23.1.81 DEENA SEVA SANGH RF_MP_6_SUDHA Bangalore, Karnataka. (1)

Gandhian with Quaker influence
Slum work through the foll. institutions:
Sevashram Boys Home, Rajajinagar.
Sr. Andals Girls Home "
Seva Samaj Community Centre "
Sevashram + Gandhi School - Srirampuram.
+ dispensary
Labour Fellowships Settlement - Seshadripuram.

Areas of work
- education - school (6000 children, 3000 Harijan)
- Childrens homes - 3
- temperance work
- life workers
- dispensary.
- library / reading room
- Bhajans / celebration for communities
- adult education in the past.
- criminal graveyard site used trees (over each grave

Special features / approaches

1 Life workers - 45, lay, married, living in the community, school teachers + some ex students all castes + backgrounds, simple lifestyle

2 School - simple buildings, open classrooms / mat level) with plenty of fresh air, trees, open air auditorium classes used as night shelters, multilingual in shifts catering to Tamil, Telugu + Kannada groups in slums who are also occupationally different; situation in the heart of slums.

3 cleanliness ++ with special cleanliness days + drives which include programmes for physical, mental + social hygiene.

4 Library + reading rooms - well stocked. used by community / students / teachers.

5 Team work good
Degree of involvement in work high - both in quality + quantity

6 Tenacity to continue inspite of problems + non recognition

7 Decentraliz(ed) responsibility, phasing out, non interference, individual responsibilities, leads council,

Other observations.

1. Health work purely 'medical' - very doctor + dispensary oriented.

2. Certain value systems, which they continue inspite of their socially relevant work need to be further questioned eg attitude to donors.

3. Though efforts in childrens educn are quantitatively impressive, they are not questioning the educational system + its relevance (of content) for urban slum life + vocation

Interview with Mr. Sadanand - aged 72 yrs.

- The force behind the growth + sustenance of the DSS force 51 years.
- Background - Doctor father socially minded - volunteered plague work Mysore State - mother succumbed to plague when he was 3 - father + only child returned to TN - father died of cholera when he was 14 - brought up by uncle - Catholic school (where they did social service - soap to slum people - protestant college inspired by Gandhian principles. Rev. Kaitholin - picketed foreign shops + toddy shops during early National movt. - CID incident in Madurai a origin of name Sadanand - influenced by Mr. Arunachalam (gandhian) to join slum work in LFS. B'lore concentrating on adult educn + temperance work among mill workers. - saw absence of family ties as fortunate - initial work with early pioneers like Major Ramachandran, Jaganathan + others all of whom left for other assignments leaving him to guide DSS. - married (intercaste) in Arya Samaj rite - family of 8 children all of whom are well settled - later Quaker influence (Friends) thru people + literature
- Origins of DSS - gandhian motivation - direct. He told them to work in the black spots of beautiful Bangalore
- They began adult education, reading rooms, Bhajan mandalis + temperance work in the 22 slums of B'lore to raise socio-political awareness of people there. (Major Ramachandran - founder - influenced by - Gandhi, Annie Besant, Swami Shraddanand, Servants of India Society)
- Team building a regular fellowship meetings with silent prayer, discn of work + tiffin. At present totals 1000/year.
  b Quarterly 2 day retreats in Malur which includes wholegroup, small group + individual reflection - about 7 hrs/day.
  Frank sharing encouraged. Inspirational literature circulated.
- Supports
  Local donors including vegetable supplies from wholesale markets.
  Quakers, War on Want + USC, + private donors.
  Now govt support to schools + Homes.
- Achievements
  a 6000 slum children at a time off the road + in school of which 3000 are Harijans
  b over 30 engineers, 30 doctors + others in good positions govt + non govt - (even minister

c 45 life workers - socially minded - good set - even religious.
some ex-students
d good library
e need for adult educ. ↓ as a result of stress on childhood
education from the beginning.
f) Harijans well mixed with others in all activities including
meals - took 6-8 years to achieve.

Problems

a) Integration of Harijans with others
b) Sacrificing of family life for community work felt
by some workers
c) not able to attract Harijan students to become life workers
because of economic status problems
d) Govt. funding leading to govt. control preventing
freedom to get right people for jobs + promote
community work or even affecting organiz' of school
due difficulty in getting leave for whole group. *
e) National gandhian organiz's not much involved
in field work of their own nor a support to such
projects
f) Difficult to inculcate reading habit among
life workers

* even considered handing over organiz' to govt.

g)

Contacts with other agencies:

a) Social workers Brotherhood - local organiz'.
b) personal contact with 'Friends' groups.
c) contact with gandhians in southern India.
d) Tour around India (Mr S + Bhakkar) seeing gandhians
working in urban slums. + Friends of India Arya
Samaj.
e) Mr S. reads widely + keeps upto date with trends
in development.

DSS motto

"I seek not Kingdom nor Paradise nor even Salvation
I seek only the deliverance from affliction of the
afflicted"
? source.

Points to ponder-

1. Value of fellowship meetings for team building.
2. Simplicity of lifestyle + environment.
3. Life worker concept - esp. lay + married.

For further enquiry at a later date:

1. experiences of temperance work.
2. any philosophy / statement reg. lifestyle / creed / methodology arising out of DSS / personal (M.S.) experience.

MP 6.32

WIDENING HORIZONS - II

Dear Friends,

In this issue we introduce two books which raise important issues about the crisis in hospital based medical services and the increasing problem of iatrogenicity or the disease producing nature of medical care itself. Illich is one of the severest critics of the medical profession and Horrobin attempts an answer to Illich's criticism on behalf of the medical profession. These two books read together gives us a balanced view of the crisis at hand.

The next two books are more personalised approaches by two committed christian doctors to find answers to the problems of providing hospital service and health care programmes to communities where poverty is an increasing constraint. How do hospitals reach out to the community ? How do we reorder our priorities ? Their experience and suggestions will be most relevant and thought provoking for all our C H A members

RAVI NARAYAN

Duplicate

LIMITS TO MEDICINE - MEDICAL NEMESIS.

THE EXPLORATION OF HEALTH

Ivan Illich, Penguin Books (Pelican 1977)

The foremost critic of trends in modern medical practice, Illich presents thought-provoking evidence that 'the medical establishment has become a major threat to health and the disabling impact of professional control over medicine has reached the proportions of an epidemic'. Discussing iatrogenesis in great detail, Illich makes one of the most forthright pleas for 'demystification of medical matters' and exhorts lay people to reclaim greater autonomy over health decision making. He writes that 'A professional and physician-based health-care system that has grown beyond critical bounds is sickening for three reasons: It must produce clinical damage that outweighs its potential benefits; it cannot but enhance even as it obscures the political conditions that render society unhealthy; and it tends to mystify and expropriate the power of the individual to heal himself and to shape his or her own environment.

The medical and para-medical monopoly over hygienic methodology and technology is a glaring example of the political misuse of scientific achievement to strengthen industrial rather than personal growth'. The book is divided into four parts and deals with Clinical Iatrogenesis in Part I, Social Iatrogenesis (medicalisation of life) in Part II, Cultural Iatrogenesis (disabling impact of medical ideology on personal stamina) in Part III and The Politics of Health in Part IV. Interestingly Illich warns that 'if contemporary medicine aims at making it unnecessary for people to feel or to heal, eco-medicine promises to meet their alienated desire for a plastic womb'. He also warns that gullible patients should not be relieved of the blame for their therapeutic greed by making physicians scapegoats. Health must be seen as a virtue, as a right and people must be involved in 'political action reinforcing an ethical awakening - that will limit medical therapies because they want to conserve their opportunities and powers to heal'.

~~A thought provoking book to be read by all GHA members.~~

3

MEDICAL HUBRIS - A REPLY TO IVAN ILLICH

David Horrobin, Churchill Livingstone, 1978

This book should be read after the earlier one since it is the first serious critique of Illich's book. Horrobin does not dispute the facts presented by Illich, but disputes his interpretation. Inspite of all the inaccuracies and exaggerations in Illich's books that he attempts to point out, he concedes that Illich's first sentence 'The medical establishment has become a major threat to health' is right and that this book could prove to be ' one of the key medical documents of the second half of the twentieth century'.

In a very open and level headed assessment of the criticisms of Modern Medical Practice the author gives his own tentative suggestions to bring about a change in this situation. He makes a plea for

a) More "Science" in medicine 'to eliminate the errors encouraged by warm emotion' that 'to do something must always be better than to do nothing'

b) Less use of technology by subjecting them to stricter control to determine whether they really benefit the patient.

c) Attempts to be made to keep medical institutions as small as possible and only for those who strictly need them.

d) Assess professional training and prescribe levels of training actually required to enable people to do jobs effectively and cut out unjustifiable part of courses.

e) Challenge the discrepancy between the high ideals which doctors often profess and their personal life styles and ensure that the profession should be more humane and less a 'certain road to wealth and security' - so that the rightly motivated people are attracted to it.

These changes should be made at four main levels ; of the individual doctor, of the organisation of the profession , of the relationship between government and medicine and medicine related industries, and of the medical school.

- A book which puts Illich's criticism in proper perspective.

MEDICAL CARE IN DEVELOPING COUNTRIES

- A Primer on the Medicine of Poverty - Ed. Maurice King

Oxford University Press, 1966.

To many doctors who are working in small rural health centres or hospitals, this book will provide interesting and ingenious solutions to many of their questions on the practice of medicine in conditions of poverty. It is not only in the suggestions but in its philosophy underlying the approach to such problems in rural health care - that the book is encouragingly different. It starts with twelve axioms of medical care which include that medical care of the common man is immensely worthwhile; medical care must be approached with an objective attitude of mind which is free as far as possible from pre-conceived notions exported from industrial countries; the maximum return in human welfare must be obtained from the limited money and skill available; all medical staff have a teaching vocation in the community they serve; and medical care must be carefully adopted to the opportunities and limitations of the local culture.

It goes on to discuss the health centre, health education, auxiliary, patient care, paediatrics, PCM, diarrhoea, under-five clinics, immunizations, tuberculosis, anaesthetics, blood transfusion, laboratory, X'ray department,

medical records and so on in thirty practical chapters which are based on ideas shared at a symposium organised by Makerere University, Uganda on 'Health Centres and Hospitals in Africa'. It invites readers to feel free to add or detract any idea and hopes that more of these ideas will come from local doctors of developing countries for whom this book was written.

PAEDIATRIC PRIORITIES IN THE DEVELOPING WORLD
David Morley, Butterworths, 1973.

This book is based mainly on the work of Dr. Morley and his colleagues in Ilesha, Nigeria where among other things over 400 children born into the village were followed up for over 5 years. The ideas generated from the Nigerian study were shared by Dr Morley with colleagues in West and East Africa, Middle East, India and South America and the discussions led to the writing of this book. In the words of the author the book is to 'be of help to those planners who are involved in discussion with the doctor-monopoly which may be at times conservative in its outlook'. Taking on from Maurice King's book, Dr. Morely defines his own axioms of child care which include that an objective and imaginative approach to child health is necessary supported by a knowledge of loca l customs and practices;

MP6.33

a maximum return in terms of reduced child mortality and healthier and happier children must be obtained from the limited funds available; do not separate mother and child; child care must be the best that circumstances allow and so on. In twenty two chapters that include topics such as care of newborn, breast feeding, at-risk child, road to health c ard, diarrhoea, acute respiratory infection, measles, whooping cough, malaria, TB, skin diseases, anemia and family planning, Dr Morley puts together an approach based on priorities, practicality and common sense. The book gives 328 references of work done on the problems covered in the book especially in developing countries and makes an impact because it comes from a committed clinician. The book has an assessment questionnaire to be filled up by every reader so that a constant feedbac k is maintained.

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SUNANDA PROJECT

KGF – 27th – 29th Jan '81

MP 6.31

Origins: Sr Celestine (of St. Josephs of Tarbe's congregation)

After about 5 years of work the project was named Sunanda but continues to be an unregistered body. working through the congregation. provincial allowed it as an experiment of working with laity (staff)

Initial activities were informal meetings + discussions + bhojan mandalis. A nutrition programme (MCH) was started with CRS aid in 1975. Then worked with PHC + mining hospital doctors to organize medical camps, clinics + some immunizⁿ from time to time. Milk powder + foreign medicines added, + funds from agencies (CIDA, KASA, Caritas India, Caritas Netherlands, DRF + CMMB, Christian Aid etc)

used for sheds, ambulance, training + salaries (community centres in villages)

Team - as the programmes increased some young men & women from KGF + locality areas were picked up to join in. They were SSLC's with no formal development training, but were interested. Social work/ then sent for short training courses in '79-80. - * 2 (sisters) to SJMC - for CHW course, 2 to Chettupattu, N. Arcot - for leprosy PMW course, 2 to Amillikai, Christian Fellowship Com. Hlth centre for Diploma in Com Hlth (2yr course). These are now working in Surunda project area as part of their 4th semester fieldwork). The 2 sisters lived out in Raghadhally for a year (1980) - a small village. Came into contact with Dalit movement youth workers, who were later incorporated into the team when they felt the need for nonformal educ^n. + community organization. They were sent for a 6 months community animators training in Dharavi slum (Bombay) by CISRS. Coordinator (Sr) went to England for short training.

* one was sent initially to CONDY (Canada) for a course in development through cooperatives

All this training was funded through various foreign agencies

Expansion - work was done in conjunction with the group Panchayat & areas extended to all 12 villages of the group on their advice. With introduction of non-formal education, the animators were allowed to train animators locally + spread into neighbouring Mulbagal Taluk

Team building: The 2 sisters share with the team ~~the life~~ + that Jesus is their guru. + introduced group prayer sessions with Bible reading + reflection + bhajans. Occasionally & orientation sessions are held for the team with visiting Jesuit priests & brothers. Jesus is also the guru of the project & recently all team members were given pictures + calendars. He is presented as one working for liberation of the oppressed + justice + they are encouraged to reflect on his life + teachings. Conversion + baptism is not their aim. Some of their non-christian team members have shared that they have been touched by the life

additional points

1. During the last ~~the last~~ few years they have received donations of land (10-20 acres) + acquired land + building (Surunda ashram + 23 acres of?).

2. Part of this is developed into a resource farm. There is full time trained agricultural extension officer who looks after the farm as well & has introduced agricultural extension work in a few villages of demonstration plots with hybrid red gram. This work is sponsored by rural dev. programmes of a bank & includes animal husbandry (sheep) project.

3. One property called Sunandashram has been used for 2 years as a training centre for animators, groups of religious. The ashram is very simple with thatch & mat level living. Since this is completed there is a plan to develop the Ashram further with a grant from CEBEMOR.

4. The centre project gets a number of youth/visitors, Indian/foreign for experience of rural life & development work of Nava Nirman Institute for Social Work, Madras, AICUF

5. Due to the range of funding agencies & amounts involved (catholic & protestant) the project has had to face some enquiries/suspicions resulting in "strained relationships" with local parishes & convents & the Bishop, but has had support of the province (congregation)

6. Move towards this work & lifestyle (by SUNANDA & a few others) has led to a questioning of lifestyle, functioning & work of the congregation itself in S. India & changes towards a greater relevance are being considered eg money spent per head for boarding & lodging, working conditions of servants etc.

Special features - positive points

1. Use of laity
2. Informal approach.
3. Non-directive
4. Acceptance of adults.
5. Nonformal education.

Negative points

1. Large amount of funds (agencies)
2. Property acquisition
3. Health work piecemeal & vague more parallel than supplementary to PHC.
4. Learning experiences of Training programmes (too varied approaches not always relevant) & are not integrated towards a single approach
5. How much is insistence on giving sharing ? subtle proselytization (external manifest of following program)

Case Study. Susaipalayam

MP 6.30

Susaipalayam is a small urban slum in KGF, a mining town in Kolar Dist. of Karnataka. The people in the slum are all Tamil christians who were part of a larger group of Tamil labour who migrated a few generations ago to the mining town.

They have had a long standing reputation of being a centre for the illicit distillation of liquor & all its associated activities.. Because of involvement with these activities for a long time (a couple of generations) there is a social stigma attached to being a resident of the place itself. Other groups, even christians do not associate with them socially.

Brewing of liquor is a cottage industry undertaken in every home with all members of the family participating in getting of raw materials, process of distilling + its distribution & marketing. The main ingredi are a chemical (white slaty stuff) wattle bark, organic vegetable material which ferments. This is kept underground in clay pots in cleverly hidden vaults camouflaged using household articles for a period of time. The wash is then distilled using 3 clay pots. This process is very closely integrated with the lifestyle of the people eg all members of the family drink, even the children get a glass before going to school in the morning. children act both as distributing agents as well as warning alarms during excise + police raids which are not infrequent.

The people from the town buy the liquor from agents in town or visit the slum. As an added attraction curried meat of suspect origins are sold on wayside (draped over umbrellas)

There was a church building in the slum which has now been moved to the outskirts on the main road. The school & convent is also situated on the outskirts of the slum

over

a peepal tree as in all traditional villages is at the entrance but there is a cross within the shrine.

We got our impressions from discussions with the Sisters running the school which has been opened in the past few years.

- The people are very god-fearing & are very protective of the religious living there
- They sometimes use the convent compound to hide their liquor since it is safe from raids
- They attend the services regularly & invite the religious to their homes for occasions
- many children attend school when they are not required for the work. hence regular attendance & other such formalities of school cannot be followed
- The children are bright & pick up the lessons very fast especially when they are punished.
- They are bold & not afraid of any authorities - police & teachers included)
- Traditional educational methods don't work (authority oriented) & a more informal approach is needed.
- Most children drop out of school at some stage
- Mothers sometimes ~~being~~ complain to the sisters that the children ask for more than their sanctioned quota of liquor at breakfast
- Development efforts by a church social service group have been unimaginative - cows were given to some people - but due to non-availability of fodder etc these were tied up in convent compound & returned (interestingly not sold)
- ~~This~~ This is a good example of church work without an analysis or understanding of the real situation. The people are caught up in a vicious cycle & in the absence of genuine efforts to intervene in this cycle (eg providing relevant education & alternative employment) the church appears as ~~being~~ encouraging the existing lifestyle (symb, - Jesus) Rather than following a live & let live policy this is a good situation where an effort could be made with the people to work out a method of getting out of the vicious cycle to a more meaningful life & support

-them through the crisis of change. Status quo forces like the owners, middlemen etc of the liquor economy, corrupt police + excise systems, customers etc would resist any attempts at change. In initiate such a change the organized church have to see these people as their own brothers + sisters + question whether their existing relationship + work with them is truly christian or not!

LEPROSY RELIEF RURAL CENTRE — 31st Jan + 1st Feb '82.

Chettipatty, Omalur, Salem Dist. — MP 6.29

A Origins – A French nurse Ms Marie Dennis started work near a Christian village, Chettipatty, in 1956 through the Diocese of Salem. Started care of leprosy patients in small hut. Helped by visiting doctor from Arisipalayam – St Mary's Hospital. Funds collected from abroad & diocese. Dr Vomstein (German) came in 1965 to work & later took over the centre when Ms Dennis moved to Kavilur to start another leprosy centre. The hospital & ancillary units were built up gradually with main funding from German Leprosy Relief Association

B Present set-up.

(1) Team: Dr Vomstein + 2 Asst Dr's. < 1 IPD; 1 field MO (Dondi)
Administrator + admin staff.
Health educator – 1
Non medical supervisors – 3
Paramedical workers – 14.
Staff for orthotic appliance centre, weaving, shoe making, & laundry.
Nursing staff, Physiotherapist + ancillaries for hospital

Total strength 80 of which 40 are ex-patients.

(2) Programmes

1) Inpatient wards – 80 beds including unit for handicapped children (25) – particularly polio.

2) Rehabilitation centre – physiotherapy & appliances, weaving + shoemaking, poultry & agriculture (poultry for income)

3) Extension work. Covers Omalur TK + part of Mettur TK ie a population of 4 lakhs. Present no. of registered Hansen's cases 9000 + 3000 come from outside the area. Since inception of project 26,000 pts have been registered.
– 23 subcentres with 14 resident PMW's supervised by NMS. with monthly visit by MO.
– PMW have allotted villages in their areas in which they run cycle, roadside clinics & do field & school + contact surveys. Also maintain records + give in monthly reports
– They are part of the NLCP (National Leprosy Control Programme) – area allotted by Govt. but not funded.

Refer Annual report souvenir & records.

4) Surgical - Rehabilitative surgery done by Dr Vomislain + monthly plastic surgery by Dr Fritschi from Karigiri.
wards are mainly used for post-op care & chronic ulcers, reactions etc & not only for long term care.

5) Staff training - mainly in Karigiri, Chetpatt + Polambakam.

