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COUNSELLING : TECHNIQUES & METHODOLOGY.

'Councelling is an enabling and helping relationship, in which the person seeking help is encouraged for positive growth, and also to take counsel with oneself'. The result of counselling understood in this way would be that the client can get back to the main stream of life as a normal human person. Thus a new behaviour in the person counselled is the overall aim of counselling.

In broad terms we can say that there are two approaches in counselling:

The first one is called Dispensary approach, and it is characterised by monologue on the part of the counsellor. Once the problem of the counselee is shared the counsellor prescribes solutions and readily provide them, instead of enabling the counselee to go deeper into the problem by himself/herself, and arrive at a decision to solve it. Sympathy towards the counselee is the predominant feeling here. When this approach is used it can hardly be called a counselling session.

The second approach is called Bartender approach. Instead of sympathy, the counsellor displays feelings of empathy towards the counselee. Companionship is offered to the counselee in his/her distress situation and not advise. The counselee is re-assured by the counsellor's attitude of ' I am with you', ' I care about you', towards him/her. Here the entire attention is focused on the counselee. The counsellor never takes responsibility of the counselee's problem, but rather (s)he encourages and enables him/her to take the responsibility.

The person who comes for counselling is apparently in a state incongruence. In other words (s)he has lost the equilibrium in his/her inner personality. The measure of happiness or unhappiness a person has is often determined by the level of congruence (s)he enjoys within his/her personality. When a person is not properly settled within oneself (s)he falls into a state of incongruence. According to Kasl Rogers this happens because of the disharmony between:

The real me: How I view myself (at this present moment)
The possible me: How I view myself that I could be.
Ideal me: How I view myself that I should be.

The counsellor's role is to enable the counselee to attain the state of congruence. This in practical terms means helping the counselee to become aware of his/her inner feelings, to accept them and also to communicate them if appropriate.

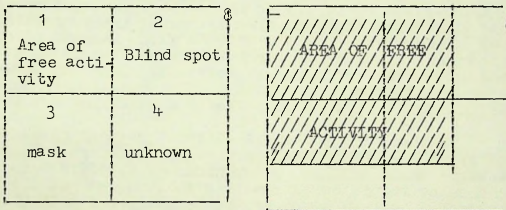
YOUR ATTITUDES & YOUR EFFECTIVENESS

Personal Attitudes: Before we start counselling others, it is very important to know and realize about our own personal attitude towards people. The check list given in Appendix I will help us to see what we ARE in relation to our attitudes. Answer them with 'Yes', 'I think so' and 'No'. Your answer should be based on what you ARE and not what you should be. If you are doubtful about the answer of any question ask your friend. (Please refer the check list and do the exercise before you proceed further)

If the majority of the answers are 'Yes' or'I think so' you have the disposition, and the potential to become a good counsellor. The 'NO's' are indicators for you to know where you need to make most efforts to become a good counsellor.

Personal Effectiveness:

The ability to handle ones own problem is important for the counsellor. 'Johari Window' as designed by Joseph Luft & Harry Ingham may help us to increase our own personal effectiveness.



1st Quadrant:

Information about myself shared by me and others. Close friendship takes place here. ' I know and you know'. In this area one feel comfortable with others. And others are also confortable with us.

2nd Quadrant:

Data not known to us, but known to others (eg. mannerisms, certain unconscious gestures etc) Unless others are free with us they will not feed us with these things.

3rd Quadrant:

Information about myself, which I know too well, but unknown to others. We keep it hidden from others. Very often it is the wrong self image that prevents one from revealing them to others. They wear masks and it is very difficult to deal with such people.

4th Quadrant:

Information not known to us and others. We must have heard people telling that ' I never know that I had so much strength in me' Usually these ' Unknown' manifests itself if emergency situations.

One measure of our personal effectiveness is the size of our Ist quadrant. Because it is in this area that we are most effective as persons. The interesting thing is that, we ourselves hold the key to increase this area of our personality. This is possible only through self disclosure and openness to feed back.

....3..

a. Self disclosure:

This means opening ourselves to others as we are. Normaly, we dont do it for fear of boasting(false humility) or because we are afraid to show ourselves to others as we are, and thus we prefer to beat around public facts or things known to everybody. Lack of self awareness also can hamper self disclosure.

To talk freely and openely about myself, I need to have a healthy image of myself. Very often we experience tension within ourselves between the 'real me, but not acceptable to me;' and the 'Acceptable me, but not the real me'. At least the awareness of this will go a long way in helping a person for self disclosure.

Love and acceptance are essential ingredients for human growth. We can love and accept ourselves only when some one loves and accepts us. We must give them a chance to do so.

b. Feed back:

Feed back means the remark, comments, or responses we receive from others about ourselves. It is not easy to be open to feed back. But it is important for our own personality development. Very often acceptance of this feed back depends also on how it is given. (eg: feed back given in an accusing and hurting way) Because emotions play an important role here.

The feed back given to us need not be necessarily cent percent true or valid. Nevertheless, it gives us an indication as to how others see us. And this is important.

To conclude this section, we may say that to function as an effective counsellor, we must improve our own personal attitudes towards others, and also increase our effectiveness through opening ourselves for more self disclosure and feedback.

THE ART OF COUNSELLING

The constituent elements of counselling are LISTENING & RESPONDING. In other words the art of counselling means listening with a sensitive ear and responding with an understanding heart. God has given us two ears, but one tounge, so that we may listen double than we talk!

Listening doesn't mean listening of the verbal experessions alone, but a clear observation of non verbal communications (Body language). eg. Facial expression, tone of voice, body position, gestures etc. When you attentively listen you are telling the person that 'you are important to me'. The following points are important for better listening.

- sitting position - to be able to look at the other directly close enough.
- There should'nt be any external distraction.
- Avoid any internal distraction eg: Frankly admitting the feeling in the beginning itself, structuring of the interview in terms of time etc.
- Being sensitive to emotionally charged words.
- Listening also includes proper clarifications at the right time.
- Silence; (reflective and not empty-head silence)

....4..

At this stage one thing the counsellor should keep in mind is to remain free from any prejudices of his own. Very often we wear 'eye glasses' made up of our own experiences, background etc. These eyeglasses may not help us to help the counselee. Another point to keep in mind is the danger of 'filtering out'. This means our tendency to listen and see what we want to hear and see, and thus we stand to miss the wholeness of the picture, which the counselee is trying to present.

Through sensitive listening and accurate responding, the counselee enters into the internal frame of reference of the other; the counselee's experiences is felt as if his/her (councellor) own experience This 'As If' feeling is called Empathy. Here the counsellor feels with the counselee and... not feel FOR him/her.

At this stage we have to check our own attitude towards the counselee. Three attitudes that seem to manifest are authoritarian, Paternalistic and Companionship. Needless to say that the companionship attitude is the one we should nurture in a counselling session.

