CHRISTIAN MEDICAL ASSOCIATION OF INDIA

COMPREHENSIVE EVALUATION
EXECUTIVE SUMMARY

1997

A. PADMANABHA
CONSULTANT- COORDINATOR CMAI EVALUATION
MANAGEMENT CONSULTANT
BANGALORE

PROF. P. RAMACHANDRAN
CONSULTANT CMAI EVALUATION
DIRECTOR INSTITUTE FOR COMMUNITY
ORGANISATION RESEARCH, MUMBAI

DR. SUKANT SINGH
CONSULTANT-OFFICER-IN-CHARGE
CMAI - BANGALORE

CONTENTS

PART A : FINDINGS AND RECOMMENDATIONS

PART B : SELECTED DATA BASE FOR REFERENCE (BASIS FOR PART A)

PREFACE:

The dynamics of an organisation compares well with a flowing river, deriving its energising power from the catchment areas, traversing along its beaten path, some times roaring, some times serene, dropping from heights, joining tributaries, breaking new paths and enabling the parched lands alongside its course to be productive, during its endless journey to fill the sea.

In these patterns of the river behaviour, the under currents of change taking place flows unnoticed beneath its serene surface. It is difficult to realise this, unless efforts are made to identify its natural course, the contour's, the depth, the erosion, the silt deposit, the swirls, the lands, the flora all along its banks, and the forces deep inside. Collecting such valuable information alone can lead to realisation of its full potential and to harness it to be more productive during its journey to the sea.

Christian Medical Association of India (CMAI) is one such useful river maintaining its continuous journey to fill the sea - The Kingdom of God - through the corridors of the healing ministry. The history of CMAI tells the saga of its journey so far, depicting its response to the needs along its path, like that of the river.

CMAI has stood the test of time for over 90 years, striving in its own way, to relieve human suffering in different parts of the country, training personnel and nurturing the christian spirit in its endeavour to assist the healing ministry through its members. Looking forward to celebrate its centenary shortly, CMAI was rightly concerned about the impact of the sweeping changes in all spheres of life breezing past at an increasing pace.

This report is a result of the decision taken by the Board of Management of CMAI to assess whether and to what extent they have and are carrying out their objectives. Further, in the given set of changing environment, to take stock of the situation as it obtains and to arrive at pragmatic approaches to maintain and improve upon its assistance to the Healing Ministry.

We were privileged to have had the opportunity to take a dip into this reputed river and swim around to trace and identify the positive as well as the negative currents in flow within and around it. More importantly, to recognise the hidden wealth of its potential through the evaluation processes. It was an exciting experience.

We do hope our findings will stimulate the CMAI fraternity to harness the positive dynamic forces within and beyond, to cause a more copious flow towards the sea - The Kingdom of God.

JULY 7TH, 1997

PADMANABHA, RAMACHANDRAN, SUKANT SINGH.

ACKNOWLEDGMENTS

OUR GRATEFUL THANKS TO:	FOR
1. CMAI	THE OPPORTUNITY TO BE ASSOCIATED WITH THE STUDY AND THE SUPPORT
2. CMAI EVALUATION ADVISORY & CORE COMMITTEE MEMBERS (LIST ENCLOSED)	THEIR TIMELY AND VALUABLE ADVICE WITH ENCOURAGEMENT AT VARIOUS STAGES OF THE STUDY
3. MS. ANNIE SOANS MS. AMMU RANI MS. MALA MS. MANIMEGHALAI PAULRAJ MS. SUZANNA	THEIR DELIGHTFUL DEDICATION, COMMITMENT & SUPPORT
4. MR. PAUL RAJ. S	HIS READINESS TO HELP & PARTICIPATE IN THE STUDY
MR. VARUGHESE K. MANI MR. JALAL MASIH DR. SHAILENDRA AWALE	PARTICIPATION IN THE STUDY
5. MR. JACOB BERNARD MS. ELSY JOHN MS. KUMUDINI VINOD MS. MERCY JOSE MR. RAJAN. K MS. SARASWATHI D	ADMINISTRATIVE SUPPORT AT BANGALORE
6. MR. J.F. THOMAS MR. BABY KUTTY	ALL HELP FROM CMAI DELHI
7. MS. GEETHA RAO (JOURNALIST)	TRACING THE HISTORY
8. MR. GEORGE KOSHI (CONSULTANT)	FINANCIAL MANAGEMENT EVALUATION REPORT
9. MR. MAURICE A. COUTINHO	SUPPORT FROM ICOR, MUMBAI
10. ALL RESPONDENTS	THEIR COOPERATION & CONTRIBUTION
11. REV. DR. IPE JOSEPH GENERAL SECRETARY -NCCI NAGPUR	PROVIDING ACCESS TO NCCI ARCHIVES
12. DR. RAVI NARAYAN SECRETARY - COMMUNITY HEALTH CELL, BANGALORE	ALL HELP EXTENDED
13. DR. CHERIAN THOMAS GENERAL SECRETARY - CMAI NEW DELHI	EVERYTHING

PADMANABHA, RAMACHANDRAN, SUKANT SINGH.

MEMBERS OF CMAI EVALUATION ADVISORY COMMITTEE

DR. P.S.S. SUNDER RAO	-FORMER PRESIDENT OF CMAI DIRECTOR, SCHIEFFELIN LEPROSY RESEARCH & TRAINING CENTRE, KARIGIRI.
DR. CHERIAN THOMAS	-GENERAL SECRETARY OF CMAI
DR. V. BENJAMIN	-RTD. PROF. AND HEAD OF THE COMMUNITY HEALTH DEPARTMENT CMC - VELLORE . PRESIDENT SOCIETY FOR COMMUNITY HEALTH AWARENESS RESEARCH & ACTION
DR. C.M. FRANCIS	-FORMER DEAN, TRIVANDRUM MEDICAL COLLEGE & ST. JOHN'S MEDICAL COLLEGE.
DR. ABRAHAM JOSEPH	-DIRECTOR, COMMUNITY HEALTH AND DEVELOPMENT, CHRISTIAN MEDICAL COLLEGE, VELLORE
REV. A.C. OOMMEN	-FORMER DEAN, RELIGIOUS WORKS DEPARTMENT, CHRISTIAN MEDICAL COLLEGE, VELLORE.
DR. DESMOND A. D'ABREO	-CONSULTANT, INDO-GERMAN SOCIAL SERVICE SOCIETY, LODHY ESTATE, NEW DELHI.
PROF. P. RAMACHANDRAN	-RTD. PROF., TATA INSTITUTE OF SOCIAL SCIENCES. DIRECTOR, INSTITUTE FOR COMMUNITY ORGANISATION RESEARCH, MUMBAI
MS. PADMASINI ASURI	-NUTRITIONIST AND CONSULTANT, ADVISOR TO DANISH INDIA DEVELOPMENT AGENCY FOR WOMEN, YOUTH TRAINING AND EXTENSION PROJECTS.
MS. SARAMMA SAMUEL	-RTD. PRINCIPAL, P.G. INSTITUTE OF NURSING EDUCATION, CHANDIGARH PRESIDENT, TRAINED NURSES ASSOCIATION OF INDIA THIRUVANANTHAPURAM
DR. (MRS.) NIRMALA MURTHY	-DIRECTOR, FOUNDATION FOR RESEARCH IN HEALTH SYSTEMS, AHMEDABAD
DR. K.C. ABRAHAM	-DIRECTOR, SOUTH ASIAN THEOLOGICAL RESEARCH INSTITUTE, BANGALORE
MR. A. PADMANABHA	-MANAGEMENT CONSULTANT - BANGALORE
DR. SUKANT SINGH	-CONSULTANT-OFFICER IN CHARGE, CMAI, BANGALORE

PART- A

FINDINGS & RECOMMENDATIONS

CHAPTER I
THE STUDY AND THE STRATEGY

A) The Board of Management of CMAI having taken the decision for a comprehensive evaluation of the organisation, set up an advisory committee and a core committee to put in motion the evaluation process in April 1995. After due deliberations, the committees agreed upon the terms of reference for evaluation as under :

1. What have been the activities of CMAI to achieve its mission, vision, goals and objectives as enuniciated periodically from its inception, and particularly during the last decade? How and to what extent has CMAI, as the health wing of the National Council of Churches of India, been able to 'serve the Church in its Ministry of Health, Healing and Wholeness?
2. What have been the contributions of CMAI towards the newer concepts of health care and innovative interventions ?
3. How far has CMAI been able to coordinate and make relevant the various training programmes in the Healing Ministry medical, nursing, paramedical and others ?
4. Two important functions of CMAI have been identified :
   a) Building spiritual, professional and social fellowship among the members.
   b) Promoting social justice, total well being, family welfare, and building health communities.
   How far have these been achieved ?
5. What is the likely future scenario affecting the health of the people ? What will be the major changes ? What are the opportunities and threats? How can CMAI meet the challenges and make use of the opportunities and help the Church to respond effectively to the changes ?
6. The following additional dimensions were added subsequently in April 1996, for coverage by the evaluation to the possible extent ;
   a. Whether Gender Bias in India was a social justice issue ? If yes, what are CMAI and Churches doing about it
   b. Review of CMAI organisational structure.

B) The terms of reference were operationalised by the study team, into the following objectives :

1. To trace the history of CMAI from its informal beginnings in the 1890s, when the seeds of the organisation were sowed, to 1995 when the decision to undertake this evaluation was taken, and focusing on its direction of growth of services over the years.
2. To undertake critical examination of CMAI performances in the last five years vis-a-vis its constitutional obligations and especially programmes and activities and ascertaining the views of its members - both individuals and institutions, as well as other 'actors' who could be having a role on effectiveness of CMAI .

3. In the light of the critical understanding of the past and present work of CMAI and keeping in sharp focus the evolving scenario in the health field within the socio - economic - political climate, to recommend to CMAI various options before it, for further growth and continuation as a pioneering institution in the country.

Relevant information for fulfilling the objectives of evaluation was gathered through a four pronged approach detailed below :

1. Interactions with members of the five sections, and office bearers of the CMAI, provided the necessary base for construction of appropriate instruments of data collection from a variety of respondents;
   a) Individual members
   b) Institutional members
   c) CMAI staff
   d) Top officials of Churches of various denominations
   e) NGOs (other than members)
   f) Government Officials
   g) Educators from Nursing and AHP training institutes affiliated to CMAI.

2. The responses obtained were critically reviewed and deliberated upon at ;
   a) Five workshops held for individual members and
   b) Workshop for Institutional members
   c) Consultation with the office bearers of CMAI
   d) Periodic review by the evaluation advisory committee and the core committee.

3. Additionally, secondary data were sourced and collected from the National Council of Churches in India, Nagpur, CMAI library. New Delhi, United Theological Library, Bangalore, The British Library, Bangalore, Community Health Cell, Bangalore, Foundation for Research in Health Systems, Ahmedabad and Bangalore.

4. All data were subjected to computerisation to facilitate processing and analysis of the voluminous information

The respondent profiles are appended in Part B.

CHAPTER II : PAST AND PRESENT

A. DOWN MEMORY LANE : A CHRONOLOGY OF EVENTS IN THE HISTORY OF CMAI

Like all big ideas, the beginnings of the Christian Medical Association of India (CMAI), were very modest. Perhaps the very first members never ever imagined that the Association would take firm root, develop into such stature and standing, influence events and establishments, or direct several programmes. At that time its mission was evangelism coupled with service. That the Association had to weather many a storm, and lose some of its importance sometimes, and carry on nevertheless, in its ninety odd years of eventful existence was perhaps inevitable. The fluctuation of fortunes, brought about by the wheels of change have not always been to the liking of many institutions of long standing.

From its origin to the present, the CMAI has been witness to two world wars, the rise of nationalism and Independence of India, the partition, its aftermath, and democracy in India. At some points, it has enjoyed the support of the Church. It has experienced its neglect or oversight too. It has also witnessed the movement of union among churches in India, the formation of the Church of South India, Church of North India and the shift of ownership of centres of healing from overseas mission boards to the Indian Church. The association has had many occasions to rethink, to introspect, to replan and to change its course in accordance with the vagaries of the times.

The history of CMAI may be reckoned in five phases of significance :

Phase I :1905 - 1925, Phase II : 1925 - 1947, Phase III : 1947 - 1963, Phase IV : 1963 - 1983 and Phase V: 1983 to date

1. PHASE I : 1905-1925 - THE BEGINNINGS AND MEDICAL INITIATIVES

This phase started with the very formation of the Medical Missionary Association (as the CMAI was then called) in 1905, and spread over a span of 20 years to culminate in the change of the name of the association to Christian Medical Association of India. The CMAI was registered as a non-profit charitable organisation in 1926.

This period was one in which the spotlight was on the formation and organisation of the Association, though, alongside, there was attention given to medical work too. During the phase, the CMAI had an amicable relationship with the Church.

The first reference to CMAI is made in 1905. However, the background to the association goes back to the time when missionaries were being sent by their Churches to India, "to preach, teach and heal," and to establish the Kingdom of God in India using their skill in relieving human suffering. Missionaries were also sent for medical relief work from countries like the USA, Canada, the UK, Norway, Sweden, Denmark, Germany, Australia and New Zealand.

Working so far away from each other (in India, Burma, Sri Lanka, Pakistan, Bangladesh and China) limited the interaction between these medical professionals. They therefore wanted to get together to exchange views and to discuss issues in their field. There were no formal meetings at this stage. It was only later that the idea gathered momentum, and was translated into a formalization of the Association. Thus, the Medical Missionary Association, or MMA as it was then called, was born in 1905. Later, in 1912, it was suggested that the Association be brought into organic relation with the National Missionary Conference Council (the present NCCI). Provincial sections of the same Association could be related to the Provincial Representative Councils.[1] Dr. Wanless of Miraj Medical School became the first Secretary of the MMA and its first treasurer. The Association launched its own quarterly journal of which Rev. J.M. Macphail was Editor.

MEDICAL WORK

During this phase, there was some attention given to Medical work too. The CMA reported in medical missions, gathered information on happenings, research and development in the Medical field.

Regarding Tuberculosis, the concern of the CMA had its impact in the establishment of several sanatoria, the most important one being the Inter Mission Sanitarium at Madanapalle in 1914. This initiative, with components of research, training, promotion of knowledge and skills, has been recognized by the government.

Emphasis on village work, public health and preventive medicine also was given early in the history of the CMAI.

As early as 1912, the medical missionaries showed an interest in the area of ophthalmic work. It was considered necessary for all preparing for medical work to undergo special training in ophthalmic and general surgery, and in diseases special to the tropics. Regarding work with the feeble-minded, Dr. Lankester in 1915 reported on the need for institutions for the control and care of such children.

---

[1] National Council of Churches in India - Extract : 1, Page 30

CMAI - CHURCH AXIS

Leprosy too received the attention of the Association as early as 1917. The MMA emphasised upon the local government the importance of enforcing the regulations regarding segregation of lepers.

By 1917, the Secretary of the MMA was presenting reports on Medical work at the NMC Conferences. Finally in 1925, the NMC accepted the MMA as the Medical Committee of the Council. Important changes were made in the constitution of the Association. Accordingly, Christian doctors who were not missionaries became members. The MMA's name was changed to CMAI or Christian Medical Association of India.

2. PHASE II : 1925-1947- APEX ROLE - CMAI ESTABLISHED

FOCUS ON TRAINING IN PREVENTIVE MEDICINE

If the first phase (from 1905 - 1925) sowed the seeds for future medical work, the second phase in the history of the CMAI spanning a little more than twenty years actually saw the fruition of such activity. The second phase placed prime focus on medical education, training, Institution building Hospital management, primary health care and preventive medicine: CMC Vellore scaled new heights despite crisis, Nurses Auxiliary grew from strength to strength, hospital management was given a professional approach, training of nurses and allied health professionals assumed importance, fresh paths were taken in preventive medicine and Community Health. Many of these secured attention as a direct result of the Survey of 1925.

Some major events and one person dominated the scene during this span. One event was the stabilization of the college at Vellore, in which CMAI played a very significant role. Another event was undertaking the epoch - making survey of efficiency and co-operation, under the instruction of the CMAI and with the approval of the NMC. The person who worked indefatigably almost throughout the twenty years, offered leadership and direction to the CMAI and medical matters was Dr. B. C. Oliver.

Alongside, CMAI also continued to play the role of reporter on medical missions and to serve as a forum for fellowship and exchange of information for medical professionals.

THE SURVEY

The Survey was mooted in 1925 out of a concern for the lack of method in medical work. It was to clarify the aim of medical mission work and "to investigate its efficiency, its relation to other medical aid and to the needs of the whole field."

What was obvious from the survey was a lack of medical policy. It threw light on various aspects of medical work. Its findings seem to have been a turning point for Medical Mission Work, with a more focussed approach thenceforth.

THE NURSES AUXILIARY

Nurses felt the need for an organisation of their own as early as 1911. It was felt that a graduate Nurses' Association should be formed within each Hospital or Mission, by means of which a fellowship could be maintained with those in other service.[2] Finally, the Nurses Auxiliary of the CMAI was formed at the conference at Arogyavaram. By the middle of Feb. 1931, the actual formation of the Auxiliary took place.[3]

Dr. Frimodt Muller, the Chairperson of the CMAI in 1933 observed that "the Church in India should take up the ownership of the healing ministry. The pioneering day of overseas mission boards is almost over." Consequently, the local Church rose to the occasion to own medical mission in India.

TRAINING AND STANDARDIZATION

CMAI continued its effort in training and standardization. By 1944, the CMAI had standardized the technician training course and provided for a diploma after examination for hospital technicians. This was considered a pioneering service in India.

THE FIRST CEO AND NCCI

For the first time a full time Secretary of the CMAI was appointed in 1933 Dr. Oliver also became the Secretary of the Medical works of the NCCI paving the way for a closer relationship between the two.

By 1940, Hospital Sunday became an annual event to celebrate and pray for mission hospitals and the healing ministry of the Church. The hospital supply agency was set up to provide reliable drugs.

With the induction of Nursing administrators in mission hospitals, initiative was taken for the formation of the Indian Nursing council in India. Other achievements around this time were a post-graduate course in nursing, 1946.

UPGRADED MEDICAL EDUCATION FOR MEN - A CMAI INITIATIVE

It was during the second phase, that the CMAI's brainchild, a medical college for men was mooted. Both the Christian Medical Colleges at Ludhiana and Vellore were established exclusively for women. The Miraj Medical School trained men only to be hospital assistants. The need was therefore felt for a Christian Medical College for men.

---

[2] National Council of Churches in India - Extract 21, Page 16

[3] National Council of Churches in India - Extract 37, Jan 1933

Initially, it was decided to start the College at Allahabad. Later, an amalgamation with the already established Christian Medical College at Vellore, was preferred. After much discussion and negotiation, with CMC (Vellore), finally, 1947 saw the admission of male students there.

In the entire exercise, CMAI played the role of initiator and negotiator. It was the dynamism of the CMAI that saw the resolution of the crisis[Q4] at Vellore.

3. PHASE III : 1947-1963 - THE STABILIZING ERA

THRUST - INDIANISATION, EDUCATION - PREVENTIVE MEDICINE

With India gaining independence, many changes were brought about in the history of CMAI. The strong missionary hold on foreign institutions was Indianised.

The time span of sixteen years (from 1947 to 1963) was notable for CMAI's thrust on fighting tuberculosis, upgrading Ludhiana, training in pharmacy and paramedical courses in preventive medicine.

This was also a period in which the CMAI enjoyed a close association with NCCI, sharing its office space at the council lodge with the new head quarters of the CMAI established at Nagpur.

CMAI continued its roles of reporter on medical events, pioneer of medical education and preventive medicine, resource mobilizer, and fund distributor (with NCCI) for fighting Tuberculosis and for establishing paramedical education.

In 1950, CMAI offered membership to Christian students studying medicine. In 1953, the Christian Medical College at Ludhiana came into being. It had started giving inportance to Family Planning and Sex Education by 1963.

During the first phase (1905-1925), much work was done regarding Tuberculosis. In the second phase (1925-47), importance to stabilization at Vellore and other events eclipsed the work done on Tuberculosis. In the third phase (1947-63), however, there was a resurgence of interest in the field.

In 1948 the CMAI's committee for training laboratory technicians drew a detailed syllabus for the course, and extended the course from nine to twelve months. Alongside, the number of training centres for X-ray technicians increased from six to nine. Paramedicals became members of the CMAI during this phase in 1961.

[Q4] National Council of Churches in India - Extract 21, Page 68

Around this time, the focus shifted to preventive medicine and community health. Indian independence had an impact on providing health facilities and services on a mass scale. The CMAI too was involved with the production of Jet_series of Health Aids. This was subsequently recognized by the UNESCO. Also, it was resolved that every Christian Medical institution should include preventive medicine according to the need in its area.

The reorganisation of the CMAI took place in 1952. Regional Executive Committees of the CMAI had now been set up in Bengal, Bihar, Gujarat, Northwest India, Mid India, Uttar Pradesh, Andhra and Tamil portions of Madras, Kerala and Orissa. In most areas, these functioned as the Medical Committees of the provincial council. Arrangements were being made to establish similar committees with Regional Secretaries in Maharashtra, Karnataka, Hyderabad and Assam.

TRAINING IN PHARMACY

The Government of India had intended to abolish the grade of compounder, and to substitute a more advanced course for pharmacists. Since hospitals could not teach the more advanced subjects, the training was to be imparted at one the Christian hospitals.[1] CMC Vellore offered a diploma course in pharmacy under CMAI's influence in 1955.

Some breakthrough was made in the field of Tuberculosis. A joint Tuberculosis fund was set up by NCCI - CMAI in 1955 to raise and distribute funds to fight against Tuberculosis.

Towards developing Primary Health Care workers at the grassroots level, community health guides were trained in 1956 in partnership with Christian Fellowship Hospital, Oddanchatram and the Madurai Ramnad Diocese of the Church of South India.

October 1955 saw the moving of the CMAI Secretaries into the NCC office in Oliver House Nagpur. In 1957, Dr. Claine Thomson, former acting Secretary of the CMAI, became the Secretary of Preventive Medicine of the Association. She shifted her office to Nagpur in 1958, for purposes of centralization of the Secretariat.

Attention was beginning to be given to Family Planning at this stage. It considered the strong recommendations made by some state governments on sterilization as a method of family limitation. It also appointed a special committee made up of doctors, nurses, social workers and clergy to make recommendations regarding the subject.

1960 reported a definite concern regarding family planning among Churches in India. "Sterilization as a method of family planning" was under study.

---

[1] National Council of Churches in India - Extract 66, Page 35

In 1960, a request was made from nineteen paramedical workers [This section belonged to the MMA from the very beginning] to form an organisation for themselves along the lines of the Nurses Auxiliary. Approval was given for the formation of the section.[2] The term "section" was to be used instead of "auxiliary". By 1962, the number of paramedical members increased to thirty one.[3]

The field of Preventive Medicine continued to do good work with visits to hospitals, talks, and production and supply of health aids.

In all, the period was one in which CMAI notched up several achievements.

4. PHASE IV : 1963- 1983 THE FAMILY PLANNING ERA - CMAI - NCCI COMBINED COMMITMENT

At the beginning of this phase, the Nurses Auxiliary became the Christian Nurses League. In 1964, the Nurses Auxiliary became the Christian Nurses League. It was around this time that CMAI became known for its Family Planning Programmes. In fact, the programme dominating the span of seventeen years, was spearheaded by CMAI, collaborating with the government and NGOs . The CMAI Family Planning Project was started at Ratlam in 1966 under Mr. Jessy Russell. It was transferred to Bangalore in 1967. Dr. Isaac Joseph became its first Medical Director in 1969 under the section of preventive medicine. Financial support from Sweden continued up to 1983, when the funds dried up. However, in those seventeen years, much work was done in this area. Since funds were in plenty, the CMAI attracted many institutions and individuals who joined the Association and became its members. The CMAI also conducted many training programmes on Family Planning. The government too focused on Family Planning from the late sixties to early seventies. So, CMAI assisted the government in its Family Planning Programmes. Thus, it carved a niche for itself in this area of service.

In 1973, the NCCI - CMAI joint project on planned parenthood was launched. Since institutional membership had started in 1971, many CMAI member institutions launched community health programmes. The Association was aware that Medical care at established hospitals were expensive. Because of this, people turned to community health. Therefore, during this phase, there was a conscious and deliberate decision to abandon the existing model of an urban and elitist centered health care and to create instead a viable and economic alternative suited to the needs and conditions of millions of our people who had long been neglected and forgotten.[1] CMAI performed an advisory role with its member institutions. A notable event in the history of the Association during this phase was

---

[2] National Council of Churches in India - Extract 79, Page 20
[3] National Council of Churches in India - Extract 77, Page 44
[1] National Council of Churches in India - Extract 100 , Page 47

institutional membership in 1971. CMAI amended its constitution to include institutional membership in 1970.

In 1972, the preventive medicine committee was fused functionally with the Family Planning Committee with full integration of activities. Thus, it became the Community Health and Family Planning Project. In 1980, for greater unification of the Community Health and Family Planning Project with the CMAI, Dr. Daniel Isaac moved to Bangalore and a separate Treasurer was also appointed that year.[2]

Several grants from abroad were to be stopped in 1973 or 1974. It implied that NCCI would face a financial crisis.[3]

In 1975, the Association advocated a three - tier health delivery pattern involving effectiveness, efficiency and viability. In 1976, the CMAI completed fifty years of service to the nation as a voluntary health agency of the NCCI. The Vice-President of India inaugurated the function where thirty fraternal delegates and eight hundred national delegates were present. By now, CMAI had assumed an advisory role to institutions.

At that time, CMAI had four kinds of membership besides institutional membership, individual membership came from Christian Physicians, nurses, paramedicals and Hospital administration sections. Each section had its own chairperson and secretary.

Besides institutions, since 1972, the Central Ministry too approached the Christian Hospitals to assist the government in meeting the health needs of the rural community.

In 1977 it invited all voluntary health agencies including the CMAI to examine means for promotion of health and family planning. In the preceeding three years, CMAI had planned with institutions for their development.

CMAI continued its thrust on training, in laboratory technology, radiography, medical record technology and nursing.

The experience of the joint programme carried on by the NCCI and CMAI on planned parenthood was published in a book entitled as "Family in the purpose of God" in 1979.

Child survival programmes were also focussed on up to 1980.

In 1980, the executive committee decided to evaluate the CMAI - NCCI, joint project. The CMAI executive committee accepted the evaluation committee's recommendation to wind up the project as it was on Dec. 1, 1980.

---

[2] History of CMAI - draft by Dr. Desmond A. D'Abreo - 1996, Page 37
[3] National Council of Churches in India - Extract 81, Page 20

Finally, financial support for CMAI's Family Planning Programme stopped in 1983.

Hospital administrators were invited for the first time to the fellowship and the hospital administrators section came into existence.

5. PHASE V. 1981-TO DATE - NEW INITIATIVES - ASSET FORMATION

From 1980 onwards, it was yet another turning point in CMAI initiatives than in its earlier years. CMAI continued to be a related agency of the council.

The major event that dominated the period after 1980 to date, has been the CMAI's efforts in the community based health programmes and special focus on AIDS with the formation of an AIDS Desk contributing to training of doctors and professionals to combat HIV.

Though the emphasis remained on AIDS, some Family Planning programmes were continued by the Association. Therefore the Family Planning programmes were merged into its main activity in 1984 and the preventive medicine section assumed a new name - Community Health Department in 1986.[01]

In 1986, the CMAI instituted the Chaplains Section under which Chaplains became members of the Association. This was done mainly to fill an observed void in the healing ministry. Doctors and Nurses continued to work at physical healing in a patient, but psychological and spiritual aspects seemed to be amiss. Hence, Chaplains whose primary concern was to provide for spiritual healing were admitted as members.

EFFORTS TO COMBAT AIDS

Around 1993, CMAI perceived the need to work in the field of AIDS, and turned its attention towards it.

The HIV was first discovered in 1986 in Tamil Nadu. This spurred the Association on to start the AIDS desk in 1993 under the Department of Community Health. The desk provides training to Doctors, Nurses, AHPs and Pastors. The Desk designed a Blue print for its AIDS programme: "Case detection, prevention, control and management at all levels from Community layman level to experts at the top in Medical Colleges."

Based on the blueprint, doctors were trained at Vellore at the departments of Microbiology and Virology in blood safety and blood banks. The government too supported the programme. Subsequently, CMAI conducted a training programme for fifty five District Medical Officers and Senior Physicians of Mission Hospitals.

