12:93

2-9-1993

Dr. Amar Jesani,
CEHAT,
310, Prabhu Darshan,
31, S.S.Nagar, Amboli,
Andheri (West),
Bombay - 400 058.

Dear Dr Amar Jesani,

Greetings from Community Health Cell!

Thanks for your letter dated 23-7-1993. We were quite busy in early August preparing for Thelma's trip to Canada. She went to present two papers from our study at the Conference of the International Network of Community Oriented Health Sciences at Sherbrooke and also attend a meeting at McMaster. Some of the groups I had met during my earlier trip to Canada have arranged meetings for her as well and so she will have a busy time and return on the 5th.

You should write to Mr. George Krause and Mr. Ulrich Dornberg of Misereor, Postfach 1450, D-52015, Aachen, Germany, about CEHAT and its evolving studies. One or both of them are likely to be visiting India in November for the CHAI Jubilee meeting in Secunderabad from 31st October to 7th November, 1993. They could probably discuss further at that time and would need to put Bombay on their itinerary. I had been to Aachen in May to facilitate a workshop on State of India's Health and many of the issues you want to do studies on, emerged as key issues for 1990s - womens health, violence/ human rights violation etc. Krause has been travelling in India for nearly two decades or more and has a very good understanding of grassroots realities and issues. They are keen to fund secular groups and are not imposing in their relationship. Presently they fund our library and documentation unit.

I was not very sure what sort of funds - levels - over what sort of time etc., you are exploring. Also a more detailed study proposal around specific hypothesis may get more easier funding than monitoring vaguely the overall focus and ofcourse depending on the study methodology, the funds needed could be very varied.

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If you write to Misereor, mark a copy to us so that we too could follow it up when we meet them in November, 1993.

Our plans after December, 1993 are still uncertain but we may have some further clarity when Thelma return.

Best wishes to you, Vibhuti, Lara and mfc-Bombay friends.

Yours sincerely,

for Ravi Narayan.

*rn/vnnr

47:93 14-09-1993

Mr. Ulrich Dornberg / Mr. Gerog Krause,
MISEREOR,
Postfach 1450
52015 Aachen,
Germany.

Dear

Greetings from Community Health Cell!

1. This is in response to your letter of 13th July, 1993 (Kr/pk 321/9.1) regr the CMAI Primary Health Care Newsletter proposal. In the rush of completing many items of work in preparation for handing over coordinatorship in July, I misplaced this letter for a while. It resurfaced recently as I was looking through piles of paper and I have just managed to show it to Dr. C.M.Francis, who now works with us as a part-time consultant and also to other team members. As you have indicated this is a 'desk reaction' to the venture from us. I always prefer to discuss the matter out with the partners concerned so that the comments are seen as 'questions' for reflection to improve or modify the project proposal rather than an outside consultants' view of whether it is C.K. or not C.K. However since CMAI is by now quite used to our critical perspectives I am sending this note to you based on our intra-team discussions.

2. Have you all written anything up as a sort of summary report or list of issues for follow up after the Aachen workshop? I would love to have a copy so that one is clearer about how the group responded to the perspectives shared etc. I wrote a very short note about the workshop and the trip for our Executive Committee and this is enclosed in a spirit of partnership. It is not comprehensive just a few salient points!

3. Thelma has just returned from her Canadian trip which was most interesting in terms of meetings and sharing perspectives. The Canadian proposal is evolving at a rather slow pace partially because of the 'funds' problem. We have also now decided to explore the London School connection more actively since the phase is scheduled to begin January 1994. For the present, we feel we shall have enough to consolidate/write up based in Bangalore itself till around April, 1994 - so we hope to move if at all ~~May~~, 1994 or thereafter. We presume one or both of you will be visiting India later this year - so hopefully there will be more to report by then and perhaps to explore as well!

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4. A group of mfc colleagues - serious researchers/activists have recently moved beyond FRCH-Bombay and set up their own group called CEHAT. A pamphlet is enclosed and in a recent letter to Dr. Amar Jesani (copy enclosed) I have requested them to approach you for support since their areas of enquiry are very relevant for the evolving current situation. Do follow it up during your next visit - especially if Bombay is on the itinerary.

5. It feels nice to be able to sit back and see CHC evolving gradually towards newer directions and initiatives. The new team is forming up and while we have been helping Dr. Shirdi Prasad Tekur in planning and orienting it is from a position of 'not being in charge' which is a new experience. Ofcourse the Research Project publications/reports are still taking up much of the time since these have to be completed definitely by December, 1993 when we phase out fully.

Best wishes from both of us and the CHC team,

Yours sincerely,

Ravi Narayan.

Encl: 1. Note on CHAI's project proposal;
2. RN's letter to Dr.Amar Jesani dated 2.9.93

*rn/vnnr

C.HAI Project Proposal: Support for relevant Primary Health Care Newsletter for India.

Some comments

1. There is no doubt that a newsletter on PHC which is practical, and links experience with evolving theory in India and abroad would be a great stimulus to Health care. The FIGMA Newsletter of CMAI is already one such. Similarly Health for the Millions of VHAI and Health Action of CHAI also provide some stimulus in this direction.

2. While the attempt to amalgamate FIGMA, and Indian edition of ARI and Diarrhoea Dialogue may seem a laudable objective - arriving at a need by reviewing existing NGO communications and identifying lacunae which need to be met in a 'new newsletter' may be a more sensible way of arriving at identifying the need.

3. Also ARI and Diarrhoea Dialogue are typical of the selective primary health care approach and though they do provide practical information regarding these two problems the new newsletter should be more integrated towards Comprehensive Primary Health Care and perhaps also strongly emphasise the Community Health perspective relevant to the Indian situation especially since the mandates of CMAI and CHAI now endorse this broader view and more comprehensive basis for action. This is not adequately spelt out in the objectives.

4. The proposal seems to be a collaboration between CHAI and AHRTAG. CHAI seems to have been an after thought! With Health Action, Catalyst and a member oriented newsletter (post jubilee) being already on the CHAI anvil what will their real contribution to this contribution actually operationalise? Is VHAI involvement in the thinking through of the focus and objectives a practical possibility. Since CHAI and CMAI members form the core of VHAI itself and VHAI has initiated so many other publications that are also now practical oriented apart from HFM - various wall papers etc., is their participation in planning feasible?

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5. The editorial group has not been spelt out. It is crucial to select appropriate persons and especially those that have 'practical' experience or atleast grassroots contact so that 'praxis' is emphasised not 'theory'. To reduce travel expenses, persons in and around Delhi may get selected but an attempt to tap experience of different and remote parts of the country are required and this needs some creative planning and establishing of linkages with 'doers' and not only 'thinkers'.

6. The amount seems huge. It is presumed that it is a monthly. This would mean the cost comes to Rs.7-00 per copy. This seems too much. It is said to be a 12 page publication with 20,000 copies. The cost will be much less unless there are multiple colours involved and or use of art paper.

7. It is difficult to got into the details of the budget. The overall impression seems it is high though whether this is a reflection of costs in the capital city, one cannot say. e.g., for postage and distribution Rs.2.2 to 3.2 lakhs is provided. If the newsletter is registered (which can be done in 3 months), the postage will be very low. So also for many items the provision seems rather high.

8. In the covering letter, there is a mention of a more comprehensive application. May be that would provide more details of the objectives, methodology, process and evaluation of effectiveness - since these need to be spelt out in greater detail to help the project get started on a much former base.

9. There is a lot of practical field experience, creative adaptation, appropriate technology and alternative ways of doing things towards empowerment of people, demystification and creating autonomy in health care. It would be a challenging task to reach this experience and share it around. Many of the existing newsletter are too top-down, theoretical and prescriptive of uniformity rather than representing the rich diversity that abounds. But getting to 'feel see and hear' this needs perhaps a little more grassroots oriented journalistic skill rather than relying on expert editorial boards. Can the newsletter introduce this dimension in the planning/ management process?

-x-x-x-x-x

CEHAT

519, Prabhu Darshan, 31, Swatantrya Sainik Nagar, Andheri West, Bombay 400058, India

INST/MISE/95/ 2167 Speed Post
November 24, 1995.

Drs. Ravi and Thelma Narayan,
Community Health Cell
367, Srinivas Nilaya, Jakkasandra, I Main
I Block, Koramangala, Bangalore 560 034.

Dear Ravi and Thelma,

Greetings from friends here.

It was nice knowing that you people are here. The *Cehat* is doing well. We had some finacial problems in last two months as the FCRA misplaced some papers of our application but that has been sorted out and the prior permission given. This project is in line with Ravi's Jalgaon study titled "Cost of Health Care" but would concentrate on the reported morbidity, practitioners utilised and cost of women's health. All household expenditure studies done so far have substantially missed out on cost of women's health. This is going to be a very difficult study, and thus makes us very excited about it. If you are interested in its progress, I will ask Sunil Nandraj to write to you from time to time.

One of our MFC friend from Kanpur, Dr. Abhay Shukla has settled down in Dahanu (in Thane district where *Kashtakari Sanghatna* works) to begin a primary health care project in the tribal people's movement. I am sure this would remind you of Dhruv/Anant's views of doing health work as a part of people's movement. Yes, Anant is involved, he will be conducting the first camp for training women health workers from villages in the first week of December, 1995. The Cehat has submitted a proposal for funding this project to the CAPART. The CAPART representative has done its appraisal last week and we hope it would be processed fast. But, as usual we are not waiting for the funds. If the funds come we will establish a modest medical/health centre in one of the villages to provide first level referral services with a doctor to provide support to women health workers' work. With this, our community level work has taken off. In the next phase, we intend to establish primary health care work in Bombay slums. Of course this would take one more year to take shape, but it is on the agenda.

On the research side, situation is equaally good. We have completed two studies (Study of physical standards for care in private hospitals in Satara district, it is a study of 49 nursing homes, and a study of legal aspects of health care) for the UNDP/GOI. We also did a substantial database report on state health expenditure, 1952-95, which has been published in the EPW, April 15 and 22, 1995 issues in two installments. These data are on the computer, so go through these statistics in EPW and if you have any special need for data, national or statewise, please write to Sunil. He would send them to you. Besides, we are doing two chapters (on Medical Ethics and Private Sector) for the Independent Commission on health of the VHAI. And a study of state financing (national and all states) of major disease control programmes, 1986-1995 (if Thelma is interested in such data, please ask her to write to Sunil)

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(Fax received only from Monday to Friday, between 10 a.m. to 5 p.m., Indian Std. Time)

CEHAT is a Research Centre of *Anusandhan Trust* Regd Under Bombay Public Trusts Act Regd No E-13480

RN 25/11/95 Regarding our Relation in CEHAT File along with other papers

25/11/95 378

for the UNDP/GOI. A major study on social aspect of abortion will be completed in Pune by March next year and a book on it will be ready by September 1996. An edited book titled *"Market, Medicine, Malpractice: Issues and Case studies"* published by the CEHAT is in press and should be available in January.

We have worked like donkeys in last two years to establish the Cehat as a reliable and good research institute. Personally, I am quite satisfied, and the results have started showing. The Cehat has started getting recognised for its expertise and we are finding it difficult to honour invitations we are getting. Ravi and Sunil are now invited to the US to present their critique of world bank's India papers on family planning. They are going there for a week from December 10, 1995.

In this rush, I had kept my plans of developing work on violence on hold. Thus, I could not follow up what I had promised to the MISEREOR. Now, I feel less insecure about the Cehat and so I have decided to get out of my health service research by December end. From January, I will have no project to work on. I have applied for a fellowship from the Times Fellowship Council, to work on the health services response to epidemic of violence but I am not sure about getting it. If I don't get it, I will have to make lots of efforts to get some support to myself and that was why I called up in case Misereor is interested in supporting something. To be frank, I have lost interest in most of the issues on health except violence, ethics and malpractice. That limits my choice but that is also a good incentive to develop those areas.

Early in this month (November) I attended a meeting at Amsterdam on human rights and health and also visited Paris where I have several friends working at the treatment centre for violence victims (Primo Levi). One of them (Francoise Sironi) has visited India several times, spent lots of time at Cehat and closely observed work I have been doing with the victims and they also provided support when I was undergoing crisis due to the experience of violence. They have established their own centre with the support of Amnesty and other groups. They have given their full commitment to provide us support whenever needed. If they get finance, a team from their organisation might visit Bombay early next year to make a report on the need for such a centre here. We felt that since we would need large funds, such a report would help in raising finances. We have also made a proposal for creating an alternative international network of NGOs involved in providing treatment to violence victims with a community based and culturally sensitive approach. While the biggest network in this field is sponsored by the IRCT, Copenhagen, there are many community based and or socially oriented groups involved in such work on violence and not part of that network due to its high emphasis on medical model and so called value free approach.

Anyway, in short, this is the direction I intend to take from January, 1996. Thus, I have enclosed proposals for the consideration of Misereor. I have apologised to them for not contacting for so long, and I have no explanation to offer except that I was too busy in establishing Cehat (and of course helping *Medical Ethics, RJH and MFC*).

Of the five proposals, the first one is sent to the Times Fellowship Council. If I get the fellowship, I may be working on torture in police custody. For Misereor, I am interested in undertaking a study of health system's response to communal violence in Bombay and if enough

funds are made available, then in Ahmedabad or Surat, too. If Ahmedabad is included, I would like to persuade our MFC friend Dr. Hanif Lakdawala who is presently working most of the time on mobilising liberal Muslim opinion on communalism, to help in the work. I would be the happiest person if the Misereor show interest in the second proposal which is about establishing medical centre for treatment of victims of violence. But it needs big funds, about 3 million rupees a year. The high funds will be needed as we will need rent for a separate place, for library documentation, remunerations for doctors and nurses and for undertaking actions to prevent further occurrance of violence to treat and rehabilitate victims. If they can't, I will continue with my efforts elsewhere.

There are two other proposals, one on medical malpractice and another on PDIC, both are known to you as for the former, much was reported in the MFC and for the latter, Anil Pilgaokar has written in the MFC bulletin.

I know that giving several proposals at a time might confuse the funding agency. But voluntary work on each (except proposal on child abuse) is already on. The funds are needed to institutionalise them as many of us are fast burning out due to spending long working days and also for doing wotk on week ends. We have no choice but to get funds to support some salaries and other expenditures so that work is made more effective, efficient, and some relief is provided to volunteers.

Lastly, we would be happy to have collaborative work on any of the project mentioned with you or CHC or both. I strongly feel that organisations which have evolved from the MFC influence should be collaborating at the national level to make our intervention very effective. I do not believe in doing work in a corner without concern for influencing larger processes for change at national level. The collaborations have their peculiar problems, but unless we learn to amicably manage such problems there is no possibility of making a greater impact. Thus, I will be interested in undertaking something that could be done multicentric or as a part of a loose collective or network of friends. I leave it to your discretion by saying that I will be open to newer ideas. So go through the papers enclosed for the Misereor and let me know.

I am also enclosing a letter for Dr. Francis. We will be very disappointed if you decide not to come for the MFC meet. Believe me, although certain things can never change in the MFC, there are also many things which are changing. The tempo for the meet is building up, and we expect 50 to 75 persons. I have also written to Dr. Francis about the meet and requested him to attend, more so because it is on ethics. We expect the January issue of Medical Ethics to be ready by December 25, so that it is made available at the meet.

I am sure reading this bundle of papers would take your day, my advance apologies for that. I do feel that I am burdening you a lot, more so as it relates to the funding and to the development of research areas. My apologies for that too.
Our best wishes and regards to all friends there.

Yours sincerely,
Amar
Amar Jesani.

Dear Ravi,
Thanks for volunteering to give the enclosed material to the MISEREOR & letter to Dr Francis. In case Misereor people do not meet you, please let me know so that I can send it to them to Germany.
Please do not hesitate in going through the material & giving your suggestion
with regards
Amar

PUBLICATIONS

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(A) Health care services and financing

Studies, reports and books:

(RA.04) Patient satisfaction in the context of socio-economic background and basic hospital facilities: A pilot study of indoor patients of the LTMG hospital, Mumbai, Iver Aditi, Jesani Amar, Karmarkar Suntosh: Mumbai: CEHAT, October 1996, pp.56.

(RA.03)Financing of disease control programmes in India, Nandraj Sunil, Duggal Ravi. Mumbai. CEHAT, February 1996, pp.53.

(RA.02)The private health sector in India: Nature, trends and a critique, Duggal Ravi: Mumbai: CEHAT, January 1996, pp.47.

(RA.01) Special statistics on health expenditure across states, Duggal Ravi, Nandraj Sunil, Vadair Asha: *Economic & Political Weekly*, Vol. XXX, *Part I* in No. 15, April 15, 1995, pp.834-844, and Part II in No. 16, April 22,1995, pp.901-908.

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(PA.24) From philanthropy to human rights: A perspective for health activism in India, Jesani Amar (Paper presented at the Diamond Jubilee Conference on "Social Movements" organised by the Tata Institute of Social Sciences, Mumbai on November 3, 1996): Mumbai: CEHAT, November 1996, pp.24.

(PA.23) National disease control programmes: Recent trends in financing, Nandraj Sunil, Duggal Ravi: *Radical Journal of Health* (New Series), Vol. II, No. 1, January-March 1996, pp.

(PA.22) Cost of medical care: Issues of concern in the present scenario, Nandraj Sunil (Paper presented at the All India Peoples Science Network, Seminar on Health For All Now, New Delhi, November 1995): Mumbai: CEHAT, November 1995, pp.13.

(PA.21) Medicos' strike: Relevant issues, Jesani Amar: *Radical Journal of Health* (New Series), Vol. 1, No. 4, October-December 1995, pp.247-50 (Editorial).

(PA.20) Market reforms in health care, Jesani Amar: *Radical Journal of Health* (New Series), Vol. 1, No. 3, July-September 1995, pp.171-3 (Editorial).

(PA.19) Public health budgets: Recent trends, Duggal Ravi: *Radical Journal of Health* (New Series). Vol. I, No. 3, July-September 1995, pp.177-82.

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(PA.16) The number game, Duggal Ravi: *Humanscape*, November 1994, pp.20-22.

(PA.15) The great divide, Duggal Ravi. *Humanscape*, October 1994, pp.14-15.

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(PA.14) Population meet: Poor impact of NGOs, Duggal Ravi: *Economic and Political Weekly*, Vol. 29 No 38, September 17, 1994, pp 2457-8.

(PA.13) Population and family planning policy: A critique and perspective, Duggal Ravi (Paper presented at International Conference on Population and Development, Cairo, September 1994): Mumbai: CEHAT, August 1994, pp.6.

(PA.12) New moves: The Indian drug scene, Pilgaokar Anil: *Voices*, Vol.: II, No. 3, 1994, pp.22-24.

(PA.11) Health finance of the Brihan-Mumbai Municipal Corporation, Duggal Ravi, Nandraj Sunil (Background paper for Medico Friend Circle, Mumbai Group's Workshop on *Improving Public Hospitals in Mumbai*, June 1994): Mumbai: MFC - Background papers, May 1994, pp.37-44.

(PA.10) Peoples economy: context and issues from India, Duggal Ravi (Paper presented at Seminar on "Market Economy Also for the Poor", Berne, Switzerland, May 1994), Mumbai: CEHAT, May 1994, pp.14.

(PA.09) For a new health policy: A discussion paper, Duggal Ravi (Paper presented at the study circle organised by the MFC/FMES/ACASH, Mumbai, on August 21, 1994): Mumbai: CEHAT, August 1994, pp.13.

(PA.08) Health manpower in India, Duggal Ravi (Paper prepared as National Consultant on WHO project, for the Ministry of Health, New Delhi): Mumbai: CEHAT, August 1993, pp.20.

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(PA.06) Resurrecting Bhore: Re-emphasising a universal health care system, Duggal Ravi: *MFC Bulletin*, No. 188-9, November-December 1992, pp.1-6.

(PA.05) Trends in FP policy and programmes, Duggal Ravi (paper presented at seminar on "Trends and perspectives for FP in the Nineties", Mumbai Union of Journalists, August 1992): Mumbai: CEHAT, August 1992, pp.15.

(PA.04) Cost and concern in primary health care, Duggal Ravi: *Health Action*, Vol. 5, No 8, August 1992, pp.

(PA.03) Regional disparities in health care development: A comparative analysis of Maharashtra and other states, Duggal Ravi (paper presented at the national workshop on health and development in India, NCAER/Harvard University, Delhi, January 1992), Mumbai: CEHAT, 1991, pp.20.

(PA.02) Ending the underfinancing of primary health care, Duggal Ravi, *MFC Bulletin* No. 177-178, November-December 1991, pp.7-9.

(PA.01) Private health expenditure, Duggal Ravi, *MFC Bulletin*, No. 173-174, July-August 1991, pp14-6.

(B) Health legislations, ethics and patients' rights

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(RB.02) Laws and health care providers, Jesani Amar, Mumbai: CEHAT, January 1996, pp.135.

(RB.01) Physical standards in the private health sector: A case study of rural Maharashtra, Nandraj Sunil, Duggal Ravi: Mumbai: CEHAT, November 1995, pp.133.

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(PB.23) Medical ethics and professional self-regulation: Some recommendations, Jesani Amar: *Health for the Millions*, Vol. 22 No. 4, July-August 1996, pp. 24-9

(PB.22) Crisis of credibility: The tale of Medical Councils, Iyer Aditi: *Health for the Millions*, Vol. 22 No. 4, July-August 1996, pp. 17-20.

(PB.21) Editorial, Jesani Amar (As guest editor): *Health for the Millions*, Vol. 22 No. 4, July-August 1996, pp. 2.

(PB.20) Physical standards in the private sector: A case study of rural Maharashtra, Nandraj Sunil, Duggal Ravi: (Accepted for publication in *Radical Journal of Health*, New Series). 1996.

(PB.19) Law, ethics and medical councils: Evolution of their relationships Jesani Amar, *Medical Ethics*, Vol. 3, No. 3, July-September 1995, pp.C-IX-XII.

(PB.18) Medical ethics: General principles, Pilgaokar Anil: *Medical Ethics*, Vol.: 3, No: 2, April-June 1995, pp.C-V to C-VIII.

(PB.17) Self-regulation or external control?, Jesani Amar: *Medical Ethics*, Vol.: 3, No.: 2, April-June 1995, pp.18. (Editorial)

(PB.16) In the pink: Need for asserting patients' rights, Jesani Amar, Pilgaokar Anil: *Keemat*, Vol.: 24, No: 3, March 1995, pp.12-4.

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(PB.14) Assessing the need for and designing an accreditation system: Situation in India, Nandraj Sunil (Paper prepared as consultancy for Institute of Health Systems, Hyderabad, July 1994): Mumbai: CEHAT, August 1994, pp.10

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(PB.10) Patient's autonomy: Throwing it to the winds?" Jesani Amar, Pilgaokar Anil: *Medical Ethics*, Vol. 1 No. 1, August-October, 1993, pp.6-7.

(PB.09) Patients' rights: A perspective, Jesani Amar, Nadkarni Vimla: *The Indian Journal of Social Work*, Focus Issue: Patients' Rights, Vol.: LIV, No: 2, April 1993, pp.167-71. (Guest editorial)

(PB.08) User charges and patients' rights, Duggal Ravi: *The Indian Journal of Social Work*, Focus Issue: Patients' Rights, Vol : LIV, No: 2, April 1993, pp.193-97.

(PB.07) Medical ethics and patients' rights, Jesani Amar: *The Indian Journal of Social Work*, Focus Issue: Patients' Rights, Vol.: LIV, No: 2, April 1993, pp.173-187.

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(PB.05) Medical ethics: Awaiting a patients' movement, Jesani Amar, Duggal Ravi: VHAI, *State of India's Health* (Book): New Delhi: 1992, pp.365-77.

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(C) Women's health

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(RC.01) Garbhapat: Samaj ani Adhikar, Gupte Manisha, Bandewar Sunita, Pisal Hema, (Slide Show, in Marathi), Mumbai: CEHAT.

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(PC.13) Women's perspectives on the quality of health care and reproductive health care: Evidence from rural Maharashtra, Gupte Manisha, Bandewar Sunita, Pisal Hemlata (Scheduled for publication in a book to be brought out by the Ford Foundation). Mumbai: CEHAT, December 1995, pp.28.

(PC.12) *Umaltya kalayanche prashna*, Gupte Manisha, Pisal Hemlata (article for AFARM). Mumbai: CEHAT, December 1995, pp.4. (In Marathi)

(PC.11) *Jant: Prasar ani laxane*, Pisal Hemlata: Mumbai: CEHAT, September 95, pp.8. (In Marathi)

(PC.10) *Saad sharirachi*. Gupte Manisha: *Palakneeti*, Vol. 65, Diwali 1995. (In Marathi)

(PC.09) Our health costs little, Duggal Ravi: in Karkal Malini (Ed.) *Our lives, our health,* (Book) New Delhi: Coordination Unit, World Conference on Women, Beijing, 1995, August 1995, pp.54-59.

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(PC.02) Sexism in medicine and women's rights, Prakash Padma, George Annie, Panalal Kuparide. *The Indian Journal of Social Work*, Focus Issue: Patients' rights, Vol.: LIV, No. 2, April 1993 pp.199-204.

(PC.01) Nurses as women, Jesani Amar. *Economic and Political Weekly*, March 2-9, 1991, pp.493. (Book Review)

(D) Investigation and treatment of psycho-social trauma

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(RD.04) Mumbai riots: January 1993: A selected documentation from a section of the print media, Jesani Amar, Alphonse Mary, D'Sa Aloysius. Solidarity for Justice, Mumbai March, 1993, pp.180.

(RD.03) An enquiry by the fact finding team into the police firing that led to the killing of a tribal and caused injury to others in Dahanu Taluka, Thane District, Maharashtra, Oza Bhushan. Jesani Amar and others. Mumbai: Fact Finding Team, July 1992, pp.17.

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Papers and essays:

(PD.15) **Violation of medical neutrality in India,** Jesani Amar (Paper presented at the international Congress on "Violation of medical neutrality" organised by Johannes Wier Foundation at Utrecht, the Netherlands, on November 8, 1996): Mumbai: CEHAT, November 1996, pp.5.

(PD.14) *Report from India:* **Post-graduate diploma course on human rights,** Jesani Amar: *PST Quarterly* (The Philippines), Vol. 1, No. 2, July-September 1996, pp.30-1.

(PD.13) Directory of persecuted scientists, engineers and health professionals, Jesani Amar: *Issues in Medical Ethics,* Vol. 4, No. 4, October-December 1996, pp. 135 (Book Review)

(PD.12) PST Quarterly inaugural issue, Jesani Amar: *Issues in Medical Ethics,* Vol. 4, No. 4, October-December 1996, pp.135 (Review of Journal)

(PD.11) INHHRO conference of health, human rights, ethics, Jesani Amar: *Issues in Medical Ethics,* Vol. 4, No. 1, January-March 1996, pp. 27.

(PD.10) Health of child labourers in India, Sinha Roopashri: Mumbai: CEHAT, December 1995, pp.6.

(PD.09) Police, prison and physician, Jesani Amar: *Medical Ethics*, Vol. 3, No. 4, October-December 1995, pp.58 (Editorial).

(PD.08) Supreme court judgement violates medical ethics, Jesani Amar: *Medical Ethics*, Vol. 3, No. 3, July-September 1995, pp.38 (Editorial).

(PD.07) The doctor's dilemma: A supreme court judgement on death by hanging violates medical ethics, Jesani Amar, Vadan Asha: *Humanscape*, March 1995, pp.12-3.

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(PD.04) Slippery slopes of Nazi medicine, Jesani Amar: *Economic and Political Weekly,* Vol. XXIX, No. 43, October 22, 1994, pp.2805-2807. (Review Article).

(PD.03) When medicine went mad: Bioethics and the Holocaust, Jesani Amar: *Medical Ethics,* Vol. 2, No. 1, August-October 1994, pp.10-11. (Book Review).

(PD.02) Doctors and hunger strikers, Jesani Amar: *Humanscape,* June 1994, pp.7-9 & 29).

(PD.01) Repression of health professionals, Jesani Amar: *Economic and Political Weekly,* October 5, 1991, pp.2291-2.

CEHAT

519, Prabhu Darshan, 31, Swatantrya Sainik Nagar, Andheri West, Bombay 400058, India

October 9, 1995.

A Brief Report for the Network meeting of Health and Human Rights Groups.

WORK OF CEHAT ON HUMAN RIGHTS AND HEALTH

About CEHAT: The *Cehat* is an institution in the non profit voluntary sector involved in the research and action in the field of health. It is in existence since 1992.

The *Cehat* has a long term research and action programme on the violence and psychisocial trauma. This programme has been undertaken, so far, without any systematic funding from any agency. However, the quantum of work done purely on the voluntary basis is substantial.

Library Documentation:

The *Cehat* has established a fairly good collection of books (3000), journals (25 received regularly) and documents (3500) on health and health care. Of them, 25% are on the psychosocial trauma, human rights investigation reports, medical ethics and violence in general.

We consciously and systematically promote the use of our library and documentation by scholars, activists, media persons and individuals from other NGOs. The utilisation of this centre by such concerned people is fairly good. On several debates that took place in the national media in last two years on public health, medical ethics and human rights issues, the media persons responsible for such reporting had used the information available with us.

Our day-to-day documentation on human rights violation is still not systematised due to lack of funds. However, selected clippings from newspapers, journals and popular magazines are maintained in order to prepare comments by our staff in the scientific journals and for the media from time-to-time.

Problems and future plans: While we have good collection and contacts for dissemination of information, we are handicapped by logistical and financial problems. (1) We do not have a full time professionals to manage our library and information system. (2) We need to computerise our library and information system, as the users do not have sufficient time to dig out documents and other information. (3) We would also like to have a publication officer who could analyse information collected and makes our efforts at publication of material efficient so that the documents prepared could be easily disseminated to a wider audience, particularly to people outside Bombay.

Telephone/Fax: (91) (022) 625 0363 *E-Mail:* cehat @ inbb.gn.apc.org

(Fax received only from Monday to Friday, between 10 a.m. to 5 p.m., Indian Std. Time)

CEHAT is a Research Centre of *Anusandhan Trust* Regd Under Bombay Public Trusts Act Regd. No:E-13480

Research, Education and Training

This has been the strongest part of our work so far. This work is carried out by our staff purely on voluntary basis within the CEHAT as well as with other organisations and associations of which they are individually members. Three such organisations need mention: (1) Indian Medical Association, (2) Forum for Medical Ethics Society, and (3) Medico Friend Circle.

(1) Research: No project based systematic research was undertaken. What we have been doing is to continuously collect information, maintain selected documentation of clippings from newspapers and magazines, and purchase necessary books and documents for research. On three subjects substantial work has been done and part of it published: (1) Custodial deaths in Maharashtra state in 1980s. (see publication nos. 10 & 11) Its findings were presented in an International Seminar organised by the Indian Medical Association in New Delhi. (2) Doctor's role in the death penalty (see publication nos. 8 & 9), and (3) Doctors role in the force feeding of hunger strikers (see publication nos. 15 & 16)

Future Research Plans: The research has been done informally so far. It is now time to systematise it by getting financial support. The CEHAT is at present looking for financial support for its research. The following topics are identified for further research: **(1) Force Feeding:** Hunger striking is the commonest form of political protest with a history of over a century. The forced feeding of hunger strikers and doctor's participation in it have been equally common. We would like to undertake historical and sociological research in this field so that advocacy for stopping doctors participation in force feeding could be strengthened. **(2) Torture in the Ancient and Medieval India:** With the rise in the religious fundamentalism, all practices of torture are conveniently laid at the doors of "outside" forces like Muslim invaders and christian colonialists. This kind of arguments are used for minority community bashing. There is however strong irrefutable evidence that torture was systematically practiced in India before these "aliens" came to India. Historical research on the subject would help in showing that the systematic violence has been part of Indian culture for centuries. It is no use blaming so called alien forces for its existence. What is required is the will and sincerity to stop it. **(3) Violence as a public health issue:** The *Cehat* is presently planning collaboration with various agencies for studying epidemiology of violence.

