# C U L T U R A L  P R O G R A M M E

by

J A N A D H A R E

ON THE INAUGURAL DAY OF THE 41st CONVENTION
OF CATHOLIC HOSPITAL ASSOCIATION OF INDIA

23rd NOVEMBER 1984

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# P R O G R A M M E

1. Invocation Dance :: "Prabhu Pithane Sharanam"
   by Clementina
   Lyrics and Music by Vincent

2. Song :: "Yelegalu Nooaru" (The leaves are hundreds but the colour is green)

3. "Mooka Baya Beli-Olage" (The Fenced Dumb) - a pla

   Script and Direction by Vincent.

4. Dalit Songs : "Sahukarara Bagilige Namme Mooleye Thwarana" (for the doors of the rich, our bones are the decoration).

   "Yarige banthu Nalavathelara Swathanthara" (To whom did the 1947 Independence come ?)

5. Kolata : A folk art of Karnataka.

   This art express the joys and sorrows through song and dance during festive seasons. Janadhare would like to revive this folk form. They are adopting the songs to bring out the cry and the anguish of the people.

   Today's programme consists of 4 songs with four different rhythms/steps in the Kolata.

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## SYNOPSIS OF THE PLAY

This play represents the people's angle to the problem of the medical care.

The poor, illiterate and mostly rural based masses are the ones who are greatly alienated from the present health system as prevalent in the Government system of health care or the voluntary and charitable institutions of health.

Though many of the hospitals run by religious and charitable institutions were primarily started for the service of the poor, yet in most of the situations the very purpose is defeated by the nature and function of the professionals and the institutional structure. For example, the way the medicine is dispensed, the hospital set-up and village set-up etc.....

To the non-availability of the heal services the primary causes are the people's situation of poverty, concentration of progress in the towns, illiteracy and exploitative situations at all levels. For the heroine, in the last scene, pleads for the life of the dead husband. In that context she raises a few questions :

Why is the access to modern medicine denied to the poor ?
Do poor have any right to live ?
Why no alternative inexpensive medical care is thought of or worked for the poor ?

Further she laments : We are in tatters so that you can have a ward-robe full of clothes.
We go hungry so that you may have plenty to eat and relish in delicacies.
Our poverty is your wealth,
Our ignorance your wisdom,
Our misery, dirt and squalor afford you to have health and decent living.
We are human beings we too have a right for a decent living, WHY DO YOU EXPLOIT US ?

TO TALK ABOUT JANADHARE:

Janadhare "PEOPLE'S STREAM" is a cultural troupe of twentyfive youngsters who are socially involved. They try to express the aspirations and struggles of the people through cultural media.

In cultural action they bring out the "Culture of the Oppressed", reinforce their value system and initiate an educational process provoking debate.

JANADHARE was formed in 1982.

On the stage:

Lilly Theresa, Shantharaj,
David, Xavier, Upakari,
Clementica, Jacintha, Carmela,
Hridayaraj, Raju, Lawrence,
Nicholas, Prakash Raj, Prasad Rai.

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# The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001
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## NATIONAL HEALTH POLICY

The approach of our ancient medical system was of a holistic nature, which took into account all the aspects of human health and disease. Nevertheless, due to the influence of the west, it has been reduced to curative, an urban-biased, top-down and an elite-oriented approach. This improvements have to be made to combate BLINDNESS, MALARIA, DIARRHOEAL DISEASES, LEPROSY, TB etc.

In order that our health service are to be effective, there arises the need for transfer of knowledge, simple skills and technologies to health voluntaries who are selected by the communities. Moreover, primary health care must be provided with special emphasis on preventive, promotive and rehabilitative aspects together with other systems of indigenous medicines, such as AURVEDIC, UNANI, SIDHA, HOMEOPATHY, YOGA, NATUROPATHY, etc. Hence the large stock of such health manpower could be utilised for promoting an effective health care services in India.

Besides these aspects, attention to be paid in the other aspects such as a well developed distribution of low cast food, of acceptable quality, available to every person especially to the rural poor, prevention of food adulteration and maintenance of the quality of the drugs, safe drinking water, proper environmental sanitation, immunization programme, a well planned matternal and child health services to reduce morbidity, disabilities and mortalities so as to promote better health.

Production of life saving drugs under their generic names especially for the treatment of TB and leprosy are to be within the reach of the rural poor who suffer mostly from these diseases. The use of low cast and no cast indigenous and herbal medicines are to be encouraged.

Nevertheless, when we critically analyse this statement, we see that very little efforts have been made in the promotion of low cast drugs for example, nearly 40 to 60 million people suffer from endemic GOITRE through its prevention is so cheap by using iodized salt which is not available to the

this today. But at the same time, out of the total production of Rs. 1000 million (in 1976) 25% was taken away by Vitamins and tonics while 20% by anti-biotics. Hence, it is not enough to see that drugs are produced by Indians and in abundence, but it is even more important to see what drugs are produced and for whom? e.g. the diseases of poverty such as TB and Leprosy get scant attention and thus DAPSON for Leprosy and INH for TB are constantly in short supply.

Hence all health and human development must ultimately constitute an integral component of the overall socio-economic development process in the country. It is thus of vital importance to ensure effective co-ordination between health and other developmental activities in order to build healthy communities.

Reference: 1. Statement on National Health Policy (1982)
2. Seminar on the National Health Policy - a report.

COMMUNITY HEALTH DEPARTMENT, CHAI

# EMERGENCE OF A NEW PUBLIC HEALTH

The process of health service development in India has thrown up a number of ideas whihh have imparted a new dynamism to discipline of public/ community health. Many of these ideas had to be generated de novo to meet special contingencies existing in a Third World country like India. Many ideas have been developed to strengthen aspects ofk hhe knowledge of public health which has evolved in Western Industrialised countir

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Ref. No. ..... Date .....

## COUNSELLING : TECHNIQUES & METHODOLOGY.

'Councelling is an enabling and helping relationship, in which the person seeking help is encouraged for positive growth, and also to take counsel with oneself'. The result of counselling understood in this way would be that the client can get back to the main stream of life as a normal human person. Thus a new behaviour in the person counselled is the overall aim of counselling.

In broad terms we can say that there are two approaches in counselling;

The first one is called Dispensary approach, and it is characterised by monologue on the part of the counsellor. Once the problem of the counselee is shared the counsellor prescribes solutions and readily provide them, instead of enabling the counselee to go deeper into the problem by himself/herself, and arrive at a decision to solve it. Sympathy towards the counselee is the predominant feeling here. When this approach is used it can hardly be called a counselling session.

The second approach is called Bartender approach. Instead of sympathy, the counsellor displays feelings of empathy towards the counselee. Companionship is offered to the counselee in his/her distress situation and not advise. The counselee is re-assured by the counsellor's attitude of ' I am with you', ' I care about you', towards him/her. Here the entire attention is focused on the counselee. The counsellor never takes responsibility of the counselee's problem, but rather (s)he encourages and enables him/her to take the responsibility.

The person who comes for counselling is apparently in a state incongruence. In other words (s)he has lost the equilibrium in his/her inner personality. The measure of happiness or unhappiness a person has is often determined by the level of congruence (s)he enjoys within his/her personality. When a person is not properly settled within oneself (s)he falls into a state of incongruence. According to Kasl Rogers this happens because of the disharmony between:

The real me: How I view myself ( at this present moment)
The possible me: How I view myself that I could be.
Ideal me: How I view myself that I should be.

The counsellor's role is to enable the counselee to attain the state of congruence. This in practical terms means helping the counselee to become aware of his/her inner feelings, to accept them and also to communicate them if appropriate.

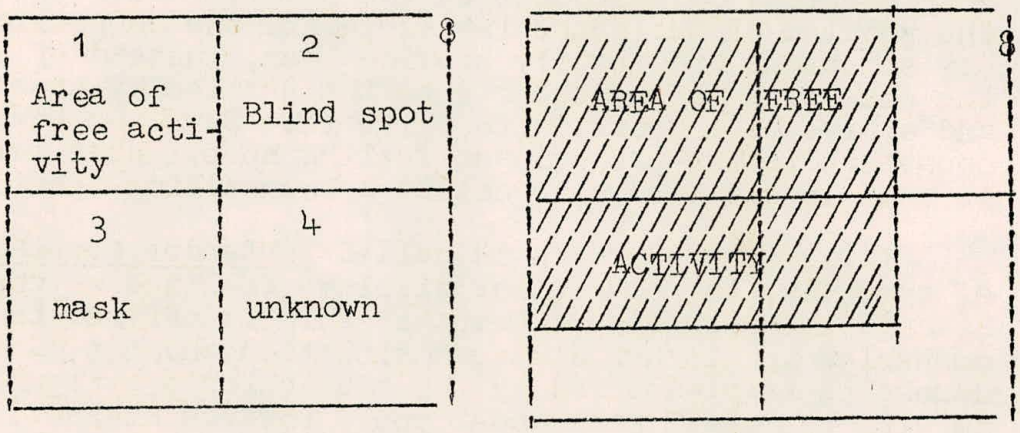
## YOUR ATTITUDES & YOUR EFFECTIVENESS

Personal Attitudes: Before we start counselling others, it is very important to know and realize about our own personal attitude towards people. The check list given in Appendix I

If the majority of the answers are 'Yes' or'I think so' you have the disposition, and the potential to become a good counsellor. The 'NO's' are indicators for you to know where you need to make most efforts to become a good counsellor.

Personal Effectiveness:

The ability to handle ones own problem is important for the counsellor. 'Johari Window' as designed by Joseph Luft & Harry Ingham may help us to increase our own personal effectiveness.




1st Quadrant:

Information about myself shared by me and others. Close friendship takes place here. ' I know and you know'. In this area one feel comfortable with others. And others are also confortable with us.

2nd Quadrant:

Data not known to us, but known to others ( eg. mannerisms, certain unconscious gestures etc) Unless others are free with us they will not feed us with these things.

3rd Quadrant:

Information about myself, which I know too well, but unknown to others. We keep it hidden from others. Very often it is the wrong self image that prevents one from revealing them to others. They wear masks and it is very difficult to deal with such people.

4th Quadrant:

Information not known to us and others. We must have heard people telling that ' I never know that I had so much strength in me' Usually these ' Unknown' manifests itself if emergency situations.

The measure of our personal effectiveness is the size of

a. Self disclosure:

This means opening ourselves to others as we are. Normaly, we dont do it for fear of boasting(false humility) or because we are afraid to show ourselves to others as we are, and thus we prefer to beat around public facts or things known to everybody. Lack of self awareness also can hamper self disclosure.

To talk freely and openely about myself, I need to have a healthy image of myself. Very often we experience tension within ourselves between the 'real me, but not acceptable to me;' and the 'Acceptable me, but not the real me'. At least the awareness of this will go a long way in helping a person for self disclosure.

Love and acceptance are essential ingredients for human growth. We can love and accept ourselves only when some one loves and accepts us. We must give them a chance to do so.

b. Feed back:

Feed back means the remark, comments, or responses we receive from others about ourselves. It is not easy to be open to feed back. But it is important for our own personality development. Very often acceptance of this feed back depends also on how it is given. (eg: feed back given in an accusing and hurting way) Because emotions play an important role here.

The feed back given to us need not be necessarily cent percent true or valid. Nevertheless, it gives us an indication as to how others see us. And this is important.

To conclude this section, we may say that to function as an effective counsellor, we must improve our own personal attitudes towards others, and also increase our effectiveness through opening ourselves for more self disclosure and feedback.

THE ART OF COUNSELLING

The constituent elements of counselling are LISTENING & RESPONDING. In other words the art of counselling means listening with a sensitive ear and responding with an understanding heart. God has given us two ears, but one tounge, so that we may listen double than we talk!

Listening doesn't mean listening of the verbal experessions alone, but a clear observation of non verbal communications (Body language). eg. Facial expression, tone of voice, body position, gestures etc. When you attentively listen you are telling the person that 'you are important to me'. The following points are important for better listening.

- sitting position - to be able to look at the other directly close enough.
- There should'nt be any external distraction.
- Avoid any internal distraction eg: Frankly admitting the feeling in the beginning itself, structuring of the

At this stage one thing the counsellor should keep in mind is to remain free from any prejudices of his own. Very often we wear 'eye glasses' made up of our own experiences, background etc. These eyeglasses may not help us to help the counselee. Another point to keep in mind is the danger of 'filtering out'. This means our tendency to listen and see what we want to hear and see, and thus we stand to miss the wholeness of the picture, which the counselee is trying to present.

Through sensitive listening and accurate responding, the counselee enters into the internal frame of reference of the other; the counselee's experiences is felt as if his/her (councellor) own experience This 'As If' feeling is called Empathy. Here the counsellor feels with the counselee and not feel FOR him/her.

At this stage we have to check our own attitude towards the counselee. Three attitudes that seem to manifest are authoritarian, Paternalistic and Companionship. Needless to say that the companionship attitude is the one we should nurture in a counselling session.

It is genuineness, understanding and acceptance that characterises the real helping relationship in a counselling situation. Genuineness of the counsellor (True to oneself, and fearlessness in expressing it) wins the respect, trust and confidence of the counselee, and also it serves as a model for the counselee to be genuine himself/herself. It is understanding that helps the client for self exploration. When (s)he feels correctly understood (s)he is encouraged to explore deeply into the source of his/her trouble. The counsellor's understanding of the counselee is communicated through responses. The responses should PARROT response. ACCEPTANCE attitude of the counsellor creates a condusive atmosphere for the counselling session. However, this does'nt mean that the counsellor agrees with everything that isbeing said by the counselee.

The counsellor should'nt take the responsibility for the counselee and his/her problems.(S)He should be an enabler of the counselee to take care of his/her problems. The possibility of confrontation in a counselling session can't be ruled out fully. It takes place normally when discrepencies are observed in the client in the following areas (a) The ideal versus the real (b) verbal expression and behaviour (c) what onesays about oneself and the counsellor's experience of him/her. These confrontations may hurt the client, but this hurting is meant to heal.(eg; surgery) However, this must be based on reality (eg. X'ray). Experiences have shown that this sort of confrontations help the counselee to be more genuine in the session and after.

For an effective counselling session, the following skills are required on the part of the counsellor.

A. Attending: Attending to the counselee has various aspects. They are 1. Attending contextually. X

1. The physical setting of the counselling room should be pleasing, welcoming and relaxing.

2. Personal attendance would mean attending to the personal needs and requirements of the counselee.

3. The posture we display in a counselling session is also important, since that too communicates the attitudes and the internal feelings of the counsellor.

4. Visual contact means the proper use of our eyes in a counselling session. It also includes the use of all our senses to grasp fully what the counselee is trying to express.

Psychologists are of opinion that only 25% of the message is communicated through oral communication.

The energy level of the counsellor as well as the counselee is also a deciding factor of the effectiveness of the counselling.

The degree of congruence also should be thoroughly observed by the counsellor. What people say and how they say it reveals the depth of problem as well as how they see it by themselves.

Attending also means listening. Listening is an art, which everybody can develop, but at the same time, which all of us tend to practice less and less in our day-to-day life. Proper and careful listening is the key factor which determines the success of a counselling session. Attention should be focused not only on the words, but also on the tune and how one says it. Who, What, When, Where, Why and How (5W H) should be throughly listend to.

B. Responding:

Adaquate, appropriate and timely responding by the counsellor, encourages the counselee to bring out more of himself/herself and also increases his/her confidence. This responding should be characterised by the empathy (experiencing of another person's world 'AS IF' you were there)

The counsellor should:

1. Respond to the content: eg: You are saying.....
(or) In other words.....

2. Respond to the feeling: The feeling can be understood through observing the behaviour and presentation. (If the counsellor feels blank, (s)he can ask himself/herself: How would I feel myself in such a situation?)

eg: you feel .....
(for examples of different feelings ref. Appendix II)

3. Respond to the content and feeling:

eg: You feel..... because..... (5W H)

Proper responses, as mentioned earlier, helps the

of his/her own situation. Personalizing in the counselling context means enabling the counselee to understand where (s)he is and where (s)he wants to be.

Personalizing has to be done in three areas. viz,.

1. Personalizing the problem: It means helping the counselee to understand what (s)he cannot do, that has led to his/her experience. In other words, what is the counselee, that is contributing to the problem? (counselee deficit)

2. Personalizing the feeling: eg., you feel ..... because you can't.....

3. Personalizing the goals. eg., you feel..... because you cant..... and you want to..... ( In personalizing the goals the counsellor's own experience can contribute a lot)

Personalizing helps the counselee for an understand of his/her problem in a better way.

1. Initiating

This means finding direction in life. Through this skill the counsellor enables the counselee to operationalize the goals identified in the personalizing process. eg., You want to.... as indicated by....., Your first step is..... (The counselee should decide what his/her first step should be) At this stage the counselee should be helped to initiate a schedule for action. (with different steps and actions)

Initiation enables the counselee for action which will ultimately led him/her towards a state of congruence and integrated personality. This ofcourse is the ultimate goal of counselling.

(Ref: Appendix III)

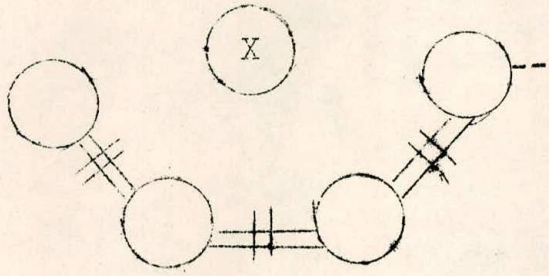
Counselling a Group in Tension

It is not uncommon that interpersonal conflicts and breakdown of communication takes place in a team or group of people working together towards a common goal. Counselling can be an effective instrument in resolving the conflict in such situations.

In such a group counselling session, the counsellor will have to display atmost restraint and balance, so that each member of the team can build trust in him/her and thus feel free to express himself/herself fully.

The most important task of the counsellor in a situation like this is to get the people concerned together in a place. Once they are collected together thus, the counsellor should ensure that each one listens to the other, with out interrupting the one who speaks. Very often when feelings run high, people tend to fail to see other's views. And during the session it might be possible that each one dwell in his/her own views, trying to articulate his/her stand. To overcome such a situation Rogers suggests [illegible]

The physical setting for the session should be arranged in a semi-circle way, through which each one faces the counsellor and sits at an equal distance. It could be in the following way.




The counsellor should show acceptance to each individual attention should be paid as in an individual counselling session. The counselees should get the feeling that they are individually attended to. This is possible only when the consellor can enter into each one's frame of reference. (S)He should never show favour to any one, for get baised. The counselees should be asked to direct the communication to the counsellor and not to any one in the group. This is important especially in the beginning of the session.

Through adaquate responses of the counsellor to each one's point of views, every one else in the group gets a chance to hear twice his/her own and other's views. This facilitates better understanding of the other's standpoint for more effective interpersonal relationship in future. It is worth mentioning here that the experience of many groups have proved that conflicts and tensions in a team or group can lead to strong interpersonal relationship, if worked out properly. The skills required by the counsellor in group counselling and tension management and the processes are the same as that of individual counselling.

Conclusion

Nobody can overemphasize the importance of counselling techniques for personnel involved in people based health and development programmes. The techniques and methodology for individual and group counselling described about is not exhaustive. This paper is meant to be a supplementary reading after the course on counselling.

prepared by

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ref: 1. "Barefoot Counsellor" by Fr. Joe Currie S.J.
2. "The Art of Helping - III" (Robert R. Carkhuff, Ph.D)

Appendix I

# C H E C K L I S T

(From Barefoot Counsellor by Fr. Joe Currie, S.J.)

1. Do I find other people interesting?
2. Do I find it easy to like others - even those who are quite different from me?
3. Am I enthusiastic about others' chances for wellbeing and happiness?
4. Can I trust others to take decisions and assume responsibilities?
5. Do I generally relate freely and easily with others?
6. Do I have a deep and open relationship with at least some others?
7. Am I consistently trustworthy and dependable?
8. Can I identify with the feelings and private personal meanings of others without becoming excessively weighed down by their problems, "downcast by their depression, frightened by their fear, or engulfed by their dependency"?
9. Are people important and significant to me?
10. Can I let others be as they are, even when I don't agree with them nor approve of their behaviour?
11. Do I have confidence in my own abilities?
12. Do I dislike dominating and controlling others?
13. Can I accept my own weaknesses and shortcomings?
14. Am I ready to accept help from others when I myself am emotionally upset?
15. Do I find it generally easy to listen, to give my full attention, to others?
16. Am I convinced that I am an important person?
17. Do I encourage others to stand on their own feet, and fight the temptation to take them under my wings?
18. Can I accept myself am I am, without undue anxiety about fulfilling the expectations of others?
19. Am I open to new and better ways of doing things?
20. Can I be a good follower as well as leader?
21. Do others generally find me a warm and loving person?
22. Do people find me approachable and easy to talk to?
23. Can I talk easily and frankly about myself, without on the one hand boasting and, on the other, feeling embrrassed?
24. Do I treat each person as an individual, giving him a chance to prove himself before fitting him into a category?
25. Can I communicate warmth toward people and sensitivity to their needs without being uncomfortable myself, or making

## CATEGORIES OF FEELINGS

(From the Art of Helping III. By Robert R. Cark

| Levels of Intensity | Happy | Sad | Angry |
|---|---|---|---|
| Strong | Excited | Hopeless | Furious |
| | Elated | Sorrowful | Seething |
| | Overjoyed | Depressed | Enraged |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Mild | Cheerful | Upset | Annoyed |
| | Up | Distressed | Frustrated |
| | Good | Down | Agitated |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Weak | Glad | Sorry | Uptight |
| | Content | Lost | Dismayed |
| | Satisfied | Bad | Put Out |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Appendix III

## C H E C K L I S T.

(From Barefoot Counsellor by Fr. Joe Currie, S.J.)

I. General attitude toward the counselee:

1. Do I respect his independence?
2. Do I feel responsible for him and want to protect him?
3. Do I look forward to seeing him?
4. Do I tend to over-identify with him?
5. Do I feel resentment or jealousy toward him?
6. Am I bored with him?
7. Am I afraid of him?
8. Am I overly impressed by him?
9. Do I want to punish or get rid of him?

II. MY behaviour during the interview:

1. Do I tend to tighten up and feel uncomfortable?
2. Do I select certain material to dwell on?
3. Do I get angry at him for not responding the way I want?
4. Do I discover that I dislike him without reason?
5. Am I vulnerable to his criticism of me?
6. Do I try to impress the other and make a favourable impact?

III. In between interviews:

1. Do I dream about the other?
2. Do I find myself preoccupied with fantasies about the other?
3. Do I plan the course of future inverviews?

IV. At the end of counselling:

1. Am I reluctant to let the other go when it is clear that he has reached as far as he can with me?

## T E N D O'S

1. Be yourself.
2. Concentrate, but in a relaxed way.
3. Listen to the full message of the other.
4. Respond adequately and creatively.
5. Communicate interest, warmth andunderstanding.
6. "Prize" the other.
7. Confront, if and when necessary, responsibly and sensitively.
8. Help the other to sort out and clarify his problem.
9. Use simple and direct language.
10. Help the other to take charge of himself.

## T E N D O N 'T S

1. Don't advise or look too hastily for a solution.
2. Don't question from couriosity or from uneasiness.
3. Don't moralize or intellectualise.
4. Don't make the other depend on you.
5. Don't categoriese or pre-judge the other.
6. Don't be falsely re-assuring or supportive.
7. Don't evaluate the other or his behaviour or attitudes.
8. Don't talk too much, or project yourself into the interview.
9. Don't bok for, or encourage, long narratives.
10. Don't use technical jargon (terms).

# TRAINING PROGRAMMES IN COMMUNITY HEALTH

The Catholic Hospital Association of India takes up training programmes in Community Health, normally after a pre-programme study for Dioceses, Congregations, Action groups and for any group seriously involved inpeople oriented health and development programmes.

The over all aim of such short term training in C H is to help people to participate in building up healthy communities with emphasis on people's involvement, using appropriate and local resources and responding to the needs of the people. During the training the participants are enabled to understand the health status of our country in relation to the wider social reality around. They are trained as to how to analyse the society, its functioning and to find out the root causes of ill health in the Indian context. The training also aims at enabling the trainees to initiate themselves to acquire and develop skills, knowledge and attitude to work with people and to build support systems with their team at the local, congregational or Diocesan levels. To make the course essentially an on going one we ensure the follow up of the participants at different intervals. The duration of the follow up visits depends on the level of involvement and the need of the people working in the field.

For a one week or ten days programme we usually follow a pattern which has topics such as social analysis, concept of health, Community health - as a process of organizing people, skills in awareness building, certain skills in training village level personnel, Drugs, Herbal and home remedies, different activities such as M C H, School Health etc. The spiritual and scriptual diamension of health and development are stressed very much throughout the course.

As a rule, the medium of instruction is English. The courses are strictly residential starting in the evening of the first day.

The course expenses of the resource team are to be met by the organizing body.

# ORIENTATION PROGRAMME IN COMMUNITY HEALTH - THE CONTENT-THE PURPOSE

The term 'Community Health' is being widely used to express various types of programmes in health. Public Health, outreach programmes extension services, village health programmes, etc. Each of these programmes when analysed will show that there are a lot of differences in the understanding and the activities.

Community health understood and promoted by CHAI/CHD is explained during the orientation programme. We also bring in the need for promoting community health taking into account the present health practises in our country, situating the existing health institutions in the context of people's health, the situation of our society, the country. Hence, social analysis becomes an essential part in understanding the Indian context and the context of the health infrastructure. Merely analysing the society and its various structures and systems in short is not sufficient to give an idea to the participants as to how to initiate community health and how to go about it. A few aspects in organizing and training of health workers are integrated. Basically one gets involved in community health practises is because of personal conviction and so the need for motivation, based on faith reflection, spirituality, Philanthrophy, depending on the group participating, in the programme will be incorporated. All said and done orientation is not training but more a concepts clarification and a peep into the wide spectrum of community health to have a glimpse of what it is.

This provides you with certain basic idea on the need for working with people and the reasons for a radical transformation in the health care system. Community health is not just curative and preventive, but curative, preventive and promotive health.

Normally an orientation programme takes 3- 4 full days but depending on the group the time element could be reduced or increased. Orientation programme is a prelude to further training in Community health as it helps the groups to decide whether to go in for community health or not.

We also charge a fee of Rs. 500/- towards our expenses

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## PRE-PROGRAMME STUDY - WHAT IT IS MEANT FOR?

Community health department of CHAI undertakes pre-programme study by field visits, contacts, discussions, before taking up any training programme and involving in any community health activities, with any group, Diocese and Congregation. This is to enable us to have a rather clear picture of the area of operation, the type of involvement required, the culture and life of the people of the locality etc. This also helps us to understand the type of activities undertaken by the concerned groups, Diocese or Congregation, the reactions of the people towards them, the kind of involvement of the concerned group in the locality and with which section of the people. Discussions at different levels give us a picture of the thinking of the party concerned in their present understanding of the society, their new thinking ( if there is any), any move to initiate new line of functioning in the light of the new thinking in the church and in the society. By our pre-programme study we don't intend to do any inspection of the functioning of the institution. This has been a fear in some cases just because we happen to be from an organization of which many of them are members.

Discussions in smaller groups in different centres provide an opportunity for personal reflections on the work they are involved in and for us to understand the hopes and disappointments of many who function, facing the hard realities of life, often without much result or even very often counter results.

The process we go through is to visit the individual centre and few villages around, along with the coordinator (director) and hold discussions with the people concerned at the centre on their activities. This process also helps the future participants to have an understanding of the type of training programme conducted by CHAI on the one hand and the requirements and expectations of the participants in term of their training on the other.

Then having a session with the higher authorities concerned clarifies various plans and programmes as well as the process of thinking taking place in the congregation etc.

This will also help us not to take up training programmes not to get involved where there cannot be a serious involvement. The success of the Pre-programme study will depend on the openness on the part of both the parties concerned and that has been our experience.

Programme Director
Community Health Department/ CHAI

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## REPORT OF THE ANNUAL REFLECTION ON THE INVOLVEMENT OF CHD/CHAI HELD AT HYDERABAD FROM JULY 24 TO 28, 1987

The Procedure :

The CHD team, the former team members - Fr Chacko, Mr John T Samuel and Sr Mariamma, CHAI's Executive Director Fr John along with the facilitators Mr Rudy Lobo, Dr K R Antony and Ashwin Patel constituted the participants. Starting on 24th evening there were deliberations in the general group on each day, followed by team level (The CHD team) meetings in the evenings where the days insights were further reflected upon and the points for the next day was identified.

A background paper prepared by the CHD team, mentioning some of the issues that the team has been concerned about, was circulated among the facilitators to serve as a pointer to the state of thinking pattern of the team and the direction they would like to take.

SETTING THE CONTEXT :

Since 1981, CHD has been involved in the promotion of community health, consolidating the experiences of the team, formulating a philosophy of community health and working out specific strategies, the team revitalized is involvements in 1983. Over the years the team has been busy catering to the requests from various groups - diocesan, congregational and lay, either for Orientation, training, project study or follow up of earlier involvements; and numerically taken such activities have been on the increase, well indicated by the fact that the previous year the team had to commit for around 60 field programmes alone.

Much more than our evaluation of the activities, it would be a process of reflection as the very involvement itself, and situating that in the wider realities of ill health viz-a-viz the society that we would like to create.

Hence the involvements of CHD/CHAI during the past 4 - 5 years and a projection for the future would be the focus of reflections. And taken in that context, the group felt that to direct the discussions effectively, we would have to identify issues which have a history and a future. It has to be a process of problem solving and direction viewing.

THE REFLECTION :

One of the issues identified was: In the light of the momentum that is gathered by the oppressors viz-a-viz the team's involvement, the team feels a sense of stagnation. Against this background the quantitative spread of the involvement of the team, the qualitative growth, and the relevance of seeking other roles would have to be looked into.

This particular mental disposition is not the result of a feeling of frustration, but a deviation of the aspiration of CHD team. Taken that way it becomes a challenge to move ahead. It stems out of a basic feeling that 'I am not utilizing my full capacities', 'which is a sign of restlessness and this is a constant attribute of 'my work' which has to be essentially a dynamic process. This adds a dimension of search to the involvement that one is making, and this is opposed to the concept of stagnation which has with it the basic trait of being static'. Again a growing sense of realization of the forces is itself an indicator of the element of growth that the team is experiencing.

The dream of CHD, as others involved in people-based involvements, is of a just society, a healthy society, and the efforts have been to generate a movement of people. But the fact remains that there is no appreciable sign of a movement taking shape while the other forces intent on choking the moves of the people are gaining strength and they make their appearance through subtle ways. The feeling of the team has to be situated in this connection. Here two questions become relevant: What is taking place in the Society, and how do we perceive the realities. And a corollary of these questions is, basically the strategy of CHD has been to work with groups that can facilitate people's action; but then why the groups are not effectively moving.

Taking into consideration the involvement of CHD/CHAI, it is a

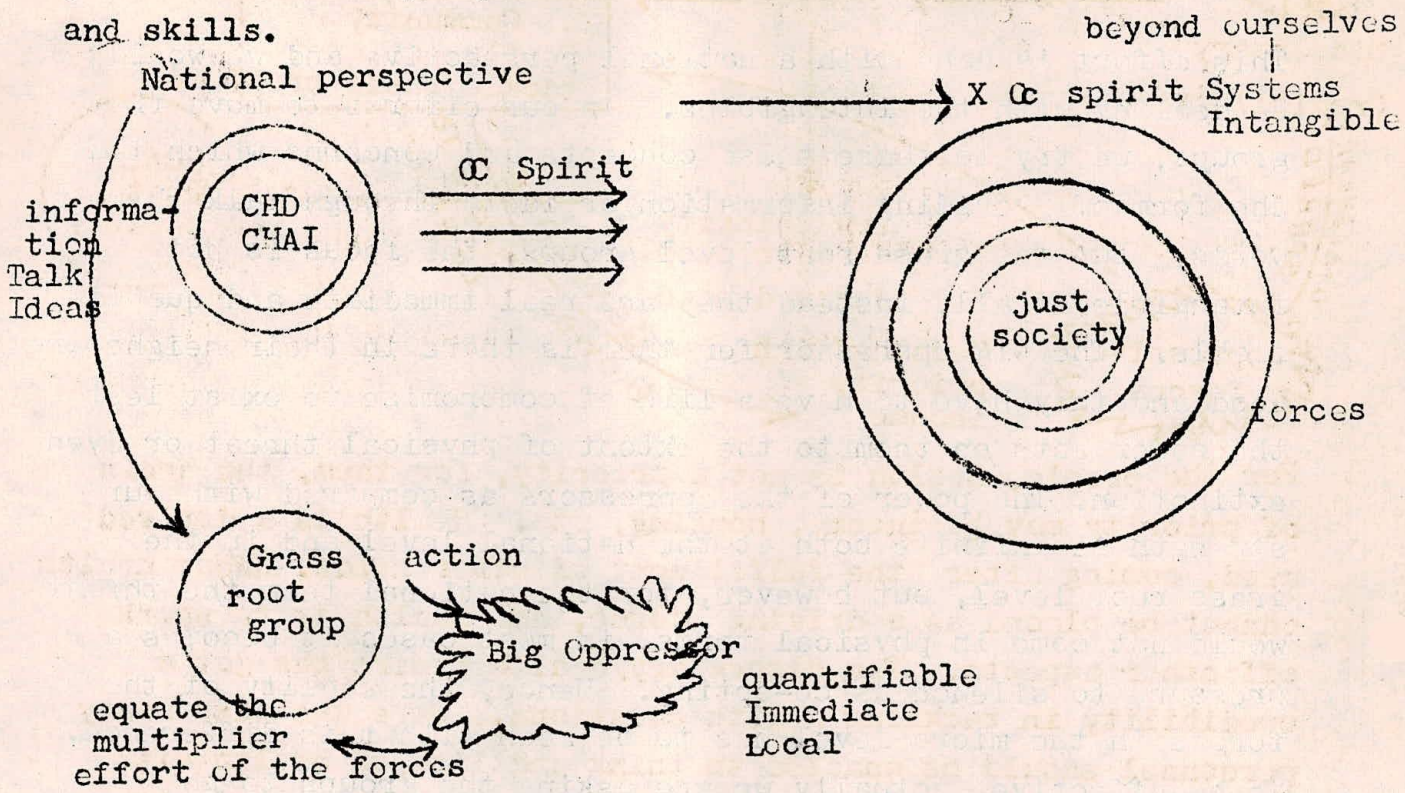
Here we try to perceive the dynamics of the wider forces that act against the emergence of such a society; and here we try to develop a structural systematic understanding of the forces.

This effort is done with a national perspective and we would be dealing with the intangibles. In our efforts to move the groups, we try to share these concepts and concerns which take the form of providing information or ideas through talk through words. But the grass root level groups, the focus is not intangible at all, instead they are real immediate and quantifiable. The big oppressor for them is there in their neighbourhood and they have to have a life of compromise to exist lest the power acts on them to the extent of physical threat or even extinction. The power of the oppressors as compared with our strength is infinite both at the national level and in the grass root level, but however, for the national team the threat would not come in physical terms, in most cases it becomes a pressure to silence us co-opting. Hence, the reality of the forces in the micro level has to be seen with this difference. To be effective, actually we are asking the groups to go beyond their life of compromise and counteract. It is sure that we have to provide the required ammunition. How can we counteract the power which has got an infinite dimension. We too have to grow into that infinite dimension to equate that. Our power, our force is but the spirit, spirit which is infinite, and imbibing the infinite proportion of it, we have to generate a multiplier effect. And basically this is what has to be transferred to the groups.

In this context we also have to critically examine the type of follow up efforts that we make.

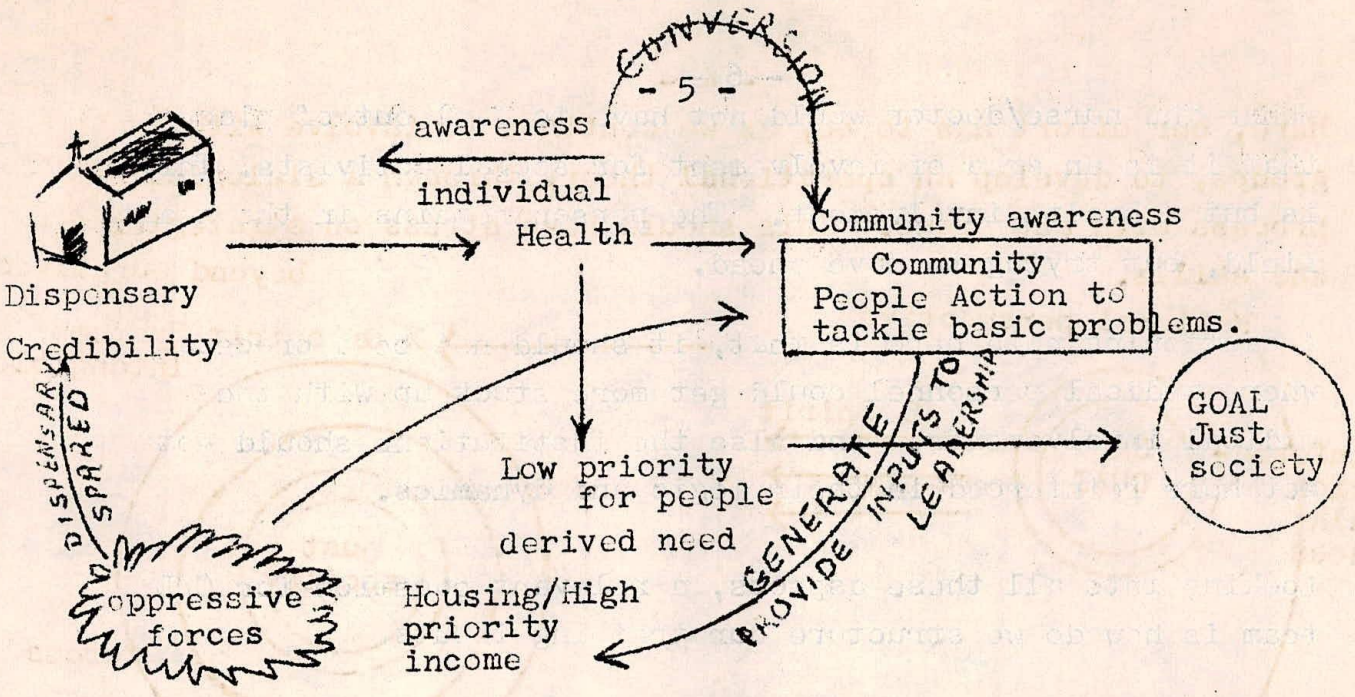
In the light of the reality of the grass root level forces, and the ongoing confrontation of the groups, we have to develop a relevant therapy. It has to have a focus on appropriate skills. Otherwise our involvements would just become that of orientation and motivation. Relevant information and ideas on appropriate strategies and skills which could be progressively imparted to the groups have to be developed. Unless we make an effort at this, our successive involvements cannot be called training programmes, and the group also would inevitably become rather ineffective. No abstract theory would help, and the situation

Here, our effort has to be, as we continue to involve with groups, to develop an operational theory through a dialogical process with the group. This should have stress on strategies and skills.

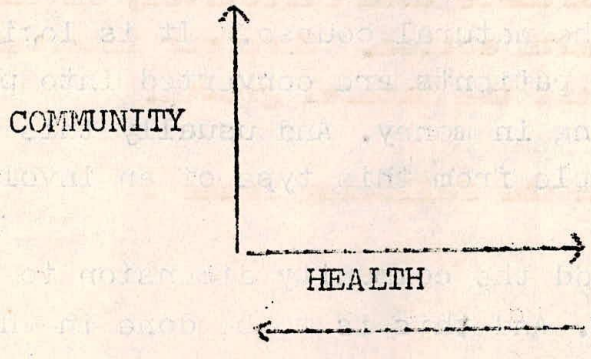



From here, we started deliberating on our clientele and the sphere of activity and infrastructure they come from. Majority of them are the medical personnel, trained and conditioned to treat sickness, working either in hospitals or dispensaries, all invariably forming part of the medical system. If we take the Catholic Sector alone, the number of institutions runs to 2500. Apparently it would look that the smaller institutions situated in the remote villages (the big institutions would be only around 600) are more susceptible to the idea of people based health action. But in principle, all these are units of one and the same system, and seeds of hospital. The natural concern for them is to germinate and grow into hospitals. Now, the question is how can we situate them effectively in the context of making a movement in health action. Here our intervention would be an action against the natural growth.

The Sharing was based on the following frame :




For the people, health is not a priority, for them, the areas of priority may be income, housing, etc. Health is a derived need, coming after the fulfillment of other needs. Hence health cannot be placed as a driving force, and health as to spark off other aspects. The dispensary/health centre has got a credibility in tackling health questions. Here the dispensary personnel should be enabled to think and link up health with other issues, issues which really make people sick, unhealthy. This effort should bring about a conversion in the medical personnel, where she/he tries to situate the sick person in the society and the individual awareness is converted into a community awareness leading to community action. It should be noted that with this, credibility increases because s/he starts working towards real solutions. As the people start taking up action, there would be more challenges from the oppressive forces, with the result that the emerging leadership gets more activated and reinforced, and the struggles sparks off. Here leadership is referred to as the capacity to mobilize people. And the role of the dispensary personnel would be to provide inputs to this leadership.

