# CHAI GOLDEN JUBILEE EVALUATION STUDY

## AT THE FIFTIETH MILESTONE

Evaluative feedback from members concerning
the Catholic Hospital Association of India (CHAI)

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# 1. INTRODUCTION

The Catholic Hospitals' Association (CHA) covering undivided India,Burma and Ceylon was formed in 1943. It was tranformed into the Catholic Hospital Association of India (CHAI) in 1957 and is now in its Golden Jubilee Year. It has not only survived but has grown from strenth to strength, both in numbers and in scope and range of activities and involvement.

During the past decade the need for an evaluation has been raised several times at the Executive Board meetings of the Association. Thus, a reflective evaluative study was initiated in 1991 as a preparation for its Golden Jubilee, and for the purpose of evolving future plans of action towards Health for All by 2000 A.D. and beyond.

Since this was the first time that a large study of CHAI was being undertaken it was broad in scope and had several components. This particular report covers the following areas:

* the awareness of members regarding the objectives and organisational structure of CHAI, along with suggestions for possible change;
* the levels of interaction between member institutions and CHAI in terms of their participation in the different activities, programmes and in the annual conventions of CHAI;
* the patterns of utilisation by members of the various services offered by the different departments of CHAI and comments/suggestions regarding these;
* the overall strengths and weaknesses of CHAI as perceived by members;
* their expectations from CHAI and suggestions regarding the future thrusts of CHAI;

The overall study included:

* an analytical historical review of the Association;
* developing a profile of the health related work of CHAI members;

* identifying future roles and policy options in the context of the predicted future scenario of the country using the Policy Delphi method of research;
* eliciting structured feedback from the staff members of CHAI, from members of the executive board and from representatives of the regional units of CHAI,
* interviews with people who were more closely involved with the Association.

Seperate reports of each component of the study have been/ are being written up. The discussion document "**Seeking the Signs of the Times**" has covered some of the key findings of this report in the section "**Feedback from the field**".

The purpose of this report is to make available to the Association the methodology and the findings of this component of the study in detail. This exhaustive evaluative - reflective study of CHAI was undertaken as part of its planning process.

The number of functioning respondent member institutions for most of the questions are 407. This number therefore is the denominator for these tables.

However, the general evaluative questions which were raised with the entire membership are also dealt with in the report. The number of functioning respondent institutions for these sections,which have been indicated in the text, are 1,415.

Thus a large proportion of member institutions have participated. They have responded to open-ended questions regarding important aspects of CHAI. While several have raised similar issues, which have been grouped together, there are also points raised by only a few persons. These suggestions/comments raised by one or less than ten persons have also been included. A quantitative cut-off point would have made the report less bulky. However, some of the views given by even just a few people are valuable qualitatively. It was felt that in a democratically functioning association all views need to be made known and considered.

## 2. AIMS AND OBJECTIVES

The overall aims of the entire study into which this particular component of 'feedback from members' fits, were as follows;

1. To undertake an analytical study reflection on the Catholic Hospital Association of India during the last five decades, focussing particularly on the last twenty five years and the present.

2. To explore possible roles the Catholic Hospital Association of India could play in the future, in the context of the needs of its members, the national the voluntary health sector and the health apostolate of the Church.

The specific objectives concerning this aspect of the study as given in the project proposal (5) are given below:

1. To elicit information and feedback from CHAI members on:
   a) their involvement and nature of interaction with CHAI;
   b) their expectations from CHAI in relation to their own activities;
   c) their views regarding the appropriateness and adequacy of CHAI's activities;
   d) their views regarding factors contributing to the gap between expected and observed actions;
   e) their suggestions regarding alternate measures to be adopted to fill in the gap.

2. To determine the views of members and of a select group of individuals (panelists of the Policy Delphi Method),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.

A few changes were made. Factors contributing to the gap between expected and observed actions were not explored specifically with this group. This was covered to some extent during interviews with people who were more closely involved with the Association. Similarly, the broader Indian scene and the role that CHAI can play in Asian and other countries was taken up in the Delphi Method.

## 3. METHODOLOGY

### 3.1 The project proposal

Based on discussions with Fr.John Vattamattom, SVD, Executive Director of CHAI, the first idea draft of the study was written by Prof.P.Ramachandran in September 1989. This was responded to by Dr.C.M.Francis and Dr.Thelma Narayan. After a brain storming session in February 1991 at which all members of the Advisory Committee and the Study Coordinator were present the first draft project proposal was written in March 1991. This was circulated to members of the Board, all Departments of CHAI and to 144 other persons. Modifications were made based on the responses and after further reading. The final project proposal for the overall study was written in October 1991.

### 3.2 Sampling

For the purpose of this detailed evaluative study of CHAI, a **20 per cent random sample of its constituent (institutional) members** was selected. The membership as of October 1991 consisting of 2,270 members formed our sampling framework. Individual associate members (who have no voting rights) were not included in the study.

The **sample was stratified** for size of institution and region of the country where they functioned. The membership was divided into two categories **according to size.** One category included those with 0 - 6 beds. This comprised 1,590 member institutions. The second category included those with more than seven beds. This group consisted of 680 member institutions. The rationale for stratifying by size was that size was indicative of different types of health/ medical functions performed by the institutions, namely involvement in primary and secondary levels of care respectively. It was hypothesised that institutions with these different functions would have different needs and different expectations from CHAI.

For stratification by region, the twenty-five States and seven Union Territories (U.T.) of the country were divided into two broad categories, based on the levels of certain well known health indicators. The two indicators used were the Infant Mortality Rate (IMR) and the Crude Death Rate (CDR). The Infant Mortality Rate is widely accepted as being a sensitive indicator of the health status and level of living of a population. It is also a measure of the health delivery system of an area / country. The Crude Annual Death Rate is also considered a fair index for comparative purposes. Statewise data for the IMR and CDR are available. These are collected by the Sample Registration System (SRS) which is considered to be the most reliable in the country.

The goal for the Infant Mortality Rate for 1990 was 87 / 1000 live births per year, and the goal for the Crude (Annual) Death Rate for 1990 was 10.4/1000 per year. During the planning phase of the study, 1987-88 was the latest year for which published data was available. Therefore achievement of goals for 1990 already in 1987-88 was taken as the cut off point for the study. States / Union Territories that achieved the goals for IMR and CDR for 1990, as laid down by the National Health Policy (of 1982) were placed in one category, namely of better health indicators or better health status. The number of member institutions in this category were 1,555.

Those States / Union Territories which had not yet reached these goals were placed in the second category of States/ Union Territories of poorer health indicators or poorer health status. The number of member institutions in this category were 715. The States/Union Territories in the two categories are given as follows.

## Division of States/Union Territories into Regions according to health status using available health indicators

| Poor Health Status (715 member institutions) | Better Health Status (1,555 member institutions) | |
|---|---|---|
| 1. Arunachal Pradesh | 1. Andhra Pradesh | 10. Meghalaya |
| 2. Assam | 2. Goa | 11. Mizoram |
| 3. Bihar | 3. Haryana | 12. Nagaland |
| 4. Gujarat | 4. Himachal Pradesh | 13. Punjab |
| 5. Madhya Pradesh | 5. Jammu and Kashmir | 14. Tamil Nadu |
| 6. Orissa | 6. Karnataka | 15. Tripura |
| 7. Rajasthan | 7. Kerala | 16. West Bengal |
| 8. Sikkim | 8. Maharashtra | 17. All the Union Teritories - (Andaman and Nicobar Islands, Chandigarh, Dadra and Nagar Haveli, Daman and Diu, Delhi,Lakshadweep and Pondicherry.) |
| 9. Uttar Pradesh | 9. Manipur | |

[N.B: Andhra Pradesh which had a CDR of 10.6 / 1000/ year and Meghalaya with a CDR of 10.5/1000/year were also included in this category. The IMR was not available for Nagaland, Manipur, Goa, Tripura, Meghalaya and all the Union Territories. They were categorised into this group based on the CDR. For Mizoram even the CDR was not available. It has a small population and a small number of member institutions. Because of its similarity to the other North Eastern States it was included in this category empirically.]

This broad categorization, using just two indicators, was done so that the differing health situations/problems and needs of people could be taken into account. It was hypothesized that the type of health interventions required, the prioritization and approaches in medical/health work,and the level and functioning of the government and health system would differ in these areas. The work responses and needs of CHAI member institutions would also possibly be different. This would also probably result in differing expectations from CHAI and its supportive services. It was felt that it would also be useful to study the distribution of CHAI members and the utilisation of services of CHAI using this criteria.

Distribution of membership by region and size of institution

| | 0 - 6 Beds | More than 7 Beds | Total |
|---|---|---|---|
| Better Health Indicators | 1,018 | 537 | 1,555 |
| Poorer Health Indicators | 572 | 143 | 715 |
| Total | 1,590 | 680 | 2,270 |

Distribution of the sample by region and size of institution

| | 0 - 6 beds | More than 7 beds | Total |
|---|---|---|---|
| Better Health Indicators | 204 | 108 | 312 |
| Poorer Health Indicators | 114 | 29 | 143 |
| Total | 318 | 137 | 455 |

In the report the two categories according to region are referred to as regions with better health status and poorer health status (of people) respectively.

3.3 Interview Schedule - the instrument for data collection

Data collection was done through interviews with key personnel (decision makers) in the selected member institutions.

An interview schedule was developed as the instrument for data collection. Part-A was identical to the mailed questionnaire that was administered to all members in order to gather data regarding the activities/profile of health related work being done by member institutions of CHAI. Part-B gathered feedback about the various aspects of CHAI. There was a special note for Diocesan Social Service Societies.

The interview schedule was pilot tested by members of the study team. This was done in 14 institutions of which 12 were in Karnataka and 2 in Kerala. They included large, medium and small institutions and a Diocesan Social Service Society. Necessary changes were made prior to printing.

## 3.4 Investigators (interviewers):

Forty volunteer investigators participated in the study by undertaking field work to visit institutions in the 20 per cent sample for the interviews. Thirty-nine were scholastics in the final years of their formation/ training to become priests and one was a priest. They were motivated, reliable, highly educated and well suited to interact with personnel from member institutions of CHAI, who were also all religious personnel. Some had previous exposure to research.

A five day training was conducted for them. This was done twice, as there were two groups. One group of Capuchin and Franciscan scholastics were based in Mysore and another group of Jesuit and Diocesan scholastics were based in Delhi. The priest from St.Thomas Mission, Mandya joined the Mysore group. Topics covered during the training included : the objectives/purpose of the study, an introduction about CHAI and its various activities, techniques of interviewing as used in research studies, use of the schedules (proformas) including explanations regarding all the technical terms that were used. Seven background papers were given to them (see Appendix-I). Mock interviews (classroom) and trial interviews in nearby member institutions were conducted using the interview schedule and discussions held regarding the experience.

Thus 41 member institutions were covered by the trial interviews. Of these 25 were in Karnataka, 6 in Delhi, 3 in Haryana and 7 in Uttar Pradesh. These were member institutions who were not in the 20 per cent sample. Data from Part-A of these forms has been included along with the analysis of the mailed questionnaire, which is reported in the 'Profile of health work done by CHAI member institutions'.

The field work was completed during the holidays in December 1991 and May-June 1992. It involved extensive travel to remote areas,often under difficult circumstances including interstate conflicts, problems of terrorism, wild animals etc. Two letters were written to participating member institutions informing them of the purpose and dates of the visits and requesting information of how to reach them. Available information from the membership department of CHAI was also used. Inspite of this we were unable to get information about some institutions and the investigators just used local sources of information and their sense of adventure to arrive at the institution.

Logistics of working out routes, purchase of journey tickets etc, was done mainly by the investigators with the help of the study team and the CHC team.

Study team members conducted supervisory field visits to a few institutions in South India when the interviews were being conducted.

After completion of the fieldwork, debriefing was held in group and individual sessions to share overview impressions and to collect the filled proformas, settle accounts etc.

### 3.5 Mailed Questionnaire

A mailed questionnaire was sent to the remaining 80% of member institutions (1,815). The first purpose was to collect information regarding the medical/health related work of all CHAI constitutional members. Therefore Part A of the mailed questionnaire and interview schedule were identical. The second purpose was to put the key evaluative questions regarding CHAI to the entire membership. The questionnaire was pretested, modified and mailed to members in December 1991. Two reminders were also sent at an interval of a month each.

### 3.6 The overall process

A summary of the purpose, aims and broad areas to be covered by the study was sent to all members for their information and comments before the final project proposal was written. This was mailed with the circular sent by the Executive Director. The membership was also kept informed about the study by the Executive Director, senior staff of CHAI and the study team during the 1991 Annual Convention, regional meetings and subsequent circulars. There was scope for interaction at all these points.

### 3.7 Data analysis

The data was coded and entered into computers. This was a time consuming task. Data entry was also cross-checked by the study team.

D-base III+ was used for the analysis of the data. The staff of St.Joseph's Evening College - Data Processing and Computer Centre helped the study team in writing out the programmes and commands necessary for analysis and in other technical problems that arose.

Computer viruses were a major problem as a number of students used the same systems for their practical work. The team also had to fit into their class schedules, examination schedules etc. However, we received much support and cooperation and without this ready help the analysis would not have been completed in time.

### 3.8 The Advisory Committee to the Study and study process

The committee played a very active and supportive role through out. It met four times during the period of the study. There were however several informal interactions and correspondence. Members also gave very valuable comments on all the reports.

## 4. FINDINGS

### 4.1 FUNCTIONING AND CLOSED MEMBERS

Of the 455 member institutions that comprised the 20% sample for the detailed study, 17 were not visited due to the sudden ill health of an investigator. They were in the States of Jammu and Kashmir (2), Himachal Pradesh (1), Uttar Pradesh (11) and Madhya Pradesh (3). We were unable to find a trained replacement and the study team members also could not be spared as the workload of the overall study was great. We therefore mailed them the proforma. Three responses were received but were too late. They were therefore not included in the analysis. We therefore have information from 438 institutions. This comprises 19.3% of the total membership of 2,270 (October 1991). Of the 17 for which we have no information 3 were from regions with better health status and 14 from regions with poorer health status, 12 were from the 0 - 6 bed category and 5 from the more than 7 bed category.

The number of functioning member institutions in this sample was 407 (92.9% of 438). This number therefore is the denominator in all the tables. The number of institutions closed/currently not functioning was 31 (7.1% of 438). It can be extrapolated roughly from this, that of the 2,270 members,about 161 would be closed or not functioning.

In some cases replies were received from other persons at the address in response to our first communication to say that the institution was closed. These institutions were not visited if they were out of the way. In other cases, the investigators found them closed during their visit. The reasons for closure given by persons from the (religious) community were:

* there was no further need for the institution because other facilities (mostly private) had developed in the area;
* due to lack of personnel, there was temperory closure;
* other problems.

## 4.2 ANALYSIS BY REGION, SIZE, LOCATION AND STATE

The break up of the group of 407 functioning respondents by region (according health status), by size of institutions and by urban, rural and tribal location is given below:

Table 1. Functioning Respondent Institutions by region

| Region | Number in sample | Number closed | Number not visited | Number funct-ioning | % n=407 |
|---|---|---|---|---|---|
| Poorer health status | 143 | 10 | 14 | 119 (83.2%) | 29.2 |
| Better health status | 312 | 21 | 03 | 288 (92.3%) | 70.8 |
| Total | 455 | 31 | 17 | 407 | 100.0 |

21 out of the 31 institutions closed are in better health status regions. There is also a disproportion in institutions not visited. 14 were in poorer health status regions and comprised 9.8% of this group, while 3 were in better health status regions comprising 1.0% of this group. Therefore the representation of institutions from poorer health status regions in the total of 407 functioning institutions becomes slightly lower.

Table 2.Functioning Respondent Institutions by location

| Location | Number | % (n=407) |
|---|---|---|
| Urban | 70 | 17.2 |
| Rural | 269 | 66.1 |
| Tribal | 68 | 16.7 |
| Total | 407 | 100.0 |

**N.B:** This and the following tables exclude the institutions that are closed/not visited.

This is similar to the overall urban, rural, tribal distribution of member institutions. This was found to be 16.6% urban, 67.8% rural and 15.6% tribal from the other component of the study.

Table 3. Size of Functioning Respondent Institutions

| Size | Number | % (n=407) |
|---|---|---|
| Smaller (0 - 6 beds)* | 267 | 65.6 |
| Larger (More than 7 beds) | 140 | 34.4 |

* This included 19 social welfare centres, diocesan social service societies etc.

As per the information, with CHAI as of Oct 1991, 70.1% were in the 'smaller' group and 29.8% in the 'larger'. The clubbed data from the 2 samples showed a slight shift that has taken place with a few less than 6 beds institutions having grown into more than 7 bed institutions. However, there is also some under representation of smaller institutions as 12 out of the 17 not visited were in the 0-6 bed category according to available information.

Table 4. Functioning Respondent Institutions by State

| State | Functioning members in 20% sample | Total membership | % of institutions in that State |
|---|---|---|---|
| 1. Andhra Pradesh | 45 | 232 | 19.4 |
| 2. Assam | 7 | 55 | 13.7 |
| 3. Bihar | 29 | 160 | 17.7 |
| 4. Goa | 5 | 30 | 17.2 |
| 5. Gujarat | 11 | 58 | 18.6 |
| 6. Haryana | 3 | 11 | 27.3 |
| 7. Karnataka | 31 | 159 | 19.5 |
| 8. Kerala | 80 | 416 | 19.2 |
| 9. Madhya Pradesh | 34 | 209 | 16.3 |
| 10.Maharashtra | 18 | 96 | 17.7 |
| 11.Manipur | 3 | 21 | 14.3 |
| 12.Meghalaya | 11 | 47 | 23.4 |
| 13.Mizoram | 2 | 4 | 50.0 |
| 14.Nagaland | 5 | 19 | 26.3 |
| 15.Orissa | 14 | 79 | 17.7 |
| 16.Punjab | 2 | 28 | 7.1 |
| 17.Rajasthan | 7 | 30 | 23.3 |
| 18.Tamilnadu | 70 | 393 | 17.8 |
| 19.Tripura | 2 | 4 | 50.0 |
| 20.Uttar Pradeesh | 18 | 122 | 14.7 |
| 21.West Bengal | 10 | 70 | 14.3 |
| Total | 407 | 2,270 | 17.9 |

The percentage of the total number of member institutions in each State is also given.

## 4.3 INFORMATION REGARDING PERSONNEL INTERVIEWED

a) The designation of key personnel interviewed in this group is given below:

Table 5. Designation of the main responding personnel

| Designation | Number | % (n=407) |
|---|---|---|
| Nurse | 109 | 26.8 |
| Administrator-cum-Nurse | 124 | 30.5 |
| Administrator (not trained) | 104 | 25.5 |
| Administrator-cum-other Health Worker | 13 | 3.2 |
| Other Health Workers | 24 | 5.9 |
| Administrator (trained) | 11 | 2.7 |
| Doctor | 14 | 3.4 |
| Trained Social Worker | 01 | 0.2 |
| No information | 07 | 1.7 |
| Total | 407 | 100.0 |

The table shows that the personnel interviewed were trained health professionals working mainly in positions of responsibility and decision making within the member institutions. Their feedback regarding CHAI is therefore valuable.

b) The length of stay of the main personnel interviewed in the member institutions is also given:

Table 6. Length of stay of responding personnel

| Length of Stay | Number | % (n=407) |
|---|---|---|
| Below 12 months | 84 | 20.6 |
| 13 to 24 months | 81 | 19.9 |
| 25 to 36 months | 63 | 15.5 |
| Above 36 months | 166 | 40.8 |
| No information | 13 | 3.2 |
| Total | 407 | 100.0 |

56.3% of the personnel have worked in the member institutions for over three years and 76.2% for more than two years. The majority have therefore had a sufficient length of stay in the member institution to understand the relationship with CHAI and to give feedback. It is also likely that previous institutions in which the religious personnel would have worked were also members of CHAI. Only recent graduates undergoing their first or second posting would be new to CHAI.

c) The number of personnel from the respondent member institutions who participated during interviews is given in the table below:

Table 7. Number of participants during each interview

| Number of personnel per interview | Number of Institutions | % n=407 |
|---|---|---|
| One | 265 | 65.1 |
| Two | 96 | 23.6 |
| Three | 34 | 8.3 |
| Four | 07 | 1.7 |
| Five | 01 | 0.2 |
| Six | 01 | 0.2 |
| No information | 03 | 0.7 |
| Total | 407 | 100.0 |

Since it was the member institution and its views regarding CHAI that was being studied, and also given the fact that religious personnel are transfered after certain periods, it was felt that more than one person could represent the institution since different persons may be knowledgeable about different aspects of the relationship with CHAI. However in all institutions the key decision maker/director/administrator was requested to participate.

## 4.4 MEMBERSHIP OF CHAI

This data is derived from 1,415 member institutions i.e.,from the interviewed group and the mailed questionnaire.

a) The year of joining CHAI as a member is given in the table below. This data is derived from both the samples.

Table 8. Trend in growth of CHAI membership

| Sl. No. | Time period in decades | Number of institutions | % of total (1,415) |
|---|---|---|---|
| 1. | 1943 - 1950 | 5 | 0.4 |
| 2. | 1951 - 1960 | 32 | 2.3 |
| 3. | 1961 - 1970 | 108 | 7.6 |
| 4. | 1971 - 1980 | 333 | 23.5 |
| 5. | 1981 - 1990 | 539 | 38.1 |
| 6. | 1990 and after | 36 | 2.5 |
| 7. | No information | 362 | 25.6 |
| | Total | 1,415 | 100.0 |

The trend shows a marked increase in the 1970's and an even greater increase in the current phase of the 1980's.

b) The type of membership is also indicated below:

Table 9. Type of constitutional membership

| Type | Number | % (n=1,415) |
|---|---|---|
| Annual member | 977 | 69.0 |
| Life member | 336 | 23.7 |
| No information | 102 | 7.2 |
| Total | 1,008 | 99.9 |

Only 917 institutions specified the type of membership. 25% of respondent institutions below 6 beds are life members and 31.6 percent of those above 6 beds are life members.

Analysis of membership according to region showed that 40.0% of respondents from States with poorer health status and 36.6% of those from States with better health status were life members.

(N.B:Analysis by size and region is for 407 institutions)

## 4.5 REASONS FOR JOINING CHAI

This question was asked both in the mailed questionnaire and in the interview schedule and are jointly reported. 71.0 percent (1,004 out of 1,415) member institutions who participated in the study gave reasons as to why they joined CHAI. They were given in response to an open ended question. Similar reasons have been clubbed together and are given below in descending order of priority.

4.5.1 For guidance/information/training (830 or 58.6%)
Large nunbers joined for guidance, support and help (388) and for information regarding new developments in health care so as to keep up-to-date and to improve the standard of service (380).

Smaller numbers joined for training of health personnel (57) and to attend courses and seminars offered by CHAI (05).

4.5.2 To avail of the benefits offered by CHAI (456 or 32.2%)
This was to obtain free medicine (172); to obtain financial assistance/material help (162), and to take advantage of all the benefits offered by CHAI (122).

4.5.3 For togetherness, cooperation and support (389 or 27.5%)
The reasons given were: to gain mutual cooperation to fulfill objectives (64), to share ideas, problems and experiences with others and for mutual support (47),to be part of a larger organisation (88), to work together (34), for solidarity (36), to strengthen CHAI (78), and for safety and security (42).

4.5.4 Because of its Catholic nature (299 or 21.1%)
These were mainly because it is a Catholic body (179), for better interaction among Catholic hospitals (48), for feeling of oneness with Catholic hospitals (25). to integrate the principles of Christianity in health care (24), and because it is a coordinating agency for Catholic hospitals (9).

Smaller numbers mentioned that it was a policy of the Congregation (6),on the advice the Bishop (2), as CHAI is a link between the Church and Government (2), as advised by CRI (1), to fall in line with Catholic health policies (1), since CHAI was started by a Sister of the same congregation (1), and to be a partner in the healing ministry with CHAI (1).