---

[01] History of CMAI - Draft by Dr. Desmond A. D'Abreo - 1996, Page 93

It also conducted a programme at Vishwa Yuvak Kendra, Delhi, funded by the Government of India, with facilitators from Geneva and Africa who were sponsored by WHO.

Further, in 1992, WHO requested the Association to provide training at the National level. After this, in 1993, CMAI sent twenty two trainers to Zimbabwe and Uganda, where they visited nine Church related hospitals and provided training, which was supported by the Government. In 1993, CMAI conducted Regional Workshops, through which 1228 physicians were trained in HIV control and prevention in four phases in a period of six months. Later, it concentrated on training lab technicians on HIV screening. In 1994, the AIDS desk conducted a two-day Workshop for nurses at Kolencherry in Kerala.

CMAI's efforts in the field are now recognized by all health directorates in all districts.

Rev. A.C. Oomen in "The Role and Vision of CMAI as we prepare for the 21st Century" which he submitted at the 33rd Biennial Conference in 1994, reflects the position of CMAI now.

CMAI made good progress in asset formation through investments in useful real estates and wise financial management. These actions have helped to stabilize the Association with its own asset base. The Head Quarters of the CMAI was established at New Delhi. The community Health Department got established, the Communication Centre was initiated. and the association got more involved with people, starting programmes and commenced addressing several issues in the society relating to health.

B. CURRENT PROGRAMMES AND ACTIVITIES
CMAI 1991 -1996-AN APPRAISAL

BACKGROUND

CMAI implements its activities and programmes largely through its formal set-up of :

1. Sections
2. Community Health Department
3. Regional Secretaries
4. Area Offices

Whereas the structure in sections and regions have remained unchanged, there has been changes in the Community Health Department and area offices. These changes occurred when the need arose.

Two area offices at Delhi and Bangalore operate under the leadership of their respective Area Manager entrusted with the responsibility of promoting all activities of the CMAI, including monitoring projects under the Community Health Departments . The area office infrastructure is as follows:-

Area Manager
↓
Assistant Area Manager
↓
Three Programme Development Officers

CMAI ACTIVITIES - 1991-1996

On analysing the activities carried out during the period 1991 to 1996 the following are observed: Each section is under the leadership of a full time Secretary and is supported by the respective Executive Committees' advice.

DOCTOR'S SECTION

The section organised three National sectional conferences, twelve workshops on rational drugs and other topics of professional interest to doctors. Apart from this only two retreats were conducted in 1996.

NURSES SECTION

During the period, this section organised three national sectional conferences, one regional retreat exclusively for Nurses and only 2 workshops and two retreats at the National level. (Detailed report on Nursing Education is appended at the end of this section).

HOSPITAL ADMINISTRATION SECTION

The Administrators section organised sixteen workshops during this period, most of which are on specific topics as personnel management, finance management and material management, besides five National workshops on health and hospital management. It also held three National sectional conferences.

ALLIED HEALTH PROFESSIONAL SECTION

This section has been able to organise a total of nine retreats only during 1991- 92. Twenty five workshops were conducted of which ten were during the year 1993. Three national sectional conferences were held .

CHAPLAINCY SECTION

This section organised ten retreats during the six years , five in 1991 and five in 1996 and none in the other years. They conducted 420 visits to institutions within six years, organised fifteen programmes exclusively for medical students and twenty four seminars region wise most of which were held in 1994.

COMMUNITY HEALTH DEPARTMENT (CHD)

The Community Health Department through the two area offices have been able to conduct sixty four sessions of informal training to promote the knowledge and skill of health workers involved in community based health delivery systems most of which were held in 1993 and 1994. The CHD conducted eighty nine workshops during the six years which seems to have gradually picked its momentum from no workshops in 1991 to twenty nine workshops in 1996. These workshops covered topics like Sustainability of Community Based Projects, Writing up project proposals, Monitoring of Primary Health Care, AIDS Management and Prevention of HIV Infections, Concientisation of congregations on Emerging Health Issues, Women empowerment and Development, Addiction and Counselling etc. Six meetings of the Chief Executive Officers of our member hospitals and four meetings of Church leaders were organised to publicise the programmes of the CMAI and identify areas where CMAI can participate as a partner with church groups in India to promote the Healing Ministry.

It is also noticed that there has been no forward annual planning in the CHD. Activities and programmes are organised in response to a need and demand made by projects, progammes and member institutions.

Analysing both the sectional and other activities of the CMAI, it appears that many more activities can be initiated by Sections and Community Health Department to reach out to the grass roots level i.e. congregations, hospitals and people. There is a need to develop more intensive link with people to involve them in healing ministry of the church. An analysis of the region wise activities makes the point obvious.

REGIONAL ACTIVITIES

Under the initiative of regional honorary Secretaries, regular Regional Conferences were organised every two years in each region, with the exception of Gujarat, Rajasthan and M.P. Other activities like workshops and retreats are barely held except in A.P., Karnataka, Kerala, Maharashtra and North East India. As a matter of fact, no retreats, workshops or seminars were held during these years in Gujarat, Rajasthan, M.P. , Orissa and West Bengal.

There is adequate scope to work out well planned time specific need based programmes to promote fellowship and professional skill at regional level, with the CMAI infrastructure especially at the sectional level. The effectiveness of activities organised by sections and community health department are not by and large assessed or reported. Several efforts were made by the Community Health Department to initiate, assist and promote member institutions and congregations in various community based activities in the country. It is gratifying to note that out of 197 Community Based Projects, initiated by the Community Health Department, 132 are continuing and serving the community after the financial help was withdrawn by CMAI. This works out to be more than 60 % . Results of evaluation conducted on specific projects of the CMAI are as follows :-

1. COMMUNITY BASED FAMILY PLANNING PROJECT OF THE CMAI (1987- 1992)

Out of twenty four Micro Projects initiated in 1987 almost all are continuing the programme in the field.

Recommendations from the Evaluations are :

a. The project has potential to serve even greater population.
b. The CMAI should explore ways to increase the project's cost effectiveness.
c. The CMAI should find ways where the project may sustain its family planning programme after the financial support is withdrawn.
d. Integration of family planning into other health out reach programme of the hospital or securing funds from the community or from the govt. or other partners to continue the project.

2. COMMUNITY BASED PRIMARY HEALTH CARE PROJECT (CBPHC 1988-1994)

The CMAI was involved in educating training and providing assistance, to enable the member institutions to understand and take up community based primary health care as one of their programmes. This project was directed to provide technical and financial assistance to members enabling them to reduce morbidity and mortality among women and children in select communities, and there by to enhance the survival of children and social development of the people. The strategy involved is FIONA PLUS. FIONA stands for Family planning, Immunisation, Oral rehydration therapy, Nutrition education and Vitamin A, and the PLUS stands for other components in Primary Health Care such as water supply and sanitation etc.

Out of 60 Micro Projects sanctioned by the CMAI, twenty five have survived till date despite withdrawal of CMAI financial support. On evaluation of these projects, it was observed that:

a. Understanding of community Health in most members has been as primary health care or as primary health and development of people.

b. The concept of community empowerment and people's participation is still new for many.
c. The CBPHC project has established good primary health care system focusing on mother and child care and an appropriate model in Fiona Plus.
d. Some micro projects have begun social and economic activities either with government funds or funds from other agencies
e. The project has benefited greatly and community participation has been good.

The evaluators have recommended that micro projects which are striving for sustainability should be further supported with funds, technical and other services of the CMAI. Where the process of enabling and community empowerment are not in evidence and top down approach was evident, such projects were recommended for closure.

3. CHILD SURVIVAL AND CHILD DEVELOPMENT PROJECT

a) First Phase (1988 - 1991)

This Project which was initiated in 1988 with a commitment to help congregations and non-medical Christian social and development organisations, has gone beyond the tradition of helping only institutional members of CMAI. Thirty nine micro project holders were invited to take up this programme. Thirty one are continuing this project even after the CMAI's assistance was withdrawn. The objective was to promote knowledge and skill of implementing agencies in child development and growth in order to effect reduction in morbidity and mortality among children especially under five years in a chosen community.

The evaluator observed at the end of three years of these projects that,

i. This is a successful innovative programme in community health and
ii. It has been a new experience for the CMAI in promoting health with non-health groups who have not dealt with health matters so far.
iii. This is a well conceived concept having freedom and flexibility which helped non-health agencies
iv. That the expectations in health return within a short time of three years, having responsibility for training and monitoring health activities centrally, has been helpful.

b) Second Phase (1994 - 1997)

Since the evaluation reports of the CSCD projects showed that it is a successful innovative programme, another set of twenty five new CSCD micro project were taken up during the subsequent years starting in 1994. Mental development of the child as one of the important components was recognised and included.

4. WOMENS HEALTH AND DEVELOPMENT

CMAI has been favourably biased towards issues relating to women such as women health and development. It is recognised that a perspective plan for women's development within CMAI should be related to the plan perspective for national development. A decade debate on women and development has culminated in the national perspective. The staggering figures available with us is an evidence of lack of equality and vulnerability of women. Over 70 % of women are illiterate, 90 % women are working in the unorganised sector, 65% of pregnant mothers are anemic. One out of eighteen mothers die out of delivery etc. This led the CMAI to focus on women's health and development project in 1986. This has been a training and technical assistance programme besides financial assistance aimed at improving women's health standards, economic status, and the literacy level to bring about awareness about the political right and social status. In implementing the programme, twenty member institutions were invited of which fifteen are continuing the programmes after CMAI's finance was withdrawn. The evaluation of the project was done in 1991 and the observations were as follows :

a. With limited extent of facilities existing within the institutions, there were positive efforts towards implementing the programme for the welfare of women.
b. Women who were isolated and silent observers, had come out of their shelter to participate in the awareness programme through functional literacy.
c. Some of the institutions had adopted programme contents to suit the people and their culture and made it meaningful. The programme has been helpful drawing the hidden potential in women even though few in number.
d. Given the limitation of the institution, its structure and the legacy of missionary approach, there were positive trends in involvement and thinking away from curative care.

Recommendations made by the Evaluator

a. To recognise some long term and short term strategy and dialogue with member institutions.
b. To initiate work for development of the community in an integrated manner recognising the place of women in the development process.
c. To network with organisations which are involved in the same area.
d. To move away from top down approach of delivering services and towards empowerment approach recognising the role of women in development.
e. To utilise the need of women on which to build a service support base.
f. To identify indicators such as sex ratio, female infanticide, child marriage, as well as non-quantifiable indicators to determine the status of women which differs from one state to another. These exercises will help CMAI to identify status and priority in which member institution would be involved in the process.
g. To focus on women among low income group living in tribal and backward areas, urban slums, migrant women, widows and destitutes

5. BIMAROU ASSISTANCE PROGRAMME

The health scenario appears bleak, and the biggest task facing an health agency like CMAI and its members is to evolve a creative multidimensional, multidisciplinary and people based response, to meet the challenges. India is a vast continent with the prospects of 1000 million people at the turn of century, with different cultural habits, languages, religious practices, beliefs and life styles. As a national organisation, the CMAI is making conscious effort to prioritize need based action plans depending on each institution, its capability and capacity to deal with the problems. Hence, the following four areas have been recognised for the thrust:

a. Geographical areas, BIMAROU states and North East India have been recognised as priority states. BIMAROU stands for the states Bihar, Madhya Pradesh, Rajasthan, Orissa and Uttar Pradesh.
b. Issue based programmes, such as empowering women and HIV infection- its prevention and Management and Combating Substance abuse, etc.
c. People oriented programmes such as urban slums, primary health care programmes for people who are marginalised and programmes for elderly and terminally ill, people suffering from AIDS , physically and mentally disabled etc.
d. Promoting alternate systems of medicines which are safe appropriate and available at grass roots level.

BIMAROU assistance programme is an outcome of the CMAI's priority to the people who need relief in the Country. In this programme CMAI is involved in creating awareness among people relating to promotion of health and development, educating people to start community based Primary Health Care programmes in BIMAROU states.

Hence, the programme emphasises education on Family Planning, women's health, child care and promoting Socio Economic Development of the Community with special focus on Womens Development. There are twelve micro projects in BIMAROU area started in 1993. The programme is initiated by the local church groups and was evaluated in 1996. The Evaluator observed that :

a) Each micro project has been able to concentrate on different areas like Agriculture, Education, Economic development. Most Projects have tried to include some health work.
b) There is a need for back up support, supervision, appropriate referral in all sectors in the programme.
c) Project staff need to be provided with greater skills in communications, Health Education, Community Organisation and Management.
d) Issues relating to congregation based healing, health and wholeness need to be more widely discussed in churches and projects.
e) CMAI should continue to foster the micro projects even though there may not be any financial commitment.

6. CHOTA NAGPUR HEALTH AND DEVELOPMENT PROJECT

More specifically as a people and the place oriented health and development programme, Chota Nagpur Health and Development Project was initiated in 1995 in an area consisting of parts of Bihar, Bengal, Orissa and M.P. Being recognised as most backward areas, with about 99 % tribal people. Parameters of health and socio-economic status are desperately low, compared to National level. So the CMAI has deliberately attempted :

a. To Promote Health and Development of people in partnership with the church groups especially among tribals in this area.
b. To establish fifteen micro projects covering a population of 1,50,000 people.

The CMAI has been responsible to create awareness among people, train and educate them from church groups in Chota Nagpur area, in establishing community based health and development programmes. CMAI aimed at training forty five leaders with technical , financial and administrative skills to support rural community and to seek solution to their struggle to better health and development. Seventeen micro projects were established in the area so far. An interim study of this project shows that :

a) Most of the church Heads/ representatives felt the project to be helpful and that they should continue.
b) People are beginning to feel empowered. They " feel good" about themselves in what they are trying to accomplish.
c) Women are assuming more effective roles in committees and in the community.

7. PROGRAMME TO COMBAT SUBSTANCE ABUSE

Considering the most pressing and emerging issues in our country, the CHD made attempts to implement schemes for comprehensive health care and combating substance abuse. Conscious efforts are made to respond since 1989 through :

a. Awareness building
b. Forming action group at regional and national level
c. Networking with other voluntary organisations
d. Establishing training centres on counselling
e. Establishing de-addiction centres

Workshops on "substance abuse" and training programmes on counselling were started having two Post-graduate counselling centres on counselling and substance abuse, at Kottayam and Calcutta. Other programmes are:

a. Substance Abuse prevention and management workshops
b. Regional ecumenical reflection on substance abuse
c. Formation of Christian agencies to combat substance abuse network (CACSAN)

8. CONGREGATION BASED HEALTH CARE ACTIVITIES

CMAI's mandate is to serve the church in healing ministry. It is committed to help the church to understand and to carry out its mission of healing. Its objectives is to help those who have lost their vision to re-discover it, to enable those who have a vision to enter into relevant activities to promote healing ministry. In order to carry out these objectives, CMAI has initiated the programme called as Congregation based health care activities project in 1992. its activities are:

a. To reflect on Healing Ministry, its dimension and scope followed by actions
b. To build awareness relating to the Health problems and needs in the Community.
c. Educating and training the congregation to build its capacity to get involved in bringing Health and Healing.
d. To develop leadership at congregation level to develop health team concept
e. To help the congregations to initiate and sustain healing ministry activities
f. To support congregations to promote the health, healing and wholeness with technical, advisory support and in some cases if necessary with small grants.

Fifty eight Workshops/Seminars for congregation members conducted in and with church groups in India, focusing on emerging Health Issues, Role of Congregation in Health and Healing, Project proposal writing, Monitoring congregation based programmes etc.

9. To address specific Issues as emerged in the national scene, the CHD has created two desks as follows :

a) AIDS DESK

This was established in 1992 with the following objectives :

i. To build capacity of our members for control of HIV infections by training health workers such as doctors, AHP, nurses etc.
ii. Creating awareness in our network and among church groups in collaborating with other sections of CMAI and desks and programmes of CHD.
iii. To strengthen the ability of churches by organising meetings and consultations with church leaders
iv. Control of AIDS infection in the hospital
v. Building up of CMAI data base on HIV infections

On invitation from the Government of India and with partnership of WHO and NACO, this desk launched programmes to train 1500 senior physicians from all over the country, collaborating with state and central government offices. Eighty seven lab technicians were trained on Blood safety methods from member mission hospitals.

Several consultations were organised with church leaders, helping them to draw up policy statements on caring for victims of HIV infections. The largest group for such consultation was from the Seventh Day Adventist and Methodist church of India which met at Surajkund. CMAI also represented at CHAI Workshops in designing the future policy of CHAI for control of HIV Infections.

b) WOMEN'S DESK

This desk was installed in 1992 as a special concern for women in India to address appropriately to issues relating to women.

1. To promote knowledge about existing problem relating to women in the society in general.
2. To find suitable innovative method to meet special needs.
3. To empower women to organise themselves.

Topics like HIV and women, girl child, women literacy, medical termination of pregnancy, early marriage etc. are taken up by the desk at different forums. Bible study materials have been prepared on such issues and networking with other NGOs is encouraged.

AREA OFFICE ACTIVITIES

Two area offices, one at Delhi and the other at Bangalore, are responsible to implement all CMAI activities in their respective areas . In order to promote CMAI activities, area offices are entrusted with the responsiblities of making contact visits, problem solving visits to member institutions within their jurisdictions and to organise programmès as per the directions of the association.

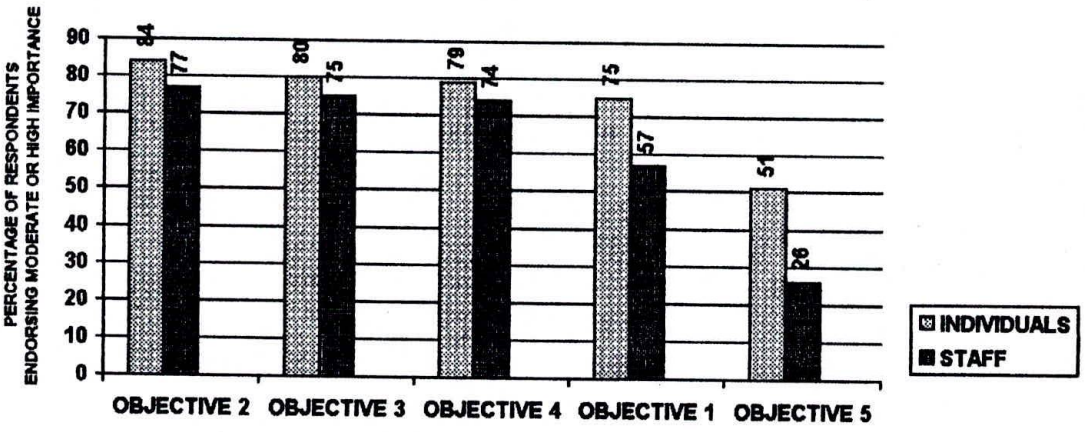
CHAPTER III : EMERGING REALITIES

A. OBJECTIVES

The CMAI constitutional objectives are ;

1. Prevention and relief of human suffering irrespective of caste creed, community, religion and economic status.
2. Promotion of knowledge of the factors governing health.
3. Coordinating activities for training Doctors, Nurses, Allied Health Professionals and others involved in the ministry of healing.
4. Implementation of schemes for comprehensive health care, family planning and community welfare.
5. Rendering help in calamities and disasters of all kinds.

IMPORTANCE GIVEN FOR CMAI OBJECTIVES - INDIVIDUAL MEMBERS AND STAFF PERCEPTION



Individual members and the staff of CMAI through their responses confirmed that :

a) Their awareness of the organisational objectives is quite high.
b) While the first four constitutional objectives have been accorded fairly high degree of importance, the fifth objective has received the least of attention.
c) Even though it is not a constitutionally proclaimed objective, there is great emphasis in the members perception on the "Nurture of Christian spirit" as the **raison d'être** of CMAI. (Please see data on Perceived objectives in Appendix)
d) The organisation began as a fellowship of Christian health professionals. The first constitutional objective was "Prevention and relief to Human suffering". Over the decades, additional objectives were incorporated, as well as five sections were established within the constitutional frame work to give an impetus to growth of professions. While these developments have influenced a greater degree of professional direction they seem to have been gradually receding "Nurture of Christian Spirit and values" in CMAI focus.

B. CMAI'S REGULAR ACTIVITIES :

Retreats, Sectional Conferences, Workshops, Regional Conferences, Healing Ministry Week and Biennial Conferences are regular features of CMAI activities. The study elicited information on the frequency of participation and usefulness of these activities from individual and institutional members and staff. Their advice for continuing the activity was also analyzed. The results were startling.

MEMBERS AND STAFF PERCEPTION SCORES BY ACTIVITY - TABLE
(MAXIMUM SCORE 100)[4]

		RETREATS	SECTIONAL CONFERENCE	WORKSHOPS	REGIONAL CONFERENCE	HEALING MINISTRY WEEK	BIENNIAL CONFERENCE
POSITIVE SCORES	INDIVIDUAL MEMBERS	34	35	36	36	34	31
	INSTITUTIONAL MEMBERS	30	34	41	35	31	28
	STAFF	64	41	54	34	52	41

1. While the general consensus in respect of CMAI activities as valued by the respondents leaves much to be desired, a few observations should be in order.

a) There is generally a gap between the perceptions of those who provide the service (Staff) and those to whom it is offered. Consumer response shows low enthusiasm, and they are not going to miss these activities, if discontinued,
b) Of the activities, workshops gathered better scores from the members.

2. The main draw-backs highlighted in conducting the activities can be classified as;

a) Organisational
   i. Deficiencies in organisation/communication
   ii. Inadequate support interms of facilities
   iii. Inconvenient venues
   iv. Incompetent Faculty
   v. Lack of action follow up.

b) Methodology and Import
   ii. Weak design and content
   iii. Lack of Participative approach
   iv. Lack of creative approach

---

[4] Score = $\frac{23+49+31}{3}$ =34]
[Example:Individual rating of Retreats:Participation=23, Usefulness=49, Advice=31, Score=

The accent on improvement primarily is on planning, effective communication, and efficient organisation. The emphasis for improvement is more on efficiency in organising the retreats, workshops and healing ministry weeks, whereas for sectional, regional and biennial conferences, it is on design and content of the activities.

C. FORMAL TRAINING PROGRAMMES

As in the case of regular activities, the positive perception scores were computed for the formal training programmes of CMAI - by combining the perceptions on usefulness, and advice for continuation of the courses.

POSITIVE PERCEPTION SCORES TABLE
(MAX 100)

	1 General Nursing	2 Medical Lab Technician	3 Medical Radiology	4 CAMS	5 ANM MPHW	6 Medical Records	7 Hospital Auxiliary	8 Opthol Tech	9 Rehab Tech	10 Addiction Counsel
Individual Members	43	43	35	38	34	33	25	24	23	23
Institutional Members	39	44	39	37	35	38	25	27	24	24
Staff	50	50	46	40	44	48	35	34	27	38

1. Though positive scores analysis on formal training courses project a better appreciative perception than CMAI activities, the scores point out to the immense scope for improvement. The general points emerging are ;

    a) The maximum appreciation score is only 50 %, meaning either the rest are not enamoured by these programmes and/or are not aware of their usefulness.
    b) Invariably, the providers of training (Staff) have better appreciation for the courses than the consumers.
    c) Of the ten, courses 1 to 6 received distinctly better degree of appreciation than the others, with general nursing and Medical Laboratory Technician courses topping the list.

2. With the exception of the AHP course, most of the institutions running the training programmes have not opted for affiliation to CMAI programme. The reasons for non-affiliation cited are :
    a. Lack of government recognition of courses
    b. Rigidity in CMAI rules
    c. Lack of awareness about the programmes
    d. Inadequate presence of CMAI

3. It is clear from the evaluation responses that :
   a) CMAI training programmes should be seriously reviewed, involving "consumer" institutions and respond to the changing needs of the practitioners.
   b) Liaison with government/employers/Universities in India or abroad to ensure recognition of the courses which will add value for the trainees.
   c) Lack of Publicity to programmes should be dealt with and frequent communications/visit to member institutions should help increase awareness of programmes.

D. SERVING THE CHRISTIAN INTEREST

The responses to the evaluation have brought out the prioritised future role for CMAI in definite terms.

	Expected Role of CMAI - Prioritised	Individual Members	Staff
		%	%
1.	**Agency for integrating Christian Spirit in the Health Field**	93	97
2.	**National Organisation for Christian Medical Profession and Institutions**	58	44
3.	**Agency for creating community awareness on health issues**	41	47
4.	**Influencing and Propagating professional health service**	3	2

The institutional expectations are for CMAI to play a key role in enhancing the Christian distinction in Institutional service and in upholding Christian values.

The need for advocacy on health issues with the Churches is covered under the future scenario.

As of now members do not perceive of any significant support by CMAI to Healing Ministry, whereas the staff think otherwise.

	Response	Members	Staff
Whether CMAI is providing any significant support to Healing Ministry	yes	43	72
	No	57	28

In the final analysis, the role expectation of CMAI goes back to its moorings - the `Christian Spirit'.

1) The role definition is unmistakably to be the integrating agency for Christian Health services.
2) To be the voice of Christian health profession and Institutions at the national level
3) An agency for enabling and creating community awareness about health issues.

Interestingly, however, the role of mere propagation of professional health service is not a role expected of CMAI.

Arising from the data are the following :

1. There is an urgent need to operationalise the Christian spirit and interest in and towards professional health services
2. Greater involvement of Church Officials in CMAI Activities and Programmes at all levels
3. Involvement of Church Officials in the CMAI decision processes
4. Propagation through CMAI publications, individual, team and institutional experiences reflecting Christian spirit and values in the health field.
5. Facilitating grass roots interactions on health issues and Christian spirit through motivating congregation and CMAI members.
6. At the level of institutional members special programmes like staff retreats, interactions with management and staff, providing broad guidelines for operationalising Christian spirit, values and ethics, should be initiated by CMAI.

E. GENDER BIAS

The question of gender bias has been probed only to a limited extent in the evaluation - and that too with the CMAI staff and the Church officials.

The investigation has clearly revealed that :

1. Gender bias exists as a general malady in the country and is deep rooted in all spheres of activity including religion.
2. It is a social justice issue in the country.
3. The responses from the Churches have been minimal and that too mostly internal, in terms of allowing ordaining of women, reservation for women in Church decision making bodies etc.

CMAI has been addressing the issue to an extent through :

1) Articles in its publications focused to educate professionals
2) Arousing community awareness through community health programmes mostly on women's health, collaborating with CASA, VHAI and Churches in the North East India
3) Conscious decision to provide equal opportunity for women in CMAI employment.
4) Discussions on Women's issues in forums of Theological Societies.
5) Establishing a women's desk at the central office.
6) Discussions on CMAI policy framework on "Gender Bias" - process before proclamation.

The role expections for CMAI are;

1) Identifying CMAI specific areas for positive action.
2) Initiator of debates on gender issues in the matters of health at the National and Church level.
3) Building awareness about the issue through publications and publicity
4) Enabling and encouraging women's literacy and education
5) Continuously develop new and innovative programmes to counteract gender bias in the field of health.

F. EXPECTED BENEFITS FROM CMAI

1. Individual members

a) The individual members of CMAI basically expect to benefit from reinforcement of Christian spirit and values through their membership in CMAI. This particular expectation surfaced at various other points of the evaluation, emphasising this as the most important factor encompassing CMAI.
b) The second most expected benefit is getting government / employer / institutional recognitions for the professionals and their attainments.
c) The third benefit is in terms of organisational support for personal problems.

2. The institutional expectations are basically :

a) Financial support
b) Support of data bank
c) Training of their personnel and
d) Services to strengthen managements.

The strong emphasis on expectation for "Nurture of Christian spirit" is a major focus area for CMAI planning for the future. As regards the expectation on financial support, CMAI would do well to correct this distorted expectation, through effective communication of its policy, that it is neither a fund raising agency on behalf of its members/churches, nor a channeling agency for funds. (See CMAI policy statement Page 14)

As regards recognition for CMAI training, strategic approach to influence the respective governments needs to be worked out.

CMAI could explore possibilities for individual member group insurance schemes to provide innovative support to members in old age. These are current features in some of the commercial corporations and clubs. CMAI also could explore possibilities for support through banks to members for continuing education.

G. MEMBER INSTITUTIONAL CHALLENGES FOR CMAI RESPONSE

1. The major concerns of mission hospitals are in respect of :
   a) Recruitment and retention of Qualified personnel
   b) Professional management of Institutions
   c) Infrastructure and
   d) Finances.

