REPORT
ON

NATIONAL LEVEL COMMUNITY HEALTH TRAINERS AND TRAINEES WORKSHOP

HELD AT
VIDYA BHAVAN, BANGALORE

4-5 JUNE 1993

ORGANISED BY:
COMMUNITY HEALTH DEPARTMENT
CATHOLIC HOSPITAL ASSOCIATION
OF INDIA, SECUNDERABAD-3

Contents

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I N T R O D U C T I O N

CHAI has undertakes a comprehensive evaluation of the efforts of its 2300 member institutions and the central organisation in connection with the Golden Jubilee celebration in October 1993. This evaluation is directed at identifying the strategy and action plan needed to meet the challenges in health and health care for the people of India in the coming decade. As part of this effort it was decided to facilitate a meeting of community health training institutions and trainers to look at the relevant issues.

Two such national workshops had been held previously, in 1988 the first one was facilitated by VHAI and in 1991 the second one was facilitated by CHC, Bangalore. A suggestion from the second workshop was to include trainees in these deliberations. Hence CHAI decided to invite trainees also of the participating training institutions to give a greater depth to the discussions.

CHAI corresponded with 12 health training groups involved in middle level training and 17 individual community health trainers inviting them to the workshop and asking for suggestion for the central focus of the workshop. Two documents arising out of the Delphi policy study organised by CHAI were circulated along with a brief summary of CHAI's training programmes. Those who replied, appreciated the need for coming together and 9 institutions, 10 trainers confirmed participation and the others intimated inability to participate.

Based on the suggestions and the needs experienced by CHAI the focus of the workshop was decided. It was decided to focus on the 'What' and 'How' of training with enough opportunity given to understand the training efforts of each group and to arrive at a consences on the objectives of middle level training in community health. Based on these deliberations it was decided that further collaboration, co-operation efforts could be explored. Accordingly the workshop was held at Vidya Bhavan, Bangalore on 4-5 June, 1993.

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EXECUTIVE SUMMARY

The two day workshop on Community Health Trainers and Trainees organised by CHAI at Vidhya Bhavan, Bangalore in connection with its Golden Jubilee celebration began on 4th June 1993. Nine community health training groups and individual trainers were present with a total of 37 participants.

The main thrust of the workshop was to explore ways and means of better net-working and co-operation.

Each group presented their own training modules. In the context of changing values and socio-economic situation the groups discussed what should be the objective of the training they impart and what should be the content and methodology, so that the training could become more relevant, meaningful and effective in liberating the marginalised and deprived majority and improving the quality of their life.

Health, the participants emphasised, should be seen wholistically, giving due importance to human values like co-operation, sharing, equality, dignity of all, justice and empowerment of the marginalised. Self-reliance of the common man in health matters in the context of the trend of commercialisation of health service was very much stressed.

People centered, experience based and participatory training method would make community health workers more effective and relevant.

The workshop came to an end with the drawing up of the following action plan.

Network:

- Each training group will make use of 'Health Action' magazine to share their activities and programmes.
- Work towards preparing a directory of trainers for better co-operation and sharing of resource materials.
- Will participate in training programmes of other group.

Accreditation:

During this year different groups will participate, observe and evaluate the training of various groups and draw up certain standards of training. The idea accreditation to the trainees by a corporate trainers group of training organisations could be considered after a year.

Collaboration with the Government:

Collaborate with Government whenever possible after critically analysing the merit of the activity, at the same time demanding that Government carries out its duty and not abdicate its responsibility.

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REPORT OF THE NATIONAL CONSULTATION ON "COMMUNITY HEALTH TRAINERS AND TRAINEES

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Held in connection with the Golden Jubilee celebration of the Catholic Hospital Association of India.

Date :: 4 - 5, June 1993

Venue :: Vidya Bhavan, Bangalore.

The workshop began at 9.30 a.m. with a prayer lead by Fr. T.A. Mathias s.j. Based on a passage from St. LK he highlighted the personal element necessary in the healing ministry.

Dr. C.M. Francis welcomed the participants on hehalf of CHAI. He drew the attention of the participants to the booklet entitled "Seeking the signs of the times" a discussion document drawn out from the evaluation study of CHAI. This document, together with the experiences of the participants will form the basis for the workshop. He concluded his remark by suggesting that the workshop could among other things, consider the following points:

a. Networking among the trainers.

b. Building up of mutual support and sharing of resources among trainers.

c. Collaboration and working together with other organisations, Governmental and non-governmental, making use their resources and expertise.

The discussion document "Seeking the signs of the times" was taken up by the group and few relevant passages were read out.

Sr. Deepthi explained the dynamics of the workshop. The following time table was accepted by the group. (see Appendix I).

Mr. Magimai Pragasam explained a short ice-breaking game to facilitate the introduction of the participants.

After the tea break the participants in pairs introduced each other.

Key note address:

Dr. Mani Kalliath gave the key note address of the workshop. In the background of the socio-economic, political and religio-cultural scenario of India as projected by the Delphi panelists, he highlighted the health situation of India and the health problems that we are facing today and the trend for the future.

In this context he emphasised the importance of training groups to come together to know and understand each other better and co-ordinate the efforts for greater effectiveness to collectively face these challenges. (See Appendix II).

Presentation of training modules:

Chair person : Dr. V. Benjamin.

The following training groups - INSA, VHAI, CMAI, CHC, St. John's Medical College, AYUSHYA, THREAD, ANITRA and CHAI gave a brief resume of their training activities and presented the training module. (See Appendix III).

Group discussion:

After tea at 4.00 p.m. we began the group discussion. The participants in four groups discussed the following question:

"Considering the relevant parts of the document, "Seeking the Signes of the Times", the Delphi report, issues raised in the presentation and your experiences, what should be the objectives of our training programmes? What should be the elements & aspects, that need modification/incorporation in our training objectives?

Report of the group discussion:

All the four groups agreed that each training group will have their specific goals and objectives. However, the following points should be incorporated if not already present.

1. Health is to be seen in its totality as involving socio-economic, political, cultural and spiritual aspects of life.

2. Sufficient emphasis should be given to human values like cooperation, sharing, equality, dignity of all, justice and empowerment of the marginalised.

3. Necessity of proper and effective co-ordination, co-operation and networking of trainers, especially trainers in a particular geographic region.

4. Make the people self-reliant in health matters as well as empower them to demand health service as their right.

In the general discussion that followed the following point was raised.

Should we work with all the groups or should we take the side of a particular group? When divisive forces are on the rise in all spheres and when communalism and regionalism is becoming a menance, is it proper to side with one group?

It was clarified that taking sides with the deprived and marginalised majority is a bias or discrimination in favour of the disadvantaged. It is necessary to pay greater attention to such groups. After brief discussion and clarification the group accepted this position.

5.6.1993:

The second day's programme began at 8.45 a.m. with a prayer lead by Fr. Vimal.

The report of the previous day was read out and passed with certain amendments.

Chair person : Dr. Rayanna.

During this session different people presented short and very relevant papers on various topics:

Dr. Hari John of ANITRA presented a paper on the history of medicine. She highlighted that the present system of drugs which originated from the introduction of chemical drugs and laboratory experimentation into health care originated from the influence of alchemists.

It took three centuries for this practice to gain acceptance by the society and health practitioners and to relegate the holistic approaches and practices existing to the realm of the 'Unscientific'.

She highlighted that simple practices were the commonly accepted method of health care before the emergence of modern medicine.

Dr. Dara Amar presented the very simple, low or no cost techniques St. John's Community Health Department uses on health education.

Dr. K.R. Antony, with the help of a set of transparencies explained the methodology of Management, Information System in Health.

Sr. (Dr.) Agnesita, shared her personal convictions that lead her to community health involvement, and made her trainees effective agents of change.

Sr. Eliza gave a brief explanation of the technique and theory of pranic healing (See the papers enclosed).

Group discussion:

The morning tea break was followed by group discussion.

The Question:

The Goal of health training ultimately means empowering the people to gain control over their health. Any training, broadly speaking, promotes values, clarifications and increasing the knowledge and skills needed to improve life situation that one is concerned with. Therefore the goal of middle level health training will mean in practice to equip the trainee to motivate, train and provide the necessary support for the people. Hence some of the areas that middle level health personnel need to be equipped with are:

1. Skills to analyse macro and micro situation of society.
2. Skills for self learning.
3. Skills in training.
4. Leadership skills.
5. Inter personal, communication and working together.
6. Media skills.
7. Management skills for training.
8. Skills in evaluation.

In your experience of training middle level personnel in health:

1. What are the knowledge, skills and attitudes (content) that are needed by such persons?
2. What training methodologies could be devisedto promote this learning? What are the processes involved?

The previous day's four groups continued today also.

REPORT OF THE GROUP DISCUSSION

1. Training institutions, trainers and trainees should have proper attitude, skill & knowledge to have credibility and effectiveness; All these 3 groups should have empathy with the people and be able to identify with the life of the people with whom they are involved.

2. The training centre and the training group should have a learning environment.

3. The training process should be considered not as supplying the trainees with knowledge and skill, rather as drawing out the potentials, knowledge and skill already there. The same holds good for grass root training as well.

4. A proper attitude towards and understanding of traditional values is very important.

5. A good training (of the middle level personnel) will be that by which the trainee becomes completely independent to develop his/her method of learning, working and teaching. Acquiring a proper methodology of learning is also part of a proper training.

6. Hence, in a training period the emphasis should not be to impart all required knowledge, but to acquire **skill to learn and research.** Training, thus becomes an on-going process.

Knowledge:

Discussing the knowledge necessary, the groups listed the following areas:

- Socio-economic situation at micro & macro level.
- Ethics.
- Health situation of India & Health policy.

