STATUS OF CHRISTIAN MEDICAL WORK: PRESENT AND FUTURE

DR J. RICHARD
and
DR. P.S.S. SUNDAR RAO

C.M.C VELLORE

SEPT. 1986

STATUS OF CHRISTIAN MEDICAL WORK

PRESENT AND FUTURE

[redacted] HEALTH CE

(A Study of member institutions of
the Christian Medical Association of India)

Dr. J. RICHARD

and

Dr. P. S. S. SUNDAR RAO

Department of Biostatistics
Christian Medical College
Vellore-632002

September 1986

Table of contents

LIST OF TABLES

ACKNOWLEDGEMENT

We thank all the respondents for patiently answering our lengthy questionnaire and the staff of the Department of Biostatistics for their help in analysing the data and for preparation of report. We are grateful to Dr.Daleep S.Mukarji for giving us the opportunity of doing this study.

Status of Christian Medical Work - Present and Future

(A Study of Member Institutions of CMAI)

SALIENT FINDINGS AND RECOMMENDATIONS

One of the priorities of the CMAI, mentioned in the policy statement is leadership development. This is a felt need of most of the institutions. Training programmes should be organised for untrained hospital administrators, directors and medical superintendents on management of hospitals and health programmes. Before an young graduate is posted as head of any hospital, as the exposure to management and administration is very limited during the training leading to MBBS degree, good training programme should be organised which includes both theoretical and practical aspects of management. Special emphasis should be given on the role of committees, its composition, the method of making best use of the committees, and the advantages and disadvantages of different types of persons constituting the committee. For example, when a politician is a member of a committee the method of getting governmental and politcal support to the institution through that member should be taught. Similarly when clergy is included in the committee the way of deriving benefits from the church and its members through the clergy should be taught. The tact of give and take in the committee, and using it to the best advantage of the institution should also be emphasized.

The problems experienced by the respondents regarding management are mostly those arising at the higher level in management. More specifically the major problem pointed out by many is the difficulty to convince the higher level management body or committee about the needs and priorities of their institutions. According to the respondents this difficulty occurs mainly because most of the members of the management body or governing body are not from health or medical profession. They are mostly clergy or lay persons who have very little experience in hospital administration. These persons should also be given orientation towards the role of hospital and health centres, the role of committees in the management of health institutions, the part played by each member in promoting health through this institution and also the special nature of administration of health institution and the problems arising in dealing with hospitals, their staff and patients. A refresher course for the management body could be a solution for this, followed by visiting all administrative personnel from the CMAI. This course can be conducted at the time when CMAI conference takes place.

It is found that among general hospitals, small hospitals have more problems in the management process than big hospitals. Probably the big hospitals had undergone this propblem stage and then stabilised. This means small hospitals with upto 100 beds, which are the pattern of most of the CMAI affiliatd institutions, need guidance for management. Those who are posted for these small hospitals should be given proper training in management

process before they take charge of these hospitals. The CMAI can, for this purpose, prepare guidelines for management process of small hospitals and keep some model institutions which are good in management and patient load but small enough to serve as replicating centres and use these institutions for giving practical training to the future heads of small hospitals. The guidelines should also give a model staff service rules and information regarding tackling trade union activities. Some aspects of the human resources development, staff training, making use of students and other trainees for the best advantage of the hospital should also be included in the guidelines or training programme.

One of the major problems spelt out by the respondents is lack of finance. This may mean two things, first they may not know the various agencies which are giving funds for medical and health care, and secondly they may not know how to approach the agencies and how to make a case for their own institution to get adequate funds. The refresher course or the orientation course must also include training on how to write a successful project proposal. The CMAI journal can publish, the addresses of various funding agencies and their interests.

Many institutions say that they lack experienced senior staff. CMAI can help by grouping some bigger hospitals with smaller ones so that the senior members of the bigger hospitals can, on a regular basis, visit the smaller hospitals and give

training to the staff of smaller hospitals. They can also discuss with them about their problems of management.

One area of concern is generating funds internally, it is heartening to find that quite a good number have enough funds for maintenance through patient fees and other internal sources. The hospitals may be encouraged to introduce paying beds so that these beds generate some income to the institution.

The views expressed by the respondents about non-medical administrators are quite interesting. Those who have not had any experience of having non-medical administrators in their institutions do not favour such administrator. At the same time, a large proportion of respondents who had non-medical administrator with them would like to have such person in their institutions and also they have favourable views about them. This reveals that not only non-medical persons should be given training on hospital administration but also the senior medical personnel should be given orientation about the role of non-medical hospital administrator and the advantages of having them. The major advantage of having non-medical administrator is releasing senior medical personnel for medical work. They will not be tied up with too much of administrative work. It is a common sight to see tha in small medical institutions, good senior medical personnel ar tied up with manifold administrative matters and thus are not abl to make themselves available for medical work.

Similar to the experience of non-medical administrators is the response on matters relating to sponsorship. Most of the institutions who had enough experience in sponsoring for various courses, express the views that the sponsored persons would return back and work. They also indicated that the sponsored candidates would be useful. At the same time a good proportion of these who had no experience in sponsoring their staff have mentioned that sponsoring is not good and sponsored candidates do not return back and work. Such institutions should be educated on the value of sponsoring proper selected staff to fill in their future vacancies.

Institutions with low emphasis on community health programmes said that they did not have proper manpower to manage and carry out community health programmes. In general the approach of both preventive primary health care and appropriate referral hospitals should be emphasized as stated in the policy statement of the CMAI. This means every institution should be encouraged to have a component that involves community health based on participation by the community and working with the community. A good training for management of such programmes is carried out by RUHSA under the name, Diploma course in Community Health and Management. Candidates who have undergone the diploma in Community Health and Management can motivate the staff, generate support, work among the people and start or revitalise the community health program on proper foundation. Once this is

done, agencies who could finance specific programs can be approached for funding either general community health program or financing special project which would involve specific areas of community health. The hospital will function as referral centre in whatever capacity it may be for the community. The CMAI can help in publicising the course and offer scholarship for persons from small institutions to take up this course. The training leading to diploma in community health and management will go a long way to solve this problem.

The problems of getting adequate committed staff and the problem of turnover of staff are mentioned very frequently. This is the problem faced by all institutions, both small and big. So, constant sponsoring of local candidates who have shown promise of returning back and working in the hospital must be done taking into account the future needs of the institution. The problem of institutions situated in very remote areas are that ;the staff are not getting either proper quarters to stay and / or have no good facilities for the education of their children. Education of children of staff, a welfare programme, should be a concern of the institution. The CMAI may select atleast one good school in each region and enter into agreement with the school authorities for admission of children of staff who are working in remote areas. It may also be necessary for CMAI to obtain hostel facilities for such students. This would reduce staff turnover, especially of experienced staff because of lack of education facility for their children.

In all institutions we find that more than 90% of the community served are the people belonging to the local area, viz., Hindus in Hindu dominated area and Muslims in Muslim dominated area. So, these institutions serve all religious groups and community group without any distinction which is in accordance with the policy statement expressed by CMAI. This character of these institutions serving all people should be encouraged.

Another encouraging aspect is that all institutions extend free or concessional treatrment to a large number of patients. Proper agencies including the government may be approached to reimburse the money spent on free or concessional treatment. Some of the institutions which have been successful in getting such funds can share their experiences with other institutions.