2. The suggested initiatives for CMAI to support the institutional members were,

a. Personnel (i) Bring about a uniform code for mission hospitals on service conditions of personnel. Improve existing conditions
   (ii) Create avenues for growth of personnel.
   (iii) Train personnel in a spiritual atmosphere.
   (iv) Church leaders to be involved in training.
   (v) Improve opportunities for professional interaction and network.

Hindrances to personnel retention is seen in terms of

i. Unrealistic expectations placed on health professionals serving in mission hospitals - without reference to changing environment.
ii. Career opportunities for growth is highly limited in mission hospitals. A way out has to be found.

CMAI initiative could be in liaising with owner Churches to examine the real issues to bring about a possible coordination among Churches to plan for professional development and growth for their employees.

b. Improving Institutional Management

i. Here again CMAI's role expectation is one of influencing the owner Churches to change their management attitudes - current low level participation and freedom to professionals in management of hospitals needs correction to inject efficiencies,

ii. CMAI may work out model constitutions for hospitals and initiate liaison for acceptance by the Churches,

iii. Train hospital managers in "efficient management" through planning processes, human resource development and finance management

iv. Initiate indepth studies of hospitals to identify corrective actions needed to make them viable and to serve the poor. Liaise with owner Churches.

v. Identify dynamic leaders in the Christian health professionals fraternity and encourage them to accept challenges of turning around sick units.

c. Infrastructure

i. The institutions need help from specialists to examine innovative cost effective approaches for maintenance and improving existing infrastructure. CMAI may set up a volunteer panel from its members and others to help institutions in need.

ii. CMAI can help co-ordination between Institution, Church, Banks etc, to optimise resources flow and utilization.

d. Finance

(i) CMAI can propose ways and means of raising funds and other resources to owner Churches and Institution Managements.

(ii) Experts' pool of CMAI in finance management may be formed which can provide necessary guidelines to institutions.

The basic issue arising in the need for a more close knit relationship between institutional managements and CMAI and the owners of hospitals. This calls for CMAI assuming the role of the initiator of needed changes through continual interactions and professional expertise inputs in various areas of management.

e. Governance

"The study on the factors determining sustainability of Christian Hospitals in India - based on six case studies" by Dr. P. Zachariah et.al. 1997, has identified the three essential factors for success of Mission hospitals.

(i) Good governance - a constructive and principled governing board would ensure greater chances of sustaining good administration
(ii) Nurturing, cultivating young professionals early in their careers - as a functional responsibility of the management.
(iii) Setting up autonomous governing boards for a set of hospitals to achieve economy of establishment and operating costs and good governance.

f. The Church officials have confirmed that closed hospitals should be revived. Also, that by and large, Church resources are favourable and growing.

The statistics show (Please see page 36) that the majority of closed Protestant mission institutions between 1937 and 1995 are dispensaries than hospitals. Most of the currently operating hospitals are in urban areas. There is thus an indication that Protestant Christian health institutions have withdrawn from their rural presence.

All the above leave plenty of scope and opportunities for CMAI initiatives - largely that for initiating changes in protestant Christian health services.

A COMPARITIVE STATEMENT OF NUMBER OF PROTESTANT CHRISTIAN HOSPITALS & DISPENSARIES IN INDIA

1937 - 1954 - 1995

Sl_no	STATE	- 1937 -			- 1954 -			- 1995 -			Difference 1937_1995		
		H	D	T	H	D	T	H	D	T	H	D	T
1	ASSAM	3	9	12	8	1	9	9	1	10	6	-8	-2
2	ANDHRA PRADESH	50	12	62	56	3	59	27	3	30	-23	-9	-32
3	BIHAR	15	17	32	16	2	18	19	2	21	4	-15	-11
4	DELHI	1	0	1	1	0	1	3	3	6	2	3	5
5	GUJARAT	8	3	11	7	0	7	6	0	6	-2	-3	-5
6	HIMACHAL PRADESH	1	0	1	4	0	4	4	0	4	3	0	3
7	HARYANA	2	0	2	2	0	2	2	0	2	0	0	0
8	KASHMIR	7	0	7	2	1	3	1	0	1	-6	0	-6
9	KARNATAKA	10	6	16	17	2	19	21	4	25	11	-2	9
10	KERALA	8	9	17	23	1	24	35	1	36	27	-8	19
11	MANIPUR	1	1	2	1	0	1	1	0	1	0	-1	-1
12	MAHARASHTRA	30	33	63	38	1	39	29	0	29	-1	-33	-34
13	MADHYA PRADESH	32	41	73	38	2	40	28	0	28	-4	-41	-45
14	MEGHALAYA	3	0	3	3	0	3	3	0	3	0	0	0
15	MIZORAM	2	0	2	0	0	0	2	0	2	0	0	0
16	ORISSA	4	4	8	7	1	8	7	1	8	3	-3	0
17	PUNJAB	25	12	37	15	1	16	6	0	6	-19	-12	-31
18	RAJASTHAN	9	2	11	6	0	6	2	0	2	-7	-2	-9
19	TAMIL NADU	44	25	69	44	1	45	42	7	49	-2	-18	-20
20	UTTAR PRADESH	40	3	43	26	2	28	22	0	22	-18	-3	-21
21	WEST BENGAL	19	18	37	9	1	10	11	0	11	-8	-18	-26
22	**GRAND TOTAL**	**314**	**195**	**509**	**323**	**19**	**342**	**280**	**22**	**302**	**-34**	**-173**	**-207**

- **H = HOSPITAL**
- **D = DISPENSARY**
- **T = TOTAL**

SOURCE : CMAI

H. STRENGTHS OF CMAI

The strengths of CMAI identified by individual members, the staff, the Church Officials, as well as the NGOs are in the following order of importance.

1. Quality of service
2. Quality of training
3. Forum for spiritual nurture and integration
4. National Identity for Christian health professions
5. Infrastructure of CMAI

However, the Church Officials considered CMAI publications as one of its important strengths, but none others endorsed it. Likewise the NGOs considered 'Networking' and CMAI staff 'Competence' as strengths but all the others rated these features very low.

Among the strengths of CMAI -though not reckoned as such by the respondents, but arising out of the data available- are the following;

1) Members are distributed all over the country though with a majority presence in the south.
2) Nearly half of the individual members are post-graduates.
3) Institutional Members' infrastructure can be made use of in joint programmes.
4) CMAI is a related institution within the Church fraternity - whose resources are considered bright and growing
5) Church leaders willing to be actively associated with CMAI
6) The financial management of the organisation operates within a defined system with adequate safe guards and is well managed.
7) CMAI is known to most Government Health Officials and to a majority of health related NGOs.
8) Government health officials foresee future CMAI role in Community and Preventive Health Services.
9) One third of all members are employed in mission hospitals of which nearly 20 % are functional heads.
10) CMAI is Non-Denominational and cuts across denominations.

While there is near unanimity among the individual members and the staff, a slight distortion is noticed in the strengths stressed by the NGOs, Church Officials and the members.

It is time for CMAI to improve its effective communications with the members including the Church Officials and the NGOs. Of particular interest is publication and networking with health related agencies. CMAI needs to project its strengths and thereby its image through planned publicity and contact programmes.

I. WEAKNESSES OF CMAI

The individual members and the staff almost unanimously identified the following as weaknesses listed in order of importance;

1) Poor publication and publicity
2) Lack of efficient service to members
3) Poor communications
4) Lack of recognition for CMAI - from the Government.

The Churches and the NGOs highlighted two other points namely;

1) Low influence on Church and Church related institutions
2) Inadequate focus on the poor and the marginalised

These responses bring out the following implications:

1) CMAI should work with the Churches and related institutions to change any distortions in its image.
2) Based on the suggestions received, detailed planning with action plans should be evolved and prioritised, for corrective actions.
3) Service to members should be vastly improved, but this can happen only if a review system is evolved for the management team to coordinate on issues and take quick decisions.

The weaknesses surfacing from other observations are :

1) On the financial front, the organisation is still heavily dependent on foreign funds - exposing itself to the risk of increasing restrictions of both donor and receiver countries.
2) The organisation has not focused seriously on raising internal resources through fund raising. Planning and competence building in this area is necessary.
3) There is a felt need for improving the effectiveness of all sections of CMAI.
4) There is no mechanism for evaluating the performance of CMAI in terms of input and output. As a professional organisation, CMAI should evolve parameters for measuring performance of each section/department and of the organisation as a whole.
5) The current set up of CMAI is not conducive to focus and develop CMAI presence in various parts of the country.

J. FUND RAISING

1. a) The question of raising internal resources by CMAI was responded to by the members, staff and the Church officials who offered suggestions to raise funds. These were ranked by the frequency of endorsements from each source.

SUGGESTIONS FOR RAISING FUNDS	RANKING BY		
	Members	**Staff**	**Church Officials**
1. Approach individuals / congregations	I	II	II
2. Better management of assets / funds	II	I	-
3. Through Churches	III	III	I
4. External Sources within India	IV	VI	V
5. Internal Resources	V	IV	III
6. Service based programmes	VI	V	IV

b) Interestingly, the members advocate raising funds through individuals/congregations, the staff through better management of assets and the Churches advising to approach them. The emphasis from all is basically to approach congregations and Churches.

2. It is conceded that current efforts to raise funds for CMAI is negligible, though there is considerable improvement through efficient fund management. It is, however, clear that CMAI's dependence mainly on external resources is fraught with uncertainties of the future.

3. CMAI may consider using some expert resources within the organisation as well as in related circles to address this issue to propose short term/ long term strategies, assuming alternate scenarios. For example ;

a) The current level of activity -
   (i) Steady and not much of an increase, except inflationary pressures for increased revenue.
   (ii) Increase in activity and budget at about 20 % per annum.
b) External Resources - (foreign funds) - Time related variation / status-quo.
c) Preparations as condition precedent for launching CMAI internal fund generation
d) Cost of fund raising and targeted revenue.

K. THE FUTURE SCENARIO

The future scenario for health service in the Country is mind boggling in an expanding horizon.

This is best summarised in the words of Dr. Deepak Paul of Christian Hospital, Shadol and Dr. George Joseph of CSI.

QUOTE

> With present political instability and lack of political will, we must be seriously concerned. This country has only 2½ % of the worlds area, but constitutes 16 % of world population, has an ever increasing mass of people draining the country's resources with no sign of abatement in sight. Today approximately 30 % of Country's population lives below the poverty line. 135 Million people do not have any access to health services and 171 Million people are without a safe source of drinking water, 640 Million have no access to sanitation. The adult literacy rate, which stands at 51 %, is one of the lowest among the developing countries.....All illiterate women put together in India surpass the total number of illiterate women in rest of the world. Six children out of every Hundred work as Child Labour. While 360 Million people spend 90 % of their earnings to buy food, their priority remains food, not health. Malaria is on the come back trail and there are now more than Two Million case of Malaria each year causing colossal man-hour loss to the Country.....The incidence of Tuberculosis is also increasing and about 18 million are presently suffering from it. They are joined by 3 million more each year and each year half a Million die. The disease is also associated with HIV infection. It is predicted that by 2000 A.D. AIDS deaths among men in their prime age will leave Ten Thousand widows each day.....UNQUOTE [o1]

QUOTE

> It is crucially important that policy planners and health administrators have to take serious note of the changing pattern of health and disease in the Indian context partially attributable to fast-changing life-styles and behaviour, more pronounced in this country as compared to other developing countries. Among the determinants, the major age-shift - the population pyramid with a wide base and now with the 'bulge' towards the top - (large proportion of the elderly), significant rural-urban migration are easily discernible. Other factors to be reckoned with are new technology - 'misinformation' included, and the rise in level of general awareness about issues and problems related to community health. There is also a positive trend, that is emerging, to be encouraged and nurtured that people's health should be in people's hands, health and wellness becoming a people's movement.
>
> It may sound paradoxical that a realistic epidemiological appraisal of the present health scenario in India would reveal a 'strange mix' of health problems, diseases and disabilities of under-development co-existing with host of emerging morbidity problems characteristics of affluent societies, hypertension, cardio-vascular diseases, accidents, cancer to name a few. This is true of urban as well as rural communities, there is an imperative need to evolve care models that are relevant in a given sociocultural setting in keeping with the overall mission of the Church. UNQUOTE[o2]

[o1] Dr. Deepak Paul - in Shadol hospital News letter 1996

[o2] Dr. George Joseph in "Perspectives on futuristic role of Church run -health Care Institutions - CSI 1996

The UNDP Human Development Report of 1997 has warned India of "worst forms of human poverty" and urged urgent action to "eliminate illiteracy, malnutrition and to provide safe drinking water." It further warns that poor people will be increasingly marginalised.

A new development gaining momentum is the new methodology of development - community initiated demand based approach, where development agencies (Both Govt. and NGO) participate and support peoples initiatives, as opposed to centralised financing and managing of programmes which are supply driven.[03]

The detailed recommendations from the responses to the study, however, envisage CMAI thrust to be multidimentional; in the sense that CMAI's direct action plans should be aimed at:

1. The congregational/community level,
2. The Christian institutions/Church level and
3. At the national level.

It is also clear from the interactions with Church Officials, that;

1) The Churches generally do not have specific policies on Healing Ministry Activities directed either to their own congregations or to their net work of Churches.
2) There is an urgent need for an apex body to initiate, coordinate and effectively integrate all Christian efforts to optimise assistance to the Healing Ministry through prevention and relief of human suffering.
3) Health is definitely a social justice issue in India, but the Churches response to charging Health scenario in dismal.
4) CMAI is looked upon favourably to take on the role of the apex body.

The projected scenario, the expectations and the recommendation on CMAIs future role envisages its first priority to be in community health services - a major thrust area of CMAI in the last ten years, inclusive of preventive and promotional services. Health Education and training continue to be the expected services from CMAI. There is a major concern for initiatives to involve the Churches and to improve CMAI - Church relationships - to optimise coordinated Christian Healing Ministry effort.

It is imperative, therefore, that an organisation like CMAI has to make a careful assessment of the various needs, identify such areas which are effectively manageable within its objectives and current competencies for a short-term approach, and work out perspective plans for medium (five years) and long-term (ten years) with concurrent action to develop its own competence and network to garner needed resources and support.

---

[03] Abstract from 'Participative Research in Health', edited by KORRIE de KONING et. al. Vistaar Publications - A division of Sage Publications - New Delhi, 1996

CHAPTER IV : CMAI's ORGANISATIONAL FORM

A. MEMBERSHIP OF CMAI

1. The membership of CMAI in confined to Christian Health Professionals and Christian health Institutions. However, the eligibility for doctors is restricted to practitioners in allopathic medicine.

The Individual members profile reveals;

a) Even the total claimed membership of around 3400 is abysmally low. The membership records are not updated at CMAI.
b) Reciprocity of contacts and responses between CMAI and its members appear to be on low key.
c) CMAI efforts do not seem to attract the younger age group members, excepting in the case of nurses.
d) Nearly half of all members are post-graduates.
e) Three fourths of the members are employed in private organisations, of which nine out of ten are in service with mission hospitals. Nearly one in five of those serving in private institutions occupy heads of functions or higher positions.
f) As expected, more than half of the members are in South India.
g) Nurses and Doctors are the predominant groups in CMAI membership, and are mostly in urban areas.
h) Membership appears more or less equal in sex distribution.
i) Church denominationwise CSI and CNI are the largest groups.

2. It is acknowledged that the membership should be enlarged. Towards this, suggestions made are :

a) Extend the reach through personal and institutional contacts to eligible Christians in all walks of life.
b) Extend eligibility to Non-allopathic practitioners or other workers serving the healing ministry.
c) Conduct membership campaign.
d) Improve efficiency of membership desk at head office to provide prompt service to members
e) Decentralise Administration, through creating/encouraging CMAI teams at all levels.

B. SECTIONS AND THEIR EFFECTIVENESS

1. Responses from individual members and the staff of CMAI were sought on their perception of "How effective is each section of CMAI" in its activities. The summarised data is given below.

FIGURES IN % OF RESPONSES

PERCEIVED EFFECTIVENESS BY MEMBER/STAFF		SECTIONS OF CMAI					WEIGHTED AVERAGE
		DOCTORS	NURSES	ADMINISTRATORS	AHPs	CHAPLAINS	
Poor/ Dont know	Members	37	33	50	54	47	44
	Staff	49	21	28	19	35	34
Good/ Very good	Members	20	25	12	9	14	16
	Staff	4	25	2	18	7	18

2. The outcome of this exercise is that :
   a) While none of the sections are perceived effective by both staff and members, nurses' section has the relatively best scores for effectiveness.
   b) There is a member/staff perceptional difference - indicating possible lack of in built feedback mechanism - thus keeping the staff away from ground realities.
   c) There is evidence of lack of intersectional communications.

3. Consequently, the emerging suggestions for improving CMAI sections effectiveness are;
   a) Improved communication between sections disseminating information on sectional plans, programmes and achievements.
   b) Vast improvement in contact with members to improve participation in programmes and feedback
   c) Improved efficiency in making sectional performances perceptible
   d) Emphasis on professional planning and activity assessment processes within CMAI.

C. FINANCIAL MANAGEMENT

1. **INTRODUCTION**

The financial and accounts function of CMAI is structured and operated within a fairly defined system which is objective, reasonable and has a flexible framework of rules, authorities, control and audit.

2. **BRANCHES/ UNITS/ ESTABLISHMENTS COVERED**

The branches, units and establishments of CMAI that have been covered in the evaluation are the following:

- Project Office - Ranchi
- Mid-India Board of Examiners Office - Nagpur
- Board of Nursing Education (South India Branch) - Bangalore
- Branch Office - Bangalore
- Head Office - New Delhi

Each of the offices mentioned above receive funds from the Head Office to meet their day-to-day expenditure. Such expenditure is met with the approval of the person in charge of the office. The accounts of all the offices, including the Head Office, are audited by H.P.Salve, Chartered Accountant.

The CMAI also has a Central Education Board with several training centres. It appears that the accounts of the CEB and its training centres are not integrated with the accounts of the CMAI as they ought to be. The Head Office of the CMAI has no record of the receipts or expenses of the CEB or its training centres. This is a serious matter needing immediate attention.

3. **AUTHORITIES**

The authorities exercising powers in relation to financial matters are:

- The Finance Committee
- The Treasurer
- The General Secretary
- The Deputy Finance Manager
- The Heads of Departments / Sections / Branches / Projects (within their individual departments / sections / branches / projects)

It is necessary that the financial powers and responsibilities of each authority be clearly specified. Similarly the discretionary and emergency powers of these authorities should also be clearly spelt out.

4. **FUNDING**

CMAI had a turnover of Rs.1,32,48,444 in the year 1991-92 and this increased to Rs.2,94,16,985 in the year 1995-96. The break up of this turnover is as under:

SOURCE	1991-92	1995-96
	%	%
Foreign grants	88.78	69.75
Indian sources		
- Interest	10.24	14.23
- Others	0.98	16.02
Total	100.00	100.00

As is clear from the above, CMAI has been and continues to be heavily dependent on foreign sources for funding. However, the extent of dependence has been reducing over the years.

In view of the increasing restrictions being placed under the Foreign Contributions Regulation Act on receipt of foreign donations it would be advisable for CMAI to increase the quantum of locally generated funds and aim at becoming self sustaining.

5. **EXPENDITURE**

The following is a break up of the expenditure incurred by CMAI:

Area of expenditure	1991-92	1995-96
	%	%
Community health	16.28	18.82
Special programmes	38.24	30.04
Human Resource Development	15.48	27.28
Regional and membership	9.75	7.70
Communication, advocacy and networking	5.87	6.01
General administration	14.38	10.15
Total	100.00	100.00

There have been fairly significant variations from budgeted figures under a few expenditure heads but, in general, the overall expenditure has been within budget limits. One of the principal reasons for such variation is that the budget is prepared for a period of five years at a time and there is no annual review of the budget on the basis of changed circumstances and current needs. It is suggested that the present system of preparing the budget for five years at a time may continue but there should be an annual review of the budget and, based on the requirements of the time, budgeted amounts may be permitted to be reappropriated from one head to another.

6. **ACCOUNTABILITY**

As is stated in item 3 above, heads of departments, sections, branches and projects exercise the authority to spend amounts budgeted in relation to their individual departments, sections, branches and projects. Along with such authority, it is necessary that such persons should also be made accountable for the amounts spent by them. For this purpose a review of performance vis-a-vis expenditure is essential. Similarly, the other authorities specified in item 3 above should also be made accountable for amounts of expenditure approved by them.

7. **ASSETS AND LIABILITIES**

The CMAI has a well thought out investment approach and its investments are in secure yet high yielding areas. Most of the investments are with the Unit Trust of India, scheduled banks, and government companies. Considering the limitations on investment placed by the Income-tax Act, 1961 and the Bombay Public Trust Act, 1950, the investments are very good and earn a reasonable return.

CMAI has invested a fairly large amount on purchase of immovable properties and these properties have appreciated considerably in value over the years. However, the investment in other assets has not been very significant. The amounts invested in other assets over the years have been Rs.6.72 lakhs in 1991-92, Rs.8.97 lakhs in 1992-93, Rs.5.36 lakhs in 1993-94, Rs.4.77 lakhs in 1994-95 and Rs.8.07 lakhs in 1995-96.

CMAI has hardly any liabilities except for the security deposit received from the bank which has rented its premises and the amount due in respect of the staff pension scheme.

8. **INTERNAL GENERATION**

The overall income generated internally has gone up from Rs.15 lakhs in 1991-92 to Rs.89 lakhs in 1995-96. This is an increase of nearly 500 per cent. The other noteworthy points are:

- 'Interest' which accounted for 91.3 per cent of the total funds generated internally in 1991-92 has substantially reduced in relative importance and accounts for only 47 per cent of the funds generated in 1995-96. However, the quantum of interest earned has gone up three times over in the same period.
- Fees, donations and grants have now become fairly important sources of income.
- No amount has been received from churches or from Government.

9. **OBSERVATION ON QUALITATIVE ASPECTS OF FUNDS MANAGEMENT** :

In our opinion, funds have been well managed by the CMAI. Our reasons for this opinion are as under:

- Expenses have, by and large, been within the overall budget. The year 1992-93 is the only year when total actual expenses have over shot the budget.
- The investment in immovable property has been very wise and has paid rich dividends. The current market values of the immovable properties of the CMAI are good. We would suggest that further investments be made in good immovable properties as the returns are likely to be very high.
- The investments made (other than in immovable properties) have also been in legally permissible, safe and high yielding areas.

10. **CMAI FINANCIAL STANDING :**

In our opinion the CMAI enjoys a fairly good financial standing. However, in order to improve its financial muscle the CMAI needs to become more financially self reliant. This is possible only by increasing its local earnings substantially.

The CMAI should also explore the possibility of raising funds from other sources abroad particularly to fund those plans of the CMAI which the existing sponsors may not like to cover. Other donor agencies may be contacted and the possibility of undertaking consultation work in the areas of its expertise (imparting training in the fields on nursing, etc.) should be explored.

11. **AUDIT**

The accounts of CMAI are audited regularly by a firm of chartered accountants (H.P.Salve, Chartered Accountant, Buty Mahal, Sitabuldi, Nagpur). There have been no significant audit observations over the years.

12. **IMPACT OF INFLATION**

CMAI has done well financially over the years. Despite inflation, the organisation has improved its financial position and strength. Each year, the growth in income generation has been in excess of the increase in expenditure. The annual surplus has also been continuously increasing. The impact of inflation has not, therefore, been very significant so far as the CMAI is concerned.

13. **STATUTORY LIMITATIONS AND OPPORTUNITIES**

So far as management of financial resources are concerned the CMAI has to contend with the provisions of three statutes, viz., The Bombay Public Trusts Act, 1950, The Income-tax Act, 1961 and The Foreign Contribution (Regulation) Act, 1976. The main limitations and opportunities are as under:

- Foreign contributions can only be accepted by the CMAI in accordance with the provisions of the Foreign Contribution (Regulation) Act, 1976. CMAI is currently registered under the FCRA and is permitted to receive foreign contributions. The returns required to be submitted are regularly being submitted by the CMAI.
- Investments can be made by the CMAI only in areas permitted by both the Income-tax Act, 1961 and by the Bombay Public Trusts Act, 1950. This places substantial restrictions on the investment possibilities. Within the limits placed by these enactments, the CMAI has invested its funds wisely.
- Investment in immovable property is permissible and substantial investments have already been made in this area in New Delhi and Bangalore.

D. MANAGEMENT SET-UP, STYLE AND FORM

1. CMAI as a legal entity is a registered charitable, nonprofit, Christian education society.
2. Its Membership is open to Christian medical and health professionals - and Christian medical and health institutions.
3. The "Biennial Assembly" is the power house of the organisation consisting of all enrolled members, who meet once in two years, and elect honorary members to the General body, the Board of management and other constituent bodies, and also appoints the General Secretary.
4. The General Body meets annually to make policies, take stock and issue directions. The General Body Consists of thirty six members, who are; **a.** Five Office bearers of the Association , **b.** Thirteen Regional Secretaries, **c.** Ten Chairmen and Secretaries of Sections, **d.** One General Secretary of NCCI, **e.** Elected Members from the Assembly, **f.** Three co-opted Members by the General Body.
5. The Board of Management consists of the President, the Vice President, the General Secretary, Treasurer and the Editor, along with six other members namely, **a.** Three Regional Secretaries - Nominated by the Assembly, **b.** Two from out of ten Sectional Representatives, **c.** One either elected or co-opted member from the General Body.
6. Constitutionally, CMAI's structure includes five professional sections namely Doctors, Nurses, Administrators, AHPs and Chaplain. Each section is headed by a full time paid Secretary. In addition four other Heads of Departments, namely Administration, Finance, Communications and Community Health Programmes, are appointed as shown in the Organisation Chart of 1997(Enclosed).

The Heads of Departments as well as the Sectional Secretaries report to the General Secretary - administratively. But each of these heads of sections and departments are functionally under the direction of their respective Executive Committees, each headed by an honorary chairman elected by the assembly. The organisational structure shows the current lines of command and control.

The organisation has evolved over a period of decades, slowly transforming in terms of additions of sections, departments and replacement of volunteer personnel by full time paid personnel. Some changes over the years, it was observed, took place as a response to a sudden spurt of activity like family planning in late sixties, which led to establishment of Bangalore and the North India Offices. With the receding of the FP activities, the structure again contracted peripherally. The main form of Assembly, Governing Board, CEO and the sections, as well as the Central Secretariat functions have remained intact.

EVALUATION OBSERVATIONS

1) A special feature of the existing structure is that the Secretaries of sections report administratively to the CEO and functionally to the Chairmen of Executive Committees. They are also full fledged members of the General Body.
2) The second feature is the fragmented functional responsibilities, with most of the executives answerable to respective Committees.
3) In view of the autonomy of sections due to structural freedom, Organisational integrated approach to "assist healing ministry" , " relief to human suffering" seems to have receded over the years.
4) Annual Secretaries' reports only state what was carried out and not what was set out to be done, what was done and why the variation - in other words "accountability" is silent.

The feed back from various respondents shows that the organisation has distanced itself from the grass roots - members and the people - institutions, the clergy and the like minded NGOs. This situation is quite palpable from other observations.

a.CMAI training programmes appear mostly centred around professional development activity rather than " concerns for health and healing " to which the professionals have to respond. **b.** Sectional effectiveness is perceived to be poor. **c.** Communication deficiency has been highlighted by members. **d.** Excluding workshops - all other activities have drawn lukewarm reception by the members. **e.** Awareness to health issues among the churches appear dim. **f.** CMAI's contribution to Healing Ministry is not seen by members as significant. **g.** Community Health Programmes" - a department having seperate identity in the structure, and apart from sections, has received appreciative feedback from the constituents - and the members endorse CHP as important in CMAI's future role.

5) The positive features of current set-up. **a.** Flexibility and autonomy to each constituent at the executive level. **b.** Participation of members as volunteers at various levels- mostly in advisory capacity. At the executive levels all are full time employees. **c.** Involvement of Volunteers in the structural hierarchy has many benefits, **i)** The contributions in terms of efforts are free, **ii)** Enables pooling of expertise to support the organisation. **iii)** Helps wider network of contacts, **iv)** Since they are elected posts, injects "new blood" through rotation, **v)** The efforts are more in the spirit of service for self fulfilment.

