United Nations Educational, Scientific and Cultural Organization

UNESCO Chair in Bioethics University of Haifa

MUHS

Bulletin of GSMC MUHS UNESCO Bioethics Unit

October 2017

World Bioethics Day
19th October 2017

Theme : 2017

EQUALITY, JUSTICE AND EQUITY

Seth G S Medical College and KEM Hospital, Parel, Mumbai -12
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GSMC MUHS UNESCO Bioethics Unit

World Bioethics Day
19th October 2017

Poster Competition on
'Equality, Justice and Equity'

Second Prize

Nidhi Ranka, Final Year, Physical Therapy

Introduction

Advances in biomedical sciences have made ethical lens imperative for medical practitioners, researchers and society at large so that adherence to moral values of beneficence, justice, autonomy in medical practice and research are up held.

Warren Reich's encyclopedia of Bioethics defines Bioethics as *'an area of interdisciplinary studies'* concerned with systematic study of human conduct in the area of life sciences and health care. Dr. James Drane calls the discipline paradigmatic because the dilemmas force the scholars to examine the essential life and death questions in the context of medical conditions. Scholars from diverse disciplines like philosophy, theology, sociology, law, biomedical sciences alongside medicine have contributed to development of the field. With their contributions to the development of bioethics core principles since 1960s, these streams have been instrumental in guiding medical practitioners towards rights based approach to health. So in way it is a union of the two trees of knowledge- humanities and philosophy on one side and medicine and biosciences on the other; that leads to growth of an integrated approach towards not only human but also environmental well-being and growth.

The Oxford dictionary defines the word *'Inarch'* as a plant graft created by connecting a growing branch without separating it from its parent stock. The term conveys the spirit of synergy between the two streams. Hence we chose this name for our bulletin which will bring to you articles on bioethical issues by medical faculty, students, ethicists, philosophers.

Our bulletin is intended for undergraduate, postgraduate students in medical, paramedical subjects and nursing as well as practitioners and teachers. It aims to open up discussion on ethics of practice, research, curriculum content and advances in biomedical sciences.

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GSMC MUHS UNESCO Bioethics Unit

Poster Competition on
'Equality, Justice and Equity'

Appreciation Prize

Nidhi Savla, IVth Year, Physical Therapy

United Nations Educational, Scientific and Cultural Organization

UNESCO Chair in Bioethics University of Haifa

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Message

I am delighted that the bioethics unit at KEM Mumbai is bringing out its annual Bulletin 'INARCH'.

As the Head of the Asia Pacific division I am aware that the Bioethics Unit at KEM Hospital is engaged in outstanding activities in sensitization, teaching and training with in the modern curriculum. This years Bulletin INARCH is being built on the World Bioethics Day Theme Equity, Equality and Justice. I take this opportunity to congratulate the Bioethics team for their outstanding contributions to the achieving the objectives of the UNESCO Chair in Bioethics.

On behalf of Professor Amnon Carmi the Head and Chair holder, Professor Mary Mathew Head of the Indian Program and myself, I congratulate you and the membership of the Bioethics Unit of the UNESCO Chair in Bioethics at KEM Hospital on the launching of the Bulletin 'INARCH and wish you all great success in the activities of these units.

Yours Sincerely

Professor Russell D'Souza MD
Melbourne, Australia

GSMC MUHS UNESCO Bioethics Unit

Poster Competition on
'Equality, Justice and Equity'

Appreciation Prize

Sweety Edwankar, IVth Year, Physical Therapy

United Nations Educational, Scientific and Cultural Organization · UNESCO Chair in Bioethics University of Haifa

MESSAGE

Prof. S. Geethalakshmi M.D., Ph.D.
Vice Chancellor
The Tamilnadu Dr M.G.R. Medical University, Chennai
Head National Teaching Faculty Training Program of the
AISHSU-UNESCO Chair in Bioethics National Program

I congratulate the GSMC MUHS UNESCO Bioethics Unit for coming out with the second issue of the bulletin -INARCH on the occasion of the Second World Bioethics Day. This is a good initiative in stimulating young minds to realize the Bioethics is the way forward to make them a better doctor in the future.

The theme "Equality, Justice and equity" is apt in the modern health care settings as it forms an integral part of health policy and planning. As health care practitioners, we want to do the best for our patients. With limited resources allocated to health care, health care providers have challenging task to recognize priorities and provide optimum health care to their patients and to the population at large. In this context, I have included Bioethics into the medical curricula of the Tamilnadu Dr MGR Medical University thereby sensitizing the medical students on these issues.

The ethical framework will help the medical community to empower, change and provide creative ways in tackling challenging health issues in our setting. The bulletin will be a platform to share ideas and knowledge and promote productive discussions among students and faculty

I wish this initiative the very best.
JAI HIND

Prof. S. Geethalakshmi

World Bioethics Day
19th October 2017

GSMC MUHS UNESCO Bioethics Unit

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'Equality, Justice and Equity'

Appreciation Prize

Prachiti Shetye, IV[th] Year, Physical Therapy

Dr Yeshwant Amdekar
Medical Director,
Bai Jerbai Wadia Hospital for Children, Parel, Mumbai
Chief Guest,
World Bioethics Day Celebrations, GMU Bioethics Unit

Message

I am happy to know that you are celebrating World Bioethics Day 2017 at Seth G .S. Medical College and KEM Hospital, Mumbai.

Biological knowledge alone cannot serve the humanity well unless it is combined with knowledge of human value system. Every doctor is bound by Hippocratic Oath that includes beneficence, non-maleficence, autonomy and justice. Progress in medical science has been possible because of ongoing research and innovations. However every research finding or new technologydemand debate related to issues of safety as well as cost-benefit and risk-benefit analysis before they are applied to the end-user.This is what bioethics stands for.

In order to strengthen bioethical principles of scientific research and innovations, World Bioethics Day is being celebrated with the hope that medical students and professionals are sensitised to follow these very principles in practice. Theme this year emphasises need to ensure need-based care to everyone with the hope that sooner everyone's needs become equal with access to equal care.

I congratulate you and your team for spreading this message and I wish you all the success.

Dr Yeshwant Amdekar

World Bioethics Day
19th October 2017

GSMC MUHS UNESCO Bioethics Unit

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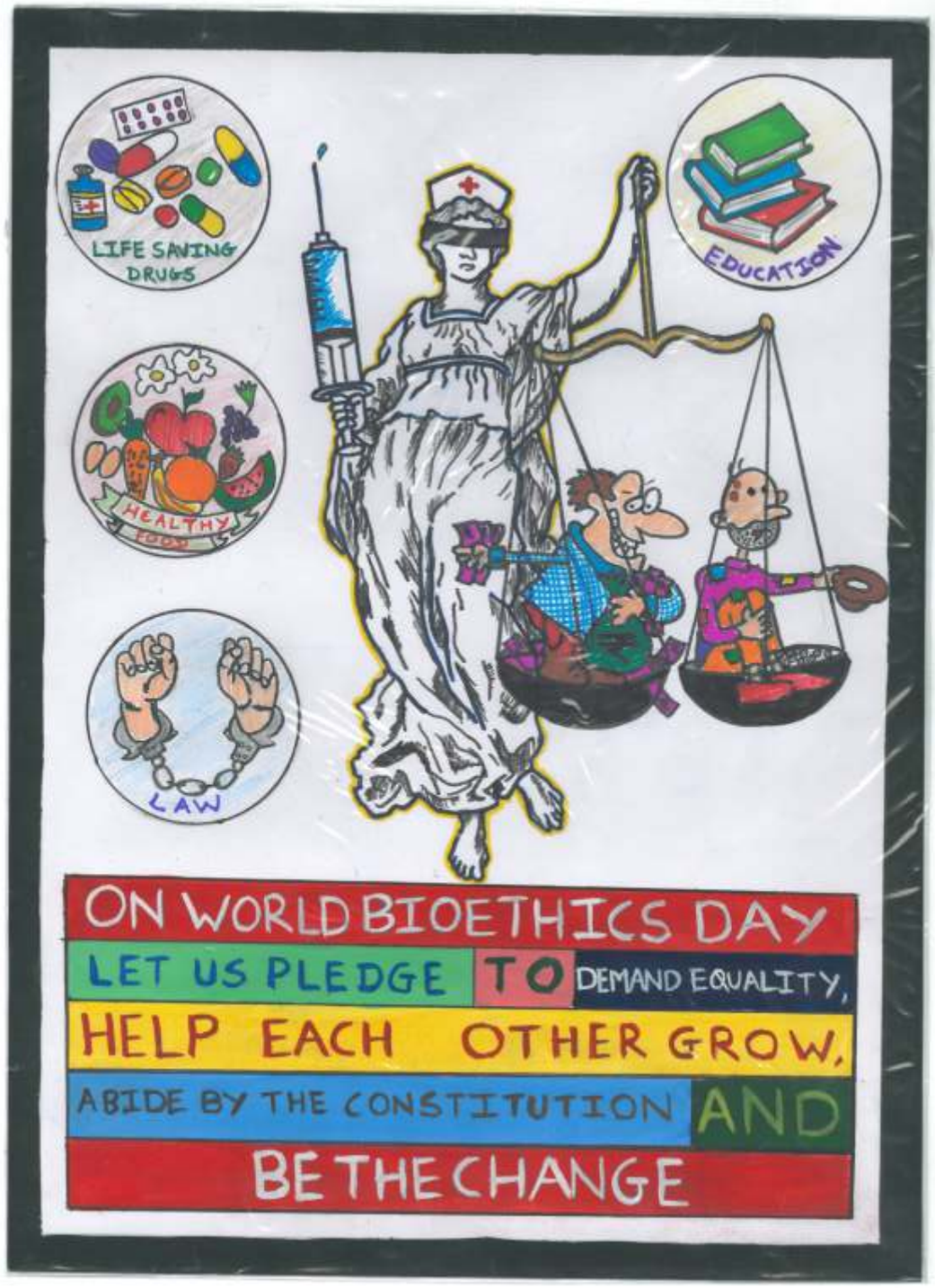


Appreciation Prize

Amogh Patekar, IV[th] Year, Physical Therapy

Municipal Corporation of Greater Mumbai

Seth G S Medical College and K E M Hospital, Parel, Mumbai

Dr. Avinash Supe
MS FICS DNBE FCPS DHA PGDME
MHPE (UIC)FIAGES FMAS FAIS

Director (ME & MH) and Dean,
Chairman, GSMC MUHS UNESCO Bioethics Unit
Professor, G I Surgery, Professor of Medical Education
GS Medical College and KEM Hospital
Director, GSMC FAIMER regional Institute
Past President, Academy of Health Professions Education