Skills:

1. Skills for analysing micro and macro situation of society.
2. Skills for self learning.
3. Skills in training.
4. Leadership skills.
5. Inter personal communication and working together.
6. Media skills.
7. Management skills for training.
8. Skills in evaluation.
9. Empathy and ability to learn from people.
10. Broader understanding of Community Health with stress on wholistic approaches.
11. Skill to generate Community participation.
12. Ability to implement training programmes.
13. Ability to address problems of urban poor throuugh an analysis of the urban situation.
14. Adaptability, flexibility and openness.
15. Ability to liason with the Government and other groups, especially groups working in the region.
16. Ability to operate with a "Bottom up" approach rather than a "Top down" approach with centralised package programmes.
17. Skill to follow up the trainers and support them in their involvement.
18. Managerial & administrative skills.

Methodology:

The training methodology of community health should be basically "learning by doing", so that one becomes competent in community based participatory planning, working and evaluation.

The following points will be important in the methodology.

- The training methodology should be flexible, dependent on local needs.
- Field placement should be an essential aspect of the training for both trainer and trainee to get sensitised to the condition and situation of common man as well as learn and interiorise proper values.

- Situation analysis of the condition of the people as well as Government resources available is important.

- Simulation, role play etc. are effective methodologies that could be used.

- Similarly folk arts should have its proper place in training programmes.

ACTION PLAN

Chair person : Fr. T.A. Mathias s.j.

The chairman introduced the session with questions regarding the following points:

1. Follow up action to be taken up to promote networking and better collaboration.
2. Accreditation of trainees.
3. Collaboration with the Government.
4. Expectations from CHAI.

I. How would we proceed as regards co-ordination and networking?

1.1. Inorder to evolve a proper networking the group expfessed the need for certain mechanisms.

A news letter for information sharing as regards the activities of the different groups was put forward as an urgent need.

Dr. C.M. Francis, the editor of Health Action, suggested that if each group regularly sends information about its activities to CHAI, the Community Health Department of CHAI can collate these informations and it can be published in the Health Action. All the groups agreed to this suggestion.

1.2. Community Health Trainers' workshop, 1994:

The need for a similar workshop in 1994 was discussed. The group felt the need for it as part of promoting better networking and co-operation.

Mrs. Sujata of INSA volunteered to organise the workshop sometime in May 1994 at Bangalore. The groups agreed to share the expenses of the workshop. It was felt that in the coming 1994 workshop, training groups in development work who have a health component could also be invited.

1.3. Mutual learning and support:

To promote better understanding and co-operation among the different training groups, as well as to promote the possibility of learning from one another, the group suggested that when one group is conducting a training programme, resource persons from other organisations could be invited. This will provide an opportunity to observe the training programme, as also lead to mutual strengthening and improving one's programme.

1.4. Directory of training groups:

The need for a directory of community health trainers (training groups) was expressed. It was agreed that since VHAI had done certain amount of ground work in this line, this point could be taken up by that organisation and see the possibility of preparing the directory. It was agreed in the group that such a directory should also include groups that give training in social involvement and development, having health component.

1.5. **Circulate the literature:**

To promote better collaboration, the literature, training material etc. that one group prepares or publishes could be circulated among other groups also.

2. **Accreditation:**

Points raised during the discussion regarding accreditation:

£ Fear was expressed that if we go for accreditation, the innovative aspect of the training may get a setback.

£ Accreditation is a basic need for the trainees, especially those who work in the rural areas.

£ If accreditation process is there, the training programme will have the following benefits:

- There will be better systematisation, consistency and accountability in the training.

- The groups will maintain higher standards.

- Accreditation will be a stimulus for training group to improve the quality of training.

£ Certain minimum standard has to be agreed upon as a condition for accreditation.

£ As for the finance and personnel involved in the accreditation, it may not be a major constraint.

£ Accreditation can be conferred by a corporate body of member organisations. No outside organisation or Government should be incorporated into this body.

After clarifying the above points, the group accepted the following suggestions:

When different groups conduct a course (training) representatives from other organisations could be present (involved). After one year of observation, study and evaluation we could concretely think of accredition, when we meet in 1994.

3. Collaboration with the Government:

£ The Government, in practice, may not promote conscientization and empowerment of the poor, majority in the strict sense, ie. political empowerment. Maximum it can support is economic empowerment.

£ Government has a lot of resources:

- In the form of teaching materials and personnel;
- In the form of finance: Especially a lot of foreign funds meant for grass root training are being channelled through the government; and Government machinery is not competent to deliver the goods effectively. Therefore, it was decided that:

  Whenever possible, voluntary organisations must collaborate with the Government; it should be a critical collaboration.

We should not however let Government abdicate its responsibility. We should rather demand that Government carries out its duty.

4. What do the different organisations expect from CHAI?

- It was expressed that CHAI could continue promoting the networking.
- One organisation expressed that the religious sisters who are trained in community health are too soon shifted to other jobs. A minimum period of atleast three years should be given for the trained person in the job of community organisation. Could CHAI do something about it?

Concluding the workshop Dr. C.M. Francis emphasised the need for greater networking and cooperation which should eventually lead to improving the quality of life of more people. And it is a challenging need, he said, to improve the quality of life of the marginalised majority to whom we are committed.

The workshop ended by 5.00 p.m.

Secunderabad
9th June '93

Dr. Arvind,
Fr. Sevanand Meloo s.j.

sm/rm

APPENDIX - I

COMMUNITY HEALTH TRAINERS AND TRAINEES - NATIONAL WORKSHOP
Hosted by C.H.A.I. , Secunderabad at Vidya Bhavan, Bangalore

WORKSHOP SCHEDULES - 4.6.1993

9.30	Prayer	-	Fr. T.A. Mathias.S.J
9.35	Welcome	-	Dr. Francis
9.45 - 10.15	Workshop dynamics explanations And Discussion document on CHAI's Evaluation 'Seeking the Signs of the times'	-	Sr. Deepthi
10.15	Tea		
10.45 - 11.30	Introduction of Participants	-	Mr. Magimai Pragasam
11.30 - 12.00	Key Note Address	-	Dr. Mani Kalliath
	Chairperson	-	
12.00 - 1.00	Sharing of training profiles by Institutions and their trainees		
	Chairperson	-	Dr. V. Benjamin
1.00 - 2.00	Lunch		
2.00 - 3.00	Sharing of training profile Contd.		
3.00 - 4.00	Group discussion on 'Objectives of training' of middle level health personnel		
4.00 - 4.30	Tea		
4.30 - 5.30	Plenary session - Chairperson	-	Dr. Dara Amar
5.30	Display of publications / Training materials		
7.30 - 8.00	Dinner		

5.6.1993

9.00	Prayer	Fr. Vimal
9.10 - 9.30	Report of previous day - Chair person	
9.30 - 10.15	Presentation of Papers contd.	Dr. Rayanna
10.15 - 10.30	Tea	
10.30 - 12.30	Small group discussion 'Content methodology and process of training	
12.30 - 1.30	Lunch	
1.30 - 3.00	Plenary Session - Chairperson	Ms. Sujatha de Magry
3.00 - 4.00	Plan of Action - Chairperson	Fr. Mathias
4.00 - 4.30	Concluding session - Chairperson	Dr. Francis

VOLUNTARY SECTOR COMMUNITY HEALTH TRAINING

RELEVANCE AND ISSUES

(KEY NOTE ADDRESS)

37 copies
Except

Golden Jubilee Evaluation:

The chapter starts for us in CHAI from the occasion of Golden Jubilee Evaluation. A herculean effort has been initiated to evaluate the efforts of more than 2300 member institutions spread through out the country and the efforts of the central organization especially over the last ten years. This is being followed up by a process of deliberation wherein the future directions for the next 10-15 years is being deliberated at the level of each institution, at the level of regions and at the national level. The context in which the future direction is being sought is based on the findings from the response of the member institutions, feedback from all those connected with CHAI and the Delphi policy panel of experts who discussed the socio economic, political, cultural and health situation that is likely to evolve in the next 10-15 years in India. The Delphi report predicts the following scenario.

Projected Scenario

At the national level the avaricious pressures of international forces in a unipolar world and the interests of the ruling class overwhelm and dominate developmental needs of the very large majority of the country's population. The poor majority will be under greater oppression. The country is steadily being pushed in the direction with the following features.

Political

- Less autonomy and greater neo-colonial exploitation in this 'new world order'.
- Political instability at the national, regional and state level.
- At the regional level problems of separatism on the increase.
- Strengthening of the conservative agenda of the Government with rightist and communal forces on the ascendency.
- Criminalization of politics.

Economic

- New economic policy would continue and international agencies would exploitatively pressurise national policy decision.

- Lead to devaluation, privatization and liberalization with escalating prices of essential items.

- Reduction in budget allocation for social service sector including health in real terms.

Percentage outlay for development programmes

1990-91 - 9.9%
1991-92 - 10.5%
1992.93 - 2.3%

Though World Bank-Country Economic memorandum (1991) suggests strengthening programs of social services for the poor (perhaps resulting from the knowledge of social upheavel elsewhere.

Percentage of total budget allocated for health in India '86 2.09%

Developing countries - 4%

Developed countries - 10%

(IMF Govt.Finance statistics)

- Industrial community and affluent middle class will be richer with marginal benefit to organized sector of labour, whereas unorganised sector (rural and urban) which constitutes the majority will be poorer.

Percentage of population below poverty line - 30% (1987-88)

Per capita National production 1989-90(prices) Rs.4,250/-
1980-81(prices) Rs.2,140/-

- Health Information 1991 - Bureau of Health Intelligence.

Registrations of unemployed in employment exchanges.38.8 million in 1992. 3.6% increase compared to 2.5% last 2 decades.

-Deccan Herald, April 26,1993.

- Promotion of cultivation of cash crops rather than essential food, deforestation and replacement with social forestry and environmental destruction.
In M.P Soyabean has replaced cultivation of coarse grains which is the staple diet of the poor
- Consumer based production in industry geared to world market without regard to local needs.