4.5.5 Because of its objectives, policies and other activities (47 or 3.3%)

Much smaller number of members gave the following reasons: because of its community health policy (10), to work with CHAI to build a healthy nation (10), to seek help in legal problems (08), to have a forum to voice problems to the Government (06), because of its objectives (05), for effective coordination of community based health care (05), being inspired by the Annual Conventions (02), and because of its approach in health work (01).

4.5.6 Other miscellaneous reasons included (14 or 1.0%)

Invitation to join (10), to ensure the participation of lay people in CHAI (02), since the institution was started with the help of CHAI (01), and being fascinated by the Association (01).

More than one reason has been given by many institutions. The need for information/ training support to their work has come out consistently even under expectations. Future thrusts indicate specific areas in which this could be provided. Availing of assistance/ benefits has also come high on the list. The need for togetherness and support and because it is a Catholic organisation come next. A much smaller proportion mention that the objectives and policies are the reasons for their joining CHAI.

## 4.6 ORGANISATIONAL ISSUES

### 4.6.1 FEEDBACK ON THE STATED OBJECTIVES OF CHAI

74.7% (304) of the respondents were aware of the objectives of CHAI. This is a very large proportion. It must be kept in mind however that the next question actually gave the objectives. This was done since we were more interested in knowing whether members felt that the objectives should be changed. In order to get specific suggestions regarding reformulation of the objectives, the present objectives were given. An additional reason was that during informal interactions with staff and members it was found that many were not aware about the objectives.

15.2% (62) members felt that the stated objectives of CHAI need to be changed. 79.9% (325) felt that change was not necessary, 1.2% (5) were unable to comment and 3.7% (15) did not respond. 39 (of the 62) gave specific O17as that should be considered when reformulating objectives. These are given below:

1) It was felt that mention should be made in the objectives regarding preferential option for the poor, and focus on people especially the rural poor and the unreached (15).

2) Mention should be made regarding need for social equity, and for social awareness regarding socio-political issues, as this was considered necessary for good health (5).

3) It was felt that CHAI should focus more on Objective Two, namely "To promote,realise and safeguard progressively higher ideals in spiritual, moral, medical, nursing, educational, social and all other phases of health endeavour"(1). A suggestion was that this objective needs to be modified by emphasising the importance of human values (2). It was also felt that this objective needs greater clarification (1).

4) It was felt that greater emphasis needs to be given to Community Health and Family Welfare programmes,namely Objective Three "To promote community health and family welfare programmes" (3).

Mention should be made of the shift from the curative to the preventive/promotive approach, health education to be specified, multi-disciplinary approach in health care and a wholistic approach in the healing ministry to be included.

5) Need to stress and emphasise Objective One,namely "To improve the standards of hospitals and dispensaries in India".(1) Another member felt that emphasis on institutions should be revised. Yet another felt that need for a uniform policy for member institutions should be stated as an objective.(3)

6) The services of CHAI could be specified in the objectives (01). This could be added to Objective One or Four or else objectives could be related to services/ activities (1).

   In this regard specific suggestions included: service in rural/ unserved areas (1), need to emphasise service to small/ poor member institutions (1), legal aid as an area of service (1), and training programmes for different health care personnel to be included (1).

7) Objectives should indicate need for flexibility by CHAI to be able to respond to the specific needs of different areas in the provision of its services (1).

There was no association (statistical) between awareness regarding objectives and the size of institution (bed-strength), region (health status) or location (urban/ rural/tribal).

There was also no association between the opinion as to the need for change of objectives and the size, region or location.

### 4.6.2. FEEDBACK ON ORGANISATIONAL STRUCTURE OF CHAI

Again, a large proportion of 64.6 per cent of respondents (263) stated that they were aware of the organisational structure of CHAI. Of these 80.9% (213) felt that the present organisational structure was suited to achieve the objectives of the association. However, 19.1% (50) felt that it was not suitable for the purpose and there was need for change. Changes suggested were predominantly regarding decentralisation of power (6) and strengthening of regional units (7). Related comments were

that the organisational structure should have equal participation ,(representation) from all levels (3),and greater representation in decision making from the lower (periferal) structure (2). The Executive Board must have representatives from the regional/ state/ local units (2). Another related suggestion was the need to shift from a unitary (centralised) set up to a more federal and participatory structure. A suggestion was that rural areas should be given greater representation in the Board. Another stated that the Executive Director should be a member of the Board. (As chief executive he is now present in all Board meetings).

Additional suggestions were that the organisational structure should facilitate the achievement of the objectives of CHAI (2). It should also enhance/ promote inter-relationship between members (1).

46.0 % of those who stated that the organisational structure should change, did not give suggestions regarding the type of changes that could be made.

4.6.3 PARTICIPATION IN CHAI UNITS

46.9 per cent of respondent institutions (191) stated that they participate in regional/State/diocesan units of CHAI. They are not mutually exclusive. The details are as follows:

| | | |
|---|---|---|
| a) | **Regional Units (covering more than one State)** | **Number of Institutions participating** |
| | NECHA (North Eastern Community Health Association) | 28 |
| | RUPCHA (Rajasthan,Uttar Pradesh Catholic Health Association) | 11 |
| b) | **State Units** | |
| | Kerala CHA | 33 |
| | Andhra Pradesh (CHAAP) | 25 |
| | Tamilnadu (CHAT) | 17 |
| | Orissa (OCHA) | 11 |
| | Karnataka CHA | 02 |
| c) | **Diocesan Units** (details give in next table) | 70 |

Table 10. Participation in Diocesan Units

| Sl. No. | Diocese | Number of Institutions |
|---|---|---|
| 01. | Ooty | 05 |
| 02. | Vellore | 05 |
| 03. | Ajmer | 04 |
| 04. | Kumbakonam | 04 |
| 05. | Salem | 04 |
| 06. | Bangalore | 03 |
| 07. | Bellary | 03 |
| 08. | Bombay | 03 |
| 09. | Indore | 03 |
| 10. | Raigarh | 03 |
| 11. | Tanjore | 03 |
| 12. | Tuticorin | 03 |
| 13. | Ambikapur | 02 |
| 14. | Jullandhar | 02 |
| 15. | Palayamkottai | 02 |
| 16. | Ranchi | 02 |
| 17. | Trivandrum (AD) | 02 |
| 18. | Vijayawada | 02 |
| 19. | Balasore | 01 |
| 20. | Bijnor | 01 |
| 21. | Coimbatore | 01 |
| 22. | Eluru | 01 |
| 23. | Ernakulam | 01 |
| 24. | Hyderabad | 01 |
| 25. | Kohima | 01 |
| 26. | Kottar | 01 |
| 27. | Madras-Mylapore | 01 |
| 28. | Pondicherry-Cuddalore | 01 |
| 29. | Raipur | 01 |
| 30. | Sivagangai | 01 |
| 31. | Trichy | 01 |
| 32. | Udaipur | 01 |
| 33. | Vishakapatnam | 01 |
| | Total | 70 |

Nine institutions did not specify the unit of which they are a part.

54.7% of institutions in regions with better health status participate in these different units of CHAI and 45.2% of those in regions with poorer health status do so. 45.6% of less than 6 bed institutions participate in these units and 63.1% of those from more than 7 bed institutions do so. This is a significant association.

Institutions based in tribal areas have a greater participation (61.8%),followed by urban (57.1%) and rural institutions (47.5%).

Some of the Diocesan Health Units /groups mentioned have been initiated by the respective Diocese or others and not by CHAI. Some are linked organisationally to State level units and some are more informal with regular or occasional meetings.

The regional and some of the State units are registered societies. All have regional level executive boards elected by the general bodies at the State level. The Kerala Unit is the oldest and was formed soon after the Silver Jubilee of CHAI in 1968. At that point formation of regional/State units was given a priority. The concept of forming secular Voluntary Health Associations in different States then evolved, with the Bihar VHA being formed in 1974. There was therefore a lull in the formation of regional/State units of CHAI members, since most of them were members of State VHA's. Formation of units however picked up again in the Eighties.

## 5.4 SUGGESTIONS REGARDING CHAI UNITS/ THEIR ACTIVITIES

Interestingly, 66.1% (269) felt that based on their experience there is a need for Diocesan Units, 32.9% (134) suggested State Units and 26.3% (107) suggested Regional Units (covering more than one State). The largest number of suggestions regarding major activities that could be carried out by the different units were also for Diocesan Units (503), and smaller numbers for State Units (161) and Regional Units (151).

It has been well stated by a member that "Diocesan Units could give concrete local expression to the objectives of CHAI".

Activities suggested for Diocesan Units were:

1. Promoting Better Interaction (145 or 35.6%)
Diocesan Units could help create closer contacts and better interaction among member institutions (85), by organising regular meetings and visits (43). Also by creating opportunities for sharing experiences and facilities available with each other (16),and supporting each other (1).

2. Providing Guidance, Training and Information (145 or 35.6%)
By conducting seminars and courses (57), providing help, guidance and support (36), information on health care in regional languages (22), and organising other training programmes (22). They could produce health education material and other publications in the vernacular (6), and conduct courses in health education (2).

3. Community Health Development and Family Welfare (79 or 19.4%)
Diocesan Units could undertake health awareness programmes (22), organise community health programmes (18), village extension programmes (15), community development activities and programmes (13), and family welfare programmes, including natural family planning (11).

4. Co-ordination (50 or 12.3%)
The health work of member institutions at a Diocesan level could be coordinated (34). Supervision of activities of members (9), and coordination of outreach programmes were suggested (5). So also the exchange of personnel among members as and when needed (2).

5. A few organisational issues were raised, namely studying the needs of members locally (4), building linkages with other organisations (2), searching for priorities in the area (1), evolving policies suited to the locality (1), representing the diocese at the State/National level (1), organising diocesan level conventions (1), forming associations of different health workers (1), undertaking evaluation and planning (1).

6. Other activities for members and their staff were suggested. Provision of financial help to needy members (15), help with management aspects of member institutions (5), arranging doctors/nurses for small dispensaries especially in rural areas (5), organising annual renewal programmes (5), working out a salary policy for personnel (2), taking care of the spiritual needs of personnel (1), providing assistance to deal with medico-legal issues (1), and to solve local problems (1).

7. Specific health and related services that could be promoted at the Diocesan level are: pastoral care (5), school health (4), mother and child health/womens' programmes (4), training traditional birth attendants (dais) (1), immunization programmes (1), promotion of herbal medicines/alternative systems of medicine (1), medico-ethical issues (1).

Promotion of social justice (3), adult/nonformal education (3), income generation schemes (2), youth welfare programmes (1), and organising social awareness programmes (1), were suggested.

Activities suggested for the State level units were largely similar. However additional points were:

a) Linkages with Government and other State level organisations for the promotion of health.
b) Coordination of Diocesan Programmes.
c) State level training programmes and refresher courses.
d) Organising State level conventions.
e) Representing the State level needs to the Centre.
f) Discussing and dealing with the specific medical/health problems of the State.

The other new and specific areas mentioned for the State level were the promotion of a rational drug policy, urban health and programmes to tackle drug addiction and alcoholism.

Very similar activities were also suggested for the Regional Units. The only additions being need for discussion of problems and issues important at the regional level and the solving of regional problems.

## 4.7 INTERACTION BETWEEN CHAI CENTRAL OFFICE AND MEMBERS

In order to understand the level of interaction and contact between CHAI and its members the following aspects were studied:

a) Visits by CHAI staff/others to member institutions;
b) Receipt by members of Circulars from CHAI; and
c) Participation in special training programmes organised by CHAI.

They utilisation by members of the services of the different major departments of CHAI is dealt with later.

### 4.7.1 Visits by CHAI staff/others to member institutions

13.8 per cent (56) institutions have been visited during the past 5 years period, i.e. 2.8% every year.

The Chi Square test shows an association between the visits and region, size of institution and location.

* 21.5% of institutions in regions with poorer health status and 13.1% in regions with better health status were visited.
* 28.4% of institutions with more than 6 beds and 9.4% of institutions in the 0 - 6 bed category have been visited.

* 33.9% urban, 16.9% tribal and 10.5% of rural based institutions have been visited respectively.

Of the 56 institutions visited in the past 5 years, 42 specified by whom the visit was paid. Details are given below.

Table 11. Details of visits paid to member institutions

| Sl.No. | Visits conducted by | Number of Institutions visited | % of 407 | % of 42 |
|---|---|---|---|---|
| 01. | Community Health Dept. | 15 | 3.7 | 35.7 |
| 02. | Executive Director | 07 | 1.7 | 16.7 |
| 03. | Executive Board Members | 05 | 1.2 | 11.9 |
| 04. | Central Purchasing Service | 03 | 0.7 | 7.1 |
| 05. | Membership Department | 02 | 0.5 | 4.8 |
| 06. | Asst.Executive Director | 02 | 0.5 | 4.8 |
| 07. | Office Bearers of Regional Units | 02 | 0.5 | 4.8 |
| 08. | Pastoral Care Department | 01 | 0.2 | 2.4 |
| 09. | Continuing Medical Education Department | 01 | 0.2 | 2.4 |
| 10. | Documentation Department | 01 | 0.2 | 2.4 |
| 11. | HAFA Staff | 01 | 0.2 | 2.4 |
| 12. | Editorial Committee | 01 | 0.2 | 2.4 |
| 13. | Zonal Officer | 01 | 0.2 | 2.4 |
| | Total | 42 | 10.0 | 100.2 |

The purpose of the visits, as expressed by members, were as follows:

* courtesy /liaison visits and to see/understand the functioning of the centres (15);
* to evaluate the community health work (5), for training and orientation seminars (7),training regarding alternative systems of medicine (1),training regarding rational drug therapy (2), regarding the writing of the CHAI-CMAI formulary (1),for consultancy and guidance (1),to get personnel for a training programme (1), to assess the health situation of the area (4), to organise exhibitions(1),
* to sell raffle tickets (5), for fund raising (4),
* to assess project proposals (2), to sanction the proposal for a general ward (1),
* regarding membership issues(1), to collect membership fee (1),
* to assess pastoral care services (2),
* to enquire about purchases requested through CPS (1),
* for diocesan advisory committee meetings (1),
* for exchange programmes (Indo-Philippines) (1),
* to settle misunderstandings (1).

The Statewise breakup of institutions visited is given in the following table.

Table 12. Institutions visited according to State

| Sl. No. | State | Visited | Not visited | Do not know | N.I** | Total |
|---|---|---|---|---|---|---|
| 01. | Andhra Pradesh | 06 | 33 | 06 | -- | 45 |
| 02. | Assam | -- | 05 | 02 | -- | 07 |
| 03. | Bihar | 04 | 22 | 03 | -- | 29 |
| 04. | Goa | -- | 05 | -- | -- | 05 |
| 05. | Gujarat | 02 | 09 | -- | -- | 11 |
| 06. | Haryana | -- | 02 | 01 | -- | 03 |
| 07. | Karnataka | 03 | 23 | 05 | -- | 31 |
| 08. | Kerala | 14 | 57 | 09 | -- | 80 |
| 09. | Madhya Pradesh | 08 | 23 | 03 | -- | 34 |
| 10. | Maharashtra | -- | 16 | 02 | -- | 18 |
| 11. | Manipur | 01 | 01 | 01 | -- | 03 |
| 12. | Meghalaya | -- | 09 | 02 | -- | 11 |
| 13. | Mizoram | -- | 02 | -- | -- | 02 |
| 14. | Nagaland | -- | 04 | 01 | -- | 05 |
| 15. | Orissa | 02 | 10 | 01 | 01 | 14 |
| 16. | Punjab | -- | 02 | -- | -- | 02 |
| 17. | Rajasthan | -- | 06 | 01 | -- | 07 |
| 18. | Tamilnadu | 08 | 55 | 07 | -- | 70 |
| 19. | Tripura | 01 | 01 | -- | -- | 02 |
| 20. | Uttar Pradesh | 07 | 09 | 01 | 01 | 18 |
| 21. | West Bengal | -- | 09 | 01 | -- | 10 |
| | Total (407) | 56 | 303 | 46 | 02 | 407 |

[N.B. * Arunachal Pradesh has no members, Jammu & Kashmir and Himachal Pradesh were not visited by investigators, Sikkim and the Union Territories did not enter the sample. This applies to other statewise tables also.
* * N.I. = No Information]

31 (55.3%) institutions visited were in the four Southern states of Kerala, Karnataka, TamilNadu and Andhra Pradesh, while 19 (33.9%) were in the four Central States of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh.

### 4.7.2 Circulars

97.3% (396) regularly receive the mailed circulars from the Executive Director of CHAI. Only 1.5% (6) said they do not receive these. Thus there is a channel of communication between the central office of CHAI and the members regarding the various activities and programmes of CHAI.

### 4.7.3 Participation in CHAI Special Training Programmes

This includes programmes for continuing medical education, spiritual growth through clinical practice, pastoral care programmes,management workshops,diocesan and regional level programmes. The programmes/activities of other Departments are given seperately,later in the report.

25.1% (102) member institutions have participated in/attended the above programmes during the past five years. The number is increasing over the years, with 80 (78.0%) having participated in 1990 and 1991. It is possible that this is related to the increasing number of courses that are being offered. Some member institutions have sent their personnel to different programmes. The total member therefore varies.

The details of the number of personnel who have participated in various programmes from this 20 per cent sample are as follows:

Table 13. Number of personnel who have participated in special training programmes

| Sl.No. | Programme | Total Number of Personnel |
|---|---|---|
| 1. | Continuing Medical Education | |
| | a) Rational Therapeutics | 26 |
| | b) Training in Oral Rehydration Therapy (ORT) | 18 |
| | c) Use of Herbal Medicines | 22 |
| | d) Others | 08 |
| 2. | Spiritual Growth through Clinical Practice | 23 |
| 3. | Pastoral Care Programmes | 36 |
| 4. | Management Workshops | 24 |
| 5. | Diocesan Level Programmes | 91 |
| 6. | Regional Level Programmes | 50 |
| 7. | Others (Legal Aid, Women and Health, Low Cost Communication etc) | 25 |
| | Total | 323 |

A total of 323 persons have participated from the 102 institutions. Each institution has sent more than one person (3.2 on an average) for one or more programmes. It is probable that having attended once, they are more likely to make greater use of such opportunities. Larger number of persons (43.6%) or 141 have attended the Diocesan and Regional level programmes. The number of institutions participating at these levels was 31 (see next table). But probably larger numbers of personnel from each institution are able to attend. Personnel could also attend all/more than one programme conducted at this level.

This substantiates the earlier opinion of respondents that the Diocesan level of functioning is preferable. These are optimal places to conduct these programmes as they are more easily accessible (in terms of time, money, and travel) and would probably be more relevant to the local situation, besides offering an occasion for members in the same region to get know each other and build working relationships.

It is not possible to say from this table which programmes are in greater demand.

The annual participation of institutions in different special training programmes for the past five years is as follows:

Table 14. Annual participation in different programmes

| Sl.No. Programmes | 1987 | 1988 | 1989 | 1990 | 1991 | N.I. | Total |
|---|---|---|---|---|---|---|---|
| 1. Continuing Medical Education | | | | | | | |
| a)Rational Therapeutics | 01 | 04 | -- | -- | 01 | 01 | 07 |
| b)Training in ORT | 03 | 07 | 01 | 02 | -- | 01 | 14 |
| c)Use of Herbal Medicines | 02 | 03 | 02 | 08 | 02 | 03 | 20 |
| d)Others | -- | 01 | -- | 03 | 02 | -- | 06 |
| 2. Spiritual Growth through Clinical Practice | 01 | 02 | 01 | 07 | 09 | -- | 20 |
| 3. Pastoral Care Programmes | 01 | 01 | -- | -- | 10 | -- | 12 |
| 4. Management Workshops | -- | -- | 02 | 03 | 11 | 02 | 18 |
| 5. Diocesan Level Programs | 01 | 01 | 01 | 05 | 04 | 01 | 13 |
| 6. Regional Level Programs | 02 | 06 | -- | 04 | 05 | 01 | 18 |
| 7. Others | -- | 01 | 05 | 02 | 02 | 01 | 11 |
| Total | 11 | 26 | 12 | 34 | 46 | 19 | 139 |

* NI: No information regarding year of participation.

139 respondent members gave their opinion regarding the content of these programmes organised by CHAI. This is given below in tabular form.

Table 15. Opinion on content of special training programs

| Sl.No. | Programmes | Number of institutions | | | Total |
|---|---|---|---|---|---|
| | | Useful | Not Useful | No information | |
| 1. | Continuing Medical Education | | | | |
| a) | Rational Therapeutics | 07 | -- | -- | 07 |
| b) | Training in ORT | 13 | -- | 01 | 14 |
| c) | Use of Herbal Medicines | 19 | -- | 01 | 20 |
| d) | Others | 06 | -- | 0 | 06 |
| 2. | Spiritual Growth through Clinical Practice | 19 | -- | 01 | 20 |
| 3. | Pastoral Care Programs | 12 | 0 | 0 | 12 |
| 4. | Management Workshops | 13 | 04 | 01 | 18 |
| 5. | Diocesan Level Programs | 11 | 01 | 01 | 13 |
| 6. | Regional Level Programs | 16 | 01 | 01 | 18 |
| 7. | Other | 11 | - | 0 | 11 |
| | Total | 126 | 07 | 06 | 139 |

Overall, a majority (90.7%) feel that the content of programmes was useful. Only four out of 18 (22.0%) who responded to the query regarding management workshops, specifically said that they were not useful. This too is a minority.

Feedback from members regarding the methodology of the programmes is given below.

Table 16. Methodology of Special Training Programmes

| Sl.No. | Programmes | Well Conducted | Poorly Conducted | No Information | Total |
|---|---|---|---|---|---|
| 1. | Continuing Medical Education | | | | |
| a) | Rational Therapeutics | 07 | -- | -- | 07 |
| b) | Training in ORT | 13 | -- | 01 | 14 |
| c) | Use of Herbal Medicines | 18 | -- | 02 | 20 |
| d) | Others | 06 | -- | -- | 06 |
| 2. | Spiritual Growth through Clinical Practice | 18 | 01 | 01 | 20 |
| 3. | Pastoral Care Programs | 11 | -- | 01 | 12 |
| 4 | Management Workshops | 17 | -- | 01 | 18 |
| 5. | Diocesan Level Programs | 12 | -- | 01 | 13 |
| 6. | Regional Level Programs | 17 | -- | 01 | 18 |
| 7. | Others | 09 | -- | 02 | 11 |
| | Total | 128 | 01 | 10 | 139 |

Again a majority of 92.0% have expressed that the programmes were well conducted.

Only two members gave additional comments/suggestions, namely: (i) CHAI staff should be available to conduct seminars on various topics in tribal areas,when regional level programmes are organised, (ii) Accommodation for participants should be ensured.

Analysis showed a significant association with location viz.,

* 43.75% of urban, 35.59% of tribal and 27.38% of rural based institutions have participated in the above programmes,
* Participation is however independent of the size of institutions and region (better and poorer health status) of the member institutions.

## 4.8 CHAI CONVENTIONS (covering the past five years)

### 4.8.1 Participation:

132 (32.4%) of respondent member institutions have been represented at any one or more of the Conventions/Annual Meetings of CHAI during the past five years. 264 (64.9%) have not attended any. 9 (2.2%) do not know and 2 (0.5%) did not respond to the question.

The Chi Square test shows an association between region and size of institutions and participation in annual conventions.

* 37.18 % from regions with better health status and 24.4 % of institutions from regions with poorer health status have participated,

* 24.1% of the 0-6 bed institutions and 49.6% of institutions with more than 7 beds have participated in conventions. However, because of the much larger proportion of small institutions in the total membership of CHAI, in terms of numbers 64 or 48.5% of participants were small institutions out of the 132 who attended the conventions. Looked at in another way while 37.0% of members (as per study findings) have more than 7 beds, 51.5% of participating institutions in the conventions are from this category.

* Analysis by location shows that 39.1% of urban, 32.8% of rural and 29.4% of tribal area based institutions have participated in conventions during the past five years. However, out of the total 132 participating institutions during the past five years 64.4% (85) were rural, 15.1% (20) were tribal and 20.4% (27) were urban. This is more or less similar to the distribution by location of the total membership,which is 67.8% rural, 15.6% tribal and 16.6% urban. There is thus no statistical association with location.

