

Activity Report

April 2000 – March 2003



Centre for Enquiry into Health and Allied Themes
Mumbai / Pune

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By

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CONTENTS

1. INTRODUCTION	1
2. RESEARCH	4
2.1. Health Services and Financing	4
2.1.1 A Study on Demand for a Public Hospital in K-East Ward, Greater Mumbai	
2.1.2 Public Health Facilities in Mumbai	
2.1.3 Maharashtra Health System Report	
2.1.4 Sathi Cell	
2.2. Health Legislations, Ethics & Patients rights	10
2.3. Women and Health	12
2.3.1 Abortion Assessment Project - India	
2.3.2 Abortion Rate, Care, and Cost: A Community based study	
2.4. Investigation and Treatment of Psycho-social Trauma	22
2.4.1 Arogyachya Margavar violence and women's health	
2.2.2 Dilaasa: Crisis Centre in a public hospital for treatment and counselling of women victims of violence	
3. ACTION, INTERVENTION AND TRAINING	31
3.1. Sathi Cell	31
3.2. Aarogyachya Margavar: Violence and Women's Health	40
3.3. Dilaasa: Crisis Centre in a public hospital for treatment and counselling of women victims of violence	44
4. SERVICE, DOCUMENTATION AND PUBLICATIONS	51
4.1. Information Centre	51
4.1.1 Library and Documentation Unit	

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4.1.2 Publication Unit	
4.1.3 Website	
4.2 Database on Health	58
5. ADVOCACY, EDUCATION AND CAMPAIGNS	60
5.1. Accreditation initiative in Mumbai	60
5.2. Exhibition organised by Mahila Aarthik	62
5.3. Health Care as a Right	62
5.4. Human Rights Education	64
5.5. People's Health Assembly/Jan Swasthya Abhiyan	66
5.6. Prenatal Diagnostic Techniques (PNDT) Act Legal Advocacy against Sex Selective Abortion	69
5.7. Relief Work after the violence in Gujarat	72
5.8. Workshop on State Population Policy	72
6. COLLABORATIONS AND NETWORKING	75
6.1. Abortion Assessment Project –India	75
6.2. Achutha Menon Centre for Health Science Studies, (AMCHSS)	75
6.3. Association of Medical Professionals	75
6.4. Brihanmumbai Municipal Corporation (BMC)	76
6.5. Central and State Governments	76
6.6. Department of Politics and Public Administration, University of Pune	76
6.7. Forum for Medical Ethics	76
6.8. Gender – in Reproductive Health	76
6.9. Global Health Council (GHC) and National Centre for Advocacy Studies (NCAS)	77
6.10. Government of Maharashtra	77
6.11. Health Watch Trust, Jaipur	77
6.12. International Federation of Health and Human Rights Organisations, Netherlands (IFFHRO)	77
6.13. International Rehabilitation Council for Torture Victims (IRCT)	77
6.14. Mahila Sarvangin Utkarsha Mandal (MASUM)	77
6.15. Nirmala Niketan College of Social Work, Mumbai	78
6.16. People's Health Assembly/Jan Swasthya Abhiyan	78
6.17. Tata Institute of Social Sciences (TISS), Mumbai	78
6.18. University of Mumbai	78
6.19. Women's Health Project, Witwatersand University, South Africa	79
7. ORGANISATIONAL STRUCTURES AND FUNCTIONING	80
7.1. Working Group (WG)	80
7.2. Peer Review Committee (PRC)	82
7.3. Institutional Ethics Committee (IEC)	87
7.4. Social Accountability Group (SAG)	95
8. ADMINISTRATION AND ACCOUNTS	96
8.1. Administration	96
8.2. Sources of Funding and Expenditures	96
8.3. Staff profile	99
8.4. Consultants	101
8.5. Utkarsha (Staff Welfare Association)	102
8.6. CEHAT at other places	103
8.6.1 Pune Office	
8.6.2 Indore Office	
8.2.3 Project Office at Mumbai	
9. ARTICLES AND PAPERS	105

1

INTRODUCTION

The entry into the new millennium was also a new threshold for CEHAT. A new thrust of growth and consolidation of the thematic areas of CEHAT's work has pushed CEHAT to a qualitatively different level. Both national and international recognition of the work done so far, the building of partnerships for doing work collaboratively are the new highlights of CEHAT's historical evolution.

But the new millennium also ushered in the strengthening of a globalised political economy with India being increasingly integrated into the world economy. This has led to considerable changes in the socio-political and economic environment of the country. We see greater deprivation, increasing inequities, a new and more intense kind of communalism, more widespread violence, larger failures of governance and abdication by the state of its social responsibilities. Within this health and healthcare has suffered severely and the consequences of this are quite harsh. On the other hand the private sector in health has not only expanded substantially but also there is a major shift towards corporatisation and privatisation. Large-scale studies commissioned by the Ministry of Health and Family Welfare (NFHS and RCH surveys) and the NSSO surveys provide adequate evidence of the collapsing public health system. The new health policy announced in 2002 acknowledges this collapse but does not offer any strategy to overcome it; on the contrary the new health policy advocates for larger private sector growth, privatisation, health tourism etc. that will only lead to the worsening of the public health system in the future. It is time for the civil society to respond to this and initiate a struggle for establishing healthcare as a right.

Fortunately we do have some hope with the emerging consolidation of the People's Health Movement (Jan Swasthya Abhiyan) in India. CEHAT is one of the key players in this movement. To support this movement CEHAT is initiating a major research and advocacy program

on right to healthcare during the next three years with the aim of strengthening the state's role in public health and to begin a process of moving towards establishing healthcare as a right.

The approach of RASA (Research, Action, Service, Advocacy) continues, with the ASA part getting a major boost during the last three years, indicating some shift from the earlier primacy in research. So a larger sense of balance within this approach has also emerged during this period. During the last three years we have also seen the consolidation of CEHAT's staff strength in the range of 40-46, even though there was some turnover of professional staff. Organisationally also CEHAT has seen greater consolidation both of its four Foundation Principles of social relevance, ethical concerns, democratic functioning and social accountability, as also the establishment of its own offices in Mumbai and Pune.

While CEHAT continues to work on its thematic areas with greater vigour in the last three years there is a qualitative difference from the initial six years of CEHAT. CEHAT is increasingly doing work collaboratively with other institutions and civil society groups from across the country on a much larger scale and this has in a sense catapulted CEHAT into a countrywide organisation. Collaborations have been on all fronts – research on abortion in 13 states with 19 institutions for which CEHAT provided the secretariat and coordination in partnership with Healthwatch, Delhi; research on impact of globalisation on women's work and health with Engender, Singapore; advocacy on abortion with Witwatersand University, South Africa; advocacy and campaign on right to health and related issues with the Jan Swasthya Abhiyan and its associated groups across the country; collaboration with the global equity gauge initiative to develop an equity gauge for India; advocacy and PIL on sex-selection and the PNDT Act with MASUM and Lawyers Collective; primary healthcare training and advocacy in collaboration with 5 people's organisations in two states; running a crises centre for survivors of domestic violence in collaboration with the Bombay Municipal Corporation; collaboration with Mumbai University in running a diploma course in human rights; and collaboration with Government of Maharashtra state in running a training program for village health workers in tribal areas.

All this has made a qualitative difference to CEHAT's work and generated a wider impact but it has also meant stretching of energies and organisational capacities and causing some stress, which we are managing through a major organisational development strategy. This is an ongoing process and we do envisage structural changes as we get along.

In the last three years we have made efforts to diversify our donor support and this has been a positive experience. In the coming years more ground needs to be covered on this front with the new challenges we face in our environment. We would like to thank all our donors, supporters, collaborating institutions and organisations for making what we have done possible. Our Trustees have been supportive of the trajectory of CEHAT's growth and have stood behind us whenever we needed them and they are actively involved in the organisation development processes and the shaping of future strategies. During this period CEHAT consolidated the Institutional Ethics Committee, which is now an example for other institutions to emulate, and we thank them for their efforts and support. The Social Accountability Group has been kept informed on a regular basis of CEHAT's work. Their report is due early next year and will be published with the next Annual Report.

The last Report of CEHAT was published in 2000 for the period 1994-2000, that is for six years. The present report is for 2000-2003, that is three years. We hope that from next year onwards we should be coming out with Annual Reports. This report is a collaborative initiative of all staff members and will be circulated as widely as possible to ensure public accountability.

10th December 2003
Mumbai

Ravi Duggal
Co-ordinator

2 RESEARCH

2.1 HEALTH SERVICES AND FINANCING

Under this thematic area research related to healthcare systems, utilisation patterns and healthcare expenditures using data from national level data sets was continued. A number of papers and articles as well as conference presentations and papers were done based on this research. Issues dealt include rural urban healthcare access and utilisation patterns, indebtedness and healthcare access, class/caste differentials in health care access and expenditures, household health expenditures, national and state health accounts, reproductive healthcare and urban health care. All this research has been supported through the institutional support program supported by NOVIB and Ford Foundation.

Another major sub-theme under this thematic area is primary healthcare. The SATHI cell based in Pune leads this area of work through collaborations with people's organisations in Maharashtra and Madhya Pradesh training activists as health workers, building capacity of these organisations to do local level advocacy to strengthen the public health system and demand accountability from it, undertaking awareness campaigns and regional and national level advocacy on issues like strengthening the public health system, advocating right to healthcare, right to food, and monitoring health and nutrition in communities. While this is mainly an action project some specific research related to the intervention and the impact of the latter in improvement of access to health care has been undertaken. Also a small survey documenting under nutrition and starvation in Madhya Pradesh was done.

Other issues taken up under this thematic area include

The right to healthcare initiative through the Jan Swasthya Abhiyan, which included a national seminar at the Asian Social Forum. CEHAT provides the research and documentation support to this campaign and over the next three years a major program on this is being initiated

by CEHAT in collaboration with other organizations. For this a proposal has been submitted to NOVIB and Ford Foundation

Low public health expenditure has been a major concern which is highlighted in our research on health financing. During this year we put in a concerted effort at building an advocacy campaign for raising the public health budget in Maharashtra state. This was done in collaboration with the Right to Food campaign, which emphasised food security issues in the campaign. During the next year this campaign will gather momentum with the aim of influencing the next years health and food security budget.

Related to the right to food campaign an initiative called Hunger Watch was initiated in collaboration with various groups linked to the right to food campaign in Maharashtra and Madhya Pradesh. This group would support the RTF through research and documentation of hunger and related issues.

As a followup to the HDR work for the state govt. CEHAT undertook followup workshops for district level officials at the request of the state govt. to sensitise them to the health and nutrition issues which had emerged in that report to which CEHAT had contributed.

The updating of the database has been continued and we plan to publish this and release soft copies of the database in the latter half of 2003.

The following studies were undertaken under this program

2.1.1 A Study on Demand for a Public Hospital in K-East Ward of Greater Mumbai

The demand for taking up this study had come from the public health department of the Brihan Mumbai Municipal Corporation (BMC), who felt the necessity of a municipal general hospital in the study area. This area is the most populous ward in Greater Mumbai but does not have a public hospital within its limits. A postpartum centre was opened by the BMC in the early 1990s at the space for the proposed hospital, but had to be closed down because of poor response from the community. Therefore, the municipal authorities felt the need for a demand assessment survey before setting up a municipal hospital in the area.

As per the agreement between CEHAT and BMC the former's role was to design the questionnaires, select the sample, and write the report of the survey. The BMC was to provide 18 community health visitors as investigators, and space for training these investigators. CEHAT agreed to collaborate with the BMC as a part of its social policy of working towards the right for basic health care, universally accessible to all. In principle, the concept of right to health and health care will be operational only if public health care systems are strengthened. The request that had come from the BMC was felt as genuine and was seen as an opportunity for CEHAT to work in collaboration with the public sector (BMC) for strengthening the latter.

A sample of 1,035 households was taken from three health-post areas surrounding the proposed hospital, using a systematic random sampling procedure. The study brought out the utility of public health care services in the area and showed how the population coped with its health care needs when public health care services were not available in the locality. The study area was a predominantly lower middle class one. . In spite of not having a public hospital, about 30 per cent of the population had sought inpatient care services (from public sector outside the locality) and 15 per cent had sought outpatient care services from BMC facilities. Though travel time and travel costs were higher, the public were still seeking health care from public health care outlets outside their locality, because of financial constraints. The study showed that the non-availability of a public hospital was forcing about 44 per cent of the households to seek inpatient care from the private sector even though they were keen on utilising the public sector. Even the outpatient care services currently available in the area seemed to be inadequate, as 67 per cent of the households had unmet demands for outpatient care services. While the poor were left with no options but to seek care from public health care facilities in other wards, the others were "managing" with services in private sector where the average out-of-pocket expenses of treating an ailment was 2.7 times higher than in the public sector. The majority of those who were currently "managing" their inpatient care needs through private hospitals were willing to shift to the public health care system if made available in the locality.

On the basis of the study it was recommended that the BMC should set up the hospital at the proposed site. Further, given the high unmet demand expressed for outpatient care services we recommended that the dispensaries available in the locality should be increased from the present number of one dispensary per 73,000 population to at least one per 40,000 population.

Team Members : T. R. Dilip, Ravi Duggal and Raman Kamble.

2.1.2 Public Health Facilities in Mumbai

The Directory of Public Health Care Facilities in Mumbai city is a collaborative initiative undertaken with the Brihan Mumbai Municipal Corporation (BMC). We, at CEHAT attempt to demonstrate in a viable way the most appropriate manner in which health care services can be made accessible, equitably and ethically.

Our interaction with the public health care system, and being in the business of dissemination of health information, we found that the information available on public health care services has been inadequate, especially those provided by hospitals. Information about health care facilities is critical in enabling people to access the public health care system more effectively.

The idea to come out with the 'Directory of Public Health Care Facilities in Mumbai' was conceived in the above context. We felt the need for a comprehensive, precise, and portable information guide on the public health care facilities existing in Mumbai city. The idea was consolidated in discussions with senior health officials of the BMC. They agreed to support such an initiative by providing the necessary information.

The directory contains both general and specific information on the various services provided by the hospitals and maternity homes. The general information contains the addresses and phone numbers of the health care facilities, landmarks, nearest railway station, and BEST buses approaching the hospital, the number of beds and visiting hours for patient's relatives. The specific information consist of the case paper registration timings and window number, available specialities and super specialities with their Out Patient Department timings and window number, and information on Blood Bank, ambulance, hearse services and mortuary. A section on other services

contains information on the grievance redressal system, benefits for the poor and cheap staying facilities close to the hospital.

At one level, this directory will be most useful for laypersons that wish to access the health care services provided by the government. Information regarding special facilities provided for disabled and senior citizens will enable them to access the public health care services easily. It will also act as a guide for the dispensaries and Health Post doctors, Auxiliary Nurse Midwives (ANMs), Community Health Workers (CHWs), Non Government Organizations (NGO) and other related staff in their work, especially related to referrals.

It is hoped that the information regarding the facilities will increase access to these utilities and strengthen the public health care facilities. This is a small effort in that direction brought about by spreading awareness and providing essential information.

Team Members : Rajeswari Balaji and Sunil Nandraj

2.1.3 Maharashtra Health System Report

The background paper on Health and Nutrition in Maharashtra was prepared for Human Development Report 2002, Maharashtra, brought out by the Government of Maharashtra/Planning Commission/United Nations Development Programme. This paper made a critical appraisal of the achievements made by Maharashtra in terms of health and nutritional outcomes. It contains sections on mortality, morbidity, nutrition, disease control programmes, family welfare programme, health care delivery and utilisation, water supply and sanitation, public expenditure on health and health sector reforms in the state.

The report indicated a notable improvement in levels of life expectancy and infant mortality in the state. However, the rural-urban differentials had increased over time. Analysis of availability of health care services showed a strong urban bias in the location of both public and private health care facilities. The rural urban differentials in health status indicators might be attributed to this.

Apart from leprosy, there was no evidence to show a decline in malaria, tuberculosis, and blindness. AIDS has become a major threat. Maharashtra has the highest prevalence of HIV among all Indian states, accounting for 50 per cent of the cases in India.

The public sector was found to be dominating only in delivering contraceptive and immunization services, while the private sector, which is better developed here than in the rest of the country, was found to be the major provider of other health care services. Because of higher treatment costs, the private sector was found to be relatively inaccessible to the poor. Not only is the share of health expenditure in the government budget lower than most of the other states in India, there has been a deceleration in public spending on health care since the early 1990s.

Despite having the highest per capita income in the country, the nutrition status in Maharashtra was not encouraging. As much as 57 per cent of the households in rural areas and 55 per cent in urban areas consumed less than the standard 2,700 calories per day. The impact of this low level of nutritional intake was observed while analysing the nutritional status of women and children, which was lower than the national average.

The report advocates the need to improve coverage of the ICDS schemes, strengthening of rural health infrastructure, strengthening the monitoring of private health care system, focusing more attention on HIV/AIDS, and to raise public spending on health care to 5 per cent of the total public expenditure.

Team Members : Ravi Duggal, T. R. Dilip, Rajshri Kamath

2.1.4 Sathi Cell

The SATHI team is taking up specific issue-based field studies to help the process of local advocacy and community based action.

During the last year of the Aarogya Sathi Project, end-project surveys were conducted in March 2001 in a sample of the programme villages in all the three field areas. The results were compared to those of the baseline survey that was conducted at the beginning of the project. This was to assess the impact of the project in the availability of First Contact Care in the programme villages, reduction in the medical expenditure on common ailments, improved health awareness about specific health issues, etc. The results showed that the AS project had successfully achieved these objectives. The details are available on our website <http://www.cehat.org>

Following reports of suspected starvation deaths in Barwani, a study on undernutrition and starvation was carried out in June 2001. Besides study of under nutrition among children and adults, death rates in the study area were calculated and verbal autopsies conducted in sample cases of deaths, to ascertain whether starvation was the cause of death. During the course of this study, a number of major methodological issues were raised. Which, in turn, triggered off the process of developing a standardised methodology for investigating starvation deaths, and which continues, with the SATHI Cell participating in the 'Hunger Watch' group of the *Jan Swasthya Abhiyan*.

Before taking up health-worker-based programmes in the Sendhwa area, a baseline survey in a sample of four villages of Sendhwa was undertaken. It provided a profile of the existing health care utilization, expenditure, and awareness of key health issues. A survey of food security schemes in a sample of three villages in each of the Pati and Sendhwa block has proved important for a state-level survey and campaign on this issue by the *Jan Swasthya Abhiyan*, MP.

A study of the status of public health services provided under *Swastha Jeevan Seva* Guarantee Yojana in Sendhwa block was carried out in June 2002. This study was further replicated in other districts of western MP and contributed to the 'Public audit' of the Health Guarantee scheme of the M.P. Govt.

Similarly, a survey on Status of Implementation of various Food Security Schemes in Maharashtra was executed by the constituents of *Anna Adhikar Abhiyan*. In this survey, the data was collected by various organisations involved in the latter, and data analysis and report writing accomplished by the SATHI cell.

Team Members : *Anant Phadke, Abhay Shukla, Amulya Nidhi, Amita Pitre, Ashok Jadhav, Nilangi Nanal, Prashant Khunte, Sameer Mone and Shalini Verma.*

2.2 HEALTH LEGISLATION, ETHICS AND PATIENTS RIGHTS

Violation of human rights and its impact on health and healthcare has been an important concern of CEHAT. In the past CEHAT has participated in investigations and enquiries, undertaken research and documentation and intervened through awareness raising, education

and legal action.

The groundwork research in this area was done in the first few years of CEHAT's functioning and in the last three years the larger focus has been documentation, advocacy for change in legislations and taking up public interest litigation.

In the arena of health legislation we have been building a database of national and state laws related to health and medicine. This has been an effort in bringing at one place all such legislations so that it can form an important resource for those working on legal and constitutional dimensions of health and healthcare as well as for those involved in advocacy and campaigns on health issues. We have identified over 500 such laws/Acts of the Central government and of Maharashtra State, and nearly half of these are available in electronic versions. The next step would be to convert it into a searchable database.

