

Working Towards Right to Health And Health Care

**Nine Years of
ANUSANDHAN TRUST
(February 1991-March 2000)**

**Six Years of the
Centre for Enquiry into Health
and Allied Themes
(CEHAT)
(April 1994-March 2000)**

**Main Office:
2nd Floor, BMC Building, 135 Military Road,
Marol, Andheri East, Mumbai 400 059, India
Tel: (91)(22) 851 9420, Fax: (91)(22) 850 5255
Email: cehat@vsnl.com**

**Pune Office:
2/10, Swanand, Aapli Sahakari Society,
481, Parvati, Pune - 411 009. India
Tel: (91)(20) 444 3225, Tele/fax: (91)(20) 444 7866
Email: cehatpun@vsnl.com**

Web-site: <http://www.cehat.org>

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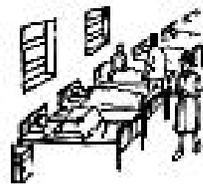
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Although the Centre for Enquiry into Health and Allied Themes (CEHAT) is only six years old its idea was conceived eleven years back, when from a mere negative critique of NGO-based research institutions we decided to move in the direction of creating an alternative health research institution ourselves. Thus, the ANUSANDHAN TRUST was formed in February and registered in August 1991. The first three years of the journey were full of doubts and dilemmas, and in 1992-3, the violent events in Mumbai almost buried the idea. However, all our associates showed remarkable resilience. They stood together when it was really needed and continued voluntary work under the new entity. And that spirit persists, for, despite numerous difficulties, they have refused to allow the foundation-day of CEHAT - the first institution under the Trust - April 1, 1994, to be an "April-fool day". To the contrary, since then, each day for last six years has been more than a "full day" at CEHAT. Of them, I had the privilege of being a part for five years and seven months.

The initial years of establishing and surviving of an institution are always exhilarating, and give a sense of fulfilment. But that achievement is not sufficient and it could even be deceptive. For, the real test is in sustaining the processes, the spirit and the tempo of progress. But the initial struggle also leads to accumulation of experience, formation of institutional loyalties and above all, commitment to the goals and objectives. With a sizeable number of the staff of the first phase of survival struggle still continuing to work with CEHAT and going stronger, one also expects the organisation to have attained maturity and technical skills. And all such things provide fertile ground for the founding principles of CEHAT to flourish.

In the last six years, we have established ourselves and made substantial contribution through four major socially relevant programmes of research. At the same time, we have developed three major action and intervention programmes in rural and urban areas. The advocacy programme of CEHAT is also gradually making its impact. Now CEHAT is poised to take over the coordination of a multi-centric research programme on abortion at the national level. I am very confident that in next few years CEHAT would provide a strong democratic institu-

tional structure for high quality social science research in health and at the same time reach out to people's organisations and policy makers for making health a human right. This is how we are on the way to achieve our programmatic objectives in terms of research, action, service and advocacy (RASA).

Numerous individuals and organisations have helped us in this process. They trusted us; they provided support and contributed in many other ways in its development. That way CEHAT is not only a collective effort of its staff and trustees, but also of so many others. In am grateful to all of them personally and on behalf of the Trust. I have no doubt that they would continue to provide support in future. I must express my gratitude to the staff of CEHAT. They know that this is their organisation, which they run. The kind of commitment they have shown is exemplary. We also thank five members of the Social Accountability Group (SAG), who for five years took pain to read not only articles and reports produced (on average 4 books/reports and 25 papers/articles a year), but also attended several meetings to interact with the staff and trustees. In 1998-9, they also surveyed the work of CEHAT and prepared the report of their social audit. All of them are very busy individuals, and we thank them for all their effort, kindness and guidance. Just like SAG, the members of ethics and consultant committees on many of our projects also spared their valuable time in monitoring and guiding our work. We thank all of them. Of course, the institution cannot be built without finances. We received funding from Government organisations, private foundations and NGOs. Without this, we could not have achieved what we have by now, and their contribution to CEHAT's development cannot be overestimated. We, at CEHAT, are all grateful to these funding agencies.

We would like to thank the Brihanmumbai Municipal Corporation (BMC), and especially the Additional Municipal Commissioner, the Deputy Municipal Commissioner, the Executive Health Officer (Dr. Alka Karande) and the Senior Medical Officer (Dr. Usha Ubale) for their keen interest in the work of CEHAT and for facilitating the collaboration.

Lastly, the trustees of CEHAT who are not only friends but also our conscience keepers, have shown that a lot could be done in nurturing individuals and an institution without ever making anybody feel that they are trustees and founders.

It took nearly nine months to put this report together. In the early days of work, we were not so careful in recording everything we did. It is difficult to find all records even from the account books as a lot was done voluntarily through individual initiatives of staff members and trustees. Of course, the situation has changed now. We do the

same amount of work but are more systematic in recording it. All concerned staff members have therefore painstakingly produced concise writings on their work for inclusion in this report. We have taken care to knit the narrative of our work with our philosophy and objectives so that both the ethos of the organisation and the direction of its progress are plainly available to the readers.

From a wider perspective, CEHAT's effort is only a drop in the ocean for making health a fundamental human right of toiling people of this country. We are striving to make its research findings useful to people's organisations in building mass movement for right to health and healthcare, and we hope that its expertise would be useful to the country in planning a social and health care system for realising such a right.

- Amar Jesani

Mumbai
October 6, 2000

Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health to all, free of charge; medicine like education is then no longer a trade - it becomes a public function of the State . . . *Henry Sigerist*

Anusandhan Trust

Foundation Principles.

1. Social Relevance.
2. Ethical Concerns.
3. Democratic Functioning.
4. Social Accountability.

II. ANUSANDHAN TRUST Foundation Principles

In the process of building CEHAT as the first institutional structure of the Anusandhan Trust, we gradually evolved and implemented four basic principles for the institutions of the Trust, namely, *Social Relevance, Ethics, Democracy and Accountability*. They constitute an ideal framework for building institutions having high professional standards and at the same time having the commitment towards the underprivileged people and their organisations.

A health research institution like CEHAT, is not a “people’s organisation”; and it should never pretend to be so. Its identification with people’s movements and organisations is more in terms of selecting socially relevant, pro-people themes and topics for research, and sharing the findings with such organisations to support their campaigns and advocacy for change. At the same time, it does not undertake research for mere academic interest, and makes efforts in making the research findings useable for social change. Its identification with the academia comes from the fact that it makes efforts to ensure high academic rigour in its research work, gets its research published in scientific journals and books and collaborates with universities and institutions of higher learning in research as well as teaching.

In short, CEHAT is an experiment to convert the unmanageable contradiction between NGO and academia, into a permanent advantage of linking academia to people, and vice versa. It is an effort to create a space for the organisation existing at the interface of activism and academics, people’s organisations and institutions. Admittedly there are dangers in working at this interface. The organisation could imbibe the worst of both sides, or it could try to do everything, lose focus and fail to make an impact. It is in this context that the above mentioned principles acquire added meaning, both for providing dynamism as well as for balancing against the dangers.

The *first principle* is about undertaking socially relevant health and related research. This principle directly applies to all themes and topics selected for research by CEHAT. In other words, this means that human rights, equity and empowerment must not only be matters of information but should also have a prominent place in the themes and topics of the research. This is operationalised by asking the following four sets of questions while planning and implementing any project:

1. Will it increase access to health care for the disadvantaged, particularly for the poor, the *dalits* (lower castes), women, etc.? Will it aid people's organisations in their campaign for access to health care?
2. Will it improve the quality of health available to such people? Will such health services be sensitive to the specific needs of deprived and oppressed communities, and empower them to access and control the services?
3. Will it lead to better control and regulation over private market and providers, and empowerment of patients/people? Will it suggest better health policy instruments for the equitable distribution of health care?
4. Will it aid in preventing violence and caring for survivors? Will it sensitise health services and professionals for assisting victims in getting justice and for treating survivors?

In addition, research is required to contribute to people's movements, policy making and policy implementation. Thus, in a way, the principle of social relevance has a strong association with the advocacy efforts and campaigns based on the research output. Moreover, the principle of social relevance is not understood in a *mechanical* way. In fact it is more of a perspective than an organisational process.

Central to the understanding of social relevance are human rights of people in general and of the deprived and oppressed people in particular. This is irrespective of whether people's organisation(s) have raised the issue of rights or CEHAT would need to initiate such demand on its own for advocacy with such organisation(s) and policy makers.

The *second principle* is that it must uphold high ethical and human rights standards while undertaking research, action and advocacy. This principle complements the first principle, i.e. social relevance or undertaking research having human rights perspective, by basing the process and conduct of research also on the operational principles of human rights. This is the reason why, from the very beginning CEHAT

decided to initiate a process of internal and external sensitisation of researchers to ethics and we began by following some broad ethical guidelines.

A CEHAT document published in 1994 stated that, "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 an inseparable part of *all research projects involving information gathering from people*:

1. **Ethics Committees:** *While we recognise that the most important element 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.* Research projects, that involve information gathering from people, should have an ethics committee comprising of individuals having background in academics and pro-people activism including individuals from the area where the study is conducted.
2. **Informing subjects and participants:** This provision applies to all works involving primary data collection and provision of services. We believe that people answering questionnaires (respondents), providing information for qualitative research, utilising conventional service or services provided as a part of research or experiment by us, have an inalienable *right to know* about it. All community level work 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 their work or study has been completed.
3. **Taking findings to subjects and participants:** We believe that respecting the right to information of participants of our studies necessarily extends to their right to know the results of work that they participated in. Accordingly, the findings of our work are communicated to them either in print form or by sitting with them in a meeting, or both.

Thus, *the principles of social relevance and ethics help CEHAT in upholding human rights in the process of selecting health research topics*

and implementing them, in three ways:

- n The researchers at CEHAT need to work out their own research agenda on the basis of the principle of social relevance explained above. The research agenda then gets divided into individual research projects, which while having specific objectives in order to get financial support, also contribute in enriching and realising the objectives set in the broad social agenda under that programme or theme of research. This is expected to provide balance between the pressure to continue getting external support and the institutional agenda.
- n They help in protecting the autonomy of the researchers and the institution. However, the autonomy needs to be balanced. That is, *the conscious pursuit of autonomy should increase the researchers' responsibility of being pro-people, doing good research and open to social audit.* Once the institution as a collective is able to secure autonomy, the researcher cannot use pressure coming from other quarters as an excuse for not being able to discharge such a responsibility. We believe that this would help in inculcating integrity among researchers, and integrity is the cornerstone of any ethically sound research.
- n The ethics make it necessary to protect participants of research. Ethics educate researchers to respect participants, protect their rights and thus understand the concept of human rights in the process of research. Moreover, this sensitivity to participants on the part of researchers vastly improves the quality of data and thus of research.

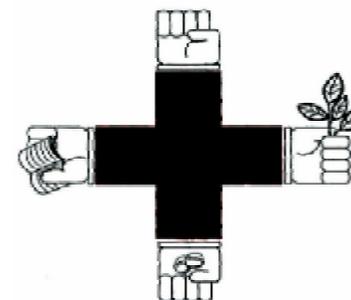
The *third principle* is institutionalisation of democracy for the internal functioning of the organisation, i.e. extending human rights concerns from the themes and process of research to the organisation's internal environment. CEHAT tries to operationalise this principle by using two mechanisms.

- n To emphasise the social commitment, and thus *restrict* the payment disparity: *What the organisation pays has human rights implications.* The salary structure of CEHAT is constructed in such a way that nobody receives less than minimum wage and at the same time the ratio between the highest and the lowest salary scale was kept below five. In addition, the salary scale is made sensitive to the social security for the staff.
- n The participation of staff is directed through the mechanism of formal democracy: This is done through the establishment of a Working Group of the staff for management functions, devolution

of power to such bodies and a clear demarcation of power and functions.

Finally, the *fourth principle* of social accountability brings in the system of transparency and audit. Readiness to be accountable for what one has done and is doing, is an integral part of sustaining democracy as well as autonomy of the research, researcher and the institution. This is operationalised through two mechanisms:

- n The first mechanism is based on transparency, and is embedded in the democratic functioning. Accordingly, the individuals associated with CEHAT have access to all information on work (research and other), finances, and functioning. They also have the right to question.
- n The second mechanism is external based, by having a Social Accountability Group (SAG) of eminent individuals. One of the major functions the SAG carries out is doing periodic social audit of the organisation.



[*Human rights, equity and empowerment must not only be matters of information but should also have a prominent place in the themes and topics of the research.*]

Research Themes

- 1) **Health services And Financing.**
- 2) **Health Legislation, Ethics And Patients Rights.**
- 3) **Women And Health.**
- 4) **Psychosocial Trauma.**

III. RESEARCH

CEHAT plans and consolidates its work into interconnected and yet, well-defined themes. They express broad priorities as well as long term commitment of CEHAT to work on the subject matter of these themes. Steady development of themes in the direction of right to health and health care is one of the ways to ensure that the project based work is driven by the social need as understood by CEHAT (and not by external forces). Projects done under each theme thus have continuity and purpose. Besides, the themes help us in systematically enriching knowledge and understanding in the relevant field and training teams of researchers having expertise on the subject. *The research projects of CEHAT are presently grouped into four themes:*

- A. *Health services and financing:* The focus of this programme is on determinants of health, people's health problems and health seeking behaviour, the structure and functioning of health care services, health expenditure and financing. It provides us with the basic critique of the existing situations, and concrete alternatives for micro and macro changes needed.
 - B. *Health legislations, ethics and patients' rights:* This programme is based on our deep conviction that no system without social control and regulation would work for people, and respect right to health and health care. The strategies to bring people and patients at the centre of health care, through policies, legislations, system of medical ethics, etc. need to be evolved in the specific situation of each country and society.
 - C. *Women and health:* Health and health care have strong socio-cultural dimensions. Gender is one of the most important among them. This programme not only undertakes research on women's health, but it also informs all other programmes with the gender dimension.
 - D. *Psychosocial trauma:* This programme concentrates directly on issues related to human rights and violence, and of course also interrelates with programmes with human rights dimensions.
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III-A. HEALTH SERVICES AND FINANCING

Five projects and rigorous regular work by CEHAT under this programme in the last six years have produced four major study reports, 39 scientific papers and essays, 15 popular articles (four of them in Marathi), and four editorials and reviews in journals. The research projects and papers done by CEHAT in last six years have studied most of the major macro and micro issues related to the health services and financing in India and across states.

Our research endeavours show the State's abject failure to protect the right to basic health care, the private sector's unbridled expansion and the commercialisation and profit in health care without any regulation. Indeed, the health services in India have stopped pursuing the social objective of making basic health care universally accessible to all. What follows is a brief report of five projects under this programme. In addition, the project for the preparation of computerised time series health database (see Section V) has evolved from work on this programme. The household studies on women's health, utilisation of services and health expenditure described in the programme on women and health (see Section III-C), has a direct overlap with this programme.

III-A-1. Health Expenditure across states

Analysis of time series data (1951 to the latest year, for all states and the central government) on the State's role in health care services was undertaken without any external financial support in 1994-95 in order to provide the basic framework to this programme. The paper argues that nowhere in the world has an effective contribution to health care been possible *without* the active participation of the State. In the advanced capitalist countries, the role of the State has been critical in ensuring universal availability of health care. In India, however, public health expenditure has been grossly inadequate right from the 1940s, when the Bhore Committee report stated that the per capita private expenditure on health was RS. 2.50 compared to a state per capita health expenditure of just RS. 0.36. In the 1950s and '60s private health expenditure was 83 and 88 % of total health expenditure respectively. Recent studies show that this is a continuing trend. Some of the important findings of this study are as follows:

- n The investment in the public sector for health has been inadequate, so much so that the state has never committed more than 3.5% of its resources to the health sector. Added to that is the fact that since the 1970s, there has been a steady decline in public sector expenditure, which reached its lowest level in 1994-95, being only 2.6% of total government expenditure.
- n The total health care expenditure has not kept pace with increase in total government expenditure.
- n The public health expenditure's share in the national income peaked at 1.3% of per capita GNP in mid-1980s, but since then has declined to 0.95% and under the structural adjustment there has been a further decrease. The central government sponsored health programmes are the most severely affected. The share of the central grants for public health declined from 27.92% in 1984-5 to 17.17% in 1992-3, and that for the disease control programme from 41.47% in 1984-5 to 18.5% in 1992-93.
- n The rural-urban gap is very wide in terms of investment, infrastructure development and availability of health care.
- n The expenditures by states account for around 90% of all public health expenditures.
- n Usually the better-developed states like Goa, Haryana, Karnataka, Maharashtra, Gujarat, Punjab have higher per capita expenditures as compared to the states of Bihar, Rajasthan, Orissa, Madhya Pradesh. The exception being Kerala which despite being economically less developed has a higher expenditure on health.
- n In the analysis, the state financing and infrastructure data were supplemented by the data gathered from various national and small sample studies. They show that there is an overwhelming domination of the private sector in health care, brought about by the gross underdevelopment of the public sector and by the complete lack of regulation and planning for the private sector.

Project completed in 1995. Supported by: Anusandhan Trust and the voluntary initiative of the team. Team: Ravi Duggal, Sunil Nandraj and Asha Vadair.

III-A-2. Financing of Disease Control Programmes

- n Our previous study of health expenditure across the states analysed the government financial data (of Ministry of Health and Family Welfare) under all major heads of accounts, but it did not have break up of data within those heads. The need for such data for research and advocacy purposes is obvious. Thus, in 1994-95 a

project to collect disaggregated data on the major disease control programmes (Malaria, Tuberculosis, Leprosy, Blindness and AIDS) for the period 1989-90 to 1994-95 was undertaken. This study revealed many disturbing trends in the financial support provided by the government for these diseases afflicting millions in our country.

- n Only in the period between 1951-61, when the country declared war against malaria, was about one fourth of the total government health expenditure spent on Disease Control Programmes (DCPs), but thereafter it has remained on an average around 12% to 13%. This is despite the fact that overall morbidity due to communicable diseases has not declined.
- n Further, the expenditure on DCPs has also shown a declining trend as a percentage of government expenditures. A major reason for this has been a decline in central government grants to the states. The states most adversely affected are Assam, Karnataka, Madhya Pradesh, Punjab, Rajasthan and Tamil Nadu. Only a minuscule per capita amount is allocated to the DCPs. For instance, Bihar, West Bengal, Assam, Karnataka, Rajasthan and Tamil Nadu spend, on an average, a meager Rs. 7 per capita per annum on the DCPs.
- n Within DCPs, on an average, more than 50% of the expenditure is incurred on malaria, 15% to 20% on leprosy, 3% to 4% on tuberculosis and less than 1% on blindness control. AIDS being a new entrant, the expenditure on it is reflected only in some of the state budgets.
- n Further, the major item of expenditure under the DCPs is on the payment of salaries of personnel while the supply of essential drugs for treatment, supplies for preventive measures, transportation etc. are provided inadequate funding.

The study concludes that the principal reason for this state of affairs is the dissipated and program based approach. What the country needs is a universally accessible comprehensive health care within which the priority areas like disease control are adequately taken care of. In the absence of the former, the latter is unlikely to realise its objectives.

Project completed in 1995. Supported by: The "Research Project on Strategies and Financing for Human Development." Team: Sunil Nandraj and Ravi Duggal. Assisted by Kawaljeet Sethi and Asha Vadair.