Although most of the training programmes fortify medical care facilities, many new train programmes are mentioned by various institutions which will indirectly increase the health status of the community. Such training courses aim at increasing the economic and social level of the community in general and upliftment of the poor and the vulneravle group in particular. CMAI can evaluate these new programmes to find out the usefulness and if they are found useful these courses can be advocated to other institutions. This would go a longway towards providing a better life for the poor and weaker sections of our country.

September 1986.

Status of Christian Medical Work - Present and Future

(A STUDY OF MEMBER INSTITUTIONS OF CMAI)

1. Objectives of the Study

In response to the request of the Christian Medical Association of India(CMAI) a study was conducted of all member institutions of the CMAI to find out the status of Christian Medical work done by them. The specific objectives of the study are to find out

a. the ownership / management and leadership of the institutions

b. services offered by the institution and their training programmes

c. broad areas of source of finance

d. staffing pattern and their needs

e. contact with the community served

f. religious activities

g. targets, goals and future plans

2. Institutions included in the study

A directory containing the addresses of all member institutions of the Christian Medical Association of India was used to identify the institutions covered by the study. All the 312 current member institutions situated in 22 States and Union Territory of India were sent a questionnaire.

Four questionnaires, (three in Andhra Pradesh and one in Tamil Nadu) were returned back with a note stating that no senior staff was available to fill out the details. After excluding those four hospitals, the total number of eligible institutions from which we expected answers was 308. Of these, the largest number 43 (14.0%) was in Kerala and 40 (13.0%) was in Tamil Nadu. The four southern States have 140 (44.5%) institutions. These four States along with Maharashtra cover 56.5% of the institutions.

The total number of filled out questionnaires received (up to 1-4-86) was 240, which is 77.9% of the total eligible institutions (Table 1). West Bengal, Himachal Pradesh, Delhi, Jammu & Kashmir and Mizoram returned 100% of the questionnaires. However these states have very small number of institutions. Nagaland which has only two institutions has not returned any. Among the states with many institutions, the percentage of

TABLE 1 RECEIPT OF FILLED QUESTIONNAIRES AS OF 1-4-1986

S.No.	STATE	No. of Eligible Institutions	No.of filled Questionnaires received	% of filled Questionnaires received
1.	Andhra Pradesh	38	35	92.1
2.	Assam	14	7	50.0
3.	Bihar	16	13	81.3
4.	Delhi	2	2	100.0
5.	Gujarat	8	6	75.0
6.	Haryana	3	2	66.7
7.	Himachal Pradesh	6	6	100.0
8.	Jammu & Kashmir	1	1	100.0
9.	Karnataka	19	17	89.5
10.	Kerala	43	32	74.0
11.	Madhya Pradesh	28	21	75.0
12.	Maharastra	34	25	74.4
13.	Manipur	2	1	50.0
14.	Meghalaya	3	2	66.7
15.	Mizoram	2	2	100.0
16.	Nagaland	2	0	0
17.	Orissa	8	5	62.5
18.	Punjab	5	3	60.0
19.	Rajasthan	3	2	66.7
20.	Tamil Nadu	40	35	87.5
21.	Uttar Pradesh	26	18	69.2
22.	West Bengal	5	5	100.0
	Total	308	240	77.9

response was, Andhra Pradesh 92%, Karnataka 89.5%, Tamil Nadu 87.5%, Madhya Pradesh 75%, Kerala 74% and Uttar Pradesh 69%. Those who have not responded included some women's Home/project, institutions for leprosy, dispensaries and small health centres.

The types of institutions vary widely, ranging from small dispensary (with only outpatient facility) to specialised hospital such as chest hospital (Table 2). General hospitals with various bed strength are 195 (81.2%); so majority of the institutions are of this category. Development projects in the rural or urban areas are 9. These include 3 centres with no beds (one is situated in an urban area), a welfare centre with 65 beds and a non-medical welfare centre (Seva Mandir with no medical work). Altogether there are 30 Institutions treating leprosy. Twenty of them are also doing leprosy community health work, one is doing ophthalmic and leprosy work and the remaining 9 institutions are 'Leprosy hospital and Home' which do not have any community health work. Among the six specialised hospitals, two are hospitals for women and one each of opthalmic hospital, Tuberculosis hospital, Chest hospital and Psychiatric hospital.

Nearly a quarter of the institutions (24.2%) have 21 to 50 beds and another quarter (26.6%) have 51 to 100 beds. A little over one fifth of the institutions (22.9%) have 101 to 200 beds. Big hospitals with more than 200 beds are only 26 or 10.8% . So mostly the institutions are small. Among the 195 general hospitals, a little over half the institutions (54.1%) have up to

TABLE 2 TYPE OF INSTITUTION

Type	No. of institutions	
	No.	%
General Hospital	195	81.2
Development Projects (Rural/Urban)	9	3.8
Institutions for leprosy patients	29	12.1
Other specialised institutions	7	2.9
Total	240	100.0

25% of all their beds as private beds and 27.9% of the institutions do not have any private bed at all.

3. Ownership/Management

These 240 institutions are owned and/or managed by Churches or diocese or Mission Trust or a Board, Association or Fellowship or Ashram. In other words they are owned by registered organisations. A large number of these institutions are run by the Church of South India (49, 20.4%), and the Church of North India (24, 10.0%). The Leprosy Mission (and Trust) runs 17 (7.1%) institutions and Methodist Church of India runs 14 (5.8%) institutions.

Answers indicating management system is provided by 235 respondents. Of those 16.1% have two tier system, 55.0% have three tier system and 25.7% have more than 3 tier system. Similar situation is reported for the decision making process.

It is good to find that 140 institutions (62.8%) are not having any bottleneck in the management process (Table 3). Only 83 (37.2%) have some problems or bottlenecks in the management process. (This information is not given by 17 institutions). Among general hospitals there is an indication that small hospitals (with less than 50 beds) have more problems of management than big hospitals. As the number of beds in the hospital increases the percentage of institutions with problems in

CMAI

Table 3

Bottleneck or Problem in Management Process and type of Institution

Type of Institutions		Any Bottle neck or Problems in Management Process			
		Yes	No	Not Recorded	Total
a. General Hospital					
1 - 50 beds	No.	30	28	8	66
	%	45.5	42.4	12.1	100.0
51 - 100 beds	No.	21	29	3	53
	%	39.6	54.7	5.7	100.0
101 - 200 beds	No.	18	23	2	43
	%	41.9	53.5	4.7	100.0
Above 200 beds	No.	5	19	0	24
	%	20.8	79.2	0	100.0
Total for a	No.	74	99	13	186
	%	39.8	53.2	7.0	100.0
b. Hospital and Rural Health Centre	No.	0	8	1	9
	%	0	88.9	11.1	100.0
c. Develoomeni project and Welfare centre	No.	3	6	0	9
	%	33.3	66.7	0	100.0
Total for b & c	No.	3	14	1	18
	%	16.7	77.8	5.5	100.0

contd...

TABLE 3 (contd.)