6) Future plans - Epidemiological unit, ophthalmic unit, physical medicine.

c Special features:

1) systematic coverage
2) roadside clinics on cycles.
3) practical, integrated, field records. village wise, easy for followup (refer sample). simple codes for analysis
4) vehicles well maintained - 12 yrs & still smoothly running.
5) large number of expatients as staff (50%)
6) patients & staff (expatients) fully accepted! + working + living with dignity.
7) products of rehabilitative units used mainly on the campus (pts & staff)
8) campus well laid out. fairly simple buildings, beautiful trees.
9) General OPD in the afternoons & unit for handicapped are signs of widening scope from purely leprosy work
10) Patient followup seemed rather good.

d) Other observations & problems

1. problem of staff union & local political involvement issue regarding dismissal of worker.
2. changing junior doctors.
3. Differences within the managing body & hence lack of team vision (institution at present has a one person charisma)
4. Though part of NLCP there is no active interaction/integration with the local govt - health work except for "intermittent supplies of dapsone"
5. Function for silver jubilee seemed a bit stiff & traditional & seemed to have been carried through at all costs inspite of differences of opinion.
6. Though difficult to judge in short time team cohesiveness seemed less & value systems different (foreign & local Tamil) & in conflict.
7. links with agencies - all within the missionary set up
8. Visuals in hospital & centres ↓.

E Meeting with Dr Donald Fernandes - alumni '72 batch.
working in LRRC as field MO - scholarship bond.

1. Total involvement with work unusual + inspiring
a rapport with patients as an absolute equal [illegible], + as the member of a family
b songs + games with kids + regular night visits (social) to the wards.
c games for the handicapped + other pts.
d good relations with staff + extension team supportive + non-hierarchical of asking other members of the team to explain things to us.
e Identification with the institution + its future growth of epidemiological unit, physical medicine dept etc.
f - supportive + constructive during the crisis.
g. growing awareness of the field of leprosy
h) involved with jubilee, souvenir, exhib., entertainment

2. Discussion regarding future
Dr Vanstein is very impressed by his work + is encouraging him to stay on in the institution on a long term basis. Is willing to sponsor him for further studies in the field + at present often leaves him in charge of the place when she goes out station.
Donald however has family problems + would like to settle in his own village near Dindigul + do general practise.
~~[illegible]~~ underlying this there is a deep social conflict.
There are conflicts between churchianity + a christian lifestyle, which is a more christian expression - attending Mass + other pure externals versus involvement with people as human being.

3. other Points from ~~the~~ visit.
1. Saw weaving of silk sarees, goldsmithy. Industrious people. Besides agriculture there are numerous cottage industries - mat making, baskets, pottery, fences from castor stem, fodder baskets (large), brasswork
2. we learnt from HE that many trades taught as rehabilitation have a caste link in the

village & hence they do not use the skills when they go home eg basket making, cobbler, weaving etc have lower caste links. Only agriculture can be done.

2. Social ostracism for leprosy patients is less or overcome ~~others~~ for those from a higher socioeconomic strata.
3. Patients show patches & ~~[illegible]~~ take Rx without hesitation, but often do not accept that it's leprosy.
4. Visited temple with underground passages to places as far as Dharmapuri. Rays of sun hits sanctum sanctorum once a year at dusk & lots of interesting stone sculpture done in single stones – chains, ball in lions mouth.
5. Open air Mass under trees – informal manner.
6. Small wattland chapel
7. Exhibition put up for jubilee simple & informative. Souvenir also of good standard. Use of visuals & HE material almost nil.
8. Heard professional mourning over loudspeaker from neighbouring village. evidently sustained by soda & alcohol!

A.M. Murugappa Chettiar Research Centre

24/2/82

(Discussion c̄ Rahis)

Origins

1. Chettiars of certain area in Tamilnadu built schools/hospitals for people
2. 1977 - Janata Policy - Income tax 'evasion' for R & D (Rural Development)
3. Dr Seshadri - Dean of Research - IIT Kanpur sold idea to group to set up Research Unit in Appr Tech.
4. Group of Engineers/Technologists/Microbiologists built up gradually thru advertised jobs

Present Set up - Research team of 12.

- Different units
- Engineers provide drawings/support for ideas
- work with local rural artisans (traditional) to filter ideas and make technology simple & relevant

(Engineers in group are tinkerers/innovators)

- Idea developed in lab - introduced into neighbouring villages - (9) - 6 - 60 Kms away
- work with individual marginal farmers. In two villages work c̄ a Harijan Society, Milk Cooperative (already existing)
- Basically Research Unit - not development project (because of Govt classfn)

Areas of Research

1. Food - Algae.
2. Agriculture - hybrids/pisciculture
3. Energy - solar/wind/biogas

(Refer Report 1980)

Other points

1. Questions during their own evaluation
   a) How does technology enter system?
   b) What is the use-value of new product? Is there any value at all?
   c) Relative role of Community mobilization/Non form. education/sharing of alternative and problem solving/technology transfer if at all necessary
2. What is appropriate?

Examples

(1) Hybrid Paddy for Alkaline fields → (Technology accepted) Out put double ———→ (Technology rejected) Reduction in Fodder. Putrefaction, + bad smell in Rice kept overnight (common food habit)

Conclusions – i) Nature can't be beaten
Grain ↑ Fodder ↓
ii) social/cultural acceptance of changed tech.

(2) Solar dried fish using polythene sheet —> Decreases time period
Reduces infestation —> Doesn't get higher pr[ice] because dried fish good/bad is eaten by lower class
(Upper classes eat fresh fish)

Conclusion i) Economic
ii) Regional variation

(3) Chulla – Has to be simple
c̄ out fancy louvres.
because artisans cannot make it.
and separate product/marketing unit becomes necessary and the cost becomes too much.

VHS - Adyar
Madras

Visited on 18/2/82
(Refer VHS publications and Dr Sanjivis papers)

~~Impressions~~

We had discussions with Dr K.S Sanjivi about the experience and the perspectives gained over the years by the VHS project. We then visited one of the mini-PHC - met the doctor and nurse (ANM) and then visited one of the Lay first aiders at her residence.

MP 6.26

Impressions

1. Philosophy - Well 'Planned' but top down
   Traditional type of participation by people
   Health Care Delivery system - separate entity from total development process.
   Very doctor & medical care oriented
   Even in Community Health very oriented to distribution of services (public health!)
   Absence of societal analysis or even of community structures
   (not clear about whom they are dealing with)

2. Impact
   - Good information outreach to govt/health service
   - Taken up by Tamilnadu Govt for replication
   - Make ideas known in all forum
   - Trying to keep in touch with others who run mini-PHCs (sharex newsletter)

3. Gets doctors/ANMs to outreach areas for clinical work but no idea of orienting doctors/health staff to rural communities - (structure & ~~functioning~~) as well as training/selection/follow up methodology for LFA's.

4. No real contact/integration with Govt PHCs other than getting some 'stuff'. ? Alternative.

5. Staff - do not present a team concept nor do they seem very clear about VHS philosophy

6. Even in replication there is structural (physical) replication rather than spread of a philosophy.

7. Centres run by VHS
   - very simple and 'grass root level'
   - well maintained

8. New training Centre - simple - fairly low cost fitting into surrounding - multipurpose - environmentally sound (raised open central courtyard, large windows)

9. <u>As a Centre</u> i) Research and open attitude to Indigenous medicine
ii) Trying to encourage – use of centre by UGs & PGs (Medical & P.G educn)
iii) Integrating Yoga etc in R, regimes in hospital
iv) Getting specialists to the periphery
v) Rehabilitating retired personnel.

10. Very vociferous/voluble – helps to spread an idea.
↑
11. Actively propagate use of indigenous/local/national resources – Anti foreign funding (e.g. ~~Large~~ Danida/world bank) – write about it.

12. <u>Lay first aiders</u> <u>Selection Criteria</u> Gandhigram approach
- Using village based worker.
- Follow up/support/refreshes ~~not~~ very ambigous
- Too much insistence on records
- Coupon idea good – but using it as check on LFA is typically Govt.

13. How system works at grass roots esp c̄ regard to SC/ST is not considered important enough to be evaluated/looked into.

TN VHA MEETING

Impressions

1. Good crowd. (about 60?)
2. Predominantly Catholic religious (mostly nuns)
3. Many deputed by agency - though not main project person and hence only a few asking questions
4. and participating in discussion (others just passive)
4. Strong Christian orientation in prayer. Insensitive to secular testament to VHAI
5. Group dynamics - poor. No one knew who the others were. Not much mixing.
6. Inaugural Session <
   - Danida - project approach
   - RN - Devils advocate but polite
   - Deeds - fully committed to people

- Too many differing views - confuse crowd and makes even testament of VHAI appear as collection of approaches.

7. Fr Emmanuels slides on Animators (Emma production)
   - Typical Americanised sales Approach, out of context visuals, people reduced to objects and 'We' and 'they' demarcated.

8. Sr's shared experience.. More from Health to development. but purely giving approach. Getting things for people. Lack of Analysis of structure.

9. Field workers consider all educational Institutions types theoretical - not open to ideas. Block in their thinking.

10. Fairly good and useful display/sales counter of books and reports.

Impressions (from talk c̄ Sr Muriel)

- Central VHAI testament not shared or even understood by State VHAI (even board members)
- Personality clashes
- Controlled by large institutions and power oriented groups.
- 'Connections' more important than 'sharing philosophy'.
- Professionalism strong - shows in attitudes of doctors and nurses to other health workers (e.g. lab technicians etc)
- People using VHAI for personal growth/improvement not spreading of philosophy.
- Wider contact c̄ projects and smaller groups all over the state
- Good contact with Govt.

(Rathis) on TN/General/Guj/UP

1. Flexibility of Rules - Fiddling of Rules / Manipulating / Manoeuvring
2. Secularism ?? nominal/namesake.
3. Fixed election. GBM eye wash! since religious vote is herded depending on what 'Frs' say.
4. Contribution to Comm Health is good.
5. How Much VHAI is really responding to the felt needs of its members is questionable?
   Is C.H orientation really a felt need of member hospitals
6. Many functions it undertakes a really those of a trade organisation (A liaison organisation for the benefit of the hospitals and health industry rather than a real response to a people's movement.)

Overview (RN/TN)

1. General Testament/Philosophy is inspiring
2. Publications and promotion is excellent
3. Relevant ideas brought to the reach of many.
4. More an Institution rather than a movement
5. State branches need building of general bodies not manouvering by large institutions or well connected senior professionals.
6. More democratization / More real discussion only then will health by the people approach take root.
7. Secularism of a more genuine nature
   - greater encouragement to non-christian groups.
   - greater openness to other systems of medicine.

Mp 6.28

ST JOHN'S MEDICAL COLLEGE, BANGALORE 560034

Directorate of Rural Health Services and
Training Programmes

NEWSLETTER 4
JUNE 1982

Dear Friends,

With great sorrow we inform you of the passing away of Major General B Mahadevan, Ex-Director of Rural Health Services and Training Programmes on 7th June 1982, after a heart attack. 'Papa' as he was affectionately called by all of you, was responsible for the development of the CHW course and we all remember with great gratitude the interest and enthusiasm with which he planned each course and guided each group of participants. Among the many contributions he made to the college during the six years that he was associated with it, as Professor of Community Medicine and Director, he will be remembered particularly for his commitment to re-orienting the college to Rural Health Work.

May his soul rest in peace!

"Yes, all men are dust, but some are gold dust"
— John A. Shedd

For those of you, who would like to communicate with his family, the address is:

MRS C. MAHADEVAN
187 Defence Colony
Indira Nagar, Bangalore 560038

(2) NEWS FROM THE COLLEGE

(a) Affiliation : The college has finally been granted affiliation for two years by the Karnataka Government. We thank you for your prayers! We are continuing the dialogue to get permission to start post-graduate courses, which has still not been given.

(b) Dr C M Francis, Dean left the college in May to take up his new assignment as the Director of Salgaocar Medical Research Centre in Goa.

(c) Dr G M Mascarenhas, Professor of Cardio Thoracic Surgery at St John's Medical College Hospital has taken over as the new Dean.

(3) NEWS FROM THE DEPARTMENT

(a) Professor SV Rama Rao will complete his term as Professor of Community Medicine on 30th June 1982 and will take over as the new Director of Rural Health Services and Training Programmes from 1 July 1982. So please keep in touch with him regarding your work.

......2

Duplicate

(b) The next Basic Course for Community Health Workers (CHW BC9) will commence on 30 Aug 82. The last date for applications is 30.7.82.

(c) The next Refresher Course for Community Health Workers (CHW RC-4) will commence on 22 Nov 82. The last date for receipt of applications is 10 Oct 82.

4. OUR PROJECT PLANS

As planned earlier, we shall be spending the summer and monsoon months - MAY-JUL - writing out our experiences of the CHW courses and analysing all the letters and questionnaires that you have sent to us since 1979. We also hope to complete other writing commitments.

Our extensive travel undertaken in January-April made us realise that it would be unrealistic to try and cover the whole country in a year. Many of our friends and CHWs are working in interior areas and getting to each of them takes a lot of time and travelling.

We feel that such a field contact can be undertaken by us over a longer period of time and need not be completed by December 1982. Also other faculty could be involved as well. We also feel that getting CHWs together at a central place for a one-day meeting would not only cut down travel time but also give opportunities for them to meet each other. The TNVHA meeting (NEWSLETTER 3) was one such opportunity. Places where this seems possible are the Nilgiris, Mangalore region, Karwar region, Goa and Wynad.

We have decided now to give the Southern States lower priority since we can continue to keep in touch with them in later years from St John's. The next trip will probably cover the Eastern region since this is a much neglected area. We are awaiting letters before we finalise details.

With best wishes and regards,

RAVI & THELMA NARAYAN

"If everyone of us could drink pure clean water, keep our surroundings free from flies and dirt, and make the best use of the food we grow and buy, we could protect ourselves against diseases and many of our health problems will disappear. For pure water, good sanitation and adequate nutrition are the world's best medicine"

Discussions / Perspectives from Fr. Claude S.J. (Director AICUF)

22.2.82
Madras
MP 6.25

- Many young people committing themselves to living + working with people after graduation / postgraduation.
- Need to support them at mental + emotional level through sharing their experiences, supporting through parental pressures / meeting parents, providing place for rest + contemplation, putting them in contact with each other.
- Most groups are lay, mixed religious background. ex. AICUF, moving from traditional charity to organizing people to solve their own problems through dialogue with existing structures. Non formal education methodology (NAEP) used. Work in slum / rural areas with all types of workers, school dropouts or any exploited groups. Problem solving, action oriented approach.
- Initial motivation may be due to various factors. Involvement during crisis (manmade or natural) proves to be a long term stimulus for some.
- Service orientation without analysis of total local situation does not produce any results hence he often stimulates research into local situations.
- During involvement in work a person needs to grow through constant stimulation.
- Such work is risky + is often misinterpreted as being anti-system by corrupt individuals when in reality it is furthering the programmes laid down by the planners. Hence there is a need for support.
  Govt. documents are being used for research + as a basis for activity since the conclusions ~~suggested~~ by them itself suggests the need for such work. And it is not radicalism in the left wing sense.
- In his experience there have been a few young priests who have shown similar sensitivity to people oriented work.
- Institutions (secular or religious) cannot be responsive to peoples movements (because of need for survival) but there will always be individuals who are sensitive.
- In his large experience with students he feels that motivational factors cannot be provided through a formal experience.

PTO

MERG Community Development Trust

Origins:

Merg is a group involved with non-formal education in Chingleput Dt. The 2 main functions are 1.) working with the 6-16 age group, evening classes, discussions around day to day life of children who work & contribute to family income e.g. occupations, housebuilding, health. They also learn to read & write. Teachers are local high school boys & girls who have been given an orientation / training in the method

(ii) Panchayat education for youth - 16-35 yrs. on Govt. programmes, rights & responsibilities

(iii) ~~[illegible]~~ As a follow up Sanghas of workers of different types are formed to take action to improve their own conditions

They have an office cum training centre in Gudavanchery, 18 centres in one taluk & will also be working in 2 other taluks

They have worked for 2 years & plan to work for another 3.

Funding - AID for childrens programme, SCCF (Swiss Christian Lenten fund) for Panchayat edn. & SWALLOWS for publications.

Impressions

- Innovations with educational methods for rural children & publications. Syllabus to ultimately include occupations, housing (building & carpentry) health, literacy. (Refer samples)

children can also sit for SSLC later - after 4 yrs.

David Horsburgh's (Neelbagh) method used. Subbu started with a training there in '75. They are also in CONTACT with NCERT

Eg of some innovations:

1) jigsaw puzzle of map of area (village) to sensitize children to land distribution:
2) use of puppet shows & other media
3) folk media of festivals used to introduce themes on social issues
4) chart showing perks of an MLA.
5) interesting visuals ~~[illegible]~~ in books & walls
6) local carpenter producing a screen printing machine
7) carpenter & mason used as teachers.

- simple low walled thatched hut - small little windows, & jute covered frames for display.
- sparse & simple centre.
-

- another instance of inspiring lay committment. simple, risk-taking, sacrificing together with family committments — open, humble, wanting to learn inspite of being highly qualified.
- Some experiences narrated.
  i) Housing board plan of multi-storeyed building for fisherman + its irrelevance to their life-style of carrying 10 kg fuels, cycles to top floors, latrines without water.
  ii) Horlicks + Bournvita suggested as alternative to local liquor for use by fishermen to warm up in the early hours before going to sea.
  iii) Snakebite case in village - not taken for medical Rx seen as entrance/visit of a God - child died - School children taken to snakepark + informed reg. poisonous/non-poisonous snakes, symptomatology so that in future children may demand treatment.
  iv) brambles in path by village opposition Development of intuition for self protection.
- perception of health needs — use of traditional medicine, minor ailment Rx, working with dais, spread education of regarding health

St John's Medical College (DRHSTP)
Newsletter (2)

(14) Draft

January, 1982

MP 6.24

Dear ,

Greetings from Bangalore!

(1) Thanks for the lovely cards, interesting letters and information that we have been receiving from you all in response to our letter and questionnaire sent in the second week of December. The prompt response from about 90 CHW's has been very encouraging. Not only has it given us great confidence in the country's postal service but we have realised that the CHW network is active and enthusiastic. Though many of you are not doing village health work we were glad to hear that the knowledge shared during the course is being put to good use in a wide variety of situations which range from teaching in schools; working in homes for aged, orphans, handicapped and leprosy patients; Infirmarians of communities and helping in dispensaries; organising income generation schemes; running community farms and estates and so on. A few have even become superiors and we hope can encourage others in the congregation to get involved in rural work.

> Economic development, anti poverty measures, food production, water, sanitation, housing and education — All contribute to health and have the same goal of human development.
>
> — Mahler-Labouisse

(2) Now for news about some of your colleagues.

(a) Location
The 150 CHWs are spread out all over India. Andhra (17), Assam (3), Bihar (12), Delhi (1), Goa (3), Gujerat (1) Haryana (1).

Karnataka (39), Kashmir (1), Kerala (9), Maharashtra (7), Manipur (1), Mizoram (1), Madhya Pradesh (12), Orissa (5), Tamilnadu (12), West Bengal (9), and Uttar Pradesh (18).

Three are abroad – Nepal (1), Ghana (1) and USA (1) and one is just preparing to go to Sudan!

Health work

(b) The community Health programmes being carried out include Maternal & Child Health, CRS Nutrition programmes, school health, Balwadis, health insurance schemes, training local health workers and animators, NFP and Family life promotion, Adult education, organising youth and mothers and health education. We shall let you know details as we visit them and in later newsletters.

(c) Furthering Skills

Some Cities have been adding further skills and knowledge through other courses.
Nursing:- Sr Tresa Jose (BC1), Sr Annakutty BC-4, Sr Malathi Daphne BC2 and Sr Eisy BC1, Paramedical course – Sr Juliana - BC4 MANI, Sr Lalitha BC-7, Community Development and Social work Sr Elsie BC-5, Sr Cicily BC-5, Sr Antonia BC-2.
Sr Bonitas (BC-2) has just completed a special course in the Care of Mentally Retarded

(d) Refresher Courses

The following returned to St Johns for a refresher course in the last two years – Sr Ann BC1, Sr Tresa Jose BC-1, Sr Suma BC-2, Sr Sushanti BC-3, Sr Justina BC-3, Sr Vinaya BC-3, Sr Jonitta BC-3, Sr Martha Soreng BC-3, Sr Therese Thomas BC-3, Sr Mary Kurumery BC-4, Sr Mariamma BC-4, Sr Cosu BC-5, Fr Joseph Purayidom BC-6, Sr Pierlisa BC-6. We hope many more of you will get the opportunity in the future.

(e) Our prayers are with the following who have been ill for a speedy recovery to an active reaching out Sr Theophane BC-4, Br Joseph Jayaprakash BC-4, Sr Veronica BC 5, and Sr Inmaculate Kisku BC-6.

"The new Community Health worker is not a passive provider of care who waits for patients to present themselves, but a dynamic promoter of self-help programmes leading to community self reliance and thus to better community health
— Earthscan.