It is genuineness, understanding and acceptance that characterises the real helping relationship in a counselling situation. <u>Genuineness</u> of the counsellor (True to oneself, and fearlessness in expressing it) wins the respect, trust and confidence of the counselee, and also it serves as a model for the counselee to be genuine himself/herself. It is <u>understanding</u> that helps the client for self exploration. When (s)he feels correctly understood (s)he is encouraged to explore deeply into the source of his/her trouble. The counsellor's underst-anding of the counselee is communicated through responses. The responses should PARROT response. <u>ACCEPTANCE</u> attitude of the counsellor creates a condusive atmosphere for the counselling session. However, this does'nt mean that the counsellor agrees with everything that isbeing said by the counselee.

The counsellor should'nt take the responsibility for the counselee and his/her problems.(S)He should be an enabler of the counselee to take care of his/her problems. The possibi-lity of confrontation in a counselling session can't be ruled out fully. It takes place normally when discrepencies are observed in the client in the following areas (a) The ideal versus the real (b) verbal expression and behaviour (c) what onesays about oneself and the counsellor's experience of him/her. These confrontations may hurt the client, but this hurting is meant to heal.(eg; surgery) However, this must be based on reality (eg. X'ray). Experiences have shown that this sort of confrontations help the counselee to be more genuine in the session and after.

For an effective counselling session, the following skills are required on the part of the counsellor.

A. <u>Attending:</u> Attending to the counselee has various aspects. They are
1. Attending contextually } Physical attention
2. Attending personaly }
3. Attending through the posture
4. Attending through visual contact.

1. The physical setting of the counselling room should be pleasing, welcoming and relaxing.

2. Personal attendance would mean attending to the personal needs and requirements of the counselee.

3. The posture we display in a counselling session is also important, since that too communicates the attitudes and the internal feelings of the counsellor.

4. Visual contact means the proper use of our eyes in a counselling session. It also includes the use of all our senses to grasp fully what the counselee is trying to express.

Psychologists are of opinion that only 25% of the message is communicated through oral communication.

The energy level of the counsellor as well as the counselee is also a deciding factor of the effectiveness of the counselling.

The degree of congruence also should be thoroughly observed by the counsellor. What people say and how they say it reveals the depth of problem as well as how they see it by themselves.

Attending also means listening. Listening is an art, which everybody can develop, but at the same time, which all of us tend to practice less and less in our day-to-day life. Proper and careful listening is the key factor which determines the success of a counselling session. Attention should be focused not only on the words, but also on the tune and how one says it. Who, What, When, Where, Why and How (5W H) should be throughly listend to.

B. Responding:

Adaquate, appropriate and timely responding by the counsellor, encourages the counselee to bring out more of himself/herself and also increases his/her confidence. This responding should be characterised by the empathy (experiencing of another person's world 'AS IF' you were there)

The counsellor should:

1. Respond to the content: eg: You are saying............
   (or) In other words............

2. Respond to the feeling: The feeling can be understood through observing the behaviour and presentation. (If the counsellor feels blank, (s)he can ask himself/herself: How would I feel myself in such a situation?)

   eg: you feel ....
   (for examples of different feelings ref. Appendix II)

3. Respond to the content and feeling:

   eg: You feel...... because....... (5W H)

Proper responses, as mentioned earlier, helps the counselee to explore his/her experience more deeply.

C. Personalizing:

The counsellor should help the counselee to go beyond the experiences (s)he is sharing. (S)He should be enabled to put together the various experiences to get a better understanding

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of his/her own situation. Personalizing in the counselling context means enabling the counselee to understand where (s)he is and where (s)he wants to be.

Personalizing has to be done in three areas. viz,.
1. Personalizing the problem: It means helping the counselee to understand what (s)he cannot do, that has led to his/her experience. In other words, what is the counselee, that is contributing to the problem? (counselee deficit)

2. Personalizing the feeling: eg., you feel .... because you can't.........

3. Personalizing the goals. eg., you feel..... because you cant..... and you want to........ (In personalizing the goals the counsellor's own experience can contribute a lot)

Personalizing helps the counselee for an understand of his/her problem in a better way.

1. Initiating

This means finding direction in life. Through this skill the counsellor enables the counselee to operationalize the goals identified in the personalizing process. eg., You want to.... as indicated by......, Your first step is...... (The counselee should decide what his/her first step should be) At this stage the counselee should be helped to initiate a schedule for action. (with different steps and actions)

Initiation enables the counselee for action which will ultimately led him/her towards a state of congruence and integrated personality. This ofcourse is the ultimate goal of counselling.

(Ref: Appendix III)

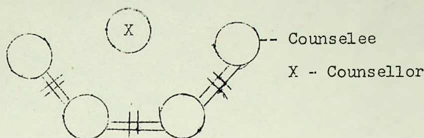
Counselling a Group in Tension

It is not uncommon that interpersonal conflicts and breakdown of communication takes place in a team or group of people working together towards a common goal. Counselling can be an effective instrument in resolving the conflict in such situations.

In such a group counselling session, the counsellor will have to display atmost restraint and balance, so that each member of the team can build trust in him/her and thus feel free to express himself/herself fully.

The most important task of the counsellor in a situation like this is to get the people concerned together in a place. Once they are collected together thus, the counsellor should ensure that each one listens to the other, with out interrupting the one who speaks. Very often when feelings run high, people tend to fail to see other's views. And during the session it might be possible that each one dwell in his/her own views, trying to articulate his/her stand. To overcome such a situation Rogers suggests a methodology called 'echo game' to ensure proper listening from each other. According to this methodology each one is made to repeat what the previous speaker has said, before (s)he start speaking himself/herself.

The physical setting for the session should be arranged in a semi-circle way, through which each one faces the counsellor and sits at an equal distance. It could be in the following way.



The counsellor should show acceptance to each individual attention should be paid as in an individual counselling session. The counselees should get the feeling that they are individually attended to. This is possible only when the consellor can enter into each one's frame of reference. (S)He should never show favour to any one, for get baised. The counselees should be asked to direct the communication to the counsellor and not to any one in the group. This is important especially in the beginning of the session.

Through adaquate responses of the counsellor to each one's point of views, every one else in the group gets a chance to hear twice his/her own and other's views. This facilitates better understanding of the other's standpoint for more effective interpersonal relationship in future. It is worth mentioning here that the experience of many groups have proved that conflicts and tensions in a team or group can lead to strong interpersonal relationship, if worked out properly. The skills required by the counsellor in group counselling and tension management and the processes are the same as that of individual counselling.

Conclusion

Nobody can overemphasize the importance of counselling techniques for personnel involved in people based health and development programmes. The techniques and methodology for individual and group counselling described about is not exhaustive. This paper is meant to be a supplementary reading after the course on counselling.

prepared by

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ref: 1. "Barefoot Counsellor" by Fr. Joe Currie S.J.
2. "The Art of Helping - III" (Robert R. Carkhuff, Ph.D)

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Appendix I

CHECKLIST

(From Barefoot Counsellor by Fr. Joe Currie, S.J.)