- Throttling of small scale sector by multinationals.

Social and Cultural:

- Consumerism guides the life style, with cultural alienation, abandonment of traditicnal practices.

- Erosion of values in personal, family and social life leading to breakdown of families, escalating corruption in social life.

- Religious fanaticism without God - experiences as love, leading to communalism. Examples of communal violence and massacres are too many in the recent years.

- Greater awareness among the oppressed groups such as dalit and tribals but without the means for effective organization which will be exploited by the ruling class.

- Improvement in literacy without improvement in the quality of education.

1971 Female literacy
illiterate women - National 39.4%

Drop out rate in (6-11 years) I-V classes 51%.

- 8th Five Year Plan document-Sec Selected Chapters.

Health:

The availability and accessibility to health care will become less for the majority, whereas the problems of poverty and development will increase.

1. Inadequate health planning which has a history of being biased in favour of the needs of the elite class and poor majority getting little health care.

   - Primary health care will be neglected further, with budgetary allocation for health decreasing in ~~rural~~ real terms.

* State of India's Health VHAI 1992.

	91 - 92	92 - 93
* Budget Allocation - Health (in c (in crores)	282	302
Family welfare	859	1000

"Backlong staggering, resource requirement to meet target astronomical, and as such unachievable in near future".

- 8th Five Year Plan Doc.

	7th Five Year Plan target	8th Five Year Plan target	No. of buildings yet to be constructed as per target 91
PHC	12,000	4,400	37%
Community centre	1,500	1,250	25%
			54% (sub centr s

- 8th Five Year Plan Doc.

- The trend will be mushrooming of high cost high technology super speciality institutions and health care cost spiralling upwards beyond the reach of even middle class.

'Big business houses have joined the bandwagaon of health Ministry'

Input of medical equipment tripled between 1980 - 1987.

2. Unwillingness to provide a Rational Drug Policy that will ensure essential drgus being affordable and available.

Irrational therapies, unethical practices and high cost of drugs even essential ones will increase under the pressure of profit oriented drug industry.

Drug Productions

Drugs	Units	88-89	89-90	90-91 (Prov)
Pencillin	MMV	330	324	230
Strepto	tonnes	240	130	160
Vit. A	MMV	75	95	80
Anti TB	Tonnes	660	720	590
DDS	Tonnes	23	3.5	4

Source: M & E Section, Ministry of Petroleum & Chemicals

3. Absence of health Education Policy - aimed at developing positive health attitudes and capacities for health.

Over production and over specialization among medical profession which ha come commercialized profe sion.

Training of paramedical staff sub optimal considerable mismatch of different categories of personnel, eg.,

Doctor/Nurse ratio 4:3 Whereas it should be 1:3

Training ofmedical graduates have outstripped the needs. No increase in medical colleges or admission capacity will be supported.

12:2:14

-8th Five Year plan document.

Yet capitation fee colleges are fighting a court battle against ban by Supreme Court.

30% sanctioned posts of specialists in rural areas lying
14% sanctioned posts of doctors vacant.

- Inadequate support tointermediate and grass root health workers who are the key groups in the health care manpower pyramid.

4. Lack of commitment to integration of health system, to make the benefits of western and indigenous systems available.

- Knowledge and usage of herbs and home remedies and other traditional practices being lost while 'Injection culture' and dominance of commercialised allopathy rises.

At the same time the health problems of the community are increasing.

1. Problems of poverty - malnutrition, preventable blindness, high mortality due to low birth weight babies, childhood respiratory illness and diarrhoea will increase.

1/3 of infants born are below 2.5 Kg (low birth weight). Vitamin A deficiency in children about 6.5% (National Survey, 1988-89).

2. Communicable disease - TB, Kala Azar, Malaria, Acute respiratory infection will continue to rise.

TB - in 200 districts short course chimotherapy started in 7th Plan. However poor case holding, treatment default, drug resistance affecting the control of TB.

8th 5 year plan document

Malaria - about 2 million cases annually reported atleast 1/3 from tribal areas. Drug resistants P.Falciparum cases rising.

- NMEP.
- 8th 5 year plan document.

3. Disease due to inadequate sanitation and protected water.

- Water borne diseases such as Cholera, Typhoid, Diarrhoea, Hepatitis B willhave high incidence.

1.5 million deaths estimated annually from diarrhoea.

- 8th 5 year plan document.

4. Diseases due to environmental pollution - Cancer, Allergies, Respiratory problems will be on the rise.

Cancer - 2 million cases estimated.

- 8th 5 year plan document.

5. Stress related diseases and social illnesses - Alcoholism, Drug addiction, Smoking, Suicides, Prostitution, STDs and AIDS will keep rising.
TOBACO RELATED MORTALITY - 6-10 Lakhs/year. estimated

6. Disabilities due to negligence and accidents - inadequate prenatal care, preventable blindness, injuries will increase.

Disabilities: 1.8% or 12 million as per NSSO 1981 Survey which included 3 types of disability - Visual, Locomotor and Communication.

However 1986-89 National Survey of Ministry of Health and Family Welfare and WHO showed 12 million blind as against 3.5 million of NSSO.

7. Iatrogenic diseases - arising from irrational practices will be high.

8. Health problems of the aged an aging population which is inadequately cared for will increase.

   By 2000 A.D. 7.6% of population will be above 60 years ie 76 million.

9. Population issues - female foeticides, female infanticide, abortions and their effects, large scale experimentation of harmful contraceptives without adequate safeguards will increase.

10. Women's health problems - will continue to be neglected.

    Higher female mortality in the age specific mortality of 0-4 years (early childhood) and upto 35 years (child bearing years)-prevalence of anaemia at 88% unchanged in 3 decades. Suggesting neglect of female from birth onwards.

    -8th 5 year plan document.

What CHAI members say

CHAI's evaluation process stretching over 15 months, eliciting the views of over 2000 members health care institutions and others connected with CHAI to identify key issues for the future, have also produced similar ideas and views. This is particularly so regarding health problems and issues that need to be addressed, and type of strategies required. These are brought out in the discussion document 'Seeking the Signs of the Times' particularly in Part B of the document. Selected relevant portions were read out earlier in the morning.

NEED OF THE HOUR

In this context there is an urgent need for the marginalized vioceless people to get organized and claim their legitimate rights to factors that control health such as just wages, availability of water, hygienic and safe environment both around home and work situation, access to food items for

balanced diet, proper housing and harmonious social and political climate. They have a right to claim a primary health care structure with adequate referal network to meet health care needs and needs for information and skills to maintain their own health.

In the context of these goals and aspirations of people, the role of health trainers in the voluntary sector is quite clear. As health trainers, we have to provide the necessary information to raise the health awareness of the people, to teach the skills to improve their health condition and to provide the supports so that they can organise and gain control over the factors affecting health. In the light of the existing situation of disinterested leadership in education in health this becomes an urgent task.

The existing situation of health manpower policy and implementation has much to be desired. There is a skewed policy regarding health manpower development where the professional groups at the apex of the pyramid gets greater emphasis than the intermidiary groups or village based health workers, whose contributions are more crucial. The institutions set up for ensuring quality in training starting from premier institution AIIMS and the numerious medical and nursing colleges to the primary health centres do not orient their training to the needs of the people. The academic sector has been besotted with thinking and planning that are aimed at the concerns of the elite, and modelled on western concepts and experiences. Though enlightened recommendations for correcting this situation has been made even before independence, in the reports of Sokhey Committee, Bhore Committee and other committees this has not resulted in the desired changes.

Response of voluntary Sector trainers

The voluntary sector of trainers and health programmes has responded to these challenges in various ways, whether it be innovative training for village people, promoting reliance on local herbs and home remedies, on low cost techniques of sanitation and protection of water, to innovation in agricultural practices, or facilitating peoples organisation to make the primary health centre function responsibly, or carrying out researches in the

areas of inherited knowledge of people. Over the decades the voluntary trainers and programmes have recognized that their work has remained isolated and localized in nature. They have felt the need to come together. In the 80's several efforts on coming together and networking of health training institutions took place. In October 88, the first dialogue of community health trainers in the voluntary sector was organized by VHAI in Bangalore.

The two day meeting led to the identification of the following objectives and mechanisms of networking among the trainers to be facilitated by VHAI.

i) To collect information on various types of training programmes in health in the country, both government and non-governmental;

ii) To store the information and disseminate it to other network members;

iii) To conduct seminars and workshops relevant to the needs of trainers;

iv) To help identify strengths and weaknesses of existing training programmes of the members for the purpose of self appraisal;

v) To develop a long-term strategy for networking;

vi) To influence the government on policies of trainign in health field.

* The meeting identified some follow-up tasks to promote the networking idea, which included:

i) The preparation of a directory of training programmes;

ii) The exploration of the possibility of regional meetings and resource centres; and

iii) the introduction of a regular column on training in the health for the Millions, magazine of VHAI.

The Directory was prepared and circulated in 1989

In 1991 October, Community Health Trainers dialogue was held at Bangalore facilitated by CHC when participants from the following areas met and discussed:

i) Community Health trainers,
ii) Medical College innovators,
iii) Social Development trainers,
iv) Health Co-ordinating agencies,
v) Other resource persons.

They discussed:

1) changes needed in education in health;
2) key issues in policy formulation for education in health; and
3) mechanisms for implementation of these ideas.

They also shared experiences and discussed networking aspects.

A statement of 'Shared concern and evolving collectivity' was produced which was to be promoted through six identified constituencies with influence.

The need for continuing such dialogue and pooling of resources of health training groups was felt for furthering this process of collectivity. It was also expressed that greater learnings from the rich experience of training groups could be culled out for mutual benefit and trainees could play a big role in this process.

