. The whole region is predominantly a tribal belt and socio-economically highly backward. The project initially would attempt to initiate the process beginning with building the capacities of the community in monitoring of health care services together with laying impetus on health funds such as the VHSC untied funds and the funds allotted to the sub centers' and PHC. Once the community begins to enquire and question on allocations and expenditure of health funds, the process would then gradually be taken further to intensive budget tracking in the next phase. Two Field Coordinators will be deployed for facilitating these processes in 20 villages and for keeping track of the district and block fund allocations and expenditure on health care. JSA Rajasthan would lead the whole process with technical assistance from BARC.

(vi) Advocacy and campaigns:

Pre budget advocacy events will be organized at the regional levels as well as at the state capital for generating demand and pushing for appropriate policies, programs and allocations for health and health care. Special impetus would be given to ensuring that

the ongoing free medicines and free diagnostics schemes in the state are sustained and that they do not fall prey of undue political agendas. This may include regional consultations, media conferences, public awareness campaigns etc raising crucial issues and demands related to health and health budget. These events would also focus on highlighting gaps in health financing and would call for greater transparency and accountability on health budget by the state government. These events will be based on campaign strategy built across the course of the project period based on program and policy developments that take place in the state. JSA Rajasthan would take the lead in organizing these activities.

vii) IEC: IEC activities would be undertaken for creating public awareness around the need for greater transparency and accountability on the part of the state around health expenditure and to make people think and question on public expenditure on health, thus making health expenditure a subject of mass concern. Posters, pamphlets/factsheets would be developed to attract public attention on health budget related issues. JSA Rajasthan would take the lead in developing these materials with inputs and assistance from BARC.

A. Deliverables:

- A statewide study to generate evidences around gaps in health infrastructure, budget allocation, access to essential and life saving drugs and diagnostics would be conducted and detailed report on the findings will be released.
- About 40 CSO members would develop fine understanding on health care financing and processes related to budget monitoring and tracking
- State charter of demands around health care and health budget would be evolved.
- All the 20 villages under Devgarh PHC of Pratapgarh district would have active engagement of community in village health planning, monitoring of health care services and demanding greater transparency in health care spending.
- Tools for monitoring of health care services and tracking of budget would be developed.
- Report cards on status of health care will be generated in all the 20 villages biannually.
- Process of health budget tracking would be initiated in the district of Pratapgarh.
- At least one state level consultation and one district level consultation will be organized forging deliberations on health care financing and scope for reforms therein.
- Pre-budget advocacy events focusing on state specific health demands will be held in the form of public meetings, consultations, media advocacy etc
- At least one poster and one pamphlet/factsheet would be developed for generating mass awareness around public spending on health and need for greater transparency and accountability in health care spending.

ENSURING SOCIAL SECURITY TO SEASONAL MIGRANT CONSTRUCTION WORKERS IN AHMEDABAD

Since October 2015, Prayas Centre for Labour Research and Action (PCLRA) has been focusing to ensure social security to seasonal migrant construction laborers living in Ahmedabad City. As such PCLRA's involvement, with these laboring families dates back to 2009, when we contacted them on the *Kadiya Nakas* (labour stands where construction labourer's seek work) studied their situation and raised several issues related to their exploitation as labourer's. These were related to underpayment, non-payment and deferred payment of wages, unsafe work practices, denial of compensation on injury at work, and verbal, physical and at times sexual violence on these labourer's where PCLRA negotiated settlements in and outside courts, and collectivized labourer's around these matters besides representing their situation to the Government. Then PCLRA also studied the vulnerability of these worker families due to lakhk of social security such as deprivation of entitlements to their little and school aged children, their limited or non-accessibility to health services and of course lakhk of safety and security due to lakhk of proper housing in the squatter settlements (*basti*).

As PCLRA pursues mainly the rights based approach to all its intervention studying the situation to be dealt with is important for which it must collect real time data. Based on statistics revealed by the data situational analysis and sharing data with the community is also important. This becomes the basis to raise demands regarding the entitlements with the concerning authorities. Further, sharing with the community as well as involving them in the advocacy efforts calls for empowering the communities and creating mechanisms for their participation. Thus the implementation of the PHF project rolled out as follows:-