(2) Education: The educational work is a very regular feature of the Cehat. It is done in three ways. (I) *Providing information to mediapersons and legal professionals.* a number of media persons and legal professionals have used our library documentation services, have interviewed the *Cehat* professionals to prepare their news reports and also participated in the meetings, workshops, seminars organised with the help of *Cehat* staff. We have also got published in the newspaper interview of visiting professional from other treatment centres. (II) *Organisation of meetings, workshops and seminars:* The Cehat has helped other organisations, such as Medico Friend Circle, Committee for Protection of Democratic Rights and Forum for Medical Ethics in organising seminars, workshops and lectures on various subjects. For instance, the Medico Friend Circle, a nationwide organisation of health activists is organising its 22nd annual conference from December 27-29 in central India on "Ethics in health care". The *Cehat* staff members will be conducting a workshop on ethical responsibility of health professionals in cases of violence. (III) *Publication of Papers, articles etc. in various journals:* So far,

SEVENTEEN papers and articles have been published in various journals, magazines and newspapers. (See papers listed from no. 8 to 24). The *Cehat* staff members are on the editorial boards of two scientific journals, *Medical Ethics* (a journal of medical professionals) and *Radical Journal of Health* (social science health journal). In addition, the *Cehat* has on its governing board the senior assistant editor of the largest circulating and prestigious social science journal, *Economic and Political Weekly.*

(3) Training: The Cehat staff is regularly invited at the *Tata Institute of Social Sciences (TISS)* a deemed University for the post graduate training of Social Workers. We have also been regularly called as visiting faculty for delivering lectures on Human Rights to the refresher training courses for the officers of Indian Administrative Service (IAS) and Indian Police Service (IPS). In addition, we also organise or participate in the training programmes for the grass roots level paramedical workers and social workers in which a part of the training is on human rights and ethical issues.

Investigations

The health professionals of Cehat have regularly participated in the investigation of human rights violation. They were parts of the investigation teams appointed by human rights organisations. So far we have participated in FIVE such investigations and their reports are listed below (nos. 3 to 7).

Networking and Advocacy

We are now making concerted efforts to establish good network with other organisations in order to make our advocacy for policy changes more effective and of course also for strengthening our work in other areas.

Recently, our staff prepared for the "Forum for Medical Ethics Society" and presented a memorandum to the **"National Human Rights Commission"** on issues such as (1) Role of health professionals in the custodial deaths, (2) Violation of medical ethics during judicial death penalties, (3) Prison health services, (4) Hysterectomy on the medically handicapped women, (5) Ethics of sex selection and (6) Violation of ethics and human rights in medical experimentation. A copy of our submission is enclosed herewith.

Future Plans: The *Cehat* would like to organise a meeting of NGOs and professional associations interested in human rights issue in order to create a loose network at the national level. Such a network could facilitate information sharing and initiation of common campaigns. The Cehat is looking for finds to support such networking activities.

Treatment and Rehabilitation

At present this is the least developed activity of the Cehat. We have one partially trained but out of touch medical professional who has been providing counselling to the survivors of various forms of violence. We also have a nurse who does not work with the Cehat but is giving some of her time in this work.

However, in the absence of a formally established medical centre this work is still at the low key. From 1996 we intend to establish a separate medical centre for treatment and rehabilitation of survivors of violence.

LIST OF Cehat PUBLICATION ON "HUMAN RIGHTS AND HEALTH"

Books, Investigation Reports and Memoranda's:

(1) *"Submission made to the National Human Rights Commission on September 25, 1995"* by Forum for Medical Ethics Society, Bombay, pp. 4 + 9.

(2) Amar Jesani, Mary Alphonse, Alyosius D'Sa, *"Bombay Riots: January 1993: A Selected Documentation from a Section of the Print Media"*, Bombay: Solidarity for Justice, March, 1993, pp. 180.

(3) *"An Enquiry by the Fact Finding Team into the Police Firing that Led to the Killing of a Tribal and Caused Injury to Others in Dahanu Taluka, Thane District, Maharashtra"*, Bombay: Fact Finding Team, July 1992, pp. 17.

(4) *"Human Rights Issues from Investigation into the Murder of Sr. Sylvia and Sr. Priya"*, Bombay: Solidarity for Justice, Nov. 1991.

(5) *"Will Truth Prevail? A Report of the Investigation Team on the Murder of Sr. Sylvia and Sr. Priya at Snehasadan, Jogeshwari"*, Bombay: Solidarity for Justice, April 12, 1991.

(6) *"Another Lock up Death : An Investigation"*, Bombay: Committee for the Protection of Democratic Rights, July 1990.

(7) *"The Jogeshwari Rape Case : A Report"*, Bombay: Medico Friend Circle, YUVA, CPDR etc., July 1990.

Papers, Articles etc. Published in Journals and Books:

(8) Amar Jesani, "Prison, Police and Physician" (editorial), in *Medical Ethics,* Vol.3, No.4, October, 1995.

(9) Amar Jesani, "Supreme court judgment violates medical ethics", (editorial) in *Medical Ethics,* Vol.3, No.3, July-September, 1995, pp 38.

(10) Amar Jesani, Asha Vadair, "The Doctors Dilemma: A supreme judgment on death by hanging violates medical ethics", in *Humanscape,* March, 1995, pp. 12-3.

(11) Amar Jesani, "Violence and the Ethical Responsibility of the Medical Profession", in *Medical Ethics*, Vol: 3 No: 1, January-March 1995, pg. 3-5.

(12) Amar Jesani, "Medical Ethics : In the context of increasing violence", (Presented at the Indian Medical Association workshop on *"Medical Ethics and Ethos in Cases of Torture*, at New Delhi from November 25 to 27, 1994, and published in the IMA document on the workshop), pp. 7.

(13) Amar Jesani, "Violence against Women and Children : The Role of Media and Health Care Professionals", (Paper presented at Xavier's Institute of Communication's seminar on Health Communication held in Bombay on November 17, 1994), pp. 3.

(14) Amar Jesani, "Slippery Slopes of Nazi Medicine" (Review Article), in *Economic and Political Weekly*, Vol. XXIX, No. 43, October 22, 1994, pp. 2805-2807.

(15) Amar Jesani, "When Medicine Went Mad: Bioethics and the Holocaust" (Book Review), in *Medical Ethics*, Vol. 2, No. 1, August-October, 1994, pp. 10-11.

(16) Amar Jesani, "Doctors and hunger strikers", in *Humanscape*, June 1994, pp. 7-9(and 29).

(17) Amar Jesani, Anil Pilgaokar, "Patient's Autonomy : Throwing It To The Winds?" in *Medical Ethics*, Vol. 1 No. 1, August-October, 1993, pp. 6-7.

(18) Amar Jesani, Ravi Duggal, "Medical Ethics : Awaiting a Patients' Movement", in VHAI, *State of India's Health*, New Delhi : 1992. pp. 365-77.

(19) Amar Jesani, "Repression of Health Professionals" in *Economic and Political Weekly*, Oct. 5, 1991, pp. 2291-2.

(20) Amar Jesani, "Medicine at risk : Health Professional as Abuser and Victim", in *Economic and Political Weekly*, July 1989, pp. 1633-7.

(21) Amar Jesani, "Health Professional as Abuser or Victim", in *FRCH Newsletter*, Vol. 3, No. 1, January-February 1989, pp. 4.

(22) Amar Jesani ,"Ruins of War", in *Radical Journal of Health*, Vol. I, No. 4, March 1987, pp. 130-131.

(23) Amar Jesani, "Health in Nicaragua: Epidemiology of Aggression", in *Radical Journal of Health*, Vol. I, No. 1, June 1986, pp. 3-10.

(24) Amar Jesani, "Doctors and Torture" in *Socialist Health Review* (now called *Radical Journal of Health*), Bombay, Vol. II, No : 4, March 1986, pp. 177-178.

CEHAT

519, Prabhu Darshan, 31, Swatantrya Sainik Nagar, Andheri West, Bombay 400058, India

INST/MISE/95/ 2167
November 24, 1995.

Mr. Ulrich Dornberg
MISEREOR
POSTFACH 1450, 52015 AACHEN
MOZARTSTRASSE 9, 52064 AACHEN
(Through Dr. Ravi Narayan, CHC, Bangalore)

Dear Mr. Dornberg,

Geetings from friends at *Cehat.*

It is a year since we met. I have been feeling guilty and uneasy for not communicating with you and for not following up ideas we discussed last time. I know that an apology is not enough for you were very kind in showing interest in our work and for considering support for it. I know at the end, the loss is ours only, and that makes me very guilty. I unfortunately got sucked in so many things that although we have devloped work on the issues we had discussed, I did not write to you about it.

Dr. Ravi Narayan's letter has brought me back to the track. Ravi wrote that you people will be in Bangalore and meeting him, and the positive thing coming from the delay is that he may also be interested in linking up with us in undertaking some work of mutual interest. So I am taking liberty to send you few proposals for you consideration. Let me explain the present status of each proposal.

On Violence and Human Rights:

(1) **"Response of health professionals and services to the epidemic of violence":** This proposal has been prepared by me for the Times of India fellowship. Thus, upto the objective section, it covers all issues on which we intend to do work. In the methodology, the scope is kept modest as it is an idividual fellowship, and so I cannot to do a large survey of the situation. I am not sure whether I will get this fellowship as the subject matter is unlikely to be on the priority list of the Times fellowship council. Secondly, it is highly competitive, the journalist standing better chance than a doctor researcher like me. In any case, even if I get it, its scope will be limited to Bombay and would address to only one or two of the several issues identified. Therefore, we would need funding support for undertaking research and action based work on the remaining issues. If you find the proposal of some interest to you deserving finding support, please let me know so that I can send it to you with revised methodology. The budget would depend on the scope and methodology finalised. There too, your suggestions are welcome.

(2) **"Establishment of treatment and research centre for survivors of violence":** This is a **preliminary note** on the subject. It was prepared in order to link up with a treatment centre

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(Fax received only from Monday to Friday, between 10 a.m. to 5 p.m., Indian Std. Time)

called "Association Primo Levi" located in Paris. The Primo Levi was created this year primarily by doctors and psychotherpists who left another treatment centre called AVRE. The Primo Levi is an association of Amnesty International (French Section), Medecin du Monde, Action des Chretiens pour l'Abolition de la Torture, Juriste sans Frontieres and the staff of the Primo Levi centre. In early November this year I had an oppotunity to visit this centre and found it having elements of collective functioning and sensitivity to the specificity of the reality of underdeveloped countries.

As the note explains, this project would need large funding support and collaboration with some centres for training the staff and for other technical inputs. The Primo Levi centre has agreed to have such collaboration. However, the funding support will have to be raised by us or by Primo Levi and us together.

I am note sure whether the Misereor would be interested in supporting such big project or a part of it. In case the Misereor is interested, please let me know as the full proposal with details of budget will be available by the end of December 1995.

In case you would like to get in touch with the Primo Levi, please write to Dr. Francoise Sironi, Coordinator, Association Primo Levi, 107 avenue Parmentier, 75011 Paris, Tel: 43 14 88 50, Fax: 43 14 08 28. I am also enclosing a copy of its brochure for information.

(3) **"Need to study and confront child abuse"**: This is a note explaining what we want to do on child abuse. It involves both research and action. It is prepared by my collegue Ms Manisha Gupte.

Action research projects on health:

(4) **"Social accoutability of medical practice"**: This proposal is based on work we have been doing for last six years in helping victims of medical malpractice. It is self-explanatory. An edited book on the work done so far in this field is under publication by the CAHAT. It is titled **"Market, Medicine, Malpractice: Issues and Case Studies"**. It contains articles on various topics related to the operation of market in health care, the lack of regulations, ethical and legal issues and five case studies of victims of medical malpractices. It should be available for distribution by end December 1995 or early January 1996.

(5) **"People's drug information centre"**: This proposal has evolved from our experiences in the rational therapeutics movement and has been formulated by Dr. Anil Pilgaokar, former Convenor of the Medico Friend Circle. It is an ambitious project for empowering the patient by providing rational information on drugs.

We have already received Rs.75,000 (seventy thousand) for continuing this work which was started with the help of volunteers few years back. Dr. Pilgaokar will be donating Rs.25,000 some time next year. Thus, out of about Rs. two million needed to achieve the objective, we have hundred thousand with us. We have continued work with this money and looking for more support. If the finances are made available, it would be accoplished within the time frame mentioned, otherwise it would take considerably longer time.

I hope, these five proposals would provide you sufficient material to let us know your interest. Personally I am interested in projects on violence and human rights. However, as a coordinator of the institute, I will be taking responsibility, along with other researchers, for the successful implementation of other projects, too.

About CEHAT:

The CEHAT is a research centre of **Anusandhan Trust** which is registered as a public charitable, non-profit organisation. The donations made to it are given tax exemption under Section 80G of Income Tax Act. It does not have permanent registration under the Foreign Contribution (Regulation) Act, but so far three projects have been given prior permission to receive foreign contribution-cleared by the FCRA. Our application for the Permanent registration is also awaiting clearance.

The Trust has nine trustees and they also constitute governing board of CAHAT. In addition, in order to make the work of the CEHAT socially accountable, a Social Accountability Group (SAG) consisting of five individuals having a public standing been constituted. This group had its first meeting in October. It has worked out its own achedule of overseeing the CEHAT. Accordingly, in 1996 it will be meeting twice (in May, to review accounts and work, and in December to undertake annual review and give a report for publishing it in the Annual report of CEHAT) and would make its views on our work publicly known.

I am also enclosing a (1) Names and addresses of Trustees/Governing Board. (2) Names and addresses of SAG members (3) Report of CEHAT (Anusandhan Trust) for the years 1993-94. (4) A brief report on CEHAT's work on Violence and human rights. (5) A brochure on CEHAT.(6) List of CEHAT publications, 1991-1995. (7) The CVs of few of us working here (Sunil Nandraj, Ravi Duggal, Amar Jesani). (8) Audited statement of Accounts of Anusandhan Trust for the year 1994-95. (9) A copy of registration certificate of the Trust.

I hope, the above project proposals and information on our organisation would be sufficient for you to let us know whether MISEREOR would be interested in providing financial support for any of the project. We would like to know about your views at the earliest so that we could plan our work for the next 2-3 years. In case you are visiting Bombay, we would be happy to meet with you people.

With best wishes and regards.

Yours sincerely,

Dr. Amar Jesani.
Coordinator.

CEHAT

Centre for Enquiry into Health and Allied Themes

310 Prabhu Darshan,
31, S. S. Nagar, Amboli,
Andheri (W.),
Bombay-400058

Tel. : 6230227

October 29, 1993

Drs Ravi and Thelma Narayan,
Community Health Cell
Bangalore

Dear Ravi and Thelma,

I am sorry for my prolonged silence. I have been following up issues we discussed in Bangalore, but bit hafazardly.

(1) Ravi Duggal knows the person in the Ministry in charge of leprosy. If your project has come through please let Ravi know, he will give you the name of the person and will also write him directly on the subject. Ravi's address is: Staff Quarters, Barrack No 6, Raj Hans School, Bhavan's College Campus, Bombay 400 058. I have also told Sunil at FRCH about your requirement and you can depend on his help if you need anything from FRCH.

(2) I have sent a letter to Misereor as per the discussion we had. It has gone bit late but by speed post and by now they must have received it. A copy is enclosed herewith for you. Please follow it up when you meet them. I will appreciate it very much if we could meet them during their visit to India.

(3) Padma was attending a meeting today in Delhi where Thelma was likely to participate. I have discussed with Padma about the Network and asked her to speak to Thelma about how to organise MFC's contribution at the 1995 meeting. Hope they will finalise that part. In the meanwhile I have talked to Aditi and she has shown reddiness to contribute an article on ANMS for the Network.

With beast wishes,
Yours sincerely

Amar Jesani

Encl: as above

RAVI & THELMA
CHC.

CENTRE FOR ENQUIRY INTO HEALTH AND ALLIED THEMES
(CEHAT)

310 Prabhu darshan, 31 S.Sainik Nagar
Amboli, Andheri West, Bombay 400 058, Tel:623 0227

14 October 1993

Mr George Krause
Mr Ulrich Dornberg
Misereor
Postfach 1450
D-52015, Aachen
Germany.

Dear Mr Krause and Mr Dornberg,

Greetings and best wishes from friends at CEHAT!

Dr Ravi Narayan from Community Health Cell, Bangalore introduced us to your organisation. He and Dr Thelma Narayan are our friends from a larger voluntary organisation Medico Friend Circle and so we share many ideas and values. For last several years we have been very concerned about the increasing violence and rising religious fundamentalism and fascist forces in our country. As health activists we often intensely discussed these issues and every time realised that there was need for us to make an intervention in the situation both by studying epidemiology of violation and by involving in the relevant action at the community level. However various other commitments and uncertainty about getting support for such work did not allow us to actually undertake such systematic work though individually many of us continued to participate in various voluntary actions against such forces.

This year some of us in Bombay and Pune decided to leave our jobs as we were not satisfied with the kind of social research in health care we were doing for last many years and we established CEHAT. This is a new organisation which wants to undertake socially relevant research and action useful to progressive people oriented causes and movements. We thought that now we were free of other constraints to begin work on

that now we were free of other constraints to begin work on the above subject and told our friends about our intentions. Apparently in his last visit to Germany Ravi found that issues of our interest were identified in a workshop as key issues for 1990s and he therefore suggested that we should contact you.

Some of the areas in which we want to evolve our research and action work are as follows:

(1) We are greatly concerned about the increasing violation in the civil society and by the state on the citizens. The events of last December and January have clearly shown that there is increasing participation of common people in such violation and that minorities (Muslims in particular and all other minorities in general) are feeling highly insecure. The fascist and fundamentalist forces have gained in strength so much so that they are making serious bid to come to power. If this happens, the situation would worsen and from their utterances it is clear that minorities would face serious threats of ethnocide and even genocide, a phenomenon becoming increasingly common in many parts of the country.

In view of this we want to work in the following two ways:

First, we would like to study epidemiology of violation in last one or two decades. We believe it will have educational value. However its usefulness would not stop there. We would like to do this in such a manner that we can at the end of the study formulate certain parameters/criteria for continuous monitoring of the situation to predict ethnocide and/or genocide. Setting up such a monitoring mechanism, in addition to disseminating findings to sensitise people against the horrors of violence, is necessary to warn the national and international community of impending holocaust in India. Such warning supported by facts would provide material to people all over the world to campaign to prevent such eventuality.

Second, the violence of last December and January in Bombay has convinced us that as health workers we should provide necessary help to the survivors to overcome their psychological and emotional wounds. To this end few doctors of us would like to set up a small medical centre in a suburban slum in Bombay which provides such medical help to all survivors of communal violation as well as to battered women, rape victims, survivors of torture etc.

(2) The second area of our interest is Medical Ethics and help to victims of medical malpractice. As members of Bombay Group of Medico Friend Circle we have on a purely voluntary basis helped (counselling, guidance as what was wrong and how to proceed to punish the guilty etc) more than 50 such victims and we are helping to build a Forum for Medical Ethics (which has now started publishing a bulletin). I will not write more on this subject as you may get our views from the chapter on Medical Ethics we did in VHAI's "State of India's Health". Suffice to add that such work of monitoring medical practice and helping victims will have to be systematised through the infrastructural support from CEHAT.

It is difficult to explain in more detail these ideas in a letter. It would be really of great help if you could meet us during your forthcoming visit in November so that in the course of a day or two we could share our concerns and ideas with you.

Lastly, I can't resist from telling you that I really felt very happy when Ravi wrote to me that there are people like you who are interested in helping work in the above areas. I therefore sincerely request you to make it possible to meet us in your forthcoming visit.

With best wishes.

Yours sincerely,

Dr Amar Jesani
Coordinator.

cc to: Dr Ravi Narayan, Bangalore

12:95

10-11-1995

Dr. Amar Jesani,
310, Prabhu Darshan,
31, S.Sainik Nagar,
Amboli, Andheri West,
Bombay - 400 058.

Dear Amar,

Greetings from Bangalore!

We returned to India in the third week of September, having had a very meaningful break at the LSHTM and experiencing complete recovery from the 'burn-out' feeling at the end of CHC's first intensive decadal experience in 1993-94.

Thelma completed her M.Phil in August and continues on with the Doctoral Programme. She is busy operationalising the TB Control Policy Project, which includes field work in Mysore District and also coordinating CHC temporarily, since Shirdi proceeded on three months leave to recover from work exhaustion.

My sabbatical continues till December 31st (completing our 10 year report and the monographs) and I then propose to rejoin CHC on a part-time basis, following up on Medical Education, CH training policy projects and providing part time for short term assignments that will focus on BIMAROU area - perhaps Madhya Pradesh more than the rest as a 2 year transition process to shifting to the North by the time Thelma finishes the Ph.D. This will perhaps be a CHC - Northern initiative but we shall gradually build up the framework and decide a base (parthenium free small town in the North if such a place exists!!) over 2 years. A more definitive framework will evolve in consultation with all our friends and contacts after we return to CHC more actively in January, 1996.

Your letter written to us on 14th September - the day we left London arrived recently in a packet, a friend posted to us. If you are writing to Sanjay and Abha let them know about this. Thelma will return for a year again from end August 1996 to August 1997 (same address). Both the boys and I are not inclined to go back again, at the present - but we shall see.

Hope you receive a prompt response from Antony. He is a good chap but a bit preoccupied with both personal and professional demands - so though we are all on the same same wave length - we could not interact adequately around the issues of common interest during this year - which was a bit disappointing. He and others were associated with a radical medical group in South Africa and during 1986-87 when he was doing M.Sc. Epidemiology with Thelma

..2

we got to know all of them and they formed a Health and Development forum like mfc which organised lunch time discussions, etc.

I found your offer interesting and perhaps you could send me some papers about what you want to do and I could respond and start up an interactive process. After January 1996 I could include it on the agenda of my BIMAROU focus. The Misereor team are visiting Bangalore between 1-4th December so if the material came before that, I may also be able to get them interested. In a report, we prepared for them last year - we have suggested victims of 'communal violence and ethnic conflicts' as a priority area which has received little attention. They are visiting us to discuss this report as well.

I had been in touch with Dhruv and Shyam during the year and also since we returned. We are really concerned about Dhruv and I hope we can all be specially supportive of him - till he recovers completely. Probably he needs a replacement immediately and we have suggested to him that should be the focus of efforts. A couple known to us from Hyderabad are in touch with him.

Have seen the announcements and preparations for the mfc meeting. One of our team members is working on a bibliography of materials other than Medical ethics forum and mfc-bulletin. Shall send it to you when it is ready in case you are interested in any particular papers. The CMC Network of medical colleges had discussed this issues on two occasions and various clinicians had presented papers. You probably also know of the large meeting which MCI/IMA etc., organised on this theme a few years back. Also Dr. Francis (whose book you had reviewed last year) made a presentation in a seminar in the US on 'Transcultural issues in Ethics' presenting a point of view from the Indian situation/ ethos. It has now been published in a book on Transcultural issues. We shall send a copy of the paper to you.

An American student has contacted us indirectly to work on Cross-cultural issues. Her fax is enclosed. In our response, we have suggested that she get in touch with you and / forum. Her request is enclosed. Since she wants to work with a practicing doctor - a link with CHC would be unsuitable. Would your forum be interested.

Best wishes from both of us and the CHC team to you, Vibhuti, and Lata. (Lata)

Yours sincerely,

Ravi

Ravi Narayan.

Encl: 1.

*rn/vnnr

CEHAT

519, Prabhu Darshan, 31, Swatantrya Sainik Nagar, Andheri West, Bombay 400058, India

PER/ACJ/95/ 2026
September 14, 1995.

Dr. Ravi and Thelma Narayan
623 Elysium
William Goodenough House
Mecklenburgh Square
London WC1N 2AN, (UK).

Dear Ravi and Thelma,

I had received your letter of April 6, 1995 and I do not remember whether I replied or not. If not, my apologies, I was totally lost in my work here and there is no respite as yet. In case I did not reply, let me cover those points first. I haven't heard from Shirdi about the email, modem etc. Perhaps he is already in it. The MFC meet is as scheduled, Dec 27-29 on "Ethics in health care". Any possibility of you two attending? I am enclosing the second announcement of the meet (minus papers mentioned in it, if you want me to mail them to you, please let me know). Doesn't the list look impressive? Lastly you had enquired about the list of articles in EPW, I don't think such list is available barring the one that Padma had prepared and circulated in the MFC.

We have run into some trouble with the FCRA for no fault of ours. Till that is over, our temporary financial crisis will not be over. But that is a part of the problems in institution building.

There are two other things: Firstly, I came to know that your friend Anthony Zwi is coordinating an international network on violence as a public health problem. I had written to him to enquire about work of the network. He has responded positively and suggested that we should plan some collaborative work. So I have sent him a long letter giving a number of areas on which such research could be conducted. If this works out, we should be able to undertake in a formal and systematic way the work on epidemiology of violence, the subject we have discussed so often. I do not know what you are doing now-a-days. But if you would like to get involved in this collaborative venture, we will not only feel happy but more confident as your inputs would give a focus to the work. If it is possible, please discuss with Anthony and let me know. I am sorry that due to my own fault, I haven't been able to follow up this part with Miserior, and now I feel miserable in writing to them after not sending proposal as promised. Will they still be interested? I am sending a letter to them. As far as I am concerned, I have decided not to take any work other than on the issue of violence from Dec. So I should be able to concentrate fully on this subject.

Secondly, friends of ours, MFC as well as one of editors of Medical Ethics, Dr. Sanjay and Abha Nagral are going to be in London for a year. Both of them are from KEM Hospital. Sanjay is leaving next week while Abha will join him in a month's time. They will be at the following place:

Telephone/Fax: (91) (022) 625 0363 *E-Mail:* cehat @ inbb.gn.apc.org
(Fax received only from Monday to Friday, between 10 a.m. to 5 p.m., Indian Std. Time)

CEHAT is a Research Centre of *Anusandhan Trust* Regd Under Bombay Public Trusts Act Regd. No:E-13480

JN 25/10.

Drs. Sanjay and Abha Nagral, Liver Transplantation Surgical Service, King's College Hospital, Denmark Hill, London SE5 9RS, Tel: 171-737 4000, Fax 171- 346 3575.

I have given them your address and they might contact, or if you get an opportunity, do get in touch with them. Four of you may be able to form London group of MFC! (Minimum requirement for forming a group in MFC is three).

Lastly, if I remember correctly, you had told me that you were planning to visit India in this month. Is your trip still on? Let me know and do visit us when you are here. In Bombay you can stay with us. In fact, on Oct 7 & 8 some of our MFC friends (Anant, Dhruv, Manisha, Anil, Padma, Ravi etc) who are also our trustees will be at CEHAT.

Dhruv is much better now. I am sure somebody must have written to you about his illness. It happened in March, when he had bleeding in his brain due perhaps to malaria. We were really scarred, but fortunately for him and all of us, Mohan and Sham were with him and they could shift him to Pune on time. It was very close and he has lost part of his vision (peripheral) and it has affected his memory. He was depressed for awhile but now he seems to be much better. Added to this, he lost his father a few months after. We keep in constant touch. I am sure you must be in touch with him, but if not, please do write to him.

As you know the political situation here is very fluid and I only hope that I am not getting into my work on violence too late.

Vibhuti and Lara are fine and have sent their love and regards. How are Lalit and the second one (I keep forgetting his name, but not Lalit's as I have seen him often at the MFC)? Our love to them and if they are visiting India with you, do bring them here.

With regards and best wishes.

Yours sincerely,

Amar

Amar Jesani.

CURRICULUM VITAE

NAME : Ravinder Singh Duggal (Ravi Duggal)

DATE OF BIRTH : 5th December 1957

RESIDENTIAL ADDRESS : Hansraj Morarji Public School, Staff Quarters No. 6, Munshi Nagar, Andheri West, Bombay 400 058. Phone : 22 - 628 6865

FOR CORRESPONDENCE : CEHAT, 519, Prabhu Darshan, 31 SS Nagar, Amboli, Andheri West, Bombay 400 058
Phone :22 - 621 0145 / 625 0363 (office hours)
Fax : 22 - 621 0145 / 625 0363 (office hours)
E-mail : cehat@inbb.gn.apc.org

ACADEMIC QUALIFICATION :

1. Schooling : ICSE from St. Mary's, Bombay : 1st class 1963-1973.
2. Graduation : BA(Hons.) in Sociology from St. Xaviers, Bombay 2nd class, 1974-75 1977 78
3. Postgraduation : MA in Sociology from Bombay University : B+ 1978-79 -1979-80
4. Certificate Courses in Computer Programming and statistical applications from Bombay University (16 weeks, 1980).
5. Certificate Course in Planning and Evaluation of Health Programs from the Indian Council of Medical Research (7 weeks, 1982).
6. Diploma in Business Management of the Indian Merchants Chambers, Bombay: 2nd class, 1979-81.
7. Diploma in Communications Arts from Xavier Institute of Communication, Bombay : A-, 1978-79.

LANGUAGES KNOWN :

Excellent written and spoken English and good fluency in Marathi and Hindi.

WORK EXPERIENCE :

1. Lecturer in Sociology for two years at Vivekananda College, Bombay (1981 and 1982)

2. Researcher in Foundation for Research in Community Health from June 1982 to March 1993, between 1982 and 1986 as Research Officer and subsequently, as Senior Research Officer. For details of research work done **see Annexure I.**

3. WHO fulltime Consultant for Health Policy and Planning and Health Economics at

the Ministry of Health and Family Welfare, New Delhi from March 1993 to Sept 1993

4. Presently working as Country Representative of SWISSAID in India since Oct 1993. Also associated with CEHAT as a Consultant on research related to quality of health care, health databases and health economics

WRITING AND RELATED EXPERIENCE :

1. Since 1984 I have been part of a working editorial team that brings out the journal 'Radical Journal of Health'. It is the only one of its kind in India that looks at health issues from a social, economic and political perspective.

2. Since 1982 I have been regularly authoring monographs, articles and papers for various journals, magazines and newspapers and making presentations at conferences and seminars on a wide range of health and related issues. **See Annexure II** for a list of publications.

3. In the past few years I have helped various International Funding Agencies, Official Funding Agencies and NGOs in reviewing and evaluating projects and research/project proposals.

International Conferences Participation :

1. World Congress of Sociology , New Delhi, 1985 : Participated actively in sessions on Health Issues.

2. World Congress on Health Economics, Zurich, 1990 : Made a presentation on the Political Economy of Health Care Underdevelopment.

3. International Seminar on Market Economy for the Poor, Berne, 1994 : Made a presentation on Peoples' Economy and Local Resources.

4. International Conference on Population and Development, Cairo,1994 : Conducted a workshop on Population Policies and Underdevelopment at the NGO Forum.

CONSULTANCIES AND OTHER ASSIGNMENTS :

Major Consultancies

1. Jan.1992 - April 1992 : Consultant to the World Bank Mission on Health Financing in India for three and a half months. Apart from assisting the Mission in various field and desk tasks I prepared a background document for the Mission titled 'Health Care Services and Financing in India'.

2. June 1992 - May 1993 : For two days every month (totally 24 working days) as a Research Consultant on an Urban Health Education and Community Organization project of the National Addiction Research Centre, Bombay. My role was to help them design the study, advise them on organisational dynamics and monitor the progress of the research project.

3. March 1993 - Sept. 1993 : Fulltime National Consultant with the World Health Organisation, New Delhi, for six months to advise the Policy and Planning Division of the Ministry of Health and Family Welfare, Govt. Of India. The work done has been compiled as an internal document titled "Health Policy and Financing" and it fed into the 1993 Annual Conference of Health Ministers and Secretaries (Joint Council of Health and Family Welfare).