BACKGROUND OF THIS WORKSHOP:

When CHAI thought of this meeting in order to gear ourselves the tasks envisaged for the coming decade, we wanted to bring trainers and trainees together to explore and share. The trainers are from national level health training institutions or are trainers in their individual capacity. The trainees who have undergone training with

them, are trainers themselves especially in their grass root work situation. They would therefore be able to highlight the genuine needs of middle level trainers from real experience and be able to point out the strengths and weaknesses of existing programmes. A peer evaluation done in an understanding atmosphere can bring out rich insight which can be very beneficial.

The main emphasis of the last dialogue was on aspects of policy formulation, objectives of training and the need for change. The content, methodologies and processes of training did not get much time for discussion. Several groups expressed the need to gain from the rich experiences of different groups. We in CHAI have been feeling this same need for sometime and hence decided to make this aspect the main focus of the workshop. We did not receive any differing suggestions in reply to our invitation, to the participants of this workshop. As we cannot dialogue without some commonality of understanding is necessitates that we have joint reflection on our objectives of training, as well as make efforts to understand what each group is doing.

Situation of health training in the voluntary sector:

Our education system, like our health system has bypassed the common man and does not relate to their needs and realities, their culture or their communication and learning methodologies. It is said that the classroom based system of education we inherited was meant to produce clerks to run the colonial administration. We trainers have been products of this system and are faced with the challenge of unlearning our ideas, methods and attitudes. Since ours is still a new frontier without much guidelines available, we are also faced with the task of creating and discovering new ways and means. We need to learn ways and means for effective communication with people for understanding their situation, for directing their energies to change their situation.

The health training in voluntary sector to a large measure is focussed on relevant issues, utilizes creative measures and elicits active participations of people and helps to bring about strengthening of people. This is a commendable contributions and need to be recognised. However it has its share of problems and limitations. It is worthwhile looking at these with the goal of looking for answers.

LIMITTATIONS

Some of the problems we notice from our perspective are that:

- there is a multiplicity of ideologies and styles influencing ~~framing~~ training
- a trend of some centres churning out programmes and trainees.
- some training centres seem to focus on temporary remedies neglecting the entirety of purpose of training.

In training methodologies a wide range of options are exercised by different groups. Some of the limitations of formal training culture seems to be retained such as that:

- class room approach with its power relationship between the teacher and the taught.
- naive belief that newer training technologies and audio-visual supports can generate participation.
- Health education not able to shed the cloak of indoctrination.
- trainees team working styles being contrary to the values system being propagated.
- the curriculum does not cover the relevant areas of skill and knowledge.

Another area of concern is that innovative and creative efforts are continuing as isolated islands, not enriching and spreading widely. On the other side, there is a self satisfaction with ones own efforts, and lack of commitment to accountability about the results of one's efforts.

In the field situation, the emphasis by and large seem to be on providing services to the people. The capacity building of people whether it be the village leaders or village level workers is yet to become the major thrust of voluntary agencies.

To keep the learning process dynamic, it needs to be updated by authentic knowledge. Efforts to gather, knowledge and skills from the evolving process in the community is minimal. What field research is done is mostly conventional variety, which keeps the people researched into as passive partners.

The trainers sometimes do not take efforts to keep upto date with knowledge and skills, perhaps from lack of opportunities, and perhaps from lack of motivation. Another area of concern for us relates to recognition of voluntary sector trainees. It is our belief that adequate means of recognition of the trainers are lacking in the voluntary sector in the areas such as financial, career advancement opportunities and security, leading to frustration, and discouraging trainers from opting into this field. In the same manner, the training programmes or the trainees who have undergone such trainings are not adequately recognized.

Hence, it is necessary for us to face honestly these issues emerging in health training and ask ourselves these questions.

1. What should be the philosophy and objective of health training that lead to empowerment, whether it be at the middle level or grass root level training?

2. What should be the curriculam and methodologies of training?

3. What should be the strategies for maintaining quality in training?

4. How can the large number of trainers working throughout the country, but in isolation join hands to meet the needs in training and follow up?

5. How can training skills for capacity building be fostered in middle level training?

6. How can participatory research skills in the health field be spread?

7. How can the trainers get continuously enriched by the experiences and learnings that are taking place in the health and developmental field?

What could be mechanism for providing adequate recognition to trainers, trainees, and training programmes

These are some of the questions that we need to ask ourselves, and reflect collectively. We need to continue this collaboration and efforts at collectivity, so that our effectiveness in capacity building or empowerment of the people will gather momentum. Hence these two days are part of an ongoing dialogue.

Dr, Mani Kalliath
CHAI

PROFILE OF TRAINING PROGRAMME OF

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Range of training: From orientation courses to M.D. & Ph.D.

Types of training:

1. Medical students - under graduate and post-graduate.
2. Nursing students - Public Health Training.
3. Community Health Workers.
4. Health & First Aid for Deacons/Novices.
5. Health Administrators training.
6. Health Aninators training.
7. Traditional Birth Attendant Training.
8. Plantation Medical Officers training.
9. Plantation Managers training in health.
10. Training of Government Officers in health.
11. Anganwadi training.
12. Rural school teachers training programme.
13. Occupational Health Training for Industrial Workers.
14. Mother's Motivation training programme.
15. Rural high/middle school health training programme.
16. Hotel worker's Food Hygiene course.
17. Public Health Training for Lab. Technicians.

Main charecteristics of training programmes:

1. Age - no barrier.

2. Language - English/Kannada/Tamil/Telugu.

3. Problem oriented & solution oriented teaching.

4. Self evaluation at end of training programme.

   Mixture of religous/lay trainees.

6. 100% rural based training at Mugalur Village Rural Health Training Centre.

7. Team of Trainers - doctors/nurses/medico social scientists/ Public health Lab. technicians/statistician/village leaders.

8. Course duration flexible based on specific need of trainees.

9. Site of training at field/rural centre/project office/ cottage/hospital.

10. Field visits to other health and development projects.

11. Trainers invited from Government/NGO

12. Emphasis on training of trainers.

13. Integrate principles of other systems of medicine such as herbal/Herbomineral/Accupressure/Homeopathy, in the form of orientation course integrated in other training programmes.

14. Health & Development training integrated.

15. Periodical colloquium & Refresher's for old trainees.

COMMUNITY HEALTH PROMOTION TRAINING PROGRAMMES

1. TRAINING OF TRAINERS

__ Long Term Goal

The long term goal of this programme is to strengthen the efforts of village level health workers through training of their trainers at state level.

Objectives

* To enhance training potentials of trainers at state level who are engaged in imparting health worker training.
* To strengthen training of health workers at grass root level through these trainers.
* To develop relevant educational material in the form of manuals, audio visual aids, case studies and so on.
* To form a network of these trainers in health.

Target Group

Trainer's of voluntary agencies

Contents

* Training need identification
* Planning a training programme
* Suitable methods for training including communication
* Conduction of training programme
* Evaluation

..2

2. DIPLOMA IN COMMUNITY HEALTH MANAGEMENT(DCHM)

Goal

The overall goal of this course is to make available people who have the knowledge and skills to be effective at the management and supervisory level of Community Health and Development programmes and project.

Objectives

* To determine the effect of socio-political and economic systems at the macro and micro level on people's health
* To create a desire to work collectively for a just and equitable society.
* To plan, organise, implement and evaluate Community Healt h and Development programmes
* To accept role of change agent/facilitator in order to make health a means and measure of development
* To understand the team concept and show the ability to take leadership role in the team.
* To promote and facilitate training, research and consultancy programmes.

Course Contents

* Study of Society
* Health and Development
* Techniques of studying Community Health
* Management and Administrative principles
* Effective Agent
* Elective, Practicum

Target Group

* People working in the voluntary sector who are directors, area managers and middle level workers of community health projects, i.e. all those who are in the supervisory cadre with decision making powers.
* Persons engaged in development activities wanting to start a community health programme in their organisation or institutions.

..3

3. TRADITIONAL SYSTEMS OF MEDICINE

Goal

Promotion of local health traditions
Promotion of herbal gardens

Objectives

* To train health personnel in identifying various local health traditions leading to utilisation of local resources.
* To train health personnel in identification of various herbs to create self reliance in common ailments.
* To train health personnel in preparation of simple recipies with the help of herbs and kitchen condiments to minimise their spending on unnecessary drugs.
* To train health personnel in propagation of medicinal plants; to meet the demand.
* To train health personnel in growing herbs in a garden and its maintenance.
* To train health personnel in identification of common ailments and treat them with herbs to create self reliance in health care.

Methodology

* Discussion
* Charts Display
* Audiovisuals aids(slides, video films)
* Field visits for identification of plants
* Practical demonstrations.

Target group

Project Managers
Health Co-ordinators
Supervisors
Vaidyas, Hakims, Dais.

..4

Contents

* Role of traditional medicine in PHC
* Introduction to various traditional systems of medicine and brief general concept of health
* Preventive and Promotive aspects in indigenous systems of health care(charts)
* Role of healers in PHC problems
* Relationship between traditional medicine and forests with
* Identification and growing of common herbs in home garden and schools and community
* Identify common ailments (limit to 10) and their treatment with herbs and kitchen condiments.
* Field visit for identification of common herbs and their usage.
* Commercialisation of herbal medicine

  Options:

  a. Planting techniques of medicinal plants

  b. Export of medicinal plants.

**

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PRIORITY NEEDS IN HEALTH TRAINING

The needs can be classified under five headings.

a. PEOPLE:

1. Grass root level workers
   i.e. Community Health Volunteers , Health workers & others
   - Organised groups in the community like youth groups, Mahila mandals etc.

2. Locally practising Health workers

3. Supervisors of Grass root level workers
   i.e. Field Supervisors

b. METHODOLOGY:

1. Audio visual aids
2. Role plays
3. Problem oriented participatory training programmes
4. Demonstration of Health Hygiene, Nutrition etc.
5. Case studies

c. Topics: Should be todays emerging health issues.

Some of the issues are given below.