In the last three years CEHAT has seen successful interventions through PILs. The campaign and SC PIL on sex-selective abortions and the PNDDT Act was supported through extensive documentation and information dissemination, debates and discussions. The outcomes have been extremely good with the PNDDT Act completely transformed and now including pre-conception technologies, as well as the state governments have been adequately activated to implement the provisions of the Act. Here CEHAT collaborated with various institutions and individuals to make all this an effective process. The next steps would be to work intensively in atleast Maharashtra and Madhya Pradesh, where we have presence on the ground, to monitor and support proper implementation of the revised PNDDT Act. CEHAT would also support groups in other states who would like to undertake such work through information sharing and trainings if needed.

Similarly, the earlier work on the BNHRA Act in Maharashtra has shown positive results in the last few years with the government open to radically change the legislation. The completely new Act has now been formulated, for which CEHAT provided extensive support through consultations and in documentation, re-drafting etc.. CEHAT has even prepared an awareness booklet on this legislation for education of health professionals.

Another PIL in which CEHAT has recently intervened is with respect to medical negligence by Railways in Mumbai on the suburban train system. Accident victims do not receive proper attention in terms of medical assistance. CEHAT was invited to intervene in this PIL in the Mumbai High Court from the healthcare angle and for this we did extensive research and documentation to provide information for the affidavit as well as liaised with a public insurance company to build a case for feasibility of hospitalisation insurance cover for all passengers. The documentation has been done and an affidavit based on that has been filed.

With regard to ethics in research and practice CEHAT has itself demonstrated in its own work intensive debates and discussions on research ethics, including rigorous implementation of ethics in all our work. Through collaborative research we have also encouraged and supported other institutions to set up ethics committees and implement ethics in practice. The next step here is to mainstream ethics in social science research through universities and ICSSR institutions. CEHAT's role would be largely in awareness building, education and training, and undertaking further research to refine tools.

Efforts have also continued to work with the medical profession in educating them on self-regulation and promoting accreditation. The efforts have resulted in the formation of a not-for-profit company being registered as Health Care Accreditation Council. The next steps here are to undertake research to develop protocols for assessment and monitoring, develop minimum standards for quality care and to educate the medical profession on the importance of self-regulation and accreditation in ethical practice of medicine and respect for patients' rights.

The above work has been supported through the Institutional support program with support from Ford Foundation and NOVIB.

2.3 WOMEN AND HEALTH

The work on abortion and domestic violence has seen further consolidation. The multicentric studies of abortion providers across the country done collaboratively with other institutions have been completed and draft reports also peer reviewed. The national report

is under preparation and before the end of 2003 these will be published. Ten working papers, which were commissioned, have also been completed and are presently being peer reviewed. These will also be published soon. The fieldwork of the household studies on abortion rate, care and cost has been completed in both Maharashtra (by CEHAT) and Tamil Nadu (*by Bharatiar University*) and the data is being presently analysed. These studies and the past work of CEHAT in this area and the advocacy on issues emerging through this work has led to national level impact, especially amendments to the MTP and PNDT Acts. The Ford Foundation and Rockefeller Foundation have supported these studies.

2.3.1 Abortion Assessment Project - India

The Abortion Assessment Project-India (AAPI) is a countrywide initiative to carry out a comprehensive assessment of abortion and abortion services. AAP-I is both multi-component as well as multi-centric so that variations across the country in understanding the various dimensions and issues relevant to abortion are studied in detail and documented.

The process for developing this initiative was indeed very elaborate and took two years of meetings and consultations involving a wide spectrum of people who have worked on this issue. Between May and December 1999 the coordination the potential donors and the Technical Advisory Committee of the project reviewed mechanism necessary for the project. It was felt that CEHAT should coordinate the project by housing the secretariat. Subsequently, draft proposals were also invited from potential collaborating agencies in these multi-centric studies in order to get a clearer picture of the financial requirements and the capacity of agencies to undertake the study.

The overall objective of the study is to review government policy towards abortion care; assess and analyse abortion services; study user perspective with special focus on women's perceptions of quality, availability, and accessibility; study social, economic and cultural factors that influence decision-making; document costing and finance issues; estimate rate of abortion and disseminate information on abortion issues widely; and do advocacy on issues of concern in the context of reproductive rights of women.

The components of the study include papers on policy-related issues, multi-centric facility survey in six states, community-based study in two states, eight qualitative studies and dissemination with advocacy programmes. This approach would help capture the complex situation as it is obtained on the ground and give policy makers, administrators and medical professionals valuable insights into abortion care and areas for public policy interventions and advocacy.

While CEHAT, Mumbai, is responsible for the overall management of the project and coordination of the quantitative studies, Healthwatch Jaipur is coordinating the qualitative studies. To support this there are two committees, which have been set up to support AAP-I, namely the Technical Advisory Committee (TAC) and the Ethics Consultative Group (ECG).

The secretariat housed in CEHAT acts as a clearinghouse, liaisons with the TAC and ECG by co-ordinating their meetings and activities, oversees the multi-centric facility studies and the community-based abortion rate studies, plans various workshops and meetings, manages financial flows, develops and co-ordinates reporting systems, facilitates information that flows across all involved in this project, and coordinates the dissemination of study outcomes.

The study partners include

- 1 Haryana : Society for Operations Research Training, Baroda.
- 1 Kerala : Achutha Menon Centre of Health Science Studies, Thiruvanthapuram.
- 1 Madhya Pradesh : Manasa, Bangalore and Centre for Health and Social Science Studies, Hyderabad.
- 1 Maharashtra : Centre for Enquiry into Health and Allied Themes (CEHAT), Pune.
- 1 Mizoram : Omeo Kumar Das Institute of Social Change and Development, Guwahati.
- 1 Orissa: Child- in- Need Institute (CINI), Kolkata.
- Rajasthan: Action and Research for Training in Health (ARTH), Udaipur.
- 1 Tamil Nadu: Bharathiar University, Coimbatore.

The Current Scenario

The Abortion Assessment Project launched in August 2000,

progressed into its third year of activities. In the last two years (2000-2003) the focus was on launching the various activities of the project and in consolidating them with the multi-centric and community-based studies under way. This year (2002-2003), most of the studies have been completed and their draft reports submitted. These include an account of the dissemination workshops that were held during the course of these studies.

The multi-centric and community-based studies devoted their full time to data collection and data processing activities. The peer review committee for reviewing the draft study reports has been finalised and it consists of three persons: one independent member, one TAC member and one ECG member. The study reports, a few of which have been completed, will be sent to this panel for critical comments.

Last year, working papers were invited. It elicited a good response—30 concept notes were received, among which nine were short-listed. The format for proposal writing was spelt out in the acceptance letters. As soon as the proposals were received, the terms of reference were drawn and contracts signed with the respective researchers. The researchers then sent in draft papers, which were peer reviewed by two independent peer reviewers and the secretariat. Their comments were communicated to the researchers, who have incorporated them in their papers. Most of the final working papers are with us now.

The policy review process has also been initiated. Dr Siddhi Hirve is conducting the review. The terms of reference were drawn up, and the work has already begun with collecting data/ material and meeting key resource persons.

With most of the individual study reports completed, a data-sharing workshop is scheduled for May '03, after which the work on the national-level report begins. The final overview and advocacy strategy finalisation will take place in November '03. We will also be commissioning working papers on any of the issues that emerge from the various facility studies. We have also identified few persons from the TAC to undertake a working paper on any related abortion issue.

Team Members : Ravi Duggal and Rajeswari Balaji.

2.3.2 Abortion Rate, Care and Cost: A Community Based Study

2.3.2.1 Background and rationale

Abortion care constitutes one of the major components of the internationally designed RCH programme around which the government women's health policies are centered. Among many other areas of concern, abortion mortality and morbidity continues to have a considerable share in maternal mortality and morbidity. There is no empirical research with exclusive focus on abortion incidence and morbidity in India. Abortion-related estimates, at the most, are calculated on the logic used by the Shah Committee way back in 1966 using small-scale community-based study and hospital-based data. This, however, from the methodological point of view and thus puts a question mark on the validity of the estimates. In addition, there are other factors, such as, thirty years of the implementation of the MTP Act, half a century of state's family welfare programme with prime focus on spacing methods, and a growing preference for a son which gets increasingly expressed through sex-selective abortion. This preference must have played a role in changing the abortion incidence rates, indications for choosing abortion, and the extent and nature of abortion-related morbidity. We, therefore, felt that it was necessary to undertake a state-level sample household survey to arrive at abortion incidence rates, and to examine the nature and extent of abortion morbidity.

The allied areas of enquiry under this project are abortion care and cost incurred. In the case of the former, both care received from providers and at the domestic level are being looked into. Similarly, both indirect and direct costs incurred are taken into account.

The other important motivating factor has been the consistent and logical continuation of research on various critical aspects of abortion. and building advocacy work based on research findings at CEHAT since the last seven years.

2.3.2.2 The specific objectives are

- 1 To arrive at estimates related to abortion incidence rate, i.e., to arrive at the proportion of women from reproductive age who have had at least one abortion;

- 1 To arrive at estimates of rate of abortions, both spontaneous and induced;
- 1 To arrive at the average number of abortions per woman.
- 1 To arrive at an estimate of the burden and nature of abortion-related morbidity for women.
- 1 To document indications of /reasons for seeking abortion, and to analyse the changing pattern, if any.
- 1 To study women's abortion needs in the light of their socio-cultural milieu.
- 1 To study women's choice of provider to meet abortion-care needs.
- 1 To study expenditure patterns on abortion care.

We have finished our fieldwork, which was spread over six months. This was preceded by an extensive training camp for the newly recruited team of 27 field investigators and other junior staff from the core team. Some of the other major tasks accomplished as part of the groundwork and as preparation for the fieldwork involved methodology details, review of the draft methodology by the external TAC for its scientific content and by CEHAT's Institutional Ethics Committee for its ethical content, pre-testing of the tools, preparation of detailed reference manuals for field investigators as online guide book, and identifying a primary sampling unit using the multistage stratified sampling method. Currently we are engaged in data coding, preparing the data structure files for data processing, refining the analysis and the chapter schemes, and documenting the field experiences from an ethical point of view.¹

The presentation below refers to some of the salient features of the methods and approaches used in completing different phases of the project till date.

2.3.2.3 Determining sample size and sampling

Given the objectives of the research, it was necessary that sampling be done in such a way that the data offers scope and opportunities for generalization of the results and findings. We used the three-stage,

¹ We anticipate the draft report for public peer review to be ready sometime during the third quarter of 2003.

stratified Proportionate to Population Size (PPS) sampling method. We used the 1991 Census data for sampling as computerized data at the village and urban block levels for 2001 Census were not available. The Primary Sampling Units (PSUs) were villages and wards in rural and urban areas respectively. The secondary sampling units were households. For selecting rural PSUs two-stage, and for urban areas, three-stage stratified sampling procedure was adopted. The sample size was estimated at 5,000 households by taking into account various factors like no response and under-reporting. Five thousand households were distributed proportionately to the rural -urban ratio of Maharashtra, which is at 3:2. That is, about 3000 households from rural areas and 2000 households from urban areas were included in the sample. The major parameter we used for arriving at the sample size was the number of conceptions (*reported*) to be captured enabling the recording of a minimum number of induced abortions.. Based on the estimates from various studies of induced abortion we arrived at the number of conceptions to be accounted for. Thereafter, using the current birth rate we arrived at the number of women and households to be covered at the 95% confidence interval.² The sample size of 15,000 households was reduced to 5,000 as we decided the recall period to be of three years.

2.3.2.4 Sample coverage

The rural sample was spread over 103 villages from 91 tehsils in 29 districts³ (*of the 30 districts according to 1991 Census*), whereas the urban sample was spread over 100 urban blocks from 50 tehsils in 27 districts. Of the 5,684 sampled households, 3,458 were from the rural areas and 2,226 from the urban areas. There was a 5 per cent loss of sample, which could be attributed to withdrawal, refusal to answer questionnaire, and inability to meet the eligible member of the household for the interview. From the sampled households, 6,263 women were found to be eligible for the sample. The sample loss of about 9 per cent could be attributed to withdrawal, refusal, and could-not-meet segments.

² The formula determining power of study was used to arrive at number of households to be covered.

³ Bombay being completely urban does not constitute part of the rural universe.

2.3.2.5 Tools of data collection

In the survey three types of tools were used – area profile recorder, the household interview schedule, and the women’s interview schedule. 300 pre-test interviews were completed in 4 villages and a few urban blocks of Pune. The major heads in the area profile recorder were: identification of the study area; area, population and community composition; access to roads and transport facilities; access to basic amenities; access to educational facilities; access to health care facilities; access to other facilities. Multiple sources of information were used to collect these data. In the household-interview schedule we recorded the profile of household members; health-seeking behaviour of the household; access to basic amenities; sources and adequacy of staple food grains; asset ownership; occupation and income of family members; religion and caste of the head of the household. For the woman’s interview schedule the data was collected under the following major heads: personal information, obstetric history, miscarriages and induced abortions of the woman in her lifetime. Information on management of care, cost, perceived morbidities and treatment-seeking behaviour associated with pregnancy wastages, that is, still birth, spontaneous and induced abortion during the reference period (*that is, since January ’96*) were recorded in detail. Information on pregnancy wastages before the reference period was not recorded in detail. Information on sex selection tests and its influence on the decision making process were also noted..

2.3.2.6 Development of the required human resources

The scale of the research study entailed the recruitment of a large number of new staff for data collection. The new recruits formed quite a heterogeneous group as they were from different educational backgrounds as well as different family backgrounds. The *Anveshis* (*the new recruits now called by this name*) were given about three weeks training:

- 1 To develop broader perspective about women and health,
- 1 To develop a common understanding among them about the project, its rationale and the subject matter,
- 1 To develop skills required for conducting fieldwork, which includes conducting interviews, community meetings, and taking care of logistics,

- 1 To develop a sense of solidarity among themselves, and
- 1 To develop skills in 'house listing' by experts in respective fields.

Some of the salient features of the training were participatory training, discussions, group work, different teaching methods and narratives used by investigators, mock sessions, training in communication skills, which included the conducting of mock community meetings.

A few investigators were chosen for the field editor's job based on their aptitude and understanding of the tools, and their overall performance. Each team has a pair of editors. These girls were separately trained for this task. *Anveshis* were involved in the process of pre-testing of the protocols, and refinement of the protocols towards their finalisation.

The women investigators practiced house listing in the presence of the trainer in both rural and urban areas. A few selected investigators did the house listing during the pre-testing phase as part of their training. This selection was primarily done for adequate supervision and guidance by the trainer. Eventually, those trained by the professional trainer in house listing trained all the investigators for this task. The advantage of having the same team for house listing was that we could forgo mapping as they were involved in data collection, and both these tasks were completed on the same visit with some exceptions.

2.3.2.7 Conducting Community meetings

In all rural PSUs we conducted community meetings which were intended:

- 1 To build mutual trust with the community,
- 1 To inform the community as a collective about our institution, its work, and about the project,
- 1 To offer them some relevant knowledge about health-related matters, which are of concern to the entire community. At the end of our fieldwork, we did achieve what we wanted from the community meetings.

There are a range of experiences about community meetings: the community's response to it, its contribution to facilitate data collection

process, its contribution to building confidence among investigators, and its contribution to the mental well being of the investigators as it gave them a lot of satisfaction on the one hand and a challenge to face new communities on the other. Conducting community meetings have played an important role in enhancing the quality of field work/data collection.

2.3.2.8 Seeking informed consent

We have made an attempt to seek written, informed consent from the research participants. A letter of introduction was drafted in Marathi, Hindi and English which mentioned in brief about:

- 1 The institution,
- 1 The project, its relevance, and how their household got selected,
- 1 Significance of their participation,
- 1 Their right to refuse to participate and/or withdraw halfway through,
- 1 Right to clarify the doubts and ask for details on project-pertinent topics, and
- 1 Contained contact address and telephone numbers of the concerned senior staff at the office in case they were interested in interacting with them.

In general, there was a positive response to this. Once again, experiences in the rural and urban areas have been different. A reluctance to sign was much more pronounced in the urban areas. In the tribal areas, we found it difficult to ensure informed consent on part of the research participants.

Some of the areas of ethical concern, which required discussion after commencement of the fieldwork, were

- 1 Participation of those below 18 years
- 1 Involvement of translators in case of non-Marathi speaking population
- 1 Stress felt by the research investigators
- 1 Dealing with tribal communities
- 1 Attending to the requests for health care
- 1 Attending to the requests for taking up issues related to poor services with the local authority.

We organised a joint meeting with the Institutional Ethics Committee (IEC), Cehat, during our fieldwork to share our concerns and to discuss the strategies we designed to address the above issues. These were the issues, over and above the other ethical issues and dilemmas, which were debated and resolved.

2.3.2.9. Some of the salient features of the study could be summarised as follows

- 1 It is a state-wide sample household survey spread across all the districts of Maharashtra.
- 1 The training of the investigators was not only for skill building but also for perspective building as regards the subject matter within the context of women's health, ethical research, methodological approaches, institution's founding principles and commitment, institution's work and its social relevance.
- 1 The entire team, including the field investigators who were also involved in the task of house-listing, conducted community meetings and looking after the management of their own teams constituted only of women.
- 1 A systematic attempt to apply the ethical guidelines developed by NCESSRH and published by Cehat through the formal institutional mechanism of IEC.
- 1 Adequate measures have been taken to enable the documentation of the experiences.

We anticipate that such a scientifically sound, and ethically sensitive methodology and approach towards conducting fieldwork will contribute to the quality of research and its outcome.

Project commenced in Feb 2001.

Team Members : Sunita Bandewar, Madhuri Sumant, Shelley Saha, Bhagyashree Khaire, Priti Bhogle and Sugandha More.

2.4. INVESTIGATION AND TREATMENT OF PSYCHO-SOCIAL TRAUMA

During this period CEHAT was not involved in any substantive investigation into violation of human rights as in the past two major initiatives on domestic violence, one in the community and other in a public hospital were undertaken.

The community based study was completed and the draft report is being currently peer reviewed. The study reveals life-time violence faced by women to be as high as 64%. The study also reveals that while physical violence is commonly reported by women, the reporting of psychological violence increases when probing questions are used to elicit information on violence. This study was supported by the MacArthur Foundation.

The Crisis Centre started by CEHAT in a public hospital in Mumbai has been consolidated during this year. All staff has been trained, a core training team within the hospital consolidated and a continuous process of awareness building through various media is being undertaken routinely. There has been a substantial increase in referrals to the center. The project includes research and process documentation as one component. The Mumbai Municipal Corporation has shown keen interest in expanding this initiative to other public hospitals and this is now being worked out. The Ford Foundation supports this project.

Apart from the above CEHAT has begun a research study on the health and related impact of involuntary resettlement of a slum community. The study commenced in March 2003 and will be done over a period of 18 months. This study is supported by SWISSAID India.

2.4.1. Arogyachya Margavar Violence and Women's Health

The research was trained on the prevalence, nature, causes, help-seeking behaviour, and community response to domestic violence against women in a poor urban slum community. It was also directed to understand the existing psychological, legal, and medical support mechanisms. It also sought women's opinions and values about existing and other required services. The understanding of the social, political, and economic contradictions, which are at the root of this violence, to highlight the linkage between broad social, economic and political contradictions that exist at a macro level and domestic violence that exists at a community level were the other prime considerations.

We began with the mapping of the community, followed by house listing and information gathering on socio-demographic indicators from all the households within the three areas of our work. The study

was undertaken using a combination of qualitative and quantitative methodologies. As part of the qualitative methodology, nine informal group discussions were conducted with 63 women from the community to understand the nuances and details of domestic violence, their beliefs, attitudes, and perceptions about the same, their coping mechanisms, their help-seeking behaviour, and opinion about existing services and those that were required. The informal groups were selected using the criteria of mother tongue, education, occupation, and duration of marriage to capture all categories of women. The discussions were conducted in Hindi, Marathi, or Tamil, the three predominant languages spoken in these communities. Minimally, three sessions each of approximately 90 minutes were held with each group. The selected participants were visited in their homes and informed about the purpose of the group discussions. Efforts were made to ensure that these discussions were held at a date and time convenient for these women. Prior to the commencement of the research, informal support structures or referral links were put in place (*i.e., contacts were established with the local police station, health posts, women's organisations, shelter homes and crisis intervention centres amongst others*) to be able to respond to a woman's needs in case she approached us for assistance.

2.4.1.1. Highlights of the group discussions

Women shared that 'all women irrespective of their age experience violence or harassment at some point in their life.' However, a few of them felt that violence did not occur in the natal home and only began after marriage.

