

HUMAN RIGHTS VIOLENCE and HEALTH

CEHAT's Work on Human Rights and Health Care (1991-8)

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CEHAT

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(I) Introduction

Rights in moral philosophy and political theory are, traditionally, understood as justified claims. A right is an entitlement a person possesses to some goods, service, or liberty. A right creates correlative obligations or duties to secure, or not to interfere with the enjoyment of, that entitlement. Human rights are a special class of rights which one has by virtue of being a human being. As such, human rights are considered to be universal, vested equally in all persons regardless of their gender, race, caste, community, nationality, economic status, or social position and so on.

The moral philosophy or the mainstream political theory dwells in the realm of ideals, but the material reality is different. Besides, while some human rights principles in the moral philosophy may be found to be relevant across time, these rights as broad human entitlements were never accepted by society since the beginning. Nor did the prevalent social structures allow resources to be distributed so as to provide for those entitlements. As a consequence, the ideals always stayed far behind the existing reality. Greater acceptance of the universality of entitlement to human rights (not only to liberty but also to goods and services) is a modern phenomenon, achieved through the long struggles of deprived masses of the world. Thus, **while morality can act as a force to regulate conduct (individual and collective), it cannot substitute the actual struggle by deprived people and constructive human efforts to realise such rights.**

In the post Second World War era, the broadened concept of rights attempted to incorporate gains won by mass struggles into the organisation of welfare states. The United Nations and its agencies also enumerated nearly two dozen specific rights, apart from the general rights of "life, liberty and property". These specific rights also include what were earlier considered "claims" over goods and services. But the concept still does not regard all productive resources of the society as social resources, and does not conceive of democratic social ownership of such productive resources as an objective of human rights movement. Thus, while conceptually, human rights are presently interpreted more progressively, much of the *actual work and campaigns* is still confined within the narrow liberal framework.

This makes it imperative that a modern human rights approach sets higher standards for real universality and equality, "Morality" should be translated to mean actual enjoyment of broader entitlements for all human beings, which is not impossible at the present stage of development in a truly egalitarian world. In the field of health, there is still no concerted international campaign for the basic minimum health care rights, or that issues like torture (United Nation's Convention against Torture) are defined only in terms of state sponsored inhuman deeds.

Therefore, the CEHAT, through its **Research, Action, Service provision and Advocacy (RASA)** endeavours to contribute in the campaign for realisation of human rights by all, particularly in the field of health care. These efforts touch on larger issues of entitlement to basic minimum health care to all as well as preventing violence and caring for survivors. What follows is a brief account of work done by CEHAT in simultaneously addressing issues of right to health care and implications of violence to health care, to health care providers and to the health of people.

(II) HEALTH CARE AS HUMAN RIGHT

Indian society is deeply hierarchical and based on structural inequality. The health care service system is not an exception. However, this is also an extension of the structural inequality between nations. The organisations and individuals from developed countries have a strong presence in the international human rights organisations. Most of these countries have well placed welfare programmes. They have, through deliberate state intervention, provided their people with basic services, health care being one of them.

In many of the developed countries in the Western Europe and in Canada, the state is financing 70 to 90 per cent of the total health care expenditure. Even in the USA where the private provision of health care is a norm, the state is financing over 40% of total health care expenditure of the nation. Unfortunately this achievement of creating fundamental entitlement to basic health care in their own societies has not been translated, by the international health and human rights organisations, into a campaign for right to health care as human right for all people in the world. For any health and human rights organisation in the underdeveloped countries, the right to health care as well violence related issues would definitely constitute top priority. The CEHAT also stands for such a holistic understanding of human rights.

The CEHAT began its work in health research with a firm conviction that all of its work should be socially relevant and yet not lacking in rigour. Such a commitment inevitably drew the CEHAT into the issue of human rights. While planning our work, we ask four major questions: (a) Will it increase access to health care, particularly for the poor, the dalits (lower castes), women, etc.? Will it aid people's organisations in their campaign for access to health care? (b) Will it improve the quality of health available to such people? (c) Will it lead to better control and regulation over private market and providers, and empower patients/people? Will it provide better health policy instruments for the equitable distribution of health care? (d) Will it aid in preventing violence and caring for survivors? Will it sensitise health services and professionals for assisting victims in getting justice and for treating survivors?