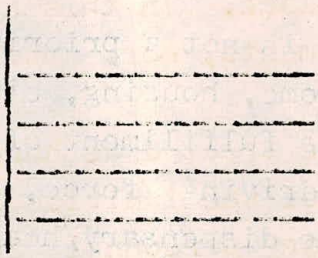



Our effort should be to look at the community element starting

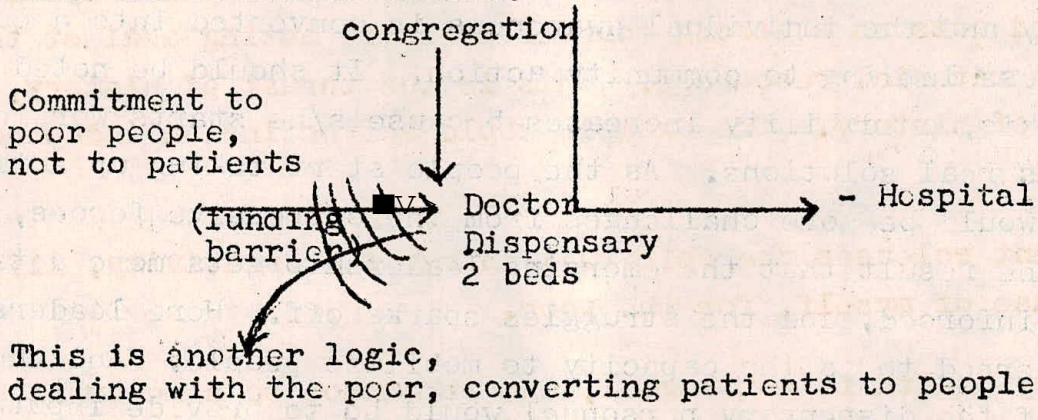
Hence the nurse/doctor would not have to feel out of place that it is an area of involvement for social activists. This is but a health involvement. The person remains in the health field, but trying to move ahead.

A cautioning note here is that, it should not be a process where medical personnel could get more stuck up with the medical involvements. And also the institutions should not get more reinforced in their logic and dynamics.

Looking into all these aspects, a relevant question for CHD team is how do we structure our training inputs.



The usual, natural logic of the evolution of the dispensaries is that as time passes on, dispensaries turn out into hospitals. Sometimes this particular evolution does not take place in physical terms but in terms of values, attitudes and thinking patterns the evolution occurs.




It is to this clientele that we are trying to present a different logic. This is a logic of moving in the opposite direction, which is against the usual, the natural course. It is logic of commitment to the poor, where patients are converted into people. But then this would not bring in money. And usually this is the barrier that blocks people from this type of an involvement.

CHD is called upon to add the community dimension to health. This politicizes health. And this is to be done in the context of the institutionalised setups where there is not much room

It is the people who take up action and they create the movement. To play a meaningful role in this the dispensary has to undergo a thorough transformation. In generating the movement the leaders from the health and community have to play a role, the dispensary

C - Leaders in community
H - Leaders in the dispensary

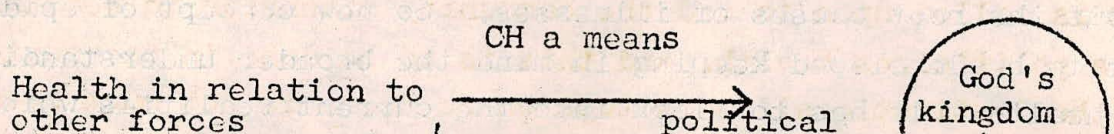
should be the meeting point, and the dispensary should make the synthesis of this. Here a different kind of commitment emerges from technical competence, from 'doctor self' to commitment to individuals, to people, to poor. In this process s/he has to depend on the people. And in the enormity of the task ahead, a demystification takes place. In this sphere, there is need to generate more experiments, more knowledge.

Here, people begin to be treated as human beings, not as objects/ cases. Here the soul of the individual is touched, the soul of the sister (the dispensary personnel) is in communion with the soul of the people.

The opposing forces are rich in material resources. We do other involvements because we lack material resources. When the spirit is motivated nothing becomes impossible. The infinite spirit generated acts as a strong counter pressure acting against the infinite material resources. This is the thrust of history, learning of history. One example would be the Indian independence struggle.

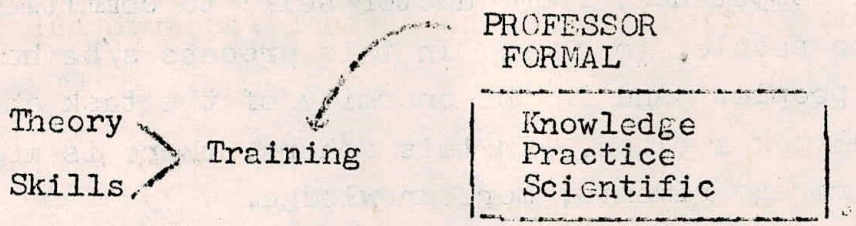
Commitment releases the spiritual energy for creativity, life giving use of myself, for the poor.

Community health is not a goal, and it cannot be a movement as such; the movement has to be the movement towards just society. Community health is a platform to discuss, to address larger issues, eg: issue of water, provision of water to achieve health. Community health is a means towards a larger goal, a means in movement. And it is not irrespective of the dispensaries, but with dispensaries acting as promotive structures.



In reality during our training sessions we meet the medical personnel (mostly nurses) who are trained and moulded to be confined to the sickness aspects by dispensing medicines. We have to basically move these people, so that they can gradually become health activists and ultimately social activists.

The CHD team shared the various types of involvements of the team orientation, training, project study & planning etc. Then the question on the expertise of the team, the structuring of the programmes, follow-up sessions etc., came up.




V S

Follow up

Trainee becomes professor

CH

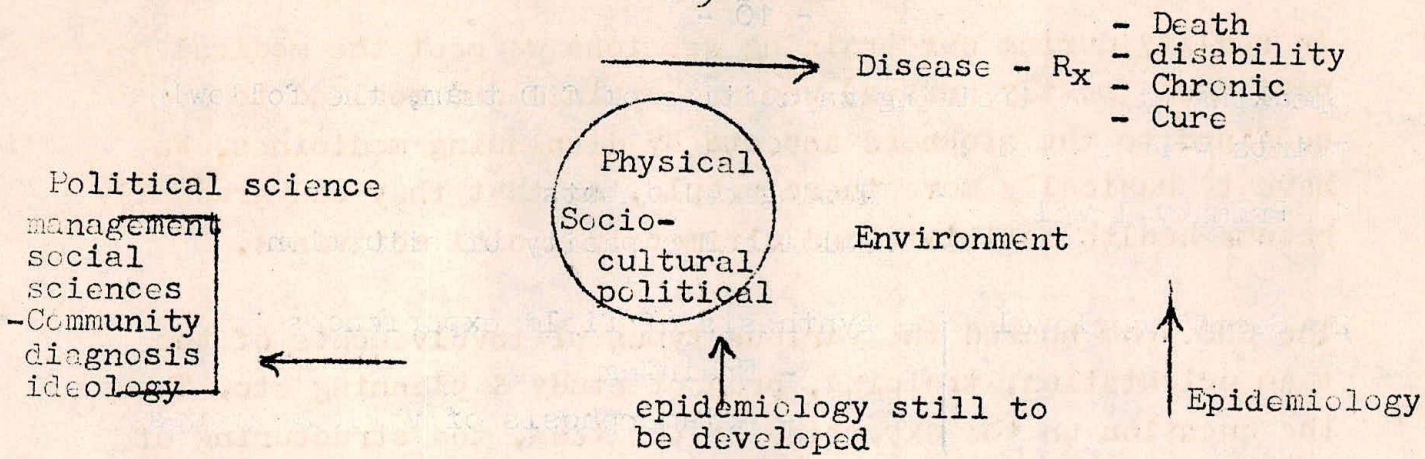
Training - Emphasis on ideological preferences/ positions Future Perspectives

NOT

Based on past body of knowledge
No Hisotry for knowledge.

The team has to seriously think about theoritizing the community health experiences, thus developing a body of knowledge, skills. Follow-up otherwise becomes a big problem without that body of knowledge. The room for progressing intensification of one's ideas and skills would be less. Theories from other disciplines could be sought, but it has to be a new synthesis, incorporating into, testing out in the field level realities. The CHD team is in a very advantageous position to do it since the team has access to the literature on theoritical input, on the one hand and the information on the field level realities and initiatives (all over the country) on the other.

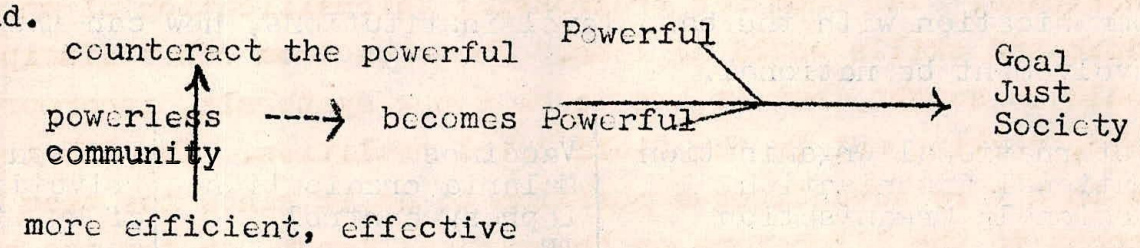
At present the medical personnel treat sickness based on a particular epidemiology which is very much confined when thinking about the root causes of illnesses. So new concept of epidemiology has to be developed keeping in mind the broader understanding of health. It has to look into the current realities which

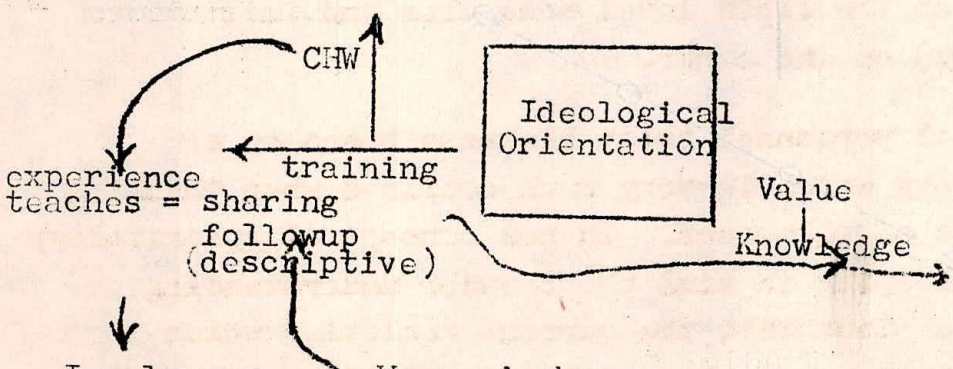



This itself has to be developed into a science drawing experiences from the field. A field based theoritical research has to go into this.

At this point, the training content follow-up sessions etc were taken up for discussion.

The community health programme as envisage. and presented by CHD|CHAI is really new and it is a pioneering effort. It is more of a good intention that a skill. Much more has to be learned from the field based on the actions that are being taken. It is a question of developing a different school of thought. The community health department team has to grow with the groups that are trained by the team, who by virtue of their involvements grow in the concepts and skills of operationalizing the community health ideology into which they were introduced. Unless this takes place there is the danger that the team gets stuck up with the motivational aspects and the ideological orientation, while the field level groups really require ongoing training which are relevant to the dynamic situations in the field.



Speaking of the training capacities of CHD team, the following points were shared :

1 Primary level
- Ideological inputs
- Analytical capacity of situation

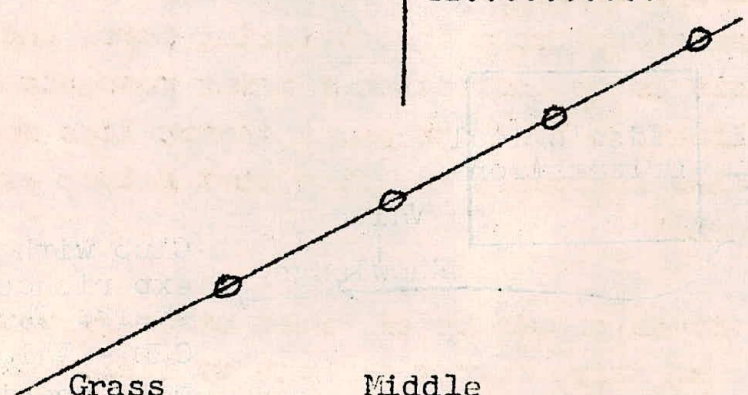
2 Secondary level
- Synthesis of field experiences
  - Training
  - Metamorphosis of various groups
- Scientific inputs to arrive at nearer effective strategies
  → Statistics
  epidemiology
  Management.

Then deliberations took another turn. What is happening to CHAI organisation :

CHAI is a political force which is not realised and utilized, placing itself in the health situation in India what is CHAI's, and hence our role : How can CHD activate CHAI, converting the potential energy into Kinetic energy: Here there is relevance for a new emergence with a projection towards future, to make a national impact.

Taking the existing situation CHD is located at the grass roots, and speaking of CHAI, at the National Level it does not have much existence. It is very much inward looking and not a force in the service of the poor. But CHD can help CHAI to emerge. In this context a question was raised - unless there are channels of communication with the base level institutions, how can the involvement be national.

| | | |
|---|---|---|
| International Organisation<br>National Organisation<br>Regional Organisation | Vaccines<br>Malaria eradication<br>Leprosy control<br>TB..... | Iodised salt<br>Privatization of health care<br>Banned drugs |

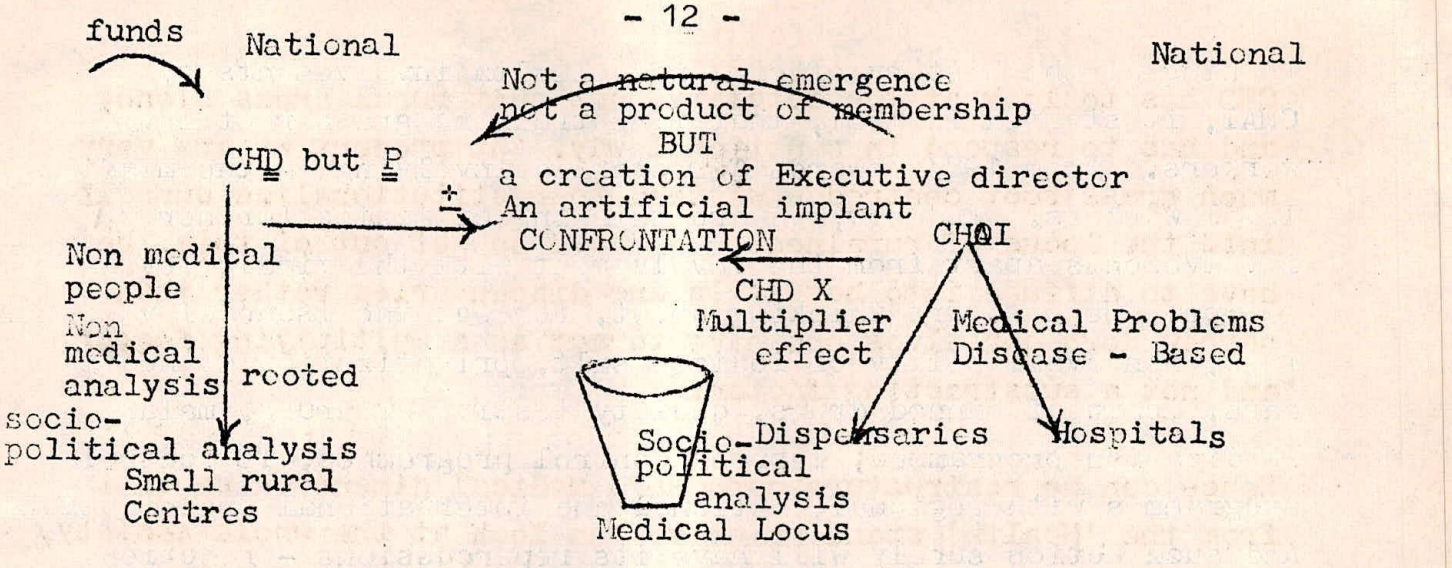


Looking at the history of community health involvements by CHAI, it started in 1981, that time training grass root level workers. From 1983 onwards CHD started involving in the middle level workers. And now, we are thinking of making further involvements apart from the involvement with the middle level groups. Here we are thinking about, for eg: the issue of vaccines, non availability of iodized salt, privatization of health care, issue of banned drugs, quality testing of drugs, malaria eradication programmes, leprosy control programmes, TB control programmes with regional, national and international organisations. And such action surely will have its repercussions - reactions from the national and even international forces, hence these would be very much political involvements too.

We should keep in mind all the activities have to be based at the base, o.e. the 2500 member institutions, and invariably we always have to address the 80% of the people, the poor - broadly speaking these are some issues and involvements to be taken up by CHAI. Here there are limitations too. While thinking about involving the member in these endeavours, the members are not aware of the channels of communication; Again another big constraint is the lack of appropriate and sufficient infrastructure at different levels which include also the lack of committed, efficient personnel. In this context it would be worth thinking of the role of CHD :

CHD is capable of identifying and picking up these issues fast. CHD has to feed CHAI with this analysis of issues. When it comes to the level of CHAI, it generates a polarization of thought processes, and there is a feeling of being threatened. Between CHAI and CHD, there is a basic difference, if not a difference of ideologies, a difference in understanding of philosophy. It may not be a difference in ideology because basically there has to be only one ideology, i.e. that of the Healing Ministry of Christ. And here CHD is percieved as a destabilizing force and it gets attacked. But this is an indication of being recognised, which comes from a realization that the power centre lies more in the CHD of CHAI. It also indicates the fact that mature attention is given by the powerful

Here the deliberations should be on 'what strategy would I use to counteract the negative forces through my life:




(P-stands for programme
CH - A programme of CHAI not exactly a dept. yet)

( A- the Association which constitutes of hospitals and dispensaries)

If CHAI had given birth to CHD, there would have been only a medical/paramedical analysis and not a socio-political thrust/ analysis as we are having right now. If our socio-political analysis is correct, the catholic hospitals will not be able to withstand the increasing commercialization and the competition creeping into the health care system. Coupled with this if the government system becomes less corrupt and little more efficient, this will be another pressure. In this process only the really mighty and established hospitals will be able to survive. But for this again there is the problem of funding as this is not a priority area for the funding agencies. And looking into this overall situation, hospitals have only a short life span. Hence naturally they would have to develop openness, and they would be forced to adopt CHD.

CHAI's national force is not recognized. And similarly CHD can become more national. CHD can become national through CHAI. CHD and hence CHAI has to become a political force on behalf of people. It thus becomes mutual. Here there is no room for confrontation but only convergence. There is only love and those in CHAI should experience this.

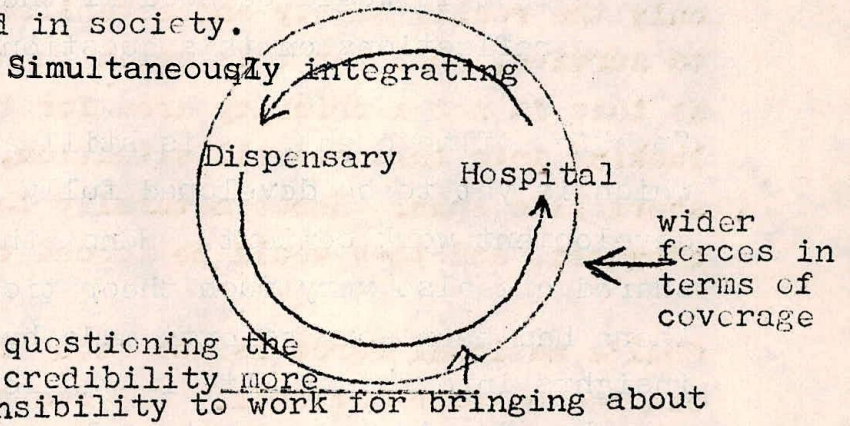
Currently, the understanding at large is that CHD is dominant force in CHAI, and the 'real children' (Hospitals and dispensaries) feel neglected.

Hospitals have always been inward looking and CHAI is basically a servant of hospitals/dispensaries and hence always insensitive.

CHD has to look at the totality, not just rural areas alone, and has to respond in a national way. At present we are very much grass root centred - we tend to institutionalize ourself into the locus of ruralness. We have to get out of this. We have to diffuse into hospitals and dispensaries rather than narrow down ourselves and have to act as a multiplying factor and not a substracting factor.

Hence can we restructure our CHD's medical dimension so that from the 'Health' stand point we can look at the whole society, so that we can have the locus of the medico-socio-political analysis, of which of course the socio-political dimension is the major constituent.

For us as well as the hospitals, there is one common factor - concern for people. But for hospitals it is the concern of people as individuals. Now, start/on the common platform,/ing the effort has to be to convert this concern for individual into the concern for community. It is possible for them to make this shift by giving them a chance to get involved in their levels not with socio-political logic but starting with hospital based logic. CHD has to diffuse itself so that hospitals get activated and get placed in society.




CHD has the basic responsibility to work for bringing about change in CHAI. Then for CHD, CHAI becomes a laboratory for experimenting the initiatives in community health in an atmosphere where there are lot of oppositions, non-coperations indifference, etc. And by attempting to do this, we ourselves would be undergoing the agony that the people are undergoing in the field. We are the grass root pressure. Unless we take up this course we cannot speak about the empowering of grass root level people. In this effort, basically, we have to work more with the policy makers since the personnel would be there only for a short while either in diocese or congregation. We have to have a hospital based analysis, taking up their

They are a dying breed. Give them a chance to live, Make a sympathetic understanding, not an attack. And based on that help them to move, live. Help them to interrelate to experience social integration rather than alienation.

And, also we are not the only forces. Ally with other forces. To activate CHAI, we have to activate the 'A' aspect (Association) that we have to activate H (hospitals). For this different methodology has to be worked out. Convert this problem into a structural analysis. Then it becomes a fact, and not a belief, and that cannot be devised.

Another common platform is the faith dimension. It is the faith dimension that impells people. Hence, this also could be starting point leading further wider questions.

While speaking about activating the 'A' aspect a strategy could be broadining our base by empowering the village-based dispensaries, so that they would emerge into a force.

> The effort of chd has been to make community health a movement for the realization of health for the poor majority in India. Hence it was felt that it would be good if there are some reflections on this question.

Speaking of movement, it is still an abstract idea, a concept which is yet to be developed fully in sociological and development work context. Hence the reflection that are shared are also very much theoretical and inconclusive. Earlier, there had been some efforts made by the team to deeper our insights into this. Yet, it was felt that our insights were very broad and we were not really able to articulate what is it that really takes place inside the movement.

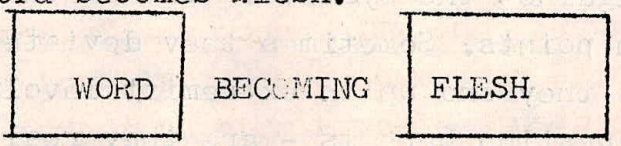
And even for a study into this, there is no proper, sufficient literature. That again is yet to be developed. There are not many experiences also; and even the very few initiatives that may be there, are not analysed and documented in depth.

Movement involves large number of people. People who have been suffering and undergoing tension. The conducive climate for movement is the time when there is an acceptance of an idea of change. This would lead to the emergence of a core

The leader moves. The others, the community feel that they would suffer because of this. The struggles begins, simultaneously the oppression by vested interests also starts. This adds momentum to the emerging struggle. The charismatic leader can convert this to give it a moral overturn. Eg: Gandhiji. The cultural and religious factor play a major role here. New type of value systems, attitudes emerges. There is a cultural transformation taking place which is basically a change in the 'self'-s of people and this leads to a greater lease of life. Such value based moral questions are fundamental and these make people emerge to a fuller life- eg: Christ, Buddha. Another eg: is technology has the capacity for total distruction. But the generation of moral and ethical values can counteract this and even direct it to the betterment of humanity.

The marginalised has the capacity to internalise the suffering and give it a religious overturn. But it would be moving from the domesticating elements, moving towards liberation. Moving away from fatalism, and moving away from the culture of silence to a culture of repression and action. To facilitate this process in the people an outsider is required - eg: Gandhiji.

The outsider comes and undergoes a rebirth with the people, an incarnation. Then he lives and dies with the people - enters into their sorrows and struggles and gives his life fully in that. Here the word becomes flesh.




This is an act which is truly human. But there is a divine intervention here. It is an instance of God intervening in history through man. And this is the power of faith. And the person is transformed to become saint, by being fully human, by fully exercising his love for his fellow-beings.

The outside person has a higher perception, a different perception by virtue of his distancing from the situation. This gives him a sense of objectivity in his understanding and analysis. Also, by exposure to other situation, literature, etc., he would have developed certain skills and frame of thought in

The leader articulates the issues in verbal form and poses it before the larger community. Here he applies a moral pressure too, which takes the form of questioning the existing values, attitudes, thoughts etc. This would touch and move the individual. There would be also an effort to build up allies. This might also lead to splits in the opposite camps.

The outside person is also an expert in faith, capable of adding a new dimension, a liberating dimension to faith. A lot of poor are dying without living their lives the human way. And they live their lives dying. People have their faith, but a faith which creates fatalism and martyr complex. Starting with faith, the outsider has to give the dimension of life in faith, confirming life instead of death so that the individual can live his life and contribute towards the society.

The people, society can have life in its fullness here and now. This is a matter of developing a new spirituality. Here, when we speak of faith, it is not only the Christian faith, but the faith that can activate the spiritual energy and release of man. There is a historic need to develop a new leadership giving emphasis to this dimension of faith, so that they can go for the impractical.

A continuing note was raised. There are very many movements of people in the country - They move towards a certain goal, fighting against the systems. But on the way they compromise at certain points. Sometimes they deviate from the track. And, othertimes they end up in extremist involvements. But the relevant question here is - are they real movements, though apparently they appear to be.

The culmination point for the movement is the just society. The distance trecked would vary. But what matters is not the distance but the direction.

The poor and the marginalised thirst and cry for freedom. The believers are the hand of God. Give the poor a hand of God.

We shall locate ourselves on the side of the poor. We are the part of this historic momentum. The specific place of ours is the part of health. People are unhealthy because of other

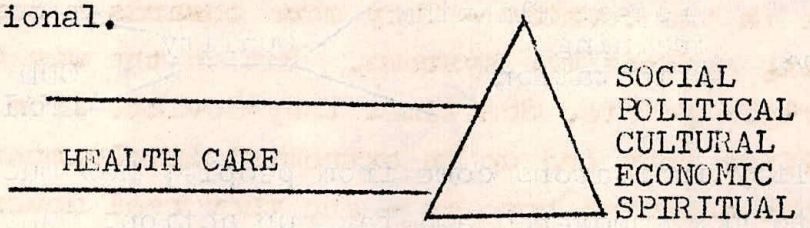
Here the medical person becomes more effective; s/he would be involved in the real role of making people healthy. The role is not played by the conventional medical practitioners.

In the movement, the group, which is a political force focusses on a specific point. For us the focus is health. Hence the medical personnel do have a role.

Community health itself is not a movement. There is only one movement. And community health is a means contributing towards it. CH is a current, a stream contributing towards the main current, the main stream. But it has all the qualitative elements. We should make constant efforts to identify the existing movements nd contribute our mite.

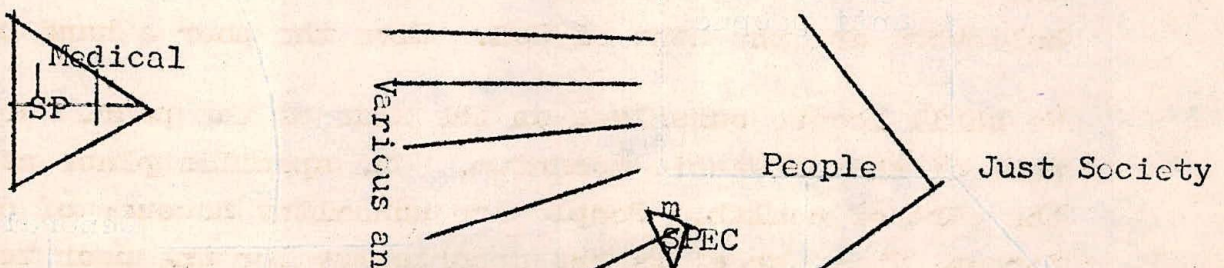
There is an orthodoxy in health care. Diocesan - Hospitals - Doctors. This is cost intensive also. But this is not meeting the needs of today since the real issues, the social factors, the community factors, are left unresolved. An approach based on social factors is cost effective also. This understanding to be ingrained into these people.

The movement in community health has to merge into the main movement that is taking shape in different parts of the country. This understanding is not based on a belief but on analysis which is rational.




Speaking of health there are different dimensions and aspects in it.

Community health is a sub movement, which has with it the medical and socio-political dimension.

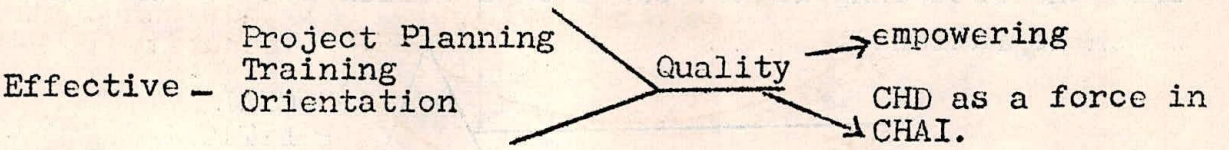


Since sometime there has been feeling in the team that we have involved in too many activities that the quality of our work has been affected. Hence the questions were :

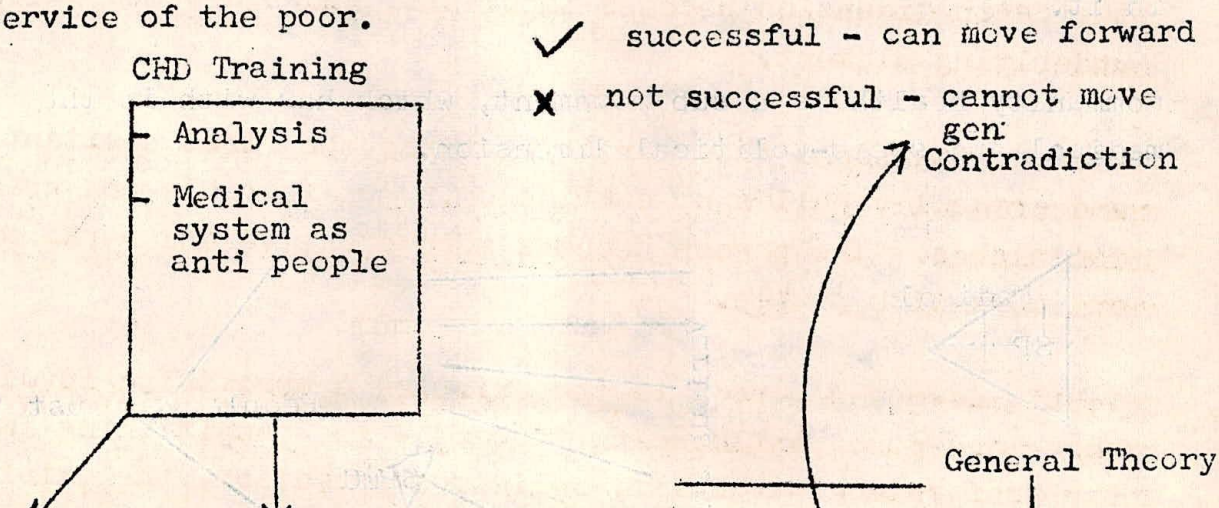
- Should we reduce the quantity to increase the quality
- or maintaining the quantity can we still extract quality.

The quality of programmes can be assessed in terms of the involvements of the participants after the programmes. Repetitions cannot stand. One session should respond to the dynamic social processes, so that the participants can respond realistically to the changing situations. Here no static theory can help. The participants lose enthusiasm when it becomes repetitive. Session after session we have to grow in quality. There has to be serious reflections into this. It should be a structured, analytical reflection focussing on the key issues.

Speaking of quality, effectiveness and efficiency are two terms that come up quite often. Being effective refers to the impact on the environment, efficient refers to being less expensive in terms of material, time and spending ourselves.

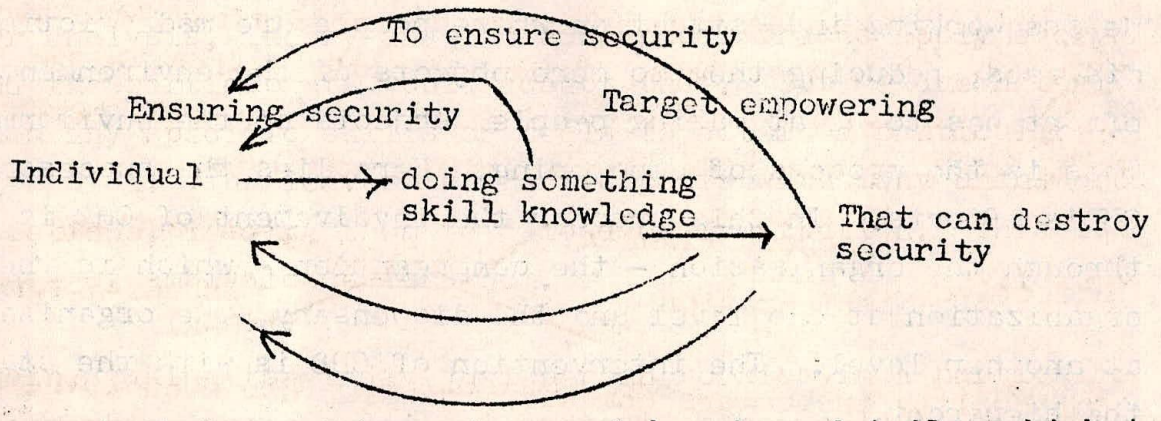



Our quality indicators come from people, how much it helps people to get empowered and take up action. And another dimension is have we, and hence CHAI has made a force for the service of the poor.



We are operating in a theoretical context and operating at the macro level, while the groups are working in the micro level. Our analysis, theory and the conceptual frames apply everywhere and the participants would accept that. But we are not giving them any specific skills or tools to act in a particular situation. The leaves the participants with many unanswered questions, leading them to a mood of frustration. This is a state of ambivalence for them.

Again, taking the individual person working in a particular geographic, socio-political context, s/he would be doing something with a certain knowledge and skills. The target of the work would be empowering which definitely destroys security. The reality forces them to go for compromise and to do something that ensures security. Our analysis tells them that what they are doing is not meaningful. But we are not giving any counter knowledge applicable in specific geographic-socio-politico-cultural context, making the individual succumb to a public confession and a sense of frustration that 'if I do I would be destroyed'. And the ultimate result is that they resort to mechanisms that defend themselves.

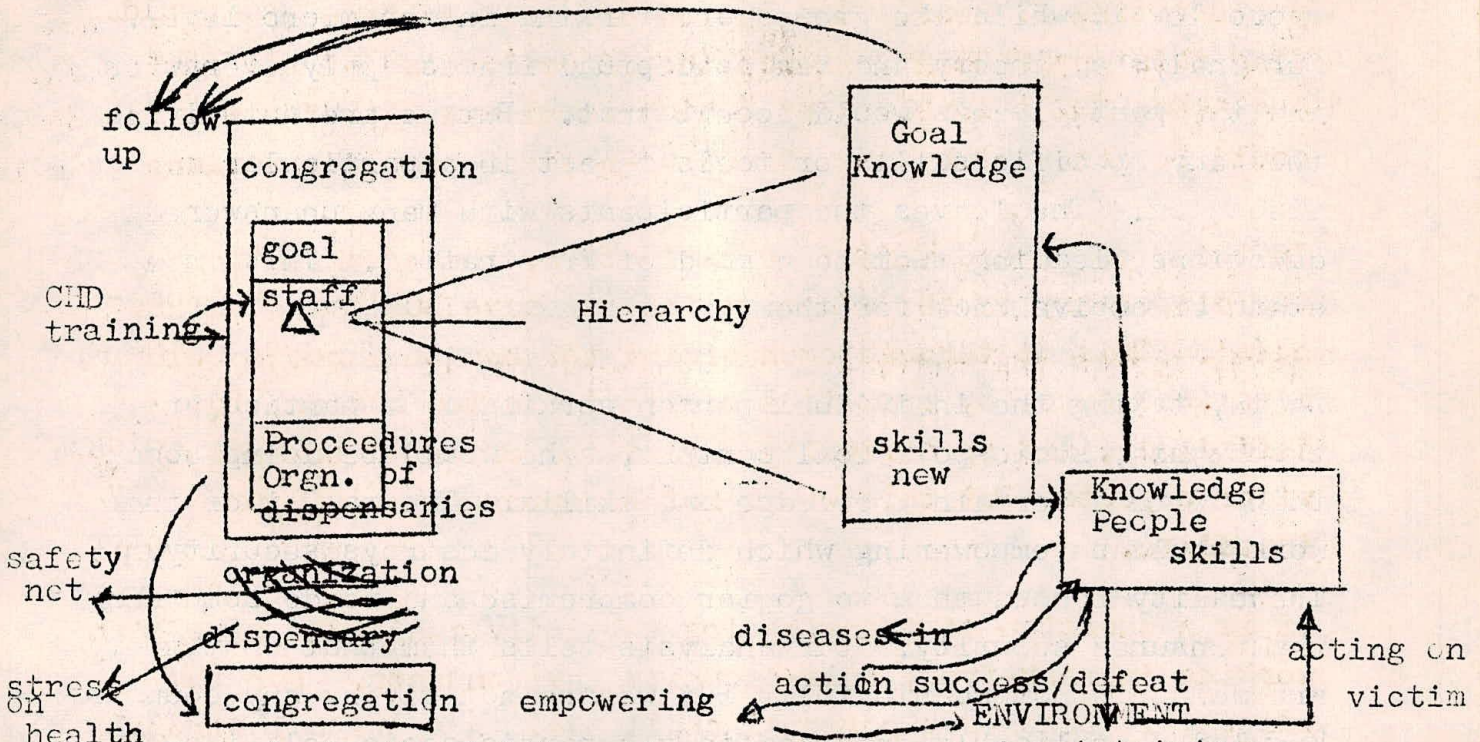



In our training sessions when we take micro-details, which is addressed to the person, fear develops. To transcend this fear, the faith dimension becomes important, and God comes as the underlying element.

Once we transcend the fear, s/he takes the first hesitant step and gradually builds up confidence. The fear element gradually diminishes. The person becomes more creative and works more and more with people.

To tie down the person to the existing compromising involvements, there are other influencing factors - the conditioning impact of

Destabilizing the status quo




Again the deliberations centred around maintaining and improving the quality of the orientation/training programmes. The above frame has been used to explain those aspects.

We are working in a situation where people are made victims of diseases, reducing them to mere objects of the environment. The effort has to be at making people subjects of the environment. This is the process of empowering. Here lies the success of CHD's efforts. In this process the involvement of CHD is through the organisation - the congregation - which is the organization at one level and the dispensary, the organisation at another level. The intervention of CHD is with the staff and the hierarchy.

In the process of people getting empowered and taking action directed against the environment, the congregation perceives threat, Based on this perception, and the attitude towards the congregation either goes for or against the programme of community health.

Here the question is how to improve the quality ?

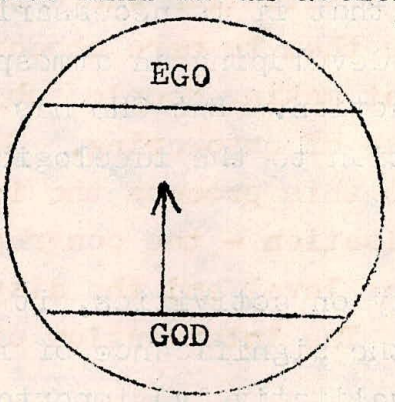
This can be assessed by the feedback we get on the action - which is success, failure or even inaction. Another means for assessment is observation of the environment. Here again the reference is action by the people - people gaining more and more concepts,

directed towards the environment which is creating and prepetrating illness. The action has to result in destabilising this environment. Hence the effectiveness of the staff and hence CHD's involvement (which is always with the staff) could be assessed by the effective-ness of people's action.

In this, to escape threat or extinction, the organisation - the dispensary or the congregation can have built in 'safety nets'. This is through emphasizing the health aspects which acts as a cure, by promoting health dominated action, but definitely, and specifically angled and oriented towards the wider aspects. But this would not be apparent, vivid or immediate.

It is a question of transforming the individuals who have been working in risk-free, self-security environments. For the person, it becomes a personal challenge. A spiritual struggle should take place so that the person can undergo a radical change, a metamorphosis.

Here again, the faith dimension is of crucial importance to urge people to this kind of an action. It needs some more eleboration.




Our training programmes are effort to push the ego element with more skills for action. But, more and more, there should be efforts to introduce more of God element into the ego. This would result in release of more energy for action, following the principle and the personality becomes a charged personality.

From here the reflections moved on to the involvement of CHD. The effort was to develop a critique of the involvements in terms of the quality, effectiveness and a futuristic thrust to emerge into new areas.

Looking at the involvement of CHD,

it could be like this - involvement ← CHD → CHAI

Now the effort of the CHD team at this juncture would be going beyond that, through a reflection consolidation of our experiences and ideas in Training, Orientation and Project Planning so that we cease to be mechanical, and filling up more quality.

Another major effort that CHD should make is to decentralise its grass root involvements with and through partners. It would be developing a higher level of trainers working at the regional level as a resource pool. Speaking about this, we have to be extremely careful to see that we really equip people so that the danger of our simplification and that of giving too much emphasis on medical expertise/inputs will not take place. If we are really successful in developing effective groups, they could share the efforts of CHD to train middle level workers.