The yearwise breakup of the number of persons who attended the conventions from this sample is as follows:

Table 17. Annual Participation in Conventions

| Year | Number of persons who attended | Venue and Theme |
|---|---|---|
| 1986 | 36 | Hyderabad,Health as if People Mattered |
| 1987 | 58 | Calcutta, Our Health Care Mission : A Search for Priorities. |
| 1988 | 80 | Cochin, Our Hospitals: Towards Greater Accountability. |
| 1989 | 29 | Hyderabad, Financial Administration and Project Planning. |
| 1990 | 77 | Bombay, Women in Health Care. |
| | 280 | |

The trend shows an increase in numbers attending,with a plateauing after 1988. In 1989, only a general body meeting with a half day session was held, thus accounting for the drop in number. It is also seen that a total of 280 persons from 132 institutions have attended, that is, an average of two per institution.

4.8.2 The designation of the personnel who attended the conventions is as follows:

Table 18. Designation of Personnel attending conventions

| Sl.No. | Designation | 1986 | 1987 | 1988 | 1989 | 1990 | Total |
|---|---|---|---|---|---|---|---|
| 01. | Staff Nurse | 15 | 19 | 34 | 09 | 42 | 119 |
| 02. | Doctor | 03 | 02 | 01 | -- | 02 | 08 |
| 03. | Administrator | 06 | 09 | 16 | 04 | 06 | 41 |
| 04. | Community Health Worker | 01 | -- | -- | -- | 01 | 01 |
| 05. | Social Worker | -- | 01 | 01 | -- | 03 | 05 |
| 06. | Pharmacist | -- | -- | 03 | -- | -- | 03 |
| 07. | Laboratory Technician | -- | -- | 01 | -- | -- | 01 |
| 08. | Staff (unspecified) | -- | -- | 01 | 02 | -- | 03 |
| | Total | 25 | 31 | 57 | 15 | 54 | 182 |

[N.B: The remaining did not answer or they did not know.]

The majority attending are nurses (65.4%) and administrators (22.5%), some of whom are also nurses. This would be useful to keep in mind when planning conventions. Conventions do not adequately reach other categories of health personnel. Either greater efforts could be made to involve them or other programmes could be more specifically designed for them.

4.8.3 The Statewise breakup of institutions who have sent personnel to the conventions follows.

Table 19 Statewise list of institutions represented at Conventions

| Sl. No. | State | Yes | No | Do not know | N.I | Total |
|---|---|---|---|---|---|---|
| 01. | Andhra Pradesh | 20 | 22 | 03 | -- | 45 |
| 02. | Assam | 01 | 06 | -- | -- | 07 |
| 03. | Bihar | 06 | 23 | -- | -- | 29 |
| 04. | Goa | 01 | 04 | -- | -- | 05 |
| 05. | Gujarat | 02 | 09 | -- | -- | 11 |
| 06. | Haryana | -- | 03 | -- | -- | 03 |
| 07. | Karnataka | 08 | 20 | 03 | -- | 31 |
| 08. | Kerala | 31 | 46 | 02 | 01 | 80 |
| 09. | Madhya Pradesh | 05 | 29 | -- | -- | 34 |
| 10. | Maharashtra | 06 | 11 | -- | 01 | 18 |
| 11. | Manipur | 01 | 02 | -- | -- | 03 |
| 12. | Meghalaya | 03 | 08 | -- | -- | 11 |
| 13. | Mizoram | -- | 02 | -- | -- | 02 |
| 14. | Nagaland | 03 | 02 | -- | -- | 05 |
| 15. | Orissa | 06 | 07 | -- | 01 | 14 |
| 16. | Punjab | 01 | 01 | -- | -- | 02 |
| 17. | Rajasthan | 01 | 05 | -- | 01 | 07 |
| 18. | Tamilnadu | 23 | 47 | -- | -- | 70 |
| 19. | Tripura | 02 | -- | -- | -- | 02 |
| 20. | Uttar Pradesh | 08 | 10 | -- | -- | 18 |
| 21. | West Bengal | 04 | 06 | -- | -- | 10 |
| | Total (407) | 132 | 264 | 08 | 04 | 407 |

[N.B: N.I. = No Information. Also refer note below Table 12.]
[82 (62.1%) were from the four Southern States and 20 (15.1%) were from the four Central States of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh]

4.8.4 Feedback on conventions: A majority of 80.2% (150) felt that the themes chosen were useful, 17.6% did not respond to this question and 2.1% felt the themes were not useful. This question was asked in the context of their work.

Regarding the quality of the sessions 75.4% (141) expressed that they were interesting, 20.8% gave no information, and 3.7% said that sessions were not interesting.

Regarding the organisation of the conventions 75.9% (142) expressed that they were well organised. 3.7% (7) felt they were not well organised and 20.3% (38)did not respond.

Additional remarks made by a few respondents regarding the annual conventions were:

* Conventions are informative,
* There is poor attendence by lay people,
* Those who attend do not participate actively,
* There is lack of adequate communication and dialogue between members,
* Arrangements for food and accomodation are poor,
* There is canvassing to elect candidates from a particular state by certain members.

4.8.5 A picture of the follow up undertaken by institutions on the themes of the past five annual conventions is as follows:

1) 1986 - 14 institutions (3.4 % of 407) organised some follow up on the theme, "Health as if People Mattered". This included sharing of experiences and knowledge of conventions with others (03); improving hospital services (2); offering person oriented services (1); starting pastoral care services (1); details not given (7).

2) 1987 - 17 institutions (4.2 % of 407) undertook some follow up on the theme "Our Health Care Mission : a Search for Priorities". The follow up included : sharing of experiences/knowledge gained with others (4); starting health awareness programmes (1); starting community health programmes (1); adopting a preference regarding treating the poor (2); starting practice of holistic health (1); details not given (8).

3) 1988 - 9 institutions (2.2% of 407) initiated follow up on the theme "Our Hospitals: Towards Greater Accountability". This included: sharing experiences with others (3); conducting medical camps (1), details not given (5).

4) 1989 - 7 institutions (1.7 % of 407) undertook some follow up on the theme "Financial Administration and Project Planning". Of these four did not specify details of follow up and three said they shared experience/knowledge gained with others.

5) 1990 - 26 institutions (6.4 % of 407) organised some follow up on the theme "Women in Health Care ". This included : sharing of experiences/knowledge with others (5); starting womens' awareness programmes (5); organising a seminar on women in health care (1); starting Mother and Child Health and village health programmes for women (4); education on Natural Family Planning (3); details not specified (8).

During the past five years, the overall follow up on the themes of the various conventions has been poor. This may not be uncommon after meetings and conventions. However considering the large investment in terms of the time of CHAI staff, of the local organising committee and of the participants and of money spent, the purpose of the of annual conventions other than conducting the annual general body meeting and business affairs needs to be reviewed. Clarifying goals and purposes, using participatory methodologies in small groups, getting feedback from participants, evaluating the conventions by the staff, Board and a small group, along with follow up by CHAI may help to make this major activity more meaningful.

4.8.6 185 (45.4 %) of member institutions have given many suggestions regarding the conventions, which are broadly grouped below:

a) Venue: It was felt that conventions should be arranged regionally/locally (64). It is inconvenient/not possible to travel long distances and close the institutions to participate in the conventions (30). Conventions should be arranged in the North and South alternately (4). They should be held at least once a year at the central level (4). Conventions should be organised in central places (3). Two seperate conventions could be held for the North and the South (2). Conventions could be conducted in each state by turn (2).Conventions should be held in Kerala every alternate year (1).

b) Participants and Participation: The participation of the laity should be encouraged (2). Focus should be on the participation from each of the diocesan units (1). Representation from all levels should be encouraged (1). There is a lack of participation from rural health centres (1). Small dispensaries are not given due importance during conventions (1). Poor/ small institutions cannot participate in conventions (1). All members should be treated equally (1). Participants are generally unaware of what is taking place
during conventions (1).

c) Preparatory work/Planning of conventions: 18 members again expressed that conventions are useful and informative and 8 felt that they are not useful and are not worth attending. The organisation of the conventions should be better (5). Group sharing should be introduced (8). Input sessions should be given greater importance (4) There should be time/space for raising regional issues (1). An open forum/ platform to express feelings and views should be arranged (1). Seminars/courses could be arranged either before or soon after the conventions (2). It is useful to have exhibitions during the conventions (1). The conventions should be used as an occasion to motivate members (1). There is a need for proper planning (1).

d) Themes and follow up: Upto date themes should be taken up (4). Members should be consulted before deciding on themes (2). It was felt that themes were not practical (2), and are not applicable to smaller institutions (2). There should be time and space for raising regional issues (1). A seperate convention could be held for leprosy workers (2). "Community Development" needs to be taken up (1). Spiritual values are not taken care of in conventions (1). Promote other systems of medicines during conventions (1).

CHAI does ot help its members to follow up on resolutions (2). There is poor follow up of resolutions (1). Follow up programmes should be arranged at the State/Diocesan levels (1).

e) Time factor: The frequency of conventions should be once in two years (12). They should be held once in three years (1). The conventions should be for more than a day (1).

f) Financial aspects: Conventions are very expensive (16). CHAI should provide travel allowance to representatives from poor institutions (5). Participants should be given some subsidy (2). It was felt that annual conventions are conducted to mobilise money (1).

g) An additional comment was that "politics" should be avoided in the election of office bearers (1).

## 4.9 PUBLICATIONS

### 4.9.1 Health Action

a) 92.9% (378) member institutions received Health Action during the years 1988, 1989, 1990. Only 19 (4.7%) specifically said they have not received the magazine. However, this number includes those institutions that started after 1990. 10 institutions (2.4%) did not know/ gave no information. This data relates to the year since it was transformed from Medical Service to Health Action and during the years when it was sent to all CHAI member institutions free, i.e., as part of their membership fee.

66.6% (271) institutions from this sample subscribe to Health Action (in 1991). There is an association shown by the Chi Square test at the 5 per cent level of significance between the location (urban,tribal,rural)of the institution and subscription. 77.3% of urban based institutions, 77.9% of tribal area based institutions and 62.3% of rural based institutions are subscribers.

Analysis according to size of institutions shows that 64.9% of smaller institutions (0-6 Beds), 72.7% of social welfare centres (including Diocesan Social Service Societies) and 71.3% of larger institutions ( more than 7 beds) subscribe to Health Action.

74.3% (87/117) of institutions in regions with poorer health status and 64.6% (184/285) based in regions with better health status subscribe to Health Action.

b) The Statewise subscription to Health Action is given next.

Table 20. Statewise subscription to Health Action

| Sl. No. | State | Yes | No | Do not know | N.I | Total |
|---|---|---|---|---|---|---|
| 01. | Andhra Pradesh | 34 | 11 | -- | -- | 45 |
| 02. | Assam | 04 | 03 | -- | -- | 07 |
| 03. | Bihar | 21 | 08 | -- | -- | 29 |
| 04. | Goa | 03 | 02 | -- | -- | 05 |
| 05. | Gujarat | 10 | 01 | -- | -- | 11 |
| 06. | Haryana | 03 | -- | -- | -- | 03 |
| 07. | Karnataka | 22 | 09 | -- | -- | 31 |
| 08. | Kerala | 42 | 36 | -- | 02 | 80 |
| 09. | Madhya Pradesh | 24 | 10 | -- | -- | 34 |
| 10. | Maharashtra | 13 | 04 | -- | -- | 17 |
| 11. | Manipur | 02 | 01 | -- | -- | 03 |
| 12. | Meghalaya | 10 | 01 | -- | -- | 11 |
| 13. | Mizoram | -- | 02 | -- | -- | 02 |
| 14. | Nagaland | 05 | -- | -- | -- | 05 |
| 15. | Orissa | 12 | 01 | -- | 01 | 14 |
| 16. | Punjab | 02 | -- | -- | -- | 02 |
| 17. | Rajasthan | 05 | 01 | -- | 01 | 07 |
| 18. | Tamilnadu | 43 | 27 | -- | -- | 70 |
| 19. | Tripura | 01 | 01 | -- | -- | 02 |
| 20. | Uttar Pradesh | 11 | 05 | -- | 02 | 18 |
| 21. | West Bengal | 04 | 06 | -- | -- | 10 |
| | Total (407) | 271 | 131 | -- | 05 | 407 |

[N.B: Refer note with Table.12.]

141 (52.0%) of subscribing member institutions are from the four Southern States and 61 (22.5%) from the four Central States (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh).

c) An enquiry was made regarding the frequency of reading of Health Action by members. 76.2% (310) read it regularly, 16.0% (65) read it occasionally, 1.5% (6) never read it, and 1.5% (6) did not respond to this question. 4.8% (20) said this question was not applicable, since their institution was formed or joined CHAI after the period when Health Action was sent free. This group are also not presently subscribers to the magazine.

An idea about the different groups of people who read Health Action is given in the table below:

Table 21. Readership of Health Action

| Sl. No. | Category | Number of institutions | % n=407 |
|---|---|---|---|
| 01. | Nurses | 293 | 72.0 |
| 02. | Administrators | 220 | 54.0 |
| 03. | Doctors | 138 | 33.9 |
| 04. | Sisters in the Congregation | 137 | 33.7 |
| 05. | Patients | 30 | 7.4 |
| 06. | Relatives | 29 | 7.1 |
| 07. | School Teachers | 06 | 1.5 |
| 08. | Community Health Workers | 06 | 1.5 |
| 09. | Office Staff | 05 | 1.2 |
| 10. | Student Nurses | 02 | 0.5 |
| 11. | Paramedical Staff | 01 | 0.2 |
| 12. | Social Workers | 01 | 0.2 |
| 13. | No information | 07 | 1.7 |

d) Members gave their opinion about Health Action. A large majority of 95.6% (374) found its contents relevant, 1.5% (6) found it not so relevant and 2.8% (11) did not respond. Regarding its presentation, 90.3% (362) said it was interesting, 1.5% (6) found it was not so interesting, 4.2% (17) said it was too technical and 3.9% (16) did not respond to the question.

e) Comments and suggestions concerning Health Action were given by 70.8 (288) of member institutions. These are as follows:

Usefulness: 158 (38.8%) again reiterated that they found Health Action useful and informative. It was also considered to be well organised (3).

Language and Presentation: (108 or 26.5%) 74 felt that it should be published in the vernacular (national/regional) language. Contents should be presented in simple English (8). Some considered it too technical for ordinary people (7). The presentation should be easily comprehensible with the use of charts and diagrams etc (4). The print was tedious to read (3).

There is need for greater use of case studies (3). Illustrations were considered good (2). Larger number of illustrations are required (1). Greater use of humour (jokes etc) was suggested (2). Medical jargon should be demystified, making it useful for ordinary people (1). Thematic presentation should be continued (1). Health and disease quiz sheets could be included to make it more interesting (1). Advertisements should be minimised (1).

Contents - Suggestions regarding specific areas: (81 or 19.9%):

Alternative systems: Information on herbal medicine/other systems of medicine should be given (17).
Drugs: Need for a column on banned/outdated drugs (14). Information on side effects of drugs (9), essential drugs (2), and drugless therapy (2) to be covered.
Rural Health: Publish reports/articles on rural health and development (8), covering also tribal areas (2). There could be a column for rural health workers (2),and guidelines for training community health workers (1).
Diseases: Specific illnesses should be covered, giving symptoms and treatment (9). Publish detailed articles regarding new diseases (4). Information on leprosy should be added (2).
Natural Family Planning and Mother and Child Health: Should have a column on Family Life Education and Natural Family Planning (3). Issues on women and child care to be included (1).
Others: There is a need for coverage on medico-ethical problems (1), adult education (1), problems of old age/ services that are available (1), and on mental retardation (1). A column on social problems and case studies of solutions (1).

Contents - General Focus (40 or 9.8%): Focus on current issues in health care (7). Articles are not upto the standard (7). Contents should be relevant to medical/ health work done by members (4). The medical aspect is often neglected in articles (4). Articles should be upto date (3). Applicability of issues to the village situation should be included (3). Wrong information is given at times (3). The members and their activities should be introduced to the readers through Health Action (3). Contents should be more oriented to the medical profession (2). It should be responsive to the interests of small institutions too. It is more practical, rather than theoretical at present (1). One page could be used for practical hints (1). The articles should reflect Gospel values (1). Articles should focus on preventive education (1).

Cost/Readership/Distribution (34 or 8.3%): It should be sent free of cost to members (19). Some said it was expensive (9). There is a need to subsidise the subscription (2). The number of copies sent to institutions could be increased according to the number of readers (1). Make more efforts to widen the readership (1). It should be made available to non-catholics also (1). (N.B.:This is already being done) Members get it irregularly (1).

4.9.2 Other priced publications/productions

The pattern of purchase of various other publications/ productions from CHAI or HAFA (Health Accessories for All) is given as follows.

Table 22. Purchase of other priced publications/productions

| Sl. | Publications | Purchase of publications | | | |
|---|---|---|---|---|---|
| | | Yes | | No | Do not know |
| | | No. | % (n= 407) | | |
| 01. | Natrual Family Planning (NFP) by Fr.Menezes | 111 | 27.3 | 273 | 23 |
| 02. | Slide/cassette set on Natural Family Planning | 11 | 2.7 | 374 | 22 |
| 03. | Health Care Products & Services : A Buyers Guide - 1987 | 77 | 18.9 | 310 | 20 |
| 04. | Herbal and Home Remedies (1987) in Malayalam by Sr.Innocent and Fr.Joseph Chittoor | 86 | 21.1 | 305 | 16 |
| 05. | Trainers Manual for Training Community Level Workers (1987) by Community Health Department of CHAI | 54 | 13.3 | 329 | 24 |
| 06. | Herbal and Home Remedies (1989) Compiled by Sr.Julie Plackal (loose leaf, pictorial format) | 48 | 11.8 | 333 | 26 |
| 07. | CHAI-CMAI Joint Hospital Formulary (1990) | 48 | 11.8 | 336 | 23 |
| 08. | Music cassette on Rights of the Child | 09 | 2.2 | 378 | 20 |
| 09. | Healing Music cassette | 16 | 3.9 | 372 | 19 |

Comments regarding the usefulness of the above publications/productions are given below. Percentages are calculated based on the number who purchased the publication/production.

Table 23. Comments about priced publications/productions

| Sl. No. | Publications | Useful | Not Useful | No information | Not applicable |
|---|---|---|---|---|---|
| 01. | Natural Family Planning | 79.3% (88) | 06 | 17 | 296 |
| 02. | Slide/Cassette set on Natural Family Planning | 63.6% (07) | 01 | 03 | 396 |
| 03. | Health Care Products and Services: Buyers Guide | 67.5% (52) | 04 | 21 | 330 |
| 04. | Herbal and Home Remedies (1987) | 83.7% (72) | 04 | 11 | 320 |
| 05. | Trainers Manual for Community Level Workers | 79.6% (43) | 01 | 10 | 353 |
| 06. | Herbal and Home Remedies (1989) | 77.1% (37) | 03 | 08 | 359 |
| 07. | CHAI-CMAI Joint Hospital Formulary | 72.9% (35) | 01 | 13 | 358 |
| 08. | Music cassette on Rights of the Child | 66.7 (06) | 01 | 03 | 397 |
| 09. | Healing Music (cassette) | 62.5% (10) | 04 | 03 | 390 |

4.9.3 Publications sent free to members

Given below are the numbers and percentages of members from this sample who have received the publications that were sent free by CHAI.

Table 24. Receipt of free publications

| Sl. No. | Publications | Institutions who received the publications | | Institutions who did not receive | | Institutions who did not know whether they received | |
|---|---|---|---|---|---|---|---|
| | | No. | % | No. | % | No. | % |
| 01. | The Memorandum of Association and Rules,Regulation and Bye-laws of CHAI (1961) | 86 | 21.1 | 221 | 54.3 | 100 | 24.6 |
| 02. | Health and Power to People : Theory and Practice of Community Health (1986) by Community Health and Development Team of CHAI | 36 | 8.8 | 278 | 68.3 | 93 | 22.8 |
| 03. | Set of ten booklets in Hindi * | 28 | 6.9 | 323 | 79.4 | 56 | 13.7 |
| 04. | The CHAI Hospitals and Other Health Care Institutions: Health Policy Guidelines (Draft) 1987-88 | 62 | 15.2 | 259 | 63.6 | 86 | 21.1 |

(N.B: The denominator for the percentages is 407)

* The set of ten booklets were on Bronchopneumonia and Pneumonia; Common Intestinal Worms-Round Worm and Pin Worm; Poliomyelits; Ears; Eyes; Tuberculosis and its Prevention; Teeth and Gums - Care of Teeth; Leprosy;Common Skin Diseases and Scabies.

Comments regarding the usefulness of the above publications are given below. Percentages have been calculated on the basis of the number who received the publications.

Table 25. Comments about free publications

| Publication | Useful | Not Useful | No information | Not Applicable |
|---|---|---|---|---|
| The Memorandum of Association and Rules,Regulations and Byelaws | 69.8% (60) | 04 | 22 | 321 |
| Health and Power to People : Theory and Practice of Community Health (1986) | 72.2% (26) | 01 | 09 | 371 |
| Set of ten booklets in Hindi | 71.4% (20) | 01 | 08 | 378 |
| The CHAI Hospitals and Other Health Care Institution: Health Policy Guidelines (Draft) 1987-88 | 69.3% (43) | 02 | 17 | 345 |

## 4.10 CENTRAL PUCHASING SERVICE (CPS)

### 4.10.1 Utilization

24.6% (100) institutions from this sample had availed of the facility/ services offered by CPS of CHAI anytime during the past. The five year cut off period was not used for the CPS as purchases through this unit could be large ones made only once in several years. 65.6% (267) institutions had never availed of the services of CPS and 9.8% (40) did not know if it had been used in the past.

Further analysis of the utilization of services of the CPS by region, location and size of institution showed.

* an association at the 5 % level of significance with size of institution. 42.4% of larger (more than 7 beds), and only 20.1% of smaller institutions of 0 - 6 beds size availed of these services.

* There was also an association with location (urban, rural, tribal) 50 % urban, 24.5 % of rural and 13.8% of tribal area based institutions availed of the services of CPS respectively.

* The association with region was not significant at the 5 % level. However, 29.4% of institutions based in regions with better health status availed of the facility offered by the CPS, and 21.9% of those based in regions with poorer health status did so. Since larger numbers of members are in regions with better status, in terms of actual numbers this group is more.

The Statewise pattern of utilisation by members of the facility offered by CPS is given next table.

Table 26. **Statewise utilization of CPS by members**

| Sl. No. | State | Yes | No | Do not know | N.I | Total |
|---|---|---|---|---|---|---|
| 01. | Andhra Pradesh | 19 | 20 | 06 | -- | 45 |
| 02. | Assam | -- | 07 | -- | -- | 07 |
| 03. | Bihar | 04 | 23 | 02 | -- | 29 |
| 04. | Goa | 01 | 04 | -- | -- | 05 |
| 05. | Gujarat | 04 | 06 | 01 | -- | 11 |
| 06. | Haryana | 01 | 02 | -- | -- | 03 |
| 07. | Karnataka | 09 | 20 | 02 | -- | 31 |
| 08. | Kerala | 25 | 47 | 08 | -- | 80 |
| 09. | Madhya Pradesh | 08 | 24 | 02 | -- | 34 |
| 10. | Maharashtra | 02 | 14 | 01 | 01 | 18 |
| 11. | Manipur | -- | 03 | -- | -- | 03 |
| 12. | Meghalaya | 01 | 08 | 02 | -- | 11 |
| 13. | Mizoram | 01 | 01 | -- | -- | 02 |
| 14. | Nagaland | 02 | 03 | -- | -- | 05 |
| 15. | Orissa | 02 | 07 | 04 | 01 | 14 |
| 16. | Punjab | 01 | 01 | -- | -- | 02 |
| 17. | Rajasthan | -- | 06 | -- | 01 | 07 |
| 18. | Tamilnadu | 15 | 52 | 03 | -- | 70 |
| 19. | Tripura | -- | 02 | -- | -- | 02 |
| 20. | Uttar Pradesh | 05 | 10 | 03 | -- | 18 |
| 21. | West Bengal | -- | 08 | 02 | -- | 10 |
| | Total (407) | 100 | 268 | 36 | 03 | 407 |

[N.B: Refer note with Table 12.]