4. Jan.1994 - May 1994 : 8 days in a month (totally 40 days) as head of a team at the Centre for Enquiry into Health and Allied Themes (CEHAT), Bombay, to design and compile a database on health care services and financing. The preliminary work done is being published in the Economic and Political Weekly in April 1995. The database includes timeseries data from 1950-51 to 1994-95 on expenditures on major health programs of the public sector, data on health infrastructure and personnel in both the public and private sectors and data on health indicators. The data is accompanied by a detailed analytical note.

5. June 1994 - Dec.1995 : Six days every month as Research Advisor in CEHAT on project on "Quality of Health Care Services' - a field based study enquiring into physical standards and qua'ity of care in private nursing homes and hospitals and of private practitioners. My role has been to design the study and monitor its progress, and presently help in analysis of the findings as they become available.

Other Assignments :

During 1986-87 I have taken occasional teaching courses in rural sociology at the Dept. of Sociology, Univ. of Bombay
During the last five years I have taken occasional lectures on health sector development and health financing at the Tata Inst. of Social Sciences
Have been a consulting resource person on health financing and health economics for the Planning Commission, Ministry of Health, Indian Council of Medical Research and the Voluntary Health Association of India
Evaluation of Project on Health Economics (2 days) for IDRC-Canada
Consultant on Evaluation Methodolgy for ACTIONAID project VACHAN

Member of panel of Catholic Hospital Association of India on National Consultation on Impact of Structural Adjustment on Health
Visiting Faculty at the Indian Institute of Health Management and Research, Jaipur during 1993

Areas of Expertise :

Health Sector : Health Care Planning and Policy, Health Economics, Financing and Expenditures, Health Services Development, Private Health Expenditures, Comparative Health Systems, Quality/Standards of Health Care, Medical Malpractice and Regulation Evaluation of Health Programs, Health Care Databases

Other Areas : NGO sector, Rural Development, Local Economies, Resources and Sustainable Development, Consumer and Human Rights, Ecology and Environment Issues, Employee Benefits and Social Wages, Program / Project Evaluation and Impact Assesment in Social Sectors

GENERAL BACKGROUND :

Since school days I have been actively involved in various action programs that have exposed me to the realities of the underpriviledged classes both in rural and urban areas: rural development and reconstruction, development programs for slum dwellers, democratic rights issues, health services and health care issues, womens issues and other campaigns in support of the underpriviledged.

I am an active member of the Medico Friend Circle (MFC), a natipnal forum of socially committed health workers. The main focus of MFC is Community Health and this is expressed through its monthly bulletin and annual conferences on issues related to it. In Bombay the local MFC group is campaigning against Medical Malpractice and violation of human rights by doctors and medical institutions in the interest of consumers. I am actively associated with these campaigns and actions of MFC. Since April 1994 I am MFC's National Convenor.

My current area of **research interest** is health policy, the NGO sector, health economics and financing, quality of health care and health databases. Besides the various research studies undertaken by me in this area I have also been networking with others working in these fields in India especially from the NGO sector. I have also been interacting with the Ministry of Health and the Planning Commission on these issues in official meetings, working groups and conferences.

Ravi

DATE : 24-4-95 **RAVI DUGGAL**

ANNEXURE I

Research Work Done by Ravi Duggal

1979-80 : As a Master's student in the Dept. of Sociology, University of Bombay, I participated in a research project titled 'Corporate Sector in Rural Development', directed by Prof. Manorama Savur. This study critically evaluated the role of the corporate sector in IRDP programs of the government. This report was published by the dept. as a monograph. Besides the field work and participation in part of the data analysis I wrote the section pertaining to **"tax expenditure"** in this report.

1982 to present : Since 1982 all the research undertaken by me has been at the Foundation for Research in Community Health (FRCH) where I have been employed during the period.

(A) The following research projects were undertaken by me independently as part of a core research team. I was the principal investigator of studies at numbers 1,2,3 and 5.

1. **Study of Health Services and the Community in Uran Taluka:** This was a field based study using group interviews to get an understanding of the people's perception of health care services available to them. It also evaluated the participation and impact of a non-government organization in health care in that area. This document is a mimeograph publication of FRCH.

2. **Critical Study of Health Services Projects in Maharashtra:** This was a field based study carried out over a three year period (1983-1986). This study made a historical analysis of 45 health and development non-government organization run projects in rural Maharashtra. Subsequently in the second part of study, four of these projects and four government run primary health centres were studied in greater detail through a household-survey-based study to look at health services utilisation patterns in a comparative perspective. The first part of the study was published in 1986 and the second part is presently under publication.

3. **Social Aspects of Leprosy in Rural Maharashtra:** The focus of this study was to evolve an understanding of stigma of leprosy in a historical perspective. The field work of this study was carried out in 22 villages of Maharashtra over 2 years. The concept of stigma was placed in the context of a stigmatized society which is a structural problem and not a behavioural one. The study findings were published in 1988.

4. **Health Status of the Indian People :** This is an information database publication about the health sector in India based on extensive research on various aspects of health. I was responsible for the sections on **"environment and health" "population and health" and "health financing and expenditure".** This document was published in 1987.

5. **Health Expenditure in a District:** For one year a household survey was carried out in Jalgaon district to record consumption and health expenditure. Besides providing data on health services utilisation patterns and cost of health care this

study provides an analysis of methodological issues in the area of **"health expenditure studies".** The study report was published in 1989.

(B) The following studies were carried out under my direction.

1. **State Sector Health Financing in India:** A historical analysis of health sector development and financing in India that seeks to provide a critique of the development of health services in the country and why they have remained underdeveloped. This study for the first time in the country has come out with a comprehensive time series health finance database The study was published in 1992.

2. **Study of the Private Health Sector:** This exploratory study critically explores private general practice and private nursing homes and hospitals with a view to finding out the dynamics of investment, user charges and a cost analysis of such practice. It is presently under completion.

3. **Study of Corporate Schemes and its Financing:** This study too is exploratory in nature as it aims to provide an overview of health benefits provided by employers to their employees. This study provides analytical data on employee benefits in over 130 companies (with a turnover over Rs. 50 million) all over the country through a mailed questionnaire as well as personal interviews. The study was published in 1994.

4. **Health Financing and Costs. A comparative study of health system of capitalist, socialist and underdeveloped countries:** This is an international study that is looking at the various health care systems globally under different economic structures. It's focus is to evolve an analytic understanding of recent trends world-wide in the health sector, especially so in the context of privatization. The draft report is at present ready and awaiting editing and publication.

5. **Health Services Utilization and Expenditure in Madhya Pradesh:** This study looks at health services utilization and expenditure by households in an area which has an intensive program approach by the government in collaboration with an international bilateral agency. It was published in 1994.

6. **Health Research Studies in India:** This is an analysis and a compilation with detailed annotations of over 300 research studies done in the country by various research institutions. It was published in 1994.

(C) **Since October 1988,** I am registered for my Ph.D. studies with Prof. Manorama Savur. I was a recipient of an ICSSR National Fellowship in Medical Sociology for three years. The title of my doctoral work is **"The Political Economy of Health Policy making in India".** The study aims at a historical analysis of health policy and programs in India with a special focus on the role played by various international agencies in shaping these health policy and programs. At present about half the chapters of the thesis are ready.

ANNEXURE II

PUBLICATIONS OF RAVI DUGGAL

RESEARCH MONOGRAPHS AND BOOKS.

NGOs in Rural Health Care : A Comparative Study with PHC's, Vol. II, (co-authors Amar Jesani and Manisha Gupte) FRCH - ICMR Pune, forthcoming.

Health Policy and Financing : Papers and Notes, Document prepared as a WHO National Consultant to Ministry of Health and Family Welfare, New Delhi, 1993.

Employee Medical Benefits in the Corporate Sector, FRCH - ICMR, Pune, 1993.

State Sector Health Expenditure : A Database - All India and States. (Co-authors Sunil Nandraj and Sahana Shetty), FRCH-ICMR, Bombay, 1992.

Health Care Services and Financing in India, Background Document, World Bank, New Delhi, 1992.

Cost of Health Care : A Household Survey of an Indian District, (Co-author with Suchetha Amin), ICMR-FRCH, Bombay, 1989.

NGOs in Rural Health Care Vol. I : An Overview (co-author with A Jesani and M. Gupte), FRCH ICMR, Bombay, 1986.

Health Status of the Indian People : A Supplement to the document 'Health For All' (research contributor) Ed. Sonya Gill, FRCH-ICMR, Bombay, 1987.

Social Aspects of Leprosy : Findings from Rural Maharashtra (Co-author with Amar Jesani and Manisha Gupte), FRCH-Damien Foundation, Bombay, 1986.

Corporate Sector in Rural Development under IRDP (co-author with M. Savur et.al.), University of Bombay, 1985.

PAPERS AND ARTICLES (1982 -1992) OF RAVI DUGGAL.

Health Infrastructure and Woman - Systems, Trends and Budgets, Chapter in Forthcoming edited book fo the International Womens' Conference, Beijing (Editor : Malini Karkal)

Health Sector Database : A special compilation on behalf of CEHAT for the Economic and Political Weekly's (EPW) special statistics section. Co-authors Sunil Nandraj and Asha Vadair, EPW, Vol. 30, Nos. , April 15 and 22, 1995.

Health Expenditure Patterns in selected Major States, Radical Journal of Health (new series) Vol. I, Jan. 1995.

The Number Game, Humanscape, Nov. 1994.

The Great Divide, Humanscape, Oct. 1994.

Population Meet : Poor Impact of NGO's, Economic and Political Weekly, Vol. 29. No.38, Sept. 17, 1994.

Population and Family Planning Policy : A Critique and Perspective, Paper presented at International Conference on Population and Development, Cairo, Sept. 1994.

Health Finance of the Bombay Municipal Corporation , (Co-author Sunil Nandraj), background paper for Medico Friend Circle Workshop on Improving Public Hospitals in Bombay, June 1994, mfc Bombay Group, Bombay.

Peoples Economy Context and Issues from India, Paper presented at Seminar on Market Economy Also for the Poor, Berne, Switzerland, May 1994.

Health for All in India, FRCH Newsletter, July-Aug. 1993, Pune.

The Impact of NIP-NEP on Labour, paper presented at seminar on Impact of New Industrial Policy on Labour, MILS/AILS/MKI, Bombay, Jan. 1993.

Health Care Utilisation in India, paper presented at seminar on Rural Medical Practitioners, SRRI-IMRB/UNICEF, New Delhi, Jan. 1993.

Resurrecting Bhore : Reemphasising a Universal Health Care System, Medico Friend Circle Bulletin, No. Dec. 1992.

Medical Ethics : Awaiting a Patients' Movement (coauthor Amar Jesani) in Alok Mukhopadhyay (ed) State of India's Health, VHAI, New Delhi, 1992.

User Charges and Patients' Rights, paper presented at workshop on Patients' Rights, TISS, Bombay, August 1992.

Trends in FP Policy and Programs, paper presented at seminar on Trends and Perspectives for FP in the Nineties, BUJ, Bombay, August 1992.

Primary Health Care under NEP - Does it really matter? Paper presented at CHAI National Consultation on The Impact of NEP on Health Care, March 1992, Hyderabad; also as Cost and Concern in Primary Health Care in Health Action Vol.5, No.8 August 1992.

Health Care in China - A model in Transition, (co-author Sonya Gill), FRCH Newsletter, VI : 1, Jan-Feb 1992.

Regional Disparities in Health Care Development - A Comparative Analysis of Maharashtra and Other States, paper presented at the National workshop on Health and Development in India, NCAER/Havard University, Delhi, January 1992.

Ending the Underfinancing of Primary Health Care, Medico Friend Circle Bulletin 177-178, Nov.-Dec., 1991.

Private Health Expenditure, Medico Friend Circle Bulletin 173-174, July-August, 1991.

Regulating the Private Health Sector (Co-author Sunil Nandraj), Medico Friend Circle Bulletin, 173-174, July-Aug , 1991.

Health Care in Underdeveloped Countries Under Imperialism and a Historical Case-study of Underdevelopment of Health Care Services in India, Paper presented at Second World Congress on Health Economics, Zurich, September 1990.

State Health Financing and Health Care Services in India, Paper presented at workshop on Health Financing, Simla May 1990, VHAI/Ford Foundation, also in Health for the Millions, XVI:3, June 1990.

Health Care Services in India - Facts Revealing Gross Maldistribution (coauthor Amar Jesani), a paper for a meeting on health services, Planning Commission, April 1990.

A Review of the Bhore Committee - 1946 and it's Relevance - 1990, FRCH Newsletter IV 1-2, January-April 1990, also in Indian Journal of Pediatrics, 58:4.

Health and Related Statistics - compilation and critique, (co-author Sunil Nandraj and Saraswathy A) FRCH Newsletter, III 6, September-December, 1989.

Planning for Whose Development? FRCH Newsletter III 6, September/December, 1989.

Exploding the Population Bomb Myth, MFC Bulletin No. 152 and 153 June-July, 1989.

Medical Education in India : Who Pays?, Radical Journal of Health Vol. III, No. 4, March 1989.

Privatisation and New Medical Technology, FRCH Newsletter Vol. 2, No. 5, September-December, 1988 (Part I) and Vol. 3, No. 1, January-February, 1989 (Part II).

Medical Services, Medical Technology and Privatisation. Paper presented at XVth Annual Meet of Medico Friends Circle at Alwaye, January, 1989.

Health Care, Health Policy and Underdevelopment, Radical Journal of Health, Vol. III, No. 1, June, 1988.

Health Financing in India : Review of investment, Research and issues for further research (Paper presented at National Workshop on Health Financing in India organised by Operation Research Group and Ford Foundation at Surajkund, Haryana) 23, April 1988. (Co-author N. H. Antia), also in Peter Berman and M. E. Khan (ed.) Paying For India's Health Care, Sage Publications, New Delhi, 1992.

Vaccines : Panacea or Palliative, FRCH Newsletter Vol.II, No. 1, Jan-Feb 1988.

Why Population Won't Fall, Indian Post, June 13, 1987.

You Can't Blame the Third World All The Time, Indian Post, May 30, 1987.

Financing Family Planning, Medico Friend Circle XIIIth Annual Meet Seminar Background Paper, 1987.

Health Personnel in India, FRCH Newsletter, Vol. I, No. 4, June, 1987.

Why We Must Ban EP drugs, Indian Post, August 6, 1987.

XYZ of Sex (feature on practice of Sex determination and sex-preselection in Bombay) (Co-author Manisha Gupte), Indian Post, May 31, 1987.

Political Economy of State Health Financing. Radical Journal of Health, Vol. I, No. 3, December, 1986.

NGOs, Government and Private Sector, Paper presented at Seminar on Health For All : Concept and Reality (FRCH/ICSSR), November 1986 - also in Economic and Political Weekly, Vol. 23 (13), March 26, 1988.

Health Expenditure in India, FRCH Newsletter, Vol. I, No. 1, November, 1986.

Health in the Seventh Plan : Boost to the Private Sector, Radical Journal of Health, Vol. I, No. 1, June, 1986.

Did Manda Padwal Die in Vain (feature on consequence of Population target approach) (coauthor with Manisha Gupte), India Express Magazine, June 19, 1986.

The Ericsson Technique . A new way to climinate woman (feature on sex-preselection) (co-author with Manisha Gupte), India Express Magazine, June 29, 1986.

Mental Health and Society, Socialist Health Review, Vol. II, No.4, March 1986.

Ills of the Health Industry, Socialist health Review, Vol. II, No.1, June 1985.

Population, Health and Development, FRCH, 1985.

Health and Population in Tribal Villages, paper presented at Seminar on Tribal Demography and Development IASP October, 1984 also in Ashish Bose et.al.(eds) Demography of Tribal Development, B.R. Publishing, New Delhi, 1990.

Politics of Ill Health and Health Care, Economic and Political Weekly, Vol XIX, No. 24-25, June, 1984.

Health Services and the Community - A field study of Uran Taluka, FRCH, 1982.

Rural Development - A critical analysis of policy and implementation, with special emphasis on the health delivery system, FRCH, 1982.

Environment and Health, FRCH, 1982.

Air Pollution and Health, FRCH, 1982.

Water and Food Contamination and Health, FRCH, 1982.

Workplace Environment and Health, FRCH, 1982.

Tax Expenditure and Rural Development, Dept. of Socio. Univ. of Bombay, 1982.

The Unregulated Private Health Sector, Amar Jesani and Sunil Nandraj, Health for the Millions, Vol. 2, No.1 February 1994.

Private Health Sector in India : A Need for Regulation, Sunil Nandraj. Background paper for the Workshop on the World Development Report 1993, held at ICSSR, Bombay, July 10th 1993.

State of health care in Maharashtra, Alex George and Sunil Nandraj, Paper Commissioned by WHO/Government of India/VHAI, Economic & Political Weekly, Bombay, Vol XXVIII Nos 32 and 33, August 7-14, 1993.

Regulating the private sector, Ravi Duggal and Sunil Nandraj, Medico Friend Circle (MFC) Bulletin, 173/174, July-Aug., 1991.

Health Policy in the Five Year Plans : A Critical Overview, Sunil Nandraj, FRCH Newsletter, Vol. V (3), May-June, 1991.

Health and related statistics, Ravi Duggal, S. Anantharam, Sunil Nandraj, FRCH Newsletter, Special Number, Vol. III, No. 6, Oct.-Dec. 1989.

Penal Institutions, health professionals and human rights, R. Raghav and Sunil Nandraj, Medico Friend Circle Bulletin, No. 164/165, June/July, 1990.

REPORTS :

An Assessment for the Need for Designing an Accreditation system in India, for Institute of Health Systems, Hyderabad, Nandraj Sunil, July 1994.

State Sector Health Expenditures - A Database : All India and States, 1951-1985, Ravi Duggal, Sunil Nandraj, Sahana Shetty, FRCH, March, 1992.

Private Nursing Homes : A Social Audit, Sunil Nandraj, July 1992, report submitted to the committee appointed to regulate nursing homes/hospitals in Bombay City.

Health Research Studies in India, Vol 1 : A Review & Vol 2 : An Annotated Bibliography. Part of the Research Team. Report submitted to the Ministry of Health and Family Welfare, New Delhi, 1993.

A Study of Household Health Expenditures in Madhya Pradesh, George A, Shah I, Nandraj S. FRCH, 1994.

Newspaper articles :

Beef up the Health Budget, Sunil Nandraj, , The Metropolis (Anniversary Special),Bombay, February 4-5, 1995.

AREAS OF EXPERTISE :

Health Sector : Health Care Planning and Policy, Health Economics, Financing and Expenditures, Health Services Development, Private Health Expenditures, Quality/Standards of Health Care, Medical Malpractice and Regulation, Evaluation of Health Programs, Health Care Databases

Other Areas : Disaster Management, Rural development, Socio economic programs for weaker sections. Implementation of

PARTICIPATION IN SEMINAR'S, WORKSHOPS, CONFERENCES, TRAINING PROGRAMS :

Clairvoyance-95 at TISS, All India Seminar on Health care managment - Future challenges and opportunities, organised by Dept. Of health services TISS, Bombay, 4th & 5th Feb, 1995

Expert group meeting on Health Financing Stratergies for strengthing Primary health care organised by WHO/MOH/IIHMR at Jaipur, March 3-4 1995.

Medico Friend Circle, Annual meet on Reproductive Health at Wardha, 12-15 January 1994.

Indian Institute of Managment, Ahmedabad, Training Programme cum workshop on Health Policy Analysis and Development Programme on Policy Formulation Process, August 29 - September 3 1994.

Workshop of select experts for Development of Training materials on Eco-health for workers in slum areas held at Jagruti Kendra in 17th November 1994

Improving Public Hospitals in Bombay Medico Friend Circle (Bombay Group), Seminar in Bombay, 26th June 1994. (Background paper for seminar with Mr. Ravi duggal)

Private Sector in Health care : Need & Means for regulation MFC Annual meet, Bombay, 5-6 Sept, 1991.

Workshop on Health Economics Jointly organised by TISS and Ford Foundation, TISS, Bombay, Oct 28th to Nov 2nd 1991, Bombay.

RELIEF WORK EXPERIENCE

1982-83 in Orissa for Flood affected victims

1984 in Bombay for Communal riot affected victims

1984 in Bhopal for Gas Victims

MEMBERSHIP IN ORGANIZATIONS

Medico Friend Circle - Co-ordinator of Regulation Cell of Bombay Group.
Co-ordinator of Bombay Group (1989-1991).
Steering group member of National MFC (Jan-Sept 1991).

MEMBERSHIP IN COMMITTEE

Appointed by the Bombay High court on the committee to oversee and supervise the functioning of private hospitals and nursing homes in the city of Bombay and make recommendations therein.

EXTRA CURRICULAR ACTIVITIES

1981 - 1982 : Student's Council member in S.I.E.S College.
Representative of S.I.E.S College in Bombay University Students Council.

1982 - 1983 : Public Relations Secretary in TISS Students Union.

1985 - 1986 : Executive Committee of the TISS Alumni Association.
(Also a member of editorial committee of the Newsletter).

OTHER RELEVANCIES

Since the beginning I am involved in activities and action programmes dealing with social issues. This has attributed social sensitivity to me and has worked as the motivating force behind my engrossment with issues related to underprivileged people, rural development and reconstruction, development programmes, democratic rights, health sector, women, children and the like. The preoccupation of this nature has been not only direct but also indirectly in the form of support to various NGOs and individuals working in the field having somewhat the similar concerns.

CURRICULUM VITAE

NAME : Sunil Nandraj

SEX : Male

NATIONALITY : Indian

RESIDENTIAL ADDRESS : NL 5/9/14
Sector 3, Phase I
Nerul, New Bombay 400 706

DATE OF BIRTH : 21st, January, 1961

ACADEMIC QUALIFICATION :

1. Graduation : BA in Economics & Political Science from University of Bombay, Bombay, 1982.

2. Postgraduation : M.A. in Social Work (Urban & Rural Community Development) from Tata Institute of Social Science, Bombay, 1984

LANGUAGES KNOWN : English, Hindi, Marathi, Tamil, Telugu, Kannada.

PROFICIENCY IN COMPUTERS : SPSS, LOTUS 123, WORDPERFECT, HPG, ISIS, FOXPRO, WINDOWS based packages.

SCHOLARSHIP AWARDED : Sir Dorabji Tata Scholarship in 1983-84.

WORK EXPERIENCE :

Year	Post Held	Nature of Activity	Employer
July 1984- Nov. 1984	Project Coordinator	Coordination and implementation of the project programs related to social issue	United Nation University (Tokyo) Project at TISS, Bombay
Dec. 1984- July 1987	Social Worker	Dealings with tribal's/non-tribal's covering issues like socio-economic, cultural health and exploitation.	Pariwartan-84 Maharashtra
July 1987- Oct. 1988	Social Scientist	Evaluation of Primary Health Health Centers in Maharashtra	Indian Council for Medical Research, Bombay
Oct.1988- April 1994	Research Officer	Health Research	The Foundation for Research in Community Health, Bombay
May.1994- presently	Research Officer	Health Research	Centre for Enquiry into Health & Allied Themes, Bombay

Consultancy :

Consultancy to prepare a background paper on **State of Health care in Maharashtra : A comparative Analysis** for Voluntary Health Association of India, September 1992.

Consultancy to **Review Health Research Studies in India**, November 1993 - March 1994, FRCH, Bombay.

Consultant to prepare paper **on An Assessment for the Need for Designing an Accreditation system in India**, for Institute of Health Systems, July 1994, Hyderabad.

RESEARCH EXPERIENCE :

Title of the Project	Nature of Project	Nature of Work Carried Out	Sponsoring Agency
State Sector Health Expenditures in India	Critical analysis of the development and financing of health sector in India from a historical perspective.	Data collection computerized data analysis	Indian Council for Medical Research, New Delhi.
Study of Corporate Sector	Exploration of the health benefits provided by employer in corporate sector, at India level.	Data collection computerization of data	Indian Council for Medical Research, New Delhi.
Health Services Utilization & Expenditure	Nature of health services utilization and expenditures incurred by households.	Data collection Training and supervising of investigators/ research associates. Data analysis, Report writing,	DANIDA, New Delhi.
Health Investment in a District	Exploration of health care resources available in a district and their investment pattern.	Data collection, analysis and report writing.	Ford Foundation New Delhi.
Review of Research Studies in India	To review health research studies undertaken in India.	Data collection, analysis of Research studies and Report writing	Ministry of Health and Family Welfare New Delhi.
Quality of care provided by the private Health Sector	To Study the standards available in the private health sector, (Nursing homes & GPs)	Data collection analysis and Report writing	Government of India & UNDP

Creating, updating and dissemination of Database on Health & Allied themes

PUBLICATIONS

ARTICLES :

Special Statistics on Health Expenditure Across States. Ravi Duggal and Sunil Nandraj,Asha Vadair, Economic & Political Weekly, Bombay Vol XXX No 15 & 16 April 15th and 22nd,1995.

Beyond the Law and the Lord : Quality of Private Health Care. Economic & Political Weekly, Bombay Vol XXIX No 27, July 2, 1994.

Health Finances of the Bombay Municipal Corporation. Ravi Duggal and Sunil Nandraj, Background paper at the seminar on Improving Public Hospitals in Bombay, June 26th, 1994.

CURRICULUM VITAE

CURRICULUM VITAE.

Name : Dr. ABAR JESANI. **Sex :** Male. **Age :** 41 years.

Educational Qualification:

M.B.,B.S. 1978 Medical College, Baroda. M.S. University.

Current Affiliations :

Coordinator, CEHAT (Centre for Enquiry into Health and Allied Themes), Bombay.

Principal Investigator and Consultant, FRCH (Foundation for Research in Community Health), Bombay, on the project, *"Educational and Training Support for the Auxiliary Nurse Midwives in Madhya Pradesh and Maharashtra".*

Member, Health Care Panel, the Task Force Constituted by the Technology Information, Forecasting and Assessment Council (TIFAC), Department of Science and Technology, Government of India.

Member, Editorial Committee, *"Medical Ethics",* A quarterly journal of the Forum for Medical Ethics, Bombay.

Consulting Editor, *Radical Journal of Health,* a quarterly journal on Social Science and Health published from Bombay.

Member, Medico Friend Circle, **Vice-Chairperson:** Forum for Medical Ethics Society, Bombay.

Research Experience :

At CEHAT, Bombay :

1994- , *"Study of Legislations and Legal Aspects of Health Care Services in India",* as Principal Investigator, the project sponsored by the United Nations' Development Programme (UNDP) and the Government of India (GOI).

1995- *"Strengthening Medical Ethics for Self Regulation of Medical Profession and Medical Practice",* a report for the Independent Commission on Health in India.

At FRCH, Bombay/Pune:

1993- , *"Education and Training support for ANMs in Madhya Pradesh and Maharashtra",* as Principal Investigator and Consultant, the project sponsored by the DANIDA.

1992-93, *"Study of Utilisation and Cost of Drugs and Pharmaceuticals at District and Cottage Hospitals, CHCs and PHCs in a District in Maharashtra",* as Principal Investigator (was involved in only first part of the study), the project sponsored by the Ford Foundation.

1988-92, *"Study of Doctors and Auxiliary Nurses at the PHCs and Subcentres",* as Principal Investigator, the project sponsored by the DANIDA.

1989-90, *"Study of Private Sector and Privatisation in Health care Services"*, as Senior Researcher, the review paper commissioned by the Joint Panel of the Indian Council for Medical Research and the Indian Council for Social Science Research.

1989-90, *"Study of Community Participation in Health care Services"*, as Senior Researcher, the review paper commissioned by the Joint Panel of the Indian Council for Medical Research and the Indian Council for Social Science Research.

1987-88, *"Study of Primary Health Centres in Maharashtra"*, An anthropological and qualitative study of PHCs, as senior researcher, the project sponsored by the Government of Maharashtra.

1985-86, *"Social Aspects of Leprosy : Findings from Rural Maharashtra"*, as research officer, the project sponsored by the Damien Foundation.

1983-85, *"Critical Study of Voluntary Health Projects in Maharashtra"*, as research officer, the project sponsored by the ICMR.

1980-81, *"Urban health in a slum of Bombay"*, A Community activation project for health and other developments in Lal Dongar slum, Chembur, Bombay, as community organiser, the project supported by the FRCH, Bombay.

1980, *"Integration of leprosy in the general health care work"*, a study of integration of leprosy work done by the Mandwa Project of the FRCH, in Raigarh district of Maharashtra covering 30,000 population, as research officer, the project sponsored by the Research Society, J. J. Group of Hospitals and the Medical College, Bombay.

1979-80, *"Health For All : an alternative strategy"*, the Study Group Jointly set up by the ICSSR and the ICMR (also known as HFA Committee or Dr. Ramalingaswamy Committee), worked in its secretariat as a research officer helping the committee in drafting its report.

Publications

Books and Published Reports:

(Ed. With Singhi P.C), *"Market, Medicine, Malpractice: Issues and Case Studies"*, Bombay: CEHAT, pp 160 (under publication, expected date of publication, November 1995)

(with Iyer Aditi) *"Walking A Tightrope:Auxiliary Nurse Midwives in Rural Health Care"* Bombay: FRCH, pp 131 (under publication, expected date of publication, December 1995)

(with Anantharam Saraswathy), *"Private Sector and Privatisation in Health Care Services"*, Bombay: FRCH, 1993, pp. 97.

(with Ganguly Shilpi), *"Some Issues in the Community Participation in Health Care Services"*, Bombay: FRCH, 1993, pp. 30.

(with Alphonse Mary, D'Sa Aloysius), *"Bombay Riots: January 1993: A Selected Documentation from a Section of the Print Media"*, Bombay: Solidarity for Justice, March, 1993, pp. 180.

"ANMs at Primary Health Centres in Maharashtra", Bombay: FRCH, 1989, pp. 124.

"Drugs and Pharmaceuticals at the PHCs", Bombay: FRCH, pp. 64,

(with Duggal Ravi, Gupte Manisha), *"Social Aspects of Leprosy: findings from Rural Maharashtra"*, Bombay: FRCH, 1988, pp. 124.

(with Duggal Ravi, Gupte Manisha), *"NGOs in Rural Health Care: Vol. I:An Overview"*, Bombay: FRCH, 1986, pp. 176.

"Integration of Leprosy in general health care: A report on Mandwa project", Bombay: FRCH, 1980.

Other Published Reports:

(as a member of investigation team), *"An Enquiry by the Fact Finding Team into the Police Firing that Led to the Killing of a Tribal and Caused Injury to Others in Dahanu Taluka, Thane District, Maharashtra"*, Bombay: Fact Finding Team, July 1992, pp. 17.

"Human Rights Issues from Investigation into the Murder of Sr. Sylvia and Sr. Priya", Bombay: Solidarity for Justice, Nov. 1991.

(as a member of investigation team), *"Will Truth Prevail? A Report of the Investigation Team on the Murder of Sr. Sylvia and Sr. Priya at Snehasadan, Jogeshwari"*, Bombay: Solidarity for Justice, April 12, 1991.

(as a member of investigation team), *"Another Lock up Death : An Investigation"*, Bombay: Committee for the Protection of Democratic Rights, July 1990.

(as a member of investigation team), *"The Jogeshwari Rape Case : A Report"*, Bombay: Medico Friend Circle, YUVA, CPDR etc., July 1990.

Articles Published in Journals and Books:

"Law, Ethics and Medical Councils: Evolution of their relationships" in *Medical Ethics*, Vol.3, No.3, July-Sept 1995, pp C-IX-XII.

"Self-Regulation or External Control?", in *Medical Ethics*, Vol: 3, No:2, April-June 1995, pg 18.

(With Pilgaokar Anil) *"In the Pink: Need for Asserting Patients' Rights"*, in *Keemat*, Vol: 24, No: 3, March 1995, pgs 12-14.