Girls being forced into marriage, demand for dowry, blaming a woman for every wrong that occurs, blaming the wife for not having a son, curbing a woman's freedom or movements, the tenuous mother-in-law and daughter-in-law relation, and self-neglect by women were seen as things that constitute harassment or *atyachar*.

Hitting, shouting, and screaming were forms of violence and harassment meted out to women.

The common forms of violence experienced by women in many homes include hitting, "dirty words" used by the husband to demean his wife, use of dirty words (*gaalies*) per se, constant bickering between

mother-in-law and daughter-in-law, violence on children, violence on the elderly by their children, sexual violence, violence at the time of puberty, treating the girl as "*paraya dhan*".

The grievous forms of violence mentioned were rape, eve teasing, murder, assault with weapon, and burning.

Poverty, lack of education, husband's nature, and lack of understanding between the husband and wife or between the mother-in-law and the daughter-in-law, or demands for dowry were stated as some of the causes of violence. In addition, women per se, by virtue of their being women and their lack of education were seen as rendering them vulnerable to violence.

2.4.1.2 Violence affects women's health both physical and mental.

Women 'tolerate' violence. This was attributed to existing norms and traditions in our society. A woman who was facing harassment/violence would ask for help only when there was no way out and when she experienced helplessness on all fronts. Till she could tolerate and bear things, she would keep things to herself and continue to remain silent. Hence, women did not use the existing counselling and rescue services.

One of the reasons for not seeking help was that most of the women felt ashamed to do so as it would show she came from a family where there was no culture or "*sabhayata*".

Violence continued to be regarded as a 'private matter' unless it was severe in nature or occurred outside the home or led to some external intervention. Community, neighbours, family and friends might or might not intervene unless the situation became 'severe'.

There was an expressed need for information on this issue.

The discussions also revealed the need to gain more understanding in terms of specifics on the nature of violence, its prevalence across the community, its frequency, the causes of violence, other determinants of violence, coping mechanisms adopted by women and their help-seeking behaviour. This understanding, gained through the group discussions, was used in the development of the survey protocol.

2.4.1.3 Quantitative study on domestic violence

Through the questionnaire canvassed to the individual respondents, information was sought on the nature of domestic violence, its forms, prevalence, frequency, and causes. 424 -married women were interviewed and the major findings of the survey were:

17 per cent of the women experienced domestic violence in one year of the reference period.

Life-long violence was reported by about 64 per cent of the women.

Differentials in domestic violence during the last one year showed younger women to be experiencing higher levels of violence as compared with their older counterparts.

Violence was higher among those with low levels of education and employment. At the same time, a woman who played a role in the decision-making process of the household was definitely at a lower risk of violence than those who did not participate in it.

Religious differentials showed domestic violence to be higher among the Buddhists, followed by the Hindu and the Muslim communities, respectively. The state of origin was another significant factor, with violence being higher among Maharashtrians than among non-Maharashtrians.

Physical violence during ones lifetime was found to be higher in women who experienced divorce, those with the middle school educated than the illiterates, with a lower level of autonomy in the decision-making process of the household; among Buddhists and Maharashtrians. The trends were almost similar for both psychosocial and economic forms of violence.

One significant finding of this study was that if violence is perpetrated it usually begins within a year of the marriage, after which the risk reduces substantially.

Reasons cited for violence were mainly related to woman's domestic role—not doing chores like cooking or keeping household items in a satisfactory manner. The situation got aggravated if the husband was a habitual drinker. The husband had a role in 79 per cent of the incidents of violence during a woman's lifetime, while in the remaining cases, the husband's family members and relatives were responsible.

Among those who reported of suffering violence in the last one year, 38 per cent were experiencing it every day. Overall, 94 per cent of these women were experiencing it at least once a month.

For many victims the intensity of violence had reached a stage where they had to seek medical care, and in some cases were even hospitalised. This necessitates the need to equip the health care system to cater to their needs and to sensitise the medical community about this whole issue of domestic violence.

It was found that 5 per cent of the women in the community had attempted suicide because of continual domestic violence, and hence it should be seen as a major reason for suicide among married women.

Future plans include publication of the research findings and its subsequent dissemination. The team plans to bring out a resource kit as part of its dissemination plan.

Team Members : Anagha Khot, Sumita Menon, T. R. Dilip, Ravi Duggal and Sushma Gamre.

2.4.2 Dilaasa : Crisis Centre in a Public Hospital for Treatment and Counselling of Women Victims of Violence

In the initial year of the project, the focus was to understand the hospital system and procedures with respect to women facing violence and to identify the problems in the existing system/procedures. A need was also felt for a needs-assessment study prior to beginning any kind of training in the hospital. We conducted a few short studies in this regards.

2.4.2.1 In-depth interviews with hospital staff

This was carried out to understand the perceptions of the staff regarding domestic violence as a health issue. The hospital staff from different levels were interviewed. The findings indicated that most of the health care providers saw violence as a social or personal issue. A few understood it to have a psychological dimension. It was not seen as a health issue that need concern the hospital. Despite probing, all that could be established was the link between physical violence and physical health consequences. Certain attitudes towards violence emerged which were then incorporated in the training sessions.

2.4.2.2 Observation at casualty

The casualty is the place where all cases related to violence are registered. Hence, it was thought that the crisis centre should be located close to the Casualty. The first step towards understanding the existing systems in the Casualty in terms of the roles and attitudes of the hospital staff towards women reporting domestic violence would be to observe the staff and patient interaction. The team members sat in the Casualty for two weeks to conduct systematic observation. What was commonly seen was that the medical needs of the patients were immediately attended to but no emotional support was provided. Doctors were apathetic towards women, who faced domestic violence but did not suffer any serious injury,

2.4.2.3 Study of medical records

In order to understand the types and patterns of the cases of violence coming to Bhabha Hospital, Bandra, we decided to study the hospital records. All suspected cases of violence are registered as MLC by the Casualty Medical Officer. We decided to study the cases registered for the year 1999. A comparative study was done with the medical-legal cases registered by men and women. We found that the incidences of violence were about 20 to 25 per cent for women.

2.4.2.4 Survey of shelters

In order to understand the policies of shelters in Mumbai and to enable us to identify a few with whom we could collaborate, we undertook a rapid survey of these. About 20 shelters were identified in Mumbai. By the end of December the shelter survey was completed and 17 were short-listed for the proposed project. We found that the admission policies of most shelters were very conditional and selective with only one shelter in the whole of Mumbai accepting women unconditionally.

2.4.2.5 Protocol

An Intake form for the crisis centre was developed, which recorded the basic information related to the woman, her history of violence and safety assessment, followed by a detailed safety plan and her expectations from the centre.

2.4.2.6 Process Documentation of the training of trainers

The Dilaasa initiative being the first of its kind, emphasis was put on documentation of all the training sessions. Based on this process documentation, the report on the training of trainers was brought out in a draft form. The focus was on incorporating changes in the report, which was reviewed by the resource persons who conducted these sessions. It is now ready for printing.

An effort was made to systematically document all the training sessions and meetings of the core group. This documentation has helped to refine the orientation module.

2.4.2.7 Study of the case documentations

A retrospective study on women registered with *Dilaasa* was conducted. This helped us to understand the profile of the women referred to the centre, the pattern of violence faced by women, as well as the gaps in the documentation. The intake form used to document the essential information about the woman was redesigned accordingly.

The findings indicated that women approaching the centre were largely in the younger age group, 40 per cent from 15-25 years followed by 35 per cent from 26-35 years. 60 per cent of these women were from the Hindu community, 50 per cent had finished their secondary education, a majority of them were not employed and amongst the employed most were in the informal sector, especially domestic workers.

Seventy-two per cent of the women who sought counselling were married and currently living within marital relationship. Five per cent were unmarried. It was noteworthy that within the married category, 33 per cent were married for less than 5 years, while 20 per cent were married for 6-10 years. The severity of violence was higher for the younger age groups. Physical and emotional violence were the most common forms. This indicated that the crisis model had the potential for early detection; crisis intervention and referral for necessary follow up.

Twenty-nine per cent of the women had come to the hospital reporting of assaults; followed by 20 per cent reporting the consumption of poison, and 16 per cent had come for the treatment of reproductive health problems. While these were the reported health complaints for which women sought health care, they also reported other health

problems like aches and pains, asthma, frequent fevers, loss of appetite, anxiety, insomnia, and depression.

Most women had never sought any formal (police/legal/women's group) or informal (family/friends/neighbours) support before coming to *Dilaasa*. For many of them, it was the first time that they were disclosing the fact that they faced domestic violence. The younger age group though, reported having sought support earlier, either by registering a police complaint or by sharing with the natal family.

Women availing of *Dilaasa* support are more likely to come in the morning, which is the OPD time. They follow up also at the same time. They visit the crisis centre on their visit to the hospital, either for their own health or for that of their children. As this is located in a public hospital, it is "safe" 'safe' for them to come for counselling. Sixty per cent of the women have followed up at least once.

Team Members : *Padma Deosthali, Anita Corea, Bhavana Kapadia, Chandra Ramamurthy, Lorraine Coehlo, Rekha Kale and Sangeeta Rege.*

3

ACTION, INTERVENTION AND TRAINING

During the last three years action and intervention activities have expanded substantially. The Arogya Sathi Program which was providing training to People's organisations for training activists as health workers and strengthening advocacy on health issues in local areas expanded substantially and has developed into a program called the SATHI Cell. The Arogyacha Margawar project wherein CEHAT was involved in community level intervention in the area of community health and building women's groups in the community to address issues of domestic violence was completed and CEHAT has withdrawn from the community, but the experience gathered there is being used in a hospital based project on domestic violence. Thus CEHAT has set up a crises centre in a public hospital to provide counselling and allied services to survivors of domestic violence. This includes training doctors, nurses and others in hospitals to understand domestic violence related issues and become gender sensitive. The success of this intervention has got the Bombay Municipal Corporation to consider extension of this in other hospitals and this is now being planned. Both these activities have become a major component of CEHAT's work and to some extent contributed to the changing character of CEHAT as an organisation.

3.1 SATHI Cell (2002 Onwards)

Primary health care has emerged as a programme area in CEHAT over the last three years, as one sub-theme under Health Services and Financing. Primary health care was identified as a key level of health services and enunciated as a new approach to health care, at Alma Ata, a quarter of a century ago. Yet, today, this remains one of the most neglected levels of the present health care system, which remains focused on doctor and hospital centered city based curative services. The basic health needs of the people, especially in rural areas, remain unaddressed. Both treatment and prevention of common illnesses and promotion of preconditions to health remain a distant dream.

The need of the hour is to resurrect primary health care in a new form, appropriate to the health needs of the society, and in keeping with the technology of the 21st century. A new phase of primary health care needs to be developed, maintaining a holistic and community-centred approach. We need to proceed primarily from below rather than from above, tackling the backlog of traditional health problems and addressing the new health challenges. This should be based on the political will of the people. Two successive projects – the *Arogya Sathi* project and the SATHI Cell – are attempts in this direction.

3.1.1 *Arogya Sathi* project

Developing Health Programmes and Advocacy with People's Organisations (Oct. 1998 - Nov. 2001)

The *Arogya Sathi* (AS) project was implemented with the purpose of helping to develop health programmes and undertake health advocacy in the context of people's organisations and mass movements. This initiative was based on the success of a community-sustained health programme since July 1995, launched by the *Kashtakari Sanghatna*, a mass organisation of tribal people in Thane district, Maharashtra.

The *Arogya Sathi* project, which began in October 1998, assisted in the development of community health programmes in three marginalised/tribal areas of Maharashtra/Madhya Pradesh (MP) where people's organisations were already functioning and leading people's movements. The community-based health programmes have been supported/ developed in Dahanu and Jawhar talukas of Thane district and Aajra taluka of Kolhapur district in Maharashtra, and in the Badwani region of Madhya Pradesh. The people's organisations, which have developed the health initiatives in these areas, are, the *Kashtakari Sanghatna*, the *Shramik Mukti Dal* and the *Jagrit Adivasi Dalit Sangathan*.

The outcomes of the *Arogya Sathi* project may be summarized as follows:

1 Bringing health into the agenda of socio-political organizations

The three collaborating people's organisations have been quite involved in the planning and execution of the field activities. They have taken up these activities as an important socio-political agenda for themselves.

Through the broader process of People's Health Assembly, the work, the perspective, the training/awareness material of the *Arogya Sathi* project has been shared with a number of socio-political organizations all over India, especially in Maharashtra and MP. Health-action is progressively becoming an agenda item for many socio-political organizations, and the *Arogya Sathi* project has contributed to this process significantly.

1 Developing CHW programmes and their sustainability -

In the three field areas, the village-level activities of the *Ârogya Sathis* have been financially sustainable, locally. One of the requirements of this CHW programme is that the *Ârogya Sathis* be paid some minimum compensation or honorarium by the local organization. As a long-term strategy it is neither possible, nor desirable, that the rural poor continue to pay this. There has to be a cross-subsidy to the health sector, as is being done all over the world. The locally sustainable health work was started in the three field areas, without waiting for the state to fulfil this responsibility to provide first contact care as part of primary health care.

The project has been implemented in 53 villages/hamlets in the three project areas, covering a population of 21,100. Sixty-five volunteers were trained, out of which 55 are presently working as *Ârogya Sathis*. Besides them, three community health organizers have also been oriented so that they act as, who act as activists in mobilizing public opinion in favour of health issues and provide organisational support to the CHWs. Direct savings in medical expenses of the people due to the *Arogya Sathi* project (*taking mean expenditure on last episode of illness*) was about Rs. 3 lakh during 1999 and about Rs 5 lakh during 2000.

The *Arogya Sathi* programme has also acted as a point of reference to put pressure on the state to fulfil its duty. This is because now we can say much more confidently and concretely that a low-cost First Contact Care programme can be implemented. Secondly, some of the *Ârogya Sathis* in the Dahanu Jawhar area have been integrated in a government scheme, due to the advocacy of the *Kashtakari Sanghatna*. We now need to popularise this process. *Gramin Lok Swasthya Yojana*, a scheme proposed by the Primary Health Care Collective is an attempt to combine people's initiative for First Contact Care with

support from public funds. Sustained advocacy would be required to see that the Maharashtra government accepts this scheme. The *Arogya Sathi* / SATHI Cell team has been considerably involved in this process.

Thus, overall, the *Arogya Sathi* project has created the basis for contributing to the popularisation of a people-oriented and improved CHW programme.

1 Developing local advocacy for health rights

In all the three field areas, the *Arogya Sathi* project supported local advocacy for health rights. This was done on issues such as the need for a locally sustained CHW programme, misuse of injection and intravenous saline, and the improvements needed in the work of the primary health centres or rural hospitals.

1 The 'Health Calendar Programme'

An innovation arising out of the Dahanu Health Programme implemented by the *Kashtakari Sanghatna*, has been a very concrete, specific tool to enhance the accountability of the primary health centres' village-level work. The process of documenting the state of public health services and interacting with the authorities for specific improvements through 'Health Dialogue' has also been an important innovation, which has wider application. In the People's Health Assembly, a number of specific demands have been formulated, to which the health-bureaucracy has responded somewhat positively. The *Arogya Sathi* team has contributed significantly to this entire process.

The gains of the *Arogya Sathi* project on advocacy thus created a basis for deepening and spreading the advocacy process on primary health care issues.

Thus, overall, the *Arogya Sathi* project, based on its work in the three field areas and as part of the PHA process, created a sound basis for the next phase. This phase consists of deepening and making pervasive the processes successfully developed.

3.1.2 SATHI Cell (Support for Advocacy and Training to Health Initiatives)

From December 2001, the *Arogya Sathi* project team (*Arogya Sathi* Team) in its new phase of work shifted from working in a project framework, with focus on specific targeted activities, to constituting

a cell, taking initiatives, responding to various situations, and having a much more flexible mandate. This cell has been termed as the SATHI (*Support for Advocacy and Training to Health Initiatives*) Cell in keeping with its main activities. This shift from a 'project-mode' to 'cell-mode' means more flexibility to choose appropriate issues, and time to conduct specific activities. There has been greater ability to respond to the specific requests, and time schedules of the various organisations. Such a mode of functioning has also enabled the team to intervene on a broader range of issues and at strategic times, acting as a 'resource cell' to support a variety of health initiatives.

3.1.2.1 Activities of the SATHI Cell during December 2001 to March 2003

The first four months' preparatory phase consisted of organizational groundwork, which included setting up of an upgraded field office in western M.P., discussions with existing partner organisations about work in the next phase, and contacting various new civil society organisations relevant for initiating future collaboration. During the last one year, the work of the SATHI Cell has expanded largely in the direction of establishing health care as a basic human right. Activities and the progress of the SATHI Cell from December 2001 to March 2003 are briefly described below.

1 Support to the existing health initiatives with partner POs in three areas

In the three field areas where the project team is collaborating with partner people's organisations (POs), (*namely Dahanu, Ajara and Barwani areas*), the village-level activities of the *Arogya Sathis* have been financially sustainable, based on the contributions/donations from village communities and the (POs). The organisational activities of the *Arogya Sathi* programmes are primarily managed by the POs. Inputs from the SATHI Cell are given only to supplement and strengthen the local initiative-, which includes upgrading some aspects of training and revision for the *Arogya-Sathis*, and providing inputs when some new initiative is undertaken. For example, in Ajra, a new batch of 8 health workers has been trained in response to the demands of a few remote hamlets. In Pati (Barwani), with the help of anaemia mirror charts the *Swasthya Sathis* have identified anaemia among women. They have also identified health problems of the women, and the *Sathi*

team has provided guidance for these endeavours. Similarly, the *Kashtakari Sanghatana* organised a 'Daru Bandi Parishad' (*Anti-liquor convention*) in January 2002 in Dahanu. The SATHI team participated in mobilizing people to attend the convention as well as put up a pictorial exhibition on the ill effects of alcoholism.

Some inputs from the SATHI Cell have focused on fostering financial support for the health workers from public funds. In Dahanu, this has meant exerting continuous pressure on the officials to modify the existing *pada swayamsevak* (*hamlet health volunteer*) scheme implemented in the tribal areas, by the Government of Maharashtra. The modifications we wish to make in the existing scheme include the suggestion that only women should be appointed as *pada Swayamsevaks*. They should be recruited for the entire year and not for the monsoon season alone. The government should supply medicines to them on a regular basis, and in sufficient amount. The training of these *Swayamsevaks* and a monitoring of their work should be more rigorous, as is being done in case of our health workers. Our existing health workers can be absorbed in this new scheme. It seems that in the coming months, in selected areas we would succeed in reshaping this scheme along these lines.

The SATHI Cell has sought the affiliation of the SNDT University to conduct VHW courses. Cehat is likely to be given permission to run these courses this year. This would add to the social acceptance of our training programme for health workers.

- 1 Training and organisational guidance for Arogya Sathi programmes to other organisations

A modified approach has been evolved to assist the development of *Arogya Sathi* programmes in new areas. While collaborating with new organisations on developing *Arogya Sathi* programmes, the Cell is providing Supportive organisational inputs to them as they take on the entire responsibility of the local management, mainly with regard to administering village-level health organisational activities. It is only with the *Adivasi Mukti Sangathan* in Sendhwa that we are helping out, especially in the initial period, to co-manage the programme. In western MP, we are mainly giving training inputs for health workers to the local NGOs—Ashagram Trust and SAMPARK.

Training inputs, with an emphasis on herbal medicines, are being given to a people's organisation, the *Khedut Majdoor Chetana Sangath* in the Alirajpur area of MP.

- 1 Support to local health advocacy activities with other groups in Maharashtra / West Madhya Pradesh

Advocacy on local health issues has been one of the components of the previous *Ârogya Sathi* project. This activity has been continued, covering larger areas and varied issues. In this context, a *Swasthya Yatra* (*health procession*) was arranged from 17th to 22nd January 2002, in Sendhwa and Pati blocks of Barwani district. A team of health activists moved from village to village with a range of exhibits, including human organs, a microscope, video programmes, slide shows, and poster exhibitions. This provided the basis for increasing health awareness and raising the issue of health rights in collaboration with the people's organisation working in the area.

In the first phase of work, there had been a successful 'sit in' protest at Ajra in January 2002 regarding the lax implementation of health-related demands.