68 (68.0%) institutions from the four Southern States utilised the facilities of CPS, while 17 (17.0%) institutions from the four Central states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh did so.

4.10.2 The yearwise items that were purchased through the CPS are given below.

Table 27. Yearwise items purchased through CPS

| Year | Vehicles | Equipment | Pharmaceuticals | Consultancy services | Total |
|---|---|---|---|---|---|
| 1960 | 01 | -- | -- | -- | 01* |
| 1973 | -- | 01 | -- | -- | 01* |
| 1976 | -- | 01 | -- | -- | 01 |
| 1977 | -- | 01 | -- | -- | 01 |
| 1978 | 03 | 01 | -- | -- | 04 |
| 1979 | 02 | -- | -- | -- | 02 |
| 1980 | 05 | 02 | -- | -- | 07 |
| 1981 | 02 | 02 | -- | -- | 04 |
| 1982 | 02 | 01 | -- | -- | 03 |
| 1983 | 06 | 01 | -- | -- | 07 |
| 1984 | 06 | -- | -- | -- | 06 |
| 1985 | 02 | 02 | 01 | -- | 05 |
| 1986 | 05 | 01 | -- | -- | 06 |
| 1987 | 04 | 01 | -- | -- | 05 |
| 1988 | 10 | 03 | 01 | -- | 14 |
| 1989 | 13 | 05 | 01 | -- | 19 |
| 1990 | 15 | 09 | 03 | -- | 27 |
| 1991 | 16 | 09 | 02 | 01 | 28 |
| 1992 | 02 | -- | 01 | 01 | 04 |
| | 94 | 40 | 09 | 02 | 145 |

[N.B: * CPS was started later, but these could have been bought through CHAI. Some institutions have made more than one purchase through CPS, hence the larger total here.]

There is an increase in the number of member institutions who utilized the services of CPS during the period 1988 - 1991. It is important to note that the number of non-members of CHAI who use the facility of CPS much greater. Annually non-members account for about 80% of institutions making use of the services of the CPS which is open to any voluntary organisation working in the field of health or development in India.

4.10.3 The overall details of items purchased through the CPS by CHAI members from this sample are.

Table 28. Items purchased through CPS

| Item | Number of institutions | % n = 407 |
|---|---|---|
| Vehicles | 77 | 18.9 |
| Equipment | 33 | 8.1 |
| Pharmaceuticals | 08 | 1.9 |
| Consultancy | 02 | 0.5 |

There is a discrepancy in totals as some institutions have availed of services of CHAI more than once and for more than one item. Some have also bought the same item/category of item more than once. This is indicated in the next table.

Table 29. Frequency of purchase of items through CPS

| Item | Once | Twice | Thrice | More than three |
|---|---|---|---|---|
| Vehicle | 65 | 06 | 04 | 02 |
| Equipment | 29 | 02 | 01 | 01 |
| Pharmaceuticals | 08 | -- | -- | -- |
| Consultancy | 02 | -- | -- | -- |

4.10.4 The purpose, given by members, of purchasing different types of items bought through the CPS are indicated below.
Vehicles: For outreach services (38), for mobile clinics (15), ambulance (12), use not specified (8),shopping/ conveyance (3), and no information (3).
Equipment: Hospital use (unspecified) (11), refrigerator (6), storage of medicines (3), incubators (2), air conditioner (2), x-ray machine (2), theatre equipment (1), computer (1), washing machine (1), laboratory equipment (1), kitchen equipment (1), photocopier (1), and no information (4).
Pharmaceutical products: For distribution to the poor people of the area (4), and no information (5).
Consultancy: To buy books (2).

4.10.5 The opinion of members regarding the services offered by CPS was elicited.

* 113 institutions felt that services were useful and 6 mentioned that they were not useful.

* 7 mentioned that services were efficient and 7 said they were not efficient.

* 43 considered that the services were useful and efficient, 7 felt that they were useful but not efficient and 1 felt that they were neither useful nor efficient.

Some members did not respond to this question.

4.10.6 Comments/suggestions about CPS are as follows:
Percentages are of the number who have utilised the services of CPS.

Usefulness (34.0%): Services were considered useful and helpful (27), and particularly helpful to poor institution (4). The response to requests is immediate (3).
Areas of problems (26.0%): There are too many procedures to be followed before service delivery (6). The vehicles provided are not of good quality (5). The rates of service delivery are high (3). There is a bureaucratic delay resulting in late delivery. The services are not prompt (4). Applications are not considered according to priorities (2). There is favouritism in service delivery (2). Services should be more efficient and responsible (2). Some applications are not considered and reasons for refusal are not given (1). Follow up is unsatisfactory (1).
Suggestions (14): CHAI should arrange for supply of drugs from foreign countries (4). More consultancy services should be offered (3). Help should also be given for infrastructural facilities (2). Members should be kept informed of the possibilities, types of services and methods of availing of the services of CHAI (2). CPS should operate from Delhi (1). It should operate on a local basis (1). It should get more involved in the purchase/ distribution of pharmaceuticals (1).

## 4.11 MEDICINES/EQUIPMENT FROM THE CATHOLIC MEDICAL MISSION BOARD (CMMB) OF THE UNITED STATES OF AMERICA

### 4.11.1 Receipt of consignments

53.3 % (217) institutions from this sample have received gift medicines/consignments from the CMMB during the past 5 years. 40.5 % (165) have not and 6.1 % (25) do not know if they have.

Further analysis by region, location and size of institution and receipt of CMMB consignments shows:

* 64.4 % (85) of institutions with a bed strength more than 7, 52.8 % (132) of smaller institutions (0-6 Beds) have received consignments.

* 64.2 % of institutions in regions with poorer health status and 53.7 % in regions with better health status received consignments.

* 58.7 % of tribal (37), 56.7 % (38) of urban, and 56.3 % (142) of rural based institutions have received CMMB consignments. As mentioned earlier actual members vary according to the proportion in the total membership.

4.11.2 Details of type of gift consignments received are given below:

Table 30. Details of CMMB Consignments

| Consignments | Number of Institutions | % (N=407) | % (N=217) |
|---|---|---|---|
| Medicines | 214 | 52.6 | 98.6 |
| Equipment | 17 | 4.2 | 7.8 |
| Books | 10 | 2.5 | 4.6 |
| Bandages | 02 | 0.5 | 0.9 |

A consignment has a varying combination of the different types of supply.

4.11.3 The yearwise breakup of the CMMB consignments are as follows:

Table 31. Annual breakup of CMMB consignments

| Year | Medicine | Equipment | Book | Bandages | Total |
|---|---|---|---|---|---|
| 1987 | 15 | 03 | 02 | -- | 20 |
| 1988 | 38 | 02 | 01 | -- | 41 |
| 1989 | 45 | 07 | 01 | 01 | 54 |
| 1990 | 59 | 0 | 04 | -- | 63 |
| 1991 | 54 | 05 | 02 | 01 | 62 |
| N.I | 11 | 0 | 0 | 0 | 11 |
| Total | 222 | 17 | 10 | 02 | 251 |

[N.I = No information]

There is an increase in the number of institutions receiving supplies over the years. Medicines form the major component of the supplies.

208 institutions who received medicines, did so only once during the past five years, five institutions received medicines twice and one institution received medicines four times. Other gift consignments were received only once during the past five years.

80.4% who received medicines found them useful. 15.9% said they were not useful and 3.6 % did not comment. Similarly,70.6% receiving equipment found them useful and 29.4% not useful. 70.0 % receiving books said they were of use.

4.11.4 Comments regarding medicines

Feedback was elicited regarding the time interval between the consignment reaching the institution and the expiry date. 43.6 % said that the time interval was sufficient, 35.6 % mentioned that this was very short, 17.6 % said that the expiry date had already passed and 3.2 % did not respond to the question.

Problems mentioned regarding gift medicines (by 124 or 30.5% of 407) were as follows:

Some drugs are not useful (68). Non essential medicines are sent (24). The procedural formalities are tedious (12). It is difficult to obtain utilisation/ distribution certificates (6). The response to requests is poor (03). The doctors do not prescribe these medicines (2). Quantities of drugs sent are too large (2). There is a long gap between the date of requests and

the despatch of the medicines (1). Banned drugs are sent (1). Unnecessary drugs are sent (1). Old bandages were sent (1). Institutions have to pay a heavy duty (1). Maintenance of records is difficult (1). People do not want CMMB medicines (1).

**Usefulness:** It was again mentioned that the CMMB scheme is useful and helpful (151 or 37.1%).

The general suggestions/comments given regarding gift medicines (by 178 or 43.7%) were: Essential and useful drugs for basic/common illnesses only should be sent (45). It is necessary to assess the needs of members before sending medicines (33). Medicines should be sent regularly and in time (32). An option should be provided to institutions/they should be consulted in the selection of drugs (23). There should be adequate time to utilize the drugs (20). We should discourage foreign medicine being dumped onto our hands (4). There is need for a variety of medicines rather than large quantities of one or two particular drugs (4). Supply of books and equipment would be preferable to medicines (4). Medicines requested for should be given (3). Money could be sent and the institutions could buy the medicines that they require (3). Information regarding the proper use of drugs sent also could be given (2). Annual supply of medicines to poor institutions would be useful (2). It should be made available to every one (2). Better administration of the schemes is required (1).

## 4.12 DISCRETIONARY FUND

This is a one time grant of Rs.5,000 to Rs.10,000, that is offered particularly to small member institutions for health education, preventive health work and primary health care.

4.12.1 **Utilisation:** 27.5 % (112) institutions from this sample had received grants from this Fund during the past five years. 61.9 % (252) had not, 10.1 % (41) did not know and 0.5 % (2) did not respond to the question. The Chi Square test showed an association between size of institution and receipt of the grant.

* 36.4 % of 0 - 6 bed institutions and 24.8 % of institutions with more than 7 beds received the grant. Since more than 60 % of members are in the category of small institutions, in terms of actual numbers, the number of small institutions receiving grants is in the majority, in keeping with the objectives of the fund.
* Analysis by location shows that 36.8 % of tribal, 30.9 % of rural and 24.6 % of urban based institutions have received grants.
* There was no difference according to region. 31.0 % of institutions in regions with better health indicators received grants, while 30.3 % of those in regions with lower health indicators did so. However since larger numbers of members are in the better health status regions, in terms of actual numbers there would be more from these regions.

4.12.2 The year wise receipt of grants from the Discretionary Fund by member institutions is given below:

Table 32. Yearwise Utilisation of Discretionary Fund

| Year | Number of Institutions | % (N=407) | % (N=119) |
|---|---|---|---|
| 1987 | 14 | 3.4 | 11.8 |
| 1988 | 22 | 5.4 | 18.5 |
| 1989 | 26 | 6.4 | 21.9 |
| 1990 | 25 | 6.4 | 21.9 |
| 1991 | 26 | 6.4 | 21.9 |
| No information | 05 | | 4.2 |
| Total | 118 | | |

[N.B: 6 institutions received the fund twice during the past 5 years.] There is an increase from 1987 to 1989 after which it has remained the same.

Table 33. Statewise utilisation of discretionary fund

| Sl. No. | State | Yes | No | Do not know | N.I | Total |
|---|---|---|---|---|---|---|
| 01. | Andhra Pradesh | 16 | 28 | 01 | -- | 45 |
| 02. | Assam | 01 | 06 | -- | -- | 07 |
| 03. | Bihar | 06 | 17 | 06 | -- | 29 |
| 04. | Goa | 01 | 04 | -- | -- | 05 |
| 05. | Gujarat | 03 | 07 | 01 | -- | 11 |
| 06. | Haryana | 02 | 01 | -- | -- | 03 |
| 07. | Karnataka | 09 | 17 | 05 | -- | 31 |
| 08. | Kerala | 15 | 56 | 09 | -- | 80 |
| 09. | Madhya Pradesh | 15 | 19 | -- | -- | 34 |
| 10. | Maharashtra | 04 | 12 | 01 | 01 | 18 |
| 11. | Manipur | 02 | -- | 01 | -- | 03 |
| 12. | Meghalaya | 05 | 04 | 01 | 01 | 11 |
| 13. | Mizoram | 01 | 01 | -- | -- | 02 |
| 14. | Nagaland | 01 | 01 | 03 | -- | 05 |
| 15. | Orissa | 05 | 07 | 01 | 01 | 14 |
| 16. | Punjab | 01 | 01 | -- | -- | 02 |
| 17. | Rajasthan | -- | 06 | -- | 01 | 07 |
| 18. | Tamilnadu | 18 | 45 | 07 | -- | 70 |
| 19. | Tripura | 02 | -- | -- | -- | 02 |
| 20. | Uttar Pradesh | 03 | 14 | 01 | -- | 18 |
| 21. | West Bengal | 02 | 06 | 02 | -- | 10 |
| | Total (407) | 112 | 252 | 39 | 04 | 407 |

[N.B: Refer note with Table 12.]

58 (15.8%) of institutions from the four Southern States have utilised the Discretionary Fund and 24 (21.4%) from the four Central States (Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh) have done so.

4.12.3 The purpose for which the grant was used by members is given below (percentages are of 112 who received the grant):

* to furnish the dispensary and to buy drugs (74 or 66.1%),
* to buy a refrigerator (36 or 32.1%)
* to buy hospital/dispensary equipment (14 or 12.5%).

Others (9 or 8.0%):
To open a laboratory in the centre (2), to buy a slide projector for awareness programmes (2), for immunization programs (1), to start a mobile clinic (1), to buy a generator (1), to conduct a women's development camp (1), and to start a community health centre (1). 3 gave no information.

Possibly a few institutions used it for more than one purpose.

4.12.4 Comments/suggestions about the Discretionary Fund Scheme were given by 41 % (167) of the institutions in the sample. These are summarised below.

Usefulness (109 or 26.8%): The scheme is useful (82), especially for poor institutions (26). It is more useful than the CMMB Scheme (1).
Problems (34 or 8.3%): It takes years to get a grant (21). The members are unaware of such a scheme (6). The amount given is too little (2). Some applications are not considered (2). Applications should not be summarily rejected (1). The objectives of this fund do not serve the objectives of CHAI (1). CHAI refuses to give funds for community development programmes (1).
Suggestions (57 or 14.0%): It should be offered from time to time to the poor institutions (27). The amount of the grant given could be increased for these small institutions (21).

The 'discretion' should be based on some parameters (2). Priorities should be specified while asking for and considering applications (1). Priority should be given to rural areas (1). The needs of the locality should be the priority (1). Grants should be given only to small/poor institutions (1). Another suggestion was that the grant should be given/ made available to everyone (1). The system of maintaining registers should be avoided (1). Another felt that it would be better to give medicines, rather than money (1).

58.9 per cent (240) institutions did not give comments/ suggestions regarding the Discretionary Fund. More than one suggestion have been given by some.

## 4.13. PROJECT PROPOSALS PROCESSED BY CHAI

4.13.1 During the past five years,the number of project proposals from member institutions to funding agencies that have been forwarded/sent through CHAI or referred to CHAI by funding agencies is 39 ( 9.6%).

The yearwise distribution of project proposals sent/referred are as follows:

Table 34. Annual processing of project proposals

| Year | Number of project proposals sent/ referred |
|---|---|
| 1987 | 03 |
| 1988 | 03 |
| 1989 | 05 |
| 1990 | 11 |
| 1991 | 19 |
| Total | 41 |

Proposals from three institutions had been sent/referred twice.

4.13.2 The purpose of the project proposals were as follows:

* To buy vehicles (11),
* for supply of medicines (free) to the poor (8),
* for rural development (6),
* for purchase of refrigerators (5),
* for purchase of equipment (3),
* for construction of building of dispensary (1),
* for the building of a general ward (1),
* for purchase of an X-Ray machine (1),
* to provide food for participants of a seminar on health care (1),
* to start a dispensary (1), and
* for a community health and development project (1).

Two institutions did not specify the purpose of project proposals.

The majority are for building of infrastructure, much smaller numbers for free curative service and none for training.

4.13.3 The response of CHAI to the requests as stated by members was as follows:

* They screened the proposal and sent recommendations (19),
* they visited the institution and gave recommendations (3),
* CHAI provided a consultancy (3),
* no response (12), and
* negative response (1).

Four institutions did not comment on the response of CHAI.

18 members said that the response of CHAI was helpful to their planning. 25 (61.0% or 41) mentioned that it was not helpful to their planning and seven did not respond. The total of 50 responses here is larger than the earlier total of 39. It is possible that:

a) some who have sent project proposals more than five years ago, have given comments here.
b) institutions could have sent more than one project proposal,to which there may have been varied responses.
c) some members have not responded to the earlier question but have responded to this one.

It is noted that there was no response from CHAI to 30.0% of requests, and 61.0% found that the response was not helpful to their planning process.

4.13.4 Comments and suggestions by 64 (15.7%) members regarding the system operating with regard to project proposals are given below:

Usefulness (27 or 6.6%): The system is good and helpful (26). It is useful and efficient (1).
Problems ( 17 or 4.2% ): Lack of awareness among members about the scheme (6). Great delay in getting a response (5). There was no response hence there is a dissatisfaction with CHAI (2). Repeated requests have been neglected (1). There is favouritism in considering applications (1). Small institutions do not benefit by this system (1). CHAI is taking an unnecessary burden on its shoulders by asking for all applications to be routed through them (1).
Suggestions (14 or 3.4% ): CHAI should provide information to members about funding agencies (3). CHAI should forward project proposals without delay (3). It should keep applicants informed about the status of their application (2). CHAI should study the needs adequately before giving comments (2). There is a need for better planning and organisation in this regard (1). CHAI should give guidelines to members regarding writing of project proposals (1). CHAI should get donors when members apply for projects (1). Priority should should be given to proposals from rural centres (1).

## 4.14 COMMUNITY HEALTH DEPARTMENT (CHD)

### 4.14.1 Participation/Utilisation of training services

8.6 % (35) of institutions from this sample have participated in training programmes organised by CHD during the past 5 years. 84.3 % (343) have not participated, 6.9 % (28) are not aware of participation by their institution and 0.3 % (1) did not respond to the question.

The Chi Square test revealed an association between location and participation.

* A greater proportion (19.3 %) of institutions in tribal areas have participated, as compared to the urban (7.9 %) and rural based (7.1%) institutions.

* 10.1 % of smaller institution (0-6 beds) and 7.6 % of institutions with more than 7 beds have participated.

* 9.1 % of institutions based in regions with better health status and 9.6 % of institutions based in regions with poorer health status have participated in training programmes organised by the Community Health Department. Both these differences are not significant statistically.

Since the overall number and percentage of participants is very small too many conclusions should not be drawn regarding differences etc.

4.14.2 The statewise breakup of institutions who have sent personnel for training programmes organised by the CHD, as given in the next table.

Table 35. Statewise participation of CHD programmes

| Sl. No. | State | Yes | No | Do not know | N.I | Total |
|---|---|---|---|---|---|---|
| 01. | Andhra Pradesh | 06 | 34 | 05 | -- | 45 |
| 02. | Assam | 02 | 05 | -- | -- | 07 |
| 03. | Bihar | 02 | 26 | 01 | -- | 29 |
| 04. | Goa | -- | 05 | -- | -- | 05 |
| 05. | Gujarat | -- | 09 | 02 | -- | 11 |
| 06. | Haryana | 01 | 02 | -- | -- | 03 |
| 07. | Karnataka | 03 | 25 | 03 | -- | 31 |
| 08. | Kerala | 04 | 71 | 05 | -- | 80 |
| 09. | Madhya Pradesh | 04 | 29 | 01 | -- | 34 |
| 10. | Maharashtra | 01 | 14 | 02 | 01 | 18 |
| 11. | Manipur | 01 | 02 | -- | -- | 03 |
| 12. | Meghalaya | 02 | 08 | 01 | -- | 11 |
| 13. | Mizoram | 01 | 01 | -- | -- | 02 |
| 14. | Nagaland | 01 | 04 | -- | -- | 05 |
| 15. | Orissa | 02 | 10 | 01 | 01 | 14 |
| 16. | Punjab | -- | 02 | -- | -- | 02 |
| 17. | Rajasthan | -- | 07 | -- | -- | 07 |
| 18. | Tamilnadu | 03 | 63 | 04 | -- | 70 |
| 19. | Tripura | 01 | -- | 01 | -- | 02 |
| 20. | Uttar Pradesh | 01 | 17 | -- | -- | 18 |
| 21. | West Bengal | -- | 09 | 01 | -- | 10 |
| | Total (407) | 35 | 343 | 27 | 02 | 407 |

[N.B: Refer note with Table 12.]

The four Southern States account for 45.7% (16) and the four Central States (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) for 20% (7).

4.14.3 The number of persons who have participated in the different programmes organised by CHD, during the past five years (1987-91) is given in the next table.

Table 36. Participation of personnel in different CHD Programmes

| Sl. No. | Programme | Total number of persons |
|---|---|---|
| 1. | Orientation seminars | 17 |
| 2. | Short term training | 63 |
| 3. | Workshops | Ø4 |
| 4. | CHOPAM Course (Community Health Organisation, Planning and Management, organised jointly with VHAI) | 36 |
| 5. | Exchange programs | Ø4 |
| 6. | Long Term Training | Ø |
| 7. | Others | 26 |
| | Total | 150 |

Each institution has sent more than 1 person, the average being 4.

We received incomplete responses to the question regarding the year in which members participated. However, the incomplete data indicates a peak in participation in the years 1988 and 1989.

4.14.5 The opinion of members who have participated in the above programmes, about the content and methodology of training is given below:

Table 37. Views on Content and Methodology of CHD Programmes

| | Orientation seminar | Short-term training | Workshops | CHOPAM | Exchange program | Others |
|---|---|---|---|---|---|---|
| Content | | | | | | |
| Useful | 11 | 10 | Ø3 | 16 | Ø1 | Ø2 |
| Not useful | -- | -- | -- | -- | -- | -- |
| No information | Ø1 | -- | -- | Ø3 | -- | -- |
| Methodology | | | | | | |
| Well conducted | 11 | 10 | Ø3 | 15 | Ø1 | Ø2 |
| Not so well conducted | -- | -- | -- | Ø1 | -- | -- |
| No information | Ø1 | -- | -- | Ø3 | -- | -- |

The majority found the content useful and the sessions well conducted.

4.14.6 The CHAI -CHD vision had a definitive thrust during the last decade. The following data indicates the level of awareness of members about the vision of the Community Health Department. This information pertains to all the 407 functioning member institutions in the sample.

Table 38. Awareness of members about the vision of CHD

| Level of knowledge | Number of member institutions | % n=407 |
|---|---|---|
| Fully aware | 30 | 7.37 |
| Partly aware | 341 | 91.1 |
| Totally unaware | 06 | 1.5 |
| No information | 30 | 7.4 |
| Total | 407 | 100.0 |

The numbers of members who identified the different aspects ofthe vision of community health are given below.

a) The distribution of medicine and prevention of sickness (165).

b) Process of enabling people to exercise collectively their responsibilities to maintain their health (261).

c) Providing better health service facilities and trained personnel to the community (222).

d) Starting income generation programmes (42).

e) Promoting rational drug therapy and alternative systems of medicines (90).

f) A process of making people aware of their real needs, making use of available resources in and around them and getting themselves organised for appropriate action (304).

(N.B: Items b,e and f represent the vision of CHAI-CHD)

4.14.7 Relevance of vision: The number of members who find the Community Health Department vision (their understanding of it as it was not given in the proforma) relevant to their work is as follows.

Table 39. Relevance of CHD vision to their work

| Relevance | Number of institutions | % n = 407 |
|---|---|---|
| Is relevant | 345 | 84.8 |
| Is not relevant | 38 | 9.3 |
| Unable to judge | 02 | 0.5 |
| No information | 22 | 5.4 |
| Total | 407 | 100.0 |

A big majority (84.8%) have said that the vision is relevant to their work.

The association of this opinion with region, size of institution and location is as follows:

* 96.6 % of institutions based in regions with poorer health status and 87.1 % of those in regions with better health status find the vision relevant.

* 92.0 % of 0 - 6 bed institutions and 86.4 % of institutions with more than 7 beds find the vision relevant.

  The associations of both the above are significant.