1. Womens' Health - status of women and girl child etc.
2. AIDS
3. Substance and alcohol abuse
4. Mental Health
5. Socio Economic issues in the society

d. FACILITY: Decentralysing the facilities in training.

1. Recogenise potential trainers in each region
2. Develop the trainers for training
3. Provide simple aids for trainers in the training i.e. audio, video cassettes, books etc.
4. Organise small training groups from the local Churches, congregations, hospitals and health centres. These people can train small group around their places.

e. NET WORKING: Preparing a directory of Organisations like CMAI, CHAI and UHAI and other voluntary agencies involved in training.

This directory will provide information about the training programmes conducted by each agency, This will help the trainers very much and also avoid duplication.

II. BRIEF PROFILE OF OUR (CMAI) HEALTH TRAINING

CMAI conducts different types of programmes for different people. They are as follows :-

1. Workshop for key people in the Churches on Emerging Health issues like:-

1. a. Womens' health
   b. AIDS
   c. Substance and alcohol abuse
   d. Mental Health
   e. Socio economic issues in the society.

2. Seminars conducted in partnership with the National Council of Churches inIndia on Womens Health and development issues.

3. Workshops and seminars for people from Church related agencies like YMCA, YWCA etc.

4. Training programmes for project holders, project managers, Field supervisors, community health volunteers.

5. Project proposal and development workshop for Church leaders and Organisations.

6. Distributing certain manuals like Fiona plmanual on Child Survival and development , Family planning manual etc.

7. Conducting conventions and melas for community health volunteers.

8. AIDS Test - Sponsored by Govt. of Kerala

Research at Regional levels

TRAINING MODULE

CHAI/CHD SECUNDERABAD

Contents	Duration	Methodology	Expected Results
Social Analysis	10 hrs.	Stimulation games, case studies, audio visual aids, group discussion.	Critical understanding about Indian society.
Indian Health Scenario-Factors affecting health	8 hrs.	Group media, group discussion, visual aids.	Wholistic dimention of health
Spirituality of involvement	3 hrs.	Lectures, slides	Develop spirituality in health and development.
Community health and its components	9 hrs.	Lecture, Audio visual aids, group work, case studies.	Understanding on community health
Community diagnosis, Organisation, Participation	8 hrs.	Group work, Case studies, group discussion, lecture	Skills needed for Community health worker.
Human relation	6 hrs.	Games, group dynamics, exercises, discussion, lecture	Importance and relevance of human relation and the problems involve in community health.
Communication and group media	16 hrs.	Lecture, role plays, exercises, group work	Effectiveness of the training programme

International Nursing Services Association

INSA / INDIA RURAL HEALTH & DEVELOPMENT TRAINERS' (RHDT) PROGRAMME

TEN-WEEK RESIDENTAL RHDT PROGRAMME

INSA / India conducts two residential, ten-week RHDT Programmes every year. One begins in January and the other in June/July.

The Course Schedule includes (theoretical and practical) learning experiences in Village Health-Worker Training and subjects such as Indigenous Medicines, Co-operatives, Community Organisation, Educational Methods and Media, Accounts, Banks' Role in development projects, an introduction to Law/ Legal Aid, Management Principles, Socio-economic Programmes, Nutrition, Women and Child Care, Tuberculosis, Leprosy, Mental Health, A.I.D.S., Programme Planning and Evaluation, Collaboration with Government and utilisation of government aided programmes.

A part of this course requires the participants to formulate a one year Project Plan for implementation on returning to their organisation/institution, which will be assessed for awarding the certificate a year later. Hence, participants are expected to bring relevant statistics and other information.

FOLLOW-UP SERVICES:

a) *FACULTY VISITS:*
The faculty of INSA/India pays at least one follow-up visit to each participant to evaluate the implementation of the Project planned and to provide any additional inputs that may be required.

b) *CONSULTATION ON REPORTS:*
During the first year after the RHDT Training, each participant is expected to send in a written report once in 3 months, on the work completed. The faculty study these reports and offer guidance.

c) *FOLLOW-UP WORKSHOP:*
At the end of one year, all participants of each group meet for a 7 day Workshop to share and learn from each other. The Workshop is hosted by one of their groupmates who is centrally located and has established a good programme. Certificates are awarded at this Workshop.

d) *CORE-GROUP WORKSHOP:*
Those INSA/India graduates who have established creditable rural health and / or development programmes are invited to join the INSA / India Core-Group and attend Workshops once in 18 months at any place in India where there is an interesting Project or Programme for advanced learning.

ELIGIBILITY:

Participants should

1. *Be Doctors, Nurses, paramedicals, social workers, teachers or any other persons working in health and / or development projects or programmes.*
2. *Be sponsored by his/her organisation (which is registered).*
3. *Continue to work at his/her organisation for at least a year after the completion of the Course.*
4. *Be assigned to work in the field following the RHDT Programme and willing to implement his/her planned one year project.*
5. *Be able to communicate in English.*
6. *Be prepared to dress in civil clothes through the Course period and at subsequent Workshops (applicable to those coming from religious institutions/organisations).*

COSTS:

- *Registration fee of Rs. 1,500/- and cost of travel to and from Bangalore for the 10-week RHDT Programme.*
- *Rs. 1,000/- refundable on attending the Follow-up Workshop.*
- *INSA/India bears all the costs for the 10 week Training Programme and Field experience, Faculty visit, Consultation, Follow-up Workshop and Core-Group Workshop. Bearing in mind the costs for the Training, we request sponsor organisations to select a "suitable" person.*

CONCLUSION:

Established in March 1982, INSA/India has trained a total number of 272 *persons. They have come from* 15 *different states in India and neighbouring countries like Bangla Desh, Sri Lanka and Nepal.* + Karnataka

Since their RHDT training, participants have established programmes in the areas of Maternal and Child Care, Sanitation, Leprosy Control, Tuberculosis control, Supplementary Nutrition, Village Health Worker programmes, A.I.D.S. prevention programmes. Non-formal Education, Mahila Mandals, Balwadis, Youth and Farmers' clubs, Saving programmes, Credit unions and Income generating projects. We recommend this Programme especially for those in the supervisory cadre.

Application forms are available for Rs. 20/- *each, payable by Money Order/Postal Order to:*

INSA/INDIA
87, 1ST FLOOR, 3RD CROSS,
NANDIDURG ROAD EXTN., BANGALORE-560 046
Post Box No : 4634

For further details please contact the address given above.

Our next two Courses begin from (1) 24th July *to* Sept 15th *and (2)* _____ *to* _____

Last date for receiving completed application forms is _____

PROFILE OF TRAINING PROGRAMME OF

AYUSHYA (CENTRE FOR HEALING AND INTEGRATION OF THE MEDICAL MISSION SISTERS)

Ayushya means life promoting or fullness of life.

Stated since 1985.

Objectives of training programme:

- Integrated approach to health ie. seeing the person in his totality in harmony within onself, society, nature and ultimately with god.
- Promoting a new health culture.
- Providing low cost health care utilizing the natural resources/non-drug therapies.
- Justice in health leading to transformation of society.
- Promoting self-responsibility/self reliance.

Details of programme:

Type :: Seminar/workshops/orientation and awareness building programme.

Duration :: Week end/one day.
One week
One month.

Broad content :: Identifying needs of the group and prioritizing.
Health issues and needs.
Analysis of health situation.
Women's issues.
Ecology/environment
Nutrition, Hygiene
Alternate methods in health care

Non-drug therapies :
Accupressure, Reflexology, Touch for health, Therapentic massage, Herbal medicine, Home remedies, Pranic healing, Yoga, Stress Management, meditation, etc.

Medium of instruction: English/Malayalam.

Target group: Community Health Personnel mainly -

- selected nationally from community health organisations,
- Particular local community health groups.
- At random selected.

Methodology:

- Talks, audio-visuals, experience sharing, practical learning sessions with class participation and evaluation, networking with various groups/organisations.

Evaluation :

- Questionnaire, field visits (need to improve this) letters, follow-up programme.

Strength and weaknesses:

Strengths:

- Awareness in health consciousness;
- Utilizing local resources;
- Empowering women to certain extend.
- Collaboration of youth groups and women groups in extending awareness programme.
- Incorporation of positive values in life and attitude.
- Networking on issues/needs and collaboration.
- Non-drug therapies promoted.

- Part of wider networking of medical mission sisters moving from professional curative care in hospitals to community based hospitals to community health and transformation of society through justice in health.

Weaknesses:

- Lack of support and team spirit when trainees return to their groups unless the whole group attends training.

- Follow-up not satisfactory.

- Consumerism in NDT.

- Lack of control in practicing NDT.

Sr. Eliza

Experience sharing

PRESENTATION OF PAPER

An Innovative experiments in training

(Abstract)

St. John's Medical College

Sharing of some field experiences in Health education: Following areas were discussed.

1. **Child to child programme** conducted in village schools during lunch hour break, using actual materials instead of charts etc.

2. **Child to Mother & Child to Community:** Innovative extensions of the child to child concept were discussed.

3. **Mother's motivation programme:** A unique opportunity provided to village mothers for clarifying their doubts in relation to gynaecological problems, by making available a lady doctor exclusively at their home for a period of half a day only to discuss and clarify.

4. **Health through Music:** Use of dubbing techniques to dub a health message on commercial film song cassettes and then playing the cassette during village public functions, marriages, festivals. There is constant reinforcement of health message, each time villager hears original film song anywhere, through a process of association.

5. **Social mapping:** Using hand drawn village maps with rangoli powder, by village women. This is followed by marking antenatal cases, diarrhoea cases, immunisation, alcoholics etc. on map with various grains. This spot-mapping is followed by discussion by mothers as to the reasons for the patterns of distribution of marked grains.

6. **Body Mapping :** Using chalk and rangoli to draw on the floor, the various perspective views of the various human anatonical and physiological systems and how they work. This is used as a basic for participatory discussion on various processes such as child birth etc. Village mothers are the participants.