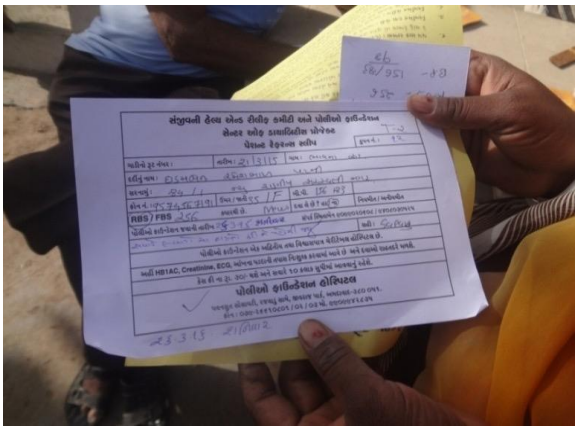
Just at the very beginning of the first half yearly implementation period, as
PCLRA was preparing to profile the settlements which would be part of the intensive work based on the previous year's involvement in labour issues a major housing rights crisis developed at Sewage Basti Part -2, in of Gyaspur, Juhapura area- a settlement on Ahmedabad Municipal Corporation's land which was acquired by the MEGA Metro- a prestigious rapid transit project between Gujarat's political capital Gandhinagar and Ahmedabad—the economic capital of the state. Since a year earlier—Nov 2014 warnings to evict about 50 shacks of migrant tribal construction labour originally from Dahod district of eastern Gujarat tribal belt and contiguous tribal areas of Jhabua district of west M.P were sent by MEGA officials as open or shielded threats. PCLRA had then (Nov, 2014) surveyed the inhabitants and proceeded with data to notify the MEGA Metro SPV authorities to not force eviction without proper rehabilitation.

The Socio-Economic survey of MEGA Metro released much later had identified these families as project affected and thereby entitled for the rehab package that included displacement and employment related cash compensation and a built-up home for each affected family. The RTI by PCLRA regarding the names of the affected had yielded a negative response earlier. Subsequently in October 2015 these very families were given notices by the Ahmedabad Municipal Corporation to vacate the land as they could not prove their domicile there. And finally an operation to raze down the habitation was cruelly undertaken by AMC on Oct. 20 2015. PCLRA in a firefighting operation mobilized the evicted community protested against the AMC and gave written representation demanding rehabilitation.

It was then that the Community Facilitation Agency engaged by MEGA Metro called Saath Livelihood Services contacted PCLRA for negotiation on behalf of MEGA and a long drawn process began whereby the identified project affected people's list was unofficially submitted and displacement related disbursements as per the guidelines commenced which is still underway. PCLRA had then filed a PIL in High Court of Gujarat against the high-handedness and lakhk of transparency of the AMC and MEGA Metro related to the 56 affected persons in the Gyaspur Depot area of the North South Corridor of MEGA Metro. PCLRA also complained to the funding institutions of MEGA—namely Japan International Co-operation Agency (JICA) and GOI. It can be confidently said that both these measures acted as a pressure on MEGA to expedite the rehabilitation process. At every step the community was alerted and supported by PCLRA in understanding the rehab package in negotiating about procedures of the rehabilitation formalities with rehab agency and even in opening bank accounts. 48 out of the 56 households all but one being poor tribal construction labour families have benefitted setting a clear precedence for other squatters to mobilize and fight for their rights to safe and secure housing as construction workers in Ahmedabad. One Muslim family already scalded from wounds of the 2002 riots uprooted from their original home

in another part of Ahmedabad left out in the initial list was also included by PCLRA intervention

Besides the above eviction episode, two other episodes related to actual and probable eviction were brought to our notice and PCLRA was led into intervening therein. A squatters basti with nearly 90-100 HHs close to the 5 bastis where we work near GST Railway Crossing-3, at Ranip suburb, called Amul Garden/ Indralok where scheduled tribe as well as scheduled caste laborers lived on railway land since nearly 15-20 years were razed down by the railway authorities of the Ahmedabad Division in Jan. 2016, and threatened with dire consequences if the hutments were rebuilt. Such eviction was not undertaken for several years in this basti before nor notices given. PCLRA was contacted by the inhabitants through the neighboring bastis with which PCLRA is involved. PCLRA undertook several meetings collected a preliminary data on the nos. of households, adults and children residing there and nature of labour work they do to assess the vulnerability and other matters. PCLRA approached the railway authorities informally as requested by the community to not harass and threaten the squatter families but rather to think about rehab. Since then shacks have been rebuilt and people have not moved out from there. PCLRA will work closely with this basti. Another basti on private land acquired from the railway where eviction was legally Stayed by PCLRA in Feb. 2015 was once more notified by railways for eviction. PCLRA intervened reminding authorities of the stay.


સંજીવની હેલ્થ એન્ડ ટીચીંગ કમીટી અને પોતીઓ ફાઉન્ડેશન
સેન્ટર ઓફ કોમ્યુનિટિસ હોસ્પિટલ
પેશન્ટ રેફરલ સ્લીપ
RBS/FBS
પોતીઓ ફાઉન્ડેશન હોસ્પિટલ