* 94.1 % of tribal, 90.0 % of rural and 86.4 % of urban based institutions find the CHD vision relevent to their work.

4.14.8 Reasons for relevance: Reasons regarding why the vision was considered relevant to their work were given in response to an open ended question. They are summarised below:

1) The vision is consistent with the vision and mission of the member institutions (108).
2) It fosters self reliance of people as far as health is concerned (44); it stresses that peoples' needs can be met by their own organisation (19); it focusses on

health being the responsibility of the people (7); it helps people to maintain their own health both personally and collectively (8).

3) It promotes total health, i.e., it is wholistic in approach (36); it aims to improve the total well being of human beings (19);
4) It helps to foster peoples' participation in health action (15).
5) It is the grave need of the time (11).
6) It focusses on conscientising people (11); it analyses the root causes of illness (1); it covers much more than service systems (1); it encourages work with oppressed sections of society (3); it provides social and health awareness (4).
7) It emphasises that prevention is better than cure (7); it helps make people aware/enlightens people regarding their health needs (8); it is essential to build healthy communities (1).
8) The healing ministry is made more meaningful and effective through community health (3).
9) It helps out reach to needy people (12); it motivates/ helps people working in villages (4); it is a sort of help to the poor (4); it takes greater interest in peoples'needs (1).
10) It is more practical where there are minimum facilities (3); it is cost effective (4); it helps provide better health services (5); it helps to spread rational drug therapy and alternative systems of medicine (1); it helps in developing a better approach in the treatment of out-patients (1); it is a guideline and a great support (1).

48 institutions (out of 345) did not specify the reason why they think the CHD vision is relevant to their work.

The reasons given by a large majority articulate ideas that are consistent with the spirit of the CHD vision.

4.14.9 Reasons were also given as to why institutions stated that the vision of the Community Health Department was not relevant to their work. These were given by 21 one out of 35 who said that the vision was not relevant. The remaining 17 did not specify the reasons. They were as follows:

Lack of a community health programme (15), lack of personnel making it impossible to start community health programmes (5), it is not practical in all situations (3), it is not practical in its approach (02), lack of time for outreach programmes (2), our thrust is curative treatment (1), CHAI itself is not sincere regarding the community health vision (1), lack of know-how makes it impossible to practice (1), illiteracy of the people (01), and financial constraints (1).

4.14.10 Comments and suggestions regarding Community Health department (CHD). Many points are inter-related. They have been put together into categories for easy grasp. 226 (55.5%) have contributed suggestions.

a) Training: 93 (22.8%)
Provide training for health workers and personnel from member institutions (47). Seminars should be conducted at the diocesan level (33). Provide training in methods of community development (5). Provide training for animators and grass-root level workers (4). Organise CHOPAM courses regularly (2). Provide refresher courses for doctors and nurses (2).

b) Information and Guidance: 92 (22.6%)
CHD should provide the necessary information, expertise and guidance to help members implement community health activities (46). They should visit village based member institutions and offer help and supervision to the work (32). They should study the needs of the locality and offer help accordingly (5). They should provide information on different methods of treatment (4). They should let members know of the facilities available with the Department (3). Provide information about successful community health programmes which could be replicated (1). Provide help or organise rural health care programmes (1).

c) Health Education: 56 (13.8%)
Provide health education material in vernacular/local languages (50). Supply health education material to rural institutions (5). Make use of mass media to propogate health (1).

d) Assistance: 48 (11.8%)
Arrange free drugs for rural areas (21). Provide financial assistance to institutions who train and appoint community health workers (20). Make common drugs available for rural areas (2). Provide planning and material help for income generating schemes in rural and tribal areas (2). Look into the staffing of health personnel in member institutions (2). Arrange personnel for community health work in institutions (1).

e) Specific areas of work: 14 (3.4%)
Establish a few model community health centres in interior villages (4). Develop new methods of handling problems in community health (2). Coordinate community health workers (2). Conduct evaluations (1). Help members

to organise income generation schemes as part of community development (1). Start medical insurance schemes (1). Work on preventive programmes for communicable diseases (1). Start programmes for drug addicts (1). Take up the problem of cancer in the communities (1).

f) Reports and Publications: 9 (2.2%)
Provide literature on community health (5). Support members with documents, reports, materials (1). Send summary reports of training programmes to members (1). Publish books on village development (1).

g) General comments: 12 (2.9%)
Be more available to members especially in rural areas (3).Be practical in appraoch and practice the philosophy (3). There should be concrete action (3). There is a need to be more effective in their service (2). Services should be extended to all institutions (1).

4.15 MEDICAL MORAL AFFAIRS

This question was introduced because medico-moral affairs/medical ethics was an important reason for the formation of CHAI. It was therefore considered worthwhile to elicit members views on this issue at this juncture.

4.15.1 85.5 % (348) member institutions from this sample expressed that CHAI should have a Department of Medical Ethics. 11.8 % (48) said it was not necessary, 0.2 % (1) was unable to say and 2.4 % (10) did not respond to the question.

4.15.2 60.9 % (248) members identified the following important areas that should be dealt with by this Department. These areas were chosen based on their experiences of medical/health work.

a. Begining of life and related issues (254 or 62.4%): Medical Termination of Pregnancy (MTP) (144), family planning methods,other than Natural Family Planning (81), Natural Family Planning (NFP) (26), and artificial insemination (3).

b. Women's Issues (26 or 6.4%): Female foeticide (12), sex determination tests (4),abuse of women (3), unwed motherhood (2), sexual abuse (2), temple prostitution (1), rape (1), and problems faced by nurses (1).

c. Marriage/Family Life (29 or 7.1%): Premarital sex (10),child marriage (6), divorce (5), sex education (4), marriage guidance/counselling (2), and family life (2).

d. Therapeutic/medical practices (61 or 15.0%): Rational therapeutics, avoiding unnecessary diagnostic tests, and unnecessary surgery, need for a rational drug policy (31), euthanasia (21), malpractices in the medical field (4), commercialisation of the medical field (3), and organ transplantation (2).

e. Values in health care (24 or 5.9%): Moral values in health care (17), promotion of Christian values in medical practice (3), seeing and healing the patient as a person (3), and pastoral care (1).

f. Patient Care (16 or 3.9%): Medico legal cases (7), care of the old and sick (4), discussions regarding controversies/disputed questions in medical practice (2), confidentiality (1), issues regarding professional blood donors (1), and doctor patient relationship (1).

g. Special groups (16 or 3.9%): AIDS (11), drug addiction (3), alcoholism (1), and rights of the child (1).

h. Others Need for training/orientation courses for medical personnel on medical ethics (1). Need for formulation of common Catholic policies for Catholic health care institutions (1). Need for good publications in this area (1).

100 respondents who stated the need for a Department of Medical Ethics, did not specify the areas that could be covered by this Department. Several have mentioned more than one area.

## 4.16. VIEWS ABOUT OTHER SERVICES/ACTIVITIES OF CHAI

4.16.1 Members opinions about the Drug Quality Assurance Central Testing Laboratory that CHAI is planning to start, to support the network of producers of low cost essential drugs, were as follows:

a) It is useful (150).
b) It is not useful (7).
c) It is necessary (40).
d) It is not necessary (7).
e) It is useful and necessary (183).
f) It is useful but not necessary (9).
g) It is not useful but necessary (1).
h) It is not useful and not necessary (2).
i) No information ( no response to this question) (8).

In summary the large majaority of 94.0% feel that it would be useful/necessary or both.

4.16.2 Members views were also elicited about the usefulness/ necessity of the model integrated health centre being planned at the CHAI farm. It is to have community health programmes and various income generation programmes (like poultry, fruit production, agriculture etc). It will also be used as a training centre. Their views were as follows:

a) It is useful (191).
b) It is not useful (9).
c) It is necessary (19).
d) It is not necessary (13).
e) It is useful and necessary (140).
f) It is useful but not necessary (13).
g) It is not useful nor necessary (10).
h) No response to this question (12).

Again a large majority of 89.0% felt that such a project was useful/necessary or both.

4.16.3 Member institutions based in urban areas were asked in what way the new unit on Urban Health could assist them in carrying out community health programmes in slums. 30 out of the 70 urban based institutions in the 20 % sample gave suggestions which are given below:

a) Provide members with health education materials (9).
b) Train member institutions to organise health programmes in slums (5).

c) Help in organising health awareness programmes (4).
d) Train urban slum based health workers (3).
e) Help members to run free clinics in slums (3).
f) Help through supply of medicines (3).
g) Help in implementation of government projects (2).
h) Develop methods of working in slums (1).
i) Offer training courses for members (1).
j) Provide personnel to undertake preventive work (1).
k) Help promote home remedies (1).
l) Arrange doctors to work in urban slums (1).
m) Get projects sanctioned (1).
n) Extend support and help (1).

Implicit in the suggestions are different approaches to health / medical work. There is thus scope for orientation and training for community health work with the urban poor.

4.16.4 Members gave their views as to <u>how the Documentation Department of CHAI could support their work.</u> The views of the 165 (40.0%) who responded to this question are given below:

a) Collect and circulate information about new diseases and their treatment among members (95).
b) Communicate the latest health information and new developments to members (41).
c) Send charts,posters and books to members (7).
d) Provide health information in local/regional languages (5).
e) Open a library/documentation unit in every Diocese for reference by members (4).
f) Be a source for providing new/uptodate books/ periodicals etc (3).
g) Send information on homeopathy (1).
h) Bring out a newsletter covering activities of the CHAI office and the departments at least every six months (1).
i) Make case studies and circulate to members (1).
j) Circulate a profile of member institutions (1).
k) Be available to members (1).
l) Conduct research (1).
m) Such a Department was not considered useful (4).

The information needs of members have also been brought out in the expectations and general suggestions given by members.

4.16.5 Members also gave their views as to how the low cost communication media unit could support their work. 178 (43.7%) of respondent institutions gave suggestions which are given below:

a) Provide low cost materials for health education (131).
b) Provide health education material in vernacular languages (19).
c) Provide training to the staff of member institutions (17).
d) Provide information about banned drugs (3). (there seems to be a slight confusion here)
e) This should help people to understand the importance of health (2).
f) The unit should help in conducting awareness programmes (1).
g) It should operate in a mobile style (1).
h) It should provide gadgets for local use (1).
i) It should provide small leaflets (1).
j) it is not useful (1).

4.17 FINANCIAL ASPECTS OF CHAI

4.17.1 28% (114) member institutions from this sample have participated in raising funds for CHAI (besides payment of their subscription/membership fee). 70.8 % (228) have not participated, 0.2 % (1) are not aware if they have and 1.0 % (4) did not respond.

There is an association between size of institution and fund raising. 41.3 % of institutions, with more than 7 beds participated in fund raising and 21.6% of institutions with 0 - 6 beds did so. Since the majority of institutions are in the 0-6 bed category in terms of actual numbers participating in fund raising, this would be the larger group.

4.17.2 The methods of participation in fund raising were as follows:

| | |
|---|---|
| a) Through the Raffle | 85 |
| b) By donation to the Corpus Fund | 26 |
| c) By contribution towards the Golden Jubilee Fund | 08 |
| d) Not specified | 05 |
| | 124 |

10 institutions have participated in more than one way.

4.17.3 Suggestions for financial self-reliance

45.7 per cent of members offered several suggestions as to how CHAI could become financially self-reliant.

A. Methods to generate/increase income (172 or 42.3%)

From members (61 or 15.0%): By contributions from members (45). Through a membership campaign (9). By raising the membership fee (7).
From external sources (52 or 12.8%): Through a raffle (18). Through donations from benefactors (18). Through foreign funding agencies (7). By tapping government resources (6). By contributions from Bishops (3).
Through its services (35 or 8.6%): By charging for services offered (11) for eg, CPS and CMMB medicines. By bringing out more publications (8). Through seminars and courses (7). By getting more subscriptions for Health Action (3). By producing television programmes on health and health care (3). By producing cassettes (2). By starting a herbal garden (1).

Through commercial means (78 or 19.2%): Through income generation projects (32). By starting a drug company (11). By starting a business firm (8). By constructing buildings and renting them out (7). Through the supply of low cost drugs to hospitals (5). Through advertisements in its publications (3). By conducting exhibitions (3). By starting a hospital/medical college (3). By buying a rubber plantation /estate (2). By starting training centres/nursing colleges (2). By running colleges/schools (1). By selling unnecessary CMMB drugs in the market (1).
General (16): Through fund raising (13). By improving its own local resources (3).

B. **Methods to reduce expenditure 27 (6.6%):** By avoiding luxuries and comforts for CHAI officers (21). By cutting down the number of office staff and economising on the infrastructure at the central office (5). By proper financial management (1).

C. **An alternative view** There is no need to be self-reliant as it will lead CHAI to forget its objectives and its members (2).

## 4.18 MAJOR PROBLEMS FACED BY CHAI MEMBER INSTITUTIONS IN THEIR MEDICAL/HEALTH WORK

As CHAI prepares its plan of action for the next decade, it was felt that it would be important to understand the professional or work related problems faced by its members in the field.

The specific question received a very large response during the evaluation study, with 1,117 institutions or 79.0 % of the 1,415 respondents sharing their views. The broad categories of common problems are given below in descending order of priority. As detailed strategies of intervention for the future are worked out by CHAI at the national and regional level, it would be necessary to keep these in mind.

4.18.1. Poor or inadequate facilities: These include:
Lack of basic facilities of electricity and water; poor infrastructural facilities and lack of transportation making it difficult to reach out the villages and undertake extension work; and lack of facilities affecting medical work, for example, laboratory equipment, health education material, ambulance, and even telephones.
48.25 per cent (539) of the 1,117 respondents to the question mentioned this particular problem.

4.18.2. Health personnel-related issues: Mentioned were the non-availability of trained,efficient and service - oriented personnel to work, especially in rural areas. Specific mention was made regarding need for doctors and for personnel trained to undertake preventive and promotive work; it was also difficult to get specialist doctors to work in such situations; there is a lack of senior doctors available for consultation; there is a high turn-over of doctors and health workers; doctors often demand high salaries. Bribing or luring doctors with offers of higher salaries by other medical institutions also sometimes takes place; a few mentioned lack of commitment and sincerity of staff; lack of competence in diagnosis and treatmnent particularly of difficult cases; lack of cooperation and understanding from higher authorities; poor job satisfaction and burnouts.
43.24 % (483) out of the 1,117 respondents to the question expressed these problems.

4.18.3. Financial Issues: Financial constraints were mentioned specifically by 37.33 % (417) out of the 1,117 respondents. In addition this factor would also be responsible for the lack of basic medical facilities mentioned in the first point.

4.18.4. Social Issues: Social issues operating at the local level among the people, affect the utilization of services and the work in several ways, for example, poverty, caste stratification, illiteracy, ignorance and superstitions, customs, exploitation, gender discrimination, social stigmas and political disturbance in certain areas. 37.38 per cent (417) out of the 1,117 respondents raised this issue.

4.18.5. Problematic expectations/responses from the people: Mentioned here were the expectation/demand by people for free medicines /treatment; unwillingness of people to accept changes in the method of healing/new methods being used, and unwillingness of people to accept natural remedies; people demanding injections/tonics for all illnesses; people seeking medical help only at crucial situations/late stages; low treatment adherence rate; (perceived) unjust interference from Consumer Protection Forum; and the demand for round the clock service.
15.48 % (173) members out of 1,117 who responded to the question raised these points.

4.18.6 Health and Health Care Problems: This included difficulty/inability to follow up cases; large number of patients coming with communicable diseases, for example, tuberculosis; mushroom growth of private clinics, health centres, fake doctors and use of irrational practices; lack of well- equipped referral facilities to send patients with complicated medical problems; lack of cooperation from other medical facilities; competition among hospitals; bribing doctors with promise of higher salaries by other institutions.
12.8 % (143) of the respondents raised these points.

4.18.7 Drug-related issues: The increased costs of drugs, non-availability of low cost drugs and non-availability of drugs against leprosy,tuberculosis etc were mentioned. 10.11 % (113) of the 1,117 respondents raised this issue.

4.18.8 Problems related to being " religious ": The frequent transfer of sisters and other religious hinders health work (9). So also lack of knowledge of the local language (28).
There is lack of cooperation because the work of 'religious' is misunderstood as being for conversion (8). Problems due to the RSS (8) and the unfavourable attitude of people towards Catholic institutions (7) was also mentioned. Insecurity of sisters working in isolated places is increasing (1).
The religious structures and time schedules were felt to be hindrance to medical work (1). The demand for sterilization after the second delivery (also goes against religious beliefs) (1). There is a lack of support from CHAI (1).
In all 5.5 per cent (62) out of the 1,117 respondents mentioned these issues.

4.18.9 Problems concerning community based health care:
There are difficulties in carrying out extension programmes and in village based work (14). People are unable to attend health education and other programmes (07). On the other hand there is a lack of health education material (5). Preventive health work is difficult (6).
It is not easy to motivate people to become self-reliant (5). There are ideological clashes with others working for development (3). Migration (1), lack of cooperation from people (2) and unfavourable attitudes of people towards small dispensaries makes this work difficult.
There is also a feeling of incompetence to understand the problems of people due to an institutionalized training (1).

4.0 per cent (45) of the 1,117 respondents raised these points.

4.18.10 Environmental problems: These included lack of sanitation and hygiene (12), polluted air (1) and the presence of wild animals in remote areas (5).
1.6 per cent members mentioned these points.

4.18.11 Other medical/health service related problems:
Lack of cooperation and support from the Government (10). Dependency on the Government to run hospitals (1) and delay in release of Government funds (1) were problems faced.
So also were the lack of opportunities for rehabilitation (2) and lack of social support to rehabilitate unwed mothers (1). Pressure from people to treat medico-legal cases (1) and the non-availability of blood for transfusion.
1.5% (17) members mentioned these points.

Several questions can be raised in attempting to respond to these problems that have been raised by large numbers of CHAI members

* What methods could be evolved collectively and individually to address the problems relating to health personnel ? This, incidentally was an issue even when CHAI was formed fifty years ago !

* The challenge of strengthening motivation, knowledge and skills of health personnel working under difficult conditions is before all of us. Could a better dialogue and link-up between institutions training health personnel and the remote health services be activated?

* Could trainers internalise those non-textbook, but real life problems of the health workers of today, into training and continuing education programmes?

* For instance, could an analytical understanding of social issues and of the rising cost of drugs be introduced? This may help not only in coping with the situation, but more importantly in evolving alternative strategies and linkages with groups already working in these areas.

## 4.19 STRENGTHS OF CHAI

The major strengths of CHAI in descending order of priority, as identified by members are given below. This question was posed to all members through the mailed questionnaire and the interview schedule. 62.0 % (878) members out of 1,415 responded. Several members expressed more than one strength. Percentages given in this section are of the 1,415 active member who were respondents to this study.

1. Support, concern and service for its members (29.2% - 414). It is "a hand to hold on" in the words of a member.

2. "Health Action" and other publications (17.8%-252).

3. Training programmes, seminars and courses (11.1%-158).

4. Meetings and correspondence with members (7.4%-105).

5. Organisational structure and functioning (11.5%-163).

That the association is organised and is functioning well (94).

The dedicated and efficient staff (20) and efficient administration (13) were appreciated. So also was its coordinating function (9) and the resource personnel who were made available for programmes (8).

Other strengths identified in this area were: Periodic evaluation (5); solid organisational structure(3); well defined objectives (2); attempts to decentralize through regional units (3); and the constitution (rules and regulations) of CHAI (2).

Also mentioned were the enthusiastic Executive Director(1); planning for the future (1); courage in taking the initiative to change (1) and the confidence of members in CHAI (1).

6. The large number of members spread throughout India- that it is a national level body (84-5.9%).

7. It is a network imparting education to Catholic hospitals and dispensaries (67-4.7%).

8. It is a forum for unity, where like-minded people can come together (63-4.4%).

9. Conventions and similar meetings (47-3.3%).

10. Community health policy (46-3.2 %).

11. Issues taken up in its work (45-3.0%): Members were appreciative of the preferential option for the poor/marginalised and involvement in social issues (20); CHAI's involvement in the promotion of a Rational Drug Policy (9) and its influence in the national health arena (9).

    Also appreciated were the focus on small institutions (3); the holistic health campaign (2); and the promotion of alternative systems of medicine (1);CHAI was considered a potentially effective instrument against evils in the field of health care (1). These issues were mentioned by 3.2% (45) of the respondents.

12. Various Other Activities/Departments: The following were also identified as strengths of CHAI by 3.1% (44) of respondents: Linkages with Government and other organisations (18); Central Purchasing Service (CPS) (12); Pastoral Care (7); Communication/Media efforts (3); Publication of the Drug Formulary (2); Production of Health Education Material (1); and coverage of Medical Ethics (1).

13. Dedication to health work (42-3.0%).

14. Alertness to the needs and signs of the times (25).

15. Philosophy and vision (22).

16. Finance (15 - 1.3%)

Its sound financial position (7); linkages with foreign partners and the deemed export scheme (5); its credibility with funding agencies (2); and being in a position to help its members financially (1).

17. Others (27 or 2.4%): These are: Helping members to apply the principles of Christianity in patient care (8); CHAI's glowing history (7); that it is a spokesman of Catholic institutions (7); its inspiration to members (3); the opportunity it provides to work for people (2); and the establishment of a Catholic medical college (St.John's Medical College, Bangalore (1).

Thus the activities and services of CHAI and the general support and concern for members has been appreciated by a large proportion of members. This has been expressed in the specific feedback given regarding each Department and it has been reiterated in this section on the strengths of CHAI. To make its presence felt through positive contributions to health centres, hospitals and other members in different parts of such a vast country is indeed very creditable. A good tradition has been established which can only be further strengthened and built upon.

## 4.20 WEAKNESSES OF CHAI

Given below are the weaknesses of CHAI, as mentioned by the members in the study. This question also was posed to the entire membership through the mailed questionnaire and the interview schedule. 45.0 % (640) member institutions responded to the question. Percentages in this section are of the 1,415 functioning member institutions.

1. Relationship with Members:

1.1 Poor interaction between CHAI and its members - (231 (16.3%). There is poor personal contact and communication. A sense of alienation was expressed. CHAI is a distant reality to members.

1.2 Inadequate focus on rural based members and their activities (90 - 6.4%).

1.3 CHAI is not aware/does not fulfill the needs of its members and does not look into their problems (64- 4.5%).

1.4 CHAI programmes are out of reach to many members in terms of their cost and location, especially for the smaller member institutions (60- 4.2%).

2. Organisational Issues (220 - 15.5%)

2.1 Central Administration and its functioning (92 - 6.5%)
Inefficient administration and inactive functioning (33); the Central office is not easily approachable (8); lack of professionalism. It is run as a religious associ- ation. There is a lack of qualified personnel, with knowledge in the medical/health fields to guide members (8); too preoccupied and worried about itself and not bothered about member institutions (8); poor system of communication with members (7); administrative problems in the central office affect service to member institutions to a great extent (3); religious sisters have inadequate representation in the administration (3).

Lack of co-operation and genuineness among staff of the central office and an indifference to the policies of CHAI (3); CHAI has grandiose attitudes, overlooking the members (3); absence of periodic evaluation (3); CHAI is interested in taking from members rather than giving to members (3); members have no voice in planning and decision making (2); CHAI is interested in controlling member institutions rather than supporting them (2);lack of adequate representation of all regions in the central office (2); it is highly hierarchical in its functioning (1); frequent change of staff (1);lack of proper planning (1); and takes up too many tasks at the same time (1).

2.2 Relationship between the Centre and Regional/State Units (46- 3.2%): Poor functioning of regional/state units and lack of interest by the central office in the State units (23); no decentralisation of power (16); differences in vision between the Central office of CHAI and the State Units (3); neglect of Diocesan units (2); the Constitution encourages centralisation of power (1); problems related to autonomy of State Units (1).

2.3 Accountability (30 -2.1%): CHAI does not stand for its objectives (8); it is not sincere about its promises and the decisions that are taken (6); it does not circulate internal audit reports and accounts before the convention (4); malpractices in the Central and State Units (3); spending a lot of money unnecessarily (3); financial mismanagement (2); the performance does not equal the resources spent (2);lack of accountability (1); lack of proper responses to requests for help (1).