		Yes	No	Not Recorded	Total
d. Leprosy with Community Health	No.	5	15	1	21
	%	23.8	71.4	4.8	100.0
e. Leprosy Hospital and Home	No.	0	8	1	9
	%	0	88.9	11.1	100.0
Total for d & e	No.	5	23	2	30
	%	16.7	76.7	6.7	100.0
f. Specialised Hospital	No.	1	4	1	6
	%	16.7	66.6	16.7	100.0
Total	No.	83	140	17	240
	%	34.6	58.3	7.1	100.0
	(%	37.2	62.8)*		

* Percentage taken including 17 cases which have not given this information

management process decreases. (More over the percentage of institutions which have not given this information is also high for small hospitals and low for big hospitals). So, during the process of expansion the management problems settle down paving way towards smooth functioning. Therefore smaller hospitals with less than 50 beds which are the pattern of most of the CMAI affiliated institutions need guidance for management. The persons in charge of these have to be trained to take care of small hospitals and also members of management committee should be given orientation in the management of these institutions.

Not all big hospitals are free of problems. Nearly one fifth of the general hospitals with more than 200 beds have problems in their management process. There are two groups of institutions which do not have this problem. They are small hospitals with Rural Health Centre and 'Leprosy Hospitals and Home'. Although small in number, one third of the institutions which are classified as development project and welfare centre and also about one fourth of the institutions classified as 'leprosy with community health' have problems. The solution may be to help tackle each institution of this category separately after ascertaining their specific problems.

A total of 95 problems or bottlenecks in management process is given by these 83 respondents. The problem frequently mentioned by most of the respondents are related to the management

process at the higher level in management. The major problem mentioned by many of these is the difficulty to convince the higher level management body or committee about the needs and priorities of their institutions. This difficulty occurs mainly because most of the members of the management body or governing body know little about health or medical care delivery. They are mostly clergy and they have little experience on administration and management. Specifically they do not understand hospital management field. Next is the delay at higher level in decision making. The current management process does not allow decisions to be taken by the local chief such as medical superintendent or business manager. They have to wait for the decision from higher level even for essential aspects like appointment of staff, getting funds for medicine and so on. This interferes in the smooth functioning of institution. The reasons for this delay are, the decision making process at the higher level is very long, indecision and postponement of many items at the higher level, infrequent meeting of the board, because the board members are living far away and scattered over a large area and hence the difficulty to convene a meeting at a short notice, lack of understanding and co-ordination and lastly lack of understanding of the local needs by the management committee.

The bottle-necks or problems at local level are, Church politics spilling over hospital administration, interference of

Church authorities in the running of hospital, personality clashes among the different members at the local level, no demarcation of duties and responsibilities of different administrative members at local level. Apart from these the Medical Superintendent who likes to be involved in professional activities has to spend more time in administrative work. In some institutions, the existence of gap between management and staff, interference of labour union in the hospital administration, lack of spirit of dedication and problems which have not been solved for a long time are contributing for this. In a few institutions untrained business manager, lack of physical facilities also contribute to problems in management. Eight respondents have said that financial contraints are the bottle-necks.

We asked whether senior staff are available in the institution and if so how many were there. In most of the institutions experienced senior staff are available. In fact, in about one third of the institutions (30.9%) senior members with more than 25 years of experience are available. In another 15.4% of the institutions there are senior members having 21 to 25 years of experience. The senior members who lead the institutions are having only 5 years (or less) experience in 12 institutions. For the question whether there is a trained hospital administrator in the institution 63 (23.3%) answered affirmatively and 174 negatively (72.5%). Therefore there is an overwhelming majority without a trained hospital administrator. They are mostly small hospitals. .

Among the general hospitals, those with higher number of beds have higher percentage of trained administrators than hospitals with lower number of beds. In fact, general hospitals with less than 50 beds have trained administrators only in 10 institutions (15.2%), whereas 37.5% of general hospitals with more than 200 beds have trained administrators. The category of institutions classified as Development Project and Welfare Centre do not have any trained administrator. So strengthening of hospital administration through trained hospital administrators is desirable.

Among all respondents 47% have favourable views about non-medical administrator and 32.6% have definite unfavourable views. 68.4% of the hospitals with trained administrator have favourable views about non-medical hospital administrator in comparison to 39.2% of the hospitals without a trained hospital administrator. 19.3% of the institutions with a hospital administrator have unfavourable views in comparison to 37.3% of the institutions without a hospital administrator. When respondents were asked to write whether more hospitals should be encouraged to have a non-medical hospital administrator, 127 (58.5%) said yes and 76 (35.0%) said no. Only 7 respondents said that it depended on the size of the hospital. (A total of 23 institutions did not answer this question). Those who have trained hospital administrators said that more hospitals should be encouraged to have trained hospital administrator. To put it

precisely, 77% of the hospitals with a trained hospital administrator and 51.3% of hospitals without a trained hospital administrator.

It is found that in institutions where a trained hospital administrator is available the proportion with problems in management process is less. 30.5% of the institutions with trained hospital administrator has problems in the management process compared to 39.9% of the institutions without any trained hospital administrator.

4. Services

The catchment area (in terms of population) of these institutions vary from 2000 to 'all over India'. Many institutions specified the area of one district; some have said four States and some of them might have taken into account the longest distance from which the patients come to their institutions. In general, many institutions do not have defined catchment area.

Most of the institutions provide general medical services. Table 4 gives community health services classified according to the type of institution. Of the 224 institutions answered the question on community health services, 203 (90.6%) have some kind of community health services. Among the general hospitals a majority has community health services. Hospitals with lower number of beds, involve less frequently in community health

TABLE 4

Community Health Service and Type of Institution

Tyoe of Institution		Community Health Services			
		Yes	No	Not Recorded	Total
a. General Hospital					
1 - 50 beds	No.	53	10	3	66
	%	80.3	15.2	4.5	100.0
51 - 100 beds	No.	45	5	3	53
	%	84.9	9.4	5.7	100.0
101 - 200 beds	No.	41	-	2	43
	%	95.3	-	4.7	100.0
Above 200 beds	No.	22	2	-	24
	%	91.7	8.3	-	100.0
Total for a	No.	161	17	8	186
	%	86.6	9.1	4.3	100.0
b. Hospital and Rural Health Centre	No.	9	-	-	9
	%	100.0	-	-	100.0
c. Development project and Welfare Centre	No.	9	-	-	9
	%	100.0	-	-	100.0
Total for b & c	No.	18	-	-	18
	%	100.0	-	-	100.0

contd..

TABLE 4 (contd)

		Yes	No	Not Recorded	Total
d. Leprosy and Community Health	No.	20	-	1	21
	%	95.2	-	4.8	100.0
e. Leprosy Hospital and Home	No.	1	3	5	9
	%	11.1	33.3	55.6	100.0
Total for d & e	No.	21	3	6	30
	%	70.0	10.0	20.0	100.0
f. Specialised Hospital	No.	3	1	2	6
	%	50.0	16.7	33.3	100.0
Total	No.	203	21	16	240
	%	84.6 (90.6%) *	8.8 (9.4%) *	6.7	100.0

* Percentage excluding Not Recorded Cases

services than those with more beds. The percentage of these hospitals involved in community health services ranges from 80.3 to 91.7%. The population covered by community health service was less than 10,000 in 36.4% of the institutions and from 10,000 to 25,000 in 13.6% of the institutions.