These concerns and priorities led us to develop our work into four inter-related themes, viz. (1) Health services and financing, (2) Health legislation, ethics and patients' rights, (3) Women and health, and (4) Investigation and treatment of psycho-social trauma. Our work on these themes has helped in generating well researched information, in disseminating it to individuals and people's groups, in devising advocacy tools to influence policy makers and health care providers, and above-all, in assisting campaigns for rights to health care by people's organisations and activist health groups. In the last four years, we have undertaken 24 major research and action projects either by obtaining financial support through grants or through our voluntary efforts. Our work is directed at demanding access to health and health care as a right, as well as investigating and combating violence.

1. Health services and financing: Through the means of well documented time series computerised databases, surveys and studies, we have been endeavouring to explode the myth that the underdevelopment of the health care services in India is the reason why

most people do not have access to basic health care. India's health care services are extremely well developed. However, nearly 70% of health care infrastructure is controlled by the private sector and over 80% of doctors are in the private sector. The government health service is extremely inadequate and there is no social health insurance provided by the government for people. Most Indians are forced to buy health care in an open and totally unregulated market. Not surprisingly, our studies show that people directly finance, through user fees and purchase of health goods, nearly 80% of the total health care expenditure. Consequently, there is increasing evidence suggesting that health expenditure is the first cause of indebtedness and asset alienation among poor households. From the point of view of access, there is a disproportionately high concentration of health care in urban areas, resulting in a better doctor/hospital bed to population ratio in some Indian cities than that obtaining in the developed societies. However, even this has not made health care accessible to poor masses in the urban areas. Our studies show that for one fourth to one third of illness episodes in urban areas, women seek no medical care due to social and economic reasons. Thus, while in rural areas, even the physical access to health care is a big problem due to non-availability of services, in the urban areas the high level of physical availability has not increased access to basic health care. ***This has prompted us to undertake a campaign for improving public health situation in urban areas (In Mumbai) and also establish a community based primary health care project.***

2. Health legislation, ethics and patients' rights: We have done studies on the legal framework within which the health care services are organised in India. Surprisingly, in India, no law was enacted for establishing health services by the government. This has deprived people any actual right to the government services, while permitting the government full freedom to deprive health centres of even resources for basic/primary health care. Legislation would ensure, to some extent, a justiciable right to basic minimum health care to all. ***We are networking with like minded organisations and individuals for building a campaign on this issue.***

We have also undertaken studies to show that due to lack of regulation and control over the private sector in health care, the quality of health care has suffered and patients have been exploited and their lives endangered. Regulations are needed to improve quality, for controlling the cost and for equitable distribution and access to services. In this endeavour, we have been promoting empowerment of patients. We have documented and promoted the struggles of patients for quality health care and for redress against medical negligence in order to make hospitals and doctors accountable. However, the market based tort laws are inadequate and expensive for our society, and the best way for empowering patients would be to reorganise private sector under a national plan for making health care universally accessible. The movement for patients' rights is complemented by us with the promotion of medical ethics among health care providers.

3. Women and health: Thinking on women's health in India is normally limited to their reproductive role. While women's morbidity burden due to reproduction is very high, and our studies confirm that, we find that women's health in general has been neglected in the households, society and the services. Women's perception of morbidity, their efforts to access health care and overcome social and economic barriers are embedded in the complex web of their social status, position in the family, household and economic

labour, sexuality and cultural norms.

The CEHAT has tried to bring into discussion and in campaigns the right to basic minimum health care for all as a human right. While we consider it our duty to assert this position, we also need to evolve alternatives for policy changes. The demand for universal access to health care needs to be supplemented by concrete alternatives to put such a system in place.

(III) VIOLENCE AND HEALTH CARE

Anusandhan Trust and its health research institution, CEHAT, have been involved in investigation of violence and in educational campaigns among health professionals and other strata of people since 1991. Some of the trustees and staff members at the CEHAT have been associated voluntarily with women's organisations, human rights organisations, consumer groups, etc. for the last two decades (i.e. even before the Trust and CEHAT were established). In the course of their work, as a part of the CEHAT and outside, they have participated in the investigation of violence and assisted human rights lawyers in getting justice for the survivors. They have also conducted studies, written extensively on the subject, conducted education and training for university students and doctors. Although the CEHAT is not a treatment centre, some of our staff members have sometimes helped the survivors by providing treatment and by assisting them in their efforts to get justice.