2.4 Organisational Structure (other aspects) (29 -2.0%): There is a lack of initiative by CHAI members in its activities and functioning (9); dependence on foreign money (9); poor organisational structure (4); very few representatives from lay people, clergy dominated (2); no control over members (1); too much power vested in the Executive Director (1); too an big organisation/association and too vague (1); difference of ideology within CHAI (1); it is not a strong association (1).

2.5 Executive Board and elections/conventions (13 - 0.9%): The executive board is not representative of its members. Only a particular lobby manages to come to power (4); domination of the South in conventions, during which elections are held (3); the existing election procedure does not bring forth suitable/ deserving office bearers (2); unhealthy politics and groupism takes place (2); the President and Vice-President do not have powers (1); craving for power in the top office bearers (1).

2.6 Linkages (11-0.8%): Poor relationship with the Catholic Bishops Conference of India (CBCI) (4); lack of collaboration with St.John's Medical College (4); lack of collaboration with governmental organisations (3).

3. Regarding Services/activities 213 (15.2%)
Besides the issues raised in points 2, 3, and 4, other weaknesses mentioned regarding services/activities of CHAI are given below:

3.1 Services : general 80 (5.6%): It is not practical in its approach (28); the services offered are meagre and are not worth the charge of the membership fee (17); there is no scientific basis in its service delivery system, for example, they are not based on proper study of needs (17); there is a concentration of programmes in the South (9); it does not take up important health issues in the country (5); there is a lack of a nationalistic outlook in its activities (3); the health efforts of CHAI often run opposite to those of the government (1).

3.2 Services- regarding its members 58 (1.4%): Concentration on bigger hospitals (27); discrimination between members in its service (in terms of religious and lay, medical and non-medical personnel and between institutions) (18); services do not reach the grass root level (3); CHAI does not take an interest to study the requests made by members (2); it does not guide members (2); the most needy institutions are not informed about its services (2); members are not informed about CHAI's activities/ services adequately (2); it has failed to reach member institutions (1); CHAI is unknown to many small health care institutions (1).

3.3 Services- specifit 54 (3.8%)

Training (11): There is a lack of training programmes in vernacular/ local languages (4); there is a lack of State level programmes (2); does not take an initiative to get religious trained as doctors (2); there is a lack of diploma/ certificate courses (1);training programmes are inadequate (1); lack of effective training programmes (1).

Publications (22): Charging smaller/poorer institutions for Health Action (11); lack of publications in local/vernacular languages (7); Health Action is irregular (2); Health Action is not relevant to smaller institutions (1); lack of health education material (1).

Project Proposals (5): The felt needs of members are not made known to the funding agencies (3); inefficient handling of project proposals (2).

Community Health (5): Over emphasis of community health and neglect of problems of hospitals (2); alternative health programmes are not promoted actively (2); CHD team is very rigid in their stand (1).

Spiritual depth not given to staff (3).

Medico-moral issues not taken up adequately (2).

Convention themes are inappropriate (1).

Membership Department functions poorly (1).

Curative treatment is emphasised on too much (2);hospital type of medical work is over emphasised (1); CHAI has not succeeded in providing doctors for rural areas strategically (1).

3.4 Services - the overall approach (21):

There is a bureauticratic delay in the delivery of services (8); there is no supervision or follow-up of the services and programmes (6); the programmes are poorly conducted (4); the monitoring system is poor (1); lack of consultancy facilities (1); there is poor recording of services (1).

4. Other weaknesses (12 -0.8%)

The public is ignorant about CHAI (5); lack of unity and cooperation among members (3); difficulty in reorienting the larger institutions (2); unhealthy competition among members (1); no coordination of activities of members (1);

5. CHAI has no weaknesses 30 (2.1%)

A fairly large proportion (45.0%) of respondents have identified weaknesses of CHAI. This is a healthy sign of interest shown by members in the further growth and imporvement of the association. The important points that have emerged are:

a) The need to focus on members and their needs in the various services offered by CHAI. The first 4 points relate directly to the relationship with members. These have been raised by 31.4% of respondents. The contribution of CHAI to the health situation in the country is through its members. Thus building on their strengths and enhancing their capability to respond creatively to the current health problems and needs, given the newer approaches that are developing in the spirit of CHAI's vision and objectives is its contribution.

b) Points regarding services- general and specific, have been raised by 213 (15.2%) of respondents. This is inspite of the fact that feedback on each service/activity has already been given before. Making services accessible to all members especially those in greater need is important- viz.,to the smaller, more remote rural/tribal area based institutions. The quality of services are also important. All services and activities of CHAI would need to relate to the situation and realities in the field. Thus there would be need for alertness,updating, ongoing evaluation and appropriate change.

c) Weaknesses relating to organisational functioning were raised by 220 (15.5%) of respondents. Strengthening itself internally, in its organisational structure, central office and regional units through improved methods of functioning and internal management would make it possible to play the above role more effectively. This aspect has also been raised by Delphi panelists.

## 4.21 EXPECTATIONS OF MEMBERS FROM CHAI

This question too was posed to the entire membership. 69.0 per cent (978) members out of 1,415 respondents have shared their expectations from CHAI. They were given in response to an open ended question and have been clubbed together in groups. Certain broad based areas have emerged as is given below:

1. Guidance/Training/Information/Publications (607 or 42.9%)

1.1. Training and related points (246 - 17.4%)

CHAI should organise training programmes at the State level in local/regional languages. Resource personnel to be available at the regional level. Courses, seminars on labour laws, legal issues, social analysis, and management are needed. Contact programmes/meetings/group discussions to be arranged to enrich personnel from member institutions. CHAI should organise Continuing Medical Education (CME) programmes, including programmes for upgrading nurses skills. It could make arrangements for more Sisters to be trained as doctors.

CHAI should: Have resources for consultancy/training. Foster understanding between teaching institutions who are members of CHAI. Organise training for dais and in practical immunization. Help nurses with many years experience to get licences as RMP's (Registered Medical Practitioners). Start courses in Pharmacy, Laboratory Technology and Physiotherapy. Get the Nurse Anaesthesia Course recognised by the Indian Nursing Council. Prepare a textbook for nursing students on moral and ethical issues. Catholic training institutions should not take capitation fees- CHAI should work towards this. Should help standardise admission procedures in member institutions that run training courses. Should start short vocational courses for rural youth.

1.2. Guidance and Support from the central office of CHAI to member institutions is expected, especially to the smaller ones 191 (13.5 %).

1.3 Information Needs (88 - 6.2 %)
CHAI to provide information to improve health work (64). It should also provide information as to how it can help its members through its programmes and projects. It could inform members about up-to-date events in Christian medical work.

1.4 Publications (82 - 5.8 %)
Produce more health education materials in vernacular/local languages. Should have more publications to refresh/update the knowledge of medical personnel. More vernacular publications. Provide Health Action free of cost. Health Action should carry information on the latest developments in the medical field. There should be publications in preventive medicine. Publish a directory of all CHAI members. Publications should reach members in time.

2. CHAI membership linkaging (387 or 27.3%)

2.1 Better Interaction between CHAI and its Members (235-16.6%)
through visits, and more personalised, and prompt correspondence. CHAI could be less hierarchical and institutional and more accessible to members.

2.2 Help in times of Members Needs 76 (5.4 %)
CHAI should: Be ready to help members out of their problems. Provide advice on legal issues and support during legal crises. Study the problems and needs of members and offer help accordingly. The Executive Director should arrange meetings at a local level to study the problems of members. Have a department which studies the problems and difficulties of members.

3. Material Assistance to Members (360 or 25.4%)

3.1 Financial Assistance (222 - 15.7 %)
CHAI should recommend the financial needs of members to sponsoring agencies. It should help mobilize resources for members. Financial assistance to be given to participants attending programmes.

3.2 Supply of Medicine (138 - 9.7 %)
CHAI should supply medicines to members on a regular basis. Have an effective system for delivery of drugs through a central pharmacy. Distribute homeopathic medicines as well. Arrange for supply of medicines available in the country. Simplify the procedure to get foreign medicines.

4. Organisational structure 165 (11.7%)

4.1 Regional Functioning (64 - 4.5 %)
CHAI should: Strengthening regional units. Hold State/regional level conventions and meetings. Start a hospital in Tripura/ Mizoram which could be used as a referral centre. Make its presence felt in the North,through conventions etc. Create core units at the regional level/appoint regional representatives. Board members should be elected from different States. Should throw away regional interests for national interests. Resource personnel at the regional level to be identified for utilisation of their services.

4.2 Policy and Planning (54 - 3.8 %)
CHAI should: Uphold Catholic principles in health care and guide members in practising them. Have a say in the national health policy. Be faithful to its objectives. Be practical in its approach. Coordinate the activities of members. Have more effective policies. Involve members more in the administrative aspects. Evolve a common health policy for Catholic hospitals. There should be effective implementation of plans and policies. Targets set should be met and objectives should be realised. CHAI must plan for the future. CHAI should be a spokesman of Catholic institutions. Instead of taking too many activities, take a few and do them effectively. It should become an effective and strong Association. Encourage non-catholic institutions too to be members.

4.3 Linkages/Cooperation 32 (2.3 %)
CHAI should: Encourage and foster mutual cooperation among members. Competition especially between members is to be avoided. Provide a forum to fight for minority rights. Cooperate with Government and take up recent developments in the health field. Provide mediation /linkage between Government and members. Network with like minded governmental and non-governmental groups. Evolve a forum of health activists under CHAI. Have a better relationship with CBCI. Take up issues at the level of the CRI (Conference of Religious of India). Organise inter-institutional programmes.

4.4 Financial Aspects of its Functioning (13).
CHAI should: Provide services and training at a low cost. Utilise its finances for a better cause. Open an industry which produces hospital equipment. Tap government resources and resources from business organisations. Use innovative programmes for fund raising. Strive for financial stability and self sufficiency. Should not demand financial help from members.

4.5 Other (08)
CHAI personnel should undergo a true orientation to its philosophy. The staff of CHAI should be appointed from different regions. There should be no favouritism. All should be treated equally. Need for efficient administration at the Centre. Give a report of its activities before conventions.

5. Community Health/Rural Health (158 or 11.2%)

5.1 Community Health (80 - 5.6 %)
CHAI should: Support/promote community health programmes. Organise training for community health workers. Help conduct health awareness programmes in rural areas. Give orientation in primary health care. Coordinate different training programmes in community health and community development. Set up a model community health centre. Study the problems of rural health centres and offer help. Adopt small health centres and offer help.

5.2 Focus on rural health/pooer sections of society (78 - 5.5%)
CHAI should: Have a greater focus on rural areas. Work should focus on weaker sections of society for example, women. Reach out to the poor and marginalised. Give new direction to members. Programmes to be community based and people oriented.

6. Other areas for focus of work (154 or 10.9%)

6.1 Help with Health Personnel for member institutions 74 (5.2%)
CHAI should: Arrange for doctors who are efficient and service minded to work in member institutions. Arrange doctors from bigger institutions for the outreach programmes of smaller institutions. Look into the appointment of staff and regulation of their salaries. Handle staffing problems in member institutions. Help solve the problem related to the registration of nurses caused by transfers from State to State. Organise camps for nurses.

6.2 Work on Drug Policy/Alternative Therapies (45 - 3.2 %)
CHAI should: Promote low cost drugless therapy. Promote alternative systems of medicine and alternative health care. Start a drug quality control laboratory. Work for and promote a rational drug policy at the national level and to make the marketing of drugs under generic names a reality. Fight against exploitation by multinational companies.

6.3 Specific Activities/Issues to be Taken - 37 (2.6 per cent)
CHAI should: Offer consultancy services on management issues, labour issues, foreign funds etc. Have more action oriented activities. Promote low cost communication media. Discuss the Consumer Disputes Redressal Act. Take up relevant health issues in the country. Evolve a policy of action during disaster relief. Work on AIDS control. Promote school health programmes. Youth welfare programmes. Hold conventions in different places with appropriate themes. Look after spiritual needs of workers (for example retreats for sisters). Undertake research. Set up a special cell in member institutions to help poor patients.

Thus, a very large proportion of members (69.0%) from respondents to the study have expressed their expectations from CHAI. The Association infact is already working or has worked at some time on several of the points raised. How these could be strengthened/revived, developing methods which they could reach all member institutions and the utilisation of the strengths and resources of the member institutions themselves in these areas, are tasks that lie ahead.

## 4.22 SUGGESTED FUTURE THRUSTS FOR THE ASSOCIATION

This important issue, which was also one of the key objectives of the study was put as a question to the total constituent membership. 55.0 per cent (775) of the member institutions, out of 1415 respondents to the study, shared their views as to what should be the priority areas of focus for CHAI in the 1990's and beyond. The large number of views have been grouped together into smaller categories. There is some overlap that is unavoidable. When there has been a sufficiently large number of points regarding a subunit of a larger point,it has been given seperately. The suggestions regarding future thrusts are given below. Percentages are based on the denominator of 1,415.

1. Rural Health/Community Health/Health for All (847 or 59.8%)

   Many dimensions relating to this overall thrust were raised by a very large proportion of respondents.

1.1 Rural Health 329 (23.2 %)
   CHAI should focus on rural and tribal areas, particularly towards the total development of these areas. It should give assistance to institutions working for rural health and study the work and needs of dispensaries in rural areas. It should arrange doctors for rural hospitals and focus on services for nurses working in rural areas. Graduates from St.John's Medical College should be motivated to opt for rural service. The villages of North India need greater emphasis. It could start referral hospitals in rural areas.

1.2 Community Health (in general) 215 (15.2 %)
   CHAI should promote Community Health and Development. It should strengthen Community Health and Development programmes in all Diocese, and encourage all religious congregations to take up community health work.

1.3 Components of Community Health 114 (8.0 %)
   CHAI should promote mother and child health programmes; family welfare programmes; natural family planning, and population control; eradication of communicable diseases; health work with urban poor; more outreach programmes; youth welfare programmes; school health programmes; immunization; nutrition programmes; community based rehabilitation of the disabled; and public health in general.

Rehabilitation of refugees should be taken up; and funds raised for preventive health work.

1.4 CHAI should work towards Health for All by 2000 AD 73 (5.2 %). It could work in cooperation with government to achieve this goal.

1.5 Health Education/Awareness 79 (4.9 %)
CHAI should promote health education and health awareness. It should produce health education material in national/regional/vernacular languages. Government could be motivated to introduce health education into the school curriculum.

1.6 CHAI should promote a preferential option for the poor and social justice in the healing ministry. This is the underlying faith dimension for the above.

2. CHAI internal dynamics and services (276 or 19.5%)

A smaller but significant proportion of members raised points related to the internal functioning of the Association.

2.1 CHAI functioning 137 (9.7 %)
There is a need for greater interaction with member institutions through visits etc. Support should be extended to members in all activities.

There is a need for better coordination and interaction among member institutions, so as to develop better health care. The relationship between members needs to be fostered by CHAI. Membership should be open to all Catholic health care institutions.
Income generation for self-reliance is needed. Coordination with foreign donor agencies/health agencies is also important. Poorer and smaller institutions could be given assistance according to need in their work. Equal amount of money to be spent for basic needs. Proper use and allocation of funds is necessary.

There is a need for efficient management of the central office. Health Action and CHAI services could be made systematic. Equal importance needs to be given to institutional and non-institutional health programmes. Bureaucratic delay in delivery of services needs to be cut down. CHAI should become more easily accessible and more flexible. It should use the vernacular language for communication with members. It should select staff with an understanding of the medical field.

CHAI hould be faithful to its objectives. Objective One of CHAI could be stressed. Objective Two of CHAI was also considered important. It should abide by decisions taken. Periodic evaluations should be conducted.
The relationship with CBCI was considered important.

2.2 Regionalised Functioning 54 (2.6 per cent)
Regional planning and action should be undertaken in keeping with the vision of CHAI. State level units should be started with decentralisation of power. State level conventions could be organised.
CHAI could cooperate with diocesan programmes and social services. It could motivate church leaders to cooperate with the work of members in each diocese. It could organise regional renewal programmes.
Programmes and more attention could be given to the North East.

2.3. Training and Information Services 85 (6.0%)
This is emerging as a key strategy for CHAI in the future. CHAI should organise training programmes on different aspects of health care and conduct seminars/ courses to help personnel working in member institutions. It could provide information to members on advances in health care and bring out publications in the medical field.
It could provide Continuing Education and provide consultancy services to members. It could also help with starting courses (for example MBBS, Nursing,Laboratory Technology) in member institutions. CHAI could help get more religious trained as doctors and nurses.

Other suggestions included providing guidelines to members regarding collaboration with government; forming a panel of resource personnel for training of members; training local people for health work; organising exchange programmes for doctors and nurses; organising follow-up programmes for conventions, seminars etc to implement resolutions; organising scientific sessions during the conventions; providing information to members regarding foreign funding agencies and publishing a "Health and Medicine Guide".

It was felt that CHAI should be a forum for sharing experiences and discussing issues and problems.

2.4 Others (5) CHAI could support NGO's (Non-governmental or voluntary organisations), promote networking and undertake research.

3. Important emerging issues in health to be taken up (180 or 12.7%)

3.1 Promotion of Wholistic Health 51 (3.5 %)
The integral development of people should be the goal.

3.2 Women's Issues 41 (2.9 %)
Specifically mentioned were: womens development programmes; social issues like child marriage, prostitution etc, and the need to promote the rights of the girl child.

3.3 Values in health care/spiritual dimensions 22 (1.5%)
There is a need for CHAI to take up medico-moral issues and help members to establish pastoral care departments. Also mentioned were the need to impart moral values to people and to improve moral standards of members!

3.4 Health problems and issues - 66 (4.6 %)
CHAI should work on prevention of AIDS/ Cancer/ Mental ill health and Alcoholism / Drug Dependence. It could also work on Geriatric Health (of the aged and elderly); Environment and health issues; and Consumer issues (Consumer Protection Act); In general the important problems faced by the country should be tackled.

4. Medical/Health care- policy issues (77)

4.1 Medical/Health care (48 or 3.4%)
CHAI should promote alternative systems of medicine, and low cost health care through use of low cost medicine and drugless therapy.

4.2 Drugs (medicines) 38 (2.7%)
CHAI should help with free medical supply. Supply of medicines should be pooled from Indian companies. On the other hand it was felt that CHAI should promote a Rational Drug Policy. It should promote/give publicity regarding banned drugs through the media, and counter the commercialisation of medicine.
CHAI could start a pharmaceutical company and a drug quality assurance laboratory.

4.3 Health Policy Issues (29 or 2.0%)
CHAI should be involved in health policy making in the country. It should prevent the proliferation of sophisticated hospitals in towns. It could evaluate the health programmes of members and evolve a policy for just wages to class IV/ support staff.

Other suggestions included: need to take a stand against the medical and health policies of the government; to encourage religious to work in government institutions; to support need for well equipped hospitals; to work towards safeguarding patients rights; strive to regulate salaries of doctors; to organise a network of blood banks; give greater importance to hospital management; to emphasise collective responsibility to promote health, and to work on labour issues in member institutions.

5. Catholic aspects 29 (2.0 per cent)
CHAI should support members to practise Gospel values through the healing ministry. It could advocate the rights of minority community hospitals and look into the safety of religious personnel working in medical institutions. It could represent Church related institutions in the national arena and reach out to non-christian doctors with its vision and philosophy.

## 4.23 GENERAL COMMENTS/SUGGESTIONS

25.6 per cent (362) respondent member institutions, out of the 1,415 respondents, gave other comments/suggestions regarding CHAI. These have been grouped together and are given below. They reiterate some of the points raised earlier. However, some suggestions are new and valuable.

1. Concerning members/membership 148 (10.5%)
   Member institutions should be visited and personalised contacts and communication developed (84). CHAI should be helpful to members in times of crisis and need (14). CHAI should have a department which visits members, studies their needs and refers recommendations to other departments (10). It is better to do something for its members, rather than spending money on frequent evaluations (5). CHAI should open its doors (membership) to non-christian institutions as well (4). CHAI is far beyond the reach of members (4). Make the facilities available with CHAI, known to members (3). Develop mechanisms to motivate/inspire and influence members (3). Members should be involved in decision making (2).

   Members involvement for the cause of CHAI has to be focussed (2). Members do not imbibe the philosophy of CHAI (2). CHAI is of the rich and for the rich (2). A directory of the membership should be published (1). Prepare a calendar of activities for a year and circulate it to members (1). Members have a very insignificant benefit from CHAI (1). Institute awards for individuals/ member institutions who have a remarkable success to their credit (1). Give awards/certificates to those working in rural areas for fifteen to twenty years (1). CHAI activities should be channelised by member institutions (1). Membership fees should not be increased (1). Help should be extended to larger member institutions too (1). Create an enviornment where small member institutions also have a feeling of belongingness (1). CHAI services go to the urban and bigger member institutions (1). CHAI should be more interested in its members (1). Take efforts to make all Catholic health care institutions join together (1). Show more concern for the members, rather than for the central office (1).

2. Concerning CHAI organisational structure and functioning 52 (3.7%)
   State units should be strengthened and enriched (26). Organise State/Regional level meetings, discussions and conventions (15). Amend the Constitution of CHAI so that

it gives greater importance to State units (3). The Executive Board should be formed by representatives from regional units (2). Conduct conventions in each State by turn (1). Change the name from Hospital Association to Health Association (1). The organisational structure has to be relooked at during the annual conventions (1). The Presidents of State/regional units should be given more powers for quick action (1). Board meetings are held in " convenient " places, with ulterior motives behind it (1). CHAI should be under the control of CBCI (1).

3. Concerning CHAI activities 230 (16.2%)

3.1 Training and information service 55

There is a need for more seminars and courses (23). Provide training programmes free of cost for small institutions (5).Collaborate with St.John's Medical College (5). There is a need for follow up of courses and training programmes (4). Try to get the rural bond system for medical students mandatory (3). Make efforts to reorient medical education (2). There is a lack of training centres for promotive health care (2). CHAI should train nurses in community health and development (2). Should pave the way for Catholic Medical colleges (1). CHAI should take the initiative to train the rural poor to undertake the MBBS course (1). Should start a nursing school (1). A good library is required in the central office and at the regional centres (1). Start courses to equip religious personnel to work as Registered Medical Practitioners (1). Need for training village leaders to impart health education (1). Need for health training programmes for high school students (1). Need for more trainers in the development field (1). CHAI should start exchange programmes at the Diocesan level (1).

3.2 Publications and productions 40

Publish health education material in vernacular languages (18). Make the public aware about CHAI and its publications (4). Need for publications in vernacular languages (3). Health Action should be sent free of cost to smaller institutions (3). Publish Health Action in vernacular (2). Subscription should not be demanded from small institutions (2). Use Health Action as a medium in the national health arena (2). Publish a handbook on Community Health in the Jubilee year (1). Publish a medical guide for the use of small institutions (1). Use mass media for village education (1). Publish the availability of trained personnel for community development programmes (1). There are too many circulars and nobody reads them (1). Produce cassettes in local languages (1).

3.3 Concerning Material Assistance 52

Financial assistance to be given to small institutions on a regular basis (24). Make arrangements for institutions getting medicines they really need (15). CHAI could import foreign drugs (8). Need for free medicinal supply on a regular basis (4). CHAI should have a project to pay the health workers of member institutions (1).

3.4 Concerning Meetings and Conventions 6

Conventions to be conducted in each State by turn (1). (given earlier as well) The participation of the laity in annual conventions to to be encouraged (1). Conventions should be evaluated (1). Illiteracy should be the theme of the next annual convention (1). The meetings are too centralised in cities (1). Since the meetings are conducted in English,we are unable to express our views (1).

3.5 Rural Health / Outreach / Community Health 27

[N.B: The section on training is also related to this] CHAI should promote more health centres in rural areas (10). It should arrange health personnel to work in rural areas (6). CHAI should recruit doctors for rural mission institutions (3). CHAI should adopt a village in every diocese or at least one in a region and have model community health activities which could be replicated by members (3). Need to give importance to the rural areas of the North (2). It should enable all the larger institutions to start outreach programmes (1). It should encourage rural hospitals (1). It should concentrate on the problem of fishermen in the coastal areas (1).