Message

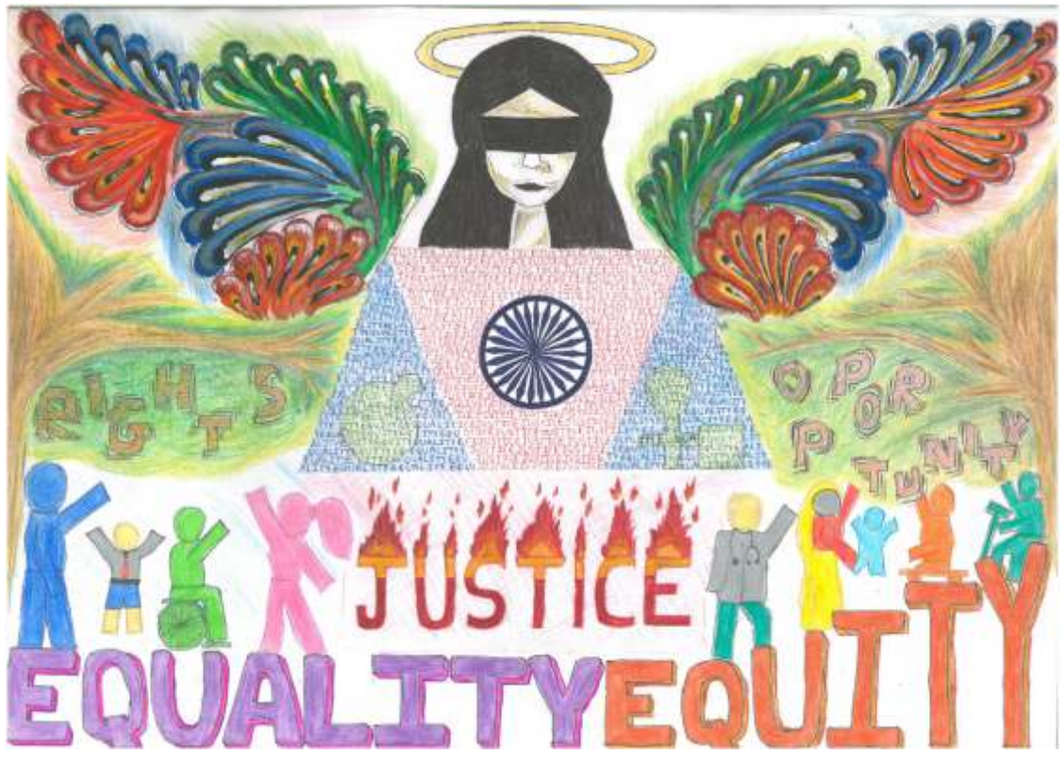
It is my privilege to write a message for **Second issue of "INARCH"**, which is the official bulletin of the **UNESCO- MUHS- GSMC Bioethics unit**. Bioethics unit of our institute is functional for last 2 years and it has grown tremendously and has been conducting activities involving all sectors of health professions educations. This year the bulletin is dedicated to the theme "Equality, Justice and Equity". In the modern era of biotechnological advances, bioethics is need of the medical specialty. Our unit has conducted various activities such as Guest Lectures, Faculty Training Program, students' sensitization to Bioethics curriculam and competitions such as essay, debate, poster, street play and short film, thus spreading awareness about ethical principles amongst all students and faculty through innovations. On the occasion of world bioethics day, unit plans to release "INARCH" not only to promote the pursuit of ethical excellence but also to disseminate the bioethical views to the trainees, faculty and practicing professionals. Along with the steering committee, the students' wing of GMU Unit is also active in organizing various events.

I am sure wisdom disseminated from various articles and editorial of this bulletin, will improve understanding of bioethics. This bulletin will also record excellent work carried out by our students and faculty in field of ethics. I congratulate all the contributors and the unit members for bringing out such a path-breaking bulletin.

Wishing them all the best!

Dr. Avinash Supe

Appreciation Prize
Minal Sapkal, II/III - MBBS



Appreciation Prize
Prabodhini Gadhari, III/I - MBBS

Editorial

We proudly present to you the second bulletin of INARCH. The theme of 2017 World Bioethics is Equality, Justice and Equity- article 10 of Universal Declaration on Bioethics and human rights. Going beyond the prescribed role of provision of health service, ensuring justice and equity in health care delivery is the mandate of the medical profession.

Hippocratic oath prescribes the principles of justice for the practitioner. Doctors and teachers have been considered 'friend, philosopher and guide' by society for a very long time, but gradually commercialization of healthcare service and conversion into health care industry has diminished this status in the social psyche. This downfall makes it critical for medical educators to incorporate bioethical principles in medical education. Students must have insight into cultural diversity, poverty and its impact on health. Religion, mental and physical challenges may make people view health differently and practice healthy behavior differently which students should be aware of.

Social determinants of health like political and economic stability, cultural diversity, gender parity, technological advances have positive impact on equitable distribution of health care services. Their absence causes catastrophic consequences like the ones we are witnessing in case of Myanmar and Syria. In addition, disease evolution, epidemiological changes, geography also have a cause and effect relationship with health interventions.

Gender parity is critical not only for women but also for the future generations that women give birth to and rear. Policy makers have a major role to play in bringing about gender equity. Law makers and judiciary have a role in creating fair environment and executive authority has a duty to approach violence against women in empathetic manner. There are effective legal instruments for women and children like domestic violence and POCSO acts, but poorly executed recording, reporting, evidence collection and testifying by doctors causes denial and delay in justice. This is clearly visible in conflict situations and their aftereffects on women and communities.

Few advances have taken place in the field of palliative care in public health. Paucity of resources and services condemns the chronically ill to suffer. It also increases burden on acute care services. Inequity is stark in this area of health care. Physically challenged people have difficulty accessing care, and most peripheral health facilities are not geared to cater to them.

We hope that incorporation of Bioethics in medical curriculum will build an empathetic newer generation of health professionals and help reduce the discrimination and inequity in health care services.

Dr. Padmaja Samant

World Bioethics Day
19th October 2017

GSMC MUHS UNESCO Bioethics Unit

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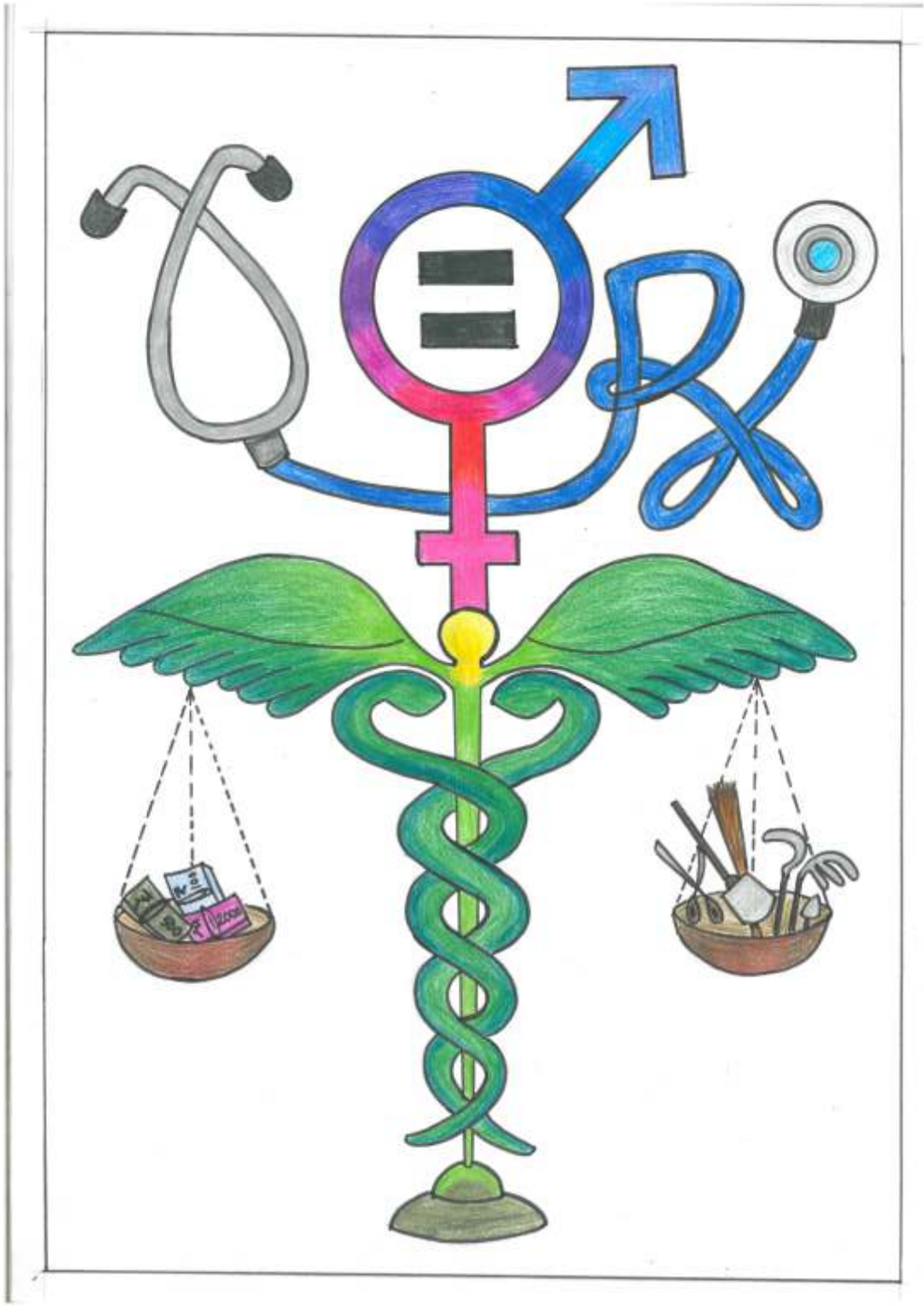

Appreciation Prize
Hiral Parmar, Intern, Physical Therapy

Equality, Justice and Equity through Medical Education - Current Status and the Path Ahead

Dr Avinash Supe
Dean and Director,
Medical Education and Major Hospitals MCGM

It is well known that economically challenged group of people bear maximum burden of medical illness. They have enormous difficulty in getting quality health care. India, especially metropolis Mumbai is characterized by diversity in economic-social strata. In Mumbai, overcrowded slums and exclusive towers are found side by side. Most public hospitals mainly cater to poor and middle income group patients and see some VIP and rich patients needing expert advice in difficult and uncommon medical illnesses. Medical students therefore get exposed to patients from all socio-economic sections of society. To get proper training they should know what is equity, equality and Justice. **Equity** is the concept or idea of fairness, particularly in regard to welfare. **Equality** is the state of being equal, especially in status, rights, or opportunities. **Justice** is subdivided into three categories: fair distribution of scarce resources (distributive **justice**), respect for people's rights (rights based **justice**) and respect for morally acceptable laws (legal **justice**)

It has been documented that there is need of improving medical students' and residents' knowledge and understanding of poverty especially the living conditions of the poor. For this improvement, efforts are required in enhancing relational skills pertaining to communication and interaction with such socially and economically disadvantaged people. The students require to develop understanding, awareness and capacity for self-reflection. It is accepted that persons living in poverty and healthcare professionals think differently because of many factors. They are from different backgrounds, live in different social contexts, not facing similar realities. Religion, mental and physical challenges add to those differences challenging health care professionals while treating patients. Diagnosis and treatment depends on various parameters. Elite health professionals miss the socio-economic perspective which results in mis-perceptions.