1. Do I find other people interesting?
2. Do I find it easy to like others - even those who are quite different from me?
3. Am I enthusiastic about others' chances for wellbeing and happiness?
4. Can I trust others to take decisions and assume responsibilities?
5. Do I generally relate freely and easily with others?
6. Do I have a deep and open relationship with at least some others?
7. Am I consistently trustworthy and dependable?
8. Can I identify with the feelings and private personal meanings of others without becoming excessively weighed down by their problems, "downcast by their depression, frightened by their fear, or engulfed by their dependency"?
9. Are people important and significant to me?
10. Can I let others be as they are, even when I don't agree with them nor approve of their behaviour?
11. Do I have confidence in my own abilities?
12. Do I dislike dominating and controlling others?
13. Can I accept my own weaknesses and shortcomings?
14. Am I ready to accept help from others when I myself am emotionally upset?
15. Do I find it generally easy to listen, to give my full attention, to others?
16. Am I convinced that I am an important person?
17. Do I encourage others to stand on their own feet, and fight the temptation to take them under my wings?
18. Can I accept myself as I am, without undue anxiety about fulfilling the expectations of others?
19. Am I open to new and better ways of doing things?
20. Can I be a good follower as well as leader?
21. Do others generally find me a warm and loving person?
22. Do people find me approachable and easy to talk to?
23. Can I talk easily and frankly about myself, without on the one hand boasting and, on the other, feeling embarrassed?
24. Do I treat each person as an individual, giving him a chance to prove himself before fitting him into a category?
25. Can I communicate warmth toward people and sensitivity to their needs without being uncomfortable myself, or making the others uncomfortable?

* *

APENDIX II

CATEGORIES OF FEELINGS

(From the Art of Helping III. By Robert R. Carkhuff, Ph.D.)

Levels of Intensity	Happy	Sad	Angry	Sacred	Confused	Strong	Weak
Strong	Excited Elated Overjoyed	Hopeless Sorrowful Depressed	Furious Seething Enraged	Fearful Panicky Afraid	Bewildered Trapped Troubled	Potent Super Powerful	Overwhelmed Impotent Small.
Mild	Cheerful Up Good	Upset Distressed Down	Annoyed Frustrated Agitated	Threatened Insecure Uneasy	Disorganized Mixed-up Foggy	Energetic Confident Capable	Incapable Helpless Insecure
Weak	Glad Content Satisfied	Sorry Lost Bad	Uptight Dismayed Put Out	Timid Unsure Nervous	Bothered Uncomfortable Undecided	Sure Secure Durable	Shaky Unsure Soft

APPENDIX III

(From Barefoot Counsellor by Fr. Joe Currie, S.J.)

CHECKLIST

I. General attitude toward the counsellee:

1. Do I respect his independence?
2. Do I feel responsible for him and want to protect him?
3. Do I look forward to seeing him?
4. Do I tend to over-identify with him?
5. Do I feel resentment or jealousy toward him?
6. Am I bored with him?
7. Am I afraid of him?
8. Am I overly impressed by him?
9. Do I want to punish or get rid of him?

II. MY behaviour during the interview:

1. Do I tend to tighten up and feel uncomfortable?
2. Do I select certain material to dwell on?
3. Do I get angry at him for not responding the way I want?
4. Do I discover that I dislike him without reason?
5. Am I vulnerable to his criticism of me?
6. Do I try to impress the other and make a favourable impact?

III. In between interviews:

1. Do I dream about the other?
2. Do I find myself preoccupied with fantasies about the other?
3. Do I plan the course of future interviews?

IV. At the end of counselling:

1. Am I reluctant to let the other go when it is clear that he has reached as far as he can with me?

TEN DO'S

1. Be yourself.
2. Concentrate, but in a relaxed way.
3. Listen to the full message of the other.
4. Respond adequately and creatively.
5. Communicate interest, warmth and understanding.
6. "Prize" the other.
7. Confront, if and when necessary, responsibly and sensitively.
8. Help the other to sort out and clarify his problem.
9. Use simple and direct language.
10. Help the other to take charge of himself.

* *

TEN DON'TS

1. Don't advise or look too hastily for a solution.
2. Don't question from curiosity or from uneasiness.
3. Don't moralise or intellectualise.
4. Don't make the other depend on you.
5. Don't categorise or pre-judge the other.
6. Don't be falcely re-assuring or supportive.
7. Don't evaluate the other or his behaviour or attitudes.
8. Don't talk too much, or project yourself into the interview.
9. Don't look for, or encourage, long narratives.
10. Don't use technical jargon.(terms).

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MINISTRY OF THE CHURCH IN HEALTH SERVICES

Introduction :

"Action on behalf of justice and participation in the transformation of the world fully appear to us as a constitutive dimension of the preaching of the Gospel".

- Synod of Bishops 1971

"Behind the revolutions of our day, is man's struggle for human dignity. Christ is at work here and we cannot proclaim Him to contemporary man if we do not participate in this struggle. In such participation we have to work with men of all faiths and no faith. Christian living is, in this sense, living in response to the WORD and to the world. It demands the conscious transcendence of our limited groups solidarities and moving towards the new humanity which is free from all discriminations".

- National consultation on the role of Church in contemporary India, 1966.

"If we wish to be faithful to Christ and take up this attitudes with regard to our fellowman, we must work for the over all 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".

- Pontifical Council Cor Unum, Document on Primary Health Care Work, 1978.

"The mission that we have given is a call for a true conversion of our hearts and also of our methods. Secularization is spreading in people's hearts from the industrialized and technological world to the developing world countries. We need to be converted all the time in order to bear witness as Christians to the sick who, through our work, will discover the love of Christ. The rapid development in the field of health service technology has often meant installing expensive equipment in the hospitals, requiring a large number of staff for a relatively low number of patients, while in many of the same countries in the world, upto 80% of the population are still without health care services.

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 conjuction with the public services, where this is allowed.

Let us ever be mindful of the fact that service to the sick begins and continues to operate through the patient's human environment. COMMUNITY HEALTH CARE IS THEREFORE PART OF THE COMPREHENSIVE PASTORAL WORK OF THE CHURCH".

- Cor Unum Document, 1978.

"Presently, despite the constraint of resources, there is disproportionate emphasis on the establishment of curative centres - dispensaries, hospitals institutions for specialised treatment - the large majority of which are located in the urban areas of the country .... A dynamic process of change and innovation is required to be brought in the entire approach to health man power development ensuring the emergence of fully integrated bands of workers functioning within the "Health Team" approach".

- New National Health Policy, 1982.

"The demand for justice has been one of the dominant notes of this half of the country. Perhaps no other period in History has witnessed a greater denial of justice also .... 'The Church, bearing within itself the pledge of the fullness of the Kingdom, views with joy the present concern for justice and with anxiety the grave threats to justice all around us. It is her endeavour to interpret the implications of the Gospel message of justice and peace in the varying situations being unfolded in the course of the human pilgrimage on earth. She has to be the 'Leaven' and the 'salt' of the earth in the confusion likely to prevail in the search for justice".

- CBCI, 1978.

"The Church should give its whole hearted support to the peaceful social changes taking place in the country by verbalising its support of any efforts made for bridging the gap between the rich and poor.

"The Church should actively involve itself in removing concrete cases of injustices happening in the society in which it exists".

- CBCI, 1972.