III-A-3. The Private Health Sector in India: Nature, Trends and a Critique

For the last five decades, the government has systematically nurtured the private health sector. This unwritten policy of the government

runs parallel to the neglect, and now gradual, withdrawal of the state from the responsibility of people's health. Such a consistent support and encouragement to the private health sector are very important reasons for the failure to provide universal basic health care to all people of the country.

Today there are approximately 11,25,000 practitioners of different systems registered with various medical councils in the country. Of them, only 125,000 are in government service (including those in central health services, the armed forces, railways, state insurance etc). That leaves about a million doctors floating around in the private sector, not to mention tens of thousands of additional unqualified and unregistered medical practitioners. 59 % of all practitioners are concentrated in cities. For instance, 60 % of all medical graduates in Maharashtra are located in Mumbai, where no more than 11 % of the state's population lives! Similarly, 84 % of hospital beds are today located in urban areas, whereas 75 % of the population still resides in villages. This selective concentration of health care providers is a major concern to be addressed, especially since studies have shown that those living in rural areas spend about as much on health care as those in towns.

The State offers subsidies, loans, tax waivers and other benefits for the setting up of private practice, hospitals, diagnostic centres and pharmaceuticals. For instance, the government subsidises the unethical and exploitative private health sector via medical education at the expense of the public exchequer. Assuming that the government spends about Rs. 10 lakhs at current prices on the education and training of each doctor and about 80% of the out-turn of public medical schools either joins the private sector or migrates abroad, the country loses large resources which could have been used for public benefit. The country loses Rs. 4,000-5,000 million as a result of the out - migration of four to five thousand doctors every year. Thus, with such support the private health sector has grown into a giant - it is the largest private health sector in the world. With 60-80 % of health care sought in the private sector, and households contributing 4-6 % of their incomes, there's a whopping Rs. 400-600 billion health care market in India. Its mammoth size notwithstanding, this sector has remained completely unregulated.

While the expansion of the private sector is primarily responsible for high and increasing inequity in access to health care, its internal functioning is riddled with problems and its claim of better efficiency and quality service are yet to be objectively proven. Besides, malpractice is very common, irrational and unnecessary diagnostic tests and surgeries are rampant, and ethics are by and large jettisoned.

All over the world there is a tendency to move towards more organised national health systems and an increased share of public finance in

health care. Almost all developed capitalist and socialist countries have universal health care systems where the public sector's share of the fiscal burden is between 60 to 100 %. This trend is inevitable in the pursuit of equity and universal coverage. A few countries which have not set up universal systems of health care, such as the USA, where 30 million people do not have reasonable access to health care, continue to have glaring inequities in health care provision despite being economically well-developed.

Project completed in 1995. Supported by: Independent Commission for Health in India (ICHI), New Delhi. Report prepared by: Ravi Duggal.

III-A-4. Review of Private Health Sector Studies in India

As a follow up to the work started on the private health sector, this study is expected to make recommendations for national level policy changes as it is being pursued closely with the Ministry of Health. Besides, it is a collaborative effort with the Department of Community Medicine and Social Health (Jawaharlal Nehru University, New Delhi) and the Department of Humanities and Social Sciences (Indian Institute of Technology, Chennai). As a part of such a collaboration, CEHAT is covering three states, Maharashtra, Gujarat and Rajasthan to examine data and policies on, and the operation of the private sector.

Project commenced in 1999. Supported by: The Government of India and the World Bank. Team: Sunil Nandraj. Assisted by Aunshuman Apte and Devika Salunke.

III-A-5. Improving Public Health System: Patient Satisfaction in a public hospital in Mumbai

In the present situation there is an urgent need to pay attention to the public health services in order to improve them. To foster such a programme, CEHAT provided research inputs for a seminar on improving public hospitals in Mumbai organised by the Medico Friend Circle (Bombay Group). As a follow up to this campaign, the Anusandhan Trust supported the above study of patient satisfaction in the L. T. M. G. Hospital (popularly known as Sion Hospital) of the Brihanmumbai Municipal Corporation in 1996. It was a collaborative effort with the Hospital and the volunteers of Sion Senior Citizens Association who collected data from 123 indoor patients (about 10% of the bed strength) using a questionnaire. We took care in the methodology to include information on the socio-economic background of the participants, their health seeking behaviour before arriving at the public hospital, the problems and

expenditure incurred at the public hospital and their perceived satisfaction with the services. Along with that we also obtained data on the hospital facilities, both through observation as well as from hospital records.

- n A large majority of the patients (71.4 %) were from the city's slums, chawls or streets. Clearly, the patients seeking indoor care at a public hospital like LTMG are in many ways disenfranchised members of society.
- n The survey showed that 3.2 % of patients were not provided beds, 19.5 % were not provided linen and 16.3 % were not given hospital clothing. Once provided, 21.1 % of linen and 27.6 % of hospital clothes had never been changed. Less than half the respondents approved of the hospital food.
- n As against 19.5 % who were provided all medicines by the hospital, a majority of the patients (68.1 %), had to buy medicines from outside pharmacies. The situation vis-à-vis diagnostic facility was found to be better; nearly two out of three were able to get all the required diagnostic tests done at the hospital.
- n One of the most startling findings of the survey was the fact that as many as 41.8 % of the patients spent more on the daily expenses on hospital care, than their entire households earned in a day. The average monthly household income was Rs. 2,749 per month, and patients spent an average of Rs. 2,533 before and Rs. 1,555 after admission. This means that, one-and-a-half times the monthly income of the entire household had already been spent, prior to the interview, on medicines, investigations and doctors' fees. By the time the patient was discharged, this ratio might probably have become twice as high. Medical expenses inevitably force the poor deeper into the debt trap, with poverty leading to illness and illness leading to further poverty.
- n The contribution of the private sector in increasing the misery of patients from the poorer strata was high, since half of them had first approached private practitioners who often squeeze them of money before sending them to a public hospital. Nearly three out of five patients had been ill for more than three weeks before they were admitted to the hospital.
- n Regardless of all the problems they encounter at a public hospital, the study found that the overall patient satisfaction was high. They were impressed by the fact that it was a "big" hospital. In a touching display of faith, an astonishing 88.6 % said that all doctors were competent, while 91.9 % believed all nurses were competent. The dominant emotion was gratitude for the expert care they received.
- n What explains these high levels of patient satisfaction? The study

argues that one reason could be a very low-key, if not a totally absent, demand for better service by users. Only the poor come to public hospitals, many of them after getting exploited and neglected in the private hospitals. Besides, their daily living condition in the slums is several times worse than the conditions in the public hospitals. They are therefore grateful for whatever care comes their way.

- n Since they expect so little, they fail to pressurise the institution to improve its standards. This absence of pressure for quality from users sets off a vicious circle of low demand, therefore low quality, leading to the alienation of larger strata of people, and again lower demand. A way out is to make a commitment to quality and user friendliness as part of the culture and tradition of the hospital, irrespective of whether or not users demand it.

The findings and recommendations of the study were presented in a seminar at the Sion hospital and also to the hospital's committee of doctors.

Project completed in 1996. Supported by: Anusandhan Trust and the voluntary initiative of the team. Team: Aditi Iyer, Amar Jesani and Santosh Karmarkar

III-B. HEALTH LEGISLATION, ETHICS AND PATIENTS' RIGHTS

Six projects, campaign and advocacy under this programme have contributed one book, four study reports, eleven scientific papers and essays, six popular articles (one of them in Marathi) and nine editorials and reviews in various journals. Laws, regulations and ethics provide a framework and decide the orientation of any health system, more so in a system existing within the market economy. It is therefore necessary to pay attention and ensure that the legislation, regulatory programmes and ethical guidelines and codes empower people and patients, and not the providers and bureaucrats. They should increase access, improve quality, reduce inequity and should be sensitive to the needs of dalits, minorities and women. In the last six years, this programme of CEHAT has helped bring the issues of regulation of private sector, various forms of self-regulation, medical ethics, ethics in social science research and the discussion on the legislative framework for health care at the centre-stage.

III-B-1. Laws for Health Care Providers: Legislation and Legal Aspects of Health Care Delivery

Although numerous government appointed and other committees have brought out their reports which have influenced frequent changes in health care delivery, there has been little long term concretisation of policies in the form of proper legislation. As a consequence, the services established by the government have only created entitlements without giving any right to people to take judicial action when the service is inadequately rendered or under some pretext, summarily withdrawn. This study reviews reports of most of the committees since independence. It shows that some of these committees, while lamenting on the government's lack of political will to properly implement good health policies, have themselves been lacking in providing plan for operationalising their own recommendations through suitable legislation(s), thereby giving adequate rights to people for demanding services. The study also does a global survey to understand existence of right to health or in its lieu, the legislated entitlements to create right to basic minimum services.

The study also looks into three other legal frameworks on the delivery system, namely, laws for self-regulation of health care professionals, regulation of hospitals and the tort laws.

- n *The analysis of the medical council and the laws governing them show that they have failed to use the laws to establish their monopoly for regulation of medical care. The medical professionals too have shown indifference to self-regulation. The nurses, on the other hand, are clamouring for self-controlled regulations and they are denied this facility. In fact the nursing councils are under strong control of medical professionals and bureaucrats who have kept under the lid nurses' demands to increase their number and to stop exploitation of the unregistered nurses in the hospitals and nursing homes.*
- n *The legislative framework for private hospitals and nursing homes is in an even worse shape. The law for registration of private hospitals and nursing homes with the health department exists only in a few states. Even in the states that have such laws, there are no guidelines for the minimum standards requisite for establishing and running nursing homes. This situation is indeed very dangerous for the large number of patients using them.*
- n *There are very few path-breaking judgements on the medical malpractice cases, thereby making case laws on medical negligence underdeveloped. The Consumer Protection Act would thus help in evolving case laws on the subject. At the same time, the study analyses the inherent anti-people logic of the tort laws and argues that at least in the cases of injuries due to adverse outcome during medical care, the tort system should be replaced by the "no-fault compensation" schemes. It also recognises that introduction of no-*

fault compensation would also mean strong regulation of, if not moving away from, the market dominated health care.

Project completed in 1996. Supported by: The "Research Project on Strategies and Financing for Human Development". Report prepared by: Amar Jesani, with contributions from Aditi Iyer, Mihir Desai and Mahrukh Adenwala.

III-B-2. Market, Medicine and Malpractice

Between 1988 and 1994, the Medico Friend Circle (Bombay Group) actively helped the victims of medical malpractice. In this period, the MFC (BG) was literally flooded with cases of medical malpractice, as if there was an explosion of public anger against a system substantially alienated from people's needs. The MFC (BG) served not only as a catalyst but also as a channel for the articulation of people's grievances against the rising cost of medical care, the growing arrogance of providers and their refusal to be socially accountable and sensitive. The MFC's campaign created a sense of urgency and forced all concerned people in Mumbai to respond. While handling individual cases of medical malpractice, the MFC (BG) organised seminars, meetings, and filed public interest litigation on the issues arising from the cases. It was against this backdrop of the campaign on medical malpractice, that a group of socially conscious doctors crystallised in Mumbai leading to the formation of an organisation for medical ethics.

CEHAT, in collaboration with Society for Public Health Awareness and Action (SPHA), decided to document the work of the MFC (BG) and the issues related to medical malpractice. Some of the relatives of victims had, in a very organised manner, not only fought their cases, but also tried to bring out public interest issues. During their struggles they acquired a good understanding of the way the medical market was organised in the country. Four of them were encouraged to document their experiences. From this emerged four exhaustive self-narrated case studies of suffering, struggles and frustration of the relatives of victims of medical malpractice. These case studies encourage people to ask questions, assert their rights vis-à-vis the professionals and take forward their individual struggles to bring about a positive change in the health care system. Along with the case studies we compiled 17 articles of this period and published a book. It covered articles on related subjects such as domination of private sector in health care delivery and virtual absence of regulation over it, the lack of strong ethical framework for monitoring doctors' conduct, the understanding of tort laws, consumer protection etc. These articles help readers to link the suffering of individuals, the market domination in health care and the need to rise above the suffering and reform the health sector in India.

The book makes a strong appeal for patients' rights and the observance of medical ethics. It asserts that our country would need a strong

movement of patients and the socially conscious doctors to ensure patients' rights and observance of ethics. At the same time the book argues that such a movement would also need to take up the larger issue of universal access and the right to basic health care. This is to ensure that patients' rights and ethics are not reduced to simple market regulatory phenomenon, and emerge as the basis for empowering people in the field of health.

This work for the documentation was done in part voluntarily and partly with the support of the Anusandhan Trust and SPHA. This documentation was published in a book appropriately titled, "*Market, Medicine and Malpractice*".

Project completed in 1997. Supported by: Anusandhan Trust and the voluntary initiative of the team. Book edited by: Amar Jesani, P C Singhi and Padma Prakash.

III-B-3. Physical standards in the Private Health Sector

Several studies have brought out that the private health sector is the dominant provider of health care in India. The pro-private sector ideology is so strong that often it is assumed that the quality of health care provided therein is high. However, the fact is that there is hardly any good data on this topic available from anywhere in India. The need for such a study was strongly felt, more so in the background of the virtual absence of laws regulating and mandating minimum standards of care in the private sector. The study focused on the physical standards of nursing homes (NHs) and hospitals in Maharashtra. For this a socio-economically average district (as per the CMIE index), Satara, was thus selected. A sample of 53 medical practitioners and 49 NHs/hospitals was drawn from the underdeveloped Patan and the highly developed Karad tehsils.. The tools used were a structured interview schedule along with an observation schedule and a checklist for equipment.

Moreover, since no institution in India, including the Bureau of Indian Standards, has evolved standards for hospitals having beds less than 30, we organised a one day workshop to prepare "Minimum Physical Standards for Private Hospitals and Nursing Homes". The participants for the workshop included researchers, government officials and doctors from the public and private hospitals in urban and rural areas. After extensive discussion, the draft for minimum standards was drawn up. This provided the context for analysing the findings of the study - The study revealed some startling facts:

The Medical Practitioners:

n One fourth of practitioners are unqualified, and amongst the

qualified, only 40% are allopaths while 52.5% from Indian Systems and 7.5% from homeopathy. Yet 79% of all practitioners in the sample were found practising allopathy.

- n 62% of all practitioners kept no medical record of their patients. 38% kept some record that consisted mostly of medicines administered and charges to be recovered from patients. Thus, instead of being an actual medical record, it was more of a trade or a business record! Fittingly, such record is maintained in diaries and notebooks rather than on the medical record sheets.
- n We also found that much of the basic medical equipment was conspicuous by their absence in the clinic of many practitioners.

The hospitals and nursing homes:

- n Over 80% of them were established in the 1980s and 1990s. 91.8% of them were individual proprietorships. 80% of hospitals were run by doctor-owners and without assistance from any other doctor. Average bed strength was 11.
- n More than 90% doctors running hospitals were males.
- n Only 71.5% of doctors owning hospitals were trained in allopathy.
- n Only three qualified nurses were found in 49 hospitals studied. Unqualified women, who were paid very low salaries, made up for the rest of the nursing staff.
- n Almost all of the hospitals and nursing homes provided general medical care. In addition, 55% provided maternity and gynaecological services and 16% general surgery. Only 2% of hospitals were treating emergency cases and only 18% had facility for pathological examination.
- n None of these hospitals were registered with any health authority.
- n A quarter of them had uninterrupted power supply and of them, 24% had installed a generator. Only three fourths of them had a telephone and none had an ambulance.
- n In only 28%, was the area of consulting room adequate. In 65%, there was no screen, curtain, or a separate room for examination of patients. A wash basin with tap was available in 59% of the hospitals, and of these in 49% there was no water available in the wash basin.
- n In only 6% of the hospitals, the space per bed was adequate. The bed sheets and pillows were found to be dirty, in more than 50% of the hospitals,

- n Most of them had an Operation Theatre (OT), but only 11% of them had adequate area. 71% had an OT table, 39% had a shadowless lamp, 10% had ECG facility and only 65% had steriliser.
- n In those providing Obstetrics and Gynaecological services, nearly a quarter did not have basic equipment. 52% had an oxygen cylinder, 74% had a delivery table and 81% had a suction machine.
- n In those providing surgical services, 39% had an X-ray machine, 56% had an Oxygen cylinder, 39% had an Electro-coterie unit and none had a Boyle's apparatus.

The study shows that the perception of high quality health care in private sector is an absolute fallacy, at least in terms of the physical and medical standards. It also makes a strong case for regulating the private sector for improving standards and for reducing exploitation of patients.

Project completed in 1995. Supported by: The "Research Project on Strategies and Financing for Human Development." Team: Sunil Nandraj and Ravi Duggal, and assisted by Asha Vadair. Veena Murlidhar prepared the document "Minimum Physical Standards for Private Hospitals and Nursing Homes".

III-B-4. Private Hospitals and Nursing Homes: Need for Accreditation

How does one make the widespread and unethical private sector accountable? The deliberate nurturing of this sector has made it financially and politically very powerful. As a consequence even, simple attempts by some state governments to enact legislation for registration of private NHs/hospitals (without any provision for minimum standards) have evoked angry protests from the medical establishments. They have also ensured that registration laws are either not implemented or are entangled in bureaucratic red tape. During its campaign on medical malpractice in Mumbai, the MFC (BG) had discovered that the registration law of Maharashtra was not properly implemented. It filed a Public Interest Litigation for its implementation. Although a court appointed committee in its study discovered appalling physical and medical standards of the NHs/Hospitals in Mumbai, and it formulated and recommended minimum standards, the government has done nothing in the last one decade to change the law. On the other hand, with increasing criticism towards the commercialisation of the private health sector and the possibility of health insurance companies imposing their own standards on the NHs/hospitals, the private health sector has been brought under great pressure and is now looking for new ideas.

It was in this context, and in order to understand views of various stakeholders of the private NHs and hospital system in Mumbai, that this study was planned. Accordingly, 113 NHs/hospital owners, eight medical associations, two consumer organisations and 100 patients were studied.

- n Almost all the stakeholders surveyed in the course of this study favoured accreditation. Five probable reasons could be identified:
 - o There has been great increase in competition.
 - o Those not observing good standards were taking unfair advantage and lowering credibility of the profession.
 - o The apprehension that the opening up of the health insurance sector would force providers to accept the standards set by the insurance companies.
 - o An Accreditation system would help the providers not only to set its own standards, but also facilitate selection of providers by the insurance companies for their schemes.
 - o The growing consumer awareness and increasing litigation against the providers have shown that people are becoming more vigilant. Interestingly, the 100 indoor and outdoor patients interviewed in this study overwhelmingly supported accreditation.
- n Of the 113 hospital owners/administrators interviewed, 93 said that an accreditation body was essential to assess hospitals for compliance with physical and functional standards. 87 of them said such a body should assist hospitals in continuous quality assurance. 42 of the owners interviewed held that it should also serve as a forum for consumer redress. 31 wanted the body to take punitive action against hospitals. 101 agreed that the body should monitor physical aspects such as operation theatres, space, wards etc., and only 44 of them felt that it should monitor the quantum of fees charged.
- n While hospital owners/administrators wanted the government to keep out of the process, all other stakeholders felt that its participation would provide much needed legitimacy to accreditation.
- n Most stakeholders felt that insurance companies should not be involved in accreditation.

The findings of the study indicate that the self-regulatory system would have to be sensitive to the views of various stakeholders and governmental monitoring. Since the stakeholders would

determine its eventual success, such a self-regulatory system is likely to take a middle path.

Project completed in 1998. Supported by: The World Health Organisation. Team: Sunil Nandraj, Anagha Khot and Sumita Menon.