(With Vadair Asha) *"The Doctors Dilemma: A supreme judgement on death by hanging violates medical ethics"*, in *Humanscape*, March, 1995, pp 12-3.

"Violence and the Ethical Responsibility of the Medical Profession", in *Medical Ethics*, Vol: 3 No: 1, January-March 1995, pg. 3-5.

"Medical Ethics : In the context of increasing violence", (Presented at the Indian Medical Association workshop on Medical Ethics and Ethos in Cases of Torture, at New Delhi from November 25 to 27, 1994), pp. 7.

"Violence against Women and Children : The Role of Media and Health Care Professionals", (Paper presented at Xavier's Institute of Communication's seminar on Health Communication held in Bombay on November 17,1994), pp. 3.

"Slippery Slope of Nazi Medicine" (Review Article), in *Economic and Political Weekly*, Vol. XXIX, No. 43, October 22 1994, pp. 2805-2807.

"When Medicine Went Mad: Bioethics and the Holocaust" (Book Review), in *Medical Ethics*, Vol. 2, No. 1, August-October, 1994, pp. 10-11.

"Doctors and hunger strikers", in *Humanscape*, June 1994, pp. 7-9(and 29).

"Medical Ethics" (Book Review), in *Medical Ethics*, Vol.: 1 No : 3 May-July, 1994, pp. 8.

(with Nandraj Sunil), *"The Unregulated Private Health Sector"*, in *Health for Million*, Vol. 2, No. 1, February 1994,pp. 25-28.

(with Iyer Aditi), *"Women and Abortion"*, in *Economic and Political Weekly*, November 27, 1993, pp. 2591-94.

(with Pilgaokar Amit), *"Patient's Autonomy : Throwing It To The Winds?"* in *Medical Ethics*, Vol. 1 No. 1, August-October,1993, pp. 6-7.

"Consumers and the Medical Community", in *Christian Medical Journal of India*, pp. 5-7.

(with Duggal Ravi), *"Medical Ethics : Awaiting a Patients' Movement"*, in VHAI, *State of India's Health*, New Delhi : 1992, pp. 365-77.

"Repression of Health Professionals" in *Economic and Political Weekly*, Oct. 5, 1991, pp. 2291-2.

"Educational Intervention in Medical Malpractice", in *FRCH Newsletter*, Vol. V, No. 4, July-August, 1991, pp. 4-5 (and 8).

"Medical Malpractice : What it is and how to fight it: Report of a workshop", *Medico Friends Circle Bulletin*, May- June, 1991, pp. 1-3.

"Nurses as Women",(book review) in *Economic and Political Weekly*, March 2-9, 1991, pp. 493-4.

"Limits of Empowerment : Women in Rural Health Care", in *Economic and Political Weekly*, May 19, 1990, pp. 1098-1104.

"Medicine at risk : Health Professional as Abuser and Victim", in *Economic and Political Weekly*, July 1989, pp. 1633-7

"Degraded Breadwinner and Harassed Health Worker: Socio-economic Background and Problems of the Auxiliary Nurse Midwife", in *FRCH Newsletter*, Vol. 3, No. 3-5, May-September 1989, pp.7-10.

"After Bangladesh, the Philippines Show the Way", in *FRCH Newsletter*, Vol. 3, No. 2, March-April, 1989, pp. 2 (and 8).

"Health Professional as Abuser or Victim", in *FRCH Newsletter*, Vol. 3, No. 1, January-February 1989, pp. 4.

"Health for All: For Women's Empowerment or Further Subjugation?", (Paper presented for the Working Group Committee for the Seminar: Empowerment of Women: Multidisciplinary Perspectives), December, 1988, pp. 8.

"Hands off the MTP Act !", A response to Nilima Dutta's comment on the law relating to Prenatal Diagnosis, in *The Lawyers*, October 1988 pp. 22-3.

"Eradicate Tuberculosis, Not TB Beds", in *Economic and Political Weekly*, Vol. XXIII, No. 39, Sept. 24, 1988, pp. 1995-1997.

"Fee for service in Maharashtra Hospitals", in *Radical Journal of Health* , Vol. II, No. 4, March 1988, pp. 99-100.

"Scope and Limits of Maharashtra Legislation: Banning Prenatal Sex Determination" in *Radical Journal of Health*, Vol. II, No. 4, March 1988, pp. 88-90.

"Target Orientation in Health Care", in *FRCH Newsletter*, May-June, 1988, Vol.II, No.3, pp. 1-2.
(with Duggal Ravi), *"Penacea or Palliative?"* (on Universal Immunisation Programme), in *FRCH Newsletter*, Vol. 2, No.1, January-February 1988, pp.8-9.

"Pesticide Poisoning", in *FRCH Newsletter*, Vol. I, No. 5, July-August, 1987, pp. 7.

"Technology in Medicine" in *Radical Journal of Health* , Vol. II, No. 1-2, June-Sept. 1987, pp. 1-2.

"...e New Drug Policy in Nigeria", in *FRCH Newsletter*, Vol. I, No. 4, May-June 1987, pp. 3.

"Ruins of War", in *Radical Journal of Health*, Vol. I, No. 4, March 1987, pp. 130-131.

"Use and Abuse of Bio-medical Technology - Amniocentesis - a Case Study", in *Medico Friends Circle Bulletin*, New Delhi, January, 1987, pp. 1-3.

"Health in Nicaragua: Epidemiology of Aggression", in *Radical Journal of Health*, Vol. I, No. 1, June 1986, pp. 3-10.

"Doctors and Torture" in *Socialist Health Review* (now called *Radical Journal of Health*), Bombay, Vol. II, No : 4, March 1986, pp. 177-178.

(with Prakash Padma), *"Political Economy of Health Care in India : An outline"* in *Socialist Health Review* (now called *Radical Journal of Health*), Bombay Vol.I, No:1, June 1984, pp.29-44

Participation in Seminars, Workshops, Conferences:

International:

•**"Sex Selection Conference"** in London, organised by the British Medical Association (BMA) and the European Commission Research Project, University of Swansea, on **April 23, 1993.**

•The International Conference on **"The Third World Debt"** in Brussels, Belgium, in April 1993. Made presentation on India in the session, *"AIDS and the Health Situation in the Third World"*.

•Delivered a lecture on the **"Violence and the role of Health Care Professionals in India"**, in Paris in a meeting organised by the Medical Division, French Section of the Amnesty International, **September, 1992.**

•The International Conference on **"Elimination and Terror: International Conference on Political Killings and 'disappearances'"**, in Amsterdam, the Netherlands, organised by the Dutch Section of the Amnesty International, in **September, 1992.**

•Training Seminar on **"Treatment and Rehabilitation of Torture Victims"** in Copenhagen, organised by RehabilitationCentre for Torture victims (RCT), Denmark, in **April 1992.**

•The International Conference on **"Medicine at risk : Health Professional as Abuser and Victim"**, in Paris, France,organised by the Medical Division, French Section of the Amnesty International, in **January, 1989.**

National: (in1993-94 only)

•The International Workshop on **"Medical Ethics and Ethos in Cases of Torture"**, organised by the Indian Medical Association, **November 25-27, 1994** in Delhi. Presented a paper, *"Medical Ethics in the Context of Increasing Violence"*.

•The National Seminar on **"Health Communication"**, in Bombay, organised by the Xavier Institute of Communication, Bombay, on **November 17, 1994.** Presented a paper, *"Violence against Women and Children : The Role of Media and Health Care Professionals"*.

•From **1991 to 93,** conducted training sessions as an **invited faculty** at the Tata Institute of Social Sciences, Bombay, for the IAS and IPS officers on **"Human Rights".**

•National Workshop on **"Joint Action by District Officers and Non-Governmental Organisations in Social Welfare Sector",** organised jointly by the Tata Institute of Social Sciences, Bombay and the L.B.S. National Academy of Administration, Massoorie, **August 5-6, 1994,** in Bombay. Participated in the discussion on**the draft of "Source Book for District Officers to Work with the NGOs and other Organisations in the District".**

•Seminar on**"Issues in Reproductive Health in India",** at Delhi, organised by CHETNA, Ahmedabad, on **May 4 and 5, 1994.**

•**"Male Gender Workshop",** at Bandipur, Mysore, organised by Sakti, Bangalore, **March 19-21, 1994.**

•Conference on **"Service Delivery System in Induced Abortion"** at Agra, organised by Parivar Seva Sanstha (MarieStopes), New Delhi, on **February 22 and 23, 1994.**

•Workshop on **"Social Security",** at the Indira Gandhi Institute of Development Research, Bombay, organised by the UNDP/Government of India's "Research Project on Strategies and Financing for Human Development", **December 8-9, 1993.**

•Workshop on **"Access to and Financing of Health in India"** at the Gujarat Institute of Devt Research, Gota (Ahmedabad), organised by the UNDP/Government of India's "Research Project on Strategies and Financing for Human Development", **November 1 and 2, 1993.**

•**"Discussion Meeting on Health Economics - Research and Training",** at the Christian Medical College and Hospital (CMCH), Vellore, organised by the World Health Organisation (WHO) and the CMCH, **November 30 to December 3, 1993.**

•International Workshop on **"Evolving Cultural Identity of Bombay, Nineteenth and Twentieth Centuries",** at the SNDT Women's University, organised by the Department of Sociology, SNDT Women's University, **December 16-20, 1992.** Acted as **discussant** on a paper presented by Ramasubam Radhika and Cook Nigel, "Political Economy of Health in the City of Bombay".----------

NGO-25-1

Tel: 3634
3617

SACHIN P. MULGAOKAR & CO.
CHARTERED ACCOUNTANTS
Veer Bhuvan 36–A Hughes Road Bombay 400 007

REPORT OF THE AUDITORS

Name of the Trust : ANUSANDHAN TRUST

Registration No. E-13480 dt. 30.8.91

We have audited the annexed accounts of the ANUSANDHAN TRUST for the year ended 31st March 1995 and we report as under:

1. The accounts are maintained regularly and in accordance with the provisions of the Act and the Rules.
2. The receipts and disbursements are properly and correctly shown in the accounts.
3. The cash balance and vouchers in the custody of the Manager or Treasurer on the date of audit were in agreement with the accounts.
4. All books, debts, accounts, vouchers or other documents or records required by us were produced before us.
5. The trust does not own any immovable property.The trust has maintained registers in respect of moveable property.
6. The Treasurer or any other person required by us to appear before us did so and furnished the necessary information required by us.
7. No property or funds of the Society were applied for any object or purpose other than the object or purposes of the Trust.
8. There are no amounts which are outstanding for more than one year and no amount is written off.
9. No tenders were invited for repairs or construction as there was no such expenditure in excess of Rs. 5000 during the year
10. The moneys of the Society have not been invested contrary to the provisions of Section 35 of the Act.
11. The Trust does not hold any immovable property and as such the provisions of Section 36 of the Act do no apply.

Tel: 3634
3617

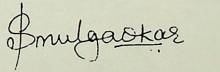
SACHIN P. MULGAOKAR & CO.
CHARTERED ACCOUNTANTS
Veer Bhuvan 36–A Hughes Road Bombay 400 007

12. So far as it is ascertainable from books of accounts and according to the information and explanations given to us there were no cases of irregular, illegal or improper expenditure, or failure or omission to recover moneys or other property belonging to the Society or of loss or waste of money or other property belonging to the Trust.
13. The budget required to be filled under Rule 16-A is filed.
14. The maximum and minimum number of the members of the Managing Committee is maintained.
15. The meeting are held regularly.
16. The minute books of the proceedings of the meeting is maintained.
17. None of the Trustees has any interest in the investment of the Trust.
18. No Trustee is debtor or creditor of the Trust.The Trust has taken loans from Trustees.
19. No irregularity has been pointed out by us in our previous report.
20. There is no special matter which we think fit necessary to bring to the notice of the Deputy or Assistant Charity Commissioner.

BOMBAY

Dated : 25th May,1995.

For SACHIN P. MULGAOKAR & CO.
Chartered Accountants



SACHIN P. MULGAOKAR
(Proprietor)

BOMBAY PUBLIC TRUSTS ACT, 1950.
SCHEDULE VIII [Vide Rule 17 (1)], Regn. No: E-13480, dt. 30-08-91
Name of the Public Trust: ANUSANDHAN TRUST

BALANCE - SHEET AS AT 31st MARCH 1995

FUNDS &LIABILITES	Rs.	Rs.	PROPERTIES & ASSETS	Rs.	Rs.
TRUST FUND OR CORPUS:			FIXED ASSETS:		
Balance as per last Balance Sheet		105.00	(As per Annexe. II forming part of Balance Sheet)		1,45,202.50
LOANS (Secured or Unsecured)			ADVANCES FOR EXPENSES:		
From Trustees		3,415.85	For Expenses		20,280.80
			Deposits		6,000.00
OTHER EARMARKED FUNDS:			CASH & BANK BALANCES:		
(as per Annex. I forming part of Balance Sheet)		3,20,356.50	Short term Deposit with :		
INCOME & EXPENDITURE ACCOUNT;			(1) HDFC	1,00,000.00	
Balance as per last Balance Sheet	(–) 1,303.85		(2) Bank of India	5,000.00	1,05,000.00
Add: Surplus as per Income &					
Expenditure Account	32,856.30	31,552.45	Savings Account with:		
			Bank of India	17,603.30	
			Shamrao Vithal Co-op Bank I	58,540.20	
			Shamrao Vithal Co-op Bank II	2,803.00	78,946.50
		3,55,429.80			3,55,429.80

As per our report of even date:

Bmulgaokar

Chartered Accountants:
Auditors.

BOMBAY
Dated at: 25/5/95

BOMBAY
DATED AT: 25/5/95

Ravindra Singh
Jitendra
Padmaprasad Gupta
Vibhuti Patel

TRUSTEES

THE BOMBAY PUBLIC TRUSTS ACT, 1950
SCHEDULE VIII [Vide Rule 17 (1)] **Regn. No. E-13480 dt. 30.08.91.**

Name of the Public Trust : **ANUSANDHAN TRUST**

INCOME AND EXPENDITURE FOR THE YEAR ENDING 31st MARCH 1995

EXPENDITURE	Rs.	INCOME	Rs.
To Email Charges	2,300.00	By Donations	14,675.00
To Bank charges	27.00	By Consultancy	7,000.00
To Miscellaneous Expenses	2,234.00	By Miscellaneous Receipts	1,559.75
To Depreciation	2,792.45	By Bank Interest	1,764.00
To Excess of Income over Expenditure	32,856.30	By Interest on SDR	15,211.00
TOTAL	40,209.75		40,209.75

As per our report of even date

Bmulgaokar

Chartered Accountants

Auditors

BOMBAY

Dated at: 25/5/95

Ravindra Singh
Advocate

Vibhuti Patel

BOMBAY

Dated at: 25/5/95

TRUSTEES

ANNEX. I

THE BOMBAY PUBLIC TRUSTS ACT, 1950
SCHEDULE VIII [Vide Rule 17 (1)] **Regn. No. E-13480 dt. 30.08.91.**

Name of the Public Trust : **ANUSANDHAN TRUST**

EARMARKED FUNDS AS AT 31st. MARCH 1995

PARTICULARS	Opening balance as on 1-4-94	Grants received during the year	Total	Expenses	Transfers	Closing Balance as on 31-3-95
FORD FOUNDATION	-	6,96,097.15*	6,96,097.15	4,41,454.85	-	2,54,642.30
IDS(AIDS)	-	15,563.00	15,563.00	14,937.25	-	625.75
UNDP (GOI)	-	3,62,000.00	3,62,000.00	2,96,911.55	-	65,088.45
TOTAL	-	**10,73,660.15**	**10,73,660.15**	**7,53,303.65**	-	**3,20,356.50**

* Includes Bank Interest Rs. 6442.00

As per our report of even date

Chartered Accountants
Auditors

BOMBAY
Dated at: 25/5/95

BOMBAY
Dated at 25/5/95

TRUSTEES

ANN - II

THE BOMBAY PUBLIC TRUSTS ACT, 1950
SCHEDULE VIII [Vide Rule 17 (1)] **Regn. No. E-13480 dt. 30.08.91.**

Name of the Public Trust : **ANUSANDHAN TRUST**

FIXED ASSETS AS AT 31st MARCH 1995

PARTICULARS	As on 31-3-94	GROSS BLOCK Additions during the year	GROSS BLOCK Total	NET BLOCK Depriciation for the year	NET BLOCK W.D.V. as on 31-3-95
ANUSANDHAN					
a) Furniture & Fixtures	-	8,943.00	8,943.00	447.15	8,495.85
b) Fax Modem	-	12,500.00	12,500.00	1,562.50	10,937.50
CEHAT					
a) Furniture & Fixtures	-	6,378.00	6,378.00	637.80	5,740.20
b) Vehicle (Bicycle)	-	1,450.00	1,450.00	145.00	1,305.00
		29,271.00	29,271.00	2,792.45	26,478.55
FORD FOUNDATION :					
a) Furniture & Fixtures	-	30,165.50	30,165.50	3,016.55	27,148.95
b) Eqipment	-	650.00	650.00	162.50	487.50
c) Computer	-	1,21,450.00	1,21,450.00	30,362.55	91,087.50
		1,52,265.50	1,52,265.50	33,541.55	1,18,723.95
GRAND TOTAL		**1,81,536.50**	**1,81,536.50**	**36,334.00**	**1,45,202.50**

As per our report of even date

BOMBAY
Dated at: 25/5/95

Chartered Accountants
Auditors

BOMBAY
Dated at 25/5/95

TRUSTEES

(Spl.—CC BPT 2

No ~~004603~~

नोंदणीचे प्रमाणपत्र

याद्वारे प्रमाणपत्र देण्यात येते की, खाली वर्णन केलेली सार्वजनिक विश्वस्त व्यवस्था ही आज, मुंबई सार्वजनिक विश्वस्त व्यवस्था अधिनियम, १९५० (सन १९५० चा मुंबई अधिनियम क्रमांक २९) याअन्वये बृहन्मुंबई विभाग मुंबई येथील सार्वजनिक विश्वस्त व्यवस्था नोंदणी कार्यालयात योग्य रीतीने नोंदण्यात आली आहे.

सार्वजनिक विश्वस्त व्यवस्थेचे नाव "अनुसंधान ट्रस्ट"

सार्वजनिक विश्वस्त व्यवस्थांच्या नोंदणी पुस्तकातील क्रमांक E-9288 (मुंबई)

डॉ. अमर जेसानी यांस प्रमाणपत्र दिले.

आज दिनांक 30 माहे ऑगस्ट १९८9 रोजी माझ्या सहीनिशी दिले.

CHARITY COMMISSIONER GREATER BOMBAY REGION MAHARASHTRA STATE

सही

हुद्दा सहायक धर्मादाय उप आयुक्त बृहन् मुंबई विभाग, मुंबई

True copy

(S. B. Chindarkar)
Under-Secretary to Government
Revenue and Forests Department
Mantralaya, Bombay-32

NGO-25.2

CEHAT Publications, 1991-95

1995

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ABOUT CEHAT (ANUSANDHAN TRUST)

ENCLOSURES

Governing Board, CEHAT / Trustees, Anusandhan Trust

Names and Addresses

(1). Dr. Anil Pilgaokar, TRUSTEE.
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(2). Ms. Padma Prakash. TRUSTEE.
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(4). Mr. Ravi Duggal. TREASURER.
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(5). Dr. Vibhuti Patel, TRUSTEE.
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(7). Dr. Anant Phadke, TRUSTEE.
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(9) Dr. Amar Jesani. MANAGING TRUSTEE.
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The "Social Accountability Group" (SAG) of *CEHAT*

Names and Addresses of Members

(1) Dr. S. L. Shetty
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(2) Dr. Sunil. K. Pandya
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KEM Hospital, Parel
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(3) Dr. Ashwin Patel
Director, TRU (Trust for Reaching the Unreached)
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(5) Dr. Neeraben Desai
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Head (Rtd), Department of Sociology
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Title of the Project I
People's Drug Information Centre (PDIC)

1. Need for Drug Information Centre

For quite some time now, those of us involved with the movement for rational use of drugs, as also others, have been very uncomfortable with the rampant misuse of drugs (medicines) in our country. Drugs are double edged weapons - put to right use, they are a valuable tool in therapeutic but wrong choice of drugs, or wrong advice on drugs by healthcare providers or wrong intake of drugs by end-users (patients) can and does (very often) end with unnecessary and avoidable harm (at times causing grievous damage to patients). Information on drugs is vital both for the prescriber as also the end-user, the patient. It is tragic that though it is always the end-user who suffers, drug information designed for end-users is not made available to them. We felt it right and necessary that drug information is provided for patients. Since there was no such facility existing in the country, we felt we should take it up ourselves. PDIC Project takes its roots from this.

Yet another reason (for starting the project) is that we believe that it is important for patients to play an 'active and informed role' in remission from diseased state (along with healthcare providers), rather than be relegated to the passive, hapless position. Active role entails an adequate understanding of the therapy which we believe should enhance compliance of the patient to the therapy. We believe parentalization in medicine should be gradually replaced with a respect for patient's autonomy and drug information and comprehension (of the end-user) serves as a first step in this direction.

In our country, the drug scene is one of plethora of irrational and even harmful drugs- drugs which have long been discarded on "more harmful than beneficial" basis, in developed countries. The State's effort in correcting this situation is painfully slow. It is imperative that the consumer is alert to the consequences of taking such drugs. Drug information in a format that is designed with end-user needs in mind is, therefore vitally important.

2. Utility of Drug Information Centre

There are over 60 to 80 thousand drug formulations in the country (no one, not even the Drug Controller of India, knows the exact figure), produced and marketed. An average doctor anywhere routinely prescribes less then 50 drugs. Thus, the prescription habit is formed by the education s/he receives from the medical representatives and not from what he or she learns in the medical college. Very often s/he prescribes drug combinations (over 50% of formulations are all kinds of combinations). Given the situation of almost non-existence of independent continuing education programme for doctors in our country, the doctor often get unduly influenced by propaganda and advertisements on drugs rather than the scientific facts.

The information provided by the drug information centre, while making the patient more informed, would also motivate patient to ask question to doctors, a healthy practice conspicuous by its virtual absence in our country. The questions of informed patients and the knowledge that the drug information centre can also provide doctors full scientific information on most drugs in the market would motivate doctors to seek reliable scientific information. We expect that such a process

would in long term change the prescription behaviour of doctors by making prescriptions rational, it would empower patients by motivating them to become active participant in their own treatment and over and above everything, it would create public and professional opinion for the pharmaceutical company to provide full and scientific information on their drug products and not to make exaggerated, unscientific or vague claims.

3. Objectives of Drug Information Centre

From the above analysis flows the following specific objectives and tasks for establishing and running the Drug Information Centre:

(1) To create a database of scientific and technical information on about 700 allopathic drug substances. (These 700 drug substances should cover about 95% of the 60 to 80 thousand formulations in the market)

(2) To create database of simple understandable information for use by patients/people on the above drugs.

(3) To create database of the formulations available in the market (brand names, the drug substance, quantity).

(4) To translate the above data base in vernacular languages (to begin with Marathi, Hindi and Gujarati)

(5) To computerise the database with preparation of appropriate software so that the quick retrieval of information on drugs for various users is possible. The software created should be user-friendly so that it could be widely used after training.

(6) To pretest the material prepared in urban and rural settings, modify the information content on the basis of responses received and to disseminate the software with database to interested individuals and organisations.

(7) To do regular updating of the database by including new formulations produced or marketed, add more drug substances and modify patient information on the basis of feed back received from patients and others

This centre would provide unbiased, objective drug information, in a form and format that would (hopefully) serve every end-users need for actively participating in remission from a diseased state.

4. Phases of Programme:

It is obvious from the objectives and tasks narrated above that lot of work needs to be done in order to actually take scientific information in the language people can understand. Thus, the work would be divised into four distinct phases.

Phase I: Database Preparation, Computerisation and Software Design: This would involve (1) Preparation of data information sheets on each drug substance (700 of them to begin with). Two types of sheets will be prepared: i. Patient Drug Data Sheets and ii. Technical Drug Data Sheets. (2) Simultaneous computerisation of these data sheets. (3) Programming for the preparation of user friendly software for the retrieval of information or database. (All information in this phase will be in English).

Phase II: Pretesting the Software and the Patient Information in English: This phase will be of short duration and would primarily test the software and English information with the educated patients in Bombay. This work would provide us with some kind of assurance that we are going in the right direction. The phase I and II will be completed in THREE years time.

Phase III: Preparation of Vernacular Database, its Field Testing and Modification in the Information Content: This phase would last about two and half years. In this period the English database will be translated into three languages (Marathi, Gujarati and Hindi), field tested with at least 1000 patients (users) in the rural and slum areas. The information contents will be modified without compromising the scientific facts. This phase will take about TWO years.

Phase IV: Dissemination of Database, Translation in more Languages and Continuous Updating: This phase is that of maintaining and continuously upgrading the work of the Centre. The CEHAT would also network with like-minded non-profit organisation to establish drug information in various parts of the country. In this phase, we may undertake research to monitor changes brought about in the consumer and provider behaviours due to the availability of information.

5. Work Already Completed

Although no institutional funds has been received for making this centre a reality, our colleagues have made voluntary efforts in last few years to complete a part of phase I work. The impetus for the project came through Mr. Kisan Mehta, member of ACASH which is a consumer organisation in the field of health. Few years back, Mr. Kisan Mehta's wife, Mrs. Mehta, was treated with 'methotrexate', a drug used in cancer treatment, and suffered from adverse side effects of the drug and finally succumbed to it. Both Mrs. Mehta & Mr. Mehta were very literate and could have responded appropriately if drug information (of methotrexate) designed for the patient was available to them. In the first two years, inspired by him, and under the auspices of ACASH we tried out our floundering steps into wilderness, trying to understand how to create such information system. We could, with the help of friends abroad, get information on such systems tried out in some advanced countries. In last three years we could collect individual donations from several persons in the country to begin preparation of data sheets on the drug substances.

Due to long hours of voluntary labour, using students and pharmacists at token payments, we have been able to prepare drug information sheets on 635 drug substances. Of these, the information on nearly 50 drugs has been supplemented with *"judgmental"* clinical responses to *"what if"* situations.

In preparation of above work a number of individuals and organisation provided moral and technical support. Since the preparation of database, software and other ligistical requirement needs an institutional support structure, the ACASH has kindly passed on the work accomplished under it to the CEHAT.

6. Liability

(1) The drug information database prepared and used, will be done as a voluntary work and will be on the principle of no-profit.

(2) Since database will be prepared by the CEHAT, all legal and other responsibility or liability of it will be that of CEHAT. The individuals or institutional funders of the project will not be in any way responsible for its content, format and use.

7. Financial Support Required

Although it is always good to get financial support for the full project at a time, we feel that given long duration of time required in operationalising the work and in order to keep scope for voluntarism, the funding should be sought to support phases of the project. Moreover, accomplishment of each phase would give us a concrete outcome in hand, it would be field tested and the experience gathered would go in enriching the next phase.

Of the four phases described above, the fourth phase is that of dissemination, maintenance and updating. The first three phases on the other hand needs research and experimental input. Of the first three phases, phase one and two will be taken together.

Of the three years required for completing first two phases, we have already completed work of one year (technical and patient information sheets on 635 drug substances completed). We therefore **need financial support for the remaining two years work for the phase I & II.**

The outcome of two years proposed work would be (1) computerised drug information database, (2) user friendly software for retrieving drug information for patient and (3) pretesting of this information with English knowing patients.

Personnel Required: We would need full time professionals to work on the project and a support group of experts to help them. The professionals required are: (1) Two pharmacists (or pharmacologist or doctor), (2) One or two computer programmers. The support staff required are: (1) Data entry operators cum secretaries (two), (2) An office attendant to help in routine work.

Capital: The capital expenditure will be primarily for Two computers (Pcs) along with necessary periferals and furniture.

Other Expenditure: This would be on photocopying, stationary, books, computer consumables and maintenance, post, fax and email, *expenditure on doing pretesting with the English knowing patients*, etc.

Budget for Two Years:

(1) Salaries of full time staff and honorarium to experts	Rs.13,00,000.
(2) Computers, peripherals & furniture	Rs. 1,50,000.
(3) Other Expenses	Rs. 3,50,000.
(4) Overheads	Rs. 1,50,000.

Total for 24 months: Rs.19,50,000.
First year: Rs.9,50,000.
Second Year: Rs.10,00,000.

NGO-255

Title of the Project
Social Accountability of Medical Practice

The work by individuals associated with the CEHAT in this field is of long duration. About seven years back a retired IAS officer of Rajasthan government approached Medico Friend Circle, a loose association of socially conscious doctors and non-doctors of which most of our staff persons are members. His problem was gross negligence and arrogance of a topmost specialist of Bombay while treating his wife who allegedly died in great pain following the medical negligence. While making efforts to understand his plight we got exposed to a large number of such complaints from patients. We were told by patients about the arrogance of doctors, their disinclination to give information on illness and the line of treatment adopted, about unnecessary investigations, cut practices, non-issuance of receipts for the payments made and so on.

Revealation of this face of medical practice made us to explore further. A letter with several questions to people on their experiences with medical practice was submitted to newspapers which published it as letter to editor. In no time we were flooded with more than 300 responses to questions. These responses showed that while there was lot good in the way an average doctor is doing, much of it is getting overshadowed by the negative aspects of their behaviour and ugly features of openly commercialised medical practice. We also realised that all those who have had bad experience of medical practice needs extensive counselling and support, moral and legal.

Since then, for last five years we have been helping such "victims" of medical practice or malpractice. Most of them have approached us because of lack of proper communication from the doctor. When such persons got full understanding of what had happened during the treatment, most of them felt satisfied. Very few cases have gone into litigations as people are not inclined to go to court so easily due to heavy toll our courts take in terms of time and finances. Those who did not go to courts have acquired better understanding of the way medicine is practiced and they would be more conscious about their rights when they approach doctor again. Those who have gone into litigation would in few years create new legal precedents as this area of law has not been sufficiently developed in India.

This work is also generating rich information on the way medicine is practiced and on the condition of our private and public hospitals. The information thus gathered so far is being published by CEHAT in a book titled "Market, Medicine, Malpractice: Issues and Case Studies". One of the editor of the book is the person who sensitised us to this issue.

Objectives and Tasks:

Overall aim of this work is

(1) to sensitise medical practice to needs and dignity of patients, (2) to impress upon the profession to have good self-regulation, (3) to make people aware of their rights and responsibilities while receiving medical care, (4) to make consumer aware of the trends, good as well as bad, in medical practice.

The tasks involved are:

(1) To help patients who have suffered due to negative outcome of medical practice or due to negligence on the part of medical professional, (2) To sensitise as many number of doctors as possible to come forward to help such patients or their relatives by carrying out educational campaigns in the profession, (3) to document, collate, analyse and publish information gathered from patients or otherwise on the trends in medical practice and by that create a public opinion for more humane and rational medical practice.

Work:

In order to accomplish above objectives and task, a small unit comprising of one para-legal worker or social worker, one researcher and an assistant will be formed. All of them will work full time and will be paid salaries. They will be assisted by 15 doctors hailing from three voluntary organisations, namely Forum for Medical Ethics Society, ACASH and Medico Friend Circle. These doctors have already agreed to provide such voluntary assistance.

The unit will be housed in the Andheri office of CEHAT or will be available at Dr. Manohar Kamath's clinic in Mahim from 12 noon to 5 p.m. every day. The aggrieved patients or their relatives will approach them while the social worker would compile full history of the problem and obtain necessary medical record. This will be referred to one of the volunteer doctor who would study it and provide his objective scientific opinion on the case and the same will be communicated to the client. The additional work that some of these doctors might be doing for the clients would be to provide their opinion in the affidavit format for the client to use it in the court of law and even to appear in the court as independent expert witness.