The nature of the problems in carrying out community health programmes were summarised and listed in table 5. 32 institutions said that they never had any problems and one Institution said that it needed more time to evaluate. Majority of them are problems regarding finance, lack of funds to carry out community programmes. Next to that is lack of staff; they need field staff or regular full time staff for community health work, and the staff of the base hospital neither have good training for village work nor find time to be away from the base hospital. Another main problem was the motivation of staff or commitment of staff for community health work. One of the responses was that there was lack of infrastructure for the staff such as quarters, education facilities for the children (when they are posted in very small rural areas). Besides finance and staff, the next problem is the community itself. The community is neither interested nor co-operative and also not participating in their programmes. Some responses highlighted social taboos, superstition and cultural beliefs of the community which act as barriers for the modern community health programme. Eight

TABLE 5

Problems in Community Health Programme

Problems	No. of problems/Institutions	
a. Finance	No.	%
Funds	53	22.4
b. Staff		
Qualified/full time staff for village work	42	17.7
Motivation of staff/committment of staff	11	4.6
No infrastructure for staff e.g. (1) education of children (2) No accommodation for Nurses	2	0.8
c. Planning & Organisation		
No expert to lead & plan	4	1.7
Lack of day to day planning	1	0.4
No organization	4	1.7
More patients at base hospital	1	0.4
d. Physical Environment		
Poor road	5	2.1
Hostile terrain	6	2.5
No transport facilities/No vehicle	25	10.5
No building at periphery	2	0.8
e. Supplies		
No vaccines from Government for immunization programme	5	2.1
Lack of educational aids	1	0.4
f. Community		
Illiteracy	9	3.8
Expects everything free	8	3.4
Poverty &/unemployment	12	5.1
Expects a hospital	1	0.4
Not interested/not co-operative/ not participating	22	9.3

contd.•

TABLE 5 (contd.)

f. continued

	No.	%
Social taboos/superstition/ cultural beliefs	16	6.8
Exploitation by the well-to-do	3	1.3
Resistance of local indigeneous practitioners	1	0.4
People do not understand	1	0.4
g. Others	2	0.8
Total problems	237	100.0
Needs more time to evaluate	1	
Institutions with no problems	32	
Institution not given the information	40	

respondents said that the community expects everything to be given free. In fact "It is always take not give". Poverty, unemployment and illiteracy of the villagers are also considered as problems in carrying out community health programme. Because of the illiteracy they could not understand the importance of health. Special type of education which does not involve written script is necessary to teach them health matters. Physical environment such as poor road and hostile terrain and lack of transport facilities were also mentioned as problems by a large number of respondents. Non-receipt of supplies such as vaccines from the Government for immunisation programme was mentioned by five respondents. Only a very few respondents mentioned that lack of planning, or no expertise to lead them to proper organised community health programme as the problem. All these show lack of expertise on organisation and management of community health programmes.

The question on rehabilitation services was answered by 222 institutions and only 7Ø (31.5%) institutions offer these services. Some institutions have specifically mentioned their nature of the rehabilitation programme (such as Tailoring, cottage industries) and some institutions have mentioned the diseases for which rehabilitation programmes are offered. Among the specific programmes offered, cottage industries, and agriculture are frequent and among the diseases, rehabilitation for leprosy is

the most frequent. Special mention must be made of the rehabilitation programme for alcoholics and drug addicts conducted by two institutions.

In all institutions all religious groups are served. Its distribution depends on the religious composition of the population residing around these institutions. Except in 2 institutions where 90% of the community groups are muslims and in another 3 institutions where 90% of the community around them are Christians, in all other places the majority served are Hindus. All these institutions serve people of all communities including scheduled caste and scheduled tribes. Almost all (97.7%) institutions have offered free treatment to deserving cases. All hospitals of 'leprosy with Community Health' and institutions with Rural Health Services have provision for free or concessional treatment. Among general hospitals 95.8% of the institutions with more than 200 beds in comparison to 89.8% of hospitals with less than 50 beds have provision for free or concessional treatment.

Only 14 institutions are situated in areas where no other private practitioners operated. So these areas are served by only these member hospitals. There are 19 institutions (8.2%) in whose area one more private practitioner operates. In 9.9% of the institutions' area, 2 to 4 private practitioners are also operating. It is really revealing to find that in 101 institutions' area (43.6%) many (4 or more than 15) private

practitioners have been working. There are instances where the facilities of the member hospitals are shared by other private practitioners. In 93 institutions no private practitioner shares the facilities. In 37 (17.2%) institutions one private practitioner shares the facilities. In 11 institutions (5.1%) many private practitioners share the facilities. The number of hospitals which are situated in places where no other Government Hospitals exist is 14 (5.7%). In areas where 146 hospitals are functioning, a Government Hospital is already functioning within 1-3 miles distance. This shows that in a majority of the areas served by the member institutions Government hospitals or medical institutions run by other organisations are also existing. There seems to be a trend among general hospitals. That is, the percentage of medical institutions run by other organisations in that area is low in areas where general hospitals with 50 beds are functioning and high for those with more than 200 beds.

5. Training Programmes

Courses offered by the institutions range from highly formal specialised post graduate courses in medical sciences to nonformal courses such as adult literacy and sewing course. (Table 6). Some of the institutions, although do not run basic M.B.B.S. course, by virtue of their specialization, are recognised for training of medical post graduate candidates (either full course or part of the course). Medical officers and also medical

TABLE 6

Courses offerred by the institution

Type of course	No. of institutions	Section Total
A. Medical		21
M.B.B.S.	2	
P.G. Courses	9	
Housemanship	7	
Medical Officer Training	1	
Medical Students Training	1	
M.Sc. (Non clinical)	1	
B. Nursing		71
General Nursing	57	
Post Cert. B.Sc.	2	
B.Sc.	1	
M.Sc.	1	
G.G.A.A. Nursing	1	
Anaesthesia Nursing	3	
Step ladder Nursing	1	
Opthalmic Nursing	1	
Practical Training in Nursing	2	
Advanced Midwifery	2	
C. A.N.M. and Dai Training etc.		42
A.N.M.	28	
Dais Training	1	
Nursing Aids	6	
Nursing Assistants Course	3	
Ward Aid Course	1	
First Aid Training	2	
Hospital Auxilary	1	

contd

TABLE 6 (contd.)

Type of course	No. of Institutions	Section Total
D. Physiotherapy (Occupation Therapy)		8
Degree Course in Physiotherapy(B.P.T.)	1	
Degree Course in Occupation Therapy (B.O.T.)	1	
Physiotherapy Technician	2	
Physiotherapy Polio Technician	1	
Physiotherapy Technician (Leprosy)	3	
E. Paramedical Courses		51
All Paramedical Courses	1	
Non medical Supervisor	2	
Paramedical Leprosy Worker	4	
Theater Technicians Course	1	
Splint Technician	1	
Leather Technician	1	
Radio diagnosis	9	
Diploma in Pharmacy	2	
Diploma in Health Statistics/ Dietetics/Hospital Administration	1	
Medical Record Technician	2	
Bachelor of Medical Record Science	1	
Laboratory Technician	26	
F. Health and Management		34
Community Health & Management	1	
Community Health Guides	3	
Community Eye Health Field Workers	1	
Basic Health Worker	2	
Village Health Worker	9	
Wholistic Health	1	
M.P.H.W.	8	
Health Staff	2	
Health Worker	4	
Village Level Worker	3	

contd

TABLE 6 (contd.)