③ St John's and Departmental News

a). We thank all of you who sent messages of support and prayers during the St John's Crisis. You will be glad to know that Bishop Patrick of Varanasi told a CBCI Meeting in Tiruchi on 12th January that a happy solution of the problem is expected by end of February. The discussions are taking place in a very friendly atmosphere (Indian Express of 13th Jan 1982)

b) Maj Gen B Mahadevan (Papa) retired from active service in February 81. He was ill for some time and is much better now. We thank all of you have kept him in your prayers.

c) The following staff left for Higher studies Dr Luis Barreto to Canada, Dr K. Nagaraj to Wardha and Dr Prakash to

d) The following have joined the team in 1981. Dr Antony Colaco, Dr Gururaj, Dr Malathi, Dr Nagarathna and Dr Kruti Kesharan.

e) Prof S.V Rama Rao continues as Professor and Head of Department.

(F) The next CHW Basic Course (BC-9) commences on 1982 and the CHW Refresher course on 1982.

(4) Project 1982 We have been planning out our travels in response to your letters. We shall let you know soon when we will be coming to your part of the country. The programme is becoming more exciting day by day – it includes a meeting of health workers in Tamilnadu, a 35 Km trek in Orissa, a meeting of parish workers in Aurangabad, a Health Education seminar in Mizoram, a sojourn through the North East and the tribal regions of Andhra, Bihar, MP and ~~other~~ Tamilnadu ~~States~~ and so on. It may not be possible for us to visit each of the 150 CHWs in their place of work as we have less than 300 days for our travels. We hope that many will come together in a central place for a day e.g Mangalore, Varanasi etc. Any suggestions will be most welcome! Do keep in touch with us particularly if you change your address or your work. Till April, our contact address will be D-16 Staff Quarters, St Johns Medical College, Bangalore - 560034.

*

(5) Keeping contact with the Dept while we are away on our travels, ~~If~~ you are interested in the following a) List of latest addresses of CHWs of your batch and those working in your area b) Letter to your PHC doctor or DMO introducing you and requesting them to ~~support and~~ encourage you and include you in their programmes (send name and address of doctor/s) c) Details of next Basic course or Refresher Course d) Any other ~~____~~ information required please write to Dept of Community Medicine, St Johns Medical College, Bangalore-560034 ~~enclosing a 35 paisa stamp~~

(6) Keeping track –

We have no news recently from the following. If you are in touch please send us their latest addresses and news about what they are doing.

BC-7 = S. Michael Teresa, BC-6 = S. Paula, Sr Stella Mary, Sr Betty, Sr Celine Sangma, Sr Amutha, BC-5 = Sr Annette, Sr Genevieve, Sr Nirmala, Sr Annie Jose, Sr Elsie, Sr Anna Joseph, Br Sebastian dung dung, Br Francis Tau, BC-4 = Sr Anastasia, Sr Egidia, Sr Evangelina

Sr Servia, Sr Josetta, Br George MM, • BC3 = Br. G. Victor.
BC2 = Sr Shuba Minj and Br. Nirmal
News of any of your other colleagues will also be always welcome.

(7) Hope you are in touch with VHAI (Voluntary Health Association of India, C-14 Community Centre, Safdarjung Dev. Area, New Delhi-110016) and CHA (Catholic Hospital Association of India, CBCI Centre, Goldakkhana, New Delhi-110001) They will keep you in touch with new concepts in health, audio-visual education materials and contacts with others working in the field in your states.

With best wishes and regards

yours sincerely

Thelma & Ravi Narayan

I seek not Kingdom, nor Paradise, nor even Salvation:
I seek only the Deliverance from Affliction of the Afflicted

* Many problems can be resolved when people work together and give each other help and support

MP 6.23

St JOHN'S MEDICAL COLLEGE, BANGALORE 560034

Directorate of Rural Health Services and
Training Programmes
0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0

NEWS LETTER - 1

JANUARY 1982

Dear

Greetings from Bangalore !

(1) Thanks for the lovely cards, interesting letters and information that we have been receiving from you all in response to our letter and questionnaire sent in the second week of December. The prompt response from about 90 CHWs has been very encouraging. Not only has it given us great confidence in the country's postal service but we have realised that the CHW network is active and enthusiastic. Though not all of you are doing village health work we were glad to hear that the knowledge shared during the course is being put to good use in a wide variety of situations which range from teaching in schools; working in homes for aged, orphans, handicapped and leprosy patients; infirmarians of communities; helping in dispensaries; organising income generation schemes; running community farms and estates and so on. A few have even become superiors and we hope they will encourage others in the congregation to get involved in rural work.

****

The new Community Health Worker is not a passive provider of care who waits for patients to present themselves, but a dynamic promoter of self-help programmes leading to community health. -- Earthscan

****

(2) Now for news about some of your colleagues.

(a) Location

The 155 CHWs are spread out all over India:in Andhra (17), Assam (3), Bihar (12), Delhi (1), Goa (3), Gujarat (1), Haryana (1), Karnataka (39), Kashmir (1), Kerala (7), Maharashtra (7), Manipur (1), Mizoram (1), Madhya Pradesh (11), Orissa (8), Tamil Nadu (12), West Bengal (9) and Uttar Pradesh (18). Three are abroad - Nepal (1), Ghana (1) and USA (1) and one is just preparing to go to Sudan.

(b) Health Work

The community health programmes being carried out include Maternal & Child Health, CRS Nutrition programmes, School Health, Balwadis, Health Insurance Schemes, training local health workers and animators, NFP and Family Life Promotion, Adult Education, organising youth and mothers, and health education. We shall let you know details in later newsletters, as we visit some of them.

.....p.t.o...2

contd...from pre-page - 2

(c) Furthuring skills

Some CHWs have been adding further skills and knowledge through other courses.
Nursing: Sr Tresa Jose (BC1), Sr Annakutty (BC4), Sr Malathi Dophu (BC2) and Sr Elsy (BC1).

Para-medical Course: Sr Juliana (BC4) and Sr Lalitha (BC7).

Community Development and Social Work: Sr Elsy (BC5), Sr Antonia/BC2 Sr Bonitas (BC2) has just completed a special course in the Care of Mentally Retarded Children.

(d) Refresher Courses:

The following returned to St John's for a refresher course in the last two years - Sr Ann and Sr Tresa Jose (all of BC1); Sr Suma, Br Susanto, Sr Justina, Sr Martha Soreng, Sr Vinaya, Sr Theres Thomas, Sr Jovitta (all of BC3), Sr Mary Kurissery and Sr Mariamma Antony (of BC4); and Fr Joseph Purayidom and Sr Pierlisa (of BC6). We hope many more of you will get the opportunity in the future.

(e) To the following who have been ill, we send our prayers for a speedy recovery to an active reaching out. Br Joseph Jayaprakash (BC4), Sr Veronica (BC5) and Sr Immaculate Kisku(BC6).

(3) St John's and Departmental News

(a) We thank all of you who sent messages of support and prayers during the St John's crisis. You will be glad to know that Bishop Patrick of Varanasi told a CBCI Meeting in Tiruchi on 12th January '82 that a happy solution of the problem is expected by end of February. The discussions are taking place in a very friendly atmosphere (Indian Express--13.1.82).

(b) Maj Gen B Mahadevan (Papa) retired from active service in February 81. He was ill for sometime and is much better now. We thank all of you for keeping him in your prayers.

(c) The following staff have left for higher studies: Dr Luis Barreto to Canada; Dr K Nagaraj to Wardha; and Dr SB Prakash to Hubli.

(d) The following have joined the team in 1981. Dr Antony Colaco, Dr G Gururaj, Dr A Nagaratna, Dr Kiriti Keshavan and Dr K Malathi.

(e) Professor SV Rama Rao continues as Professor & Head of the Department.

(f) The next CHW Basic Course (CHW BC9) commences on 30.8.82 and the next Refresher Course (CHW RC4) commences on 8.11.82.

With best wishes and regards,

Yours sincerely,

Thelma and Ravi Narayan

"I seek not Kingdom nor Paradise nor even Salvation. I seek only the Deliverance from Affliction of the Afflicted"

Mandya - cont'd.

Miscellaneous points

1. Since they work with non-christians, religious duties with laity do not form part of their work but is carried out only for the group (traditional colourful Syromalabar rite)
2. Had discussion with Fr Joseph & suggested.
   1) group sharing of field experiences for building research methodology
   2) more contact with govt. & other agencies for mutual support network.
   3) analysis of records,
   4) visit to KOF
   5) CISRS + ISI course.
   6) continued contact with Dept.
3. Mandya is a very fertile region due to the canals. - also malarious for the same reason - sugarcane in plenty - coconut - ragi - rice
   Sugar mills, - alcohol & chemical industries - rice mills - brickkilns - jaggery making - castor oil
   Mixed popⁿ - Tamils immigrated
   Harijan area neat with small garden plots.
   Plenty of G.P's.
4.

MP 6-22

House No______ Sl No______

ST THOMAS MISSION SOCIETY, MANDYA

Town __________

Nagar__________

Socio-Economic Survey : 19____ __________

Village__________ Hobly__________ Taluk__________

1. Name__________ 3. Religion__________

2. Address__________ 4. Caste/Comm__________

5. Members' Name	Sex	Age	Rel to Head	Educa	Occupa	Remark
1)						
2)						
3)						
4)						
5)						
6)						
7)						
8)						
9)						
10)						
11)						
12)						

6. Disabled : ( ) Deformed ( ) Mentally retarded ( ) Dumb ( ) Deaf ( ) Blind ( ) Lame ( ) Old ( ) Orphan

7. House : Own/Rent ( ) Single/Joint ( ) RCC/Tiled/Thatched ( ) Mud/ Brick / Stone ( ) Cement floor / Dung ( ) Electr. / Not ( ) Own well / comm. Well / pipe ( ) Bath room ( ) Closet ( ) Phone ( ) Oven by Keros/wood / Dung cake / chaff/Gas/charcol ( ) News paper ( ) Magazine ( ) Radio

8. Land	Acre	Cultivation	Production	Water facility	Pump
Wet :-					
Dry :-					

9. Live-stock :-	Bullock	Cows	Buffalo	Sheep	Goat	Donkey	Pig	Others
Number :-								

10. Industry

	Name	No of employee	Profit	Problems
Big				
Sm. scale				
Cottage				

11. Other Industry — Name possible ones 1)
2)

12. Vehicle ( ) Bullock cart ( ) Horse cart ( ) Cycle ( ) Bike ( ) Auto
( ) Car

13. Educational facility ( ) Nursery ( ) Primary Lower / Higher / English / Kannada
( ) High School / Engl / Kannada ( ) College ( ) Adult ed. scheme

Distance to the nearest Higher Primary......................

Distance to the nearest High school......................
The school your children go......................

....

14. Medical facility ( ) Hospital ( ) Clinic ( ) Dispensary ( ) Health Centre

( ) Homeo ( ) Ayurvedic......................

Distance to the nearest Hosp/Clinic/Dispen/......................

....

Recurring diseases ?
Rural Health programmes ?
Preventive medicines ?

....

15. Recreational facility ( ) Clubs ( ) Theatre ( ) Reading Room ( ) Playground
( ) Park

16 P and T Post ( ) Office. Distance to the Post Office......................

Distance to the Telephone PCO......................

17. Marketing & Banking ( )Milk Society ( ) Co-operative Society ( ) Bank ( ) Chit fund ( ) Small saving scheme. Nearest Bazaar......................

Problem of marketing :-......................

2)......................

18. Felt needs : The needs of the place are ;-

1)......................

2)......................

19. Assessment of the family's economic position:-
( ) Upper ( ) Middle ( ) Lower ( ) Lowest

20. Surveyed by......................

Date......................

Dr. ARA Fernandez - RBS alumni Doctor 1974 Batch MP 6.18

- Clinically seems good - large OPD, full wards, emergencies - however not as confident as GDR.
- good PRO with hospital staff, religious, priests + ~~other~~ doctors in Chickmagalur (not joined IMA) + local bigwigs
- Has not kept much in touch with SJMC staff + students - + even RBS colleagues
- He has had some problems in his work situation (which may ~~have~~ be ~~more~~ common to working with a religious group) viz
  - i) Senior sisters (nurses) often take clinical decision regarding patient care often overruling the RBS doctors judgement.
  - ii) Hierarchy problems of junior + senior sisters -
  - iii) lay young RBS doctor expected to fit into a mould often unrealistic.
  - iv) is lonely - social contacts limited.

- Has worked out a referral system with a local pvt. ObG specialist. Not much contact with the Govt PHC near Bushnil or Dist Hospital at CMR.
- Kept in touch with routine clinical text-books - not much wider reading or awareness of broader health issues

- Planning to stay for another year if his condition of regular visits to Bangalore + his work in Chickmagalur is accepted.
- sees his future as setting up a general practice.
-

Dr G D Raindhan — RBS Alumni Doctor — 1974 batch.

- Plan for RBS started early in career (IInd MB) inspired by books (The Citadel by A J Cronin) & also by family doctor — Schweitzer Primeval Forest
- Family pressures — neutral
- Strong traditional Catholic background. Has a deep religious faith which comes through even without talking about it.
- very organized & planned in his approach to his objectives (more vocation than profession)
- all this however is not due to or resulted in a naivety but he is quite analytical about SJMC, church, religious & his work situation
- work — very involved in all aspects of clinical work — much less so with community medicine though this is reflective of the fact that the PHN is in control of it
- faces emergencies with equanimity + skill eg is expert at forceps for area, attempted successful skin grafts c blade, managing psychiatry cases, cardiac cases, paediatric emergencies etc.
  Method reflective of technical competence + creativity. learns from each situation
- good relationships with staff, sisters, ITMA + PHC, priests — analytical more than emotional about situations where relationships have been strained.
- aware of need for continuing education
  Subscribes to PGIMER drug bulletin, MFC, health for the millions etc, attends IMA meetings regularly + also NIMHANS regional training progr for GP's (also attended a weeks course at NIMHANS during holidays)
  Keeps in touch with professors other than liaison officers for technical matters, has written for bulletin.
- perception of community needs of health & development not clear. — more Schweitzer than Morley.
- Has extended his contract of work in Ramapore for another year.
- Interested in doing PG — MNAMS in GP.
- Keeps in touch with other RBS doctors & even potential ones among juniors. has visited Burnal

VISIT TO KAMAGERE — 4th, 5th, 6th Feb '82.
CHIKMAGALUR/BUSKULL 9th–11th Feb '82 MP 6.18
HOLY CROSS HOSPITAL + HEALTH CENTRES

Holy cross congregation – a few points
Originated in Switzerland. A capuchin father found that there were young girls in the parish who could be given religious education + motivated to work in schools + hospitals. He started a small parish group of 3. The need for a larger group was felt as the work increased. This developed into 2 congregations of the Holy cross sisters dedicated to medical work + teaching. The motto of the founder was "The need of the times is the will of God".

In the early part of this century a foreign Bishop working in Quilon in Kerala felt the need for medical work among his people. With permission of the Govt. of India he invited the Holy Cross Sisters to work in Kerala. Initially the sisters worked in Govt. Hospitals but over the years began to develop hospitals of their own. Their main area of work was nursing + later leprosy work in the 60's. According to their capabilities they were trained as nurses, leprosy paramedical workers + now doctors + social workers. They also established a nursing school in Kottayam

Centres in Karnataka In '70-'71 they established a convent in Bangalore + on the request of the Bishops of Mysore + Chickmagalur also established the following 6 centres.
1) Buskull – '71 – 18 bed hospital in Bishops coffee estate
2) Kamagere – '74-75 – 19 " "
3) Chickmagalur – '79 – 18 " "
4) Hannur – 79-80 – health centre
5) Marianagar – dispensary in christian settlement.
6) Prakashpalyam – Jan '82 – 24 bed hospital

About the same time some sisters did their public health nursing in CMC Vellore + Lady Reading Health school in Delhi. They (mainly Sr. Vaseline) initiated public health work in the neighbouring slums + villages around their institutions. This continues to be a wing of the hospital + is now the expression of a major reorientation of their health work
all the public health work centres

PTO

around CRS food programme which includes family records, home visiting, weekly "MCH clinics" along c̄ the distribution, training of nutrition aides (late CRS policy) + nutrition & health education.
All these routes were also part of the Karnataka study of NFP of Dr M. Mascarenhas. Sisters attended training programme + 40 to 50 families were taught the method & followed for 16 months.

The Holy Cross Hospitals joined the Rural Bond scheme of SJMC in 1980 + 2 doctors were sent to Kamagere + Buskull respectively (Dr G N Ravindran & Dr A R A Fernandez). In 1980 one of the sisters also attended the CHW course (BCG) at St. John's & subsequently went to Kamagere.

In 1980 they moved to U.P. in Piplare near Delhi + Khairabad near Lucknow. Two SJMC - RBS doctors (George D'Souza + Tauti) went to Khairabad in mid-81.

Setup (organiz^n)

(i) Kamagere - The hospital is situated on the outskirts of the village opposite the church in a building that was constructed as a leprosarium by a Polish group of missionaries. Double storeyed modern concrete building which had to be adapted into a general hospital and convent. Pay wards (2), Doctors quarters CH Dept office and Convent on 1st Floor. General wards Emergency Room, Garage, Labour Room, Lab, pharmacy. Stores. OPD (Registr + waiting) and Doctors room (consultation) on ground floor. In addition there are kitchens for patients, an open shed for CRS programme and a 8-10 acre campus c̄ borewell and pump, cultivated with Mulberry, ragi, coconuts, papayas, sapotas and other fruit trees and vegetables. They also had a poultry and reared rabbits.

Work schedule

General OPD - 9-1 pm and 3-6 pm (80-90 pts)
Casualty service + Maternity
Weekly MCH clinics / CRS distribution (500 beneficiaries)
Individual Health Care programme for TB / leprosy / aged / handicapped (40 beneficiaries) | weekly
Thrice weekly afternoon extension clinics by MO
Hannur (twice) + Prakashpalayam (once)

Community Health work covers 6 villages and includes Family visiting includes health education, MCH work, immunis^n Eradn of Malaria, TB / leprosy follow up. Kitchen gardens. NFP, Savings Scheme (Kamagere, Singanelloor, Indiravady Mangala, Gundapura, Kannoor)

Contact c̄ PHC - Kangere minimal - 10-12 Private practitioners in Kangere

Referrals to Mysore (Mission Hosp & Medical College) and SJMCH

(1) There is a future plan to build a new hospital since ~~Hassor~~ existing accomodation is found to be unsuitable. The existing building will be mainly for CH. work.

Kangere Church - Simple rural, church c̄ tiles fitting into surroundings. Parish Priest runs a boarding for boys from neighbouring villages, a filatury to generate local employment and also had a 'food for work' programme for farming work on church land.

The small filatury employs permanent and temporary workers (ESI evasion) and produces silk thread of high quality. Workers are paid a rupee more than local rates

Next to hospital is a 7th day adventist church as well as a Protestant community further on

(2) Hannur - Started 1979-80. Mainly health centre

New modern, incongruous, sophisticated building

- most plush and neat.
- Not many pts except during Doctors weekly clinic.
- PHU of Rampura PHC.
- Church and a school
- Church lands - on which cotton is cultivated

(3) Prakashpalayam -

- Started some time ago as a health Centre next to the church.
- A completely Catholic village - of resettled immigrants many Tamils
- New 24 bed hospital inauguarated Jan 82 - Visited by Dr once a week. Not fully functional except OPD and some beds. New buildings for leprosy wing, pts kitchens, garage under construction

(There is a village close by with prevalence rate of over 90% of leprosy (second highest in the world - many neighbouring villages have many leprosy patients)

- Approach road to Prakashpalayam is very bad (refer separate note on village as Case Study)

Church - New church inaugurated in 1971 - quite simple beautiful ~~and~~ work (stations of the cross) - inspired by local life style (Indian figures) and colours

- Small tomb of first french missionary father behind church. He was much revered by the local people and died at the end of the sixties
- Church owns over 50 acres of land which is being cultivated
- A school is also run for local children and extension health work and other programmes are carried out in surrounding villages (Ref: Case Study)

(District Hq)

(4) Chickmagalur – Small town - in plantation area of Karnataka
History – given to youngest daughter of the Maharaja of Mysore - ie Chikka Magalur. Now famous for being the constituency of Smt. Indira Gandhi.

Holy Cross Hospital – Outskirts of town (3km away) 18 beds
Usual Holy Cross pattern of Hospital & Convent + Family welfare Centre (now partially converted into guest house) and doctors quarters.
Wards full. OPD average 60-70.
- Recent transfer of RBS doctor (ARA) from Buskull.
- Initially he made weekly visits to Buskull but now once in 2-3 weeks.

Referral to General Hospital (District) – Surgery – OBG
Many Private practitioners and Pvt Nursing homes

Maintain good relationships c̄ DMO, GH & Pvt Nursing home.

Town – has Bishops house/office, school run by Bishop. Several Cathedral in town along with school runs by St. Joseph of Tarbes.