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"We want our health services to take primary health care to the masses, particularly in the rural and urban slums. Catholic Hospitals and dispensaries should stress the preventive and promotive aspects of health care. Specifically, we would urge them to join hands with the civil authorities in their programme for the eradication of leprosy.

Our health outreach programmes may demand a change in the routine especially of religious communities of men and women involved in this work, and their formation should prepare them to meet the new spiritual challenges that are posed".

- CBCI, 1978.

" The commission being conscious of :

a the situation of massive poverty of over 60% of our people;
b the unjust structures which maintain and perpetuate it;
c the injustices perpetuated on the weaker section of the people;

considers it imperative to reaffirm our commitment to the poor in imitation of Christ's preferential option for the poor.

The creative struggle of the people to bring about a new society invites us to enter into critical collaboration with people of all religions, ideologies and agencies who strive after a just society.

A meaningful participation in this struggle calls for :

a. a serious analysis of society with the tools of social sciences and in the light of faith;
b. taking definite and unambiguous stand on various issues;
c. initiating concrete action programmes for change.

As a credible sign of this process the Church initiates action for justice within its own structure. In this context participation of all sections of people especially of the laity is of vital importance".

- CBCI, 1983.

"With this orientation in view the Commission proposes the following priorities of work, in the field of health :

1 Promote Community Health Programmes on the Priority basis;
2 Train health care personnel with a bias to rural health programmes. In this connection it is of utmost importance to reorient doctors, nurses & para-medical personnel in our institutions and programmes with Christian values.

3 A commission could be set up to study the prevailing conditions and problems, attitudes and values of doctors, nurses, para-medical personnel and other employees.

- CBCI, 1983.

The relevance of quotations cited above can be viewed by different people differently depending on the concept of health one has. One thing is getting more and more clear that health is no more an isolated factor and it is not merely the absence of sickness but the total well being social, physical, mental and spiritual of individuals, families and communities. It is in this sense that the above quotations have their relevance when dealing with ministry of the Church in Health Care.

Health care is a field in which the Church in India has been busy for over a hundred years. With more than 2000 health care institutions all over the country run directly by the dioceses or religious congregations, the volume of work done by the church is enormous. With one well established medical college and more than hundred nurses' training institutions we train every year an army of health care personnel and add to the already existing ones in the field. With the emphasis since some years on the field of community health, a new army of village level health workers (called under different names) are trained and they are in the field. We have also national organisations, under the auspices of the Church, dealing with various aspects of health care i.e. the Catholic Hospital Association of India, Catholic Nurses' Guild, Catholic Doctors' Guild, Natural Family Planning Association of India etc. This certainly shows the richness of the resources at our hand. The question will have to be asked is are all these properly utilised for the best interest of the people of God in India particularly the vast majority of them living in rural areas and urban slums.

1. COMMUNITY HEALTH :

CHAI has definitely committed to this cause for the coming years. And we do hope to do something thereby contributing our share to achieve the goal set by WHO and accepted by our country, i.e. Health For All by 2000 A.D. This we hope to achieve through our member institutions and others, and with the cooperation, help and guidence particularly from the members of the CBCI and CRI. We have now an eight member team for the promotion of Community Health. The team has worked out a philosophy and vision for our community health programme and a broad plan of action.

2. Promotion of Pro-Life Activities :

Efforts will have to be made by all concerned to bring an awareness about the seriousness of this all important aspect of life. CHAI will be taking some definite steps in this regard in the coming years.

3. Pastoral aspect of health care :

This is a field rather neglected by the Church. Complaints about even rude behaviour by the Staff towards patients in our health care institutions are not a rare phenomenon. Then the question is, have we given them the necessary training and orientation ? Keeping this in mind CHAI organises seminars for health care personnel from time to time. It is our plan to develop a separate department in CHAI to meet this crying need in our country. We also plan to organise regular residential course for Chaplains etc. in the future.

Against all what has been mentioned, particularly the various documents mentioned, the following suggestions are put forward for Justice, Development and Peace in General and the health section in particular. In this connection, it was very meaningful to have put the health section with commission for justice, development and peace.

1. To have an evaluation of our existing institutions for education, training and services in the field of health in accordance with the present concept of health mentioned in the documents (of also the CHAI documents)
2. Community Health Programme accepted as a priority should be promoted in all the Dioceses. The members of the CBCI and CRI should accept this end and make it known to all our health care institutions.
3. In order to implement this, St. John's Medical College, National Organizations like CHAI, NEPAI, CARITAS INDIA, IGSSS etc. will have to plan together in collaboration with other organisations in the field such as VHAI, CMAI, ISI etc.
4. Possibility of organisations like, CHAI, Catholic Nurses' Guild, NEPAI to work together will have to be explored, for better effect and to avoid any unnecessary duplications.
5. The teaching of the concept of Community Health based on the various documents dealing with the subject should find a place in the Curricular in Seminaries and Religious formation houses.

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6. In this connection this commission will have to work in collaboration with the commission on Seminary Training etc.

7. This commission should also work in collaboration with the commission for Laity and Family.

These are a few suggestions, however practical they may be which came to my mind. The implementation of them may be difficult but necessary if we want to respond to the needs of the time. We all agree that making statements (for which we seem to be experts in this country) alone will not solve the problems. We need to translate them into action, which is by far difficult. But we are left with no choice but to do it if we want to be meaningful to the society today and faithful to the gospel message. Let me conclude this with another quotation, this time from Ashok Menta.

"We must reclaim 900 million people (the number is more now) of the world who are today in a state of abject depression. This human reclamation requires a peculiar type of social engineering. This is to my mind the big challenge that all people, all men of religion, all men of God have to face. And if it is the proud claim of the Christian Churches that they have that spiritual understanding, that spirited agony and that spiritual out glow is greater than that of other men of God, it has to be proved, as I said in the crucible of life itself. If it is the claim of Christians that even to this day they feel the agony of Christ on the Cross whenever humanity suffers as it were, it has to be proved, in action and not by statement".

Fr John Vattamattom svd
Executive Director
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DIFFERENT APPROACHES TO DEVELOPMENT

In India, especially after the independence, we see thousands of individuals and groups engaged in the field of development either full time or part time. To be a social worker or development worker, to some extent adds to ones status and position in society today. In spite of all these countless efforts we hardly see any significant changes in the life of the nation as a whole. A national net work for a concerted effort in the field of development is yet to be evolved.

A close look at these groups and individuals in the field of development will show us that their understanding of poverty and the corresponding approaches to development varies and in certain cases diametrically oppose each other. Though one cann't question their good will and sincerity of purpose, we should know that, mere good will and a sense of sacrifice and committment do not indeed suffice to make our contribution to development and social justice meaningful.

The approaches commonly adopted by different people in the development field can be classified into three. They are :

1) Welfare approach;
2) modernization approach
3) social justice approach

All these approaches proceeds from a clear and definite analysis and understanding of poverty or underdevelopment, however scientific or unscientific the analysis may be.

Before we proceed further, let us be clear about certain initial facts.

1 Our ability to identify factors and forces that create wealth and poverty determines our ability to tackle the problem.