3.6 Concerning Medical Care 47

Less importance should be given to big hospitals and sophisticated treatment (28). Fix a salary policy for Catholic hospitals (3). Low cost drugs to be promoted (2). It should enable institutions to start herbal gardens (2). It should promote integrated health care systems and all systems of medicine (2). It should start one referral hospital in all States (2). It should have an influence in the national health arena (2). CHAI should work for population control (2). It should concentrate on leprosy eradication (2). AIDS awareness programmes are necessary (1). It should provide help/ support to psychiatric rehabilitation facilities (1). Central Purchasing Service does not suit small institutions (1). CHAI should make arrangements for service contacts for equipment bought (1).

3.7 Other activities/departments 3
Membership department functions poorly (1). No more raffles- we have had enough and more of it (1). Stop planning about the Drug Quality Assurance Control Laboratory (1).

4. General thrust and approach (35)
CHAI should reach out to the poor in a major fashion (14). CHAI should believe in action and practice the preached philosophy (6). CHAI should work for social change (4). Focus on member institutions ideologies. They should be service oriented rather than commercial (4). CHAI should work for the realisation of its objectives (3). "Give more and ask for less" policy should be adopted (2). CHAI should have a sense of poverty (1). Should cater to the spiritual growth of people (1).

5. Suggestions (24)
CHAI should focus on producing low cost drugs (10). CHAI should collaborate with government (4). CHAI should have a consultancy cell (2). The Executive Director should have discussions with CRI to solve issues related to personnel and funds (2). CHAI should have a legal aid cell (1). Programmes/projects of CHAI should continue irrespective of the interests of individual persons working in the office (1). CHAI should take action against mismanagement of money (1). CHAI should not duplicate the work done by other voluntary organisations (1). CHAI should safeguard Christian and moral values (1). Should take care of evangelisation through patient care (1).

6. Administration/management (15)
Efficient administration is required (7). Proper office management is required (2). CHAI should have more lay people in the administration (1). Politics should not be mixed with administration (1). The central office staff should have field experience (1). There should be better planning (1). The Bishops should have a hand in administration (1). CHAI should improve, taking this evaluation as a base (1).

7. General feedback (16)
CHAI's work is rather satisfactory and helpful (5). CHAI should avoid a 'difficult to practice' attitude (3). CHAI enjoys comfort at the top level at the expense of others (2). CHAI is more institutionalised than people oriented (2). CHAI performance does not equate the resources spent (1). CHAI is of the rich and for the rich (1). CHAI is trying to concretise an outside ideology and is not need oriented (01). CHAI is a white elephant (1).

## 5. DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 It has been a courageous and timely decision by the Executive Board, the Executive Director and others in CHAI to undertake a reflective evaluative study of the Association. Put simply **the main question was 'where are we and where should we go'.** Since CHAI is a large and diverse Association, with a long history, functioning in a complex and rapidly changing situation it was considered appropriate not to use a quick "external evaluation" approach, though that would have been easier. **The question itself was seen as part of a process of generating change. Therefore a multi-pronged approach was used with the involvement of members and others.**

It was decided to draw on many perspectives regarding the same entity namely CHAI and a feedback from members about the present. Important among these were the views of members.

**MEMBERS VIEWS**

**Delphi panelists views**

**CHAI 1943 - 1993 evaluative study reflection**

**Views of Executive Board members and representatives of regional units**

**Views of the study team**

**Staff views**

**Views of the financial consultant**

**Views of friends and people involved with CHAI**

Views of different groups of people were sought, because it was felt that based on their experience and expertise points would emerge that would be of use to CHAI in its planning and action in the future. **Thus, the purpose of the exercise was to get a sense of direction for future action and a feedback from members about the present.**

5.2 This report deals with the views of the constituent or institutional members of CHAI. This large group infact constitutes CHAI. They have the power to determine its direction. They also interact with the executive part of CHAI, its central office, the various departments and their activities and services. The views of this group are therefore of value.

Since a scientific methodology was used in the study design and in the drawing of the 20 per cent sample, taking into consideration the diversity of its membership, the findings from this group are generalisable to the total membership. The response rate to the mailed questionnaire was also large. Put together we have data from 1,472 member institutions or 64.8% of the total membership. 57 of these institutions were closed/not functioning presently, hence the actual data derives from 1,415 (62.3%) member institutions. As has been mentioned the key evaluative questions were put to the total membership. Sufficient information and feedback has therefore been generated regarding the key questions on strengths, weaknesses, expectations, future thrusts etc.

Data concerning the respondents from the member institutions show that they are a trained, responsible and experienced group of people representing the experiences and views of their institutions. Thus, the findings are important for consideration by the Association.

5.3 Feedback has been obtained about:

a) the objectives of CHAI;
b) the organizational structure of CHAI.
   Both these are of importance as CHAI revises its Memorandum of Association and its Rules, Regulations and Byelaws;
c) the levels of interaction with CHAI;
d) the different activities and services of CHAI, and
e) views regarding the strengths, weaknesses, expectations from and suggested future thrusts for CHAI.

5.4 Numbers and percentages have been given as a quantitative measure. However the qualitative dimension of the feedback and suggestions given are equally important. While major thrusts have emerged using the quantitative measure, the wisdom and experience of the decision makers of CHAI would help to make choices and decisions regarding the many other suggestions, some of which are also very useful.

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5.5 The report is lengthy inspite of the process of condensation after the analysis. The number of respondents was large and it was felt necessary to give atleast some detail for each of the Departments/activities so as to be useful for their planning processes and to do justice to the feedback.

5.6 **The distribution pattern of members** is predominantly **(82.8%)** rural/tribal in keeping with the rural/urban distribution of the population. **The proportion of smaller 0 - 6 bed institutions (65.6%) to the larger more than 7 bed institutions is 2:1.** A later overview table summarising the pattern of utilization of CHAI services/participation in its activities shows that the smaller and the rural institutions do not utilise services/participate adequately. Future departmental goals and strategies need to work towards reaching these member institutions proportionately and later preferentially.

**70.8% of the 20 % sample are in regions with better health status presently.** It could be possible that when the institution started this was not the case. It is also possible that they may be located in District/Taluks within better health status regions that may still be under-developed. This aspect cannot be commented upon in this study. However, during further investments in newer health centres or expansion of present institutions, priority should be given to areas with greater need.

5.7 **Data regarding the year of joining CHAI shows a marked increase in membership of CHAI in the Seventies** (23.5% joined at this time). This showed an **even greater increase** in **the Eighties** upto the study period (1991), with 40.6% having joined during this period. Data regarding year of establishment of member institutions shows a roughly similar pattern. Thus there is an continuing active process of growth in numbers and also of membership in CHAI. One of the areas in the ten point programme of 1983 was a "Membership drive for strengthening the organisation". While no specific targets were set,study data reveals that this goal has been attained. Information from the Catholic Directory of 1990 however shows that there is still further scope as there are institutions listed here who are not members of CHAI.

**Life membership** which was also introduced during the Eighties is already 23.7% in 1991 and has since increased even further, **also indicating sustained interest by members in the Association.**

With this consolidation the scope, advantages and limitations of other types of membership could be explored, eg.,associate membership, membership of lay groups and individuals. This could reflect the increasing focus on the role of the laity in the Church in general. It may also strengthen the movement towards community health (an identified major thrust) which builds on people and on networking.

5.8 The majority of members have joined the Association with the expectation of gaining something,either in terms of training,information and guidance or in terms of material assistance. Others join from a sense of duty because of its Catholic nature. A relatively smaller proportion have joined for togetherness, solidarity and cooperation towards a common cause or because of its objectives.

**There is scope for changing this 'giver-receiver' relationship and making it more an Association of equals with debate and action, greater taking up of responsibilities by members for CHAI and pooling of skills and resources for the cause of improved health of people,particularly the poor.**

5.9 The number of suggestions regarding change of objectives is small but important points have been raised. Since such an exercise of reformulating objectives is not undertaken frequently the points raised by members need to be kept in mind.

The first two current objectives are replicas of the objectives of the CHA of U.S.A. formulated more than three decades years ago. We need now particularly to relate to the realities and needs of the Indian situation, with focus on the poor and marginalised. **The ideas generated by the Delphi panelists especially regarding underlying philosophical assumptions of health would be useful. They infact reinforce the points raised by the members here. They have also suggested that the change of objectives should have the concurrence of members.** The proposed new objectives and other major changes could be mailed to all members with agree/disagree boxes as a referendum. Study findings show that the attendance at General Body Meetings is not representative and for an important issue as this, views of all members need to be sought.

**Efforts also need to be made to make the objectives known to members, staff and others.** They could be given in an attractive form in its pamphlets, in all issues of Health Action, and other CHAI publications. Colour posters with pictures/illustrations regarding the philosophy and objectives could be placed in the CHAI office as well as distributed to members.

Currently as part of the management process, even secular professional teaching institutions have goal and mission statements and objectives that are widely disseminated. **More important however is the ongoing process of internalising the philosophy, objective and thrusts, e.g. the ten point programme, at all levels of the association.**

5.10 While the majority of respondents have opted for status quo as regards **the organizational structure of CHAI, a significant minority in the study feel the need for decentralisation.** This has been also raised in the sections on weaknesses, expectations, future thrusts and comments /suggestions. This has been coming out more strongly during the regional meetings. The important points that have arisen and that need to be considered are:

a) That the **Diocesan level** is the most practical and feasible for members to function in a collective manner, meeting regularly (2 - 3 monthly), implementing programmes, and relating to local needs. Participation in special training programmes reveal larger participation of personnel in Diocesan level programmes;

b) **State/regional level units** also are an important level in the structure of the Association. Organizational efforts, liaison work and major training inputs could be made through this level;

c) The **question of elections** and representation from different regions and type of members needs to be addressed.

5.11 Regarding **levels of interaction** between the CHAI central office and members:

a) **A very high proportion receive the circulars** sent by the Executive Director from the central office.

There however seems to be some discrepancy between this fact and the lack of knowledge about the various services, as expressed by members during regional meetings. There is possibly a difference between receiving and reading the circulars. The circulars are also sometimes not circulated within the member institutions.

**Since Health Action is not subscribed to by all members, the suggestion of a regular newsletter could be seriously considered.** This could cover both, the activities of the CHAI central office/other units and also news and views from members.

b) The urban based, larger institutions, situated in regions with poorer health status are visited more frequently by CHAI staff/others. The total number of visits to members however is low. Perhaps during the frequent travel of some of the CHAI staff and executives, they could make it a point to visit members or to call a meeting of members who are geographically close by. If the programmes of the coming year are planned in advance, best use could be made of such occasions, with input sessions with and for members as well.

c) The participation in the special training programmes listed has been gradually increasing over the years. Again urban based institutions have a significantly higher participation than rural and tribal based institutions.
Note must be taken of the fact that a substantial proportion (43.0%) of those who have participated have attended Diocesan level programmes.

This could probably be the best level for organizing the bulk of training programmes in the future. This will help make the much needed training accessible and available to members in different States of the country, in rural/tribal areas, and particularly to the smaller health centres/projects.

5.12 a) The average annual participation by member institutions at the conventions is fairly low at about 6.0% of the membership. The number of actual participating individuals is higher. The average is also low because during the past five years, the larger conventions have been held only in alternate years. If the conventions are seen as primarily for continuing education purposes through the input sessions, the number of participants would be considered good. However since conventions are also occasions for the annual general body meetings at which decisions of policy and direction are made, and elections held for three positions in the Executive Board, the representation is small. There is also a significantly greater representation at these General Body Meetings/conventions by institutions from regions with better health status and from larger institutions.

Several suggestions have been coming up from the regional meetings regarding elections. Some of these are about the need for representativeness, by region, size and type of membership; federal structure; whether elections could be held once in two years; longer term for executive board members; postal ballot; lay membership etc.

The system of annual general body meetings with elections, to which conventions were added later, was instituted since the formation of the Association. At this time the number of members was very small and they were mainly hospitals. **Now with a very large membership, with the majority being small, rural health centres alternative methods need to be explored regarding elections.** CHAI could draw on the experience of its previous Board members and also that of other large national level associations for ideas in this regard.

b) Individual **participants at the conventions are primarily nurses (65.4%) and administrators (22.5%), some of whom are also nurses.** Planning of themes, technical input sessions, should keep this in mind. Organizing a variety of pre and post convention workshops in smaller groups for different health personnel/ on different themes would make participation in the conventions more attractive and fruitful. Methods to reach other health personnel in member institutions should be thought of, particularly for multi-purpose workers, auxiliary nurse midwives and other allied health professionals.

c) The question of **follow up on convention themes** needs to be considered. Different aspects/topics related to the same theme could be taken up at intervals, working groups could be set up, inclusion of the topic/theme into the training programmes of CHAI, organizing diocesan level programmes on the same theme,having a column in Health Action in the year preceding and following the theme could be considered. The findings show that **both the quantity and the quality of the follow up is extremely low.**

d) Several suggestions have been given by members regarding the conventions. These need to be considered by the Board and Executives for future conventions possibly through the formation of a convention committee (technical). It has often come up in the past that the conventions should be evaluated. While findings of the study could be utilised, **an evaluative exercise by participants could be built into each convention.** This could cover the usefulness/relevance of the theme, the contents of input sessions,exhibitions etc, feedback on methodology, use of audiovisual aids, participation of members, comments regarding the planning, preconvention information, background papers, comments on organization aspects, accomodation and food, suggestions for follow up etc.

5.13 a) The Health Action magazine has received the highest appreciation from members for its content, presentation and usefulness. Findings show a greater equality according to region, urban, rural and tribal location and size of institution in the subscription to Health Action. Currently (June 1993) a little over 50.0% of the total membership are subscribers to the magazine.

Going back to history we find that one of the 3 resolutions of the first meeting in July 1943 was " That the CHA publish a pamphlet or magazine". The 'Catholic Hospital' was published regularly since 1944. In the new constitution passed by members in 1958 and registered in 1961 this activity was introduced into the Aims and Objects of CHAI viz., "3. To print, publish and circulate matter setting forth or dealing with, or relating to the aims and objects of the Association." The reasons for the magazine were to keep members in touch with each other and to keep them updated on new trends in the medical/health and related fields. These reasons are relevant even today. Publication of this magazine for members has been a constant feature during the fifty years. While making it available to non-members is a progressive step, the original purpose of such a medium of communication between members is still important and should not be the lost sight of.

While a newsletter could serve this purpose,it would be useful if all members could also get Health Action. The overall feedback during regional meeting is that the magazine should have a seperate subscription and should not be part of the membership fee. A special subscription drive among members especially those based in rural areas could be made. The need to keep upto date and informed could be one of the selling points for the magazine. Offering a gift subscription to members who contribute an article could be considered. A drive among Bishops and superiors to take subscriptions for the samller health centres in their diocese/congregations could also be attempted. In the section on expectations and reasons for joining CHAI the information needs of members have come out rather high. Health Action could well serve that need.

b) The readership of Health Action is quite diverse. This reiterates the findings of the readership survey of Medical Service (1987-88). Greater efforts to make it known and available to relatives of patients in the hospitals, to teachers, high school and college students, and possibly through Diocesan and Parish levels could be made.

c) **Bringing out the magazine in the national language, Hindi,** needs to be seriously considered and perhaps later in one or two other major Indian languages.

A number of interesting suggestions regarding content and presentation have been made by members that could be taken up by the editorial committee.

The order of preference of readers for various items in the previous readership survey rated 'reports about various experiences very high, followed by feature articles, editorials, medical ethics forum and CHAI news and notes.

5.14 a) Regarding the **other publications and productions for sale by CHAI and HAFA ( Health Accessories For All)** the number of member institutions that have purchased them is small between 2.2% and 27.3% with an average of 12.5% (51). It seems unlikely that purchases by non-members would be high. The members views regarding usefulness of the different publications ranges between 62.5% and 83.7% for the different publications, i.e., they have been found useful by most. **The production of such publications should be cost effective and more importantly should reach people,especially from member institutions, to whom they would be of use.** Wider sales promotion is needed,including through other health/ medical journals, for example Health for the Millions, Christian Medical Journal of India, mfc bulletin, FRCH Newsletter etc. Advertisements in Christian newspapers and general newspapers could also be tried. There could also be guidelines/ a policy regarding choice of topics for publication of books by CHAI, style of presentation and promotion of the publications. One or two of the editorial committee members of Health Action could be asked to give their comments before publication. Alternatively a person from the field covered by the topic of the publication could give their comments. This would **introduce the concept of peer review, which will improve standards.**

b) Regarding the **publications that have been sent free** to all members, including the Memorandum of Association, again **only a small number seem to have received them.** This varies from 6.9 % to 21.1% with an average of 13.0%. There may be different reasons to explain this, 20.5% said they do not know whether they were received, probably since most were circulated several years ago. Changing personnel too could be a reason.

Members were requested by the investigators to check their files particularly for important documents like the Memorandum of Association and Health Policy Guidelines. However, inspite of this, 66.4% stated they have not received these documents. Whatever the reason the situation needs to be looked into and improved upon. Because besides the financial implications, the desired impact of disseminating such information (for example, Health Policy Guidelines) will not be realized.

5.15 A quarter of member institutions in this sample have ever utilised the services of the Central Purchasing Service (CPS). The utilization has been significantly more by the larger and the urban based institutions. There has been an increase in the number of members utilising the facilities of CPS from 1988. Suggestions and feedback by members have been given, which need to be considered by CPS and by CHAI. Methods by which CPS facilities and know how could be made useful and accessible to smaller and rural based institutions need to be thought of. The study shows that many of these institutions lack basic equipment for medical/health work. Sources where low cost appropriate technology within the country is available could be made known to members. For instance, kerosene and other refrigerators for storage of vaccines in health centres without electricity, simple equipment for basic laboratory work and equipment for sterilization.

5.16 No comments are being made about the feedback regarding the Catholic Medical Mission Board gift supplies (CMMB) as the scheme is already in the process of change on the basis of experience and feedback already received. While study findings support earlier impressions, it must be noted that inspite of many problems the majority have found the CMMB scheme useful.

Mention is here made of a question raised as to whether CMMB money (when it is available) could be used for purchase of homeopathic medicines and those of other systems of medicine as well.

The question may also be raised whether such money could/should be used for the range of primary health care work, including health education, starting herbal gardens, training of community health workers etc.

5.17 Regarding the discretionary fund, 27.5 % of members have utilised the fund during the past five years with an annual average of 5.6%. There is an increase in numbers over the years. It is good to note that a significantly larger number of smaller institutions have used the fund and also that these have been more in the tribal and rural areas. These seems to be a positive discrimination in favour of the above, which is what the purpose of the fund was. Greater efforts though could be made so that it is utilised more in regions with lower health status of people. Two-thirds of recipients used it for purchase of drugs or equipments for the dispensary/laboratory (excluding refrigerators). While curative care is part of primary health care, which is the purpose for which the fund is to be used, greater emphasis needs to be given to other aspects of primary health care.

There is scope for making known to members and all concerned, the policies on which the fund operates and to use the policies and objectives of the fund as a yardstick to evaluate it annually. This is necessary because of the large sums of money involved. It could also be considered whether CHAI could allot different proportions to the different regions,especially those most in need. Some more detailed and concrete suggestions/guidelines to members as to how they could utilise it for primary health care/community health work could be drawn up in consultation with the Community Health Department. This needs to be made available to members in the introductory pamphlet/note about the fund. In the absence of this knowledge it may continue to get utilised mainly for curative work.

5.18 Project proposals from nearly 10.0% of member institutions have been processed by CHAI during the past five years, making an average of about 2.0% per year. In most cases a desk review was done and a fairly large proportion of members (64%) have mentioned that CHAI's response was not helpful to their planning.

It must be considered how this activity could promote the goals,objectives and vision of CHAI and of the member institutions and if it could be used as a method of learning and growing, rather than just being a service to funding partners.

5.19 It was found that only a very small proportion (8.6%) of members have participated in the various training programmes organized by the Community Health Department during the past five years. Feedback about the content and methodology have been given good. However, a very large proportion of members (91.0%) are partially aware of the vision of the Community Health Department which was articulated in 1983. Again a big majority (84.8%) find the vision relevant to their work. This higher level of awareness could be attributed to CHAI through Health Action, conventions etc. But it could equally be due to a similar thrust given by other associations and organizations, for example the Voluntary Health Association of India (VHAI), Caritas, Indian Social Institute (ISI) etc.

The reasons given for relevance of the vision to their work indicates a good level of understanding of the vision and are fairly similar to the ideas given by Delphi panelists regarding underlying assumptions for health work and indicate a deeper understanding of the concept. The phase of orientation thus needs now to give way to skill training and actually trying out the various approaches and ideas in the field.

Promotion of community health and family welfare was included as an objective of the Association in 1978 through an amendment of the Constitution after many years of discussion. "Promotion of Community Health Programmes according to our new vision" was also the first priority in the ten point programme for the next decade, as articulated in 1983. This 8.6% therefore, is an extremely small number of members reached. Since members and Delphi panelists have now rated Community Health again as being of highest priority particularly in rural areas, there is an urgent need to get more training programmes and other inputs off the ground. A planned approach through the regional and diocesan units could be tried rather than the present one of responding to requests as and when they come. This would also help in time and resource management. A few designed programmes could also be offered at the central level/in different centres. A quick brainstorming should help to evolve training approaches suited to different regions of the country and for different categories of member health institutions. They could build on the modules developed in the past as well as on the approaches of other training groups developed in the voluntary sector that have already been documented.

As has been brought out by the study, diocesan and State level training programmes are most suitable. Regional resource personnel could be used. These could be from member institutions,previous Community Health Department staff members of CHAI, Delphi panelists,persons from the voluntary and government sector, and medical and nursing college staff. Ideas are aplenty, there is now an urgent need for implementation.

The many suggestions and feedback given by members could be considered by the Community Health Department as it undertakes its ongoing planning and evaluation.

5.20 Some of the key questions on which evaluative feedback from members was crucial, was put to the entire constituent membership, through the interview schedule covering the 20 % sample, and the mailed questionnaire to the remaining 80 %. As has been mentioned earlier these covered the following areas:

- reasons for the institution joining CHAI;
- problems faced in medical/health work;
- strengths and weaknesses of CHAI, based on their experience and interaction during the past five years;
- expectations of the institutions of/ from CHAI;
- future thrusts i.e., priority areas of focus for CHAI in the 1990's and beyond;
- other comments and suggestions regarding CHAI.

There was a difference in methodology and probably therefore in the quality of response, in that for the 20 % sample institutions, feedback was generated through discussions and in the questionnaires members wrote in their responses. Our experience with the interviewed sample was that some of the feedback was written down, but some was not. This we elicited during debriefing discussions with the investigators. Those not written were often related to the more negative feedback. However, the important points that emerged have been raised in the twenty issues given in the Discussion Document.

There would also probably be an additional difference between the response of the two groups. Findings from the 20 per cent sample are more representative of the membership in terms of region and size of institution. However, at this stage the two groups have not been analysed seperately. For academic and other reasons this could be undertaken later only if considered necessary.

Even in response to general open-ended questions certain areas have been identified by large numbers. we have not taken quantitative cut off points to prioritize the issues. This could be done for example, by rating issues raised by more than 15.0% of the respondent members as being very important/of highest priority, those raised by 10 - 14.9% as important, between 5 - 9.9% as fairly important,etc. However we have, in this document given points raised by even one or two members. This was done because: a) in a democratic group all the views should be made known;

b) some of the views raised by smaller numbers were more specific and some were very useful. It is also probable that individuals who have had a closer interaction with CHAI by being on the Board or staff previously or in some other way or who may be more involved in certain health issues may give more insightful suggestions which are valuable;

c) the decision whether to consider the view and to take action also was felt to be rightly with the Executives, the Board members and the different departments. We therefore have not taken the option of deleting views based on a quantitative or qualitative yard stick.

d) this is also the internal document containing the detailed backup information to be available for reference/use for by the Association and the Departments. Therefore at the cost of being lengthy, details have been given.