(5) Buskull – 18 bed hospital in land given by Bishop within his own coffee estate (400 acres). Land for Convent is $7\frac{1}{2}$ acres. Holy Cross type hospital with small room for C.H. work, doctors residence and guest quarters, dairy, convent and garden full of flowers vegetables, fruit, ragi, tapioca, coconuts etc.
- One Sr runs a creche in village close by – 40 kids (day care centre)
- New church under construction
- Some land of coffee estate has been distributed to the local population during Emergency

- ~~[illegible]~~ The reason for this situation may partly be due to the fact that professionally trained public health nurses have organized & are carrying out the programmes through traditional emphasis on activities rather than changes in awareness of people

- One of their own sisters, ~~who~~ has done the CHW course at SJMC in which health & development are taught as being a process rather than a endpoint. This sister however has not been utilized to her full potential as a contact between the people & the centre. This is because of a professional attitude that 3 months is too short a course for a person to understand much about health. She is used mainly as an odd job person. This is particularly surprising because many other CHW's of the same calibre have understood the health situation of their area & are carrying out health programmes in coordination with existing health services in their area (PHC/mission health centres)

- Hospital Services: Because of the training of the sisters the quality of hospital care especially obstetrical care, is of a high order. It is questionable whether the really poor & underprivileged can afford this. Though the OPD's were well attended, it was not possible to assess who was really being served. For young doctors who are medically oriented ~~[illegible]~~ wide clinical experience can be gained & there is opportunity for development of surgical obstetrical skills. Due to years of experience in large hospitals the sisters are supportive to the doctors especially in obstetrical work.

- Pharmacy — mainly stocked with costly patent medicines (except mixtures) ~~[illegible]~~ (mostly obtained from Bangalore) - & there is not much effort in working out low cost regimes.

- Contact with Govt. health services is inadequate (both c PHC & district hospitals) There is a strong element of competent rather than as being complementary & mutually supportive agencies working ~~[illegible]~~ together in the field of health. Referral links with hospitals

to allow for Land Ceiling act requirements
- Coffee estate of bishop has both permanent workers (on labour lines) and temporary from neighbouring villages. Pulping and processing unit Run by a Fr Stan. Relationships with labour strained and under tension following the writer of the estate having being fired on grounds of embezzlement.

Overall impressions

- a highly professionalized ~~[illegible]~~ institutionalized medical group. ~~[illegible]~~ used to providing traditional type high quality (technology + efficiency) medical + nursing care. This quality stamp is carried over even into their rural centres making it incongruous to the realities of the environment eg telephones, fridges, lab instruments like colourimeter, x ray machines; complete O.T setup which mostly underutilized or not used, the latter being due to lack of training + lack of need.
- There is such a premium on efficiency + maintenance of orderliness taking up most of the time of the staff + hence making them unavailable for more important health needs. eg health education.

Since they see themselves mainly as a referral unit + catering to people who come to them (floor-mopping) they are fully aware + responding to the real health needs of the area.
- The community health work is mainly stimulated by the presence of CRS doles though in principle all the components have been included in the programme in actual practice they are secondary to CRS food distribution

In most of the centres the family folders started by Sr Pascaline + group are not being used since this work is not an expression of a reorientation of thinking on health care. The com. Hlth work may pack up when CRS doles stop. Some of the activities are just routinely done 'for the sake of being done' + ~~are~~ not oriented to bringing about real attitudinal change and awareness among the people

is poor.

- general lifestyle of the convent especially regarding food was found to be rather high & westernized. In relation to the lives of the people whom some of the sisters are visiting this seems incongruous & confronting eg. multi course meals, rich food, pastries, rich cakes, icecreams even in the small centres.
  high clearances & teas
  table napkins
  plush furniture, crockery etc
  hobnobbing (dinners) with local bigwigs.

- In our discussions with the sisters we noticed the foll:
  i) references to 'them' the people in traditional terms of being uncivilised, dirty, unscientific etc
  ii) 'pay wards' + 'common' wards.
  iii) hierarchical distinction of work among team based on professional training, we were told that each were trained according to their 'ability' + lesser qualified were seen as less important
  iv) lack of team sharing - many sisters did not know what the others were doing.
  v) not so good group interactions & interpersonal relations (as related by RBS doctors)
  vi) lack of much contact with or interest with other congregations working in the same area eg Marsally + St. Josephs of Tarbes + Parish school.

The experience of being in close contact with the Holy Cross convent + their rural health centres raised a numbers of questions in our minds of the relevance, role & attitudes of religious in health & development work (refer separate note).

MP 6-19

CATHOLIC RELIEF SERVICES - USSC MADRAS ZONE
NUTRITION EDUCATION PROJECT INDIA 76 - 45
MATERNAL CHILD HEALTH PROGRAM
MONTHLY REPORT FOR MEDICAL AID GIVEN

1. Name of the Centre

2. Month of Reporting 19

3. a. Number of anti - natal mothers participating in MCH Program ....

   b. Number of Post - natal mothers participating in MCH Program ....

   c. Number of women delivered ....

   d. Common ailments among this group

      i.
      ii.
      iii
      iv.
      v.
      vi.

   e. Treatment given.

4. **Pre-school children**

   a. Number of children treated for ;

      1 Scabies
      2 Other skin diseases
      3. Worm infestation
      4. A G. E. (Acute Gastro enteritis)
      5. Respiratory Infections
      6. C. S. O. M.
      7. Others

   b. Deficiency Diseases Observed

      1. Anaemia
      2. Kwashiorkor
      3 Marasmus
      4. Vitamin Deficiencies (specify)

5. Others

5. Treatment given

6 Causes

7. Advice given

8. Follow-up Action

9. Other remarks

Date :

Signature of Nurse

Seal :

REPORT OF FAMILY NUTRITION COURSE

1. Name of the Centre :

2. Name of Centre - in - Charge :

3. Name of Local Aide :

4. Reporting Month : .... 198 .

5. Number of mothers Selected for FNC :

6. Number of Absentees :

7. Reasons for Absenteeism :

8. Number of days FNC conducted

9. Course content :

Date	Topic	Teaching method	Visual Aid used	Demonstration conducted	Mother's response

10. Problems Faced :

11. Others :

Date : Signature.

Signature of the Organiser

LW :

MP 6.20

REPORT FOR CENTRE-IN-CHARGE

1. Name and Location of the Centre.

2. Reporting Month

MCH NEP

3. Total number of Recipients:

a. No of expectant Mothers

b. No of nursing mothers

c. No. of children 7 months — 3 years

d. No. of children 3 years — 5 years

4. Health and Nutrition Education

Centre	Groups	Dates of Clinics	Topic selected for Nutrition Health Education	Food Demon stration conducted	Visual Aid Used

5. *Family Nutrition Course*

a. No. of mothers participated regularly

b. No. of absentees

c Reasons for absenteeism

6. Problems faced by the Centre in organising classes

a. Climate

b. Mothers go out to work

c. Others

7. Follow-up visits

a. Number of families visited

be. Remarks

1.

2

3.

4.

5.

8. Immunization

Name of the vaccine and doses			Please write if there is any reaction
DPT	I	dose	
	II	"	
OPV	III	doses	
	I	"	
	II	"	
	III	"	
SMALL POX			
BCG			

9. Other Remarks

Date

Seal

Signature of Centre-in-charge

8 Finance :

Particulars	Opening Balance	Receipt	Expenses	Closing Balance
Balance B.F.				
Receipts				
1. Collection from Mothers				
2. Registration Fee				
3. Sale of Empty containers				
4. Others				
Expenses				
1 Freight & Service Charges				
2. Sale of empty containers				
3. Reg. fee to Diocesan Director				
4. Salaries for full-time workers				
5. Wages for Part-time workers				
6. Transport expenses to villages				
7. T. A. & Supervision				
8. Stationery & Postage				
9. Medicines				
10. Miscellaneous				
TOTAL				
Grand Total				

CRS — 2 Rs/yr Registration for Consignee / Tpt from dock / Printing costs

Beneficiary — 2 Rs/mth For Total Tpt, Medicines, H-Educn material other costs

Activities

H. Educn

(1) Home Visiting – Kamagere, Singarelloor, Induvordy, Mangala, Gundlapura, Kannoor

- Eradn of Malaria
- TB/Leprosy Control
- Kitchen Garden
- NFP
- Savings schem

(2) MCH Programme – on Fridays (Well Baby Clinic)

- H-Educn
- Immunization
- Rx of M+Ch for Anemia/malnutrit.
- Nutrn Education Programme
- Savings Schem
- CRS Food distribution

(3) Individual Health Care Clinic on Saturdays

a) Re. treatment for TB, Leprosy
b) CRS Food distribution for disabled

(4) Savings Scheme

a) People of the visiting area
b) NFP Clients
c) Employees

Nayantara Mallavia
Office of the Direct Consignee
CRS, Bishops House
Mysore.

Ph. No - 23545.

— x —

CRS also has a 'food for work' programme

VISIT TO MANDYA 3rd + 4th Feb '82.

MP 6.21

Work of the Missionary Society of St. Thomas in Mandya region of Manantavady Diocese of Syro-Malabar rite.

I. Centres / Stations

1. Guthalu – Vimalaya. – Fr Jose, Fr Joy + 1 Br.
   Vimala Convent – Sr Elsy (BC 7)
   + 3 sisters.
2. Mandya – Deepti Bhavan – central Headquarter.
3. Kalenahally – Jyothi & V. Rosa, – Fever Treatment Depot.
   Fr. Joseph Purayidom – BC 6 + Fr Jose
   Sr. Francilla – BC 7. + 4 sisters.

[4. a new station in Narayanpura in a neighbouring taluk]

Origins – A group of secular priests in Kerala got together 12 years ago to start a missionary society or association to work with people outside of Kerala in non-Christian areas. They first started work in Ujjain diocese + in the last 10 yrs have built up many schools + institutions. After a review there has been a recent trend to move away from large institutions in towns to smaller rural stations. A few are also experimenting with just living in an area without institutions or service. The Mandya Diocese was taken up in 1979 + this new policy of rural stations is being attempted. In the last 3 years 1 central & 3 rural stations have been started – above. [Approximately 30 out of 150 fathers have made moves in this direction] In each rural station a group of sisters of the Sacred Heart congreg^n are also working.

Activities :-

1) Living among the people – getting land – settling in – getting to know the people
2) Village surveys – including felt needs is completed in Kalenahally region.
3) Each station has small dispensary + 2-3 extension clinics, thrice weekly, on cycles (using CHW kit-box).
   One station is a recognised Fever Treatment Depot under NMEP – (appreciated by WHO!)
4) Centres also run nursery schools + classes for non-school going children.
   + Tailoring classes.

Special features

1. Young Kerala group. trying to adapt to Kannada region eg doing Kannada course, visiting village families regularly.
2. Move towards simple living & non-hierarchical sharing of work.
3. More planned approach to creation of team. attempt to train teams for each station - CHW - St. John's course - ~~Adult-formal~~ adult PSI course. (AUPE)
4. Commitment & continuity. in Mandya area
5. Increasing manual labour - working in the fields, firewood cutting etc, cooking.
6. sharing of course resource material
7. Close link with local NMEP structure & recognised as FTD - fast becoming showpiece for visitors
8. Fairly good records incl. FTD requirements,

Other observations & problems

1. Analysis of local situation poor - identify too closely with rich.
2. Approach during househ. visiting awkward.
3. Linkages with PHC, referal hospital & other govt-dev. programmes & agencies v. poor.
4. Though general orientation is good details of methodology are vague, & not much contact or knowledge of other mission experiments & development.
5. Though present structures are very simple moves towards institutionaliz" are already underway - land, buildings etc MISEREOR supported. (How to know where to draw the line!)
6. Educational effort irrelevant - english medium
7. Rice bundles ~~alphabetical~~ training of school dropouts - traditional & counterproductive ie they are working with the rural rich.

-ve

Church and Development

MP 6.12

1. Lack of understanding of and analysis of
   a) socio political structure/forces
   b) culture
   c) economic relationships & exploitation

   in village / state / nation

   Lack of interest in wanting to know.

2. They consider their own culture/life style as (mainly religious) good and superior.
   People are usually seen as being ignorant, uncultured, irresponsible.

3. Need to give something to the people is strong. Usually material good which they get from others (funding agencies, ~~of~~

4. Idea of learning from people exists in very few. Know-all attitude. Smug in their own thinking/conclusions.

5. Identification c̄ people often lacking. we/they attitudes strong. "Pagans" consciousness+

6. Life style (of religious) very affluent, westernised (one point) and completely out of context of the life of the people.

7. Identified with dominant groups caste/economics and intellectual. See them as great/good people. Heirarchy consciousness high. Fawning ++ Deifying

8. Teams are heirarchical and interpersonal relationships are most often strained.

9. Interaction c̄ Lay members of team is not very good. Judgemental. Expectations of fixed roles. Slightly superior attitude

10. Decision making is heirarchical. even in development fields.

11. Understanding of family life is very unrealistic

12. Understanding of Christ's message or the life described in the Gospels - is nearly nil.

+ve

A few groups have begun to move in a direction closer to the Gospel message.

1. Simple lifestyle – as close to the poorest of the people
   - Food – open house
   - Simple ~~[illegible]~~ clothes
   - Much less or minimum furniture
2. Sharing type of Genuine prayer
3. Work a lot with the lay of the community – of all faiths (team members)
4. Manual/Household jobs are undertaken.
5. Fixity of timings abolished – more emphasis to immediate human need.
6. Non formal education and community organisation. – rather than health and development projects
7. Supportive agencies – helping with training etc.
   CISRS | ISI | Amruthvani.
   AICUF (Fr Claude)
8. Understanding/Analysis of Local situation deeper.
9. All inspired/encouraged by Vatican II.

In the absence of such efforts being based on an analysis of the situation (In society & in church) there is a danger that those who have gone into it intuitively may end up building an institution. closer to the people yet not with them. because we found that most of the existing large institutions. were started in small humble ways by their founders who may not have intended to become so institutionalised.

Caste problem in Health Care

MP6.13

1. Problems for a SC Doctor

a) People of higher castes do not go to them in spite of their technical competence

b) Members of Health team do not treat them with as much respect

c) Lose interest in studying — often due to humiliating experiences even in medical colleges (Christian Instns also)
- teachers discriminate
- colleagues don't mix.
- previous educational background not very good stds of Med. college difficult to keep up with

d) Antagonism by Higher Caste candidates to reservations concessional facilities offered to SC/STs

e) There is a 'class problem' as well since many come from a low income background (group)
Others view them with suspicion in event of theft etc because they are considered in need.

f) One incident when sisters running a hospital had a Sc doctor. when OPD numbers came down - it was attributed to caste factor and the doctor was eased out. Later he set up clinic right opposite the church and continued to flourish.
Was it caste bias of the church itself or was it the pressure of few influential upper caste groups?
Since people continue to go to his clinic opposite the church it definitely was not the peoples bias!

2. Many doctors flourish in a small town because they often represent and cater to specific caste groups.

3. Colour problem is also related. Fair doctors are often thought to be Brahmins and hence accepted by all. The converse may be true.

4. Most Health Care projects esp those that are profit or self support oriented allign with the dominant classes (economic and caste) and hence keep the lower caste/economic groups out.

VISIT TO KALATHIPURA   10th Feb, 1982   MP 6.14

- Franciscan brothers started this mission station about 3 years ago. The village (a small hamlet) is situated in the midst of coffee + cardamom plantations in the base hills. Most of the people work as temporary or permanent labour on the plantations owned by individuals + companies. The plantation size is smaller than tea but the profit margin is larger. (apparently + on hearsay)
[This congregation was started about 80 years ago by a German in the Madhya Pradesh region + have now spread in India + abroad)
- They work in twos/threes in remote areas)

- Present setup

1 Sr. brother (in 70's) ē degrees in Ayurveda + Homeopathy Varanasi -
1 CHW (Br Wency)
1 young recently professed brother
living in a small rented village house typical of that area. It has a small room as chapel, one as dispensary + the rest as residence - very small + humble abode.

i) Dispensary - very well stocked with medicines (of all systems + combinations - Dechane, Ayurveda, Allopathy - some foreign donations. very obvious emphasis on the curative aspect including injections due to the orientation of the older brother.
- 2) Night classes for non school going children + dropouts + adult literacy
3) survey of christian families on the request of the Bishop - small percentage of total popⁿ
4) religious functions → catechism.

- Impressions.
- Br Wency has come to this area 2 mths ago.
- Had a fairly good understanding of the local situation viz
i) plantation setup + conditions of work for the people.
ii) The health setup within the plantations (compounders, dispensaries, referrals) PHC + the paramedics (has met them + uses it as a referral centre), dais + some of the MCH + health practices.
iii) presence of VD + its social causes including sexual exploitation
iv) Alcoholism + consequences + relationship to indebtedness

- aware of the need for working among the people, open + enthusiastic after an initial exposure.
- inspite of a traditional orientation towards curative medicine by the senior brother he is pushing the case for moving ~~into~~ health work.
- He has met Fr Jerome, Holy cross hospital team including RBS doctor (ARA) + also meets Bishop regularly. (Diocesan meeting + otherwise)
-

we wondered whether Br Wency's approach was reflective of the new orientation in BC's leadership. Meeting others of same batch may confirm hunch.
- An interesting experience was the reaction of the nurses (sisters) who accompanied us.
i) surprise at the range of information collected by a CHW in 2 months. which they were unaware of despite of years of functioning in the area.
ii) immediate response was ~~that school~~ the area was ideally suited for a hospital! (Medical orientation makes one see only need for hospitals etc)
iii) The openness + questioning attitude of the CHW was in direct opposition to the smugness + know-all attitude of the medical professionals (D's + N's).
iv) Strangely there seems to be a class alignment + consciousness between a CHW + a nurse. Though they are both christian religious - maybe because of the ideologies of working for ~~to~~ with people.

Case Study: Prakashpalayam

Based on narration of experiences of parish priest Fr.—

Prakashpalayam is a village in Kollegal Taluk, 17 km from Kamapere. Years ago a French christian missionary acquired land there & distributed to ~~converts~~ converts to the faith who came from neighbouring areas of Tamil Nadu "Such a prospect must have attracted the scoundrels of the local villages" The church itself owned a large amount of land which was cultivated by the people in addition to their own plots. The ~~church~~ missionary built a church & school and helped the people to "come up". The Mysore Bishop sent an Indian priest on the death of the missionary. A convent & a health centre was started & recently a new hospital building (Holy cross convent) is under constru other programmes that have been initiated are :- CRS food programme, housing, ~~with extra aid~~ During this whole process the priest, had many experiences which raised questions in his mind.

1) He discovered that many things were started because he couldn't bear to see them like that.
2)

The present parish priest narrated his experiences & experiments in development : which raised many questions as to the role, approach of the church in development &

: He came straight out of the seminary, with an urban background & was full of enthusiasm to work for people. His initial reaction was to give them some ~~help~~ material help towards housing, food etc because he could not bear to see the poverty they were living in. He initiated various programmes like CRS. housing & school with the help of various funding agencies. These efforts often provoked responses in people which were unexpected eg.

1) CRS food programme :- ~~as~~ the people got 10 bags of grain per year per family therefore

they did not feel the necessity to work on their own land + grow food.

ii) Many of them sold the land so that they could become beneficiaries of various projects (for landless)

iii) Many families were aware of + had also availed of govt, Bank + other voluntary agency programmes besides those of the church i.e. many people had thus become beneficiaries of multiple programmes. They made no attempt implement any of the programmes or make any external changes in their life so that they could continue to be beneficiaries of easy money. In later years the priest made them sign agreements on stamped paper to prevent them from applying for various programmes simultaneously. However even this was circumvented.

iv) During the housing programme
- some got the money but did not built
- others built with substandard building
- local contractors made a fast buck at their expense.

ultimately the father modified the programme + provided good roofing material once the walls ~~___~~ of the houses were put at the families own expense.

v) A lot of the money given to the people for different programmes was being spent on alcohol. There were 2 or 3 illicit liquor shops in the village. Interestingly during the Janata govt rule when prohibition was being implemented the father managed to get the men + women (both of whom drank alcohol) of the village to sign a petition asking for the removal of the liquor shops. This was brought about by an intense campaign for 3 mths - church sermons not so much on the evils of alcohol but of the practical reality of the economic drain on the people - he even announced per week + per day ~~expenses~~ expenses + profits made by the liquor shops which he obtained from the shops itself.

vi) A school was started for children in a neighbouring village and an unemployed educated local youth was employed as the teacher. Though he came regularly to collect the funds, the school was mainly non-functional + what was surprising was that the

parents neither complained nor reported the matter when enquiries were made in the same village.

vii) A project for the digging of a well was undertaken by a group of villagers in a nearby place, but in the absence of supervision due to his illness no work was done beyond a few feet, & fake claims were made for payment which resulted in double payment being made for the same job.

viii) A youth club was started with facilities for games & other activities. Many non-christian youth from neighbouring villages also joined. It progressed fairly well at first with regular meetings, games etc. Some of the local christian youth members not liking the way it was progressing, themselves spread the fear of conversion among the parents of the non-christian members leading to their withdrawl from the club.

ix) After many such attempts at 'development work' for the people the father found that such charitable efforts only killed the initiative to work and created a dependency among the people neither of which was conducive to 'real development'. He then decided to stop all the programmes and though in the process he became very unpopular (people made representations to the bishop to remove him) he found that the people became more hard-working and dependent on their own resources. He also decided to work more among the non-christian neighbouring villages where the people ~~were more~~ appreciated such efforts. The only project that he now supports is the clinic and hospital which benefits people in all the surrounding villages also. He is also promoting awareness camp for city children.