In April 2002, SATHI Cell members participated in a people's campaign on health issues at the office Alibag Zilla Parishad. The campaign was organised by the *Shoshit Jan Andolan* (*a coalition of people's organisation working in Raigad district*).

A *Stree Arogya Melava* was organised by *Kashtakari Sanghatana* in Dahanu on 3rd February 2003 where hundreds of women from nearby tribal villages had gathered. Information regarding various facets of women's health was given to these women with the help of slide shows, flip charts, posters, etc. Dr Meena, Commissioner of Tribal Development Department, attended the programme, along with local officials.

- 1 Inputs to state / regional-level advocacy related to Primary Health Care and Health rights

The People's Health Assembly (PHA) process, now continued as *Jan Swasthya Abhiyan*, has laid the basis for state-level advocacy for health rights. The Cell plays a significant role in supporting state-level advocacy on health issues in Maharashtra. Similarly, in MP, interaction

with various organizations in the western part of the state has been taking place, strengthening the Jan Swasthya Abhiyan in West MP.

On the issue of generalizing the VHW programme team members also facilitated a series of meetings of the PHC collective, which is a group of Public Health specialists in Maharashtra. This was followed by a workshop organised by the PHC Group for health sector NGOs in Maharashtra, on the issue of village health worker programmes and an incipient new government scheme of VHWs – The *Gramin Lok-Swasthya Yojana*’ (GLY). Thanks to the advocacy of the PHC Group, the planning commission of the Maharashtra government has now included the GLY in the forthcoming 10th Five Year Plan of the state.

The SATHI Cell, on behalf of the *Jan Arogya Abhiyan*, is part of the *Anna Adhikar Abhiyan (AAA- Right to Food Campaign)*, which is a coalition of various organisations working on the issue of food security. The SATHI cell has been actively involved in various programmes organised under the aegis of the AAA, and has played a catalytic role in its functioning. The SATHI cell members were involved in preparations of the protest programme from 11th to 13th March 2003 at *Azad Maidan*, Mumbai. This was a campaign demanding an increase in the Budget allocation for the social sector—specially the health sector and for food-related schemes.

The Bombay Nursing Home Registration Act 1949 (BNHRA), is now being substantially improved to lay down minimum standards for quality of care in the private health care sector. The SATHI cell has played an important role in co-ordinating with various health organizations and health NGOs to undertake state-level advocacy and make consensual suggestions to improve the draft of the modified act. Many of our suggestions have been accepted by the Health Secretary at a state-level meeting. To increase awareness about this modified act among doctors and health activists a booklet in Marathi has been published.

The SATHI Cell members have also been actively involved in the *Jan Swasthya Abhiyan*, in M.P., and have contributed to a programme of ‘Public audit’ of the Health Guarantee Scheme of the Madhya Pradesh government. A dialogue has followed this with principal secretary, health, and other senior health officials regarding

health policy issues. Similarly, the SATHI Cell members have actively contributed to the survey of food security schemes, and the preparation of a report on the status of these schemes, which was done by the *Jan Swasthya Abhiyan*, Madhya Pradesh.

- 1 Development of relevant training, awareness, and advocacy material

Training material

Development of training and awareness, and advocacy material appropriate to the above activities is an integral part of our job. Material published during the last three years includes:

Pictorial training manual for illiterate health workers—*Arogya Sathi* (Marathi) and *Swasthya Sathi* (Hindi) in two volumes of 100 pages each.

A training manual in Marathi for primary-educated village health workers – two volumes of 200 and 150 pages respectively.

A book on women’s reproductive health, based on compilation and reprint of certain existing booklets published by ‘NIROG’ and ‘IDEAL’ the health NGOs in Gujarat

Awareness material

Slide show on anaemia and health rights in Marathi and Hindi; a pictorial poster in Marathi on anaemia, and flip charts on anaemia in collaboration with Tathapi Trust

Eight posters in Marathi on various health issues, six of them also in Hindi, a Hindi poster on *Anganwadi* services, distributed for use by the Right to Food campaign in MP.

A pictorial poster exhibition and multi-coloured slide show in Marathi on the ill-effects of alcoholism on health and social well-being.

Slide show in Marathi and Hindi on health care as a right and a pictorial exhibition in Marathi on the same.

Hindi edition of the booklet for village health committees — *Swasthya ki Samajh Badhayen, Swasthya ke Hak ko Payen*.

Advocacy material

People’s Health Assembly (PHA) related Advocacy material—

Booklets: *Jan Arogya Sanad* 2nd edition, (*People's Health Charter*), and *Jan Arogya Abhiyan* (compilation related to *Jan Swasthya Abhiyan [JSA] activities in Maharashtra*).

A Health Services Monitoring Calendar being used to monitor village-level health services.

A Marathi booklet on the experiences of the *Arogya Sathi* team in building up a health movement in collaboration with people's organizations, *Chalwal Aarogyachi, Janwadi Paryayachi*. A similar booklet in Hindi, *Swasthya Ke Liye Vikalp Va Sangharsha*.

Hindi edition of the booklet on health dialogue, *Aao Milkar Karen- Swasthya Samvad (How to conduct a health dialogue)*.

A Marathi booklet, *Doctoranvar niyantran!*, on the proposed modifications in the Bombay Nursing Home Registration Act, 1949.

A brochure of the above Cehat publications for health awareness, training, and advocacy gives details.

Team Members : *Abhay Shukla, Amita Pitre, Amulya Nidhi, Anant Phadke, Ashok Jadhav, Nilangi Nanal, Prashant Khunte, Sameer Mone and Shalini Verma.*

3.2 Aarogyachya Margavar: Violence and Women's Health (1998 Onward)

Cehat had conducted a research on reproductive and general morbidity in parts of a slum in the *Jari Mari* area. The study brought out that large number of women were suffering from reproductive health problems, and despite a plentiful supply of health care facilities in Mumbai, they remained silent about nearly half of their health problems and approached no health care provider. Moreover, instances of violence came to the fore during the interactions with women from this community, but due to methodological constraints, information on violence against women could not be recorded as part of this study. This was the genesis of the research and action programme *Aarogyacha Margavar*. Since its inception in 1988, the programme aimed to be women-centred and community-based in its values, objectives, and strategies. We aimed to develop the programme as a model for community health work in an urban area prioritizing the health of women and children. We also laid equal emphasis on the physical and

the mental well being of the community, highlighting the inter-linkage between the two. Health work was seen as a doorway to develop work on domestic violence. It was envisaged that all our activities would serve as an intervention programme for addressing the issue of domestic violence in the urban slums. The health programme included the training of women community health workers, increasing the accessibility of slum dwellers to affordable and reliable reproductive health services, through properly trained women CHWs. A systematic, qualitative and survey-based study of the prevalence, forms and problems related to violence against women in this area eventually led to the setting up of a response unit for survivors of violence in the slum area. This was initiated both at the medical clinic and in the community by training CHWs in basic counselling skills.

Health work began by conducting health awareness sessions in the community, which led to identifying women interested in a long-term training programme. This was conducted in two phases—comprehensive learning (*from October 1999 to December 1999*) and the internship phase (*from January 2000 to June 2000*). The training covered issues related to comprehensive health care with supportive subjects like the status of women, communication skills and community work. Special emphasis was laid on the health of women and children, reproductive health, and mental health. It was proposed that para counsellors be trained to address the issues of domestic violence. However, this module could not be conducted, as all health workers were not willing to participate in it. Although, 16 women of various ages, and belonging to diverse backgrounds, underwent the training, there were a large percentage of dropouts due to various community dynamics. Six women completed the training and the internship, and five were actively working as health workers. Refresher trainings to update their knowledge and skills were an integral part of the programme, and were participatory in nature. A formal evaluation of the CHWs was conducted in January 2001.

Curative work, along with preventive and promotive work, formed the core activity of the health workers. Each health worker has been responsible for about 500 households. This number has gradually increased over the last three years, now covering the entire area of intervention. As part of providing curative care, the CHWs enquired

about health problems at home and treated common ailments. As part of preventive and promotive care, they provided home-based care, advice to pregnant women on antenatal and post natal care—emphasizing the care of the new born, the importance of complete immunisation, enquiring about immunisation history for children below five, motivating the mother and referring the cases to the nearest health post.. As an important component of comprehensive primary health programme, health education sessions were regularly conducted in the community. The topics covered included irrational use of injections and saline drips, mental health and reproductive health (including ante-natal and post-natal care).

A clinic was also set up to provide referral support to the community health workers. Over the last three years, the clinic has paid equal attention to both curative and preventive services to the community. Gradually, over the last two years, a network with public health system and other health centres has been developed in conjunction with a three-tier system for the routine functioning of the clinic. CHWs, the first contact person at the community level, treat minor illnesses. Cases requiring special medical attention, emergencies or referrals are referred to the doctor at the clinic. Depending on the nature of the illness, patients are either treated at the clinic or referred by the doctor to public hospitals or health centres for investigation and further treatment.

Although community organisation was not a planned activity, we believed it was imperative that community members be involved in the organisation of various activities undertaken, that they assumed leadership of this programme and together build sustainable community structures for providing support to the health programme and other activities. Sensitising people about their problems, creating a bond among them, mobilising them to deal with their daily problems and addressing local issues could thus be achieved. A conscious effort was made to involve women in actively participating and taking initiatives in community work. As a result active informal groups emerged which were converted to self-help groups (SHG) through savings and credit activities. To regulate the work of these self-help groups, as well as other activities taking place in the community, a core group called 'Astitwa' (*identity*) was formed. Over time, this group was

registered as the 'Astitwa Mahila Mandal' (AMM) under the Societies Registration Act. This group has been involved in conducting various community-based activities like the running of the self-help groups, literacy classes, imparting pre-vocational skills such as beautician courses and tailoring classes, addressing issues related to the functioning of or lack of civic amenities, as well as, income generation activities.

Response Cell

It was envisaged that all our activities—the health work and the research—would feed into developing an intervention programme at the community level. This would take the form of a response unit for survivors of violence in the slum area, both at the medical clinic and in the community by training CHWs in basic counselling skills. Over the years, following intense discussion regarding the feasibility of training health workers as para-counsellors to deal with victims of violence, it was found that it would be more appropriate to set up a community-based response system built on the foundations of the self-help groups and the core-group, *Astitwa*. However, in light of the decision of a phased withdrawal of Cehat's direct input in the programme, it was felt that the setting up of a response system should not be initiated at such a point. In a series of discussions held with the core group members of the *Astitwa Mahila Mandal*, the health workers, as well as the self-help group members have indicated a willingness to provide support to women in different situations of distress. Therefore, though a formal response system has not been put in place, efforts are underway to prepare the core group of the *Astitwa Mahila Mandal* to address this issue. Simultaneously, contact has been established with the local police and *mohallah* committee, and shelters and crisis centres have also been identified. Casework with women in distress was undertaken by the social worker on the project with increasing participation of the community members, especially community health workers and members of the core-group. CEHAT would continue to provide inputs and develop this initiative further. Perspective building sessions on the issue of domestic violence and training of the group to intervene directly in cases of intra-familial violence would be undertaken. A resource kit, which includes relevant information on this issue, is being developed and would also contribute in these efforts.

While CEHAT has withdrawn from the area in terms of formal commitments, in the last one year, efforts have been initiated to strengthen the capacities of the local group—the *Astitwa Mahila Mandal*—to take the various processes forward in whatever limited way they can, depending on the decisions made by the women. It is planned that the *Astitwa Mahila Mandal* would continue to support the clinic and health activities along with other developmental activities. CEHAT has extended its support by donating all the equipment and has created a revolving fund for drug expenses. It has also agreed to provide support to the *Astitwa Mahila Mandal* in dealing with official matters with the charity commissioner and provide any other help required. CEHAT would continue to provide inputs and develop this initiative further. Perspective building sessions on the issue of domestic violence and training of the group to directly intervene in cases of intra-familial violence will be undertaken. A support group of like-minded people has been formed to provide both financial assistance and management inputs to the *Astitwa Mahila Mandal* till a period where the members acquire skills to handle it independently.

Team Members : Anagha Khot, Aruna Kartik, Bhavana Kapadia, Ratnaprabha Pedhambkar, Sumita Menon, Sushma Gamre.

3.3. Dilaasa: Crisis Centre in a Public Hospital for Treatment and Counselling of Women Victims of Violence

3.3.1 Background

Violence against women is a universal phenomenon cutting across age, culture, caste, religion, and socio-economic status. It occurs in various guises, daily. Of these, domestic violence is almost ubiquitous and has become socially and culturally accepted. It is an ongoing experience of physical, emotional, and/or sexual abuse faced by women within the household. Each episode of abuse results in physical and psychological trauma that remains hidden. The morbidity and mortality resulting out of violence imposes a large burden on the public health services. Apart from causing immediate injuries, such acts of violence result in chronic pain, disfigurement, miscarriages, and also stress, anxiety, hypertension, and insomnia. One of the most common effects of violence is the infliction of self-harm. The victims refuse to eat or drink, wish to commit suicide, and neglect their health.

The women approach the health care system for the treatment of post-violence traumas. When a victim approaches a health professional, her physical injuries are treated but she does not receive any emotional support. If, at this first contact, the doctor could provide her with the much-needed emotional sustenance, and refer her for counselling, she would be in a better position to stand up against any future violence. While there are many women's organizations providing counselling services to women facing domestic violence, no concrete effort has been actually made to sensitise doctors on this issue and the role that they need to play in documentation and referral.

Evidence indicates that a large number of women do approach public hospitals for treatment of injuries arising from domestic violence but receive only symptomatic treatment. The doctors do not think that they have any further role to play. There are many reasons for that. Firstly, they treat domestic violence as personal, and therefore do not probe into it. Secondly, they too come from similar social milieu where domestic violence is an accepted norm. Thirdly, they consider it to be a law and order problem, and so believe that the police should look into it. Fourthly, they are not trained to enquire into it. There is, thus, considerable resistance on their part to document the current episode or ask for history. They are placed in a unique position, since a woman is more likely to share the actual cause of her injury or desire for suicide with a doctor than with any other person.

Women's movements have consistently raised the issue of the role of doctors in documenting violence against women. There have been several cases where the doctors have not documented important evidence related to rape and sexual assaults. In the absence of sensitive medical evidence against the violence rape victims have suffered, the survivors have found it extremely difficult to fight for justice. In cases of domestic violence the episodes of assaults, burns, consumption of poison get documented as MLC (*medico-legal cases*), but the history behind these incidents is never documented. While the most common reason for divorce is domestic violence, due to lack of evidence women cannot prove it. CEHAT has been advocating the role of the health care professionals in responding to violence, caring for victims, and preventing violence. The investigations of sexual assault/rape have brought to light the apathy of the concerned doctors. The idea of Dilaasa, or the first hospital-based crisis centre emerged during

the investigations. A crisis centre within a public hospital would be accessible to a large number of women as well as being safe for them to use it.

The Dilaasa Crisis Centre is a joint initiative of CEHAT, a research organization, and the public health department of the Brihanmumbai Mahanagarपालिका (*Bombay Municipal Corporation*). The Dilaasa Crisis Centre for women is a hospital-based project that was started in August 2000 at K.B Bhabha Hospital, Bandra, in the “H” ward of the western suburb of Mumbai. It is a three-year project started on an experimental basis. At the end of March 2004, this centre will be handed over to the hospital to be run by the BMC.

The focus of *Dilaasa* is to ensure that every episode of violence inflicted on a woman gets recorded and she receives emotional support. The woman may or may not seek police/legal action but the record would help her if, and whenever, she decides to take action.

The aim is to sensitise doctors so that women coming to the casualty and the OPD would be screened by them for domestic violence, and would also be referred to *Dilaasa* for social and psychological support.

3.3.2 Objectives

To assist the Public Health Department of the BMC in the establishment and running of the crisis centre for women survivors of domestic violence at the K. B. Bhabha Municipal General Hospital, Bandra West, Mumbai.

To assist the Public Health Department of the BMC in creating a conducive environment and concrete conditions for inter-departmental collaboration, and for collaboration with NGOs and other concerned groups in running the crisis centre for women in the hospital. Such collaboration would be based on mutual respect, and on the principle that care for the survivors would be the dominant concern.

In the final year of implementation, the goal will be to help the BMC make the programme a part of its services, to link it up with its peripheral institutions and to replicate it in other hospitals in Mumbai, as well as outside.

3.3.3 Training

This is an important function of the project. Domestic violence is not recognized as a health issue at all. The health care providers,

therefore, had to be trained to be sensitive to issues of gender and violence. There was a need to train the staff in screening skills that would enable them to identify women facing domestic violence. The first year of the project was focused on getting resource persons to plan and develop the training component of the project. The resource persons were Ms Manisha Gupte, *Masum, Pune*, Ms Radhika Chandiramani, *Tarshi, New Delhi*, and Ms Renu Khanna, *Sahaj, Baroda*. They selected a group of 40 health care providers from the hospital as key trainers who would undergo intensive training conducted by them.

It was decided that they would in turn train the rest of the hospital staff. The key trainers were doctors and paramedical staff who were also the permanent staff of the hospital.

The key trainers had seven training workshops in all. These covered topics like domestic violence, gender, patriarchy and its relation to violence, role of health professionals in dealing with domestic violence, counselling, role of trainers, principles of adult learning and participatory learning, legal issues related to violence against women, and violence as a health issue.

The Dilaasa team that would run the centre was also trained at the same time. Each team member had joined the project with prior skills and experiences; therefore, the focus of the training was to help equip each member with uniform knowledge in areas of gender, patriarchy, sexuality, documentation, counselling and communication skills, and team building.

From the group of key trainers, a core group of 12 trainers had emerged and six pairs (one medical staff and one paramedical staff) were formed who would take the training sessions jointly. The core group met regularly and sessions were conducted as a refresher course. A three-hour module emerged. The rest of the hospital staff, along with the community health workers, were trained. 97 community health volunteers and 443 hospital employees have been trained.

A need was felt for intensive training. Therefore, a three-day training session was organised for the core group and teams from three other BMC hospitals. The Family Violence Prevention Fund, San Francisco, supported the training. The focus was on skill building for

the screening of domestic violence as well as comprehending the dynamics of domestic violence.

While working in a hospital-based crisis centre, one has to frequently liaison with the police on behalf of women facing domestic violence. Further, the police and the health system need to work in tandem to document the necessary evidence in cases of violence. Hence, a training workshop was organised for the police and the doctors. 26 police Inspectors and police sub Inspector attended the workshop from police stations of the western region of Bandra emerging issues have been documented and further dialogue would be conducted with the state women's commission.

With a view to extending such centres in other hospitals, a one-day training programme was organised this year. The aim was to orient the staff members of different peripheral hospitals to the issues of domestic violence with an emphasis on its health-related fallouts.

This year, the team plans to evolve a manual for the training of health care providers. Ms Renu Khanna, one of the trainers, conducted a session on developing manuals. We have listed the various modules and the sessions that would form a part of the manual. The topics listed for the modules were:

- 1 Domestic Violence: A Public health issue,
- 1 Gender,
- 1 Role of health care providers in responding to domestic violence,
- 1 Setting up a crisis centre, and
- 1 Counselling.

3.3.4 Counselling

The centre provides social and psychological support to women facing domestic violence. The components of counselling are the providing of emotional and social support, safety assessment of the woman, a safety plan, and the ability to provide comprehensive support through referrals, etc.

A formal understanding with two shelters to be used as temporary shelters has been reached. Besides this, the hospital too has promised to provide shelter by way of admission in the hospital. Two meetings with shelter homes and women's organisations in Mumbai were

organized to facilitate mutual sharing. A meeting with *Mahila Mandals* working on violence at the community level was held to discuss the various ways of helping the victims of violence.

The systems and procedures at the centre for counselling were put in place in the very first year. While only 111 women registered at the centre in the year 2002, a substantial increase in the referral was seen this year. In the second year, 204 women have sought support from the centre. On an average, the centre saw an increase in the number of new cases from 12 to about 22 per month this year. The follow-up sessions are about 38 per month. About 2 to 3 women drop in for counselling every day. We see a higher number of women coming to the centre in the morning, during the OPD time, as they club their visit to the hospital with follow up to the centre. It is clear though, that, the assimilation of domestic violence as health issue within the system is happening at a slow pace.