Type of course	No. of Institutions	Section Total
G. Others		14
Business Management	1	
Office Management	1	
Vocational Training	1	
Animator	1	
Creach running	1	
Adult Literacy	1	
Sewing Course	3	
Carpentary	1	
Handicrafts	1	
Training the Trainees	1	
Transactional Analysis	1	
Advanced Transactional Analysis	1	
TOTAL		241

TABLE : 7

TYPE OF COURSES WHICH ARE RUN BY INSTITUTIONS THEMSELVES

TYPE OF COURSE	NO.OF INSTITUTIONS
Nursing/Nursing aid	
Practical Training in Nursing	2
Opthalmic Nursing	1
Advanced Midwifery	1
Nurses aid Training	5
Nursing assistant courses	3
Paramedical Courses	
Physiotheraphy Technician	1
Laboratory Technician	3
Theatre Technician	1
Health and Management	
Community Health & Management	1
Community Health Guide	1
Community Eye Health Field Worker	1
Basic Health Worker	1
Village Health Worker	8
Village Level Worker	2
Health Staff	1
Others	
Advanced Transactional Analysis	1
Transactional Analysis	1
Training the trainee	1
Creach running	1
Carpentary	1
Seuing Course	1
TOTAL	38

students from other colleges come to such special institutions for short-term training. Of all the courses run by the institutions, nursing courses are conducted by a large number of institutions (run by 71 institutions). General nursing is the most frequent among all courses. Among nursing courses General nursing stands first (57 institutions offer this) next is ANM training (28 institutions offer this), next is laboratory technician's course (27 institutions offer this). Thirty four courses are related to community health, ranging from community health and management to training of village level worker. Courses on social and economic development aspects of the poor people, such as adult literacy, handicraft training are given by only a few institutions. 9.1% of these courses are affiliated with an organization/organ of the State Government, 24.5% of the courses with CMAI, 23.7% of the courses with Nursing Council and 4.1% of the courses with an organization at the All India Level. The courses run by the institutions themselves is 15.8%. These courses are innovative, of short duration and of informal type (Table 7).

Of all the training courses, 39% are of one to two years duration and another 30.7% are of less than 12 months duration. In 43.6% of the courses the number of students admitted per year is 10 or less and in another 28.6% of the training courses 11 to 20 students are admitted.

TABLE 8

Trend of out patient attendance during the last five years

Trend of out patients over last five years	Number of Hospitals No.	%
Increasing	82	37.6
Decreasing	29	13.3
Fluctuation (No definite trend)	107	49.1
Total	218	100.0
Not Recorded	22	9.2
Total	240	100.0

TABLE 9

Trend of inpatients over last five years

Trend of inpatients over last five years	Number of Institutions No.	%
Increasing	74	36.6
Decreasing	25	12.4
Fluctuating (No definite trend)	103	51.0
Total	202	100.0
Not Recorded	38	16.5
Total	240	100.0

6. Patient Load

The institutions vary in turnout of patients considerably. They range from less than a thousand to more than one lakh out patients per year. About one third of the institutions have out patients between 10,000 and 25,000 per year. Six institutions (2.7%) get more than one lakh out patients a year. In 40.4% of the institutions the sex distribution of outpatients were not available. Among the institutions from which such statistics are available, 59.4% of the institutions have more female patients than male patients. The trend of outpatient attendance (Table 8) indicates that 37.6% of the institutions have increasing trend of outpatient attendance, 13.3% of the institutions show a decreasing trend, and in a large proportion (49.1%) there is no definite trend. An oscillating trend may also indicate oscillating income through outpatients.

Similar to out patients, the number of female inpatients is higher than the male inpatients in 58.1% of the institutions. (Sex distribution of inpatients are not available in 39.6% of the institutions). Just like outpatients in half of the institutions (51%), there is no definite trend of inpatients over the last five years. It is encouraging to note that, in 36.6% of the institutions there is an increasing trend (Table 9).

Among the general hospitals 4 institutions had less than thousand out patients during 1984. Among the hospitals with less than 50 beds, 40.9% have 1000 to 10,000 out patients in a year. Another 34.8% have 10,000 to 25,000 out patients. Hospitals with larger beds, as anticipated, had large number of out patients. We find that 29.2% of hospitals with more than 200 beds have 25,000 to 50,000 out patients and another 25% have more than 1,00,000 out patients in 1984. More over larger proportion of bigger hospitals show an increasing trend of out patients during the last 5 years than the hospitals with less than 50 beds. The number of institutions and percentage of institutions which do not show steady trend, are distributed nearly equally among hospitals with less than 200 beds. The number of inpatients during the last five years showed that there was no trend over the size of hospitals. Nearly a large percentage of all size hospitals showed irregular fluctuations in the trend. This is not a healthy situation for these hospitals, because it is very difficult to plan for future if no proper trend is visualised.

Among the States with more than 10 institutions, the highest proportion of the institutions (18.4% for inpatients and 28.9% for out patients) with decreasing trend of inpatient and out patient attendance is in the Andhra Pradesh.

The bed occupancy shows that 38.1% of the institutions have more than 75% of occupancy and 34% have 51% to 75% occupancy.

Only a few (11.6%) have occupancy less than 25%. From this it inferred that most of the institutions do not have full occupan of their beds. Usually a bed occupancy of around 85% is taken full occupancy. (A total of 84 (35.0%) institutions did n supply occupancy rates, probably because they either do not kn how to calculate bed occupancy or do not keep the need statistics). The average length of stay of inpatients is le than 5 days in 21.7% of the institutions and 6-10 days in 50.9% the institutions. It is encouraging to find that 72.6% of t institutions have average length of stay less than 10 days.

Blood examinations were done in 185 (77.1%) institution Facility for stool examination exists in 181 (75.7%) institution A total of 183 (76.2%) institutions have facilities for uri examination. 165 (68.7%) institutions have facilities to sputum examination. 151 (62.9%) institutions have facilities t take X-Ray. Only 82 institutions have facilities to take EC Facilities for doing surgery exist in 184 (76.6%) institution Diagnostic aids such as facilities for blood examination, uri examination and so on do not exist in greater proportion amo smaller hospitals compared to bigger hospitals. This mea strengthening of diagnostic aids is necessary at the sma hospital level.

TABLE 10

Main Sources of Income for Capital Expenditure

Main Source	Number of Institutions No.	%
1. Self supporting	2	0.9
2. Fees, House rent etc (Hospital generated income)	59	26.6
3. Fees, donations & grants from government	13 *	5.9
4. Church/Mission (Indian)	23	10.4
5. Indian Mission with International connections	22	9.9
6. Gifts and donations	31	14.0
7. Foreign gifts/donation	56	25.2
8. Investment by one member (private)	1	0.4
9. No definite source	15	6.7
Total	222 (92.5%)	100
Not Recorded	18 (7.5%)	
Total	240	

* Includes loan from bank - 1

TABLE 11

Main Sources of Income for Maintenance (Recurring) Budget

Source of Income	No. of Institutions No.	%
1. a. Patients Fees	115	55.3
b. Patients Fee and Local contribution/Local Income	20	9.6
c. Patients Fees and Occasional Foreign Donation	15	7.2
2. From Abroad	11	5.3
3. Church/Synod/Ashram/Head quarters	25	12.0
4. Donations and Gifts	5	2.4
5. Leprosy Mission	17	8.2
Total	208	100.0

Specific Purpose Grant/Fee

CMAI	8
CRM	9
OXFAM	1
Government	7
BFW	1
TEAR Fund	1

7. Finance

The main source of income for capital expenditure is given in Table 1Ø. Two institutions have declared that they are self-supporting. The next category of 59 institutions (26.6%) generate their income from fees, house rent and so on. All other institutions get some financial help from other sources. Foreign gifts and donations are the main source for another 56 (25.2%) institutions. Indian Missions with international net work such as the Leprosy Mission, SDA are the main source for 22 (9.9%) institutions. Indian Church/Mission or Diocese is the source of income for 23 (1Ø.4%) institutions. No definite source is available for 15 institutions. Thus the majority of the institutions depend on gifts, donations, grants etc. either internally or from abroad for their capital expenditure.