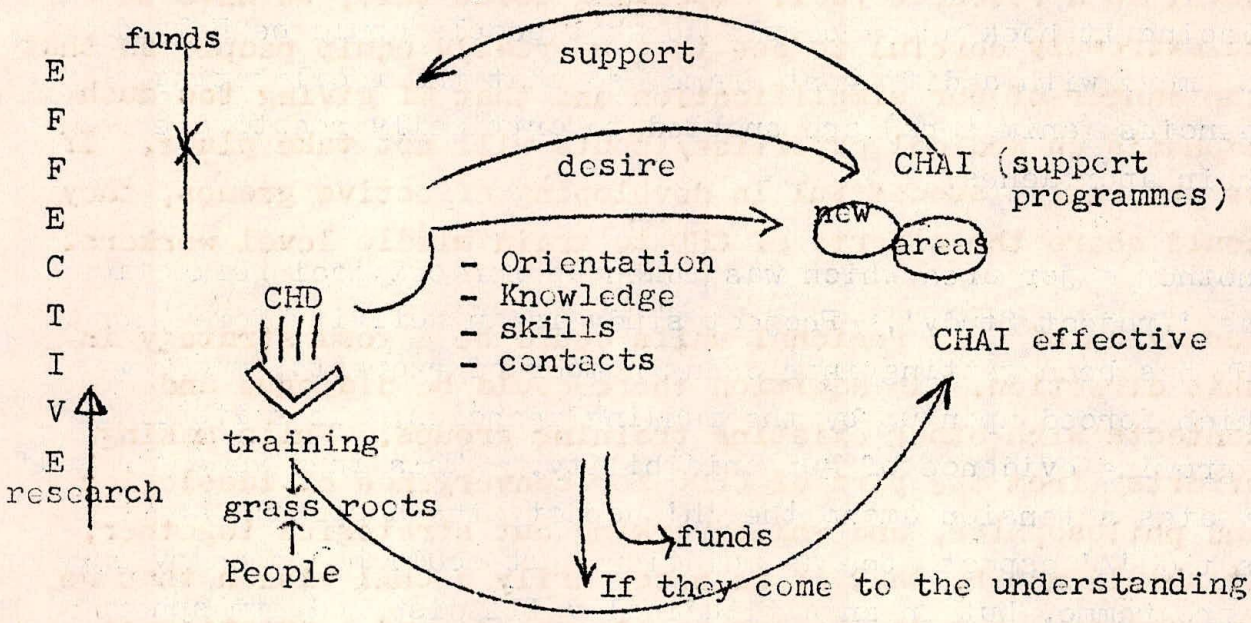
Formation of CHAI regional units could be a good strategy in this direction. In addition there could be dialogue and contacts with other existing training groups. While making efforts (from the part of CHDO for convergence of ideologies and philosophies, and while working out strategies together, it should not be that it is necessarily a CHAI vision that we are pushing, but developing an atmosphere and a practice of dialogical interaction. But CHD has to become more skill oriented in addition to the ideological and motivational orientation.

Speaking generally on activities, it is not the quantum of activities, but the significance of it at the national level that makes it (qualitatively) important, relevant. The involvement of the trained groups of CHD, and hence the trainings undertaken by CHD, can be made more significant by linking up these various groups.

The training should emerge as orienting people, equipping with skills and activating them to make involvements in their areas as well as to establish networks. This, then becomes training as establishing networks among people's organization. To make this effective, improve our professional quality based on the involvement with people. If our existing involvements are really authentic, then we will become nationally relevant.

The involvement of CHD tends to be unidimensional
- concentrating on socio-political dimensions, and unifocal
- catering only to nurses. But CHD has to open up to more and more categories of people, groups. For eg: it could move on to conducting programmes for health consumers - either directly or through groups.

Another major area is that of drugs and rationalization of the use of drugs in our institutions which can set a trend in the wider society.




CHD has been involved in training, orienting, skills development, etc., and has been in touch with the grass roots and the people through the groups (agencies) and for these groups, not withstanding the fact that there is genuineness in their involvements, coming to the understanding of CHAI has been the legitimizing factor for receiving funds and this becomes more and more dominant.

For CHD the desire at present is to move on to more areas, through direct ventures as well as through eliciting, facilitating supportive activities from and in CHAI. And as said earlier, this benefits both CHD and CHAI, in making both relevant to the poor and nationally significant, relevant.

Research and regional involvements are two political areas in which CHD can concentrate more. There could be a separate cell for research. But usually research programmes without taking people/grass roots turns out to be of the dominant mode. But in its place grass roots should acquire the

Documentation based just on narrative information becomes conventional. But there is room for incorporating analytical, research inputs into documentation.

The research that CHD/CHAI could involve is field based. And this is possible for CHD by virtue of its very locus among people. It should be an effort to collage evidences and emprical date from the people on their lives, struggles, initiatives, their moves, the efforts made by facilitating groups etc., processing, organising and synthesizing such data and placing it back anong people so that people could be helped to move with a different frame, so that the facilitating agencies (animators) are enabled to critically reactivate their approaches.

Another major area which was taken up for critical reflections was 'Project Study'. Project study is an activity for which CHD has been getting increasing number of requests; much of which forced upon us by the funding agencies. This itself is a growing evidence of our cridibility. This involvement itself creates a tension among the 'h' aspect, the hospitals as well as the 'A' aspect, the association. It could be an entry into a programme, but in an attitudinally ill disposed atmosphere from the part of the group (that has requested for funds). And that too in an atmosphere where we don't have time. Hence the opportunity becomes a burden. One involvement in the post funding period, with orientation and ongoing training, becomes very intensive. In this context, the relevant questions are
- how do we enhance our credibility, and how do we deepen our involvements.

Taken the positive aspects, it offers us opportunity to widen our networks, establishing more contacts, and initiating a different planning process and presenting the danger of groups going for approaches counter to our ideology. But the negative aspects would be, the material - quantitative aspect involved in the project on that we might have to spend time, the power attached to money, and the consequent relationship based on that, the increasing number of requests, etc.... in this context how can we maximize the positive aspects and minimize the negative areas.

We should not be succumbing to the needs of the funding agencies,

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THE CATHOLIC HOSPITAL ASSOCIATION
OF INDIA
C.B.C.I. Centre, Goldakkhana, New Delhi -110001
Tel: 310694/322064/322174

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# COMMUNITY HEALTH PROGRAMME - THE NEW VISION OF THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA (CHAI)

## Introduction

The members of the community health department together with some resource persons and some others representing other organisations, had discussions, orientation and planning in two sessions lasting for ten days each in the months of April and June 1983 at St. John's Medical College, Bangalore. The session was organised jointly by CHAI and the Preventive and Social Medicine Department of St. John's Medical College. Between the first and second session the community health department team members spent some time to study some existing projects and also to study in detail the various documents from the Church, Government and otherwise, dealing with Community Health. The following is a brief account of what resulted from the various discussions. In putting this on record we are fully aware of our limitations and we know for certain that we can not claim anything new, nor this as the last word. However, we do hope this will serve as a guideline for our future work, and with the help, suggestions, guidence and encouragement of all concerned we will be able to contribute our share to make the dream of WHO, i.e. Health for All by 2000 AD, a reality, for which the count down has already begun.

## Philosophy and Vision

In the light of the WHO's call "Health for All by 2000 AD", the revised national health policy of the Government, and in line with the document by Pontifical Council Cor Unum on "the new orientation of health services with respect to primary health care", the teaching of the Church and of the recent Popes, and the statements of the CBCI from time to time, as well as in the light of this consultation, the working team of CHD of CHAI concludes that:

1. In a country like India, so vast and varied, where 80% of its population live in the rural areas and about 90% of the country's health care system caters to the needs of the

2. Health is the total well-being of individuals, families and communities as a whole and not merely the absence of sickness. This demands an environment in which the basic needs are fulfilled, social well-being is ensured and psychological as well as ppiritual needs are met. Accordingly a new set of parameters will have to be considered for measuring the health of a community such as the peoples part in decision making, absence of social evils in the community, organising capacity of the people, role of the women and youth play in matters of health and development etc. other than the traditional ones like infant mortality rate, life expectancy etc.

3. The present medical system with undue emphasis on curative aspect tends mainly to be a profit-oriented business, and it concentrates on 'selling health' to the people, and is hardly based on the real needs of the vast majority of the people in the country. The root causes of the illness lie deep in social evils and imbalances, to which the real answer is a political one, understood as a process through which people are made aware of the real needs, rights and responsibilities, available resources in an around them, and get themselves organised for appropriate actions. Only through this process can health become a reality to vast majority of the Indian masses.

4. The concept of Community Health here should be understood as a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right. Thus it is beyond mere distribution of medicines, prevention of sickness, and income generating programmes.

In the light of the above conclusions,we identified the expl.ited and the unorganised masses, particularly in rural areas as our target group. We intend to reach this groups through the existing health institutions in the country, especially through the member institutions of CHAI and other individuals and groups engaged in the field of people-oriented

with other voluntary organisations, which up-holds similar philosophy and objectives will beexplored to the maximum.

We also felt that the Church in India should take a clearer stand on our involvement in the health field based on the documents mentioned and this stand should be made known to all our health care institutions and others concerned. In order to facilitate this we also felt that this study of the documents dealing with this new concept of health shouldform an intergral part of the curriculum in seminaries and religious formation houses. The same, we felt, holds good for all our educational institutions.

Conclusion

We are fully aware that we have still a long way to go towards the implementation of these plans. Yet we are optimistic and confident that, with the guidelines from the various documents and cooperation from the thousands fo our institutions and in collaboration with and with the assistance of various organisations with similar vision at various levels, we will be able to intitiate this process of education for liberation and development at least in some parts of this country.

J. Vattamattom

Fr. John Vattamattom SVD
Executive Director, CHAI: and
Secretary, Health Section of the
CBCI Commission for Justice,
Development and Peace.

29 - 8 - 1983.

Appendix - I

List of some of the documents refered and studied.

1. New Orientation of health services with respect to primary health care work - Pontifical Council Cor Unum 1978.
2. Statement on National Health Policy, Government of India, Ministry of Health and Family Welfare, 1982.
3. CBCI documents, particularly reports of 1978 and 1983.
4. Health for All, and Alternative Strategy, ICMR, ICSSR, New Delhi.
5. Encyclicals such as Populorum Progression, Call to Action, etc.

Appendix - II

Resource Persons who assisted the team during the sessions.

1. Dr. Ravi Narayan, St. John's Medical College, Bangalore.
2. Dr. (Mrs) Thelma Narayan " "
3. Dr. Dara Amar " "
4. Mr. S. M. S. Shetty " "
5. Fr. D.S. Amalorpavadas, Anjali Ashram, Mysore.
6. Fr. Stan Lourduswamy, ISI, Bangalore.
7. Mr. . . T. Rajan, SOLAI, Katpady.
8. Fr. Claude D'Souza, Bangalore.
9. Sr. Dolores Kannampuzha, Kottayam, Kerala.
10. Dr. Jessie Tellis Nayak, Bangalore.
11. Prof. R.L. Kapur, Bangalore.
12. Dr. Marie Mignon Mascarenhas, CREST, Bangalore.
13. Dr. Daniel Isaac, CMAI, Bangalore.
14. Ms. Lehka, SEARCH, Bangalore.
15. Ms. Krupa, SEARCH, Bangalore
16. Ms. Sujatha de Magrey, INSA, Bangalore.
17. Ms. Simone Liegeois, VHAI, New Delhi.

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# JESUS' INVOLVEMENT IN PALASTINE

To understand Jesus and His involvement we have to understand the Socio-Political context in which He lived and worked.

We all know for certain that Jesus of history lived in Palastine. For about 600 years, Palastine was under the dominion of colonial powers. (Persia B.C 538-33; Greece: B.C 333 - 63: Rome B.C 63 - AD 135). During the time of Jesus Palastine was subjected also to the internal domination of the Landlords and the Rich in Palastine itself.

## Geographic Features:

Palastine had two distinct geographic regions.

### 1. JUDEA

This region was situated around Jerusalem and the Temple. It was a mountaneous area, having mostly dry land. Predominantly, Olive and fruit were cultivated here. Sheep and goats were also reared here, since the region had lots of shurbs and forests.

### 2. GALILEE

This was a fertile region. Wheat and Vine were grown here extensively. Fishing in the lake of Galilee and the costal regions gave occupation to many. The people in this region were hard working, and industrious. This was the region, which was most exploited during Jesus' period. Agriculture, business, handicrafts, fishing etc. were the livelihood of the people. There were two commercial routes that passed through Galilee. One from Egypt to Damascus and the other from Damascus to Jerusalem. Foreign merchants passed through these routes, and had great influence in this region. Galilee was called 'territory of gentiles' and 'Land of mixed blood' since there were many illegitimate children born from the business travellers. The 'zealot' movement originated here and there were peasant revollts in this region, especially during the time of Jesus. (Map of Palastine during Jesus Ministry - Appendix I)

As mentioned above, Palastine was under the Roman Empire since B C 63 onwards. At the economic and political level the Roman domination manifested itself in the following way.

## Economic level:

The wealth of Palastine was expropriated by the Romans mainly through two types of taxes. They were:

1. Tributum - This was personal tax, which amounted to ⅓ of the total harvest
2. ii. Annona - The tax in kind or through work, for the Army

Apart from these, there were unofficial amounts which the Roman officials snatched away from the people.

Through official taxes of the Roman Empire alone, about 6 million Roman Denarii were extracted from Palastine every year. (One Denarius was equal to one day's work.

Along with the above mentioned two taxes, the Temple was also extracting taxes from the people. They were;

i. Publicum: This was something similar to the state tax we have today (eg. Sales tax). This was meant for thestate.

ii. Didrachm - for the temple

iii. Tithe - for the clergy
(ii and iii were Religious taxes)

Political level

The Roman Procurator of Judea, who lived in Casarea, personified the Roman colonial power. It was he who nominated the High Priest in Jerusalem ( a very powerful position, religiously and politicaly) from among the 4 dominant and rich families of the time.

- In Galilee, Roman Political power manifested itself through King Herod Antipas.
- The Roman Empire indirectly controlled the land owners through its arbitrary powers of dismissal of property rights. During the reign of Herod (B.C 37 - 4) he confiscated the land from small land holders and marginal farmers and handed it over to Zamindars and businessmen, to facilitate increased agricultural production and large scale export of the produce
- The intermediary officials in Palastine were recruited by Rome, from among the Sanhedrin members and the great families. They remained docile to the Roman powers and perpetuated the imperial domination.
- Those responsible for collecting the taxeswere chosen by the Romans from among the lower social classes in Palestime.
- The political power of the Roman Empire was manifested also through the continuous pressure of the Roman Army in Palastine who were normally recruited from among the non-News of Palastine and from Syria.
- Rom also controlled the Jewish autonomy. They reserved for themselves the power of capital punishment

ANALYSIS OF THE VARIOUS SYSTEMS THAT EXISTED IN PALASTINE

1. Economic System

Originally, collective ownership of land prevailed among the jews, since they believed that the land ultimately belongs to God. (Leviticus 25/23: 'Your land must not be sold on a permanent basis, because you do not own it; you are only

and you are like foreigners who are allowed to make use of it). But since the time of Herod feudal system emerged in the villages. Barter system was also not uncommon at the village level. Jerusalem Temple was the centre of intense trade and commerce. The Temple possesed the treasury and functioned the role of a National Bank. Jerusalem had trade links with Rome, Greece and Phoenicia. The celebration of Annual Jewish feasts were an occasion for the Jewish people to come to Jerusalem. The Urban workers, and the lower middle class, especially the small farmers suffered very much during Jesus' period on account of the multipple tax system that existed at this time, due to which inflation, unemployment, poverty, birth of armed bands etc. resulted.

Social System:

Palastine was a highly stratified society, during the time of Jesus. There were different social groups. They were:

1. Saducees: They belonged to the Jewish Aristocracy, and represented the most conservative group. They were closely linked to the colonial power for their economic interest. They were learned people and were specialists in 'Torah' the original law of Isreal. They opposed the escatological believes and denied the ressurection of the dead.

2. Pharisees: They belonged to the urban middle class, and upheld the escatological beliefs and believed in life after death. They had a very pessimistic idea of man and stressed on the other world, which according to them had to be attained through strict observance of the law. They believed in individual salvation.

3. Scribes: They were the specialists in religious legislation and of the penal code, and enjoyed a monopoly over it, since they knew Hebrew well. This group believed in escatolosy and exerted tremendous control over the masses and were very active in the synagogues on sabbaths. However, they could'nt get along will with the Priests.

4. The Priests: They were a special ethnic group, belonging to the tribe of Aaron. Among the priests there were 'Higher Clergy' and 'Lower Clergy'. The priests enjoyed the monopoly over the rituals and were responsible for law and order. The latter function was carried out through the intermediary of the levites.

5. Levites: Law and order was maintained by them; ie the police function. They also assisted the clergy in their various functions.

6. The Publicans: They had very low social status. Among those who had Jewish origin were entrusted with the task of Tax collection.

7. Sinners: Those who had one way or other transgressed the law.

8. Possessed: Those with illness, especially mental ill nesses.

9. Lepers: Were

II. The Zealots:

This group was essentially a political one engaged in guerrilla activities against Romans, to restore Jewish State in its theocratic dimension, in the line of Davidian Messianism. (The zealots took over power in A.D 68, after killing the high priest in Jerusalem. They established a new high priest, from one of the traditional families. In 70, the Romans retaliated and the zealots tried to defend the temple (symbol of power and authority) to its last man, but in vain. And the Romans destroyed the Temple thoroughly).

Social Classes: At the Rural Level the upper class consisted of mainly the big land owners. Generally they lived in the cities. The different craftsmen belonged to the middle class. (Those who made perfumes and religious costumes) These products were sold out during the Jewsih feasts in Jerusalem. The agricultural workers, the slaves ( generally owned by the merchants), and the unemployed (Mt. 20: 6) belonged to the lower class.

At the Urban level, the upper class was constituted of the sacredotal aristocracy, (composed of the four families, from among who the Roman procurator choose the High priest) the big merchants and the high officials. The urban craftsmen, small merchants, middle level officials, the priests and the levites formed the middle class. To the lower class belonged the workers attached to the temple, slaves, sinners, publicans, unemployed, beggers etc.,

The social stratification was done also on ethnic factors, ie. pure and impure jews. Purity of Jewish blood had to be proved tracing one's origin, to one of the twelve tribes of Israel (Mt1 : 1-17). Parental authority in the family was very much respected.

Political system: The political structure in the Palastinian Society was in the following way. At the village level decisions were taken and power was exercised by the council of elders - composed of chosen heads of Jewish households - through regulating communal affairs. Settling village disputes, punishing transgressors lf law etc. There was also a priest in the council.

At the urban level, also there was a council composed of aristocratic families, large landowners etc. They monopolised the political and economic power.

At the state level: The Sanhedrin, which was the council of elders in Jerusalem, composed of 71 members (Pharisees, scribes, saducees, and priests) was the powerful body. Sanhedrin was located in the Temple, and was similar to the supreme court. This body generated ideology and exerted tremendous influence on the lives of the people. Thus the state power was located in the temple. Though the sanhedrin represented authority, the High Priest represented supreme authority at the social, economic, political and administrative levels. (See Apendix II)

Ideological System:

Ideology means the explanation or moral justification of the social, political and economic life of a person or society of a given time. Ideology is the basis of

In palastine it was essentially a religious ideology, which was very conservative and law oriented. The temple, symbolized the ideology, for Isreal. Since God resided in the temple, it gave a divine guarantee to the ideological system.

The producers of this powerful religious ideology were the religious elite. (The high priest, the pharasees, the scribes etc). The ideological system kept the social and political system completely under its control.

It was into this Palastine, that Jesus, the Redeemer, Liberator and the Prophet, was born. As he lived mostly in Galilee, He was fully exposed and thus aware of the plight of the poor. He took a defenite option for the poor and He chose to live with them and His associates were from among them.

Right in the beginning of His ministry itself, Jesus declared His mission in unambiguous terms; That is:

I have come...." To bring good news to the poor
To proclaim liberty to the captives
To bring sight to the blind
To set free the oppressed
To announce that the Lord will save His people"
(Lk 4: 18-19)

To some extent, the word 'poor' used by Jesus is misinterpreted today. In the gospel according to St. Luke, whenever Jesus spoke this word He always meant those people who were economically and socially deprived, and those who were in the lower strata of the society. ( and NOT the spiritually poor!) When Jesus spoke to the disciples of John the Baptist He mentioned who were the poor for Him..... The blind, deaf, lame, lepers..... (lk 7:22) While speaking about the invitiees for the banquet, he again speaks of the poor; the crippled, the lame, the blind....(Lk 14:13) Talking about the rich man and lazurus, (Lk 16:20) Jesus illustrates clearely what he meant by poverty. When Jesus asked the rich man to sell everything and give it to the poor, He meant material wealth, and He had in mind those who were deprived of it, and not the rich who have made the vow of poverty (Lk 18:22, Mt. 19:16-21). The economic dimension of richness or poverty is clear again, when Jesus spoke about the poor widon (Lk: 23:3); and the rich fool (Lk 12: 16-20). From all these it is very clear that Jesus' option was for those people who were poor in the literal and ordinary sense of the word.

Well, does this mean that Jesus excluded the rich in His mission, or that He had no message for the rich? One thing that is clear from the Bible is that Jesus never overlooked the rich people because they were rich. Nevertheless, on many occasions, the good news of Jesus turned out to be a bad news to the rich. (Because He never rationalised or compromised!)

Many a time Jesus accepted the hospitality of the rich (Lk 14: 1, 19: 6). But He always had the guts to speak to their face about their greed and injustice and very often sitting under their own roofs! (lk 6: 24, 18:25 etc) The response of Zacheus (Lk 19:8) clearly indicates the radical change that occured in him, probably after the long discussion that Jesus had with him. While eating a meal in the home of a leading pharisee, we see Jesus boldly exposing their attitudes and challenging their mentality, and making concrete suggestions. (Lk 14: 1-14, Lk 7: 36-50). In those days, some at least would have really thought that to invite Jesus was to invite trouble!

Jesus situated himself basically within the religious field. But he did not belong to the religious elite and was therefore not entitled to enter the ideological system (Mk 11:27-28; what right do you have.....?) He took upon the escatology of the prophets , and severely criticized the Jewish religious practices, as made up of purely external laws and observances. This brought Him to the violent confrontation with the Pharisees, who saw Him as a threat to their position and power. He was seen as one who defied religious authority and was accused as a disruptive element (lk 23: 5), that must be got rid of for the good of the nation.

Apart from upsetting theestablished order, the popularity which Jesus enjoyed through His presence and His teaching (Jn 11: 47,48; Mk 11: 48), increased the worry of the elite. And accordingly they concluded that it was better that one man die than the whole nation getting destroyed (Jn 11:50). But as capital punishment was reserved to the Roman authorities, the only possibility that was open to the Sanhedrin was to make it appear that Jesus had defied the Roman authority.

The sanhedrin condemened Jesus before the High Priest on the grounds of blasphemy, but played a clever role and changed their accusation from the religious order to the political order, in front of Pilate (Lk 23 : 2-5). When Pilate was not convinced of His culpability to deserve a death sentance, he was threatened of his own position (Jn 18:28-38). The game played by the Sanhedrin to get Jesus killed is very clear from the passion narratives given in St. John and St Luke .

Lk 22: 35-38, 47 -54; 63 - 71
23: 1 - 27 and

Jn 18: 1-14; 19-40, 19: 1-16

It is important to note that the questioning of Jesus and the court procedure were conducted ' early in the morning' (Jn 18:28; Lk 22:66). This was shrewdly and cunningly planned by the Senhedrin. Because it was easy, for them to handle Jesus in the absence of His supporters, who were already in Jerusalem in large numbers for the passover feast. They were the people from the country sides, who heard and loved Jesus. They were not staying in the Temple complex. The 'People' and the 'crowd' which St John and St Luke speak of were the many

masters told was a matter of their own daily bread, and they simply reflected and resounded what was in their masters' minds.

After a heavy and late dinner (passover feats) on the previous night, it was very late in the morning when the real followers and supporters of Jesus came to the temple complex; but only to be witnesses of their leader being led to Calvary. "Weeping and wailing they followed Him' (Lk 23:27).

Conclusion

It has to be noted that the execution of Jesus was the result of the plot jointly hatched by the coalition between the Jewish religious and social elite and the Roman authority, because Jesus was a threat to the social & religious order of the day, which the rich and the powerful were determined to keep at all costs to maintain themselves in their priviledged position in the society. Jesus' death was therefore primarily a political event. Jesus was crucified (crucifixion was the punishment for political criminals) not because he claimed to be the Son of God, but because he attacked the traditionally established ideological system, which dominated and maintained all other systems, and because his message and practice aimed at the subversion of the social order that existed, towards the creation of a new society where peace, justice and brotherhood would prevail.

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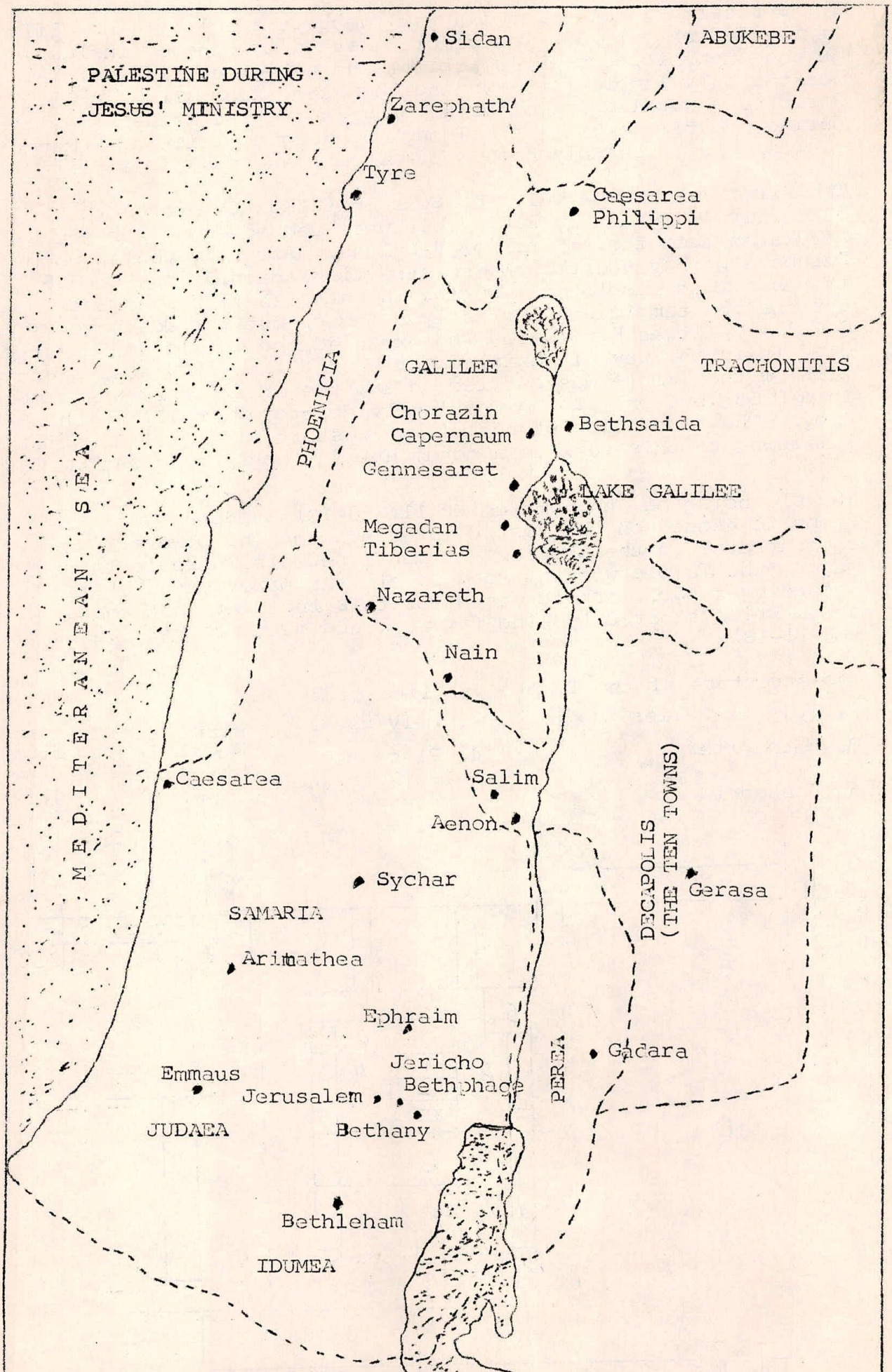
Appendix I


PALESTINE DURING
JESUS' MINISTRY
Sidan
ABUKEBE
Zarephath
Tyre
Caesarea
Philippi
PHOENICIA
GALILEE
TRACHONITIS
Chorazin
Capernaum
Bethsaida
Gennesaret
LAKE GALILEE
Megadan
Tiberias
Nazareth
Nain
MEDITERRANEAN SEA
Caesarea
Salim
Aenon
DECAPOLIS
(THE TEN TOWNS)
Sychar
Gerasa
SAMARIA
Arimathea
Ephraim
Gadara
Jericho
Emmaus
Bethphage
Jerusalem
PEREA
JUDAEA
Bethany
Bethleham
IDUMEA

## The Jerusalem Temple

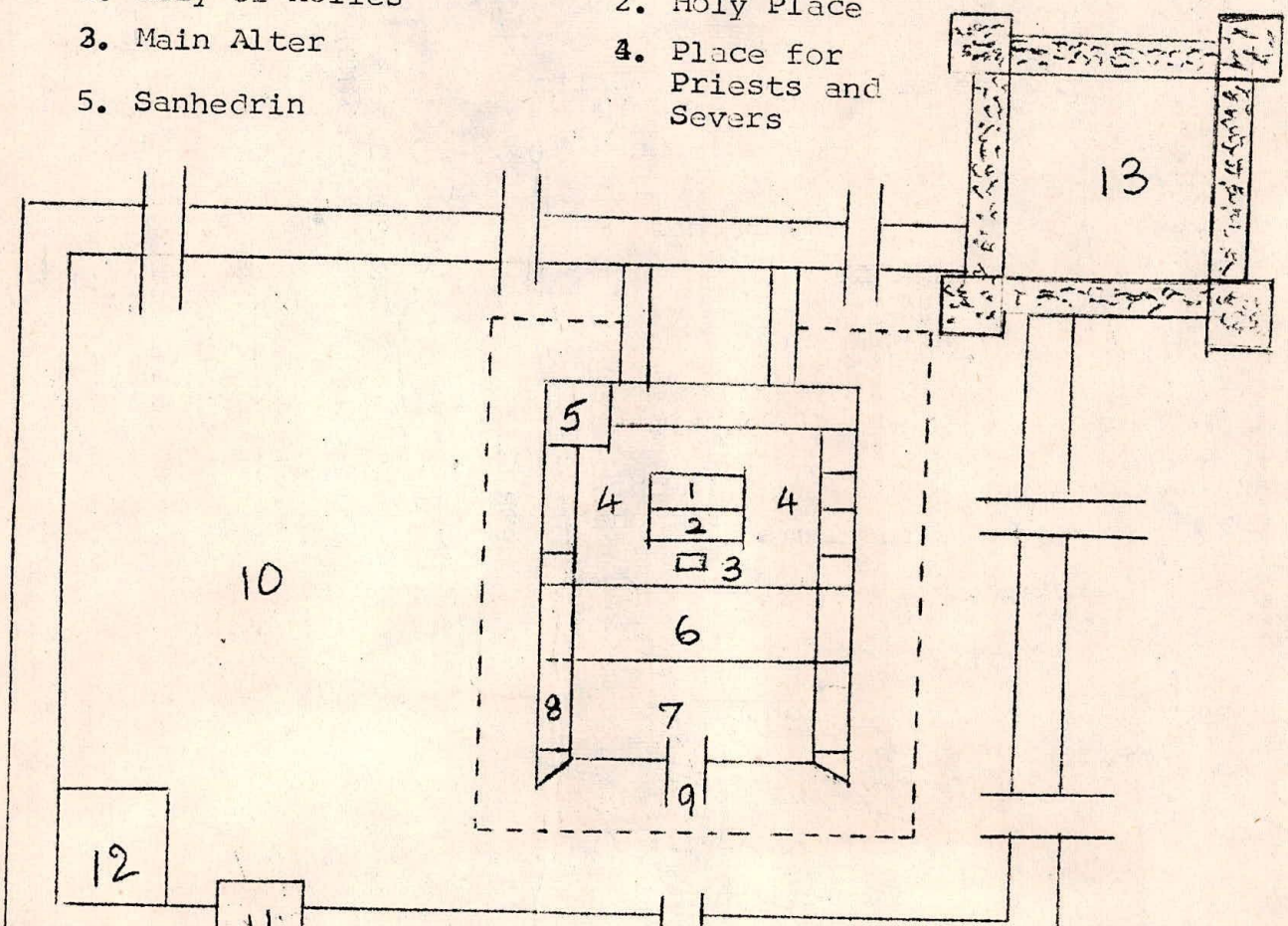
The Jerusalem Temple played a very important role in the life of the Jewish people. The temple exerted tremendous influence in the economic, social, political and religious fields. This was the only Temple for Jews and they came from all over the world to Jerusalem for offering prayers and sacrifies especially during the time of feasts. Though Synagogues existed in many places, they were only houses of prayer, and not for sacrifices.

The first Temple was built by Solomon ( 1Kgs Chapter 5 to 8), but after 400 years in B C587, it was robbed and destroyed by Nabukaden eser the emperor of Babylone. After 50 years, under Zerubabel, they started the construction again. In B C. 515 it was almost completed. During the attacks of Greeks and Syrians the temple was partially damaged, but not destroyed. In B C 20-10, itwas King Herod who expanded the Temple and constructed it in the way it existed during the time of Jesus. Renovation of the Temple was carried on and the entire work was completed in A D 63; but only to be completely destroyed in 70, by the Roman Army. The foundation stones of the western side wall is still remaining to this day, as a monument of thegreat Jerusalem Temple.

The cleansing of the Temple (Mk 11: 15-18) by Jesus was a symbolic attack on the vested interests and the powers that were concentrated in the Temple. As mentioned elsewhere in this pager, the Temple was the seat of all the power structures. According to St. Mark it was after this incident that the Jewish authorities started looking for ways and means to kill Jesus (Mk 11-18)

The structure of the Temple was like this:

1. Holy of Holies
2. Holy Place
3. Main Alter
4. Place for Priests and Severs
5. Sanhedrin



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CATHOLIC HOSPITAL ASSOCIATION OF INDIA

NEW DELHI

QUIZ:

POVERTY AND HEALTH

1. The Largest number of deaths in India are because of:

   a. Deficiency diseases b. Heart disease c. Cancer
   d. Low birth weight and diseases of infancy

2. In Bombay babies born in rich families have a moan birth weight of 3300 gms. While in poor families have a weight of:

   a. 2000 gms b. 2600 gms c. 2800 gms d. 3000 gms

3. The percentage of children under 5 years who are underweight is:

   a. 30% b. 50% c. 65% d. 78%

4. In India the typical diet has how many kilo calories?

   a. 1500 b. 2000 c. 2500 d. 3000

5. a) What is the daily calorie requirement for a man doing heavy work (Ploughing, Stone breaking etc.)?

      a. 2400 b. 2800 c. 3200 d. 3900

   b) According to an estimate in a poor family the average kilo calories for a man is:

      a. 1400 b. 1600 c. 1700 d. 2100

6. a) What is the daily calorie requirement for a woman doing heavy work (Agriculture, Construction work etc.)?

      a. 1900 b. 2200 c. 2800 d. 3000

   b) According to an estimate in a poor family the average kilo calories for a woman is:

      a. 1400 b. 1600 c. 1700 d. 2100

   c) What is the extra daily calorie requirement for pregnant woman?

      a. 100 b. 200 c. 300 d. 400

   d) A survey in South India showed that percentage of pergnant woman with symptoms of malnutrition is:

      a. 20% b. 30% c. 50% d. 60%

7. Which of the following diseases are directly related to the nutritional status of the person?

   - Diarrhoea - Tuberculosis - Measles - Upper resp

8. The percentage of all conditions reported in India which are definitely preventable are:

   a. 40% b. 50% c. 60% d. 70%

9. In 1976 the patients treated for dysentry, typhoid and gastro-enteritis (all spread by contaminated water and food) were more than:

   a. 10 lakhs b. 29 lakhs c. 49 lakhs d. 69 lakhs

10. The percentage of diseases occuring in rural areas which are caused by lack of clean drinking water and sanitation is:

    a. 40% b. 60% c. 75% d. 80%

11. In a city in U.P. after water work and sanitation were installed, the cholera death rate decreased by:

    a. 25% b. 52% c. 74% d. 85%

12. A survey found that of all the tube wells installed by the Government, the percentage of wells still in use are:

    a. 15% b. 25% c. 50% d. 99%

13. What is the percentage of villages in India which still does not have a safe drinking water supply?

    a. 30% b. 50% c. 70% d. 90%

14. In India it is estimated that the rich have a life expectancy of 65 years while the poor have an average life expectancy of:

    a. 35 years b. 45 yrs. c. 50 yrs. d. 60 yrs.

After discussing the answers write down the conclusion that emerges out of this quiz.

I. The per capita comparable land:

in India is 0.27 hectacres
in China is 0.15 hectacres

Life expectancy:

in India is 51.5
in China is 64

Infant mortality:

in India is 129/1000 live births
in China is 56/1000 live births

Annual death rate:

in India is 13.9/1000 pop.
in China is 8.8/1000 pop.

How is it that a country like China with more population and less per capita land as compared to India able to have better health status?

II. The population of India in
1971 was 54,81, 59,652
1981 was 68,38,10,051

The total grain production in
1971 was 9,40,80,000 tons
1978 was 11,38,10,000 tons

The amount of per capita grain availability in India in:
1971 was 453 gms/day
1978 was 469 gms/day

The amount of per capita grain required by man doing sedentary work (office) : 400 gms

Man doing hard work : 650 gms

The amount of land used for growing food crops was 12,81,22,000 hectacres

Non-food crops like tobacco, coffee, tea was 11,41,000 hectacres

The amount of food exported by India in 1979 was 3,12,997 tons

Pulses are the major source of protein in the diet

The amount of pulses produced per person in
1956 was 70.4 gms
1975 was 40 gms.

Analyse the information given above and give your conclusion

## POPULATION

1. The average number of children produced by a family in India is:

   a. 5.7 b. 4.8 c. 6.3 d. 8.0

2. The reasons for producing so many children are:

   a. Ignorance
   b. Children are an economic asset
   c. Children are a security in old age
   d. Too many children die in the 1st year of life
   e. No family planning services available
   f. No other entertainment in the village

3. How many children does a family in India need to help collect enough fire wood for cooking, lighting etc. for

## HEALTH SERVICES

1. The amount of money spent on training a doctor is:

   a. 20,000 b. 50,000 c. 70,000 d. More than 1,00,000

2. The amount of money spent on training an ANM is:

   a. 3,000 b. 4,000 c. 5,000 d. 6,000

3. The amount of money spent on training a VHW is (Govt.):

   a. 600 b. 800 c. 1,000 d. 1,200

4. The percentage of ailments that can be prevented or treated by a VHW in the village (before becoming serious) is:

   a. 20% b. 40% c. 70% d. 85%

5. The percentage of ANM working in the rural areas is:

   a. 47% b. 57% c. 70% d. 87%

6. The percentage of Doctors working in the rural areas:

   a. 20% b. 30% c. 40% d. 50%

7. The number of people for each nurse (nurse population ratio) is:

   a. 1500 b. 3000 c. 4500 d. 6300

8. The number of people for each doctor(doctor population ratio) is:

   a. 2500 b. 3900 c. 4500 d. 10000

9. The percentage of hospital beds in rural areas where 80% of the people live is:

   a. 14% b. 32% c. 48% d. 57%

10. Through the Fifth Five Year Plan what percent of the health budget was spent in rural areas?

    a. 10% b. 20% c. 30% d. 50%

11. The number of children that go blind every year due to Vitamin A deficiency is 14,000. To prevent blindness by giving Vitamin A. the cost per child per year would be Rs:

    a. 0.50 b. 1.00 c. 2,00 d. 3.00

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## HEALTH CARE IN CAPITALIST AND SOCIALIST COUNTRIES.

Modern societies, without exception, view certain basic health care services as commodities to which every member of the society should be guaranteed access, regardless of their ability to pay. Whatever their cultural and political outlook this has been accepted. However, vastly different approaches have been adopted for achieving the goal. It has long been established that 'basic health care' includes food-clothing-shelter - safe-water - sanitation as well as medical care. But to many it still means medical intervention to prevent and treat diseases. In the socialist countries, the state is responsible for all aspects though the citizens contribute to its financing. In the developed capitalist countries in the matter of safe water supply, education and sanitation the state's responsibility is quite significant but food - clothing - shelter remains an individual's responsibility. However, various social security schemes help the poor citizens and guard against death from poverty.

### CAPITALIST COUNTRIES:

A study of the evolution of health standards in developed capitalist countries reveal three significant points.

1. During the second half of the 19th century a definite improvement in the general health of the public became apparent in much of Europe and North America as reflected in the fall in death rates from infectious diseases and malnutrition. Greater economic prosperity brought about improvements in the general nutritional state. Better housing and working conditions rather than antibacterial drugs and vitamins brought about better health. The basic progresses in health standards took place before the outstanding medical discoveries of our times were widely made use of. It was therefore due to overall improvement in nutrition and living conditions rather than to purely technical advances.

2. Public health and preventive medicine also greately contributed to this health progress. In response to the growing evils of industrialisation and the frequent epidemics of Cholera, public health was born around 1840 in England and 1850 in N.America and spread to most of Western Europe in the second half of the 19th century. This was the period of the "great sanitary awakening": Anti-filth crusade, clean water and proper sewage systems and housing. Preventive medicine began towardsthe end of the 18th century and introduced "the era of disease prevention by specific measures".

3. The capitalist economic system transformed medical care into a commercial commodity. This process by individualising medical care and making it available in the market place restricted it to those who can afford it. Medical care became a most profitable industry. The scientific and technological advances of modern medicine which resulted was how-

Approaches to medical care differ. In the U.S. there is no direct state intervention. But in the last twenty years, the state has taken the largest share in national health care expenditure. Programmes like Medicare (for the care of the aged) and Medicard (for the poor) have been introduced and the state is also providing financial support to other agencies. The situation in the United Kingdom is quite different from other capitalist countries. In the U.K., the National Health Service which takes care of the medical care of all, is run entirely with state revenue. In Canada medical care is almost totally state care. Other countries of the West depend heavily on different kinds of insurance systems with heavy state and employer contributions.

SOCIALIST COUNTRIES:

There are wide differences in health standards and delivery systems within socialist countries like Russia and the Eastern European countries and the developing countries. The health indicators of China, Cuba and Vietnam were formerly very pitiful. But today they are closer to the health indicators of developed countries than to those of developing countries. Let us take a look at the health indicators of some capitalist an socialist countries in 1960 and 1985 to give us an idea of progress made.