This year we were able to bring about some changes within the system that would ensure the identification and referral of cases of domestic violence. One of the changes was in the Management Information System. The casualty medical officers have to state the number of women patients that they have screened for domestic violence as well as the number of women they referred to *Dilaasa* in their report of the registered medico-legal cases. The team did the analysis of case documentations. It was a useful exercise as it helped us to understand the profile of the women coming to the centre. It also aided in data compilation of violence and the review of the interventions made for each of the woman. It further sharpened our understanding of the specific skills that needed further honing, and the challenges that a crisis intervention model would face. To cite an example, a large number of women coming to the centre are from the younger age group, facing severe violence. The experience of a new marriage coupled with violence has a numbing effect on women. Women are not in the emotional state to acknowledge that there is abuse. Therefore, counsellors have to sharpen their skills to be able to reach out most effectively to these women.

While much of this has evolved during the weekly presentations, the analysis has helped us in identifying specific skills that would be

part of training modules, as well as has thrown up areas for further research.

One concern that remains to be tackled is the violence faced by the health professionals themselves. This issue needs to be studied, and the mechanisms required to address it has to be worked out. Nurses, for example, face domestic violence themselves. In the last two years, very few women from the system have sought support from *Dilaasa*. The reasons given being, that, as they work within the hospital “everybody” would come to know about their “personal” problems. While we realise the need to emphasise confidentiality, the centre may have to evolve other strategies or create other spaces where the nurses could share their own pain. This is very important because they are the ones who spend a lot of time with the patients, and they are also the potential para-counsellors.

3.3.5 Outcomes

The centre has become a part of the system, and has been recognised as a department. The changes in the information system, for the identification and referral of women facing domestic violence, have been made in the hospital.

A core group of trainers has emerged from amongst the hospital staff. The BMC wants to replicate it in other hospitals, and the next phase of the project will look into that.

Team Members : *Padma Deosthali, Anita Corea, Bhavana Kapadia, Chandra Ramamurthy, Lorraine Coehlo, Rekha Kale and Sangeeta Rege*

4

SERVICE, DOCUMENTATION AND PUBLICATION

The consolidation of the health information center has seen good progress during the year. The library is now fully computerized. The reprints and documentation have been reorganized and will be computerized during next year. The library has set up a current awareness and bibliographic service which is also located on the CEHAT website. The publication unit of this center is still to be consolidated, though a number of publications, including awareness and training material were brought out. CEHAT’s website www.cehat.org is well consolidated and updated regularly. It now has many of the papers and articles of CEHAT online and abstract of reports and books, as well as data from the CEHAT database.

While in the previous year there was a setback to the database updating and consolidation, it has been completed this year and we will be coming up with relevant publications as well as soft copies of the database later in 2003. The activities of this center are supported mostly through the ISP grant from NOVIB and Ford Foundation and to a small extent from various other projects.

4.1. HEALTH INFORMATION CENTRE

Health Information Centre is a core activity of CEHAT. The Health Information Centre consists of three units: library and documentation, publications and website, and health information database. A team of five professionals and support staff in Mumbai and Pune manage it.

4.1.1 Library and Documentation Unit

The Library is as old as CEHAT is. It started functioning with a few books donated by the trustees and well-wishers and has completed nine years of service. At present, the library has a collection of 7,681 books, 3,000 articles, reprints and 300 bound volumes of periodicals and journals. The library subscribes to 23 periodicals and six daily newspapers, and receives 25 bulletins and newsletters on gratis.

In the last three years, the Library has concentrated on:

- 1 Rearrangement
- 1 Updating its collection
- 1 Creating new sections, including the Reference Section
- 1 Computerisation of its collection
- 1 Library administration.

During these three years, the Library collection has grown in the following manner

<i>Year</i>	<i>Accession Nos.</i>	<i>Books added</i>
2000 – 2001	4901 – 6239	1338 (Including un accessioned books)
2001 – 2002	6240 – 7037	797
2002 – 2003	7038 – 7681	643

Eighty per cent of the library documents have been reclassified using the DDC 17th edition (*as it was available in the library*) with some modifications in class numbers to fulfil the requirements of the library users—those with Cehat and those who are not. Books are placed clock-wise on the shelves with nametags. The shelf list is in progress and will be completed very soon.

New sections for pinpointed search has been created in the library, such as Health Economics, Health Care Privatisation, Health Legislation, Health Care and Role of NGOs, Rural Health, Urban Health, Right to Health Care, Health Insurance, Medical History, Health Education, Health Research.

The Reference Section comprises reference documents such as annual reports of Ministry of Health and Family Welfare, Government of India, bibliographies, census reports, dictionaries, directories, district gazetteers, Human Development reports, Technical Report Series of WHO, World Development reports, State and National Budget documents, NFHS and RCH reports and papers, National Accounts Statistics, Health Information India Statistical Abstracts and a number of other database volumes are now easily accessible to readers. Detailed list of available reference books is also prepared and efforts are made to procure missing volumes.

The library has created a database using the WINICDSISI software package developed by the UNESCO. Bibliographical information of about 6,292 documents is now available for quick search and retrieval of the required documents. Separate database on the bound volumes of periodicals is also being created and maintained. Borrowers issuing record too is partially computerized.

Furthermore, the library administration has been revamped—new filing systems have been introduced, the accession register for books and other materials has been duly maintained, and the new accession register for bound volumes of journals has been prepared. Similarly, a separate accession register for miscellaneous publications has been prepared. Periodicals are registered and a record of those being issued is maintained to remind the borrowers on non-receipt of periodicals. 363 volumes of old periodicals and journals, and books were bound. Over and above, a library visitor’s register is maintained. This is the first time that a 100 per cent physical verification of library books and other material has been conducted. The report is being compiled.

As part of the documentation process, the library has introduced a Current Awareness Services (CAS) and a New Arrivals Bulletin (NAB). It has prepared a list of reference books available in the library. It has compiled subject-wise bibliographies Health Economics, Medical Ethics, Godhra: Genocide in Gujarat and has posted them on CEHAT’s website along with CAS and NAB. The library has maintained 45 files on newspaper clippings on selected subjects and topics. Last year the Library compiled a document on the Gujarat incidents, *Genocide in Gujarat 2002: Impact on Health and Women*.

The Library is planning to undertake following activities during the next year as part of updation of Library

- 1 Rewriting of old Accession Registers.
- 1 To strengthen the Pune base library.
- 1 Establishment of a small library at the Indore office.
- 1 Library brochure to be prepared.
- 1 Make efforts to procure missing issues of periodicals/journals.
- 1 To create separate section on Mumbai (*Multidisciplinary Aspect*)

Team Members : Ravindra Thipse, Kottrayya Agadi, Shailesh Dikhale, Vijay Raut and Vijay Sawant

4.1.2 Publication Unit

During these three years (2000-2003) the publication unit has brought out the following 23 publications:

Research Reports 8

Reference Books 1

Volumes in Health Panorama Series 4

Document 1 Genocide in Gujarat 2002: Impact on Health and women.

Marathi 8

Hindi 1

4.1.2.1 Books/Reports

A Study on Demand for a Public Hospital in K-East Ward, Greater Mumbai

This book is a product of detailed field investigation carried out in K (*East*) ward of the Brihan Mumbai Municipal Corporation. The book gives an in-depth analysis of the utility of public health care services available in the area. The study emphasizes the need to strengthen the public health care system in order to maintain equilibrium in the country's health outcomes across different subgroups of the population.

1 *Gender and Medical Education: Report and background material*

National consultation report on Gender and Medical Education along with background material has been released.

1 *Abortion Practice in India: A Review of the Literature*

The first paper in this series advocates the need for expanded community-based education to address issues of women's reproductive health in specific, and the issues of women's right to high quality health care services in general. This literature review draws attention of readers on abortion, and the associated morbidity and mortality from unsafe abortion. This is a common problem and needs to be given top priority for safe motherhood issues in India.

Women and Health Care in Mumbai: A Study of Morbidity, Utilization, and Expenditure on Health Care in the Households of the Metropolis

The study makes an attempt to understand and document analytically the perceived morbidity patterns; the problems faced by women in accessing health care facilities with regard to their utilization; and expenditure incurred by households on women's health care, with special reference to socio-economic differentials.

1 *Private Health Sector in India*

This is systematic review of the available empirical studies on the private health sector in India. The private health sector is seen, among others, from the point of view of its accessibility, affordability, quality of health care, and policy intervention. This book is appended by an annotated bibliography of about 85 documents.

1 *Studies in Reproductive Health Services in India (1990-1991): A Select Annotated Bibliography*

The references cited in this compilation are helpful in identifying research gaps and sharpening the perspective for future research in reproductive health. This volume is a must for researchers, health activists, programme implementation agencies working on reproductive health care, and is an indispensable reference tool born out of the rich experience of the compilers.

1 *Ethical Guidelines for Social Science Research in Health*

This is the first comprehensive document on ethical principles and guidelines for conducting social science research in health-related issues. It throws light on the rights and responsibilities of the researchers, reviewers, editors, organizations, funding agencies, and publishers who play an important role in the dissemination of information obtained through research.

1 *Health, Households and Women's Lives: A Study of Illness and Childbearing Among Women in Nashik District, Maharashtra*

This report covers most of the health problems of women in rural as well as urban areas in the Nashik district of western Maharashtra. The study throws light on health care services, health expenditure covering gender age, and other socially important factors.

4.1.2.2 Reference Books

1 *Public Health Care Facilities in Mumbai*

This directory is most useful for the layperson who wants to avail

of health care services that are available within the Brihan Mumbai Municipal Corporation area. It gives information about various services provided by the hospitals and maternity homes, the availability of specialists, number of beds, addresses, contact numbers, landmarks, nearest railway station, bus numbers, visiting hours, blood bank, ambulance and hearing services, etc.

4.1.2.3 Health Panorama Series

1 Health Panorama No.1 - Violence: A Health Issue

This is the first volume in the *Health Panorama* series devoted to “Domestic Violence”. The entire volume deals with various facts of domestic violence, such as the socio-cultural, political and economical.

1 Health Panorama No. 2 - Abortions in India

This is a systematic compilation of articles on abortion. Selected newspaper clippings and abortion statistics indicate the current public interest on this issue. This document carries MTP Act 1971.

1 Health Panorama No.3 - Health Policy Making in India

This is an endeavour to put together research papers and articles that can facilitate an understanding of the various health policy issues. The present issue carries a draft of the National Policy on Indian Systems of Medicine.

1 Health Panorama No.4 - Private Health Sector in India

This is the fourth volume of the *Health Panorama* devoted to the private health sector in India. It is a compilation of well-known articles, research papers, newspaper clippings and bibliography on the private health sector. This document carries The Bombay Nursing Home Registrations Act 1949 also.

4.1.2.4 Document

1 Genocide in Gujarat 2002: Impact on Health and Women

This document is a compilation of selected and relevant newspaper clippings, articles and fact-finding reports of various agencies such as the National Human Rights Commission, the Medico Friends Circle, etc., on the communal violence in Gujarat in February 2002, popularly known as Genocide in Gujarat.

4.1.2.5 Marathi Publications

1 Kawade Ughdooya

This book is dealing with women’s health issues such as Menopause, Pregnancy, Health care during pregnancy, Safe delivery and common diseases etc.

1 Arogya Sathi Bhag I

This is handy manual for health workers gives information about Community health, Health care services, Common diseases and its remedy, Personal hygiene

1 Arogya Sathi Bhag II

Second part of the Aarogyasathi gives information about various symptoms, diagnosis, appropriate remedies and prevention of common disease such as Temperature, Cough, and Stomach pain, Anemia etc.

1 Arogyasamvad Kasa Sadhava

Communication is very important skill of health worker. This booklet is dealing with various health care services offered by government, and how to avail these facilities. How to create awareness about health services schemes, how to keep a watch on this activity. Also this booklet has information about how to conduct the health dialogue with health professionals and community.

1 Chalwal Arogyachi: Janvadi Paryayachi

Since 1998 CEHAT’s Arogya Sathi team is engaged in health movement in Maharashtra and Madhya Pradesh. This health movement has passed through various stages and this document is detailed account of this movement.

1 MTP Kendra Nodani Karan Margadarshika

This document is a handy guide of legal information about registration of MTP Centre.

1 Jan Arogya Abhiyan

1 Jan Arogya Sanad

4.1.2.6 Hindi Publications

Swasthya Sathi Bhag I and Bhag II

Swasthya Ki Samaz Badhyae: Swasthyake Haka Ko Payae

The publication unit participated in the Asia Social Forum held at Hyderabad, the Mahila Mela held at Nagpur, the human rights meeting held at the University of Mumbai for the dissemination of Cehat's publications. All these efforts received encouraging response.

Team Members : *Ravindra Thipse, Margaret Rodrigues, Shailesh Dikhale and Sharda Mahalle*

4.1.3. Website

We have set up a website where abstracts from new reports and books have been posted. Besides information on various projects and activities of Cehat, database on various health indicators and issues, a complete set of Cehat papers and articles, reports of projects, updates on campaigns, etc., are available there. So far, the response has been quite good and we have received a number of requests for publication and for other information.

Team Members : *Margaret Rodrigues and Ravi Duggal*

4.2 DATABASE ON HEALTH

Work on the database on health is part of CEHAT's policy of making health-related data accessible to researchers, activists and journalists. These data on health in India have been collected from several state and central government documents and fill in the lacunae of non-availability of such information in one place. It has a unique collection of time series data on health indicators, health infrastructure, health manpower, health finances, and select socio-economic indicators. All-India and state-level information on these items are available from 1951 onwards.

In order to encourage research advocacy and activism in the field of health Cehat undertook the task of computerizing state-wise time series data. In 1998, Cehat released this database with its own software programme in the DOS environment, for accessing and analyzing the data. This is the only database on health in India that provides users with time series information for a set of 500 health and health-related indicators.

The database is being converted into the Windows environment with more user—friendly features. This up gradation of the earlier

version was carried out during 2001-2002. Along with this, it was updated by including data for the period 1993 to 2001, or for the latest year for which corresponding information was available. This new version of database will be released soon.

This information is being partly disseminated through Cehat's website which displays 15 tables giving state-wise data on manpower, infrastructure, and finance at five year intervals.

Team Members : *Ravi Duggal, T. R. Dilip, Margaret Rodrigues and Sushma Gamre.*

5

ADVOCACY, EDUCATION AND CAMPAIGNS

Advocacy and involvement in campaigns has also become a major involvement during the last three years. The changing socio-political and economic environment has necessitated larger involvement in this arena. The Peoples Health Movement has got consolidated in the last three years and CEHAT is an important part of this initiative, with the India secretariat now moving to CEHAT. This is important because CEHAT is also getting involved in a big way on the issue of right to health care through both research and advocacy initiatives. The PIL on sex-selection ended with both a good final order as well as complete amendment of the PNDT Act. But a lot needs to be done on monitoring the strict implementation of this act in the states for which CEHAT is planning a major collaborative initiative with civil society groups in different states. Advocacy on regulation of medical practice and accreditation to support this has gathered momentum with a new Bill on Regulation being formulated and this is now awaiting being tabled in the state assembly. The accreditation initiative too moved one step forward with the Healthcare Accreditation Council being registered as a non-profit company. The next step in this is to take this process in the direction of education of the medical profession on the importance of this and developing the mechanism for its operationalisation. The support to the human rights course in the university continues but more importantly we are planning to evolve a separate course on health and human rights under the new program on right to health which is being planned.

5.1. ACCREDITATION INITIATIVE IN MUMBAI

Regulation of the private health sector, examining issues relating to health care standards, and the quality of care concerning private hospitals has been one of the core areas of work of CEHAT. CEHAT has been involved in various micro-level studies involving the examination of physical standards of private hospitals and nursing

homes in the country, and regulations concerning private providers. The findings of the above studies motivated us to undertake more work on the subject. In light of non-implementation of the few existing legislations, a need was felt to assess the stakeholder opinion in relation to self-regulation. In 1997-98, CEHAT undertook a study to assess the need of various stakeholders along with their views and willingness to participate in an accreditation system, and evolve a framework for an accreditation system for private hospitals and nursing homes in Mumbai. The findings of the study and response of the participants at the two workshops (*at the national and Mumbai levels*) was very positive. Many of the participants felt that concrete steps should be taken to evolve such an accreditation system. After much discussion, it was decided that a committee should be formed with representatives from various stakeholders.

A stakeholder based “Health Care Accreditation Council” has been recently formed in Mumbai. Uniquely, the Council includes a range of stakeholders - representatives of hospital owners, professional bodies, consumer organizations, and NGOs. CEHAT, and individuals from CEHAT are among the stakeholders involved in the council. The council has been an outcome of a research study mentioned above. Informally this group has been meeting on a voluntary basis since February 1998 and it has now been registered as a non-profit body under Section 25 of the Indian Companies Act, with the founding members making the initial contributions for establishing the body.

Presently, the council is in the process of finalizing standards for small, private hospitals with a focus on certain key aspects, which include structural design, equipments, wards, rooms, operating theatres, essential drugs, reception rooms, consulting rooms, medical records, and waste management, among other aspects. It is examining systems and process-related issues, including grading, method, and periodicity of assessment, and financing of the Council as well as other areas e.g. Indicators. Subsequently, the forum plans to develop standards and indicators for specialties and super specialties.

This initiative is an attempt to create a more positive environment for the well-established private sector. This can be done by involving them more meaningfully with other stakeholders in a quality assurance mechanism. The Council is at a formative level, though the potential

exists for it to become a credible accreditation body on the basis of a collaborative and democratic system that addresses the needs of most of the stakeholders through open dialogue.

Future plans:

To further consolidate and establish the Health Care Accreditation Council as a credible accreditation body

To develop standards and indicators for specialties and super specialties.

To develop systems and process-related/issues, including grading, method, and periodicity of assessment and financing of the Council
Fund raising to ensure sustainability of this body.

Team Members : *Sunil Nandraj, Anagha Khot, Sumita Menon and Ravi Duggal*

5.2. EXHIBITION ORGANISED BY MAHILA AARTHIK VIKAS MAHAMANDAL (MAVIM)

Khulja Sim Sim was an exhibition organised by the Mahila Aarthik Vikas Mahamandal (MAVIM) at Patwardhan Ground, Nagpur, from 16th December to 25th December 2002.

CEHAT ran a stall for the sale of its publications—books, reports, and posters, and other Institutional Ethics Committee material such as flip charts, slides, etc. Apart from the sale of its publications, the other objective was to provide information on Cehat's work and the issues it dealt with.

Vijay Sawant and Qudusiya Contractor from Mumbai, Joti Kudale, and Shailesh Dikhale from Pune managed this at Nagpur during the over week long event.

5.3. HEALTH CARE AS A RIGHT: WORK ON ISSUES RELATED TO RIGHT TO HEALTH CARE:

Cehat along with the Global Health Council (GHC), USA, and the National Centre for Advocacy Studies (NCAS), Pune, has initiated work on developing a partnership programme on working on issues related to Right to Health Care. As a first step, a meeting on "Fostering Partnership in India Towards Right to Primary Health Care" was held

on 14th February 2002 in Mumbai to arrive at a common understanding and develop the structure for collaborating on opportunities in India that would be of local as well as global relevance.

The presentation provided a justification to the right to health care in the Indian context. Furthermore, the broader objectives of achieving a system for universal health care, and basic health care as a fundamental right were highlighted. The core content of right to health care in the first phase, viz., right to a set of basic public health services, right to emergency medical care, care based on minimum standards from private medical services, right to essential medications, right to patient information, and the setting up of redressal and accountability mechanisms were emphasised.

Various areas of activity for a potential coalition on the right to health care, such as involving diverse social sectors in a dialogue on the issue; organizing state and national conventions on the subject; collating international experience on it; discussing detailed proposals to implement it and form a multi-sector, independent body to monitor that, as well as focus on issues of debate while creating a consensus on the matter were also presented.

Participants of the seminar across two groups then considered developing a partnership program that would work with various organizations from the government, NGO, private, and academic realm to address the issue of right to comprehensive health care. Each group deliberated upon the organizational goal and mission of this partnership programme, the key stakeholders who would need to be involved, mechanisms to be set to ensure good decision-making and management of the program and conflict resolution. Issues relating to funding, monitoring, and management were also discussed.

As a follow up, the first step envisaged was drafting of a concept note detailing the perspective and activities to be undertaken. This would build upon and detail out the discussions and issues raised at the meeting. (*Currently a small group is working on this*). This would be followed by the formation of a 'core' group or a 'working group' to carry forward the various activities. This is an on-going activity.