Other factors influencing outcomes of healthcare delivery systems are diversity of students, variations in curricula, and different teaching approaches. This may lead to inequality in health status due to improper interventions by the doctors. Curricula may differ from country to country, and even from university to university. Certainly, the characteristics of different curricula affect the training in the medical schools and eventually these characteristics are reflected in their practice. The Core curriculum of basic medical education should be the same for all the schools world over. The medical educators should understand that institutions have a responsibility to ensure the production of health personnel who have adequate knowledge, proper attitudes, and desirable skills to meet with the requirements of their own communities and people from all sectors to maintain equity.

Every health professional should understand the health needs of their region, community, and individual patients by interacting with the community from the first year of study to the last year in their medical school and should be held socially accountable and remain contextual. Every medical school curriculum should have overt and hidden aspects of education that would ensure making students understand justice, equity and equality. Periodic visits to slums and rural areas and interacting

with patients from all sectors and bringing about depth of understanding of medical students regarding these issues is as essential as new science and technology.

Medical schools should strengthen their curricula in such a way that future physicians are better prepared to deal with patients living in poverty and its impacts on health and healthcare. Evidence shows that transient exposure to poverty(for instance, through lectures and one-time visits to clinics and organizations serving poor communities) is unlikely to adequately prepare medical students and residents to care for economically disadvantaged patients. Also a constant high exposure to poverty during medical training (e.g., studying at a teaching hospital located in a socioeconomically disadvantaged area) does not necessarily result in greater understanding of impact of living in poverty on health issues and empathy either. In fact, it may corrode positive attitudes of students towards persons living in poverty subsequently during their remaining course of study. Most importantly, reflection on their experiences and discussion with teachers may help to develop empathy and sense of justice. This helps to develop a healthy perspective.

To conclude, there is a need for curricular change in medical education to make Indian students understand equity, equality and justice better. Each medical school should design curriculum to ensure that students understand health issues in context of poverty, inequality, religion and challenged person. This will definitely have positive impact on the way doctors will treat patients in community and follow justice and equity in medical practice.

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“ The opposite of poverty is not wealth. In too many places, the opposite of poverty is justice.”

- Bryan Stevenson

Gender Justice and Equity in Health

Guest Author
Kamaxi Bhate
Addl. Professor, PSM
Secretary, Savitribai Phule Gender Resource Centre, MCGM

As doctors, it is our firm belief that in the eyes of science and more so in the eyes of much finer science like medicine, there cannot be any gender discrimination that may add to ill health. Neither do we believe that we can ever be guilty of gender bias and neglect of health issues of women. Till recently, even the World Health Organization (WHO) did not include gender as a determinant of health issues like bacterial or viral infections; because it was have to believe that such infections could affect men or women differently! Thanks to epidemiologists who considered social determinants of health, gender has become one of the very important determinants.

It is interesting to see how WHO evolved the concept of gender in Health. Around 1970, WHO acknowledged that secondary social status & discrimination of women affects their health, &referred to ' Women in Health'. Research cell for women centered subjects of WHO was established in 1975. Ten years latter 1985 Nairobi - Women's conference adopted 'Women in Development (WID)' model, and very interestingly, soon enough, WHO adopted the same WID model.

WID model did bring about lot of changes in the health field. Maternal mortality reduced by half, literacy rate of women went up from 54% to 74 % by 1995. However, the basic position of women did not change. Criticism of WID model is - Women are looked at as passive victims, who are in need of welfare.

One more international women's conference added a little more clarity to this model, in 1994 at Cairo, 'Gender and Development' model was adopted. Quickly enough in 1996, WHO adopted this change and brought out a technical paper “Gender and Health”, and gender became one of the determinants of health, that gave birth to WHO's Gender Policy around 2000.

Although the gender policy of WHO was made in 2000, at local level like in any other field, in medical field also there is lot of confusion about the terms, like ‘sex’ and ‘gender’. They were used and they are believed to be interchangeable words. However it is important to understand the word **Gender**. Men become defensive and believe that it has something to do with women and women alone. Let us try and simplify this concept. “Sex” refers to the biological and physiological characteristics of male and female. External genitalia, reproductive organs, chromosomes, hormonal environment, etc. are attributes of a person's sex. Mostly sex does not change lifelong. Whereas,“Gender” refers to the socially constructed roles, rights, responsibilities, possibilities and limitations in a given society, which are assigned to men and women. Gender is what is considered “masculine” and “feminine” behaviour expected from men and women respectively in a given society, at a given time and place. To put it simply “male” and “female” are sex category and masculine and feminine are gender category. Thus sex is what a person is born with, permanent and universal; gender construction varies from one society to another.

However, how does it affect health? Can medicine as a science be discriminatory towards men or women? Is medicine Gender blind? Does medicine ignore gender and cause health consequences?

I am sure most of us know that, wards for women and number of beds for women is almost 1/3rdof that for men. This could be because the system believes either that women fall ill less often, or they believe that women do not come to hospitals or they don't get admitted to hospitals when required. Not being able to come to hospital on her own or due to lack of money and not getting admitted to the hospital due to family responsibilities is understandable as the

effect of gender inequality entrenched in the society. But medical system planning smaller wards, keeping fewer beds for women is like indicative of an insensitive system! This will lead fewer oxygen cylinders, fewer drugs and less equipment. I can give one very stark example here. I was conducting inspection of hospital in beggar's home. Both men's and women's wards were in bad condition; but still, in men's ward a few medical instruments, medicines, oxygen cylinder, dressing material, injection material and other emergency drugs were available. However, the women's ward side room had only breast pumps! More than 10-to-12 in number! These pumps were to be used during engorgement of breasts in lactating mothers and sadly, all those hand pumps were 40-50 years old.

The same insensitivity is reflected in OPD paper. There are only two sexes on paper, M/F. What about "others"? There must be mention of others on the OPD papers. Even protocol for sexual assault examination should have F/M/ Others. Some hospitals have made this change but we have to still go a long way to call ourselves sensitive.

We learn most our medicine through books. When these books were reviewed after the WHO gender policy was made; the vice chancellors and deans of the medical colleges were asked in 2002 to review the existing service situation from gender perspective. One such review was of Preventive and social medicine books. It was an eye opener. 'Medicine is a social science and politics is Medicine on a large scale'. Human beings are not only biological animals but also social beings; disease has social causes, social consequences and social therapy. Social medicine is not really a new branch of medicine but new orientation of medicine towards the disease cassation. Health and diseases are multifactorial. There are numerous social determinants and gender is an important social reality. After the review, 'gender' got promptly included as early as 2003-4 in the book of Dr. K. Park,17th edition. Park is considered the bible of PSM. But even this social scientist did not realize that by just putting gender as determinant of health in one chapter and not addressing gender in other chapters, it is neither possible to prevent disease nor achieve health.

Epidemiological data are meant to help in designing policy and program interventions. However if in the entire book, a social scientist author mentions host as male and if environment is not engendered in epidemiology, the policies and programs interventions derived from such data cannot be effective. For example, in Maternal Mortality, data never mentions Domestic Violence as the antecedent cause of death because no one elicits such a data.

Frequency of Sexually Transmitted Diseases is higher in " single, divorced and separated persons than in married couples"- Such description applies to only men in India, because for most of the women only risky behavior is getting married to men with multiple sexual partners.

The society is understood from the man's point of view, there are loose statements about Sexually Transmitted Diseases in some text books like – ' 80 % of infected women are reported to be asymptomatic carriers'. One more author goes few steps ahead and write,-' Females are particularly liable to spread the disease, since they have few symptoms or no obvious signs.'

Look at these social scientists blaming the silent sufferers as silent carriers! In Indian scenario, women do not come with genital symptoms easily to doctors because of embarrassment and lack of access. Sadly, this is forgotten.

Social scientists have not mentioned anything about doctor patient relationship, especially while examining a women patient, precautions to be taken by male doctors.

Gender blindness can make doctors ignore decreasing child sex ratio, before PCPNDT act came, doctors believed that, they were helping aspiring couples to have child of preferred sex!

Such is the state of Medicine and Medical Education. Only if this picture changes, will there be equity and justice in health for women and the third gender.

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Equity in Health Care

Dr Santosh Salagre
Dr Anjali Telang

The essence of global health equity is the idea that something so precious as health might be viewed as a right- Paul Farmer

Right to health is an important human right upheld by national constitutions globally. Ensuring distributive justice and equity in accessing health systems is mandate of governments across the world.

What is equity in health? Why is it important to know inequities in health? Why is it important for health care system to consider geography while planning health policies? How budget for healthcare sector affects equitable distribution of health services? All these questions are very important for a health care provider as a part of health care system while providing health care services to the community.

Historical perspective:

'Sarve janah sukhino bhavantu' (May all humans be free from disease and May all be healthy) was an ancient saying in the Vedas. During post vedic period (600 B.C. to 600 A.D.) the medical education was introduced in the ancient universities. A hospital system was developed for all. We can say this was the first attempt for equitable distribution of the health in society. During Mughal era (650-1850 A.D.), the medical education and medical services became static and the ancient universities and hospitals disappeared. During the British rule in India, during middle of the 18th century, many significant steps were taken with respect to health of British army. Commission of the public health was established to take care of many things affecting health of British army. After 1947, during post-independence era in India, the health care system improved a lot due to health policies. The state tries to provide equitable distribution of health services to benefit each and every individual 'the highest attainable standard of health'.

Definition of Equity:

Equity is frequently defined as an expression of social justice. Most of the dictionaries define it as "The state or quality of being just and fair". Equity in health can be defined as the absence of systematic disparities in health between social groups who have different levels of underlying social advantage or disadvantage. The ethical principle of equity is based on distributive justice and is closely related to the principles of human rights. Equity calls for responses that are in accord with the needs of the individual in relation to the needs for all. From the point of view of health, equity can be defined in various ways :

a) equal resources expended for each individual (supply equity);
b) equal resources expended for each case of a particular condition;
c) equal access to health services;
d) equal quality of health care;
e) equal status of health for all (which is eutopic);
f) equal healthy life gained per currency expended;
g) care according to needs (demand equity).