I. U.S.A.

| | 1960 | 1985 |
|---|---|---|
| Death Rate | 9 | 9 |
| Birth rate | 24 | 16 |
| Life Expectancy | 70 | 75 |
| Infant Mortality Rate | 26 | 11 |

II. U.K.

| | | |
|---|---|---|
| Death Rate | 12 | 12 |
| Birth Rate | 17 | 13 |
| Life Expectancy | 71 | 74 |
| I.M.R. | 23 | 10 |

III. U.S.S.R.

| | | |
|---|---|---|
| Death Rate | 7 | 9 |
| Birth Rate | 24 | 19 |
| Life Expectancy | 68 | 72 |
| I.M.R. | 38 | 24 |

IV. CHINA:

| | | |
|---|---|---|
| Death Rate | 19 | 7 |
| Birth Rate | 37 | 19 |
| L. Expectancy | 47 | 69 |
| I.M.R. | 150 | 36 |

V. CUBA.

## VI. VIETNAM.

| | 1960 | 1985. |
|---|---|---|
| Death Rate | 23 | 10 |
| Birth Rate | 41 | 30 |
| Life Expectancy | 44 | 60 |
| Infant Mortality Rate | 156 | 72 |

After the revolution, Chinese policy makers understood that in order to ensure mass participation in the public health programmes the peoples' felt need of medical care must somehow be met. So they set up a comprehensive organisation to serve even the remote inaccessible areas. The three key problems they faced were:
(i) Drastic shortage of medical personnel
(ii) Heavy concentration in cities.
(iii) Elite attitudes.

To overcome this, thousands of urban personnel were transfered to the countryside to serve on mobile medical teams. The wage disparity was diminished by freezing higher salaries. The difference in status between specialists and doctors was minimised by their common work with paramedics. It was in China that the concept of barefoot doctors first emerged. These are young people of peasant background who go through 3 to 4 months of initial training by health progessionals. They provide environmental sanitation, health education, preventive medicine and first aid while continuing their farm work. They are chosen by their communities and their responsibility is to the community which selects and maintain them. The first Congress of Public Health laid down 4 principles which still guide health care in China today. They are:

1. Health care must serve the common man the majority of whom live in rural areas.
2. Prevention must be given priority.
3. Western medicine and Traditional medicine must be integrated.
4. Health campaigns must be ombined with other mass campaigns

The Chinese realised that the point was to provide some form of medical care to all regardless of standard and quality which could come later. The Chinese health system is now so organised that a citizen of a remote village is assured of the most sophisticated treatment, if needed in an urban centre.

CUBA: In Cuba health is considered a fundamental human right and health service are free for everyone. After the 1958 revolution, high priority was given to rural areas. Most of the Physicians and hospitals were located in urban centres. For eg. 65% of the physicians and 55% of the hospital beds were in Havana, the capital of Cuba which had only 22% of the population of the country. But through the policy of regional

VIETNAM: In Vietnam too the most important achievements were the creation of the whole medical-health net work down to village level, making medical care available to the peasant living in the remotest village and the training of medical and health workers of peasant stock. These countries emphasise preventive rather than curative medicine. Issues like sanitation and immunization are taken up and implemented at local level. Mass campaigns aimed at eradication of disease and health education form part of the programme.

Medical care continues to be one of the most pressing felt-needs of all societies. For people's acceptance of any health care service, it is necessary to have medical care components. But the health achievements of China, Cuba and Vietnam are clearly related to their radical socio-economic, political andideological transformations. Their experience shows what improvements in nutrition, water supply, sanitation, education, mobilisation, employment, land distribution etc. mean in raising health standards of developing countries. This confirms the growing recognition everywhere that the fundamental requisite for a healthy society is not just effective medical care but ensuring that suitable conditions are created in which health can thrive.

* * *

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18/11/1987.

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# AN OVERVIEW OF DIFFERENT COMMUNITY HEALTH PROGRAMMES IN INDIA (MODELS AND APPROACHES)

## 1. INTRODUCTION

Community health approach to health care has been widely recognised as the right alternative for ensuring health to the poor millions in developing natives. In India too, governmental as well as voluntary efforts are made for the promotion of community health. In the evolution of health care system, this approach has emerged through a process of dialogue between the medical and the social sciences in an effort to make the health care system relevant and responsive to the socio-politico-economic realities in the society. Again, in the process of evolution and formulation of community health in terms of its principles, philosophies and methodologies, various models have been proposed and practised. In this paper an attempt is made to categorize these models into four, each with its own characteristic features.

Further, each model with its characteristics could be explained as following a certain approach in community health. These approaches are broadly divided into three. Am understanding of these three approaches could give us a frame work to assess as to which approach each models follows. Another interesting correlation is that each of these three approaches reflects a certain philosophy of development work.

In the following paragraphs an introduction is made into such an analytical overview. In the latter part of this paper the four models with their characteristics are listed out. Under each model, the particular approach into which it fits into it is also given with certain indicators of assessment.

## 2. DIFFERENT MODELS IN COMMUNITY HEALTH

A study of the ongoing projects and the literature available on them reveals that in India there exists different models/ types of community health products. They fall under four major categories. Each one is run by different types of institutional set ups as big hospitals, small hospitals, rural dispensaries, or run by non structured voluntary health/action groups. Again, each model is unique in terms of infrastructure, services rendered, needs met, and the results achieved. It

## 3. DIFFERENT APPROACHES IN COMMUNITY HEALTH

Three approaches have been identified in community health. They are : Medical approach, health extension approach, Comprehensive approach.

a) Medical approach :

Considers health as the absence of diseases brought about by medical intervention based on modern sciences and technology and sees the role of the community (the people) as responding to the directions given by the medical professionals. It has its roots in the medical model of health care which believes that the eradication of ill health depends on doctors and medicines.

b) Health extension approach :

Based on a critique of medical approach. It accepts WHO defination of health as the total physical, mental and social well being of the individual. Mere advancement of medical technology and the sophistication of services would not bring health to the majority of the people - especially the poor - and that the approach should be a planned re-distribution of health care facilities to reach the vastness of the society. The approach also advocates other socio-economic uplift programmes to enable people to benefit from health care facilities. Preventive care is also emphasized.

c) Comprehensive approach :

Views health, the concept of total well being in the context of the situational realities of the individual. This concept is elaborated by stating that health, the state of total well being, is also a human condition which does not imporve either by providing more services or mobilizing the community for providing more health services. It improves only by having the community take control and responsibility for decisions about how to mobilize, utilize and distribute services and resources. Here community is the subject, decision maker. It is a process of sonscientization* organisation and capacitation of the community for action. It has bearing on the social, economic, political and cultural dimensions of human life, in the sense that the approach strives to bring about changes in them so that there would emerge a society

4. COMMUNITY HEALTH AND THE DIFFERENT APPROACHES IN DEVELOPMENT :

Development work is based on certain analysis of the backwardness of the people. According to the analysis, different philosophy of development work are arrived at. They are mainly three approaches : Modernisation approach, welfare approach, and social justice approach. In the context of speaking about different approaches in community health work, it would be worth mentioning these approaches. It is interesting to note that reflections of these approaches are found in the three community health approaches.

a) The modernization approach analyses poverty as the lack of enough production and it makes efforts to gear up production through advanced technology in the field of agriculture and industry. It believes that the results of modernization would trickle down to the lower strata of society.

b) The welfare approach recognizes different classes and castes existing in the society. It is due to the co-existence of development and under development in the society. This state is accepted as a normal reality. Efforts are made to alleviate the sufferings of the poor through organizing relief and charity work. People are passive receipients here. Recently there has been some changes in this approach and it recognizes the participation of the people and the mobilization of their resource. Programmes also have improved remarkably from relief work to development programmes aimed at the uplift of the poor, through income generating programme, literacy programmes, vocational training etc. The poor continues to exist and the disparity between the rich and the poor also continues as a reality. Statusquo is not disturbed.

c) In social justice approach a critical analysis of the society employed and poverty and backwardness are understood as man made historical reality. The reasons are attributed to the various forces and the dynamics at work in the society. Poverty is precipitated as a result of injustice. Justice could be brought in only through a restructuring of the society. It could be achieved through empowering the people through awareness building and organization. Ultimate development of the poor would mean fair distribution of the means of production, living wages, consumption of good food, availability of public amenities, practice of human values as love, cooperation and unity.

It becomes clear that the analysis and approaches of development work has co relation with that of community health work, characteristics of modernization approach are reflected in medical approach and features of welfare approach find expression in health planning approach. Social justice approach goes well with, comprehensive approach in terms of its analysis and approach.

## 5. FOUR MODELS AND THREE APPROACHES IN COMMUNITY HEALTH

As mentioned already the community health programme existing in the country could be classified into four based on the characteristics. The following table would give that. Under each programme a note is made as to which approach of community health it belongs to. To make it clear six indicators are given based on which this assessment is made. These indicators are :

- role of health services
- role of professional
- role of community worker
- Community participation
- Evaluation & Financial support.

For each approach these indicators show different explanations.

---

* Conscientization is "an awakening of consciousness, the development of a critical awareness of a person's on identity and situation, a reawakening of the capacity to analyse the causes and consequences of one's own situation and to act logically and reflectively to transform that reality"

(David Millwood)

MODEL I

## A - CHARACTERISTICS

| Type of institution/ infrastructure | Nature of Services Rendered | Need |
|---|---|---|
| Capital intensive, highly sophisticated and institutionalized big hospitals.<br><br>Mobile medical team with doctor & medicines | - Extensive service from hospital.<br>- Curative care<br>- Running village clinics.<br>- Referral service, free medicines.<br>- Weekly or fortnightly visits. | - Treatme physica<br>- Referra transpo hospita |

## B - THE APPROACH FOLLOWED

The approach followed is medical approach- The following are six indica assessment on that :

| Indicators | Explanation |
|---|---|
| a) Role of health service | - means to improve the health status |
| b) Role of Medical Professional | - Key to the programme - manager, pla clinician, leader, teacher, evaluat |
| c) Role of community health worker | - a means by which medical advances c |
| d) Community participation | - A means to ensure more acceptibilit |
| e) Evaluation | - Based on analysis and interpretatio and results of applied medical scie |
| f) Financial support | - needed to create, expand and mainta |

MODEL II

## A - CHARACTERISTICS

| Type of institution/ infrastructure | Nature of services rendered | N |
|---|---|---|
| Capital intensive, sophisticated and institutionalised small hospitals.<br><br>Medical team with or without doctor. | - Extension services.<br>- Curative and preventive care<br>- Village clinics<br>- Referral services<br>- Medicines at reduced rates<br>- weekly or fortnightly visits.<br>- Health education<br>- MCH programmes/immunization<br>- Village health workers with medical kit. | - Trea ailm<br>- refe tran the<br>- pers ronm |

## B - APPROACH FOLLOWED

The approach followed is Medical approach. But there are certain chang strictly Medical approach. There is an inclination towards Health Exte

| Indicators | Explanation |
|---|---|
| a Role of health services | - Means to improve the health status |
| b Role of medical professional | - Medical professional continues to b a role here. |
| c Role of Community Health Worker (CHW) | - Along with being a person to ensure CHW also imparts preventive health |
| d Community participation | - a means to ensure more acceptability minate ideas of preventive health ed |
| e Evaluation | - Based on analysis and interpretation and result of applied medical scienc health education. |
| f Financial support | - needed to create, expand and maintai |

MODEL III

A - CHARACTERISTICS

| Type of institution/ infrastructure | Nature of services rendered | Needs |
|---|---|---|
| Rural health centres manned by nurses, not institutionalised, still very much structured.<br><br>A team composed of a nurse and social worker. | - Preventive, promotive and curative<br>- Community health workers with simple medicines.<br>- Health Education, Adult Education<br>- Small income generating projects<br>- Kitchen garden<br>- MCH<br>+ Collaboration with Govt. and other agencies<br>- village meetings and discussions on different problems<br>- promotion of collective action. | - Better env sanitatior<br>- M C H Ser<br>- Supplement for a sect population |

B - APPROACH FOLLOWED

The approach followed is health extension approach. The following indi

| Indicators | Explanations |
|---|---|
| a Role of health services | - as it views that good health isthe res from other fields as economists, socia make services effective. |
| b Role of medical professional | - The medical professional is viewed as experts from other disciplines are als etc. Attempts are also made to include |
| c Role of Community health Worker | - CHW is considered as an agent of chang worker which include medical services, education, nutrition education, food p |
| d Community Participation | - Participation of the community is cons a resource base, a means to mobilize m material. Mainly it involves the comm |

| | |
|---|---|
| e Evaluation | - Concerned with assessing whether a program from health to economic development progra terms of health improvements for the least |
| f Financial support | - Used to build small health centres and to man power, moeny and material. The program |

## A - CHARACTERISTICS

MODEL IV

| Type of institution/ infrastructure | Nature of service rendered | Needs m |
|---|---|---|
| Rural health centres/ action groups<br><br>Flexible and non structured.<br><br>One team composed of a nurse and activitist. | - Services aimed at building healthy communities.<br>- Community diagnosis<br>- Critical understanding of health & its relation to unjust social order.<br>- Awareness building through non-formal education programmes.<br>- Organising the people for collective action.<br>- Exposing social illness<br>- Formation of Action groups, Mahila mandals, youth clubs, village committees, farmer's club, Trade unions.<br>- Demanding services from the Govt. from health as well as other departments.<br>- Identifying and training village animators.<br>- Promotion of low cost and simple home remedies. | - Basic r the pe their effort<br>- Better the Go |

B - APPROACHES FOLLOWED

In this model the comprehensive approach is followed. The following expl

| Indicators | Explanations |
|---|---|
| a Role of health services | - The concept of health is totally integr of the community. Hence health services point for development and a tool in pro |
| b Role of medical professional | - Since the role of health service is to structures (to bring about equity of op is viewed as a resource - an enabler, c the decision maker which defines the ro professional is accountable to the peop |
| c Role fo community health worker. | - Community health worker (CHW) is an ager selected by the community. Uses health about change in the attitudes and behav structures through health and developme social justice and social, political ar out the health and traditional communit called community level worker (CLW) sir |
| d Community participation | - Community participation in health is a over their own lives by collectively wo and political structures compatible with the poor. It starts with awareness bui decision maker in the community progra through a process of learning to live and take control of policies which affe |
| e Evaluation | - The community is the evaluator - it is decides on the objectives, priorities a ment worker, as an enabler helps the co itself is the tool and a method for co growth. In the entire process, stress people and the effort at bringing abou system and the establishment of alterna |
| f Financial support | - To spark off a programme finance is ne which is able to be sustained through through outside finances. The investme and expanded services. It also means m resources in terms of man power, mater it looks/seed money. Maximum efforts a at the cost of allowing them to dictat in its process of growth towards aware |

/for

CONCLUSION :

Community health is a term understood and interpreted in different ways by different people. This is due to the differences in the analysis of the ill health. Based on one's analysis the programme that is initiated would confirm to a particular approach and philosophy.

This paper, we think, would help the implementors of community health programmes as well as those who intend to start one to develop a still more reflective understanding. This understanding blended with our commitment to the poor would help us all to make our involvement more meaningful.

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# AN OVERVIEW OF VARIOUS SYSTEMS OF MEDICINE IN INDIA

All ancient civilizations developed their own systems of medicine : Ayruveda, Arabic, Egyptian, Greaeco-Roman, Chinese, etc... Most of them have been practiced in India to some degree. While western medicine or allopathy has been on the scene in India for only about 200 years it has entrenched itself and grown. But now there is a growing awareness of traditional systems like the ayurveda. The Indian system starts with the rigveda in 2000 B.C. and is known as Ayurveda.

Ayurveda in sanskrit means "the science of life". According to ayurveda there are three constituents in the psyiological system called 'doshas'. They are 'vayu'(wind), 'pitta'(bile) and'kapha'(phlegm). Good health results from an ideal balance between the three factors. The ayurvedic physician evaluates the patient and sets right the balance by means of drugs, diet and practices.

There is a predominant 'dosha' in one's constitution and this decides which foods and activities are suited for the person. Ayurveda teaches exercising the highest care in selecting what is wholesome in the matter of food, conduct and behaviour. It does not treat a person in parts. The body is dealt with as an integral unit.

In India today there are

243153 practitioners of ayurveda
1452 ayurvedic hospitals
11100 ayurvedic dispensaries
97 ayurvedic colleges.

Sidha The Sidha system which resembles ayurveda is said to have originated from the sage Agastya with its records in Tamil and is practised almost only in Tamil Nadu and Kerala.

105 Sidha hospitals
311 Sidha dispensaries
1 Sidha college.

Unani Unani Tibb came to India as early as the 13th century with the Persian scholars fleeing from Persia and Central Asia. With the support of the Mughal emperors, this system of Arab medicine took root in India under the name 'Unani' which is derived from the Sanskrit 'yavana' meaning Greek. It was the Greek 'father of medicine' Hippocrates who laid the foundation of the Unani system more than 2000 years ago. It is based on the Hippocratic theory of humours. Each person is a combination of four humours - blood, phlegm, yellow bile and black bile. One's temperament is sanguine, choleric, phlegmatic or melancholic depending on which of these humours predominates. The Unani physician treats a person's body as one unit and not the symptoms of the disease. It holds that the human body has its own regenerative powers. Medicine is given to help these regenerative powers to surface once again. There are in India today

28021 Unani practitioners
98 Unani hospitals
860 Unani dispensaries
17 Unani colleges.

Homeopathy Unlike other indigenous systems of medicine, there is controversy on whether homeopathy can be classified as'traditional medicine'. It is neither ancient as ayurveda or Unani nor is it native to India. But it has been so widely practised in India that the government recognises it as a traditional system of medicine. In the 18th century, Hahneman a German physician founded the principles of homeopathy. A basic principle of homeopathy is 'like cures like'. To strengthen the patients' reative powers, he is given a drug known to imitate the particular symptoms observed. In homeopathy it is not the disease that is cured but the symptom it generates in a particular individual.

In India there are today

122173 homeopathic practitioners
121 homeopathic hospitals

Naturopathy Holds that good wholesome food, enough sleep, exercise and no tension are prescriptions for good health. The main aim of nature cure is to prevent disease. It teaches a person the principles of balanced living. The body has natural ways to counter the onset of disease. The aim of treatment should be to assist nature in eliminating toxins from the blood. Suppressing the symptoms by medicine, only results in the basic disease becoming chronic.

In India today there are

97 naturopathy practitioners
10 naturopathy hospitals
26 naturopathy dispensaries.

Yoga Therapeutic yoga is basically a system of self-treatment. In any medical system the primary reliance is on medicine. In the yogic system this external agent is not needed at all - rather, it is the patient himself whose personal understanding, practise and care cures his disease. It ensures health by physical and mental purification through control of mind and body.

In India today are

3 yoga hospitals
6 yoga dispensaries

Acupuncture is a system of treating disease by penetrating needles to know points of the body selected according to the disease. Like the traditional chinese medicine system, the principles of acupuncture are based on the concepts of Yin and Yang, the universal opposites. Ill health is due to an imbalance between Yang(male, sun, sharp, strength, warm, positive) and Yin (female, moon, dawn, quiet, cold, negative) and acupuncture is designed to restore the balance. The art of acupuncture is widely known for its pain relieving abilities.

Acupuncture was introduced to India in 1959 at Calcutta by the late Dr. B K Basu a member of the Dr. Kotnis Medical Mission to China.

Allopathy The allopathic system of medicine was introduced into South India by the Portuguese in the early 16th century. It was spread by the doctors of the East India Company & European

However its costs are high, it makes people dependent on drugs, the side effects of its drugs and abuse of drugs are all drawbacks of this system

Today in India there are

297228 medical practitioners
7474 hospitals
26840 dispensaries
106 medical colleges

Modern medicine had brought hope for everybody once. But now people all over the world are looking for alternatives : In the west there is a growing demand for "alternative" herbal remedies and in the Third World it is now accepted that cheap readily available remedies should replace expensive western drugs on the market. Almost 70% of our people cannot afford the high cost of drugs and diagnostic proceedures of allopathy. Traditional medicinesare being recommended as an added component to India's health care system because they are cheap and do not have the side effects associated with allopathic treatment.

Sources

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3 Manorma year Book 1987.
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14-11-87/100

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Opp. Cantonment Workshop
P.B. No. 2126,
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## MINISTRY OF THE CHURCH IN HEALTH SERVICES

### Introduction :

"Action on behalf of justice and participation in the transformation of the world fully appear to us as a constitutive dimension of the preaching of the Gospel".

- Synod of Bishops 1971

"Behind the revolutions of our day, is man's struggle for human dignity. Christ is at work here and we cannot proclaim Him to contemporary man if we do not participate in this struggle. In such participation we have to work with men of all faiths and no faith. Christian living is, in this sense, living in response to the WORD and to the world. It demands the conscious transcendence of our limited groups solidarities and moving towards the new humanity which is free from all discriminations".

- National consultation on the role of Church in contemporary India, 1966.

"If we wish to be faithful to Christ and take up this attitudes with regard to our fellowman, we must work for the over all development of each man, and focus on the sick person more than on his sickness. Since development also means solidarity we must necessarily turn our attention towards the human community of the patient, his family first, but also his neighbourhood or village. This means we must practice community medicine".

- Pontifical Council Cor Unum, Document on Primary Health Care Work, 1978.

"The mission that we have given is a call for a true conversion of our hearts and also of our methods. Secularization is spreading in people's hearts from the industrialized and technological world to the developing world countries. We need to be converted all the time in order to bear witness as Christians to the sick who, through our work, will discover the love of Christ. The rapid development in the field of health service technology has

Since Christians are the leaven, we must reach out towards the masses by providing simple, accessible and promotional health care according to our own possibilities, modest as they are, or in conjuction with the public services, where this is allowed.

Let us ever be mindful of the fact that service to the sick begins and continues to operate through the patient's human environment. COMMUNITY HEALTH CARE IS THEREFORE PART OF THE COMPREHENSIVE PASTORAL WORK OF THE CHURCH".

- Cor Unum Document, 1978.

"Presently, despite the constraint of resources, there is disproportionate emphasis on the establishment of curative centres - dispensaries, hospitals institutions for specialised treatment - the large majority of which are located in the urban areas of the country .... A dynamic process of change and innovation is required to be brought in the entire approach to health man power development ensuring the emergence of fully integrated bands of workers functioning within the "Health Team" approach".

- New National Health Policy, 1982.

"The demand for justice has been one of the dominant notes of this half of the country. Perhaps no other period in History has witnessed a greater denial of justice also ..... 'The Church, bearing within itself the pledge of the fullness of the Kingdom, views with joy the present concern for justice and with anxiety the grave threats to justice all around us. It is her endeavour to interpret the implications of the Gospel message of justice and peace in the varying situations being unfolded in the course of the human pilgrimage on earth. She has to be the 'Leaven' and the 'salt' of the earth in the confusion likely to prevail in the search for justice".

- CBCI, 1978.

"The Church should give its whole hearted support to the peaceful social changes taking place in the country by verbalising its support of any efforts made for bridging the gap between the rich and poor.

"We want our health services to take primary health care to the masses, particularly in the rural and urban slums. Catholic Hospitals and dispensaries should stress the preventive and promotive aspects of health care. Specifically, we would urge them to join hands with the civil authorities in their programme for the eradication of leprosy.

Our health outreach programmes may demand a change in the routine especially of religious communities of men and women involved in this work, and their formation should prepare them to meet the new spiritual challenges that are posed".

- CBCI, 1978.

" The commission being conscious of :

a the situation of massive poverty of over 60% of our people;
b the unjust structures which maintain and perpetuate it;
c the injustices perpetuated on the weaker section of the people;

considers it imperative to reaffirm our commitment to the poor in imitation of Christ's preferential option for the poor.

The creative struggle of the people to bring about a new society invites us to enter into critical collaboration with people of all religions, ideologies and agencies who strive after a just society.

A meaningful participation in this struggle calls for :

a. a serious analysis of society with the tools of social sciences and in the light of faith;
b. taking definite and unambiguous stand on various issues;
c. initiating concrete action programmes for change.

As a credible sign of this process the Church initiates action for justice within its own structure. In this context participation of all sections of people especially of the laity is of vital importance".

- CBCI, 1983.

"With this orientation in view the Commission proposes the following priorities of work, in the field of health :

1 Promote Community Health Programmes on the Priority basis;
2 Train health care personnel with a bias to rural health

3 A commission could be set up to study the prevailing conditions and problems, attitudes and values of doctors, nurses, para-medical personnel and other employees.

- CBCI, 1983.

The relevance of quotations cited above can be viewed by different people differently depending on the concept of health one has. One thing is getting more and more clear that health is no more an isolated factor and it is not merely the absence of sickness but the total well being social, physical, mental and spiritual of individuals, families and communities. It is in this sense that the above quotations have their relevance when dealing with ministry of the Church in Health Care.

Health care is a field in which the Church in India has been busy for over a hundred years. With more than 2000 health care institutions all over the country run directly by the dioceses or religious congregations, the volume of work done by the church is enormous. With one well established medical college and more than hundred nurses' training institutions we train every year an army of health care personnel and add to the already existing ones in the field. With the emphasis since some years on the field of community health, a new army of village level health workers (called under different names) are trained and they are in the field. We have also national organisations, under the auspices of the Church, dealing with various aspects of health care i.e. the Catholic Hospital Association of India, Catholic Nurses' Guild, Catholic Doctors' Guild, Natural Family Planning Association of India etc. This certainly shows the richness of the resources at our hand. The question will have to be asked is are all these properly utilised for the best interest of the people of God in India particularly the vast majority of them living in rural areas and urban slums.

1. COMMUNITY HEALTH :

CHAI has definitely committed to this cause for the coming years. And we do hope to do something thereby contributing our share to achieve the goal set by WHO and accepted by our country, i.e. Health For All by 2000 A.D. This we hope to achieve through our member institutions and others, and with the cooperation, help and guidence particularly from the members of the CBCI and CRI. We have now an eight member team for the promotion of

2. Promotion of Pro-Life Activities :

Efforts will have to be made by all concerned to bring an awareness about the seriousness of this all important aspect of life. CHAI will be taking some definite steps in this regard in the coming years.

3. Pastoral aspect of health care :

This is a field rather neglected by the Church. Complaints about even rude behaviour by the Staff towards patients in our health care institutions are not a rare phenomenon. Then the question is, have we given them the necessary training and orientation ? Keeping this in mind CHAI organises seminars for health care personnel from time to time. It is our plan to develop a separate department in CHAI to meet this crying need in our country. We also plan to organise regular residential course for Chaplains etc. in the future.

Against all what has been mentioned, particularly the various documents mentioned, the following suggestions are put forward for Justice, Development and Peace in General and the health section in particular. In this connection, it was very meaningful to have put the health section with commission for justice, development and peace.

1. To have an evaluation of our existing institutions for education, training and services in the field of health in accordance with the present concept of health mentioned in the documents ( of also the CHAI documents )
2. Community Health Programme accepted as a priority should be promoted in all the Dioceses. The members of the CBCI and CRI should accept this end and make it known to all our health care institutions.
3. In order to implement this, St. John's Medical College, National Organizations like CHAI, NEPAI, CARITAS INDIA, IGSSS etc. will have to plan together in collaboration with other organisations in the field such as VHAI, CMAI, ISI etc.
4. Possibility of organisations like, CHAI, Catholic Nurses' Guild, NEPAI to work together will have to be explored, for better effect and to avoid any unnecessary duplications.
5. The teaching of the concept of Community Health based on

6. In this connection this commission will have to work in collaboration with the commission on Seminary Training etc.

7. This commission should also work in collaboration with the commission for Laity and Family.

These are a few suggestions, however practical they may be which came to my mind. The implementation of them may be difficult but necessary if we want to respond to the needs of the time. We all agree that making statements (for which we seem to be experts in this country) alone will not solve the problems. We need to translate them into action, which is by far difficult. But we are left with no choice but to do it if we want to be meaningful to the society today and faithful to the gospel message. Let me conclude this with another quotation, this time from Ashok Menta.

"We must reclaim 900 million people (the number is more now) of the world who are today in a state of abject depression. This human reclamation requires a peculiar type of social engineering. This is to my mind the big challenge that all people, all men of religion, all men of God have to face. And if it is the proud claim of the Christian Churches that they have that spiritual understanding, that spirited agony and that spiritual out glow is greater than that of other men of God, it has to be proved, as I said in the crucible of life itself. If it is the claim of Christians that even to this day they feel the agony of Christ on the Cross whenever humanity suffers as it were, it has to be proved, in action and not by statement".

Fr John Vattamattom svd
Executive Director
Catholic Hospital Association
of India.

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MOVEMENT AGAINST REPRESSION (MAR),1-1-296/1,ASHOK NAGAR,HYDERABAD.

NTR POLICE RAJ IN ANDHRA PRADESH .

The A.P.Police has once again figured prominently in the national news.This time it is the increasing number of custodial deaths which earned them notoriety, In September month alone six people have been tortured to death in six different police stations.The deaths occurred in Tungathurthy Police station (Nalgonda Dt.) , Vijayawada V Town police station (Krishna Dt),Gudjala police station(Guntur),Banswada police station (Nizamabad Dt),Bellampally police station (Adilabad).In 1986 so far 16 people have been killed in lock-ups.And all together 61 people have been tortured to death in the police stations since NTR has assumed po wer.

In all the instances police tried to portray the deaths as natural deaths or sucides.But civil rights organisations have brought into lime light the facts about the incidents.In all the cases the persons who died in the custody were hail and healthy at the time of detention.All of them died due to torture in the lock-up.In two instances even the judicial enquiry has proved that police men are guilty of murder.These enquiries were conducted t into the death of G.Rama Rao and Prabhakar Rao in Vijayawada and Chirala Police stations respectively.

In view of the massive protest against the custodial deaths from defferent sections of the society and the extensive punlicity given to these incidents by the press the government was forced to order judicial enquirty into the six custodial death incidents that occured in the month of September 1986.However a careful scrutiny of the state ments issued by the government only shows the dual attitude of the government regarding the gustodial deaths. The government has announced that judicial enquirty would be ordered into all the custodial death incidents.Further they also stated that guilty police men would not be spared.But it is note worthy that judicial enquirty is ordered into eight incidents of custodial deaths only. So far only one police official is punished.In the remaining cases FIR is filed.But that is no guarantee that criminal proceedings would begin.Police may close the case by saying that there is no evidence to prove that the policemen are guilty.In fact government has preferred judicial enquiry instead of launching criminal proceedings against the erring policemen,only to delay the matter.The government appears to be dragging its feet in punishing the guilty policemen.The statements made by the Chief Minister that "police men are gods" and that "they are his right Hand",prove this point beyond doubt.

The 'encounter' incidents,for which the state was famous,are also occuring with equal rapidity.Since NTR has assumed power 52 people have been killed in 'encounter's'. In September 1986 alone 4 people were killed in fake 'encounters'. While two were killed in Warangal town the other two died in 'encounter' in Karimnagar and Nizamabad.

It is well known fact that during emergency period 77 people have been killed in 'encounters'.The Tarkunde committee,which enquired into these 'encounter' deaths has characterised them as cold-blooded murders

After three years respite these incidents started recurring again. There is one noticeble feature about the encounter death incidents in the post-1980 period.During this period many people were killed brazenly in the towns itself.During the emergency police men used to kill the detained persons in the forest areas to show that a real 'encounter' took place.As the government is totally supporting the policemen they now kill the detained person in the vicinity of towns with impunity.

The repression on the people in the rural areas of Nizamabad, Warangal,Karimnagar,Adilabad,Khammam and East Godavari districts is even more henious.Crops are destroyed,houses are pulled down, property is damaged with out compunction. In Karimnagar alone 350 houses are estimated to have been destroyed by the police in the past two yeats.In two weeks alone, commencing from 1985 August last week,81 houses were destroyed ,in Karimnagar.

In the tribal areas people are chased w away from houses and the entire village is burnt down.In boath,Utnoor and Khanapur talukas of Adilabad district alone 20 villages have been burnt down.Many such instances also occurred in the tribal areas of East Godavari district. Women are the worst victims.In many tribal areas women are subjected to sexual harassment.

Mass arrests and torture is yet another form of harassment.Between 1985 September and 1986 May 408 people were arrested in Mahadevpur tq. of Karimnagar.In theensuing torture it is alleged that 3 people died. Many people bribe the policemen to escape the arrest and torture.

The houses of various leaders of Rythu Coolie Sangham are being raided everyday in Warangal district in view of the anti-arrack contractors agitation.The arrack contractors onit crores of rupees by duping the people and the police is deployed to safeguard this exploitation. The house of Smt.Phoolamma,president district RCS was raided twice and their relations abused and insuited by the police.

In none of the Telangana districts meetings are permitted. In 1986 itself attempts to hold RCS conference in Aleru,Nalgonda district were foiled.All the delegates were chased away by the police.Police prevented a convention on drought in the same district in the month of June 1986 . The attacks on the civil rights organisations should be seen against this backdrop.As the civil rights groups are bringing into lime light the police excesses and illegal activites they have become target of the police attacks.Members of the civil rights groups are implicated in cases,threatened and physically assaulted.Every attempt is made to silence the protest against the police assault on the rights of people.

We are sending to you this note to seek your support to fight against the police o raj in Andhra Pradesh.

Yours Faitnfully,

Dated:24-10-1986.

(T.MADHUSUDHAN RAJ)
CONVENOR.

# GUIDELINES FOR THE MAINTENANCE OF RECORDS IN COMMUNITY HEALTH AND DEVELOPMENT PROGRAMMES.

A good record system helps us to plan, implement and evaluate our work effectively. It also aids in the smooth running and systamatic functioning of the programme as well as for its continuity in the future.

Why records are important?

1. Records are important in setting objective, evaluating our work and modifying them if necessary. For example, inorder to build a healthy community, we have to make the community realise that many diseases are preventable; we have to record the illness they suffer from; how many are suffering from preventable diseases; what are the social illness found in the community; how diseases are influenced by socio, political, economic and cultural factors etc, have to be identified from the records.

2. Records facilitate the smooth functioning of our work as well as to build good rapport with both govt. and funding agencies inorder to avail their assistance in our work.

3. An effective report should contain components such as: AN INTRODUCTION containing the statement of the problem or task; THE SUMMARY of what has happened; BODY of the report contains the method used, significant facts given in the body of the report; RECOMENDATIONS OR SUGGESTIONS; And the appendix containing a table as well as less relevant informations.

## Records and report necessary for community health and development Programme.

I. Minutes book
II. Village Diary
III. Daily Diary or Chronicle
IV. Family Record.

## I. MINUTES BOOK

Why do we maintain a minutes Book?

a. It helps the team to plan ahead the activities to be carried out during a limited period of time.

b. It gives the team the opportunity to discuss and plan together the activities to be implemented.

c. It also gives them the chance to set priority for various activities within the limited time.

d. Team spirit is strengthened by their role assignment and getting support and strength from each other.

e. Planning helps in performing the task more systematically.

f. It also paves the way for evaluation and assessment of the team work.

g. Setting time limit for the implementation of programmes and evaluation, helps us to keep up with our work.

HOW TO MAINTAIN THE MINUTES BOOK?

Though minutes refer to the summary of the meeting or discussion that had taken place with its various details, here we refer to both the evaluation of the activities since last team meeting and the plan of action for a specific future period ( eg; 15 days)

In the beginning of the team meeting itself the report of the previou team meeting should be read. Special attention will have to be given to the second part of the previous report, which is the plan of actic since we have to evaluate them in the beginning of the team meeting itself. For example: The team members A, B and C had their team meeting on 1-3-1985. In that meeting the following activities were planned.

1. Visit to BDO office before 7-3-85, by A & B.
2. Discussion with the Parish Priest on 9-3-85
3. Visit to the Programme village on Tuesday and Friday.
4. One meeting of the women group 'C' will lead the discussion on 'attrocities of women'
5. Meeting with the sisters of the community on 14th. 'B' will initiate the Discussion.
6. To have the next team meeting on 15-3-85.

Minutes of the team meeting on 15th March, 1985.

The meeting started at 3.00 p.m., members present - A, B, C

Topics to be discussed (Agenda)

1. Formation of youth groups
2. Immunization of the children
3. Non Formal Education for women.

After fixing up the agenda, the report of the previous team meeting (ie. 1-3-85) is read out and an evaluation of all the activities in particular is done. For Example

Evaluation of the Previous Plan of Action.

1. Unfortunately BDO could'nt be met, since he was on leave. In a way it was good because 'B' could not go that day because of illness, and 'B' only had met him before.
2. Though the meeting was fixed on 9th, since the Parish Priest was busy we had the meeting on 13th. He listened to us but not with much interest. Perhaps we should invite him to the village once.
3. Except on 13th Friday we visited the programme village as planned. This was because of the meeting with Parish Priest.
4. The discussion could have been more interesting and participatory if some photos or paper reports could have been used. 'Malathy' could have been asked to share her own experience with the group, and with that we could have started the discussio However 'C' did a good job in helping the women to think more.
5. Since we had two (two) guests on 14th the community meeting could not be held

We learned that women are more interested to be silent listeners than active participants. We have to think of different methods and techniques to be used for discussion with them.

The following are the plan of action for the next 15 days:

1. To conduct one youth meeting to know the interests of the youth. 'B' will be in charge of it.

2. Make a survey of the village to know how many children are there without immunization. 'C' will take care of it.

3. Begin informal discussions with the women to motivate them for non formal education.

4. Briefing of the work with the community on 17th January. 'B' will initiate the discussion.

5. Visit to B.D.O. office on 21st. 'B' & 'C' will go to BDO.

6. Meeting with the women on 26th. 'A' will prepare a set of cartoons to help the discussion on Unity.

7. Visits to the programme village will be on Tuesdays and Fridays. Other villages will be visited depending on the convenience.

The meeting was concluded at 5.30 p.m.

II. VILLAGE DIARY

Village diary is a record of significant events which we have seen or heard about during our village visits. It is also a record of our own thoughts, feelings and observations about our village.

Why do we need to keep a village diary?

1. It helps us to see the change in our villages over a period of time. These changes could be:

   - in people's attitude towards us
   - in people's living habits
   - more unity in the village etc

   Eg. After working for a number of months in a village the local dai brings a pregnant woman to us for examination. This could mean that the dai has finally accepted us as persons who will help her and not try to take away her livelihood. She has changed her attitude towards us!

2. It helps us to see the change in our own attitudes and behaviour towards the people we are working with. Over a period of time we have:

   - developed greater trust in the people
   - understood the reasons for certain habits in the village
   - learnt how to resolve conflicts in village meetings etc.

3. The above points are extremely useful in evaluating the effect of our community health programmes. Changes in attitude and behaviour are difficult to evaluate, so making note of significant events in the village can help us see the change over a period of time.

4. A village diary can help a new member of the team familiarize herself with all that has been happening in the village. It will help her to get to know the finer details of the village in a shorter time.

How do we maintain the village diary?

1. Keep a separate diary for each village.

2. Note down the date of the visit.

3. Below the date give a short summary of the visit. This should include the following:

   a. Any significant event like discussions with the Sarpanch, village leaders, quarrels in the village etc.

   b. Any observation and tentative conclusions drawn from the observation.

   c. Plan of action if any for the next visit.

4. All village meetings must be recorded even if they are routine meetings.

5. Make it a habit to fill in the village diary immediately after the visit, otherwise you will forget to note down important points.

6. It is necessary to record every single visit to the village.

Events that took place in the village (Example)

April 10th: We visited the programme village named Bhedia. We went to the house of Panchayat President Mr Ramen who was getting ready to go out on an important errand. Hence he promised that he would meet us on Friday at 4 p.m. We found that inspite of the fact that he was in a hurry, the President showed interest in us and so, he promised that he would meet us on Friday. After he left, we spent some time with his wife who extended her warm welcome to us and asked us the purpose of our visit. While we were explaining, she showed great interest which gave us encouragement to go there again. She told us that he was teaching in the village school and she will be glad to render any services to us. Thus we came home happily.

April 15th

We visited few houses in different parts of the village and we found that, on the whole the people were very welcoming. Many were asking us to come again to their village, preferably after

happy to meet us again. We discussed with him in detail about the purpose of our visit to the village. He seemed to be very understand and really interested in his people. He invited us to the village meeting which ~~will~~ be held on April 20th to attend the village meeting.

April 20th

We reached the village to attend the village meeting. The president and about 40 men and 10 women participated in the meeting. The president introduced us and our purpose in visiting the village to the people. On hearing this, the people were happy and showed interest in their work. They asked us to attend the village meeting every month and this gave us encouragement to start our work with confidence. The meeting was concluded at 8 p.m. after which we came home.

III. DAILY DIARY OR CHRONICLES:

Daily activities of the sisters working in the health team have to be recorded in brief, in the daily diary.

Why do we need the daily diary?

a. It helps the sisters to recall the various activities undertaken by them during each day of the month, year etc

b. It helps the team during evaluation to see how many days they have spent for their work, whether that is sufficient etc.

c. It also helps in the continuity of the work when written chronologically.

How to maintain the daily diary or chronicles:

February 10th - Visit to the programme village.

February 11th - Preparation of assignment, reading, study etc in the convent.

February 12th - Visit to Gody village ~~adjacement~~ adjacent to the programme village

February 13th - Visit to PHC and discussion with the Doctor

February 14th - Community meeting in the convent for discussing the village work.

However, the details of visits in the programme village such as what happened in the village during the visit, what discussion was held in the PHC in relation to the programme village etc., will be given in the village diary while the content of the community meeting will be written in brief in the minutes book.

IV. FAMIL RECORD:

Why do we maintain a family record?

a. Family record gives the history of each family with its members and their particulars.

b. It gives an idea about the size of the village, family etc.

c. Since it contains various details about each family, it is a help to establish better rapport and inter-personal relationship with the members of the family.

d. It helps in immunization programme and to identify the ~~member~~ members of youth both boys and girls, children, men, women etc. Who could be organised into different groups.

How to maintain a family record.