Aadharshila School

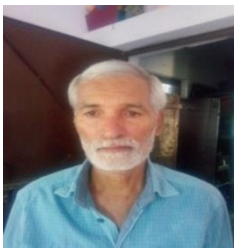
The residential educational camp for girls named Adharshila School for the age group of 8 to 13 years was started in the year 2008 at village Amarpura in Bhadesar tehsil of Chittorgarh Dt. Fifty five girls from extremely poor families mostly from Bhil community were residing and studying in the camp in the year 2015. The objective to start the school lied in the fact that female literacy in the area is very low and very low in the communities from socially excluded castes. Girls soon after they learn to walk are pushed into doing domestic chores which includes tending animals, looking after younger siblings, help older women in household or farm related work and marrying them of at quite a young age. It was observed that unless the girls not withdrawn temporarily from the families and brought to a residential education facility, it was impossible for them to pursue studies. A majority of the girls studying in the facility have either not attended any school any time or had dropped after couple of years of schooling. This education facility provides opportunity to the girls to qualify class five examination and after that Prayas has facilitated admission in the Kasturba Gandh

Avasiya Vidhyalaya (KGBV) of the government where again they receive complete residential facilities gratis till class ten and then through Sharide residential facility till class XII. A total of 105 girls have passed out from Adharshila Educational Facility. Out of this 78 are pursuing further studies. Five girls are about to qualify class 12 examination. Adharshila has provided a milieu to the girls for their all round development and as a result all the girls who are studying in higher classes are securing very good grades.


©Shreniki Sadalgi/Survival

Executive Committee of Prayas

Photo	Name of Board Members	Designation	Tenure
	Shri Ashok K. Pandey	President	Since 2009
	Shri B.M. Sanadhya	Member	Since 1984
	Ms. Preeti Oza	Secretary & Treasurer	Since 1986
	Dr. V. Pendse	Member	Since 2002
	Shri Sudhir Kumar Katiyar	Member	Since 1990

	Shri Khemraj Choudhary	Member & Director	Since 1988
	Shri Shakeel Ahmed	Member	Since 2015

Prayas Offices
Coordinating and Administrative Office:

8, Vijay Colony,
Chittorgarh 312 001
India
Tel: +91.1472.243788

Other Offices:
#202, Plot No. 158 S.B. Vihar,
Swage Farm, Sodala,
Jaipur 302 019
Tel: +91.141.2290593