Heath inequities:

Inequities in health are defined as inequalities in health that are unfair, unjust and avoidable. There is a wealth of research demonstrating the relationship between social inequality and health inequity. With social enquality, health inequality also increases; the richer people with excessive consumption suffer

health problems of overnurtrition and life style related diseases, and the poor pay the price due to increasing violence, mental health issues, malnutrition. Diminished community life and social relations, lower life expectancy due to the prevalence of drug abuse and other physical (e.g., obesity and cardiovascular disease) and mental health (e.g., anxiety and depression) problems, teenage pregnancies, violence and imprisonment, lower educational performance, and limited social mobility are all outcomes of health inequities.

Geographical considerations related to equity in health:

As we talk about health care system and equity in health, geography influences health of an individual and thereby equity in health as organisation of many health care systems and specific location of hospitals imply geographical considerations. The Aristotelian principles of horizontal and vertical equity are reflected in equal access to health care (horizontal equity) and equal outcomes (vertical equity) respectively.

Direct environmental influence, historical background and cultural inheritances of the community, financial status of the community in a particular region, specific type of employment prevailing in a particular area and geographical distribution of the health care facility are the factors affecting equity in health either directly or indirectly. Geographical area affects health care provision as well as heath care utilization due to status of development of that area, availability of transport system, rural- urban lifestyle differences.

So it is imperative to consider geography while working for equitable distribution of the health care services.

Challenges in implementing Equity in health care:

1. In practice, geographical allocation of health care finance complying with ethical principles is a formidable task. Equity objectives, such as securing equal access to health care for equal need, or securing equality of health outcome, can never be fully achieved. In practice, inequalities in provision of health care will always exist, if only because of geographical variations in the costs of reaching services, and equality of health outcome can be pursued only in part by redeployment of health service resources.
2. Competitive market-driven approaches to healthcare brought about by capitalism, neo-liberalization, and globalization, based primarily on a competitive framework, have contributed to growing inequities with respect to the social determinants of health, and have undermined equal opportunity to access health care and achieve health equity. Partnership and cooperation only will help us achieve our goal of health for all.

Future approach:

- Ethics, equity and respect for human rights must be incorporated in all aspects of health care.
- Indicators must be devloped to measure gaps and effects of interventions. These indicators should be valid, cost-effective and sensitive.
- Multi-disciplinary research involving biomedical, behavioural, social, legal and anthropometric scientists will be required to prioritize health interventions that can ensure equity.
- Ideological perceptions from other cultures have to be recognized in order to contribute towards a common understanding on health ethics equity.
- Networking between international organizations, the United Nations and non-

governmental, as well as with governmental, academic and advocacy groups will promote the continuous and sustained development of ethics equity.

The health sector has the obligation of considering the ethical dimensions of the major determinants of health. Political stability is important for forging equity in health. Economic balance helps the poor access health and creates financial provisions for them. Burgeoning population and poverty together worsen health prospects of the vulnerable. Women's health has always taken the brunt of social inequality. Harmful ecological effects of so called development harm all especially the poorer societies. Hence the richer nations have an obligation towards the global community to provide technological, financial aid to fight adverse effects of ecological damage. They must help the disadvantaged countries fight newly emerging diseases. Social mobilization in support of health ethics, equity and human dignity is a responsibility of the academic and advocacy groups involved in ethics and human rights.

While the twentieth century went down in history as a century characterized by the quest of knowledge, the twenty-first century, it is hoped, will be characterized by the wisdom with which the acquired knowledge is applied with equity.

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" Gender equality is more than a goal in itself. It is a pre-condition for meeting the challenges of reducing poverty, promoting sustainable development and building good governance."

- Kofi Annan

Health Equity and Justice in Conflict Situations – Role of Health Care Providers

Dr. Padmaja Samant

Background:

A few months ago a picture of a dead Syrian refugee child washed ashore hit the Internet and print media, pleading with conscience of civilsociety to pay heed to the plight of refugees.

Rohingyas from Myanmar, pundits from Kashmir, Syrian refugees from the war ravaged Syria, sex slaves of Al Shabaab- all tell the same story of conflict causing denial of basic human rights of dignity, right to attain health and full potential to lead a productive life.

During conflict: women, children, the poor and the marginalized communities are the sufferers. The dominant faction wields power over the vulnerable lot either for purely material gains or for some supposedly larger cause like religious reform.

Even as health care providers, we all are part of the larger system, with our personal views, political leanings and beliefs. It makes us prone to be biased with respect to these people. Even if we have sympathy for the deprived, we do not venture out of our safety zones to fight for their rights. Help we would; if they came to us, and that too from within our safe zones! That makes us as blind as the system that rules.

Origin of ethical principles and guidelines:

Historically the ethics principles and guidelines were led down in response to the rights violations and ethical transgressions that occurred during conflict situations. Nuremberg code was born out of the felt need due to atrocities on war victims and prisoners of war. Incidentally the crimes were perpetrated in the name of science and the doctors performing the experiments actually believed it. Did they? Or because they too were from the dominant race and so were tolerant of the madness unleashed by the victors? Though the codes emerging out of the Nuremberg trials revolved mainly around research ethics, violation of human rights and health implications were the central part around which the principles evolved. The same principles are applicable in healthcare.

Warring states, terrorists continue to use ordinary citizens like Kashmiri civilians as a shield or a tool to arm-twist political and ideological opponents. In spite of efforts by peace keeping missions, civilians are killed and tortured. Medical bodies and groups world over have taken a humanitarian stand in such conditions, an example being Médecins Sans Frontières (MSF) also called Doctors without Borders. Syrian doctors from all over the world funded hospitals, devoted and sacrificed lives for their brethren devastated by war. But does this magnanimity always extend to the devastated people when they belong to communities of different ethnicity, or to enemy countries? Sometimes, medical professionals from the dominant communities prefer to be neutral and to keep out of these issues as they think that the issues are political or social problems.

It is important that medical personnel to use their ethical reasoning and act in conflict situations because-

- There are numerous long-term public health implicationsof the conflicts. Elimination of inequity will help in mitigating the implications and reduce human suffering.
- Doctors are respected members of society, they can be advocates for the deprived and humanitarian work by medical persons is likely to set an example for the society. Equitable health care provision should be our motto.

What is equality? How is equity different from equality?

- Equality is the quality or state of having the same rights, social status.

  Many times equality a
- Equity in health is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/ disadvantage. Equity addresses the unfair resource allocation, denial of health rights and other systematic processes that drive a particular kind of health inequality visible across groups.
- Equity in health implies distributive justice and involves both process and outcome. The forms of equity in health are-

a. Supply equity b. Equal access to services like transportation, public distribution system c. Equal quality of health care like dignity, respect, autonomy and confidentiality d. Care according to needs - demand equity.

Conflict:

On this background, let us study what conflict is and what health effects of conflict are.

Gillin and Gillin defined conflict as - the social process in which individuals or groups seek their ends by directly challenging the antagonist by violence or threat of violence.

Conflict could be due to either ideological differences, cultural mismatch or power struggle for economic reasons; it is almost always hostile to a group and may have various degrees of violence involved. Conflict could also be in response to frequent natural disasters that leave the population shelter less, hungry, sick. Few resources cause fight; but this type resolves soon. It is said that conflict is natural and integral to growth- like churning of liberal ideology- as eventually the conflicting people settle the differences and live together. But in this discussion we are inspecting the negative and deliberate conflicts rather than those that have positive culmination.

The broad types of conflict that have serious impact on health of the vulnerable are

1. Wars including civil wars
2. Impersonal ideologies like communism, religious movement where proponents of each intend to bring a better world order. Either way; women, children, elderly and minorities suffer. The young generation shows detrimental effects of conflict over years.

   Sisaye, in her doctoral thesis on post election violence in Kenya, divided health consequences of violent conflicts into four categories.

   The Health impacts can be due to-

   - Economic and infrastructural factors: where in there is collapse of health systems and the poor are deprived the most as they cannot afford other than free services.
   - Environmental factors: due to destruction of transport facilities, access is denied to the beneficiaries as well as providers. Food chain gets disturbed and hunger, malnutrition and death ensues which is commonest among the poor. Crops are destroyed resulting in famine like situation.
   - Policy related effects are due to selective allocation by the powerful who control finances to the civil groups they favor. The poor, the rural depend on the health budget for preventive campaigns like immunization, water, sanitation works, and public distribution system of grains. Malnutrition, epidemics rise due to these services getting hampered. Acute curative expenses rise and preventive expenditure for chronic care is slashed. Polio eradication programme and immunization have taken beating in the countries in conflict. Even the health workers have been

targeted and killed. Campaigns against Malaria, HIV AIDS are among the seriously compromised.

- Social factors: These are relatively occult. The affected population may be displaced internally or externally. Refugees live on threadbare budgets, living conditions may cause disease outbreaks and malnutrition is almost certain. Crime rates increase. These groups also are faced with social discrimination due to ethnic differences.

Health care burden due to conflict situations: More than 10 million people died due to direct and indirect results of armed conflicts at the turn of century. Civilians were in much larger number than armed forces or rebels. Children suffer the most as malnutrition, epidemics claim lives. More than 50 million refugees worldwide need health care.

Outcomes of natural disasters in the countries affected by conflict are worse than those having peace.

Impact on doctors, nurses, paramedical forces: Health care providers are either held hostage by the dominant faction and are made to obey them or are harassed/ killed if they resist. In wars across the Middle East, thousands of health care personnel were killed in the last decade. Numerous doctors have perished providing services to injured civilians in Syrian war. Hospitals and ambulances have been targeted to wipe out the injured civilians and the health workers. Allegedly, the 'kneel or starve' policy of the Syrian government is aimed at making rebels kneel but the civilians are dying.

On the other side the testimonies and stories of Gujrat pogrom in which the doctors were complicit with the police and state, are a blot on the medical fraternity.

In the pogrom, atrocities on women were more brutal, sexual violence was rampant. There was violence against the unborn fetuses. These were crimes of mindless masculinities against women, children and weaker men of the minorities. But the doctors failing to document injuries, avoiding to opine on causes of injuries and ignoring treatment of the victims is worse than the crimes themselves.

The gaps in the health system response to the crisis were in the form of

- Inadequately prepared medical records and post mortem findings, which under reported violence.
- Sexual violence detection and reporting was incomplete, compounded by otherwise insensitivity towards the victims. Confidentiality and respect was lacking as per the testimonies to the women's rights activists.
- Psychological trauma as always was overlooked.

Weaker men are also subjected to humiliation and torture that they cannot even narrate.

Oosterhoff and colleagues came across reports of male sexual torture in conflict situations in many parts of the world including Croatia and Srilanka.