The main source of income for regular maintenance of the institution (recurring expenditure) was given by 2Ø8 respondents (Table 11). It is gratifying to note that more than half of the institutions (55.3%) meet all their maintenance expenditure through patient fee alone. In addition to these institutions 2Ø respondents have said that they meet all their maintenance expenditure through patient fees and local contribution or local income. Moreover 15 institutions completely rely on patient fees and occasional foreign donation. In other words 72.1% of the institutions have patient fee as the main source of income. The

second main source of income is the parent Church or Synod or the parent Society. This category of institution is 25 (12.Ø%). 17 institutions said that they get the main income for maintenance from Leprosy Mission India and Leprosy Mission International. Very few institutions get their income for maintenance from abroad (11 institutions, 5.3%). Some of them are running specific projects with grant earmarked for them. General funds and gifts are the main sources for 5 institutions. Apart from this, these institutions get earmarked grant or fee (for service) from various international agencies and organisations such as CMAI for tubectomy cases, CBM for eye services, Government for tubectomy beds and so on.

The information on the proportion of total income contributed by patients is given by 173 institutions. 16 (9.2%) institutions reported that there was no contribution at all by the patients. 9Ø institutions (52.Ø%) reported that they had received more than 76% as contribution by the patients. Moreover, in the majority of the cases contribution by local people is either nothing or negligible. In fact 59.6% of the institutions reported that they had no contribution by local people and another 22.3% have reported that the contribution by the local people is negligible. Similar situation exists regarding contribution by churches and congregations. Altogether 73.3% of the institutions recorded either no contribution or negligible contribution from the churches and congregation. No substantial income was got through other services in most of the institutions.

TABLE 12

Frequency of preparation of audited statement of accounts

Audited statement of accounts	Number of Hospitals No.	%
Twice a year	2	0.9
Once a year	219	97.3
Not once a year	4	1.8
Total	225	100.0
Not Recorded	5	2.2
Total	230	100.0

TABLE 13

Year for which the last statement of accounts was prepared

Year	Number of Hospitals NO.	%
1985	43	19.7
1984	167	76.6
1983	4	1.8
1982	2	0.9
1981	1	0.5
before 1980	1	0.5
Total	218	100.0
Not Recorded	22	9.2
Total	240	100.0

Audited statement of accounts are prepared by 230 institutions and only two institutions do not prepare this. (10 members have not given any information regarding this.) 219 institutions have replied that the audited statement of accounts have been prepared every year, and two institutions have said that the statements are prepared twice a year (Table 12). 43 institutions prepared the last statement of accounts for the year 1985. 167 members have prepared the last statement for the year 1984 (Table 13). It is interesting to note that only 125 (57.9%) institutions make provision for depreciation. It is equally interesting to find that 106 (47.3%) have received help from the Government. Mostly they received help for family planning work or for an earmarked project.

8. Staff

The strength of doctors in these institutions vary considerably. Most of the institutions (61.0%) have doctors up to 5. 26.6% of the institutions have up to 5 nurses. 47.2% of the institutions have 6 to 25 staff nurses. 118 institutions have up to 5 paramedical workers and another 37.1% have 6 to 25 paramedical workers. In a majority of the institutions (69.4%) more than 70% staff are Christians. The distribution of category of staff turnover is given in table 14. 30.7% of the institutions said that they had turnover problem of doctors, nurses and paramedical workers. Apart from this the single category in which

CMA I

TABLE 14

Category of staff in which turn over problem experienced

Category	Number of Hospitals No.	%
Doctor	16	8.5
Nurse	33	17.5
Paramedical	5	2.6
Administrator	2	1.1
Doctor, Nurse & Paramedical	58	30.7
Teaching staff	4	2.1
All	12	6.3
Others	14	7.4
No problem	45	23.8
Total	189	100.0
Not Recorded	51	21.3
Total	240	100.0

TABLE 15

Return of Sponsored persons for work

Do you sponsor anybody (for course) with the aim of adding to the staff		Do the sponsored persons/staff return promptly and work				
		Yes	No	Most of them/usually	Not desirable	Total
Yes	No.	131	17	14	2	164
	%	79.9	10.4	8.5	1.2	90.1
No	No.	4	12	0	2	18
	%	22.2	66.7	0	11.1	9.9
Total	No.	135	29	14	4	182
	%	74.2	15.9	7.7	1.1	100.0

turnover problem is experienced frequently is nurses (17.5%). 12 institutions (6.3%) have said that they have turnover problem of all category of staff. It is good to note that 23.8% of the institutions report no turnover problem. (Information on this aspect is provided only by 189 institutions.) The member institutions were asked whether they experience any difficulty in getting fully trained staff and they were asked to specify the category of the staff. It is reported that 14.3% of the institutions have difficulty in getting all category of staff. Another 29.5% said that they have difficulty in getting doctors, nurses and paramedical workers. Apart from these two categories, a group which is difficult to get was nurses. Only two hospitals reported that they were not able to get fully trained administrator. (This information is provided by 224 institutions).

It is reported that 64.2% of the institutions have adequately trained senior staff. Most of the institutions have recorded that there is a need for further training of the staff through refresher course or update course for various category. Nearly half of the institutions recorded that all staff (or doctors, nurses and paramedical workers) need refresher courses. Apart from this the single highest category which needs refresher course is the doctor.

Most of the institutions sponsored persons for training courses with the aim of adding to the staff. Hospitals which

sponsored staff (or some other persons) for various courses with the aim of absorbing them are cross classified with their experience on the return of sponsored persons to the institution for work. This is given in table 15. This table clearly shows that those institutions who have sponsored persons for studies have said that a large proportion of them return and work. In fact 88.4% have said that they have returned promptly for work (this includes the answer yes, most of them, and usually). Among the institutions which have not sponsored anybody 66.7% have told that they do not return promptly and work. This suggests that there is a feeling in the latter institutions that if they sponsor somebody they may not come back and join. In fact as far as the experience of the institutions which sponsored persons, 10.4% have said that they do not return promptly and work.

86 institutions (40.6%) have said that they have staff development programme and 126 have said that they do not have any staff development programme. Written staff service rules are available in 197 (86.4%) of the institutions. In 31 institutions no written service rules are available. In most of the institutions (78.4%) the salary of the staff was lower than the Government salary. In some institutions (12.8%) it is equal to Government salary for some categories. The institutions in which the salary of staff is higher than Government salary is negligible (2.2%).