Team Members : *Anagha Khot, Ravi Duggal and Abhay Shukla*

5.4. HUMAN RIGHTS EDUCATION : POSTGRADUATE DIPLOMA IN HUMAN RIGHTS OF UNIVERSITY OF MUMBAI

In 1996, the University of Mumbai introduced a one-year postgraduate diploma course on human rights. Though this wasn't the first initiative in human rights education, it has been a significant move as University of Mumbai is one of the biggest universities in the country, and being a formal diploma course it has a better chance of continuing in the future.

The course was planned in consultation with human rights activists and NGOs. A committee of university professors, and a retired judge who had participated in the investigation of human rights cases on behalf of human rights NGOs, devised the syllabus.

The stated objectives of the course are

- 1 To train citizens, create awareness among them about human rights, and to promote a more effective exercise of rights of citizenship;
- 1 To train the police, media, and citizens to develop their culture and identity, and make them aware of the benefits of modernity, education, and equality of opportunity, etc.;
- 1 To develop the ideology, attitudes, and institutions for the protection and promotion of human rights values with the help of ideas contributed by human rights organizations in India and abroad;
- 1 To create consciousness among the bureaucracy, police, paramilitary and military on the nature and importance of human rights.

To enable those who are employed or occupied during the week the course is conducted during the weekends. This schedule allows NGOs to participate in teaching the course.

People from diverse streams and different walks of life have enrolled for the course, and therefore one finds journalists, lawyers, employees of government and semi-government departments, individuals associated with community-based organisations or non governmental organisations, post graduate students, etc, filling in the muster.

When the course began, CEHAT was involved in teaching and guiding the students on several topics in health and human rights. The senior staff of CEHAT volunteered to provide guidance to students who did their dissertation and fieldwork on any of these issues. Since the fieldwork and the writing of the dissertation involve some expenditure, CEHAT announced two fellowships. These will be awarded to students selected by the university. The fellowships are modest allowances sufficient to meet the fieldwork expenses as well as the costs of paper, typing and binding of the theses.

The topics taught at the course in 2001 were

- 1 Right to Health Care (*Indian and Global context*) by Ravi Duggal (*Cehat*)
- 1 Patient's Rights by Anil Pilgaonkar
- 1 Women's Health and Violence by Neha Madhiwala (*Cehat*)
- 1 Rights of Sexual Minorities by Shalini (*Forum against Oppression of Women*)
- 1 Torture and Human Rights by Amar Jesani
- 1 Sex Selection and the PIL by Sumita Menon and Qudsiya Contractor (*Cehat*) and
- 1 People's Health Assembly by Anagha Khot (*Cehat*).

The topics taken in 2002-2003 were

- 1 Right to Health Care (*Indian & Global Context*) by Ravi Duggal,
- 1 Monitoring Right to Health Care- People's Health Assembly by Anagha Khot (*Cehat*)
- 1 Right to Primary health Care by Amita Pitre (*Cehat*)
- 1 Women's Health and Violence by Qudsiya Contractor (*Cehat*)
- 1 Transplantation and trade of human organs by Dr. Sanjay Nagral (*Forum for Medical Ethics*)
- 1 Communalism and the role of Medical Professionals by Neha Madhiwala (*Cehat*)
- 1 Rights of Sexual Minorities by Shalini (*Forum Against Oppression of Women*)
- 1 People's Right to Environment by Lata P. M. (*Narmada Bachao Andolan*).

This year, we helped the students hold an awareness programme

on health and human rights issues in the Mumbai University Campus during the UGC national seminar on ‘Globalisation and Human Rights’ from September 7th to 8th 2002.

Team Members : *Qudsiya Contractor, Sumita Menon and Ravi Duggal*

5.5. PEOPLE’S HEALTH ASSEMBLY / JAN SWASTHYA ABHIYAN

Over the last 10-15 years, the policies of governments and international agencies across the world have led to the worsening health of the poor. In the name of liberalization and globalization, people’s livelihoods have been threatened. As a result, poverty has increased and people’s health has suffered. The grand slogan, ‘Health for All by 2000 AD’, which was raised in 1978 in Alma Ata lies forgotten today. The People’s Health Assembly (PHA), initiated in 2000, is an international, multi-sectoral initiative aimed at bringing together individuals, groups, organizations, networks and movements—long involved in the struggle for health to obtain a reaffirmation of the commitment of the governments to ‘Health for All’, to ensure accountability of health services and to kindle people’s initiatives for health. The genesis of this idea can be traced to the World Health Assembly, wherein it was felt that there was a need for a new forum to lend visibility to people’s voices. The prime objective of the PHA is to give a “voice to the people and make their voices heard” in decisions affecting their health and well being. The international organizers of the campaign included, Asian Community Health Action Network (ACHAN), Consumers International (CI), Dag Hammarskjold Foundation (HDF), Gonoshasthaya Kendra (GK), Health Action International (HAI), International Peoples Health Council (IPHC), Third World Network (TWN), and Women’s Global Network for Reproductive Rights (WGNRR). The PHA process involved three phases: pre-assembly activities, a major international assembly event, and post-assembly activities.

5.5.1 India-level campaign

At the India-level, various health and non-health networks came together to evolve a global and national solidarity. In consultation with all the partners at Chennai, 18 national networks and the Department of Social Medicine, Jawaharlal Nehru University, Delhi,

and CEHAT led the campaign at the national level. These 19 organizations constituted the national coordinating committee (NCC) which co-ordinated the campaign activities leading up to the International assembly at Dhaka. The networks included were: All India Democratic Women’s Association (AIDWA), All India Drug Action Network (AIDAN), All India People’s Science Network (AIPSN), All India Women’s Conference (AIWC), Asian Community Health Action Network (ACHAN), Bharat Gyan Vigyan Samithi (BGVS), Catholic Health Association of India (CHAI), Christian Medical Association of India (CMAI), Federation of Medical and Sales Representatives Associations of India (FMRAI), Forum for Child Care and Crèche Services (FORCES), Joint Women’s Programme (JWP), Medico Friends Circle (MFC), National Alliance of People’s Movements (NAPM), National Association of Women’s Organizations (NAWO), National Federation of Indian Women (NFIW), Ramakrishna Mission (RKM), Society for Community Health Awareness, Research and Action (SOCHARA), and Voluntary Health Association of India (VHAI), amongst others. Apart from these networks, a large number of organizations and networks working at the state level, or on special themes, also participated in the campaign. In all, over 1200 organizations were involved in the campaign at various levels.

As part of pre-assembly activities various tasks were taken up. It included publication of books and development of a People’s Health Charter; holding of training workshops; formation of state, district and block coordination committees; conducting block and primary health centre level surveys and enquiries; holding district conventions and policy dialogues; state-level mobilizational activities like signature campaigns, *Kala Jathas*, dear doctor letters, state conventions and policy dialogues. The culmination was the holding of the National Health Assembly in Kolkata on November 30-December 1, 2000. Over 2,000 delegates, including doctors, government officials, politicians, delegates from NGOs and people’s movements, health activists, village health workers, researchers and educationists, participated. from 17 state conventions and 250 districts were presented at the Assembly. The deliberations pointed to the fact that the promise of ‘Health for All by 2000’ remains unfulfilled. The delegates endorsed the Indian People’s Health Charter and took an oath to carry out a

political campaign to ensure health for all. They vowed to ‘declare health as a justifiable right and demand the provision of basic health care as a fundamental constitutional right of every citizen of this country’.

The Global Health Assembly took place from December 4-8, 2000 at Dhaka, Bangladesh. 1,453 participants from 92 countries came to the Assembly, which was the culmination of 18 months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross section of the people who had been involved in thousands of village meetings, district-level workshops and national gatherings. At the Assembly, they reviewed their problems and difficulties, shared their experiences and plans, and formulated and endorsed the People’s Charter for Health. The Charter is now the common tool of a worldwide citizen’s movement committed to making the Alma Ata dream a reality.

Following the Assembly, the Indian delegation continues to work on issues raised through the PHA. The network continues its work as the *Jan Swasthya Abhiyan*. The People’s Health Charter and booklets produced from this campaign are being discussed with the people and their representatives, policy-makers and others to extend the consensus. Advocacy and lobbying activities at the local, national, and international levels have been planned, and mechanisms for further networking among participating individuals and organisations have been co-ordinated.

5.5.2 CEHAT’s involvement in the People’s Health Assembly/ Jan Swasthya Abhiyan

CEHAT staffers have been involved in the PHA/JSA activities at the national as well as the state level. Its members are part of the National Working Group as well as the state-level working group. CEHAT, as part of the collective, has contributed to planning, conduct, and organization of various activities. Its staff members have served as participants as well as resource persons, conducted village-level enquiries as well as an inquiry in an urban area, held health dialogues, critiqued proposed health, and health-related policies, amongst others. Some of CEHAT’s contributions worth a mention are: inputs in developing and finalizing the People’s Health Charter, preparation of

a booklet in Marathi on how to conduct ‘Block-Level Health Enquiries’, publication of a Marathi booklet on ‘People’s Health Charter’, publication of eight pictorial posters in Marathi, and initiating discussions on the proposed amendments to the Bombay Nursing Home Registration Act (*BNHRA*) with various medical associations and related actors. Even today, its members continue to be involved in various state and national level initiatives.

Team Members : *Anagha Khot, Abhay Shukla, Anant Phadke, Nilangi Ninal and Ravi Duggal.*

5.6 PRENATAL DIAGNOSTIC TECHNIQUES (PNDT) ACT (2002 ONWARDS LEGAL ADVOCACY AGAINST SEX SELECTIVE ABORTION)

Sabu George (*an activist*), Masum (*Mahila Sarvangeen Utkarsh Mandal*), an NGO working on women’s health issues from Pune, and CEHAT filed a public interest litigation (*PIL*) in February 2000 to re-look at the Pre-natal Diagnostic Techniques (*Regulation and Prohibition of Misuse*) Act, 1994. The PIL was filed with two goals: 1) to activate the central and state governments for rigorous implementation of the central legislation, and 2), to interpret the legislation and/or to demand amendment to ensure that the techniques which use pre-conception or during-conception sex selection, like the Ericsson method (*X and Y chromosome bearing sperm separation*) and Pre-implantation Genetic Diagnosis (*PGD*), are also brought under the purview of the Act. CEHAT’s decision to be a co-petitioner for the PIL was primarily a result of its commitment to women’s health and rights issues, ethical medical practice, and upholding human rights.

Despite this Act being around for over five years, female feticide continued rampantly in many states. The 2001 Census figures pertaining to sex ratio of the 0-6 year population bear adequate testimony. There had been a declining trend of females in the sex ratio all these years, but the 2001 Census shows an even greater decline, especially in states like Haryana, Maharashtra, Punjab, Gujarat, and Tamil Nadu.

The petition draws attention to the gross misuse of the reproductive technology in a society characterised by a strong bias against the female child. Even as female infanticide is yet to be eradicated,

techniques like amniocentesis, chorionvilli biopsy, and ultra sound, to the more advanced tools, such as the Ericsson's technique and PGD, have widened the gap in the already skewed sex ratio. Sex-selective abortion needs of society find its roots in the patriarchal social norms, and the low status accorded to women. The new reproductive technologies—unregulated and abused—are further perpetuating these practices, which are discriminatory and unethical from the standpoint of medicine, as well as violative of the human rights of women. That a link exists between the elimination of female foetuses during pre- or intra-conception or infanticide, and the widening sex ratio has long been accepted by demographers. The sophisticated technique of PGD helps couples with genetically determined conditions, but this does not out-weigh the damage caused by its misuse by unscrupulous practitioners.

There have been encouraging outcomes of the litigation. The following are the milestones in the course of the PIL:

May 4, 2001- This was the first positive step forward. The interim judgement by the Supreme Court called for all the state governments to take necessary steps towards the implementation of the Act. The government, that is, the Department of Family Welfare, too got energised and issued an advertisement in the national dailies saying that it was a crime to carry out sex selection; it also activated the Central Supervisory Board by calling a meeting. The order also came down heavily on the medical profession and their unethical practice. As a result, the Indian Medical Association (IMA) at the national level made a turnaround and issued a warning to its members. The Federation of Obstetrician and Gynaecologist Societies of India (FOGSI) too showed some concern through its newsletter. The state governments were also asked to conduct a survey of the existing bodies conducting these tests.

December 11, 2001- The Supreme Court called upon the chief secretaries of Punjab, Delhi, Bihar, Rajasthan, Gujarat, Haryana, Uttar Pradesh, Maharashtra and West- Bengal to remain present before the Court on January 29, 2002 for non-compliance of orders passed by them. The SC also directed companies manufacturing ultrasound machines to provide information about the individuals or groups to whom these machines had been sold in the last five years. Furthermore,

the Customs & Excise Department was directed to supply information on the number of ultrasound machines imported/sold to clinics or individuals, as the case may be. The Centre was asked to frame rules for ensuring action. Until the time that such rules were framed, companies manufacturing and trading in these equipments were directed to keep providing information on who the equipment was being supplied to. These companies include Wipro GE, Philips Medical Systems, Siemens, Toshiba, Larsen & Toubro, and Aloka. It also directed states to publish details of the stipulated committees within the Act.

January 29, 2002- A breakthrough during the hearing occurred when an order was passed directing the FOGSI, the IMA, and the Indian Radiologist Associations to submit names of their members who possessed ultrasound machines and to verify if they were registered. This was the first time that the medical community had been pulled up ever since the PIL was filed two years ago. Interventions were however made by doctors and the radiologists' association during the PIL.

December 18, 2002- During the hearing, a document was submitted by the petitioners to the Supreme Court that contained the following:

Directions given by the SC to the central, state and union territory governments through the orders passed so far

Suggestions of the petitioners on awareness, functioning of the Central Supervisory Board (CSB), regulatory bodies, survey and registration, proposed amendments in the PNDT Act, and

Information sought from other bodies namely manufacturing companies, medical associations such as the IMA, IRA, and FOGSI.

January 2003: Parliament passed the Amended Act which now covers pre-conception techniques also, apart from other important changes made in the Act to give it more teeth.

Through this case, the issue of sex selection and the declining sex ratio has been brought into focus. The case has got the central and state machinery moving and there has been a better implementation of the Act. However, there are a few issues that have surfaced out of this PIL. There has been a poor response from the medical profession in ensuring a better implementation of the Act. The registration of

clinics has been achieved but the regulation of these still seems to be far from complete except in a few districts, such as Faridabad and Gurgaon in Punjab, and Dharwad and Belgaum in Karnataka. Though over 350 cases have been filed for violations, almost all of them are related to non-registration of bodies.

This PIL has been a step forward and we hope that all stakeholders, the state, the medical profession, NGOs, activists, women and health groups, journalists and media, etc., come together to see that the provisions of the PNMT Act are fully implemented.

Team Members : Sumita Menon, Qudsiya Contractor and Ravi Duggal

5.7 RELIEF WORK AFTER THE VIOLENCE IN GUJARAT

Four CEHAT staff members were involved in the relief efforts of the victims of the Gujarat violence from 10th July to 16th July, 2002. This initiative was coordinated with a local NGO, Anandi, involved in the rehabilitation process. Cehat carried out its work in Halol, Boru, and Sanjeli villages of the Panchmahal district. The work was also in coordination with the local camp organiser, Mehboob Bhai Sheikh, of the Halol Muslim Rahat Committee Camp. The experiences of the team have been documented in the form of a report. CEHAT also has published a compilation of investigation reports and new clippings on the genocide which took place in Gujarat and took up this issue in the international arena through the IFHHRO network of which CEHAT is a founder member.

5.8 WORKSHOP ON STATE POPULATION POLICY

CEHAT, along with Vikas Adhyayan Kendra (VAK) organised a two-day workshop at the J P Naik Centre for Development and Education of the Indian Institute of Education (IIE), Kothrud, Pune, on December 15 & 16, 2001 on 'Maharashtra State Population Policy'. 53 participants from 19 organisations based in Mumbai, Pune, Ahmednagar, Satara, Usmanabad, Hingoli, and Thane attended the workshop. The intention of the workshop was to orient the participants in critiquing the national and state population policies.

Various resource persons shared their views and experiences with the group. Prof Ram Bapat traced the roots of the 'population problem'

and linked it first to the developments of capitalism and then to the contemporary phase of capitalism. Dr Sulbha Brahme traced the links of the concept of population problem and population control to the prevailing economic systems, particularly globalisation and imperialist hegemony. Mr Ravi Duggal brought out the lack of integration between the health policy and the population policy. Jayashree Velankar traced the developments since the International Conference on Population Development in Cairo (ICPD) that supposedly introduced a paradigm shift in population policies. She termed the population control policies anti-people, anti-poor, and anti-women. Prof Malini Karkal based her arguments on various statistical data. She emphasized that we need to stress on women's health issues rather than only looking at family planning and population policy. Furthermore, she raised the question of whether family planning would ensure a better quality of population.

These presentations were augmented with group discussions to allow the participants to have a debate on the meaning and import of the inputs in light of their field experiences and actual work. The group discussions and presentations brought out various issues:

The participants questioned the concept of 'small family' as a norm. It was felt that instead of the government deciding the number of children that a family should have, people should be involved in the decision-making. The pros and cons of a small family norm should be explained to them.

The group opposed the levying of any kind of disincentives.

There was a need for increase in health services.

In terms of benefits available to 'below poverty line' (BPL) people, the definition of who constitute the BPL segment should be questioned. Moreover, people should have the right to information in terms of who constitute BPL.

The group opposed holding of family planning camps. It should be done as part of a government programme, according to people's conveniences. At camps, services were not provided properly. There should be no 'targets' to be met with—however subtle or direct.

The state should make more efforts to motivate men for vasectomy. There should be public education on this topic to change people's attitudes.

In terms of eligibility for elections, there should be no conditionalities, especially for those belonging to SC/ST/OBC.

While numerous follow up measures were suggested, it was decided, however, that there would be no hasty formation of any network; there would be no duplication of work already taking place; and that there would be efforts to cooperate and collaborate with ongoing efforts of other organisations and campaigns. It was agreed that the organizers of the workshop, viz., CEHAT and *Vikas Adhyan Kendra*, should take the lead in initiating these efforts and act as informal conveners for future efforts.

Team Members : *Ravi Duggal and Anagha Khot*

6

COLLABORATIONS AND NETWORKING

As mentioned earlier during this period collaborative initiatives in research and advocacy got a major boost. This has helped CEHAT's growth qualitatively and also helped in raising CEHAT's status to a national level organisation. In the coming years we envisage further scaling up of collaborative work as we work towards establishing right to health and healthcare.

6.1 ABORTION ASSESSMENT PROJECT - INDIA

CEHAT collaborates with the following institutions for Abortion Assessment Project –India: Society for Operation Research and Training (*Baroda*), Action and Research for Training in Health (*Udaipur*), Centre for Health and Social Sector Studies (*Secunderabad*), Achutha Menon Centre for Health Science Studies (*Thiruvananthapuram*), Child- In- Need- Institute (*Kolkatta*), Omeo Kumar Das Institute for Development and Change (*Guwahati*), Bharthiar University (*Coimbatore*).

6.2 ACHUTHA MENON CENTRE FOR HEALTH SCIENCE STUDIES, (AMCHSS)

CEHAT in collaboration with Achutha Menon Centre for Health Science Studies, (*AMCHSS*) *Thiruvananthapuram*, organised a National Consultation comprising of medical and social scientists to brainstorm on concerns pertaining to gender issues in medical education. AMCHSS is also a partner in conducting a study on abortion providers in *Kerala*. Senior staff from CEHAT are visiting faculty at AMCHSS.

6.3 ASSOCIATIONS OF MEDICAL PROFESSIONALS

CEHAT has increasingly been interacting with various medical associations like the Association of Medical Consultants and Nursing Home Owners Association. The issues for collaborative work include developing accreditation systems and standards for quality care. This work is being undertaken under the auspices of the Health Care Accreditation Council, a registered non-profit organisation.

6.4 BRIHANMUMBAI MUNICIPAL CORPORATION (BMC)

Since 1996 CEHAT has had an active interaction with the BMC public health department. Apart from the collaborative Dilassa Project, CEHAT researchers have provided consultation to the BMC on their women centered health project and have undertaken a demand survey for the BMC for setting up a hospital in K-East ward of *Mumbai*.