In genocide, births in the victim community are prevented by forced pregnancy terminations and forced sterilizations. The dominant community or state uses doctors in this crime.

The already weak collaboration between the health care workers, especially the forensic department, the police and the judiciary fails totally in conflict situations when the powerful groups dominate the state. Hence crimes, especially sexual crimes are poorly recorded. This makes redressal difficult.

The way ahead: For rectifying the injustice and inequities in health during conflict measures are required on numerous fronts; from the state and the policy makers to medical teachers and action groups.

Fundamental right to attain the highest standard of health is non negotiable and the state mandate to ensure it is absolute. Even in times of conflict health service collapse must not be allowed and affordable

culturally acceptable, accessible health care services should be provided.

Health care providers should be trained to be aware of the social factors like gender discrimination, racism, casteism, poverty and political instability that cause ill health and at the same time deny the poor, the minorities, deprived classes and women to access to equitable health care.

Reproductive and sexual health issues cause embarrassment in women and girls. Privacy and confidentiality is of paramount importance. Gender sensitivity has to be integral to the teaching of medicine.

Health policy makers must be gender sensitized and should be aware of implications of conflict for health as human right.

Culturally compatible care must be offered to the beneficiaries. Otherwise women, young girls, minorities will not come forward to use services.

Message of the WHO Director General to the 53rd World Health Assembly sums it up where it mentions the role on health partners and medical bodies world over in conflict situations and highlights the importance of "staying *to the end* and *to come in early"*.

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Access: For the differently abled

Karuna Nadkarni,
Mariya Jiandani

Background: Dashrath Manjhi, famous mountain man of India carved a path through the mountains of Gehlor Hills of Bihar, so that his village could have an easier access to medical facilities. Though right to health is a constitutionally applied fundamental right, yet 32% rural & 8% urban population have to travel for more than 5 kms to get access to basic hospital facility.

Accessibility is defined as the ability to access a system or a service. Enabling access to people with special needs or disabilities requires consideration in designing and a wide applicability from mobility to healthcare; and education to employment.

Introduction: According to the 2011 census of India, 2.21 per cent of the population suffer from disability. Disabilities can affect a person's capacity to communicate, interact, learn and get about independently. In the International Classification of Functioning, Disability and Health, endorsed by all WHO member states in 2001, disability is defined as a "degree of functional impairment(s) involving an organ or body part that may result in activity limitation(s), such as difficulties executing tasks or activities of daily living, and also in participation restrictions that hinder a person's ability to play a meaningful role in society". Activities taken for granted, such as travel, shopping, recreation and decision making may not be possible easily for them. Along with the individual, the family and care givers face the impact of this. Additional difficulty is seen with those in remote or rural areas. There also exists a gender disparity where women with disability are neglected and face barriers to a greater proportion than males.

As community members the differently abled and their caregivers have same right as any other individual to access the local government or public service. The Accessible India campaign, also called as the **Sugamya Bharat Abhiyan** was launched in December 2015 to enable Persons with disabilities (PWD) to gain universal access, equal opportunity for development, independent living, and participation in all aspects of life. Its most prominent goal is to make at least 50% of all government buildings in the national capital and all state capitals "fully accessible" by July 2018. There exists a deplorable state of facilities for the differently abled in public buildings, hospitals, railway stations and educational institutions with almost 95% of the buildings lacking toilet for the disabled.

The common elements of access and inclusion are the removal or reduction of barriers to participation in the activities and functions of a community, by ensuring that information, services and facilities are accessible to people with various disabilities without gender bias.

Legal rights of the disabled :

-Article14 (Right to equality) and article 15 (Right against discrimination) of the Indian Constitution has implications for people with disability(PWD) and allows affirmative action for the benefit of PWD.

-Article 21 guarantees the people of India the right to live with dignity & respect and further affirms the PWD should be entitled to enjoy all liberties that are granted to all.

-Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD) reinforces the right of persons with disabilities to attain the highest standard of health care without discrimination. India

is a signatory to the UNCRPD and is among the first few nations to ratify it. People with disabilities have a greater need for healthcare and have higher unmet needs.

Article 9 of the UNCRPD emphasizes that PWD to live independently and participate fully in all aspects of life and also imposes obligations on all states to take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportations, to information and communications and of the facilities in public domain, both in urban and rural areas. It further imposes a duty on all states to develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public.

-Rights of Persons with Disabilities Bill (RPwD) 2016 define 21 categories of disabilities as compared to only seven in the previous 1995 act. It emphasizes that the appropriate government shall ensure that the PWD enjoy the right to equality, life with dignity and respect for his or her integrity equally with others. This law mandates accessibility /barrier-free access in all parts of Government and private establishments, and gives time frame to implement the changes.

It also ensures that PWD are able to exercise the right to access any court, tribunal, authority, commission or any other body having judicial investigative powers without discrimination on the basis of disability. Educational institutions should admit children with disability without discrimination and provide education and opportunities for sports and recreational activities equally with others and make building, campus and various facilities accessible.

Overcoming accessability barriers :

Accessibility is empowerment. The first step towards social inclusion is to have the right infrastructure in place. In order to effectively cater to the needs of the differently abled and the provisions of the PWD act, following measures should be undertaken to overcome barriers.

1) Physical access and transport: People with disabilities should have the same opportunities as other people to access the buildings and other facilities of a public authority. Automobile accessibility also refers to ease of use by disabled people like raising foot pedals or replacing with hand-controlled devices. Infrastructure accessability can be facilitated by

a) Making wide entries, ramps of adequate gradients with hand rails to public places, allowing wheel chair users space, ease and assistance.

b) Adequate stair height and markings with yellow line to allow visually impaired to understand the difference in gradient.

c) Disabled friendly waiting area, visual screens and auditory systems.

d) Adequate parking spaces and large signposts.

e) Installations of elevators wherever required.

In spite of most places being inaccessible, some of the places in India have adhered to barrier free norms e.g. Prince of Wales Museum has installed hydraulic lifts, ramps and Braille signage for the benefit of the disabled.

Local trains and ticket counters in Mumbai are partly disabled friendly for PWD (deaf /dumb and blind) with appropriate auditory and visual signages.

A significant development in transportation and public transport in particular, to achieve accessibility, is the move to low-floor vehicles. Taxi for wheel chair users is a unique service by Mobility India which enables PWD to commute with maximum safety and comfort.

Hospital infrastructure designing should consider access, waiting area, canteens, toilets, examination couches, and ease of movement within the hospital to facilitate evaluation and treatment for the PWD and their caregivers.

2)Information access: People with disabilities should

receive information from a public authority in a format that will enable them to access the information as readily as other people are able to access it. Advances in information technology and telecommunications have represented a leap forward for accessibility.

Access to information on health paramaters, regular check-ups, health education and sex education is of paramount importance. A wide range of technical aids including screen magnification for monitors, braille displays, and voice operated phones and tablets and a text interface for a speech synthesizer can be used.

Bengaluru based NGO EnAble India recently launched their **Enable Academy** website which provides PWD with educational content, general awareness information, appropriate articles and helpful videos, guidance and connections to people who can help.

Sugamya Pustakalaya, an on line library initiative by Ministry of Social Justice and Empowerment in collaboration with various NGO's makes use of industry standard techniques and high level of accessibility and ease of use to all including Person with Print disability.

3) Staff awareness: People with disabilities should receive the same level and quality of service from the staff of a public authority as other people receive and should have the same opportunities as other people to make complaints to a public authority. A health care professional needs to be sensitive, aware and develop the right positive attitude and communication skills .

People with disabilities have reported inadequate skills of health care providers in meeting their needs, being denied care and treated badly. Integration of disability education is a must in health care professional's curriculum.

4. Participatory opportunities in public consultations, decision-making processes and socialization**:** People with disabilities should have the same opportunities as other people to participate in any public consultation by a public authority, employment and education. Legislation of certain countries supports equal access to education for students with disabilities. It is challenging for some of these students to fully participate in mainstream education settings, but many adaptive technologies and assistive programs are making improvements. There is provision for reservations created in education for PWD.In India, the MCI has passed the directives to all the medical institutions to make them accessible to persons with disabilities. Children with disability have higher dropout rates due to their physical and emotional vulnerability. They are generally left out in vital health education due to societal bias. To make them socially inclusive professional vocational training and employment opportunities need to be created.

5) Health care service: PWD should have the same opportunities as other people to access to health care irrespective of age, gender, religion or economic standards. National policy for persons with disabilities focuses on physical, social and economic rehabilitation and prevention. Eg screening for cervix cancer in women with disability needs proper examination tables.

Rehabilitations efforts include early detection and appropriate medical facilities and care of PWD. The Rehabilitation Research and Device Development lab at IIT Madras focuses on developing indigenous and affordable products for the disabled. Non affordability and lack of transportation are two main reasons why the much needed healthcare cannot be received.

Developing more equity in healthcare infrastructure between urban and rural areas by allocation of funds to build more healthcare centers and convert more primary health centers into 24X7 community health centers is become need of an hour. Failure to make the necessary adjustments to promote equality of access to healthcare results in inequity.

Looking forward :

Equity in health implies that everyone should have a fair opportunity to attain their full health potential and that none should be restricted from achieving this potential. Equity in health care implies 'equal access to available care for equal need, equal utilization for equal need, and equal quality of care for all.'

Until a few decades ago, it was almost unimaginable for the disabled to lead independent lives. But recent advances in technology and internet have the potential to change the scenario for better functioning for PWD.

As per the social model disability is not an individual tragedy, but a social construct. Infrastructure needs to be created in society for all inclusive approach as per human rights model. Strategies to improve access and inclusion for people with disabilities requires co-ordination and cooperation between all areas of Local Government, Policy makers, institutions, legislations and individuals. Extending healthcare services is a critical priority in India and despite numerous efforts; the gap between aspiration & provision of quality healthcare on an equitable and affordable basis across all regions and communities still remains a challenge.

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Returning hate for hate multiplies hate, adding deeper darkness to a night already devoid of stars. Darkness cannot drive out darkness; only light can do that. Hate cannot drive out hate only love can do that.

- Martin Luther King Jr.

Gender Equality in Health care Profession

Ekta Nitin Patil
Physiotherapy Intern .

"A gender equal society would be one where the word 'gender' does not exist: where everyone can be themselves."

- Gloria Steinman

Gender Equality, as defined by UNICEF is a state where women and men, and girls and boys, enjoy the same rights, resources, opportunities and protections. This term has been in discussion for a very long time, yet achieving it in the society has been a herculean task. One of the most commonly encountered problem is gender based discrimination that occurs in the workplace .The Health Care profession, however evolved it may be, is definitely not immune to this problem.