—

VISIT TO MARTALLY - MP 6.16 5th Feb '81

(40 km from Kamagere)

Martally & neighbouring Otterthotai & Santhapalya are 3 small mission stations in a remote valley of Kollegal Taluk surrounded by hills (near MM Hills). French missionaries came here many decades ago to work among the people including the nomadic Lambadis. Being part of the old State of Madras (division took place in '56) the people are mainly Tamilians. The area is covered by the Rampura PHC.

We visited Fr George D'Souza Parish Priest of Martally & the FMM Sisters, Sr. Christine D'Souza of ACFC at Sr. Joseph's Convent.

School There is a Tamil Medium Primary & Middle school with a boarding for children from neighbouring villages. In Otterthottai there is a Nursery & Primary & in Santhapalya a high school (Kannada medium). In Martally there are 800 children in school, & 11 teachers living locally. However there are about 600 children not attending school. 80% dropout around middle school. Few Lambadi children attend & dropout after primary. Boarding is completely free. Martally is the examination centre.

Church - Large, modern, incongruous church built 4 years. Giant sized wall painting of Christ holding bread & wine. Underneath which was a large Om. Mosaic flooring.

Hospital. - built in 1965. Solid rectangular building around a central courtyard with lots of woodwork. Morning OPD run by Sisters - approx 20/day. Few pts admitted & job maternity cases, wards mostly empty. Maintenance poor. Termites eating the woodwork. Hoping to get a rural bond doctor.

Earlier doctor belonged to the area - was scheduled caste & fall in OPD was attributed to this. Now has set up practice opposite church compound (failure of rapport between health team & doctor)

Property: of convent consisted of fields of cotton, ragi, paddy, chillies, fruit & vegetables. Borewell with pump.
Convent building same style of architecture as hospital, built earlier! Was being whitewashed during visit.

PTO

Lifestyle seemed simpler + more relevant than HCC. Sisters teach in the school + do hospital work

Other points – accident of P.P. followed by disabling Rx in Mysore Medical College Hospital during 1 yr ? P

– multipurpose work of priest eg teaching in schools etc

exaction by French Fathers in neighbouring village

Impressions

- remote pocket, picturesque, fertile, mixed population
- difficult area to work – geographically (isolated) ethnic people from non Karnataka area (Tamils) + nomadic tribes, historically (dependance created by early Christian charity by missions), strong caste consciousness as elsewhere.
- church buildings + property appear overpowering though we learned that the French missionaries apparently lived + continue to live in simpler structures
- sweet little crosses on villages tiled houses
- age old customs related to agricultural lifestyle have continued with slight Christian modification eg: pongal is celebrated in the church compound by bringing gaily decorated bullocks + preparing pongal which is blessed by the priest (a positive point)
- inspite of educational effort in which caste plays no role, caste consciousness among Christian converts remains + is not challenged by the church – eg when the doctor had problems with caste consciousness he should have been supported.
- The visit raised many issues about the attitude of the church in India + its efforts in development (refer separate note)

Newsletter 2.
February 1982

MP 6.11

Dear Friends,

We have been planning out our travels in response to your letters. The prospects are becoming more interesting day by day. It now includes a 35 km trek in Orissa, a meeting on health in Aurangabad, a Health Education seminar in Mizoram, a sojourn through the North East and the tribal regions of Andhra, Bihar and Madhya Pradesh and so on. We are also ~~[illegible]~~ visiting some alumni doctors of St Johns working in rural areas and some health and development projects run by other groups. It will not be possible therefore to visit all the CHW's in their place of work as we have less than 300 days for our travels. We hope that we will be able to meet some of you in small groups at central places for a day eg Mangalore, Goa, Karwar region, Manantawady, Calcutta, Hazaribagh, Varanasi etc. You will soon get letters from the organisers. The first phase of our travel starting from last week of Januay ~~and ending in 1st week of May~~ till end of April will include Kolar, Salem, Mandya, Kollegal, Chickmagalur, Madras, North Arcot. Then to Delhi, Rohtak, Jagadhri, Chandigarh, Ludhiana, Tillonia, Udaipur, Ahmedabad Vadodara, Rajpipla, Zankhvar, Talasri, Thane, Talegaon, Pune, Jamkhed, Nasik, Aurangabad, Amravati, wardha Nagpur and back. We shall be writing letters to individuals giving further details.

In Madras on 19/20th Feb the Tamilnadu Voluntary Health Association have arranged a meeting and we hope to meet many of our

P.T.O

CHW's there. Do keep in touch with us particularly if you change your address or your work. Our contact address will be D-10 Staff Quarters, St John's Medical College Bangalore 560034 till June. You will have to excuse us for delays in replying since we shall be on wheels most of the time. If the matter is very urgent, ~~eg regarding the programme of our visit etc~~ please mark '<u>Urgent</u>' and '<u>Redirect</u>' on the cover of the letter - Otherwise they will await arrival.

*

February Newsletter

Dear Friends,

(1) Project-1982

We have been planning out our travels in response to your letters. ~~We shall let you know soon when we will be coming to your part of the country.~~ The programme is becoming more exciting day by day--it ~~includes a~~ meeting of health workers in TamilNadu, a 35 km trek in Orissa, a meeting of parish workers in Aurangabad, a Health Education seminar in Mizoram, a sojourn through the North East and the tribal regions of Andhra Bihar, MP and Tamilnadu ~~and so on~~. It ~~may not be~~ is therefore not possible for us to visit each of ~~the 150~~ the CHWs in their place of work as we have less than 300 days for our travels. We hope that ~~many~~ we will ~~come together in a~~ be able to meet some of you ~~[illegible]~~ Central places for a day, where possible eg., Mangalore, ~~Varanasi~~, etc. Any further suggestions will be most welcome. Do keep in touch with us particularly if you change your address ~~will~~ or your work. Till ~~April~~ May our contact address will be D-10, Staff Quarters, St John's Medical College, Bangalore 560034. We

We are also visiting some alumni of St John's working in rural areas and in small groups or a few health and development projects

Our plans will include end of April Goa etc.

(continue here)

****

"Many problems can be resolved when people work together and give each other help and support"

****

(2) Keeping contact with the Dept

While we are away on our travels, if you are interested in the following:

a) List of latest addresses of CHWs of your batch and those working in your area; (b) letter to your PHC doctor or DMO introducing you and requesting them to encourage you and include you in their programmes (send name and address of doctor/s); (c) Details of next Basic Course or Refresher Course; (d) Any other information/ please write to Prof S.V Rama Rao Dept of Community Medicine, St John's Medical College, Bangalore 560034.

Element 5: Humour

a.5 My humour is very often seen by others as irrelevant or pointless.

b.5 My humour aims at maintaining friendly relations; or when strains do arise, it shifts attention away from the serious side.

c.5 My humour is very often hard-hitting, e.g. loud and pointed.

d.5 My humour is putting me, or a position, in a favourable light.

e.5 My humour fits the situation and always aims at giving perspective to the situation; even under pressure I retain my sense of humour.

Element 6: Effort

a.6 I just put in enough effort to get by

b.6 I rarely lead, but extend help

c.6 I drive myself and others hard

d.6 I seek to maintain a good and steady, but not fast pace.

e.6 I put in vigorous effort and others join in.

WORK SHEET

PARAGRAPHS

________ a : ________

________ b : ________

________ c : ________

________ d : ________

________ e : ________

(Enter the rank 1 or 2 or 3 or 4 or 5 against each paragraph (a,b,c,d,e) on the dotted line)

ELEMENTS

Copy the code letter (a or b or c or d or e) against each Element (1 to 6) in the dotted space below:

________ Element 1 : Decisions : ________

________ Element 2 : Convictions : ________

________ Element 3: : Conflict : ________

________ Element 4 : Emotions : ________

________ Element 5 : Humour : ________

________ Element 6 : Effect : ________

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(3) Keeping track

We have no news recently from the following. If you are in touch please send us their latest addresses and ne s about what they are doing.

~~BC7 - Sr Michael Teresa,~~ BC6 - Sr Paula, Sr Stella Mary, Sr Betcy, Sr ~~Celine Sangma~~, ~~Sr Amutha~~, BC5 - Sr Annette, Sr Genevieve, Sr Nirmala, ~~Sr Annie Jose~~, ~~Sr Elsie~~, Sr Anna Joseph, Br Sebastian Dung Dung, Br Francis Tiru; Bc-4 - Sr Anasasia, Sr Egidia, Sr Evan gelir Sr Servia, Sr Josetta, Br George MM; BC3 - Br G Victor, BC2 - Sr Shuba Minj and Br Nirmala.

News of any of your other colleagues will also be always welcome.

(4) Contacts with VHAI/CHA

Hope you are in touch with VHAI (Voluntary Health Association of India, C-14 Community Centre, Safdarjung Development Area, New Delhi 110016) and CHA (Catholic Hospital Association of India, CBCI Centre, Goldakkhana, New Delhi 110001). They will keep you in touch with new concepts in health, audiovisual education materials and cont cts with others working in the field in your states.

With best wishes and regards,

Yours sincerely,

T helma and Ravi Narayan

****

"I seek not kingdom, nor Paradise, nor even Salvation, I seek only the Deliverance from Affliction of the Afflicted."

****

Element 5: Humour

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_____ Element 3: Conflict : _____

_____ Element 4 : Emotions : _____

_____ Element 5 : Humour : _____

_____ Element 6 : Effect : _____

5) Newsletter – We would like you to share some of your experiences with the others through short articles on your work. Please write and we shall put them in.

If you have not written to us or to the department after Nov 81 – please acknowledge receipt of the newsletter giving latest address to continue getting further issues.

With best wishes and Regards

Ravi & Thelma Narayan

"Primary Health Care is not just medicine. It means ditches, water pipes, nutrition, latrines, Family welfare. Health is development"

– Earthscan

19th Feb '82. TN-VHA-GBM Madras

MP 6.9

- 'enable' + not rogue for private health care
- 'The project is important' - 'generate skills in the community' 20-30
communicate simple skills to beneficiaries - capable of being understood + practised by the community.
- DANIDA - small leather industries, fisheries, + dairy dev: all over India + the world.
The biggest projects are for health care in MP + TN.
TN - 2 districts - Salem, S Arcot + 1 Block in Tanjavur (fisheries)
9 experimental blocks taken in 1st yr c̄ commenced on 1/3/[illegible]
action cum research on sp. diseases eg JE.
village welfare committees - their suggestions will certainly be given consideration!
planning, implementation + carries corrections!!
↳ they want 'culvert' across a stream
ii) Lambadis in Salem want to organize their women to make garments, they will give them 'modern' designs!
project hopes to start projs + building up so that the people can continue them 'almost forever'

- South Arcot DT - Arcot Lutheran Church.
Danish Mission Hospital - Thirukoilur } old Danish
Leprosy unit.
- The system has to deliver the goods.
- World Bank working in 6 other DTs. - mainly on nutr.
- If we activate 30% of the system it is a great achievement.
- for drinking water go 1000ft to activise where there is 600 ft of water.
- rendering social justice - in loc: + reach of benefits
50% rep: of weaker gups

- are we developing a breed of exploiters
from victims to perpetrators of injustice
- the team members of one mind
- the team an example of community + sharing
no hierarchy, no salary diff.
issues - rescue for harijans, widows pensions
house pattas, burial ground for harijans, minimum wages
no money transaction bet project - fieldworker or people

Article for Alumni Bulletin

MP 6.10

Pioneers

It was not long ago that we read about the experiences of K.R. Antony in the hills of Wynad. Following this a few others took up the challenge of the Rural Bond Scheme and went to remote places in Karnataka, Kerala, Tamilnadu, MP. and UP. Recently we had the opportunity of meeting Donald Fernandes in Settipatty, G.D. Ravindran in Kangere and ARA Fernandez in Buskull; Our encounter with their work situation made us ponder over the educational process we all have gone through in the Medical College.

Amidst the routine of seeing and treating patients in busy overcrowded clinics their work experience has included —

a) handling a medical team (their professional qualification itself thrusting the leadership role on them). This is inspite of the fact that they are much younger than most of the team)

b) Total responsibility of a packed inpatient ward with no seniors to consult.

c) Facing all types of medical/surgical & obstetrical emergencies. In most of these cases they are the final referral point since the next level care is many miles away and most patients are reluctant to go any further. Some of the emergencies we heard about were uterine inversion, all the abnormal presentations, acute abdomens, Snake bites, Cardiac arrhythmias and so on — Consulted for problem [illegible]

d) Being in charge of laboratory work, extension health clinics and in Supervision of paramedics work.

e) Handling Psychiatric/orthopaedic/Dental/ENT and other so called

Article for Alumni Bulletin

MP 6.10

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→ Consulted for problem rel. laboratory work, extension health

d) Being in charge of ... and in supervision of paramedics work.

e) Handling Psychiatric/orthopaedic/Dental/ENT and other so called

specialist problems.

f) Handling a social role which includes PR exercise with govt health staff, religious leaders, congregation and the local [illegible]

While the graduate out of St Johns would be able to understand the problem in the above situations the question that comes uppermost is :- whether the educational process has provided him with practical skills to handle them. The challenge in this is not one of an theoretical knowledge of the problem but a confidence in one's own practical skills.

Looking back on the year of internship which precedes such a moving out one is shocked at the contradiction of roles played. The average internship experience consists of filling of forms, writing out orders of ones superiors, clerking reports, holding retractors, and generally being the odd job man in an over-doctored situation. This "many" years of a preoccupation with details and oddities at a microscopic level and observation rather than involvement in real bead side medicine.

By this end of this process one so preoccupied with high powered [illegible] technology, that one loses the ability to see and which stresses theory rather than practice abstractions rather than practical skills. The professional competence that develop rather questionable

a) How many of us at the end of internship can handle a forceps delivery, set a plaster for a fractured limb, rehydrate babies with collapsed veins, do an emergency tracheostomy, tackle a poisonous snake bite, or other such common occurrences in rural hospitals

b) How many of us are aware of low cost medical preparations which would better suit our rural economic conditions or are immunised to handle the half truths of high pressured medical advertising which often thrusts unnecessary drugs on hospitals

b) How many are really confident of their diagnostic skills in the presence of only basic lab facilities? How many are confident of carrying/supervising such basic procedures like blood/urine/stool/sputum/water investigations

d) How many of us are confident in the basic procedures of disinfection/sterilisation of equipment, blood transfusion, spinal and other simple clinical adjuncts

e) How many of us can use our knowledge to innovate/create simple hospital aids from locally available materials e.g splints, back rests, use pressure cooker as an autoclave and so on.

Rural reorientation of Medical Education needs gearing up of every dept to prepare graduates to handle such situation with confidence competence and an innovative approach

The reliance on referral, specialist consultat. and high powered medical technology must gradually give way to a more daring skill transfer approach with even specialist putting himself in the shoes of one of these pioneers and handling the ~~st~~ problem within the ~~restraint~~ constraints of the local situation

~~Are~~

~~This~~ is very clear that these pioneers have ~~handled~~ managed to do well in spite of the St Johns education but the challenge could be that more and more in the future are competent because of us.

MP 6.8

WIDENING HORIZONS - II

Dear Friends,

In this issue we introduce two books which raise important issues about the crisis in hospital based medical services and the increasing problem of iatrogenicity or the disease producing nature of medical care itself. Illich is one of the severest critics of the medical profession and Horrobin attempts an answer to Illich's criticism on behalf of the medical profession. These two books read together gives us a balanced view of the crisis at hand.

The next two books are more personalised approaches by two committed christian doctors to find answers to the problems of providing hospital service and health care programmes to communities where poverty is an increasing constraint. How do hospitals reach out to the community ? How do we reorder our priorities ? Their experience and suggestions will be most relevant and thought provoking for all our C H A members

RAVI NARAYAN

Duplicate

LIMITS TO MEDICINE - MEDICAL NEMESIS.

THE EXPLORATION OF HEALTH

Ivan Illich, Penguin Books (Pelican 1977)

The foremost critic of trends in modern medical practice, Illich presents thought-provoking evidence that 'the medical establishment has become a major threat to health and the disabling impact of professional control over medicine has reached the proportions of an epidemic'. Discussing iatrogenesis in great detail, Illich makes one of the most forthright pleas for 'demystification of medical matters' and exhorts lay people to reclaim greater autonomy over health decision making. He writes that 'A professional and physician-based health-care system that has grown beyond critical bounds is sickening for three reasons: It must produce clinical damage that outweighs its potential benefits; it cannot but enhance even as it obscures the political conditions that render society unhealthy; and it tends to mystify and expropriate the power of the individual to heal himself and to shape his or her own environment.

The medical and para-medical monopoly over hygienic methodology and technology is a glaring example of the political misuse of scientific achievement to strengthen industrial rather than personal growth'. The book is divided into four parts and deals with Clinical Iatrogenesis in Part I, Social Iatrogenesis (medicalisation of life) in Part II, Cultural Iatrogenesis (disabling impact of medical ideology on personal stamina) in Part III and The Politics of Health in Part IV. Interestingly Illich warns that 'if contemporary medicine aims at making it unnecessary for people to feel or to heal, eco-medicine promises to meet their alienated desire for a plastic womb'. He also warns that gullible patients should not be relieved of the blame for their therapeutic greed by making physicians scapegoats. Health must be seen as a virtue, as a right and people must be involved in 'political action reinforcing an ethical awakening - that will limit medical therapies because they want to conserve their opportunities and powers to heal'.

A thought provoking book to be read by all CHA members.

MEDICAL HUBRIS - A REPLY TO IVAN ILLICH

David Horrobin, Churchill Livingstone, 1978

This book should be read after the earlier one since it is the first serious critique of Illich's book. Horrobin does not dispute the facts presented by Illich, but disputes his interpretation. Inspite of all the inaccuracies and exaggerations in Illich's books that he attempts to point out, he concedes that Illich's first sentence 'The medical establishment has become a major threat to health' is right and that this book could prove to be ' one of the key medical documents of the second half of the twentieth century'.

In a very open and level headed assessment of the criticisms of Modern Medical Practice the author gives his own tentative suggestions to bring about a change in this situation. He makes a plea for

a) More "Science" in medicine 'to eliminate the errors encouraged by warm emotion 'that 'to do something must always be better than to do nothing'
b) Less use of technology by subjecting them to stricter control to determine whether they really benefit the patient.
c) Attempts to be made to keep medical institutions as small as possible and only for those who strictly need them.

d) Assess professional training and prescribe levels of training actually required to enable people to do jobs effectively and cut out unjustifiable part of courses.

e) Challenge the discrepancy between the high ideals which doctors often profess and their personal life styles and ensure that the profession should be more humane and less a 'certain road to wealth and security' - so that the rightly motivated people are attracted to it.

These changes should be made at four main levels ; of the individual doctor, of the organisation of the profession , of the relationship between government and medicine and medicine related industries, and of the medical school.

- A book which puts Illich's criticism in proper perspective.

5

MEDICAL CARE IN DEVELOPING COUNTRIES

- A Primer on the Medicine of Poverty - Ed. Maurice King
Oxford University Press, 1966.

To many doctors who are working in small rural health centres or hospitals, this book will provide interesting and ingenious solutions to many of their questions on the practice of medicine in conditions of poverty. It is not only the suggestions but the philosophy underlying the approach to such problems in rural health care - that the book is encouragingly different. It starts with twelve axioms of medical care which include that medical care of the common man is immensely worthwhile; medical care must be approached with an objective attitude of mind which is free as far as possible from pre-conceived notions exported from industrial countries; the maximum return in human welfare must be obtained from the limited money and skill available; all medical staff have a teaching vocation in the community they serve; and medical care mustbe carefully adopted to the opportunities and limitations of the local culture.

It goes on to discuss the health centre, health education, auxiliary, patient care, paediatrics, FCM, diarrhoea, under-five clinics, immunizations, tuberculosis, anaesthetics, blood transfusion, laboratory, X'ray department,

medical records and so on in thirty practical chapters which were based on ideas shared at a symposium organised by Makerere University, Uganda on 'Health Centres and Hospitals in Africa'. It invites readers to feel free to add or detract any idea and hopes that more of these ideas will come from local doctors of developing countries for whom this book was written.

PAEDIATRIC PRIORITIES IN THE DEVELOPING WORLD
David Morley, Butterworths, 1973.