III-B-5. Medical Ethics for Self-regulation

The pride of the medical profession is in its self-regulation on the basis of professional codes of ethics. The profession has traditionally opposed outside interference and control over its internal matters so much so that, a section with a misconceived notion of no-accountability is vehemently opposed to applying the Consumer Protection Act to medical services.

This study has examined the meaning of self-regulation, the code of ethics and its role in self-regulation, and the history and evolution of laws establishing councils for health professionals in developed countries and in India. The Medical (allopathy, Indian systems and homeopathy) and Nursing council offices for Maharashtra in Mumbai were visited to understand their functioning. The findings of this quick study of the functioning of these councils show that they have not fulfilled even some of the preliminary objectives of self-regulation for which they were established in the first place.

The study argues that the health care ethics are normally violated in the market-based health care since the section of people not having purchasing power are denied basic minimum health care. Thus, it is difficult to conceive an ethical health care service scenario without having fundamental or legal right to basic minimum health care. While recognising the great strength of the community health approach using village level workers and paramedics, it makes a strong case for formalisation of the semi-professional work of these workers through registration and other means.

The study also recommends that the functional unit of the council should be brought down at the district level. The licensing or registration provisions in the laws related to Councils should be amended to affect redistribution of the health care professionals. The control of government bureaucrats on councils should be removed, in order to make them genuinely self-regulatory. The work of Councils should be made transparent; the complainant patients should be given more rights and information, etc.

Project completed in 1995. Supported by: The Independent Commission for Health in India (ICHI), New Delhi. Team: Aditi Iyer and Amar Jesani.

III-B-6. Ethical Guidelines for Social Science Research in Health

Self-regulation and ethics have been issues for debate within research more often in medicine than in social sciences. This is, at least partly because historically ethics has been used as a defining principle for medicine. In recent years, there has been a growing concern for ethics in medical research in India. Many socially conscious groups (such as women's groups, health activists' groups) have brought into public focus, the unethical conduct of medical research, particularly with reference to contraceptive research on women. These issues have also attracted media attention. In 1980, the Indian Council of Medical Research (ICMR) adopted its first code of ethics, and it is currently undergoing revision. A consultative document was published in 1997 but the new guidelines are yet to be formally released.

In the social sciences, however, interest in ethics is only now emerging. Although many social scientists have paid serious attention to the appropriate conduct of research and have set personal examples, such important issues are hardly discussed as ethics and little effort has been made to formalise a code of conduct for researchers. Neither the national councils for social sciences (the ICSSR, etc), their institutions, nor the national bodies for higher education such as the UGC have published comprehensive guidelines for research in social sciences. In other countries, particularly in the developed countries, however, in last three decades various disciplines of social sciences have adopted comprehensive codes of ethics. Besides, in the last one and half decades, there has been growing realisation that in all sciences, the need to protect participants and to preserve the autonomy of researchers is fundamentally similar. As a consequence, some countries have made efforts to evolve common ethical guidelines by medical, social science and natural science disciplines. For instance, the Research Councils for Medical, Natural Sciences and Engineering, and Social Sciences and Humanities (jointly called Tri-Council) in Canada adopted a common code of ethics, titled, "The Code of Ethical Conduct for Research Involving Humans), in 1997.

In this context CEHAT decided to make an organised effort to draft and popularise ethical guidelines for research in social sciences, and to promote appropriate institutional mechanism for their implementation. An exhaustive survey and analysis of various national and professional codes of ethics for research was carried out and Indian literature reviewed to understand the ethical concerns shown by the researchers. In the later part of the project, in 1999, a multi-disciplinary committee of scholars and experts was formed to draft the guidelines. While the project team of CEHAT constituted the secretariat, the committee has the following ten persons: (1) Ghanshyam Shah (Sociology, JNU, New Delhi). (2) Lakshmi Lingam (Sociology and Women's Studies, TISS, Mumbai). (3) V R Muraleedharan (Economics, IIT, Chennai). (4) Padma

Prakash (Sociology and Journalism, EPW, Mumbai). (5) Thelma Narayan (Public Health, CHC, Bangalore). (6) Ashok Dayalchand (Community Health, Pachod, Maharashtra). (7) Manisha Gupte (Women and Health activist, MASUM, Pune). (8) Sarojini Thakur (Add. Secretary, Ministry of Women and Child Development, New Delhi), (9) Geetanjali Misra (The Ford Foundation, New Delhi). (10) Radhika Chandiramani (Psychology, TARSHI, New Delhi).

The draft guidelines have been published in the March 18, 2000 issue of the *Economic and Political Weekly* for promoting discussion among the social science community in India. CEHAT has also presented these guidelines to the scholars of six institutions across the country and has solicited feed back from over one hundred institutions and scholars. The draft guidelines are scheduled to be discussed at the national meeting on May 29 and 30, 2000 in Mumbai. They are likely to be finalised by the committee by early August 2000 and then released. We also hope to follow up this work by promoting formation of a national network of institutions and individuals for the implementation of guidelines and for sharing ethical dilemmas and issues encountered during research.

Project commenced in 1998. Supported by: The Ford Foundation, New Delhi. Team: Amar Jesani and Tejal Barai

III-C. WOMEN AND HEALTH

The study of women's reproductive health (abortion) was one of the first projects undertaken by CEHAT when it was established. Since then, *in six years, six projects and several other activities have contributed seven research reports, 26 scientific papers and essays, nine popular articles (eight of them in Marathi) and one book review.* Indeed, the research programme on women and health is the best-developed and expanding programme of CEHAT. It is also influencing the other research programmes and action/intervention work of the organisation. This is in a way a natural consequence of both the ideological commitment as well as the fact that a substantial majority of CEHAT staff is women.

III-C-1. Illness and Childbearing among Women

A woman's health is intricately linked with the social environment she lives and works in. When one studies women's health, one must, therefore, study not just her biological problems but the whole social

process that gives rise to these problems. Given their subordinate position and the fact that they are being constantly discriminated against, one would expect women's health and health care utilisation to be substantially low. However, to our surprise we found that most of the national and local surveys had inadequately captured this reality. This contrasted sharply with the recent qualitative information, particularly on reproductive health. Thus, CEHAT decided to undertake a district level survey in 1998 using a methodology that incorporated certain elements of the qualitative research, for a study of women's morbidity, utilisation of health care services and expenditure. Nashik district in Maharashtra was selected for the study as it has average development index, a substantial tribal population and readiness of an NGO friendly to us working in the area to provide us support.

The study covered 3,581 women belonging to 1,193 households in rural areas of Igatpuri taluka and in the city of Nashik. The study made several innovations in the survey method:

- n Women of the household were interviewed to get information on the members of the household.
- n Only female investigators conducted the survey.
- n The investigators were trained rigorously and sensitised on women's health issues and about the data collection technique.
- n A longer process of interaction between the women in the community, the investigators and researchers was established.
- n The morbidity among women was recorded first as reported by the women respondents and then by using 14 probing questions.
- n We also asked questions on women's perception of, and how they relate their health problems to their bodies, household, work and environment.

The findings of the study revealed that the quantum of morbidity existing among women was higher than had been reported in any earlier household surveys. In fact, the morbidity reported among men was also higher than in any of the previous surveys. It recorded a rate of 569 morbidity episodes per month for 1000 persons. The rate for males was 330 and for females 812. Besides, 506 females per 1000 as compared to 307 males per 1000, reported sickness in the reference period of one month. Nearly 20% of morbidity reported by women was associated with their reproductive health.

- n The ill health reported by women tended to be predominantly chronic and linked to the living environment (air, water, food etc), work, childbearing and contraception. There is a high correlation between morbidity and age, marital and occupational status, socio-economic class and composition of the household.

- n The utilisation of health care by women was quite low, relative to the quantum of morbidity reported by them. 45 percent of the episodes reported by them were not treated. One of the major reasons cited for not seeking treatment was financial problems (40%). 23.2% reasons were attributed to the nature of the illness ("treatment was not required or would not be effective"), and 12.4% of the reasons were related to the lack of physical access to the health facilities. The use of informal care was an important part of a woman's help seeking behaviour. While the use of home remedies constituted 15 percent of the services utilised, the use of self medication accounted for 11 percent of the total services used.
- n A high association between health care utilisation and the position of women in their households was found. Unmarried girls and aged women utilised more health care per episode than women who were heads of the household or wives of male heads of households. Besides, the women from deprived groups (remote villages, scheduled castes and urban minority community) received inadequate health care for a large proportion of their illnesses.
- n The study found that the household health expenditure was Rs. 624 per capita per annum. The expenditure per episode, per capita and per facility in the rural areas was higher than in the urban areas. The cost of inpatient care as well as outpatient care in the rural area was lower.
- n Doctor's fee, cost of medicines and injections comprised the major part of the outpatient expenditure. The cost of surgery and hospitalisation, though infrequent, was extremely high.
- n The type of treatment was found to influence the expenditure. When only medicines were dispensed, the per facility expenditure was recorded at Rs. 24, but when injections were also administered, it rose to Rs 77. This explains economics of the overuse of injections in the private sector.

This study has made two major contributions. Firstly it has shown that the traditional survey methodology needs to be appropriately modified in order to capture women's health issues in the national surveys. Secondly, it provides insight and explanation on women's morbidity, health seeking behaviour and the household expenditure on women's health.

Project completed in 1999. Supported by: The John D. and Catherine T. MacArthur Foundation, New Delhi. Team: Neha Madhiwalla, Sunil Nandraj and Roopashri Sinha.

III-C-2. Women and Health Care in Mumbai

In order to test the modified survey methodology for the study of women in household's development in Nashik district, a pilot study was planned in Mumbai. As the pilot survey was eventually done for a large sample of 430 slum and non-slum household, its findings found independent relevance and a separate report was prepared. The study had the same objectives and methodology as described in the Nashik study (ref. Section C-1). The study was conducted in 1997 in the 'L' ward of Mumbai City, in five clusters - two slums, two chawls and one apartment block. The trends of the findings follow a similar pattern as those in the Nashik study.

- n The monthly prevalence rate of illness was 363 per thousand (169 for males, as compared to 597 for females). We found a steady rise in the morbidity rates with age of women.
- n Reproductive illnesses form the largest group of problems accounting for 28.2% of all episodes among women.
- n The study reveals high non-utilisation (32.5% of the illness episodes). Non utilisation was also found in relation to pregnant women and those who had delivered. 43% of the pregnant women did not utilise any facilities. Thus, despite having some of the best health care facilities in the city, the access to health care was poor, and financial problems was one of the major causes for non-utilisation.
- n There is a very high utilisation of the private health services. In 85% of the illness episodes, approach was made to the private facility and only 10% to the public facility.
- n The average per capita health expenditure incurred was Rs. 415.68 per year. As compared to that, the government expenditure in Mumbai was only Rs. 250 per person while the average per capita government expenditure in the country for the same year was Rs. 90 per annum.

Project completed in 1998. Supported by: The John D. and Catherine T. MacArthur Foundation, New Delhi. Team: Sunil Nandraj, Neha Madhiwalla, Roopashri Sinha and Amar Jesani.

III-C-3. Women, Work, Environment and Health

This ongoing project intends to study the impact of globalisation (a process that began in the 1980s and continues to this day) on women's work and living environment and how their work and environment in turn affect their health. The process of structural adjustment has altered the government's priorities in the field of social welfare and funding of welfare projects. The objective of the study is to understand the impact of changes in welfare policy and

in the economic sector, on the lives of women and communities. In order to understand the complexity of the situation, the project is being implemented as three case studies.

- n The *first case study* documents the impact of de-industrialisation on women belonging to marginalised communities in two slum settlements of Kurla, an eastern suburb of Mumbai. The economy of Mumbai is undergoing a structural transformation. The manufacturing base is narrowing, while the service sector is witnessing rapid growth. However, a large section of the working class in the city (residing primarily in the slums) is still trying to survive in the fragmented, informal industrial sector. Certain marginalised groups such as Muslims and scheduled castes cannot share in the gains of the service sector because they are politically marginalised and educationally backward.
- n The *second case study* is looking into the impact of capitalist farming and grape plantations introduced in Pune district more than a decade ago. Big and medium farmers belonging to the landed castes invest the capital and hire labourers from the Thakur tribe possessing specialised skills required for grape production. With the introduction of export-based cultivation, the Thakurs have been compelled to adapt their skills as well as adhere to more 'scientific' production methods. The relations of production have also undergone changes, thanks to substantial fluctuations in world market prices as well as changing preferences in the global market. The Thakurs have adapted to the new situation with some success. This is however, at some cost to their health, especially the health of women. This study records their perception of their work and health status and the manner in which the changed economic scenario is affecting their well being.
- n The *third case study* is on the effects of industrialisation on a predominantly agricultural community in Tamil Nadu. As part of the government's policy to introduce industries in rural areas, industrial units were set up in Chengalpet district of Tamil Nadu, originally an area of subsistence agriculture. A decade later, industries have replaced agriculture as the main source of employment in the villages surrounding the industrial estates. The younger women of the Dalit households in these villages have entered the industrial workforce in large numbers. The transition from agricultural labour to industrial work has brought about not only economic changes, but also a social and cultural transformation. However, the industrial work available is essentially semiskilled, with neither security of service nor continuity in work. This third case study documents changes that have occurred in the nature of work as well as changes in the perception of health as a result of the new organisation of work.

Project commenced in 1998. Supported by: ENGENDER, Singapore. Team: Neha Madhiwalla, Padma Deosthali, Shardini Rath, Kalpana Dixit (all from CEHAT), Jeyaranjan, Padmini Swaminathan (MIDS, Chennai), and Avadhut Nadkarni (SNDT, Mumbai).

III-C-4. Women's Abortion Needs and Practices in Rural Maharashtra

How do women perceive the issue of abortion? What are their abortion needs? What standards of abortion care do they expect? What are their concerns when choosing abortion service providers? What are the complex dynamics involved in decision-making on abortion? How much do women know about the Medical Termination of Pregnancy (MTP) Act? Even 25 years after the implementation of the MTP Act we have very little understanding of abortion issue from this perspective. Most of the earlier research on abortion focused on the interests and motivations of policy-makers, doctors and demographers. Women were simply not in the picture. To understand politics of abortion and to place abortion in the larger context of women's rights to determine their own sexuality, fertility and reproduction is very important. This project emerged from this need. A qualitative study to understand abortion from women's perspective was carried out in the villages of Pune district using qualitative methodology. The study revealed that -

- n Women were poorly informed about *the abortion legislation*. Besides, the MTP Act does not provide right to abortion, but essentially liberalises use of medical technology for termination of pregnancy in certain conditions. Thus, women do have to give reasons for seeking abortion. This complicates women's real life problems and the moral dilemmas. Often, women approached the issue of abortion tentatively, with some guilt and as something that is necessary to bail them out of a no-choice situation.
- n Various factors have an impact on *women's role in abortion decision making*. They are: their status in the family, fertility history, number of sons she has had, her husband's status (including his economic capacity) in the family, the relationship between spouses, relationship with in-laws, etc.
- n Women's sexuality was disregarded, denied or suspected. The abortion decision that women may take in these situations though appear liberating, but were in fact reflections of women not having any space. As a result, they resorted to clandestine abortions, indicating the reduced bargaining power in negotiating their sexuality.

- n Use of contraception and undergoing sterilisation has its own complex dynamics, once again woven with sexuality and unequal spousal power relationship, in favour of men. Men do not allow their wives to use contraception, fearing the latter's promiscuity. Men do not undergo sterilisation perhaps to keep their reproductive options open at all times. Wives refuse to consent to tubectomy out of fear of their husband. Since, the husband (if the family too desires) could get another woman under the pretext that she was not able to produce any children.

These complexities in decision making suggested that there is a need to increase space for women to negotiate their sexual and reproductive rights within and outside the family. She needs to have back-up support through legislation and social activism. Enhancing women's role in decision making in other aspects of their lives, including that related to marriage, is an important pre-requisite to making women more assertive about their reproductive rights. Empowering women in all aspects of life, within a marriage or otherwise, is essential if we wish to increase women's role in decision-making in the area of reproduction and sexuality.

This study indicated that women are far from happy with the existing abortion services. They are upset that doctors demand their husbands' approval before performing an abortion and that government services pressurise them to accept an IUD after abortion. They are upset that doctors in the private sector take advantage of their situation and charge unreasonably high fees. They resent having to pay for health services in the private sector because the Primary Health Centre is inadequate or indifferent to their needs. They would like easier physical and economic access to abortion services.

Project completed in 1997. Supported by: The Ford Foundation, New Delhi. Team: Manisha Gupte, Sunita Bandewar and Hemlata Pisal

III-C-5. Research and Advocacy Programme for Improving Quality of Abortion Care Services

CEHAT followed up its study of women's perspective on abortion by conducting a study of the abortion care facilities and providers in two districts of Maharashtra. Simultaneously, this project also initiated our advocacy on abortion at the state level. The study covered the registered as well as non-registered, and the government as well as private abortion care facilities in nine tehsils of two districts. The survey involved the study of physical and medical standards, interviews with the providers, observation of the provider-client interaction, exit interviews of the clients and so on. It was found that -

- n Of the 159 abortion care facilities identified by us in these nine tehsils, the ratio of registered to non-registered facility was 1:2.8. Only about one quarter of the government health care facilities in this area provided abortion care. About two thirds of the abortion care facilities were urban based.
- n Little more than a quarter of the abortion care facilities were equipped, fully and completely, with essential anaesthetic and resuscitation equipment. About two thirds of them were having all surgical instruments required for the MTP procedures and about 60 % stocked all the life saving drugs. Many of them did not have the service of anaesthetist available. Only about 43 % of the abortion service providers were qualified as per the Act. Non-allopaths constituted about 28 % of all abortion providers in the sample.
- n The content and texture of woman-provider communication were found to be unsatisfactory. Counselling was either poor or completely absent. Not many providers felt necessary to tell women about the “dos and don’ts” of post-operative care.
- n There is increasing commercialisation of abortion care. There is high use of irrational drugs and unwanted abortion procedures. We also found rampant sex selective abortion practices.
- n The study captured the unwarranted role of abortion service providers as ‘gate keepers’. This role is a consequence of over-medicalisation of abortion care. Commercial interests of the medical fraternity, the patriarchal value system, stigma attached to the act of abortion, tendency to moralise, denial of women’s sexuality and reproductive rights, etc., have an impact on the providers’ role as gate keepers, often against the interests of women.
- n The study also revealed the range of problems that heads of health care facilities face while seeking MTP registration. Lack of access to information, ill-equipped government staff at the concerned offices, apathy on part of the medical fraternity and hospital administrators about medical legislation and regulatory mechanism and unsatisfactory response of the state administrators, contribute to the existence of a large number of non-registered abortion care facilities.

This study found the quality of abortion services available to women substandard. The poor implementation of the law and rules for quality care by the government and low compliance with the legislation by the medical profession, were chiefly responsible for this state of affairs. We feel that improvement in the quality of abortion care should be a part of the strategy for general improvement in the health care delivery system.

Project commenced in 1997. Supported by: the Ford Foundation, New Delhi. Team: Sunita Bandewar, Madhuri Sumant, Hemlata Pisal, Mugdha Lele and Shelley Saha.