House No.....

| SL NO. | Name | Age | SEX | Head/relation to head | Marital Status | Educat. Quali. | Occup tion |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Two pages at least should be set asile for each family in which the various details of that family is recorded. As visits are made regularly to some family, some more details containing confidential matters could also be noted which will help us to understood persons in a better way.

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Com H- 16.17

| SYMPTOMS OF DECAY | SOLUTIONS SUGGESTED |
|---|---|
| 1. Exploitation of the poor<br>- in the market place<br>- by business men<br>- by media | |
| 2. Harassment by officials<br>- corruption<br>- bribery | |
| 3. Landlessness/Land alienation | |
| 4. Lack of food | |
| 5. Adulteration of food | |

SYMPTOMS OF DECAY

SOLUTIONS SUGGESTED

6. Lack of safe drinking water

7. Lack of proper facilities
   - education
   - transport
   - govt. health care
   - communication facilities

8. Lack of credit facilities

9. Money lending practices

10. Low Wages

11. Lack of knowledge in legal matters.

| SYMPTOMS OF DECAY | SOLUTIONS SUGGESTED |
|---|---|
| 12. Illiteracy | |
| 13. Inferiority Complex | |
| 14. Unemployment | |
| 15. Migration | |
| 16. Bonded Labour | |
| 17. Child Labour | |
| 18. Child Marriage | |

| SYMPTOMS OF DECAY | SOLUTIONS SUGGESTED |
|---|---|
| 19. Exploitation of Women<br>- no decision making power<br>- female foeticide<br>- wife-beating<br>- Purdah system<br>- rape<br>- prostitution<br>- dowry system<br>- widowhood-remarriage<br>- female invalidism<br>- property rights<br>- occupational hazards<br>- undernutrition and mal-nutrition | |
| 20. Discrimination on the basis of caste | |
| 21. Alchoholism, smoking.<br>- leading to quarrels<br>- poverty & ill-health | |

| SYMPTOMS OF DECAY | SOLUTIONS SUGGESTED |
|---|---|
| 22. Extravagance in marriage and other celebrations | |
| 23. Fatalism. | |
| 24. Individualism.<br>- lack of unity | |
| 25. Environmental pollution<br>- no sanitary facilities<br>- pesticide pollution<br>- water pollution | |
| 26. Unhygienic Housing | |

| SYMPTOMS OF DECAY | SOLUTIONS SUGGESTED |
|---|---|
| 28. Rapid urbanisation<br>- increasing number of slums | |
| 29. Loss of respect for the culture and traditions of people.<br>- craze for "modern" & "foreign" things | |
| 30. Unquestioning faith in doctors and medicines | |
| 31. Commercialisation and privatisation of health care. | |
| 32. Proliferation of irrational drugs.<br>- ineffectiveness of drugs<br>- lack of essential drugs<br>- massive misuse of drugs | |

| SYMPTOMS OF DECAY | SOLUTIONS SUGGESTED |
|---|---|
| 33. Non-availability of vaccines | |
| 34. Sexually transmitted diseases<br>- AIDS | |
| 35. Religious fanaticism<br>- communalism<br>- religious fundamentalism | |
| 36. Lack of committed leadership | |

Com H-16-18


# THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

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## STRUCTURES AND SYSTEMS :

(This is an attempt to understand and explain certain terms and expressions often used by Social Scientists and others to express their understanding of Society and to analyse it. This is not a critique of the structures and systems but just a theoritical description)

The term 'Structure' is used today to understand various realities, which are related to man's life. The word 'structure' evokes in our minds the image of various parts, components or elements organised into a unit. Infact the different elements of a structure can be understood only in through their relationship with one another and the totality. There is a functional relation between them. This can be illustrated by the example of the diverse organs of the human body, which are parts of a whole, as as such draw their meaning from their relationship with one another and the whole.

When we apply this concept of structure to the field of human activity we can identify certain structures there too. For instance, a family, an army, an institution, in it each person possesses his position and status as well as his own role and funtion. Each person carries on his task in relation to others and to Society.

In the simplest understanding this term is applied to understand a construction, a building, a set up because of which the transformation or change of structure is often understood as getting rid of a demolition of a building or an institution. We use this term to understand the social realities and functions of the Society. Social position can be defined as the particular point occupied by a person or group in a Social Structure. This is often identified with social status and includes the set of attributes or priviliges attached to that position. In the context for example we have the caste system, the hierarchy of castes with their attributes and previliges or discriminations.

There are established patterns of behaviours and standardised procedures - and we can say that the interactions are institutionally defined and controlled. In other words, we can say that a Social Structure is a set of - institutionally defined and controlled - relations between individuals and especially groups; these relations are studied and understood through a proper analysis of the society which will bring out the various control measures and hidden mechanisms which control and limit man's life and actions.

Different structures have different interests and values, often they become conflicting and one tries to control the other or overpower the other, which leads to disharmony, tension and exploitation. Thus the very structure itself becomes oppressive, dehumanizing and exploitative. The powerful structures force their ideology, values, rules and regulations on therestof the community to dominate them and keep them under their control, unless suitably challenged gives them more power and better positions in the Society. This controlling mechanisms is often not understood by the vast majority of the poor sections of the society and thus not in a position to counteract, as often the powerful use ideological system to achieve this end. In this process the injustices get institutionalized and in turn internalized by the society. Thus it becomes an established order of behaviour and remained unchallenged until someone wakes up andunderstands the undercurrents and the diverse mechanisms employed to achieve this end. This structure today we call an unjust structure.

A social system can be defined as a coherent complex of structures and behaviour arranged according to time and space. A system is a broad unit comprising several structures which interact as different components do in a structure. The structures of Production, distribution, exchange and consumption for example interact and form a single economic system. And the various social systems similarly interact and make a 'global system' or Society. A Society is comprised of the economic, political, social, religious, cultural and ideological systems. The first three systems concern the organization of Society while the last three deal with the meaning that men give to their individual and collective life.

Religious and cultural systems don't seem to be of much concern to them, though Marx has a critique on religion.

## Economic Systems

Every individual and Society has to satisfy certain physical and psychological needs or wants, as for example food, clothing, shelter, medicine, entertainment etc. Man's Primary and basic activity is that of Production. The economic system comprises of four basic structures : Production, distribution, exchange and consumption. In the process of producing and circulating the material goods that meet these needs man relates to nature through certain technological tools called instruments of labour. They also relate to one another and form certain relations. The sum total of all these is called the economic system.

## The Political System

Man basically is a being with intellect and will which enable him to make decisions for his own benefit and that of the society. But when there is a bigger group, individual decisions can affect the common good and hence there is need for a joint decision making to ensure the benefit of all the members of the society. This process of making the decisions is the political system. When this decision making power is exercised through the elected representatives of the people we have a democracy ; a rule (govt.) of the people, for the people and by the people. This is to ensure a smooth functioning of the Society/Nation. The decision making power is handed over to the elected representative so that rules and regulations can be made to the advantage of the whole community. Historically speaking we also come across many others forms of government. Autocratic, Military and Monarchy. Even in a democratic system the common good very much depends on the ideology behind, namely capitalist or Socialist approach.

## The Social System

Interactions between man and man, and between social groups when structured and institutionalized becomes the Social System. This concept implies a certain distribution of Social Prestige and Status, or in other words a certain Social Stratification understood as the differential ranking of human individuals,

Various factors do, or can contribute to form this social stratification in different types of societies. In the Indian context the social system influenced and determined by caste system , which divide the people into high and low on the basis of birth. Set of rules and regulations are established by the society in terms of man's life, relationships and behaviour, hence traditions, customs become part of this system. But today we realise that there is a class caste combination which controls and dominates each aspect of Indian Society.

Religious System

Religion basically is the established form of Man & God relationship. This relationship when organised and institutionalised becomes a religious system which regulated and controls various aspects and structures in terms of worship, Morality, ethics and values. It is distinguished from other meaning systems by its emphasis on the ultimate. It offers a systematic message capable of giving a unified meaning to life, by proposing a coherent vision of the world and of human existence, and by giving them the means to bring about the systematic integration of their daily behaviour. This message is always situated in a precise historical context, and provides believers, reasons justifying their existence as in a given social position.

Cultural System

Culture could be said as the sum total of Man's Social Life in a geographical, historical context in terms of the values expressed through attitudes, thinking pattern and behaviour which are manifested in the customs and traditions in a given sociological Milieu. Knowing the people is to know their culture : Why they behave and act in a particular way, what decides their life circle, why certain parctices exist, why they have certain value systems etc. The value system in turn also influences their life and activity. The very value system is also very much influenced by the religion they practice. Thus culture and religion has a close link.

Ideological System

The term ideology was first used in 1797 by Claude De Tracy as

ideas and judgements which serves to describe, explain, interpret or justify the situation of a group or collectivity and which largely inspired by values proposes a precise orientation to the historical action of this group or collectivity. Houtart speaks of ideology as a system of explanations bearing on the existence of the social group, its history and ins projection into the future, and rationalising a particular type of power relationship : The legitimation that an ideology provides to a social group is never absolutely logical, but contains emotional elements which are capable of motivating men and giving them a feeling of security. Ideology is thus a fundamental element in the culture of every human, ethnic, social or even religious group. In this modern sense, ideology always includes in a more or less explicit manner an understanding (analysis) of society, a vision of the future, and a choice of strategies and tactics understood in this way. The concept of ideology can be used for both a small group (trade union, political party etc.) and a whole society or nation. They foster the interest of a particular group in society, and promote a specific socio economic and political organisation. They can be classified as reactionary, conservative, liberal and revolutionary.

* * * * * * * * *

20-11-87/250

SP:mm

# MICRO LEVEL VOLUNTARY HEALTH PROGRAMME

## A Case Study

Village S is situated off the national highway on the main bus route to the taluk headquarters. It has a population of 3000 people. The main occupations of the people are agriculture, sericulture and dairy. A few families weave carpets out of unprocessed sheep wool. The land is owned by 65 per cent of the families. The plots range from half an acre to twenty-five acres. 35 percent of the people are landless labourers. Most of them are harijans and they live in a separate part of the village.

The village has a primary and middle school, few shrines and a chawki rearing centre. The Government health centre (PHC) is 8 kms away and one of its subcentres is 2 kms away. The highlight of the village is a milk cooperative which collects 3000 litres of milk per day and sells it to a government dairy in the city 45 kms away. The cooperative provides feed, fodder, fertiliser, tractor facilities and loans to all its members which include 45 percent of the families.

## Health Programme

1973-75 : A voluntary agency (VA) based in the city and interested in community health work initiated discussions with the leaders of the milk cooperative to start a health centre in the village. As an experiment in self-support the cooperative agreed to set aside 3 paisa per litre of milk for health activities. From the Rs.2400 - 2700 that was available each month through this scheme, the VA assisted the cooperative in identifying a doctor and nurse from the city to work in the centre. Three villagers were identified, to be trained informally as record clerk, compounder and dai.

The health cooperative (HC) was run by a committee which consisted of leaders of the milk cooperative and representatives of the VA, government dairy and PHC. The doctor was the secretary of this management committee. It met every month to assess and plan the work of the centre.

The HC rented out an old hotel for the centre and some accomodation for the staff. Medicines were brought at wholesale rates from the city. Tonics and injections were stocked to prescribe to non-members and supplement the income of the centre. Some medicines, vitamins and vaccines were tapped from the PHC. The VA provided technical advice and obtained donations of medical equipment and a motor-bike for the doctor from foreign donor agencies.

He provided curative services through a daily clinic. Preventive and Promotive services which included maternal and under-five child care, immunizations, vitamin and iron supplementation, chlorisation of wells and film shows were also organised. Curative services were available free to members while non-members had to pay a nominal cost. Preventive services were available to all free of charge. Poor non-members families were

The doctor and his wife started a Mahila Mandal which organised a balwadi, child feeding programme and obtained a sewing machine for the village women. A young farmers club was also started which organised games for village youth and helped the centre during immunization, health and education programmes and specialist camps.

1976 : The cooperative stopped setting aside Rs.200/- per month for concessional treatment for poor families. The VA took up this responsibility. The doctor left the centre after differences of opinion with the leaders and started private practice in a neighbouring village. The VA helped the centre to identify another doctor. The Mahila Mandal closes down and the sewing machine is kept by a panchayat leaders wife.

1977: The nurse left the centre after training the dai in all aspects of the centre's work. The committee tried to find a replacement but ultimately decided to appoint the trained dai as the 'nurse' of the centre. Committee meetings were held once in 3-4 months.

1978 : The milk production in the village came down drastically while sericulture increased in the area. The health cess per litre became too high to run the basic health services. Since it was difficult to cooperatise sericulture the milk cooperative after some hesitation invested some money it had kept aside for a chilling plant, into a fixed-deposit endowment for the health centre.

Because of the increase in sericulture, landless harijan families began to get more work and many acquired a local milch animal. They tried putting some milk into the common pool to get membership status and free health facilities. The cooperative committee closed membership to keep them out.

1979: An evaluation was done to study the impact of the centre. It found that though all families were aware of the centre, some of them did not utilise its services. Some richer families preferred private practitioners in neighbouring villages. Many landless families had apprehensions about theattitudes of some of the staff. Triple antigen and polio immunizations had been given to 85 percent of the children. Malnutrition and Vitamin A deficiency had not improved - in fact there were indications that it had become worse. There was no change in environmental sanitation. The centre did no family planning work, because of the church connections of the VA.

1982: The centre got its fourth doctor since 1977. Each of the previous ones had stayed for periods ranging from few months to two years / with the help of government subsidy and some savings the cooperative also built a health centre and medical officers quarters. The VA donates furniture and more equipment to the centre.

Task: 1. What are your impressions about this health programme ?

## CHILDREN'S SERVICES

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | | | 9 | | | | 10 | | | | | | | | | | | | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | D P T | | | | P O L I O | | | | WEIGHT OF THE CHI[illegible] 1981 | | | | | | | | | | | | REMARKS |
| Date | From Road to Health Chart Child's No. | House No. | Father's Name | Child's Name | Child's Date of Birth | BCG | 1 | 2 | 3 | Booster | 1 | 2 | 3 | Booster | January | February | March | April | May | June | July | August | September | October | November | December | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |

## MATERNAL SERVICES

EYPECTED MPNTH OF DELIVERY : SEPTEMBER

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | | 9 | | | | 10 | | | | 11 | 12 | 13 | 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | DATE OF FIRST ANC CHECKUP TRIMESTER | | | TETANUS TOXOID | | | | DETAILS OF DELIVERY | | | | | | | REMARKS |
| Date | House No. | Mother's Name | Husband's Name | Mother's Age | Parity | E D D | I | II | III | 1 | 2 | 3 | Booster | Date | Type | Place | By Whom | Still/live birth | Sex of child | Birth weight | |
| | | | | | | | | | | | | | | | | | | | | | |

TABLE III

OUT PATIENT RECORD

| 1 S. No. | 2 Name of Patient | 3 Age | 4 Sex | 5 Caste | 6 Village | 7 Diagnosis | 8 Treatment | 9 Register | 10 Actual cost of Medicine | 11 Service charge | 12 Total charge | 13 Amount paid | 14 Concession | 15 REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |

## VALUES & VALUES (F)

Miss Sumati was from a very poor family. She lived in a hut near the bank of a river. She was in love with Mr. Sunil, who lived on the other side of the river, and was also from a poor family. This love affair was known to both the families.

One day Sumati heard that Sunil is seriously ill. It was monsoon time and the river was overflowing. She had to cross the river by a country boat. But she had no money to pay the boat man. She approached Suresh, her neighbour to borrow some money, but he refused to give. She then met Shankar, the boat man and explained to him the situation, and assured him that she will pay him the boat fare later. Shankar insisted that only if she pays the boat fare (Rs. 2/-) he will take her to the other side of the river. She pleaded with him and told that her lover is seriously ill, and that she must meet him immediately. Shankar told her that if the matter is so urgent he will take her to the other side on the following day provided she is prepared to sleep with him that night. When Sumati realized that arguments were of no use she agreed to the condition.

On the following morning Sumati reached Sunil's house, and in the course of their heart to heart talks, she narrated the hardships she had to go through inorder to meet him. Sunil got a shock of his life when he realized that Sumati is no more a Virgin, and in his anger he beat her and chased her out of the house. Sumati returned home very sad and frustrated.

When Sathish, her brother asked Sumati the reason for her sadness she told that Sunil rejected her and she was ill treated and beaten by him when she visited him at his sick bed. Infuriated by this Sathish rushed to Sunil's house, pulled him out of his bed and killed him.

Who is the most virtuous character in this story? Why?

Who is the worst character in this story? Why?

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# A NEW WAY TO SOLVE AN OLD PROBLEM: AN EXPERIMENT IN ADULT LITERACY

( J.T. Matheikal, St. Xavier's Delhi )

As Freire explains ( of his books "Pedagogy of the oppressed" and "Cultural Action for Freedon"), it is not enough to give a person the ability to read and write, if our basic concern is to enable him to achieve more human conditions of life. More important even, he should be enabled to see what elements contribute to his dehumanised situation and he should be helped to acquire the conviction and confidence that he can bring about greater humanisation by action on the unjust order that oppresses him

This new method of adult literacy was tried out in a pilot programme undertaken by an AICUF Unit of Delhi. It has been found that it could train a group of people, who did not know how to read at all, in such a way that in only five weeks of our one hour sessions per day, they could begin to read the Hindi newspapers. In this period they learned how to write two or three paragraphs, in simple Hindi, on a variety of topics. Along with this literacy achieved there were several other benefits also that came to these people. These will be pointed out later as they will be understood best perhaps only after the method has been explained.

## THE METHOD

First a picture, preferably of a social situation common to their daily life, eg. that of a bazar (market place), is shown to the group. They are asked questions about the situation depicted in the picture or about the people who appear it, and they are helped to discuss the event in their daily life symbolised by the picture. This discussion will last ordinarly for about half and hour, but the duration can be adjusted to the exigencies of the session.

This discussion has the very important function of enabling the adult-students to acquire a critical comprehension of the social reality, the first step in conscientisation, according to Freire. The picture helps the student to objectify the social situation and gain a certain psychological distance from it. The unreflecting illiterate, on the contrary, experiences himself submerged in the world. "With no possiblity of emerging from it, and adjusted and adhering to reality" (Freire); hence also lacking both self-knowledge and knowledge of the world. The objectification and analysis of reality enables men to "add to the life they have the existence they make" (Freire). Thus the discussion of the picture helps the students to acquire gradually the quiet dignit that comes from a certain detached understanding of life; and also insight into the causes of the problems of life gives them confidence, faith in their ability to change the dehumanising order.

When we have had a discussion that is satisfactory we tell the group that they have been so far discussiong the ""ba:ja:r". Now the word "Ba:ja:r" is writen on the black board (in Hindi characters

When the students write, especially during the first few days, they need close supervision by the instructions. A ratio of one-to five of instructors and students, is found to be necessary. (This need discourage us since what is demanded of the instructors who supervise the writing is only that they know how to write Hindi letters; primary school Hindi is more than enough. Hence any school boy can be an instructor here)

This stage demand a great deal of patience from the school boy who act as instructors and is an education in itself for the boys. For they see how the adults painfully form the letters, how difficult the adult finditto grasp many things the boys take for granted, and the finally through repeated failures emerges success in mastering the contours of the alphabets. Besides, the understanding and the helpfulness that the school boys ordinarily show the adult-students at this time brings the instructors and the students closer together in mutual understanding and appreciation.

Next the word "ba:ja:r" is split up into its phonemes (or different syllabic sounds) as bajar, and the group shown how different, sets of phonemes could be formed with each consonant. As for example:

ba ba: bi bi: bu bu: be bai: bo bau bam
ja ja: ji ji: ju ju: je jai: jo jau jam
ra ra: ri ri: ru ru: re rai: ro rau ram

The students are made to write down all these phonemes of the three different consonants. This will be a laborious process for them the first few days. Afterwards, however, they will find it quite easy as the vowel-combinations are writen the same way for practically all the consonants.

When the students have written down all the three sets of phonemes we tell them that as the word 'ba:ja:r' can be formed selecting and writing together three of the phonemes in the sets they have, so many other words they know can be formed by selecting and joining other phonemes, e.g., jor; ra; ja: Now the students are asked to make as many words like these as they can.

After the students have exhausted all the different possibilities and have made quite a number of words we collect all the words they have written, from each individual, and write them on the black board, If one or orther student notices on the board that he does not have in his list he writes it down on his paper.

In the above manner our pilot group able to make the first day about 35 words. In a group where the first picture used was that of a boy to introduce the generative word 'ba:lak' (boy) the students made words like the following on the first day: Ba:l (hair), Ka:la: (black), kal (tomorrow), bulbul (one variety of bird), bail (bullock), bi:bi: (wife), bo:la: (he said), ke:la: (plantain).

Next session, the whole process is repeated with another picture e.g. of a cha:dar, to lead the students to a new words with some letters different from those of the proceeding. In this way partically the whole alphabet can be covered in two weeks.

In the next stage we train the students how to write joint consonants, again with the help of pictures and discussions. This work could occupy the third week. By the end of this week the students can read and write all the letters and their combinations. At this stage they can also read the matter in the newspapers, al-

In the fourth week we start discussing a picture with the students. After the discussions the students are asked to write four or five sentences about the picture: actually just to write down that they have been saying during the discussion. In the beginning the students, especially if they are villagers, write sentences in their village dialect. Then the instructors help them to make the proper alterations to change the dialect-language into simple granatical Hindi.

During the fifth week the students can be taught how to fill in forms e.g. money orders forms, applications, etc. They can be also given instruction on how to write dufferent kinds of letters. The best method appears to be give these activities as assignments and then to make the necessary corrections through common discussions.

## SOME SIGNIFICANT ASPECTS

i) In the first stage, during the discussion the students become emotionally involved in the situation and the word that depicts the the picture is engraved in the subsonscious firmly. The result is that when the word is finally written on the black board it is received as some thing almost expected and is retained by memory with little effort.

ii) The words that introduce the letters and the word that are made by the students are all completely relevant to their life, and entirely functional.

iii) When the students form words they are choosing certain phonemes and rejecting certain others. This "choosing and creating" enables them to experience a deep sense of achivement which is not a small factor in keeping up their interest in the programme.

iv) The discussion part has another important function, Depending on the instructor who guides this, it can become an excellent occasion to sensitise the people to any subject or value. For example, asking the proper questions, we can, during a discussion of the ba:ja;r, discuss topics like the price rise, the mechanics of a market, budgeting, storage, hoarding, the laws of demand and supply consumer-cooperatives, etc. It is for this part that we need instructors who are knowledgeable in the language and who are experts in the art of putting across ideas to others

v) The discussion part also develops the ability of the students to think logically and express themselves clearly and systematically. Besides, soon the students lose their inhibitions about speaking before others, and learn how to listen and take part in a discussion fruitfully.

vi) Writing the different phonemes and the words the students make vies them also the much-needed drill in writing the letters, without their realising that they are being drilled in them. In fact they experience this exercise as a game and thoroughly enjoy it.

vii) As I hope it is clear, except for the discussion part, it is not, necessary that the instructors be experts in Hindi. In several cases, as in the pilot group in Delhi, the instructors were actually able to learn new words and ways of expressing things, from the students.

In order to instruct boys and girls of colleges or schools in the method it is enough if they come and attend one session of the programme. No special course is needed as far as the teaching of the alphabet is concerned. To carry out the sensitisation part, on the other hand, orientation course, preparatory study classes, etc., will be helpful, even necessary.

viii) Another advantage that this method has is that the same instructor need not be present at all the sessions. We can have a group of seven people, for example, and have them take turns during the week in guiding the sessions, one each day; thus each one will not hinder the learning process but will rather introduce some refreshing variety into the work.

ix) For our young people, especially college and high school students, this is a very easy but extremely useful project in social action. The students will be able to help their fellow-citizens to become literate and to sensitise them to different aspects of life. At the same time, especially during the discussion part, they will become aware of the socio-economic conditions of the people, their health situation and cultural values, in short, they will come into intimate contact with the oridinary, real Indian.

As indicated earlier, the school boys who act as instructors in this programme get ample opportunities to come to know the patience, maturity and good sense of their "illiterate, under-privileged" adult students. This enables the former to grow in respect and love of their less fortunate brethern, which not only reduces barriers between classess but also helps the school boys to cultivate social concern in the truest sense.

x) The literacy programme will be a welcome project in any village or slum. Almost everybody is anxious to become literate. If some of the common misunderstandings of the people are cleared and if the location of the sessions and their timings suit the convenience of the people it should not be difficult to persuade them to come for the programme. And since the method is completely functional the interest of the people will also be kept up throughout.

xi) It is suggested that this literacy method be tried especially for young people of the age group, 15-25. They are the people who feel they have just missed school education, who experience their illiteracy as a great handicap in modern life. They are still young and unafraid of new ideas. They also have the advantage of hoping for the prospects of betterment in their work and in emoluments when they become literate. Besides, they have time on their side to venture farther end deeper in their adventure of educating themselves. Last but not the least, the young are idealistic and can become enthusiastic instructors, in their turn, to the elder members of their community once they become convinced of the power of this method to change their life.

xii) This method is also one that involves very little expense. All that a student needs is paper and pencil. (Paper is better than slate because anything they write can be kept for futnne reference.) The instructor needs a coloured surface and some chalk. The picture he needs can be taken from any paper or magazine, or could be even drawn by himself.

xiii) For villagers or slum-dwellers it will be better if the sessions are held in their locality, in a shed, under a tree, etc., near their houses, rather than in the unfamiliar surroundings of a school or a big building.

xiv) This method, of course, can only be used to teach people their mother tongue. (One cannot teach English, for example, using this method). Any Indian language can however be taught through this method to those who speak it since all Indian languages are phonetic in elaborating their script.

xv) The words that were used in our Delhi programme were the following, in the order in which they were taken up:

Ba:lak (boy), Cha:dar (shawl), Machali: (fish), samne (opposite), bhikha:rin (beggar-woman), gari:b (poor), Bhojan (meal), Koyala(coal), a:dmi (man), aurat (woman), odhni: (veil), jharna: (water-fall), ta:la:b (lake), Tabala (drum), ha:th (hand), dhanush (bow), Va:n (arrow) hathaudi: (hammer), khargos (hare), pha:vada: (spade), pa:thsa:la: (school), ghonsla: (nest) u:nt (camel), akshar (letter), vigyan (knowledge-picture used;a book), Amru:d (guava) a:i:na(mirror), ina: rat (building) utna: (so much),(picture showing contrast), ainak (spectacles).

The amin principles we had in mind in choosing the words were the following:

a) The words were to be from the ordinary life of the people and as far as possible, depicting concrete situations. (b) Especially in the beginning the words should have at least three consonants (c) the courses are begun with letters that are easy to form and more frequently used.

Although some thought had gone into the selection of the words they were not the result of any rigorous linguistic analysis and they need not be the most appropriate words nor in the best sequence.

xvi) It is important that there should be a well-though-out follow-up programme for some months at least after the course, if the newly literate are not to lapse back into illiteracy. It should be most desirable that there is available literature that is relevant to the lives of these adult-students. The material presently available in Hindi is quite inadequate, Writers in Hindi and the government and other educational agencies will do a great service indeed to the country if they show some enthusiasm to produce literature suitable to the new-literate.

Meanwhile one of the best methods we found for following up on the students has been to take daily newspapers to them and, after making them read out relevant items from the papers, help them to discuss the topics and write about them. This way these adults are kept abreast of many important developments here and in the rest of the world and, at the same time, some taste is cultivated in them for nrespaper reading and discussing the current affairs, which hopefully will enable them to grow in their personal enrichment and effective participation in social and political life.

COMM-16.23


# The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001
Tel. 310694, 322064


Ref. No. ..... Date .....

## ADULT EDUCATION AND CONSCIENTIZATION

### ACCORDING TO PAULO FREIRE


YVON AMBROISE


(Note: This paper was prepared with the notes of Dr. Mary Pillai and Dr. S. Emmanuel.)

1. Man : Subject or Object

The starting point of Adult Education or Non Formal Education programme of Paulo Freire is man. Man in the concrete existential situation. He defines man a being of relationships with Nature, others, society and with the Transcendental power (God/Gods). The relationships are pluralistic and they are impregnated with challenges. Man has to face these challenges and thus react. Such reactions may be reflex actions or reflected action, Reflex actions pertain to birds and animals. Man should reflect and act. That is to say man should relate himself to nature, others and the society in a critical way. In other words he should have a critical perception of those with whom he enters into relationships

In the act of critical perception men discover their temporality - i.e. - they reach back to yesterday, recognize today and come upon tomorrow. This consciousness of temporality creates in them a sense of their historical nature. Thus men do not submerge in a totally one dimensional 'today' but emerge from time. They cease to be prisoners of a permenant today but free themselves from it. Their relations with one another and with the world become thereforce impregnated with consequences.

For Paulo Freire the normal roleof man is thus not passive, rather it is one of participation and intervention in the reality of existence with the object by changing it. Entering into and intervening in the reality consists of:

- inheriting acquired experiences
- creating and recreating
- intergrating themselves into their context
- responding to the challenges of realities of life
- discerning, transcending, and with these entering into the domain of history and culture.

Whnn man intervenes in the reality in this way Paulo Freire says he becomes an integrated man. According to him, integration IS A DISTINCTIVE HUMAN ACTIVITY. It results from man's capacity to know the reality plus the critical capacity of making choices in order to transform the reality. The integrated man is a person, a SUBJECT

Opposite to this stands ADAPTION to reality which means man's inability to understand the reality and to make a

## 2. Levels of People's Consciousness

The Central problem of our Non-formal Education is to undertake programmes that will raise the level of awareness of the illiterate, poor and the oppressed masses of our people, so that they become aware of the variety of forces- economic, social, political, religious and psychological- that are affecting their lives. A key concept developed by Freire in 'Conscientization' - a social process by which human beings (not as receipients, but as knowing subjects) achieve an increasing awareness of social-cultural realities which influences and shapes their lives and develops their abilities to transform their society.

If these processes of conscientization has to take place first of all the level of consciousness of people has to be found out. From experiences we see that all people are not in the same level of consciousness. Based on this experiece Paulo Freire divides the consciousness of awareness into three levels. This concept of levels of consciousness has been defined in a more concrete way by Smith. According to these experts verbal behaviours of a person are the manifestations of the level of his awareness, namely, either magical, or naive of critical.

### 2.1 Magical or semi-intransitive consciousness

It is the consciousness of men belonging to "circumscribed" and"introverted" communities. It is the characteristic of men 'submerged' in the historical process. Men of this consciousness cannot understand problems situated outside their sphere of biological necessities. Their interests centre almost totally around survival and they lack sense of life on a more historical plane. This consciousness represents a disengagement between men and their existence. Discernment is difficult in this state. In men of such consciousness there is a confusion in their perception of the objects and challenges of the environment and they fall a prey to magical explanation because they cannot apprehend true casuality.

Hence they are trapped by the myth of natural inferiority. It is this sense of inferiority and impotence which prevents them from identifying the de-humanizing situations and restricts them to magical explanations and limits their activities to passive acceptance and resignation. Their problems are of physical nature, related to basically survival concerns and they feel that these problems are governed by some superior powers, beyond their control.

In short, the casualities of the problems are attributed to supernatural forces which control them fully and hence they feel they have to submit to them since they cannot fight against Supernatural forces. Naturally a total submission and inaction results. Thus magical consciousness is characterised by fatalism which leads men to fold their arms and be resigned to impossibility of resisting all the supernatural powers.

### 2.2 Naive or transitive Consciousness

Initial stage of naive consciousness is characterised by these qualities:

- by an over-simplification of problems
- by a nostalgia for the past.
- by under-estimation of the common man
- by a strong tendency to gregariousness
- by a lack of interest in investigation
- taste for financful explanation
- by a strongly emotional style
- by a practice of polemics rather by dialogue and
- by magical explanations.

Although men with naive consciousness response to stimuli, their responses have a magical quality. Naive transivity is the consciousness of men who are still almost part of the mass, their capacity for dialogue is fragile and capable of distortion.

At the naive level of consciousness the oppressed do not conform to the siutation any more, but they desire to reform themselves and certain corrupted individuals and group of individuals. According to them the system itself is sound. Nothing is wrong with it. This is expressed by two sub-levels; (a) the individuals blme themselves and their community members for breaking the rules and regulations of the system They thus "Play host" to the exploiters' beliefs, ideas and values, by expressing self-guilt and violence against members of their own community. Therefore, their actions are directed naturally at reforming themselves and becoming more like their exploiters. (b) At the second sub-level the exploited individuals accuse an individual exploiter or a particular exploiter group for breaking the rules and norms of the system. They know that the actions of the exploiters are harmful, but they hold the individuals responsible for it. So, they try to defend themselves from the violence of the exploiters.

Oppressed individuals at the naive level of consciousness accept that something is wrong. They can identify specific injustices and relate long stories how they are exploited. But, their under-standing does not go beyond blaming individuals. They fail to see that a system of powerful forces act together to coerce both the oppressed and the oppressor. They naively, romantically, nostalgically assume that individuals are basically free agents, independent of socio economic system in which they live.

2.3 Critical or critically transitive Consciousness.

The qualities of the critical consciousness are the following:

- depth in the interpretations of the problems
- substitution of causal principles for magical explanation
- the testing of one's findings and 'openness' to revision
- attempt to avoid distortion when perceiving problems and to avoid preconceived notions when analyzing them.
- refusing to transfer responsibility
- rejecting passive positions.
- soundness of argumentation

Critically aware individuals perceive that the system is in need of transformation, No more patching up the relationship between the exploiters and the exploited will change the basic reality that a system, a coercive set of norms which govern both, is the cause of exploitation. The transformation process begins when the exploited start rejecting, casting out the ideologies and views of the exploiters and are led to an increased sense of self-identity, self-worth and peer powers. From the periphery of the problem, they reach to the real cause, the core of the socio-economic-politico-religious spheres where the events and facts are placed in the universal context. At this critical level individuals begin a process of trying out new role-models, specifically relying on self and community resources, boldness, risk-taking and independence of the exploiters. This helps him to be creative and self-determinant.

Oppressed individuals moving into the third stage of consciousness come to realize that no matter how hard they try, they cannot be like the oppressor; and they decide they do not want to be like the oppressor as a role-model. They focus upon their own ethnicity, not because they hate the oppressor and want to be different, but because they want to be themselvees unique persons who are honest about their heritage and their habits.

3. Conscientization

Conscientization represents the development of the awakening of critical consciousness of awareness. IT MUST GROW OUT OF A CRITICAL EDUCATIONAL EFFORT based on favourable historical conditions. It requires an active, dialogical educational programme concerned with social and political responsibility and prepared to avoid the danger of massification.

The growth of self-awareness involves being critical of social, economic, political conditions in an effort to change the existing institutions, so that full humanization take place. The raising of awareness is necessary so that people can not only analyse critically their 'world' and thus attain freedom, but also become aware of their own dignity as human beings.

COMH-16.24

Community Health Cell
CHAI Golden Jubilee Evaluation Study

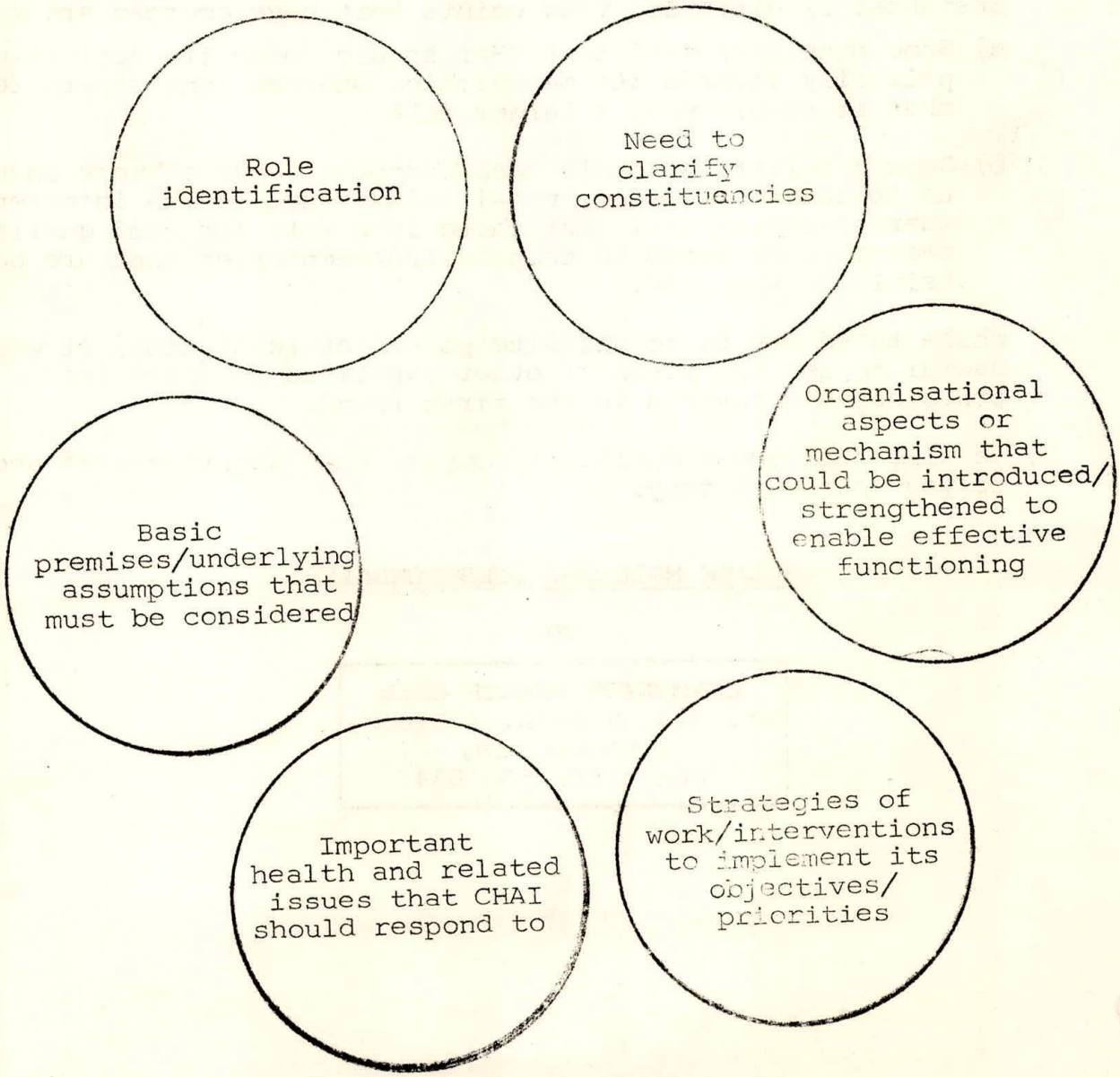
4th July, 1992

## QUESTIONNAIRE - II

## SECOND ROUND OF POLICY DELPHI METHOD TO IDENTIFY FUTURE THRUSTS

**NOTE TO PANELISTS**

1. We have received varied and interesting responses to Question - Four from 37 panelists (73%). This is regarding issues that CHAI should take up as areas of priority in its future work. The ideas that emerged broadly fit into six groups namely :-




2. These have been used to develop Questionnaire II comprising of seven questions. We would like you to rate all items/ideas according to the scale given for each question. Please do not leave any item unanswered.

..2

3. As you undertake this exercise, we request you to keep in mind the predicted broader situation in India (fifteen years from now) as it relates to health/health services and also the possible priority health problems and issues. However it is particularly important to keep in mind the specific reality of CHAI - its membership and infrastructure etc., and in this context to rate the different ideas. Please give reasons for your choice in short statements.

4. Please continue to think widely, creatively, even differently and critically about the process and the issues raised so far. If you would like to introduce a new idea or a different perspective, or to bring up something that has been omitted, please do so.

5. It is important to keep your focus on a period fifteen years ahead from now - so that CHAI can undertake futuristic planning.

6. The method benefits from opposing/dissenting view points. Some instances of differing view points that have emerged are :

   a) Some panelists feel that CHAI should focus its activities primarily towards its membership, whereas some others feel that it should play a larger role.

   b) Some panelists strongly feel that the focus of work should be on community based, non-institutional health interventions, whereas others feel that there is a role for good quality medical care based in hospitals/dispensaries that are accessible to the poor.

   While there may be no definite points of resolution, it would be useful to get the views of other panelists on these issues and other aspects covered in the first round.

7. We will mail you a duplicate copy of this questionnaire shortly as your personal copy.

**PLEASE MAIL THE QUESTIONNAIRE**

**TO**

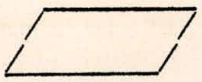
**COMMUNITY HEALTH CELL**
No. 326, V Main, I Block,
Koramangala,
Bangalore-560 034.