This book is based mainly on the work of Dr. Morley and his colleagues in Ilesha, Nigeria where among other things over 400 children born into the village were followed up for over 5 years. The ideas generated from the Nigerian study were shared by Dr Morley with colleagues in West and East Africa, Middle East, India and South America and the discussions led to the writing of this book. In the words of the author the book is to 'be of help to those planners who are involved in discussion with the doctor-monopoly which may be at times conservative in its outlook'. Taking on from Maurice King's book, Dr. Morely defines his own axioms of child care which include that an objective and imaginative approach to child health is necessary supported by a knowledge of loca l customs and practices;

a maximum return in terms of reduced child mortality and healthier and happier children must be obtained from the limited funds available; do not separate mother and child; child care must be the best that circumstances allow and so on. In twenty two chapters that include topics such as care of newborn, breast feeding, at-risk child, road to health c ard, diarrhoea, acute respiratory infection, measles, whooping cough, malaria, TB, skin diseases, anemia , family planning, Dr Morley puts together an approach based on priorities, practicality and common sense. The book gives 328 references of work done on the problems covered in the book especially in developing countries and makes an impact because it comes from a committed clinician. The book has an assessment questionnaire to be filled up by every reader so that a constant feedbac k is maintained.

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MP 6.7

WIDENING HORIZONS-I (CHA)

Dear Friends,

In the Editional of 'Medical Service' of January 1982, our editor wrote "The Catholic Hospital Association of India, through its member institutions, need to realise the seriousness of the present day challenge. Option for the poor is all the more important in the health care field. If our option is for the poor, then we need to rethink about our health services. We need to shift our emphasis for curative aspect of health to health promotion, and health maintenance by the people themselves. This is a great challenge but worth taking."

While considering this challenge medical teams in all the member hospitals will have to get together to reflect on this option, feel convinced of the alternative, evaluate their own present-day efforts and move gradually towards the new ideal. The 'Medical Service' through its new orientation will attempt to provide articles and case studies to stimulate and encourage this process of change. There are no definite directions or clear cut answers but it is most important that we are open to dialogue with those who are raising issues and spear-heading change. In this column we shall keep you in touch with the contributions of committed workers in this field. You are invited to get hold of these books/reports (sources have been mentioned) and initiate discussions on them to help the process of change in your hospitals. Any suggestions for books to be included in this column would be most welcome. The extracts and notes on each book are merely to help you understand the scope of the book. The selection is open-ended and do not represent the thinking of CHA always. We feel you must

read them yourselves and make your own decisions on the perspectives shared by the authors. All we know is that these books have helped initiate dialogue every where.

ravi narayan

1. <u>The New Orientation of Health Services with Respect to Primary Health Care Work</u> - The Pontifical Council Cor Unum, Vatican City, 1978 (Available through CHAI or CBCI in New Delhi)

This booklet contains the conclusions of an expert group of Medical and Health Care Professionals invited to examine the new orientations of health services to fit in with the Primary Health Care Policy. The booklet starts on the premise that 'If we wish to be faithful to Christ and take up his attitudes with regards to our fellowmen, we must work for the overall development of each man, and focus on the sick person more than on his sickness. Since development also means solidarity, we must necessarily turn our attention towards the human community of the patient, his family first, but also his neighbourhood or village. This means we must practice community medicine'. It then reviews the WHO and National Policies of Primary Health Care and the role of the doctor, nursing staff, health auxiliaries and community health workers. It also suggests a new orientation to the hospital, health care centre, and government health organisations. Health services based on hospitals only are 'leaven far removed from the loaf' and therefore it exhorts all of us to 'reach out towards the masses by providing simple, accessible and promotional health care according to our own possibilities, modest as they are, or in conjunction with the public services, where this is allowed'.

A must for all members !

2. <u>Rethinking the Healing Ministry of the Indian Church</u>
Jacob Chandy (Pamphlet on Social Concern - New Series No. 2) Christian Literature Society, Madras (1970) - Rs. 1.25/-

Professor Chandy starts by reviewing the studies on christian medical work in India, listing out problems including their curative orientation, obsolescence in building and equipment, underpaid staff, catering to rich rather than the very poor, business orientation, isolation from other mission or governmental work and dependence on overseas donating agencies. He questions whether most of such hospitals are really symbols of the healing ministry? He goes on to warn that 'Christian Medical Work cannot afford to ignore its theological basis - that total health or wholeness is salvation' and the Indian Church must pioneer once again to discover 'a new role within the context of national development'. The churches will have to be responsive and take new directions within the mandate of Christ which asks us to 'Go and Heal'. He outlines areas of change such as i) a new relationship between the church and medical teams

ii) a new local leadership

iii) integrated health care programmes which emphasise family care

iv) greater utilization of governmental facilities and programmes

v) congregational and community participation in recognition of needs and promotion of public health measures

vi) community orientation of existing mission hospitals

vii) a new financial outlook stressing local fund generation

This little booklet raises many questions for each of us to discuss with our colleagues.

3) An Alternative System of Health Service in India

Some proposals - J P Naik, Indian Council of Social Sciences Research, Alternatives in Development Series, Allied Publishers, 1977. Rs. 10/-

This booklet presents three articles by J P Naik, D Banerji and Jacob Chandy - three pioneers in India who seriously question the philosophical framework and organisation of the health care services in India and suggest alternatives. It also presents important extracts from the significant report of the Group of Medical Education and Support Manpower set up by the Government of India in 1976 (Srivastava Report). These four articles put into proper perspective, the growing national debate on alternative strategies in health care - alternative to the 'over centralised, over expensive, over professionalised, over urbanised and over mystified' health service that we have at present. Even though the contributors are mainly concerned with the governmental health care and planning, members of CHA will find this booklet particularly useful since Catholic hospitals today by and large are even more closely alligned to the existing system, the lacunae and shortfalls of which are described in this book. While rethinking our own role this booklet will help us to see it within the national context.

4) Health for All - An Alternative Strategy -

Report of a study group set up jointly by Indian Council of Social Science Research and Indian Council of Medical Research (available at VHAI, C-14, Community Centre, SDA, New Delhi 110016, Rs. 18/-)

This is latest in a series of efforts of ICMR/ICSSR to initiate a national debate on Health Care strategy and is probably the most important of the four publications mentioned in this note. A must for every CHA member!

In the words of the authors "The objectives of the National Health Policy should be to provide health for all by 2000 AD. These objectives and targets are realistic and feasible. But they cannot be achieved by a linear expansion of the existing system and even by tinkering with it through minor reforms. Nothing short of a radical change is called for; Health is a function not only of medical care, but of the overall integrated development of society - cultural, economic, educational, Social and Political. During the next two decades.....integrated overall development, improvement in nutrition, environment and health education and provision of adequate health care services for all......should be pursued side by side within the health sector........... The existing, exotic, top-down elite oriented, urban biased centralised and bureaucratic system which over emphasises.....large urban hospitals doctors and drugs should be replaced by the alternative model which is strongly rooted in the community, provides adequate, efficient and equitable referral services, integrates promotive, preventive and curative aspects and combines the valuable elements in our culture and tradition with the best elements of the western system. It is also more economic and cost effective".

The why, what and how of this alternative model are discussed in fourteen chapters. A report that needs to be closely scrutinised and reviewed by all of us interested in health issues.

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MP6.6

KEEPING TRACK - II (mfc)

Dear Friends,

The next three books in our column raise important issues on the philosophy of Medicine and the increasing problem of 'Iatrogenicity' or the disease-producing nature of medicine itself. The authors write mainly from their experience of Medicine as practiced and developed in the West, but in India, the same Western model in our urban centres could well be facing the same crisis.

Interestingly the ICMR/ICSSR Report (refer keeping track I - No.4) already warns us that 'eternal vigilance' is required to ensure that the health care system does not get medicalised, that the doctor-drug producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill health'. For a group like the mfc these are three books of utmost importance.

ravi narayan

duplicate

5) LIMITS TO MEDICINE - MEDICAL NEMESIS. THE EXPROPRIATION OF HEALTH

Ivan Illich, Penguin Books (Pelican 1977).

The foremost critic of trends in modern Medical Practice, Illich presents thought-provoking evidence that "the medical establishment has become a major threat to health and the disabling impact of professional control over medicine has reached the proportions of an epidemic". Discussing Iatrogenesis in great detail, Illich makes one of the most forthright pleas for 'demystification of medical matters' and exhorts lay people to reclaim greater autonomy over health decision m aking. He writes that "A professional and physician-based health care system that has grown beyond critical bounds is sickening for three reasons: It must produce clinical damage that outweighs its potential benefits, it cannot but enhance even as it obscures the political conditions that render society unhealthy; and it tends to mystify and expropriate the power of the individual to heal himself and to shape his or her own environment. The medical and para-medical monopoly over hygienic methodology and technology is a glaring example of the political misuse of scientific achievement to strengthen industrial rather than personal growth". The book is divided into four parts and deals with Clinical Iatrogenesis in Part I, Social Iatrogenesis (medicalisation of life) in Part II, Cultural Iatrogenesis (disabling impact of medical ideology on personal stamina) in Part III and The Politics of Health in Part IV. Interestingly Illich warns that "if contemporary medicine aims at making it unnecessary for people to feel or to heal,

eco-medicine promises to meet their alienated desire for a plastic womb". He also warns that gullible patients should not be relieved of the blame for their therapeutic greed by making physicians scapegoats. Health must be seen as a virtue, as a right and people must be involved in "political action reinforcing an ethical awakening - that will limit medical therapies because they (the people) want to conserve their opportunities and powers to heal". A thought provoking book to be read by all mfc/[illegible] members.

6) MEDICAL HUBRIS - A REPLY TO IVAN ILLICH

David Horrobin, Churchill Livingstone, 1978.

This book should be read after the earlier one since it is the first serious critique of Illich's book. Horrobin does not dispute the facts presented by Illich, but disputes his interpretation. In spite of all the inaccuracies and exaggerations in Illich's books that he attempts to point out, he concedes that Illich's first sentence "The medical establishment has become a major threat to health" is right and that this book could prove to be one of the key medical documents of the second half of the twentieth century".

In a very open and level headed assessment of the criticisms of Modern Medical Practice the author gives his own tentative suggestions to bring about a change in this situation. He makes a plea for -

a) More "Science" in medicine to eliminate the errors encouraged by warm emotion that 'to do something must always be better than to do nothing';

b) Less use of technology by subjecting them to stricter control to determine whether they really benefit the patient;

c) Attempts to be made to keep medical institutions as small as possible and only for those who strictly need them;

d) Assess professional training and prescribe levels of training actually required to enable people to do jobs effectively and cut out unjustifiable part of courses;

e) Challenge the discrepancy betwcen the high ideals which doctors often profess and their personal life styles and ensure that the profession should be more humane and less a 'certain road to wealth and security' so that the rightly motivated people are attracted to it.

These changes should be made at four main levels: of the individual doctor, of the organisation of the profession, of the relationship betwen government and medicine and medicine related industries, and of the medical school.

A book which puts Illich's criticism in proper perspective.

7) CONFESSIONS OF A MEDICAL HERETIC

Robert S Mendelsohn, Warner Books, New York - 1979

"If you're ready to learn some of the shocking things your doctor knows but won't tell you; if you're ready to find out if your doctor is dangerous; if you're ready to learn how to protect yourself from your doctor; you should keep reading, because that's what this books is about", so writes Dr Mendelsohn in the introduction to a book which could quite well be the fore-runner in a new people's health movement to gaurd themselves against the harmful impact upon their life of doctors, drugs and hospitals. In a very sensational style of writing he presents facts to prova his convictions that in America today, "annual physical examinations are a health risk, hospitals are dangerous places for the sick, most operations do little good and many do harm, medical testing laboratories are scandalously inaccurate, many drugs cause more problems than they cure and the X-ray machine is the most pervasive and most dangerous tool in the doctors office." Incidentally he is Chairman of the Medical Licensing Committee of the State of Illionois and Associate Professor of Preventive Medicine and Community Health in the University of Illionis.

After eight chapters on his belief that "more than ninety percent of Modern Medicine could disappear from the face of the earth - doctors, hospitals, drugs and equipment and the effect on our health would be immediate and beneficial" he presents his blue print for a new vision of medical care which includes, taking on

the responsibility of ones own health and the health of ones family; having faith in life and a system of ethical values; eschewing any practice that promotes or condones violence against life; letting the doctors only be a life guard and so on. He then discusses the profile of the 'New Doctor'. "The new doctor will be in the front line of people's struggles. He will be confortable with people of all walks of life. He will be conversant with the language of the people and willing to place alternatives clearly to the patient. He will acknowledge nature as the prime healer and so regard natural supports of health such as family as having supreme importance in the healing process. Above all he will be a life guard motivating people to avoid disease and have healthy habits". He also makes suggestions for the new medical school to produce such doctors. He writes "The students of such a school will be easily identifiable their first rule will be : First do no harm'".

This book needs a careful perusal and probably will be among the most important references for mfc/[illegible] members as we define our own future perspectives.

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MP 6-5

Contact address:

B-10 Staff Quarters
St John's Medical College
Bangalore 560034

18 Jan 82

Dear

Six months since we last wrote to you about our plans for 1982. Sorry to have missed you in Hyderabad in August and Bombay in January. Our travel plans prevented us from getting to Bombay for the annual meet but since all of you are on our itinerary for 1982, we hope to visit you and spend some time with each of you to share perspectives.

We have received very interesting suggestions and comments on some of the issues raised in our last letter.

Anant suggested that we should spend 6 months visiting projects and people and use Abhay's article as a working hypothesis to pose concrete questions. Also an attempt should be made to look for small little innovations and ideas in projects--simple methods to keep records, train people, treat people etc. He hoped that the MFC plan for a project cell equipped with some definite perspective and lot of relevant information about work done in India would probably take shape with our tour.

Ulhas shared his personal growth after completion of his visit to various projects, the move in emphasis from medical projects to people's movements around issues. He regarded medical work as a costly tool of entry in the generation of people's power. He suggested visits during vacations rather than a whole year and made interesting observations on working within and outside the system. He saw the opportunity to meet radical groups involved in conscientization as one of the useful points of such a trip.

Abhay suggested that we get in touch with the Dr Arati of Tilonia who had done a somewhat similar project. He thought that discussion informally with mfc members -(core group particularly) would itself be interesting since some of them hold diametrically opposite views. Health work for the sake of improving health or for political change? He also raised questions on how much did a health project really affect health indices, the real role of VHWs, role of homeopathy (based on an evaluation project he did recently). He suggested Deenabandhupuram and Gonoshasthya Kendra as projects which were frank and honest in the analysis of their work.

Anil, Ashvin, Ashok shared that as far as 'community health programmes are concerned in India, the opinions are virtually polarised. Either there is unjustified romantic euphoria about it or equally unjustified and confused pessimism or even rejection'. 'The tone of the debate and most of the issues raised in this context have got congealed in rigid categories'. They have suggested

a drastic revision of the whole frame work within which the philosophical, theoretical and practical problem of Community Health work are being discussed and have urged us to take this project in that light.

Lalit Khanna sent us a detailed report of his field work experience which was continuing to raise similar questions.

Narender has also suggested that though we should concentrate on groups working and thinking on alternative health we should think of expanding the base later to wider aspects.

On the whole we both were very encouraged by the meaningful responses from all of you. The whirl of programmes in St. John's kept us busy till December. We began our leave from 15th Dec. and have spent the first month collating information that we already had about our ex-students and trainees working in rural areas as well as a large number of Health and Development projects and some movements as well. These were from VHAI, CHA, MFC, ISI, ICSSR, FPF, UNICEF, OXFAM AYS, OPF and others--these being organisations with which we have been in touch in various capacities.

Another important decision is that in the last 3 years we had trained 150 people in 3 month courses of community health with a development bias. Many of them are working in interior villages in all the states. Though they are all from christian religious background we have had an opportunity to share perspectives with them during the course which have stimulated grass-root level work. We plan to use them as a base of our travels since we get a wider view of the work from a health worker's context unbiased by medical professionalism. All the others we visit are along this route which covers most places. We don't plan to visit a very large number but some from each of the ideological and motivational background.

We have also decided to divide the year equally between travelling and reference/writing/analysis since when we force ourselves to put things down on paper we get a clearer perspective.

We plan to travel in the South till April and then move eastward and do North and West in the later half of the year. This is tentative since it depends on the situation and the replies from all our contacts. Do please let us know at once details of how to reach your place and if you have visited projects some comments on some of them.

We have been getting frantic letters from Anant and Kamalabehn about the MFC bulletin. We must confess that we have not been very responsive because of various reasons. However, this year we hope to be more useful to the bulletin but no great expectations till 1983. Are there groups of medical students or staff in medical colleges who are showing interest in MFC perspective other than where some of you are already working? If so, please send us names and contacts to keep in mind during our trip.

With best wishes and regards and hope the annual meet went off well.

Yours sincerely,

Ravi & Thelma

MP 6-4
(CHA)

WIDENING HORIZONS - II

Dear Friends,

In this issue we introduce two books raise important issues about the cirisis in Hospital based Medical Services and the increasing problem of Iatrogenicity or the disease producing nature of medical care itself. Illich is one of the severest critics of the Medical Profession and Horrobin attempts an answer to Illich's criticism on behalf of the Medical Profession. These two books read together gives us a balanced view of the crisis at hand.

The next two books are more personalised approaches by two committed christian doctors to find answers to the problems of providing hospital service and health care programmes to communities where poverty is an increasing constraint. How do hospitals reach out to the community ? How do we reorder our priorities? Their experience and suggestions will be most relevant and thought provoking for all our CHA members

RAVI NARAYAN

Illich
Horobin
Maurice King
Morley

Medicine, Health and Social Issues

– a personal perspective.

In June, 1971 an appeal from CARITAS (a Catholic Relief Agency) For doctors to work in the camps being set up by the GOI for Bangladesh Refugees, set of a series of events which resulted in a team of three young doctors from St John's Medical College (two of my batchmates and myself) setting off along with an ex-army dispenser (a museum technician in St John's Dept of Pathology) to work in a refugee camp off Neelganj near Barrackpore. The first month was such a rewarding experience that I could not resist the temptation of spending 2½ months of my three month rural internship there. These 10 weeks spent with thousands of refugees and a team of volunteers from all over India became a turning point in my life as a doctor. The experience was interesting, exhausting, frightening, satisfying and confronting, and eye-opening. Above all it was a challenge to our recently completed medical education – and I found the education sadly wanting.

The experiences were too varied to be even listed out – but I present a few facts about the situation to help one see the sorts of challenges and dilemmas we faced

1. Magnitude of the Problem:
We were put in charge of approximately 8-10000 people living on land the size of an average football field (guestimates) Each family had been given space of 1-2 mats in large thatched shelters. Rations, Firewood, Clothes, Mats, oil, Milk, bread were all provided as rations and life was mainly lived in long queues. Between 150-300 of these came for medical attention as our little thatched dispensary became known. As a student we had at the most been in charge of 5-10 beds in a ward

As an intern we had been in charge of 25-30 beds in a ward and seen ~~20-25~~ 15-20 patients in a morning O.P.D.

The numbers we were faced with - had never been expected in our remotest expectations

2. Range of Problems

The majority of the cases were diarrhoeas and dysenteries, upper and lower respiratory infections fevers, eye, ear and skin infections, back aches and joint pains, and malnutrition. In addition there were epidemics of what appeared to be Smallpox, measles, polio, cholera. There were deliveries, hosts of gynecological problems, Tuberculosis, cuts and wounds including gunshot or bullet wounds. Mental illness and minor surgical problems. A host of vague aches and pains and manifestations of an uprooted people in great distress.

3. Range. Responsibility - From being the lowest functionary in a highly compartmentalised and heirarchical hospital system - well supported and supervised by seniors, three of us were suddenly put in charge of planning, organising and managing the entire health service - dispensary and extension work for the camp. Our sponsors

Medicine, Health and Social Issues — a personalised overview of two decades.

In May 1962 I selected biology instead of geometrical drawing while entering the 9th standard of Highschool and probably established the first milestone for a future career in Medicine. George Sava's 'Healing Knife' and A.J. Cronin's 'Citadel' were probably the only two books I read about doctors which kept up the decis. In July 1965 three years later I joined the Pre-professional course of the St Johns Medical College after a 3 day selection procedure consisting of interview, group discussions, essay writing, psychological test and a medical examination. Deciding not to use the usual statement that was currently in fashion that 'my desire to become a doctor was linked to a desire to serve the suffering millions' I made a plea for a career in Cancer Research.

Till Feb 1971 the medical course kept full sway over one's time and pre-occupations. That we were the pioneering batches of the newly developing college was firmly entrenched in our psyche by the frequent speeches, functions, socials and ceremonies that mark the early years of any medical college. That we were aiming to be the best medical college in Asia was firmly entrenched too. That of all things we had to be better than CMC Vellore was even more firmly entrenched. That being the best had anything to do with working in rural areas with dedication was never conveyed. During the 5½ years of education we visited a slum close to St Martha's Hospital 4-5 times and a Primary Health Centre near I.T.I.