B-19, Subhavna Niketan
Pitampura
Delhi 110 054

Village : Devgarh (Deolia),
Pratapgarh Dt. 312 625

Village – Amarpura,
Bhadesar Tehsil,
Chittorgarh 312 602

285 Shankar Colony,
Above “E” Mitra, Fatehpura,
Udaipur 313 001

19, Narayan Residency,
Section -2, Chandkhera,
Ahmedabad 382 424


2 DAYS NATIONAL CONSULATION ON
"WOMEN'S REPRODUCTIVE RIGHTS,
HUMAN RIGHTS AND USING THE LAW"
HkLN



STATE LEVEL WORKSHOP ON
SEXUAL and REPRODUCTIVE HEALTH
RIGHTS - CALL for


"WOMEN'S REPRODUCTIVE RIGHTS,
HUMAN RIGHTS AND USING THE LAW"
HkLN

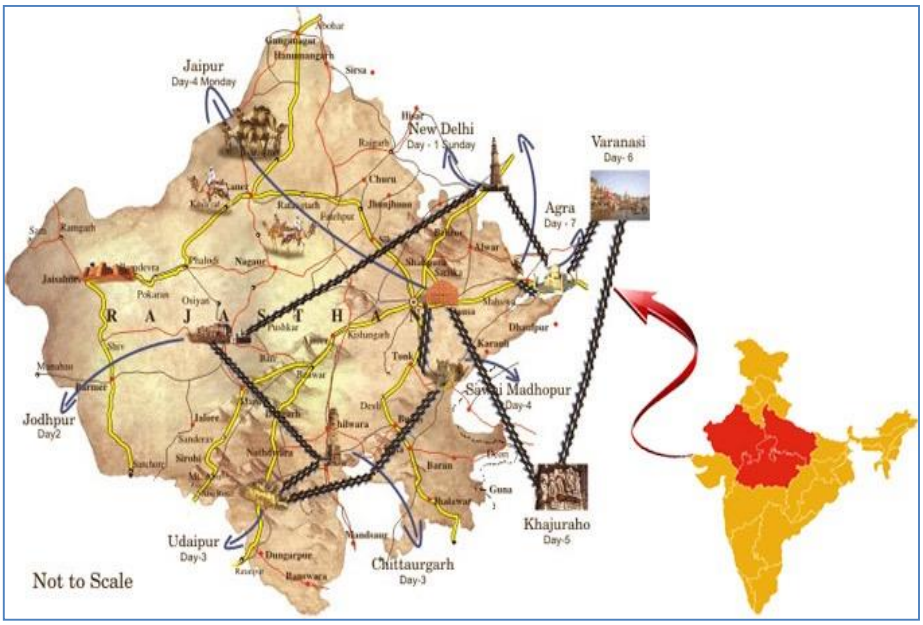






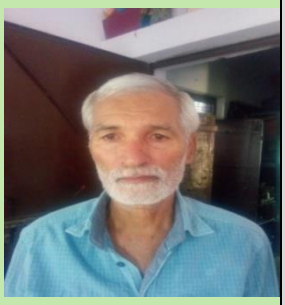


HkLN



Head Office
8,Vijay Colony,
Chittorgarh 312001,
Rajasthan

प्रयास Prayas
www.prayaschittor.org

Photo	Name	Designation	Photo	Name	Designation
	Khemraj Choudhary	Director		Preeti Oza	Coordinator Services
	Dr. Narendra Gupta	Adviser		Sudhir Kumar Katiyar	Project Director
	Chaya Panchauli	Sr. Programme Coordinator		Kshitiz Sisodia	Sr. Programme Coordinator
	Suman Chohan	Coordinator		Rameshwar Lal Sharma	Administrative Coordinator

	Vijal pal Sing	Sate Unit coordinator		Uma Amera	Field Coordinator
	Dinesh Bhai Parmar	Sr. Programme Coordinator		Goverdhan Yadav	Sr. Programme Coordinator
	Jawahar Singh Dagur	Sr. Programme Coordinator		Denis Semon Macwan	
	Madhav Lal Meghwal	Field Coordinator		Dinesh Kumar Yadav	Data Entry Operator

	M.N. Sasi	Sr. Accountant		Tushita Mukharjee	Researcher
	Udai Lal Meghwal	Field Coordinator		Roshan Lal Menariya	Sr. Accountant
	Pankaj Kumar Garg	Finance Manager		Kusum Lata Songara	Teacher
	Ashok Bhai Parmar	Manager		Dinesh Bhai Parmar	State unit Coordinator

	Seema Kanwar Rathore	Asstt. Accountant		Sudhindra Kumawat	Lawyer
	Narayan Salvi	Office Assistant		Dayal Thakor	Fild worker
	Shyam Lal Prajapat	Office Assistant		Bihari Sharan Vyas	Asstt. Accountant
	Phool Shankar Sharma	Driver cum Office Assistant		Geeta Mathur	Field Coordinator

	Ram Chandra Bhil	Driver cum Office Assistant		Shetan Regar	Field Coordinator
	Ramesh Rajeshwar Srivastav	Programme Coordinator		Lalu Ram Gameti	Field Coordinator
	Rav ji taviyad	Field Coordinator		Ratan bhil	Field Coordinator
	Vinod Kumar Bari	Office Assistant		Meena jadav	Programme Coordinator

	Balwant Singh Rajput	Driver cum Office Assistant		Madan Vaishnaw	Coordinator
	Unkar Lal Bhil	cook		Nagu Lal Meena	Office Assistant
	Rekha Nagda	Field Coordinator		Meena Ben Mulaji Bhai JAdav	Field Coordinator
	Divya tiwari	Program coordinator			

Financial Report

NYATI MUNDRA AND CO.
Chartered Accountants

2-3, ASHUTOSH NAGAR, CHITTORGARH,
RAJASTHAN 312001
Ph. 9414111446, 01472-244175

FORM NO. 10B

[See Rule 17B]

Audit Report under section 12A (b) of the Income-tax Act, 1961 in the case of charitable or religious trusts or institutions

We have examined the balance sheet of PRAYAS AAATP5082D [name and PAN of the trust or institution] as at 31/03/2016 and the Income & Expenditure account for the year ended on that date which are in agreement with the books of account maintained by the said trust.

We have obtained all the information and explanations which to the best of our knowledge and belief were necessary for the purposes of the audit. In our opinion, proper books of account have been kept by the head office and the branches of the above-named trust visited by us so far as appears from our examination of the books, and proper Returns adequate for the purposes of audit have been received from branches not visited by us subject to the comments given below:

In our opinion and to the best of our information, and according to information given to us the said accounts give a true and fair view: -

i. In the case of the balance sheet of the state of affairs of the above-named trust as at 31/03/2016.

ii. In the case of the income and expenditure account, excess of income over expenditure for its accounting year ending on 31/03/2016.

The prescribed particulars are annexed hereto.

For NYATI MUNDRA AND CO.
Chartered Accountants

NYATI MUNDRA & CO. Chittorgarh 312001 Chartered Accountants

(ARJUN MUNDRA)
PARTNER
Membership No: 074290
Registration No: 008153C

Place :CHITTORGARH
Date : 30/06/2016

Prayas
Village - Devgarh (Deolia), Pratapgarh, (Rajasthan) - 312605
CONSOLIDATED BALANCE SHEET
AS AT MARCH 31ST, 2016