III-C-6. Profile of Women’s Health in India

In 1997-98, the Women’s Health and Development department of the World Health Organisation, in collaboration with the Voluntary Health Association of India (VHAI), New Delhi, commenced a country level exercise to prepare Women’s Health Profile in India. Researchers, institutions and consultants from different parts of the country were brought together to undertake preparation of a database volume for the country profile. CEHAT prepared the following four major sections for the volume:

1. *Country profile on health and health care in India:* This section deals with the development of health care services, the sectoral and regional distribution of services, the health service programmes of the country, financing of health services in India, etc.
2. *Women’s access to health care:* The data and analysis of health seeking behaviour, use and non-use of health care services by women, the socio-economic determinants of the use and non-use of services, etc., are dealt with in this section.
3. *Women’s reproductive health:* The data from secondary sources and from numerous surveys carried out to understand women’s reproductive health are brought together in this section to provide a comprehensive picture of the status of women’s reproductive health in India.
4. *Leading causes of morbidity and mortality:* In the recent past, there have been several studies of reported and observed reproductive morbidity among women. This section brings them together. In addition, the hospital-based data and data reported by the health system on women’s morbidity are analysed. This section also provides similar overview of data on mortality among women and its causes.

This project provided an opportunity to CEHAT to carry out an overview of existing information on women’s health at the national level, understand the differentials across the states and various socio-economic classes in India. The WHO/VHAI are likely to publish the final edited volume on women’s health profile sometime in the year 2000.

Project completed in 1998. Supported by: the VHAI/WHO. Team: Aditi Iyer

(Sections 2, 3 and 4) and Amar Jesani (Section 1)

III-D. INVESTIGATION AND TREATMENT OF PSYCHOSOCIAL TRAUMA

This programme of CEHAT on human rights and violence was continued for a long time (from 1991 to 1997) as a voluntary commitment of the trust and the co-ordinator. In this period, CEHAT contributed by participating in several investigations of human rights violations and in the national and international human rights networks. Besides, CEHAT also undertook regular educational work on the subject. Towards the end of 1997, we took the first project grant to study human rights situation in Maharashtra and subsequently, domestic violence against women. In November 1998 an International Conference, titled "Preventing Violence, Caring for Survivors: Role of Health Services and Profession in Violence" was organised by CEHAT. Since then, this programme has been systematised and now it is not only influencing other research programmes, but has its own research projects. *In last six years, CEHAT has contributed nine study or investigation reports, seven scientific papers and essays, five popular articles and nine editorials and book reviews under this programme.*

III-D-1. Domestic Violence against Women

Violence against women and girl children is widely prevalent. In every socio-economic class, it is accepted as normal and legitimised. Violence has health consequences, and often the victims/survivors do seek care from the health care providers. The health care system has, however, failed to recognise violence against women as a health issue. Medical conditions directly associated with violence are not given due consideration unless they are catastrophic or acute. Although there is no accurate estimate of prevalence of domestic violence against women presently available, there are several studies, based on community surveys and research on the survivors. They indicate that the prevalence of such violence is very high. However, there is little recognition that such violence could be responsible for a variety of physical and mental problems. Consequently, such women are not provided the right kind of care by the health care services, when they approach providers for various symptoms. This study was conceived and designed in this context. Accordingly, it endeavours to study the prevalence, nature,

causes, help-seeking behaviour and community response to intra-familial /domestic violence against women in a poor slum community in Mumbai. Besides, CEHAT would be using the findings to establish a response cell for the women survivors in the slum.

We have recently completed the base line survey of the slum community, and the study is now proceeding to collection of qualitative data through the case studies and focus group interviews. This will be followed by a quantitative survey. The study is expected to be completed in early 2001.

Project commenced in 1998. Supported by: The John D. and Catherine T. MacArthur Foundation, Chicago. Team: Ravi Duggal, Anagha Khot, Sumita Menon and Leela Visaria.

III-D-2. Analysis of Police Custody Deaths in Maharashtra

In 1992 the Amnesty International (AI) published a report titled, "*India: Torture, rape and deaths in custody*". This report became highly controversial with the media publishing conflicting views on the subject. We were particularly interested in looking at the causes of deaths in custody. Fortunately for us in 1991, a post-graduate student at a social work institution in Pune had completed a dissertation on the custody deaths in Maharashtra in 1980-89 period and we were kindly allowed to have a look at the data on medical aspects. We also compared these data with the claims made by AI in its report.

- n The AI report cites 13 cases of custody deaths due to torture in the period 1985-89 in Maharashtra. The analysis of data made available to us showed 155 custody deaths in 1980-89 period, and of them, 102 deaths were recorded during the AI reference period of 1985-89. Although almost eight times more deaths are reported in custody during the period 1985-89, it is claimed that all these deaths are not due to torture.
- n On classifying the specific cause of the 155 custody deaths, we found that only 9.7% (15) were admitted to have been caused as a result of police action (which could be torture).
- n Nearly half of them were attributed to suicide or acts of the accused, and the rest to acts of the public, to disease and illness, or natural deaths. The specific causes mentioned in some of the cases were astonishing. These causes included the following. Nine died due to "alcohol consumption". 45 "hanged themselves". Three "jumped in the well". Two "jumped under the train". Three "jumped under the auto-rickshaw". One "jumped under the bus". One died on "falling from the cot or bed". One died due to "skin disease".

One died due to “giddiness”. One died due to “unconsciousness”, and so on.

- n Given the norm that every death in the custody ought to be investigated and proper autopsy done, such causes are not only incomprehensible but create suspicion about the true cause of death. Since these data were not collected by us and were collected by a student who did not aim to analyse the deaths from a medical angle, they are insufficient for a systematic study. However, a proper independent medical audit of all deaths in police custody needs to be done on regular basis.

Work completed in 1996. Supported by: Anusandhan Trust and voluntary initiative. Work done by: Amar Jesani.

III-D-3. Survey of Torture in Maharashtra

This study was undertaken in order to not only to understand the prevalence of violence in general and torture in particular, but to also assess the need for a rehabilitation centre in Mumbai or anywhere in Maharashtra. In the course of this work we collected statistical information on the prevalence of violence, interviewed a cross section of individuals and organisations: retired and serving police officials and judges, doctors and medical associations, activists and human rights organisations, human rights lawyers, and many others.

We found that torture by the police is widespread and routine. Even senior police officials admit that it happens. Specific methods of torture are used, and these often leave very typical, well-known signs. They also cause familiar psychological problems. The weakest sections of society – children, women, poor – are the most frequent targets of torture. The report concluded that the rehabilitation of torture victims (some would say all prisoners) is certainly a societal imperative. A centre to take up this task is needed. The report provides the guidelines for the services such a centre should provide. It adds that a rehabilitation centre for police torture victims should also welcome victims of other kinds of torture and violence. Secondly, as vital as it is to rehabilitate torture victims, prevention of torture should be a greater long-term priority. This could be done through training programmes, by human rights curricula and by strengthening human rights groups.

The report states that, “Human rights need to be much more widely known and respected in India. In particular, human rights must be part of professional training programmes for doctors and police/military personnel. More generally, human rights – perhaps defined as a greater respect for all human life – must become a part of society

itself in ways it is not today. It should be integrated into school and college curricula across the country. Human rights groups must find ways to expand their activities. In the long run, there has to be an end to the kind of social sanction violence has, sanction that makes torture acceptable, accepted and not worth making a fuss over. There is a case here for a near-radical makeover of society. Of course, this kind of social reform has a number of dimensions, but clearly torture cannot be viewed simply as an evil whose victims need help. It is a social disease, no less; that must be eradicated. This overarching view of torture, this overall goal, must guide any work on this subject in India”.

Project completed in 1998. Supported by: The Rehabilitation Centre for Torture Victims, Copenhagen. Team: Dilip D'Souza.

III-D-4. Torture in Hindi Films and Serials

As a follow up to our finding that there is high prevalence of torture and other forms of violence in society, this study was planned to understand how they are reflected in the media and how the media in turn influence people, particularly children. The study involved an analytical review of violence depicted in films and TV serials. The landmark or trend - setter films of 1970s and 1980s, and several films of the 1990s are included in the review. For the TV serials, the ongoing serials of 1999 were watched and reviewed.

A random study of the television programmes across the channels found that violence, both physical and psychological are there in plenty on the small screen. These include threats, slapping, screaming, shouting, assaulting, expletives, pushing, clobbering, stabbing, mental torture, eerie sounds and threatening music. In fact these categories of violence accounted for over 50 % of the total actions shown in these serials. Much of the violence is explicit and graphic. Some depictions of violence include torture in police lock up or verbal violence. Social dramas also have a large quantity of violence. In one day's programme across the channels, 178 acts of violence were found in one form or the other.

A survey of 108 children (with an average age of 9.9 years) from Delhi was conducted. They belonged equally to the lower income, middle income and upper-middle income groups. There were equal number of boys and girls. All of them spent at least one hour every day (many spent more), watching TV. The survey investigated research questions such as (1) What is the impact of legitimisation of police violence? (2) Does the average child see both violence and torture on screen and its manifestation in real life as a routine method of solving problems? (3) Does the audience that watches police brutality begin to accept

brutality as a vital part of the police's functions, and as the only solution to larger-than-life problems? (4) Do children not having a caring social and family environment, seek role models offering compensation through power and aggression? Some of the findings of the survey are as follows:

- n The action serials *Seahawk* (53%) and *Hindusthani* (36%) topped the chart of favourite serials amongst the children. *Bhanwar* and the controversial *Shaktimaan* are also popular.
- n 50% of the boys preferred action/violent and 11% preferred romantic films. 39% of the girls preferred comedies, 30% romances and 19% action films. When distributed over income groups the data showed that 72% of the lower income group boys like violent films compared to 67% from the other two groups.
- n 42% of the children reacted negatively to the character of a policeman, 28% positively, and 30% were indifferent.
- n When they saw policemen beating someone up in a serial, 22% of the boys felt happy, 31% felt uncomfortable and 19% were scared by such scenes.
- n Twenty-eight percent of the boys felt happy when the cop was beating the bad guys, but felt bad when he was thrashing the innocent.
- n In the lower income group, the percentage of boys and girls who either felt bad or were scared by such scenes was much higher than their counterparts in the other two income groups. This was perhaps because they can relate police torture to experiences in their everyday environment, while middle and upper income group children view torture from a much safer position in society

The study also produced a small documentary film giving clippings of the violence from various films with commentary.

Project completed in 1999. Supported by: Centre for Victims of Torture, Nepal and Anusandhan Trust. Team: Kiran Shaheen.



IV. ACTION, INTERVENTION AND TRAINING

Although CEHAT was established specifically to undertake research and related activities in the field of health and allied themes, in the course of work it also initiated field based activities to directly reach out to the underprivileged people and their organisations. This way, Anusandhan Trust has extended its work towards fulfilling its objective of RASA (Research, Action, Service and Advocacy). The field based activities are making our research and researchers people oriented, providing opportunities to undertake demonstration, action and intervention projects, and above all, are helping the organisation to link up with grass root level organisations.

Thus, we have endeavoured to establish two community-based projects one each among the rural and urban poor, and a third project within the public health system is likely to become operational in the later part of the year 2000. These projects being very recent (first two projects began only in 1998), organisationally the Anusandhan Trust is at the stage of accumulating and assimilating this initial experience in the area of action and intervention work. In coming time, based on our experiences, efforts to systematise and integrate this work would be undertaken. We expect that such efforts, along with our ongoing research work, would provide greater intensity and depth for making health and health care a human right.



IV-A. Arogya Sathi: Developing Health Programmes and Advocacy with People's Organisations

Health care is increasingly getting inaccessible to a big section of people in India. This is primarily as a result of physical unavailability in rural areas, and the rising and unaffordable costs despite physical availability, in urban areas. Whatever governmental health services are available in urban and rural areas, are being whittled down as a consequence of new economic policies. The people are being forced to take recourse to private health services, which are by and large irrational and exploitative. In rural areas, especially the backward and the remote ones, even the elementary first contact medical care, including health-education, is sparsely available. Moreover, many private practitioners in rural areas are not appropriately qualified.

What is the alternative? The alternative model of first contact care in rural areas that has been developed in many rural community health projects is based on the concept of Community Health Workers (CHWs). Such a model is distinct from the models used by, both the government in its health structure as well as by the private doctors and hospitals. CHW based projects in India have, in many cases, been remarkably successful in providing immediate relief in diverse conditions. However, so far they have remained externally dependent for resources and have not succeeded in becoming programmes of the people in the true sense. They have also not succeeded in going beyond the medical paradigm, to try and tackle the root causes of ill health such as malnutrition, lack of clean drinking water, inadequate sanitation, environmental degradation and so on.

The *Arogya Sathi* project stresses the importance of developing health programmes and health advocacy that are *in tandem* with people's organisations and mass movements. This initiative is based on the success of a community-sustained health programme since July 1995 in the *Kashtakari Sanghatna*, a mass organisation of tribal people in Thane district, Maharashtra. Began in October 1998, the *Arogya Sathi* Project is in the process of establishing community health programmes in three marginalised/tribal areas of Maharashtra/Madhya Pradesh (MP) where people's organisations are already functioning and leading people's movements. The community based health programmes have been established in Dahanu and Jawhar talukas of Thane district and Aajra taluka of Kolhapur district in Maharashtra. We have begun work from December 99 in Badwani region in Madhya Pradesh. The important features of the strategy employed by this project are as follows:

n The community health programmes have the support of the existing people's movements, which have already mobilised people around basic socio-economic issues. Organisational support is essential

not just to select the health activists, but also to back them in case of problems from vested interests like local quacks.

- n From the outset, the local communities are financially sustaining the village-level health and related activities of the programmes. This is expected to ensure continuation and replication of the programme. The families in the areas pay a flat collective insurance amount, while the cost of drugs as decided in consultation with village level health committee (*Jan Arogya Samiti*) is recovered through user charge.
- n These health activists are trained to manage majority of the ordinary acute illnesses at the village level, and thus attempt to replace the local quacks. In the remote and tribal areas, it is generally non-literate or semiliterate women who come forward for training. Initial training is for 10-15 days, divided into camps of 3-4 days for the convenience of women, who generally cannot stay away from home for long. This is followed by monthly continuing education meetings/follow-up. Training methods are interactive, with lots of visual aids, group discussions, diagnostic games, quizzes etc. The development of standardised training and health-related materials and manuals in Marathi and subsequently in Hindi, is an important part of this project. Printed posters and pictorial poster exhibitions on health issues for mass education have been prepared and are used extensively in the project. In each area, a trained Community Health Organiser facilitates and co-ordinates the day to day work of the health programmes.
- n The health programme in each area makes an effort to not only ensure access to the first contact care through health activists, but also to generate pressure on existing public and private health services to make them responsive to people's needs.
- n Being embedded in various people's organisations and linked by common guidelines, these programmes have the potential for co-ordinated action and advocacy. Besides providing basic curative care with standard low cost medicines, they also work to advocate key public health issues at a local level and to sensitise people's organisations to the importance of health in the overall social movement. In the *Arogya Yatras* (health march) organised in two areas to raise people's awareness, issues such as gender inequality in reproductive health, exploitative medical practices, the ill effects of addiction, etc. have been taken up. The discussions during the *Arogya Yatras*, also explored the possibility of widening such community health programmes to other areas.
- n An innovative strategy as part of this programme has been the initiation of People's Health Organisations (PHOs) in all the three areas. These are committees, which combine the involvement of

some middle class persons (school and college teachers, salaried employees, socially active urban persons) with representatives of the village health committees, on the issues of health. These PHOs form the implementing agency of the health programme and are the bodies which will sustain the health activity even after phased withdrawal of the project. These form the wider base in civil society for the health initiative, complementing the support from people's organisations while retaining autonomy for this activity.

Project commenced in 1998. Supported by: The NOVIB. Team: Anant Phadke, Abhay Shukla, Amulya Nidhi, Prashant Khunte, Ashok Jadhav.

IV-B. Arogyachya Margavar: Women Centred Community Health and Community Based Response Cell for Survivors of Domestic Violence

This project evolved from experiences while doing research on women's health (see Section III C: Women and Health: C-2. Women and health care in Mumbai), in the slums on Andheri-Kurla road in Mumbai. The study found that for a significantly high proportion of morbidity reported by women, they did not seek health care. There was also an increasing reliance on self-medication due to inefficient public health services and the financial barriers in accessing private care. After the study, CEHAT continued to have close relationship with the community and in the process, it was decided that we should establish the women centred community health project in the slums in that area. Unlike in the *Arogya Sathi* project, there is no people's organisation in this area and hence it is not embedded in an actual movement; it is thus more in the mould of classical community health projects. Began in 1998, it covers 10,000 people and the distinctive features of its strategy are as follows:

- n Selected women from the community are provided with training in primary health care, communication and work in the area of public health. Thus, in three to four years, it would provide us a good understanding of the scope of the work by the Community Health Workers (CHWs) in the urban set up.
- n The CHWs are provided continuous training and clinical support by a clinic in the slum, run by a public health doctor and social workers.
- n While establishing the primary health care work, a study of familial violence in the same locality was started (see Section III-D: Investigation and treatment of psychosocial trauma. D-1. Domestic violence against women). The findings of the study would provide us information on the magnitude of the problem, women's health seeking behaviour and the society's attitude towards domestic violence. The study would thus form the basis for the programme

and support system needed to tackle the issue of domestic violence and would be integrated with the women community health care.

- n The CHW would be further trained to identify, provide primary counselling and help in getting wider support for the survivors of domestic violence.
- n In the process, the clinic providing training and clinical support to the CHWs would also establish a response cell for women in the community. At the same time they would enlist support of the community based organisations and the other agencies such as legal aid groups, women's organisations, government departments, etc. in this work.

The process of establishing women centred community health project was begun in 1998 by identifying nine groups of women in different clusters of the community for general health awareness classes and discussions. These women were also given a basic explanation on health and common ailments, along with home remedies for some of the ailments. From these groups, six CHWS have been intensively trained and placed for regular primary health care work in the community. Simultaneously, linkages have been built up with the nearest public health facilities for referral support.

Project commenced in 1998. Supported by: The John D. and Catherine T. MacArthur Foundation, New Delhi. Team: Ravi Duggal, Ratnaprabha Pedhambkar, Bhavana Kapadia, Mani Mistry, Lalitha D'Souza.

IV-C. Crisis Centre For Women in a Public Hospital in Mumbai

CEHAT's work on human rights, including violence, has always revealed that violence affects the physical and psychological health of survivors and that the survivors often seek care from the health care providers for such and other related problems. Various hospital-based studies have not only confirmed this, but also pointed out at the enormity of the problem. For instance, they show that a very significant proportion of the serious injuries reported by women in the emergency departments of the public hospitals are as a consequence of domestic violence. Although the screening of women reporting at the OPDs (Out Patient Department) and indoor services at the public hospitals have not been systematic, we suspect the incidence of domestic violence among them also to be substantial. Besides, our experiences and findings of various studies show that although women survivors of violence do approach health services in large numbers, the health providers normally fail in identifying them and they do not have any specific system to care for them. Not only that, the services are grossly insensitive and indifferent to the specific needs of the survivors.