Objectively examining the positive and the negative aspects of the set-up, it appears that the present structure is not conducive to use its full potential for effective contribution to the central purpose of the organisation, namely "Relief to human suffering" and " to assist the Healing Ministry" - Training of personnel which is a "means" to achieve the goal - seems to hog

the limelight in terms of efforts - with no scope for measuring the extent of contribution towards the main purpose .

The Structure of today, all the while when it was evolving must have served the organisational purposes of yester years, but now it appears to be reaching nowhere - at the executive level.

6. A new approach appears imminent to release the real potential of the organisation - particularly through more people oriented integrated approach, than profession oriented sectional approach.

The Objectives for changes in organisational form should,

a). Meet the expectations of members to "decentralise" the organisation.
b). Provide an integrated CMAI in operation at "local" and "Regional levels".
c). Enable sharing executive responsibilities through a team approach with accountability - relieving the CEO to concentrate on planning, reviewing, leadership initiatives - vigorous networking at policy levels and directing the organisation.
d). Pave way for clear cut performance parameters for executives and accountability at all levels for organisational growth and success.

MAN POWER

From the profile of the staff of CMAI, the following points need consideration.

1. Out of the eighty seven staff employed - eighteen are attenders, drivers and cleaners.
2. The organisation reflects almost a perfect inverted pyramid with people at A Grade being the highest number, followed by B and C (bottom grade for white collar staff) .
3. Qualification wise, nearly half of the staff are post-graduates, but those qualified in medicine are significantly less.

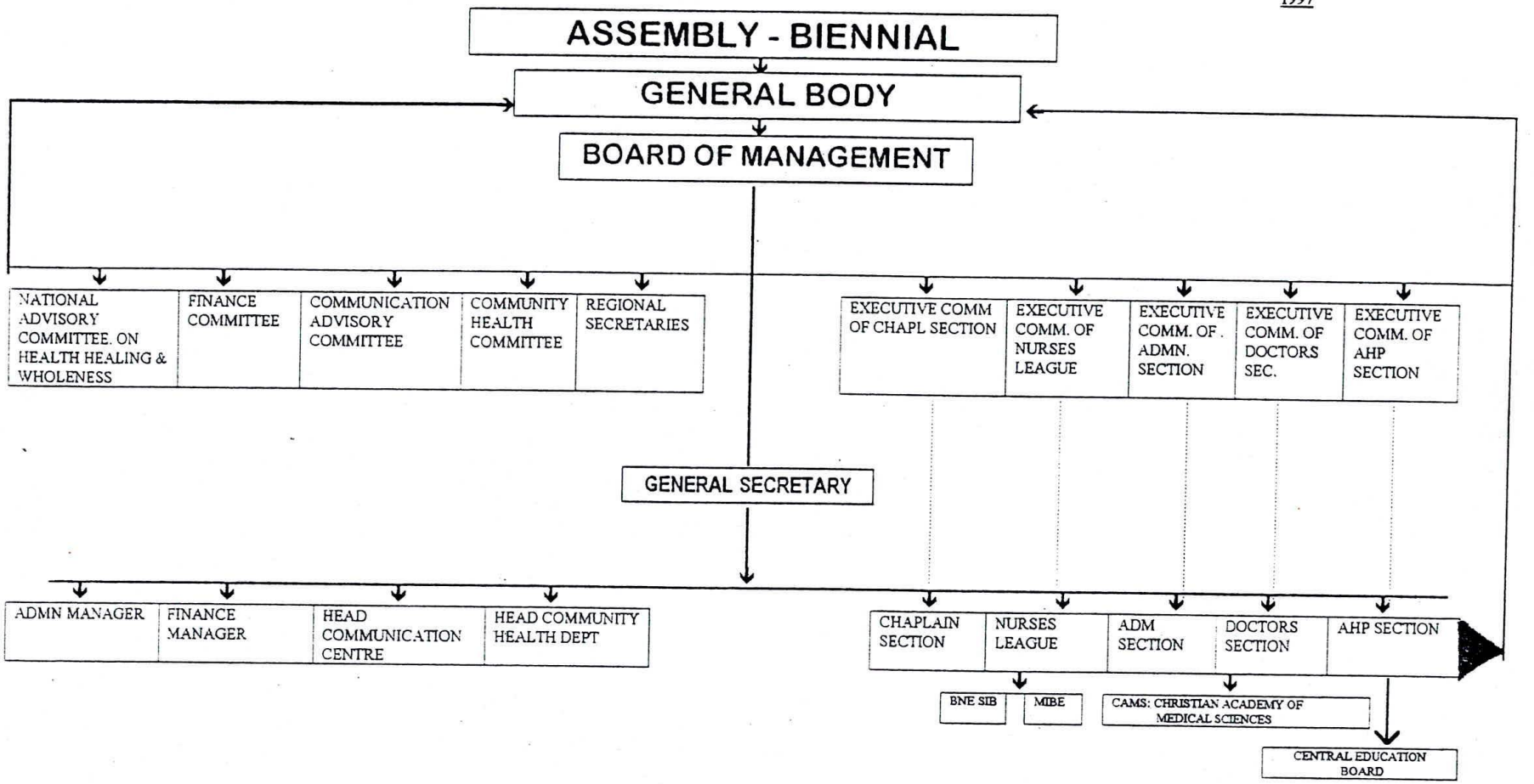
This needs attention from the point of view of organisational competence. The point has been stressed by the staff and the members both institutional and individual.

4. General Administration accounts for the highest number deployed- followed by Community Health. Among the sections, Nurses section takes the first position and the Chaplains the second in terms of numbers employed.

Since this evaluation was not directed towards assessing manpower needs, Job specifications or workloads - there is no ground to analyse this aspect for a possible review. But the following points may be relevant.

1) Prima facie, it appears that the number of drivers, attenders and cleaners are too many to serve a complement of sixty nine staff members.
2) Personnel competence needs to be assessed against organisational challenges ahead, long-term and short-term plans and expectations. Plans for structured internal training to improve competence needs to be evolved.

ORGANISATIONAL STRUCTURE 1997



CHPATER V : THE POINTERS

A. EVALUATION TERMS OF REFERENCE - FINDINGS

REFERENCE 1 : What have been the activities of CMAI to achieve its mission, vision, goals and objectives as enunciated from time to time from inception and particularly during the last decade ? How and to what extent has CMAI, as the health wing of the NCCI, been able to serve the Church in its ministry of health, healing and wholeness ?

FINDING 1. In general, since its inception, CMAI has responded to needs arising out of problems of people's health.

a. FROM INCEPTION

It responded to perceived needs at different phases through :

i. Providing a forum for Christian health professionals to exchange and update knowledge,
ii. Responding to training needs of health professionals from time to time,
iii. Collaborating with Churches in India in their concerns and actions relating to health of people with special reference to the poor and the marginalised.
iv. To the extent possible, initiating actions in public health in rural areas, as well as responding with preventive and curative services.
v. Advising and collaborating with Governments on issues of health and programmes
vi. Being a catalyst for initiating of action in health related matters by the Churches and related institutions.
vii. Bringing out its own publications to promote knowledge as well as a common communication link with its constituents.
viii. At times, co-ordinating resources for Christian health institutions.

The above stated generalised CMAI response activities have contributed towards its goals and objectives in varying degrees at different periods in CMAI' s history. However, precise quantification of its contribution eludes measurement. Yet, there is no doubt that CMAI in its history of ninety years has established its responding capabilities in times of crises, in training of health personnel and medical/health relief work, with close relationship and collaboration with Churches and related institutions.

b. SINCE LAST DECADE

Specifically in the last decade, CMAI's activities to fulfill its objectives have been more in terms of :

i. Continued activities to promote fellowship among Christian health professionals and promotion of knowledge, along with nurture of Christian values and spirit.

ii. Continuing established formal training programmes and new programmes for AHP's and on "substance abuse".
iii. Innovative and self sustaining community and congregation based health programmes with special emphasis on woman and Child.
iv. Conscious efforts to bring about a meaningful association with the Churches and related agencies for a more effective assistance to the healing ministry
v. Responding to request from government and other health agencies for support in combating HIV/AIDS, by designing and implementing programmes of training health professionals, health workers and congregations.
vi. Continuing its publication activity.
vii. Inducting Chaplaincy section to focus and support nurturing Christian spirit and wholistic health.
viii. Raising resources to sustain its current level of activity.

c. CURRENT ASSESSMENT

The Evaluation findings, however, bring out the current status of CMAI fulfiling its objectives.

i. In so far as CMAI's service to the ministry of health, healing and wholeness is concerned, there are perceptible changes over the past decades. The CMAI - Church strong collaborative relationships of the past appear to have become passive and distant. The Churches are looking for guidance and professional support.
ii. CMAI training programmes have retained their stamp of quality and the training objectives have been endorsed as being fulfilled to a great extent, though fewer institutions are seeking CMAI training affiliation.
iii. Nurture of Christian values and spirit among health professionals is looked forward to by members as the **raison d'être** of CMAI - Other CMAI activities need radical improvement in their vision, planning and implementation.
iv. CMAI's community / congregation based programmes have been assessed largely by members as contributing towards relief to the poor and marginalised. This also finds support from the increasing number of programmes that were initiated by CMAI, continuing to be active and sustained even after CMAI withdrew its support. Thus CMAI is contributing substantially to its objective of comprehensive health care and community welfare.
v. CMAI has responded to the call of the nation for combating newer challenges to health like HIV/AIDS, substance abuse through its training programmes - networking with the government agencies - A major contribution towards "Prevention and relief of human suffering", irrespective of caste, creed, community, religion or economic status.
vi. CMAI's response to its objective of rendering help in calamities and disasters has not been significant.

REFERENCE 2: What have been the contributions of CMAI towards newer concepts of health care and innovative interventions ?

FINDING : 1. CMAI has contributed substantially in the development of Nursing and Allied Health Professionals through training programmes to meet new challenges for health.

2. CMAI programme for continuing education of practicing doctors is an innovative training intervention.

3. CMAI is contributing through the new concept of community/congregation based health programmes thus enabling communities to take responsibility for their own health. This is an area for greater focus and expansion.

REFERENCE 3: How far has CMAI been able to coordinate and make relevant the various training programmes in the healing ministry, medical, nursing, paramedical and others ?

FINDING: 1. Three formal training courses namely; i. The laboratory technician course, ii. The general nursing course, iii. The radiology course have been endorsed as useful and hence retain their relevance.

2. Most of the other courses have attracted reservations from members either in terms of their current relevance and/or value/utility in terms of recognition.

3. Most of the Christian training institutes have refrained from seeking affiliation to CMAI training programmes, except for some of the courses for AHP's.

4. Thrust and co-ordination efforts from CMAI need improvement to raise level of demand for and relevance of the training programmes.

REFERENCE 4: How far has CMAI achieved building spiritual, professional and social fellowship among members ?

FINDING : 1. CMAI's inadequate service to members and Lack of communication have been identified as its current weaknesses.

2. CMAI's low sectional effectiveness and sectional activities reflect sporadic unplanned efforts and lack of co-ordination.

3. There is large scope for expanding the membership base of the organisation.

4. CMAI's current organisational set up is not conducive to render co-ordinated service towards this objective.

REFERENCE 5: How far has CMAI achieved promoting social justice, total well being, family welfare and building healthy communities.

FINDING: 1. CMAI indeed is addressing these issues in different ways and the degree of effectiveness vary and are often difficult to assess.

2. In so far as the social justice issue is concerned, CMAI's efforts have been;

(a) Establishing a women's desk at its head office to specially focus coordinating CMAI programmes to include special attention on women and child health.
(b) Conscious efforts to develop its own policies on issues of social justice.
(c) Creating awareness through its publications, to gender discrimination issues affecting health and well being of women and children.

3. As far as total well being, family welfare and building healthy communities are concerned, CMAI has launched several community / congregation based programmes in the last decade in different regions of India. Evaluation of projects till date have been encouraging. There is evidence of increasing self sustenance of these programmes.

Till about 3 years ago, the programmes on family welfare and child survival were concentrated more in southern parts, whereas the women and community based development programmes of recent years are more in the central region.

In brief, 1) CMAI has commenced addressing problems of Social justice, and is evolving its policies.
2) Community based programmes of CMAI seem to have made an impact in enabling the participants to learn the skills of implementing self sustaining Community / Congregation based participative programmes to promote and build healthy communities. However, these programmes are confined to certain parts of the country.

REFERENCE 6: What is the likely future scenario affecting the health of the people? What will be the major changes? What are the opportunities and threats?

How can CMAI meet the challenges and make use of the opportunities, and help the Church to respond effectively to the changes.

FINDING : The Future scenario for health services in India seems like opening Pandora's Box. Future events can be briefly classified as follows.

1. Prevalent infectious, communicable diseases related to nutrition, quality of life, environmental deterioration and poverty will increase with the population, needing greater emphasis on preventive and curative services.

2. Special diseases like HIV/AIDS, drugs and substance abuse will continue to rise at an alarming pace demanding services to create community awareness and counselling.

3. Stress and pollution related non-communicable diseases will be increasing the load for preventive, curative and promotional services. Services to prevent Accidents and Geriatric care /rehabilitations will call for greater efforts.

4. Economic liberalisation policies will push commercialisation of services at a greater pace - making it increasingly inaccessible to the poor, particularly health and education. There will be inequitable distribution of resources.

5. A large population of small farmers, unorganised and landless labour and other poor classes will become poorer.

6. Issues of social justice in health, education, employment, and gender bias will be looming larger.

7. Demand for quality health care will increase along with consumer awareness - leading to increased legal implications.

OPPORTUNITIES AND THREATS:

1. These changing scenarios would demand more and more collaborative network of operations. There will be increasing demand for innovative, planned and definitive responses from the Church and the Christian Community, particularly for the rural poor and marginalised sections of society.
2. There will be shortage of qualified personnel, particularly in church/mission related institutions, as more and more investment oriented commercial hospitals mushroom everywhere.
3. The non-profit oriented traditional, curative service institutions will face severe competition from commercialised institutions - since those who can afford will move away from non-profit institutions for their care. Sustainability of such institutions will be under increased threat.
4. In view of inaccessibility of secondary and tertiary services for the poor, the demand for primary health care services will increase with better community response to preventive and promotional activities. This will open greater opportunities to NGOs.

CMAI RESPONSE OPTIONS:

1. The pressures on the healing ministry would open opportunities for CMAI's professional advisory role to the Church. Unlike in the past, CMAI will have to seize the opportunities for services, particularly utilizing the resources of the churches, related institutions, congregations, with the support of CMAI members. The Churches are aware of the enormity of the problem and are looking-up to an apex body to integrate resources and optimise services. They favourably look upon CMAI to play this role.
2. CMAI should be proactive in projecting the future health scenario with detailed dimensions and implications of the problem. It is time for planned initiatives to set in motion processes of integrating the Christian resources for health services.
3. CMAI needs to address the problems at different levels of operations.

    a. At the national level - proactive advocacy role based on authentic, researched data to arouse public awareness and Co-operation to health priorities. To Influence the policies of the government to protect and improve health related services to the poor and the marginalised. To this end CMAI needs to create a research and documentation unit.
    b. At the Church and related institutional level - to bring about a proper understanding of issues and problems to evoke positive responses to optimise resources support. Help review resources status and viability of hospitals to determine management options to improve viability and service levels.
    c. At the congregational and Community level to encourage and enlarge Community based wholistic health initiatives, for long-term sustainable people initiatives. The purpose should be to make available services to prevent ill health and promote health of the poor at their places of residence to overcome the problem of inaccessibility. This should reduce considerably the need for secondary and tertiary care services which are very expensive.
    d. CMAI should continue training of health professionals with necessary modifications in methodology, content and develop appropriate nurturing of the young professionals.
    e. Members expect CMAI to integrate the church and related agencies to regain the vision of the healing ministry, redefine the policies to suit the changing times in tune with the Christian Values and spirit. Use the collective Christian voice to highlight and mitigate the suffering of the poor and marginalised.
    f. Improve upon the current positive image of CMAI in the Government circles and NGOs for future network.
    g. Restructure CMAI functionally and administratively to increase its active presence in various parts of the country through volunteer member initiatives.

B. EVALUATION RECOMMENDATIONS - PRIORITISED

1. Functional areas. CMAI to initiate change

a) **Nurturing the Christian Spirit in the health professionals.**
Members seek this from CMAI as first priority.

There is an urgent need to operationalise Christian spirit and values in health profession.

i. CMAI may consider setting up a task force to identify areas for resurgence of Christian spirit and values in health service areas. With the help of experienced professionals and practical theologians develop meaningful and pragmatic approach and attitudes that practitioners can follow. Hospital CEOs and young professionals should be involved in the process.
ii. Steps should be taken to attract more young professionals into the CMAI membership fold, which itself needs to be enlarged.
iii. Periodic retreats on "practical work" should be held at all regional levels cutting across "professional sections" and more often through member initiatives.
iv. Illustratively, CMAI may consider making it a policy to invite for every program/activity, at its cost, a professional who is well known, in service, competent, who can articulate and share Christian experiences in practice which gave her/him value satisfaction. For every activity, programme CMAI may invite a local Pastor/Bishop/Theologist (by rotation to avoid denomination sensitivities) to share Christian messages which practitioners can relate to their work.
v. As a process for integration and nurturing Christian spirit, CMAI may consider getting senior officials nominated from Churches of various denominations by rotation, on CMAI general body, in addition to the NCCI nominee, perhaps three more members. CMAI also should seek representation on Church decision making bodies - particularly in healing ministry.
vi. Provide special designated space in "Health for all: and other publications, for members to narrate actual "incident" based experiences which gave them satisfaction of fulfilling Christian commitment to "Healing".
vii. Members attending "retreats", "workshops" and "Conferences" should be encouraged to visit nearby mission hospitals to "experience" and share their ideas for improvement.
Similarly members' visit to a nearby Church, with a planned special service, may be a helpful process for both "nurturing" and "integration".

b) **Institutionalising Planning and Review systems**

(i) The evaluation has brought to surface the sine qua non for any effective management - Planning and review system, with evolved parameters of Input, Output and outcome, as well as process guidelines enabling periodic monitoring and evaluation. CMAI should identify a planning resource within, for co-ordinating and institutionalising the process and annual calendar for planning.

(ii) Illustratively, the recommended steps are :

- A detailed organisational annual plan be evolved from each section/department, with specific time schedules for all activities, in the last quarter of the previous financial year.
- The plans, inter alia, should specify each activity, venue, number of expected participants, the agenda, and why the activity is necessary at the specified venue.
- The detailed budget (including fund generation).
- Expected benefit for the participants and how such participation would enhance the `Christian' and 'professional' value of the participants, their organisation and in what ways it serves CMAI's purposes
- Feedback and follow-up plans.
- Schedule for quarterly review and recommendations.
- While deciding or fixing an agenda and/or a theme for an activity, the views of some of the potential participants be pooled well in advance, so as to make the activity relevant and `Contemporary' to meet the needs of participating members.
- CMAI may find it worthwhile to explore various possible ways of reaching the members - to overcome the deficiencies in communication pointed out by the members.
- It may be worthwhile to evolve a standard format, specifying all points to be covered in communications on `activities' to members, to avoid omissions.
- A detailed plan of publicity for each type of activity be evolved and circulated to the `organisers' to follow, so as to "optimise" effective reach to prospective participants.
- A minimum lead time - say one month, be fixed as a rule - for completing necessary process before an activity is conducted - and such lead times be incorporated in the plan.

Sectional/Departmental plans so developed, deliberated and finalised by the CMAI Executive be incorporated within CMAI annual plan and budget for approval of the Board of Management.

c) **To address the emerging issues**

It is imperative for CMAI to examine in detail the emerging issues and identify areas for continued thrust and new initiatives.

(i) As a first step, identify a handful of competent professionals from among Christian fraternity and outside to help develop short term and long term strategies on the following lines. (Illustrative) - perhaps by the end of 1997.

- Crucial "here and now" issues which are within the framework of objectives, current competencies and resources of CMAI. Suggestions for effective implementation.

- Issues which need advocacy for awareness and influencing policy - (Government/Church/Funding agencies), for which CMAI can pool and enable experts with contacts at various levels to represent CMAI on specific issues.

- Issues which can be addressed through coordination and support of Churches and Congregations in the next two or three years.

- Long term issues which need to be addressed in the next five years or more, with preceding planned preparations for developing internal competencies, and network to garner needed resources and support.

- Emphasise more and more on participative approach to support congregations and communities. Make 'Health' a people movement. Move away from central decisions, as much as possible, and as and when enabled people can take responsibility. CMAI members and Churches are willing to support this change. Involve them.

ii. The recommendations of the expert pool be deliberated by CMAI management and decisions taken incorporated in the CMAI plans commencing from March 1998.

iii. Responsibility for various emerging issues incorporated in the plan be distributed among CMAI executives with freedom to act and defined accountability. Accountability should be in terms of co-ordinating and developing action plans with set time and resources parameters, monitoring implementation, results, reporting and review.

iv. For special focus on "Gender Bias" make a policy decision to have a session on Gender Bias in all activities and training programmes of CMAI - to keep the members and trainees abrest of developments and scope for service.

d) **Towards an apex body to assist Healing Ministry of the Church**

Several factors are pointing to the felt need for an apex body, which can integrate, influence and converge efforts of all Church bodies, Christian hospitals, Congregations, donors and every Christian health professional to optimise the level of Christian Concern and contribution to "Teach preach and heal" - the command of Christ. They are mainly,

- The difficult times ahead for the poor and marginalised, for sustenance, health, education and welfare
- Protestant health institutions are increasingly crumbling under various pressures; Low rural presence.
- Lack of trained personnel to serve the healing ministry.
- Acknowledgment by Churches that policies are not framed to assist healing ministry work - and Church response to changing health scenario is poor.
- Churches want an advisory apex body, and favour CMAI to play the role since it is non-denominational.

(i) CMAI to be effective, should initiate steps for inter-denominational consultations immediately seeking participation from among

- Bishops,
- Church Medical Board Representatives,
- Theologians,
- CMAI representatives,
- Institutional representatives,
- Experts from Health, Education, Economics, Sociology, Social work etc., and
- Christian Health NGOs.

(ii) Immediate Consultations may be organised on focused limited issues of health, with facts and figures. Participants views be invited on what they can contribute to needed efforts. The process should be so guided as to avoid conflict of interests and evolve consensus on priorities and commitment.

(iii) CMAI would do well to install a "data bank" to help gather data to support its multidirectional and multidimensional responsibilities. CMAI's investment in computerisation being in place, this would need a good resource in statistics as support. Initially this cell should first address itself to current issues providing support of authenticity to CMAI's initiatives from secondary sources - while parallel actions to design and develop specialised data bank for CMAI.

(iv) CMAI should identify and co-opt from its members and others knowledgeable persons to continually assist CMAI to succeeded in its endeavour to integrate Christian resources

(v) CMAI management should periodically examine the process critically and be proactive in directing its efforts for integration.

e) **Support to Institutional Members**

The various issues brought up on CMAI support to Institutional members need critical review by the management to evolve a pragmatic action plan. Suggested actions are:

(i) Constitute an expert committee (of Christian professionals of standing) to evaluate the current status and future challenges, of selected few willing institutions, in two or three regions. Detailed SWOT analysis be made by the committee on each case and recommendations translated into action plans in terms of :

- Needed structural and operational changes to be viable and to support its commitment to healing tuned to future challenges.
- Needed resources - Personnel, finance, infrastructure, and networking.
- Training and Development needs.

(ii) Develop proposals for owner managements on actions needed, clearly stating the support CMAI can offer. Persuade through consultations, Institutional Managements to implement recommendations, monitor and nurture the institutions to viability.

(iii) Develop a few turned around institutions as models for replication.

(iv) CMAI can, with the available data, evolve a practical uniform personnel policy with guidelines on terms and conditions of service to attract and retain trained personnel in service. Through a consultative process persuade owners to adopt the model personnel policies.

(v) Continue formal training programmes. In close association with institutional staff, feedback from trained members and keeping in view professional challenges of the future, periodically review the content and methodology of training.

(vi) Take steps to effectively publicise and communicate on each of CMAI's training programmes to potential trainees and employers. Seek and obtain recognition for the courses from the Government, Universities and employers.

(vii) As a long term plan, CMAI may consider being an agency for accreditation of professional skill, on USA model.

(viii) CMAI can help evolve model standard work loads for professions.

(ix) CMAI can explore and evolve a policy for Institutions to offer alternate systems of medical care.

(x) Develop a directory of Protestant Christian Health Professionals to enable institutions to seek support when needed.

(xi) Compile a manual of model hospital management for mission hospitals and publish.

(xii) Involve the institutions in increased focus on primary community based services and away from tertiary care calling for heavy investments to benefit relatively small number.

f) **Publicity, Publications and Communication**

These functional areas of CMAI need to be refurbished to provide greater customer satisfaction.

(i) Appropriate efforts should be made for CMAI's activities to be known outside mission hospitals.
(ii) Publications of CMAI to be enjoyed by members in general, has to address the problems of language, regional content, professional content and members participation in journals.
(iii) For effective communication, the members' lists with addresses need updating regularly. Efficiency in communication and follow-up cannot be overemphasised.

2. Organisational Form And Set-Up

(a) **Objectives**

(i) Among the current objectives of CMAI "Rendering help in calamities and disasters of all kinds" is identified as getting low attention.
- CMAI management should identify reasons for this situation.
- CMAI should develop a "disaster" management manual clearly stating the steps to be taken to activate relief when need arises.
- CMAI should seek and announce the list of volunteer members and institutions willing to participate in CMAI response to Calamities and Disasters, in their respective regions.