2 Each one of us has an understanding of poverty and under-development, whether at the conscious or sub-conscious level. We may have never formulated it, but a closer look at our work will reveal it to us. Always the solutions and methods adopted, follows from our analysis.

3 Our understanding of underdevelopment and analysis of the problems are largely influenced or conditioned by our own socio-economic background.

Our preception of reality is conditioned by our position in the society. Thus the causes of poverty identified by the rich may not be the same as those indicated by the poor.

1) The Welfare Approach :

This approach is deeply rooted in the mentality of religious minded people and humanists and is favoured by many private agencies and governments in both developed and in developing countries. The fabulous investments in men and money that welfare enjoys, compels us to reflect seriously on whether it deserves it or not.

In this approach, development and under development are considered as two parallel realities that have always co-existed, and that will always co-exist. Here poverty is accepted as a normal result of forces outside the control of man. These forces are identified as natural and super-natural. Here the symptoms are treated with a rather fata-listic approach, rather than the root causes of the problem with a critical analysis. Natural forces are seen as disasters, epidemics, earthquakes, cyclones, floods, draughts, etc. over which man has no control. In the supernatural sphere, man's status in life is seen as predet-ermined. It is his fate, it is in the plan of God, and explanation of poverty reflects a religious tone. Development workers with this understanding regrets poverty, but accept it as fate.

People who see poverty as created by forces outside the control of man, see little possibility for change. The solution is seen as a sharing of material goods and talents by the blessed and privileged, and the acceptance of these goods and services by those who are in need of them. The disposition advocated is a basic contentment with one's state of life. Work for the poor assumes the nature of alleviating the suffering of the poor rather than eradi-cating poverty itself. Development work here becomes an ongoing relief or charity, characterised by 'dolling out' benefit to the poor people according to their needs. (Giving the man the fish) It is often a spontaneous response to a situation with little effort made to identify and tackle the root causes of the problem.

And in the recipients, it often develops attitudes of dependence, laziness and passivity and sometimes creates division among the poor. It always diverts the attention of the poor from the real issues and anaesthatizes them.

Even a limited study of the history of the welfare approach and a superficial analysis of the functioning of society reveal that most of the evils treated by the welfare approach are the inevitable by products of certain forms of social organization.

2) Modernization approach

Like the previous approach modernization too rests on a certain understanding of poverty and under development. The cake, they say has to be bigger before it can be shared. So in this approach increased production and economic growth is stressed, to remove poverty. Here it is implied that people are poor because there is not enough production of goods. Modernization approach relies on industrialization and on rather sophisticated and capital intensive technology. Family planning compaigns are also of prime importance to keep down the birth rate and thus to promote economic growth.

Here, development is seen as the successful utilization of resources, natural and human. Such an understanding stresses the need for patience, hard work, self descipline, sacrifice investments and quality education, needed for the production of bigger cake. Under development is seen as the result of the slow and inadequate establishment of the system of production and consumption present in the developed countries. To a great extent modernization then means westernization - following closely the methods and patterns of the developed. The advanced countries become the guides of the developing countries. On the cultural level it leads to the acceptance of the ideals of western countries and the adoption of their attitudes and values.

Those who can produce more are encouraged to the level best, with the contention that the benefits will 'trickel down' to all. This method of 'Backing the strong' (green revolution) is easily recognizable in our five year plans, government policies and in the projects run by voluntary agencies.

Even though impressive statistics can be given on the growth of agricultural and Industrial production, on the number of students enrolled in educational institutions, education and public services, a question could be asked : who progresses?

The rich, who only posses the purchasing power, with their demands, command and control the market, and often fund to imitate western standards of living. Industrialization responds to this demand and produces luxury articles which give higher rates of profit. The production is done at the minimum cost often introducing sophisticated and capital intensive technology, thus increasing unemployment. Poverty and unemployment place the workers at the mercy of the land-lords and industrialists, with low wages, and miserable and inhuman conditions of work. The state accentuates the situation by limiting or forbidding strikes. Whenever the labour force is so large and employment so scarce, favoritism and corruption unavoidably prevail. Extreme poverty drives poeple to borrow for their subsistence and social needs; money lenders prosper, for no bank or credit society would lend money in such circumstances. All this creates a vicious circle.

In a society where serious inequalities already exist a technological advance leading to increased productivity is likely to be limited to those endowed with superior wealth and social status to the exclusion of the poor majority' says the United Nations research institute for social development, Geneva.

The modernization approach, therefore, ends with the abundence of luxury articles and the scarcity of basic goods; with sophisticated technology and unemployment, low wages, debts and bonded labours. It produces the wealth of the few and the poverty of the many. The limited resources of the nation are thus used by a small groups for their selfish interests.

3) Social Justice Approach

The Failure of the modernization and welfare approach lead some to evolve a different approach to development based on a critical analysis of the various forces and dynamics at work in the society. It examines the organization of society and it's functioning at both micro and macro levels.

There is the conviction that non-economic factors that is the overall social context of society with its institutions and structures - Play a very important role in development. It tries to tackle the root causes of poverty and pays great attention to the proper distirbution of wealth. It does not accept mass poverty or under development as a fate. Modernization becomes important only when fare shares to the masses are possible. The root causes of under development according to this approach is injustice. If 85% of Indian population are below or just above poverty line, it is because 15% unjustly enjoy the results of the labour of the 85%.

In this approach one is convinced that deprived groups and nations can develop only in the context of a direct attack on poverty and a move for just distribution of wealth and power. Instead of depending dispropotionately on capital formation and move modern attitudes and values, development ultimately depends on land ownership, land utilization, employment, wages and the level of food comsumption. What would development mean in this historically created condition of under development. It means the restructuring of society! Efforts in this direction can be seen in Trade Union, (Balance of power in the production sector through collective bargaining) marketing co-operatives (challenge to the unscruplous exploitation of middleman) credit unions, (against money lenders) Mahila mandals (against low status of women). Always it was the awareness of injustice and exploitation in these cases that resulted in the organization of people at various levels. So in this understanding of development, the approach one would adopt will be awareness building which will definitely culminate in action.

Genuinely effective development work will have to challenge and re-organise the relations between the substructures in the society. The wealthy are the socially privileged, and the politically powerful. Power and privilege proceed from economic standing. Culture and religion seem to reinforce the interrelationship by providing sanctions andjustifications. A total transformation of these structures and support, is inevitable. In the economic sphere, this would mean policies geared to serve the needs of the people and not as at present, for the profit of a few. This would require that the means of production, land and capital be socially owned. On the social and cultural levels, this would mean relationships of equality between groups of people;

New ways of thinking feeling and acting, collective promotion rather than individual promotion. On the political level, to evolve an organizational set up that makes possible real and effective decision making power for the people. Thus this approach aims at a socialist society.

Unlike the previous two approaches to development, this one is a rather distributing approach, as it demands a commitment to struggle, and a struggle against the powerful dominant group; and it is no easy task. As development workers, what options does our above understanding leave us with? Can our sincere desire to alleviate the wretched misery of our countrymen express itself in meaningful actions that contribute to this process of collective awareness, collective organization and collective struggle?