From such concerns, and learning from other countries' experiences and our ongoing collaboration with the health department of the Municipal Corporation in Mumbai (BMC), the plan to sensitise the public hospital staff to gender-specific needs and establish a Crisis Centre for women there, emerged. After several rounds of discussion with high-level health officials of BMC, it was decided to visit such Crisis Centres in public hospitals run by women's organisations and by the government in the Philippines and Malaysia. In 1999, such a study tour for four BMC health officials was organised by CEHAT. Later a proposal was prepared and an agreement signed for collaboration with BMC for establishing such a Crisis Centre at the Bhabha Hospital in Bandra West in Mumbai. The distinct features of this strategy are as follows:

- n We would train our staff (counsellors and trainers) and two professionals from the hospitals to establish and run a counselling centre. The centre would provide care to all women directly approaching it and referred to it by other departments of hospitals. The other departments of hospitals would provide their own specialised care to women referred to them by the centre. Besides, at the hospital, temporary shelter for 24 hours to the survivors needing such support would be provided.
- n A training programme for the sensitisation of the health and non-health staff of the hospital would be undertaken. Besides, the hospital staff would be trained to screen the survivors of violence and encouraged to refer such women to the centre.
- n Similar sensitisation training of police personnel, social workers etc. would be carried out. The centre would also train persons from other organisations, with which it would network for providing support and rehabilitation for the survivors.
- n The centre would network with women's organisations, legal aid groups, shelter homes and so on in order to provide support and rehabilitation services.
- n We would also place our staff at the BMC hospital for training and research. Public awareness and preventive campaigns would be undertaken.
- n The programme would be extended to the peripheral institutions of the BMC and to other hospitals in the third year, if found necessary.

This project is likely to commence sometime in the latter part of 2000. After three years, the BMC is expected to run the programme on its own.

Groundwork for the project, done in 1999. Supported by The Ford Foundation.,New Delhi Team: Amar Jesani, Padma Deosthali.

V. SERVICE, DOCUMENTATION AND PUBLICATION

In order to improve the quality of work and to make it useable and relevant for society, it is essential for an institution specialising in research to develop at least two regular activities. One is the systematic development of a specialised library, documentation and a database. This should be disseminated and be made easily accessible. The other is advocacy, teaching and training.

In the field of health there are good reasons for assigning top priority to library, documentation and the database. There is not enough quality library material available at one place in the field of health, particularly, on social science and health. Health data are scattered across numerous documents, are inconsistent and non-standardised, and lots of literature produced by health NGOs is inaccessible.

The services provided by library, documentation, publication and dissemination consume time and material resources. The Anusandhan Trust did not have sufficient material resources to equip its institution, but what it had was a commitment and an understanding of the need. Thus, some trustees and members of the staff donated many books and materials, and also gave lots of voluntary time to organise and run the library and documentation service. What we have today in CEHAT; a library, documentation, database, publication and dissemination unit is a testimony to what could be achieved through voluntary commitment. This unit is now being professionally managed, and in times to come, we expect it to be more proactive in providing more services. The unit is also gearing up to computerising the library, release the CD-ROM containing a new version of the database on health and the software for accessing it, and it is also building a web-site from where the information can be accessed by all those who need it.

V-A. Library and Documentation

CEHAT's library and documentation centre began mainly as a purely voluntary effort. The trustees and other friends donated a large number of books from their personal collection. For long, the books and documents were maintained and the library was run with voluntary effort of the staff. Gradually, the library work has been systematised with the appointment of professional staff. The unit has now around 3000 books, 2500 reports, conference, seminar, workshop papers and reprints and back volumes of selected journals.

There is a continuous effort made to identify new material and add to the existing collection. The collection is rich and contains a specialised selection of literature on health and related subjects. It is envisaged that the library and documentation centre would evolve as a specialized resource centre for health issues. Students, journalists, medical professionals, social workers, lawyers, trainers, activists, development workers, counsellors, are welcome to use the library for reference.

CEHAT library has adopted the Dewey Decimal Classification (DDC) system. Presently the classification system is available in catalogue cards for subject index and in future would have the same in the title and author index format. Efforts are being made to computerise the entire library using the WIN ISIS library package, which would make interaction with other libraries easier.

The library provides various facilities and services to its members. CEHAT has taken institutional membership of the British Council Library, Tata Institute of Social Sciences, International Institute of Population Studies and Centre for Education and Documentation. Photocopying facilities are provided.

V-B. Publications and Dissemination

Recognising that the NGOs do not have adequate outreach, from the beginning we had taken a conscious decision to minimise publication by CEHAT and to encourage the researchers to publish in journals, magazines and books. The main function of CEHAT in this regard was envisaged more for dissemination of material to those who do not have direct access to journals and books. However, in due course of time, we realised that in order to be more effective, we will have to do some of both. While the papers based on the studies do get published in journals, the full reports of the studies do not find a publisher so easily. Given the demand for the report, we started keeping bulk copies of the reports. *So far, over two dozen books, research reports, monographs and investigation reports have been published by CEHAT.*

In addition, CEHAT also supplies the reprints of the papers and essays by the staff published in various journals and magazines. Unpublished papers and essays are also made available to those interested. *So far, the staff of CEHAT has published over 150 research papers, essays, reviews and editorials.* They are available at the publication and dissemination unit of CEHAT.

Health Panorama

Towards the fulfilment of its commitment to gradually establish a clearing-house of information and its dissemination to other organisations and individuals, CEHAT published the first issue of the *Health Panorama* in January 2000. The first issue put together material on violence, under the title, "*Violence: A Health Issue?*" Such publications will now be brought out by CEHAT as and when needed.

The Ford Foundation Publications

In early 1999, all the publications of The Ford Foundation on reproductive health were transferred to CEHAT for distribution. Ten books and monographs, 14 working papers and 9 published papers in this series of Ford Foundation publications are also distributed by CEHAT.

The library, documentation, publication and dissemination are core activities of CEHAT. They are supported by the Anusandhan Trust, the documentation budget in various projects and for last two years also by the institutional grant from The John D. and Catherine T. MacArthur Foundation. Team: Vijay Raut, Vijay Sawant, Margaret Rodrigues, Kotrayya Agadi

V-C. Database on Health

For long, researchers, policy makers, journalists and activists have been feeling despaired about the non-availability of data on health in India at one place. For such data, they need to refer to numerous government, departmental and other documents. The problem is compounded by the fact that health is a state subject, and hence a lot of data needs to be collated from the documents of the states. In order to encourage research, advocacy and activism in the field of health, CEHAT undertook the task of computerising state-wise time-series data on health indicators, infrastructure, human-power and health financing.

In 1998, CEHAT released this database with its own software programme in the DOS environment for accessing and analysing the data. It provides health data (over 500 variables) for the central government and all the states, from 1951 to the latest available, year on two floppy diskettes with a manual, and costs Rs.300. The database is now in Windows environment, making it even easier to use it with user friendly features. Simply clicking on a variable of one's interest, tables could be constructed. To view a trend, or to compare the situation across states,

one could draw area graphs, line graphs, bar charts or scatter plots for meaningful, attractive and appreciative presentations. What more, one can even compute new variables of one's own interest using the basic ones. One can also save newly generated tables and graphs in 15 different formats, export the tables to Word, Excel, Access print directly. Some of the state-wise time series information provided in the database, includes:

- n **General profile:** State's area, number of districts, number of electrified villages, population, sex ratio and rural-urban break-up. The standard of living is expressed in terms of factors such as the average life expectancy at birth, the state domestic product and the number of people living below the poverty line.
- n **Health indicators:** Death rate, infant mortality rate, stillbirth and neonatal mortality rates, causes of deaths, etc.
- n **Health infrastructure:** The number of hospitals, dispensaries, primary health centres, community health centres, medical colleges, nurses training institutions, dental colleges and so on, in a state and in the country, with break up of distribution (rural-urban, public-private).
- n **Health human power:** Doctors (of different systems of medicine) registered with different medical councils, nurses and midwives; pharmacists, nutritionists, other paramedical workers, veterinary doctors etc. Besides, it also provides information available from the census documents on them.
- n **Health finances:** Under the major budget heads of the central and state governments, the data on the government expenditure.

First phase of the project completed in 1998 and was supported by the Actionaid India, Bangalore. The second phase commenced in 1998 and is supported by Anusandhan Trust and The John D. Catherine T. MacArthur Foundation. Team: Sunil Nandraj, Quazi Khabeer Ahmed, Kawaljeet Sethi, Nilanjana Roy.

V-D. Slide Shows and Films

(1) Slide show for AIDS Awareness (in Marathi and other languages)

There has been increasing prevalence of the HIV infection and cases of AIDS in India since the first case was detected in the mid-1980s. Given the social conditions of poverty, seasonal migrations of millions of labourers (15% of adult workforce) from rural area to towns in search of livelihood, crass commercialisation of sex in media and in real life, there is no wonder that the problem is becoming more acute. Thus, the

need contributing to the awareness programme on this problem was pressing. Besides, one important lacuna in the health educational campaign about HIV/AIDS was the lack of a good slide show/poster exhibition, which is sound both from medico technical and social angle. CEHAT therefore, in collaboration with PRAYAS in Pune, prepared such a slide show and promoted its use for building the awareness programme. This set of 75 slides in Marathi was prepared with meticulous professional inputs of doctors, health-educators, social activists, feminists and media experts. It was extensively field-tested. The slide-set contains a range of slides. Different slides are meant for different types of viewers like doctors, health workers, urban and rural people etc. Some are common to many groups.

The slides have been prepared on a computer, so that by just inserting the translated text at appropriate places, different language versions could be prepared. Hindi and English versions are already available. PRAYAS also held a workshop in 1999 to facilitate translations into other languages. A-4 size paper output of each of the slides constitutes the mini 'paper exhibition', which can be used in small groups. A book in Marathi giving more information needed by the health educator, on each of the slides, has also been published. It acts as a resource book for the health educators. PRAYAS continues to hold workshops for health educators, who in turn use this slide-show extensively.

Project completed in 1997. Supported by: India Development Service (IDS), Chicago, USA. Team: Vinay Kulkarni, Sanjeevani Kulkarni, Satish Kulkarni

(2) Vyatha Streechi, Katha Garbhapatachi (in Marathi): (Agony of women, tale of abortion)

Abortion continues to be a tabooed subject despite women's need for abortion care. Given the stigma attached to an act of abortion, women often tend to compromise on quality of abortion care they receive. This naturally exposes them to unsafe and/or illegal abortion care. The State's obsession with population control, commercial interests of the private practitioners, ill-functioning public health care system, etc. contribute to poor quality of abortion care services. Low level of awareness among women about legal provision of abortion care, women's secondary status in society, their lack of power in sexual relationships, poor contraceptive services, etc. obstruct her having access to safe and legal abortion care. There is little educational material available on abortion, which articulates the issue from women's perspective. We, therefore, decided to prepare this set of 53 slides using insights gained from women in rural Maharashtra while doing research on abortion. The slides contain messages with pictorial depiction of various dimensions of the abortion issue in the Indian context. Women and men in the community, health workers, health activists, researchers,

VI-A. HUMAN RIGHTS

VI-A-1. Hysterectomies among mentally challenged women

In 1995, some staff and trustees of CEHAT were actively involved in raising a public debate when hysterectomies were conducted on 17 mentally challenged girls at a state-run institution in Pune district. They also raised the issue through the Forum for Medical Ethics in Mumbai and helped prepare and publicise ethical guidelines for doctors on this subject. In the course of this campaign, we found out how ignorant and uncaring doctors, surgeons, psychiatrists, professional social workers and government officers were towards the disabled and of their rights.

Supported by Anusandhan Trust. Participants: Manisha Gupte, Anant Phadke, Anil Pilgaokar, Amar Jesani.

VI-A-2. Documentation of Violence during Mumbai riots

In 1992-93, when Mumbai was rocked by large-scale communal violence, CEHAT helped a human rights organisation, Solidarity for Justice, prepare and publish a selected documentation of media reports on the violence in the city. Some CEHAT staffers also interacted and worked with the survivors of communal violence. In the course of this interaction, valuable insights were gained into the attitude and role of doctors in situations of violence.

Supported by: Nirmala Niketan, College of Social Work and Solidarity for Justice. Participants: Amar Jesani, Aloysius D'Sa and Mary Alphonse.

VI-A - 3. Human Rights Teaching and Training

Since 1996, CEHAT has been conducting a formal programme of education on human rights and health for the Department Of Civics and Politics at Mumbai University. This is a regular, post-graduate, one-year diploma course. CEHAT has been instructing students on nine topics: (1) Right to health care; (2) Torture; (3) Medical investigation of human rights violation; (4) Violence against women; (5) Patients' rights; (6) Human rights of HIV/AIDS patients; (7) Trade in human organs; (8) Violence against children; (9) International human rights organisations. Sixty students took the course in the first two years, and CEHAT's work has been widely appreciated. Our involvement in this course has made us systematically document

material on human rights, prepare draft outlines for each topic taught, and guide students with their dissertations on human rights issues.

We also helped the University of Mumbai conduct a two-day training workshop in 1999 for doctors on Medical Ethics and Human Rights. Thirty-five doctors – many of them senior functionaries of hospital institutions – participated. Since the first workshop was a great success, we hope to organise several more.

From CEHAT, Dr. Amar Jesani is also recognised by the University of Mumbai as teacher, examiner and guide for dissertation for this course. So far, three students of the course have done their dissertation on health and human rights under Dr. Jesani and used CEHAT library and documentation support.

Supported by: Anusandhan Trust, Department of Civics and Politics, University of Mumbai. Participants: Amar Jesani, Anil Pilgaokar, Neha Madhiwalla, Manisha Gupte, Lalitha D'Souza.

VI-A-4. International Conference on “Preventing Violence and Caring for Survivors: Role of Health Services and Profession in Violence”

The conference held on November 28, 29 and 30, 1998 at Mumbai created space for doctors, nurses and other health workers to interact with activists from feminist, human rights, humanist and other movements. It provided an opportunity for interaction with organisations and individuals outside India who are involved in the pursuit of similar goals. Participants included representatives from Physicians for Human Rights (USA, UK, Israel, Palestine, South Africa), the British Medical Association, International Federation of Health and Human Rights Organisations, as well as treatment centres for survivors of torture in Bangladesh, Nepal, Denmark and so on. Over 225 persons participated in the conference.

In various sessions of the conference over three days, ninety-three papers were presented. Of these, seventy-three written papers were made available in advance while the rest (twenty), were made available as abstracts. The conference focused on four sets (or sub-themes) of human rights issues in health: (1) Violence against women, (2) Caste and Communal violence, (3) Violence by state agencies, and (4) Violence and development, and violence within and by the health system. A wide range of topics were discussed under these four sub-themes such as, the impact of riots on children, the response of doctors to communal conflict, the violence experienced by sex workers and dalits, violence in female wards of prisons, the mental health concerns of families affected by terrorism, role of the examining doctor in sexual assault cases, violence against women in Tajikistan,

corporate violence in Bhopal, the role of nurses in preventing violence and caring for survivors, the role of health services in disaster management and so on.

The inaugural session of the conference was chaired by Justice B. N. Srikrishna, Honourable Judge, Mumbai High Court and was inaugurated by Justice V. S. Malimath, member, the National Human Rights Commission. Ms. Binoo Sen, Member Secretary, the National Commission for Women, Ms. Ann Sommerville, from the British Medical Association, Dr. Adriaan van Es, Secretary General, International Federation of Health and Human Rights Organisations and Mr. Jaap Walkate, Chairperson, UN Fund for Victims of Torture delivered key note addresses at the inaugural session of the conference.

The participants of the conference strongly supported the idea of campaigning and networking on the health and human rights issues. It was also decided that a clearinghouse for the documentation on health and human rights issues should be established in India.

The conference papers are available at CEHAT. A book containing selected papers of the conference will be published soon.

Supported by: Actionaid India, The John D. and Catherine T. MacArthur Foundation, The Ford Foundation, International Federation of Health and Human Rights Organisations. Team: Amar Jesani. Suresh Nair.

VI-A-5 Investigation of Sexual Assault

A team investigating a case of gang rape in a slum in Mumbai in 1990 found gross inadequacy in the medical examination and collection of forensic evidence. Some of us (who later joined CEHAT), had participated in this investigation as members of the MFC (BG). Neither did the doctor record the full medical history nor did he thoroughly examine the survivor. As a consequence, most of the vital medical and forensic evidence was lost. In the discussion with the doctors it was revealed that although they are supposed to do such examinations, they receive inadequate training thus often failing to give them important information and skill. Besides, the official books of forensic medicine studied by them give outdated, sexist and sometimes even misleading information. Above all, it was found that their attitude towards survivors and victims was not at all sympathetic. The survivors were examined as medico-legal cases and hardly any effort was made to regard them as individuals needing care. Counselling, treatment and rehabilitation were not considered part of the work of doctors!

On September 21, 1997, a deaf mute juvenile was raped in a government run Observation Home for Juveniles in Mumbai, by an employee of the organisation. The officials of the Observation Home

did not report the crime for twenty days to the police. However, they did get the victim examined by their in-house doctor, who neither did proper medical and forensic examination, nor followed proper legal procedures. Indeed, the doctor also failed to do the medical examination of and collect forensic evidence from the offender who was present at all times in the premises of the institution. The Forum Against Child Sexual Exploitation constituted a team for the investigation of this case. The members of the team included Sudha Kulkarni (Mahila Dakshata Samiti), Lalitha D'Souza and Amar Jesani (CEHAT), and it was assisted by Sangeeta Puneekar (Snehasadhan), Monica Sakrani, Monisha Coelho (Human Rights Law Network), Vidhya Apte (TDH). After a thorough investigation, the report of the team was released to the media.

The homes for the juveniles (girls below 18 years and boys below 16 years) are expected to provide for the care, protection, treatment, development and rehabilitation of neglected and delinquent juveniles. However, the services provided by the government for the neglected juveniles are grossly inadequate, and the existing juvenile homes are oppressive to children. The situation is reportedly so bad that the children routinely run away from these homes and prefer to live as street children than get exploited in the juvenile homes. After following up few such deaths in the juvenile homes in and around Mumbai, a sensitive social worker, Mr. Kris Pereira filed public interest litigation in the Mumbai High Court. As a consequence, in February 1998, the High Court appointed a commission to look into the conditions of the juvenile homes in Maharashtra. Dr. Lalitha D'Souza from CEHAT was appointed on this commission. The commission visited juvenile homes in different districts of Maharashtra and submitted its report to the High Court.

Supported by: Anusandhan Trust. Participants: Lalitha D'Souza, Amar Jesani, Mani Mistry.

VI-A-6. Manual and kit for physicians examining survivors of sexual assault

On September 21, 1997, a 13-year-old deaf-mute girl in the Observation Home for Children in Umerkhadi, Mumbai, was raped by an employee of the institution. The honorary doctor who examined the girl and recorded the clinical evidence in four lines. Naturally, this medical record was inconclusive - there was no history recorded by the doctor; considering that the girl was deaf and mute, no interpreter was summoned; other than sealing the clothes she was wearing, no forensic specimens were taken; no investigations were ordered; she was never examined again for injuries or infection; no prophylaxis for

pregnancy and STD was offered; the assailant who was on the premises was not examined by the doctor, and certainly no first-contact counselling was offered to the confused child by the doctor.

This case of custodial rape of, a clear case of cognisable criminal offence was lost from the start, thanks to the lack of a methodical and lucid initial medical examination of the survivor and accused by the in-house doctor called upon to do so.

All-India statistics show that successful conviction of the accused is less than 30 % of registered rape cases. Although it is difficult to pinpoint the causes of the low rates of conviction, the role of medico-legal evidence and the value of experienced medical witnesses is considered most significant, for many of the essential ingredients of the offence of rape cannot be proved or disproved without medical evidence.

The examination of survivors of alleged sexual offences is one of the most difficult tasks in forensic medicine. In India, experts such as forensic consultants, police surgeons and gynaecologists are available in the cities. But often, in the villages and small towns – and as in the case above even in a metropolitan city – it is a qualified but inexperienced physician who is asked by the police or courts to examine the woman and the accused. Many qualified physicians just don't know how to go about the examination or present the evidence in court. It is thus possible for a case to be lost not only because of lack of evidence but because the medical witness is inexperienced.