Undergraduate to Postgraduate

Every teenager who dreams of becoming a doctor has to go through same rigorous routine, irrespective of whether one is a girl or boy. However it has been noticed that the number of women joining and completing postgraduation is about one-third of the number than at the undergraduate level. There can be multiple factors to this disparity such as lack of job opportunities or female mentor models. In the Indian society specifically, many women are expected to get married within a year or two of their graduation though this is not applicable to their male counterparts. Marriage, though not a hindrance to education per se, is the beginning of societal expectations like household responsibilities and child bearing that may be obstacles in the career growth of the female doctor.

Paternity leave is a positive example of gender sensitive policy in which the men get to undertake responsibility of the child, and the women get help in rearing the child.

Gender Stereotyping

Gender stereotyping has many a time led to the patient assuming a male doctor to be at the helm of all operations and a female doctor getting called as "sister or nurse". This may be a crude generalization but is a situation faced on a daily basis by the healthcare workers. In the context, in our society, the field of nursing is generally associated with females as helpers to the male doctors. It should be highlighted that the work done by nurses is equally and sometimes more important than the doctors and is something that should be promoted among men as well to be pursued as a profession.

Some medical fields such as Orthopedics or Gynecology, to this day, are faced with being male or female dominant respectively. This can be attributed to the skewed perception of comfort that uneducated patients have about their doctors and stereotype that heavy duty work can be done successfully by a certain gender. It is important to realize that irrespective of the branch of medicine, the quality and ideals of patient care remain the same. It should be the intellectual capacity and skill of the doctor besides their desire that should decide their field of specialization rather than preconceived notions about gender.

A common question which arises during our daily medical practice is why the relatives seem pretty content with a male doctor's opinion but when a female doctor gives the same opinion they ask a male doctor for his second opinion .why does the female doctor not command the same respect as a male questions is an unanswered everywhere. Gender

stereotyping suggests that women are less trustworthy and less capable of handling certain "tough " jobs than men. While women account for a significant part of the healthcare workforce, authority and decision making roles are generally given to men.

Leadership Roles

The paucity of women in the leadership positions in the healthcare industry is another example of gender inequality. The prestigious and well paying positions including that of the Dean are more commonly occupied by men. In the private sector specially, the difference in pay among male and female workers also comes up as an issue.

Women's Safety

This is of great importance in the healthcare profession. In a society with growing number of molestation and harassment cases, women should be able to feel safe in their work environments. Their ability to do night shifts and work in remote areas to provide services to the underprivileged should not be hampered. Provision of security in the premises as well as safe transport to and from work should be available.

Workplace Harassment

Most women in the healthcare industry admit to having faced some kind of harassment from male patients or their male relatives, colleagues and superiors at some or the other point. This issue needs to be tackled head on by creating awareness among both male and female professionals about recognizing signs of harassment and how to deal with them. Fortunately there are strong legal provisions to address workplace sexual harassment, but due to fear of victimization and awkwardness, girls and women do not come forward to complain. Also subtle gender based harassment is not addressed by this law.

The Third Gender

In this ever changing society, with the acceptance of the third gender, the healthcare professionals should also open their minds regarding working with these people both as patients and as colleagues.

Conclusion

Gender equality will remain a distant dream until the society (which also includes
us) stands up and fights for it. We need to ensure that every individual in every profession get
equal opportunity to express themselves and not taking account their gender. It is
when a female gets the same status in the society as her male counterpart, the world
will truly become a better place to live in.

After all, "We are all but mere mortals, made of the same red blood, the same pink
flesh and in the end, get assimilated in the same brown mud."

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I measure the progress of a community by the degree of progress which women have achieved.

- B.R. Ambedkar

Equity in Rural Health Care In India

Gautami Chaudhari
(III/I MBBS Student)

The Alma Ata conference 1978 defined primary health care as 'Essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford.'

About 40 years ago, the World Health Assembly decided to launch the movement called 'Health For All' (HFA).

The fundamental principle for HFA is 'Equity' -HFA can be said to be achieved when we see an equal, healthy status of people across all the parts of the world. Health is a term that is hard to quantify. But the aim of starting HFA was to ensure the highest attainable standard of health to every individual irrespective of any social, economic, caste, geographical barrier.

This is the Utopia we aim to achieve.

Let us see the ground reality.

There are many policies and programs being run by the government for ensuring universal access to health care for all. But in rural India, the number of Public Health Centers (PHC) is limited. The infrastructure is not adequate; many of them are shut down due to lack of funds.

Infant mortality rate(IMR) is often considered a sensitive marker of socio-economic and health care development. According to Deogankar's analysis in 2009,the IMR in the poorest 20% of the population in India was 2.5 times higher than in the richest 20% of the population.

Similar data is available for maternal mortality rates across states.

Apart from these inequities, availability and accessibilty of health care show many deficiencies .

The reluctance of the Government in funding the existing health care facilities and generating new facilities can be concluded from the alloted 1.2% of the gross domestic product as opposed to the global average of 5.4%.

70% of Indian population still live in rural areas. 86% of the patients seeking medical facilities today are the people from these rural areas who are forced to travel over 100 kms for accessing them.70-80% of the expenses are borne out of pocket which lands them into poverty.[1]

Although under National health mission(NHM),the government has built health infrastructure for the rural population, the qualitative and quantitative availability of them is far below the recommendations of WHO and also inferior to that available in the urban areas. The rural-urban variations in the access to public health service are hugely present even today.

Unregulated commercialization of health care and largely mutually exclusive functioning of public health sector and private health sector have made it even more difficult for the rural population to access affordable and good quality help further widening the inequity of health service.

This divide has caused inadequate focus on preventive medicine on one hand and out of reach advanced technology for curative health on the other hand by the rural population affecting the national health of the country.

To ensure Health for all(HFA),special attention needs to be given to this vulnerable population. Rural areas have inadequate health facilities and the poor people in rural areas travel long distances in ill health for accessing affordable basic health care. Advanced diagnostic technology is also

out of bounds of the rural poor. This makes them vulnerable to ill health. Providing quality, accessible, affordable and acceptable services to them will be our way to achieve HFA.

Our ultimate goal of equity in healthcare is to match the health care facilities according to the level of need to ensure each individual in every part of the country has access to best possible medical provisions.

In order to achieve this :

1) Actions taken by the government should be directed specifically with regard to tackling aspects of the inequity.

2) The existing policies and programs directed towards rural health should be regularly monitored to ensure their ideal and efficient services.

3) Appropriate tools and indicators to measure the extent of inequities in the system to keep a track of the progress should be used.

4) There should be adequate representation of the people facing these inequities in the policy making.

5) Innovative and practical methods in the form of 'Telemedicine' should be used to reach out to the rural and remote population.

6) Viable, dependable and thriving public-private partnership to make healthcare affordable to all should be established.

A new way of thinking when formulating policies, monitoring their utilization and impact, and giving voice to the voiceless to ensure that no segment of the population is left out will be the way we achieve our aim of a healthy nation.

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“Ethics and equity and the principles of justice do not change with the calender”

- David Herbert Lawrence

Reflections

Sayli Kalzunkar
Physiotherapy - Intern

Bioethics, the ethical journey .... Now as I look back joining the dots from the beginning of a surreal experience unfolding, I realize that none of us expected ethics teaching learning to impact us all to this extent . At the beginning, that is two years ago I walked into the Jivraj Mehta lecture theater of our college completely unaware of what exactly ethics is for an essay competition to be a member of the team. I didn't know what exactly it would bring to me; but irrespective, I wanted to be a part of team. Rejoicing on confirming that I had been selected to be member, I still didn't know what I was in for.

Over two years, I learned and observed over and over again that Bioethics was a multifaceted field that added a moral dimension to the health care and decision making involved in it. This field is no doubt an amalgamation of compassion and empathy. As a kid, I always thought that doctors are algid hearted and that is why they work efficiently, but when I was introduced to Bioethics in the very first year, I realized that it wasn't the fact. Instead Bioethics forms the basis of compassion and awareness of the determinants of health and causes of inequity. Rrather than having sympathy, we practice empathy and this realization was something I gained here.

In National Bioethics conference, talking and expressing thoughts in front of Dr Olinda Timms and not even knowing it was her, was something I still remember vividly. Her guidance and her words mentioning her work was something that would be memorable forever. Being able to experience the making of first Bioethics bulletin of UNESCO MUHS GSMC Bioethics unit will be with me for many years to come. On the occasion of world bioethics day we had the good fortune of listening to Dr Snehalata Deshmukh, whose voice was a melody and words were magical and inspirational.

There were a lot of competitions that were organized by the students' wing and the teachers' committee during the year. I realized that in this process, I was groomed as a negotiator in the students' wing. Knowing ethics had already refined my outlook.

The journey has also groomed me for my practice. Today I spend sometime of the therapy informing the patients about the disease and building rapport. It has also made me sympathetic Not only my approach to the disease but also my outlook has broadened towards the treatment and I am confident of doing my best for patients.

Conventionally, we as doctors have been taught to keep professional and personal lives different, but for me, work becomes a personal journey of growth. I am not over attached but I strive to do the best for them. This has also taught me to study more and discuss with my seniors to enhance my knowledge.

Guidance of Dr. Salagre while preparing for and presenting my experience as a student of bioethics on the 12thInternational World Bioethics conference was a vivid experience and gave me a wisdom and tutelage of its kind. At that stage, sitting there and waiting for my turn to speak in front of all the faculty and delegates at international conference, there was anxiety but somewhere amidst all the chaos, I knew that the wisdom gained here will be cherished life long. I was glad I could stay true to my teachers' expectations. After the presentation words of appreciation were overwhelming, but all the appreciations and the knowledge also humbled me to the core and I was thankful for this experience and al the knowledge that it brought me.

I met wonderful people as team members who were not only hardworking but also curious and a team of teachers who guided me in confusing times. Today, I apply ethical perspective to the therapy while working in wards. I am glad that I chose to be here, as a part of the team and am gaining knowledge and experience that I would cherish throughout my life. Wherever I go, this apprenticeship will stay with me. Medicine might be the body, but bioethics is the soul .

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Essay Competition on " Equality, Justice and Equity
Award Winning Essay

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– III/I MBBS

"From this earth, we were born.
From this earth, we prospered,
Unto this earth, we give ourselves.
Into this earth, we will descend."

In the barren deserts of Rajasthan, where wandering tribes roamed, where trees do not grow until rains are promised on our land, and where animals come out only at dusk, there lived a community, which flourished among nature – the Bishnois. The Bishnois were nature lovers. Their basic principles were protection of plants and animals that thrived on their land. Many lost their lives, in this valiant effort. But today their relevance has been lost. How? Under the pressure of technological advancement, it no longer became possible to continue in the old ways of their folk. Due to the population boom, along with advancement at the cost of tradition, even the environment started suffering, lush groves made way for small towns. And what happened to Bishnois in return? Displaced from their land, they were also enstranged from their identity. Thus, the loss of the environment, lead to the loss of a community. Who truly suffered? Man or the wild? Or did both?