- Seek, nominate and publicise a regional disaster coordinator among the volunteers to spring to action in leading the local team of CMAI.
- Nominate and publicise an executive in CMAI who will be responsible to monitor and support local team to respond to the need. Nominate the second in line and a contigency support team at Head office.
- Provide for contingency funds in the budget to facilitate quick financial response.
- Liaise and concretise understanding of co-ordination and cooperation with other Christian specialised agencies for helping in calamities and disasters, on what CMAI can do and the support it needs.
- Seek and keep ready a list of supplier donors who are willing to support CMAI with medicines/materials in such emergencies. Intimate regional co-ordinators.
- With the current donors, negotiate agreement for diverting a percentage of funds to meet such situations without reference. It would be ideal if a special budget provision for "release on call" is agreeable by the donors.

ii. There is need to include **"Nurturing the Christian Spirit in Health Professionals"** as an official objective of CMAI, to bring in to focus the raison d'être of CMAI and to give an official status to the widely believed objective of CMAI.

iii. A word of caution in adding the new objective - In view of the possible sensitivities that may arise under F.C.R. Act and the income tax act, legal advice may be obtained in wording the new objective suggested, to ensure no adverse reaction.

b) **Membership Issues.**

i. Responsibility for membership co-ordination desk at CMAI - Head office should be with a senior executive. CMAI is an association of members and the base needs attention and service - First, update membership and subscription information. Computer environment should make the task none-too-difficult once updated.

ii. Responding to members and growth of membership in different regions should be shouldered by the members of the management team at Head Office for effective communication and service.

iii. In view of the growing recognition to non-allopathic systems of medicine, CMAI may consider extending membership to accredited non-allopathic practitioners (Doctors) to enlarge the scope for service. Some Institutional members are offering non-allopathic system of treatment anyway.

iv. CMAI should launch a membership campaign, involving current members, to enlarge its membership now clustering around mission hospitals. Non-mission hospitals sectors should be vigorously reached to enlarge its area of contacts and influence.

v. CMAI may examine ways and means of making its membership useful to members by publicising benefits to members.

vi. A plan to encourage local chapters in different regions, on the model of chartered secretaries, Engineers, Accountants etc. to facilitate larger CMAI presence and relevance to individual members through encouraging local activities on voluntary basis.

vii. Such local chapter may be given status support through intimating local Government officials, Churches, NGOs and other Church related institutions, about the local chapter, its office bearers that they are CMAI representatives.

viii. CMAI may consider identifying annual "Health Themes" for members' participation - with broad guidelines on implementation. Financial support may be considered on a "percentage of matching grant" against local resource generation by members.

c) **Effectiveness of sections of CMAI**

i. The present organisational set-up on the lines of professional responsibilities needs review.

ii. It is necessary to effectively involve each section in the development of CMAI as a whole and to increase interdepartmental and intersectional communication on plans and progress.

d) **Management set-up, style and form**

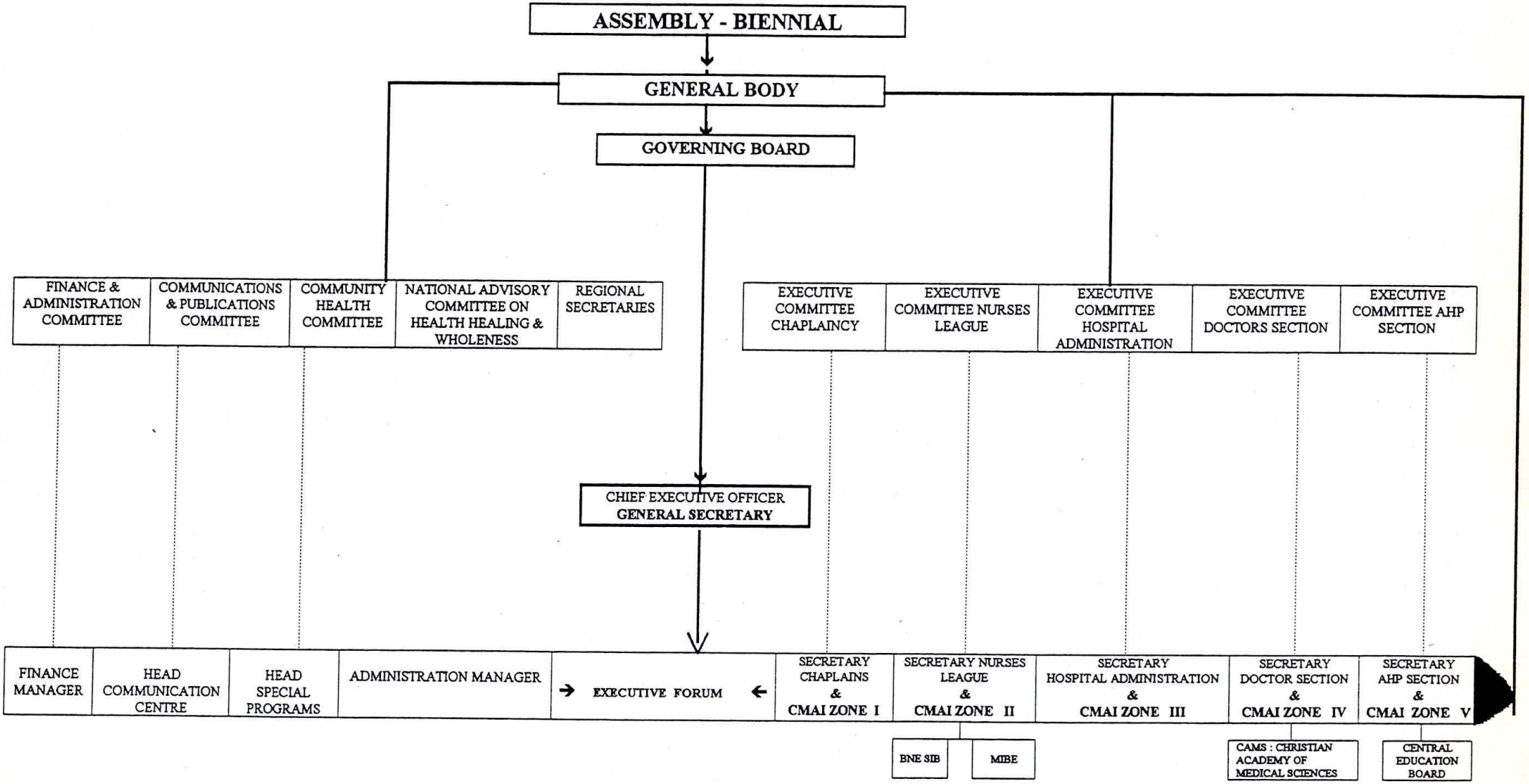
i. Increase the number of members on the General Body by three more members, to develop an axis of help and co-operation with the Churches. Senior Church officials of various denominations may be nominated by rotation for the three posts.

ii. In order to create effective presence of CMAI in different parts of the Country, identify five zones demarking the physical areas. Responsibility for developing each zone in terms of CMAI presence by activity co-ordination, membership and service networking with Churches in the area, be assigned to each sectional secretary in addition to the sectional responsibilities. This would also enable inter-sectional co-ordination and support. It relieves the CEO to focus his/her time and energy on policy, planning and coordination. (Please see enclosed chart for suggested changes)

iii. All sectional secretaries, functional heads and the general secretary should form the "management forum" and be accountable to implementation of all approved plans. The CEO should have the deciding powers over the forum.

SUGGESTED
REORGANISATION

CHRISTIAN MEDICAL ASSOCIATION OF INDIA
ORGANISATIONAL SET-UP



ZONES **STATES**
(ILLUSTRATIVE)

ZONE I = J&K, HARYANA, H.P. DELHI, PUNJAB, U.P., CHANDIGARH
ZONE II = GUJRAT, RAJASTHAN, MAHARASHTRA
ZONE III = ORISSA, BIHAR, M.P.
ZONE IV = ASSAM, MEGHALAYA, MIZORAM, NAGALAND, MANIPUR, W.B., SIKKIM, TRIPURA
ZONE V = A.P., T.N., KARNATAKA, KERALA, PONDICHERRY, GOA, DAMAN DIU, ANDAMAN/NICOBAR

PART- B

SELECTED DATA BASE - FOR REFERENCE

CONTENTS

PART B - LIST OF TABLES & CHARTS

CHART 1

CONSTITUTIONAL OBJECTIVES OF CMAI

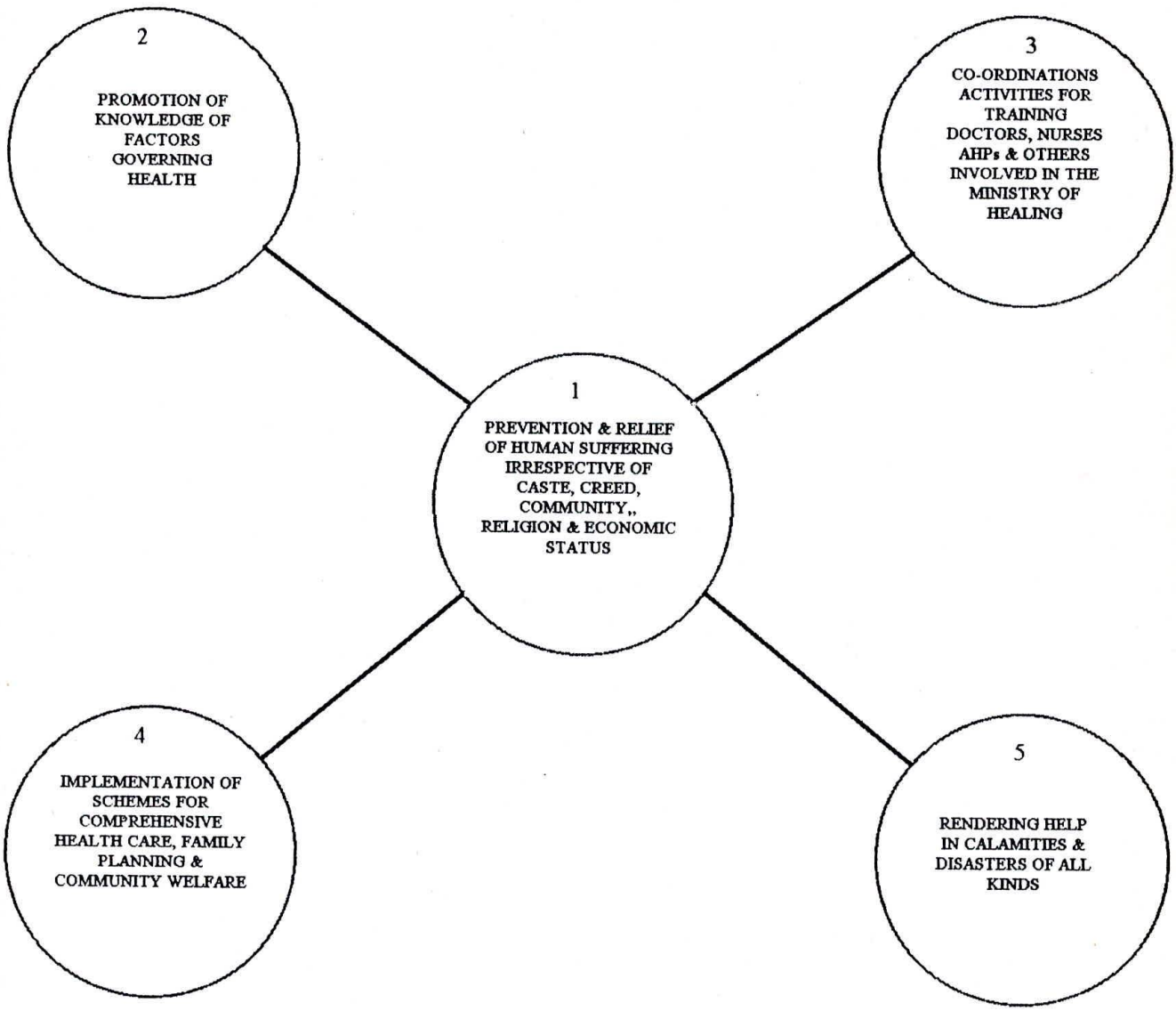
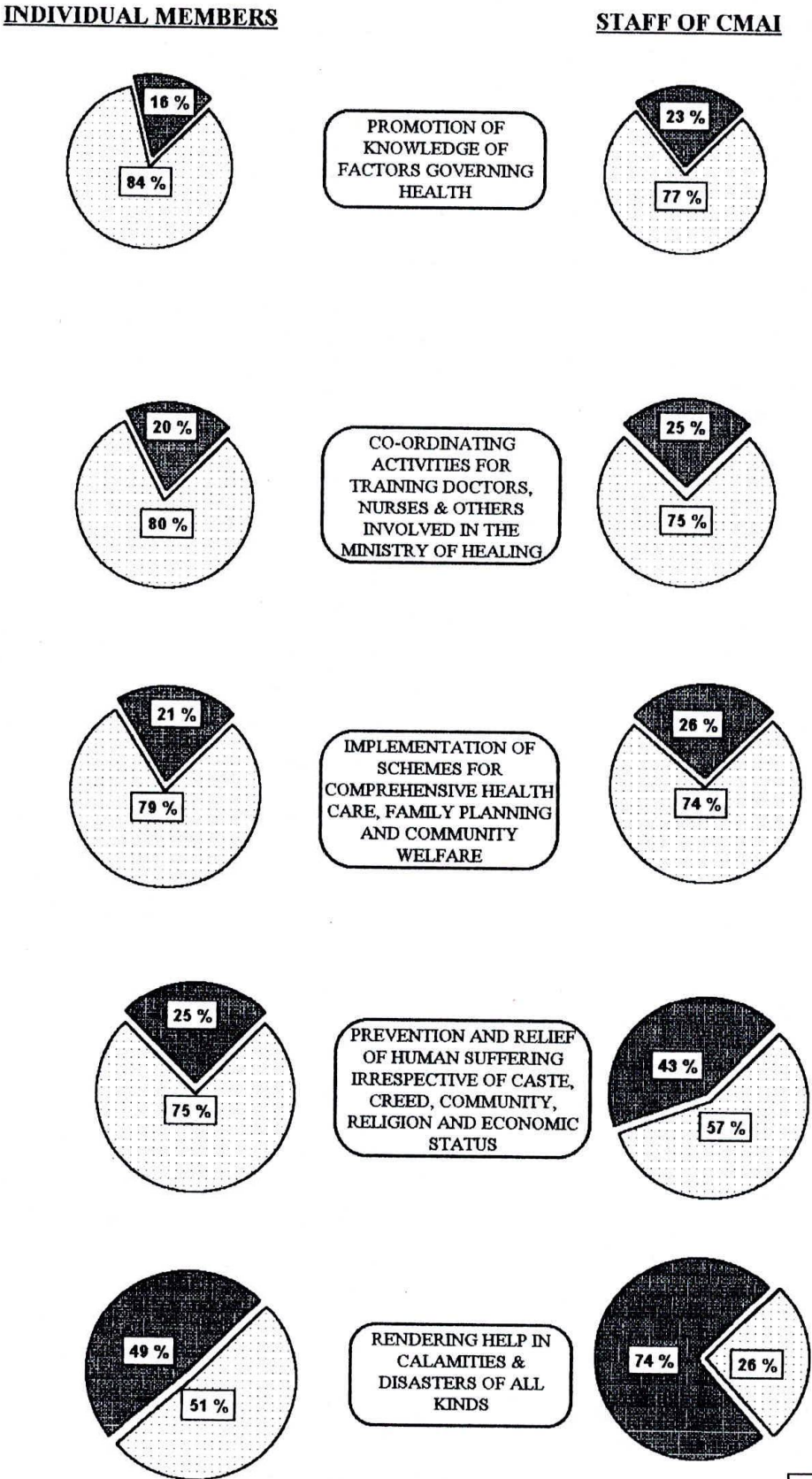


CHART 2

IMPORTANCE GIVEN TO EACH CONSTITUTIONAL OBJECTIVE BY CMAI - AS PERCEIVED BY



DISTRIBUTION OF MEMBERS BY SECTION

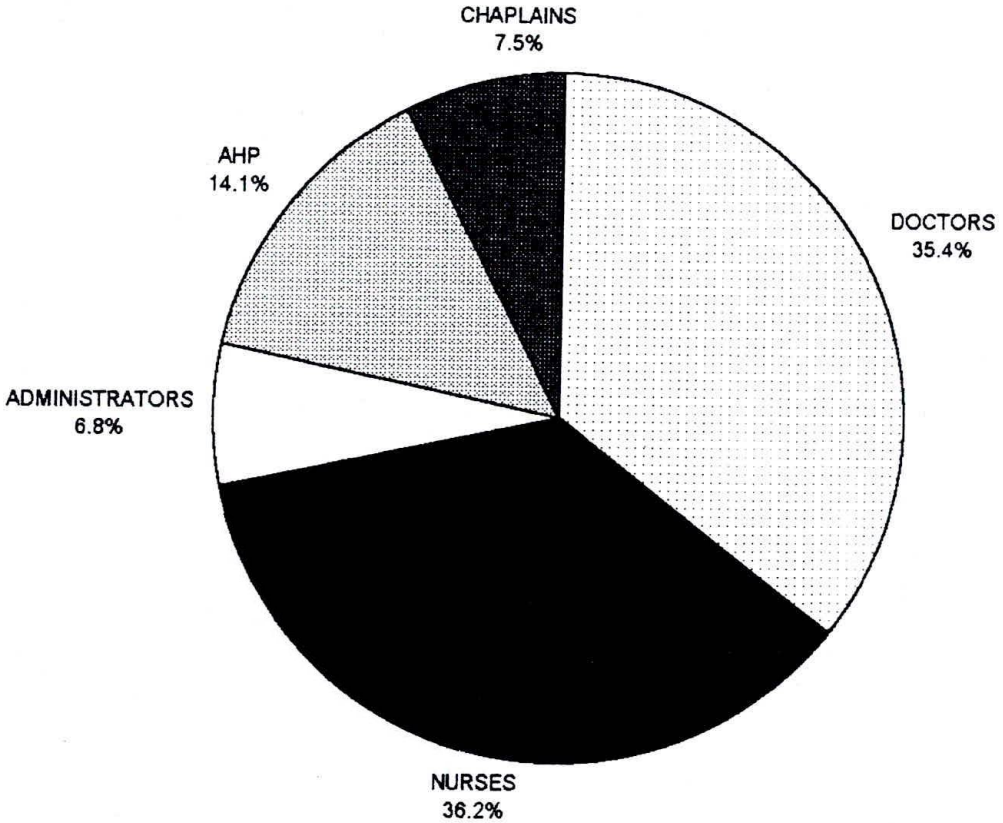


CHART 3

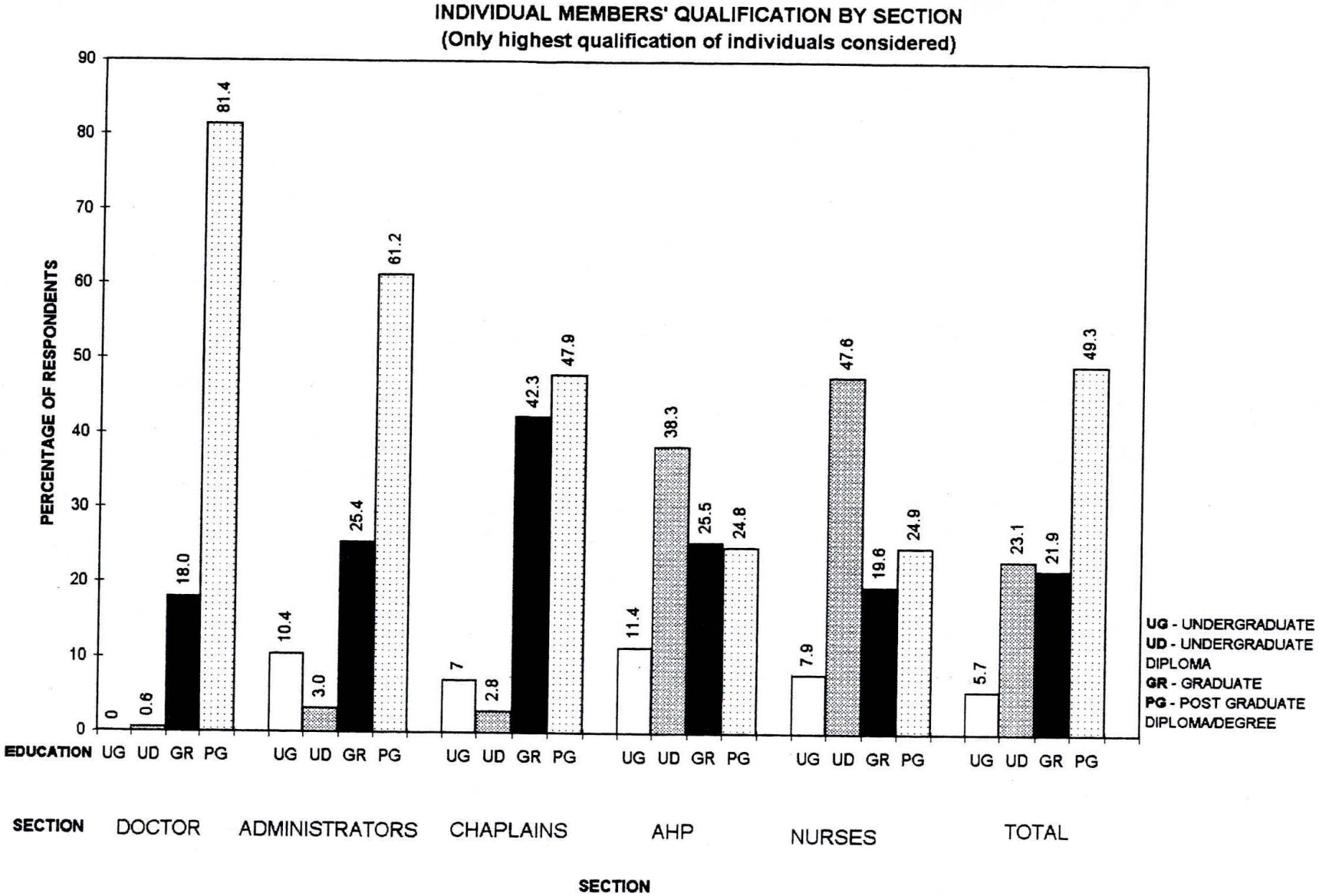

INDIVIDUAL MEMBERS' QUALIFICATION BY SECTION
(Only highest qualification of individuals considered)
PERCENTAGE OF RESPONDENTS
90
80
70
60
50
40
30
20
10
0
0
0.6
18.0
81.4
10.4
3.0
25.4
61.2
7
2.8
42.3
47.9
11.4
38.3
25.5
24.8
7.9
47.6
19.6
24.9
5.7
23.1
21.9
49.3
EDUCATION UG UD GR PG UG UD GR PG UG UD GR PG UG UD GR PG UG UD GR PG UG UD GR PG
SECTION DOCTOR ADMINISTRATORS CHAPLAINS AHP NURSES TOTAL
SECTION
UG - UNDERGRADUATE
UD - UNDERGRADUATE DIPLOMA
GR - GRADUATE
PG - POST GRADUATE DIPLOMA/DEGREE

CHART 4

REGIONAL DISTRIBUTION OF MEMBERS BY EDUCATION
(Only highest qualification of Individual considered)

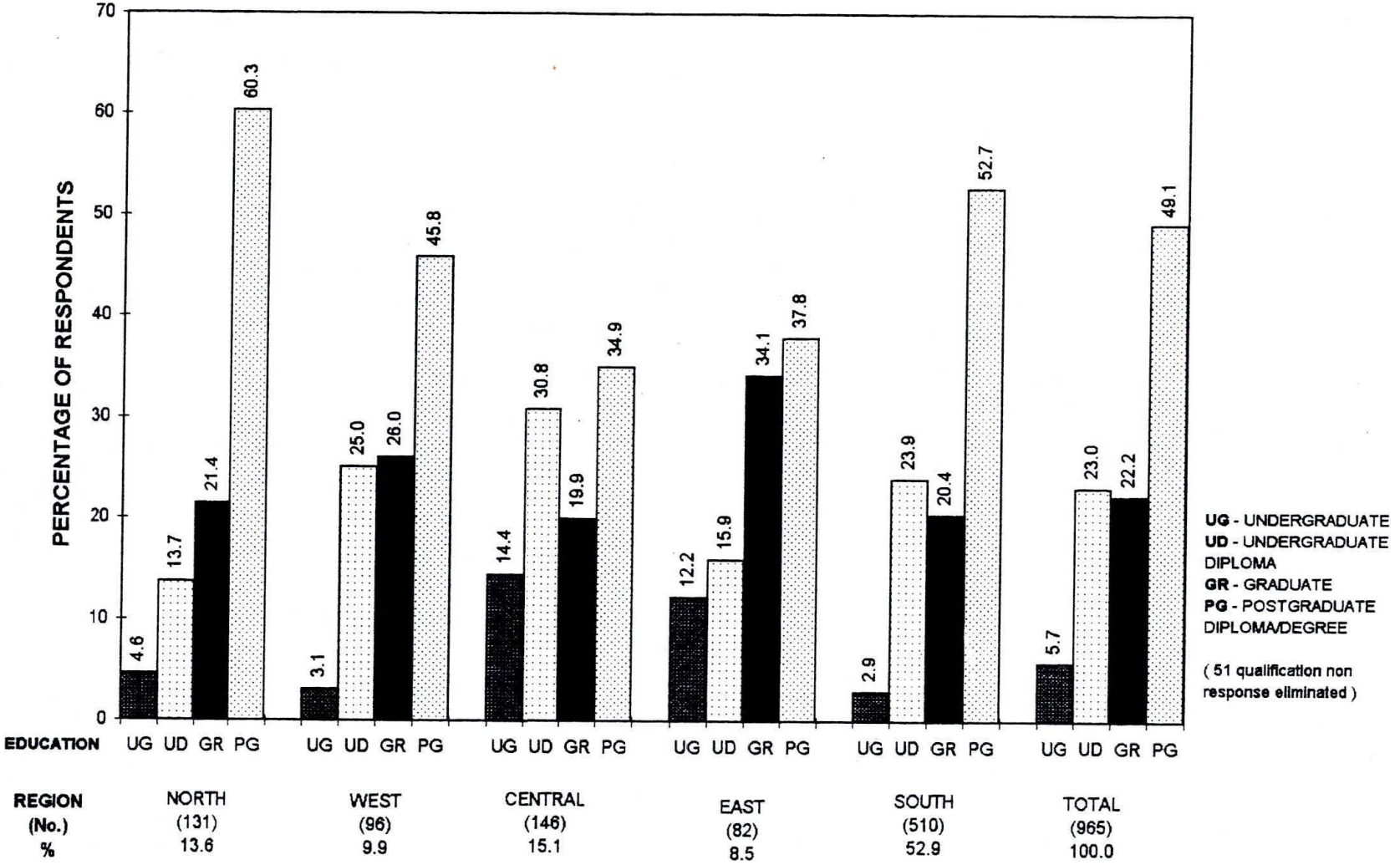


CHART 5

EMPLOYMENT SETTING OF CMAI INDIVIDUAL MEMBERS

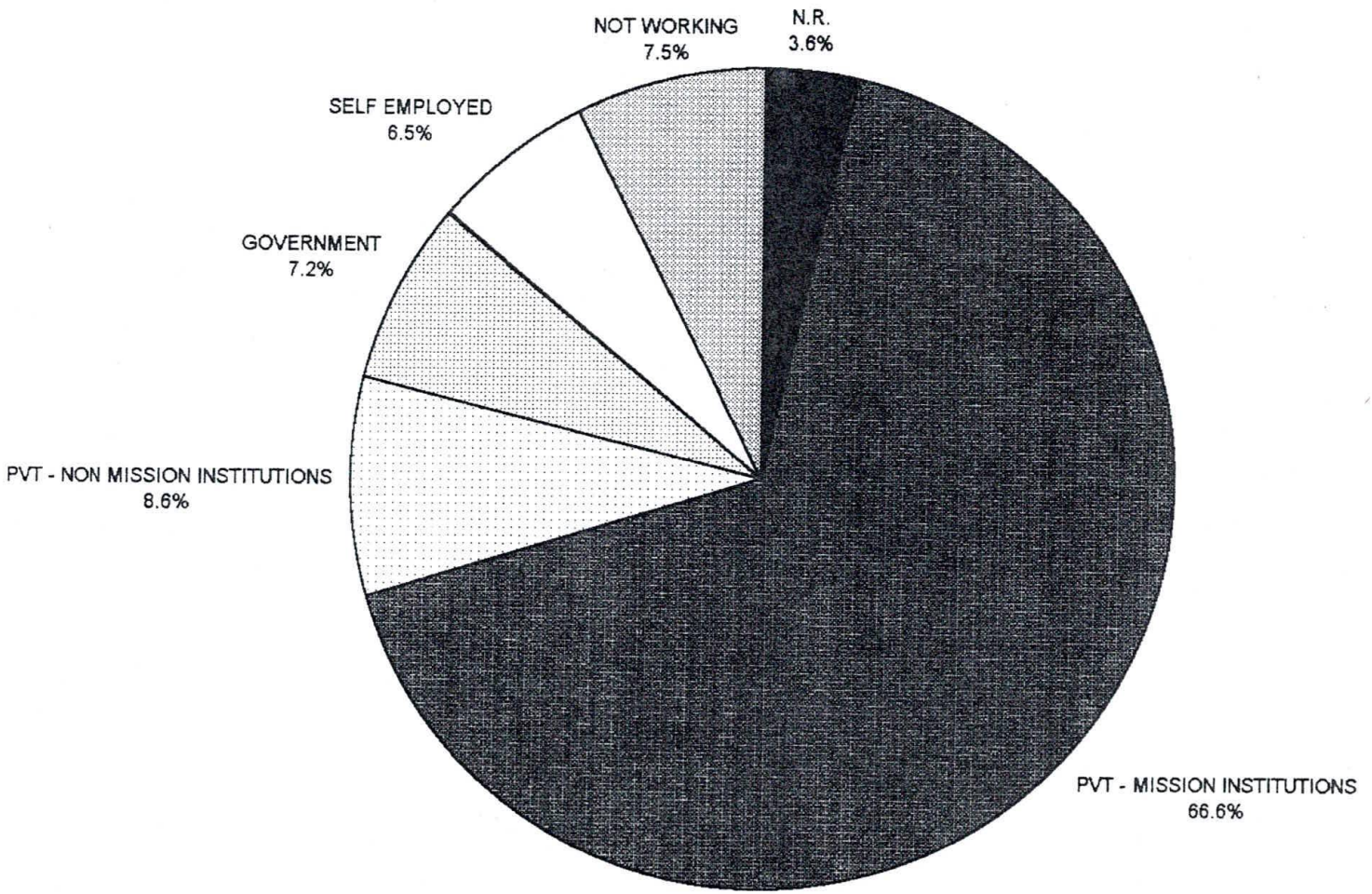
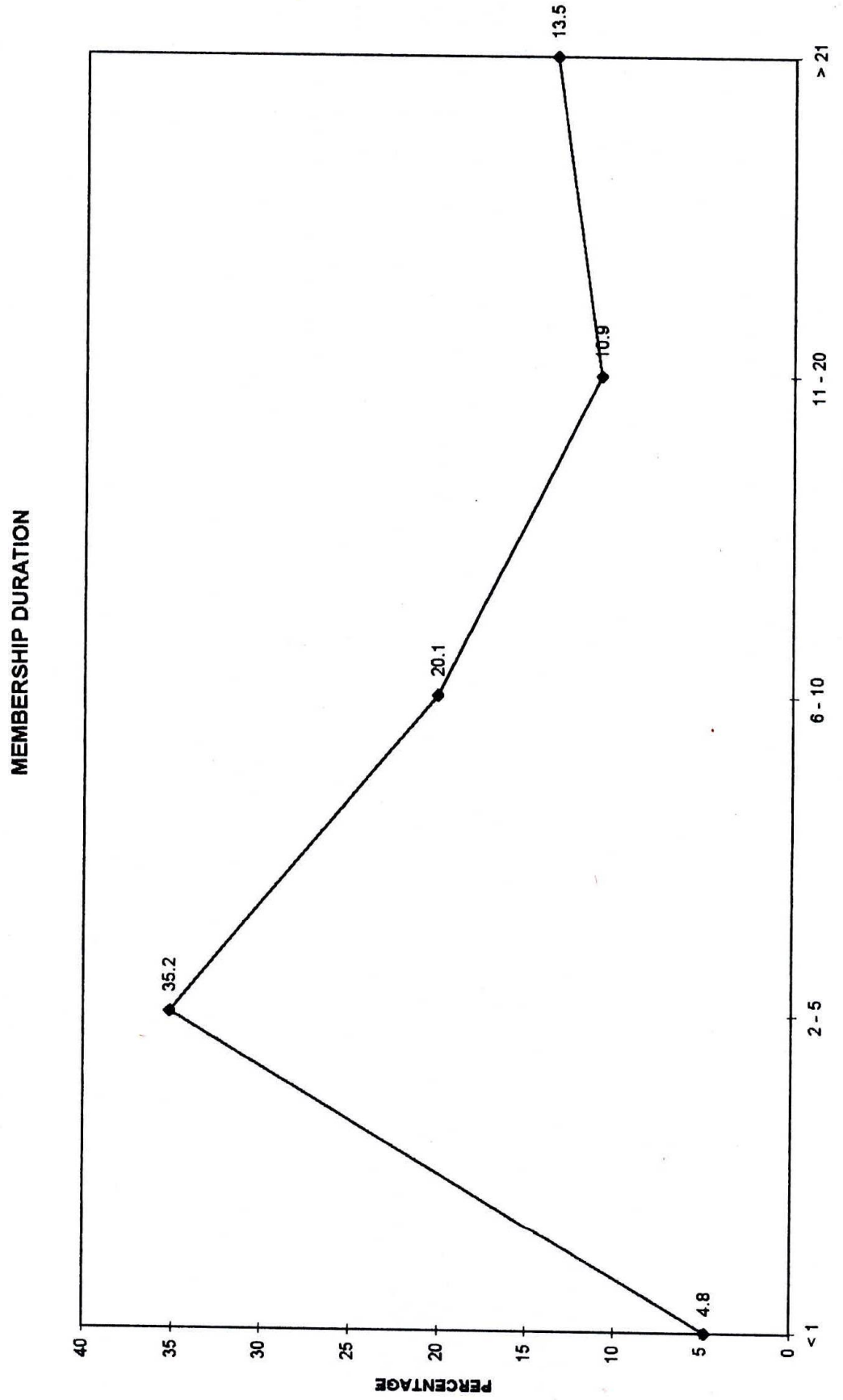