Financial Support Needed:

The financial support needed is mainly to support salary of two persons and expenditure on travelling and documentation.

Budget for Two Years:
Salaries: 3 persons for two years: Rs.3,50,000.
Honorariuim & Consultancies: - Rs. 40,000.
Other Expenditures: Rs. 50,000.

Total Budget for Two Years: Rs.4,40,000.
Budget for One Year: Rs.2,20,000.

CEHAT: **Centre for Enquiry into Health and Allied Themes, Bombay.**

NOTE ON THE NEED TO STUDY AND CONFRONT CHILD ABUSE

In the nineteen seventies, before the women's movement took up the issue of rape, it was widely believed that rape was an act of the psychopaths and that such things didn't exist in our society as a rule. Many myths regarding rape were challenged by women and a change in the law regarding custodial rape was brought about. Being able to name the crime gave women the strength to speak about it, and to seek redressal. **Even though most attitudes regarding the crime have not changed at societal level, atleast a beginning has been made to understand the politics and power-relations within the act of rape. A woman-centered perspective was evolved.**

On numerous occasions, women friends have shared with each other their personal experiences regarding abuse- physical, emotional and sexual, during their childhood years. One has also seen children of friends being sexually abused by trusted or casual acquaintances. The scars of physical and mental battering as well as those of sexual abuse stay for long and it is quite possible that they adversely affect our perceptions of sexuality, relationships, childbirth, self-confidence and so on. **Worse still, there is no space to speak about child abuse and so most of us carry these guilty burdens alone. In a sense we remain the frightened and lonely child forever.**

The sharing of friends regarding childhood abuse led us to believe that child abuse exists extensively in our society. It is not an imported perversion. It carries on furitively within the environments that children believe to be the safest- the home, school, institutions for child care and state run homes such as remand homes, prisons, asylums and so on. **The crime is committed more often than not by people children love, trust and/or fear. When the criminal is a custodian (either permanent or temporary), children are forced to keep quite for reasons of survival.** The tiny minds are sick with fear that they may be the cause of breaking up the family and they keep silent for the same reasons that grown-up women do in violent homes.

Furthermore, very few people would believe the child if she or he were to talk about abuse. Since disciplining of children through coporal punishment is accepted in society, what exactly would constitute abuse is a grey area. Being born as a daughter itself would lead one to be emotionally abused, either through discrimination or through taunts or negative attitudes of family members. If children were to identify this behaviour as abusive, they would at best be counselled by adults to be more obedient and at worst would be targeted for further abusive treatment.

The problem of sexual abuse is more severe and complex. In most households, sexuality - even that which is considered 'normal' is hardly discussed. Rarely would parents consider it their duty to talk to children about menstruation, intercourse, conception, childbirth, pleasures in sexuality, contraception and so on. To talk of rape, dangers, abuse and violence in a rational and realistic fashion is unheard of, in most homes. **This ignorance, stigma and irrational fear of sexuality that parents harbour prevents them from communicating with their children about mature and responsible sexual behaviour and also exposes the children to abuse from adults.**

In a household that considers sexuality harmful and speaking about t perverse, the child cannot confide in any loving adult about abuse. Receiving negative signals about sex, the child may feel that the adults would disbelieve her/him, resulting in loss of face and tensions at home. This dilemma would be aggravated in a household where a abuser is a close relative residing in the same house. Many studies and observations all over the world have shown that mothers tend to keep quite when the daughters are abused by the father and watch the humiliating act helplessly. When the daughters grow up, they hate the mother more than they hate the father. Two victims are thus pitted against each other.

Growing up abused has serious consequences for the survivor. The limits of privacy and body sanctity are lost in hostile touch, either of battery or of sexual abuse. Pain is equated with love and sex becomes either an act of power or of seeking security and self-worth. **On the one hand, unnatural fears of sexuality may result in fear of menstruation, childbirth and building stable relationships, whereas on the other hand physical and sexual abuse may precipitate a dangerous adventurism that predisposes the individual to further abuse, rape and battering.** The vicious cycle of lack of self-esteem and further abuse is generated.

Some psychologists have now accepted that childhood abuse results in various disorders in adulthood. Eating disorders, sexual disorders, allergies, addictions, mental ill-health and so on may be precipitated or aggravated by unconscious memories of childhood abuse. Even in 'normal' individuals, the inability to build loving relationships and the inability to get out of abusive once may have some connection with harmful experiences in childhood.

For innumerable reasons, the silent crime that kills the innocence of thousands of children has to be confronted. Children's rights to security, love and to a nurturing environment cannot be violated at any cost. Battered and abused children would have a hard time trying to blossom into creative, fearless and well-adjusted adults. Who gives adults the right to maim a

child's body and mind or to destroy a child's present and future? **Protecting children from abuse is thus nothing short of a human rights issue.**

Areas of Work and Methodology:

The entire problem of child abuse would have to be tackled through a long-term and sustained effort of many individuals and groups. *To name and identify the crime, to acknowledge that child abuse is far more prevalent in society that we would like to admit, to help children to resist abuse, to counsel parents and teachers, to offer help in crisis situations, to teach children to avoid dangerous situations, to develop a positive attitude to the body and to sexuality* - the list is endless. Some of the work will also have to be done with adults, either survivors or parents or abusers.

At **the Centre for Enquiry into Health and Allied Themes** ***(CEHAT)***, we would like to develop the area of looking into, understanding and confronting child abuse. We are seeking funding partners who will assist *in research and service project* related to the issue. Undoubtedly, one would have to start from a couple of projects in the beginning; but that would be done with the overall child-centered perspective towards abuse.

The first task would be to place child abuse in the Indian context. This would include research as wells as documentation of primary and secondary evidences/experiences and coping mechanisms of victims and survivors. This work would be carried out *in schools, neighbourhoods, child-care institutions as well as meeting adults in different walks of life.*

Another task involved is actually providing as well as sharpening and **adapting counselling techniques** for victims, survivors and their supporters, and **preparing manuals** for children, parents, custodians and teachers. Abusers would also have to be counselled and/or confronted. This experience would help us in the **setting up of sensitive and child-oriented services** in the form of education, counselling, legal advice, temporary shelter, placing in foster homes or in state care if necessary, and providing **institutionalized, specialized services** such as psychiatric, medico-legal, psychological help and so on. **Training facilities** to NGOs and child-related institutions (mainly schools) could also be a meaningful service to provide after sufficient expertise has been generated.

Time Frame:

The type of work that needs to be done in the form of research, documentation, service provision, manual preparation, education, training etc. is undoubtedly massive and we are committed to do sustained work in

this field on long term basis. At the same time we are aware that there is lot to be learnt and social obstacles to be overcome before we could make a real dent in the situation.

Keeping this in mind, we propose to make a modest beginning in both the research, documentation and in providing help to the abused children in Bombay. This will be done in several public and private schools, in a slum and neighbourhood and in some of the child care institutions like orphanages, street children's homes etc.

This first phase of work will be for *two years*.

Financial Support Required:

In two years, the total financial support required is: Rs.10,22,000.

Salaries and Consultancies: Rs.6,72,000., Contingencies: Rs. 2,75,000., Misc. and other expenses: Rs.75,000. And the overheads.

Le nom de l'écrivain Primo Levi a été choisi en raison de sa valeur symbolique : refus des traitements inhumains, cruels et dégradants, refus de la violation organisée de la dignité de l'homme, refus de l'exclusion au titre de l'origine.

"Vous qui vivez en toute quiétude bien
au chaud dans vos maisons (...),
N'oubliez pas que cela fut,
Non, ne l'oubliez pas".

Primo Levi. *Si c'est un homme*

« Le Centre observe une indépendance d'action et d'expression par rapport aux organisations politiques, syndicales, religieuses, qu'elles soient françaises, étrangères ou internationales...

« Compte tenu du secret qui pèse sur l'utilisation de la torture et de l'aggravation des positions négationnistes, les personnels du Centre peuvent être amenés à témoigner des souffrances et des cruautés infligées aux victimes soignées au Centre, avec leur autorisation ; cette fonction de témoignage s'exercera auprès de toutes les instances et de tous les publics qui nous solliciteraient ou que nous solliciterions. Transmettre ou dénoncer ce que nous voyons et entendons, fait partie de notre engagement dans la lutte pour le respect des droits de l'homme.»

Extraits de la Charte

Pour toute information sur l'Association Primo Levi et le Centre de soins :

107, avenue Parmentier
75011 Paris

Tél. : 43 14 88 50

Fax : 43 14 08 28

métros : Goncourt et Parmentier

Responsable médical du centre :

Dr. Nathalie Monbet

Consultations uniquement sur rendez-vous

ASSOCIATION PRIMO LEVI

POUR L'ASSISTANCE AUX VICTIMES DE LA TORTURE ET DE LA VIOLENCE POLITIQUE

Groupement interassociatif créé et animé par :

Amnesty International Section française

Médecins du Monde

Action des Chrétiens pour l'Abolition de la Torture

Juristes Sans Frontières

Trêve - Personnel soignant

Des moyens pour l'action

Le Centre PRIMO LEVI : un centre de soins à Paris pour les victimes de la torture et de la violence politique, qui, en partenariat avec les ONG fondatrices :

- conçoit et réalise des missions à l'étranger auprès de populations victimes de traumatismes collectifs ;
- offre un soutien psychologique aux expatriés d'ONG qui ont été confrontés à des situations de stress au cours de leurs missions ;
- élabore et réalise des formations sur la spécificité des soins aux victimes de torture ou de répression politique ;
- soutient les victimes appelées à témoigner devant les juridictions internationales créées pour sanctionner les crimes contre l'humanité et les génocides.

Une équipe pluridisciplinaire

Médecins, psychothérapeutes, psychiatre, kinésithérapeute, interprètes, assistant social et juristes, forment une équipe pluridisciplinaire au service des victimes de la torture et de la violence politique – ainsi que leurs familles.

Dans une approche globale de la personne ; avec le souci de respecter les valeurs, les cultures, les traditions, des personnes traumatisées. Son objectif est d'aider les victimes à revivre, après un passé traumatique, dans le pays d'accueil, à témoigner si elles le désirent - ou à témoigner pour elles à leur demande.

Un Conseil d'administration et un Bureau

Des responsables qui sont l'expression d'un groupement de partenaires :

Président :
Hubert PREVOT

ACAT	Michel DRAVET* Bernard LEDESERT
AISF	Michel FOURNIER* Bernard JOMIER
JSF	Philippe RYFMAN* Georges PERIDIER
MDM	Claude AIGUEVIVES* France ARRESTAT
TREVE	Diane KOLNIKOFF* Sibel AGRALI

Secrétariat administratif :
Catherine Pinzuti-Thomas
Marie-Thérèse Petraz

* *Membres du Bureau*

NGO-257

Establishment of a Treatment and Research Centre for Survivors of Violence

The land which produced world famous proponent of non-violence, *Mahatma* Gandhi who led a largely non-violent independence movement of India, is in the grip of unprecedented epidemic of violence to day. This does not mean that the Indian society has otherwise been a non-violent society. Far from it. The caste and gender violence, and interspersed events of large scale political violence let loose by the ruling tyrants and invaders, have been constant feature of violence since time immemorial. The communal (the violence on religious lines) is also as old as two centuries. It was the violence so deep rooted in the Indian reality that perhaps motivated Gandhi to direct the national movement on the concept of non-violence and create a counter force against tendencies of violence.

What is new in the over last two decades old epidemic of violence is that various political processes and movements have brought much of the reality out of the closet, made it sharply visible. These movements have exposed the hypocricy of Indian elite preaching non-violence in the atmosphere of all pervading violence in the society. Thus, in last two decades, while the intensity of violence has increased and newer facets added to it, there have been more movements and actions against the violence. One such area in which the movement against violence taking shape is health care.

Gender Violence: The modern feminist movement in India emerged and took shape on the issues related to violence against women in the early 1980s. Indeed, in the early 1980s the feminist consciousness spread along with large scale women's mobilisation against rape, dowry deaths (women burnt, hanged, killed by in-laws and husbands demanding more money as dowry from women's parents) and wife battering. This movement not only spearheaded changes in the rape laws and laws related to dowry deaths, it also created support structures for providing counselling and shelter to the victimised women. A number of such women's centres have been established and run by women in almost all big cities of India.

Caste Violence: After gender, the caste violence is the oldest form of violence in India. India is a caste divided society. Though caste is the specific feature of India's dominant religion, it is not restricted to Hinduism alone. All other religiouns also have their caste hierarchies. Further, the caste division and violence is also related to the class structure. For the caste positions of High and Low castes groups also often correspond with their class or economic position in the society.

In last two decades there has been great assertion by the low and lower middle castes in the social and political arena. The caste violence has intensified also due to the backlash from the high castes groups. Noteably, the students of medical colleges in the western Indian state of Gujarat triggered and were at the forefront of an agitation in ealy 1980s against providing reserved seats in the medical education to the low caste people. This agitation took a violent turn with mass scale attacks on *dalits* (the low oppressed castes).

Communal Violence: The communal violence is indeed a modern phenomenon started about two centuries ago as a part of "divide and rule policy" of the colonial government, and its

ideological menifestation ulitimately resulted into the division or partition of India in 1947. The partition also witnessed one of the massive violence between Hindus and Muslims. The post partition communal violence has got intensified in last one decade. The communal violence is expressed in the street fights, in which the state machinery either goes to sleep for few days or a few weeks, or sometimes help fomenting violence. During these days and weeks, the innocent citizens, particularly those who are marked out for attack, experience real terror producing great amount of traumatic stress. From all empirical evidence it is very clear that the minority religious community has suffered the worst during the recurrent communal violence. The traumatic stress produced by such violence is such that it has completely changed the psyche of the sufferer community and in the absence of significant psychosocial relief privided, the sufferers have continued to be haunted by the trauma.

State, Terrorist and Political Violence: From the late 1960s, when the peasant rebellion rocked several states of India and produced a violent backlash from the state to repress it, this form of violence has only increased. The traumatic 19 months (1975-6) of suspension of democracy under the state of emergency, produced a strong democratic movement and created many human rights organisation all over the country. The custodian violence, torture and deaths in police lock ups and prisons, the encounter deaths (killing of individuals in the so called encounter with the police) etc have been well documented by now due to the relentless work done by the human rights organisations in last two decades. In last one decade the issue of violence unleashed by armed dissident groups has been increasingly reported.

Role of Health Care Professionals:

The health care professionals occupy an unique place in the situation of violence. They are considered neutral agency, providers whose primary concern is healing. Thus, the survivors of the violence at some stage in their suffering do seek help from the health professionals. Similarly, in cases of deaths, the health professionals are also brought in the service for examining the dead bodies and in conducting autopsies. Indeed, the ethically oriented health professionals could do a lot in treating the survivors of violence and through meticulous autopsy and medical records could assist survivors and victims' relatives to get justice.

However, the record of health professionals so far in this regard abysmally poor. This has happened due to ignorance on the part of health professionals as well as due to negligence which have most often gone unpunished by the courts and the professional associations. In our interaction with victims, for instance with the battered women, we have found that the doctors have failed to elicit history of battering, and even when women volunteered on their own, have deliberately nated it as an accidental injury on the medical record giving an excuse that such battering was normal and was internal matter between husband and wife or that the doctor wanted to avoid his/her duty to go to courts to give evidence. Often, the perpatrators of rape have gone scot free because the medical examination of the rape victim conducted by the doctor was inadequate or left inconclusive. In cases of torture in police custody we found during the investigations that the doctors did not take priliminary precaution of taking history of patient after sending the police out of his or chamber. A number of investigations of human rights violence, including those done by the Amnesty International, Human Rights Watch and Physicians for

Human Rights have found the deficient or some times even patently false autopsy reports prepared by doctors.

Treatment of Survivors of Violence: In the treatment of survivors of violence the health profession has acted in a conservative way. That is, most of the reports suggest that treatment of physical injuries has been carried out in a reasonably efficient way. For instance, during the communal riots in Bombay city and the bomb blasts that followed the riots, the public hospitals were overloaded with patients with grevious injuries. Although it was noted that the health care system was not properly geared to respond such disaster situation, the health workers rose to the occasion and provided reasonably good care to the injured people. Only in last few years some reports of some doctors discriminating against patients from certain communities have come out showing that the prejudices taking roots in the society may be getting reflected in the practice of maedicine. Nevertheless, on the whole, the performance of health professionals in such violence has been commendable.

However, the failure on the part of health professionals is noticeable when one considers diagnosis and treatment of the long term psychological problems suffered by the survivors due to the severe spychosocial traumatic stress. This failure is glaring even amongst the otherwise highly enlightened professionals. For instance, one is not surprised to get a self referred case of post torture traumatic stress who was otherwise well treated by public or private health professional but was not at all examined for his or her state of mind. Partly this indifference to the psychological stress is due to the less importance given to the psychological problems, particularly of common people, in general, or lack of motivation and time.

Prevalence of Psychosocial Stress Among Survivors of Violence:

A Case study, findings of one research and some observations derived from our work would illustrate the problems faced by the survivors of violence.

(1) A 25 years old semi-skilled worker working in the maintenance division of a lift (elevator) manufacturing firm was picked up by the police when the workers of his company went on strike. He was neither the leader nor even a vociferous activist of the union which had organised the strike. He suffered this fate because he was close friend of some the union leaders and was often noticed in their company. Besides, due to the police crack down on the unionists, the leaders had gone underground, so he became an easy target. He was taken to a police station close to his sister's residence which he used to visit frequently. Here, in an interior room, he was surrounded by the 8-10 police constables and a sub-inspector who started beating him. The next thing he knew was that his closes were taken off and he was standing at the centre of circle of policemen laughing at him and pushing and hitting him all the time. This continued for about half an hour. He was repeatedly asked to tell them the whereabouts of his union leaders but he could not provide the answer as he had no idea about their whereabouts. His pleas about his ignorance were brushed aside by the police. They took him beside a small electrical machine mounted on a table. The naked parts of the cables coming out of the machine were first put on his fingers and toes and they told him that they were going to electrocute him. The electricity was switched on, and he shouted out in pain. In response he heard deafening laughter. His face was taken close to the

machine and shown how the electric current was increased by pressing a switch. Then they kept on increasing the intensity of the current amking him to face more and more pain. Then, suddenly a policeman came very close to his face and asked him, "Are you married?" He failed to understand the meaning of the question writhing in pain all over his limbs. The policeman asked again, this time he replied in negative "OK, then we will see that you never get married as we will now do something that will make you permanently impotent." He was shaking and crying loudly, with folded hands he told them to release him. But the electrodes were put around his penis in no time. All policemen started laughing and told him, "Here goes one man permanently " He felt pain on his genitalia, it was unbelievable that they could do such thing to him. This electric torture continued for awhile, he had lost count of the time. After doing all these things when the police could not get the information they wanted, he was transferred to the lockup while threatening all the time that they will do worse to him as soon as they were able to lay their hands on him.

He was eventually released on bail. When he came out, his collegues took him to the public hospital for the treatment of injuries. He was meticulously treated, a medico-legal case paper describing in brief the torture was also prepared. He also filed a complaint against the policemen responsible for his ordeal. A departmental inquiry by an inspector was ordered but a year and half after the incident, no report has been made. In the meanwhile, his problems continued. First of all, he started having sleep disturbances, hallucinations and so on. He was so scared of the police that as soon as he heard the siren of the police car at the distance, he used to hide under the bed. He found it difficult to walk on the same side of the road where a policeman stood. Further, while visiting his sister's residence, he started avoiding walking in front of the police station where he was tortured. And he genuinely believed that he had gone impotent and would not be able to marry. Further, when the strike was withdrawn and he started working, he found it difficult to work on his job as he was so afraid of electricity. Being a maintenance person, this affected his work drastically and that brought him to us for treatment.

(2) A study of 104 villagers in a state in the north eastern region of India, who were tortured by the army revealed that after 22 months of the experience of torture, it was found that 24 of them showed the visible physical marks of the torture on the body, but as many as 101 out of 104 were found to be mentally unwell, while 35 showed severe mental symptoms due to the trauma suffered. The study also found the relationship between the type and nature of torture reported with the symptoms suffered. It was found that 39% suffered from recurrent dreams of torture, 66% from disturbed sleep, 55% were incapable of enjoying village festivals, food, sex and even friendship. One third of them had lost their self confidence and believed that they were ruined physically although the medical team found no physical disability on examination.

The medical team of investigators also found that most of the tortured villagers were not provided any medical treatment either in the detention centre or after their release. 22 months after the torture, so many of suffering from the severe psychological problems were not treated by any agency and they continued suffering.

(3) As against the psychosocial problems suffered by the torture victims, what are the features of problems suffered by the survivors of communal and caste riots? There is very little clinical and research material available on the subject. Our study reveals that the survivors receive three

intense forms of traumas at the time of riots. **Firstly,** there is trauma due to general terror. Here the victims are in their own houses, or have taken shelter in somebody's house, are expecting murderous attack on them at any moment. **Secondly,** the trauma is due to witnessing violence. This is common to both who are marked as victims and vulnerable as well as for those who are otherwise safe but forced to witness gruesome violence as it is taking place in the close vicinity. However, the *degree* of immediate traumatic effect created by witnessing violence appears to be different for those who are actually endangered and under the fear of suffering similar fate (for being of the sufferer's community) than those who witness but are not under threat or believe that they were not likely to suffer (for being members of the attackers' community). And **Thirdly,** there is trauma of those who actually get violently attacked, suffer but survive. Needless to add that their suffering, physical as well as psychological, appears to be greater.

It is really unfortunate that although few psychiatriasts were involved in treating a sizeable number of cases of post-riot psychosocial conditions, the follow up of the cases doesn't seem to be so adequate. From our own experience of voluntary work in this field, we have come to realise that it is very difficult to make patients of such condition to complete the treatment. Further, the health professionals in the public sector are overburdened with work and they have little resources and time to make rigorous follow up. This only emphasises the fact that there is a dire need to establish a medical centre which makes a concentrated effort to treat the patients suffering from psychosocial stress.

Objectives of the Medical Centre:

The Treatment and Research Centre for Survivors of Violence will be established with the following five objectives. All five objectives make a comprehensive whole and they would be addressed to in totality.

(1) To provide medical and psychotherpeutic treatment to the patients/clients suffering from the psychosocial stress brought about by the trauma due to any form of violence.

(2) To rehabilitate such clients through appropriate and sensitive support services.

(3) To document traumatic stress produced by violence in the individuals and in the society.

(4) To undertake clinical and social research to understand causes of violence, ins impact on individual's and society's mental health and to find ways and means for treatment of individuals and for eradication of violence from the society.

(5) To inform people, the leaders, the media and all those who care on the effect of violence and to aid the campaigns for eradication of violence in the society.

As suggested by the above objectives, the proposed medical centre will not be a passive agency. It would undertake systematic research and documentation, it would make full efforts to disseminate information, it would undertake public education campaigns, it would contribute in the processes

of getting justice for the victims and above all it would strive to upholding rights of people and the independence of health professionals. Further, given the varied forms of violence prevailing in India, their different effects and menifestations, and the multicultural melieu from which the sufferers come from, the centre would provide an essential basis for the extensive clinical research in psychothrapy, counselling etc. Thus, apart from meeting needs of the suffering victims, it would give inputs for enhancing understanding of the national and international medical and psychologist community on the traumatic stress.

Both as a necessity for rehabilitation of the sufferers and for creating wider awareness, the centre will network with humanist NGOs, legal community, medical associations, the media, women's groups, human rights groups, trade unions and so on. Such networking will also enable people to understand what to expect from such a medical centre.

Further, the centre would make efforts to cater to all forms of violence, such as survivors of riots, battered women, dowry harassments, abused children, torture by the state agencies as well as private agencies and so on. Thus, this endeavour would aim at creating holistic understanding and treatment methods relevant to various forms of violence. Secondly, it would not use only modern medical methods of treatment, but integrate the relevant methods from the indigenous systems. And thirdly it will try to provide complete treatment to survivors of violence by offering medical, physiotherpeutic, counselling and psychotherapeutic help.

While inculcating the norm of professional excellence, the centre would be very sensitive and responsive to three other issues. (1) The institution advocating eradication of violence and oppression cannot be run on the rigit oppressive hierarchy within. The oppressive hierarchy and lack of participatory and democratic functioning is a major problems with most of the institutions and in the way profession is organised in the country. Thus great care will be taken to inculcate participatory democracy and respect for the clients. (2) There is a great erosion of ethics in the profession and medical practice in India. The centre must have strong, functional ethics committee comprising of medical and non medical individuals with impaccable integrity. (3) Such a centre cannot remain insensitive to the needs of the local community within which it will be existing. In that area at least it will make some efforts to help the community in meeting its health care needs. Such effort could be in training health care workers, undertaking health education campaigns etc.

Requirement to be Met for Establishing the Centre:

There are four major requirements to be fulfilled in order to establishing such centre, they are, (1) Personnel selection, (2) Their orientation and training, (3) Library and documentation, and (4) Investing in the physical structure and meeting financial requirements.

(1) The personnel selection. This part of the work is very important as getting medical, nursing and other personnel with right kind of commitment to work for the victims would mean half battle won. This is difficult, too. There is a lure of money in the private practice, and the income of medical people in private practice is very very high. The centre obviously cannot pay so much to its staff. Yet, the payments at the centre cannot be so low as to fail in attracting individuals with good competency in work. At the same time the individuals shuold possess impaccable ethical

character. Given the great erosion of ethical norms in the medical practice in India, one must adequately stress this point. For, the health professionals would be dealing with a very sensitive issue, some indiscretion on the part of them could lead to great harm. They must have unshakable commitment, moral and political, to the welfare and safety of the survivors of violence.

At the moment we have only a few individuals with such motivation and commitment collaborating with us in this work. When we systematise our work, of course we will be able to get more individuals to work with us.

(2) Orientation and Training: This is a must as our work so far in the field is episodic and experience minimum. We infact have no experience in systematic work on the subject. Besides, we feel that the initial nucleus of the health professionals formed by us at the centre will not have relevant professional expertise, or formal training in the work we intend to undertake. Thus, some of us may need a crash course of training in the basics of say, psychotherpeutic methods. And of course we would need training at the centre(s) where such work is already underway. Since at present there is no such centre working in India, it is imperative that few of us undergo training at a centre where such work is already on so that we could adopt some of such work to our understanding and needs in India. Although we have no idea as to how we would actually do the adaptation of such work, we do strongly believe that it would not be correct and useful to blindly duplicate what is done elsewhere. This means we will have to work hard, be innovative in our work and keep our feet firmly rooted in the indian reality. We believe, that is how it should be.

This would only mean that we will have to pay great attention to the details of the clinical aspects of psychology and psychitry in our work. Without that it would be impossible or messy.

(3) Library and Documentation: This would be collection of information, preparation of library databases for use by people, lawyers, media persons etc, analysis of information and wider dissemination of information to people and professionals. The information would pertain to the larger social information on the incidence, trends etc of violence as we as to the databases for clinical work and research.

We feel that this work should be initiated at the earliest so that by the time the medical centre actually starts offering services we already have some amount of information base ready.

(4) Investment and financial implications. Although we have been voluntarily working on this subject for fairly long time, the task of systematising the work and establishing a medical centre not attempted due to the lack of financial support. In order to do this work few of us may have to leave our current work and devote full time in estblishing the medical centre, undergo necessary training and also build up credibility for the centre. That means few professionals will have to be supported full time from the beginning of the work. In addition, we have to take, initially on rent at least 2000 sq.ft place and furnish it, in the suburb of Bombay to establish a functional medical centre.

(~~$~~ One hundred thousand only)

The financial requirement would be (rough estimates) about US $ 100,000 per year (in the first year it may be little more as there will be establishment cost) and to begin with we must ensure that the finacial support is committed for at least for three years.

PROJECT PROPOSALS

Proposal

Response of Health Professionals and Services to the Epidemic of Violence

(A) THE PROBLEM

The mainstream social sciences in India have largely ignored the fact that India is a very violent society. Although the investigation and documentation of political violence was started in a systematic manner by many small voluntary groups and the media much earlier (the 19 months of State of Internal Emergency in the mid 1970s provided impetus to it), the mainstream social sciences had not taken sufficient interest in the phenomenon. The other forms of social and political violence, viz. gender, caste, communal etc. were also analysed inadequately.

However, the decade of 1980s has heralded some change. For example, three edited volumes by Prof. A.R. Desai (1986, 1990, 1991) and in his recent study of Gujarat (with D'Costa, 1994) have brought together collection of documents and writings on the political violence and violation of democratic rights which would have otherwise found less recognition in the social science discourse. Similarly, social scientists have also started paying attention to the communal violence and violence against women. For example, the works of Asgharali Engineer, Veena Das (1992), Flavia Agnes (1990, 1992), Chhaya Datar (1992), Vibhuti Patel and many others have done much needed conceptual and empirical work on the subject. Due to their work certain types of violence which suffered from social taboos, such as rape, wife beating, child abuse etc have now found a place in the social science discourse and in the campaigns of concerned organisations. In fact, these concerns have altered the political agendas of many social and political movements. At the same time this has brought in its wake more concern for the victims and survivors of violence.

Violence as a public health issue:

In this regard, the health care professionals have fared even worse than the social scientists. In the medical discourse in this country the concern for violence is conspicuous by its virtual absence. In much of the medical research, discussion and publications, the mention of the victims and survivors of violence, and their special medical needs and rehabilitation, is rare. Is this because the health care workers do not come in contact with the victims and survivors of violence? Answer is categorical "No". Violence invariably inflicts physical or psychological trauma and in any violence, the victims and many survivors come in contact with the health care workers. Survivors approach or are taken to health care services, for the treatment of their physical injuries and psychosocial trauma suffered. The dead victims of violence are examined for autopsy by the doctors. In fact, the medical record of violence on the survivors and victims constitute one of the important evidences for the police investigations and legal processes for punishing the offenders and compensating victims and survivors.

The figures quoted by the media and social science researchers from the various sources on the incidences of all types of violence and the estimated numbers of sufferers are indeed shocking. What is also shocking for the health care providers is that there is hardly any mention in our scientific journals and in the health policy documents on the implication of such a phenomenon for the health care services. While one doesn't want to sensationalise and exaggerate the phenomenon of increasing violence in our society, one also can't resist saying that for health care services it is a big but ignored epidemic of the present time. Its size needs to be assessed, but sadly our public health

experts have done little in this direction. Information quoted by us in the later part of this document, albeit insufficient, point to an epidemic which is bigger that most of the well known diseases identified as public health problems. No doubt, therefore, the violence is a public health problem. It is absolutely essential that our health policy makers and the health care providers accept this fact, estimate the health care needs of the sufferers, train health care providers for their treatment and above all, reorient the health care providers in such a way that their work could become an important social instrument for preventing violence, for punishing offenders and for properly rehabilitating victims.

Unfortunately, the conscious response of the health professionals to one of the bigger epidemics of violence in recent times in our country has been grossly inadequate. They have either shown plain indifference or clumsy and adhoc crisis management attitude when faced with the situation of violence. This does not auger well for a profession claiming to have scientific basis for its practice. The implied failing in discharging *social responsibility* raises ethical questions for the profession at large in the country.

Violence and the Health Professions:

The science of medicine incorporates sociological and epidemiological understanding. The medicine, and for that matter any science, not geared to the real social and epidemiological issues often loses its humanitarian content. As stated earlier, the social scientist have of late started responding to the phenomenon of violence. What is the reaction of health professionals? The violence does not leave the health professionals completely unaffected. Afterall, doctors also come from the social milieu which has varied and conflicting standpoints on the violence. To what extent is the attitude of doctors to violence shaped by their social positions and ideological orientation in our country? Answer to this question is not easy as there has been very little empirical research conducted to find out health care providers' attitude on the subject and the extent to which individual biases get reflected in the medical practice. However, some indication on what is happening at the ground level within the profession is available from the investigation reports of various local, national and international groups, and some research studies.