9. Contact with community

In 79 institutions (33.6%) there is a local committee representing the community served by those institutions. In 156 institutions there is no such committee. 72.8% have said that such a committee is not advantageous. Moreover those who have experience in having local committees say that it is advantageous to have such a committee in a higher proportion (87.3%) than those who do not have a local committee representing community (30.6%). In fact, 58.3% of institutions without local committee and 2.8% of the institutions with a local committee said that it is not advantageous (or it is a hindrance) to have such a committee in the institution. 8.5% of those having local committee said that it is both advantageous and hindrance to the institution to have such committee.

The role of local committee representing community was spelt out by those who have a local committee. Many are common and some are specific for those institutions. Most of the roles can be classified under the title 'General help and Guidance or Advice to the management or director'. (Many respondents might have thought that the local committee was the Hospiotal administrative committee in which local leaders are members). Next to this is the role of the committee as far as community health is concerned. 16 times (21.9%) the role of helping in

TABLE 16

Details of Targets or goals of 170 Institutions which have targets

Target or goal	No. of Institutions No.	% out of 170
Improvement of health care	30	17.6
Providing improved medical care	24	14.1
Up grading/expansion	21	12.4
To develop full fledged Community Health Programme/Centre	20	11.8
To show Love of Jesus Christ and to obey His commands	18	10,6
Family Planning and Community Health	15	8.8
To improve care in specialised department	15	8.8
Training/Education	14	8.2
Leprosy Control/treatment etc.	14	8.2
Self supporting	13	7.6
To meet the needs of poor tribals and backward people	6	3.5
To develop low cost health care	3	1.8
Indianization of Hospital Staff	1	1.2
Establish Cordial relations between staff & management	1	
Total targets/goals	195	

planning and implementation of community health programmes is mentioned. (This is the real aim for which this question is asked). 8 times (11.Ø%) the role of maintaining public relations or to keep up co-operation of the people and gaining community participation is mentioned. Only once, getting feed back from the community is mentioned. The other roles are related to the institution and its functioning.

1Ø. Targets or goals set for the institution

The number of institutions which have replied for the question on targets and goals is 216. Out of this 46 (21.3%) have said that they do not have any target fixed or they do not have written targets. The 17Ø (78.7%) institutions which have targets, mentioned 195 items as targets or goal (Table 16). Among them 3Ø (17.6%) institutions have target to improve the quality of the health care. Next to this is the target to improve the quality of medical care, which includes all aspects of patient care including love and concern. Upgrading their institution and expansion either by adding physical facilities such as building, equipment and so on or by increasing diagnostic facilities or extending the care for a larger population is the target or goal of 21 (12.4%) institutions. To develop a comprehensive community health programme or to provide community health centre with all aspects including community participation is the target of 2Ø (11.8%)

TABLE 17

Role of Clergy in the Management Process*

Role	No. of Institutions	
	No.	% out of 141*
Chairman/President of Managing Committee/ Governing Board etc.	21	14.9
Vice Chairman of Managing Committee/ Governing Board etc.	4	2.8
Member of Managing Board/Administrative Committee/Executive Committee/ Medical Board etc.	67	47.5
Representative at Diocese level	4	2.8
Manager/General Superintendent/ Administrative Officer	14	9.9
Role of advisor, guide and giving suggestions	12	8.5
Very minimal involvement in management	5	3.5
Management co-ordinator	1	0.7
Participates in Management as a staff member	1	0.7
To help reduce difference between the Church and the hospital	1	0.7
Chaplaincy services only - No management involvement	26	18.4
Total	156	

* 156 roles were mentioned by 141 institutions.

institutions. 18 (10.6%) institutions have recorded that the target or goal is to show love of Jesus Christ and to obey His command. 15 (8.8%) institutions have written targets either of their own or that of fixed by the Government for family planning and community health services. The target or goal fixed by 15 institutions (7.7%) is to improve patient care in specialised departments. These institutions fixed targets for each speciality departments like obstetrics, gyneacology, intensive care, tuberculosis, surgery and so on. Emphasis on training (both training the staff and also training new persons in paramedical services) is mentioned by 14 institutions. The institutions serving leprosy patients have got clearly defined targets. Some of the other targets are to develop low cost health care, to meet the needs of poor tribal people and backward people, to Indianise hospital staff and to establish cardial relations between staff and management.

11. Religious Activities

72.5% of the institutions have a chapel. Mostly the chapel is used for daily prayer and special religious programmes. Staff, students and patients participate in those activities. 123 (52.6%) institutions have a Chaplain and 44 (19.1%) institutions have neither a chapel nor a chaplain.

Religious activities such as prayer and special religious programmes have been conducted in all the institutions whether these institutions have a Chapel or not.

125 institutions answered the question on ecumenical services rendered by them. Of those answered, 52.5% have said that they render ecumenical services and 30.4% have said that they do not do any type of ecumenical service.

11.1 Role of clergy in management process

Of all the 240 institutions, the role of clergy was given by 205 (85.4%) institutions and nothing was recorded by 35 institutions.

Of the 205 respondents who specified the role of clergy in the management process of their institutions, 64 (31.3%) recorded that clergy do not have any role at all in their institutions. The remaining 141 institutions, gave 156 answers which are given in table 17. A total of 25 (17.7%) have written that clergy is the Chairman or President or Vice President of the Managing Committee or Governing Board of their institutions 67 (47.5%) have said that the clergy are members of Managing Board or Administrative Committee or Executive Committee or Medical Board of their institution. This is the largest group. In four instances they have said that clergy at the diocese level has representation in the management committee and boards. A total of 14 (9.9%) have recorded that clergy were Manager, General Superintendent or

CMAI

TABLE - 18

Response for the question "What are the plans and priorities for next five years?"

Plan / Priorities		Number of responses No.	%
1. Strengthen Community Health		98	22.1
(i) Community health project	56		
(ii) Out reach programme	16		
(iii) Improve health centres	26		
2. Develop a particular Department*		52*	11.7
3. Improve Patient Services		111	25.0
(i) Improve the Quality of Service	46		
(ii) Extend more facilities to patients	27		
(iii) Leprosy Control	15		
(iv) Maternal and child health	12		
(v) Surgical services	11		
4. Increase Specialities Services		18	4.1
(i) Introduce specialities	11		
(ii) Intensive care Unit	5		
(iii) Diagnostic Equipment	2		
5. Finance		37	8.3
(i) Attaining self sufficienty	35		
(ii) Reducing Foreign Subsidy	2		
6. Training Programme		32	7.2
(i) Start training Programme	27		
(ii) Training the Paramedicals	5		
7. Building Programme*		54	12.2
8. Others		42	9.5
(i) Satisfy the needs of staff	19		
(ii) To Build a Healing Community	11		
(iii) Family Planning	8		
(iv) Increasing staff	3		
(v) Rehabilitation	1		
Total		444	100.0

* Details are in table 18.a.

TABLE - 18.a.