CHART 6

CHART 7


MEMBERSHIP DURATION
PERCENTAGE
40
35
30
25
20
15
10
5
0
35.2
20.1
10.9
13.5
4.8
< 1
2 - 5
6 - 10
11 - 20
> 21
MEMBERSHIP DURATION IN YEARS

CMAI MEMBERS BY CHURCH DENOMINATIONS

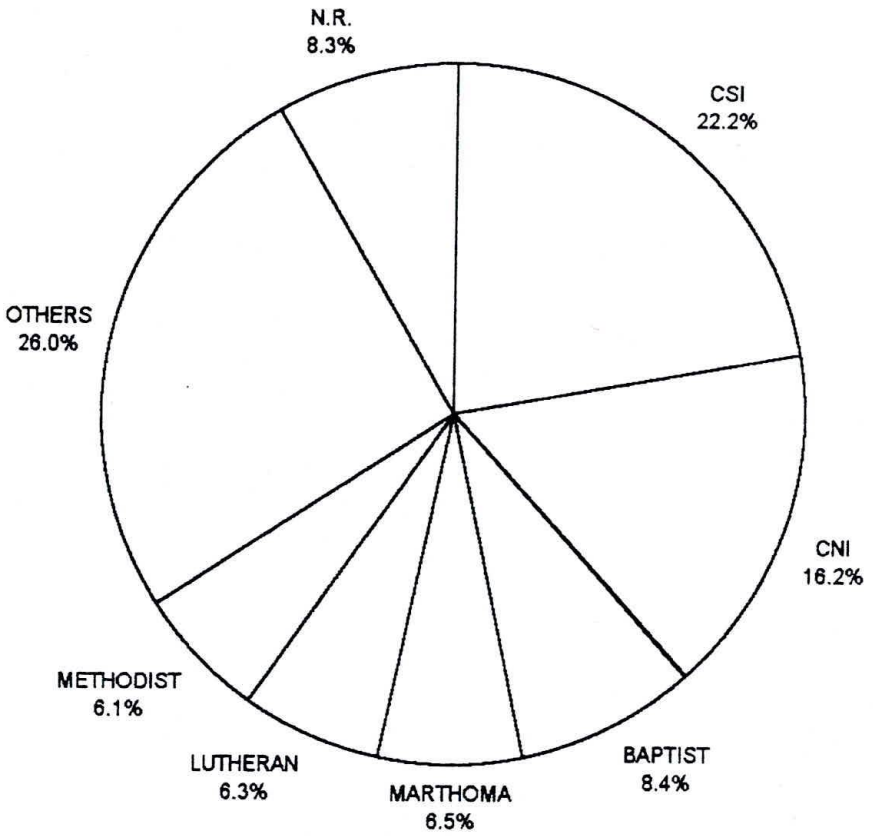


CHART 8

AGE OF MEMBERS

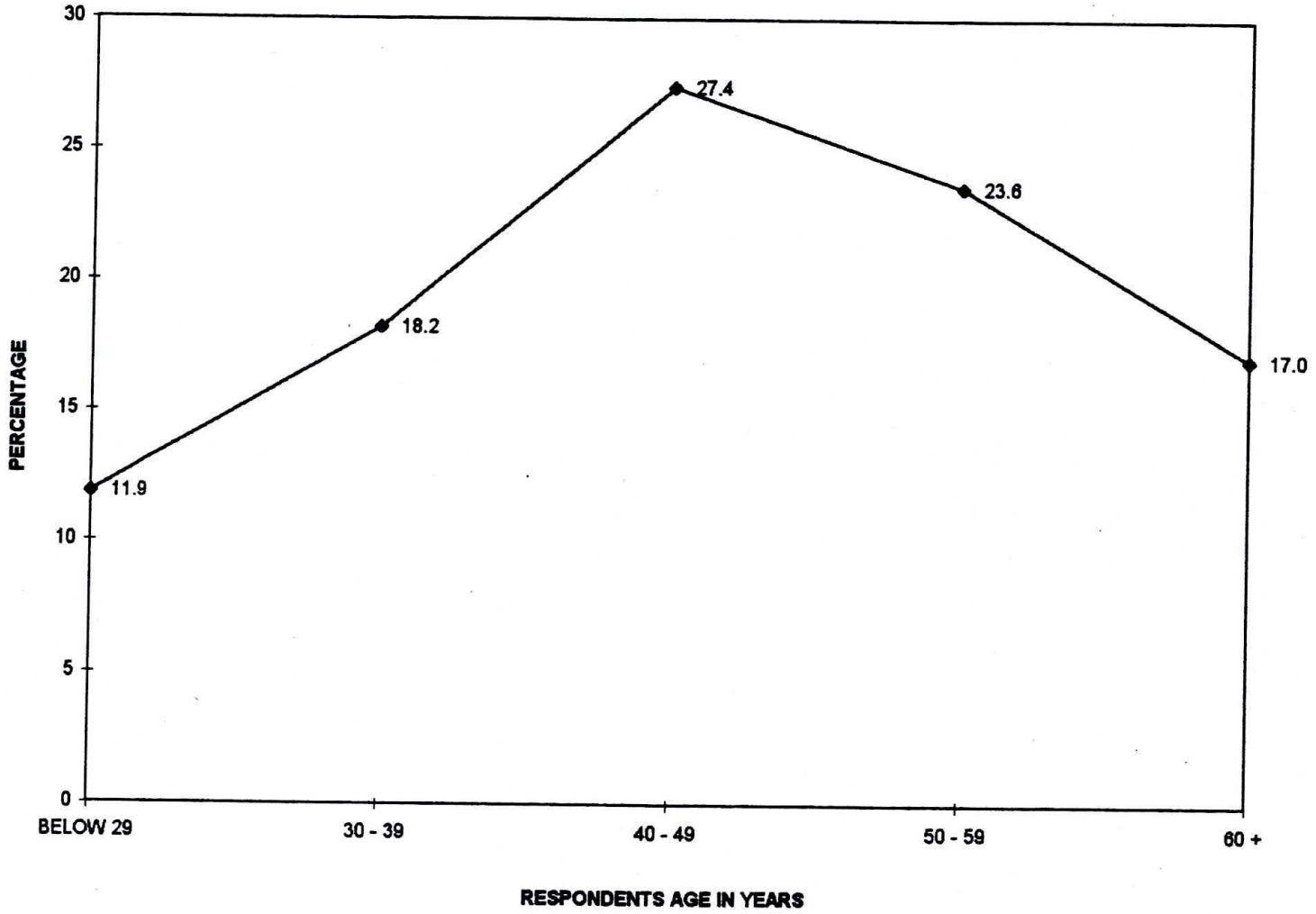


CHART 9

CMAI STAFF BY QUALIFICATION
(ONLY HIGHEST QUALIFICATION)

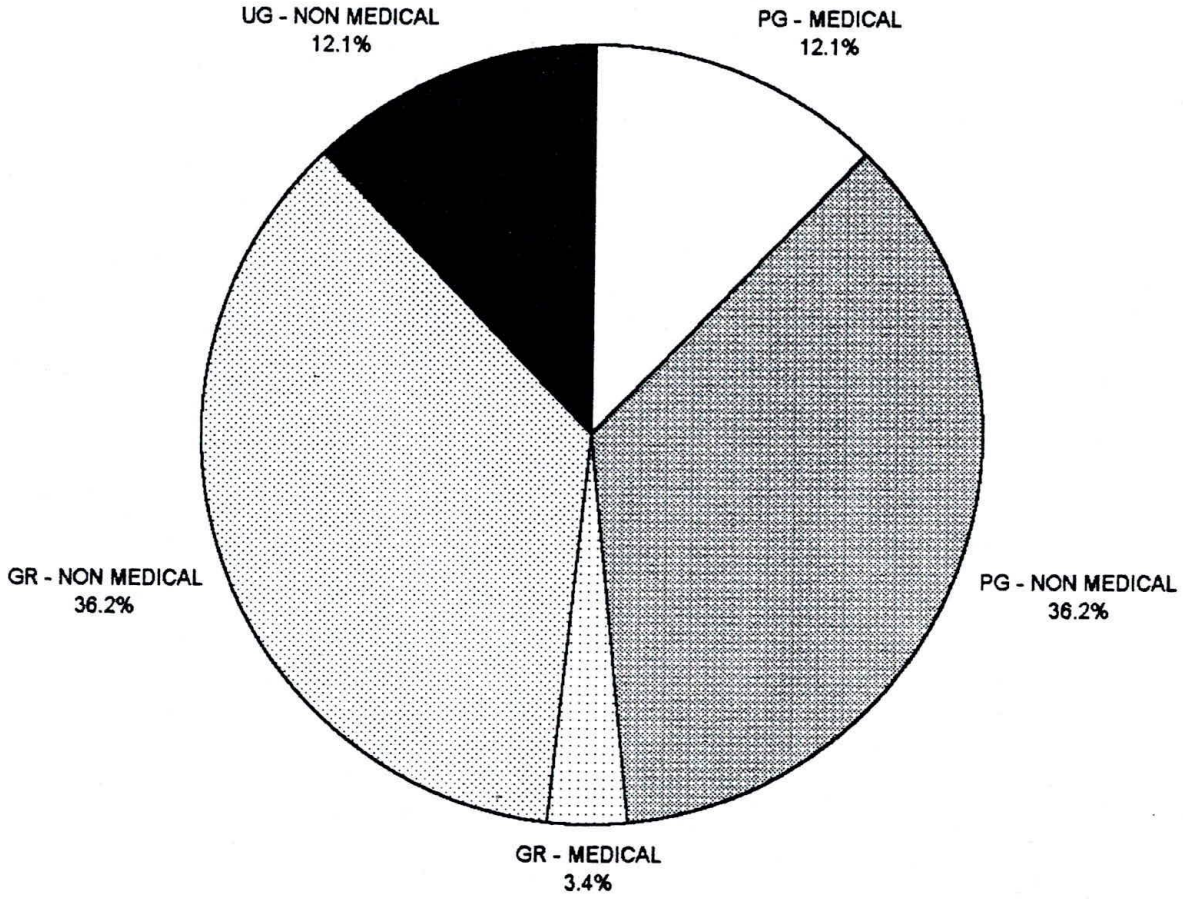


CHART 10

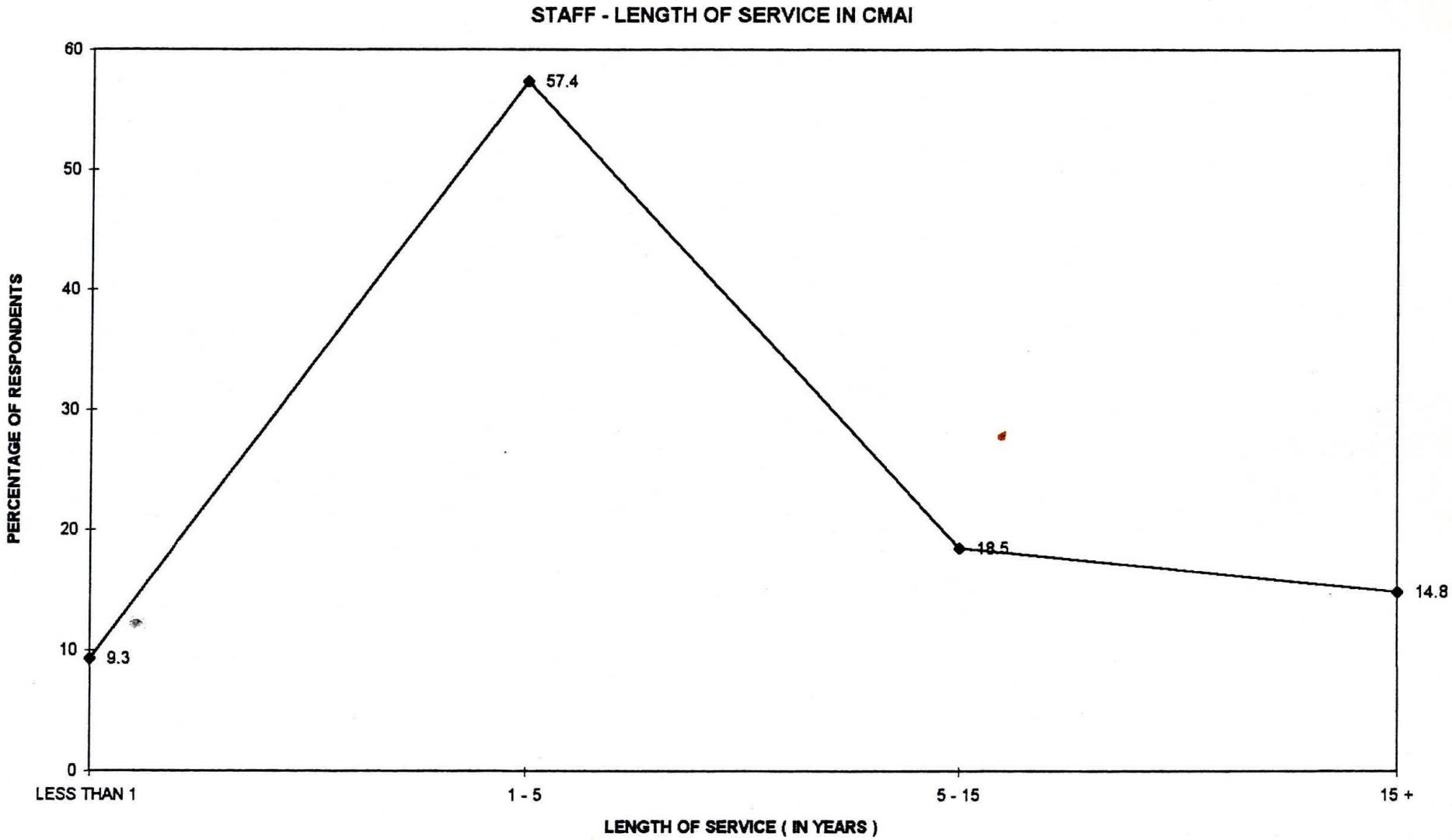

STAFF - LENGTH OF SERVICE IN CMAI
PERCENTAGE OF RESPONDENTS
60
50
40
30
20
10
0
57.4
18.5
14.8
9.3
LESS THAN 1
1 - 5
5 - 15
15 +
LENGTH OF SERVICE (IN YEARS)