(a) Autopsy: The way autopsies are conducted, the reports written, the access to the reports etc have been a bone of contention for long. There have been reports in the press about the pressure exerted by the police on the doctors to give favourable findings. The famous case of police custody death of Dayal Singh made the Resident Doctors' Association of the AIIMS (New Delhi) protest against such pressure is mentioned in the Amnesty International (AI, 1992) report titled *"Torture, Rape and Deaths in Police Custody"* which generated lots of controversy only a couple of years back. Similarly, the autopsy reports of two nuns murdered in a Bombay suburb and doctors' role in unscientific interpretation of its findings created great furor (Solidarity for Justice, 1991). In addition to the autopsy reports of these nuns, I also had an opportunity to go through a sizable number of autopsy reports of the custody deaths and the so called encounter deaths in last few years.

In general I found several disturbing issues which have great implication for the ethical behaviour of the doctors involved in conducting autopsies. For instance, autopsies in custody deaths are normally conducted by the police doctors in police hospitals or departments in public hospitals to which lay people and other doctors have no access. An independent medical audit of work being done there is unheard of. This situation is neither conducive for good science nor for good ethics; and should make

the profession at large suspicious of the standard of ethics practised, unless such suspicion is disproved by an independent body of the profession. Further, a study of autopsy reports of the violence victims would probably show that normally they have incomplete and often unscientific documentation. It is significant to note that the Supreme Court had to pass an order in 1989 that all postmortem examinations held at the AIIMS be standardised. However, this High Court order has remained inadequately implemented. This is observation is corroborated by the way autopsy (not once, but three times) was conducted on the charred remains of Naina Sahni in the well known gruesome murder case involving a politician. While legal implications for such autopsy were highlighted, nothing has been written about the doctors involved. (Jesani, 1995).

(b) Torture and rape: There have been numerous official denials that the so called third degree methods of interrogation or torture are practiced by our police and security personnel. However, the evidence accumulated so far do not support such a claim. Some of the retired and senior police officers, "reared in the old school of correct policing" have publicly criticised the "new methods of policing" which are "supposed to be firm, unorthodox, effective and harsh, and they condone the use of torture, illegal detention and tempering with records, and in worst cases even condone execution by police officers of hard core criminals" (Rustamji, 1992).

The above mentioned 1992 report of the AI cites 13 cases of custody deaths due to torture in the period 1985-89 in Maharashtra. However, a Bombay newspaper (*The Independent*, 1991) reported a study by the prestigious Karve Institute of Social Work, Pune giving the toll of custody deaths in Maharashtra to 155 in 1980-89 period. On inquiry, I (Jesani, 1995) found that of these 155 deaths, 102 (20.4 per annum) had taken place in the five year period of 1985-89 for which the AI had reported only 13. On analysing the causes of the 155 custody deaths, I found that only 9.7% (15) were admitted as due to police action, 44.5% (69) were attributed to suicide or acts of the accused, 7% (11) to acts of the public, 22.6% (35) to disease and illness, 13.6% (21) were termed natural deaths and in 2.6% (4) the cause was not known or record not available. I was further astonished to learn about some specific causes mentioned, viz. alcohol consumption (9 cases), hanging (45), jumped in well (3), jumped under the train (2), jumped under the autorickshaw (3), jumped under the bus (1), fell from the coat or bed (1), skin disease (1), giddiness (1), unconsciousness (1) and so on. Given the norm that every death in the custody ought to be investigated and proper autopsy done, such causes are not only incomprehensible but they create suspicion that a larger proportion of them were due to torture. The role of doctors doing such autopsies therefore need to be investigated by researchers and the media.

In one of the investigations (CPDR, 1990) of the police custody death in Bombay (of which I was a member of the investigation team along with two journalists and a lawyer), we found that the young victim accused of a petty theft was, in the course of interrogation, brought to a public hospital in serious health condition which included (as per hospital records), typical torture inflicted injuries on his wrists and thighs, bloody vomiting, pain in the region around kidney etc. He was given routine treatment and asked to go back to his torture cell by the doctor. It was also found that the doctor had taken case history and done medical examination in the presence of the police officer who had accompanied the victim. The doctor did not consider presence of the police in the doctor patient relationship unusual but termed it as routine and yet insisted that he did not suspect torture as the victim never reported it to him. The victim went back and later died. Similar thing was found by us in an investigation (YUVA, MFC et el, 1990) of a gang rape wherein, inspite of the visible signs of injuries in regions which could make any medical person suspicious of rape, the male doctor turned

away the patient with routine treatment of injuries simply because the woman could not tell him that she was raped. In this particular case the woman had reported rape to the nurse on duty but could not communicate the same to the male doctor. In another case of custodial gang rape and torture of a tribal woman by police in Gujarat (AI 1988), the commission of inquiry constituted by the Supreme Court found that two doctors at the government hospital were guilty of shielding the policemen and also for issuing a false certificate.

These examples, I have reasons to believe, only represent a tip of the iceberg. It is not that the doctors who often come into contact with the survivors and victims are always conscious accomplices in covering up the cases. A section of doctors involved are plainly ignorant about this aspect of medical work. Another section is indifferent to the plight of sufferer due to their own social biases against the victims and survivors. Such indifference is also produced by social pressure to conform to the dominant belief. Thus for instance, in cases of torture inflicted on persons labeled as terrorists, doctors often faithfully treat the injuries but show great reluctance in mentioning torture due to the fear of being seen as opposed to state's efforts at fighting terrorism, separatism etc. Besides, the psychosocial trauma inflicted by torture is completely ignored, often because there is no training imparted to them for managing such trauma and also due to low commercial value of such medical work. A third section simply believes that being in the employment of the government, the police department or the prison, they are bound by the orders of their superiors and the code of their service did not allow them to "blow the whistle". Another reason for doctors' apathy to these issues is that they consider themselves as mere technicians (as some doctors have often remarked, "we are doctors, we treat illness, we are not interested in torture or rape") and therefore they do not make necessary efforts to explore the causes and history. This is both inadequate science as well as inadequate understanding of medical ethics.

(c) Family Violence: The great surge of women's movement in the 1980s brought issue of violence against women on the political agenda of the country. Yet, a survey of violence against women in the less developed countries has shown that it is a grossly neglected public health issue (Heise, Raike et el, 1994). The family violence involves violence against women and children.

The violence against women and children is the most common form of family violence and it has social, cultural and religious sanctions. The studies done by Flavia Agnes in the 1980s in Bombay and other studies have shown that it cuts across the class and class barriers. These social variables only change the form of violence, not the high prevalence of it. In a study of 120 families done at the NIMHANS, Bangalore, Bhatti (undated) found that some form of violence against women was prevalent in all families, the physical and verbal violence being the highest (88%) in the low income families while in the middle income (43%) and high income (35%) families those forms were less prevalent. However in the latter groups, there was higher prevalence of social and emotional violence. In a large study of 230 women from urban middle and upper classes, Sathyanarayan Rao and his collegues (1994) from the department of psychiatry in the Medical College at Mysore, studied the pattern and causes of psychological violence against women in the family and came to the conclusion that psychological and emotional torture are highly prevalent in the middle class families. In a study by Mahajan A, Madhurima (1995) of 115 women in the lower caste households in one village at the outskirt of Chandigarh in Punjab, it was found that as many as 87 (75.7%) women reported physical violence against them by their husbands. Further, of these 87 women, 58 (66.7%) said that they were beaten regularly. Similarly, the dowry deaths and their increasing numbers despite changes in law, point to the pernicious prevalence of family violence.

While women's movement has brought the family violence out of the closet and made it a social and political issue, the violence against children in the family and outside is still not properly recognised, except in the campaigns against child labour and the problems faced by street children. The studies on child abuse in India are difficult to find although our experiences suggest that the violence against girl child, including sexual violence, is as highly prevalent as the wife beating.

The role of health care professionals is highly ambiguous in cases of family violence. Although batterred baby syndrome as a cluster of signs and symptoms for battered children was medically recognised in the early 1960s, very little work on it by health professionals in India is available. Similarly, the battered wife syndrome is almost unheard of in the medical discourse in our country. A practical implication of such indifference of health professionals is felt by women's groups in their cases in the family court. In our discussion with women activists we were repeatedly told that in the cases filed in the Family Courts though the cruelty by husband is the biggest reason given by women for separation and divorce, they normally do not have any documentary evidence in the form of medical records to support their claims. This does not mean that such battered women never approached doctors for treatment when severely beaten up, but the medical record invariably showed the injuries as accidental. In many cases women had not reported correct cause of injuries due to social fears, in some cases when such reporting was done they had found the doctors uncooperative. The studies done so far on this problem have normally not paid much attention to the response of health professionals and health services. For instance, in the study by Mahajan and Madhurima (Ibid, 1995) neither in the survey conducted nor in the case studies, the response of health professionals and health services to whom many of these battered women must have approached from time to time for treatment is even explored. The child abuse while being a health problem in itself, it is also a public health problem in the adult life. For the abused children suffer from multitude of psychological problems crippling some parts of their lives when they grow to be adult.

(d) Communal and Caste violence: Most of the sociological studies have shown that the doctors hail from upper caste and class strata of the society (Ommen T.K., 1978, Venkatratnam R., 1979). With the phenomenal increase in the number of private medical colleges, the dominace of these strata is on the increase. It is interesting to note that in the anti-reservation agitations of 1980s, particularly of Gujarat in mid 1980s, the medical students played a very prominent role. For that matter, in the communal and caste mobilisations, a significant support has come from the professional classes which include doctors. Our personal experiences with doctors at professional level and in our interaction with them in several health service studies in urban and rural Maharashtra, we have found the health professionals highly coloured by the caste and communal ideologies.

While day to day discrimination against women and lower castes in the provision of health care is prevalent and unethical, the role of health professionals during the large scale caste and communal violence has remained unexplored. During the communal violence in Bombay in 1992-3, we came across many doctors in public and private hospitals who justified the violence against minorities, but we also came across some who showed heroism at that time to take care of victims, although the number of the latter was much less as compared to the former. To what extent the caste and communal biases amongst doctors get menifested into overt discrimination in the treatment? This subject needs more exploration and research.

Treatment, Rehabilitation and Documentation:

All types of violence produce traumatic effect on the victims. The truma could be on the body or on the mind. In a famous case of mass torture of villagers by the security forces in Manipur, although there were official denials, a team of doctors which also included psychiatrists visited and examined 104 survivors in that area after 22 months of the incident. They found that a very high number of them were suffering from the post-torture traumatic stress. They found that 36.6% were suffering from recurrent dreams of torture, 66.3% of disturbed sleep, 54.4% were not able to enjoy village festivals, food, sex and even friendship, 37.6% showed loss of self confidence, developed a sense of foreshortened future, etc. (Biswas, Das et el, 1990),

There is extensive work done on the treatment and rehabilitation of survivors of violence in many countries, it is conspicuous by its absence in India. The survivors of violence are special types of patients, and they would be missed, continue to suffer if not treated. While there is no doubt about their individual sufferings, they also add into the socio-political problem. Their rehabilitation also has a socio-political dimension as the medical documentation could be a formidable evidence to get justice for them. An independent, conscious and trained health professional thus while treating cases of violence can also become a source of deterrence and prevention of violence.

OBJECTIVES OF THE PROPOSED STUDY

The problem narrated so far is based on my own experiences and work done as a volunteer while doing my research on health in various institutions. It is infact a summary of voluntary work done in last six years. The issues raised therein are those which were actually experienced in the course of work. The conclusion arrived at and assertions made are also based on experiences and study of work done by others, and are therefore tentative. Unfortunately, in my project based research in other aspects of health in last 15 years, I could never afford to give full time concentration on this aspect of work. Unless one is able to concentrate solely on this task, a systematic exploration of this subject will never be possible.

Overall aim: The aim of my study is to explore violence as a public health issue and the role played by health professionals (doctors and nurses) in the situations and cases of violence.

Specific Objectives:

(1) To collate information on the incidences of violence from the secondary sources in order to understand the violence as a public health issue in last one decade (1984-95) in Bombay.

(2) To analyse such information to understand changing pattern, if any, of the violence.

(3) To study attitude of health professionals to the impact of violence on health of individuals and communities in Bombay.

(4) To study role played by health professionals in cases of violence in Bombay.

(5) To formulate concrete practical suggestions for educational and training needs of health professionals, for changes in the protocols for medical records and mangement of victims and survivors of violence, for changes in codes of medical ethics etc..

METHODOLOGY

Approach:

(i) The objectives and the narration of problem make it clear that we treat issue of violence from the human rights perspective. However, our perspective does not narrow down human rights issue to the political violence or violence perpetrated by the state agencies. Since such an approach makes the coverage of human rights issue too wide and thus perhaps unwieldy for a research to last for only a year.

However, at the same time it is not possible to specify particular types of violence that the study would cover. For, there are difficulties in gathering hard data on certain forms of violence, particularly medical records. The data to be gathered from the victims and survivors would, however, not create such problem, as such group of people will be accessible to me or the research assistant who would work with me. Thus, in the micro study, two of the following four types of violence would be taken up for indepth exploration:

(1) Torture and deaths in police custody. (2) Communal violence. (3) Violence against women in the family, including deaths. (4) Rape.

(ii) While the violence will be necessarily explored to understand its cuases, the focus would be, throughout the study, on its implication to the health of individuals and community to which they belong. Their problems, expectations and the actual assistance received will be viewed in relation to the role played by the health professionals, particularly doctors and nurses.

(iii) The above issues will be explored keeping in mind the following research questions:

(1) What are the levels of involvement of health care professionals in the instances of violence?

(2) What is the knowledge and attitude of health professionals, and their professional associations, on the role expected of them?

(3) What actual role the health professionals are found to be playing at each level?

(4) What are the reasons for the kind of role that presently health professionals are playing?

(5) What is the opinion of victims and survivors about the role of health professionals?

(6) What are the specific areas where inputs and changes are required for the health professionals to play an ethical and sensitive role in cases of violence? How?

Study Design:

I. Collation and analysis of information from secondary sources: Some amount of work has already been done by me in putting together available information. More information will be collected in the first three months of the study.

(1) I do not have full documentation of data pertaining to the instances of violence. For such data, hospital and police sources will be approached. (2) More information will be collected from the newspaper clippings and reports of various concerned organisations active in Bombay.

II. Collection of primary information:

Method:

Chiefly, the qualitative method for data collection will be used. The techniques of case studies, observation (if permitted) and analysis of documentary evidences will be carried out. Such qualitative methods will provide indepth data on what is happening at the ground level. Although such data will not enable use to do quantitative estimates, they will provide material for understanding trends and patterns; and to an extent make it possible to do theoretical generalisations.

Study units:

The case studies of a select number of doctors, nurses,survivors or victims of violence and the concerned individuals or representatives of organisations involved in helping victims will be carried out.

(1) 5 case studies of doctors who are working in the public hospital, coroner's court etc and who receive cases of violence will be done.
(2) 5 case studies of nurses working in the similar situations.
(3) 5 case studies of police officials selected from the constables to higher officials will be conducted.
(4) 15 case studies of survivors of violence will be undertaken.
(5) 10 individuals involved in helping survivors of violence will be interviewed.

Thus, totally, **at least** 40, **and if necessary** more, case studies will be done.

Documentary data: From the organisations involved in helping victims, lawyers pleading such cases and other sources, the medical records of about 30 victims on the subject selected for indepth study will be obtained. An effort will also be made to get records from public hospitals, police and coroner's office, etc.

Observations: The onservation of doctor patient relationship, with the permission of attending doctor and the patient, will be done at ... of the public hospitals in Bombay. If such permission is not given, detailed information obtained about the process from the patient and doctors in their case studies will be used.

Instruments:

Case Studies: For the case studies, an interview guide for each set of unit will be prepared keeping in mind the study questions given in the previous section (approach) and the newer one as I give the final shape to the methodology immediately after commencing the study. Each case study will be done in at least two lengthy sessions.

Documentary data: First of all, using medical scientific books and manuals, a guide for analysing madical and autopsy reports will be prepared. The documents will be examined to understand whether the protocol or format for recording information is scientific, whether thet are complete, the information lacking is vital or not, the medical procedures followed, investigations carried out, and so on.

Data analysis:

I have experience in using computer packages for analysing qualitative data. I also have my own laptop (notebook) compter with the necessary packages installed. Using appropriate packages, the content analysis of case studies will be carried out. The observational and documentary data will be meshed with the case study data while preparing reports.

Report:

The final report will be in the form of monograph or book of 100 pages or more.

In addition, two scientific papers based on the study will be prepared for publication in the medical, nursing or social science journal(s). Three essays or articles for publication in popular newspaper or magazine will also be prepared, in the style that suits for such publications.

PRACTICABILITY AND SIGNIFICANCE

Although while dealing with the problem, literature review and methodology, we have emphasised the significance and practicability of the proposed work, some of those ideas are brought together here to make them explicit.

Significance:

As it is pointed out by many social scientists and media personalities, the violence has been a significant feature of the Indian society. In last one decade this problem has only intensified and its character has changed. This development is so serious that many commentators have felt compelled to warn again and again that if no serious effort is made, it would have detrimental effect on the larger process of deveolpment, so much so that the unity and integrity of the country might get jeopardised. Further, the epidemic of violence has also made the human rights situation in the country worrisome. Although the National Human Rights Commission (NHRC) has shown much more initiative than was expected of them, if various responsible strata of the society do not

contribute in such initiatives, there is a possibility that might remain a paper tiger as it does not have sufficient powers to put into action its pronouncements.

The health professionals and health services occupy a very crucial position in the situations and cases of violence. They not only provide much needed services to people who have suffered from violence, but their medical records could be essential evidences to get justice for the sufferers.

It is indeed unfortunate that inadequate attention is paid by the researchers to the health professionals and health services in relation to violence. The health professionals, a great proportion of them (over 80%) busy in commercialised private practice, have also not shown necessary social responsibility in creating independent and effective space for themselves in order to provide care to victims and ensure justice.

Thus, it needs no further emphasis that it is now high time to pay more attention to this sector and professionals working there. Our aim is, by highlighting the present lamentable situation in general, by giving due recognitions to those who have made sincere efforts to uphold professional ethics and help victims, and by arriving at concrete, practicable suggestions, to orient the health professionals and services for making solid and positive contribution in society's efforts for combating violence, the agressors and get justice for the victims.

The proposed study, if undertaken, will be perhaps the first or one of the few, of its kind in our country.

Practicality:

My narration of the problem would have given an indication that I have not arrived at the study of the problem purely from intellectual work. I am a medical professional involved in social science research and my formal research assignments at the institutions I have worked had very little connection to the issue of violence. My voluntary practical work outside office hours, in collaboration with health activists groups, women's groups, human rights groups etc brought me face to face with the violence and made me acutely aware of the shortcomings in the response of health professionals and services. I also find myself in a unique position to fall back on my medical background, experience of social science research and of course network of contacts formed while participating in social activism to accomplish the task of proposed research.

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REPORT

(1992 - 1994)

ANUSANDHAN TRUST

(Registered Under the Bombay Public Trust Act, 1950. Registration No: E - 13480, Bombay)
519 Prabhu Darshan, 31 S. Sainik Nagar, Amboli, Andheri West
Bombay 400 058, India

Anusandhan Trust is an educational public charitable Trust registered under the Bombay Public Trusts Act, 1950 (Bombay Act No.XXIX OF 1950). It was registered with the Charity Commissioner, Bombay on August 30, 1991. Its registration number is **E - 13480 (Mumbai).** The primary objective for which Anusandhan Trust is established is to conduct educational, research, training and service activities in the field of Health and related areas for the well being of the disavantaged and the poor.

A Modest Beginning:

In 1992, we began work for the fulfilment of the objectives of the Trust. In January 1992, the office of the Trust was set up in the residence of one Trustee. However, soon another Trustee offered an exclusive 850 squarefeet place at the above address to house the office. It was decided to begin work with educational and research activities. In persuance to the decision, a library and documentation unit and a research centre were established at the above address in April 1992.

Library and Documentation:

For establishing library and documentation unit, we made an appeal to our Trustees and well wishers to make generous donations in cash and kind. We needed books, documents and furniture for the library. In no time, donations, mainly in kind, started pouring in. Within few months, we acquired more than **2000 books and equal number of reprints (documents)** from our Trustees and well wishers. We also received from them necessary furniture for keeping books and for the users to sit and work. The books and documents were further divided into two different library set ups, one primarily for children and another for researchers, academicians, media persons, activists etc.

Children's Library: Our office is located in an area where there is no public library for the citizens. The private circulating libraries are too expensive for the kids to utilise. The schools in this area do not have library for the kids to take books home and aread. We invited few kids to come and see our collection. They were very excited on looking at the collection of books and journals, like National Geographics with the Trust. We wanted children to run the library on their own. Some children volunteered to work in their spare times, accession all the books, keep the library for a few days in a week, lend books to children, keep record and ensure that books were returned by the borrower in a specific time period. Thus a children's library managed by them in the Trust office was born.

The children have named their library as **"Kidds' Nook"** and it is run by their own commitee of volunteers and **its use by chilren is totally free of any cost.** Presently there are about 800 books and numerous old issues of educational journals at the Kidds' Nook.

Health and Allied Themes Library and Documentation: Simultaneously, we established a specialised library on Health and Allied Themes for researchers, media

persons, health activists and others. This library has now about **1500 books and about 2000 documents** which are regularly used by our own staff and by the people from outside.

Research Centre:

The Trustees of Anusandhan Trust had decided in July 1991 to establish, own and operate a research, education and training centre in the field of Health and Allied Themes at the Trust office. It is named as **Centre for Enquiry into Health and Allied Themes,** or in short, **CEHAT** (which in Hindi means **Health**). Project proposals for undertaking relevant research were prepared in the late 1991 but there was a great delay in receiving funds.

Objectives of CEHAT: The research centre is established with three major objectives: (1) To identify relevant research priorities in health and allied fields at local, national or international levels and to formulate problems based on these priorities. (2) To conduct research and action research on topics of importance for the benefit of the poor and the disadvantaged, and of interest of people's movement in the country. (3) To interect with progressive individuals and organisations active for the betterment of and in defense of rights of the disadvantaged people and provide research inputs and access to relevant data base.

CEHAT's Mode of Functioning: On principle, the Anusandhan Trust does not regard society either as a ground for experimentation or as unexplored terrain for data gathering for intellectual exercises. Given this, as a policy of the Trust, the CEHAT's research projects endeavour to create space for the participation of populations under study without compromising on academic rigour. All CEHAT's projects have ethics committee and are committed to return to study population the results of research in an appropriate form.

The Trust has created institutional structures in the research centre for ensuring democratic and participatory mode of decision making. The research centre is supervised by a **Governing Board** made up of nine Trustees. In addition, it is periodically evaluated by an external **Social Audit Group**. The Social Audit Group examines CEHAT's performance in collective management, relevance of research projects undertaken and so on.

Reseach Projects Presently on at the Trust' Centre:

From April 1, 1994, the Anusandhan Trust has commenced its research work in Bimbay as well as Pune. The Trust has also established a branch office in Pune at 11 Archana Apartments, 163 Solapur Road, Hadapsar, Pune. First Project on Women and Abortion, funded by the Ford Foundation, received approval of the Government of India in March 1994 was commenced from April 1, 1994. Two more projects, funded by the UNDP and Government of India on the Legal aspects of Health Care Delivery and Quality of Health Care in the Private Sector were started from June 1, 1994. From August 1, 1994 the

fourth research project on Preparation and Application of Sensitive Health Education Material on AIDS Awareness funded by India Development Service was also commenced. All in all, the Trust's research centre is presently working on four research projects.

In order to undertake these projects and for managing library and documentation centre, presently there are **five researchers and two secretaries (total Seven persons)** working full time in the Trust's offices at Bombay and Pune. Of the seven, four are employed at Bombay and three at Pune. Inaddition, we have two senior experts helping in research as consultants.

Women and Abortion Project: This project is to understand poor women's abortion needs and to study social aspects of abortion in rural areas. We have selected villages in Purandar Taluka of Pune district for this study. Using methods of case studies and focus group interviews, we are studying abortion needs, abortion seeking behaviour and the social, economic, cultural factors influencing their choices. The abortion provides in those villages are also being studied

The **objectives** of women and abortion projects are: (I) ***Abortion Behaviour:*** (a) To understand social attitudes and practices on abortion in the context of the position of women in their families and work situations, their sexuality and contraceptive practices and values that motherhood holds for them. (b) Factors influencing choice of abortion provider. (c) Role of men in influencing the decision to abort and on choice of provider. (d) Medical and psychosocial consequences of abortion as known as well as experienced. (II) ***Abortion Providers:*** (a) To study providers available in women's immediate surroundings and in the official public-private helth care services. (b) To study providers of abortion services from the point of view of quality of services offered, their background, qualifications, accessibility and their legal status. (c) To study types of services provided by them. (d) To document the experiences of women who utilise these services.

This project is for a duration of 21 months. It is financially supported by the Ford Foundation and has a budget of US $33,200 or Rs.10,26,850.

Project on the Study of Physical Standards of Health Care in Private Sector: Several studies have brought out that the private sector is the main provider of health care to patients in India. Although it was assumed so far that the private sector provided best quality of care, recent revelations have shown that many private hospitals and nursing homes even it city like Bombay do not conform to minimum standards and that malpractice is rampant. This study explores the physical standards of care as obtaining in the private sector in the rural areas of a district.

The **objectives** of the study are: (1) To document and review various guidelines available in the Government, NGO and Private Sectors for the minimum physical standards necessary for the provison of reasonable quality of health care of various kind. (2) To study the existing *Physical Standards* of health care in *rural areas* of a district and at

different levels of health care provision (GP, Consultant, Nursing Home, Hospital, etc..). (3) To compare the findings of the study with the guidelines for minimum physical standards at different levels of health care delivery and to understand reasons for adequacies or inadequacies in fulfilling such physical in the private sector.

The information collection on the private sector for this study is being done in two Talukas of Satara District in Maharashtra. This district is selected as it is an averagely developed district in the country.

This project is for a duration of 18 months. It is financially supported by the **United Nations Development Programme and the Government of India** and has a budget of Rs.2,68,000.

Project on Study of Legal Aspects of Health Care Delivery: It is now being increasingly realised that although the private sector overwhelmingly dominates the health care delivery system in our country, there are inadequate laws and regulations to monitor its work. It is also argued that private health care delivery sector in India is one of the least regulated sector in the world. As a consequence, the consumers are suffering from the arrogance and malpractice of the practitioners and often fleeced at a time when he/she needs more care and support.

The **objectives** of the study are: (I) *The overall objective:* To document, collate, critically examine, and to study legislations and regulations applicable to individuals and institutions involved in the **delivery** of health care services. (II) *The Specific Objectives:* (1) To collate the existing legislations and regulations applicable to individuals and institutions involved in the delivery of health care services in India. (2) To study gaps, inadequacies in the existing legislations and regulations and to make recommendations for changes and also, to identify areas where new legislations and regulations are needed, with a view to increasing efficiency, improve quality and access of services and to empower people. (3) To compare legislative and regulatory mechanism as existing presently in India with that in a developed country.

This project is for a duration of 15 months. It is financially supported by **theUnited Nations Development Programme and the Government of India** and has a budget of Rs.1,86,100.

The Project on AIDS Awareness: This project is for preparation and application of sensitive health education material on AIDS awareness.

The **objectives** of the project are: (1) Collection of health education material on AIDS awareness, both in India and elsewhere. (2) Preparation of sensitive health education material (a slide show, a booklet and a mobile poster exhibition) on AIDS awareness in the community. (3) Continuous field testing of all our material in three areas of Pune district in Maharashtra.

This project is for a duration of three years. The field testing of the material prepared will be done in various rural and urban areas of the Pune district. This project is financially supported by **India Development Service and Vikas, Chicago, USA** and has a budget of US $ 6000.

NGO-25-10

CEHAT

Centre for Enquiry into Health and Allied Themes

519
[redacted], Prabhu Darshan, 31, S. Sainik Nagar, Amboli, Andheri (West), Bombay - 400 058

[redacted]
Tel/fax: 6250363

The process and purpose

The Centre for Enquiry into Health and Allied Themes, CEHAT, is a non-profit research collective / organisation set up with the primary objective of conducting research on topics of relevance to the health and well-being of the disadvantaged and the poor. It will function as an interface between progressive and pro-people movements and academic expertise.

CEHAT represents the outcome of a long process of debate and discussions on the increasing need to create a structure which could in a disciplined manner enquire into the many troubling questions thrown up by and within peoples' movements and provide a data base and well-substantiated answers. Some of these topics may involve quantification and estimation such as, for instance, the volume of resources wasted on irrational drugs. Others may extend, deepen and influence currently applied norms of medico-legal jurisprudence, such as research on domestic violence, torture or rape. Some may impinge on medical ethics and may raise further questions as in explorations of the responsibility of the medical community towards patient. Studies and surveys on women's experience with abortion or contraception, or their perceptions of health and illness will seek to inform mainstream analyses, while those on psycho-social trauma of populations forcibly displaced, or the concept of social wage and what it implies, will reveal what is hidden even as they influence the process of change towards a more sustainable and equitable society.

How we function

On principle, **CEHAT** does not regard society either as a ground for experimentation or as unexplored terrain for data-gathering for intellectual exercises. Given this, all **CEHAT's** projects endeavour to create space for the participation of populations under study without compromising on academic rigour. All **CEHAT's** projects will include ethics committees and are committed to return to study population the results of research in an appropriate manner.

OBJECTIVE

1. Conduct research and action-research on topics of importance or interest from the point of view of peoples' movements in the country.

2. To interact with progressive movements in related areas, such as women's groups, trade unions and campaigns or organisations involved in human rights issues and provide research inputs.

3. To identify research priorities in health at local, national or international levels, the findings of which will be of use to progressive groups or movements and which will directly or indirectly benefit oppressed sections in society.

The emphasis in **CEHAT** is on a democratic and participatory mode of decision-making. An external social audit group will periodically evaluate **CEHAT's** performance in collective management and will evaluate the relevance of research directions of the centre.

At present **CEHAT** functions on a project to project basis. At some point in the future, a corpus fund will be raised to ensure a degree of continuity in the institution. At all points of time **CEHAT** will aim to provide its staff with a just pay on scales comparable to UGC scales, and a participatory and conducive work environment.

CEHAT is a research activity of **ANUSANDHAN TRUST** whose trustees are: Amar Jesani (who will coordinate the activities of **CEHAT**), Anant Phadke, Anil Pilgaokar, Dhruv Mankad, Manisha Gupte, Mohan Deshpande, Padma Prakash, Ravi Duggal and Vibhuti Patel. The **CEHAT** team is multidisciplinary with academic training and experience in the fields of medicine, economics, sociology, journalism, biochemistry and microbiology. Most of them are currently engaged in full-time research in health and related issues and women's studies.

Anusandhan Trust is registered under the Bombay Public Trust Act 1950. Regd. No. E - 13480, Bombay

CEHAT

Perspective and organisation

CEHAT
*C*entre for *E*nquiry into *H*ealth and *A*llied *T*hemes
Research Centre of ANUSANDHAN TRUST

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ABOUT *ANUSANDHAN TRUST*

Anusandhan Trust is a non-profit educational trust registered on August 30, 1991, under the Bombay Public Trust Act, 1950 (Registration No: E-13480). Donations made to the Anusandhan Trust are given exemptions under the Section 80G of the Income Tax Act. Anusandhan Trust is permited to receive contribution from the Foreign sources. It is registered with the Ministry of Home Affairs, under the Foreign Contribution (regulation) Act, the registration number: 083780565

Goal:

The long term goal of the Trust is to establish and run democratically managed institutional structures undertaking research, welfare, services, education, training and advocacy in various fields and locations for the well being of the disadvantaged and the poor; and to collaborate with organisations and individuals working with and for such people.