(A) Investigation of Violence

1. Violence Against Women

1.1 Sexual assault: As a part of its ongoing research work on Women's Health, the CEHAT has striven to document the prevalence of violence, their forms, problems of the survivor etc. As a part of the team investigating a case of gang rape in a slum in Mumbai in 1990, we found gross inadequacy in the medical examination and collection of forensic evidences on the survivor. Neither did the doctor record full medical history nor did he thoroughly examine the survivor. As a consequence, most of the vital medical and forensic evidence was lost. In the discussion with the doctors it was revealed that although they are supposed to do such examinations, they receive inadequate training which often fails to give them important information and skill. Besides, the official books of forensic medicine studied by them give outdated, sexist and sometimes misleading information. Above all, it was found that their attitude towards survivors and victims was not at all sympathetic. The survivors were examined for the medico-legal case, but hardly any effort was taken to regard them as individuals needing care - counselling, treatment and rehabilitation were not part of the work of doctors!

In a recent case of the rape of a hearing impaired girl in a government run Observation Home for Juveniles in Mumbai, the same pattern was observed in the doctor's behaviour. This investigation was conducted by a team in which two doctors from CEHAT participated along with others. In this case, the officials of the Observation Home did not report the crime for twenty days to the police. However, they did get the victim examined by their in-house doctor, who also failed to follow proper procedures. Indeed, the doctor also failed to do the medical examination of and collect forensic evidence from the offender who was also present all the time in the premises of the institution.

1.2 Manual and Kit: Thus, CEHAT decided to make a systematic educational intervention in this field. Recently, with financial support from the Swissaid India, the CEHAT has prepared a draft "*Manual for the Collection of Medical and Forensic*

Evidence in cases of Sexual Assault of Women". Along with this manual, we will be making available a *kit and forms for collecting and recording evidence* in sexual assault cases. In January 1998, two workshops were organised with participation of health professionals, lawyers, women activists, human rights activists and other NGOs to discuss and modify them so that a final version for use could be prepared. We have taken care to provide clear guidelines for doctors so that they do not become instrumental in the secondary victimisation of the survivor in court. The manual also explains to the doctor their role in caring and outlines the full range of treatment to be provided to the survivor. We feel that this manual and kit will be useful for education and training of doctors and help in improving quality of medical records prepared for the survivors. Besides, they will help activists in investigating sexual assault and getting justice. The Manual and Kit will be available for use at some time in the later part of 1998.

2. Violence Against Children

Children in India are most vulnerable to violence. Though India has signed the United Nation's convention on the Right of the Child, children are still grossly neglected and there are numerous reports of violence perpetrated on them. In 1997, we were invited by the Forum Against Child Sexual Exploitation to be a part of the team investigating rape of a hearing impaired girl in a government run observation home for the juveniles in Mumbai. The homes are expected to provide for the care, protection, treatment, development and rehabilitation of neglected and delinquent juveniles. (i.e. girls below 18 years and boys below 16 years.) However, the services provided by the government for the neglected juveniles are grossly inadequate, and the existing juvenile homes are oppressive to children. The situation is reportedly so bad that the children routinely run away from these homes and prefer to live as street children than get exploited in the juvenile homes.

After following up few such deaths in the juvenile homes in and around Mumbai, a sensitive social worker Mr. Kris Pereira filed public interest litigation in the Mumbai High Court. As a consequence, in February 1998, the High Court appointed a commission to look into the condition of the juvenile homes in Maharashtra. A doctor from the CEHAT has been appointed on this commission. Presently the commission is visiting juvenile homes in different districts of Maharashtra.

3. Violence by State Agencies

The involvement of individuals connected to CEHAT in the investigation of torture, police custody deaths and atrocities by police is long standing. We have narrated here only the work done since 1991. On November 16, 1990, two nuns taking care of orphan children in a home in Mumbai run by an NGO, *Snehasadan*, were brutally murdered. There was an immediate public outcry. However, the next day, newspaper reports were published alleging that the autopsy reports have showed that both nuns were used to sexual intercourse and one was suffering from venereal diseases. This was extensively followed up in the media in order to sideline the issue and malign the victims. It took some time for people to regain their composure and look at the real tragedy. But an

investigation team was formed in 1991 and we discovered that some police officials and the doctors had, perhaps deliberately misinterpreted the autopsy report that was very badly compiled in the first place. We also participated in a campaign insisting that such character assassination of the murdered women must be stopped and the people responsible for their murder arrested. This case also showed that the forensic medicine establishment in India harbours a deep bias against women.