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GUIDELINES FOR COLLECTING INFORMATION ABOUT A VILLAGE

Most of us do not belong to the village where we actually work and therefore, it is most important for us that we learn as much as we can. These guidelines meant to help you in collecting information on the village where you live or where you intend to develop a community health programme.

THESE GUIDELINES ARE NOT MEANT FOR YOU TO CONDUCT A FORMAL SURVEY

Most of this information should be got through informal discussions with groups or individuals in the village. Observe as much time as you can with the people in your visits. When people come to know you better they will be more willing to talk openly about the real problems facing them.

There are two types of information we need to collect. One is facts. Eg: Location, population, number of schools, number of wells etc. The other is related to what people think and feel. Eg : what do people and feel and think about the schools, drinking water facility etc. We also need to know how people relate to each other in the village.

It is important to collect both types of information. Facts are easier to collect. It will take longer to find out what poeple feel and think. Therefore, it is essential to build a good relationship with all the people in a village.

INFORMATION TO BE COLLECTED

Read these guidelines carefully and remember what you should find out when you go to the village. Do not take these guidelines with you when you go to the village. If you do, people will think you are conducting aurvey. These guidelines are by no means complete. You may want to collect more detailed information on some of the points given below :

1. LOCATION

- Name of village/block/tehsil/district/state.

- Distance of village from block office/tehsil office/district head-quarters and nearest town.
- Are there any important rivers, forests, dams, factories, markets etc. nearby?

2. GEOGRAPHICAL SET-UP

   - Type of land(sandy, rocky, hilly etc)
   - Rainfall, floods, drought etc.

3. COMMUNICATION SYSTEM

   - How do people travel?
   - What is the condition of roads (kutcha, pakka)?
   - Frequentcy of transport (buses, trains etc) (goods trains & passenger trains)?
   - What are the links with the outside (Eg. information through people working in towns, radio, TV, through extension workers visiting the village etc.)?

   What do people think and feel

   - About the transport facilities
   - About information from outside (Do they feel isolated, do they feel the need for more information on outside happenings etc.?)

4. ABOUT THE POPULATION

   - Total number of people, number of households, hamlets etc.)
   - Caste, religions

5. EDUCATIONAL FACILITIES

   - Schools (primary, secondary, technical etc.) and where are they located, who runs them?
   - Are they for boys and girls, if not where do girls study ?
   - Do teachers come regularly ?
   - How many students in village school and who are they ?
   - How many adults know how to read and write ?
   - Was this village included in the National Adult Education Programme ?

   What do people feel

   - Is school education important for children - for boys, for girls ?
   - What would they like their children to learn ?
   - Do adults feel the need to know how to read and write ?

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6. ECONOMIC LIFE

A) What is main occupation in the village (agriculture, looking after animals, local craft, quarry workers)?

AGRICULTURE :

- Total land in village available for cultivation
- Any land not being cultivated in village (if yes, how many acres and why ?)
- How much land is irrigated ?
- Source of irrigation(river, canal, dam, tube well etc.)
- How many crops grown in a year and what is grown ?
- How much is produced per acre on the average (for wet land and dry land)?
- Does village get any agricultural help from BDO ?

LAND HOLDING :

- Who owns most of the land in the village, is it irrigated ?
- How many families cultivate land belonging to others ?
- How many families work as labourers in fields belonging to others ?
- How much land would a family of six require to produce enough food for themselves for the whole year ?

EMPLOYMENT :

- For how many months do families work on land ?
- How many families migrate, for how many months and where do they go ?
- What are the wages per day for agricultural labour in the village and when they migrate ?
- Are the wages different for men, women and children ?

What do people think

- About land distribution
- About irrigation facilities
- About help from the block development office
- About wages
- About employment

LIVESTOCKS, POULTRY ETC

- Are there buffaloes, cows, goats, sheep, pigs, hens, etc. in the village ? (is it the main source of income ?)
- Who owns the majority of these animals ?
- Is there any organized dairy, poultry in the village ?
- Is there any potential for developing this ?

- What do people think
- Is there possibility of expanding this craft ?
- Is there need to start some village craft ?

B. ECONOMIC RELATIONSHIPS

- To whom does a small farmer sell his products ?
- When does he sell it ?
- How much does he sell it for ?
- How much does he have to pay, when he needs to buy it back ?
- Who are the money lenders in the village ?
- How many acres does the money lender own ?
- What rate of interest do they charge ?
- What happens if the person is not able to repay the loan ?
- Which group of people are mainly borrowing money ?
- What do they borrow the money for ?
- What is the approximate amount borrowed by an average family ?
- What govt. facilities are available for loans (eg. banks, cooperatives) ?
- Who uses these facilities ?

What do people feel and think

- What do people feel about the money lender's system ?
- Are they satisfied with the selling and buying rates ?
- Do people think it is possible to have grains/seed/ fertilizer banks ?

7. SOCIAL - POLITICAL FORCES

A. Social forces :

- What are the main castes in the village ?
- Which caste has the most power ?
- How does the caste feeling affect the day to day lives of the people ?
- Do different caste groups live separately from each other ?
- Is untouchability practiced ?
- Is everyone allowed to take water from the same well ?

b. Political Forces :

- Who makes the decisions affecting the village ?
- Who is the Sarpanch and what is his economic status ?
- What castes does he belong to ?
- Who are the panchayat members ?

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- What is their economic status and what caste do they belong to ?
- Who are the other leaders in the village ?
- What influences do they have in the village ?
- In what ways do the different leaders influence the community ?

8. CULTURAL PATTERNS

- What are the main festivals in the village ?
- What are the customs related to marriage, childbirth, death etc. ?
- How much money do people spend to perform such rites ?
- What are some of the important beliefs of people regarding religion, superstition etc. ?

9. SERVICES AVAILABLE

- Drinking water facility and cleanliness of drinking water.
- Bank services
- Government services like development of agriculture, irrigation, animal husbandry, welfare activity like anganwadi etc.
- Health services - PHC, sub centres, Malaria workers etc.

10. HEALTH AND NUTRITION

- What is the diet of an average family , poor family ?
- What are some of the beliefs related to nutrition of infants, small children, pregnant mothers, in specific diseases ?
- Where do people go when they fall sick (local healers, ANM, PHC, private doctor etc.)
- Who conducts deliveries in the village and what are the practices followed during delivery ?
- What are the common diseases in the village ?
- What is general sanitation in the village ?

What do people think

- Is health important ?
- About the causes of ill-health ?
- When do they consider themselves sick ?
- Are health services adequate ?
- About cost of health services (local healer, dai, ANM, private doctors)

11. ORGANIZATIONS IN THE VILLAGE

- Are there any farmers clubs, youth clubs, mahila mandals, coperatives etc. ?
- Who are the members and leaders ?
- What do these organizations do ?
- Were there any such Organizations which have ceased to exist ?

What do the people think

- Are they satisfied with the organizations existing in the village ?
- What are some of the problems faced by these organizations ?
- Is there need for such organizations ?