In the absence of any training, the doctor may refer to standard texts. However, standard textbooks on medical jurisprudence tend to be outdated and inadequate on the subject, reflecting a preoccupation with virginity. This is why CEHAT undertook the preparation of a manual for the physician examining a woman for sexual assault. The manual guides the doctor through the requirements and processes of collection of medical and forensic evidence, and follow-up medical treatment and psychosocial rehabilitation. The manual lists the physical and psychosocial effects of sexual assault on women and girls. It defines the purpose of examination, stipulates where it should be conducted and in whose presence. It emphasises the need for consent and preparation of complete record of the history of sexual assault. And it provides guidance on exactly how to conduct the examination. The accompanying kit helps in the actual collection and record of evidence in sexual assault cases.

In performing a medico-legal examination, the physician is performing a public duty and acting on behalf of the State. But this manual stresses that she/he is a care-giver first, entrusted with the responsibility of helping judges understand the physical and mental condition of the woman and offering primary level counselling and referral. Since the

doctor is often the first person the traumatised victim comes in contact with, it is imperative that he treats the woman with sympathy and kindness, and that he does not become instrumental in the secondary victimisation of the survivor in court.

This manual and kit will go a long way in education and training of doctors, helping them improve the quality of medical records prepared for survivors. They will also help activists to investigate sexual assault cases and get justice for them.

Project completed in 1998. Supported by: SWISSAID India . Team: Lalitha D'Souza.

VI-A-7. Health Care as a Right

CEHAT works with the perspective that the state has duty to provide health care to all people. The people in the field areas of CEHAT's projects contribute towards the expenses of first contact care, because support for such work is not available from the government. Efforts are however made to access public resources for this work as much as possible. The following initiatives have been taken in this regard.

- n Accessing government health supplies such as chloroquine tablets, chlorine solution etc. in Dahanu area for use by our health workers on a regular basis.
- n Advocacy for acceptance of health workers as '*Pada Swayam Sevaks*' in Dahanu area by the government health system.
- n Facilitating meetings between representatives of Village Health Committees, Peoples Organisation and government health officials on various aspects of provision of health care. The monitoring by people of the work of health personnel by means of village health calendars and other methods.
- n Orientation of members of Village Health Committees in Dahanu and Ajara area regarding services which can be expected from government health system, especially at village level. A delegation was taken to the Rural Hospital in Ajara to demand these services and to initiate a dialogue with health officials.
- n Participation in the process of 'Peoples Health Assembly' in which the perspective of Health as a Right is being pursued at national and international level.

To further the objective of raising the issue of 'Health as a Right', CEHAT interacts with various People's Organisations (POs). There is regular collaboration with People's Health Organisations in three areas where POs are active and health worker programmes have been initiated.

Besides this, there is dialogue with other POs regarding taking up of health issues and health rights. The underlying perspective is that health issues can be taken up much more effectively in concert with existing movements where people are organised on basic socio-economic issues. Such an approach also ensures greater sustainability to health initiatives compared to situations where there is no local organisation and hence health activities are continuously dependent on external resources.

This campaign for right to health care is facilitated and supported by the team working on the Arogya Sathi project - Anant Phadke, Abhay Shukla, Amulya Nidhi, Prashant Khunte

VI-B. REGULATION OF PRIVATE HEALTH SECTOR

Minimum Quality Standards for Private Hospitals and Accreditation System: An Initiative in Mumbai

An outcome of the accreditation study was the establishment of the Forum for Health Care Standards (FHS) - a voluntary group, which has been meeting regularly since February 1998. The members of this forum include the various stakeholders in the health care system.

Keeping in mind the ground reality and in the absence of standards for the smaller hospitals, the forum felt the need to develop standards for hospitals having upto 10 beds, 10-20 beds and 20-30 beds. The indicators for each were space, equipment and manpower. The forum has evolved standards for wards, labour room, operation theatre, essential drugs, waiting area or reception room, consulting room, changing room, pantry, medical records and waste management for a general hospital with an average of 10-12 beds. It also plans to develop standards for different specialities and super-specialities.

Presently, aspects relating to registration and constitution of this body, status of members, structure and functioning of the body, the process of accreditation and financing are being discussed.

The advocacy for accreditation system and improving quality of health care is facilitated by the research team working on the accreditation project - Sunil Nandraj, Anagha Khot, Sumita Menon.

VI-C. ADVOCACY INITIATIVES TO IMPROVE WOMEN'S ACCESS TO SAFE AND LEGAL ABORTION CARE

CEHAT's continuity in abortion research since 1993 fetched us unique advantages. It made possible for us to interact extensively and in a

focused manner with the two important constituencies, women and abortion service providers. This provided us time and space to develop resource material bringing to the forefront the empirical perspective to be used for abortion advocacy purpose. It also gave us an opportunity to provide a common platform to representatives of various concerned constituencies as regards abortion care.

Our advocacy campaign has been multifaceted and had to be designed to suit the needs of various constituencies at different levels. It involved building awareness on abortion issues, identifying larger issues concerning improvement of the quality of abortion care services and their expansion, inviting state-level consultations to generate a discourse on them, lobbying with the concerned constituencies, and advocating legislative amendments which would facilitate the procedure of MTP registration.

In any advocacy campaign, bringing various stakeholders on a common platform is a prerequisite to initiate dialogue among the representatives of the stakeholders who are to impact the various policy processes. Developing such a common platform provides them space to share their views on the issues at hand. It also facilitates in arriving at some minimum common agenda, which could be fought for in a united manner. This is also to recognise, appreciate and debate with the stakeholders, specific agendas and their consequences for the community at large and specific groups, for instance, women in the context of abortion.

To reach this stage, a range of other activities need to be taken up to prepare the groundwork. These strategies would differ issue to issue and from one context to the other. The strategies that we followed are the following:

- (1) Understanding the present abortion policy and legislations, their implications for women's health and doing a critique of it.
- (2) Undertaking women-centred community based research to understand the issue from their perspective.
- (3) Undertaking abortion care facility based research to understand quality of abortion care. These are described at length under Women and Health section.
- (4) Developing resource material to be used for advocacy purpose. For this, we prepared a slide set and a booklet in Marathi. Short notes on these are presented elsewhere in this report.
- (5) Undertaking activities, such as, dissemination and education. This we achieved by writing in popular press, both, in Marathi and English and by writing in academic journals. Presentations and writing in the mass media were to create awareness, educate people on the issue and to help form public opinion on the issue.
- (6) Developing a common platform to provide space to the representatives of the concerned constituencies. This required conducting workshops at the local level and inviting state level

VII-A. UNIVERSITY AND ACADEMIC INSTITUTIONS

1. University of Mumbai

Since 1996, CEHAT has been collaborating with the Department of Civics and Politics at the University of Mumbai in teaching courses, examination and guidance for preparing dissertation by students for their post-graduate diploma course on human rights.

2. Tata Institute of Social Sciences, Mumbai

The staff of CEHAT has been collaborating since 1994 with various departments of TISS as visiting faculty. A researcher is on the advisory committee of its Health Studies Centre and recognised as guide for students doing dissertation on medical ethics/legislation for the post-graduate degree of Masters of Health Administration the Department of Health Service Studies. In December 1999, a joint course in Epidemiology was organised for staff of CEHAT and TISS.

3 Nirmala Niketan (College of Social Work, Mumbai)

CEHAT researchers collaborate mainly as visiting lecturers; they also help students doing research in the field of health.

VII-B. GOVERNMENT AND POLICY MAKING BODIES

1. Brihanmumbai Municipal Corporation (BMC)

Since 1996, CEHAT has had an active interaction with the BMC public health department. CEHAT researchers have provided consultation to the BMC on their women centred health project, have collaborated with the BMC in beginning a process to set up crisis centre in a public hospital to treat victims of violence and provide them temporary shelter.

2. Central and State Governments

Collaborating with Ministries of Health and Family Welfare at both the central and state levels as resource persons and advisors on issues related to health policy and planning, health financing, quality and standards of health care, health insurance, legislation for the health sector etc. CEHAT was also represented in the subcommittee on Health Financing and Planning for the Ninth Five-Year Plan.

VII-C. NETWORKS AND FEDERATIONS

1. Health Watch, India

Post-Cairo (ICPD) CEHAT along with other organisations founded the Health Watch, a national network. In 1997-98, CEHAT in collaboration with Health Watch organised the western regional consultation with various NGOs, activists and state officials from the health sector to review the target free approach and the RCH program of the government.

2. International Federation of Health and Human Rights Organisations (IFHHRO)

Since 1995, CEHAT is member of this international federation comprising of the Physicians for Human Rights and other groups from different parts of the world and having its secretariat in the Netherlands. The IFHHRO actively collaborated in the International Conference organised by CEHAT in November 1998.

3. IRCT (International Council for the Rehabilitation of Torture Victims)

The IRCT networks over 70 treatment centres for victims of violence in different part of the world, and CEHAT contributes in this effort by participating in their campaigns and by providing research inputs.

VII-D. NGOs, PROFESSIONAL ASSOCIATIONS AND OTHER ORGANISATIONS

1. MASUM, Pune

A joint effort is on way by CEHAT and MASUM to address the issue of violence against various sections of society – women, aged, children, minority communities and the disabled. Working groups were set up to look into how these issues could be addressed. This would lead to bringing out a manual, which would serve as a useful tool for advocacy.

2. VACHAN and Abhivyakti, Nashik

For our research work, in Nashik district, CEHAT was provided excellent support by both these organisations. Some of their members also provided guidance to the research team by being on the ethics committee of the project.

3. The Foundation for Humanisation

This foundation and its journal have constantly helped in the dissemination of the views of CEHAT staff on various health issues.

4. Society for Public Health Awareness and Action (SPHAA)

The SPHAA provided guidance and inspiration for our work, and also actively collaborated in putting together material for the joint publication (book), *“Market, Medicine and Malpractice”*.

5. People’s Health Organisations

In three places (two in Maharashtra and one in Madhya Pradesh), CEHAT is facilitating the work of People’s Health Organisations and networking with them for a campaign on people’s right to health care.

6. Associations of Medical Professionals

We have increasing interactions and partnerships with various bodies of medical professionals. Some of them are:

- n The Forum for Medical Ethics Society
- n The Indian Medical Association (Mumbai Suburban West Branch)
- n The Nursing Home Owners Association and Association of Hospitals in Mumbai
- n The Forum for Health Care Standards
- n The Consultants’ Association, Mumbai

The issues for collaborative work include education in medical ethics, developing accreditation systems and standards for quality care.

7. PRAYAS, Pune

In collaboration with PRAYAS in Pune, CEHAT prepared a slide show and promoted its use for building the awareness programme towards HIV/AIDS.

8. Forum Against Child Sexual Exploitation (FACSE), Mumbai

As a part of its work on the violence, the CEHAT associated with the FACSE, and with them, undertook the investigation of sexual assault on a deaf and dumb girl in a government run juvenile home in Mumbai.

9. India Centre for Human Rights Legislation (ICHRL)

We have collaborated and worked together on the subject of health laws and human rights.

VIII. SOCIAL ACCOUNTABILITY

The Founding Principles of the Institutions of the Anusandhan Trust demand that its institutions (CEHAT) should not only be socially committed and democratic but should also undergo a social audit, the findings of which should be made public. We appointed a Social Accountability Group (SAG) in 1995. The senior and eminent members of the SAG, along with the trustees made sincere efforts to evolve a simple and adequate methodology for social audit. The process followed was as under:

- (a) The SAG observed the work of CEHAT for a specific period. It was not brought in as only as evaluator/reviewer, but also watched the events as they developed.
- (b) In this period, CEHAT provided the members of the SAG all information - all publications, all reports, all financial statements, all minutes of the trust meetings and the staff meetings, and information on grievance redress and debates within the institution and amongst the trustees. In short, by being very proactive in supply of information, CEHAT expressed its intention of complete transparency to the SAG as well as to the staff and others interested in the work of the institution.
- (c) Conscious efforts were made to ensure that the members of the SAG were able to interact with the members of the staff and trustees as often as possible. The SAG members were invited for all meetings of the staff, and the seminars and conferences organised by the institution.
- (d) The SAG had full autonomy to design its own methodology for review of the work of the institution, and the data collection tools adopted by them were fully complied with by the individual staff members and the project teams.

What follows are: (1) The report by the SAG, and (2) the report on action taken by CEHAT on the SAG report.

VIII-A. REPORT OF THE SOCIAL ACCOUNTABILITY GROUP

The Social Accountability Group (SAG) that received the work of CEHAT for the period April 1994 - March 1999 (five years) consisted of the following persons:

For the review of the period April 1994 to March 1999 (five years), the SAG consisted of the following persons:

- (1) Dr. S. L. Shetty. Director, EPW Research Foundation, Mumbai.
- (2) Prof. Neera Desai. Director (Rtd), Research Centre for Women's Studies, and Head (Rtd.), Department of Sociology, SNDT Women's University, Mumbai.
- (3) Dr. Sunil Pandya. Head (Rtd.), Department of Neurosurgery, KEM Hospital, and Editor, *Issues in Medical Ethics*, Mumbai.
- (4) Dr. Ravindra Soman. Deputy Director (Retd.), National Institute of Virology, and Secretary of Lok Vigyan Sanghatna, Pune unit.
- (5) Dr. Ashwin Patel. Director, Trust for Reaching the Unreached (TRU), Vadodara, Gujarat.

The review by the SAG was facilitated by Dr. Mohan Deshpande. The following is the report completed by the SAG in 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 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:

- n 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).
- n Processes involved in operationalising the research programme.
- n 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:

- n To conduct research and action research on topics of importance or interest from the point of view of people's movements.
- n 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.
- n 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 part of the SAG members and partly due to inability to evolve the *modus operandi* 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.

- n A number of SAG meetings at CEHAT office.
- n Reports of Staff meetings.
- n Minutes of Trustees meetings.
- n Document containing rules and regulations of CEHAT.
- n Meetings with the staff at Khandala.

- n Reports of WG (Working Group).
- n Auditors' reports.
- n Report of evaluation of the Co-ordinator of CEHAT.
- n Workshops organised by CEHAT.
- n 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 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 its findings for the disadvantaged.

So far as the use of outcomes of various projects is 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:

- n Clear personnel policy.
- n Delegation of power and responsibilities to the WG (Working Group) which also has many powers of decision-making.
- n Grievances redress forum.
- n Decision making systems and processes are outlined without ambiguity.
- n Responsibilities of individuals and teams are specified.
- n Methods of evaluation of the members and teams have been clearly outlined.
- n Information sharing with SAG (an outside group) and the WG (inside group) remarkably efficient.
- n Evaluation of the functioning of the Co-ordinator of CEHAT.
- n 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 issues 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.

VIII-B. ACTION TAKEN REPORT

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 unlearned 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 regards 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. The research skill development through an epidemiology workshop was done last month 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.

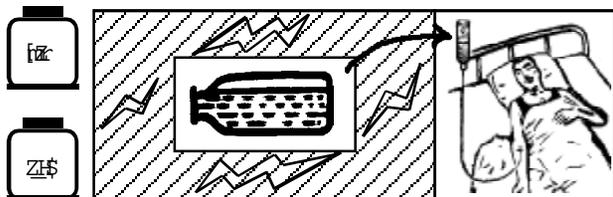
4. For reaching out to people, apart from the dossiers mentioned above, strengthening of CEHAT library is high on our priority list. We have offered our infrastructure for becoming a clearing-house for information and documentation on issues of public concern in health. We have set up a web-site also 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. 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 income 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

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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.

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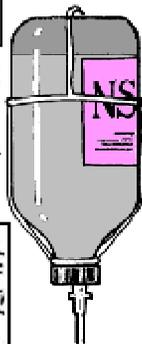
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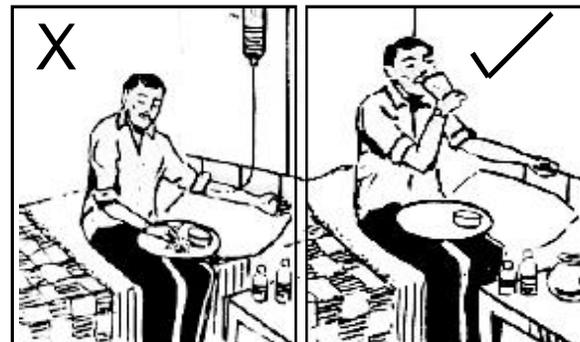
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IX. ORGANISATIONAL STRUCTURE AND FUNCTIONING

Institutionalising democratic structures and processes in an institution among “members” who are otherwise paid employees, is a very difficult task. Such “voluntary” institutions are dependent upon external funds (government, private, voluntary, foreign), and are governed by a complex set of laws. They create major stakes in terms of moveable and immovable properties, credibility and careers. This is more so in a broad-based research institution like CEHAT. Indeed, most of the established education/research institutions (of the ICMR/ICSSR, Government, University, Medical Colleges) are structured hierarchies and command systems. Therefore, the experiment in democratic functioning by CEHAT has demanded extra-ordinary efforts on the part of the staff and the trustees, and there is always a possibility that such a system would collapse in the event of slackening of the effort.

Institutional democracy integrates rights and responsibilities. The very process of exercising the right creates the need to discharge responsibilities. There is no external body running the institution. The democratic right is to self-govern the institution within the prescribed boundaries (legal, administrative and the founding principles). This demands preparation on the part of the staff as well as the co-ordinator and trustees. Any irresponsible self-governance by the staff could affect livelihoods of colleagues and survival of the institution. Thus, the success of the system depends on the fine balance maintained between rights and discharge of responsibilities. It also depends upon the balance between the processes for empowerment and mutual evaluation and check.

The live experiment of this kind is relatively recent, constantly evolving and gathering experience.

An Experiment in Democratic Functioning

Organisationally CEHAT has grown from an informal set up into a relatively large institution, which is managed by its staff in a democratic and participatory way. As on March 31, 2000, CEHAT had a staff strength of 32 persons.

The Trustees of the Anusandhan Trust constitute the governing board of CEHAT. The Trustees are responsible for the overall vision and mission of CEHAT and provide guidance, act as a sounding board and the final authority for the redressal of grievances, and intervene if there is a crisis. The Managing Trustee of Anusandhan Trust devotes some time to oversee the administrative matters impinging on the Trust as well as provides advice and inputs to CEHAT team when called upon to do so. Similarly individual Trustees involve themselves with the work of CEHAT which is of direct interest to them and also provide advice and guidance to the researchers and administration when called upon to do so.

The institutions are known for the kind of people they have and the work they do. Therefore, the Staff is the biggest asset of CEHAT. The democratic structure and functioning are impossible to achieve without the active participation of the staff in the decision making and work. Institutional democracy is not merely rights, but it is the right in order to perform a duty. The success of such responsible democracy also demands sensitivity, training of all individuals in such work and above all a sense of solidarity. The staff, therefore, need to transform themselves from disparate project based groups within an institution to a collective working in co-ordination and in solidarity for achieving the institutional objectives through the execution of their projects.

The entire staff of CEHAT meets twice in a year, away from the office. One of the two meetings is chiefly devoted to staff training. The first formal meeting of the staff was organised in 1996, and since then the staff meetings have become important for debating and evolving new proposals for methods of functioning and ideas for work. The rules governing the staff, the salary structure, etc. are first shaped and re-shaped in the staff meetings before the Trust decides on them after having a joint meeting with the WG.