5.21 **The response rates to these crucial questions were as follows:**

| Question | | Response Number | % n=1,415 |
|---|---|---|---|
| 1.Reasons for joining CHAI | - | 1,004 | 71.0 |
| 2.Problems in medical/ health work | - | 1,117 | 79.0 |
| 3.Strengths of CHAI | - | 878 | 62.0 |
| 4.Weaknesses of CHAI | - | 640 | 45.0 |
| 5.Expectations from CHAI | - | 978 | 69.0 |
| 6.Future thrusts for CHAI | - | 775 | 55.0 |
| 7.Other comments/suggestions | - | 362 | 25.6 |

Percentages are from the 1,415 functioning member institutions who participated in the study. There is a variation in the response to different questions, though on the whole the response in high, especially in terms of actual numbers. This indicates an interest in the association. Members have filled in/given views in response to questions at the end of lengthy (and tiring) questionnaires. The interview schedule was twenty-four pages and the mailed questionnaire fourteen pages !

It is the problems faced by members in their work, the expectations from CHAI and the ideas for future thrusts that are most important for CHAI's planning.

5.22 An important factor to be kept in mind when planning programmes and during interactions with members are the problems that they face in their medical/health work. These vary according to region and size of institutions and will also change over time. Programmes may need to include methods of handling these problems or to evolve methods of functioning inspite of these problems.

For instance many health personnel in member institutions have to diagnose and treat cases of tuberculosis, malaria etc. These are most often done without basic laboratory facilities (see problem one). Referral facilities are also not always available close enough. Possibilities of making a wrong diagnosis are very real. Misdiagnosis of TB occurs even with laboratory facilities. Can putting doubtful patients of TB on prolonged treatment with potential side effects be justified? How can CHAI as a national level health association, help in such a situation?.

Similarly a very large number of member institutions lack communication facilities of telephone and transport. While this may be essential only in the case of relatively rare emergencies like severe post-partum haemorrhage etc, it can not only effect the lives of people but also the confidence and credibility of the institutions and their health personnel.

The problems relating to getting health personnel to work in rural/ difficult areas have existed since the inception of the Association. In keeping with the medical developments and thinking of those days members set up nursing schools, worked towards establishment of a medical college and towards standardizing the training of pharmacists and laboratory technicians. It was a great

contribution, the benefits of which are felt to this day. However because of the rapid increase in the number of health centres in remote areas, the need for personnel continues to be felt. Additionally, is the vital need for personnel adequately trained and equipped regarding the newer approaches in community health that have grown in the country and internationally.

**Could CHAI help in promoting greater dialogue and link up between institutions training various categories of health personnel and health centres and services functioning particularly in remote rural/tribal areas.** This would be in addition to CHAI's own work of orientation and training,particularly skill training. Through this dialogue, could trainers internalize the real life problems of people and of health workers into their training and continuing education programmes? Resources within the CHAI membership need to be utilised more. There are nursing tutors and others who have left their training institutions and hospitals and opted to work in remote health services. Their experience and expertise could be drawn upon.

**Introducing an understanding of social issues and societal analysis** into the programmes of different health personnel run by institutions could also be promoted. Thus the experience of the CHD training team and the methodologies developed during the past decade could be spread.

**Joining hands with secular and other groups who raise issues** like the campaign for a rational drug policy and against irrational therapeutic practices, issues of womens' health etc could be strengthened at the national, regional and local levels. Active participation and contribution in the All India Drug Action Network, the Lok Swasthya Parampara Samvardhan Samiti, the medico friends circle, womens and environmental groups, Bhopal victims solidarity groups, citizens for secularism, and the many local issue raising and action groups and peoples movements is of great importance. CHAI and its members could, through such linkages, contribute more to improving peoples health and grow from this involvement.

**Interaction with** CBCI, CRI, Caritas, with congregational decision makers and with Diocesan structures and Social Service Societies etc is also a msjor role for CHAI, keeping in mind the fact that most member institutions are run by religious personnel.

Several of the above points have already been initiated in the past by CHAI, but will need to be strengthened. Provision needs to be made at the central, regional levels in terms to personnel, time and other resources to do this effectively.

5.23 The many strengths of CHAI that have grown over the years have been identified and appreciated by a substantial proportion of members. 62.0% have mentioned specific areas of strength. These are:-

* support and service to members;
* Health Action;
* training programmes;,
* meetings;
* the functioning of the Association;
* various services and activities; and
* the issues taken up.

Large numbers have mentioned the first two - 29.0% and 17.8% respectively in response to an open ended question. The training programmes and organisational structure and functioning come next with 11.1% and 11.5% mentioning them. The remain are mentioned by smaller numbers. These have been developed with much effort,hard work and sacrifice by the executives, staff and others, with the support of the Board and members. The Golden Jubilee is the most appropriate moment to pay a tribute to the large number of people who have nurtured the association and also to recognize the positive contributions that CHAI has made. With this long tradition and commitment to the health of the poor in India and with the guidance of the Spirit it can prepare itself for greater involvement and still greater contributions, building further on its existing strengths.

5.24 The section on the weaknesses of CHAI highlights specific areas on which further work is required. There is a fair degree of internal consistency between weaknesses, expectations, ideas for future thrusts and general suggestions expressed by members. It would be good if the departments of the CHAI central office, the whole staff and the Executive Board study these issues and use them as a plank for developing their future plans of action. Each will have to relate the points raised to their own work and roles.

**As identified from the list of weaknesses the areas to be worked on further by CHAI are :**

a) **Improved interaction** with members, with services of CHAI relating to their problems and needs and greater focus on the rural based and smaller institutions;

b) **Organizational issues** such as:
   * improved internal management and functioning within the CHAI central office;
   * some issues regarding organizational structure, especially relationships between the central office and the Regional/ State Units and the elections of the Executive Board members.
   * issues concerning accountability and linkages.

c) **The focus, and quality, including content, of services offered.**

Additional feedback regarding training,publications, project proposals, community health and other services have again been raised, besides those already given under each department.

5.25 The **expectations that member institutions have from CHAI** have been expressed clearly by a large proportion of 69.0% of respondents. They have been grouped together and the main points that have emerged are:

a) **Interaction between the CHAI central office and its members** has emerged as CHAI's major strengths (29.2%), its major weakness (16.3%) and the highest expectation (16.6%) of member institutions. **The management and all departments need to make efforts to keep this vital link functioning well.** The turnover rate of senior staff in the central office of CHAI plays a role in this relationship, as does to a lesser extent the changing personnel in member institutions. If different staff could be given greater responsibilities for liaison work with certain States/regions, rather than respond to the whole country, it would help strengthen contacts. They could also work more closely with the concerned executive committee members of those regional units.

b) CHAI needs to clarify whether meeting financial needs of members is its role as a health association. Could members be 'enabled', to utilise other resources, including those from government and local sources, and to utilise low cost,people building methods in their health work.

Health care financing in India is slowly emerging as an area in which experience has been gained. Dialogue could be held with the concerned resource people/groups. An analysis of approaches that are useful and those that are counterproductive to the community could be discussed.

c) The supply of medicine (foreign gift supplies) has a fairly long history with CHAI. This could be reconsidered. Indian manufacturing capability and local availability of drugs has increased immensely during the past decades. However with the new drug and economic policies costs are escalating and some essential drugs are not always easily available. There are also now a small number of low cost, essential drug manufacturers. However, only 13.4% of members in the study ( of 1,415) purchase medicines from them. CHAI has been supporting the network of lowcost drug manufacturers and could promote them more actively among its members. Helping smaller dispensaries,run by nurses,with methods of planning purchase of drugs according to their needs could be done by the CME Department. 36.0% of members (509 out of 1,415) presently use other systems of medicine (Herbal Medicine, Ayurveda, Naturopathy, Homeopathy etc) with or without allopathy. Thus a major shift is taking place in the therapeutic practices requiring other forms of indigenous support systems.

d) The need for guidance and support,training and information could be taken together. They are consistent with the reasons given by members for joining CHAI. It is important to keep in mind that 57. 1% (808) of members are health centres with less than 6 beds, that 83.4% are in rural/tribal regions, and that a large proportion of these are run by sister nurses. The needs of this group for training, information and support to play their roles effectively, is great. In contradiction the access of these groups to such services is minimal. The basic training for nurses, doctors, auxiliary nurse midwives, etc are conducted in hospitals/institutions that do not prepare or equip personnel adequately for the challenges in the field.

Therefore meeting these needs emerges as the most key role/strategy of work for CHAI in the future. The section on future thrusts identifies specific areas that members feel are important. They need to be covered by the training and information services of CHAI. Delphi panelists have also rated continuing education for members as the highest priority among strategies of work to be adopted by CHAI. They have also identified areas to be covered by such programmes. This is given under 'Important health problems of the country and components of health care/health action that need to be promoted by CHAI'. The expectations regarding community health,therapeutics and specific activities/issues would be covered by the above.

e) The other expectations of members relate to key areas concerning of the mechanisms of functioning of CHAI. These include regional functioning,building linkages and cooperation, the financial aspects of the Association, policy and planning and help in times of members needs.

5.26 Given the large range of expectations, an assessment will have to be made by the Executives/Heads of Departments, based on discussions within their own departmental teams, as to how they could be internalized into the plans of action of the departments and of CHAI.

These expectations will have to be linked with the ideas given by members and Delphi panelists regarding the possible future policies thrusts/roles that CHAI could play in the predicted future scenario (socio-economic-political-health) of the country. Reports of the Regional meetings and members rating of ideas generated by the Delphi Method should also be considered. Since this is a complex task, the later stages of converting them into plans and mechanisms of actions could best be undertaken by a small group.

5.27 CHAI is already working on several of the areas mentioned. Other groups too are active in these areas. Personnel from CHAI member institutions are also members of other Associations/groups and make use of their facilities. Resources of other groups could be utilised through further collaboration.

For instance the major expectation of members regarding need for guidance and support, training and information could be addressed through:

a) CHAI
b) Christian Medical Association of India, New Delhi and their member institutions, including Christian Medical College, Vellore and Ludhiana, and Miraj Medical Centre.
c) Voluntary Health Association of India, New Delhi, and its State level branches.
d) St.John's Medical College and Hospital, Bangalore.
e) The member training institutions for nurses and allied health professionals.
f) The large group of alternative community health trainers of middle level health workers. There are fifteen major groups and other smaller groups.
g) Other specialized resource groups in the voluntary/ quasi-government sector.
h) Government institutions and personnel including medical colleges, nursing schools,District and Taluk level facilities and Primary Health Centres.
i) Professional Associations, like the Trained Nurses Association of India, Indian Medical Association, Indian Hospital Association etc.

CHAI could have a unit ( the Continuing Medical Education Unit) that could undertake ongoing liaison to collaborate in training/learning activities that are developed to serve the need of different categories of health personnel in member institutions. Upgradation of the professional knowledge and skills of health personnel would be the goal. The existing facilities/resources in the country could be utilised, particularly in the area of curative medicine which is a major activity of several members. However, CHAI needs to focus only on those member institutions who are not reached by or who cannot avail of available facilities. For instance, the nurse sisters working alone in small 0 - 6 bed health centres in remote rural/tribal areas find it difficult to close their centres and also to pay for courses/travel etc. They may need to be reached by distance education methods. The course design would have to be broad covering curative medicine, including simple diagnostic methods, rational therapeutics, indigenous alternative systems and methods of healing; community health, management of health centres; social analysis; community development,community organization; basic legal literacy concerning medio-social issues etc.

The cell/unit could also possibly be part of a working group for evolving methodologies to improve the basic training of religious sister nurses to make it more relevant to the needs of the situation in which most of these sisters have to function in their professional capacity. Field visits and several discussions during regional meetings indicate that many centres are run by nurses who may have been trained anytime during the past 30 years. They need a lot of support and training inputs on the topics mentioned above.

5.28 CHAI would also have to **make a greater effort in training and in promotion of newer areas / areas of priority according to its goals and objectives and in areas which need to be developed further** based on the experience already gained. **This would be in the areas of community health according to CHAI's vision, family welfare, womens' health, pastoral care and medical ethics, alternative systems of medicine, mental health, wholistic health and disability.**

**Training modules** to equip personnel to initiate and sustain grass-root level work have to be developed and used.

The need for **developing and publishing health education material,** particularly in Indian languages had been raised. Hindi could be a starting point.

Responding to requests for financial assistance, and material assistance (for medicines/ equipment etc) would need to be done with discernment. The focus should be only on small/ remote health centres. **Infact the overall shift should be away from equipping buildings and infrastructure and towards equipping personnel with knowledge, skills and attitudes so that they in turn could enable people and communities among whom they work.**

5.29 Members views regarding the **future thrusts of the Association** have also emerged clearly. They have identified priority areas of focus for CHAI in the 1990s and beyond. There is a resonance between ideas suggested by them and by the Delphi panelists. They are broadly in the areas of rural and community health.

a) Points relating to **rural and community health** have been also raised as highest priority by Delphi panelists as components of health care/health action that need to be

promoted by CHAI. This was intuitively or prophetically determined way back in 1969 at a meeting in Bangalore of health professionals from the voluntary sector. It was introduced as an objective of CHAI in 1978 and as priority number one in its ten point programme in 1983. This relates a lot to the work of the Community Health Department. However the number of member institutions reached by training programnmes of the CHD is very low as has been mentioned earlier.

b) There is also much scope for the **Media Unit** to produce material for Health education and Education for Health in English, the national and major regional languages. Slides and videos are powerful means that can be used where slide projectors and VCR's are available. These are useful audiovisual aids during training programmes for health personnel from member institutions which are conducted in centres which usually have these facilities.

However, given the lack of even basic facilities in a large proportion of members, training and utilisation of traditional and low cost communication methods would be able to be used by a larger number,especially those working in areas of greater need. Posters and use of pictorial forms for children and those unable to read and write also still play a role.

c) There is similarly much scope for the **Documentation Department** to respond to information needs for health action by members. In this context it must be remembered that about fifty per cent of CHAI members do not get the Health Action magazine presently. Supporting the formation of **Regional/State Documentation Units** ( and perhaps one or two Diocesan Units as a trial) could be considered in collaboration with the Regional Units. Other health resource centres already exists, for example the Foundation for Research in Community Health, (FRCH) Bombay, Centre for Health Care Research and Education (CHCRE), Rajagiri, Kerala, Community Health Cell, Bangalore etc. Initiatives for new Documentation Units could be in regions where such centres do not exist. Members could also be encouraged to utilise the existing centres more. Regional language documentation and information is also important and could be undertaken by Regional/State Units.

d) It could be considered if a seperate unit could be formed to work on the spiritual dimensions of health and wholistic health. A majority of members have expressed the need for a unit on medical ethics. Pastoral Care Program was also need to be continued. To start with these could be covered by one overall unit, which could gradually grow. Modalities of the what, how and who need to be worked out.

5.30 IN SUMMARY SN OVERVIEW OF THE :

a) * levels of interaction with CHAI,
* participation in its activities, and
* utilisation of services by members and their analysis by region, size, location and State is given in the following tables.

Table 40. Overall levels of interaction/participation/utilisation by members of different services and activities of CHAI during the past five years.

| | | |
|---|---|---|
| 1. | Visits by staff/others | - 13.8% (56) in 5 years |
| 2. | Receipt of Circulars | - 97.3% (396) " |
| 3. | Participation in special training programmes (Continuing Medical Education, Spiritual Growth, Pastoral Care, Diocesan and Regional level) | - 25.1% (102) " |
| 4. | Annual Convention | - 32.4% (132) " |
| 5. | CMMB gift medicines/ consignments | - 53.3% (127) " |
| 6. | Discretionary Fund | - 27.5% (112) " |
| 7. | Project Proposals (to funding agencies) | - 9.6% (39) " |
| 8. | Community Health Department (all training programmes) | - 8.6% (35) " |
| 9. | Receipt of Health Action in 1988, 1989, 1990 | - 92.9% (378) " |
| 10. | Subscription to Health Action (1991) | - 66.6% (271) 1991 |
| 11. | Receipt of publications sent free by CHAI | - 13.0% whenever sent |
| 12. | Central Purchasing Service | - 24.6% (1,100) any time during the past |
| 13. | Participation in fund raising | - 28.0% (114) " |

**For an Association of its nature, these and other services/activities not mentioned, form an impressive list.**

There is further scope for increased outreach to/ utilisation by members of the services/ training by the Central Purchasing Services, Community Health Department and other training programmes (Continuing Medical Education, Spiritual Growth through Clinical Practice, pastoral Care, Management and Diocesan and Regional Level Programmes.)

b) The overview analysis of utilization of services by region, size and location is given below.

Table 41. **Utilisation of different services of CHAI analysed by region, size and location of member institutions**

| Services of the different departments | Poorer Health Status | Better Health Status | Less than 6 bed institutions | More than 7 bed institutions | Urban | Rural | Tribal |
|---|---|---|---|---|---|---|---|
| 1.Visits by CHAI Staff/others | 13.1% | 21.5% | 9.4% | 28.4% | 33.9% | 10.5% | 16.9% |
| 2.Participation in programmes (Continuing Medical Education, Spiritual Growth, Pastoral Care, Diocesan and Regional) | 27.2% | 33.5% | 29.4% | 36.0% | 43.7% | 27.4% | 35.6% |
| 3.Annual Conventions | 24.4% | 37.2% | 24.1% | 49.1% | 39.1% | 32.8% | 29.4% |
| 4.Health Action (1991) | 74.3% | 64.6% | 64.9% | 71.3% | 77.3% | 62.3% | 77.9% |
| 5.Central Purchasing Service (CPS) | 21.9% | 29.4% | 20.1% | 42.4% | 50.0% | 24.5% | 13.8% |
| 6.CMMB medicines/ consignments | 64.2% | 53.7% | 52.8% | 64.4% | 56.7% | 56.3% | 58.7% |
| 7.Discretionary Fund | 30.3% | 31.0% | 36.4% | 24.8% | 24.6% | 30.9% | 36.8% |
| 8.Community Health Department (CHD) | 9.6% | 9.1% | 10.1% | 7.6% | 7.9% | 7.1% | 19.3% |
| 9.Participating in Fund Raising | 26.9% | 29.0% | 21.6% | 41.3% | 34.8% | 29.4% | 17.6% |

[N.B: Points 1, 2, 3, 6, 7, 8, and 9 refer to a five year period.
Point 4 refers only to 1991, and
Point 5 to the time since CPS started functioning.

The subscription to Health Action is more or less evenly distributed and so is the distribution of CMMB consignments. The Discretionary Fund is used more by smaller and tribal area based and rural institutions. The training programmes of the CHD are also utilised slightly more by smaller institutions and more by tribal area based institutions. Visits by CHAI staff are also more frequent in areas where health status is poor.

On the other hand, visits are more to the larger, urban institutions. Participation in training programmes from larger, urban institutions situated in regions with better health status. The utilisation of CPS has the same pattern and so does the participation in fund raising.

The number of activities and services of the Association are fairly large and continuously growing. Changes and new thrusts are already occuring and developing in the areas of social need and relevance. These can be further strengthened and expanded through:

* regional, State and diocesan level units;
* improved functioning at the central office with enhance capacities in the area of training, networking and collaborative work with the many resources among members, in the Church and voluntary sector in the country;
* greater focus and interaction with members

c) An overview of the Statewise pattern of utilisation of CHAI services is given in the next table.

Table 42. **Statewise pattern of utilisation of CHAI services**

| State | Visits by CHAI staff/ others | Participation in conventions | Health Action subscription | Use of CPS | Use of Discretionary Fund | Participation in CHD programs | Functioning members in 20% Sample |
|---|---|---|---|---|---|---|---|
| 1.Andhra Pradesh | 6 | 20 | 34 | 19 | 16 | 6 | 45 |
| 2.Assam | - | 1 | 4 | - | 1 | 2 | 7 |
| 3.Bihar | 4 | 6 | 21 | 4 | 6 | 2 | 29 |
| 4.Goa | - | 1 | 3 | 1 | 1 | - | 5 |
| 5.Gujarat | 2 | 2 | 10 | 4 | 3 | - | 11 |
| 6.Haryana | - | - | 3 | 1 | 2 | 1 | 3 |
| 7.Karnataka | 3 | 8 | 22 | 9 | 9 | 3 | 31 |
| 8.Kerala | 14 | 31 | 42 | 25 | 15 | 4 | 80 |
| 9.Madhya Pradesh | 8 | 5 | 24 | 8 | 15 | 4 | 34 |
| 10.Maharashtra | - | 6 | 13 | 2 | 4 | 1 | 18 |
| 11.Manipur | 1 | 1 | 2 | - | 2 | 1 | 3 |
| 12.Meghalaya | - | 3 | 10 | 1 | 5 | 2 | 11 |
| 13.Mizoram | - | - | - | 1 | 1 | 1 | 2 |
| 14.Nagaland | - | 3 | 5 | 2 | 1 | 1 | 5 |
| 15.Orissa | 2 | 6 | 12 | 2 | 5 | 2 | 14 |
| 16.Punjab | - | 1 | 2 | 1 | 1 | - | 2 |
| 17.Rajasthan | - | 1 | 5 | - | - | - | 7 |
| 18.Tamilnadu | 8 | 23 | 43 | 15 | 18 | 3 | 70 |
| 19.Tripura | 1 | 2 | 1 | - | 2 | 1 | 2 |
| 20.Uttar Pradesh | 7 | 8 | 11 | 5 | 3 | 1 | 18 |
| 21.West Bengal | 0 | 4 | 4 | - | 2 | - | 10 |
| Total | 56 | 132 | 271 | 100 | 112 | 35 | 407 |

A comparision of the utilisation/participation by the four Southern States (Kerala, Karnataka, Tamilnadu and Andhra Pradesh) and the four Central States (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) has been done and is given overleaf.

Table 43. Comparision of utilisation/participation in CHAI activities between Southern and Central States

| CHAI activity/ Service | 4 Southern States 226 (55.5%) | 4 Central States 88 (21.6%) | Total participation |
|---|---|---|---|
| 1. Visits by CHAI Staff/others | 31 (55.3%) | 19 (33.9%) | 56 |
| 2. Participation in conventions | 82 (62.1%) | 20 (15.1%) | 132 |
| 3. Subscription to Health Action | 141 (52.0%) | 61 (22.5%) | 271 |
| 4. Use of CPS | 68 (68.0%) | 17 (17.0%) | 100 |
| 5. Use of Discre-tionary Fund | 58 (5.18%) | 24 (21.4%) | 112 |
| 6. Participation in CHD training programs | 16 (45.7%) | 7 (20.0%) | 35 |

There is a some disproportion viz., a larger number from the four Southern States, in comparision to their overall number and percentages in the sample, participate in conventions and use CPS. This would have some impact in the election of Executive Board members. The number of larger institutions is more in the South and hence also the use of CPS. The utilisation of other services by the two State groupings is roughly proportional to the number/ percentage of members in these States respectively.

## IN CONCLUSIONS

In conclusion this report gives detailed reflections and feedback from members on CHAI and its functions. For its various services and activities this relates to the past 5 years in most cases. Information about the involvement,interaction, participation in activities and utilisation of services is available. Members expectations from CHAI, their suggestions regarding various aspects and views regarding possible future roles have also been articulated.

Follow up has already been initiated through regional and profesional group meetings. This emphasizes the process dimensions of this entire exercise of evaluative study and reflection. We are confident that the equally important component of continued action that has also been initiated will evolve.

We would like to end by expressing our gratitude to CHAI for giving us this opportunity to conduct this research study. We also remember the words of Sir. A.Bradford Hill,
**" All scientific work is imcomplete - whether it be observational or experimental. All scientific work is liable to be upset or modified by advancing knowledge. That does not confer upon us a freedom to ignore the knowledge we already have or to postpone the action that it appears to demand at a given time."**

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   A note on aims, objectives and methodology,
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## 7. APPENDIX

### List of background papers prepared for (the training of) investigators.

1. CHAI Golden Jubilee Evaluation Study, 1991-92,
   A note on aims, objectives and methodology.

2. The interview technique - a brief overview.

3. A note on medical terms used in the interview schedule.

4. A brief history of CHAI (Part-I).

5. A brief overview of the thrusts and activities of CHAI from 1980 onwards.

6. A note on CHAI membership.

7. Organizational structure of CHAI.

8. What is Health.
   (Extract from a report of a study conducted by the Christian Medical Commission of the World Council of Churches. The report is titled "Healing and Wholeness- The Churches Role in Health").