7. **Focussed interviews** for eliciting participatory reactions and discussions in maternal and child health.

8. Story telling, incomplete stories, anologics, simulations were also described. Problems and peculiar perspectives of the people, regarding use of audio visuals such as films, charts, magnipication, cross section etc. were described.

Dr. Dara S. Amar

MANAGEMENT INFORMATION SYSTEM IN HEALTH

Data Generation for

1. Epidemiological forecasting - Control of Epidemics.
2. Developing monitoring tools - Coverage of services and quality.
3. Planning interventions/programmes.

A. Good MIS-H will

a. Identify only minimal essential indicators.
b. Collect data timely and consolidate quickly.
c. Provide useful output tables.
d. Analyse data critically.
e. Derive sensible conclusions.

M I S - H

A. INPUT DATA

Manpower No. (Unit wise)
Category
Pre placement skill
Ongoing training

Infrastructure - building
facilities.

Inventory - Furniture,
Equipment
Vehicle

B. PROCESS DATA

- Number of planning exercises
- Assessment of situation
  Estimation of eligibles
  Coverage evaluation of services.
  Utilisation of services.
- Service delivery data (Performance data)

C. OUTPUT DATA

Target achievement - Sterilization
- Immunization coverage.

Reduction of Vacc: Prev: Diseases.

Reduction of communicable diseases.
Reduction of maternal deaths.
Reduction of infant mortality.
Increase in life span.

Dr. K.R. Antony

SOME ESSENTIAL ASPECTS IN TRAINING

Quality of the training is essential.

I share with you my conviction with which training programmes were planned.

1. People with vision, clarity of ideas, thrust be available to people at the grass root leve. So we did a lot of spade work. People come to a level that they started thinking of themselves, analysed their problems.

2. People choose their representatives to be trained. She was accountable to people.

3. Health cannot be treated in isolation.
So at the very beginning, along with health topics, socio economic, political analysis, legal knowledge, why and how of organising people etc.

People liked the programme because they felt we have understood their problem. So how health workers, women association have become social activists, bringing about a change in the society.

4. People must demand health services from government.

Women's association insist that Govt. multipurpose health workers come to the village, carry out all the health programme.

Now can we create this awareness in our training? With increased cost of health care, today from privitisation it is our duty to counteract and organise people to demand health care service from Government and fight medical corruption.

If you must train MLW, the quality is important.
The quality will depend on your

1. Creed and belief.
   Do you believe in people?
   Do you believe that they want to change, can change?
   Yes, they can, they want.

2. Conviction:

   Are we convinced that we can achieve what we believe in theory? That theory can be translated to practice.

3. Credibility:

   Are our words and action consistent? Do we say something and act entirely in a different way?

CONSULTATION ON

COMMUNITY HEALTH TRAINERS & TRAINEES

HELD AT VIDHYA BHAVAN, BANGALORE

4 - 5 JUNE 1993

Name & Address of the participants:

1. Sr. Agnesita
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   Palliagaram
   Chengalput Dt
   Tamil Nadu - 603 107

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3. Fr T A Mathias, sj
   XLRI Jamshedpur
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   Jamshedpur - 831 001

4. Dr. P.C. Bhatnagar
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5. Dr. Bhoomikumar
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14. Sr. Mariamma Antony
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15. Dr. Hari John
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    Basantnagar
    Madras - 90

16. Ms. Tara John & Mr. Arun Prasad
Deenabandu Training Centre
R.K. Pet - 631 303
Tamil Nadu

17. Mrs. J. Jaganatham
Deenabandu Training Centre
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18. Mr. M. Santhosh
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22. Sr. Fatima
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29. Dr. Mani Kalliath
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30. Fr. Joy
Member, CHD
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Secunderabad - 500 003

31. Fr. Sevanand Meloo
Member, CHD
CHAI, PB No. 2126
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32. Dr. Christopher
Medical Officer, CHD
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33. Mr. Aloysius James
Training Officer, CHD
CHAI, PB No. 2126
Gunrock Enclave
Secunderabad - 500 003

34. Sr. Deepthi
Member, CHD
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Gunrock Enclave
Secunderabad - 500 003

35. Fr. Vimal
Member CHD
CHAI, PB No. 2126
Gunrock Enclave
Secunderabad - 500 003

36. Mr. Magimai Pragasam
Head, Department of
Media & Communication
CHAI, Secunderabad

37. Mr. Sreenivas Rao
Member, CHD
CHAI, Secunderabad

COURSE METHOD

Problem solving and result oriented approach based on participatory methodology and tailored to individual participant's needs. This will be based on a strong foundation of societal analysis with special reference to the causes of poverty and the correlation between poverty and ill health. This will include some theory, field visits and much training under actual field conditions based on the action reflection-action process. Three distinct models will be studied in detail.

DURATION

Eight weeks, from 15th August to 9 October 1993.

TRAINING CENTER

Deenabandu is situated 120 kms. west of Madras in Tamilnadu, in a rural atmosphere. It is reached by buses 97A and 97D from Broadway Bus-stand in Madras. The nearest Railway Stations are: from the West-Arkonam, from the North and East-Madras, Bus stop-R.K. Pet

Simple accommodation including bed linen is provided. Vegetarian and non-vegetarian South Indian food is available. Please bring a torch and one bedsheet for project visits.

COURSE FEE

Rs. 2000/- will cover tuition, food, accommodation, establishment charges, hand-outs, internal travel and other incidentals. This must be paid either earlier by a draft or definitely on arrival.

SCHOLARSHIPS

In deserving cases some partial scholarships are offered by Asian Health Institute and other partner agencies such as Asian Community Health Action Network. No applicant should hesitate to apply because he/she cannot pay the course fee.

SELECTION

25 Places are available on a "first-come-first served", basis with various considerations in mind. 8 places are reserved for Sri Lanka, Bangaladesh, Nepal, Pakistan, Bhutan and S.E. Asia.

FOLLOW-UP

Participants will be individually followed up by faculty visits, regular correspondence and a Re-union Seminar one year hence. Outstanding participants are offered further training, sometimes in Japan. Those participants who wish to develop independent programs can have a continuing relationship with Deenabandu including project development, identification of funding sources and monitoring.

FACULTY

The core faculty consists of Dr. Hari John of ANITRA Trust, Madras and Mrs.J. Jeganathan, Mr. Arun Prasad and Mrs. Tara Arun Prasad who are the resident faculty in Deenabandu. They will be assisted by an eminent group of visiting faculty - activitists and academics alike, from all over India. Training Task Group (South) from Bangalore will be specially involved.

Applications in the prescribed form to be sent to:

Mrs. J. Jeganathan
Course Co-ordinator, DTC
Post Bag 1404
Madras - 600 105, INDIA.

Our Madras Contact:

ANITRA TRUST
702 B. Shivalaya
16, Commander-in-Chief Road,
Madras - 600 015.
Tel: 044-825 2702
Cable:HEALTHNET, Madras - 105.
Fax: 91-44-827 0424

Last date for receiving applications:

15 July 1993

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PEOPLE'S HEALTH IN PEOPLE'S HANDS

Course On

Human Potential Development,
Community Based Actions for Health
and Social Change

Sponsored By

Asian Health Institute
Aichi, JAPAN 470-01

And

Anitra Trust
Madras - 600 105

15 August - 9 October 1993

Organised By

DEENABANDU TRAINING CENTER
R.K.Pet - 631 303, INDIA

DEENABANDU

Potentiating Community Action - An Alternative Approach

BACKGROUND

Community Health, as a discipline, evolved in the early seventies in response to the needs of the rural poor which went largely unrecognised and unmet by existing health care delivery systems. Health statistics, supplied by the authorities themselves, clearly established that the health status of the poor was barely better than what it was fifty years back, while that of the rich was equal to that of Americans. Also recognised were rural-urban disparities, particularly access to even the most basic health care, but the overwhelming majority of facilities and professionals continue to be situated in urban centers even now.

The response of NGOs in health care at that time was to take 'modern medicine' to the doorsteps of the community. Village level health workers were trained, first as adjuncts to professionals, later, unfortunately much later, as trainers and facilitators. Community Health was thus reflecting the processes that were taking place in development thinking, from a 'service delivery' approach to an 'enabling' role in which the community, poor and oppressed as it is, began to play an increasingly significant role. By mid-eighties it was realised that programs that did not involve the people, did not succeed. It was also realised that sectoral action could make only marginal changes, development action having gone through the mono-sectoral-multi-sectoral- integrated development cycle to wholistic development.

Involvement of the community came to be in vogue but it is only lately that many NGOs have come to realise that they had often held on to the mere shell of the idea while losing sight of the spirit, the ethos and the philosophy behind true participation, where the community plans, initiates, manages and 'owns' their own transformatory processes. Facilitating these processes became the crux of the problem. Out of this realisation evolved CBAH - community based actions for health, in which 'health' is defined at its most wholistic and broadest sense, a state which all actions at the community level will result in, being the ultimate goal of human life.

Practitioners have since realised the crucial role that mid-level workers who are community trainers have to play in order to make true alternatives a reality, be it merely in health or in total 'development'. They have also devised training programs for them. On the basis of that, training has been going on but the sheer variety of approaches and philosophies has prevented any real consolidation of benefits. It is only lately that concerted efforts are being made to streamline and implement training based on actual field experiences of the past decades with a solid and appropriate theoretical base. Deenabandu is one such initiative.

THE PROGRAM

This is the twelfth leadership development course since 1981 that Deenabandu is conducting in cooperation with Asian Health Institute of Aichi, Japan. This started as a mere knowledge and skills enhancement course in 'health' but over the last four years, has attained a new orientation based on the values and vision of an alternative society and their implications for action. In India, as in most Asian countries, the dominant development ideology is one of modernisation based on economic growth, industrialisation and profit maximisation. This has brought about severe environmental and economic problems whose adverse effects are most often seen on the poor in general (and ultimately on their health), and among them specially on the weakest - women, tribals and outcastes. To limit ourselves to teaching about 'health', under the circumstances, will be futile.