LIABILITIES		AMOUNT	ASSETS		AMOUNT
FIXED ASSETS W/O (CONTRA)	Annexure-01	7,862,108.00	FIXED ASSETS W/O (CONTRA)	Annexure-01	7,862,108.00
			MISC. ASSETS	Annexure-05	3,501,662.00
INCOME & EXPENDITURE ACCOUNTS	Annexure-02	16,903,962.13			
- Opening balance as on 01/04/2015	18,975,776.28		DEPOSITS	Annexure-06	104,830.00
- Less : Payment during the year	4,023,096.00				
- Add : During the year (I&E A/c)	1,951,281.85				
			ADVANCE RECOVERABLE IN CASH OR KIND	Annexure-07	4,577,946.00
LIABILITIES AGAINST EMPLOYEES WELFARE FUND					
- Staff welfare		2,320,854.00	ADVANCE AGAINST PROJECT	Annexure-08	273,974.00
- Opening balance as on 01/04/2015	6,037,463.00				
- Add: during the year	864,139.00		STAFF LOAN (VEHICLE)	Annexure-09	56,229.00
- Less: Paid during the year	4,580,748.00				
UNSPENT GRANT BALANCES	Annexure-02	9,298,246.04	GRANT RECEIAVBLE OF EXPENDITURE AGAINST PROJECTS	Annexure-02	916,289.00
CURRENT LIABILITIES	Annexure-03	4,910,764.11	CASH AND BANK BALANCES		
			1 Cash in hand		8,520.00
			2 Cash at bank (SB & FD Accounts)	Annexure-10	24,089,376.28
PROVISION	Annexure-04	95,000.00	- SB Accounts	11,839,337.28	
			- FD Accounts	12,250,039.00	
TOTAL		41,390,934.28	TOTAL		41,390,934.28

0.00

Notes on accounts

The schedule referred to above form part of the accounts signed in terms of our report of even date

For: Nyati Mundra & Co.
Chartered Accountants
FRN No. : 008153C

(CA Arjun Mundra)
Partner
Membership No. 074290

NYATI MUNDRA & CO. Chittorgarh 312001 Chartered Accountants

Place: Chittorgarh (Raj.)
Date : 30-06-2016

For : Prayas

(Preeti Oza)
Secretary

Secretary
Prayas

(Khemraj Choudhary)
Director

Director
Prayas

Prayas
Village - Devgarh (Deolia), Pratapgarh (Rajasthan) - 312605
CONSOLIDATED INCOME AND EXPENDITURE ACCOUNT
FOR THE YEAR ENED ON 31-03-2016

EXPENDITURE		AMOUNT	INCOME		AMOUNT
FOREIGN CURRENCY PROJECT (EXPENSES)			**FOREIGN CURRENCY (INCOME)**		
1 Addressing Rights to Health by Promoting greater government accountability for safeguarding people's rights to access to essential medicines budget	Schedule No. - 01	5,087,981.00	1 Grant in aid to Foundation to Pramote Open Society, Newyork	Schedule No. - 01	4,225,567.19
2 Expanding Access to Reproductive Rights: Using the Law to Guarantee Reproductive Health and Rights in India	Schedule No. - 02	9,759,746.00	2 Grant in aid to Social Legal Information Center, New Delhi	Schedule No. - 02	2,136,053.00
3 Residential Educational camp (ASHA)	Schedule No. - 03	1,301,366.50	3 Grant in aid Asha for Education, USA	Schedule No. - 03	2,098,000.00
4 Barc Study Expenses	Schedule No. - 04	2,894.00	4 Grant in aid Ashta Sanstha, Udaipur	Schedule No. - 04	10,000.00
5 Empowering CSOs for Decent Work and Green Bricks in India's Brick Kilns	Schedule No. - 05	333,413.00	5 Grant in aid Centre For Education and Communication, New Delhi	Schedule No. - 05	2,896,723.60
6 Building State's Accountability on Health Care Financing through Research, Advocacy and Community Engagement in Rajasthan	Schedule No. - 06	377,024.00	6 Grant in aid National Foundation for India, New Delhi	Schedule No. - 06	377,000.00
7 Advocacy with the state is expected to make the state organs sensitive to the problem leading to favourable action and it is also expected to have judicial intervention supporting the target community.	Schedule No. - 07	1,020,019.00	7 Grant in aid Paul Hamlyn Foundation , New Delhi	Schedule No. - 07	1,378,350.00
8 To support the capacity building and formation of a community of young Indian scholars and activist to actively engage with Intellectual Property (IP) issues and strengthen the movement for access to essential and lifesaving medicines	Schedule No. - 08	3,071,582.00	8 Grant in aid to Foundation to Pramote Open Society, Newyork	Schedule No. - 08	3,129,464.16
			9 Grant in aid Oxfam India, Lucknow		50,000.00
9 Reducing child labour in brick kilns of Ajmer – Bhilwara districts of Rajasthan	Schedule No.-09	364,163.00	10 Grant in aid UK High Commission,New Delhi	Schedule No.-09	363,307.00
10 Research on the working conditions in certified (ginning) units in Gujarat	Schedule No.-10	77,702.00	11 Grant in aid Sudwind Institute, Germany	Schedule No.-10	622,597.00
11 Prayas Administrative Expenses	Schedule No.-11	568,051.08	12 Prayas Administrative Receipt	Schedule No.-11	408,500.00
Grant to Refunded to Donor	Annexure No. 02	134,668.00	13 **Bank Interest (FCRA ACCOUNT)**	Annexure No. 02	746,102.18
UNSPENT GRANT BALANCES	Annexure No. 02	8,893,494.07	14 **Opening Unspent Grant Balances as on 01/04/2015**	Annexure No. 02	12,703,600.44
LOCAL CURRENCY PROJECT (EXPENSES)			**LOCAL CURRENCY GRANT (INCOME)**		
1 Releasing brick kiln workers from debt bondage {P.353-2 (15)}	Schedule No.-12	696,234.00	1 Grant in aid United Nations Human Rights,Geneva	Schedule No.-12	-
2 A Research Study on understanding the barriers to antenatal care services use and institutional delivery in Rajasthan, India	Schedule No.-13	8,025.00	2 Consultancy from Columbia Global Center - Mumbai	Schedule No.-13	143,825.00
UNSEPNT GRANT BALANCES	Annexure No. 02	47.22	3 **Bank Interest (LC ACCOUNT)**	Annexure No. 02	37,173.00
			Opening Unspent Grant Balances as on 01/04/2015	Annexure No. 02	696,281.22
PCLRA , UDAIPUR PROJECT EXPENSES			**PCLRA , UDAIPUR GRANT INCOME**		
1 Towards a Wage Labour Exchange: Streamling Recrutment and Ensuring Social Security for Seasonal Migrants to Gujarat	Schedule No. - 14	785,416.00	1 Grant in aid Jamsetji Tata Trust - Mumbai	Schedule No. - 14	-
2 Towards a Wage Labour Exchange: Streamling Recuritment and Ensuring Social Security for Tribal Migrants to Gujarat	Schedule No. - 15	3,113,132.25	2 Grant in aid The J.R.D. Tata Trust - Mumbai	Schedule No. - 15	3,218,000.00
3 Orgnization Project on Migration Labours - Prayas	Schedule No. - 16	1,547,319.45	3 **Bank Interest (PCLRA ACCOUNT)**	Annexure No.- 2	74,793.00
4 **UNSPENT GRANT BALANCES**	Annexure No. - 2	154,567.75	4 **Opening Unspent Balances as on 01/04/2015**	Annexure No.- 2	828,430.06
5 **GRANT REFUNDED TO DONORS**	Annexure No. - 2	68,107.06	5 **Receipt from Prayas Resource Center, Chittorgarh**		1,547,026.00