Details of Plans and Priorities classified as "Develop a Particular Department" and "Building Programme"

Develop a Particular Department		No. of responses
1.	Peadiatrics	6
2.	Medicine	2
3.	Surgery	1
4.	Dentistry	2
5.	Obstetrics & Gynecology	1
6.	ENT	2
7.	Opthalmology	8
8.	Psychiatry	1
9.	Pathology	1
10.	Microbiology	1
11.	Maternity Ward	1
12.	Neuro-Surgery Ward	1
13.	Physiotherapy Services	2
14.	Rehabilitation Centre	2
15.	Nephrology	1
16.	Micro-surgery Unit	1
17.	New Cobalt Unit	1
18.	Super Speciality Departments	1
19.	Upgrading the Institution	1
20.	Anté-Natal Clinic	1
21.	X-ray Unit	4
22.	Blood Bank	3
23.	Nursing School	4
24.	Community Health Programme	1
25.	Leprosy Hospital	1
26.	Institute of Health Services	1
27.	Developing Sub centres	1
	Total	52

contd...

TABLE-18.a. (contd)

Building

		12
1.	Staff Quarters	6
2.	New Hospital Complex	5
3.	O.P. building	4
4.	Maternity Block/Labour Ward	3
5.	Modernizing the buildings	3
6.	Extensive building programme	2
7.	Construction of clinics in villages	2
8.	Pediatrics building	1
9.	Administration building	1
10.	Community Health Building	1
11.	Emergency block	1
12.	Community hall	1
13.	X-ray plant	1
14.	Inpatient building	1
15.	Canteen	1
16.	Isolation Ward	1
17.	Optholmic Unit	1
18.	Nursing School	2
19.	Private rooms/ward	1
20.	Separate Leprosy Complex	3
21.	Operation Theatre	1
22.	Compound Wall	
	Total	54

Administrative Officer of their institutions. The role of adviser or guide has been played by clergy in 12 institutions. Although they do not have much authority in 3 institutions they have been used as management co-ordinator, participant in management as a staff member and also as a management co-ordinator. In 5 institutions the clergy play a minimal role in management. In 26 institutions clergy involve themselves only in chaplaincy services but not in management. Additionally the respondents said that active and useful involvement by the clergy was noticed in one instance as member of Managing Board, in 2 instances as member of Administrative Committee, in one instance as Chairman of Management Committee (and in four instances in 'Advisory and supportive role'). It is also mentioned that the clergy played an unfriendly or incompetent role as members of Managing Board in 2 instances, as representative of diocese at one instance and as an Administrative Officer at another instance. Apart from these, the rest of the roles mentioned above are not specific as to the direction (positive or negative) of the role of clergy.

12. Future Plans

The details of plans and priorities for next 5 years are given in Table 18. Altogether a total of 444 were mentioned by 213 institutions. The main aspect of it is improvement of patient services which is mentioned by 111 (25.Ø%) of the institutions.

Next comes strengthening community health (98). Development of a department of the institution is the priority of 52 institutions (11.7%). Again attaining self sufficiency and reducing foreign subsidy is the priority for 37 institutions and priority for training programme is given by 32 respondents (7.2%).

187 respondents gave information on Commitment on Community Health. Out of them 49 (26.7%) recorded that they do not have any commitment on Community Health. Another 45 (24.1%) have said that they have been committed to a full community health programme which includes a small curative programme (The comprehensive community health programme covers immunisation, maternity and child health, Home visit, Health education and a development programme). 51 institutions (27.3%) recorded that they have committed to community health programme, but their programmes are not full programmes as the previous group. They have either immunization programme or mobile clinic programmes for villagers or weekly visit by nurses to the villages and so on. 18 institutions have only a minimal or very limited programmes. Apart from this 7 institutions have recorded that they have community programme related to leprosy control.

It is heartening to find that 57 (26.2%) are already self-supporting, another 108 (49.5%) have plans to make their institutions self-supporting. Unfortunately 13 (6%) institutions

TABLE 19

Material needs of the Institution

Description of need		Number Needed No.	%
Finance		48	9.2
Medicine/drug		10	1.9
Building		116	22.4
Buildings	14		
Staff Quarters	64		
Hostel for Nurses/staff	4		
Guest house for visiters	1		
Modern Operation Theatre	7		
Accomodation for patient attendent	1		
Compound Wall	6		
Labour room	1		
Operating room	1		
Chapel	1		
Auditorium	1		
Ward	11		
O.T.Ward	1		
Indoor kitchen	1		
Canteen	2		
		12	2.3
Unit			
Intensive care unit	4		
Dialysing Unit	1		
Dental Unit	2		
ENT Unit	1		
Cobalt Unit	1		
Lab services	1		
ECG services	1		
X-Ray services	1		

TABLE 19 (contd.)

	No.	%
Equipment & Instruments	170	32.8
Plastic surgery equipment	1	
Surgical instruments	12	
Modern equipments	21	
Lab equipments	13	
Culture & Sensitivity test facilities	1	
Radiotheraphy equipment	1	
Beds	3	
Cradles	1	
Endoscopic instruments	1	
Diathermy set	1	
Radient heat	1	
Wax bath apparatus	1	
Cardiology equipment	1	
Dressing material/Linen	6	
Delivery Table	1	
X-Ray equipment	30	
Physiotheraphy equipment	2	
Operation instruments for tubectomy	2	
Laproscope	3	
Diagnostic equipment	1	
Heavy grinding machine	1	
Surgical Table	2	
Orthopedic operating Table	6	
ECG	11	
Pedestal Shoe Finishing machine	1	
Suction apparatus	4	
Bayles apparatus for Anaesthesia	6	
Orthopaedic operating instruments	2	
Microscope	5	
Endoscopes	3	
Gastroscope	2	
Bronchoscopes	1	
Calorimetre	2	
Radium	1	
Infant Incubator	8	
Neuromytone	1	
Autoclave	9	
Delivery kits	2	

TABLE 19 (contd.)

		No.	%
Monitors		6	1.1
Cardiac monitor	3		
Faetal monitor	2		
Ultrasound monitor	1		
Staff facilities		6	1.1
School for staff children	2		
Staff sponsership	1		
Education materials	1		
Allowance/PF/Gratuvity	2		
Others		151	29.1
Generator	16		
Refrigerator	2		
Vehicle	17		
Ambulance	19		
A.Video player	3		
Projector	2		
Calculator	1		
Still	1		
Water cooler	1		
Water/Water tank	13		
70 mm X-Ray films (not roll type)	1		
Transformer	2		
Motor cycle	1		
Bicycle	1		
Auto-Trailer	1		
Oxygen cylinders	1		
Oxygen supply	4		
Recreation facilities	1		
Furniture	1		
Replacement of furntiture	1		
School for Leprosy children	1		
Bore well for agriculture	1		
Planting more trees	1		

TABLE 19 (contd.)

Location for Hospital	1	
Pumps, Fitter and pipes etc for the water supply scheme	7	
Better road	4	
Medical surgical stores' supplies	1	
Internal Communication system	2	
Stationery	1	
Books and Periodicals for library	3	
Laundry soap/section	3	
Fence	1	
Typewriter	2	
Computer for accounts	1	
Mixing mill for Microcellular rubber	1	
Repair of building	15	
Repair of Vehicle	4	
Furnishing of Lab, Ward, OT	1	
Loan for Private Housing	1	
Technicians	1	
Renovation of chest clinic	1	
Recurring grant	1	
Trained and dedicated christian staff	1	
Linen, blankets, bed sheet etc	7	
TOTAL	519	100.0