6.5 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.

6.6 DEPARTMENT OF POLITICS AND PUBLIC ADMINISTRATION, UNIVERSITY OF PUNE

Senior staff from CEHAT organise research methodology workshops for post graduate and doctoral students every year at this department

6.7 FORUM FOR MEDICAL ETHICS

CEHAT collaborates closely with this Forum on promoting work related to Ethical Issues in the medical community through meetings/consultations and dissemination of information.

6.8 GENDER – IN REPRODUCTIVE HEALTH

CEHAT is part of the co-ordination committee of this national level initiative. The Secretariat is situated at AMCHSS. Under this initiative members of the co-ordination committee reviewed the existing literature on 6 various aspects of reproductive health leading to series of annotated bibliographies to identify gaps in the existing literature in terms gender blind perspectives, conceptualisation and methodologies. Based on these findings, small grants programme was announced in the form fellowships to pursue the unexplored areas with gender and ethics at their core. The co-ordination committee functions as a technical support group to the grantees.

6.9 GLOBAL HEALTH COUNCIL (GHC) AND NATIONAL CENTRE FOR ADVOCACY STUDIES (NCAS)

CEHAT along with GHC, *USA* and NCAS, *Pune* has initiated work on issues related to Right to Health Care and Universal access to health care services.

6.10 GOVERNMENT OF MAHARASHTRA

CEHAT prepared the background paper for the chapter on Health and Nutrition for the Human Development Report, Maharashtra 2002, brought out by the Government of Maharashtra/Planning Commission/UNDP. This document made a critical appraisal of achievements made by Maharashtra State, in terms of health and nutritional outcomes.

6.11 HEALTH WATCH TRUST

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 programme of the government. CEHAT and Health Watch are currently co-coordinating a national initiative on abortion assessment.

6.12 INTERNATIONAL FEDERATION OF HEALTH AND HUMAN RIGHTS ORGANISATIONS, NETHERLANDS (IFFHRO)

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. The IFHHRO actively collaborated in the International Conference organised by the CEHAT in November 1998.

6.13 INTERNATIONAL REHABILITATION COUNCIL FOR TORTURE VICTIMS (IRCT)

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

6.14 MAHILA SARVANGIN UTKARSHA MANDAL (MASUM)

A joint effort 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. CEHAT and MASUM also collaborate on a number of other initiatives linked to women and health issues.

6.15 NIRMALA NIKETAN COLLEGE OF SOCIAL WORK

CEHAT researchers collaborate mainly as visiting lecturers and also by helping students doing research in the field of health as well as providing opportunities through block placement of their students at CEHAT.

NALSAR, *Hyderabad*, Tata Institute of Social Sciences (*TISS*) *Mumbai*, Nirmala Niketan, *Mumbai*, Karve Institute of Social Work, *Pune* have sent their students to CEHAT for block-placement.

6.16 PEOPLE'S HEALTH ASSEMBLY / JAN SWASTHYA ABHIYAN

More than 1200 organisations from all over the country working in the field of health, science, development convened the National Health Assembly in *Kolkatta* in December 2000, to form a movement towards attaining the goal 'Health for all now!' Jan Swasthya Abhiyan (*JSA*) emerged from this PHA process in India as a coalition of various organisations. CEHAT is a member of the National Coordination Committee of *JSA* and contributes to the state level co-ordination of *JSA* activities in Maharashtra and Madhya Pradesh. Since August 03, CEHAT is housing the National Secretariat of *JSA* and in September 03, in *Mumbai*, hosted *JSA*'s National Programme on Right to Health Care.

6.17 TATA INSTITUTE OF SOCIAL SCIENCES (TISS)

CEHAT staff have been collaborating since 1994 with various departments of *TISS* as visiting faculty. In December 1999 a joint course in Epidemiology was organised for staff of CEHAT and *TISS*.

6.18 UNIVERSITY OF MUMBAI

Since 1996 CEHAT has been collaborating with the dept. of politics and civics at the university in teaching courses, examination and guidance for preparing dissertation by students for their post-graduate diploma course on human rights.

6.19 WOMEN'S HEALTH PROJECT, WITWATERSAND UNIVERSITY, SOUTH AFRICA

CEHAT has been one of the partners representing India with other 10 countries from the world of a southern based international initiative intended to facilitate processes to improve women's access to safe and legal abortion care services.

7

ORGANISATIONAL STRUCTURES AND FUNCTIONING

7.1 WORKING GROUP

The Working Group (WG) of CEHAT is the main decision making body. All staff members elect it each year. The tenure of a WG member is two years and it meets atleast once a month for two days to review, plan and take decisions. The strength of the WG is 25 per cent of the total staff strength or 11, which ever is less (*inclusive of the coordinator*). The coordinator is the ex-officio member of the WG and has the power to veto decisions taken by the WG. Decisions in the WG are normally taken by evolving a consensus.

The WG in the last couple of years has consolidated itself as a monitoring body rather than an executive body. The WG primarily involves itself in personnel management – appointments, induction, evaluations, dismissals and grievances - monitoring of projects and other activities within organisation, and planning future strategies.

The working group is a participatory group and comprises of representatives of all levels of staff from all units. It provides opportunities to staff members, especially juniors to get involved in organisational matters and enhance their capacities in decision making, organisational discussions and to develop leadership qualities along with the seniors of the organisation.

7.1.1 Composition of Working Group

In the year 2000 the WG comprised of 8 members with female: male ratio standing at 5:3. In the year 2001 there were 8 members with F: M = 4:5. In the year 2002, there were 9 members with F: M = 5:4 (Jan to July) and 4:5 (*Aug to Dec*).

7.1.2 Meeting with Trustees

The WG also meets with the Trustees of *Anusandhan Trust* twice a year to discuss broad based organizational issues and their implementation / moving towards common vision.

7.1.3 Major steps by WG

Some of the major steps taken by WG since 2000 have been:

- 1 Constitution of Institutional Ethics Committee.
- 1 Initiating OD process and conducting Human Resource Planning meeting.
- 1 Monitoring by internal as well external bodies.
- 1 Sharing of views with the staff and accepting suggestions from them.
- 1 Developing various policies / projects of the organisation.

7.1.4 Constraints and Lacunae

The WG is not without lacunae and other constraints. For instance, the WG has not been able to give adequate attention to financial management and planning for the future. The WG needs to develop its capacities in this direction in the near future so that it gains a larger control over organisational management. This would also take CEHAT a step forward in achieving its objectives of participatory and democratic mode of functioning.

Members of Working Group

<i>Name</i>	<i>Period</i>
Abhay Shukla	2002 January onward
Amulya Nidhi	January 2000 to December 2001
Amita Pitre	January 2003 Onward
Anant Phadke	January 2000 to December 2001 & January 2003 Onward
Anagha Khot	January 1999 to December 2000 & August 2001 to December 2002
Anirban Bose	January 2001 to December 2002
Dilip T. R.	January 2003 to June 2003
Margaret Rodrigues	January 1999 to December 2000 & January 2003 Onward
Neha Madhiwalla	January 2002 to July 2002
Padma Deosthali	January 2000 Onward

<i>Name</i>	<i>Period</i>
Prasanth Kunte	September 2002 Onward
Qudisya Contractor	January 2003 Onward
Ravi Duggal	November 1999 Onward
Shailesh Dikhale	January 2003 Onward
Shelly Saha	January 2003 Onward
Saramma Mathew	January 2000 onward
Sunita Bandewar	January 2001 to December 2002
Sumita Menon	January 1999 to December 2000
Tejal Barai	January 2001 to May 2001
Vijay Sawant	January 2001 to December 2002

7.2 PEER REVIEW COMMITTEE (PRC)

The PRC is an internal scientific body, which periodically reviews the content and quality of the work, outputs of various projects undertaken in CEHAT. It meets twice in a year wherein ongoing projects and other activities are critically reviewed, new proposals are vetted and outputs are discussed to strengthen its quality.

7.2.1 Role and Responsibilities of the Peer Review Committee

The Peer Review Committee has been constituted primarily to do the internal peer review of the work done in CEHAT, in order to improve and maintain the quality of such work. Earlier, it was called as Scientific Committee. But with the emergence of action project. It also helps shaping researchers. The 'Role and responsibilities of PRC' as emerged from a series of discussions, is as follows –

PRC as internal peer group: The Peer Review Committee must function as a peer group within CEHAT. It would thus :

- 1 Act as in-house consultant for project/s on a regular basis (*this implies that the ongoing projects are assigned to the members of PRC for this purpose*)
- 1 Review each project report within CEHAT before its publication
- 1 Review research papers post publication.

Staff development: PRC is responsible to identifying potentialities

of researchers and shaping and developing them. This is to be done by:

Imparting training to researchers as per their aptitudes and requirements,

Inviting resource persons

Discussing the contemporary socio-political issues in the PRC meetings. This is to help developing an understanding of the wider socio-political context amidst which we conduct our research.

Enhancing the quality of publications: Researchers are being encouraged to write in the peer-reviewed journals. PRC members are to give comments and suggestions for improvements in the draft circulated by fellow researchers.

Development of the project proposals: The Peer Review Committee is to play an important role along with the co-ordinator, in developing project proposals.

Before being sent to the funding agency, a project proposal has to be cleared first by the PRC for its scientificity, then by the Institutional Ethics Committee (IEC) for its ethicality. Any proposal going to the IEC for ethical clearance must first be cleared by the PRC for its scientificity.

With the above role in mind, PRC meetings are organized six monthly. All staff members at the level of Research Officer/Project Officer level and above are to participate in these PRC meetings. Staff members at the level of Junior Research Officer/Junior Project Officer can participate as observers.

The general methodology of discussion in the PRC is - Generally every research team makes one or more presentations in every meeting, about its work, at whatever stage the work has progressed. It could range from study design to final report. The presentation, participants comment upon issues. The team later prepares a note on what suggestions were made and what is the team's response to it along with the rationale for the response. Other types of discussion are also held for example, deciding Cehat's role in advocacy on certain issues.

With the above role in mind, PRC meetings were held six monthly during which following topics were discussed. The presentations made

and the subsequent improved versions of these papers, presentations are available with Cehat.

7.2.2 List of topics discussed-

10th – 11th April, 2000, at Khandala

- 1 Ethical Guidelines for Social Science Research
- 1 Women, Work, Environment and Health – Concept Paper
- 1 Critical Review of Private Medical Sector. Methodology of the study by the Aarogyachya Margavar Project, of Domestic Violence in the Community.
- 1 Arogyachya Margavar – Training methodology / future plans
- 1 REAP Report – brief presentation
- 1 National Abortion Assessment Project (NAAP) – overview/ methodology
- 1 Crisis Centre Project – overview/methodology
- 1 Evaluation of training of ANMs in the PHCs in MCH (GTZ study) – methodology
- 1 Arogya Sathi Project – brief overview of the last two year's work

18th October, 2000

- 1 Joint meeting of all action project staff in CEHAT
- 1 Locating action projects in the context of CEHAT
- 1 Strategies for community organisation and mobilisation
Training and training material
- 1 Key problems in action project work and how to tackle them
- 1 Ethics in action projects
- 1 Linkage of action projects and research in CEHAT

10th - 11th May, 2001, Khandala

- 1 Arogyachya Margavar action component – withdrawal strategy
- 1 Training modules of Bhabha Hospital project
- 1 SATHI – Cell to support people's health initiatives; the pre-proposal note

- 1 Feedback on papers: i) Evolution of health policy in India
ii) Maharashtra health system
 - 1 Women and Health – perspective paper
 - 1 RAI survey methodology
 - 1 Accreditation of health care institutions as an activity of CEHAT
 - 1 Review of the research process in CEHAT
- 28th - 29th November, 2001, Khandala
- 1 Arogyachya Margavar (*Action-component*) – Review of work
 - 1 Modified perspective paper on Womens' Health
 - 1 AS project – self evaluation of field activities
 - 1 AAP India / Health status of Maharashtra
 - 1 Media analysis on health issues
 - 1 Issues regarding modification of BNHRA Act
 - 1 Advocacy – review of previous discussions and decisions
 - 1 Discussion on Advocacy background papers Team wise presentations of advocacy issues
 - 1 Outline of organisational strengthening and advocacy strategy for CEHAT

2nd - 3rd May, 2002, Pune

- 1 Demand for Public Hospital in a ward in Mumbai
- 1 Health & Nutrition in Maharashtra
- 1 Issues regarding modifications in BNHR Act
- 1 Manual for Primary Educated Health Workers; suggestions for improvement
- 1 The Nutritional Crisis in MP
- 1 Film on Quality of abortion Care
- 1 Methodological issues, analysis, experiences
- 1 Study of MLC cases – presentation by the Dilaasa team
- 1 Arogyachya Margavar Presentation of the initial analysis of the data on domestic violence Job responsibilities of IEC
- 1 Limits of NGO-contribution to campaigns

27th- 28th Nov. 2002, Mumbai

- 1 Framework for Research and & Advocacy in Health Sector Reforms
- 1 Pre-proposal note on Health Sector Reforms
- 1 The impact of involuntary resettlement of a slum in Mumbai, a human rights perspective
- 1 Draft Perspective Paper on Primary Health Care
- 1 Pre-proposal note on further work on the Sexual Assault Kit
- 1 Pre-proposal note on a community based study on rates of Caesarean section and hysterectomy in Ajra

Members of Peer Review Committee (PRC)

<i>Name</i>	<i>Designation</i>
Ravi Duggal	Coordinator / Sr. Scientist
Anant Phadke	Sr. Scientist
Abhay Shukla	Jr. Scientist
Ravindra Thipse	Jr. Scientist
Sunil Nandraj	Jr. Scientist (till 24 th July 2001)
Sunita Bandewar	Jr. Scientist
Anita Corea	Sr. Research Officer (till 11 th August 01)
Neha Madhiwalla	Sr. Research Officer
Rekha Kale	Sr. Research Officer (till 9 th October 01)
Amita Pitre	Research Officer
Aruna Kartik	Research Officer (till 11 th May 2001)
Ashraf A	Research Officer (till 17 th July 2002)
Bhavana Kapadia	Research Officer (till 11 th April 2002)
Chandra Ramamurthy	Research Officer (till 20 th May 2003)
Dilip. T.R	Research Officer (till 12 th June 2003)
Padma Deosthali	Research Officer

<i>Name</i>	<i>Designation</i>
Ratnaprabha Pedhambkar	Research Officer (till 30 th June 2000)
Amulya Nidhi	Project Officer
Nilangi Nanal	Project Officer
Saramma Mathew	Administrative Officer
Vijay Raut	Chief Librarian (till 10 th July 2001)

7.3 INSTITUTIONAL ETHICS COMMITTEE (IEC)

Addressing ethical concerns and dilemmas in research as well as action programmes have been essential processes within CEHAT. In fact, one of the four founding principles of Anusandhan Trust is that we will conduct research and other activities ethically. In the initial years CEHAT constituted ethics committees for individuals projects to honour this principle. But a search for developing an enabling institutional mechanism for doing ethically sound research has always been there. In keeping with our commitment towards building a democratic institutional ethos and encouraging ethical practices in social science and health research and action, CEHAT constituted its first Institutional Ethics Committee (*IEC*) in January 2001.

7.3.1. *The objectives of the IEC are*

To make all our research and action projects not only scientifically rigorous but also ethical,

To provide our staff with more opportunities to actively engage with ethical issues in their work,

To provide our staff learning opportunities in ethics by interacting with resource persons from various disciplines,

To standardise practices across projects, and

To evolve a code of ethics for CEHAT bases on hands-on experience of ethical reviews of ongoing projects.

Work Done

7.3.2 *Work done by the IEC*

Two broad categories of work done by the IEC in the last year were:

- 1 evolving and streamlining procedural aspects of IEC, and
- 1 conducting ethical reviews of projects.

7.3.3 Procedural aspects of IEC

To make the IEC's work relevant and enabling of CEHAT's activities, the IEC had the task of developing frameworks and procedures for its own work, and for conducting project reviews. We are presenting two tangible outcomes of this work

- 1 defining job responsibilities for the IEC, and
- 1 preparing checklists for ethical review of research and action projects.

7.3.3.1 Defining job responsibilities of IEC

Preparation of the document defining roles and job responsibilities began in the first meeting of the IEC and evolved through four meetings spread over a year. This received feedback from the staff before finalisation. (Annexure I). Thus, there was an interactive process involved between the IEC and the staff of CEHAT.

The scope of the document is as follows:

- 1 Overall objectives of IEC,
- 1 Functions of IEC,
- 1 Responsibilities of IEC,
- 1 Rights of IEC,
- 1 Framework for IEC functioning,
- 1 Structure of IEC,
- 1 Procedures for ethical review,
- 1 Format of ethical review, and
- 1 Documentation and dissemination of review.

7.3.3.2 Evolving checklists:

The IEC developed checklists for project teams to respond to while applying for ethical review. The checklists would help project teams identify and clearly articulate ethical issues involved in their work. It would also lead them to respond in a focused manner. To some extent resolving reservations about reviewing action projects, the IEC evolved checklists for both research as well as action projects.

In submitting a project for review to the IEC, a studied response to the checklist is required, along with other relevant documents, such as, the project proposal, study design, tools of data collection, the draft of informed consent letter, and draft plan of analysis. Other relevant documents may be presented at various phases of the project review.

Research Projects: The guidelines developed by NCESSRH provided a ready framework for developing checklists. The checklists have been prepared for the four phases of research projects, i.e. the phase (a) of submitting proposals, (b) after finalisation of the methodology and before launching field-work, (c) after completing the field work, and (d) prior to publishing the research report. (*Annexure II A, B, C, D*).

Action Projects: Whether action / intervention projects should be brought within the scope of IEC work was itself a subject for discussion. There was no prior framework available for action projects, which could be used. The IEC therefore had reservations about developing a framework and checklists. It was decided that one of the internal IEC members who was engaged in action or action research would evolve a framework. Accordingly, a perspective note was prepared. The former outlined the specific ethical issues involved in action projects and developed a checklist. (*Annexure III A,B*).

7.3.4 Ethical review of projects

The scope of the IEC includes an ethical review of research and action projects of CEHAT. However, certification is restricted only to research projects. In the case of action projects, the role of IEC is limited to deliberating on various ethical issues involved so as to bring greater clarity and heighten understanding of the issues involved.

7.3.4.1 Overview of projects reviewed and decisions made

During the reporting period, 7 projects, components of projects or proposals were reviewed as under:

- 1 Abortion rate, care and cost: A community based study (*methodology, research tools and field experiences of research investigators*),
- 1 Aarogyacha Margawar (*research component*),
- 1 Rapid needs assessment of local residents for setting up new

health care facility by the Bombay Municipal Corporation (*proposal and research tools*),

- 1 Investigation of starvation deaths and nutritional status of children in Badwani, Madhya Pradesh following long period of drought,
- 1 Dilaasa – a response cell for survivors of domestic violence at Bombay Municipal Corporation hospital (*protocols for intake and recording of cases and overall functioning*),
- 1 SATHI (*Support for Advocacy and Training for Health Initiatives*) Cell,
- 1 Fostering People Centred Health Care Reform (*proposal submission stage*).

The IEC has reviewed four research projects and three action projects. All the research projects reviewed have been either at the proposal stage or prior to data collection. Of the four research projects reviewed, one was certified affirmatively. For others, recommendations were made for improving methodology and re-articulation of aims and objectives and relevance of the research. One project was submitted *post-facto* and thus there was no certification involved.

7.3.5 Work done by the IEC Secretariat

Through the IEC's tenure, the roles and responsibilities of the IEC Secretariat have evolved. The Secretariat has been doing two types of tasks- (a) routine tasks, which were required on a regular basis to enable the functioning of the IEC, (b) specific tasks, which were required in specific situations. The Secretariat functioned as a bridge between the IEC and various other structures of CEHAT. It also played the role of facilitator for some project teams when they applied for ethical review.

7.3.6 Routine tasks

The Secretariat has done the following during the reporting period:

- u Organised IEC meetings as per requirements,
- u Provided required administrative support,
- u Prepared and compiled background material,
- u Prepared agendas in consultation with the IEC members and focusing CEHAT's requirement,

- u Interacted with project teams, providing orientation and inputs while applying for ethical review,
- u Established and maintained regular communication between the IEC and CEHAT Working Group(WG) and Peer Review Committee(PRC),
- u Prepared and finalized minutes of meetings after addressing feedback of the IEC members in subsequent IEC meetings,
- u Followed up on IEC decisions.