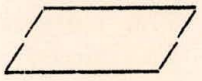
| Please enter the alphabet code in the boxes provided and respond to all points |
|---|

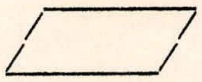
| SCALE | |
|---|---|
| A - Very Important | - first order priority |
| B - Important | - second order priority |
| C - Unimportant | - third order priority |
| D - Not able to judge | |

QUESTION - 1

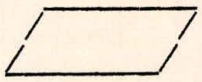
**Please rate the different types of roles that CHAI could play in the future?**

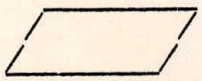
1.1. Inspirational role, with/for members 

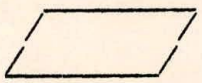
1.2. Coordinating role, with/for members 

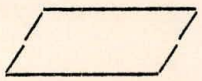
1.3. Trainers role, with members 

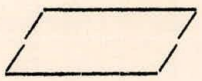
1.4. Technical support role to members 

1.5. Information/communication role to members, public 

1.6. Supplementary role to government, through members 

1.7. Catalyst role, with members and others 

1.8. Networking role, with like-minded groups 

1.9. Activist role with/supportive of people's organisations 

1.10. Any other (specify)

COMMENTS, REASONS ETC.,

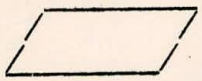
Please enter the alphabet code in the boxes provided and respond to all points.

| SCALE | |
|---|---|
| A - Very Important | - Most relevant |
| B - Important | - Relevant |
| C - Slightly Important | - Insignificantly relevant |
| D - Unimportant | - Nor relevant |
| E - Not able to judge | |

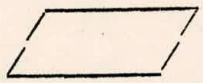
QUESTION - 2

**Please rate, according to the scale given, the basic premises that must be considered by CHAI for their future work (perhaps as a statement of philosophy).**

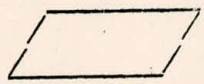
2.1. Need to focus on spiritual dimensions of health and healing
(deeper spirituality, nurture of role of faith and idealism, relate faith to medical work)



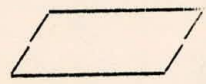
2.2. Focus on preferential option for the poor
(promote work in remote rural and backward areas, particularly of underdeveloped States, urban slums, tribal groups, marginalised groups, indigent population)



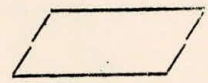
2.3. Focus on enabling/empowering people in health work
(to analyse and respond to their health problems themselves, to avoid everything that creates dependancy and non participation, to support a people's health movement, enhance liberation and growth of people, to increase community responsibility for health work)



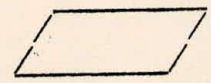
2.4. Focus on justice dimensions of health/health work
(to support/build the organisational capacity of people, to demand a more just health and social service system, to act as a counterveiling power to the pharmaceutical industry and to vested interests)



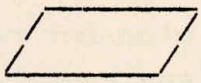
2.5. To improve accessibility for the poor to medical/health care services
(life saving biomedical services, good quality, low cost basic health care)



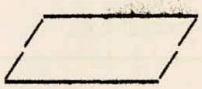
2.6. To promote community based, non institutional health work
(demystification, deprofessionalization, building on people's health knowledge/practices, culture sensitive))



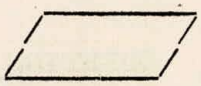
2.7. To promote an integrated approach to medicine and health
(studying, understanding, using Indian and other systems of medicine - Ayurveda, Siddha, Unani, Homeopathy, Acupuncture, etc.,)



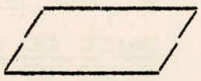
2.8. To promote a holistic approach to health
(harmony in body, mind, spirit, society and environment)



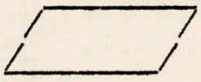
2.9. To focus on gender related issues
(women's health status, their access to health care, impact of technology on women)



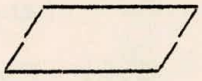
2.10. To create awareness on environmental/ecological issues
(as they relate to health)



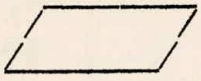
2.11. To strengthen/foster self-reliance at all levels
(promote herbal/home remedies, non drug therapies, low cost care, appropriate health technology, reduce dependance on drugs/medical industry)



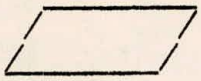
2.12. To promote rational therapeutics and rational drug policy



2.13. To develop a sense of understanding and caring among health workers and in health institutions



2.14. To promote a sense of community and belonging as being critical to well being and wholeness
(make people interdependant and concerned about each other)



**COMMENTS, REASONS ETC.,**

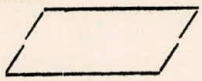
| Please enter the alphabet code in the boxes provided and respond to all points. |
|---|

| SCALE | |
|---|---|
| A— Very Important | - First order priority |
| B - Important | - Second order priority |
| C - Unimportant | - Third order priority |
| D —Unable to judge | |

QUESTION - 3

**Please give your rating regarding the constituencies/groups on which CHAI should focus its activities**

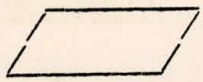
3.1. On its membership
(to support, strengthen, challenge, to meet genuine needs as felt by them though it might be in conflict with CHAI's most important agendas, but this is the only way that they can have a sense of belonging)



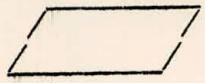
3.2. Also on the Church membership
(the lay congregation, the religious, the structures, the educational system)

3.3. Developing working links with other national level associations
(Voluntary Health Association of India, Indian Hospital Association, Christian Medical Association of India, Indian Society for Health Administrators etc. These are important to achieve Health For All and to help in restructuring of health sectors in both the voluntary and non-voluntary sectors)

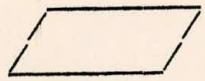
3.4. Better operational links with non-catholic, secular health organisations/persons
(at national, regional, local levels)



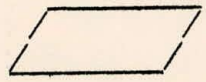
3.5. Linking with development groups/volags at the grass roots



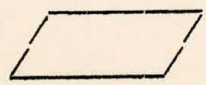
3.6. Developing functional linkages with Government



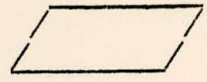
3.7. Interacting/influencing Government in policy making and legislation
(in association with entire voluntary sector)



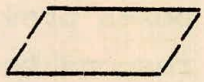
3.8. Supporting/working with activist groups/peoples organisations
(in different fields - environmentalists, women's movement, dalits, labourers, working children)



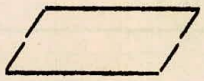
3.9. Focus on youth



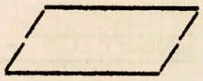
3.10. Work at parish level
(smallest unit, composed of families in a geographical locality that worship in a Church)



3.11. Focus on society at large
(Mobilize public opinion)



3.12. Play a role in South East Asian countries
(besides within the country as well))



**COMMENTS, REASONS ETC.,**

Please enter the alphabet code in the boxes provided and respond to all points.

**SCALE**

A - Very Desirable - extremely beneficial
B - Desirable - beneficial
C - Undesirable - not beneficial
D - Harmful
E - Not able to judge

QUESTION - 4

**Please rate according to the scale given, the organisational aspects or mechanisms that could be introduced/strengthened to enable effective functioning.**

4.1. Define /redefine objectives
(with the concurrence of members)

4.2. Formulate clear strategies to achieve objectives

4.3. Increase internal cohesiveness between member institutions
(CHAI is too loosely knit, with no clear corporate objective)

4.4. Prioritize, make choices and work consistently and vigourously on them
(do a few things well)

4.5. Encourage lay membership

4.6. Decentralize and promote regional units and regional planning
(these units can also be reference points for members within the area)

4.7. Work out a health policy for catholic health care institutions

4.8. Set up a mechanism for reviewing/monitoring/ evaluating the work done and implementation of recommendations

4.9. Make a conscious effort to maintain a simplicity of life style and structures within CHAI
(also encourage members to live in simple temporary dwellings. Present concrete structures make them far removed from reality)

4.10. Encourage/support members to move to/work with the most needy, the marginalised groups and the most dehumanising health problems
(considered a strength of catholics)

4.11. Change name
(drop hospital from it, call it Catholic Wholistic Health Association or something similar)

Any suggestions?

**COMMENTS / REASONS ETC.,**

Please enter the alphabet code in the boxes provided and respond to all points.

| SCALE | |
|---|---|
| A - Very important | - First order priority |
| B - Important | - Second order priority |
| C - Slightly important | - Third order priority |
| D - Unable to judge | |

QUESTION - 5

**Please rate the important health problems that CHAI could respond to**

5.1. Mental Health
(counselling including for chronically ill, terminal care, hospices, promoting positive mental health)

5.2. Substance Abuse
(alcoholism, drug addiction including tobacco)

5.3. AIDS and STD's
(educational work for prevention, developing hospices for AIDS cases to die in dignity)

5.4. Natural Family Planning/population issues
(family welfare programmes, family counselling, there was mention by some panelists that Natural family planning has not been successful)

5.5. Child Survival
(Through growth monitoring, oral rehydration, breast feeding, health education, nutrition and immunization)

5.6. Care of the Aged
(geriatrics in hospitals/dispensaries, also to open homes/day centres for the elderly)

5.7. Disability Care
(rehabilitation and prevention)

5.8. Communicable disease prevention

5.9. Occupational health
(of unorganised labour, women, organised sector)

5.10. Women's Health Care

5.11. Urban Health Care
(for urban slums)

COMMENTS, REASONS ETC.:

Please enter the alphabet code in the boxes provided and respond to all points.

**SCALE**

A - Extremely necessary
B - Necessary
C - Not very necessary
D - No judgement

QUESTION - 6

**Please give your rating regarding the necessity for CHAI to promote the following in its future work.**

6.1. Health Education
(education for health using effective communication skills, developing effective material, public education regarding understanding of health)

6.2. Primary Health Care, Preventive and Promotive Health Care
(find ways of effectively implementing principles and components of PHC towards Health For All)

6.3. Community Health
(Staffing of community health care units with mental health, spiritual health, social work personnel, besides medical and para-medical staff)

6.4. Improving hospital/dispensary based health care systems
(by introducing spiritual and counselling methods, mental health care, health education, rational therapeutics, effective lowcost humane care, technologies that can be taken closer to the community and by making service accessible to rural and urban poor. Keeping in view the growing privatisation of health services, the small clinic and hospital member institutions of CHAI have an important role to play in the future)

6.5. Help government run hospitals and dispensaries
(to improve overall situation and work ethic)

6.6. Medical Ethics
(issues relating to human fertility, abortion, end of human life, use of human organs and tissues)

6.7. Pastoral Care/Spiritual health
(training courses for lay, religious, on an inter-religious basis))

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6.8. Traditional/indigenous health knowledge and systems/ Alternative methods of healing
(develop a pharmacopeia for use by primary health workers and for their training, promote investigation and study, prepare teaching materials for members, integrate different systems into health care services)

6.9. Understanding of public health principles and epidemiology
(including changing epidemiological scene in the country and its implications for health services)

6.10. Health Care financing
(improved cost effectiveness, innovative models)

6.11. Management principles and skills in health
(planning, personnel management, improved service effectiveness, concept of total quality management, identifying performance indicators, developing management information systems, increasing inter-institutional cooperation)

6.12. Rational Drug Therapy / Policy
(introducing concept actively in member institutions, campaigning at national level)

6.13. Lobbying for regulating the standard of operation of health services

6.14. Research and Documentation
(of health problems, health service research, evaluation)

6.15. Involvement in determining training of health personnel
(a. more community oriented formation;
b. participate in evolving nursing curricula, e.g., include women's issues, AIDS, addiction, role of new technology, increasing specialisation in nursing profession is making it competitive with allied professions;
c. training para-professionals/non-professionals for comprehensive health care work;
d. participate in re-orienting, reorganising medical education to produce more socially sensitive physicians)

6.16. Multi-disciplinary health team functioning
(with equal respect for people from the different disciplines, have less places with nuns and priests working together on teams- there will be less scandals and better reception from people)

**COMMENTS, REASONS ETC.,**

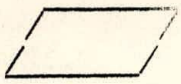
| Please enter the alphabet code in the boxes provided and respond to all points. |
|---|

| SCALE |
|---|
| A - Extremely useful and necessary |
| B - Useful and necessary |
| C - Not very useful and necessary |
| D - No judgement |

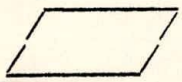
**QUESTION - 7**

**Please rate the different possible strategies of work that can be utilised by CHAI to implement its objectives**

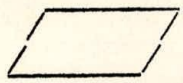
7.1. Continuing education for members
(human resource development for various types of health workers through workshops, seminars, training programmes - to introduce greater professionalism into peripheral health care programmes of CHAI members)



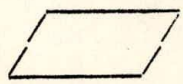
7.2. Publications
(more in regional languages to support community primary health care workers; in English about healthy living, causes of ill-health, health hazards, drug issues etc.,))



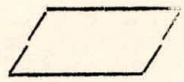
7.3. Evolving models/innovative programmes of health care
(that would be viable, applicable by religious and non religious workers, affordable and sustainable by the people, taking into consideration the socio-economic-political structures)



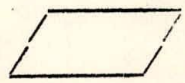
7.4. Developing education/training models
(in tune with our realities, at various regional levels in regional languages, to support the models developed and to cater to the vast majority of people still outside the health care system)



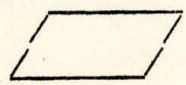
7.5. Re-assessment, re-orientation, rejuvenation of Catholic resources in health care to the urgent priorities of the time



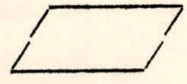
7.6. Networking with voluntary organisations
(at national, regional, local and international levels, increasing sharing and collaboration, avoid duplication)



7.7. Appropriate manpower/health personnel development, especially to meet new needs

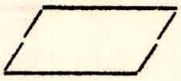


7.8. Advocacy/lobbying/campaigning for change at a national level
(so that basic health needs, for example clean water are satisfied for all, and for government to revise priorities to emphasise health services for the poor, also against alcoholism, drug addiction, environmental degradation)

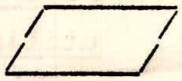


7.9. Bold media coverage
(national/regional to educate/inform regarding components of health, causes of ill-health, what ails the system etc.,)

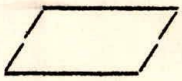
7.10. Developing a capacity for policy level input into national health policies/plans



7.11. Organising national/regional consultations and conventions
(for example organise an inter-religious, ecumenical convention to prepare a health covenant for life for service to the poor, to which medical personnel, christian and others can commit themselves))



7.12. Inter-sectoral coordination in areas of their work to demonstrate the need and scope in this area, get involved with non health issues, for example water shed management, eco-farming, developing credit systems for poor/women.



**COMMENTS, REASONS ETC.,**

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THANK YOU FOR YOUR RESPONSE

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COMMUNITY HEALTH CELL

Dt:08.05.1992

ANNEXURE-I

# THE DELPHI METHOD *

## General Background

The Delphi method was developed initially in 1964. During its early years it was used primarily for technological forecasting,particularly in the areas of defence,industry and business.

Typically it used several geographically seperated experts to make forecasts or estimates about the development of new technologies, to assess their impact,to estimate markets in the future etc.

However the method which hypothetically used both the left half of the brain( the more logical half basing on factual information) and also the more intuitive right half,generated a lot of interest among futurologists in general.

A broad definition given by Linstone and Turoff states that "Delphi may be characterized as a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem".

Since 1969 it has been used increasingly for a variety of different purposes. Thus from the original "Classical Delphi" method developed by the Rand Corporation in the United States of America for defence purposes and still used for technological forecasting,various modifications have developed for example Decision Delphi,Policy Delphi etc.

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* A background note prepared for the panelists in the Delphi Method,being used as part of the Catholic Hospital Association of India Golden Jubilee Evaluation Study.

The Delphi method is therefore essentially a group method, performing functions similar to a committee,but different in that-

a) Anonymity is maintained - this avoids identification of an poinion with a person.
b) The questionnaires/communications from the study team not only ask questions but provide information and controlled feedback or summaries of responses of the panelists (respondents).
c) There are repeated rounds of questionnaires so that arguments for or against options can be shared and panelists can change their ratings in subsequent rounds if they want to.
d) A statistical group response for different issues/options is provided. Rating scales for importance,desirability, feasibility etc can be used.

The Policy Delphi rests on the premise that the decision maker/s are not interested in having a group generate decisions, but rather have an informed group present all the options and supporting evidences for consideration. It is a tool for analysis of policy issues.

Generating a consenses is not the prime objective,though a rating is obtained. It infact seeks to generate possible opposing views or to explore differing positions and the principal pro and con arguments for those positions.

It is therefore an organised method for correlating views and information pertaining to specific policy areas and for allowing the respondents the opportunity to react to and assess differing viewpoints.

Further Reading:

1.Linstone H A and Turoff M,1975, The Delphi Method- Techniques and Applications,Addison - Wesley Publishing Co., Massachusetts.

2.Rauch W,1979, The Decision Delphi, Journal of technological forecasting and social change,15,159-169.

3.Colligan D, "Your gift of prophecy",1982,Readers Digest, pp 223-232.

4.Sackman H.,"Delphi Assessment: Expert Opinion Forecasting and Group process,Rand Corporation,1974.

COMMUNITY HEALTH CELL

CHAI Golden Jubilee Evaluation Study

Dt:09.05.1992

Annexure II

## THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA (CHAI)

## A BACKGROUND NOTE FOR THE PANELISTS ON THE DELPHI METHOD

1. CHAI is a national level association of health care institutions and facilities under Catholic auspices.

2. It has 2,304 members (as of October 1991) spread across the country. The breakup according to size of institutions:

| | | | |
|---|---|---|---|
| i) | Health centres/dispensaries with no beds for inpatients to be admitted | 1,150 | (50%) |
| ii) | Health Centres/dispensaries with 1 to 6 beds | 388 | (17%) |
| iii) | Hospitals with 7 to 100 beds | 591 | (26%) |
| iv) | Hospitals with more than 100 beds | 86 | (4%) |
| v) | Diocesan Social Service Societies | 57 | (2%) |
| vi) | Associate members (individuals having no voting rights) | 32 | (1%) |
| | Total | 2,304 | (100%) |

3. The geographical distribution of members is as follows:

| | | | |
|---|---|---|---|
| i) | The four Southern States (Kerala - 403,Tamilnadu - 380, Karnataka - 153 and Andhra Pradesh-228)- | 1,164 | (52%) |
| ii) | The BIMARU States (Bihar - 160,Madhya Pradesh - 205, Rajasthan - 30 and Uttar Pradesh - 118)- | 513 | (23%) |
| iii) | The North Eastern States (Manipur - 20,Meghalaya - 47,Mizoram - 04,Nagaland - 19,Tripura - 4,Sikkim -01 and Assam - 51) | 146 | (7%) |
| iv) | Other States (Goa - 29,Gujarat - 58,Haryana - 11, Himachal Pradesh - 03,Jammu & Kashmir- 05,Maharashtra - 94,Orissa - 79,Punjab - 28, West Bengal - 68 and Union Territories - 17) | 392 | (18%) |
| | Total | 2,215 | (100%) |

(NB: 57 Diocesan Social Service Societies and 32 Associate Members are not included here)

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4. The Aims and Objectives of CHAI are :

i) To improve standards of hospitals and dispensaries in India;

ii) to promote,realise and safeguard progressively higher ideals in spiritual,moral,medical,nursing,educational, social and all other phases of health endeavour;

iii) to promote community health and family welfare programmes;

iv) to assist Voluntary Health Organisations in procuring quality amenities/equipments/medicines at the minimal possible rate.

(N.B:(i) and (ii) were articulated when the constitution was reformulated in 1961 and (iii) and (iv)were introduced by an Amendment in 1978. CHAI has been a registered Society since 1944).

5.a In the organisational structure the members of the general body elect a 9 member Executive Board with a President, two Vice-Presidents,Secretary,Treasurer and four Councillors. The Board appoints an Executive Director. There are various departments staffed by over sixty people.

b Regional Units:

There is a provision for the formation of Regional Units in the Constitution. Sporadic attempts were made to form them with varying success. Regional or State units are seperate registered bodies, but linked to the Centre. The membership fees are divided equally between the centre and the units. The units at present are :

1) Kerala Catholic Hospital Association.

2) Catholic Health Association of Tamilnadu.

3) Catholic Health Association of Andhra Pradesh.

4) Orissa Catholic Health Association.

5) NECHA - North Eastern Community Health Association covering seven states.

6) RUPCHA - Rajasthan, Uttar Pradesh Catholic Health Association.

Karnataka and West Bengal have had occasional meetings. Some dioceses also have diocesan level activities.

6. The Headquarters and Units

1) Departments

a) Administration (general)
b) Accounts and finance
c) Central Purchasing Service
d) Community health with four sub units-
   1. Rural Health
   2. Urban Health
   3. Research (Planning stage)
   4. Low cost communication media.
e) Continuing Medical Education
f) Documentation
g) Electronic Data Processing
h) Membership
i) Pastoral Care

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ii) There is a Zonal Office in New Delhi.

iii) A seperately registered Society named "Health Accessories For All" (HAFA) brings out a monthly magazine called Health Action and other publications.

iv) Additional Projects:

a) The CHAI Farm Project - with poultry, agriculture, etc, for income generation and plans to start a model integrated health centre with community health programmes and a training centre.

b) A Central Drug Quality Assurance Laboratory is planned. This will test drugs and pharmaceuticals as part of quality control for rational drug therapy and to support the network of low cost generic name drug manufacturers.

c) The Golden Jubilee Project, which includes this evaluation study.

7. Funding

The funding of the activities of the Association depended on membership fees and donations from members. Some funds were available from purchases from abroad through donor agencies. Additional sources from exhibitions of medical products and advertisements at the conventions also brought some funds. This has been restricted since the mid eighties in order to fit in with the overall philosophy of the Association. In the mid seventies and in the eighties, funds from foreign donor agencies began to be utilised for specific projects and programmes. Other initiative have been the starting of a Corpus Fund, the farm and a raffle,besides sale of publications by HAFA.

8. Thrusts in the 1980's

a) In 1980, CHAI adopted the goal of "Health for Many More" - a modification of the WHO Alma Ata goal of Health For All by 2000 AD. A department of Community Health was initiated. There was a more specific and analytical focus on the issues and problems of the poor. A new vision of health was articulated where health was understood as the total well being of individuals, families and communities as a whole and not merely the absence of sickness. Community Health was understood as a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right. They developed strategies and a variety of training programmes towards realization of the newly emerging goal of building a healthy and just society.

b) The Headquarters which had a small office space in Delhi shifted to a much larger place in Secunderabad in 1986, preceding further development of departments and training programmes.

c) Pastoral Care courses with outside resource people were held and a new department started in 1990.

d) The in-house journal 'Medical Service' was discontinued. Under a seperate registered body, the new magazine, "Health Action" was launched. It is available to subscribers from the membership and general public.

e) There was an increased focus on smaller member institutions. Voting rights were equalised. A discretionery fund was started to support these institutions in the area of primary health care.

f) The department of Responsible Parenthood was merged into that of Community Health.

g) Advocacy and training towards Rational Therapeutics and a Rational Drug Policy were initiated and promotion of alternative non-drug therapies is being done.

h) Several short courses and workshops are offered in the areas management, legal aid,human and spiritual growth through clinical practice , etc.

i) Developing and maintaining linkages has always been done and was continued actively with groups like the Christian Medical Association of India (CMAI),Voluntary Health Association of India (VHAI),Asian Community Health Action Network (ACHAN) and the All India Drug Action Network (AIDAN). An Indo-Philippine exchange programme has been initiated.

9. A few important points from the history

a) It was an association that was started and run by religious sisters who were medical professionals (nurses,doctors, pharmacists, etc). This continued for fourteen years.

b) The focus during these years was on professional education so that far flung medical institutions could be staffed adequately. Their endeavours were in the area of nursing, pharmacy,lab technology, and other grades of health workers. They also worked towards starting a Catholic Medical College. This project was then handed over to the Catholic Bishops Conference of India and resulted in the starting of St.John's Medical College, Bangalore.

c) Annual Meetings (which are used for educational purposes) and publication of a journal have been regular features from 1944 onwards.

d) The formation of Catholic Nurses Guilds and Doctors Guilds were encouraged and fostered. These were later federated at the national level as totally autonomous bodies.

e) One of the reasons for this was to uphold ethical values in medical practice. This was considered an important aim in the formation of the organisation.

f) There were no full time staff during these years and no external funding.

g) THe first full time Executive Director was appointed in 1957.

h) There was the formation of Departments and increased staff from the mid sixties.

i) The importance of Public Health, Social and Preventive Medicine and outreach into the community was recognised since the 1950's.

j) The term "Community Health" was first used in 1969. This resulted from a consultation of Christian health leaders in that year held under the sponsorship of the Christian Medical Commission, Geneva. This lead to the formation of the ecumenical Coordinating Agency for Health Planning (CAHP), with the joint support of CMAI and CHAI. The Executive Director of CHAI, who had been in that position for seventeen years, was very actively involved in all these developments, which led to the formation of the Voluntary Health Association of India (VHAI). He held the leadership position in VHAI for several years. Several members of CHAI became and still are members of VHAI as well.

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No.326, V Main, I Block,
Koramangala,
Bangalore 560 034

COMMUNITY HEALTH CELL

Annexure III

# CHAI GOLDEN JUBILEE EVALUATION STUDY

## DELPHI METHOD - LIST OF PANELISTS*

| SL.NO. | NAME | PLACE |
|---|---|---|
| 01. | Mr.Desmond A.D'Abreo. | Bangalore |
| 02. | Prof.Alfred Mascarenhas. | Bangalore |
| 03. | Prof.V.Benjamin. | Bangalore |
| 04. | Dr.Daleep S.Mukerji. | New Delhi |
| 05. | Prof. B.Ekbal. | Thiruvananthapuram |
| 06. | Fr.Claude D'Souza,SJ | Bangalore |
| 07. | Dr.Prem Chandran John. | Madras |
| 08. | Fr.George Lobo,SJ | Pune |
| 09. | Dr.Hari John. | Madras |
| 10. | Mr.S.Srinivasan. | Baroda |
| 11. | Dr.Sulochana Krishnan. | New Delhi |
| 12. | Mr.G.Kumaraswamy Reddy,I.A.S. | Hyderabad |
| 13. | Mr.A.K.Roy. | Bangalore |
| 14. | Dr.R.Parthasarathy. | Bangalore |
| 15. | Dr.Esther Galima Mabry. | Bangalore |
| 16. | Dr.Rajaratnam Abel. | Vellore |
| 17. | Mr.Averthanus D'Souza. | New Delhi |
| 18. | Prof.Jacob K John | Vellore |

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| SL.NO. | NAME | PLACE |
|---|---|---|
| 19. | Dr.P.Zachariah. | Vellore |
| 20. | Dr.Gerry Pais. | Bangalore |
| 21. | Mr.Alok Mukhopadhyay. | New Delhi |
| 22. | Dr.Abhay Bang. | Gadchiroli |
| 23. | Fr.S.Arockiaswamy,SJ | New Delhi |
| 24. | Prof.R.Srinivasa Murthy. | Bangalore |
| 25. | Dr. B.M.Pulimood. | Vellore |
| 26. | Prof.Grace Mathew. | Bombay |
| 27. | Ms.Sujatha De Magry. | Bangalore |
| 28. | Dr.Qaseem Chowdhury. | Bangladesh |
| 29. | Mr.P.O.George. | Kalamassery |
| 30. | Prof.E.P.Menon. | Bangalore |
| 31. | Prof.(Sr.)V.J.Kochuthresia. | Kalamassery |
| 32. | Fr.Joseph Thadathil. | Thiruvananthapuram |
| 33. | Fr.Theo Mathias,SJ | Jamshedpur |
| 34. | Mrs.R.K.Sood. | New Delhi |
| 35. | Dr.L.N.Balaji. | New Delhi |
| 36. | Francis Houtart. | Belgium |
| 37. | Dr.Marie Mascarenhas. | Bangalore |
| 38. | Prof.H.R.Amit. | Canada |

* As on 09.05.1992 thirty-eight experts have agreed to be in the panel. We expect a few more would join the panel. Therefore this list is incomplete now.

CHAI GOLDEN JUBILEE RESEARCH PROJECT

Dear Shirdi,

Greetings from Community Health Cell !

As you may know CHAI (Catholic Hospital Association of India) will be celebrating their Golden Jubilee Year during 1992-1993. The Governing Board and Executive Director felt that it would be important at this point in the history of the Association, to take stock by conducting a study of the organization, its past and present and also look to the future.

Brainstorming around the objectives and methodology for the CHAI Golden Jubilee Research Project has been done during February and March 1991. This draft proposal which is enclosed, is being sent to you and several others for your comments and suggestions. We feel that this exercise will help to fill in areas/gaps that we may have overlooked. We would appreciate receiving your feedback by the end of ~~June~~ July 1991, so that we can go ahead with the finalised proposal. The time framework of the study is such that the final report should be ready by October 1992. Since member institutions of CHAI (currently 2,224 in all) are spread across the country, we will have to keep to a fairly tight time schedule.

Looking forward to your comments,

Thanking you,

Yours sincerely,
for CHAI GOLDEN JUBILEE RESEARCH PROJECT,

Thelma

THELMA NARAYAN,
CO-ORDINATOR.

Please send reply to : Community Health Cell,
No. 326, V Main, I Block,
Koramangala,
Bangalore - 560 034.

*mk/tn

COMMUNITY HEALTH CELL

Bangalore,
15-3-1991

# CHAI GOLDEN JUBILEE RESEARCH PROJECT

(Second draft proposal)

## Preamble :

The Catholic Hospitals Association was formally initiated at a meeting of 16 Sisters in Guntur, Andhra Pradesh, in 1943. This was under the dynamic leadership of the first ever nun-doctor, Dr. Sr. Mary Glowery, M.D. J.M.J. The sisters, who were all involved in medical work, were moved by the suffering of the masses of people, especially women and children. They were also concerned about the need to uphold ethical principles of medical practice. To meet these two needs they felt that it was important to work towards the establishment of a Catholic Medical College in India. They looked forward to the day when young Indian graduates, imbued with a sense of values would be able to work in health institutions in different parts of the country. Thus, with remarkable vision and faith and a rallying cry of 'Union gives Strength' they registered the Association. They decided to meet regularly and run a bulletin for their members.

The Association has come a long way since those early days. There has been a quantum growth in the number of members from 16 to 2,224 in early 1991, spread over different parts of the country. After several years of determined work the Medical College project was handed over to the CBCI and St. John's Medical College became a reality in 1963. The early in-house journal 'Catholic Hospital' started in 1944, was transformed into 'Medical Service' and more recently into 'Health Action' which is available to a wider readership. Annual meetings or conventions have been a regular feature. Besides dealing with organizational issues discussions around topical health themes were introduced since the fifties.

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The central office and also the range of activities taken up by it has increased manifold. These include the membership section, the central purchasing service, the community health department, the continuing education unit, the pastoral care department and the Health Accessories for All (HAFA) Trust (with its major monthly publication Health Action) among others.

During the Silver Jubilee of CHAI in 1968, the Executive Committee felt that it was important to document its history. This was done by Sr. M. Adelaide Orem, S.C.M.M., and CHAI published the book 'Out of Nothing - the genesis of a great initiative'. An earlier 'Short History of the Catholic Hospitals Association of India' has been written by Mother M. Kinesburge in 1961. With the Golden Jubilee drawing near, the Governing Board and the Executive Director thought that it would be a good time to pause, take stock and renew its vision for the future.

When undertaking such an exercise, it would be important to keep in mind important events and changes that have taken place since 1943, in the church and also in the Indian and International situation, particularly in the area of health. Within the church there has been the Second Vatican Council, the Cor Unum document, several statements by the CBCI, a greater indigenization and inculturation of the church in India etc., all of which have been important influencing factors. Within India, since Independence, the Government has built up a countrywide health service infrastructure and an army of health personnel. More recently, the contributions of the indigenous systems of medicine, folk health practices and of the large numbers of personnel working in this sector are gaining increasing recognition. Today, India also has four decades of experience of health planning and organizing control programmes for major health problems. Simultaneously, the private sector in medical care has also developed and is flourishing. Internationally too, there have been very rapid developments in the health sector. Side by side with technological and curative developments, there have been major changes in thinking regarding

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health and health care. Issues of equity and social justice underlie some of these changes. For e.g., The Alma Ata Conference of the World Health Assembly accepted Health for All as a goal with primary health care as a major strategy. Another aspect that any health service system must take into consideration is the health status of the people it seeks to serve, the major determinants of health and disease in that society and the complex interaction between all these factors. These points have been mentioned briefly to illustrate the changed and dynamic situation in which CHAI and its members have to function and to find a meaningful role to play in the light of its own vocation of being part of the healing ministry of Christ.

The study being planned in preparation for the Golden Jubilee will attempt first to know and understand more about CHAI itself - the what, where, who, how and why of its own members. It will attempt to enlist as much participation as is possible in the circumstances, from the member organizations in the process of the study. It will try and contextualise the role played by CHAI and its members in reference to the broader realities of Indian Society in which they function. Together with the CHAI members it will try to evolve broad directions in which CHAI could move forward in the future.

At this moment all this does seem a rather large task. We need to look back for inspiration to the far-sighted vision, enthusiasm, faith and hard work of the pioneers of the Organization. The project will also require a certain flexibility to allow for creative innovation in approaches and methods that may be used for the study. The study will not be, therefore, an orthodox evaluation by a team of outside resource persons, but a reflective and interactive process with the members and all those involved with CHAI.

I. GENERAL OBJECTIVES :

1. To build up a data base of the member organizations of the Catholic Hospital Association of India.

2. To undertake an analytical study-reflection on the organization and functions of the Catholic Hospital Association of India during the past 5 decades, focussing particularly on the past 25 years.

3. To explore possible roles the Catholic Hospital Association of India could play in the future, in the context of the voluntary health sector and the national health policy.

II. SPECIFIC OBJECTIVES :

1. Data base of CHAI Members :

To collect information regarding a number of aspects of work of CHAI members so that a composite picture of the current health work being carried out by them is available. This would include information about :

1.1. Geographical distribution according to State, district, diocese, urban, rural, tribal.

1.2. Distance of nearest referral facility.

1.3. Year when institution was founded.

1.4. Size of institution - bedstrength.

1.5. Facilities available
pharmacy; lab-routine/other; X-ray; blood bank; labour room; O.T.; staff quarters.

1.6. Health personnel available.

1.7. Classification of main activities, viz., curative - outpatient; inpatient,

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extension clinics, mobile clinics,
pastoral care programmes,
preventive health and community health programmes,
mother and child health, family planning/welfare,
school health, health education,
leprosy/T.B./other communicable disease programmes,
mental health programmes,
care of the disabled, care of the aged,
participation - collaboration with Government health programmes,
socio-economic programmes,
community organization and awareness building.

1.8. Utilization of services - a profile
average number of outpatients/day,
Total number of outpatients during 1990,
Bed occupancy,
Total number of inpatients during 1990,
Number of deliveries/year,
Number of surgeries/year,
Population covered by community health programme.

1.9. Training programmes conducted for different levels of health personnel,

Undergraduate, diploma, postgraduate, continuing education.

1.10. Linkages established with other Voluntary/NGO agencies.

1.11. Management.

1.12. Funding.

2. Analytical study-reflection of CHAI :

2.1. To undertake an analytical historical review of the policies and activities of CHAI in the context of :

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i) The vision of the initiators of CHAI,
ii) The Memorandum of Association, and
iii) The change of direction as it evolved over the years.

The review would take into account the broader context of the healing ministry of the church and the appropriate national policies.

2.2. To ascertain the views of the CHAI members regarding :

i) Their expectations about the organization and activities,

ii) The appropriateness and adequacy of CHAI's current activities,

iii) The factors contributing to the gap between expected and observed actions, and

iv) Alternate measures to be adopted to fill in the gap.

3. Future role of CHAI :

To determine the views of a representative sample of members and of a select group of individuals regarding the possible future role of CHAI with particular reference to :

i) its mandate,
ii) its role in the broader Indian Scene,
iii) the role it can play in Asian and other countries.

The section would also take into account

i) the evolution of health policies and health services in India since Independance,

ii) a brief overview of the health status of the people of India and existing services from available reports, with an attempt to identify areas of need,

iii) a brief look at international trends in thinking regarding health and health services,

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iv) a review of statements of the church regarding medical and health work.

III. METHODOLOGY :

1. For Objective 1 (data base of CHAI members) :

A questionnaire will be developed. It will have 4 sections, besides a common introductory note. Section A will be relevant particularly to health centres/dispensaries with less than 6 beds. Section B will cater to larger health institutions. Section C will be specific for Diocesan Social Service Societies and Section D for Associate Members.

This questionnaire will be made computer compatible, so that data can be entered directly into the computer. The questionnaire will be pilot tested and analysed. Modifications will be made based on this.

Suitable modifications will have to be written into one of the existing software packages (e.g., D base 1, 2, 3 or Lotus 1,2,3) to facilitate data entry and analysis.

The questionnaire will be administered to all the CHAI member institutions.

The current list of members from the CHAI membership department will be used for this purpose. 80% of members will receive just this basic questionnaire by post. The remaining 20% will be studied in greater detail (see under methodology for objective 2).

Two reminders will be sent to members who do not respond to the posted questionnaire within a month. Notices requesting participation will also be carried in Health Action. If feasible the Regional Units of CHAI will also be asked to help in getting back filled questionnaires. Response to postal questionnaires in India is generally rather low - about 15-20%. Hence special efforts will be needed to ensure as great a response rate as possible. Since the idea of this exercise is to build up a data base, a 90-100% response would be ideal.

It has been suggested that we may have to think of translating

the questionnaire into 2 or 3 major Indian languages - Malayalam, Tamil, Hindi.

Computer facilities in one of the existing institutions in Bangalore will be utilized. A couple of private organizations and some of the existing facilities within the church network have been approached with favourable response.

2. For Objective 2 (analytical study-reflection on organization and functions of CHAI)

For the historical review, sources of information would be of 2 types :

i) Secondary sources would include

a) Minutes of the Association; Council/Board meetings, Catholic Medical College Committee.

b) Convention reports, Annual reports.

c) Issues of Catholic Hospital, Medical Service, Health Action.

d) Autobiography of Dr. Sr. Mary Glowery, JMJ.

e) Books -

- 'A short history of the Catholic Hospitals Association of India' by Mother M. Kinesburge, FMM, 1961.

- 'Out of Nothing' by Sr. M. Adelaide Orem, S.C.M.M., CHAI, 1968.

- 'A Nun Revolutionizes' by F.L. Swamikannu, JMJ Provincialate, Secunderabad, 1972. and

f) Other documents pertaining to the Association.

ii) Primary sources would consist of discussions/interviews with relevant persons.

A detailed questionnaire will be administered to 20% of the 2,224 members. It will be a stratified random sample taking into consideration geographic distribution and size. Besides the first part of the proforma which collects basic information (the same as for objective 1) it is intended to ascertain member's

views through open-ended questions regarding the different activities of CHAI. Their views as to the role CHAI could play in the broader context will also be requested. This questionnaire will be personally canvassed by interviewers who will receive a prior orientation cum training. Ten to fifteen interviewers would be required to cover the 20% sample of 445 members i.e., each interviewer would be required to cover 30-45 members. Possibilities of utilising the services of seminarians or social work/sociology graduates as interviewers are being explored. They would require to have a certain competence and maturity as they will have to meet and discuss with senior personnel at the member institutions viz., the administrator, medical superintendant, doctors, nursing chief and pharmacist. We are also considering the utility/ possibility of conducting focus group discussions with each of these 20% member organisations.

3. For Objective 3 (future role of CHAI)

i) As mentioned above, the questionnaire and discussions for the 20% sample would elicit the members views regarding the role of CHAI.

ii) The Delphi method in two rounds would be employed for the additional group of 50-75 thinkers/experts.

iii) This question will also be posed during personal interviews conducted for objective 1 i.e., to the previous governing board members, director, and key staff (past and present).

iv) We may need to hold 2-3 regional meetings of about 20-25 people to discuss the role of CHAI in the broad context mentioned earlier and also in the context of the actual work situation of the members. This would be done during the latter part of the project.

4. In general, background reading and discussions with key members of similar organizations within the voluntary health sector in India will also be conducted e.g., with the Christian Medical Association of India, Voluntary Health Association of India and the CSI Ministry of Healing.

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IV. ORGANIZATIONAL DYNAMICS :

This important aspect will be finalised once feedback and suggestions are received on the sections sent so far. Broadly this will include :

Advisory committee,

Peer group,

Time frame work,

Budget,

Format of final output.

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THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

Objectives :

" i) To improve standards of, provide services to, member institutions and others;

ii) To promote, realise and safeguard progressively higher ideals in religious, moral, medical, nursing, educational, social and all other phases of hospital endeavour;

iii) To promote community health; and family welfare programmes."

Memorandum of Association, 1961

*mk/tn

# HISTORICAL PERSPECTIVE POPULATION GROWTH & ITS EFFECTS

By Dr.Luis Barreto

Basic Data :

World population today has crossed 3.8 billion mark. There has been a rapid increase during the last 2 decades.

World population :
Guesstimates' 10-15 million at the end of stone age. Beginning of Christian Era - 250 million.

By A.D. - 1650 population doubled and rose to about 500 million. A century later 1750-700 million.

1850 - A hundred and fifty years ago population extended the first billion, 1,091 million.

1830 - 1 billion
1900 - 1½ billion
1925 - 2 billion
1966 - 3 billion
1971 - 3.5 billion
1976 - 3.89 billion

ANALYSIS: It took human species about a million years to multiply to a billion in 1830's.
But it took less than a century to add the second billion and 30 years to add the 3rd billion.
At the current rate - we might have over 7 million by 2,000 A.D.

GROWTH OF HUMAN POPULATION FROM MILLION B.C. TO A.D. 2000

| Approximate period or year | Total population |
|---|---|
| 100,00 B.C. | 125,000 |
| 300,00 B.C. | 1 million |
| 25,000 | 5 million |
| 8,000 | 10 million |
| 1,000 | 100 million |
| A.D. 1 | 250 |
| 1,500 | 300 |
| 1,650 | 565 |
| 1,700 | 623 |
| 1,800 | 906 |
| 1,830 | 1 billion |
| 1,850 | 1,194 |
| 1,900 | 1,608 |
| 1,925 | 2 billion |
| 1,960 | 3 billion |
| 2,000 | projection 6-7 billion |

REASONS BEHIND THIS ASCENDING GRAPH:

During first million years of man's evolution births and deaths almost cancelled each other - due to enormous environmental hazards people were exposed to.

2nd billion was easy enough since Jenner, Pasteur, Listre and Sennel Weiss launched the beginnings of the health revolution - to save man from micronganisms.

The third billion has come about during this century that has witnessed more inventions and discoveries, then all the others put together - both in health, agricultural development and production, industrial production and overall economic advancement.