The training program, with its emphasis still on joint actions for health, therefore, has been squarely placed in the wholistic societal context of Asia in general and India in particular, with the central focus being on women. Also taking into account the present context of the globalisation of the economy, increasing environmental degreadation and the consequent disastrous effects on the weakest, it will focus on the Environment, the rural poor and the increasing disparities between the haves and the have nots. Alternatives in development as well alternatives in health action rooted in the value premise of a just, participatory, pluralistic and sustainable society in which a wholistic sustenance can be secured for **all** people will be explored in depth.

THE OBJECTIVES

The pedagogical *(value based)* objective is to motivate, orient and direct middle level workers in a structured educational process to become aware of the values, norms and perspectives of a just, participatory and sustainable society.

The *action based* objectives shall be to train middle level workers who will:

1. have the **Capability** :

a) to analyse Indian society - also from a historical perspective at the macro and micro levels, with particular reference to the situation of the marginalised groups such as Tribals, Dalits and Women.

b) to understand the role and implications of development ideologies, concepts and patterns on the situation of the poor and marginalised, particularly on their health situation.

c) to identify and analyse some of the most critical issues confronting the contemporary development scene in India.

d) to actualise the gender issue, both within the Voluntary Organisations as well as in their actual program activities.

e) to work towards an alternative perspective of development in India with particular reference to an alternative system of health care modelled on the Community Based Actions for Health approach.

2. have the **knowledge:**

a) to identify the needs of the communities of the Poor and Marginalised with focus on Tribals and Dalits and among them particularly Women.

b) to plan, implement, monitor and evaluate programs to meet those needs within the framework of a just, participatory and sustainable development process.

c) of methods of participatory planning, training and evaluation.

3. have the **skills to:**

a) study, get involved, organise, motivate and train the communities to take a critical look at themselves.

b) train, enable and support the Community in alternative information gathering, collating and prioritising.

c) enable the community in setting objectives for themselves which are achievable within their own resources.

d) enable the community to identify other available resources to implement the best alternative that they have identified.

4. have the **ability to motivate and accompany** community based programs that are directed towards a just, participatory and sustainable development process by

a) organising communities of the poor and marginalised, particularly women.

b) facilitating a comprehensive process of education leading to generation, elaboration and continuous consolidation of knowledge among the poor and marginalised.

c) involving already identified or newly emerging leadership particularly Women.

5. have the **aptitude to manage** the program by

a) developing mechanisms of community involvement at all stages of the process.

b) using appropriate and people centered management skills.

c) being able to monitor and evaluate the programs by developing and using simple and appropriate participatory tools.

d) initiating appropriate people's action.

e) ensuring a continuous process of action-reflection-action to enhance the process of social change in favour of the poor and marginalised.

PARTICIPANTS

The course is meant primarily for non-doctors from NGO programs who are highly motivated and with a definite commitment of going back to the community. They should have demonstrated leadership ability, have worked in a community-based program for atleast **two** years and **be able to read and write English.**

3. PRANIC HEALING BASIC COURSE

Date — September 25, 26
(Refer Course No. II for details)

VI. Weekend Programme on Zen Way of Learning
(FOR COLLEGE STUDENTS ONLY)

Date — October 1 — 4
Seats — 30
Food and Accomodation — Rs. 90/–
Course Fee — Rs. 60/–
Language — English
Resource person — Mr. Nelson Dias

This is intended for the College students who are looking for developing their skill of learning fast and sharpening their power of concentration. The participants will be trained in some of the Zen techniques and meditations to bring about the hidden powers of the mind, thereby, actualizing the remarkable power of learning, and increasing memory.

VII. Pranic Healing – Basic Course

Date — October 23, 24
Language — Malayalam
(Refer Course No. II for details)

VIII. Enneogram ~~Worship~~ Workshop

Date — November 15 — 21
Participants — Open to all
Seats — 40
Food and Accomodation — Rs. 180/–
Course Fee — Rs. 75/–
Language — English
Resource person — Sr. Emily Kottaram

The enneogram is an instrument, rooted in Sufism, which describes nine basic personality types. These types have envolved from compulsions developed in early childhood. A study of the enneogram enables one to discover one's type and to search for ways of personal healing. A new understanding of self takes place and this leads to greater inner freedom and wholeness.

IX. Pranic Healing - Advanced Course

Date — December 11, 12
Time — 9 a.m. — 6.00 p.m.
Participants — Open to all
Seats — 50
Fees — Rs. 250/–
(including Lunch & Tea)
Language — English
Resource Person — Sr. Eliza Kuppozhackel & Team

This course is only for those who have attended the Basic Course and have fulfilled the criteria for attending the Advanced Course.

X. Pranic Psychotherapy

Date — Decembr 13
Time — 8.30 a.m. — 6.00 p.m.
Seats — 40
Fees — Rs. 150/–
(including Lunch & Tea)
Language — English
Resource persons — Sr. Eliza Kuppozhackel & Team

The course is only for those who have attended the Basic Course in Pranic Healing and have fulfilled the criteria for attending the advanced course.

NOTE on Pranic Healing Courses: The Pranic Healing courses are conducted in collaboration with the World Pranic Healing Foundation Inc. India.

AYUSHYA HEALTH CLINIC

Daily : 9.00 a.m. — 12.00 p.m.
Sunday — Holiday

Treatment for acute and chronic illness, therapies for enhancing physical and mental well being, concentration, memory power and reducing pain, using Drugless Therapies, Stress management, Counselling, Yoga, Herbal medicine and Nutrition education.

HOW TO REACH AYUSHYA
AT ITHITHANAM

From Changanacherry private stand take Changanacherry-Kottayam private bus passing via Railway Station and St. Thomas Hospital, Chethipuzha etc. Get down at 'Enachira Kurisu' [Re. 1/- point]. From there walk ahead a few yards and you will find the Ayushya sign board directing to the centre.

Auto Rickshaws from the town costs about Rs. 18/–

For all information and Registration Please write to:–

Programme Co-ordinator
AYUSHYA
Veroor P. O.,
ITHITHANAM
Changanacherry–686 104
Kerala, S. India

Telephone: (04824) 20544

Printed at The Sandesanilayam Press, Changanacherry

Medical Mission Sisters

AYUSHYA

CENTRE FOR HEALING AND INTEGRATION
VEROOR P.O. ITHITHANAM
CHANGANACHERRY. 686 104

PROGRAMME
FOR JULY — DECEMBER 1993

AYUSHYA

CENTRE FOR HEALING AND INTEGRATION

AYUSHYA aims at wholeness and integration within persons, community and society through its various programmes. Integrated health programme focusses on health as the right and responsibility of each person with the vision of promoting a new health culture. Emphasis is also on providing low cost health care utilizing the natural resources and promoting healthy life styles. Yoga, meditation, retreats, stress management, counselling, psychotherapy, integration programmes, non-drug therapies, herbal medicine and nutrition are included as part of an integrated approach to promote health and wholeness in persons.

INFORMATION ABOUT PROGRAMME BOOKING

In order to reserve a seat for any of the programme send the registration fee of Rs. 50/- by M. O. to:

The Programme Co-ordinator,
AYUSHYA,
Veroor P. O.,
Changanacherry-686 104,
Kerala

When you send M. O. for registration, please specify the number and date of the programme to which you are applying.

Once your M. O. is accepted you can presume admission to the course.

The Registration fee is non-refundable and will be adjusted against the course fee.

All the courses, unless otherwise specified, will begin on the evening of the first day and will end on the morning of the last day.

Please bring your toilet articles, bed sheets and pillow cases.

Programme is open to all irrespective of caste, creed and sex.

A warm welcome to AYUSHYA,

JULIA VALIAVEETIL M.M.S.
Programme Co-ordinator

I. 5th National Training Programme in Intergrated Approach to Health

Date — July 1 — 31
Participants — Health Co-ordinators, Health and development activists.
Seats — 30
Fees — Rs. 1500/- (Subsidized by CHAI)
Language — English
Resource Persons — CHAI & AYUSHYA Personnel
Course Director — Sr. Eliza Kuppozhackel

The course will deal with the approaches to Community Health, Dimensions of Integrated Approach to Health, Analysis of the Health situation of India, Ecology, Nutrition, Herbal medicine and Home remedies. Low cost communication media in health education; Theory and practice of Non-Drug Therapies viz., Acupressure, Reflexology, Pranic Healing, Naturopathy, Therapeutic Massage, Stress management, Yoga and Meditation.

Selection and admission to this course will be done through CHAI. For further information and admission kindly write to:-

Executive Director,
Catholic Hospital Association of India,
P. B. No. 2126, Gunrock Enclave,
Secundrabad - 500 003

II. Pranic Healing — Basic Course

Date — July 23, 24
Time — 9.00 a. m. — 6.30 p. m.
Participants — Open to all
Seats — 50
Fees — Rs. 150/- (including Lunch & Tea)
Language — English
Resourse Persons — Sr. Eliza Kuppozhackal & Team

The term 'Pranic Healing' originates from the sanskrit word 'Prana' which refers to the vital energy or life force which keeps the body alive and healthy. Pranic Healing is the process of transferring the vital energy or life force from the healer to the patient. It requires no physical contact since the healer works on the bioplasmic body rather than on the physical body.

Pranic Healing can bring down abnormally high temperature due to fever in just a few hours, in most cases. It relieves headaches, gas pain, tooth aches. mild asthma, migraine, ulcer, wounds, muscle and back pain almost immediately.