7.3.7 Specific tasks

Being the first year of the IEC, CEHAT, groundwork and some facilitation was done as follows:

- u Preparing a document detailing procedural aspects and IEC checklists for project reviews,
- u Convening a meeting of action project staff with internal IEC members to discuss ethical issues in action projects,
- u Preparing the status report of the IEC, which formed the basis for self evaluation,
- u Preparation of the draft annual IEC report for dissemination,
- u Compiling ethical issues along thematic categories to facilitate the process of codification of ethical guidelines,
- u Providing support to the IEC in terms of maintaining track of the changes suggested during deliberations, during finalisation of different documents, such as job responsibilities of IEC, check-lists.

7.3.8 Facilitation for project teams

The internal members, and especially the IEC Secretariat also have a role in preempting ethical problems during the planning phase through discussions with the research teams and also serve as a sounding board for the staff. Some facilitating functions are listed below:

- u Communication: When necessary independent communication, electronic as well as face to face, was established with the respective teams. (*eg. Dilaasa*).
- u In certain cases, especially when revisions were suggested,

the problems gathered during the joint meetings of the IEC and project team and as perceived by the Secretariat were communicated to the co-ordinator. This was to facilitate revisions through due processes set by CEHAT to maintain scientific rigour and quality of work. (*e.g. Arogyachya Margawar - insisting on the need to interact with the consultants' committee members*).

Based on experiences the following are some of the mechanisms/systems suggested by the Secretariat to be used by the staff consciously. It may be mentioned that these are in place in CEHAT during different phases of the project (*conceptualising the projects, planning and designing the methodology, contemporary analysis, presenting literature review etc.*):

- u The respective teams should discuss various matters with the other staff members on a one-to-one basis as and when required,
- u There should be formal presentation in the weekly office meetings,
- u There should be formal consultations with the PRC members and inviting of specific tasks meetings when required,
- u There should be formal presentations to the WG when required, of the problems faced while working on the project in any phase,
- u There should be constituting of a consultants' committee as per CEHAT's system and the seeking of timely formal consultation from the committee members,
- u In addition to the above, the members of the IEC from within CEHAT could be contacted/consulted when required.

7.3.9 Orienting CEHAT's staff for planning ethically sound research

As described earlier, it was the beginning of the processes involved in ethical review. Thus, in most of the cases there was close interaction of the project teams and/or PIs with member secretaries while working on the response to the checklist/IEC protocols. In the case of action and action research projects, as mentioned earlier, small meetings at

the project level were organized to discuss the projects from an ethical point of view. This was followed by a joint meeting to discuss the checklist prepared by one of the IEC members from CEHAT (Dr Abhay Shukla) organized by the IEC Secretariat to discuss the ethical issues in the respective projects and related matters. This was found to be a fruitful and educative exercise.

7.3.10 Documentation of processes and deliberations

This IEC is among the first of its kind in any social science research organisation. There is no specific training available to train ethicists in India. Hence, the role of this IEC has been both to train its own members – self-learning and also to provide a model for others. Against this backdrop, detailed documentation of the deliberations of the IEC has served more than one objective. They are as below:

- u It enabled the streamlining of the functioning of the IEC,
- u It provides information about various kinds of ethical issues that arose, the consequent discussions and the manner in which the issues were resolved or not resolved,
- u It allowed the IEC to reflect on its functioning, problems encountered by it and key decisions taken after discussion. Thus, it provides resource material for self learning for the IEC members,
- u This documentation will also serve as resource material for other organisations contemplating the setting up of such a committee.

7.3.11 Communication with other structures/bodies within CEHAT

As stated earlier, one of the important tasks of the IEC Secretariat has been to develop and maintain communication links between the IEC and other structures in CEHAT. The tasks performed to achieve this are as below:

- u The IEC protocols and IEC procedures (*the document based on the first IEC meeting containing the IEC constitution, its objectives, responsibilities and rights, the procedures it would follow for ethical review etc. and checklists evolved for the*

purpose of ethical review) were sent to all the staff members to update and inform them about the IEC,

- u There has been periodic communication to the WG about the IEC's work,
- u The ethical review reports, including the intermediate stage certifications were sent to the WG and Trustees in June, 2001. This will be done periodically in the future too, to keep members of these bodies updated on the functioning of the IEC,
- u A specific issue related to review of methodology and scientific review was raised in the PRC of CEHAT because the IEC felt that considerable time and effort would be saved if proposals/ tools/ reports were vetted for scientific rigor prior to appearing before the IEC.

Members of Institutional Ethics Committee

<i>Name</i>	<i>Organisation</i>
Anant Phadke	Sr. Scientist, CEHAT, Pune
Anil Pilgaonkar	Social Activist, Mumbai (February 2001- June 2002)
Abhay Shukla	Jr. Scientist, CEHAT, Pune (February 2001-June 2002)
Bhargavi Davar	Bapu Trust, Pune (February 2001-June 2002)
Jaya Sagade	Law College, Pune
Joseph Lobo	Fergusson College, Pune
Nagmani Rao	Karve Institute of Social Service, Pune
Neha Madhiwalla	Sr. Research Officer, CEHAT, Mumbai
Padma Deosthali	Research Officer, CEHAT, Mumbai
Sandhya Srinivasan	Executive Editor – Issues in Medical Ethics, Mumbai
Saumitra Pathare	Consultant Psychiatrist, Pune
Shabana Diler	SNDT College, Pune

<i>Name</i>	<i>Organisation</i>
Shraddha Karhadkar	Masum, Pune (February 2001-June 2002)
Sunita Bandewar	Jr, Scientist, CEHAT, Pune (February 2001-June 2002)
Tejal Barai	Jr. Research Officer, Mumbai (February 2001-June 2001)

7.4 SOCIAL ACCOUNTABILITY GROUP (SAG)

The SAG is a body of independent persons appointed by Anusandhan Trust to review CEHAT's work in terms of its stated objectives. The main function of the social accountability Group is to carry periodic social audit of the organisation. The present members of the SAG as on 31st March 2003 are as follows:

Members of the Social Accountability Group

<i>Name</i>	<i>Organisation</i>
Medha Kotwal	Aalochana, Centre for Documentation and Research on Women
R.Nagaraj	Indira Gandhi Institute of Development Research (IGIDR)
Ravi Narayan	Community Health Cell
Ravindra R. Pandharinath	School of Biomedical Engg, I.I.T. Powai
Vijay Kanhere	Participatory Research in Asia

The first SAG report was published in 2000 and the next one is due in early 2004.

8

ADMINISTRATION AND ACCOUNTS

8.1 ADMINISTRATION

CEHAT's administration and accounts unit in the last three years has both grown substantially as well as got consolidated with office and accounts systems well organised. The team of this unit is an integrated team and functions organisation-wide not being attached to any project. While the team is centralised, the systems are designed for decentralised functioning. In the last three years with the Pune office too expanding substantially, a separate admin team has evolved in Pune also but it is an integral part of the overall administration and accounts unit.

Administration units and Accounts provides support to project/program teams, including secretarial assistance, fund flows, project administration, and financial monitoring. This team is fully responsible for statutory functions, liaison and reporting, personnel administration, accounts management, facilitating audit, accounts and financial reporting. The team provides support to the Coordinator in organisational management and both external and internal liaison. Presently the admin and accounts team consists of 15 persons placed at Mumbai, Pune and field office – Dilaasa.

There are plans to set up small field office at Indore for routine administrative work.

Team Members : Saramma Mathew, Anirban Bose, Aarti Dalal, Dattatraya Taras, Devidas Jadhav, Harish Kumar, Kiran Mandekar, Meena Indapurkar, Muriel Carvalho, Netralal Sharma, Pramila Naik, Rajesh Shetye, Ravindra Mandekar, Rozina Virani, Ruma Bhowmick, Sanjana Bhingarde, Sapna Pillai, Shobha Kamble, Sneha Fulambikar, Sudhakar Manjrekar

8.2 SOURCES OF FUNDING AND EXPENDITURES

8.2.1 Funding Agencies

We are thankful to the following funding Agencies for their generous support to CEHAT's activities.

- u Asha for Education, USA
- u Centre for Environment, Gender and Development (Engender) Pvt. Ltd., Singapore
- u Family Violence Prevention Fund, USA
- u Global Health Council, USA
- u GTZ, Basic Health Programme, Maharashtra - Pune
- u HIVOS, Netherlands
- u Indian Council for Research on International Economic Relations, New Delhi
- u Indira Gandhi Institute of Development and Research, Mumbai
- u Institute of Social Studies Trust, New Delhi
- u IPAS, USA
- u Macarthur Foundation, New Delhi
- u NOVIB, Netherlands
- u Rockefeller Foundation, USA
- u Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram
- u Swissaid, Mumbai
- u The Ford Foundation, New Delhi
- u University of Witwaterstrand, South Africa
- u United Nations Development Programme, New Delhi
- u World Bank, New Delhi

8.2.2 Financial Statements for three years

Expenditure For the Year 2000-2001

Utilisation of funds	Amount	Percentage
Research	3,626,233.35	36.39
Training / Services	2,058,353.80	20.66
Advocacy	1,078,564.00	10.82
Information center	1,079,428.10	10.83
Capital expenses	269,557.91	2.71
Overheads	1,852,464.60	18.59
TOTAL	9,964,601.76	100.00

Income For the Year 2000-2001

<i>Funds received</i>	<i>Amount</i>	<i>Percentage</i>
Private Foundation	13,804,725.00	66.49
Govt. and UN organisations	1,340,670.00	6.46
Donor NGO	4,966,386.46	23.92
Own Funds	648,858.19	3.13
TOTAL	20,760,639.65	100.00

Expenditure For the Year 2001-2002

<i>Utilisation of funds</i>	<i>Amount</i>	<i>Percentage</i>
Research	8,890,280.00	33.80
Training / Services	2,517,398.50	9.57
Advocacy	933,985.00	3.55
Information center	1,311,485.50	4.99
Capital expenses	9,453,763.42	35.95
Overheads	3,191,989.00	12.14
TOTAL	26,298,901.42	100.00

Income For the Year 2001-2002

<i>Funds received</i>	<i>Amount</i>	<i>Percentage</i>
Private Foundation	20,137,000.00	74.79
Govt. and UN organisations	365,000.00	1.36
Donor NGO	4,327,585.00	16.07
Own Funds	2,095,294.27	7.78
TOTAL	26,924,879.27	100.00

Expenditure For the Year 2002-2003

<i>Utilisation of funds</i>	<i>Amount</i>	<i>Percentage</i>
Research	6,862,509.00	41.72
Training / Services	3,134,684.76	19.06
Advocacy	569,049.50	3.46
Information center	918,890.00	5.59
Capital expenses	2,130,627.40	12.95
Overheads	2,834,344.50	17.23
TOTAL	16,450,105.16	100.00

Income For the Year 2002-2003

<i>Funds received</i>	<i>Amount</i>	<i>Percentage</i>
Private Foundation	9,700,000.00	57.87
Govt. and UN organisations	866,836.00	5.17
Donor NGO	5,357,622.00	31.96
Own Funds	838,392.32	5.00
TOTAL	16,762,850.32	100.00

8.3 STAFF PROFILE

At present CEHAT's team is of 40 members from various disciplines having good experience and expertise in the relevant fields.

List of Staff Members

<i>Name</i>	<i>Designation</i>	<i>Period</i>
Aarti Dalal	Jr. Office Secretary	Till 1 st Oct. 2002
Abhay Shukla	Jr. Scientist	
Amita Pitre	Research Officer	
Amulya Nidhi	Project Officer	
Anagha Khot	Jr. Research Officer	Till 27 th Jan. 2003
Anant Phadke	Sr. Scientist	
Anirban Bose	Administrative Assistant	
Anita Correa	Sr. Research Officer	Till 11 th Aug. 2001
Aruna Kartik	Research Officer	Till 11 th May 2001
Ashok Jadhav	Jr. Office Secretary	
Ashraf A	Research Officer	Till 17 th July 2002
Bhagyashree Khaire	Research Associate	
Bhavana Kapadia	Research Officer	Till 11 th April 2002
Chandra Ramamurthy	Research Officer	Till 20 th May 2003
Dattatraya Taras	Sr. Office Secretary	
Devidas Jadhav	Office Assistant	
Dilip T.R	Research Officer	Till 12 th June 2003
Harish Kumar	Sr. Administrative Officer	Till 8 th July 2002
Kiran Mandekar	Sr. Office Secretary	

<i>Name</i>	<i>Designation</i>	<i>Period</i>
Kotrayya Agadi	Jr. Research Officer	Till 31 st Aug.2000
Lorraine Coelho	Research Officer	Till 28 th Feb.2003
Madhuri Sumant	Research Associate	Till 30 th Nov. 2001
Margaret Rodrigues	Administrative Assistant	
Meena Indapurkar	Office Assistant	
Muriel Carvalho	Sr. Office Secretary	
Neha Madhiwalla	Sr. Research Officer	
Netralal Sharma	Office Assistant	
Nilangi Nanal	Project Officer	
Nilanjana Roy	Jr. Research Officer	Till 30 th Oct. 2000
Padma Deosthali	Research Officer	
Pramila Naik	Sr. Office Secretary	
Prashant Khunte	Jr. Research Officer	
Priti Bhogale	Research Associate	Till 31 st May 2002
Qudsiya Contractor	Research Associate	
Rajshri Kamath	Jr. Research Officer	Till 19 th Oct. 2001
Rajesh Shetye	Office Assistant	
Rajeswari Balaji	Research Associate	Till 1 st Nov. 2003
Ratnaprabha Pedhamkar	Research Officer	Till 30 th June 2000
Ravi Duggal	Sr. Scientist	
Raviendra Mandekar	Office Assistant	
Ravindra Thipse	Jr. Scientist	
Rekha Kale	Research Officer	Till 9 th Oct.2001
Rozina Virani	Office Assistant	Till 30 th Sept.2001
Ruma Bhowmick	Jr. Office Secretary	Till 30 th Sept. 2003
Sameer Mone	Jr. Project Officer	
Sangeeta Rege	Jr. Research Officer	Till 4 th Oct. 2003
Sanjana Bhingarde	Sr. Office Secretary	
Sapna Pillai	Jr. Office Secretary	Till 14 th Dec. 2001
Samma Mathew	Administrative Officer	

<i>Name</i>	<i>Designation</i>	<i>Period</i>
Shailesh Dikhale	Sr. Office Secretary	
Shalini Verma	Jr. Project Officer	Till 30 th Nov. 2002
Sharda Mahalle	Jr. Office Secretary	
Shelley Saha	Jr. Research Officer	
Shobha Kamble	Office Assistant	
Sneha Fulambikar	Jr. Office Secretary	Till 30 th Sept. 2000
Sudhakar Manjrekar	Office Assistant	
Sugandha More	Research Associate	
Sumita Menon	Jr. Research Officer	Till 24 th Nov. 2002
Sunil Nandraj	Jr. Scientist	Till 24 th July 2001
Sunita Bandewar	Jr. Scientist	
Sushma Gamre	Research Associate	
Tejal Barai	Jr. Research Officer	Till 25 th May 2001
Umesh Dwivedi	Jr. Research Officer	Till 5 th Sept.2000
Vidya Bansode	Research Investigator	Till 31 st Jan.2002
Vijay Raut	Chief Librarian	Till 10 th July 2001
Vijay Sawant	Sr. Office Secretary	
Vikas Gamre	Office Assistant	

8.4 CONSULTANTS AND REVIEWERS

List of Independent Consultants and Reviewers who have provided support to various projects and programmes of CEHAT during 2000 – 2003.

Amar Jesani	Ghanshyam Shah
Anil Pilgaonkar	Hutokshi Doctor
Aruna Burte	Indranee Gupta
Ashwin Patel	Kalpna Sharma
Avadhoot Nadkarni	Kamini Rao
Bela Ganatra	Ketki Marthak
Bhargavi Davar	Kush Singh
Dilip Shivalkar	Leela Visaria
Ena Singh	Lestee Cautinto
Firoza Mehrotra	Madhukar Pai

Malini Karkal	Saroj A. Deshpande
Manisha Gupte	Seema Malik
Marie D'Souza	Sharad Iyengar
Narika Namshum	Shireen Jeejobhoy
Neeraj Patel	Siddhi Hirve
Nirmala Rao	Smriti Koppikar
P.M. Kulkarni	Soumitra Pathare
Padma Prakash	Sri Vidya
Padmini Swaminathan	Sudarshan Iyengar
R.J. Chhabra	Sudha Tewari
R.N. Gupta	Sumati Kulkarni
Radhika Chandiramani	Surabhi Sharma
Rajani Desai	Suresh Mohite
Rajani Ved	Swatya Paranjpe
Rajshri Kamath	T.K. Roy
Ravi Varma	Thelma Narayan
Renu Khanna	Umesh Dwivedi
Ritu Priya	V.R. Murleedharan
Roopashri Sinha	Vandana Khaire
S.S. Sathye	Vasantha Muthuswamy
Sandhya Srinivasan	Vidya Kulkarni
Sanjeevani Mulay	Vidya Pillai
Saramma Thomas Mathai	Vimala Ramchandran

8.5 UTKARSHA

Utkarsha-Cehat Staff Welfare Association is an initiative undertaken by CEHAT staff in the year 1998.

8.5.1. The Objectives of the association are as follows :

- 1 Motivate CEHAT staff members to save regularly.
- 1 Provide opportunity to members to improve their living condition.
- 1 Provide loan at reasonable rate of interest to CEHAT staff in times of need. The priority for giving loans are i) health ii) house repair/ buying/renting iii) education iv) vehicle/computer v) any other.

8.5.2. Eligibility for Loan

The staff members of CEHAT who are taken on assignment of not less than one year and who have cleared their probation are eligible for membership in the association.

Disbursement of Loan

Year	Recipients of Loan	Amount Rs.
2000	8	63,000
2001	14	2,05,000
2002	22	3,38,000
2003	18	6,03,000

8.5.3 Funds Management

When the association started in 1998, the members decided not to take any interest from their share amount and also not to disburse any loan for two years. This was done to accrue some funds in the association's account. From the year 2000 it was decided to charge interest on the loan @ 12% per annum. and @ 6% per annum interest on deposits will be given. Interest on deposits will not be given to the members but it will be added to their share account. As the association is primarily involved in staff welfare and also keeping in view the vast change in the Country's economic scenario and falling of rate of interest in the banking sector, the Association in 2003 declared a reduced rate of interest for deposits and loans. The interest on loan will be charged @ 6% p.a and interest on deposits will be @ 3% p.a .

Status of Utkarsha

Year	Members	Share Amount
2000	24	44,650
2001	38	1,37,000
2002	38	2,52,200

For the last three years the association went from strength to strength due to increase in shares by the staff members. The Association other than fulfilling the social objectives within the organisation, also would like to take up social causes outside within its own limitation in future.

Utkarsha is being managed by a team of four members. The present executive committee members, who were re-elected in the general body meeting in January 2002 for a term of two years.

Present Executive Committee

<i>Name</i>	<i>Position</i>
Anirban Bose	President (2000 onwards)
Vijay Sawant	Secretary (2000 onwards)
Kiran Mandekar	Treasurer (1998 onwards)
Rajeswari Balaji	Executive member (2001 onwards)

8.6 CEHAT AT OTHER PLACES**8.6.1. Pune office**

Centre for enquiry into Health and Allied Themes
Flat No. 3 and 4, Aman Terrace
Plot No. 140, Dahanukar Colony, Kothrud
Pune - 411 029
Tel. : 91-20 - 2545 2325
Fax : 20-2545 1413
E-mail : cehatpun@vsnl.com.

8.6.2. Project Office at Indore

Centre for enquiry into Health and Allied Themes
C/o M.S. Vijay Wargiya
45/A, Chandralok Colony
Khajrana Road, Palasia
Indore - 452 001
Tel. : 0731-256 1233

8.6.3 Project office at Mumbai

Dilaasa Project
Department No. 101
K.B. Bhabha Municipal Hospital
R.K. Patkar Marg, Bandra (West)
Mumbai - 400 050
Tel. : 91-22- 2640 0229
E-mail : dilaasa@vsnl.net.

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Foundation Principles

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