Man's countless inovations in the health sciences have alleviated suffering,

It took $16\frac{1}{2}$ centuries .....to double to $1\frac{1}{2}$ billion

3 centuries 1650 - 1960 ..... 3 billion(six fold)

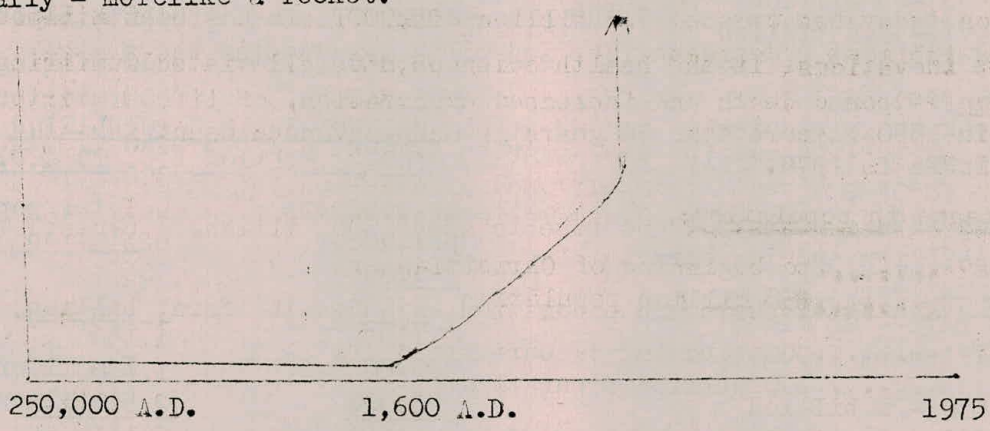
Multiplication rate has therefore been at an accelerating rate.

Roughly everytime the clock ticks: day and night another hungry mouth is born .....170,000 people in one day are born

130 million in one year born

70 million in one year die

The population curve therefore if we start from 250,000 years ago - the Swancombe Man and his Missus - it is like an aircraft taking off - for most of the times it skims along time axis then about A.D. 1600 the undercarriage is raised and it begins to soar today it is rising almost vertically - morelike a rocket.




INDIA'S POPULATION GROWTH :

India today(in the world) ranks second in population numbers. China tops the list. More than 750 million people.

Land area - India 7th. i.e. 2.4% of world area

i.e. 3 million sq km.(1.17 mil sq miles)

India has to support 14% of worlds population and this population enjoys only 1.5% of the world's income.

India 2/5 of U.S. $2\frac{1}{2}$ times U.S. population(204 million in 1970)

NATURE OF INDIA'S POPULATION GROWTH :

Very slow - during early years

Rapid during last half century

300 B.C. -100 - 140 million(?) (world 250 million)

If this is true then it remained static for about 2,000 years because of high death rates.

1600 A.D. - undivided India (excluding Burma and Ceylon)

100 - 300 million (world's - 500 million)

During next $2\frac{1}{2}$ centuries (upto 1850) ----------150 million(we find that during this period i.e. 20 million in 250 years).

High birth rates and high death rates(wars, economic equalled eather other famines and epidemics).

Population grew more rapidly after British rule ------growth slow initially and rapid after 1921.

GROWTH OF INDIA'S POPULATION 300 B.C. to 1971 A.D.

| Period or census year | Population in millions | Increase or decrease in millions | Percentage variation during preceeding decade |
|---|---|---|---|
| 300 B.C. | 100 | - | - |
| 1600 A.D. | 130 | - | - |
| 1750 | 133 | - | - |
| 1881 | 253 | - | - |
| 1901 | 236.3 | 0.4 | 0.20 |
| 1911 | 252.1 | 15.8 | 5.73 |
| 1921 | 251.4 | 0.7 | 0.31 |
| 1941 | 316.7 | 37.7 | 14.22 |
| 1951 | 361.1 | 44.4 | 13.31 |
| 1961 | 439.2 | 78.1 | 21.50 |
| 1964(Mid year estimate) | 471.6 | - | - |
| 1970(mid year estimate) | 550 | - | - |
| 1971 | 547.3 | 108.1 | 24.48 |

Analysis:

1881 - 1891 - Population grew 9%

1891 - 1901 - Increase 0.2% - extensive crop failures, plague, cholera and malaria 5 - 6 million lost their lives

1901 - 1911 - India recovered from famine and plague,

1911 - 1921 - First world war and influenza epidemic 1918 - 1919 crop failures

12 - 13 million Indians died

This wiped off the population increase of the last 7 years.

Therefore 1891-1921 was a slow period

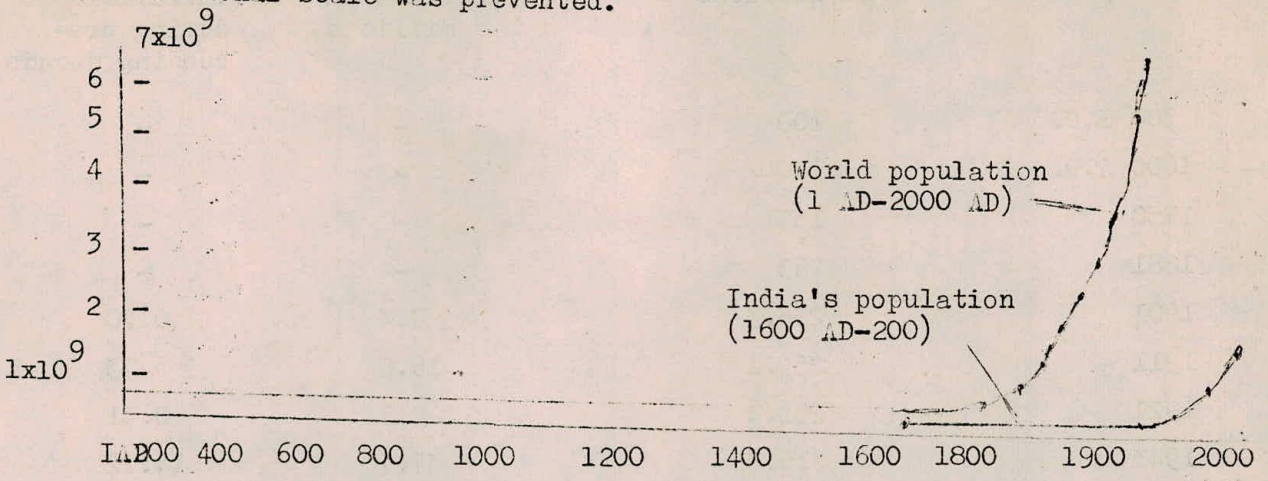
1921 - total decrease of 0.3%

1921 - Makes a division in the history of India's population

Improvement of health facilities, modernisation. The fertility and mortality patterns began to vary considerably.

| | |
|---|---|
| 1891 - 1921 | 15 million only in 30 years |
| 1921 - 1951 | 110 million |
| 1951 - 1961 | 78.1 million |
| 1961 - 1971 | 108 million |

Droughts, floods, and food scarcity was handled better - suitable measures have taken to control epidemics by the Government. Therefore, calamities on a national scale was prevented.




REASONS FOR GROWTH IN NUMBER DURING LAST HALF CENTURY

1. High population to start with
2. High birth rates
3. Decrease in death rates

India has a young population 1961 - 40.2% of total population in the 0-14 age group
15-49 age group - 47.9%
50 and above - 11.9%

4. Universality of marriage bring - religious.
5. Early marriages (Sarada Act 1924)
   Marriage 13-16 for female in this century
6. Remarrying of widows was banned earlier (last decade -30 million remarried)
7. India - basically on Society - need for sons and labour,,but now this has been abolished.
8. No old age nor retirement benefits nor any kind of social security nned for sons
9. Beginning of health revolution in India
   1901 - D.R. - 42.6/1000
   1910 - D.R. - 14/1000
   M.M.R. and I.M.R. have decreased.

Last decade has witnessed a greater decline in the overall death rate than in the proceeding half century.

CAUSES FOR DECREASE IN THE DEATH RATE :

| | | |
|---|---|---|
| Increase in the number of medical colleges in related institutions | 1941 | 20 |
| | 1971 | 94 |

...5

2. D.D.T. Spraying for malaria eradication.
3. B.C.G. Vaccination for T.B.
4. Increase services of midwives.
5. American technical aid particularly in malaria eradication.
6. Assistance of WHO and Colombo Plan. Expectation of life has increased Therefore higher Birth rate. This however is not the cause of decrease in the death rate.
7. New River-valley projects:
   Decrease in floods / droughts
   Increase in irrigation
   Green revolution etc...
8. Better transportation rapid food movement and import of large amounts of food.

ECONOMIC AND SOCIAL IMPLICATIONS OF POPULATION GROWTH

We can study this in relation to
- food supply
- Educational facilities
- Job opportunities
- per capita income

Total food production - 1950 - 51 → 50 million tonnes
→ 1968 - 69 → 96 million tonnes

Net availability of food increased by 43% 1951 - 69
Per capita availability increase by 18% for same period.
The reason is of-course the growth of India's population.
Minimum requisite of food intakeaccording to FAO-18 oz./day.
Availability of food grains 1968 - 14.8 oz.
Therefore the Average Indian consumes 82% of his needed daily calorie requisites.

2.out of 4 persons in India are malnourshied. One out of 4 are underfed.
That is only 325 million people in India are well nourished.
Even Green revolution has not solved the problem.

During 1975 - 76 ---- 135 million tonnes of food grain had to be imported Therefore no self sufficiency in food inspite of the political slogan 'NO FOREIGN BREAD'. that cannot be implemented unless we double our agricultural production. This can be done only at the cost of our industrial development which may not be advisable.

Valuable foreign exchange therefore will be spent and Indian economy will continue to be more extractive than productive.

Educational Facilities:- The picture is the same -- considerable progress but poor per capita shares

| | | |
|---|---|---|
| Number of universities | 1947 | 16 |
| | 1970 | 72 |

(together with hundreds of liberal arts, science and agricultural and medical, engineering, veterinary and other proffessional colleges.)

But still 1000's of students with requisite accademic qualifications fail to be admitted in these colleges.

The increasing facilities fail to keep pace with the needs of the growing population.

Position of labour force is an indication of the development of a country
This depends on a) country's population size
b) growth rate
c) structure
d) other characteristics

India - unfavourable age structure, with large population of juvenile population - - high dependency ratio.

Because of this low ratio of adults; children ------ labour force has been increasing at a slower rate as compared to total population increase. Though in relation to population Labour force is small, total number added to it every year is large. Therefore increase in unemployment problems. (there is

Chart 9: Chandrasekar pg 257

1966-71 - According to Planning Commission 23 million added to national Labour Force with an existing backlog of 12 million. i.e. 35 million more jobs have to be found

4th Five Year Plan (1968-74)- would provide 20 million jobs

Even if this materialised 15 million still would remain unemployed
Low wages- low levels of consumption and poor standards of living quality of labour force falls.
The impoverished population multiplies flooding the labour market making labour cheap, unskilled, inefficient and improductive

India's Total National Income:- 1948-49 -- 86 billion Rupees
1967-68 -- 147 billion Rupees

This shows an increase by 73.25 percent over two decades

But per capita during same period Rs.248 -- Rs.297.17 i.e. 19.76 percent

Indias per capita is amongst the lowest to-day.

The most important reason for all this is the growth of India's populations

The gains of the growth of national income were absorbed by the growing population to maintain the existing low standard of living.

To provide for net additions of nearly 13 million every year the country needs

- 126.500 schools
- 372.500 teachers
- 5.9 million housing units
- 188 million metres of cloth
- 12.545 quintals of food
- 4 million jobs etc.

} should be provided

High illiteracy/overcrowding/poor housing facilities/urbanisation etc. are amongst the main reasons responsible for perpetuating the cycle.

All these suggest a necessity of introduction of certain policy measures.

(1) Large families -- Higher Infant Mortality Rate
(2) Highe· B[illegible] -- Higher Infant
(3) Higher p[illegible]rity -- Higher infant mortality

Effective Family Planning -- Smaller Family - better share of family resources/child, lower morbidity & lower IMR etc

Once community achieves a lower IMR - the parents realise that a great majority of infants survive and small family norm can become an accepted pattern.

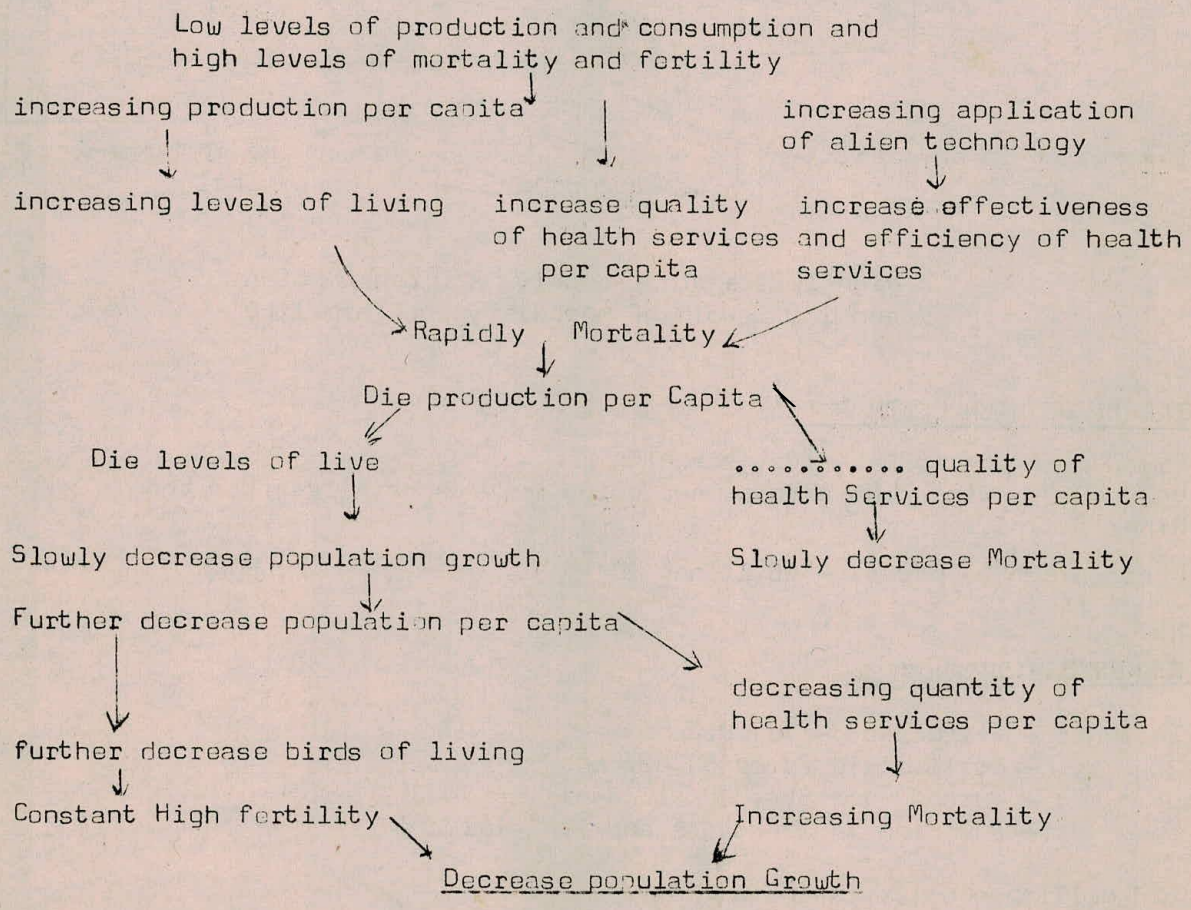
Rapid population growth is manifestly central to the economic and social development of many countries.

The relationship between large additions of population levels of production etc. can be studied under two schools of thoughts

(i) the neo-Malthusian and (2) Humanitarian

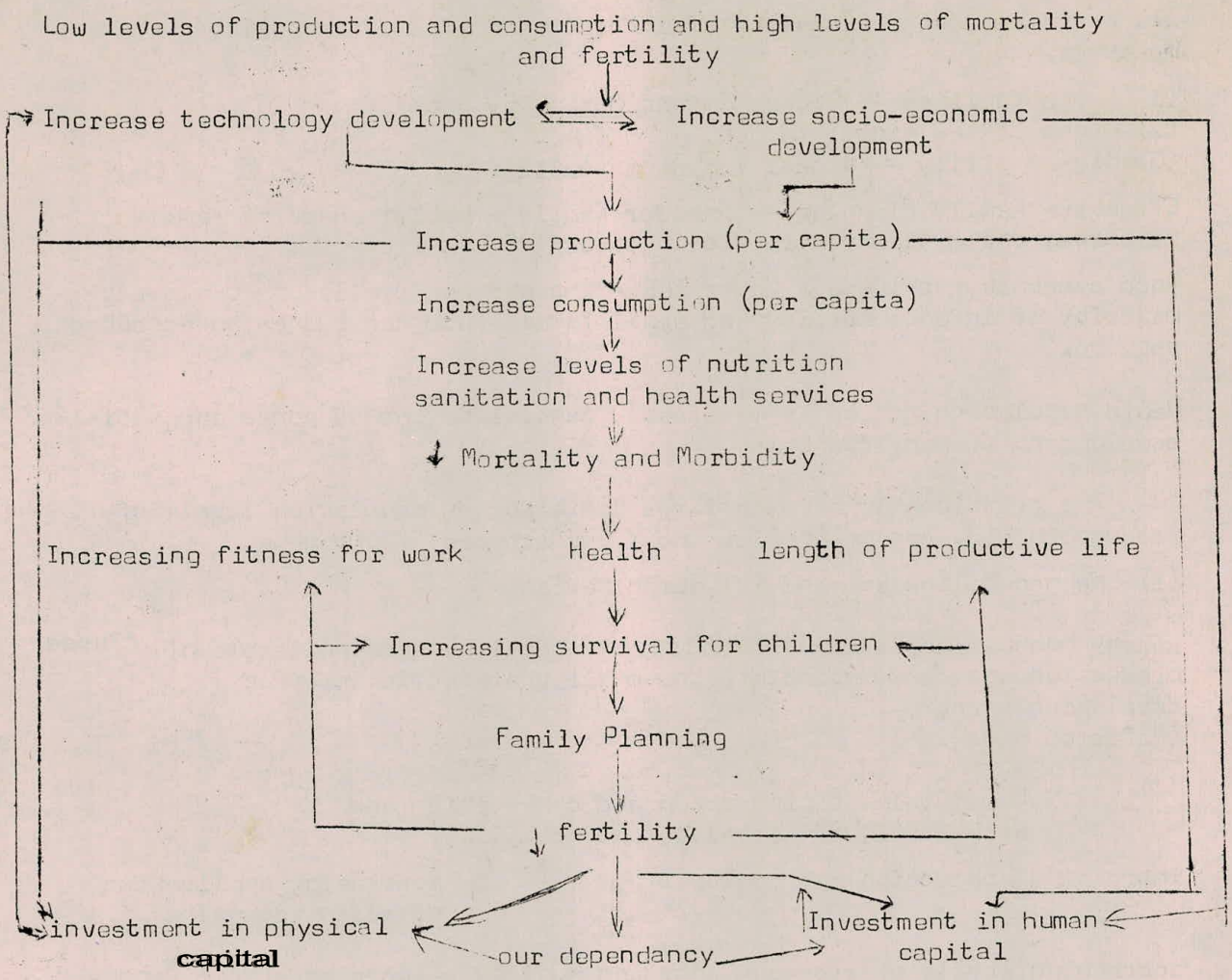
/ [illegible]ssume that high level of fertility and morality and low levels of production and concumption are the major characteristics of a developing country /These

(Refer to page 265)




Low levels of population a -- high

HUMANITARIAN CYCLE




High levels of productive and consumption
and low levels of mortality and fertility

TACKLE OF HIGH DEATH RATE:

Layed down in the 1st five year plan
Only 1967 - vigourous efforts are being made especially after the Bihar Famine.

Decided to buy BR 41 - 25 if not 20

COMMUNICATION PROBLEM

In India - Illiteracy - 70 percent
- small scale farms 80 percent
- Spread over 564,000 villages
- speaking 14 languages and 200 dialects

105 million couples in India today

90 million are in the Reproductive age

Target Couples

ORGANISATION OF FAMILY PLANNING SERVICES:

National : Ministry of Health and Family Planning

State: Family Planning unit in every state

Approvals: Interview/ Dialogues / plays / skits / radio / television

RED △

************************************

METHODS:

Cafetarea Approach
(a) vasectomy } Incentives 5 days pay + Rs. 250.00
(b) Tubectomy }

(c) IUD
(d) Condom - Requirment - 300 million; Indigineous - 100 million
(e) Pill - 1,00,000 urban wives.)
(f) Abortion

In 1970: 3,687 urban family planning clinics
1,926 other urban institutions doing family planning
862 mobile units -- for inserting / and performing sterilisations /IUD
15,000 doctors trained
125,000 paramedical workers

Funds:

1st Five year plan 3 million Rs. (147 Family Planning clinics started and only 1.5 million spent) (1951-56)

2nd - 56-61 - Rs. 22 million - 4,165

3rd 61-66 - Rs.270 million

4th 69-74 - Rs. 3,150 million 1.2 percent of total plan outlay.
11,1680 cents

FOREIGN AID:

United States - 40 $

# UNEMPLOYMENT AMONG DOCTORS

## ITS ROOTS IN SOCIO-ECONOMIC DEVELOPMENT IN INDIA.*

"People are sick because they are poor, they become poorer, because they are sick and they become sicker because they are poorer".

B.R. BLOOM

In India health is more than a problem. It is a challenge - a challenge that has to be met by the majority of the population.

The most obvious shortcoming of the health system in India is that it caters to the few at the cost of the majority - this is not an unique situation, for the WHO states bluntly that in most developing countries the health system "tends to concentrate on urban areas and in particular for the wealthy sections of the big cities - the rural masses are deprived of adequate health care".

Some of the important reasons for this disparity are:

1. The vast majority of people for whom the health services are run, have been left out of the process of planning and determining the goals of the system which is meant to cater to their needs.

2. Increased dependence on the doctor and lack of encouragement to the community to cater to their own health care.

3. Health planners and policy makers and those who have a powerful voice in the shaping of health programmes (such as medical man-power) are themselves by and large from the urban elite and naturally have vested interests in providing the type of medical education to suit their own class.

4. Our elite has been greatly influenced by Western models which are unsuitable to our health needs. Very few planners may have spent some time in rural areas and therefore this has reflected in their planning and specially so, in as much as health is concerned.

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Abundant in concepts and novel techniques and packaged into well drafted documents with what John Lewis has acclaimed as 'the superb Indian ability to articulate' (Lewis 1964) our V year plans have even been held as models for developing nations to emulate.

The primary aim of our plans has been to take the country forward towards the goal of a steady rate of economic growth bringing with it the benefits of a better standard of living.

Towards realisation of this objective a two-pronged strategy has been adopted which deploys on one hand rapid industrialisation and on the other modernisation of agriculture.

The implementation of the plans due to various reasons, was however very slow as a result of which in many sectors like public health the progress was far from satisfactory.

Why are we discussing all this when talking of unemployment amongst doctors. This is because all along in our planning, the elite which found its way in the various planning committees, was planning to suit their interests and the health situation today is a reflection of the system wherein the urban bias of health policy is again the result of reversal of priorities so that the major beneficiaries are elite.

From the 1st plan onwards there has bee a dichotomy between the stated and the actual priorities.

1. Provision of water supply and sanitation, pa-rticularly in the rural areas.

2. Control ~~the~~ eradication of communicable diseases.

3. Increasing the number of medical and paramedical manpower in the country.

4. Building and improving institutional framework for health care, particularly in the rural areas (by establishing Primary Health Centres).

What a parody when we analyse the situation today?

These priority sound impressive but a glance at the existing situation makes one wonder what went wrong and where.

Inspite of heavy investment of over one thousand crores in the 1st 4 plans on water supply and sanitation, more than one lakh villages have no water supply within one kilometer distance. Most of the large cities have water supplies, for it is here that a large percentage of the elite lives. A walk to the suburbs of these cities shows how scarce water is in these slums and it is not strange to see people, bathing in what to them is water, but is actually industrial effluents.

In the combat of communicable diseases it is the preventive measures and the paramedicals which have played a major role in eradication of smallpox and other communicable diseases. Inspite of these efforts we find that malaria is coming back in a big way. TB leprosy and water-borne diseases together with malnutrition continued to be the major causes of morbidity and mortality specially in rural India. In training of medical and paramedical personnel the lion's share of funds has gone to medical colleges and what is the by product of the 106 medical colleges existing in our country today - poorly sophisticated trained doctor unfit for rural areas - not prepared mentally, neither professionally to work in a rural set up. This results in his negative attitude to work there, even for a short period of time.

Majority of our medical institutions are situated in the urban areas and just a handful in the rural areas, the so called rural medical colleges. One has a tendency to look at them rather as medical colleges in a rural area because the product from here is not really much different from that passing out from other medical colleges, situated in an urban area.

Who does usually get into the medical colleges? It is invariably the sons of the elite, political leaders, big businessman etc. Of course a few candidates from the rural areas, schedule casts and schedule tribes tends to appease the conscience.

Coming from urban background, a customed to certain standard of life which is usually maintained in our medical institutions, it is but natural that when the students passes out he will refuse to work in a rural areas where the basic amenities like a good house, social life of a respectable standard, schools of the class his children should go to, picture houses etc. are not available. In fact, it would be surprising if he opts to work in a rural set up

We have not done anything to change their mentality either during the 5 years of medical education. Why should we anyway-as long as he is armed with the toold to work in an urban hospital,or take the next flight abroad. This is definitely guarenteed in our Medical colleges.

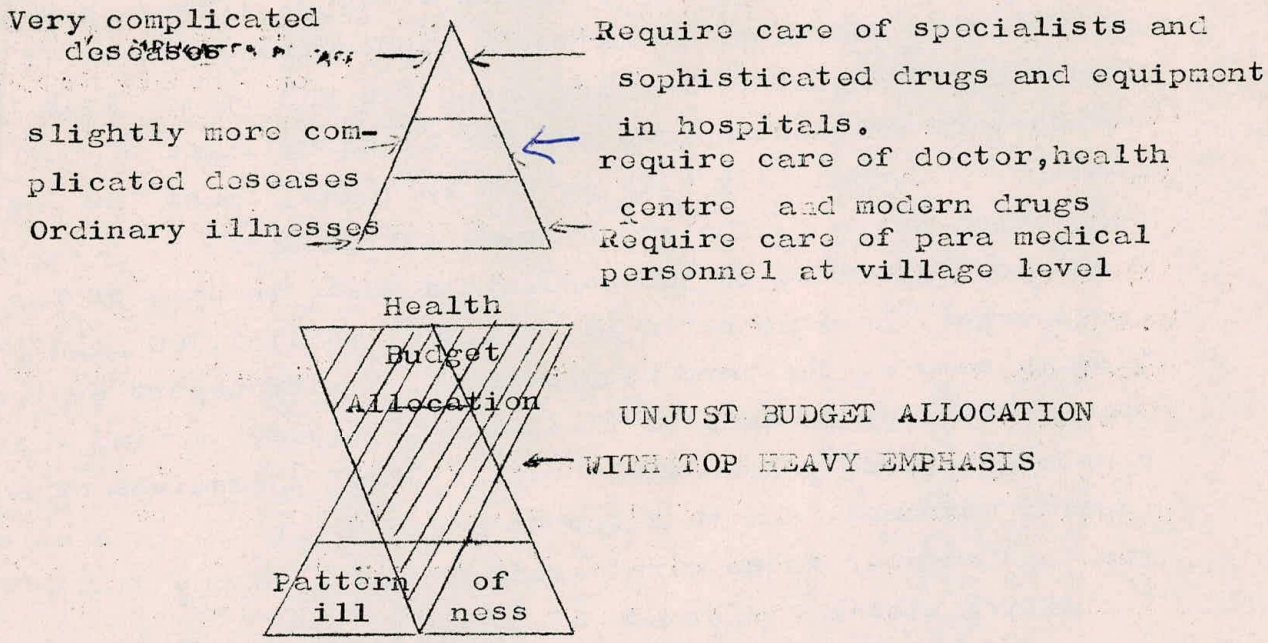
A look at our V year plans shows that the outlay on health has increased from a mere 140 crores during the Ist plan to Rs. 2334 crores during the V plan. A closer look reveals that the highest amount is spent on Medical Education, training and research. This has increased from 21.6 crores in the Ist plan to 117.76 crores in the V plan. This has resulted in an increase from 42 medical colleges to 106 colleges today.

Corresponding increase for other systems of medicine has been from 20.20 crores during the 1st plan to 40.81 crores during the V plan.

Primary Health Centres have increased from a mere 52 during the first plan to 5328 in the Vth plan with 34,088 sub-centres. This surely is remarkable, but a look at the budget allocation of the same is not very encouraging. It was Rs.25.00 cores during the 1st plan and today, it is 155.62 crores. With over 100 villages to cover, with an average population of about 80,000 this definitely shows a great disparity.

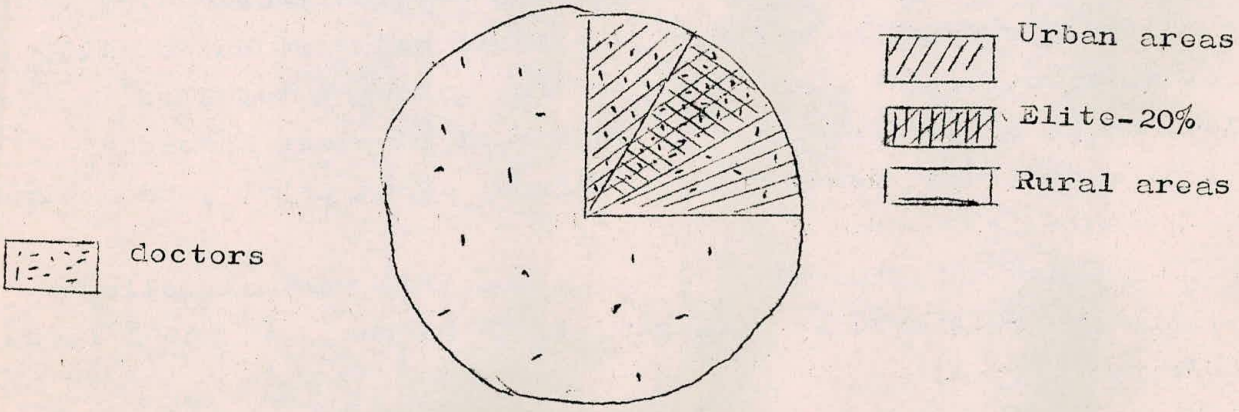
In fact the budget triangle shown below shows the budgettry discrepencies in our health planning.

PATTERNS OF ILLNESS PYRAMID




This is yet another evedence of the way the elite class perpetuates its vested interests in budget allocation in health wherein the left overs trickle down to the bottom , where they are most required.

. . The present system of education for health personnel as mentioned earlier is hospital based, sophisticated, curative oriented and results in trained health personnel, whose main concern cannot be identified with the health needs with of the majority of the people.



The outcome of the present medical system can be diagrammatically represented by the diagram given on the previous page.

There are today 200,003 doctors registered with the various Medical Council in different states. 138,000 doctors are supposed to have graduated from our 106 Medical Colleges. Of these 3940 are postgraduate diploma or degree holders.

This gives a doctor population ratio of 1:4200, which is not far from Mudaliar committee's expectations-namely 1:3500 These figures however are very deceptive and it may look that our doctors are spread into the far flung villages of our country. Unfortunately this is not the case, since the doctor population ratio in the urban areas varies anywhere between I:200 population to I: 500 population while in some of the rural areas the same ratio is 1:II,000, to 1:50.000 population in some of the very remote areas. The transport system being very poor in some of these remote areas, we find that people sometimes take a whole day to avail themselves of any health services, and that too at a P.H.C. It has been reported that some of these rural areas do not have any health facilities within a distance of 50 Km-

We have been talking so far mainly of allopathic doctors. Let us have a look at the Indian systems of Medicine.

17,325 qualified homeopathic doctors and 71,058 registered on experience making a total of 88,383 are registered with State Homeopathic Boards/ Councilsas on I.I.&6. Another 53,402 are enlisted ringing the total to 141,785.

Besides these there are 90,155 institutionally qualified registered Ayurvedic practicioners, 73,317 not institutionally qualified Ayurvedic practicioners, 1495 institutionally qualified Unani practicioners, 9033 not institutionally qualified practicioners and 60 institutionally Sidha and 1235 not institutionally qualified doctors, giving a total of 184,584 as on 31.12.74. How is this vast manpower resource readily available today being utilised. If it is'nt , then why is it so?

Besides 106 Medical colleges allopathis Medical Colleges there are 89 Ayurvedic Colleges, 12 Unani colleges and I Sidha Colege.

With much emphasis that has been laid on allopathic medicine these colleges have received comparatively lesser attention. This is also reflected in the budget allocation namely 20.20 crores in the 1st plan and 40.81 crores in the V Plan.

The sons of the elite usually do not try for admission into these institutions unles they have miserably failed after all sorts of techniques, to get into one of the allopathic medical colleges.

However it is worth noting that htese students would respond to the call from the rural areas more easily then allopathic medical doctors, coming as they do invariably from a comparitively lower socio-economic background. Another reason for this is the fact that they find it difficult to compete with the allopathic doctors, in the large cities

The drug industry in India has played an important role in preparing the type of doctor we have today.

The pharmaceutical industry is the largest industry( excluding fertiliser) in the country today. Capital investment today stands at Rs 250 crores as compared to 24 crores in 1952, a tenfold increase. The total amount of production of drugs is Rs. 500 crores. 25 crore worth of drugs are exported from India. 8 crores are spent on R & D. The development of this company has surpressed the development of the Indian Medicines. The brainwashing by medical representatives starts even during the preclinical period. The attractive presents, literature, parties and dinners thrown for the doctors, make him so dependent on these fanciful preparations , that when he has to work with simple drugs and a limited quantity of the same as is the case in most of our P.H.C.'s, he finds he is unable to cope up with the situation , and thus his discontent grows.

It has been estimated that about 13,000 doctors are today unemployed in India, and many more are underemployed. Is it really that they are unemployed ,or is it that they refuse to respond to the call to work in rural areas, and even if they do not get Government jobs, to start private practice in these areas? Most of the doctors may join the medical institution with good intentions of serving the people. Unfortunately the millieu

in our medical institutions not being very conducive to sustain these interests, results in production of doctors, who are more interested in practicing in an urban hospital, or migrating to a foreign country for better financial and educational pastures.

Coming as most of them do from economically sound background, they can easily afford to wait for sometimes prolonged periods of time , till such time as they get a chance to work in an urban hospital, or they get a post-graduate seat, or perhaps till they get their visa to migrate to a foreign country.

Can we really change their mentality as long as we keep on taking students from the present background? If doctors for the rural areas are to be produced, then the government has to see that... people from rural area s find their way into medical faculties . Besides this it is important that the training be done in these areas. This will however will pose a problem to our staff who are tuned to teaching withing the 4 walls of our medical institutions.

The social values attached to a doctor, the expectations, a good car, suit perhaps, a good wife with a fat dowry and so on, all play it's role. If a practicioner is seen with his shirt and pant on a cycle, the people may say that he is'nt doing very well in his practice.

This is by no means a comprehensive analysis. I am sure that my freinds Dr. Vinayak sen and Dr. Vidyut will deal in detail with the root causes of unemployment in the medical education system and the cultural inheritage of an Indian doctor. What I tried to bring out is that the problem lies in the political will and a radical change in the concept of and approach to health is required to meet Gandhi's goal of wiping every tear from every face.

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(*) Paper prepared for presentation at the IIIrd Annual Convention of the Medico Freinds Circle, to be organised from the 26th-28th of January-'78

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21-12-1978.

# DIFFERENT APPROACHES TO DEVELOPMENT

In India, especially after the independence, we see thousands of individuals and groups engaged in the field of development either full time or part time. To be a social worker or development worker, to some extent adds to ones status and position in society today. In spite of all these countless efforts we hardly see any significant changes in the life of the nation as a whole. A national net work for a concerted effort in the field of development is yet to be evolved.

A close look at these groups and individuals in the field of development will show us that their understanding of poverty and the corresponding approaches to development varies and in certain cases diametrically oppose each other. Though one cann't question their good will and sincerity of purpose, we should know that, mere good will and a sense of sacrifice and committment do not indeed suffice to make our contribution to development and social justice meaningful.

The approaches commonly adopted by different people in the development field can be classified into three. They are :

1) Welfare approach;
2) modernization approach
3) social justice approach

All these approaches proceeds from a clear and definite analysis and understanding of poverty or underdevelopment, however scientific or unscientific the analysis may be.

Before we proceed further, let us be clear about certain initial facts.

1 Our ability to identify factors and forces that create wealth and poverty determines our ability to tackle the problem.

2 Each one of us has an understanding of poverty and under-development, whether at the conscious or sub-conscious level. We may have never formulated it, but a closer look at our work will reveal it to us. Always the solutions and methods adopted, follows from our analysis.

Our preception of reality is conditioned by our position in the society. Thus the causes of poverty identified by the rich may not be the same as those indicated by the poor.

1) The Welfare Approach :

This approach is deeply rooted in the mentality of religious minded people and humanists and is favoured by many private agencies and governments in both developed and in developing countries. The fabulous investments in men and money that welfare enjoys, compels us to reflect seriously on whether it deserves it or not.

In this approach, development and under development are considered as two parallel realities that have always co-existed, and that will always co-exist. Here poverty is accepted as a normal result of forces outside the control of man. These forces are identified as natural and super-natural. Here the symptoms are treated with a rather fatalistic approach, rather than the root causes of the problem with a critical analysis. Natural forces are seen as disasters, epidemics, earthquakes, cyclones, floods, draughts, etc. over which man has no control. In the supernatural sphere, man's status in life is seen as predetermined. It is his fate, it is in the plan of God, and explanation of poverty reflects a religious tone. Development workers with this understanding regrets poverty, but accept it as fate.

People who see poverty as created by forces outside the control of man, see little possibility for change. The solution is seen as a sharing of material goods and talents by the blessed and privileged, and the acceptance of these goods and services by those who are in need of them. The disposition advocated is a basic contentment with one's state of life. Work for the poor assumes the nature of alleviating the suffering of the poor rather than eradicating poverty itself. Development work here becomes an ongoing relief or charity, characterised by 'dolling out' benefit to the poor people according to their needs.

And in the recipients, it often develops attitudes of dependence, laziness and passivity and sometimes creates division among the poor. It always diverts the attention of the poor from the real issues and anaesthatizes them.

Even a limited study of the history of the welfare approach and a superficial analysis of the functioning of society reveal that most of the evils treated by the welfare approach are the inevitable by products of certain forms of social organization.

2) Modernization approach

Like the previous approach modernization too rests on a certain understanding of poverty and under development. The cake, they say has to be bigger before it can be shared. So in this approach increased production and economic growth is stressed, to remove poverty. Here it is implied that people are poor because there is not enough production of goods. Modernization approach relies on industrialization and on rather sophisticated and capital intensive technology. Family planning compaigns are also of prime importance to keep down the birth rate and thus to promote economic growth.

Here, development is seen as the successful utilization of resources, natural and human. Such an understanding stresses the need for patience, hard work, self descipline, sacrifice investments and quality education, needed for the production of bigger cake. Under development is seen as the result of the slow and inadequate establishment of the system of production and consumption present in the developed countries. To a great extent modernization then means westernization - following closely the methods and patterns of the developed. The advanced countries become the guides of the developing countries. On the cultural level it leads to the acceptance of the ideals of western countries and the adoption of their attitudes and values.

Those who can produce more are encouraged to the level best, with the contention that the benefits will 'trickel down' to all. This method of 'Backing the strong' (green revolution) is easily recognizable in

Even though impressive statistics can be given on the growth of agricultural and Industrial production, on the number of students enrolled in educational institutions, education and public services, a question could be asked : who progresses?

The rich, who only posses the purchasing power, with their demands, command and control the market, and often found to imitate western standards of living. Industrialization responds to this demand and produces luxury articles which give higher rates of profit. The production is done at the minimum cost often introducing sophisticated and capital intensive technology, thus increasing unemployment. Poverty and unemployment place the workers at the mercy of the landlords and industrialists, with low wages, and miserable and inhuman conditions of work. The state accentuates the situation by limiting or forbidding strikes. Whenever the labour force is so large and employment so scarce, favoritism and corruption unavoidably prevail. Extreme poverty drives poeple to borrow for their subsistence and social needs; money lenders prosper, for no bank or credit society would lend money in such circumstances. All this creates a vicious circle.

In a society where serious inequalities already exist a technological advance leading to increased productivity is likely to be limited to those endowed with superior wealth and social status to the exclusion of the poor majority' says the United Nations research institute for social development, Geneva.

The modernization approach, therefore, ends with the abundence of luxury articles and the scarcity of basic goods; with sophisticated technology and unemployment, low wages, debts and bonded labours. It produces the wealth of the few and the poverty of the many. The limited resources of the nation are thus used by a small groups for their selfish interests.

3) Social Justice Approach

The Failure of the modernization and welfare approach lead some to evolve a different approach to development based on a critical analysis of the various forces and dynamics at work in the

There is the conviction that non-economic factors that is the overall social context of society with its institutions and structures - Play a very important role in development. It tries to tackle the root causes of poverty and pays great attention to the proper distirbution of wealth. It does not accept mass poverty or under development as a fate. Modernization becomes important only when fare shares to the masses are possible. The root causes of under development according to this approach is injustice. If 85% of Indian population are below or just above poverty line, it is because 15% unjustly enjoy the results of the labour of the 85%.

In this approach one is convinced that deprived groups and nations can develop only in the context of a direct attack on poverty and a move for just distribution of wealth and power. Instead of depending dispropotionately on capital formation and move modern attitudes and values, development ultimately depends on land ownership, land utilization, employment, wages and the level of food comsumption. What would development mean in this historically created condition of under development. It means the restructuring of society! Efforts in this direction can be seen in Trade Union, (Balance of power in the production sector through collective bargaining) marketing co-operatives (challenge to the unscruplous exploitation of middleman) credit unions, (against money lenders) Mahila mandals (against low status of women). Always it was the awareness of injustice and exploitation in these cases that resulted in the organization of people at various levels. So in this understanding of development, the approach one would adopt will be awareness building which will definitely culminate in action.

Genuinely effective development work will have to challenge and re-organise the relations between the substructures in the society. The wealthy are the socially privileged, and the politically powerful. Power and privilege proceed from economic standing. Culture and religion seem to reinforce the interrelationship by providing sanctions andjustifications. A total transformation of these structures and support, is inevitable. In the economic sphere, this would mean policies geared to serve the needs of the people and not as at present, for the profit of a few. This would require that the means of

New ways of thinking feeling and acting, collective promotion rather than individual promotion. On the political level, to evolve an organizational set up that makes possible real and effective decision making power for the people. Thus this approach aims at a socialist society.