NYATI MUNDRA & CO. Chittorgarh 312001 Chartered Accountants

P. R. Uza
Secretary
Prayas

Director
Prayas

Prayas

Village - Devgarh (Deolia), Pratapgarh (Rajasthan) - 312605

CONSOLIDATED INCOME AND EXPENDITURE ACCOUNT

FOR THE YEAR ENED ON 31-03-2016

EXPENDITURE		AMOUNT	INCOME		AMOUNT
LOCAL CURRENCY PROJECT ACCOUNTS (PCLRA URBAN RESOURCE CENTER, SURAT)			LOCAL CURRENCY PROJECT ACCOUNTS (PCLRA URBAN RESOURCE CENTER,SURAT)		
1 Scheme for setting up of service exchange Promotion Center & Urban Resource Center, Surat	Schedule No. - 17	218,793.00	1 Grant in aid Surat Municipal Corporation, Surat	Schedule No. - 17	270,812.00
			2 Bank Interest (PCLRA URC ACCOUNT)	Annexure No. - 2	2,599.00
OPENING OVERSPENT GRANT BALANCES AS ON 01/04/2015	Annexure No. - 2	139,541.00	CLOSING OVERSPENT GRANT BALANCES AS ON 31/03/2016		84,923.00
PRAYAS RESOURCE CENTER EXPENSES			PRAYAS RESOURCE CENTER (INCOME)		
1 Prayas Resource Center Expenses	Schedule No. - 18	250,846.08	1 Prayas Resource Center Income	Schedule No.- 18	410,020.68
			2 Bank Interest (PRC Account)	Annexure No. - 2	1,180,226.06
PRAYAS CENTER FOR HEALTH EQUITY EXPENSES			PRAYAS CENTER FOR HEALTH EQUITY (INCOME)		
1 Bank charges -(PCHE)		-	1 Bank Interest (PCHE)	Annexure No. - 2	593.00
PRAYAS GGCA/NGGCA TRUST FUND EXPENSES			PRAYAS GGCA/NGGCA TRUST FUND (INCOME)		
1 Prayas GGCA/ NGGCA Trust fund Expenses	Schedule No. - 19	23,081.28	1 Prayas GGCA/ NGGCA Trust fund Income	Schedule No. - 19	304,668.00
			2 Bank Interest (GGCA Trust fund Account)	Annexure No. - 2	3,861.00
EXCESS OF INCOME OVER EXPENDITURE		1,951,281.85			
TOTAL		39,948,495.59	TOTAL		39,948,495.59