The Working Group (WG) is about one-fourth the staff strength of CEHAT. The first one and half years after CEHAT was established on April 1, 1994, when the total staff strength was only seven to nine individuals, the processes were more participatory but with centralised decision making powers vested in the Co-ordinator. In October-November 1995 it was decided to constitute the WG by inviting the interested individuals from the staff to volunteer for participation in the monthly meetings. The first meeting of the WG took place on December 4, 1995 and three members of the staff and Co-ordinator

attended it. From December to April (five meetings), the WG meetings were kept open for all staff without naming anybody as formal member of the WG. These meetings also evolved the role and responsibility for the WG members. In this period, the individuals were required to understand the responsibility and then decide whether they would like to take formal membership. On May 3, 1996, four volunteers from the staff and the Co-ordinator formally constituted the first WG of CEHAT.

The WG, so evolved with the voluntary commitment and participation of some members of the staff, underwent transformation on December 1- 2, 1997 in a meeting of the staff at Khandala. This was brought about by discussions over a period of six months within the WG and individuals of the staff on making the WG membership, an elected post. Accordingly, the general body of the staff formulated criteria for WG membership and framed rules for the election to WG; they also elected six members of WG through secret ballot. Since then, one third of the members of the WG retire every year and their posts are filled up through election. The retiring member(s) could be re-elected. The Co-ordinator is an ex-officio member of the WG, and thus not elected.

At present there are eight members including the Co-ordinator. Within the Working Group, responsibilities are distributed amongst members. For instance, each member is assigned at least one project or unit (one on which they do not work) to oversee. The Working Group meets once a month and reviews all projects/units/activities, discusses problems, decides on actions, reviews personnel and administrative matters and takes relevant decisions for implementation. The Working Group is also responsible for staff recruitment, staff evaluation and redressal of grievances. The Working Group's structure and functioning is still evolving and as staff capacities develop, other responsibilities which are presently centralised in the Co-ordinator will also be devolved, especially administration and financial management. To facilitate this process, the Trustees are committed to support an Organisation Development initiative during the latter half of the year 2000, which will involve all staff.

The overall responsibility vests in the Co-ordinator, as s/he is CEHAT's face to the outside world. However, a number of senior as well as junior researchers are increasingly representing CEHAT. The Co-ordinator also promotes this process.

The Anusandhan Trust appoints the Co-ordinator of CEHAT. The Co-ordinator, along with the Working Group, has full responsibility for the development of the institution, achievement of its goals and the co-ordination of work and management of CEHAT. The Co-ordinator has thus double accountability, to the Trust or Governing Board and to the Working Group. The Co-ordinator has decision-making and

implementing powers and at the same time those powers are circumscribed and regulated.

In early 1999, due to the expansion of work, increase in number of the staff members and the projects, and due to the increasing responsibility of the Co-ordinator, the Trust and the WG jointly decided to appoint two Joint Co-ordinators to assist the Co-ordinator. Besides, it was expected that the joint co-ordinators would learn the work of the co-ordinator and make it easier in future for the rotation of co-ordinatorship. Accordingly, in July 1999 one joint co-ordinator was appointed. However, unfortunately, this initiative was short-lived, as in September 1999 the joint co-ordinator resigned from CEHAT due to differences. CEHAT looks at this as a learning experience.

In principle, CEHAT believes in evolving collective leadership for the institution. This is easier said than done. Since 1997, when the first Co-ordinator of CEHAT completed three years' term, we have been making efforts to rotate the Co-ordinatorship. But being a fast growing young institution, it is having shortage of experienced persons; and the tempo of its growth and the amount of work demanded were discouraging individuals from taking over the responsibility of the co-ordinator. Ultimately, one of the trustees had to come forward for the first change over in November 1999. We are making efforts to ensure that periodic rotation of Co-ordinatorship gradually becomes a norm at CEHAT.

CEHAT's functioning has some other unique features. We have an independent, external Social Accountability Group comprising of socially committed people who independently review CEHAT's work in the context of Anusandhan Trust's and CEHAT's objectives and mission. The first report of this group and the action taken report are reproduced in the previous section.

Further, for all research projects, CEHAT appoints a Consultant Committee and for research involving human participation, also an Ethics Committee. Apart from this, CEHAT has an internal scientific committee comprising its senior researchers, and is called the Peer Review Committee. This committee reviews all research, training and advocacy work periodically and provides feedback and a critique to the research/project teams.

Finally, the performance of each staff member is reviewed annually through a well-defined evaluation process, which is participatory in nature. The participatory performance evaluation was introduced in CEHAT by the staff and CEHAT from April 1996. The evaluation involves self-evaluation, co-worker feedback and an interview with a panel appointed by the Working Group. The result of the evaluation is communicated to the candidate and submitted to the Working Group for action. The Working Group on the basis of the recommendations of

X. SOURCES OF FUNDING AND EXPENDITURES

The issue of external funding by voluntary agencies working with people has been highly contentious in India. At one extreme are those who believe that such agencies should be financed only by the members or by those for whom they are run, and thus rule out any external funds, Indian or foreign. At another extreme are those who just do not care for the character of the source. The funding of institutions, on the other hand, has been less talked about, though all the contentious issues equally apply to them. Traditionally, the chief source of their funds is from the government. Even the NGO-kind of institutions, have ultimately sought recognition from national government bodies (e.g. ICMR, ICSSR, etc.) and the state government support in order to survive/sustain and develop organic linkages with the academia. However, most of them do accept project-based non-government funding from corporate sector or foreign sources.

Anusandhan Trust has also gone through a very long and heated debate on the issue of sources of funds. The debate still continues and it has also been raised in the report of the Social Accountability Group. Evidently, a large proportion of CEHAT's grants are from foreign sources, the share of Indian sources being very small. This is also a reflection of the priority that the government and private Indian sources accord to health research in general, and to social science research in health in particular.

CEHAT began as an exclusively project-based institution. With almost negligible institutional funds, it had to work very hard to ensure that its internal priorities for research were not overshadowed by the individual projects and their different funding sources. Besides, it also had to ensure that multiple project based staff integrated in one unit, with loyalty to the institution and its objectives and not only to the project. Indeed, the future financial stability of CEHAT would depend upon how the proposals made in the Action-Taken-Report (response to SAG report) are implemented; and whether the transition from project-based to partial institutional or research programme based funding is made in the near future.

Financial Profile of Anusandhan Trust

From 1991 onwards Anusandhan Trust began with a lot of small voluntary initiative from its Trustees and other friends. Between 1991 and 1994 Trustees and friends donated over 1500 books and an equal number of reprints, and some basic furniture. One of the trustees even provided rent-free premises to house the office of the trust and CEHAT. This facilitated limited voluntary research work and action by trustees and friends and a number of publications were also generated. This initial involvement led to the fruition of CEHAT as the research centre of Anusandhan Trust.

The first grants in fiscal 1994-95 came from both private foundations and public agencies. In subsequent years donor NGO support became a larger component of Anusandhan Trust's resources, even though private foundations continued to be the largest donors averaging two-thirds of resources received by the Trust. The Trust's own fund is very limited as of now and is adding on gradually with the objective of taking on activities which would not be project based. The Trust is concerned that its corpus must increase substantially and for this special efforts would be needed. What is heartening to note is that a number of CEHAT staff have imbibed the culture of volunteer work and a number of small "projects" are carried out with volunteer time of staff, and this does not get reflected in the data and graph below! (Graph : 1 & Table : 1)

Graph 1: HOW ARE WE SUPPORTED

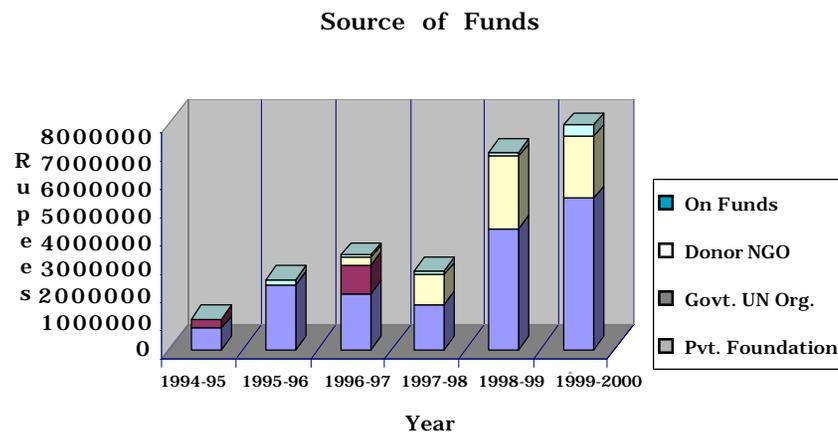


Table: 1. ANNUAL RECEIPTS (Rs.)

	1994- 95	1995-96	1996 -97	1997- 98	1998 - 99	1999-2000
Private Foundations	711660.15 (64.9%)	2232614.20 (90.1%)	1943326.37 (58.7%)	1576765.55 (57.0%)	4273000.33 (61.8%)	5293753.30 (67.1%)
Govt. and UN organisations	362000.00 (33.0%)	40000.00 (1.6%)	1027164.00 (31.0%)	0.00 (00.0%)	0.00 (00.0%)	0.00 (00.0%)
Donor NGO	0	0	230000.00 (6.9%)	1048416.00 (37.9%)	2497822.80 (36.2%)	2194098.00 (27.8%)
Own funds	23234.75 (2.1%)	205030.75 (8.3%)	111801.00 (3.4%)	141999.00 (5.1%)	137396.00 (2.0%)	401481.00 (5.1%)
TOTAL	1096894.90 (100%)	2477644.90 (100%)	3312291.37 (100%)	2767180.55 (100%)	6908219.13 (100%)	7889332.30 (100%)

In terms of resource use we have organised the expenditures on the basis of RASA:

Research - Research both primary and secondary, including research seminars and Workshops.

Advocacy - Campaigns, education and information dissemination, and meetings, workshops, symposia for advocacy.

Services - Information centre, library, documentation, database, website etc.

Action - Training and Services in the field including action research and intervention programs.

Overheads - utilities, infrastructure support, admin salaries, rent, office expenses etc.

Capital - Computers, equipment, furniture etc.

Research has been the single largest area of resource use which increased from 43% in 1994-95 to 54% in 1997-98, but subsequently as other components got strengthened, especially advocacy, the proportion of expenditure on research has declined to 36% in fiscal 1999-2000. Administrative costs and overheads, which are basically support costs to the research and other programs and include infrastructure support, started at a fairly high level but are getting consolidated between one-fifth and one-sixth of the Trust's total expenses. In a sense since fiscal 1999-2000 RASA is getting consolidated.(Graph: 2 & Table: 2)

Graph: 2. PROFILE OF EXPENDITURE 1994-2000

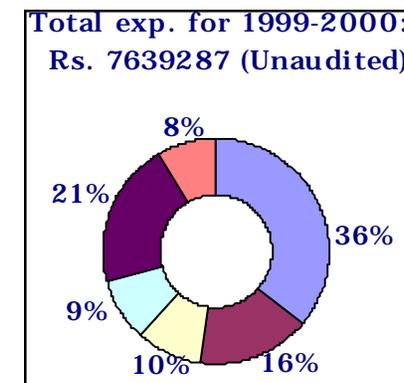
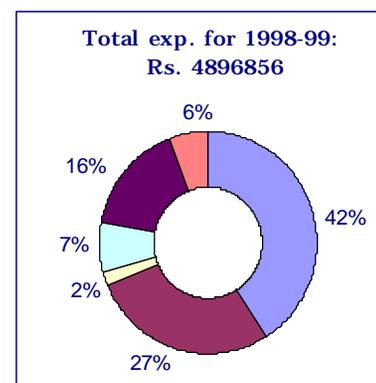
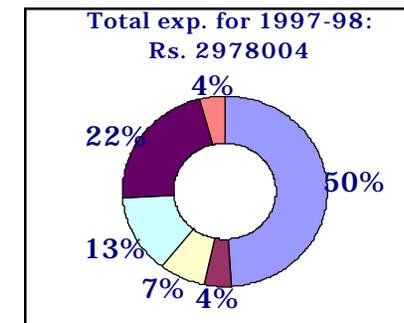
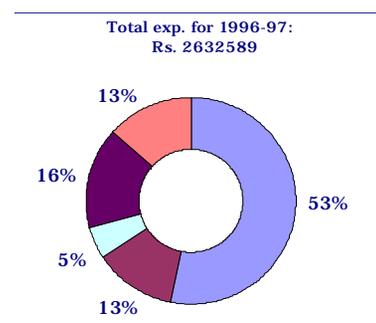
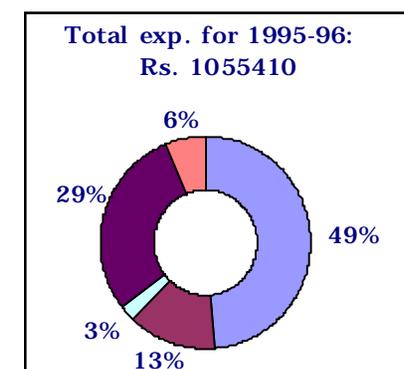
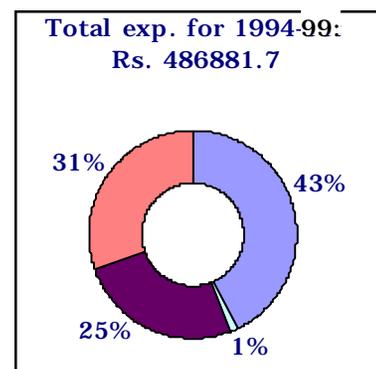


Table: 2. SUMMARY OF HOW RESOURCES ARE USED (Rs.)

	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000
Research	209262.05 (43.1%)	514175.00 (48.7%)	1396148.00 (53.0%)	1458029.00 (49.0%)	2017775.85 (41.2%)	2749572.80 (36.0%)
Advocacy	0	140434.00 (13.3%)	335991.15 (12.8%)	131348.50 (4.4%)	1342962.90 (27.4%)	1232875.70 (16.1%)
Training / Service	0.00 (00.0%)	0.00 (00.0%)	0	217357.10 (7.3%)	110685.00 (2.3%)	736810.90 (9.7%)
Information Center	5939.00 (1.2%)	29602.50 (2.8%)	133707.70 (5.1%)	390101.55 (13.1%)	354053.25 (7.2%)	664093.50 (8.7%)
Over-heads and admin	122799.65 (25.2%)	306576.00 (29.1%)	415306.30 (15.8%)	665042.90 (22.3%)	788992.25 (16.1%)	1612687.20 (21.1%)
Capital Expenses	148881.00 (30.6%)	64622.00 (6.1%)	351434.90 (13.3%)	116125.00 (3.9%)	282387.00 (5.8%)	643247.20 (8.4%)
Total	486881.70 (100%)	1055409.50 (100%)	2632588.05 (100%)	2978004.05 (100%)	4896856.25 (100%)	7639287.30 (100%)

Expenditures by line items is given in the table and below. Salaries on average constitute less than half of the expenditure, and infrastructure support and materials about two-fifths. The table is self-explanatory. (Graph: 3 & Table: 3)

Graph: 3. LINE ITEMWISE EXPENSES

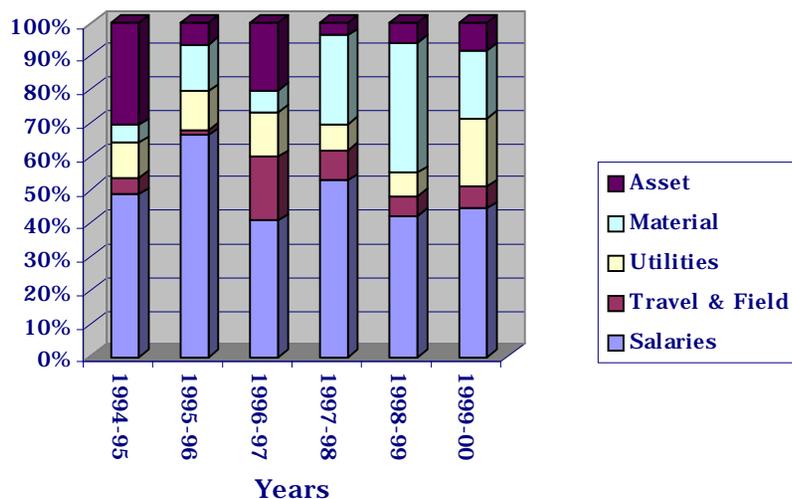


Table: 3. SUMMARY OF LINE ITEMS EXPENSES (Rs.)

	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00
Salaries	236093.00 (48.5%)	700819.00 (66.4%)	1071141.00 (40.7%)	1566713.00 (52.6%)	2064528.50 (42.2%)	3382320.80 (44.3%)
Travel & Field	24336.95 (5.0%)	13494.10 (1.3%)	504165.90 (19.2%)	273546.40 (9.2%)	293186.85 (6.0%)	511750.45 (6.7%)
Utilities	50812.00 (10.4%)	125617.50 (11.9%)	351884.85 (13.4%)	233302.25 (7.8%)	342262.00 (7.0%)	1576237.10 (20.6%)
Material	26758.75 (5.5%)	148283.10 (14.0%)	168689.00 (6.4%)	787717.40 (26.5%)	1914491.90 (39.0%)	1525731.75 (20.0%)
Asset	148881.00 (30.6%)	67196.00 (6.4%)	536707.30 (20.3%)	116725.00 (3.9%)	282387.00 (5.8%)	643247.20 (8.4%)
Total	486881.70 (100%)	1055409.70 (100%)	2632588.05 (100%)	2978004.05 (100%)	4896856.25 (100%)	7639287.30 (100%)

We thank the following organisations for providing financial support:

- Actionaid - India, Bangalore
- Citicorp, Mumbai
- Centre for Victims of Torture, Nepal
- ENGENDER, Singapore
- The Ford Foundation, New Delhi
- Government of India, New Delhi
- Independent Commission for Health in India (ICHI), New Delhi
- India Development Service, Chicago
- International Federation of Health and Human Rights Organisations (IFHHRO), the Netherlands
- The John D. and Catherine T. MacArthur Foundation, Chicago
- NOVIB, the Netherlands
- The Rehabilitation Centre for Torture Victims, Copenhagen
- Research Project on Strategies and Financing for Human Development, (Government of India and UNDP)
- SWISSAID - India, Mumbai
- The World Bank - New Delhi
- World Health Organisation (WHO), Geneva

XI. STAFF PROFILE AND TRUSTEES

Regular Paid Staff

Present Staff (As on March 31, 1999)

32 (17 Females, 15 Males)

(Average duration of work at CEHAT: 23.3 months)

Professionals (Research and Action Projects)
(10 Females, 7 Males) (Average duration: 24.1 months)

1. Abhay Shukla	M.D. (Public Health)	(From October 1998)
2. Amulya Nidhi	M.S.W. (Social Work)	(From October 1998)
3. Anagha Khot	M.A. (Social Work)	(From June 1997)
4. Anant Phadke	M.B.B.S.	(From October 1998)
5. Bhavana Kapadia	M.S.W. (Social Work)	(From April 1999)
6. Madhuri Sumant	B.Sc.	(From January 1998)
7. Nilanjana Roy	M.A. (Economics)	(From January 2000)
8. Padma Deosthali	M.S.W. (Social Work)	(From April 1998)
9. Prashant R Kunte	M.S.W. (Social Work)	(From January 1999)
10. Quazi Khabeer A.	M.C.A (Computer Appl.)	(From Nov 1996)
11. Ratnaprabha Pedhambkar	M.D. (Public Health)	(From Sept. 1999)
12. Ravi Duggal	M.A. (Sociology)	(From Nov 1999)
13. Shelley Saha	M.A. (Social Work)	(From August 1999)
14. Sumita Menon	M.A. (Social Work)	(From June 1997)
15. Sunil Nandraj	M.A. (Social Work)	(From May 1994)
16. Sunita Bandewar	M.Sc.(Anthropology)	(From Nov 1994)
17. Tejal Barai	M.A. (Political Science)	(From May 1999)

Investigators and Assistants:

(2 Females, 2 Males) (Average duration: 9.75 months)

1. Ashok Jadhav	—	(From Nov. 1998)
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Library and Publication:

(1 Female, 2 Males) (Average duration: 33.3 months)

1. Kotrayya Agadi	B.Sc. M.Lib.Sc. (Library Science)	(From Sept. 1999)
2. Margaret Rodrigues	B.Sc.	(From Sept. 1997)
3. Vijay Sawant	S.S.C. (10 th Standard)	(From Feb. 1995)

If "Small is beautiful", then is big ugly and unmanageable? New institutions necessarily debate this question, and CEHAT was no exception. After experiencing problems of small size in the first four years, CEHAT is experiencing problems of having a big size in the last two years. One thing is certain, the institutionalised democracy needs a size of more than 10 individuals to ensure that time demanded by processes does not bog down the institution. Bigger and expanding size on the other hand demand more attention to perspective building and integration of the staff in the institutional processes. So it is not the size alone, but there are other more important factors, which decide whether the growing institution would lose its basic ethos or strengthen it.