Unlike the previous two approaches to development, this one is a rather distributing approach, as it demands a commitment to struggle, and a struggle against the powerful dominant group; and it is no easy task. As development workers, what options does our above understanding leave us with? Can our sincere desire to alleviate the wretched misery of our countrymen express itself in meaningful actions that contribute to this process of collective awareness, collective organization and collective struggle?

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## STRUCTURES AND SYSTEMS :

(This is an attempt to understand and explain certain terms and expressions often used by Social Scientists and others to express their understanding of Society and to analyse it. This is not a critique of the structures and systems but just a theoritical description)

The term 'Structure' is used today to understand various realities, which are related to man's life. The word 'structure' evokes in our minds the image of various parts, components or elements organised into a unit. Infact the different elements of a structure can be understood only in through their relationship with one another and the totality. There is a functional relation between them. This can be illustrated by the example of the diverse organs of the human body, which are parts of a whole, as as such draw their meaning from their relationship with che another and the whole.

When we apply this concept of structure to the field of human activity we can identify certain structures there too. For instance, a family, an army, an institution, in it each person possesses his position and status as well as his own role and funtion. Each person carries on his task in relation to others and to Society.

In the simplest understanding this term is applied to understand a construction, a building, a set up because of which the transformation or change of structure is often understood as getting rid of a demolition of a building or an institution. We use this term to understand the social realities and functions of the Society. Social position can be defined as the particular point occupied by a person or group in a Social Structure. This is often identified with social status and includes the set of attributes or priviliges attached to that position. In the context for example we have the caste system, the hierarchy of castes with their attributes and previliges or discriminations.

In a social structure, the interrelationships

There are established patterns of behaviours and standardised procedures - and we can say that the interactions are institutionally defined and controlled. In other words, we can say that a Social Structure is a set of - institutionally defined and controlled - relations between individuals and especially groups; these relations are studied and understood through a proper analysis of the society which will bring out the various control measures and hidden mechanisms which control and limit man's life and actions.

Different structures have different interests and values, often they become conflicting and one tries to control the other or overpower the other, which leads to disharmony, tension and exploitation. Thus the very structure itself becomes oppressive, dehumanizing and exploitative. The powerful structures force their ideology, values, rules and regulations on therestof the community to dominate them and keep them under their control, unless suitably challenged gives them more power and better positions in the Society. This controlling mechanisms is often not understood by the vast majority of the poor sections of the society and thus not in a position to counteract, as often the powerful use ideological system to achieve this end. In this process the injustices get institutionalized and in turn internalized by the society. Thus it becomes an established order of behaviour and remained unchallenged until someone wakes up andunderstands the undercurrents and the diverse mechanisms employed to achieve this end. This structure today we call an unjust structure.

A social system can be defined as a coherent complex of structures and behaviour arranged according to time and space. A system is a broad unit comprising several structures which interact as different components do in a structure. The structures of Production, distribution, exchange and consumption for example interact and form a single economic system. And the various social systems similarly interact and make a 'global system' or Society. A Society is comprised of the economic, political, social, religious, cultural and ideological systems. The first three systems c ncern the organization of Society while the last three deal with the meaning that men give to their individual and collective life.

Religious and cultural systems don't seem to be of much concern to them, though Marx has a critique on religion.

Economic Systems

Every individual and Society has to satisfy certain physical and psychological needs or wants, as for example food, clothing, shelter, medicine, entertainment etc. Man's Primary and basic activity is that of Production. The economic system comprises of four basic structures : Production, distribution, exchange and consumption. In the process of producing and circulating the material goods that meet these needs man relates to nature through certain technological tools called instruments of labour. They also relate to one another and form certain relations. The sum total of all these is called the economic system.

The Political System

Man basically is a being with intellect and will which enable him to make decisions for his own benefit and that of the society. But when there is a bigger group, individual decisions can affect the common good and hence there is need for a joint decision making to ensure the benefit of all the members of the society. This process of making the decisions is the political system. When this decision making power is exercised through the elected representatives of the people we have a democracy ; a rule (govt.) of the people, for the people and by the people. This is to ensure a smooth functioning of the Society/Nation. The decision making power is handed over to the elected representative so that rules and regulations can be made to the advantage of the whole community. Historically speaking we also come across many others forms of government. Autocratic, Military and Monarchy. Even in a democratic system the common good very much depends on the ideology behind, namely capitalist or Socialist approach.

The Social System

Interactions between man and man, and between social groups when structured and institutionalized becomes the Social System. This concept implies a certain distribution of Social Prestige and Status, or in other words a certain Social Stratification understood as the differential ranking of human individuals, their treatment as superior or inferior etc.

Various factors do, or can contribute to form this social stratification in different types of societies. In the Indian context the social system influenced and determined by caste system , which divide the people into high and low on the basis of birth. Set of rules and regulations are established by the society in terms of man's life, relationships and behaviour, hence traditions, customs become part of this system. But today we realise that there is a class caste combination which controls and dominates each aspect of Indian Society.

## Religious System

Religion basically is the established form of Man & God relationship. This relationship when organised and institutionalised becomes a religious system which regulated and controls various aspects and structures in terms of worship, Morality, ethics and values. It is distinguished from other meaning systems by its emphasis on the ultimate. It offers a systematic message capable of giving a unified meaning to life, by proposing a coherent vision of the world and of human existence, and by giving them the means to bring about the systematic integration of their daily behaviour. This message is always situated in a precise historical context, and provides believers, reasons justifying their existence as in a given social position.

## Cultural System

Culture could be said as the sum total of Man's Social Life in a geographical, historical context in terms of the values expressed through attitudes, thinking pattern and behaviour which are manifested in the customs and traditions in a given sociological Milieu. Knowing the people is to know their culture : Why they behave and act in a particular way, what decides their life circle, why certain parctices exist, why they have certain value systems etc. The value system in turn also influences their life and activity. The very value system is also very much influenced by the religion they practice. Thus culture and religion has a close link.

## Ideological System

The term ideology was first used in 1797 by Claude De Tracy as the 'Science of ideas'. Most contemporary Sociologist, under-

ideas and judgements which serves to describe, explain, interpret or justify the situation of a group or collectivity and which largely inspired by values proposes a precise orientation to the historical action of this group or collectivity. Houtart speaks of ideology as a system of explanations bearing on the existence of the social group, its history and ins projection into the future, and rationalising a particular type of power relationship : The legitimation that an ideology provides to a social group is never absolutely logical, but contains emotional elements which are capable of motivating men and giving them a feeling of security. Ideology is thus a fundamental element in the culture of every human, ethnic, social or even religious group. In this modern sense, ideology always includes in a more or less explicit manner an understanding (analysis) of society, a vision of the future, and a choice of strategies and tactics understood in this way. The concept of ideology can be used for both a small group (trade union, political party etc.) and a whole society or nation. They foster the interest of a particular group in society, and promote a specific socio economic and political organisation. They can be classified as reactionary, conservative, liberal and revolutionary.

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Community Health Cell
CHAI Golden Jubilee Evaluation Study
Policy Delphi Method - Response to Question-1 of first round

27th June, 1992.

## A SUMMARY OF RESPONSES CONCERNING ECONOMIC, SOCIAL AND POLITICAL TRENDS IN THE COUNTRY AND THEIR POSSIBLE IMPACT ON THE HEALTH STATUS OF THE PEOPLE

To facilitate collation and reading we have separated the three factors, though in reality they are closely inter-related. There is therefore some overlap.

### I. ECONOMIC TRENDS :

These were foremost in the responses and are described first.

Twenty-six panelists (80%) felt that the new economic policy recently introduced would continue for sometime and would have an overall adverse effect on the health status of people and on health care services. A summary of the broader economics related scenario and health impact is given first and later the more specific impact on health care services.

### A. National and International Economic Scenario

1. With the new economic order we are now in a unipolar world. The economically advanced and industralised nations are coming together and dictating terms. The underdeveloped/ developing nations will keep on seeking grants/aid/loans and gradually become overdependant and impoverished. International trade has always favoured the advanced nations since the Second World War. The situation will be worse in the unipolar world as there will be no bargaining power at all.

2. International agencies like the World Bank, IMF, IDA, IFC and ADB have become tools of exploitation, determining national policies.

3. All this has been added on top of our already mismanaged economy running on deficit financing and with a parallel economy in black money over which the government has no control!

4. These new trends have been variously described as globalization of the economy, moving towards a more capitalistic form of production and distribution, free market economy, the neo-liberal model of development, the Americanisation of our economy etc.

5. There are very few options with the new policy. We will have devaluation, privatisation, liberalisation, an increase in exports, a decrease in imports, an increased need for repayment of foreign loans, and a decrease in government spending. Unscrupulous middle men and women will play havoc.

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6. Decreased government spending will occur primarily by a reduction of expenditure in the services and development sectors as other changes in government spending would cause an upheaval among the organised labour and elite minority. Thus several panelists felt that subsidies to health, education, housing and other services will reduce. There will be a reduction of budget allocation per person for health.

7. This economic process will benefit the business and industrial community to become richer, with marginal benefit to the organized sector of labour. There will be a more affluent middle class. However the majority comprising of marginal farmers, workers in the unorganized sector, landless labourers and daily wage earners will not be benefitted. Among them the children, women and the illiterate will be the sufferers. Poor people(s) everywhere will lose control more and more of the ability to determine their livelihood and lifestyles. Their health status will deteriorate and they will be unable to avail themselves of the services of privatised health, education etc.

B. Poverty

1. It was widely felt that the gap between the 'haves' and 'have-nots' would increase due to inequitable distribution of resources.

2. Impoverishment and the absolute number of the poor would increase.

C. Agriculture, Forestry

1. The agriculture sector will move towards cash crops rather than essential foods. This would further deplete available food stuffs for the poor, especially the rural poor, leading to greater malnutrition.

2. Due to pressures of modernization, deforestation and replacement with social forestry programmes using fast growing trees like Eucalyptus would cause decreased precipitation, decreased rain, decreased water table, increased droughts and floods and therefore an increase in water borne diseases. Deforestation would also cause loss of top soil, decreased fertility of soil, decreased production of food, malnutrition and starvation.

D. Industry

1. The present liberal industrial policy will lead to a proliferation of all kinds of industries throughout the country, causing pollution related health problems. The government would not have adequate machinery, or the will, to safeguard the environment.

2. The new economic policy would bring about a growth in consumer based production geared to the world market. This would have the following results, namely

   a) ignoring of local needs, which will affect the poor badly,

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b) growth of large national and multinational agencies, throttling the small scale industries, resulting in increased unemployment and breakdown of mental health,

c) large scale environmental destruction with resultant health hazards and avoidable deaths.

3. The technological model of development will be pursued vigourously to meet middle class needs. It will have ill effects on health eg., increasing power (energy) needs will be met by coal (highly polluting) or dams (dislocating people) or through nuclear plants (causing hazards due to radiation).

4. The opening of markets to multinational companies will result in increased availability and consumption of more chemicalised, preserved foods, and artificially flavoured and coloured foods. This will cause dietary imbalance and increased cancers.

## E. Lifestyle Changes

1. As already indicated above the market economy and growing consumerism will affect lifestyles of the middle class and create consumerist compulsions for the poor eg., there will be a loss of traditional food habits.

## F. Changes in Budgetary Priorities

1. Changing attitudes to social concerns and the reduced availability of resources for 'welfare' will affect the quality of nutrition, education etc., and consequently health, particularly of high risk groups.
2. There will be a diversion of funds from basic needs like health to the para-military and military sectors.

Comments regarding the impact of these economic forces on health care services were as follows

## G. Commercialisation and Privatization

1. Several panelists predicted an increased commercialisation and privatization of medical/health services.

2. This is already evident in the rapid proliferation of private polyclinics and the 'Apollo Syndrome'.

3. There will be further mushrooming of corporate "business health centres" with expensive, high tech facilities and consumerist promotion and values.

4. This will be promoted by the leaders of the country at the cost of basic health services.

5. Health professionals in general and medical professionals in particular have succumbed to commercialisation of curative services.

6. Only the profitable services will flourish eg., new drugs and diagnostics and certain higher specialities.

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7. The affluent middle class will create a demand on the system for these type of services. They will be mainly urban based.

H. Accessibility

1. Medical facilities will marginally increase with little or no accessibility to specialised or super-specialised services for common people.

2. The cost of diagnostic and curative medical services will keep on going up at a galloping rate. Many services presently affordable to common people will go beyond their reach in 10-15 years.

3. Church based groups providing health services will compete with the private sector to retain "market share". Overall less attention will be paid on lower income groups.

4. There will be an increase in health insurance schemes for the public.

5. There will be less money for the health sector under the government. This will mean that health care will be neglected. The poor will suffer the most and have less access to medical services.

I. Type of Medical Care

1. As indicated earlier there will be an increase in the expensive, technological facilities, benefiting fewer people at the apex of the pyramid. These will primarily satisfy the caregivers. There will be increased dependancy on the medical system to maintain health, rather than self reliance.
2. Presently, the government health care system is hardly working, partly because of shortage of funds. It will be unable to cope with increased demands and pressures on the system in the future. Rural and tribal health care may suffer.

J. Pharmaceutical / Medical Industry

1. There will be a sharp rise in drug prices due to unjust claims of intellectual property rights.

2. The pharmaceutical industry will now have a greater say in the setting of priorities and in determining the direction that health services will take.

3. There will be increasing dependance on pharmaceutical multinationals at the cost of indigenous and traditional health care systems.

4. There will be increased large scale experiments of new drugs on the poor.

5. There will be an increased pushing of mechanistic procedures

In summary, so far, there will be a greater need for health services for the poor, while paradoxically, access to health services will be limited to the privileged groups only.

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K. Health Personnel, their education and aspirations

1. There will be an increasing commercialisation of education in health sciences, with proliferation of capitation fee, educational institutions turning out untrained, unmotivated health personnel. Their education will be inappropriate.

2. Doctors, nurses and other medical personnel seeking jobs in India or abroad for a better salary and living conditions may often fail to maintain/develop a correct attitude to their profession/association.

L. 1. Three panelists (9%) felt that the economic trends at present and those likely during the next 10-15 years were positive. It was felt that market economy would increase income and money flow. More people would be brought above the poverty line. There would be an increased production of goods. There would be increased and better transportation. All these would affect the health status positively.

2. There would be a growth of hospitals in the corporate sector, greater professionalisation in hospital/health management and the development of insurance as a means of third party payment.

3. Communicable diseases would be eradicated or controlled but there would be an increased incidence of heart diseases, diabetes, cancer etc.

M. 1. One panelist felt that improvement in education may be the most important factor affecting health. Economic improvement and reduction in population growth are often associated with improved educational status, particularly of women.

2. It was felt that urban migration encourages industry, improving the GNP and thus helping in bringing about economic growth.

3. AIDS could cause a depletion of the workforce with massive economic losses.

N. 1. Another panelist suggested that health was not totally dependant on economic, political and social issues alone.

2. It was felt that the questionnaire was not formulated to find out objectively the causative factors of health and sickness, so that one can ascertain in which direction to move in the future.

3. It was felt that the economic and social status of people in the world and in India would rise independant of any political system. However haves and have-nots would increase.

O. One panelist did not comment on the economic aspect.

## II. SOCIAL TRENDS

### A. Urbanisation

1. The process of increased urbanisation will continue and will be a major factor affecting the health of Individuals.

2. There is an extension of big cities and the urban poor have a lower health status than the rural population.

3. Adequate facilities will not be available for this group. Sanitation problems, garbage piles, over crowding, insufficient civic services lead to degeneration of quality of environment, subhuman conditions and more ill health.

4. Slum lords and mafias further deprive families in slums of their earnings, resulting in further deterioration of health.

5. Increasing pollution due to industries.

**B. Demographic Changes**

1. The health status of women is going to get worse as the sex ratio over the years is going from bad to worse. Social pressures and the low value for women and girl children will continue for sometime.

2. The increasing number of the elderly will bring about a major shift in health service needs.

3. Further increase in population will put greater pressure on existing services, with the result that they will be less efficient. It will result in deterioration of other available resources.

**C. Family Types**

1. The single or nuclear family system will be more common.

2. The breakdown of the family unit would bring most of health care from homes to the service sectors.

**D. Education**

1. Improvement in education may easily be the most important factor affecting health, particularly education of women.

2. However, the quality of education and values promoted by it could be questionable.

**E. Role of Media**

1. Television will play a major role in the social lives of people leading to greater consumerism.

2. For eg., advertisements will bring about an attitudinal change with respect to food stuffs, moving people away from healthy natural foods to junk foods.

3. With a new culture dominated by TV propaganda, old values systems will be replaced.

**F. Values / Spirituality / Religion**

1. The sense of community will loose ground and a narrow sense of individualism will thrive.

2. Several health and related problems stem from common ills like man's confusion, lack of identity and responsibility, materialism and humanistic beliefs, false values and lack of spiritual strengths.

3. There will be a progressive erosion of values in social life.

4. The most disturbing element in the present social condition is moral degradation. From the highest offices of the country, the politicians, the bureaucracy, it has gradually started lengthening its tentacles to all types of social institutions and social services. Majority of the so called intelligentsia are willing to make any kind of compromise in their life for personal gain/prosperity. The system of accepting "capitation fee" alone has opened up a flood gate of corruption. Tax avoidance, unscrupulous trade and business practices have crept into the social service institutions in a significant manner. Even institutions related to various religious bodies are not free from dubious practices. The tiny minority who try to stand against such a wave are labelled as "unsmart" and "outdated".

   Socio economic maladjustment is resulting in increased social tension and violence of various forms. Mental disorders are on the increase. Many modern health problems originate from social problems eg., drug abuse, AIDS, STD etc.

5. Churches will loose their popularity. There will be many more splincer groups of Christianity.

## G. Cultural Changes

1. There will be accelerated cultural alienation eg., leading to abandonment of traditional systems of medicine, traditional food practices.

2. Many will follow a westernised style of life.

3. There will be a marginalization of sections of the population including dalits.

## H. Change in Life Styles

1. There will be an increase in smoking, drinking (alcohol), and an increase in levels of tension.
2. Change in dietary habits and increased use of vehicles.
3. Need pattern and so health pattern will change.
4. Change of life style will change the epidemiological scenario of the country. The problem of chronic non-communicable diseases will increase, while most communicable diseases will be eliminated or controlled.

## I. Fundamentalism / Separatism

1. Regional, ethnic, linguistic, communal and caste conflicts will lead to large scale victims who will have to be treated. This is already happening in Jammu and Kashmir, Punjab and other places.

2. Religious consciousness, probably without god-experience as love, and the consequent communalism could be on the increase affecting social and individual life and health.

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3. The associated problems of mental health and adjustment will need greater attention.

**J. Social Problems**

1. Social problems like crime, delinquency and prostitution will increase.
2. There will be increased social disharmony and tension.

**K. Awareness**

1. The awareness of people will grow and a sort of helplessness may grow leading to greater unrest and violence. This will be exploited by vested economic and political groups.

2. The public are going to be more aware of their rights to medical services. There is likely to be more litigation in the health field.

3. Consumer protection councils will make all government employees to be more accountable. This may make government jobs less attractive than now, forcing even currently employed personnel to leave the government service.

**L. Social Trends**

On the positive side

1. Educational level will be on the rise. Therefore need for freedom and better life style will be on the rise.

2. Science and Technology will be increasingly at the hands of our people with techniques and skills to improve life.

3. Focus on ecological and gender issues in public policy.

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## III. POLITICAL TRENDS

**A. International**

1. Politically we are not going to be as autonomous as we are today.

2. There will be greater neo-colonial exploitation through the oppressive "new world order".

3. India will be more and more subject to one new world order, dictated by the West and Washington, with the cooperation of the local elite.

4. The fall of communism in Europe will adversely affect the concept of national health insurance in other parts of the world.

5. There is a chance of a stable government. Changes in the Soviet Union will have an impact on political parties. Relationship with United States will not be very good as our country tries for self-sufficiency and development.

6. Another highly disturbing element is that some politicians, though small in number, serve the interests of the foreign nations.

B. National

1. Several panelists raised the issue of political instability and inadequacy. There is hardly any political party with the goals of good government based on a policy or direction. And there is no reasonable chance of continuity. Health will be one of the difficult areas which cannot be improved in a developing country without political will and stability. Unless ofcourse, effective health care is possible outside the governmental system.

2. There will be greater criminalisation of our politics.

3. Political power is grabbed at whatever cost.

4. There will be negative political activities.confusing and confounding the average person at the grass roots level. At present there are many political parties working in an aggressive and competitive way, each decrying the other party and the party in power in a particular state, making it difficult for constructive and progressive work to be undertaken to completion in the overall interests of the people and country. People at the grass-roots who need the services of health personnel will not get it as there will be artificially created hurdles.

5. With political instability at national level and other seperatist/fundamentalist movements and divisive forces of language and caste working on a political level, health and social welfare programmes for the marginalised will be most affected.

6. There is a serious fear that communalism is on the ascent. If by any chance such parties gain control the whole political life will change. This would seriously affect all volunteer agencies, especially as foreign money for social services will be seriously curtailed. The church will be asked to remain with the four walls for Sunday worship and not to enter the field of health or education.

7. The principle of "divide and rule" is being used by politicians of all ideological colours. Communalism is dividing the poor also, so that they are unable to get together in an organised movement and fight or struggle for their rights, with regard to health and other basic human necessities.

8. Political support to corruption and dishonesty at all levels of the government health care delivery system, forcing people to go to non-governmental private agencies.

9. Politically it will be the moneyed who run the country.

10. There will be efforts by the marginalised groups to take to extremism.

11. The organised might of the organised sections will resist efforts to mobilise the unorganised million.

12. A strengthening of the conservative agenda of the current government will set the climate for national development. Health budgets will be reduced.

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13. Politics and politicians in the country have earned a very negative connotation because of the degraded form of political culture pursued since 1947. Honest politicians interested in the welfare of common people cannot survive. They will be attacked mentally and physically even - all under the Gandhian veil of non-violence. People who protest get labelled as terrorists and disruptionists. Most nefarious socio-economic violences are skillfully protected by the guardians of the country, with no punishment meted out.

14. The overwhelming majority of politicians are self-seeking. The odd idealists here and there cannot give their work the shape of a movement to bring changes.

15. The left wing is totally unnerved by recent political changes in the international scenario. They never did have a big say in Indian politics, neither is any significant change expected. The right wing is divided into two basic group social democrats and ultraright. The so called social democrats have substantially lost popularity and power as they could not demonstrate social interest, they did not try to distance themselves from the self-seeking (investor class of) politicians. Gradually thei image was tarnished. The emergence of fundamentalist force could be even disasterous. But people are more or less tired with both Gandhian and non Gandhian democrats, they are aware about all big promises since 1947, and opt for a change in the coming election. There is reason to believe that the fundamentalist group may try to change and adapt to secure their position in Indian politics. New forces are not at sight, no sane person amongst the intelligentia are willing to enter into politics. It is the unscrupulous who are jumping into it, their attraction is big money, big name (may be due to notority), big position in society, all black deeds, stupidity, failure could be covered up quickly by the miracle touch of "Money force".

16. Indians, as people in Russia and so on will hate violent social movements and Marxist analysis, seperating or focussing on the poor or weak alone, creating imbalance in approach to social issues and so to health issues.

17. There will be stabilisation of the Government by the Congress as a political party.

18. Rightist and communal forces will be on the increase. Several panelists felt that the latter will affect health services adversely.

19. Decline of trade unionism - this will make it possible for hospitals to run without too much labour trouble.

20. The growing disparity between haves and havenots caused by inequitable distribution of resources shall result in social tension, strife, disturbance, de-stabilisation, increased criminal activities seriously affecting quality of life.

21. There will be an increasing political consciousness and literacy. Hospitals will need to give more personalized care.

22. There will be increased student movements.

23. Total absence of a positive national interest by the leaders, in the public services and the various sectors that contribute to the health of people.

C. **Regional**

1. Problems of seperatism especially in border states may intensify.

2. Instability of government at the regional level (as is already happening in the North-East, Punjab and Kashmir) will affect health care services (government and private) and health status too.

3. There will be increasing autonomy to the states. This will require hospitals to satisfy local needs and abide by local laws.

4. There will be increasing consciousness among tribals and dalits. Assertion by ethnic groups and subgroups, politically and economically, resulting in increased autonomy by/for such groups. Their demands and needs will have to be satisfied by hospitals/ health services.

5. There will be greater awakening among the marginalised, especially dalits, tribals, and backward classes. It would mean their participation in social, political and economic processes in the country will become a demand, and justly so. People centred, participatory health care processes will be the demand.

6. Increased regionalisation will lead to intolerance of people from other regions in the country.

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## IV. EFFECTS ON HEALTH/HEALTH CARE - due to a combination of the varicus factors (other than those already mentioned)

### 1. Basic Factors

influencing the health status of the population and contributing to the quality of life are water supply, sanitation, housing, food (nutrition), environment, education(awareness), overall socio-economic conditions (including safety and security). Trends in the different factors are :

### 2. Water Supply

Some quantitative improvement in coverage (through tube-wells etc.,) is expected. But maintenance of quality (safe, potable water) will not occur in the next ten to fifteen years. Mortality is already reduced, but morbidity due to water borne diseases will remain high.

The two other views were that due to deforestation and increased water utilisation for agriculture, the availability of drinking water will become critical leading to increased water related diseases.

### 3. Sanitation and Housing

Presently committed resources are meagre as compared to the need. There could be a marginal improvement in this. However incidence of air borne diseases will remain high.

4. Nutritional Status

There could be a major breakthrough in food production. However, chances of improvement in nutritional status of the poor are low. Withdrawal of subsidies will cause further rise in food prices - the impact on pulses and oilseeds has already created havoc. Production costs are rising disproportionately due to use of improved farming methods and technology - hybrid seeds, irrigation, use of chemical fertilisers and pest control. The distribution system is also faulty. There is increased export of food items to meet the foreign exchange crisis. The lot of the common people will therefore remain unchanged.

5. **Environmental Degradation**

Will continue. The small movements here and there are like ripples that will not develop into a tide in the near future. Manifold effects on health will result.

6. **Education (Awareness)**

There will be improvement in literacy rates, but there is cause for pessimism regarding real "education". The new education policy and the system promotes mass production of technocrats. There is a neglect of the humanities and overemphasis on science and technology, which will produce more technologically knowledgeable "inhumans". Schooling facilities for the poorer sections will be inadequate. The government schools are already overcrowded and in a poor state.

The holistic approach to health is practicable in an educated society only.

7. There will be an increase in tobacco related diseases including cancer, respiratory tract and cardiovascular disease. The huge profit margins of the cigarette manufacturing companies is clear evidence of this.

8. The pandemic spread of HIV and AIDS could result in the reversal of the gains of other health programmes. A conservative estimate is that over one million people in India are affected by HIV.

9. Increased cancers and other diseases due to industrial pollution and dumping of industrial waste including nuclear waste, from rich countries into the Third World.

10. The increasingly complex drugs in the market will be used and prescribed indiscriminately, so that iatrogenic or medicine induced illness will increase, for example allergies, side effects.

11. Ethical problems related to the use of modern medical technology have already surfaced, for example provision of services for diagnosing and eliminating the female fetus.

12. Wholesale adoption of allopathy, without critical evaluation, will create new health hazards and economic exploitation.

13. The weaker sections will realise that unless they have a significant say in the running of health services, they will be cheated of their rights to health as in education.

14. Monopoly in the medical system - in our vast country, there is room for many levels of health workers, who need to be trained and deployed to do their jobs responsibly and competently. With a strong support system (up and down and sideways) and with good team leadership, the impact on health will be positive. However professional councils do not want to change with the times, and continue to act selfishly in isolation, for fear of loosing their monopoly.

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COM H-1632.
Enclosure - I

Community Health Cell
CHAI Golden Jubilee Evaluation Study
Policy Delphi Method - Response to Question-2 of first round

4th July, 1992.

## A SUMMARY OF RESPONSES CONCERNING MAJOR HEALTH ISSUES AND PROBLEMS OF THE PEOPLE OF INDIA LIKELY IN THE NEXT FIFTEEN YEARS

(The 35 panelists, whose replies were used for this collation on the 'Health Scenario', listed out a wide range of problems and issues that would be significant in the next fifteen years in India. Some ideas seemed to be of much greater concern to a larger number, than some others which were brought up by one or more participants only.

While analysing the response we classified the responses into:

i) Specific Health problems
ii) Broader 'health' issues
iii) Health Care issues - broader and specific.

The classification was arbitrary to allow for a more comprehensive understanding of the response from the panelists. Most of the panelists had however not used such a distinction and their list of ten or more ideas had combinations of all these subsections. While listing the more frequent ideas initially, we have included all the responses in the scenario to represent the wide range and diversity of concerns. There is some overlap between sections but, this is inevitable in an exercise of this sort.)

### Health Scenario In India In The Next Fifteen Years

The Health problems of India will show a complex epidemiology in the years ahead. While we shall continue to have problems of poverty, poor hygiene, poor nutrition and poor environment, we shall increasingly experience the problems of development, affluence and modernization. New diseases will come up along with the resurfacing of older disease problems with newer trends and patterns. While this 'double burden' of disease will severely stretch our limited resources, our ability to deal with the situation will be severely hampered by the broader socio-economic, political, cultural factors emerging on the national and international scene that will determine our development, welfare and health policies.

### Health Problems

The significant health problems that we will have to tackle in the years ahead, will be : -

1. Nutrition related problems

This will include malnutrition, which will continue to increase due to poverty, population, deforestation, the effects of new economic policies of the government

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on the poor. These will be further complicated by increasing adulteration and chemicalisation of our foods as also the promotion of junk foods by the food industry simultaneously with decreasing state/governmental intervention in nutrition programmes.

2. Water borne diseases

This will include diarrhoeas and dysentries, gastroentertis, typhoid, cholera, Hepatitis B, parasite infestations. While rural areas will continue to be affected due to inadequate sanitation resources, urban areas including metropolitan cities will not be spared due to grossly inadequate services. This may be further compounded by increasing 'waterlessness' due to indiscriminate harvesting of water table, destruction of natural forests, and monopolising of water resources by commercial interests, urbanisation, and cash cropping.

3. Communicable Diseases

Some of the major communicable diseases like Malaria, TB, Leprosy, Kalazar, acute respiratory infections and preventable childhood diseases will continue to take their toll. While resources/knowledge are available for their control and prevention, these will be neglected or inadequately utilized and complicated by the problems of inadequate therapy and problem of resistance. With decline in public health and health care investment of the State, national programmes for these diseases will suffer.

4. Non-Communicable diseases

Diseases such as heart disease, hypertension, diabetes and cancer will increase due to development especially of the middle classes with increasing ageing population, change in food habits and life styles, increase in stress and smoking and increase in obesity and sedentery occupations.

5. AIDS

This was predicted to become a major public health problem due to i) neglect of measures in hospitals to prevent spread, ii) breakdown of values and taboos that have determined sex patterns, iii) change in sex hygiene and habits, iv) infected blood donations, v) increased migration and tourism, vi) ineffective control measures, vii) lack of proper awareness, viii) present apathy about the problem and time lost in recognising its significance. Other sexually transmitted diseases will also increase for some of the above reasons.

6. Problem of Mental Ill health

These will include the whole range of stress related disorders, psychosomatic and psychological problems, suicides, dementias and other mental health disorders.

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They will be caused by i) increasing stress, ii) effects of urbanisation and increasing unemployment, iii) family breakdown, iv) increased disparity and dissatisfaction, v) increased competition, vi) loss of meaning/significance of life, vii) breakdown of family and traditional support system, viii) increased family and community violence, ix) breakdown of values, x) increased miseries in an economy of lopsided distribution and security, xi) reduction in vital faith and motivation, xii) lack of positive powerful 'myths' to sustain society and breakdown in ideals of honesty, compassion, socialism and nationalism.

7. Addictions and Substance Abuse problems

These will include problems related to narcotic and hallucinogenic drugs, alcohol and tobacco. The problem will increase due to i) increased tensions, ii) breakdown of religion and values, iii) profiteering by pushers, iv) changing cultural values, v) and inadequate efforts to create awareness, prevent or control the problem. Some of the factors described in (6) will also contribute to the increase in the problem.

8. Pollution related diseases including allergies, asthma and other hazards

These will increase due to increasing environmental pollution of air, water and soil by chemicals and other hazards ii) adulteration and harmful additives in food, iii) pesticides and other occupational hazards, iv) inadequate dumping of nuclear and industrial wastes, v) increased pollution by fuel burning and smoking, vi) increased covring up of facts by commercial interests and, vii) inadequate measures for prevention and control.

9. Disabilities and Handicap problems

This will be a major problem particularly affecting children due to i) inadequate pre-natal care and immunization programmes, ii) neglect of curable blindness, iii) increased drug iatrogenesis, iv) genetic diseases, v) decreased mortality. This problem will be further compounded by breakdown of traditional family and other support systems and inadequate intervention or non-availability of better solutions/methods for handicap care putting strain on the families and increasing the distress of the children.

10. Health problems of the Aged

Problems of the aged (geriatric problems) will increase due to an ageing population caused by increased longevity, and there will be a consequent increase in the number of neglected, lonely, depressed, inadequately cared for old people.

Similar to the above group this will be complicated by breakdown of traditional family support systems especially joint family system.

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11. Iatrogenic diseases

This will be recognised as a new and increasing problem especially medical drug-related due to i) indiscriminate medication, ii) over-prescription, iii) gunshot therapies, iv) irrational drug therapy, v) spurious drugs, vi) inadequately tested drugs introduced into the market, vii) unbridled advertisement of pills and related factors.

12. Accidents

Both road traffic vehicular and occupational related accidents will increase due to urbanisation, industrialisation nd increase in transportation and travel. This will be further compounded by increasing violence in society - social conflicts, at work place, on roads and in the family.

At work apart from accidents, occupational hazards will also increase a great ceal.

Apart from the above 12 major groups of diseases and problems which the panelists commonly identified a few other problems were mentioned in passing. These included i) more rheumatic fever and related heart conditions in children, ii) ulcers and piles, iii) iron deficiency anemia, iv) iodine deficiency, v) resistance to drugs, vi) chronic ill health and sub-optimal functioning in daily work particularly among women. Some of the participants emphasised that many of these problems would primarily affect the poor and among them women and children would be most affected.

## Health Issues

Related to the above groups of health problems and contributing to them (as mentioned above) or complicating the situation further, the panelists listed a number of health issues that would gain significance in the next fifteen years, these are:

1. Environmental pollution and deterioration of ecology, with consequent effects on health and quality of life. This will be of air, water &land and affect both rural and urban areas.

2. Challenge of Environmental Sanitation

Inadequate provision of safe potable water, poor sanitary facilities or solid wastes management, including disposal of garbage & night soil due to inadequate resources and increasing disparities. Large segments of the population will be denied this basic requirement for health.

3. Urbanization and its consequences/contribution to health of slum dwellers

The problems of slums will probably become unimaginable due to inadequate planning, inadequate financial resources,

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inadequate housing and lack of government concern or abilities for providing essential amenities to slum dwellers. There will be increased migrant labour, increase of urban poor, increase in urban stress and unemployment and all the related consequences.

4. Breakdown of Family

Many panelists have predicted increased family breakdowns due to problems of divorce, separation and other marital problems, increased family disorganisation and violence and break up of traditional joint family system and support systems with their consequences on mental health of people, as also on the family's ability to handle its health problems especially care of children, aged and the handicapped.

5. Ethical issues in medicine and medical care

These will become very important and will cover the whole range of issues such as invivo and invitro fertilization, human organ transplantation, use of foetal tissues, euthanasia, trading in human organs for transplants, with poor becoming cheap suppliers, drug misuse, overuse and so on. Medical ethics and values will be increasingly focused upon.

6. Rational Therapeutic issues

The growth of multinationals in the pharmaceutical industry the increase in consumerism and the factors of the market economy are expected to increase the problems linked to drugs and spurious drugs. Exploitation by the drug industry and increasing dependence on western technology at the cost of self reliant indigenous knowledge is predicted. Unbridled advertisement of pills and tonics will contribute to aggravating the problem.

7. Population Issues

The problem of increasing pressure of population growth coupled with high illiteracy and its consequences on resources and health have been predicted. There will be need for increasing efforts in family planning and population control, but these will be complicated by family planning issues which include newer contraceptives, female foeticide, abortion, infanticide, invivo/invitro fertilization, effects of abortion/sterilization health, especially of women and so on.

In addition to these broader issues some panelists added the following to the list though the exact nature of their contribution to the health scenario was not outlined.

i) Increasing violence in society
ii) Increasing problem of religious bigotry
iii) Absence of god/religious experience as love.

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iv) Influence of international politics and their adverse effects on health related problems.
v) The paradox of longer life span but poorer quality of life.
vi) Increase in more incurable ailments - caused by high technology power generation, radiation related gadgets like microwave, TV and Computer terminals, reactors and nuclear installations.
vii) Irrational and non-consistent political decisions about alcohol use/prohibition policy leading to increasing death due to poisoning from spurious brews.
viii) The issue of control of technology and the type of multinational operations in India with its implications from the perspective of medical ethics and the development of indigenous research capabilities and foreign exchange.

## Health Care Issues

As distinct from health problems and health issues outlined in earlier sections, panelists also identified many key aissues which may be classified as health care issues or issues significant to the development of health care delivery systems that could respond to the evolving health scenario. These included:

1. Health care planning - chellenges and problems

This would include a host of questions and issues:

i) Inadequacy of comprehensive health care planning at national level and overall lack of coordination.
ii) The dilemma of basic health care Vs sophisticated health care - problems of perspective.
iii) Increasing inappropriateness of existing health care service and non-availability to majority.
iv) Pressure on limited resources of a complex epidemiological situation in the future i.e., diseases of poverty and diseases of development/modernization occurring side by side.
v) Increasing rural-urban disparities.
vi) Increasing government priority to high technology medical care.
vii) Inadequate planning of secondary health care.
viii) Universal access to health system, particularly to the poor.
ix) Effective referral system beyond primary health care/centre.
x) Need for greater clarity in content, direction, objectives and strategies of public health policy.
xi) Clarifying role of public/private/NGO philanthropic groups in development of services. Harmony with autonomy within a negotiated overall framework of policy and priorities.
xii) More equitable distribution of health care delivery, corresponding to population distribution and need.

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2. Costing and Financing of Health Care - The issue of investment.

These would include issues like:

i) Less and less government allocation of funds for health care.
ii) Tightening belt and increasing austerity - affecting welfare and health investments.
iii) Rising prices of food, drugs and equipment.
iv) Higher cost of treatment, beyond economic capabilities of majority.
v) Escalation of cost of drugs and equipment by MNCs in the name of quality, intellectual property rights etc.
vi) Rise of consumerism and the market economy.
vii) Increasing privatization/commercialisation of health care.
viii) The question of affordability of higher tech medical care.
ix) The quest for cost effective medical care.
x) The challenge of organising self-financing and self-support systems including health cooperatives etc.

3. Human Health manpower development - chellenges and problems

This will include on the one hand inadequate supply of the right type of doctors to run the system because:

i) Medical education remaining inappropriate for our needs.
ii) Mushrooming of medical colleges and declining quality of medical education.
iii) Over-specialisation among doctors and inadequate availability of GPs.
iv) Lack of committed medical personnel.
v) Medical profession becoming a lucrative business rather than a service profession with doctors becoming very money minded.

On the other hand there will be a lack of intermediate people with medical expertise as well as lack of village based health workers. There will be need for seriously re-looking at categories of health training including doctors.

4. Rational Drug Policy

The availability of adequate drugs for the health care delivery system must be ensured by a rational drug policy that clearly identifies roles and limits for drug production, availability, distribution and sale for the government, multinational and small industry sector and controls medical advertisement as well as misuse, overuse of drugs.

5. Primary Health Care Issues

The commitment of Health for All (HFA) through Primary Health Care will include the challenge of providing:

i) Primary Health Care services - accessible to all

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ii) Primary education for all.
iii) Minimum housing facilities for all.
iv) Increasing health education and health awareness building. In the community and particularly in schools.
v) Need for appropriate technology in health care.
vi) Need for increased accountability of government health care services.

6. Secondary/Tertiary Care Issues

These will include the issues of affordability of high technology medical care, priorities and need for appropriate choices at different levels. Quality of care will also become important. This concept will need definition as well as the development of a system of quality assurance.

7. Health Education

This will be an important issue and will have to be actively pursued to develop more positive health attitudes and capacities towards primary good health at all levels and stages of life.

The school system will need to be more involved and the consumers made more aware of the available services. Care will have to be taken not to allow health education efforts to become commercialised.

8. Integration of medical systems

There will be need to integrate various health systems, western and indigenous, into an overall system of service delivery with mutual learning and even fertilization between systems. For this the inadequate emphasis and promotion of other systems will have to be changed towards a more supportive development - standardising, regulating, researching and priority setting in these systems.

Efficacy of indigenous systems of medicine and research on herbal medicines and home cures will become important issues.

9, Research in Health Care

Issues for greater research in the new health scenario will be

i) research into alternative approaches to medical and health care including efficacy of other systems.
ii) deeper study of social psychology to understand health behaviour.
iii) increased focus on womens' health issues.
iv) increase research into holistic health care and related issues

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10. Towards Holistic Health

Finally the issue of Holistic/wholistic health in the context of a positive wellness model will become increasingly important with stress on the five basic dimensions:of self responsibility, nutritional awareness, environmental sensitivity, physical fitness and stress awareness and management. This will have to be built on our own rich heritage and culture of positive health especially in the Ayurveda/yoga system.

The overall health scenario painted by the panelists may appear somewhat stark and bleak but looking at it from a more positive angle one could conclude that the scenario of health and health care in the next fifteen years will need a creative, multi dimensional, multi disciplinary and holistic response and this will be the greatest challenge facing health organisations such as CHAI by 2000 AD.