CONCLUSION

As already stated, the points mentioned above are only GUIDELINES. Once you start discussing these points with people, many more questions will come to your mind. It is up to you to find out more about the life of people in the village. It is also important to know if people have taken any initiative whatsoever in changing their life situation and with what result.

Do you and the people think that some action can be taken for bringing about change for the better ?

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CRITICAL ANALYSIS OF THE INDIAN REALITY

India is a great nation having a democratic system of government, which is a great industrial economy and a country which has made much headway in Agriculture. Today, India is in the nuclear community and is in the forefront of other developing nations in space research. Since Independence, India has been making rapid increase in the production of Iron, Aluminium, Electricity, Fertilizers, cement etc. India's export industry is remarkable In 1978 it was worth Rs. 3,156 crores, while it was only Rs. 1535 crores in 1970-'71. Growth rate of Agricultural production in 1977-'78 was about 11 to 12% and the stock of food grains was about 20 million tonnes. India exports grains to USSR and Bengaladesh. Food corporation of India is finding it extremely difficult to provide enough space to store up the stock. This however, is only one side of the coin

On the other side we see that more than 48.4% of our countrymen(govt. calculation) live in a constant state of starvation, nakedness and disease; and that they do not have money to spend for a day on food even for survival. There are 68%, i.e., 465 million who can not read and write. 70% (i.e. 478 million) of rural people live in one room huts and 1.90 lakh villages exist without drinking water. Diarrhoea kills 3 children every minute. There are 3.2 million leprosy patients and 9 million bling people in our motherland.

Why this contradiction? Why are people landless inspite of 36 years of land reform? Illiterate inspite of about Rs. 1350 crores being spent annually on education? Unemployed inspite of massive plans? Unhealthy inspite of huge budget allocations on health?

It is not enough to see what is the state of the majority of Indians, we have to ask also why? A socio-economic and political analysis of the Indian reality is necessary to find out the causes of such massive poverty, misery and to answer the WHY. It is an investigation into the laws which govern and direct the interaction among different groups in the society. We analytically observe and percieve even the invisible elements in a given society and this analysis given us the total and overall picture of the society in all its dimensions, for we analyse the society with reference to its social structures,

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the ways and processes of decision making, the forces behind these decisions, the real beneficiaries of this decisions, etc.

Our country and for that matter any society, has a particular manner of socio-economic and political organisation, which in general could be termed as the organisational system. This organisational system is maintained and sustained by the values that the society promotes. These values are provided by the culture, religion and ideology - which together could be called the meaning system. Social analysis studies both these systems in detail. To understand the Indian reality, we have to study in detail, how the Indian society is organised and how this organisation is maintained.

The reflections of Julis Nyerese, the President of Tanzania can help us to grasp the various structures and systems that contantly contribute to the miserable state of affairs of our... people. "Poverty is not the real problem of the modern world... The real problem - the thing which creates misery, war and hatred among men - is the division of mankind into rich and poor..... The reality and depth of the problem arises because the man who is rich has power over the lives of those who are poor, and the rich nation has power over the policies of those which are not rich." As a consequence of this the rich get ever richer and more powerful, while the poor get relatively everpoorer and less able to control their own future. Sometimes this happens through the deliberate decisions of the rich, who use their wealth and their power to that end. But often or perhaps usually it happens 'naturally' as a result of the normal working of the social and economic systems men have created for themselves. To group it better, take the case of a landlord and his tenants or coolies. Even if as an individual the landlord is the most generous, just and considerate person, who becomes richer as the years passby? The landlord or his tenents or coolies? If we take the case of factory owner and his workers, who will be richer at the end of the year? So irrespective of the qualities of the persons concerned, the system functions automatically: the rich will becomes richer and the poor becomes poorer and the gap widens. This also illustrates that the moral transformation of individuals does not suffice to profoundly alter the conditions of life of our people, unless structures and systems must are radically changed.

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With this brief introduction let us again go back to the organisational and meaning systems existing in our society. As stated earlier, economic, political and social systems forms the organisational system and religion, culture and ideology forms the meaning system of any given society.

ORGANISATIONAL SYSTEM

Economic system

Every individual and society has to satisfu certain physical and psychological needs or wants, as for example food, clothing, shelter, medicires, art, entertainment, ceremonies etc. In the process of producing and circulating the material goods that meet these needs man relates to nature through certain technological tools called instruments of labour. They also relate to one another and form certain relations, Every society thus posses an economic organisation or system.

There are two widely a ccepted approaches to economics: The capitalist and socialist. The former takes for granted the private ownerwhip of the means of production, the existence of wage, labour and the unequal distribution of income. Such an economic approach is divested of its real purpose, namely the satisfaction of the needs of all people and aims at private profit for the capitalist, who owns the means of production and employ wage labour. The socialist approach follows from a stand in favour of social justice, equality and solidarity.

The economic system comprises of four basic structures: Production, distribution, exchange and consumption. In the production structure we can identify the productive forces (man-nature) and the production relations (man-man), Land Labour (Instruments of labour - tools, mechines, infrastructures) and capital (money, r_aw materials) are the means of production and it gives birth to particular types of social relations and organisations and forms particular types of social classess. The instruments of labour play a significant role in the production process and to a great extent determine the level of

production. The social relations are transformed with the development of the productive forces especially the division of labour. So in the economic analysis of a given society, it is important to study the overall development of the productive forces and the existing social relations and the mutual relation and influence between the productive forces and production relations. eg. Are the existing social relations an exploiters - exploited relation or a collaboration - solidarity relation of production? What types of relations are the productive forces fostering?

The distribution structure - is intimately connected with the production structure, especially the ownership of the means of production. Through this structure, the social product or national income is distributed. In the structural analysis of the economic system, this income distribution ad well as the growth or reduction of inequali••ties, in relation to the ownership pattern of the means of production, has to be studied.

In a natural or subsistence economy, where production was for use, there wasnot hardly any exchange. The development of the productive forces and in particular the division of labour rendered exchange necessary, first through baster - exchange of goods and later on through money, the general equivalent.. Production for exchange or commodity production increased. With the use of money and commodity production, the market progressively developed. In fact commodity production is geared to the market. Though most often externally peaceful, market transactions and relations are conflictual. The interests of the buyers and sellers indeed oppose one another, conflicts also exist between different traders. In a market people meet as commodity buyers and sellers and class relations are in evidence. In a developed economy, trade is not mainly carried out in view of exchanging goods, but of acquiring profit. In analysing the exchange structure, one has to relate it to the production and distribution structures to uncover this exploitation of the dominated classes.

Consumption means the purchase and utilization of a good or service for the satisfaction of a need. Though man's needs are conditioned by subjective and cultural factors, there exists a certain objective hierarchy of needs. Without the fulfilment of primary needs such as food, clothing, shelter and health,

life itself becomes impossible. The secondary needs as for example education, transport, recreation, security etc. are some what less essential while tertiary needs could be classified as luxuries. Man certainly possesses the right to satisfy his primary and if possible his secondary needs, both quantity-wise and qualitywise. In the analysis of the consumption structure the quantity and quality of the primary, secondary and tertiary needs consumed by each social group or class should be calculated and related to the income, exchange and wealth patterns.