Another ethnic group, the aborigines of Australia have lost their individual identity, as their love for nature, lost out to the thirst for development. Tribal pockets even in our country staying in the fringes of sanctuaries, or trying to hide under thick foliage, are losing their homes. Where is the justice, really, in this? When did marginalization lead to octracization? When did nurturing of nature become a means of losing out to the rest of the human race?

Welcome, to the wide world of "Environmental Justice". In definition, it means the complete inclusion of all people, not differentiated by any race, colour, social class or any such divide, in the development, implementation and enforcement of the laws, regulations and policies pertaining to the environment. In principle it is the simple rule of equality for all, in their environment. Till a few days ago, even I was unaware about the correct usage of this term until I realized that it is simply one thing – Equality when it comes to the environment. If we are all born from the same earth, it is our duty equally to restore it to its previous glory.

Just as we seep in the deep meaning resonating behind this term, we must also know the opposite of the above – Environmental Elitism. When the environmental movement starts excluding people, only to eventually become a club for the rich and the powerful – that is when elitism creeps in, and the "justice to all" who are part of this movement is lost. There are several examples of such elitism existing throughout history! For years, on an international level, India has been the worlds dumping ground for harmful toxic waste. India receives annually, over a million tones of e-waste from western countries, in addition to the waste which is generated indigenously.

The Alang shipyard along the Gujarat coast is the world's largest graveyard for ships. For years, men and women have worked tirelessly, to breakdown metal and pull down masts, and to dispose off the world's ships. Much has always been said about the state of the coast, the health of the people and the long term hazards of dumping some of the most toxic metals and chemicals at Alang. Things reached a zenith, when the clemencies ship, which had been rejected by shipyards in the developed nations, was headed to its floating mortuary at Alang. Known for its toxicity, environmentalists rallied to stop the ship, and send it back to its parent nation – France. Eventually the protests payed off, and the ship was not dismantled at Alang. But still the conditions of people haven't improved dramatically, skin lung and eye diseases still abound.

One of the most tragic environmental disasters to have happened in our country, the Bhopal gas tragedy, had only one face for years- the face of a lifeless child, half buried in the mud, after suffocation from inhaling methyl isocyanate leaked Union Carbide factory. Justice came, but after 27 years, and only in the form of an apology and a settlement. We were still unable to apprehend the murderer – the owner of the plant. Somehow, through the judgement, the words, "justice delayed is justice denied" rang true. Let's come down to our very own streets and alleys of our nation. Prevailing

in every nook and corner is the attitude of NIMBY – Not in my backyard, which means that if the waste is not in my home, then it is not my responsibility anymore. But replacing this adage with a new colloquial term, PIMBY = Place in minorities' backyard, because most minorities cannot raise their voice and oppose, we will dump our waste in their backyard. It is interesting to know that Gandhiji, on whose birth anniversary, we began the Swacch Bharat Abhiyaan was strictly against any inequality, either by birth or merit, but believed in one nation, working to keep it clean and green.

Even after 70 years of independence and after 69 years of Gandhiji's death, we live in a nation where the deprecating act of manual scavenging still exists. The term itself means that a person goes into the sewer pits or septic tanks and cleans up fecal matter, toxic waste and other garbage which is dumped into it. Not only are these scavengers exposed to dangerous skin, lung and other infections, but also to death by inhalation of toxic gases. And most importantly stripping away their dignity, the ostracization and the inhumane way in which this section of the society is treated, is shameful, not for them, but for the rest of us- those of us who allow it, perpetrate it, and watch it like voyeuristic bystanders.

"If we were to hold the globe in our hands, and watch as it spins around an imaginary pole, day by day, we will see the green turning brown, the blue turning grey, and the earth dying little by little." If we were to hold each other's hands instead, and take it upon ourselves to work together, to keep the blue azure, and the green emerald, we might just be able to breathe life back into our little globe. The problems began with us, and the answers too lie with us.

In 2010, India launched The National Green Tribunal, A legislation of sorts, under the appellate court authority of India, Looking to provide justice to those who wish for cleaner air, water and other needs for their living. Similarly, under the constitution of India, as well as the United nations declaration of Human rights, it is our right to clean environment, a safe workplace and access to clean air, water, sanitation etc. and this right is independent of race, colour, sex, region or any other difference.

But, legislation can provide only so much help. Change is to be found within us, within our community. It begins with small acts of environmental justice – if you keep the streets of your city clean – you are allowing every person who lives in your city, a right to a cleaner city. You are also reducing the burden on the rag-pickers, and giving them a greater opportunity in life. Do you know the "butterfly effect"? A ripple of air because of the fluttering of the butterfly's wings, can lead to a storm elsewhere. Perhaps nature believes in this principle. Once it starts feeling the change in attitude of humans, it reciprocates too.

Some enthusiastic volunteers have taken up regular beach cleaning, especially after the Ganesh visarjan, and help keep the marine ecosystem healthy. Similarly cleanliness drives, even within our KEM hospital, help all persons – from peons to Dean sir himself, be a part of the common goal – and hence lead to upliftment of all, and greater enthusiasm from people.

When large communities join in actively to fight for their right to a safe, clean and healthy environment, not only are they aggressive for changes in policy, but are also better aware of where the changes need to be allocated to. From the community, by the community, for the community, must be one's ideal.

Many non-profit organizations are mobilizing communities in finding their voices and raising them. The Basel action network, acts to prevent dumping of toxic waste in under-developed countries. Green Peace works for equality and the environment.

Local communities have fought, won and lost. Whereas radioactive plants have been shut down, or prevented from being built in some parts of India, a few hamlets of Jharkhand, suffer from congenital anomalies, large tumours and general ill-health due to the nearby nuclear power plant in the area.

This is a battle. A long drawn, tough and difficult battle, not against development, not against the forces of nature and not against the elitist people. At the end of the day, it is a battle against our own demons. It is easy to forget about climate change and environmental diseases on a daily basis. The true battle is, to remember them every day and to change; so that we keep our homes clean, we keep our streets, city, country clean, and eventually come to respect our environment. The true battle is to believe, that this battle is our own, not someone else's, but our very own, and we are all warriors, with no difference of rank in this army, fighting for a common cause.

The true battle, hence, is yet to come,

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GSMC MUHS UNESCO Bioethics Unit.

Seth G. S. Medical College and K. E. M. Hospital, Mumbai, Maharashtra, India

NURTURING ETHICAL VALUES.....
ENRICHING MEDICAL EDUCATION.

Vision :

"Establishing highest level of ethical and professional standards in health professionals education, practice and research."

Mission:

"To inculcate the basic ethical, professional and humanitarian values in medical students right from the first day of training in order to make them not only expert clinicians but also compassionate human beings."

The 'GSMC-MUHS UNESCO Bioethics Unit' was formed in the month of August 2015. The solemnisation of the Unit under the MCGM Nodal Bioethics Unit and affiliation with UNESCO, Chair in Bioethics Haifa Australia was on 9th November 2015. The MCGM nodal unit was established at an event held in Topiwala National Medical College auditorium.

The objective of Bioethics Unit is to integrate the MUHS approved UNESCO Bioethics curriculum in the undergraduate and postgraduate students education and to train the faculty in effective implementation of the same.

1. To introduce and deliver bioethics and professionalism training in undergraduate and postgraduate curriculum.
2. To prepare an updated and modern curriculum, reflecting the need for integration of ethics during the training period and for its effective implementation in clinical practice.
3. To increase interest and respect to values involved in health care delivery and raising awareness for competing interests. To introduce various non-medical facets of medicine: sociology, economics, and public administration to students.
4. To add new chapters to present curriculum that will relate to new dilemmas, accommodating medical, technological and scientific progress.
5. To create training programs for teachers and instructors of ethics in medical institution.
6. To initiate, collaborate, facilitate and participate research related to bioethics.

GSMC MUHS UNESCO Bioethics Unit.
Seth G. S. Medical College and K. E. M. Hospital, Mumbai.
- Students' Wing -

Aarsi Popat	Intern BPTH
Ameya Kakodkar	IV BPTH
Ashwini Jadhav	II Year GNM
Asmita Wankhede	I Year GNM
Devi Bavishi	III MBBS
Ekta Patil	Intern BPTH
Gautami Chaudhari	III/I MBBS
Hema Joshi	Intern RGNM
Himani Girolkar	II BPTH
Jayashri Pawar	III Year RGNM
Omkar Thakur	III BPTH
Puja Bhujbal	I Year GNM
Pooja Zipre	III Year RGNM
Prajakta Kulkarni	Intern BOTH
Pratik Debaje	II/I MBBS
Reshma Mestri	Intern RGNM
Sanjeevanee Charde	III BOTH
Sarah Sarosh	II BOTH
Sayli Kalzunkar	IV BOTH
Siddhi Patange	II Year GNM
Vaishnavi Maske	III/I MBBS

GSMC MUHS UNESCO Bioethics Unit.
Seth G. S. Medical College and K. E. M. Hospital, Mumbai.

Steering Committee

- Office Bearers -

Dr Avinash Supe	Chairman	Dean and Director
Dr Santosh Salagre	Head of Unit	Internal Medicine
Dr Padmaja Marathe	Head Steering Committee	Pharmacology
Dr Nayana Ingole	Secretary	Microbiology
Mrs Mariya Jiandani	Treasurer	Physical Therapy
Dr Padmaja Samant	Editor 'Inarch'	Obst. & Gynaecology

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Mrs Vaishali Chavan	Nursing

World Bioethics Day Celebrations 2016

First World Bioethics Day was celebrated on 19th October 2016 in JMLT on the theme "Human Dignity and Human Rights" along with activities like Ebate – the ethics debate, Poster competition, interactive games, skit, panel discussion. The key note address was delivered by Chief Guest- Dr. Snehalata Deshmukh, Pediatric Surgeon, Former Vice Chancellor, University of Mumbai. This was followed by a Panel Discussion on the theme. 'Human Dignity & Human Rights' with a special emphasis on children, with eminent panelist Dr. Vaswani, Ms. Alpa Vora, Mrs. Neha Madhiwala and Dr. Ashish Deshpande. Dr. Padmaja Samant moderated the session.

Release of first annual Bulletin "INARCH"

The first annual bulletin of GSMC MUHS UNESCO Bioethics Unit "INARCH" was released by the Chief Guest Dr Snehalata Deshmukh. The logo of Inarch was designed by student wing member Ms Ekta Patil. The name "INARCH" was coined by Dr Padmaja Samant which meant a plant graft created by connecting a growing branch to a parent without separating its stock.