CHART 11

SECTION / DEPARTMENTWISE DISTRIBUTION OF STAFF IN CMAI

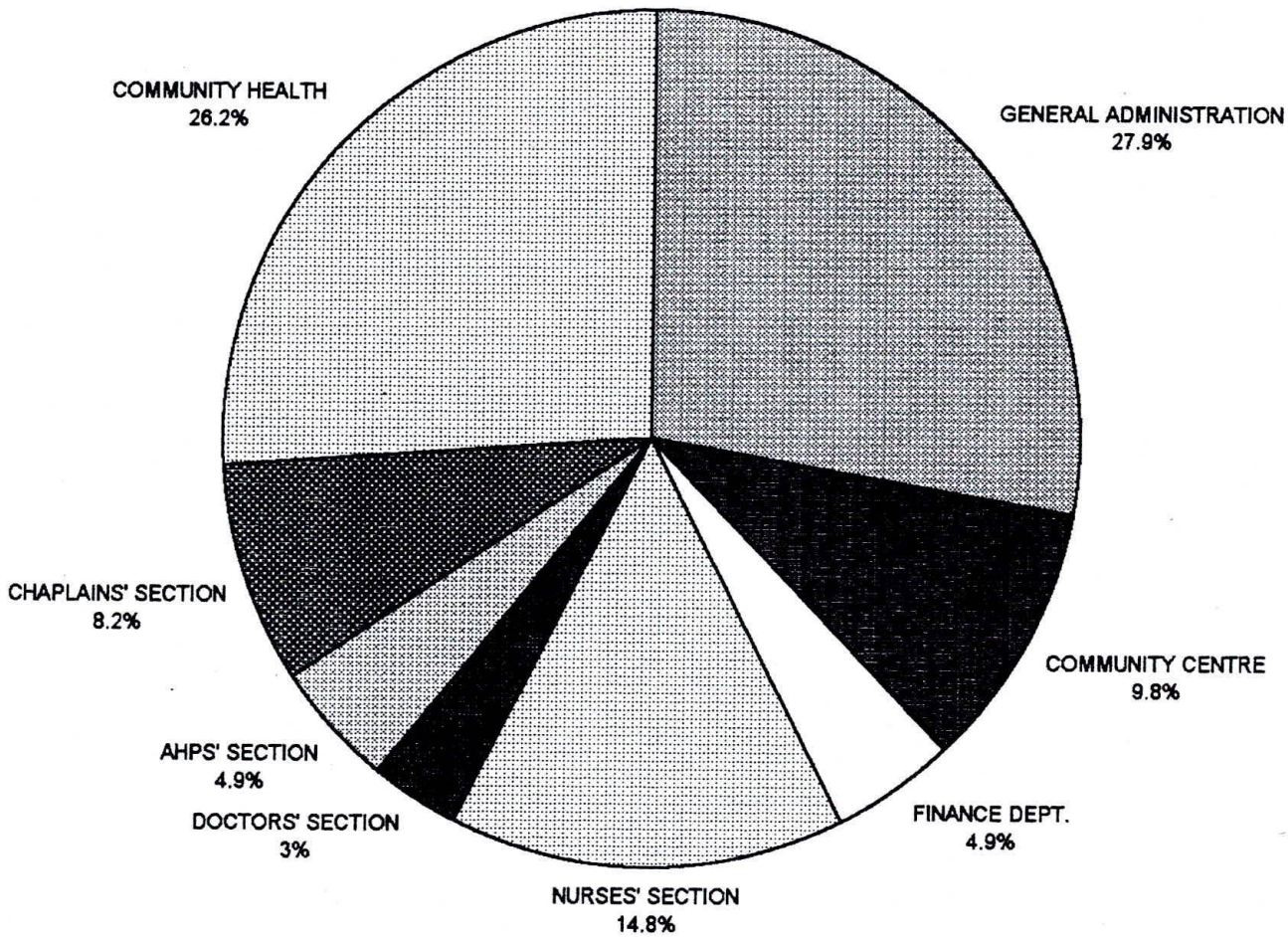


CHART 12

CMAI STAFF MEMBERS BY RESPONSIBILITY LEVELS

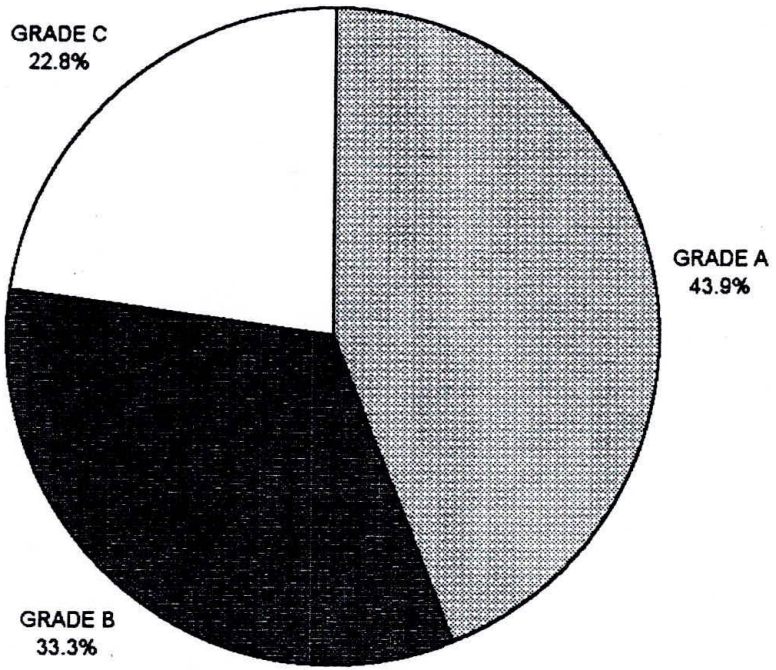


CHART 13

STAFF - AGE DISTRIBUTION

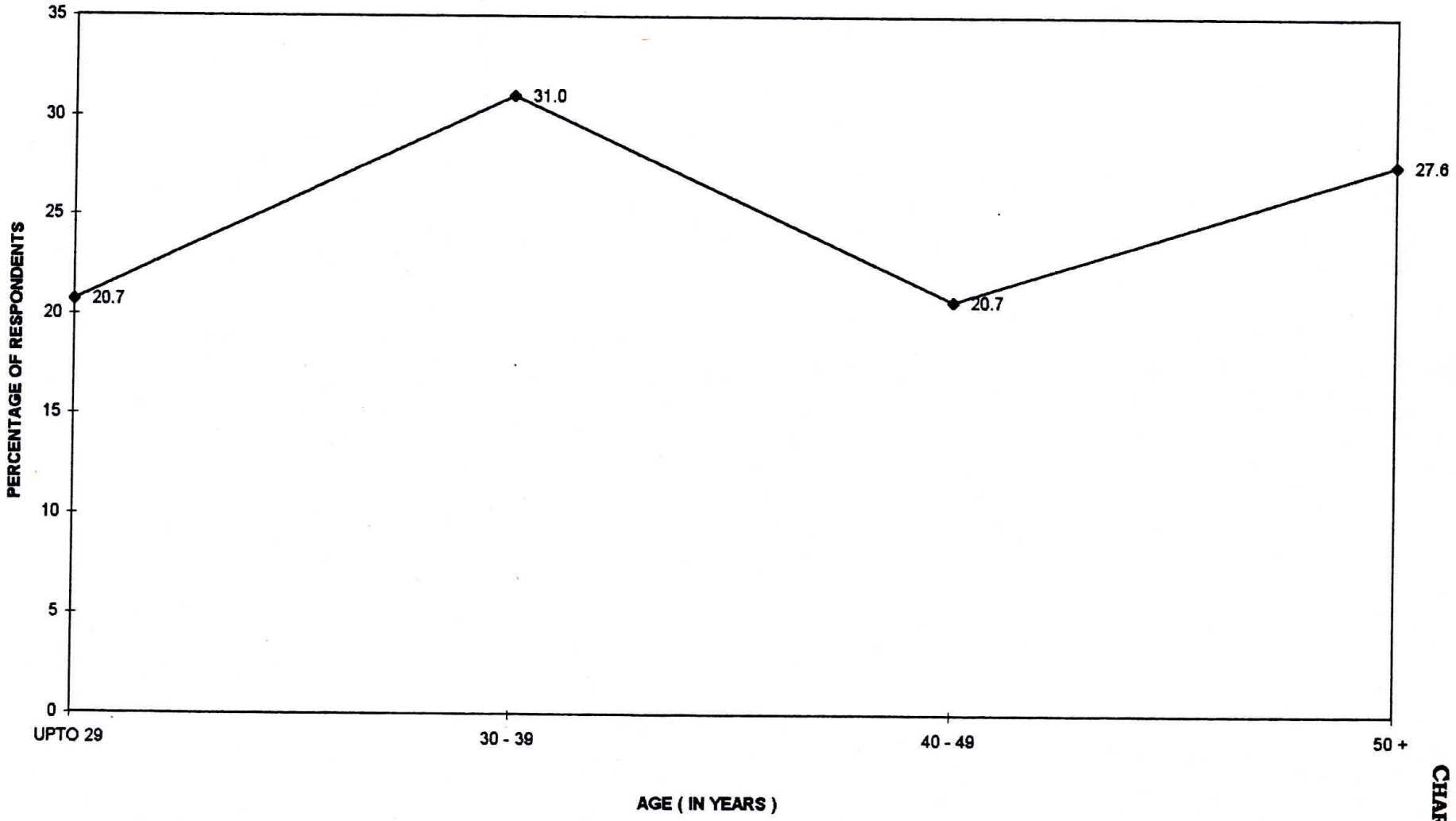


CHART 14

CHART 15

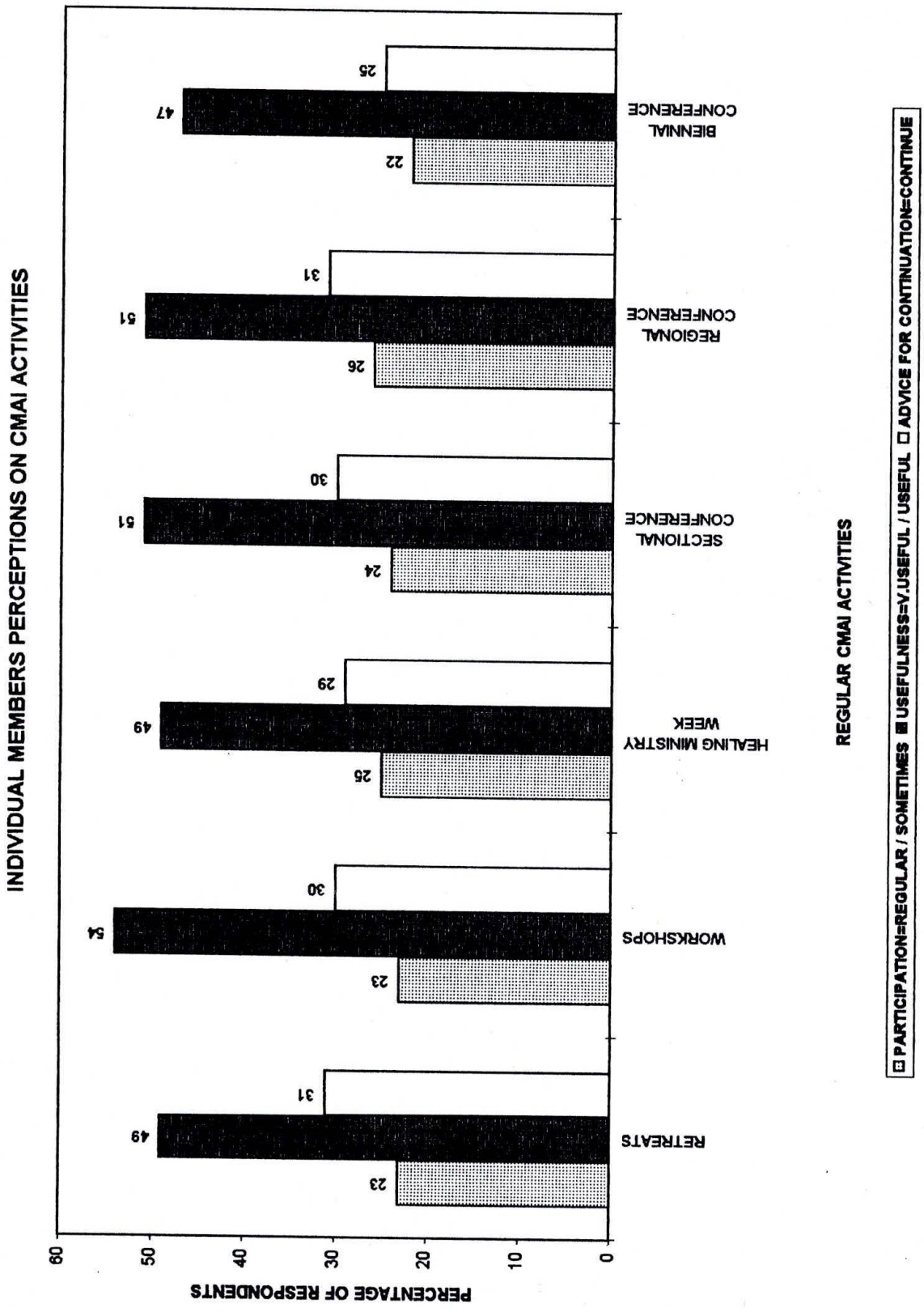
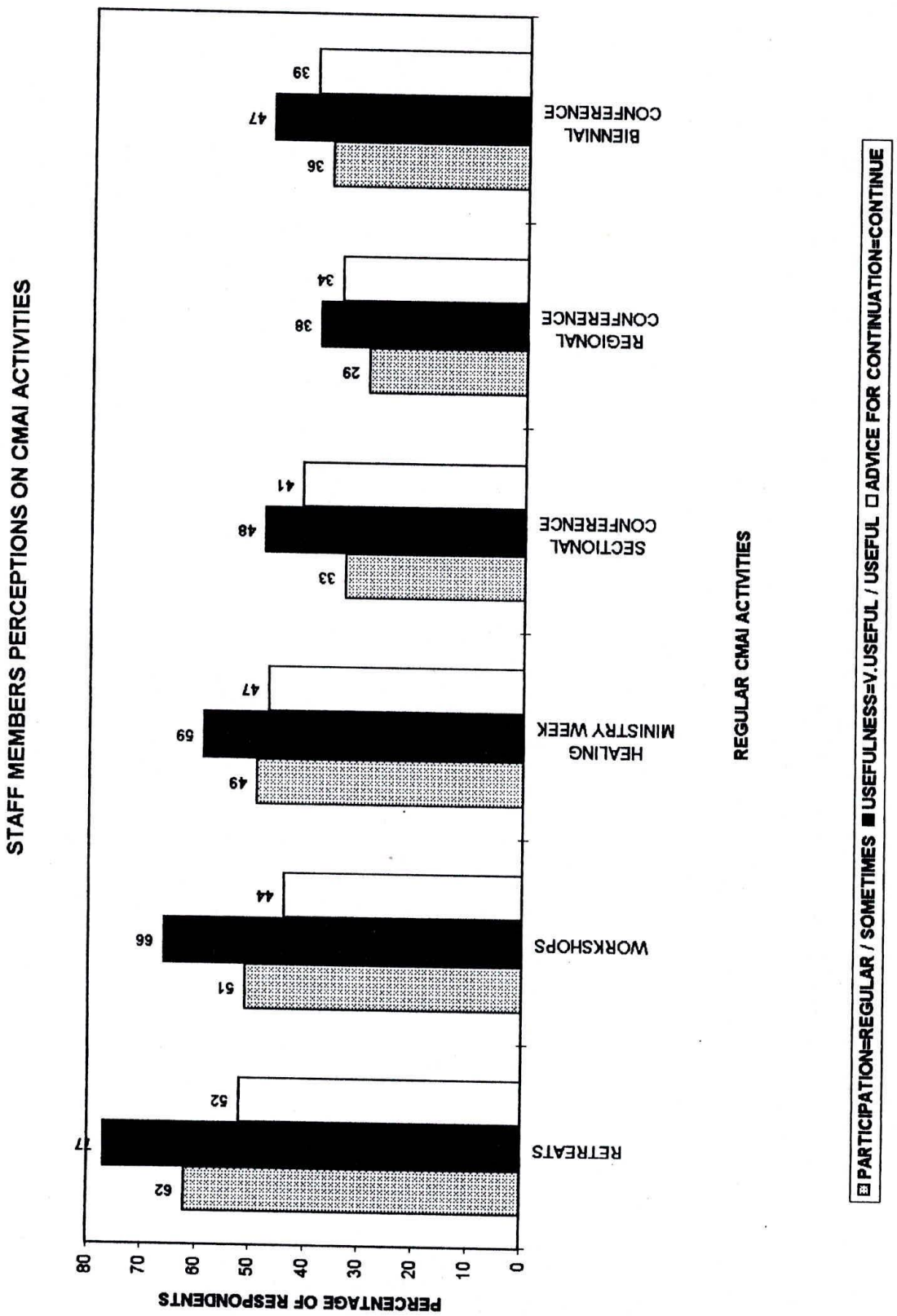

INDIVIDUAL MEMBERS PERCEPTIONS ON CMAI ACTIVITIES
PERCENTAGE OF RESPONDENTS
0
10
20
30
40
50
60
RETREATS
23
49
31
WORKSHOPS
23
54
30
HEALING MINISTRY WEEK
25
49
29
SECTIONAL CONFERENCE
24
51
30
REGIONAL CONFERENCE
26
51
31
BIENNIAL CONFERENCE
22
47
25
REGULAR CMAI ACTIVITIES
PARTICIPATION=REGULAR / SOMETIMES USEFULNESS=V.USEFUL / USEFUL ADVICE FOR CONTINUATION=CONTINUE

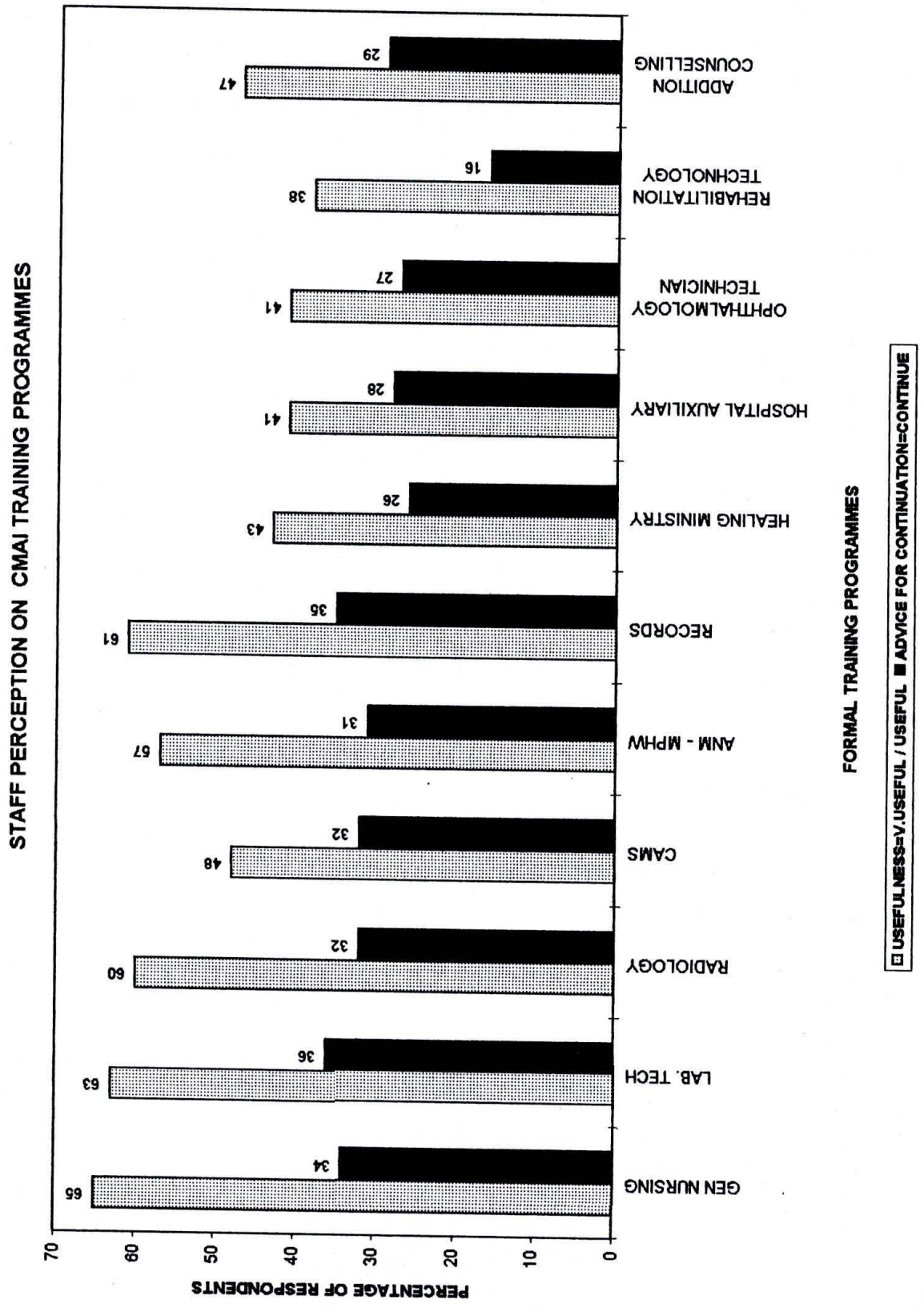
CHART 16


STAFF MEMBERS PERCEPTIONS ON CMAI ACTIVITIES
PERCENTAGE OF RESPONDENTS
0
10
20
30
40
50
60
70
80
62
77
52
51
66
44
49
59
47
33
48
41
29
38
34
36
47
39
RETREATS
WORKSHOPS
HEALING MINISTRY WEEK
SECTIONAL CONFERENCE
REGIONAL CONFERENCE
BIENNIAL CONFERENCE
REGULAR CMAI ACTIVITIES
PARTICIPATION=REGULAR / SOMETIMES ■USEFULNESS=V.USEFUL / USEFUL □ADVICE FOR CONTINUATION=CONTINUE

PERCENTAGE OF RESPONDENTS
0
10
20
30
40
50
60
GEN NURSING
59
27
LAB. TECH
58
27
RADIOLOGY
48
22
CAMS
47
28
ANM - MPHW
46
21
RECORDS
44
22
HEALING MINISTRY
38
19
HOSPITAL AUXILIARY
33
16
OPHTHALMOLOGY TECHNICIAN
31
16
REHABILITATION TECHNOLOGY
29
16
ADDITION COUNSELLING
29
17
INDIVIDUAL MEMBERS PERCEPTION ON CMAI TRAINING PROGRAMMES
FORMAL TRAINING PROGRAMMES
USEFULNESS=V.USEFUL / USEFUL ■ ADVICE FOR CONTINUATION=CONTINUE

CHART 17

CHART 18


STAFF PERCEPTION ON CMAI TRAINING PROGRAMMES
PERCENTAGE OF RESPONDENTS
0
10
20
30
40
50
60
70
GEN NURSING
LAB. TECH
RADIOLOGY
CAMS
ANM - MPHW
RECORDS
HEALING MINISTRY
HOSPITAL AUXILIARY
OPHTHALMOLOGY TECHNICIAN
REHABILITATION TECHNOLOGY
ADDITION COUNSELLING
65
63
60
48
67
61
43
41
41
38
47
34
36
32
32
31
35
26
28
27
16
29
FORMAL TRAINING PROGRAMMES
USEFULNESS=V.USEFUL / USEFUL ADVICE FOR CONTINUATION=CONTINUE

DISTRIBUTION OF CHURCH OFFICIALS BY DENOMINATIONS

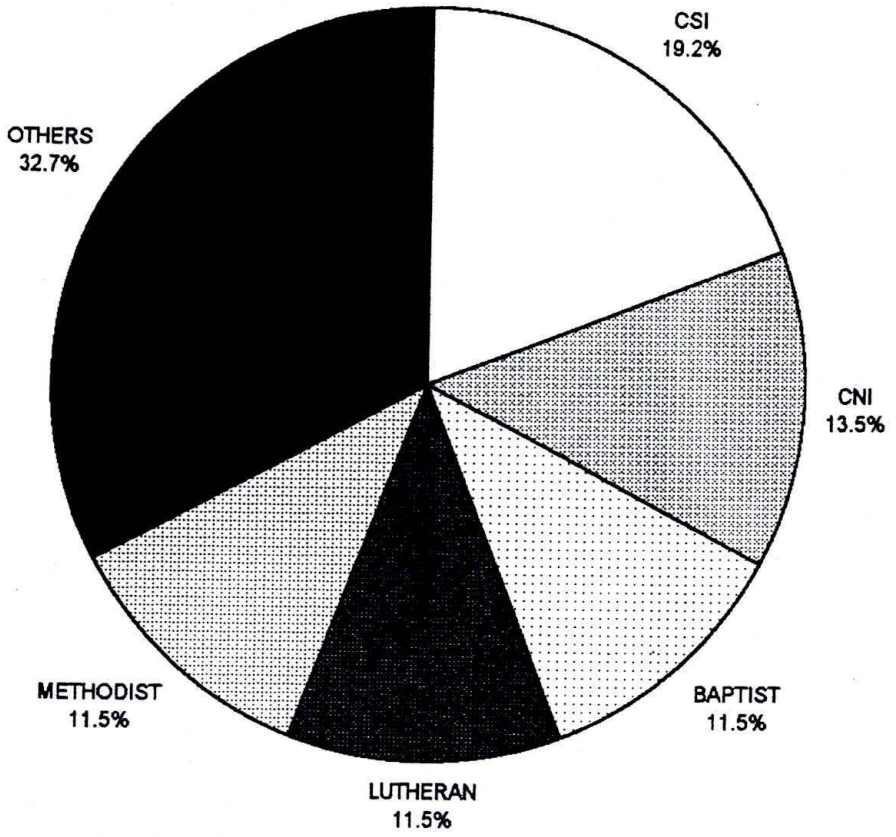


CHART 19

REGIONAL DISTRIBUTION OF RESPONDING CHURCH OFFICIALS

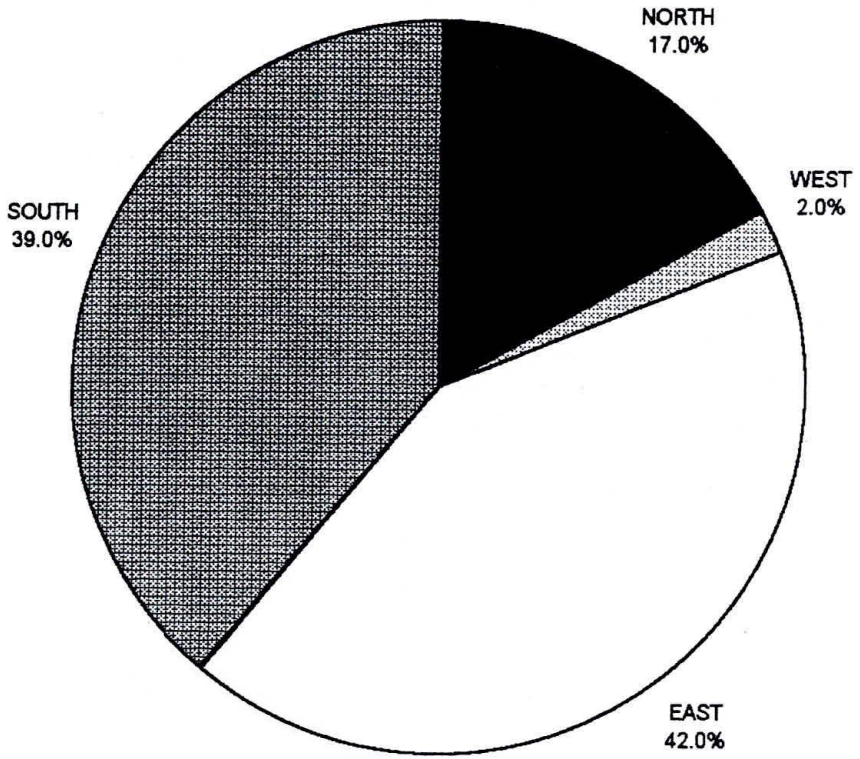


CHART 20

RESPONDING CHURCH OFFICIALS - AGE DISTRIBUTION

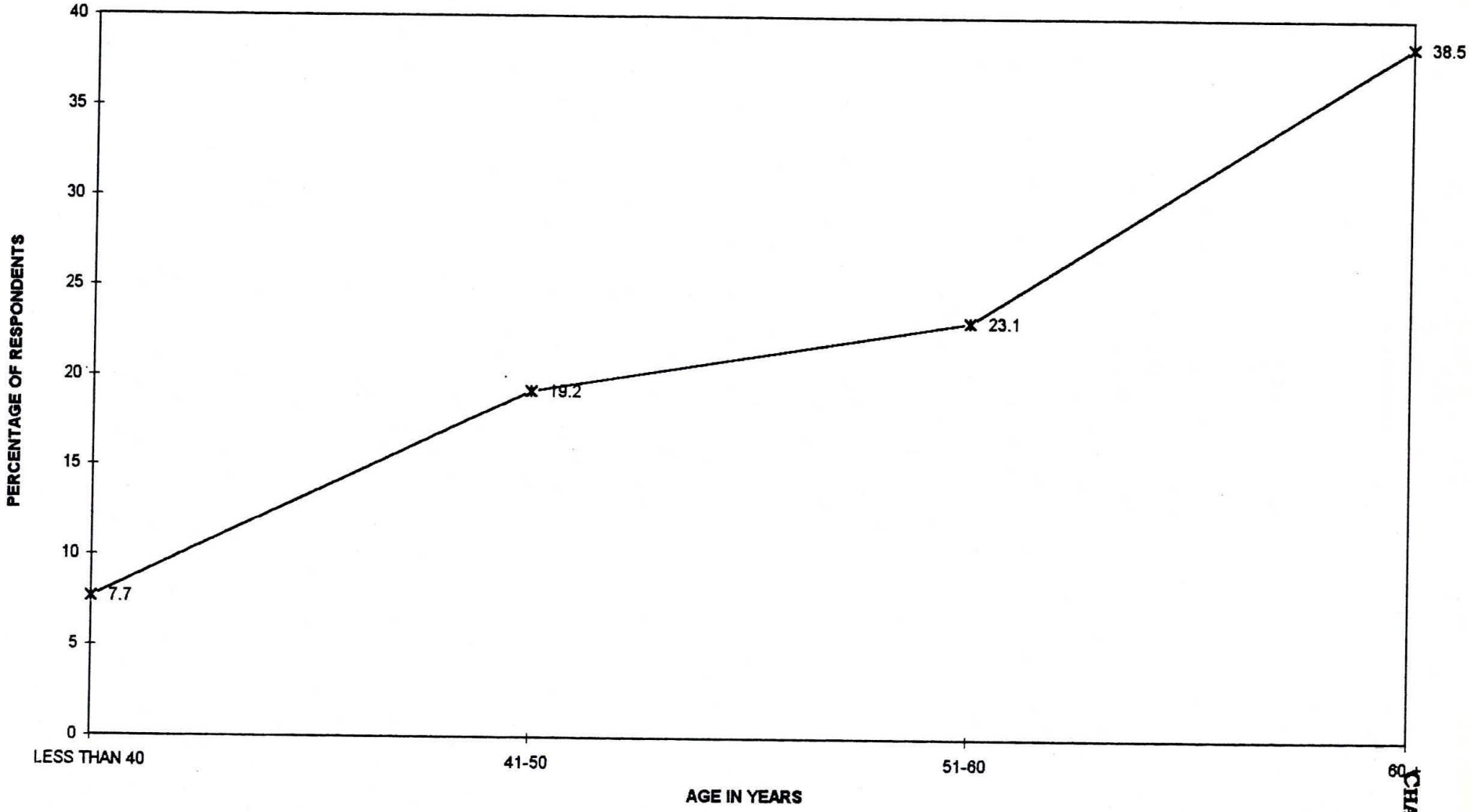


CHART 21

RESPONDING CHURCH OFFICIALS - DURATION OF SERVICE IN CHURCH

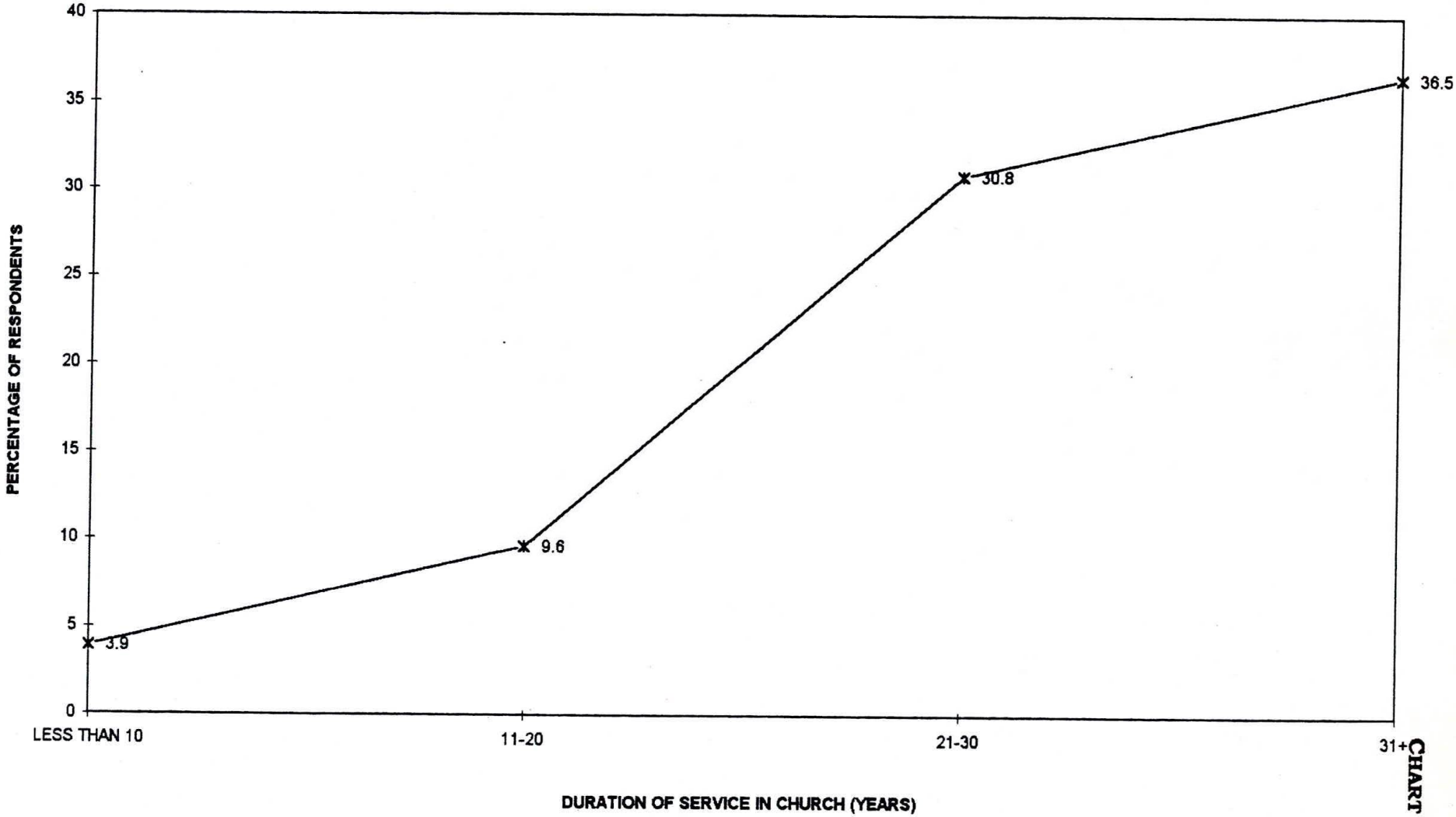


CHART 22

CMAI INSTITUTIONAL MEMBERS - NATURE OF INSTITUTIONS

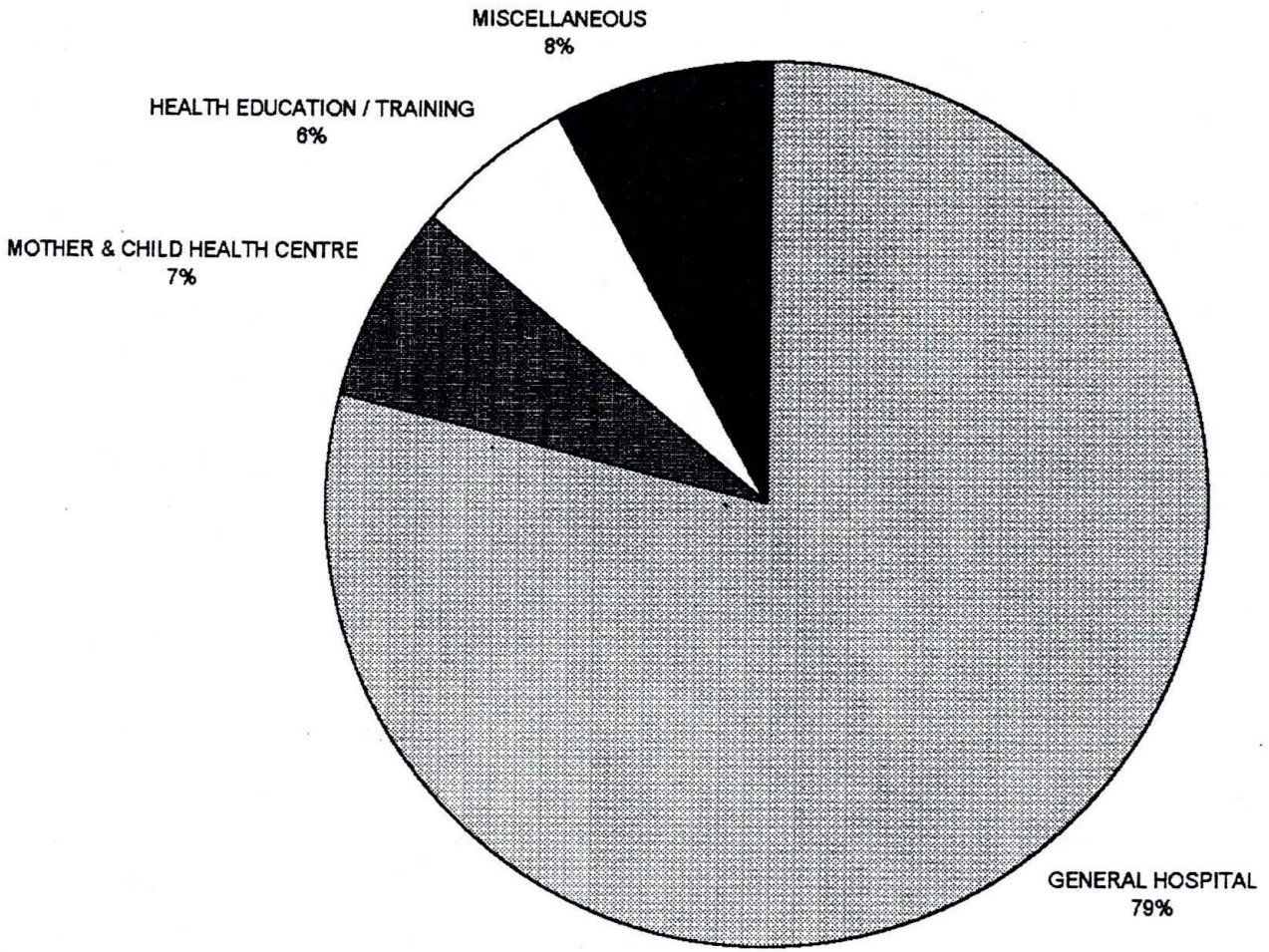


CHART 23

RESPONDENT NGOs - FIELD OF SERVICE
PERCENTAGE OF RESPONDENTS
0
10
20
30
40
50
60
70
NR
7.6
10.0
11.8
2.8
HEALTH RELATED
46.2
30.0
52.9
63.9
NON-HEALTH
0
10.0
5.9
2.8
BOTH
46.2
50.0
29.4
30.5
FIELD OF SERVICE
NORTHERN
CENTRAL
EASTERN
SOUTHERN