In 1992, we also participated in an investigation of police firing in Dahanu Taluka of Thane district. In this case, the police had fired on the unarmed and peaceful protesting members of the *Kashtakari Sanghatna*, a mass organisation of tribals in this region. One person was killed in the firing and several injured, while efforts were made to intimidate the leadership of the organisation. In 1996, we also accompanied a local human rights organisation, *Shramjivi Sanghatna*, in the forest of the Thane district to exhume presumed mass graves of tribal families who were allegedly killed a few years back. The police had accompanied the team that carried out this investigation. Although we could not discover the mass grave(s), we did discover large number of human bones. This case is being pursued by the *Shramjivi Sanghatna*.

(B) Research and Services

Systematic research into violence has been started only recently by CEHAT. In its early years, the CEHAT only documented reports of various human rights organisations and reviewed studies done in this field.

1. Violence Against Women

From 1998, with the financial support from the MacArthur Foundation, we have begun systematic and community based action research work on violence against women. Last year we had prepared a systematic review of various studies available on violence against women. Now we are in the process of establishing a community based primary health care project, in a slum of Mumbai (*Jari Mari*, Andheri East). As a part of it, we will be training women health workers who, in addition to providing basic health care and education to the community, will also be trained to detect family violence and take care of the survivors. They will also be trained in basic counselling techniques.

In the same community we will be doing a household-based study of family violence. A methodology for this study is being evolved. The study will be completed in the next 18 months. This study as well as establishment of the primary health care service project in the community will pave the way for the establishment of a response cell for women survivors of violence in the same community.

At the same time we are making efforts to mainstream our concerns on violence against women by linking up with the public health services provided by the Brihanmumbai Municipal Corporation (BMC). A dialogue is presently on with high-ranking medical officials of the BMC and a hospital to establish a crisis centre for women. This process starts with a sensitisation programme for the health workers, followed by a feasibility study, training and the establishment of the crisis centre.

2. Violence by state agencies

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

The AI report cites 13 cases of custody deaths due to torture in the period 1985-89 in Maharashtra. The analysis of data made available to us showed 155 custody deaths in 1980-89 period, and of them, 102 deaths were recorded during the AI reference period of 1985-89. Although almost eight times more deaths are reported in the custody during the period 1985-89, it is claimed that all these deaths are not due to torture.

On classifying the specific cause of the 155 custody deaths, we found that only 9.7% (15) were admitted as due to police action (or torture, and this number compares well with that given by the AI). Nearly half were attributed to suicide or acts of the accused and the rest to acts of the public, to disease and illness, natural deaths. The specific causes mentioned in some of the cases were astonishing. These causes included: 9 died due to "alcohol consumption", 45 "hanged themselves", 3 "jumped in the well", 2 "jumped under the train", 3 "jumped under the auto-rickshaw", 1 "jumped under the bus", 1 died on "falling from the coat or bed", 1 died due to "skin disease", one died due to "giddiness", 1 died due to "unconsciousness" and so on. Given the norm that every death in the custody ought to be investigated and proper autopsy done, such causes are not only incomprehensible but create suspicion about the true cause of death. Since these data were not collected by us and were collected by a student who did not aim to analyse the deaths from a medical angle, they are insufficient for a systematic study. However, a proper independent medical audit of all deaths in police custody needs to be done on regular basis.

2.2 Survey of Torture in Maharashtra state: At the request of the RCT (Rehabilitation Centre for the victims of Torture), the CEHAT undertook work of preparing an overview (a kind of survey) of human rights situation in Maharashtra. Mr. Dilip D'Souza, a free lance journalist, undertook this work for CEHAT to understand the prevalence of violence in general and torture in particular; and to assess the need for a rehabilitation centre. In the course of his work he collected statistical information on the prevalence of violence. He interviewed a cross section of individuals and organisations: retired and serving police officials and judges; doctors and medical associations; activists and human rights organisations; human rights lawyers, and many others. He found that torture by the police is widespread and routine. Even senior police officials admit that it happens. Specific methods of torture are used: these often leave very typical, well-known signs. They also cause familiar psychological problems. The weakest sections of society – children, women, the poor – are the most frequent targets of torture. The report concluded

that the rehabilitation of torture victims (some would say all prisoners) is certainly a societal imperative. A centre to take up this task is needed. The report provides the guidelines for the services such a centre should provide. It also adds that a rehabilitation centre for police torture victims should welcome victims of other kinds of torture and violence. And secondly, as vital as it is to rehabilitate torture victims, to prevent torture should be a greater long-term priority in the first place. That is, by training programmes, by human rights curricula, by strengthening human rights groups.