N. B. This course is non-residential, however, accommodation is available for those who require it.

III. Three in one Concepts

Date — August 7 — 17
Language — English
Resource person — Sonja Kreyenbroek (Amsterdam)

This programme includes Touch for Health, Tools of the Trade, Basic one Brain and Advanced one Brain. This programme is open to all. However all those interested in Non-Drug Therapies will benefit more as they will gain an additional tool in their healing mission. Kindly write for further details and application form.

IV. Neo-zen Meditation Camp

Date — September 2 — 6
Participants — Open to all
Seats — 30
Food and Accomodation — Rs. 120/-
Course Fee — Rs. 75/-
Language — English
Resource Person — Mr. Nelson Dias

Meditation is the greatest adventure the human mind can undertake. The ancient mystics have shown in various methods of meditation to move into our own original blissful state. The essential core, the spirit of meditation is to learn how to witness our nature and be conscious of our day to day activities. During the three days of camp the participants will have the opportunity to learn the techniques of higher concentration, increase memory power which ultimately leads them to meditation.

V. Training in Non-drug Therapies

1. REFLEXOLOGY

Date — September 19 — 22
Participants — Open to all
Seats — 30
Food and Accomodation — Rs. 90/-
Course Fee — Rs. 60/-
Language — English
Resource Person — Sr. Eliza Kuppozhackel

Participants will be instructed in practical knowledge of Hand and Foot reflexology and Zone Therapy.

2. BASICS IN ACUPRESSURE

Date — September 21 — 24
Participants — Open to all
Seats — 30
Food and Accomodation — Rs. 90/-
Course Fee — Rs. 60/-
Course Material — Rs. 25/-
Language — English
Resource person — Dr. Sr. Elizabeth Vadakekara

This is a basic course in Acupressure / Acupuncture theory and practice.

FOR HEALING SERVICES PLEASE VISIT THE FOLLOWING PRANIC HEALING CENTRES

1. World Pranic Healing Foundation, Inc. – India.
   Central Office
   Chungam, Kottayam–686 001
   Tuesdays between 3 p. m. — 6 p. m.
   Phone : 0481 — 3332
2. Ayushya,
   Centre for Healing and Integration,
   Medical Mission Sisters,
   Veroor P. O., Changanacherry–686 104
   Monday to Saturday 9 a. m. — 12 noon
   Phone : 04824 — 20544
3. TRADA,
   Aymanam P. O., Kottayam–686 015
   Phone : 0481 — 3198
4. Wellness Clinic,
   Kerala Voluntary Health Services (KVHS)
   Mullamkuzhy, Kottayam
   On Thursdays 9 a. m. — 5 p. m.
5. Kurji Holy Family Hospital,
   P. O. Sadaquat Ashram,
   Patna–800 010, Bihar
   Phone : 262540 / 262516
6. Arpana,
   Medical Mission Sisters,
   Arpookara East P. O., Via Gandhi Nagar
   Kottayam–686 008
   Phone : 0481 — 7984
7. Holistic Health Clinic
   C/o. St. Michael's Church, Edamattam
8. Pooppally Hospital
   Chengannur – 689 121
9. St. George Dispensary
   Vakathanam
   Phone : 265
10. Catholic Mission,
    Barpetta Road, Assam – 781 345
    Phone : 03666 — 2124
11. New Hope Institute of Health,
    Kalpana P. O., Mangalore–575 002
    Phone : 0824 — 23497
12. C/o. Dr. A. Saradamba
    6.3—596 / 47 A, Venkata Ramana Colony
    Hyderabad– 500 004, Andhra Pradesh
    Phone : 0842 — 228261
13. FATRI,
    Veloor, Trichur Phone : 4413
14. C/o. Mr. A K. Ramachandran
    11, 2nd Main, Sultan Palya
    Bangalore–560 032
    Phone : 0812 — 33096

MEDITATION ON TWO HEARTS

Meditation On Two Hearts is a technique which aims to achieve expansion of consciousness or illumination.

This can, in the long run, increase intelligence and comprehension skills — a distinct advantage for students, executives, businessmen and others.

Meditation On Two Hearts is a form of "Planetary healing". Because this technique is founded on the principle that the earth is blessed with loving kindness.

Its potency increases when done in a group.

The two hearts refer to energy centers— one on the heart area for the emotional heart center, the other one on the crown of the head which is the seat for the divine heart center.

FOR DETAILS

EXECUTIVE DIRECTORS

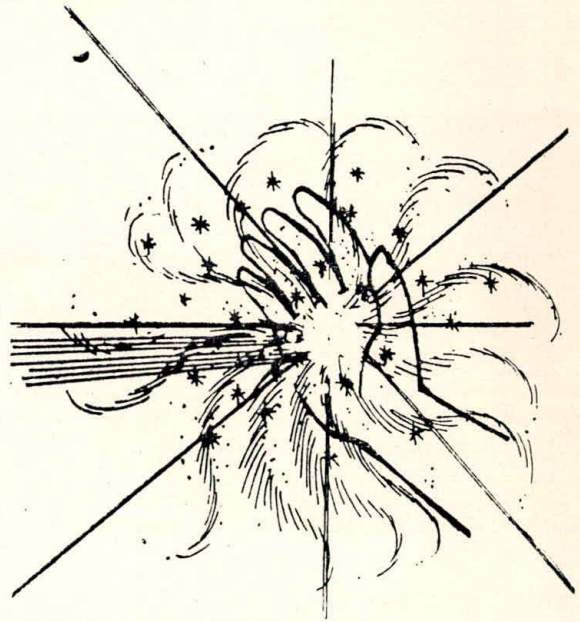
1. **Fr. GEORGE KOLATH**
   (Administration)
2. **Sr. ELIZA KUPPOZHACKEL**
   (Training)

World Pranic Healing
Foundation, Inc. — India
Central Office
Chungam
Kottayam — 686 001
Kerala
Phone : 0481 — 3332

WORLD PRANIC HEALING FOUNDATION, INC. INDIA

FOUNDED BY

MASTER CHOA KOK SUI



CENTRAL OFFICE
CHUNGAM, KOTTAYAM – 686 001
KERALA. INDIA

PRANIC HEALING

Pranic healing is a no–touch scientific form of healing which uses vital energy (PRANA) to heal one's self and other people. This method of healing was prevalent in ancient India and China. It is now being revitalized through research.

Pranic Healing can heal or alleviate simple ailments, chronic illnesses and psy–chological and psychiatric problems. It is a powerful non–drug therapy which can be used by itself or in combination with other healing methods. Healing is accomplished by removing diseased energy from the pati–ent's energy body and by transferring energy to the affected areas.

PRANA

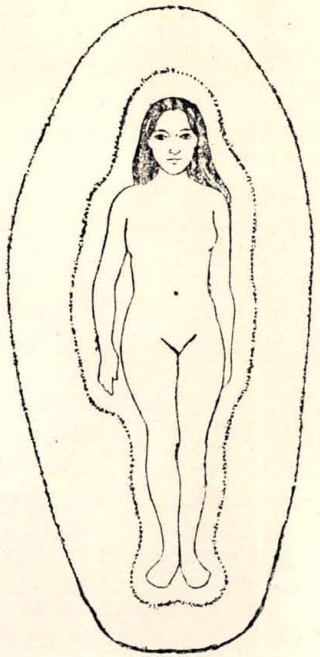
Prana is a Sanskrit word which means vital energy which keeps the body alive and healthy. It is called in Japanese as "ki" in Chinese as "chi", in Greek as "pneuma", in Polynesian as "mana", and in Hebrew as "ruah" or "the breath of life".

By undergoing a systematized training one can easily transfer solar, air, ground, tree and Divine energies and heal many kinds of ailments.

THE ENERGY BODY

The energy body is an energy field which surrounds and interpenetrates the visible physical body. It has the same shape as that of the physical body and extends beyond the surface of the skin by 4 to 5 inches in most people. Scientists call this the BIO-PLASMIC BODY from the words bio, which means life, and plasma, which is the fourth state of matter. Clair-voyants (people who can see subtle en-ergies) call this the human aura.

Science, with the use of KIRLIAN PHOTOGRAPHY, has shown that diseases manifest first in the energy body before they appear in the phy-sical body, and that thoughts and emotions affect the energy body which in turn affe-cts the physical body. By balanc-ing the energy level in the energy body one can heal, alleviate or pre-vent the appear-ance of physical and psychological ailments.



The outer and inner aura

THE WORLD PRANIC HEALING FOUNDATION, INC. -- INDIA

World Pranic Healing Foundation was founded in the Philippines by Master Choa Kok Sui, to help alleviate the sufferings of millions of sick people throughout the world. He has done extensive research in Pranic Healing and has published several books. 'The ancient science and art of pranic healing' which is the basic book of pranic healing has an Indian edition which is available for Rs. 80/–

World Pranic Healing Foundation was initiated in India in December '91 by Mas–ter Choa Kok Sui. The foundation, which aims to propagate wholistic healing has the following aims:

1. To train one pranic healer per 100 persons in every community.
2. Establish pranic healing centre and healing groups through c... India.
3. Spread the Meditation on Twin Hearts and the great invocation to help usher in the era of global peace and goodwill.

SERVICES AVAILABLE

1. Seminar and Workshop on Basic Pranic Healing.
2. Seminar and Workshop on Adva-nced Pranic Healing.
3. Training of Pranic Healing Trai-nors.
4. Establishment of Pranic Healing centres.

TOPICS INCLUDE

1. Self–healing, healing others and distant healing techniques.
2. Preventive health care and impro-ving defense mechanism.
3. Diagnosing ailments by scanning the energy body.
4. Nature, locations, and physical and psychological functions of the en–ergy centers of one's body.
5. Value formation, character build-ing, and the Law of Cause and Effect and their applications to improve one's well being.
6. Pranic breathing and creative visualization for stress management goal setting and increasing pro-ductivity level.
7. Meditation on Twin Hearts and the use of The Great Invocation for World Service, attainment of inner peace, higher intelligence illumination, and expansion of consciousness.