PSM Dept was a vague entity. We had a 'preventive' professor with a 'social' assistant. The Professor's method of education was best exemplified by Tagore's views on Indian Education ie transfer of information from the notes of the Professor to the notes of the student without passing through the heads of either. Having borrowed a senior's notes I did not have to bother to write down notes and hence got an opportunity to listen to the Professor and understand some of the concepts in the bargain. The preoccupation

with sanitation, entomology and epidemic control was not very stimulating. The lectures ~~interspersed with~~ The Assistant Professor covered issues such as Family Health, Population Dynamics, School Health and through a range of interesting anecdotes and shocking statistics was able to convey somethings of the holistic attitudes being engendered by PSM. The subject was too cut from the realities of clinical Medicine or Field work and therefore made only a peripheral impact.

Apart from Academics – the years in St John's gave me a great scope for participating in ~~out~~ co- and extra-curricular activities. I ~~was~~ which a student member of various college committees – discipline, curriculum, magazine, class representative, Gen. secretary of the Student's Association

Medicine, Health and Social Issues

— a personal inventory of learning experiences.

A person's perspectives on life and any specific interest is developed through a series of learning experiences that start in early childhood and continue right through life. Our society's current pre-occupation with formal educational systems and its use as a measure of an individuals learning often makes us link our perspectives to formal courses of studies rather than the people, places, situations meetings, readings and reflections that has been our daily experience. A tendency to label views on life and methods of analysis by the various current 'isms' of the day prevents one from evolving a holistic view of life since the compartmentalised views conflict, divide and confuse our psyche. To understand the realities of life or of any particular situation one has to try and live in that reality and experience it rather than read about it and rationalise thereon. On the other hand the realities of a situation are often too complex to be understood by the very fact of living in it since personal bias, attitudes, insights can limit the understanding. Here one has to get an overview by listening to the experiences of others and sharing their insights of the situation so that the united horizons of learning based only on personal experience is widened and built upon. Over the last ten years I have realised that a combination of both these approaches helps ones learning process and more than anything prevents system or idealogical strait jacketing which has become the bane of present day thinking and evaluation.

Field experience and listening to the field experience of others and taking a overview of these is probably

the best way today of building upon the reality of issues as complex as Health, Medicine, and Development especially in a country like India

Twenty years is a long time of learning in any one's life and I could say that probably it is two decades that I have been involved with Health, Medicine and Social issues

The first decade was mainly formative. — the second mainly one of field involvement.

A Note on a year of Travel and Reflection

(1982)

'We are trying to be part of the solution, ignoring that we are still part of the problem

– Anon

Contents

1. Background

2. Plan of the Year

3. What we actually did.

4. Overview.

5. Follow up

x–x–x–x

1982 A year of Travel – Reflection – Evaluation

(1) Background

Both of us have been members of the Staff of the Department of Preventive and Social Medicine now Community Medicine since we graduated from St Johns Medical College (R in 1972 and T in 1978) Both became interested in this area of medicine following the experience of volunteering for disaster relief during our internship. (R. in the Bangladesh relief camps in 1971 and T during the Andhra cyclone in 1977-78). The experience brought us in close contact with people, poverty, and the need for basic health care for villages. From 1972-81 (in Rs case) and 1978-81 (in Ts case) respectively we have seen the Community medicine and rural reorientation programmes and projects of the department grow phenomenally and have been involved with all the various developments – Mallur, Silurepura and Dommasandra subcentres, Action group for Community Welfare, Venkatala clinic, Internship programme and Rural camps, Ross Institute Unit and plantation programmes. We have particularly been closely involved with all the new (non-university) basic and continuing education programmes like CHW basic and refresher course, Plantation Medical officers course, Alumni doctors and Nurses refresher course and rural orientation programmes for undergraduates

As the years went along however we observed / realised the following:

a) Our main interest was the organisation and delivery of health care in the actual situations of rural or urban needs relevant to situations of poverty rather than the teaching of the compartmentalised components of the subject of Preventive and Social Medicine, in an academic setting governed by archaic curriculum, and a strong examination orientation. Though individual components of the curriculum are of increasing relevance we found the complete separation of PSM from the hospital clinical setting as well as lack of concrete facility for PSM staff intervention

in health care delivery in the community setting an important factor for alienation from the work of the department

b) The phenomenal growth of community medicine programmes as part of the overall rural orientation thrust of the institution had inevitably resulted in quantitative growth of staff, facilities; courses, & field practice situations in the absence of adequate qualitative growth in planning, staff motivation, enrichment and evaluation. Pilot programmes had very soon become routinised and due to a constantly changing staff pattern - the working had often been adhoc and one of crisis intervention. The pressure for such programmes to become 'show pieces' rather evaluated interventions of attitudinal change had been very great. Even though all this basically stems from the inability of medical college management (St Johns is no exception) to understand and plan for the realities of rural/urban field practice areas because of their preoccupation with the 'teaching hospital' - the continued frustration of PSM staff to expose students/interns to field situations where community medicine services are not seen to be delivered due to shortage of staff, finances, transport and medical supplies continued to plague some of us.

c) We also found as in most colleges that though Rural reorientation was given increasing lip service it had inevitably been misunderstood as the efforts of a single department rather than the all out efforts of the entire faculty of the medical college. Increase in field programmes organised by Community Medicine Dept faculty rather than increasing field involvement (outside of college and hospital) in the realities & needs of rural life and even urban slum life of the clinical and other faculty, for service and research became a sign of the reorientation. In the absence of real attitudinal

change among the medical college teachers as a group - increase in rural/field programmes of the department was making little dent in the general ethos of the institution and hence to both of us these efforts were appearing to be a jumping on the 'rural bandwagon' to save face' situation.

d) Our experience with the informal training of community health workers, alumni doctors from rural hospitals, nurses in rural dispensaries and plantation medical officers through programmes of the Ross unit and the Directorate gave us an opportunity to experiment with non-formal training programmes using a group dynamic approach. Working with people who are committed to community health work, building and supporting their experience was a very rewarding task and gave us great satisfaction. As teachers/trainers one naturally gets greater satisfaction when what is being shared has a good chance of being attempted in the field because the group is already involved in such work.

e) Over the years we had also moved in our understanding of health from its historic medical connotation of 'sickness care' to its broader positive definition of physical/mental/social well being and its close relationship to socio-cultural and political factors and the whole development process. Community health thus becomes a very positive area of intervention outside the medical college set-up, and within the educational system and the community development process. Whereas the medical profession continues to 'floor mop' diseases as they manifest, the health professionals and workers can begin to 'turn of the tap' of disease at its very source in the individuals personal lifestyle, family life and environment. As this ideas began to predominate in our thinking we began to get interested other traditions of medicine

alternative approaches to health care, Team building and group dynamics, church view on health and development, the dimension of healing, and holistic health, socio-political change and attitudinal change in the medical and allied professionals in this paradigm shift from Medicine to Health.

f) Inevitably an active involvement with rural life and urban slum life during community medicine department field work, confronted one with social issues such as inequality and injustice. One's value system, life style and attitudes were confronted both at an institutional team level and a personal level. Swinging between the mat-level simplicity of the Dommasandra gurukula to the ivory towered affluence of the college and hospital raised a constant tension in us. Working with and among the rural people also heightened our sensitivity to the dehumanised and impersonal culture and attitudes of the large highly westernised medical college and hospital complex and the cross cultural conflicts it produces for a patient from the rural area

g) Over the years our interest in community health had brought us in contact with a number of other groups/agencies like the Medico-friends circle, Voluntary Health Association of India, SEARCH, Indian Social Institute, Society of Young Scientists, Science for the Villages, CREST and Family Welfare Centre, ASTRA of Indian Institute of Science, OXFAM, Lokayan-peoples dialogue, Catholic Hospital Association of India and ACHAN-Asian Community Health Action Network. Our involvement in many of these ranged from active membership to being resource personnel at meetings and this brought us in contact with many others - committed to health work - often outside the formal government or university network

h) The experience of the '1981 Crisis' in the college and the

organisation of a solidarity movement to raise public opinion against arbitrary decisions affecting medical students in particular, gave us an excellent opportunity and insight to understand the levels of commitment and the dynamics of motivation among the campus population. Questions regarding the nature of the 'value systems' that this institution was following and could/should follow and related issues came up and one wondered about the deeper issues of this crisis - which were probably failures in communication, team work and value formation.

Among others the above factors led to a lot of personal frustration and a desire to rethink our role in the medical educational set up. We therefore decided to 'drop out' of St Johns for a year and spend it travelling, visiting health & development projects in the country, meeting friends, 'health' contacts, alumni and CHW's and reflecting and evaluating, at a personal rather than an institutional level our work since graduation. (10 years in R's case and 4 years in T's case)

② Plan of Year

After some months of reflection which began in mid 1981 we decided that

a) This would be primarily a year for 'personal growth' and hence would not be a project for or sponsored by the college or any other agency. We therefore decided to apply for extraordinary leave without pay.

b) We wrote to a dozen close friends in the field (mostly medicofriends circle members) sharing our plan and asking for ideas and suggestions. We wrote to all the alumni on the Rural bond scheme and some others working in small rural hospitals. We sent a special questionnaire to 155 CHW's who had been trained by Nov 1981.

c) We reviewed the replies we got from all of the above (b) and also collated information from our papers/files and projects reports that we had collected over the years. We identified peoples/places/agencies/projects that were worth contacting and drew up a tentative list and a general travel plan for the year.

d) We finally decided that the selection would consist of representative sample of four groups of people i) Friends and colleagues in community health and development projects to widen our perspectives ii) Alumni on RBS and in small rural hospitals to get a feedback on their medical education iii) CHW's to see their work and evaluate our basic training programme iv) Some coordination, funding and communication agencies involved in health work

e) We also decided that in addition to travelling - some part of the year would be spent documenting information, reading, reflecting and analysing issues related to our work and perspectives.

f) A few months were to be spent completing the analysis and final reporting to ICMR of the study done on 'Health Status of Tea plantation workers' which had been long delayed due to unavoidable circumstances

g) We decided to maintain a diary of travels, notes on our observations and discussions, and also keep in touch with

friends through correspondence and all the others through newsletters written at intervals.

h) Finally we shared the idea of the year with the Head of Department, Dean and Management and after obtaining permission phased out of the involvement in the departmental activities and began the year on 15th Dec 1981

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(3) What we actually did:

a) We travelled through parts of Karnataka, Tamilnadu, Haryana, Rajasthan, Gujerat, Maharashtra, Orissa and West Bengal covering approximately ________ kms. This in itself was a fantastic experience of seeing the diversity of our people and the countryside. Living a few days in the villages of Rajasthan, Gujerat, Maharashtra and Bengal and in the tribal areas of Gujerat, Maharashtra & Orissa was a very good experience.

b) We met and interacted with the following:

- members of the medico friends circle at Delhi, Udaipur, Rajpipla, Mangrol and Wardha & Tamluk.
- health and development projects including Social Work & Research Centre (Tillonia), Sewa Mandir (Udaipur) Voluntary Health Services (Madras), VIKAS & ASAG (Ahmedabad) Taporan Leprosy colony in Amravati, Child in Need Institute, Calcutta, Pallimangal of Ramakrishna Mission at West Bengal, Chandabrahi in Tamluk West Bengal
- coordinating and resource agencies such as Catholic Hospital Association of India (New Delhi) Voluntary Health Association of India (New Delhi), Centre for Science and the Environment (New Delhi), Vikram Sarabhai Institute of Science & Technology. VIKSAT (Ahmedabad), Safai Vidyalaya (Ahmedabad), Indian Social Institute (New Delhi) & Lokayan (New Delhi)
- alumni on the rural bond scheme at Kollegal and Chickmagalur in Karnataka and Omalur in Tamilnadu and those who have now returned to St Johns
- alumni in rural hospitals in Zankhvar, Unai, in Gujerat, Talasri and Sevagram in Maharashtra, and many doing postgraduation at PGI (Chandigarh) and AIIMS (New Delhi) apart from some who visited us at Bangalore
- 21 community health workers trained at St Johns and now working in KGF, Mandya, Kollegal, Kalathipura in (Karnataka) Devikapuram, Villipuram, Trichy, in Tamilnadu, Jagadhri, in Haryana, Talasri-Shilonda and Alaiyapur in Maharashtra, Jubaguda in Orissa, and Purulia, Thakurnagar and in and around Calcutta in West Bengal.

c) We visited Departments and/or Rural centres of Community Medicine at All India Institute of Medical Sciences (including Ballabgarh comprehensive rural health project), Mahatma Gandhi Institute of Medical Sciences, Sevagram, Wardha, PGI, Chandigarh and met staff of PSM Department of Udaipur Medical College.

d). We attended i) the Tamilnadu Voluntary Health Association annual meeting and addressed the participants on 'Health by and thru people', ii) Value Orientation Seminar organised at Vishwa Yuvak Kendra in New Delhi by Vivekananda Nidhi of Calcutta • iii) organised a seminar on Community Health for religious and lay leaders, teachers of Aurangabad diocese iv) Spoke on New concepts in Health to the religious/teachers of Amravati Diocese v) Organised a seminar on Community Health, thru Seva Kendra Calcutta for CHWs and MCH project holders of the Archdiocese of Calcutta vi) Talk to the Yuvak/Yuvati Sanghas of Jubaguda Mission. A workshop for the newly formed diocesan health teams of the six diocese of the North East was planned but got postponed at the last minute.

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e). We also met and informally interacted with a host of interesting people (many of these at accidental meetings) eg Fr Claude of AICUF (Madras), Rathin Roy of MCRC - Appropriate Technology Centre (Madras), Desmond Ahreo of Deeds (Mangalore) Fr Heredero, team of Behavioural Science Centre (Ahmedabad) Fr John Vattanattom (CHAI) and Fr Tong (VHAI) at New Delhi Daleep Mukherjee of RUHSA (Vellore), Dr Raj Arole of Jamkhed (Maharashtra), the Jesuits working in the Gujarat Maharashtra region - base at Ahmedabad, Bunker Roy team of Tilonia (Rajasthan) Kirtee Shah of ASAG (Ahmedabad), Kishore Saint of Seva Mandir (Udaipur), Ravi Mathai of IIM (Ahmedabad), Swami Yuktananda of Vivekananda Needhi. (Calcutta),

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F) We got an opportunity to see hospitals/health projects and some development schemes of the Church in Mysore, Chikmagalur, Aurangabad and Amravati, Berhampur and Calcutta diocese many of them organised by congregations such as St Thomas Mission Holy Cross sisters, Vincentians, Missionaries of Charity and others by Diocese Social Service societies

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g) We wrote four newsletters to CHWs, and two sets of book reviews, entitled, Keeping track for the Medico friends Circle bulletin and Widening Horizons for Medical Service journal of Catholic Hospital Association of India apart from the usual correspondence that such a scheme entails

h) The I.C.M.R pilot project report on 'Total Health Status of Tea plantation workers with specific reference to their occupation' – was completed and despatched to the Indian Council of Medical Research for further follow up action. A second report with some further analysis will be completed in ~~early~~ 1983.

i) We read and reflected on a whole range of subjects important to our work including objectives of SJMC, rural reorientation of medical education, 'positive health' orientation in our training programmes, Health and Development interactions, the Church's view on health/development/social justice, demystification of medicine, ~~and so~~ the 'low cost' drug issues, alternative therapy and so on.

j) We continued further documentation and collation of all the resource material we had collected over the years as well as during this trip.

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④ Overview

The year 1982 and all the activities we undertook was a very rich and meaningful experience for both of us at a personal level. We visited a whole range of field projects and met people of different ideological motivations which helped to widen our own perspectives. ~~and~~ The trip brought us in contact with many committed and interesting people – a contact which we are sure will be mutually enriching in the years to come. We met alumni in small hospitals and reflected with them on the inadequacies of the medical education at St Johns especially with reference to the challenges of ~~small~~ rural hospital practice and community medicine. We met many community health workers and saw their work and reflected on the successes and failures, limitations and risks of our training programmes.

. We read and reflected in depth on many issues concerning our work and vocation, - in greater depth than had been possible in the busy years full of programmes. We searched for answers to many professional and social questions facing us and though we did not always arrive at definite conclusions, we discovered points of contact with the experience of others and identified processes through which more meaningful answers could be obtained: In many cases the question itself became better focussed.

Finally we had the happy event of the growth in our family as well.

The year was a response to a personal quest and that in itself has served a purpose. However since the lessons learnt during the year will we hope be reflected in our work we have listed out some broad perspectives in a spirit of dialogue. We have also made some suggestions, through which this experience may help, if thought necessary, the institutions continuing search for social relevance.

Broadening Health Concept

a) 'Health' in its broadest concept of Physical, mental and social well being of both individuals and community has failed to capture the imagination of the medical profession and educationists because of their historic preoccupation with 'illness care'. Years of a 'floor mopping' attitude to the overflow of disease has resulted in the development of 'highly sophisticated curative practices along with all their paraphernalia of mystification, professionalisation and total submission to the dictates of the drug industry'. The new 'tap turning' off attitudes in response to the peoples needs - consisting of primary health care; health education, demystification of medicine; and strengthening of the peoples tradition in self care therefore continue to be seen with suspicion, resentment and intellectual opposition. The ethos of medical education even at St Johns and of most so called health services under church auspices still reflects this myopic view.

Health, Development and Socio-political change

b) Ill-health in the ultimate analysis is a direct product of unjust socio-political system resulting in poverty and inequality. A health project/service or institution if rightly lead, then should inevitably become part of a developmental process which seeks solution for issues of social injustice. especially if it is in the voluntary, private or mission sector. Christian institutions which are meant to be 'leaven' are called upon "to reach out towards the masses by providing simple accessible and promotional health care according to their own possibilities, modest as they are, or in conjunction with the public services where this is allowed"[2]. Development of alternatives in the quest for health thus becomes a political process of extending the process of democratisation of making people enthusiastic to shape and run their health services

Quest for Appropriate Technology'

c) Those of us who function at technological levels in our professional capacities are called upon to creatively and innovatively evolve alternative and appropriate frameworks of technology, manpower, process and communications which are oriented to people and conditions of poverty. In such a quest there is not much scope for publicity stunts such as mobile clinics and camps but a concerted effort by all faculty of a medical college or the members of a hospital health team of how their own professional and technological training can be made more relevant to the needs and conditions of the people. e.g A professor of a clinical subject therefore spends his time evolving skills, procedures and training programmes to adequately tackle the problems encompassed by his speciality through the human and material resources available at every level of the health pyramid and not pursuing his own myopic view of what constitutes good technical competence or excellence in his speciality. ie Not just excellent care out of context of social reality – but the best possible under the circumstan

d) Process of Change – (both Professional and Institutional)

Every team/project/institution committed to 'health and social change' and a quest for social relevance must undertake it with a sensitivity to a 'process' rather than do it through a whole series of adhoc often un-integrated steps. This process will evolve through acceptance of the need for

- an understanding of historical factors in the growth of the institution and the overall social context in which it operates
- a ~~def~~ clearly defined measurable objectives
- a planning process
- a value system
- a team building approach
- stress on human resource development rather than material resources
- a constant, informal feedback
-

e) Team work – in any endeavour professional or social – the success or failure of an undertaken objective or activity depends primarily on the team work that is built up, encouraged and actively supported. Team building needs a concerted effort which includes:

- an evolution of mutually shared and common objectives
- a constant concentration on 'strengths' of individuals and not their weaknesses
- an increasing complementarity of roles
- increasing opportunity for sharing of ideas, hopes and feelings
- a constant effort to internalise a shared value system
- an informality and openness in interpersonal relationships

f) Preventing Institutionalization of Effort

One of the greatest dangers of any social undertaking is a rapid setting in of institutionalization of the process and relationships within a team. This is hastened by routinisation, formalisation of effort and role models, bureaucratization,

discouragement and or disregard of informal feedback and communication, lack of group dynamic efforts and inability of team leaders to stimulate, encourage, enrich and support the members of a group. During this year we realised that team building needs lot of time and effort since ideal teams dont just happen. However we also realised that institutions or social structures are not inherently stifling but depend to a large extend on the formality with which we function within them.

(g) Rural orientation of Medical Education is a term that needs to be changed — since the need is not just to focus on a geographical setting but on social factors and issues in the community. It is therefore a social or community orientation.
The efforts in this orientation must not only be to get doctors/teachers/students into the rural areas as an educational effort – but also a serious attempt to change attitudes within the institution and profession. These attitudes include a desire to rehumanise the hospital environment by humanising doctor-patient relationships, improving doctor-patient communication, increasing the sensitivity of hospital structures and persons to conditions of poverty and poor people, and modifying hospital management by increased sensitivity to socio-economic and cultural factors affecting health and disease in the community. Attitudinal change is the crux of the whole effort and if our college is serious than the focus must shift to within the hospital system rather than only in the community.

(h) Attitudinal change can seldom come about by pressure, coercion, 'bonding' or purely monetary incentives. Even if they do – the change is temporary

and unstable. Rural/social orientation must be brought about by greater positive efforts of open discussion, example by role models among staff, positive field experience, encouragement, democratic decision making, and a constant and continued exposure to people already involved in the field through their own motivations.
This is one area where the counterproductivity of hastily applied impractical and irrelevant methods should be constantly kept in mind. eg field exposure without adequate preparation - both of the student and the community, planning by/for the professional team rather than by/for the village health committee, and so on.