Human rights need to be much more widely known and respected in India. In particular, human rights must be part of professional training programmes for doctors and police/military personnel. More generally, human rights – perhaps defined as a greater respect for all human life – must become a part of society itself in ways it is not today. It should be integrated into school and college curricula across the country. Human rights groups like PUCL (People's Union for Civil Liberties) and CPDR (Committee for the Protection of Democratic Rights) must find ways to expand their activities. In the long run, there has to be an end to the kind of social sanction violence has, sanction that makes torture acceptable, accepted and not worth making a fuss over. There is a case here for a near-radical makeover of society. Of course, this kind of social reform has a number of dimensions, but clearly torture cannot be viewed simply as an evil whose victims need help. It is a social disease, no less; that must be eradicated. This overarching view of torture, this overall goal, must guide any work on this subject in India.

(C) Library and Documentation

The CEHAT has excellent library and documentation resources, particularly on issues concerning health and human rights. It has nearly 3,000 books and an equal number of reprints from journals, reports, reference material and so on. The CEHAT also receives many journals, newsletters and bulletins from India as well as from abroad. Almost a quarter of this collection is directly related to human rights issues. These library and documentation facilities are well used by scholars, activists and media people.

In July 1998 the CEHAT has released the first computerised database on health. The database provides time series (1951 to the latest year) state-wise statistical data on health. The data are categorised into five groups: profile, indicators, infra-structure, human-power and finance. It has customised software to access data and compute new variables. The documentation and preparation of database is evolving as a regular work of the CEHAT. We now intend to expand the scope of the computerised statistical database to include other service sectors, and also to encompass information on the state police machinery (personnel, infrastructure, financing), the prisons and their inmates, the crime statistics, and on human rights violations.

(D) Education and Advocacy

The CEHAT has begun systematic research and service provision work only recently. Education and advocacy on human rights issues have been our strengths so far.

1. Hysterectomy on the mentally challenged:

In 1994-5, some of the staff members and trustees of CEHAT were actively involved in raising a public debate when hysterectomies were conducted on 17 mentally challenged girls residing in a state-run institution in Pune district of Maharashtra. They also raised the same issue through the Forum for Medical Ethics in Bombay and helped prepare and publicise ethical guidelines for doctors on the subject. The attitude of concerned doctors, surgeons, psychiatrists, professional social workers and government officers was found to be defensive and rather ignorant about the rights of disabled people.

2. Documentation of media reports on Mumbai riots:

In 1992-3, Mumbai city was rocked by large-scale communal violence. One of the CEHAT staff assisted a human rights organisation, *Solidarity for Justice*, in preparing and publishing a selected documentation of media reports on the violence in Mumbai. Some of us also had an opportunity to interact and work with the survivors of communal violence in Mumbai. Besides, we could also get insight into the doctors' attitude and role during such violence while interacting with the doctors working in public hospitals in Mumbai.

3. Medical ethics:

Training in and adherence to Medical Ethics are the most neglected areas of medical education and practice in India. Discussion and studies conducted among doctors, medical students, interns and teachers suggest that there is almost no teaching and training in medical ethics in medical colleges of India. Of course, there are a few exceptions. About four out of 150 allopathic medical colleges in India have a good educational component on medical ethics. In addition, there are 300 medical colleges of non-modern (Indian systems of medicine and homeopathy) where the teaching and training in medical ethics is equally poor. The self-regulatory statutory bodies of the medical profession, Medical Councils have neglected their duty of disciplining the profession on ethical matters. In 1992, in order to reform the profession through education and advocacy a group of doctors and others in Mumbai formed an organisation, *Forum for Medical Ethics Society* (FMES). In 1993, it began publishing the only journal on medical ethics in India, called *Issues in Medical Ethics* (IME). This journal is published every three months and 21 issues have been released so far. The Forum also conducts training and education in medical ethics and human rights. Some of the staff members of the CEHAT and trustees are founder members of this organisation and they also provide voluntary service on the editorial board.