Multi-disciplinary character:

The ***Anusandhan Trust*** was established by coming together of nine friends who have been active in health and allied fields for last two decades. Each one has in the course of her/his work, contributed extensively and intensively in those fields. The formal educational and training background of the trustees is in biomedical and social sciences, representing **Medical Science** (four of them), **Sociology** (two), **Economics** (one), **Biochemistry** (one) and **Microbiology** (one). The multi-disciplinary character of the board of trustees is reinforced by the fact that each trustee has acquired expertise in at least one field other than the one in which he or she was formally trained.

The Board of Trustees:

The following nine individuals constitute the Board of Trustees of the ***Anusandhan Trust.*** In that capacity, they also constitute the Governing Board of ***CEHAT.***

(1) Ms. Manisha Gupte.	(2) Dr. Anant Phadke.	(3) Dr. Vibhuti Patel.
(4) Dr. Dhruv Mankad.	(5) Dr. Anil Pilgaokar.	(6) Ms. Padma Prakash.
(7) Mr. Ravi Duggal.	(8) Dr. Mohan Deshpande.	(9) Dr. Amar Jesani.

Establishment of *CEHAT*:

To begin its march to achieve the goal, in July 1991 the Anusandhan Trust decided to establish first institutional structure for undertaking activities in the field of Health and related areas. Thus, the ***CEHAT*** (which in Hindi means health) or *C*entre for *E*nquiry into *H*ealth and *A*llied *T*hemes came into being.

Objectives of *CEHAT*

The main objective of *CEHAT* is to undertake *R*esearch, *A*ction, *S*ervice and *A*dvocacy *(RASA)* in the health and allied fields. The advocacy and action also involves education, training and information dissemination. Specifically, it endeavours to do the *RASA* in the following manner:

(1) To identify relevant priorities themes in health and allied fields at local, national or international levels and to formulate problems based on these themes.
(2) To conduct *RASA* for the benefit of the poor and the disadvantaged, and in the interest of people's movements in the country.
(3) To interact with progressive individuals and organisations active for the betterment of and in defence of rights of the disadvantaged people and provide inputs and access to relevant information and data base.

CEHAT's approach to work

Evolution of a collective voluntary effort is a process. A non-profit voluntary institution demands a strong commitment to the cause as well as the high standard of professional inputs. The research and other efforts made by a voluntary institution for the well being of disadvantaged people and their movements **ought not to** be of low standard. In fact, such work needs to be of as good quality as, if not of higher quality than, done by the institutions supported by the government and the private agencies. Strong commitment and the high quality of process and output are indispensable for a non-profit voluntary institution to bring the well being of the disadvantaged and the poor to the local, national and international agenda.

On principle, CEHAT does not regard society merely as ground for experimentation or as unexplored terrain for data gathering for intellectual exercises. While the methodology used for each work shall meet high academic standards, it is also kept in mind that it is only a tool for the advancing the social commitment. The social relevance of work is therefore given the crucial importance it deserves. In order to ensure social relevance, sensitivity and responsibility to participant people, the following three important ingredients are made inseparable part of all research projects involving information gathering from people:

(1) Ethics Committee:
In social science research in our country, the ethical issues are almost never talked about and documented, so much so that in such research reports it is assumed that no such ethical issues existed or were ever encountered. Even in large national surveys involving collection of sensitive data from people, we normally do not find a mention of an independent or institutional ethics committee which monitored the research process. While work in provision of health care involving not-so-conventional experimental research and service is very popular among highly committed or no-so-committed health NGOs, they are also normally found to be indifferent to need for instituting ethical safeguards.

We are aware that it is easier to criticise the present social science research than to provide an alternative. However, a new and good beginning in research must be made, and CEHAT has been doing it by making it mandatory for each research project involving information gathering from people to have an ethics committee comprising of individuals having background in academics and pro-people activism, and such individuals from the area where the study is conducted. While we recognise that the

most important thing in respecting ethics is high level of consciousness and commitment on the part of the research team, we believe that observance of ethics must not be left entirely to them. We have observed in research everywhere that the best of the research team is highly susceptible to the exigencies created by the pressure of research. Having an separate body of individuals to monitor the ethical aspects is only one of the ways to prevent the such exigencies going unnoticed and uncorrected.

The ethics committee of CEHAT projects normally meets twice or thrice, depending on the size and duration of the project. The first meeting is when the draft methodology with instruments and sampling are completed, second when the preliminary findings and draft plan of analysis are ready and third when the draft report or book is ready. In projects of shorter duration, second and third meetings are combined. The subjects providing information, if not each individually then at least in the meetings organised in the village or neighbourhood, are informed about the individuals on the ethics committee. The reports also give names and addresses of the ethics committee members, and if the ethics committee desires to give a written report on the ethical issues encountered, respected or violated in the process of research, it is appended without any change to the report.

(2) Informing subjects and participants:
This provision applies all works involving primary data collection and provision of service. We believe that people answering questionnaire ("respondents"), providing information for qualitative research utilising conventional service provided or service provided as a part of research or experiment, have inalienable right to know about it. All works of the CEHAT respect this right and efforts are made to use various methods to put it in practice. Some of the methods used are as follows:

When surveys are conducted using service of investigators, before starting the canvassing of questionnaire the investigators along with the member(s) of research team spends at least a day in the community to explain the purpose of research. This is done by organising village, *basti* or neighbourhood meetings, by giving simply worded written material the language people understand or by both. The information normally has (1) purpose of research, (2) who is doing it (about CEHAT and research team), (3) others associated with it (consultants and ethics committee), (4) why that particular community, and within that only certain people, have bee selected, (5) the individuals or households selected for the survey have a right not to respond, (6) that no benefit would directly accrue to anybody responding to the questionnaire, (7) what use of the information thus gathered would be made and (8) that a summarised and simply worded findings in their language will be sent to each person responding to the questionnaire.

In the qualitative and other researches, in addition to providing the above information, longer duration of time is allocated for direct interaction with the community. For collecting information as participant observer, even at the risk of disturbing their normal pattern of behaviour, our purpose of being their and participating in their community life is made known. In researches and works involving longer duration of interaction, if we do not intend to stay with the community at the completion of such work, the same is made known. Similarly surveys or works involving medical examinations and diagnosis are undertaken only if we have resources to provide primary health care level treatment to those who are found suffering from ailments.

Needless to add, all community level works must be sensitive and respectful to the culture, belief systems and other aspects of the community. The researchers are encouraged, if they so desire and are able to make adjustment with their work commitments, to keep in regular contact with the people with whom they completed a study or work.

(3) Taking findings to subjects and participants:
We believe that respecting right to information of subjects and participants necessarily extends to their right to know the results of work they participated in. Accordingly, findings of work are communicated to them either in printed form or by sitting with them in a meeting or both. For an institution sustained primarily on projects, there is a real problem of resources and time as the concerned individuals move on to the work on the next project. Thus, care is taken to integrate time and finances needed for this into the proposal itself, but in the event of that being not feasible, the CEHAT takes the responsibility to raise, spare funds to accomplish this work. Even if there is delay in communicating results, as a policy it is not allowed to be used as a pretext to dispense with this task. As soon as resources and time available, work is accomplished without fail.

Organisational structure and functioning

The objective of making CEHAT a democratically managed institutional structure is also more difficult to achieve in practice. There are not many living examples of such institutional functioning for us to follow. However, we are learning from our own and of others' experiences and making sincere efforts to avoid pitfalls of highly bureaucratised structures on one hand and the loosely structured personality dominated organisations on the other.

The functioning of the CEHAT is structured on the following five principles:

(1) The institutional democracy, while vesting formal rights to participants, demands responsibility, sincerity of work and optimum efficiency from them. (2) Creation and effective working of the formal bodies to facilitate democratic participation, decision making and implementation of decisions. (3) Accountability of each person, irrespective of his/her position in the institution, to such bodies, and the larger social accountability of the institution. (4) Maintenance of informal and respectful interaction within the hierarchy of position and tasks. (5) Periodic rotation of Coordinatorship and encouragement with training to deserving and interested individuals to make this possible,

Coordinator:
The Coordinator is the director of the institution. The change in the nomenclature is to reflect change in the manner of exercising authority, method of work and temporary character of responsibility assigned to an individual. The idea behind it is that as a core group of committed individuals evolve, the "directing" should give way to "coordinating". This indeed heavily depends upon increasing number of talented individuals giving long term commitment to the institution and their readiness to undertake greater responsibility of collectively building and running the institution. Further, the coordinator exercises authority as vested by the Working Group (WG) in daily administration, has discretionary power when the WG fails to reach a consensus, and in the event of his/her over-ruling of the majority decision of WG, the same is brought up within a specified time for discussion with the Governing Board (GB) or Trustees.

Working Group(WG):
The WG is the core forum for executive decisions, such as identification of work/research areas, obtaining funding support, fund allocations, external reporting, project administration, growth planning, staff recruitment and development etc. The WG appoints a coordinator from within and decides his/her tenure. Thus, the WG is also a place for training the future coordinators. The WG is collectively accountable to the GB and the Social Accountability Group (SAG). The membership to WG is on the basis of aptitude and talent of individuals, and is given on the consensus decision of the existing members of the WG. In course of time, as the more number of individuals decide to give long

term commitment to CEHAT, we intend to effect a periodic turn-over in the membership by a proportion of members retiring every one or two years and new ones taking their place. The optimum size of the WG is not less than 10% and not more than one third of the total staff of the institution. The WG meets at least once in a month.

Governing Board (GB):
The Trustees of the *Anusandhan Trust* constitute the GB of CEHAT. Thus, they are finally and legally responsible for the institution. We believe that trust in order to make a balanced and healthy development of the institute possible, the trust should neither be concerned with the day to day work, nor it should be completely aloof, looking only at the balance sheet at the end of the year. Thus, in addition to having the statutory responsibility, the trust undertakes two functions: (1) Interacts with the WG and the staff for framing the basic policies related to work and its development, and (2) Acts as the final forum for resolution of disputes within the institute. The GB meets at least three times in a year.

Social Accountability Group (SAG):
While all NGOs are supposed to be public endeavours, except meeting the requirement of the law, there is little transparent attempt made for showing public accountability. The CEHAT is making sincere effort to inculcate a sense of public and social accountability in the individuals associated with it and in its work. The SAG represents a mechanism for the CEHAT to undergo such accountability and to make the results of it known to people. The SAG normally meets twice in a year.

The SAG consists of the following five individuals having long standing experience in public work:

(1) Dr. Sunil Pandya, Head, Dept of Neurosurgery, KEM Hospital, Bombay, and Chairperson, Forum for Medical Ethics Society. **(2) Dr. Neera Desai,** Head (Rtd), Dept of Sociology and Director (Rtd), Research Centre for Women's Studies, S.N.D.T. Women's University, Bombay. **(3) Dr. S. L. Shetty,** Director, EPW Research Foundation, Bombay. **(4) Prof. Ravindra Soman,** National Institute of Virology, Pune. **(5) Dr. Ashwin Patel,** Director, Trust for Reaching Unreached, Baroda.

The SAG was constituted and the first meeting to define its role took place in October 1995. Accordingly, the SAG would observe the progress as compared to the aims and objects, assess the social relevance of the work done and the general social relevance of the CEHAT as an institution. From the year 1996 onwards, the SAG will prepare its own report on these aspects and the same will be published, without any change by the CEHAT in its annual reports.

In order to facilitate this task of the SAG, its members regularly receive, (1) Minutes of the Trust/GB meetings, (2) Copy of all internal discussion documents, (3) Summary of reports of the work done, and (4) Any other material desired by the member.

Financial support and salary structure

Core fund and core staff:
The CEHAT began with high social objectives but without any core fund to provide financial support to the work and the staff. In the first three years all work was done by the concerned individuals making non-paid voluntary efforts. However, as the scale of work increased, the corresponding need for finances increased too. From 1994 onwards, this is being met by making the major aspects of our work into well defined and time bound projects on which the staff take temporary employment. Thus, all individuals working at the CEHAT are employed on a project-to-project basis. This basis financial

constraint is a big hurdle in ensuring long term commitment of the core staff to the institution, and is therefore, also a potential disrupter of the internal democratic process. We are acutely aware of the necessity to overcome this difficulty so that in a course of time, at least the core staff is provided relative employment security. The following three efforts are being made in this direction:

(1) We are looking for agencies which would like to provide basic stability to our endeavour by giving corpus funds and endowments. We also make efforts to persuade individuals and agencies to give generous donations for the objectives of the institution.
(2) We generate small funds by undertaking consultancy and specific tasks for various agencies and institutions.
(3) We are also looking for a permanent office space in Bombay as well as in Pune.

Salary structure:
Although at present the CEHAT is run on project-to-project basis and employment of all staff members is temporary, we try to pay reasonable salary to the staff. For this the CEHAT has taken the following steps:

(1) All full-time employees and regular part-time employees are put on a salary scale.
(2) The CEHAT salary scales are kept as close to the University Grant Commission scales for the university teachers as possible.
(3) As a good tradition, the employees are covered under the social security, irrespective of whether given the size of the institute the relevant laws for it are applicable or not. Thus, provident fund (till we have a staff of 20, the payment of employer's contribution in the PPF account), Graduity (given the project based employment, made applicable at one year's service), termination allowance (when employment is terminated by the institution due to completion of project or other constraints), etc. are paid as social security.
(4) A care is taken to ensure that no regular employee is paid less than the minimum wages as applicable in Bombay.
(5) The ratio of the emolument received by the lowest level regular employee to that of the highest level employee is maintained at less than 4.

CEHAT's priority themes

After intensive debates, creation of a body of literature and involvement in research and action, the CEHAT has identified **four prioroty themes** for its work in *R*esearch, *A*ction, *S*ervice and *A*dvocacy (*RASA*). These themes are of course not fixed categories, they are evolving as we gain in experience and expertise. These themes are:

(A) Health services and financing, (B) Health legislations, ethics and patients' rights, (C) Women's health, (D) Investigation and treatment of psycho-social trauma.

The individuals working at and associated with the CEHAT have contributed in evolving perspective and a body of literature consisting of published papers, research studies and databases on each theme. Some of the studies completed or presently on are also encompassing subject matter of more than one themes. In last five years, a core team of researchers and activists having expertise on each theme has been consolidated at the CEHAT.

ACTION TAKEN BY THE ANUSANDHAN TRUST ON THE SAG REPORT

Dhruv Mankad
Managing Trustee, Anusandhan Trust
Ravi Duggal
Coordinator CEHAT

At the outset we thank the SAG members for their interest and concern with the work of CEHAT and giving their time over the last three years, despite their very busy schedule. This being our own first experience with trying to understand social accountability of CEHAT's work, we have both learnt and unlearnt a great deal. We acknowledge the courage and efforts of the SAG members to be a part of this process about which all of us were still trying to learn and gather first hand experience. It has indeed been an enriching experience from which we can now take the process of social accountability (SA) forward with greater confidence.

As mentioned at the beginning of the report, we acknowledge that there is indeed a need to seek further clarity on the concept of social accountability and setting better defined criteria, tools and modus operandi for it. Having gained some experience we are definitely in a better position to develop a more appropriate framework and guidelines, and if need be we will seek consultation from an expert on SA.

As regards various comments and suggestions by the SAG we are giving a serious thought to these. Certain steps being taken to fulfil the expectations expressed by SAG are outlined below. It may be pointed out that after the last SAG meeting, in which Cehat's work was presented, certain developments have already taken place in this direction. They are reflected in the paragraphs below :

1. The SAG Report mentions that we need to have in place a specific plan as to how we address specific needs/concerns of oppressed and disadvantaged people. In projects like the 'data-base project', though they are socially quite relevant in changing policies in favour of the oppressed, such direct linkage with the immediate needs of the oppressed people would not be possible. But in choosing other projects, we will pay more attention to this aspect, as this is a central concern of Cehat. Further, the SAG Report also speaks about the use of outcomes of the research towards this aim. CEHAT during the last year has become increasingly active on the advocacy front influencing policy and planning at one level and collaborating with peoples' movements, human rights groups, NGOs, public institutions, academia etc., at the local, regional, national and international levels. Research being planned in the near future will be strengthening this aspect further.

2. With regard to staff orientation, decision-making processes, devolution of responsibilities the SAG has complimented our achievements but we feel a lot more needs to be done. Even though we have a democratically elected Working Group (WG), its confidence and strength in taking over greater responsibilities in decision making and carrying a larger burden of administrative and organisational accountability needs building up. Towards this end, at one level, a process of staff development has been enhanced and will be carried forward. Research skill development through an epidemiology workshop was conducted in which nine researchers from CEHAT participated; researchers were encouraged to participate and make presentations in conferences at regional, national and international levels; researchers and staff were encouraged and supported

to volunteer time in various development initiatives, etc. At another level a lot of discussion has taken place as to how to strengthen the WG so that it becomes the decision making body of CEHAT. In the next couple of years we should be moving much ahead on this front. One immediate action we have taken is that at least twice a year the Trustees and WG would have a joint meeting making the governance structure further transparent, accountable and democratic.

3. The SAG has also suggested that we have a greater collaboration with peoples' movements, other NGOs etc. This is already a growing strategy in CEHAT's work. We are training health workers in people's organisations, in slum communities. We are bringing together NGOs and academia to address concerns like ethics in social science research and development work; we are collaborating with local governments in cities and rural areas in strengthening public health and reorienting it to felt needs of local communities. In collaborative research; we are working on an action research program along with the Bombay Municipal Corporation to help them set up a One-Stop-Crisis Centre in one of their larger hospitals, which will help victims of violence. We are documenting and disseminating dossiers on issues of public concern – the first one on domestic violence has been completed and others on private health sector, abortion, quality of care etc. are being planned.

4. For reaching out to people apart from the dossiers mentioned above strengthening of the CEHAT library is high on our priority list. We have offered our infrastructure for becoming a clearing-house for information and documentation on issues of public concern in health. We have set up a web-site also to fulfil this objective. The concern expressed by SAG about reaching out to people with literature in Marathi and Hindi languages is shared by all of us. And efforts are being made in this direction so that in the next few years a much larger proportion of documentation coming out of CEHAT will be in Marathi and Hindi.

5. Finally we would like to respond to the concern of the SAG with regard to future stability of CEHAT and linked to it questions raised about funding sources. We share their concern and would like to point out that this has been a constant debate within Anusandhan Trust and CEHAT. We have now reached a juncture in our growth where this concern has acquired a greater significance since we have reached a more or less optimal size. We have to now consolidate and stabilise. This means a more serious look at financing sources, which are not project-dependent. We are presently negotiating with one of the donor agencies a more comprehensive grant, which includes a strong component of institutional development. In this context acquiring our own place becomes quite crucial and we are working towards that. Similarly we are diversifying our base of funding sources. Senior researchers are taking up consultancy assignments, which bring in direct incomes for the Trust and this is helping us build our own resources. As suggested by the SAG we have to plan to raise resources within the country in innovative ways. We have to work out an action plan for this at the earliest.

The SAG's concluding remarks in the paragraph relating to funding about CEHAT maintaining its freedom to publish and being independent from donor doctoring of our work are highly appreciated by CEHAT. In fact, this is the main concern when negotiating with any funding agency for a new research proposal. Several donor agencies have acknowledged this.

SOCIAL ACCOUNTABILITY OF CEHAT
A REPORT

Dr. Neeraben Desai
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(Facilitator: Dr. Mohan Deshpande)

October 1999

We, the members of SAG (Social Accountability Group) are happy to present the first and the much-awaited report on Social Accountability of CEHAT. What follows does a combined effort on our part to understand and give justice to the very concept of Social Accountability and to apply it to this organisation. While we began the task, we soon realised how complex the concept is in the actual operational terms and how difficult it is to deal with, even though it is generally appreciated as a value to be cherished.

The Concept, Areas and Scope of Social Accountability

The terms, 'evaluation', 'social audit' and 'social accountability' look quite synonymous. We would at the outset like to differentiate these concepts from each other and then assign to ourselves a more specific task of social accountability Evaluation is a generic phenomenon which measures processes, impact etc. vis-à-vis objectives, norms and envisaged impact stated by the programme under evaluation. Social audit is a specific kind of evaluation which is guided by the notion of social accountability, and aims to examine whether the programme and the processes involved in operationalising it and its impact are socially relevant, and useful. Tools used for such social audit are usually devised externally by social auditors. Social accountability (SA) on the other hand is more of a continuous process, evolving constantly by the programme/organisation itself guided by internal need, and which wants to be socially accountable. This is true even when the tools of social accountability are not consciously designed by the organisation. In such a case, it is necessary to locate tools in the stated objectives and in the actual functioning of the organisation.

We felt that certain areas as regards SA should be considered in the context of CEHAT and its work so far:

- Relevance and Utility of research conducted (content of themes, and outcomes for the society or the section of society for which it claims to have worked)
- Processes involved in operationalising the research programme.
- Functioning of the programme/organisation: Norms and Values (ethical norms while selecting themes, sources of funding, devising methodology, democracy, transparency, simplicity, interaction with other organisations etc.)

The quintessential aspects of social accountability are just three: (a) the democratic functioning of the organisation; (b) upholding of social concerns in conceiving and reporting research projects; and (c) ensuring ethical standards in selecting sources of funds for the organisation and its activities.

The scope of social accountability of CEHAT is determined by its objectives, which are:

- To conduct research and action research on topics of importance or interest from the point of view of people's movements.
- To interact with programme movements in related areas, such as women's groups, trade unions and campaigns or organisations involved in human rights issues and provide issues for research.
- To identify research priorities in health at local, national and international levels, the findings of which will be of use to progressive groups or movements and which will directly or indirectly benefit oppressed sections of the society.

Obviously, one would like to see whether these objectives are reflected in deciding/selecting research themes and in follow-up actions with people's movements, progressive groups, deprived sections of the society and with advocacy groups. It is also equally important to see whether the norms and actual functioning of CEHAT are congruent with these norms and values which the progressive movements and groups cherish and try to practice.

Though as SAG we are not expected to evaluate the research projects per se from academic point of view, we feel that the focus of research and broad methodology need to be evaluated particularly when we contend that the respondents are not mere 'samples' in the study.

A very crucial issue in social accountability is the sources of funding. This has been dealt with at the end of this report.

Limitations

Lack of adequate interaction with CEHAT team: The SAG could not spare enough time for interacting with CEHAT staff members for the purpose of social accountability.

There was not enough clarity as regards criteria to understand the actual functioning of CEHAT. This was partly due to the lack of time on the part of the SAG members and partly due to inability to evolve modus operands for such interaction.

Only one tool i.e. a questionnaire evolved by SAG was used. The questionnaire was filled/answered by the concerned CEHAT teams quite meticulously and it helped us a great deal in understanding various facts of CEHAT and its work. But this in fact highlights the need for an in-depth interaction with researchers that would have certainly brought out a better result.

Methodology

Since the entire concept was new and our experience as SAG was fresh, having no blue-print at hand and with the above limitations, no explicit methodology was devised, except the questionnaire so laboriously answered by CEHAT-teams. Besides this, following meetings and materials contributed fruitfully.

- A number of SAG meetings at the CEHAT office.
- Reports of Staff meetings.
- Minutes of Trustees meetings.
- Document containing rules and regulations of CEHAT.
- Meetings with the staff at Khandala.
- Reports of WG (Working Group).
- Auditors' reports.

- Report of evaluation of the Co-ordinator of CEHAT.
- Workshops organised by CEHAT
- CEHAT's Publications

We have been receiving these documents regularly since the time we accepted our present role. One remarkable and praise worthy tradition nurtured by CEHAT is the transparency and that of sharing information by sending all document, reports of meetings, publications etc. to us. It shows sincerity and willingness for honest social accountability. While reading/through these documents and questionnaires we witnessed genuine efforts to develop and stabilise democratic traditions. CEHAT also shared with us the problems (and their probable solutions) encountered in such democratic functioning.

We distributed the areas of research projects among ourselves in one of the SAG meetings and began examining each of the CEHAT projects through questionnaires. The areas were i) Women and Health ii) Health Services and Financing

Our findings and recommendations

The projects are generally in line with the objectives of CEHAT. Most are related to social science research. There is a conscious effort at incorporating social accountability in the project itself.

There appears to be a keen awareness at the senior level about the importance of the perspective of the research team.

Most of the projects are selected as a follow up of previous studies or assessed needs of larger society, rather than specific campaigns or movements. A specific plan should be worked for identifying the felt needs of the movements and the oppressed sections. Study proposal should be reviewed critically regarding specific use of findings for the disadvantaged.

So far as the use of outcomes of various projects in concerned, CEHAT needs to work out a plan. Strategies to influence the policy, strategies to reach out to people's movements and oppressed sections, follow-up action in the Target group, and the use of the findings by other groups – all need to be emphasised more than what it is today.

For the purpose of realisation in practice the above stated goals of CEHAT, we are of the opinion that it is *imperative* for CEHAT to have *a stable, continued and assured existence*. Only this will enable the organisation to carry out necessary extension programmes, follow up actions etc. based on the results obtained through various present investigations.

Enough has been said earlier about the norms, values and functioning of CEHAT. 'They' are evident from the documents and what we saw and experienced through the limited interaction. The values are pro-people research, participatory and democratic functioning, accountability, efficiency and competence.

There are a number of mechanisms and dynamics for participatory and accountable intra-organisational functioning that have been consciously evolved in CEHAT. These are:

- Clear personnel policy.
- Delegation of power and responsibilities to the WG (Working Group) which also has many powers of decision-making.

- Grievances Redress forum.
- Decision making systems and processes are outlined without ambiguity.
- Responsibilities of individuals and teams are specified.
- Methods of evaluation of the members and teams have been clearly outlined.
- Information showing with SAG (an outside group) and the WG (inside group) remarkably efficient.
- Evaluation of the functioning of the Co-ordinator of CEHAT.
- Organising workshops for critical review of the projects at various stages.

The projects are generally well designed, showing keen awareness about professional acumen required to design especially the methodology part of it. However CEHAT need to pay more attention to action and advocacy after the projects bring out significant results. Though there has been some effort at preparing material in Marathi/Hindi, we suggest that for reaching out to the community at large, more concerted efforts are required. For this and also for advocacy on various health and health related issues and about the role of the state, CEHAT will have to plan a policy of working with other NGOs and groups.

Ethical Issues as regards funding

In the context of globalisation and the pursuit of liberal economic policy, the issues of self-reliance and indigenously based development have lost their earlier significance. Yet it still remains too important an issue for an institute like CEHAT to gloss over. It may now appear more difficult than in the past to apply any cut-and-dry yardstick in choosing the source. Even so, it should be possible to lay down some broad rules for accepting funds.

It is necessary to get a profile of the funding agency, its history, objectives and priorities – hidden, written and spoken.

Priorities and interests of the funding agencies have to be juxtaposed with those of CEHAT and Anusandhan Trust, to ensure that there is no violation of the mandate while accepting the funds. This is applicable even to the public/govt. agencies in India.

The objectives of the specific funded project should be acceptable to CEHAT and they should help build the organisation.

It is necessary to insist on freedom to publish research results on our own, without they being doctored by the funding agency. The publication rights should cover both the primary results and that of any offshoots of the research endeavour that the project may generate.

We are happy to say that the broad principles stated above are generally observed by CEHAT. The trustees are quite aware of the ethical issues and they seem to have debated on these issues very often. Individual professionals have undertaken many projects without expectation of rewards or remuneration. But the existing knowledge about ethical issue and principles of accepting funds is *not* adequately reflected in some of the responses given by the project-chiefs. (One of them has raised doubts of the validity of the question itself!) It is necessary for the senior members of the institution to share their thoughts on these issues with other staff members and the new entrants as well.

Anusandhan

A note for (potential) Social Accountability Group (SAG) members for CEHAT.

Relevant History

Anusandhan Trust was envisaged and formed in 1991. Though, the thinking then was to engage in rigorous research in the areas of health - {research, particularly from the pro-people (particularly the disadvantaged) perspective} - there was a clear understanding that the outcome of research should make enabling environment for social action. Also, (additionally) (it was conceived) that it was important (where existing social action was not evident) to research and establish data that could lead to initiating social action.

To Anusandhan, it was clear that all pro-people work was important and restricting itself to areas of research would not suffice and hence whilst drawing the Trust Deed a wide spectrum of possible areas to work in were included. It was envisaged that initially there could be a centre for research, but if the need arose, Anusandhan would initiate other centres as well. CEHAT (Centre for Enquiry into Health and Allied Themes) was started some three years later and is engaged in research and action in areas related to health. Over the past six years CEHAT has grown speedily.

Whilst initiating its endeavour, ANUSANDHAN pledged itself to the values of (I) transparency (ii) honesty, (iii) openness, (iv) democratic functioning, (v) collective governance, (vi) constantly improving standards for quality output and (vii) social accountability in all its units. When CEHAT was started, structures for implementing these values were gradually put in place.

The Trust Board of Anusandhan - since the very beginning - realised that merely *constructing* structures was not enough to ensure their effective purposes. Anusandhan believes that just as featuring of financial audit report is mandatory in a company's report to the public, social audit report must also be a responsibility of an organisation in its report to the society in which and for which it exists. Nonetheless, Anusandhan also is alive to the ground realities. While norms for financial audit are tangible and quantifiable and by and large universally accepted, those for social audit are not yet sufficiently well developed. Largely, this is because of three reasons viz. (I) organisations themselves have not laid enough priorities and efforts in developing these aspects (ii) there are no existing paradigms on setting up social audit procedures and (iii) outcomes relevant to social benefits & harms are difficult, if not impossible to quantify and measure.

Rather than wait until such procedures are set up, Anusandhan thought it best to subject its 'efforts' to social accountability. It was envisaged to set up a Social Accountability Group (SAG) of persons with integrity, sensibilities and ability to critically review *all that went into the work of its centre and along*

with it the output of its work. It would be mandatory to include (attach) report of SAG along with the Annual Report of that year. As response to SAG report, Anusandhan would carry (in its next annual report) the action taken report on the recommendations of the SAG report. This way Anusandhan would have the benefit of critically evaluated appraisal for improving its own endeavour on the one hand and would serve to social accountability report before the society it aims to work for, by making it accessible to anyone who requires it and requests for the report. In time, perhaps, parameters (to build up a system) for social audit would (may) also emerge.

In 1994 (check the year / date), the first SAG - comprising of Dr. Neera Desai, Dr.S.K.Pandya, Dr.Ashwin Patel, Dr. S L Shetty & Dr Ravindra Soman was constituted and served until now (a tenure of 5 years). A worthy exercise was an outcome of this SAG. But this was the first SAG and Anusandhan requested this SAG to assess the Trust's centre in the way the SAG deemed it fit. For this purpose, CEHAT provided extensive material that was generated in the centre (e.g. all papers / reports published and unpublished , minutes of the Trust Board Meetings, the Staff meetings, rules & regulations & salary structure of CEHAT, etc.).

Reviewing the exercise of SAG now, the Trust now feels that specific & critical evaluation of the Centre (from SAG) in important areas would be helpful to the Trust and the Centre for development and direction in which the Centre moves. This note attempts to list out these areas and also suggest procedures for interactions between the Trust, the Centre and SAG.