As on March 31 2000 thirty-two individuals were working as regular paid staff at CEHAT. The number would increase beyond 40 or so before the year 2000 ends. Over half of the staff (53%) is of professionals directly involved in research and action/intervention works. In addition, there are professionals too in the support staff (library and administration). Over half (53%) of the staff consist of women, , while among professionals directly involved in research and intervention works, nearly three fifth (59%) are women. Besides, main administrator and accountants are women. Since CEHAT has grown in the last two years, naturally a bulk of the present staff is new. In fact two third (21 out of 32, 65.6%) of the present staff joined CEHAT only after April 1998. However, despite that, the present staff has worked at CEHAT on the average two years (23.3 months). Indeed, seven (22%) of them joined CEHAT in its first three years.

Statistically, we had a fairly good turnover of staff as 25 persons joined and left in last six years. However, CEHAT has not "lost" most of them to "higher bidders". Nearly two fifth (about 10) of them were recruited for only short-term (less than 9 months) project work.

Administration:*(4 Females, 4 Males) (Average duration: 24.4 months)*

1. Anirban Bose	B.Com.	(From August 1999)
2. Dattatraya Taras	B.Com.	(From Feb. 2000)
3. Devidas Jadhav	S.S.C.	(From July 1999)
4. Kiran Mandekar	12th Std.	(From July 1996)
5. Ruma Bhowmick	B.Com.	(From August 1999)
6. Rozina Virani	9 th Std.	(From Oct. 1999)
7. Saramma Mathew	B. Com., L.L.B	(From July 1994)
8. Sanjana Bhingarde	B.Com.	(From Feb. 1999)
9. Shobha Kamble	5th Standard	(From December 1999)
10. Sneha Fulambrikar	M.Com.	(From August 1996)
11. Vikas Gamre	12 th Standard.	(From August 1999)

Regular Staff Who Contributed and Left: 25*(17 Females, 8 Males) (Average duration of work at CEHAT: 19.2 months)***Professionals (Research and Action Projects)***(12 Females, 3 Males) (Average duration: 23.7 months)*

1. Amar Jesani	M.B.B.S	(April 1994-October 1999)
2. Asha Pol	M.B.B.S.	(April 1999-June 1999)
3. Asha Vadair	B.A.	(June 1994-August 1995)
4. Aspi Mistry	B.Sc.	(Feb. 1999-August 1999)
5. Hemalata Pisal	M.Sc. (Anthropology)	(January 1995-March 1999)
6. Kawaljeet Sethi	B.Com, L.L.B.	(Nov. 1996-Dec. 1997)
7. Lalitha D'Souza	M.B.B.S.; D.C.H. (Paediatrics)	(August 1997-Feb.1999)
8. Mani Mistry	M.S.W. (Social Work)	(Nov. 1997-August 1999)
9. Manisha Gupte	M.Sc. (Microbiology)	(April 1994-April 1997)
10. Mugdha Lele	M.Sc. (Health Sciences)	(July 1996-September 1998)
11. Neha Madhiwalla	M.A. (Social Work)	(February 1996-March 2000)
12. Rohini Lele	M.A. (Sociology)	(Dec. 1998-March 1999)
13. Roopashri Sinha	M.A.;M.Phil. (Political Science)	(February 1996-Feb 1998)
14. Sharadini Rath	Ph.D. (Physics)	(July 1998-August 1999)
15. Suresh Nair	M.A. (Social Work)	(Sept. 1998-Jan. 1999)

Investigators and Assistants:*(2 Females, 1 Male) (Average duration: 8.3 months)*

1. Anand Utekar	12 th Standard	(October 1994-June 1995)
2. Mangala Lakhan	12 th Standard.	(June 1997-October 1997)
3. Sunita Parab	M.A	(June 1997-August 1997)

Library and Publication:*(1 Male) (Average duration: 10 months)*

1. Sandeep Mohite	S.S.C. (10 th Standard)	(October 1996-July 1997)
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Administration:*(3 Females, 3 Males) (Average duration: 17.6 months)*

1. Ajay Kamble	12 th Standard.	(Sept. 1994-April 1996)
2. Dashrath Pathre	B.Com.	(Sept. 1997-March 1999)
3. Madhavi Mane	B.A.	(Feb. 1996-August 1997)
4. Shantaram Kamble	S.S.C. (10 th Standard)	(April 1999-July 1999)
5. Shraddha Kardhadkar	M.Com.	(July 1994-August 1996)

Regular Consultant/On Work Assignment**Present consultant for specific project:**

Leela Visaria: Project: Study of family violence in the slum area of Mumbai (From September 1999).

Those Who Contributed as Consultant or on Work Assignment:

1. Aditi Iyer: *Projects:* (1) Study of patient satisfaction in public hospital. (2) Laws for health care providers. (3) Medical Ethics for professional self-regulation. (4) Preparation of three sections for National Profile on Women, Health and Development. (5) Preparation of the project proposal on "Women's abortion needs and practices in rural Maharashtra".
2. Dilip D'souza: *Project:* Survey of torture in Maharashtra.
3. Hutokshi Doctor: First editing of CEHAT's Annual Report.
4. J. Jeyaranjan: *Project:* Women, work, environment and health: Case study of women industrial workers in Chingalpatu district of Tamil Nadu.
5. K. Gnanaprakasam: *Project:* Women, work, environment and health: Case study of women industrial workers in Chingalpatu district of Tamil Nadu.

6. Kiran Shaheen: *Project*: Portrayal of police torture in Hindi films and television serials and its impact on children.
7. Maveen Soares Pereira: *Project*: Women, work, environment and health: As coordinator of three case studies.
8. Padmini Swaminathan: *Project*: Women, work, environment and health: Case study of women industrial workers in Chingalpatu district of Tamil Nadu.
9. Ravi Duggal: *Projects*: (1) Health expenditure across states. (2) Financing disease control programme. (3) Private health sector in India: Trends and critique. (4) Physical standards in private health sector.
10. Sandhya Srinivasan: *Project*: Documentation and Dissemination of Database on Health for Empowerment and Advocacy: For editing its dissemination material.
11. Sanjeevani Kulkarni: *Project*: Slide show on AIDS Awareness.
12. Satish Kulkarni: *Project*: Slide show on AIDS Awareness.
13. Surabhi Sharma: *Project*: Women, work, environment and health: As producer of short film on the living and work environment in Ambedkar Nagar and Sevak Nagar (Mumbai slum case study).
14. Vinay Kulkarni: *Project*: Slide show on AIDS Awareness.

Joint Co-ordinator

Mani Mistry (June-September 1999)

Co-ordinators

Ravi Duggal (From November 1999)
Amar Jesani (April 1994-October 1999)

The Founding Trustees

The following nine trustees founded the *Anusandhan Trust*:

1. Amar Jesani: Graduate in medicine and present co-ordinator of CEHAT. Has been involved in social health research, with experience in trade unions, working class and human rights organisations.
2. Anant Phadke: Graduate in medicine. Has been involved in health and people's science movements for last three decades. Trains health workers in rural NGOs/people's organisations.
3. Anil Pilgaokar: Biochemist and experienced in Ayurvedic and

homeopathic medicine. Consumer activist and involved in rational drug movement.

4. Dhruv Mankad: Graduate in medicine. Working as a community health activist in rural Maharashtra. Former director of VACHAN, a Nashik based NGO and has also worked with Actionaid.
5. Manisha Gupte: Masters degree in microbiology. Women's rights, health and social activist. Has helped establish Streedhan, a credit society and bank for women in rural Maharashtra. Presently Co-convenor of MASUM, women's NGO in Pune district.
6. Mohan Deshpande: Graduate in medicine. Involved in school health education. Has prepared four major training manuals and conducts health training of teachers in schools.
7. Padma Prakash: Masters in sociology and journalist. Women's rights, and health activist. Presently, senior assistant editor of the Economic and Political Weekly.
8. Ravi Duggal: Masters in sociology. Health researcher, and activist, pioneered work in health economics. Has worked with the Ministry of Health and Family Welfare, New Delhi and was the country co-ordinator of SWISSAID.
9. Vibhuti Patel: Doctorate in economics. Women's rights and social activist, has made major contributions to women's studies and gender economics. Former Reader at Research Centre for Women's Studies, SNDT Women's University, Mumbai.

Present Trustees

Of the nine founding trustees, three (Anant Phadke, Anil Pilgaokar and Ravi Duggal) have retired/resigned. Thus, presently (March 2001) the Anusandhan Trust has six trustees (Amar Jesani, Dhruv Mankad, Manisha Gupte, Mohan Deshpande, Padma Prakash and Vibhuti Patel).

Managing Trustees

Dhruv Mankad (From October 1999)
Ravi Duggal (September 1998 - September 1999)
Amar Jesani (February 1991- August 1999)

XII. CEHAT PUBLICATIONS (1991- 2000) (as on March 2000)

(A) HEALTH CARE SERVICES AND FINANCING

Studies, Reports and Books:

(RA. 03) Iyer Aditi, Amar Jesani and Santosh Karmarkar, Patient Satisfaction in the Context of Socio-Economic Background and Basic Hospital Facilities: A Pilot Study of Indoor Patients of the Lokmanya Tilak Municipal General Hospital, Mumbai, Mumbai: CEHAT, October 1996, pgs.57. (Rs. 50/-)

(RA. 02) Nandraj Sunil and Ravi Duggal, Financing of Disease Control Programmes in India, Mumbai: CEHAT, February 1996, pgs.55. (Rs. 50/-)

(RA. 01) Duggal Ravi, The Private Health Sector in India: Nature, Trends and a Critique, Mumbai: CEHAT, January 1996, pgs.47. (Rs. 45/-)

Papers and Essay:

(PA. 36) Baru Rama and Amar Jesani, The Role of the World Bank in International Health: Renewed Commitment and Partnership, *Social Science and Medicine*, Vol. 50, 2000, pp.183-184. (Rs. 2/-)

(PA. 35) Shukla Abhay and Anant Phadke, Health Movement in India, *Health Action*, Vol.12, No.12, December 1999, pp. 6-9. (Rs. 3/-)

(PA. 34) Duggal Ravi, Private Sector's Clout, *Health Action*, Vol. 12, No. 9, (Special Issue), September 1999, pp. 44-45. (Rs. 2/-)

(PA. 33) Shukla Abhay, Advocacy for Right to Health Care, *MFC Bulletin*, No. 262-63, July-August 1999, pp. 7-10. (Rs. 3/-)

(PA. 32) Phadke Anant and Ashok Kale, Some Critical Issues in the Epidemiology of Hepatitis B in India, (Paper Presented at the *Medico Friend Circle Meet* July 1999), Pune: CEHAT, July 1999. pgs. 10.(Rs. 8/-)

(PA. 31) Kale Ashok and Anant Phadke The Case of Intra-dermal Route Hepatitis - B Vaccination, Pune, CEHAT, pgs. 3 (Rs. 2/-)

(PA. 30) Duggal Ravi, Health Care and New Economic Policies: The Further Consolidation of the Private Sector in India, (Paper Presented at the *National Seminar on the Rights to Development*, University of Mumbai, December 10-11, 1998), Mumbai: CEHAT, December 1998, pgs.13. (Rs. 10/-)

(PA. 29) Duggal Ravi, Health Care as Human Right *Radical Journal of Health*, Vol. III, No. 3 (New Series), July-September 1998, pp. 141-142. (Rs. 2/-)

(PA. 28) Duggal Ravi, A New Health Policy for Health Sector Reforms (Paper Presented at the *International Seminar on Emerging Public Health Issues in South Asia*, AMCHSS, Thiruvananthapuram, May 1998), Mumbai: CEHAT, May 1998, pgs.16. (Rs. 12/-)

(PA. 27) Duggal Ravi, Making a Health Services Database: A Discussion Note, (A Review and Feasibility Report of the ICSSR Data Archives Committee, New Delhi, April 1998), Mumbai: CEHAT, April 1998, pgs. 6. (Rs. 5/-)

(PA. 26) Duggal Ravi, India's Socio-Economic Database: A Review and a Critique, (A Resource Document Prepared for Lead India, New Delhi, March 1998), Mumbai: CEHAT, March 1998, pgs.13. (Rs. 10/-)

(PA. 25) Mistry Mani, Health Rights of the Urban Poor, (Paper Presented at the *Medico Friend Circle Annual Meet on Resurgence of Infectious Diseases and the Indian Society*, Wardha, January 1-3, 1998), Mumbai: CEHAT, January 1998, pgs.7. (Rs. 5/-)

(PA. 24) Jesani Amar, From Philanthropy to Human Right: A Perspective for Activism in the Field of Health Care, *Indian Journal of Social Work*, Vol. 59, Issue 1, (Special Issue *Towards People-Centred Development - Part 2*), January 1998, pp. 291-320. (Rs. 23/-)

(PA. 23) Duggal Ravi, Health Care Budgets in a Changing Political Economy, *Economic and Political Weekly*, Vol. 32, Nos.20-21, May 17-24, 1997, pp. 1197-1200. (Rs. 3/-)

(PA. 22) Nandraj Sunil, Unhealthy Prescriptions: The Need for Health Sector Reform in India, *Informing and Reforming, The Newsletter of the International Clearinghouse of Health System Reform Initiatives ICHSRI*, April-June 1997, pp. 7-11. (Rs. 4/-)

(PA. 21) Duggal Ravi, A Note on Health Care and Financing Strategies for the Ninth Five Year Plan, Sub-group on Health Financing Strategies, (*Planning Commission*, New Delhi, April 1996), Mumbai: CEHAT, April 1996, pgs.10. (Rs.8/-)

(PA. 20) Duggal Ravi and Sunil Nandraj, National Disease Control Programmes: Recent Trends in Financing, *Radical Journal of Health*, Vol. II, No. 1, (New Series), January-March 1996, pp.86-91. (Rs. 5/-)

(PA. 19) Duggal Ravi, Health Sector Financing in Context of Women's Health, (Paper Presented at the *National Seminar on Gender, Health and Reproduction*, ISSST, New Delhi, November 1995 and as *ISSST Occasional Paper No. 4/96*, New Delhi, 1996), Mumbai: CEHAT, November 1995, pgs. 15. (Rs.12/-)

(PA. 18) Nandraj Sunil, Cost of Medical Care: Issues of Concern in the Present Scenario, (Paper Presented at the *All India People's Science Network, Seminar on Health for All Now*, New Delhi, November 1995), Mumbai: CEHAT, November 1995, pgs.13. (Rs. 10/-)

(PA. 17) Duggal Ravi, Public Health Budgets: Recent Trends, *Radical Journal of Health*, Vol. I, No. 3, (New Series), July-September 1995, pp.177-82. (Rs. 5/-)

(PA. 16) Duggal Ravi, Sunil Nandraj and Asha Vadair, Health Expenditure Across States - Part I, *Economic & Political Weekly*, Vol. XXX, No.15, April 15, 1995, pp.834-844. (Rs. 8/-)

(PA. 15) Duggal Ravi, Sunil Nandraj and Asha Vadair, Health Expenditure Across States - Part II, *Economic & Political Weekly*, Vol. XXX, No.16, April 22, 1995, pp.901-908. (Rs. 6/-)

(PA. 14) Duggal Ravi, Health Expenditure Patterns in Selected Major States, *Radical Journal of Health*, Vol. I, No. 1, (New Series), January 1995, pp.37-48. (Rs. 9/-)

(PA. 13) Duggal Ravi, Population Meet: Poor Impact of NGOs, *Economic and Political Weekly*, Vol. 29, No.38, September 17, 1994, pp.2457-8. (Rs. 2/-)

(PA. 12) Duggal Ravi, Population and Family Planning Policy: A Critique and A Perspective, (Paper Presented at *International Conference on Population and Development*, Cairo, September 1994), Mumbai: CEHAT, August 1994, pgs.6.(Rs. 5/-)

(PA. 11) Duggal Ravi, For a New Health Policy: A Discussion Paper, (Paper Presented at the *Study Circle Organised by the MFC/FMES/ACASH*, Mumbai, August 21, 1994), Mumbai: CEHAT, August 1994, pgs.13. (Rs. 10/-)

(PA. 10) Duggal Ravi, People's Economy: Context and Issues from India, (Paper Presented at *Seminar on Market Economy for the Poor*, Berne, Switzerland, May 1994), Mumbai: CEHAT, May 1994, pgs.14. (Rs. 11/-)

(PA. 09) Duggal Ravi and Sunil Nandraj, Health Finance of the Brihan-Mumbai Municipal Corporation, (Background Paper for Medico Friend Circle, Mumbai Group's Workshop on *Improving Public Hospitals in Mumbai*, June 1994), Mumbai: MFC - Background Papers, May 1994, pgs.37-44. (Rs. 6/-)

(PA. 08) Pilgaokar Anil, New Moves: The Indian Drug Scene, *Voices*, Vol. II, No. 3, 1994, pp.22-24. (Rs. 2/-)

(PA. 07) George Alex and Sunil Nandraj, State of Health Care in Maharashtra: A Comparative Analysis, *Economic and Political Weekly*, Vol. XXVIII, Nos. 32-33, August 7-14, 1993, pp. 1671-1677, 1680-1683. (Rs. 8/-)

(PA. 06) Duggal Ravi, Health Humanpower in India, (Paper Prepared as *National Consultant on WHO Project, for the Ministry of Health*, New Delhi), Mumbai: CEHAT, August 1993, pgs.20. (Rs. 15/-)

(PA. 05) Duggal Ravi, Resurrecting Bhore: Re-emphasizing a Universal Health Care System, *MFC Bulletin*, No.188-9, November-December 1992, pp.1-6. (Rs.5/-)

(PA. 04) Duggal Ravi, Trends in Family Planning Policy and Programs, (Paper Presented at *Seminar on Trends and Perspectives for FP in the Nineties*, Mumbai Union of Journalists, August 1992) Mumbai: CEHAT, August 1992, pgs.15. (Rs. 11/-)

(PA. 03) Duggal Ravi, 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/Harvard University, Delhi, January 1992), Mumbai: CEHAT, January 1992, pgs.20. (Rs. 15/-)

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