CHART 24

CMAI ACTIVITIES BY SECTION - PERIOD 1991-1996 - TABLE - 1

YEAR	ACTIVITIES	SECTIONS					TOTAL
		DOCTORS	NURSES	ADMINISTRATORS	AHP'S	CHAPLAINS	
1996	RETREATS	2	-	-	-	5	7
	WORKSHOPS	1	-	1	1	-	3
	SECT. CONF	1	-	-	-	-	1
	SEM/R.CONF	-	-	-	-	5	5
	INST. VISITS	-	-	-	-	160	160
	STUD'T PRG	-	-	-	-	6	6
1995	WORKSHOPS	4	-	-	3	-	7
	SECT.CONF	1	1	1	1	-	4
	INST. VISITS	-	-	-	-	70	70
	STUD'T PRG	-	-	-	-	6	6
1994	RETREATS	-	1	-	-	-	1
	WORKSHOPS	3	1	2	6	-	12
	SEM/R.CONF	-	-	-	-	16	16
	INST. VISITS	-	-	-	-	130	130
	STUD'T PRG	-	-	-	-	3	3
1993	RETREATS	-	1	-	-	-	1
	WORKSHOPS	1	1	2	10	-	14
	SECT CONF	1	1	1	1	-	4
1992	RETREATS	-	-	-	4	-	4
	WORKSHOPS	-	-	6	1	-	7
	SECT CONF	-	1	-	-	-	1
1991	RETREATS	-	-	-	5	5	10
	WORKSHOPS	3	-	5	4	-	12
	SECT CONF	1	1	1	1	-	4
	SEM/R.CONF	-	-	-	-	3	3
	INST. VISITS	-	-	-	-	60	60
	TOTAL	18	8	19	37	469	551

INDEX: SECT.CONF = SECTIONAL CONFERENCE,

SEM/R.CONF = SEMINARS/ REGIONAL CONFERENCE

INST.VISITS = INSTITUTIONAL VISITS

STUD'T PRG = STUDENTS PROGRAMME

BIRDS EYE VIEW OF CMAI PROJECTS : TABLE - 2

NAME OF THE PROJECT	SOUTH	NORTH	WEST	EAST	CENTRAL	TOTAL	OBJECTIVES	EVALUATION AND RECOMMENDATIONS	AFTER CMAI FINANCIAL SUPPORT WAS WITHDRAWN
CBFP started between 1987-92									
upto - 1 year	9	-	-	-	-	9	To promote Family Welfare Service & temporary FP Methods	Potential to serve greater population. Funding period is too short	7
2 - 4 year	5	-	-	-	-	5			
5 & above	10	-	-	-	-	10			
TOTAL	24	-	-	-	-	24			
CBPHC started between 87 - 93									
upto - 1 year	4	3	1	-	1	9	To reduce mortality & morbidity among women and children	Understood concept of CBPHC, Established rapport with community. Institutions benefited and staff had good commitment to work.	25
2 - 4 year	6	2	2	-	6	16			
5 & above	13	8	6	-	8	35			
TOTAL	23	13	9	-	15	60			
CSCD started between 88 - 91 upto 3 years	19	2	8	4	6	39	To reduce IMR to 60/1000 live births	Successful innovation in community health oriented interventions. New experience for CMAI to work with non health groups. Well conceived, freedom of flexibility. Too much expectation in short time.	31
TOTAL	19	2	8	4	6	39			
CSCD started between 93-94 upto 3 years	12	1	1	7	4	25	To reduce IMR	On going project	25
TOTAL	12	1	1	7	4	25			
WHD started between 86-94 upto 3 years	-	-	11	-	9	20	To create awareness among women and to increase literacy to improve status of women	Suggested more integration in development process with special focus on weaker sections. Linkage with other NGOs.	15
TOTAL	-	-	11	-	9	20			
BIMAROU started between 93 - 96	-	-	-	-	12	12	To enable church and related agencies to implement CBPHC in BIMAROU States	On going project	12
TOTAL	-	-	-	-	12	12			
CHOTA NAGPUR started between 95 - 97	-	-	-	-	17	17	Promote the Health and Development of people at the grass root level. To establish 15 micro projects to cover 1,50,000 people	On going project	17
TOTAL	-	-	-	-	17	17			
GRAND TOTAL	78	16	29	11	63	197			132

PERCEPTION OF IMPLIED OBJECTIVES - BY MEMBERS
TABLE - 3

ALL FIGURES IN %

IMPLIED OBJECTIVES	PERCEIVED BY	
	INDIVIDUAL MEMBERS N = 984	STAFF N = 61
1. Nurturing Christian Spirit	77	67
2. Funding Agency Programs	59	62
3. Church Programs	59	61
4. Support To Hospitals	57	59
5. Govt. Projects	55	61
6. Poor & Marginalised	55	59
7. Debates On Health Issues	65	48
8. Fund Raising For Hospitals	39	20

EFFECTIVENESS OF SECTIONS - MEMBERS VIEW - TABLE 4

N = 1016

PERCEPTION	REGIONS	DOCTORS	NURSES	ADMINIS TRATORS	AHP	CHAPLAINS	WEIGHTED AVERAGE PERCENTAGE
POOR/DK	NORTH	39.1	34.6	41.1	43.0	37.6	**39.1**
	WEST	31.6	35.0	53.0	62.0	54.1	**47.1**
	CENTRAL	28.2	30.2	43.6	59.0	51.0	**42.4**
	EAST	38.1	43.0	69.0	51.2	39.3	**48.9**
	SOUTH	42.3	34.0	54.0	57.0	51.2	**47.5**
	TOTAL	**37.0**	**33.0**	**50.0**	**53.5**	**46.9**	**44.1**
V.GOOD	NORTH	21.8	28.6	14.3	10.5	18.0	**18.6**
	WEST	18.4	23.5	9.2	9.2	13.3	**14.7**
	CENTRAL	30.0	35.0	19.0	5.3	16.0	**21.4**
	EAST	19.0	20.2	17.0	8.3	14.3	**15.7**
	SOUTH	18.7	23.4	10.8	10.0	13.0	**15.1**
	TOTAL	**20.2**	**24.7**	**12.4**	**8.6**	**13.8**	**15.9**

EFFECTIVENESS OF CMAI SECTIONS - STAFF VIEW - TABLE - 5

N = 57

Figures in %

		SECTIONS					
PERCEPTION	LEVEL OF STAFF (GRADE)	DOCTORS	NURSES	ADMINIS TRATORS	AHP	CHAPLAINS	WEIGHTED AVERAGE PERCENTAGE
POOR/DK	A	56.0	12.0	32.0	12.0	36.0	**38.8**
	B	42.0	27.0	21.0	26.0	43.0	**34.3**
	C	46.0	31.0	31.0	23.0	23.0	**33.1**
TOTAL		**49.1**	**21.1**	**28.1**	**19.3**	**35.1**	**34.4**
V.GOOD	A	4.0	36.0	4.0	28.0	12.0	**26.9**
	B	-	21.0	-	16.0	-	**18.8**
	C	8.0	8.0	-	-	8.0	**8.0**
TOTAL		**3.5**	**24.6**	**1.8**	**17.5**	**7.0**	**17.9**

CMAI'S ROLE IN REPRESENTING CHRISTIAN INTEREST INDIVIDUAL MEMBERS VIEW TABLE - 6

N = 1016

Figures In %

EXPECTED ROLE OF CMAI	SECTIONS					REGIONS					
	Doc.	Nur.	Admn	AHP's	Chp	North	West	Central	East	South	Average
Agency for Integrating Christian spirit in Health Field	96.7	89.1	94.2	94.4	92.1	97.0	93.9	96.0	91.7	93.8	93.1
National organisation for Christian Medical Profession & Institutions	62.2	52.2	50.7	65.0	53.9	57.9	68.4	45.6	57.1	59.5	57.6
Community Awareness	29.2	51.6	40.6	44.1	42.1	37.6	48.0	49.0	35.7	41.3	41.1
Influencing & Propagation of Health Services	2.5	2.2	1.4	3.5	2.6	0.8	4.1	3.4	3.6	1.7	2.5

CMAI'S ROLE IN REPRESENTING CHRISTIAN INTEREST - STAFF VIEW TABLE - 7

Except column total figures in %

EXPECTED ROLE OF CMAI	RESPONSIBILITY LEVEL			
	Grade A	Grade B	Grade C	Total
Agency for Integrating Christian spirit in Health Field	100.0	100.0	84.6	**96.5**
Community Awareness	40.0	47.4	61.5	**47.4**
National organisation for Christian Medical Profession & Institutions	48.0	42.1	38.5	**43.9**
Influencing & Propagating Health Issues	-	-	7.7	**1.8**
Total	**25**	**19**	**13**	**57**

ARE THERE HINDRANCES FOR GROWTH & DEVELOPMENT OF WOMEN IN INDIA - STAFF VIEW - TABLE - 8

N= 61

EXCEPT COLUMN TOTALS FIGURES IN %

	STAFF GRADES				
RESPONSE	A-GRADE	B-GRADE	C-GRADE	NA	TOTAL
YES	88.0	57.9	61.5	75.0	**72.1**
NO	8.0	31.6	-	-	**13.1**
DONT KNOW/NO RESPONSE	4.0	10.5	38.5	25.0	**15.8**
TOTAL	**25**	**19**	**13**	**4**	**61**

MEMBERS EXPECTATION OF BENEFITS BY SECTION

TABLE- 9

[% FIGURES BASED ON THE SECTIONAL TOTALS]

	SECTIONS					
EXPECTED BENEFITS	DOCTORS	NURSES	ADMN	AHP	CHAPLAINS	TOTAL
REINFORCEMENT OF CHRISTIAN SPIRIT & VALUES	86.4	70.7	76.8	73.4	85.5	**78.1**
PROFESSIONAL RECOGNITION & KNOWLEDGE UPDATE	58.6	63.6	59.4	58.0	57.9	**60.3**
ORGANISATION SUPPORT - PERSONAL	27.2	54.9	47.8	53.1	28.9	**42.4**
OPPORTUNITY TO CONTRIBUTE	25.3	14.7	20.3	17.5	34.2	**20.7**
ORGANISATIONAL SUPPORT - PROFESSIONAL	6.7	11.4	17.4	14.7	17.1	**11.0**
TOTAL (NO.)	**360**	**368**	**69**	**143**	**76**	**1016**

STRENGTHS OF CMAI - MEMBERS VIEWS

TABLE- 10

N = 1016

IDENTIFIED STRENGTHS	NO	%
1. Recognition for Quality of Service	784	77.2
2. Recognition for Quality of Training	771	75.9
3. Spiritual Integration	649	63.9
4. National identity for Christian health profession	597	58.8
5. Built in Infrastructure	453	44.6
6. Quality of Publications	366	36.0
7. Net Working	223	21.9

STRENGTHS OF CMAI - STAFF VIEW

TABLE - 11

EXCEPT COLUMN TOTALS FIGURES IN %

STRENGTHS	A-GRADE	B-GRADE	C-GRADE	TOTAL
RECOGNITION FOR QUALITY SERVICE	80.0	94.7	76.9	**84.2**
RECOGNITION FOR QUALITY TRAINING	88.0	57.9	76.9	**75.4**
SPIRITUAL INTEGRATION	72.0	68.4	61.5	**68.4**
INFRASTRUCTURE	28.0	84.2	76.9	**57.9**
NATIONAL IDENTITY	52.0	57.9	53.8	**54.4**
QUALITY OF PUBLICATIONS	28.0	36.8	46.2	**35.1**
NETWORKING CAPABILITIES	16.0	5.3	-	**8.8**
N =	**25**	**19**	**13**	**57**

WEAKNESSES OF CMAI - MEMBERS VIEW - TABLE- 12

	ENDORSED BY	
	NO	%
1. Publications & Publicity	709	69.8
2. Deficiency in Service to members	635	62.5
3. Management of resources	487	47.9
4. Communications & followup	453	44.6
5. Organisational Identity & recognition	447	44.0
6. Influence on Church & Related Institutions	373	36.7
7. Organisational competence	337	33.2
8. Focus on Rural & Marginalised people	218	21.5

WEAKNESSES OF CMAI - STAFF VIEW - TABLE -13

EXCEPT COLUMN TOTALS FIGURES IN %

	LEVEL OF RESPONSIBILITY			
WEAKNESS OF CMAI	A-GRADE	B-GRADE	C-GRADE	TOTAL
PUBLICATION & PUBLICITY	68.0	78.9	53.8	**68.4**
SERVICE TO MEMBERS	72.0	57.9	76.9	**68.4**
RESOURCE MANAGEMENT	80.0	73.7	30.8	**66.7**
ORGANISATIONAL COMPETENCE	48.0	57.9	46.2	**50.9**
COMMUNICATION & FOLLOW-UP	48.0	47.4	61.5	**50.9**
RECOGNITION IDENTITY & POLITICAL INFLUENCE	40.0	31.6	38.5	**36.8**
INFLUENCE ON CHURCH INSTITUTIONS	32.0	26.3	46.2	**33.3**
FOCUS ON RURAL/MARGINALISED	8.0	10.5	15.4	**10.5**
N =	**25**	**19**	**13**	**57**

CMAI INSTITUTIONAL MEMBERS - PROFILE - NATURE OF INSTITUTIONS - TABLE - 14

	%
General Hospital	77
Community Health Centre /Project	30
Training Centre	26
Maternity Centre	24
Mobile Clinic	20
Mother & Child Care Centre	20
Health Education Centre	17
Dispensary	16
Leprosarium	14
Tuberculosis Sanitarium/Centre	6
Eye Hospital	5
Cancer Centre	2
De-addiction-Rehabilitation Centre	2
Research Centre	2

REGIONS BY NATURE OF INSTITUTION (NATINST)- TABLE - 15

Except column totals figures in %

	Gen Hosp	Mch Centre	Hlth Edu / Training	Miscella Neous	Total
Northern	8.4	16.7	20.0	14.3	**10.2**
Western	7.6	16.7	-	7.1	**7.8**
Central	16.0	8.3	-	14.3	**14.4**
Eastern	6.1	8.3	10.0	-	**6.0**
Southern	61.8	50.0	70.0	64.3	**61.7**
Total	**131**	**12**	**10**	**14**	**167**
%	**79**	**7**	**6**	**8**	**100**

YEAR OF ESTABLISHMENT BY NATINST - TABLE - 16

EXCEPT COLUMN TOTALS FIGURES IN %

YEAR ESTABLISHED	GEN HOSP	MCH CENTRE	HLTH EDU / TRAINING	MISCELLA NEOUS	TOTAL
NO RESP	9.9	16.7	-	21.4	**10.8**
UPTO-1900	16.8	8.3	20.0	14.3	**16.2**
1901-1950	43.5	25.0	10.0	42.9	**40.1**
1951-1975	24.4	25.0	30.0	7.1	**23.4**
1976+	5.3	25.0	40.0	14.3	**9.6**
TOTAL	**131**	**12**	**10**	**14**	**167**
%	**79**	**7**	**6**	**8**	**100**

SERVICES AND FACILITIES

ALTERNATE MEDICAL SYSTEMS OFFERED AT MEMBER INSTITUTIONS

TABLE- 17

N = 165

EXCLUDING 2 NR

	%
ALLOPATHY	**89.7**
ALLOPATHY & AYURVEDA	**1.8**
ALLOPATHY & HERBAL	**1.2**
ALLOPATHY & NATUROPATHY	**0.6**
ALLOPATHY & ACUPRESSURE/ACCUPUNCTURE	**2.5**
ALLOPATHY & HOMEOPATHY	**0.6**
ALLOPATHY, AYURVEDA & HERBAL	**0.6**
ALLOPATHY, AYURVEDA & HOMEOPTAHY	**0.6**
ALLOPATHY, NATUROPATHY & ACUPRESSURE /ACCUPUNCTURE	**0.6**
ALLOPATHY, AYURVEDA, HERBAL & NATUROPATHY	**0.6**
ALLOPATHY, AYURVEDA, HERBAL & HOMEOPATHY	**0.6**
AYURVEDA, HERBAL, NATUROPATHY, ACUPRESSURE/ACCUPUNCTURE & HOMEOPATHY	**0.6**

TRAINING PROGRAMMES - AT MEMBER INSTITUTIONS TABLE- 18

EXCEPT WHERE % INDICATED FIGURES ARE ABSOLUTE NUMBERS

NATURE OF INSTITUTIONS

TRAINING	GEN HOSP	MCH CENTRE	HLTH EDU / TRAINING	MISCELLA NEOUS	TOTAL
N =	131	12	10	14	167
%	79	7	6	8	100
NURSES	56	4	3	-	63
AHPS	20	1	4	1	26
DOCTORS	7	3	2	-	12
ADMINISTRATORS	4	-	-	-	4
CHAPLAINS	3	-	-	-	3
CHWS	18	2	4	-	24

TRAINING PROGRAMS & CMAI AFFILIATION - TABLE- 19

EXCEPT WHERE % INDICATED FIGURES ARE ABSOLUTE NUMBERS

TRAINING FOR	NO. OF INSTITUTION HAVING PROGRAMS	NO. AFFILIATED TO CMAI	% AFFILIATION
AHP's	26	17	65
NURSES	63	22	35
ADMINISTRATION	4	1	25
DOCTORS	12	2	17
CHW's	24	3	12
CHAPLAINS	3	-	-

STAFFING PATTERN IN MEMBER HOSPITALS - TABLE - 20

IN PATIENT RANGE PER ANNUM FIGURES IN NUMBERS

		NIL/NR	UPTO 500	501 - 2500	2501 - 5000	5001 - 10000	10001 - 20000	20000 +	TOTAL
	No.OF INST →	**27**	**25**	**43**	**26**	**27**	**9**	**10**	**167**
STAFF	**No.↓**								
D	**NIL/NR**	6	1	-	-	2	-	-	**9**
O	**1 - 5**	14	21	34	10	4	1	1	**85**
C	**6 - 10**	2	3	7	12	6	1	2	**33**
T	**11- 20**	1	-	2	4	9	1	3	**20**
O	**21- 30**	1	-	-	-	4	3	1	**9**
R	**31 +**	3	-	-	-	2	3	3	**11**
N	**NIL/NR**	7	-	-	2	3	-	-	**12**
U	**1 - 5**	8	20	8	1	-	1	1	**39**
R	**6 - 10**	4	5	15	1	5	-	-	**30**
S	**11- 20**	3	-	19	11	1	2	1	**37**
E	**21- 30**	1	-	1	6	4	-	3	**15**
S	**31 +**	4	-	-	5	14	6	5	**34**
	NIL/NR	9	6	2	3	5	-	1	**26**
A	**1 - 5**	13	8	22	8	6	2	2	**61**
H	**6 - 10**	-	5	10	10	7	1	2	**35**
P	**11 -20**	2	6	5	3	3	4	3	**26**
'S	**21-30**	-	-	2	1	3	2	-	**8**
	31 +	3	-	2	1	3	-	2	**11**

NOTE : ADMINISTRATORS & CHAPLAINS BEING SMALL IN NUMBER ARE NOT INCLUDED IN THE TABLE - THE COMMENTS APPLY TO THEM ALSO.

DECISION MAKING IN INSTITUTIONS -TABLE - 21

EXCEPT WHERE % INDICATED FIGURES ARE ABSOLUTE NUMBERS

NATURE OF INSTITUTIONS

DECISION MAKERS INCLUDE	GEN HOSP	MCH CENTRE	HLTH EDU/ TRAINING	MISCELLA NEOUS	TOTAL %
N =	131	12	10	14	167
%	79	7	6	8	100
CONGREGATION	77	5	3	8	56
LOCAL COMMITTEE	56	6	5	5	43
HEALTH SPLST	36	5	3	2	28
GOVT OFFICIALS	13	1	3	2	11
OTHERS	32	2	6	-	24

PROBLEMS OF INSTITUTIONAL MEMBERS - TABLE - 22

	%
PERSONNEL	80
INFRASTRUCTURE	74
FINANCE	59
POOR SERVICE CONDITIONS & FACILITIES	20
MANAGEMENT & ADMINISTRATION	10
TOUGH COMPETITION	5
PATIENTS/COMMUNITY	5
LACK OF AUTONOMY	3
GOVERNMENT APATHY	1

EXPECTED SUPPORT FROM CMAI BY INSTITUTIONS

TYPE OF SUPPORT- TABLE - 23

N =167

	%
FINANCIAL SUPPORT	59
DATA BANK	38
TRAINING	28
STRENGTHENING OF MANAGEMENT	24
PROGRAM SUPPORT TO COMMUNITIES	17
UPDATE KNOWLEDGE/ TECHNIQUES	8
PUBLICATIONS /COMMUNICATIONS	8
NET WORK	7
DEVELOPING INFRASTRUCTURE	5

INSTITUTIONAL PARTICIPATION IN CMAI ACTIVITIES - TABLE - 24

EXCEPT COLUMN TOTALS, FIGURES IN %

LEVEL OF PARTICIPATION IN CMAI ACTIVITES	NATURE OF INSTITUTIONS				
	GEN HOSP	MCH CENTRE	HLTH EDU/ TRAINING	MISCELLA NEOUS	TOTAL
NIL	52.7	41.7	70.0	50.0	52.7
LOW	24.4	25.0	30.0	14.3	23.9
MODERATE	19.8	33.3	-	14.3	19.2
HIGH	3.1	-	-	21.4	4.2
TOTAL	131	12	10	14	167
%	79	7	6	8	100

CMAI TRAINING - INSTITUTIONAL PERCEPTIONS - TABLE - 25

FIGURES IN %
N=167

	USEFULNESS OF PROGRAMS/SERVICES			
TRAINING	VERY GOOD	GOOD	SATIS	POOR
LAB TECH	33.5	27.5	3.0	-
GEN NURSING	30.5	22.2	1.8	-
RADIOLOGY	24.6	26.9	1.8	-
MED RECORDS	21.6	26.9	3.6	-
PG-PRG DOCTORS	24.0	22.2	3.0	0.6
ANM- MPHW	22.8	22.2	3.6	-
HEALING MINISTRY	18.0	17.4	2.4	0.6
OPHTHALMOLOGY TECH	15.0	19.2	2.4	-
HOSPITAL AUXILIARY	11.4	19.2	3.6	-
REHAB TECH	12.0	16.8	2.4	-
ADDICTION COUNSELING	12.6	16.2	1.8	-

ISSUES OF HEALTH AND HEALING MINISTRY

CHURCH OFFICIALS RESPONSE - TABLE - 26

N =52

All Figures in %

HEALTH ISSUES & CONCERNS		DENOMINATIONS						
		CSI	CNI	Methodist	Lutheran	Baptist	Others	Total
1.THERE ARE SPECIFIC HEALING MINISTRY POLICY GUIDELINES		27.3	42.9	–	–	16.7	29.7	**23.1**
2. HEALTH IS ISSUE FOR SOCIAL JUSTICE		100.0	100.0	83.3	66.7	100.0	88.2	**90.0**
3. GENDER IS A SOCIAL JUSTICE ISSUE		90.0	85.7	100.0	83.3	50.0	94.1	**86.5**
4.ARE CHURCHES RESPONSIVE TO CHANGING HEALTH SCENARIO	Yes	54.5	42.9	60.0	33.3	–	64.7	**48.1**
	No/ DK	45.5	57.1	40.0	66.7	100.0	35.3	**51.9**
5. ARE CHURCHES RESPONSES TO CHANGING HEALTH SCENARIO ADEQUATE	No/ D.K	100.0	85.7	100.0	100.0	100.0	82.4	**90.4**

FUTURE PROSPECTS - CHURCH OFFICIALS RESPONSE - TABLE - 27

N = 52

Figures in %

1. IS THERE A NEED FOR AN APEX BODY TO ASSIST CHURCHES IN H.M. POLICY AND IMPLEMENTATION?	Yes	No	
	90	10	
2. SHOULD THE APEX BODY RECOMMENDATIONS BE OBLIGATORY FOR CHURCHES TO FOLLOW ?	40	60	
3. WHO SHOULD CONSTITUTE THE APEX BODY	Health Professionals	Church Officials	Combination
	2	8	79
4. SHOULD CONGREGATIONS BE ACTIVATED TO PROMOTE HEALTH OF COMMUNITIES ?	Yes	No	Don't Know
	73.1	3.8	23.1

TABLE -28

N = 52

Figures In %

CHURCH OFFICIALS		DENOMINATIONS						
		CSI	CNI	METHODIST	LUTHERAN	BAPTIST	OTHERS	TOTAL
WILLINGNESS TO BE ACTIVELY ASSOCIATED WITH CMAI	YES	90	71	83	50	83	83	**81**
	NO	–	–	–	17	17	6	**6**
	CAN'T SAY	10	29	17	33	–	6	**13**

TABLE - 29

N = 52

Figures in %

CHURCH OFFICIALS VIEW		DENOMINATIONS						
		CSI	CNI	METHODIST	LUTHERAN	BAPTIST	OTHERS	TOTAL
SHOULD CLOSED HOSPITALS BE REVIVED	YES	80	71	67	83	83	82	**79**
	NO	10	–	–	–	–	–	**2**
	CAN'T SAY	10	29	33	17	17	18	**19**

CHURCHES RESOURCE POTENTIAL - TABLE - 30

N = 52

Figures in %

CHURCHES RESOURCE POTENTIAL	CHURCH OFFICIALS DENOMINATIONS						
	CSI	CNI	METHODIST	LUTHERAN	BAPTIST	OTHERS	TOTAL
BRIGHT & GROWING	70	43	33	67	83	59	**60**
STAGNANT	–	–	–	17	–	12	**5**
DECLINING	10	29	17	–	–	6	**10**
CANT SAY	20	28	50	16	17	23	**25**

NGO PERSPECTIVE OF CMAI

PROFILE OF RESPONDENTS - FIELD OF SERVICE - TABLE - 31

EXCEPT COLUMN TOTAL ALL FIGURES IN %

REGION	NR	HEALTH RELATED	NON-HEALTH RELATED	BOTH	TOTAL
NORTHERN	7.6	46.2	-	46.2	**17.1**
CENTRAL	10.0	30.0	10.0	50.0	**13.2**
EASTERN	11.8	52.9	5.9	29.4	**22.4**
SOUTHERN	2.8	63.9	2.8	30.5	**47.4**
TOTAL	**5**	**41**	**3**	**27**	**76**

NGOS KNOWLEDGE OF CMAI - TABLE - 32

EXPECT ROW TOTAL ALL FIGURES IN %

CMAI:HEARD-ASSOCIATED				
REGION	NO-NO	YES-NO	YES-YES	TOTAL
NORTHERN	69.2	15.4	15.4	**13**
CENTRAL	40.0	60.0	-	**10**
EASTERN	41.2	41.2	17.6	**17**
SOUTHERN	38.9	41.7	19.4	**36**
N =	**44.7**	**39.5**	**15.8**	**76**

GOVERNMENT OFFICIALS PERCEPTION OF CMAI

AWARENESS OF CMAI TABLE - 33

N = 25

Figures in %

AWARENESS		
AGE IN YEARS	KNOW- NOT INVOLVED	KNOW INVOLVED
Less Than 50	44	56
51+	56	44

SPECIAL ROLE FOR CMAI - TABLE - 34

	%
Community Services	56
Prevent diseases	48
Control AIDs	40
Train Personnel	28
Promote health	20
Support govt. Programmes	12
Provide leadership	8
Support Mission Programmes	4