In addition to the above we enclose a series of extracts from the writings/reports of various people searching for social relevance in the health field which could aid our further reflection and planning. (refer appendix)

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(5) Follow Up - There are various ways and means by which this could/will be attempted.

a) Sharing of the field observations, reports, resource materials and reflections with the staff of the Community Medicine Team to begin with.
This will help define perspectives, establish role definitions, widen horizons, aid team building and share feed back that will help future effort

b) Clearly demarcate the objectives/needs/infrastructural and a perspective plan for various components of the existing department - e.g Community Medicine or PSM curricula teaching, Establishment of Rural/urban field practice areas/Ross Unit and RAGSGH/DRHSTP/other programmes (this could be also a department effort followed by formal feed back/presentation of plan to management)

c) Evaluation of the CHW Programme - based on 9 course experiences, two formal follow up questionaire, informal post course correspondence and the feedback obtained from the actual field situation this year.
This should be done in a few months involving all those who have been involved in the past.
In addition to course content, finances, and expansion through teacher-training courses as visualised at the inception of the scheme - certain definite steps for consolidation, refresher training and enrichment and establishment of a formal support network of the 176 CHWs already in the field should be undertaken.
In our opinion this is a vital first step before the training effort is continued and we suggest 1983 as a year of consolidation involving field resource of CHAI and VHAI and the Diocesan Social Service Societies
A separate report of the entire CHW training efforts of SJMC is being prepared which could be used for the evaluation.
This effort will also help clarify the objectives functions and scope of the DRHSTP unit which should gradually become an Extension Community

unit of the college preferably in collaboration with the Catholic Hospital Association of India.

d) A meeting with Administrator priests / chaplains of the college and hospital to share ideas on generation/encouragement of a 'value system' so strongly mentioned in a statement of objectives but so weakly administered in practice. Ideas are based on work of people we met during the year.

e) A meeting with Staff to share the informal feedback from alumni on the Rural bond scheme and those working in small rural hospitals about their medical education at St Johns - the positive and negative aspects and suggestions for change. This opportunity could also be used to share interesting/relevant ideas in Health and Medical care arising out of the work of many teams/institutions in India. The sharing of certain other possible roles of St Johns departments e.g continuing education for the CHA network and so on can also be a part of the session.

f) A meeting with Alumni on the Staff of the institution to share the same points as (e) and also to attempt group work through which meaningful policys and programmes of change and relevance can be evolved and put up to the college management

g) Sharing with batches of students formally/informally the experiences of this years and the observations on the challenges/prospects of Community Health work and the work of committed groups;

h) Sharing with interns/final year students especially those keen to undertake the 2 year rural hospital posting - ideas based on feedback - to help them in preparation, planning and self enrichment before they join the bond scheme

i) Having given such an important role to rural service in the recent selection of postgraduates to our institution

a sharing with them of ideas from the field and organisation of informal seminars or workshops to supplement the formal postgraduate teaching in the departments. This could be for the whole group and planned in consultation with them and mainly with an objective to support their interest and commitment to community work.

j) Rural/Urban Field Practice Areas – A concerted effort to plan realistically for the organisation of services and support framework for rural/urban field practice areas taking into account the increasing future demands of UG, internship, PG and continuing education programmes. If Dommasandra & Anekal Taluk are to be our area for a long time to come we need to

- integrate SBI projects, interdisciplinary camps, mobile clinics in a more meaningful way.
- improve our relationship with the existing govt. and non-governmental health structure in the area.
- organise a meaningful referral services complex ie links between health institutions and SJMCH
- draw up integrated health/developmental efforts with close liaison with all field agencies and supplementing/complementing existing and future planned programmes and keeping in mind the leaven or catalytic role of the institution
- building up a sound information base for this whole area as an aid to research & service
- planning and obtaining adequate financial support for this whole process from Govt/Bank or funding agencies
- most important - getting the commitment and full support of the management since development of Field Practice Areas are as important as the Teaching Hospital. Short term efforts and small project funding as has been done in the past is inadequate.
- The Srivastava report very clearly outlines that "a medical college hospital whose health care has its outreach in the community through an efficient, and readily accessible referral services complex can

become an effective training ground for training personnel oriented to community health and for the more efficient delivery of health services to the community. Taken as a whole, the programme will not only provide the most efficient health care services possible to the community but will also provide feed back from the community to the system of health care itself and lead to great improvements therein over time".

(k) Health Education - All the above efforts need a very planned back up by a good communication effort to help various groups and possible future trainees the new horizons in Health Care and the needs of increasing our efforts in areas of relevance in medicine and Health. This communication effort needs some infrastructure. The present Central Health museum has had a rather limited scope and function formally (ie as a museum) in our educational effort. The staff of this unit has however informally contributed a great deal to all the WHO Day exhibitions, in Hospital village based exhibitions organised by interns and exhibitions organised by the department at plantations, and CHA meetings. It may be possible to seriously evaluate the historic development of the Central Museum concept and study the feasibility of its gradual metamorphosis into a unit for Education for Health which would actively support all our future efforts in Health and Continuing Education. We would be happy to undertake this effort over the next year.

(L) Finally as a longer term plan we see the need for the gradual development of a Health Unit/Dept which will work closely with the Department of Community Medicine but will have a scope and function that will not only integrate some of the existing - non-university linked activities of the college but will encourage, support and actively promote the increasing community health orientation

of Church and Voluntary Health effort through our existing contacts.

Cor Unum publication on Health Care clearly raises the issue - that if a Christian Institution wishes to be faithful to their inspiration and they must work for i) overall development of each man (ie Holistic Health) ii) Focus on the sick person ~~rather~~ more than on his sickness (ie Humanised Hospital Medicine) iii) we must turn our attention towards the human community of the patient, his family first, but also his neighbourhood or village (ie Community Health) iv) To ensure that the sick person will be restored to physical and psychological health - so that with the aid of his human community he can duly take charge of his own evolution towards a more human state becoming the craftsment of his own development (ie Development by the People).

It is important to understand that this unit ~~should be a~~ is not another department of a medical college but a catalyst and support structure for the increasing community health efforts in the field. It will therefore have to be informal in its structure and field oriented in its scope. The ACHARA concept, the adhoc development of the DRHSTP and the recent community health efforts ~~of~~ of CHAI could be brought together in the planning of such an effort. Without attempting to concretise the scope and function of the unit in any definite manner we draw up some tentative suggestions based on this years reflection which need to be seriously considered by a much larger group of interested people in St Johns, CHAI and CBCI before its final evolution.

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Unit For Community Health

1. **Infrastructure** — ? amalgamation of → Existing DRHSTP + Central Museum + CHA-Community Health Dept effort ? + Liaison office.

2. **Staff** — A small interdisciplinary core team whose field experience is more important than degrees/academic achievements
   + additional resource persons
   + additional short term attachments of interested doctors/nurses/CHWs/other health workers

3. **Scope** — Catalyst role always working closely at regional/State level with CHA regional secretary, State VHAI branch and Diocesan Social Service Society, and or Bishops office - with ultimate idea of organising state/diocese level Community Health support teams

4. **Functions** (Possibilities)

   1) Training Programmes
      - a) CHW Basic
      - b) CHW Refresher
      - c) CHW Teachers Training
      - d) Doctor Refresher (CH Reorientation)
      - e) Nurse Refresher
      - f) Health Team Reorientation

   2. Information and Advisory Services on
      - a) Resource Materials
      - b) Team training/Staff development
      - c) Project Planning
      - d) Evaluation.

   3. Career Guidance
      - a) Liaison work for Rural Bond Scheme (St Johns)
      - b) Help to identify staff for small hospitals (non bond)
      - c) Small hospital medical team enrichment
      - d) Contact c̄ peripheral medical team — newsletters, regional meeting for continuing education

   4. Preparation for educational materials for Community Health effort (close cooperation c̄ VHAI's)
      - a) Training manuals.
      - b) Health Exhibitions

   5. Research
      - a) Health and Development interactions
      - b) Team building.
      - c) Alternative therapies/approaches to health.

6. Coordination and Constant Interaction to promote - Tap turning off Health attitudes among
i) Religious heirarchy & Superiors
ii) Hospital managers.
iii) Funding agencies -
iv) Medical College Departments
v) Professional associations

7. 'Health' orientation (Evolution of Schemes)
a) Teachers Training / School curriculum
b) Component of Family welfare Activity
c) Parish work.
d) Training for religious/seminarians

8. Demystification of Medicine / Health issues
a) Articles for Lay public.
b) Interaction with all agencies evolving peoples health movement and health consumers movements.

9. Contact c̄ S.J.M.C - a) Comm Medicine Dept
b) RFPA
c) UFPA

10. "Medical Service" journal - C.H. orientation

Appendix - Some Reflections

(a) If you are not certain of where you are going ... you may very well end up somewhere else ... (and not even know it.)

— Mager[1]

(b) We are trying to be part of the solution, ignoring that we are still part of the problem.[2]

(c) Today if you are not confused you are just not thinking clearly. — Irene Peter[2]

(d) "Science and Technology is like genetic material. It carries the code of the society in which it was born and sustained and tries to reproduce that society..... its structure, its social values. The adoption of a capital-intensive, luxury oriented Western Technology in India has thus created a dual society — metropolitan centres of western oriented affluence amidst vast expanses of rural poverty, mass unemployment, large migration to cities and wide income disparities"

— A.K.N Reddy (ASTRA)[2]

(e) Why schools of Higher Learning to be organised under Church auspices?

"To help the students of these institutions become men truly outstanding in learning, ready to shoulder society's heavier burdens and to witness the faith to the world"

— Vatican II[3]

(f) Aims and ideals of St Johns

"This memorial has a spiritual, cultural and a social aspect and it is mainly its social aspect that represents its ultimate purpose."

— Joint Pastoral of CBCI, 1964[4]

"It is only a goal such as this (to form Catholic doctors characterised by a marked sense of dedication, so that after the manner of priests and religious in their own fields they may give themselves wholeheartedly to the mission of healing) that can justify the preoccupation of the entire hierarchy and of Catholics of India with this project and the fantastic expenditure that it will entail..."

— Rev Angelo Fernandes[4]

(g) Teachers for St Johns

"Besides academic qualifications, experience, teaching ability and general character, it should be understood that they are persons who are committed to the idea of the college ie have an almost missionary zeal for community health in rural areas, have experience in this field and are willing to work part time in such situations, are interested in doing research in this field and show a potential for being able to inspire the students in the direction required" - Review Commission CBCI, 1972[4]

"No one can be educated by maxim and precept. it is the life lived and the things loved and ideas believed in by which we tell one upon the other. Everything therefore about the Professor is important; his manners, his habits, his speech, his outlook, his character, his faith". - Aims and Function of STMC[4]

(h) Medical Education in India

"the system of medical education remains heavily oriented to the conditions of the highly industrialised countries, with emphasis on highly sophisticated curative practices along with all their paraphernalia of mystification; professionalisation and total submission to the dictates of the drug industry" - D. Banerjee[6]

"The true yardstick of Medical Education is not whether our graduates will be accepted by foreign universities but whether they are acquiring the training to meet the medical and health needs of our people". - I. Gandhi.[6]

"No matter how useful a heart surgeon may be in the right situation, he is of little value in a country where thousands of infants still succumb every year to infectious diarrhoeas; and it would be far better if his talents had been turned towards a more useful, if less spectacular, direction - Margulies[6]

(i) Challenge to Medical Profession

"We share in a call to openness, to new visions and insights and a daring readiness to explore complex relationships at the interface between science and human values".

"The challenge to individuals is that in our daily work setting and relationships we must make our part of the action more just in allocating more equitably those resources we control. But we have to start where we are and use what we have as we move incrementally towards innovation"

"The corporate challenge is that we review critically the justness of the health system as a whole. This does not mean condemning or discarding the means and understanding that have contributed so much in the past. We can now build on the past with our new insights just as those in the future will build more just systems as todays justice becomes tomorrows injustice. We justify this call in the belief that there is no force as aggressive yet as healing as love"

— Christian Medical Commission, Geneva[7]

New efforts towards community health bear fruit to the very extent that they become free from a hospital set up ..... Most positive aspects of these efforts - lies in the fact that the medical personnel may realise the limitations of the hospital approach and look for more relevant measures

— Stan Lourdusamy[7]

(j) Challenge to the Church

"How can the Church meet the need of the total man?
How can we have new dimensions in the thinking, planning and doing of christian medical work?
Will the Indian church have the courage, wisdom, power and faith to make radical changes in its thinking on and its structuring of medical work? — Jacob Chandy[8]

(k) Elite Educational Institutions

"In spite of the good intentions of their personnel, elitist institutions cannot become effective instruments of social justice and social transformation. They cannot enable the church to assume a meaningful role in the present-day Indian Society. As they themselves are part of the society's dehumanising structures, their functioning reinforces rather than weakens socio-economic, political and cultural inequalities. As long as the church is saddled with these institutions which absorb so much of its energy and resources for the pseudo-elite, it can only pay lip service to the cause of liberation. Elitist institutions are much more a liability than an asset"

— Stan Lourdusamy[7]

(l) The new orientation of health services (Christian)

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

— Pontifical Council, COR UNUM, 1976[9]

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

— Pontifical Council COR UNUM, 1976[9]

(m) "Eternal vigilance is required to ensure that the health care system does not get medicalised, that the doctor drug producer axis does not exploit the people, and that the 'abundance' of drugs does not become a vested interest in ill health".

— ICMR/ICSSR[10]

Reading List

1. Guilbert, J.J, (1977) Educational Handbook for Health Personnel, WHO, Geneva.

2. MFC (1977), In Search of Diagnosis – analysis of present system of Health care, Medico Friends Circle

3. Walter. M. Abbott, S.J (1966) The Documents of Vatican II Geoffrey Chapman, London.

4. A Perspective Report to CBCI (1977) on St Johns Medical College.

5. Naik J.P (1977) An alternative system of Health care Service in India, ICSSR, Alternatives in Development series

6. Ravi Narayan (1973) Trends in Undergraduate Medical Education in India – Training Doctors for Community Health Services – London University, DTPH Dissertation

7. Stan Lourdusamy (1979) Church and Social Justice CSA publication

8. Jacob Chandy, (1970), Rethinking the Healing Ministry of the Indian Church, CISRS/CLS pamphlet on Social Concern (New series) No. 2.

9. Pontifical Council COR UNUM (1976), The new orientation of Health Services with respect to Primary Health work, Vatican City.

10.

From keeping alive or forging the set of values around which the new society will be built,

From helping crystallise for the people the latter's experience.

From actively helping organise the group or movement that will deliver the new society.

they are the ones
who have not succumbed
to the successes of the present
culture, they have not
internalised its characteristic
ideology.

Anis Shoune

'There are individuals who will put themselves out, who will take risks, who will suffer to see that the world is realised, to see that the better way prevails

Romans 2 1-11

When you judge others and then do the same things which they do, you condemn yourself

Do you think you will escape His judgement

Or perhaps you despise his great kindness/tolerance and patience.

He is kind because he is trying to lead you to repent - But you have a hard and stubborn heart and so you are making your punishment even greater.

He will reward every person according to what he had done.

Some keep on doing good. and seek glory, honour and immortal life

Some are selfish and reject what is right in order to follow what is wrong.

There will be suffering and pain for all those who do evil. and glory, honour and peace to all who do what is good

Romans 2 12-16

For it is not by hearing the Law that people are put right with Him but by doing what the Law commands.

The Gentiles do not have the Law; but whenever they do by instinct what the Law commands, they are their own Law, even though they do not have the law. Their conduct shows that what the Law commands is written in their hearts. Their consciences also show that this is true since their thoughts sometimes accuse them and sometimes defend them.

"It is infinitely difficult to begin when mere words must move a block of inert matter. But there is no other way if none of the material strength is on your side. And a shout in the mountains has been known to start an avalanche...."

Solzhenitsyn
(The Oak & the Calf)

Go to the People,

Live among the people

Learn from the people

Plan with the people.

Start with what the people know.

And build upon what the people have.

Teach by showing

Learn by doing.

Not a showcase,

But a pattern.

Not odds and ends,

But a system

Not piecemeal,

but with an integrated approach

Not conforming,

but transforming.

Not relief, but release

The daily bread of Dialogue

1. Communication or sharing of emotions
   to
   come to a deeper knowledge,
   understanding
   Fuller acceptance of each other in
   love

—

2. It is alway moving towards encounter
   towards mutual experience of each
   others person through
   Sharing of feelings

3. Not For — solving problems.
   exchanging ideas.
   making choices
   giving advice.
   receiving advice.
   laying plans.
   reasoning things out

All these belong to Discussion

4. Assumptions on Feelings.

Very natural reactions

Results of countless influences spaced out over the whole of ones life.

Can be stimulated by another.

Never caused by him/her

In us.

Stored since early Childhood.

Represent no danger.

Absolutely no moral implications.

No reason necessary for the way one feels.

No excuse "

No explanation "

OK to feel whatever we feel.

Only real danger is to ignore, deny or refuse to report our feelings

5. Dialogue has no place for

Argument

Competition

Analysis

Rationalization

Assigning Responsibility

6. Faliure

If we think the partner should not feel the way they do.

One is rejecting the whole idea of dialogue
rejecting the partner as well.

7. Success

Discovering a fresh beauty

. New depths of goodness in each others person

Growing feeling of getting to know each other

—

S.J.M.C

1. Out of nothing - CHA Publication
2. SJMC Perspective Report 1977.
3. Teaching objectives of SJMC.
4. Mallur Health Project - Published papers (MGM & RN) by ICMR
5. Training Doctors for Rural Areas - DTPH Dissertation (RN)
6. Annual Reports of Dept.
7. Ross unit Perspective Report (6 yrs)
8. CHW Course Reports.
9. Internship objectives/handouts.
10. Bangalore University - Comm Medicine syllabus and curriculum.

Church

1. Vatican II
2. Cor unum publication on new orientation to Health Services
3. VHAI - testament.
4. Church and Social Justice - Stan Lourduswamy S.J. (ISI)
5. Rethinking the Healing Ministry of the Church (CIS) - Jacob Chandy.
6. Caring and Healing (Contact special issue)
7.
8.
9.
10

Manuals

1. Where there is no doctor
2. Primary Health worker - WHO
3. Manual for community Health worker - GOI
4. Manual for Male Multipurpose worker 2 volumes
5. Manuals for Female multipurpose wkr 2 vols.
6. Teaching Village wkr to learn - Abverne
7. Training of Com. Health workers - 4 volumes
8. Manual for ANM in MCH (Narangwal)
9. PHC Manual - Dhillon & co
10. Teaching V.H.W - a kit - VHAI

Bulletins

1. Health for the Millions
2. Medical Service
3. Mfc bulletin
4. Contact
5. Swasth Hind
6. Tropical Doctor
7. Salubritas
8. Science for the villages
9. MCNK (Achan)
10. Basics
11. New Internationalists

Yogana
Kurukshetra
Social welfare

Comm. Health Books (Trend setters)

1. Medical Care in Dev. Countries - Maurice King.
2. Paediatric priorities in the Dev. world - David Morley.
3. Health and the Dev. world - John Bryant
4. Medical Nemesis - Ivan Illich
5. Confessions of a Medical Heretic - Mendelsohn
6. Medical Hubris - David Horobin
7. Health by the People - WHO (Newell)
8.
9.
10

Indian books

1. Bhore Committee Report Health & Development
2. Mudaliar Committee Report Health & Planning
3. Srivastava Report Medical Education and Support Manpower
4. Doctors for the Villages - Carl Taylor.
5. ~~Alter~~ Alternative approaches to Health Care - ICMR
6. Health for All an alternative strategy - ICMR/ICSSR
7. Alternatives in Health - ICSSR
8.
9. In Search of Diagnosis
10. Health Care - which way to Go

Projects

1. Jamkhed
2. Mini PHC/VHS
3. Health Cooperatives
4. Rehbar-e Sehat
5. Project Poshak
6. Indo-dutch Project
7. Health for a Million
8. CINI
9. ~~[illegible]~~
10. RUHSA
10. Palghar.
11. Chipko Movt
12. Jaipur Limb
13. Ramponar Movt
14. Ankodaya
15. Gramswaraj Kendra
16. SEWA
17. ICDS
18. CRS
19. IPPF
20. ROME

People | Health & Dev

1. Aroles.
2. P.C. Sethi
3. Chandiprasad Bhat
4. Manibhai Desai
5. Ela Behn
6. J.P. Naik
7.
8.
9.
10.

Medico friends circle
VHAI
CHAI
CMAI
SYS
Lokayan
KSSP
PSM
Samudaya
IBFAN

Check list

1. SJMC Documents.
2. Church Reorientation
3. General books
4. Bulletins
5. Projects
6. Movements.
7. Events
8. People
9. Organizations
10.

(Awareness)

For Community Health work

= 100

For SDW