CEHAT's working structure

1. At present, CEHAT has offices in Mumbai & Pune and other field offices in Maharashtra and MP.
2. The Centre has as its chief administrator the Co-ordinator. He / She has duties & responsibilities towards (a) the Trust, (b) the administrative wing (accounts / personnel etc.), the research wing, the external contacts. He / she is authorised to depute anyone to this work. In addition, the Co-ordinator has his / her own research responsibilities on the Research Projects he / she is involved in.
3. Wage structure and Rules and Regulations are written down and are available for anyone (even outsider) who asks for a copy. A new employee is furnished with these. These could serve to foster transparency. Whenever, revisions in the wage structure are made, a meeting with staff is organised and the subject is thrown open to debate.
4. In order to nurture collectivism, democratic practices and effective space for communication within personnel and to evolve leadership qualities within the staff , the Centre has instituted a **Working Group (WG).** WG has elected representatives from both the Mumbai and Pune offices. The WG meets once a month. The Co-ordinator is an ex-officio member of the WG. Expenses (travelling etc) are borne by the Centre. Elections to the WG are held every

year and any member of the staff is eligible for this. The tenure of the member is 2 years with one-third retiring each year. Care is, however, taken to ensure that both the Mumbai & the Pune offices are represented on WG. Work on the WG entails responsibilities in addition to the work that the individual on the WG has. However, for this additional work the members do not get any allowance. This is made explicit to the individuals on the WG.

5. In addition to the WG meetings Staff Meetings are held twice a year. These are organised as residential meetings at some resort that is both convenient and economical. The agenda for such meetings try and incorporate presentations of the work done by the staff, changes in administrative / accounting as also the hurdles and difficulties in the procedures etc. And any other personnel matter. Often the agenda tries to include a lecture from someone outside the Centre or a workshop. These meetings try to provide space for the staff to have a general awareness of the status (as also the difficulties, challenges etc,) of the work of other members of the staff. It also can (and hopefully does) provide space for harmonising personnel matters.
6. The Centre has put in place the Grievance Redressal Structure (GRS). This is currently under review.
7. The financial accounting and reporting is the responsibility of the accounts wing and Co-ordinator heads this wing. Chartered Accounting Firm is entrusted to oversee and certify the financial accounting. This accounting is done on the half yearly basis but the certification of accounts by the Chartered Accounting Firm is only done after the financial year ends. The Centre has an FCRA account and accounting for this purpose also forms the part of the duties of the accounts wing.
8. Research Projects are submitted by the Centre for funding. These projects are drawn out by the Principle Investigator (PI) and discussed within the staff and the WG. For every research project (involving primary data collection) setting up of Ethics Committee (EC) is mandatory. This EC reviews the work at the beginning (planning stage), intermediate stage and final stage. As a procedural requirement all research and action work is subjected to a peer review at various stages and the work discussed threadbare. Copies of publication of these works (and any other publication brought out by the Centre) is sent to SAG members.
9. The Trust Board sends the minutes of its meetings to the SAG. CEHAT sends the minutes of the Staff meetings to SAG and the Trust Board Members. CEHAT also sends the minutes of GRS to SAG members and the Trust Board.
10. The Trust Board Members and the SAG members are encouraged to meet the staff.

Trust Board and the constitution of new SAG.

Trust Board of Anusandhan has laid great importance to the report of SAG and its (SAG's) report along with the ATR will be a part of Anusandhan's Annual Report this year. Learning from the experience, the

Trust Board recommended some inputs to address the issue For one, it has to facilitate the co-ordination between SAG and the Trust Board on the one hand and to make Trust's requirement written and itemised for facilitating SAG report. This note is for that purpose.

Anusandhan Trust seeks to have SAG opinion /evaluation / recommendations on the following areas:

- On meeting core objectives of CEHAT
- On transparency of CEHAT's work within the Centre and with the outside environment.
- On Worthiness of the output of CEHAT - preferably with respect to individual projects and administration
- On honouring ethical concerns
- On the aspect of CEHAT's provision of space for nurturing excellence and leadership qualities of individuals on the Staff.
- On CEHAT's interaction with other Organisations
- On the space and nurturing of democracy and collective functioning within the Centre and between Trust Board and Centre.
- On CEHAT's growth and development
- On the Grievence Redressal mechanism and functioning and effectively of it
- On the quality of research and shortfall in the area.
- Other areas that SAG may think pertinent and important.

Anusandhan believes that with a written request to SAG, it may facilitate the SAG to include the items in its report to the Trust on the one hand and to the Public on the other. It will be a binding for Anusandhan Trust to publish (as attachment to its own Report) the SAG report and to state its response to SAG report in form of ATR and what is not taken up for action with explanation to the Public.

Facilitating the functioning of SAG.

For facilitating the functioning of SAG, CEHAT had been furnishing to SAG (on a regular basis) (a) reports of the research work published and unpublished (b) the minutes of Staff Meeting and any request that SAG makes. The minutes of WG are not sent (because these take place every month and are mainly relevant to the staff co-ordination) (**check if this is correct**) but if the SAG makes a request these also can be sent to members of SAG. The Trust Board furnishes (on regular basis) the minutes of the deliberations at Trust Board meetings.

CEHAT helps SAG in organising venues for SAG meeting and re-imburses the expenses incurred for travelling and organises hospitality. Anusandhan Trust has now resolved the ethical hurdle of making allowance payment to members of SAG. Allowance for the SAG members for the days of meeting will be borne by Anusandhan Trust - not from CEHAT's funds. Also to facilitate administrative work of the SAG, - particularly in the 3rd year (when the written report of the SAG is sought) the Trust will provide

funds for a secretariat (of one or two persons) that the SAG may like to set up. The Trust urges SAG to appoint a Chairperson to co-ordinate its activities and to facilitate liaison between Co-ordinator CEHAT and Managing Trustee Anusandhan and SAG.

This note is for preparing a foreground to initiate the new SAG. It is hoped that in the first meeting between SAG members, Trust Board Members and Co-ordinator CEHAT a complete protocol will emerge.

Anil Pilgaokar, cJuly 2000
Ravi Duggal, cAugust 2000, minor modifications

Following section added by Ravi Duggal

Modalities of SAG

It is suggested that the SAG should have five members. These members should be sensitive to social research and action and must have made some significant contribution in it. They will select a Convenor from amongst themselves. The tenure of the SAG would be for three years, at the end of which a social audit report will be produced.

The SAG will get all secretarial assistance needed by them from CEHAT. CEHAT will provide SAG members all documentation, reports, papers, minutes etc., to members once every quarter for review of work. The SAG should meet once a year to take stock of the work of CEHAT and discuss amongst themselves. Also they should meet and hold discussions with all staff members at this meeting. The SAG members may choose to review the work of CEHAT selectively as per their area of interest etc.. This the SAG members must decide at their first meeting. At this meeting they must work out how they would like to structure their working and distribute responsibilities and the process of review to be followed etc..

At the end of each year a brief report after their annual meeting must be sent to the Trustees. The members are also free to send feedback to the Trustees as and when they desire. At the end of three years the SAG should carry out a formal social audit for which Anusandhan Trust will provide resources to set up a Secretariat with an anchor person of the SAG's choice, if such a person is necessary. Once the social audit report is ready it will be presented to the Trustees at a meeting and discussed. Once it is finalised the SAG report will be made public. The Coordinator and Managing Trustee will subsequently prepare an Action Taken Report and both these will be published in the next Annual Report of CEHAT / AT.

Ravi Duggal
24th Oct. 2000

Social Accountability and Social Audit of NGOs

Some loud thinking for an approach to conduct it.

NGOs (or Voluntary Organisations[VO], as some of them insist on calling themselves - to distinguish themselves from private commercial organisations which, also, in a way, are non-government by status and therefore NGOs) come into existence because (they strongly feel) that something needs to be done to harness "progress" of the society in a meaningful and appropriate manner. "Something critical is wrong! Something critical is lacking! Something critical is side-lined! Some sections of society are wronged or neglected or cheated and something needs to be done to address these issues". These (and other compelling) issues trigger initiation of VOs.

In many ways these VOs are self-appointed and are simultaneously 'independent' (in being self-appointed) and yet answerable to society (which is their *raison-d'etre*). They are also answerable to the society and to themselves to ensure that their practices and endeavour moves appropriately in the direction towards 'ideal' society (they proclaim to cherish) and also the *values* generally attributable to *humane society e.g. secularism, egalitarianism, pluralism, transparency, honesty, and most importantly humane interactions.*

VOs use monitory, human and other resources (of the society) in their "*social" entrepreneurship.* These resources are ***tools)*** and tools can be 'used', 'mis-used' and 'abused'. In any enterprise, the function and (with it), the importance of audit is self-evident

1. **Fiscal audit**

   Mandatory (legal) requirements call for fiscal (and monitory) accounting and fiscal (and monitory) audits. Fiscal audit has the longest history and have continuously developed into more and more sophisticated exercises. The important feature of this type of audit is that it is more or less standardised and universally accepted. Because of this reason it is also relatively easy to conduct.

   Unfortunately, with its sophistication, fiscal accounting practice(s) has (have) also carved out ingenious methods for 'hiding' / or camouflaging / or colouring fiscal picture. Auditor's work (in this area) is to 'monitor' 'access' and "point out" variances in the fiscal picture and to ensure that 'legal requirements are complied with before certification or to give 'qualified' certification. Audited report may not be 'transparent' In this case the auditor is not expected

to 'penalise' In fiscal audits, the auditor merely checks, monitors, reports findings and makes qualified certifications

2. **Management audit**

The next in line has been the management audit. With important strides in techniques of management (of resources and people), management accounting and management audit has grown in importance and harnessed in practice. The area has been nurtured and developed mainly to usher in 'efficiency' and 'effectiveness' and navigation towards the goals set.

There are many important tools and concepts that have been generated through the development of management science (and art) but the most important for the purpose of the discussion here is the concept of 'optimal'

"Optimal". We use the word 'optimal' to distinguish from the word 'minimal' / 'maximal'/ 'average'. To my mind "optimal" means that which "appropriate with holistic considerations". (What is *optimal* keeps changing from time to time with changes in the situation). It takes into under its wings considerations of (I) economically sustainable, & (ii) harnessing of resource e.g. fiscal, time, effort, personal and personnel etc., on the one hand and creation of space and opportunities for nurture, growth and development of individuals and Organisation.

3. **Social Audit**

I do not know if the term 'Social Audit' is precisely defined. Which is good for now because it gives one a lee way to define it as one pleases. I would define it as auditing the existence (and performance of Organisation / individual) in terms of meaningful value to the society and its 'idealised' future

What would that include. I do not know for sure, but for brain storming I am enlisting some 'heads' and elaborating on these wherever I can. (See below)

- **Worthiness Indices**
- Investment worthiness index
  - In an Organisation like CEHAT the funders invest money, the staff its time and effort and the peer Organisations their 'concern and support' (whatever that means). To each of these segments, a repeat of investment would be reason enough to signal *an increment* in 'worthiness' Again the more investors would mean a signal for greater *perceived worthiness by that investor segment.* A scale would be drawn out based on this 'repeated'

or continued investment. A scale could also be drawn out based on the number of such investors. Larger the base, the larger would be the perceived worthiness to that segment. Based on the score of each of these a "Worthiness Index' (for this segment) could be constructed. This index could be from the investor's angle. Likewise there could be those from the point of view of (1) social action angle (which could be sub-divided into sections as I have tried to list below.

- Social action angle
  - Support to existing social action
  - Research for new avenues for social action
  - Lobbying facilitation
  - Academia facilitation / support
- Debt : Equity ratio (A little diversion for the moment)

This is a thumb rule popular within the Corporate circles. "If the Share-holders are willing to invest 'x' amount of funds (i.e. investment) then the 'lenders' would brave a risk of '2x' and all this '3x' would be worthwhile, if the product of the enterprise is valued at least '300x' Perhaps if one is able to give 'value' representations to the efforts (and time) put in by the Organisation in terms of 'money' (That is already done because the Organisation pays 'salary 'where the notion is based on converting effort into 'money' - even if this is Hobson's choice. The difficulty would be to set values (in monitory terms) to product of enterprise.

- Honesty index

It will take some time and effort to develop on this. I have put it here for brain-storming exercise.

- Transparency index

The term "Transparency" is well known and abundantly used. And yet, I suspect everyone's notion of *transparency* is slightly (and sometimes widely) different. Thankfully across the board there is a common consensus that the greater the transparency between the interacting entities the better it is.

I shall therefore qualify what I presume transparency means in the context of Organisational behaviour. Used in the context of Organisational behaviour, it entails that entities interacting "with" and "within" the Organisation know (or have access to) information that is (or can be) relevant to the interacting entity. Does this mean everything that goes on within the Organisation is *out on display?* I think not. There are a number of matters that need to be shielded from exposure on ethical grounds (e.g. confidentiality of the personal working

within the Organisation and many such matters) or on grounds of vulnerability to competition (commercial grounds), but transparency demands that these area be demarcated, notified to the entities interacting and be substantiated with appropriate explanation (particularly the ethical merits for such non-disclosures). The commercial (or political) shields against disclosures must also be spelled out with adequate explanations. The *more the disclosure the more Open would be the Organisation. One could workout a scale for Openness of the Organisation based on this concept.*

Likewise, there could be non-disclosures scoring also. Positive scoring for ethically appropriate to null score for commercially / politically appropriate to negative for unacceptable reasons (++++ / +++ / ++ / + / 0 / - / -- / --- /----) Based on the **Openness score (0 % to 100%)** and the **Non-disclosure score** an *index of transparency can be worked out.*

CEHAT is (I am told) planing to have a 'web page' on the internet. On the web page, it is common to have a sub-site titled "about us", In this 'about us' what is the site visitor able to access information (even if that calls for a payment of a fair fee) *about CEHAT* would give a degree of "Openness" and if properly extended transparency of the Organisation.

- Fairness index
  1. Is the Organisation fair to employees
  2. Is the Organisation fair to funders
  3. To the society it uses for its work (e.g community in field research)
  4. Is the Organisation fair to the society in which it operates (country)

- Equality index

  To be developed
- Sensibility index

  To be developed.
- Reference index / Reference score (no. of citations of research products)

  CEHAT is a research Organisation It publishes papers and other publications which are to be referred to and quoted. Based on the density(?) of citations a score can be constructed.
- New approach index :
  - Different positions > common goals (Hospital accreditation)

In Hospital accreditation programme - a new approach to zero-in segments from varied "positions" to common acceptable and workable level is - to my mind an innovation - value that could be constructed for 'worthiness index.

- Universal publication (on the internet) access to beat plagiarism? (Web page) (Floppy) (data publication in Journals)

  This is yet another innovation to defeat copy-right madness. This 'value' could be subjected to 'scoring'

- Outreach accessibility

  To be worked out.

- Internal democracy - How much? How effective exercised? How fruitful in nurturing internal 'pluralism' A score could be devised

- Interdependence - support index

  CEHAT has liased with a number of Organisations (programmes) - complimentary / and supportive functions for a common goal. These inter-responsiveness could be subjected to a value score.

- Optimisation index (?)

  To be developed.

- Ripple (meaningfulness) effect index

  - Immediate next group > next immediate group > so on. Each Organisation builds its ethos. The founding members (are presumed to imbibe this ethos *maximally*). The next proximal segment (say, the staff) is expected to be influenced next and so on. For instance practising doctors (who founded the Forum for Medical Ethics FMES) are expected to *fully contribute to the ethos of FMES.* The next proximal groups is expected to be influenced more preferentially in relation to the distal groups. Audits could aim at exploring the reality of this presumption.

- Personnel growth and development index.

  (In house poll Entrance poll / Exit poll) The entering staff and the exiting staff of the Organisation have their 'picture' of the worthiness of the Organisation. Some times this is coloured by personal fancies or prejudices. These prejudices or fancies are at their high point immediately (on entering) or (on leaving). Some Organisations (or their representative) try and evaluate the perceptions of these segments *after a cooling period, say of 6-months*. This score (it is believed) is useful..

- Intra-Organisation personality gradient - Space score / involvement score / 'belonging' score

- In house value nurture index - ethics-ethos / social justice index / empathy index / open-mindedness index
- There could be more areas that could be included, with further work in this area.

One method of scoring

(Many of these indices are *intangible* in character. It is difficult to make measured scoring. The approach adopted in sports like *gymnastics or figure skating* is that there are 6, 8, or10 evaluators. They record their instant score. The highest and the lowest scores are weeded out and an average of the rest is drawn out for arriving at score of that individual).

1. 10 evaluators to cover the range of proximity levels (very close to very distant). Evaluators who *are close* to Organisation and those which are *not close,* form a team of evaluators.
2. On each index organise score gradient (highest to lowest) Leave out the highest and the lowest and add the rest and divide by 10 (or eight) to get score for each. It is expected that scoring of individual evaluators follows a (?) curve. If it happens to be otherwise / the evaluators need to be changed -
3.
4. Organise indexes score wise and divide the range into 3 components The highest segment need to be sustained and middle segment needs to be fortified and the lowest needs to be urgently addressed to for improvement.
5. There are some indices which may need monitoring throughout Some may need to be moderated on the basis of age of the project. Some based on the category of the project. Some through correspondence. Some through personal interview
6. Grading of project vis-à-vis meaningfulness
   - to social action
   - to academia
   - to lobbing value
   - to peer Organisations
7. Slippery slopes and Iceberg technique.
   It is important to be aware of areas with slippery slopes and Iceberg technique could be harnessed to investigate these areas. Some such areas that come to my mind are:
   - Asset-building - an exercise for sustenance and necessity or for ego and avarice

Me10 - 26.

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA

Date: Sunday 21, July 2002
Time: 10.00 a.m. to 1.00 p.m.

Place: Conference Hall
St.Martha's Hospital
Nrupathunga Road
Bangalore – 560 001

SEMINAR

THEME: INTEGRATION OF DIFFERENT SYSTEMS OF HEALTH CARE

PROGRAMME

9.30 to 10.00 a.m.	Registration
10.00 to 11.00 a.m.	**INAUGURATION** - Invocation - Welcome - Lighting of the lamp - Inaugural address Dr.A.B.Malaaka Raddy Hon'ble Minister for Medical Education - Keynote address by Dr.R.M.Varma Emeritus Prof.of Neuro Surgery, NIMHANS - Vote of thanks
11.00 to 11.15 a.m	TEA BREAK
11.15 to 1.00 p.m.	**Panel discussion** **Chair Person – Dr.R.M.Varma**
Ayurveda	Dr.K.S.Jayashree Prof. Govt. Ayurvedic College, Bangalore
Homeopathy	Dr.B.N.Prakash Principal, Govt.Homeopathy College, Bangalore
Allopathy	Dr.K.S.Gopinath Bangalore Institutte of Oncology
Unani	Dr.Roohizaman Lecturer, Govt.Unani College
Yoga	Dr.Shamanthakamani Narendran
	OPEN HOUSE
Concluding remarks	Dharmadarshi N.C.Nanaiah President, VHAK

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA

VHAK/98/C-1/Prog. Date: 22nd June 1998

Dear Sir/Madam,

We are grateful to Member Organisations who co-operated in materialising VHAK Programmes during the previous years. Some of you have not participated and we do not want to keep you out of it. We are very much concerned about your involvement.

This year we are taking up the following programmes which may be, your area of interest. The details of the programmes are given below for your kind co-operation to organise and conduct the same.

Sl.No.	Programmes	Duration
1.	Traditional Systems of Medicine	3 days
2.	Village Health Worker's Training	10 days
3.	Health for Non-health (for Developmental workers/ Gram panchayat members)	3 days
4.	School Health Programme (Schools Teachers)	3 days
5.	Training of Traditional Birth Attendants (for Dais)	5 days
6.	STD and AIDS Training	4 days
7.	Women & Health	5 days

Programmes would be finalised on first come first serve basis.

Please specify the programme you are interested to take up from the above mentioned and fill in the enclosed format and send it back to us by 15th of July 1998 to enable us to finalise the calender of programmes.

We solicit your kind co-operation in realising the above programmes. Please feel free to write back to us for any further clarifications.

With kind regards,

Yours Sincerely,

(T.NEERAJAKSHI)
Promotional Secretary

encl: as above

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA
TRAINING PROGRAMME APPLICATION

NAME OF THE ORGANISATION :

POSTAL ADDRESS :

TEL.CODE: TEL.NO. FAX: TELEGRAPH CODE:

PERSON IN-CHARGE OF THE PROGRAMME.
DESIGNATION

VENUE OF THE PROPOSED PROGRAMME :

DURATION & DATES OF THE PROGRAMME:

NO. & NATURE OF PARTICIPANTS :

TRAINING NEED IDENTIFIED (tick one) :

Health for Non-Health / Training for Traditional Birth Attendants / Women & Health / Traditional System of Medicine / Mental Health / Communicable Diseases / Family Welfare Education / Environmental Sanitation / HIV & AIDS Awareness / School Health Programme / Any other (Specify)

WHAT DOES THE PROPOSED TRAINING PROGRAMME ENVISAGE?.
(brief statement)

SUBJECTS CONCERNED	RESOURCE PERSONS (give maximum information)
1.	
2.	
3.	
4.	
5.	
6.	
7.	

- Commiting any expenses other than those specified above will be subjected to the availability of resource with the concerned organisation. Most of the organisations have their own designated resources for such causes.

- Food provided should be akin to peoples day to day consumption, befitting the local traditions.

- In addition to VHAK personnel, assistance of locally available resource persons may be availed in order to be able to nurture and enhance local participation and to ensure effective communication.

- VHAK does not encourage honororium and the such to resource persons; however would consider minimum local conveyance expenses.

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA

MINUTES OF THE ANNUAL GENERAL BODY MEETING HELD ON SATURDAY, THE 23RD JUNE 1998 AT VISHRANTHI NILAYAM, INFANTRY ROAD, BANGALORE - 560 001.

The Annual General Body Meeting started at 2.30 p.m. with the following agenda.

1. Invocation
2. Roll Call
3. Welcome Address
4. Presentation of minutes of the previous Annual General Body Meeting held on 19th July 1997 and adoption.
5. Presentation of Annual Report for the period 1997 - 98
6. Presentation of Annual Audited Statement of Accounts for the period 1997 - 98.
7. Appointment of Auditors for the year 1998 - 99
8. Presentation and adoption of Budget for the year 1998 - 99
9. Policies & vital issues: Nursing Home Bill
10. Any other matter

The President Dr.H.Sudarshan took the Chair and called the meeting to order after observing one minute silence.

There were 24 members representing 21 Member Institutions.

The President welcomed the members of the Executive Committee and the representatives of the organisations.

The minutes of the previous General Body Meeting held on 19th July 1997 at St.John's Medical College, Bangalore; was presented by the President and accepted by the General Body. It was proposed by Mr.Venkatesh, RLHP and was seconded by Mr.R.B.Hiremath, I.D.S.

The Hon.Secretary, Dr.S.M.Subramanya Setty presented the Annual Report, Highlighting the calender of events and various programmes organised by the VHAK. He gratefully acknowledged the co-operation extended by the Government and Member Organisations in making the programmes successful.

Commending the success of the Training in Traditional Systems of Medicine, he underlined the need for VHAK to assume the responsibility to co-ordinate the RCH Programmes.

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He also called for greater participation of the Member Organisations to make the programmes of the VHAK more meaningful. This report was proposed by Fr.Sebastian Ousepparampil, Administrator, St.John's Medical College Hospital and seconded by Mr.Neelaiah, PMSR and the Annual Report was accepted by the General Body.

The Audited Statement of Accounts for the year 1997-98 was presented by the Treasurer, Mr.Kumar.

An ambiguity under allowances for conveyance and travel was satisfactorily clarified by the Treasurer.

The Hon.Secretary explained the need for additional financial requirements and sought the Member Organisations to suggest ways and means to mobilise local resources. Increase in membership and prompt settlement of subscription dues were identified as ideal measures.

Appreciating the commendable contribution made by the Treasurer in systematising and presenting the accounts, the President suggested the need for appointing a part time accountant.

The President has expressed his concern about the inadequacy of space and such other amenities for the VHAK and stressed the need for a own office premises. Towards this, he suggested mobilisation of grants and loans from appropriate sources and called on all the Member Organisations to contribute their best. The audited statement of accounts for the year 1997-98 was accepted by the General Body after it was proposed by Mr.Neelaiah, PMSR and seconded by Ms.Lily, Sandeep Seva Nilayam.

Discussing over the appointment of Auditors for the year 1998-99 it was unanimously decided to continue with the present Auditors viz: M/s.Charles Prabakar & Associates. Further it was decided to conduct a mid-term audit in the VHAK Premises by the Auditors to ensure better financial management. This was duly accepted and it was proposed by Mr.Joby Jacob Vargheese, Vision India [illegible] and Mr.Neelaiah, P.M.S.R. seconding the same.

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presenting the budget for the year 1998-99; the Promotional Secretary Ms.T.Neerajakshi said that the budget was already approved and accepted by the funding partners. However, she focussed on the need for additional resource requirement for the programmes on Traditional Systems of Medicine. She also offered to share with all the Member Organisations. The study materials on vital themes such as 'Safe Motherhood' shortly. Besides, she explained the need for considering programmes on a regional basis involving more organisations, to facilitate to cut down the cost and time effective on each programme.

This was proposed by Mr.Neelaiah, PMSR and seconded by Mr.Venkatesh, RLHP and the budget was accepted.

Discussing on the policies and vital issues, Fr.Sebastian Ousepparampil made a preliminary presentation of the impending Nursing Home Bill and highlighted the magnitude of the problem that it might pose for the Voluntary Agencies involved in health care delivery services in remote rural areas and slums. Supplemented with several pertinant points by Dr.P.T.Abraham, Mr.Emerson Samuel and Dr.S.M.Subramanya Setty; the General Body was enabled to foresee the positive and negative factors of the bill.

It was resolved to:

* Constitute a Committee comprising of Fr.Sebastian Ousepparampil, Mr.Emerson Samuel, Ms.T.Neerajakshi, Dr.Shoba Yohan and Sr.Elise Mary in consultation with Dr.C.M.Francis and such other experts to study the bill in depth and present their observations to the Executive Committee.

The Suggestions are:

* To net work with CMAI, CHAI and IMA and initiate a dialogue with the Health Minister.

Could CHC be involved (Again HS to coordinate)

* To refer, compare and to review the policies of other States in this regard in order to understand the implications better.

Against the observation of the Hon.Secretary that the budget allocation of the State for health was comparatively too less; the President, quoting the Health Minister and the provision of World Bank felt it was fairly good.

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He suggested that the VHAK and all its Member Organisations to play more dynamic role in Health Care delivery system.

The President requested the Member Institutions to play more active participation and more dynamism on the part of the VHAK staff in order to enable VHAK become an alternative Health Force in the State of Karnataka. He appreciated the VHAK team for their collective work.

After proposing vote of thanks by the President, the meeting came to a close by 4.30 p.m.

S M Subramanya

(DR.S.M.SUBRAMANYA SETTY)
Hon. Secretary

N40-26.

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA

Report of the Seminar on 'Integrated Approaches towards Health and Development' held in connection with AGBM on 23rd May 1998 at Vishranthi Nilayam, Infantry Road, Bangalore - 560 001.

Programme started with an invocation song by Baby Kruthika, Deepa & Vidya. 51 representatives from Member Organisations were present for the programme.

Dr.H.Sudarshan, President, Voluntary Health Association of Karnataka welcomed Dr.M.C.Modi, renowned Eye Surgeon, Mr.Alok Mukhopadhyay, Executive Director, Voluntary Health Association of India, New Delhi, Dr.P.S.Prabhakaran, Director, Kidwai Memorial Institute of Oncology, Bangalore and Dr.H.C.Mahadevappa, Hon.ble Minister for Health & Family Welfare Services, Govt. of Karnataka.

Dr.M.C.Modi inaugurated the Seminar by lighting the lamp. He said that this type of theme is very important in the present context for those who are working in the field of promoting health and wished all the best for success of the programme.

This was followed by the presentation of the summary of the Seminar by Dr.H.Sudarshan. He said that earlier more emphasis was given curative aspects, now the trend has changed to promotive aspects. In India Health was of low priority. If we neglected health we cannot progress, hence importance should be given to health. If the status of health of an individual improves definetely the country will becoming progressive in all aspects. so health and development were two faces of the same coin; they are interlinked and co-related. He stressed Govt. to provide life saving drugs for rural poor.

Dr.P.S.Prabhakaran, Director, Kidwai Memorial Institute of Oncology was of the opinion that the barriers between the Govt. and private hospitals and Voluntary Organisations should go and they should compliment each others activities. Voluntary help for public health care did count if health for all was to become a reality. Finally he assured that all possible help from KIDWAI would be extended for the promotion of health of the rural people.

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29/6/98

Dr.H.C.Mahadevappa, Honourable Minister for Health & Family Welfare released the report 'The Independent Commission on Health in India' brought out by Voluntary Health Association of India, New Delhi. He said that a new scheme under which the poor would be provided with life saving drugs free of cost from Government Hospitals would soon be implemented in the State. He said that a large section of the population lived below the poverty line and found it very difficult to purchase medicines. Under the new scheme the poor would be provided medicines including expensive life saving drugs free of cost. He said that Rs.800 crore has been alloted by the Central Government and other agencies to the state for developing the necessary infrastructure for health care. The state has already achieved a record by reducing the infant mortality rate from 62 to 53 percent 10000 live births, he pointed out that no other state has achieved this. The Minister observed that under the India Population Project VIII and IX Rs.47 crore has been earmarked to be utilised in the state. He said that a Health Policy was required at the state level for which he is going to call all the NGOs to discuss the possibilities at the earliest and he would try his best for the implementation of the same.

We must get HS to coordinate these so that VHAK and HM are involved with KSCST/CHC initiative

Dr.Mahadevappa pointed out that unless illiteracy was eradicated from the country it was very difficult to achieve health for all by the year 2010. Education is essential to create health awareness among the people which inturn can improve the health status of the people.

Mr.Alok Mukhopadhyay, Executive Director, Voluntary Health Association of India, and also convenor of the Independent Commission on Health In India briefly presented the gist of the report. The Report attempts to look at the variations and disparities in health achievements prevelant in different states. and regions in the country. He lamented that none of the reforms, progress or development, have reached 30 percent of the population in the country. The commission also studies the modern trends in Health Care and forces responsible for them. It also probed into health facilities available in rural and urban areas in the aftermath of globalisation, liberalisation of Medical Care. If has recommended solutions to problems encountered by the Health Care Sector. Dr.(Sr)Aquinas, Member, VHAK Board proposed vote of thanks to dignitaries and participants.

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After Tea a panel discussion on Integrated Approaches to Health & Development was held. The panelists were Mr.Alok Mukhopadhyay, Dr.H.Sudarshan and Dr.Mohan Issac. Dr.H.Sudarshan requested the participants to share their experiences before the commencement of plenery discussion. This was followed by Mr.Alok's views on the Theme. He emphasised that Health is an integral part of Devt. Development cannot be considered as a separate identity; the role of Health Workers was very important. They are the pioneers in changing the societal problems. He quoted that in Rajastan the Local Panchayats, now a days is represented by more & more Health Workers and they are taking tremendous decisions regarding health related issues. He called upon that in this regard, health worker needs to work as a catalyst or awareness creater in the community.

Dr.Mohan Issac from NIMHANS shared his experiences and said that health cannot be fragmented. It is an overall development. Health is having different components, without Health, Development cannot be achieved and he highlighted the different dimensions of Health i.e., health is part of development, it relates to economic development the goal of development activities was health. The consequences of health and development should be looked from both qualitative and quantitative level. Increase in sophostication of health technology has burgen on health care activities by people. The important thing here is to identify the objectives which are qualitative for well being and the vulnerable group who do not have the capacity to improve their economic status.

Mr.Gopinath from Association of People with Disability, Bangalore Mr.Siddartha of MYHADA, Kamasamudram Project and Dr.P.T.Abraham CMA Hospital, Ankola shared their experiences in the field.

Dr.H.Sudarshan, President, VHAK expressing his views regarding health issues was of the opinion that there was a lopsided approach by Government to health care. Subsidies were given for tobacco growers and for beedi rollers. While money was also spent on Cancer hospitals. The liquor industry was also encouraged as the Government needs excise revene. Huge amounts were spent on dams and reservoirs and their back water is a breeding site for mosquitoes which cause Malaria. A better and broad based approach to health care was needed he said.

Dr.Sudarshan thanked the representatives from all over Karnataka for actively participating in the Seminar.