Bioethics Teaching module III: For UG Students of Medical, OT and PT - 8th December 2016

Bioethics Teaching module was conducted on 8th December 2016 for undergraduate students of second year MBBS, Occupational Therapy and Physiotherapy. Approximately 150 students attended the session. Empathy, Benefit and Harm, Research ethics and principles of research were covered using various interactive teaching learning methods including videos in regional language and different real life scenarios. Ethical Dilemmas in these scenarios were discussed.

Bioethics Teaching module I for UG Students of I MBBS, OT and PT 13th December 2016

Module 1 of Bioethics curriculum for first year MBBS, Occupational Therapy and Physiotherapy students was conducted on 13th December 2016. The workshop began with address by Dr. Avinash Supe, Director (ME & MH) and Chairman of GSMC MUHS UNESCO Bioethics Unit. He emphasized the need of understanding principles of Bioethics through a solid curriculum right from the first year of medical course to enable students to play a vital role in health research and decision making in health related issues. Interactive sessions on Introduction to Principles of Bioethics, History of Bioethics, Human Dignity & Human Rights and Cultural Diversities were conducted using video clips in regional language and case discussions.

Bioethics Teaching module II for UG Students of I MBBS, OT and PT 3rd February 2017

Bioethics teaching Module 2 of UNESO Bioethics curriculum was organized on 3rd February 2017. Topics such as autonomy, consent, equality and justice, non-stigmatization and non-discrimination were covered using various interactive teaching learning methods including role play.

Interns Orientation on Bioethics - 3rd March 2017

The "Orientation Session on Bioethics" for the interns (November 2016 batch) was organized on 3rd March 2017 and was attended by approximately 175 interns. The session focused on commonly faced situations by the interns in clinical wards. The problem of **consent in vulnerable population** was discussed with the help of role play. Professionalism, privacy of patient, cultural and social issues, autonomy, consent, etiquettes of a health care professional, patient respect and dignity were explained using video clips. The bioethical principles of autonomy, beneficence, non-maleficence, justice and confidentiality were explained using **power point presentation with examples. A role play on autonomy** was also performed highlighting the doctor's role in helping the patient to make an informed decision. The session ended with "***A page from Diary of Mrs. Desai***"**:** An elderly single lady refusing chemotherapy for breast cancer in view of poor quality of life that is likely to follow after chemotherapy.

Training Course in Bioethics for Health Science Teaching Faculty of MCGM Medical / Dental Colleges 27th February to 1st March 2017

GSMC MUHS UNESCO Bioethics Unit organized 3T-IBHSc bioethics training program for Steering Committee members of Bioethics Units of MCGM run medical and dental colleges from 27th February to 1st March 2017. 63 faculty members participated in the training. The accredited 3T-IBHSc bioethics training program has been designed to introduce Medical, Dental and Health Science teaching faculty of Universities and Colleges to teaching the modern Vertically Integrated Bioethics Curriculum based on the core curriculum, which reflects the 15 principals enshrined in the UNESCO's Universal declaration on Bioethics and Human Rights (2005).

National and international faculty led by Dr Russell D'Souza Head & Chair Asia Pacific Division UNESCO Chair in Bioethics Haifa conducted the training. The faculty team consisted of Dr S Mini Jacob, Dr Avinash Desousa, Dr Santosh Salagre, Dr Padmaja Marathe, Dr Shaguphta T Shaikh , Dr Pinaki Wani, Dr Anjali Telang, DrAnuradha Kanhere, Dr Mangesh Lone, Dr Shivani Bansal. The course used the methodology of a group of 'Co-Learners' where training faculty and participant teaching faculty are co-learners, using the process of 'Learning through osmosis." The 3 day course had 3 components : Part A: Bioethics Principles Part B: Bioethics Knowledge Transfer Technology Part C: Integrated Bioethics

Representation of GMU Bioethics Unit at 12th World Conference on Bioethics at Cyprus, 20th - 23rd March 2017

UNESCO Chair in Bioethics – 12th World Conference on Bioethics, Medical Ethics & Health Law was organized from March 21-23, 2017at Limassol, Cyprus. Dr Santosh Salagre, Head of GSMC MUHS UNESCO Bioethics Unit attended this conference on behalf of the institution.

Dr Salagre shared his views on "**Bioethics Education Through Communication Skills Enhancement Workshops for Postgraduate Students". He mentioned** lacunae identified in understanding and implementation of bioethical principals were enhanced by the training program in postgraduate students. The conclusion of his presentation was - Postgraduate students of medicine in their formative years should be assessed and trained in bioethics through soft skills enhancement to bring out skilled Indian Medical Postgraduates.

He participated in various meetings of the International Chair and interacted with many international faculty and delegates.

The work of GMU unit was presented to the delegates from Italy. Many international unit heads appreciated the work done by GMU Unit.

Representation of GMU Bioethics Unit at 12th World Conference on Bioethics at Cyprus, 20th - 23rd March 2017

Sayli Kalzunkar and Prajakta Kulkarni, students of Bachelor of Occupational Therapy and Students' wing members of GSMC MUHS UNESCO Bioethics Unit attended 12th World Conference on Bioethics, Medical Ethics & Health Law at Cyprus.

Sayli Kalzunkar presented paper on 'Movies and Arts' as an effective tool in Bioethics Training for Health Profession Education Students from India. Her presentation reflected on the need of Interactive T-L methods in core curriculum implementation and planning hidden curriculum effectively in bioethics training.

Prajakta presented paper on 'Competitive Learning' in bioethics education – an Indian Experience. Her presentation was on the model of Competitive Learning **and it's** effectiveness in imparting bioethics education beyond the borders of classroom. The reinforcement of bioethics curriculum topics can be effectively implemented through competitions.

Competitions Organised by Unit as a part of World Bioethics Day Celebrations - 2017

Essay Competition

An essay competition was organized for MBBS, OT, PT, Nursing, PG students and all faculty of GSMC on Tuesday, 3rd October 2017.

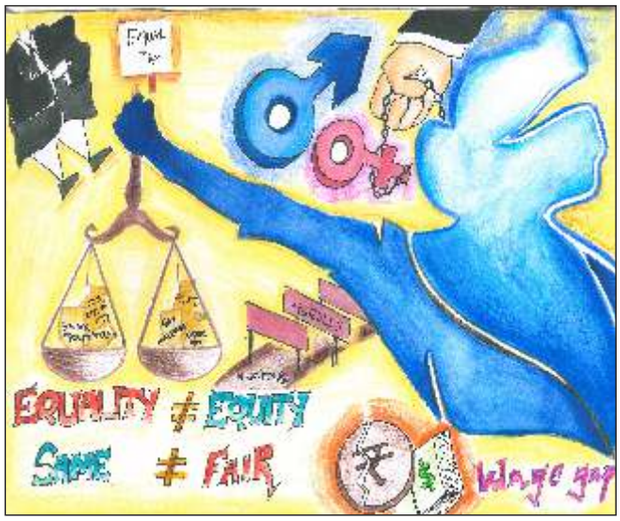
Topics for the essay

1. Gender equality.
2. Equity for disabilities – in health care.
3. Distributive justice and health care for all.
4. Environmental justice.

A total of 96 faculty and students participated in the competition. The essays were written in 3 languages (47- Marathi, 48- English and 1- Hindi).A set of 10 judges among faculty members evaluated the essays were Dr Kamakshi Bhate, Dr. Yuvraj Bhosale, Dr Snehal Desai, Dr. Anjali Telang (Marathi essays) and Dr SmratiTiwari, Dr. Pravin Iyer, Dr. Usha Bhojane, Dr. Yashashri Shetty, Dr Urwashi Parmar and Dr. Priyanka Prasad (English and Hindi essays).

Competitions Organized by Unit as a part of World Bioethics Day Celebrations - 2017

Poster Competition



Blending with the theme of World Bioethics Day 2017 – "Equality, Justice and Equity", the GSMC MUHS UNESCO Bioethics unit held a poster competition for Undergraduates Postgraduates students of all disciplines, Faculty & Seth GSMC and KEMH employees. A total of 59 participants submitted the posters which were judged by Dr. Kamaxi Bhate, Dr. Y. B. Chavan and Mrs. Swati Bhide.

The theme "Equality, Justice and Equity" came out effectively with creative minds and hands from the participants. The prize winning posters are printed in this bulletin. Such competitions help students to learn complex Bioethical principles in simple and creative way.

Competitions Organized by Unit as a part of World Bioethics Day Celebrations - 2017

Street Play Competition

A street play competition for undergraduate students of all MCGM Medical and Dental colleges was organized. There were four entries including two from Seth GSMC and one each from TNMC and LTMMC. The elimination round was held on 9th October 2017 at 10 am in front of UG – PG hostel in KEM Hospital and it was judged by Dr. Aparna Deshpande, Dr. PadmajaSamant and Mrs. Anju Parade. Two teams were chosen for the finals to be held on 12th October 2017.

Competitions Organized by Unit as a part of World Bioethics Day Celebrations - 2017

Short Film Competition

A short film making competition for undergraduate students of all MCGM Medical and Dental colleges on this year's World Bioethics theme "Equality, Justice and Equity" was organised. There were seven entries including six from Seth GSMC and one from TNMC. The elimination round was held on 9th October 2017 at 10 am in MLT, KEM Hospital and it was judged by Dr. Rujuta Hadaye, Dr. Sandhya Kamat and Dr. Somnath Sonvalkar. Four teams were selected by the judges for the finals to be held on 12th October 2017.

Competitions Organized by Unit as a part of World Bioethics Day Celebrations - 2017

Ebate - The Ethics Debate

As part of World Bioethics day 2017 celebration Ebate – the ethics debate was organized for all undergraduate students of Seth GSMC & KEM Hospital. A total 12 teams consisting of two members each participated in the elimination round on 9th October 2017 in MLT from 1 pm onwards on various topics such as

- Is state control of medical devices pricing justified?
- Does India have gender friendly health policies?
- Is triage ethical during disaster management?
- National exit examination (NEXT) - Will it improve quality of medical education?
- Should AYUSH practitioners be allowed to practice allopathy?
- Is euthanasia justified?

The ebate was judged by Dr. Reena Wani, Dr. Shweta Salgaonkar and Dr. Renuka Munshi and two teams were selected for the final Ebate competition on 12th October.

GSMC MUHS UNESCO Bioethics Unit

World Bioethics Day
19th October 2017

Poster Competition on
'Equality, Justice and Equity'

Third Prize

Manasi Dhangar, Third Year, Physical Therapy

GSMC MUHS UNESCO Bioethics Unit

World Bioethics Day
19th October 2017

Poster Competition on
'Equality, Justice and Equity'

First Prize

Meghal Mehta, Final Year, Physical Therapy