Notes on accounts

The schedule referred to above form part of the accounts signed in terms of our report of even date

For: Nyati Mundra & Co.
Chartered Accountants
FRN No. 008153C

(CA Arjun Mundra)
Partner
Membership No. 074290

Place: Chittorgarh (Raj.)
Date : 30-06-2016

NYATI MUNDRA & CO. Chittorgarh 312001 Chartered Accountants

(Preeti Oza)
Secretary

Secretary
Prayas

For : Prayas

(Khemraj Choudhary)
Director

Director
Prayas

Prayas
Village - Devgarh (Deolia), Pratapgarh (Rajasthan) - 312605
CONSOLIDATED RECEIPT AND PAYMENT ACCOUNT
FOR THE YEAR ENED ON 31-03-2016

RECEIPT		AMOUNT	PAYMENT	AMOUNT
OPENING BALANCES			**PROGRAMME EXPENSES (FCRA)**	
Cash in Hand		12,802.00	1 Addressing Rights to Health by Promoting greater government accountability for safeguarding people's rights to access to essential medicines budget	5,072,981.00
Cash at bank		31,374,383.77		
- SB Accounts	18,559,374.77			
- FD Accounts	12,815,009.00			
GRANT IN AID (FCRA GRANT)			2 Expanding Access to Reproductive Rights Using the Law to Guarantee Reproductive Health and Rights in India	9,744,746.00
1 Foundation To Pramote Open Society, New york		4,225,567.19		
2 Asha for Education, USA		2,098,000.00	3 Residential Educational camp (ASHA)	1,296,366.50
3 Ashta Sansthan, Udaipur		10,000.00		
4 Center for Education & Communication,New Delhi		2,896,723.60	4 Barc Study Expenses, Udaipur	2,894.00
5 National foundation for India, New Delhi		377,000.00		
6 Paul Hamlyn Foundation, New Delhi		1,378,350.00	5 Empowering CSOs for Decent Work and Green Bricks in India's Brick Kilns	333,413.00
7 Foundation To Pramote Open Society, New york		3,129,464.16		
8 Oxfam India, Lucknow		50,000.00	6 Building State's Accountability on Health Care Financing through Research, Advocacy and Community Engagement in Rajasthan	377,024.00
9 Sudwind Institute for Okonomie and Okumene Germany Sudwind Institute		622,597.00		
10 UK High Commission, New Delhi		363,307.00	7 Advocacy with the state is expected to make the state organs sensitive to the problem leading to favourable action and it is also expected to have judicial intervention supporting the target community	1,020,019.00
11 Bank Interest (FCRA)		746,102.18	8 To support the capacity building and formation of a community of young Indian scholars and activist to actively engage with Intellectual Property (IP) issues and strengthen the movement for access to essential and lifesaving medicines	3,071,582.00
			9 Reducing child labour in brick kilns of Ajmer – Bhilwara districts of Rajasthan	364,163.00
			10 Research on the working conditions in certified (ginning) units in Gujarat	70,202.00
			11 Bank Charges	18,392.08
			12 Prayas Administrative expenses	512,159.00
GRANT IN AID (LOCAL GRANT)		180,998.00	**PROGRAMME EXPENSES (LOCAL)**	
1 Columbia Global Center- Mumbai	143,825.00		1 Releasing brick kiln workers from debt bondage (P.353-2(15))	696,234.00
2 Bank Interest (LC)	37,173.00		2 A Research Study on understanding the barriers to antenatal care services use and institutional delivery in Rajasthan, India	8,025.00
GRANT IN AID (PCLRA GRANT UDAIPUR)		3,292,793.00	**PROGRAMME EXPENSES (PCLRA, UDAIPUR)**	
1 Grant in aid The JRD Tata Trust - Mumbai	3,218,000.00		1 Towards a Wage Labour Exchange: Streamling Recruitment and Ensuring Social Security for Seasonal Migrants to Gujarat	785,416.00
2 Bank interest (PCLRA)	74,793.00		2 Towards a Wage Labour Exchange: Streamling Recuritment and Ensuring Social Security for Tribal Migrants to Gujarat	3,068,095.25
			3 Orgnization Project on Migration Labours - Prayas	1,547,319.45
GRANT IN AID (PCLRA URC GRANT , SURAT)		273,411.00	**PROGRAMME EXPENSES (PCLRA URC , SURAT)**	
1 Grant in aid Surat Municipal Corporation, Surat	270,812.00		1 Scheme for setting up of service exchange Pramotion Center & Urban Resource Center, Surat	218,793.00
2 Bank Interest	2,599.00			
Prayas Resource Center - Income		1,590,246.74	**Programme Expenses (Prayas Resource Center)**	250,846.08
Prayas Center for Health Equity - Income		593.00	**Programme Expenses (Prayas Center Health Equity)**	-
(Bank Interest - PCHE)	593.00			
Prayas GGCA/NGGCA TRUST FUND - INCOME		3,861.00	**PROGRAMME EXPENSES (Prayas GGCAT/NGGCA TRUST FUND)**	234.28
(Bank Interest - GGCA/NGGCA trust fund)	3,861.00		*(Bank Charges)* 234.28	