4. Human rights Education at the Mumbai University:

The CEHAT has evolved a systematic human rights education programme. In 1996, the Department of Politics and Civics of the **University of Mumbai** began a regular post graduate diploma course for one year in human rights. The CEHAT has been entrusted with the task of teaching and training students on health and human rights.

For the past three years, we have been teaching on nine topics, viz. (1) Right to health care, (2) Torture, (3) Medical investigation of human rights violation, (4) Violence

against women, (5) Patients' rights, (6) Human rights of HIV/AIDS patients, (7) Trade in human organs, (8) Violence against children, (9) International human rights organisations. In the last two years, 60 students have taken this course and CEHAT's work in teaching human rights has been widely appreciated. Our involvement in this course also made us systematically document material on human rights, prepare draft outlines for each topic to be taught, and gave us an opportunity to give guidance to some students in preparing their dissertation on an issue in human rights. Three students have so far prepared their dissertations on topics pertaining to health and human rights.

As the next phase of our collaboration with the University of Mumbai, we helped the Department of Politics and Civics in organising a two-day training workshop of doctors on "Medical Ethics and Human Rights". The first session of this training workshop was organised on **February 7 and 8, 1998**. The Vice Chancellor of the Mumbai University inaugurated the workshop and 35 doctors participated. Many of these doctors are senior functionaries of the hospital institutions in Mumbai. The CEHAT contributed in this effort by collecting background material for the participants, helped in locating health professionals for making presentations on some subjects and its staff also made presentations. The proceedings of the workshop were well publicised by the media. The first experimental session of the workshop was thus a great success. We hope to collaborate in organising such events regularly for doctors as well as medical students.

(E) International Networking

While making concerted efforts in developing national level contacts for medical ethics and human rights, the CEHAT did not neglect work of building links with international health and human rights NGOs. In 1995, CEHAT was invited to a meeting of the *International Network of Health and Human Rights Organisations (INHHRO)*, a network promoting establishment, activities and collaboration among the medical groups involved in the work similar to *Physician for Human Rights*. In 1996, the CEHAT became its member, and in order to make the combined work of all such organisations more effective, the network was converted into a federation, now called as, *International Federation of Health and Human Rights Organisations (IFHHRO)*. In 1996, in an international conference, the IFHHRO gave a call for appointing a special United Nations rapporteur on health professionals and human rights. The CEHAT also presented a testimonial from India and supported such a campaign.

1. CEHAT's work with the IFHHRO: For last three years, the CEHAT has regularly attended meetings of the IFHHRO, shared with its members reports of our activities, collaborated with some members in their work and made efforts to disseminate information on the work of IFHHRO and its constituents in India. The CEHAT presented a paper on violation of medical neutrality in India in the International Congress organised by the Johannes Wier Foundation and the IFHHRO, at Utrecht, the Netherlands. This congress sparked off the campaign of the IFHHRO for appointment of a Special United Nation's Rapporteur on Health Professionals and Human Rights. Besides, the affiliated members and observers of the IFHHRO will be participating in the international conference on role of the health profession in human rights, being organised by the CEHAT in November 1998 in Mumbai.

2. Assistance to the International Campaign on Medical Profession and Human Rights in India: Due to frequent reports of doctors' negative role (autopsy reports, false medical certificates, etc.) in human rights violation, India came to occupy some spotlight on this issue. The medical division of the Amnesty International, French Section, invited a representative of the CEHAT on a one week tour to address meetings and speak to media on the subject. This tour received considerable coverage in the French media.

3. British Medical Association's Steering Group on Human Rights: In 1996-7, the CEHAT was made a Corresponding Member of this steering group. The BMA appointed this steering group to follow up its last report (book) titled, "Medicine Betrayed: The Participation of Doctors in Human Rights Violation", with a report on Medical Ethics and Human Rights. As a corresponding member, the CEHAT provided comments on some of the draft chapters of the report. The report of the steering group is ready and under publication as a book.

There is a continuous attempt at the CEHAT to integrate various activities on human rights and health so that effective change can be brought about in this field. The entire range of activities, including research, documentation, training, activism and advocacy is aimed at building alliances with groups and individuals at every level to create a situation where a mass struggle for a right to health care becomes a reality.