NYATI MUNDRA & CO. Chittorgarh 312001 Chartered Accountants

P. R. Oza
Secretary
Prayas

Director
Prayas

Prayas
Village - Devgarh (Deolia), Pratapgarh (Rajasthan) - 312605
CONSOLIDATED RECEIPT AND PAYMENT ACCOUNT
FOR THE YEAR ENED ON 31-03-2016

RECEIPT		AMOUNT	PAYMENT		AMOUNT
OTHER RECEIPT DURING THE YEAR		5,997,843.00	OTHER PAYMENT DURING THE YEAR		6,067,241.72
1 Philip Kumar Bags, Bhubneshwar	18,200.00		1 Manorama Jaiswal, Patna	6,500.00	
2 Tax Deduction at Source (TDS)	7,500.00		2 Develop.Resource & Training Center , BBSR	354.00	
3 Prayas Administrative Receipts	346,783.00		3 Prayas Kraya Karta Bachat Samuh	53,500.00	
4 Ashala Krishna	2,262.00		4 Goverdhan Yadav	5,000.00	
5 P. Sriniwas Rao	3,800.00		5 Sudhir Kumar Katiyar	1,302.00	
6 Programme & Admin fund	164,504.00		6 Tushita Mukharjee	434.00	
7 Bharat Sanchar Nigam Limited, Chittorgarh	5,000.00		7 Umesh Bhai Kuntar	3,500.00	
8 Mehul L Parmar	5,000.00		8 Mahima Creation, jaipur	58,702.00	
9 Gattu Pargi	19,475.00		9 Ganesh Printers, Jaipur	35,000.00	
10 Prayas Resource center, Chittorgarh	834.00		10 Shri Ram Sports & Bags, Chittorgarh	37,150.00	
11 Pranita Rane	1,309.00		11 Oxfam India, New Delhi	109,280.00	
12 Bharat Sanchar Nigam Ltd	1,810.00		12 IGSSS, New Delhi	25,388.00	
13 Life Insurance Coporation, Ajmer	4,085,285.00		13 Nyati Mundra & Co., Chittorgarh	87,110.00	
14 Narayan Lal Salvi (Vehicle Loan)	11,000.00		14 Amit Bhai Bhikha Bhai Patel, Surat	10,000.00	
15 Madan Das Vaishnav (Vehicle Loan)	6,024.00		15 Parmar Amit, Ahemdabad	17,000.00	
16 Pankaj Kumar Garg (Vehicle Loan)	10,427.00		16 Jamset ji Tata Trust, Mumbai	68,107.06	
17 M. N. Sasi (Vehicle Loan)	2,000.00		17 Outstanding Payable	24,500.00	
18 Vijay pal Singh (Vehicle Loan)	8,000.00		17 Professional Tax	880.00	
19 Madhav Lal Meghwal (Vehicle Loan)	9,000.00		18 ITO TDS (AY 2016-17)	170,377.00	
20 Gotam Lal S/o Galji Meena	25,500.00		19 Vodafone Digilink Ltd.	500.00	
21 Income Tax Department	382,680.00		20 NHRC, Mumbai	22,000.00	
22 Arihant Hardware & Plywood	80,000.00		21 Chairperson JNU, New Delhi	50,000.00	
23 Manish Suthar	10,000.00		23 Chhaya Pachauli	48,729.00	
24 Life Insurance Coporation, Ajmer	486,782.00		24 Lalu Ram Gameti	5,000.00	
25 Interest on GGCA Policy No. 310199	304,668.00		27 Staff Welfare	4,456,118.66	
			28 Staff Grauity payable	770,810.00	
			CLOSING BALANCES		
			1 Cash in hand		8,520.00
			2 Cash at bank		24,089,376.28
			- SB Accounts	11,839,337.28	
			- FD Accounts	12,250,039.00	
TOTAL		58,624,042.64	TOTAL		58,624,042.64

Notes on accounts
The schedule referred to above form part of the accounts signed in terms of our report of even date

For: Nyati Mundra & Co.
Chartered Accountants
FRN No. : 008153C

(CA Arjun Mundra)
Partner
Membership No. 074299

NYATI MUNDRA & CO. Chittorgarh 312001 Chartered Accountants

Place: Chittorgarh (Raj.)
Date : 30-06-2016

(Preeti Oza)
Secretary

Secretary
Prayas

For : Prayas

(Khemraj Choudhary)
Director

Director
Prayas