The political system:

Politics constitutes an inescapable dimention of human existance. It plays an ever greater role in day to day life. With the existence of Atomic Weapons, the very survival of mankind is now in the process of being determind by politics and politicians. Political analysis helps one to understand the world he lives in. There are two basic approaches to politics: The capitalist and the socialist. The capitalist approach takes for granted and judges inevitable the internal division of society into two groups or classes the rulers and the ruled. On the contrary, the socialist approach introduces the ideology of equality. In the capitalist approach there are different schools of thought on politics. One sees politics as the 'art and science of government' while the other considers it as the 'science of power'. The first theory focusses on the state as nationa and government, to protect the interests of the nation in relation to other states and to govern its territory, maintain law a-nd order etc. For this, the state has certain machinery: The Army, the police, the judiciary and the administrative apparatus. According to this, politics is the study of state and its institutions. The second theory looks at politics at the exercise of power at different levels, especially in the society at large. According to this, political system is understood as a ny persistent pattern of human relationship that involves, to a significant extent, power rule, or authority. History thus becomes a struggle for power; and the state and its institutions have to be analysed in the light of this phenomenon of power.

(Capitalist scholars have place the basis or source of power in different realities: e.g. physical strength, personal charismatic leadership, natural superiority, technical competence,

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the military, industrial and political complex, professional political expertise etc.)

Here the state will only safeguard the interests of the dominent class. And, political power is the capacity of a social class to realize its specific objective or interests even utilising the state apparatus. And the state does everything to safeguard the capitalist mode of production and ensures the law a-nd order in a manner which would not jeopardise this foundation.

In both capitalist or socialist understanding of political power the state is not and cannot be neutral. This also holds good for the whole state apparatus - the police, the army, the judiciary, the administrative machinery, etc., as well as for the ideology prompted through mass media and the education system. In spite of a certain autonomy, all these subsystems fundamentally serve the state and its objectives.

Only when power is distributed among the individuals and groups of a society, maximum freedom can be ensured. Men are free to the extent to which power is distributed and organised so as to prevent or at least minimize its abuse. And only through the diffusion and distribution of both economic and political power can be present exploitative political system can be changed.

<u>The social system</u>

In every society, there is a social system or set of interactions between social actors or groups. This concept implies a certain distribution of social prestige and status, or in other words a certain social stratification, understood as the diiferentia l ranking of human individuals, their treatment as superior and inferior etc. Various factors do, or can contribute to form this social stratification in different types of societies: Physical or military power, a ge, sex, birth, religion, certain moral or spiritual qualities, profession, education, wealth, political power etc. In fact these factors are usually combined.

Apparently in India, the social inequalities are rather passively accepted. But this is an important aspect of the organisational system of the society, and should be seen a-s a structure of exploitation.

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An analytical study of the economic, political and social systems of our country using the above guidelines will reveal the shocking fact that it is about 20% of the Indians who control the resources of the country; the production is geared to cater to the needs of this minority, education health care etc. are meant for them. It is they who influence the decisions; and these decisions do take care of their interests. It is this minority which has power, which has voice. There is a caste-class combination which controls and dominates each aspect of Indian society. In other words, such a study will disclose the fact that there is unequal and unjust distribution of wealth and income - with its consequences. Lack of accessaries for the majority, and abundance of laxuries for the minority. It will also be seen that the majority of villages and people exist to cater to the needs of a handful of cities and minority of people. There is a division in the Indian society into a minority of owness of the means of production (dominatiny, exploiting and powerful) and a majority of non-owners. (The poor, dominated, the illiterate and the powerless). Such a division, such an unjust organisation of the society is the basic or the rootcause of hunger, disease, unemployment, malnutrition, illiteracy etc. The functioning of the dominent groups, in this systems, seems to be normal, legal and within the constitutional rights - for the socio economic and politico legal systems are the creation of this minority.

Meaning systems

The questions that should be asked now are: 'why don't people change the unjust organisation of the society?' Why did they accept such inequalities? Why did they not strucutre their social life differently? Because, they have been the prisoners and victims of a wrong understanding of society that privileged the dominent groups and classes. In the past, men have been as much exploited by the meaning systems - Religion culture and ideology - as by the organisational systems.

All human beings, whether religious-minded or secularised need a comprehensive meaning and explanation for their existence 'why do I live? Where do I come from? What is my ultimate destiny? Why suffering and death? Why these social contradictions? Why am I poor or rich? Powerful or powerless? Why

do I belong to such a caste or group? Why such social customs? In different ways, religion, culture and ideology provide this meaning to man.. (In this context, we focus attention only on the social functions of religion and culture and on ideology). The whole meaning system is sometimes called ideological systems also.

The inter dependence of the organisational and meaning system is very much striking although they enjoy a relative autonomy. Experience shows that men's understanding of the world is profoundly shaped by their socio-economic position in society. The state use the media and educational system to change men's vision of the world and value system.

The meaning system influences the organisational system in two ways: through values (value system) and ideologies. The impact of values on society is rather indirect and progressive. Religious or secular ideologies on the other hand, influence society much more directly and immediately. Their impact can either maintain the status quo or promote change.

Every meaning system, whether religious or secular, ultimately tends to adjust itself to the existing politico-economic organisation of society and to legitimize it. Consequently in a capitalist system, it becomes an instrument of explotation in the hands of the dominent class. It tends to maintain the privileges of the class by justifying the order or by diverting or transforming feelings which might otherwise subvert it.

Religion and culture

All religions unavoidably exercise a social function. It is distinguished from other meaning systems by its emphasis on the ultimate. It offers a systematic message capable of giving a unified meaning to life, by proposing a coherent vision of the world and of human existance, and by giving them the means to bring about the systematic integration of their daily behavious. This message is always situated in a precise historical context, and provides believers, reasons justifying their existence as it is in a given social position. The social position of the privileged is justified as being part of an order fixed and

ordained by a divine will, while the promist of better conditions in an afterlife is offered to the under privileged as a compensation for their present position. Thus if supernaturalizes the relations between the dominant and dominated, since each group finds in its religious beliefs and action the justification of its own condition.

In history, religion has played two functions. (1) Prophetic or revolutionary function (Protest against politico-economic injustices and plea for a new society) (2) submissive function (Legitimization in supporting the statusquo; Rationalization in explaining the statusquo; compensation in offering other worldly rewards for the oppressed; social control, in influencing social behaviour promising afterlife rewards and punishments). Religion often plays a rather nagative role in the structural transformation of societies (eg. the caste system; divine right of kings, slavery, colonialism, and capitalism)

Far from being apolitical and neutral, religions are often conservative forces in the society. They often preach various human values without translating them into the socio-economic and political organisations of society. The meaning system which the religions provide often moulds the culture of a particular society influencing their way of thinking, feeling, and acting. Religion and culture often promote inequalities and oppose social changes, and thus become ideological instruments of exploitation.

Ideology

The term ideology, was first used in 1797 by Claude de Tracy as 'the science of ideas'. Most contemporary sociologists, understand ideology as 'an explicit and genarally organised system of ideas and judgements which serves to describe, explain interpret, or justify the situation of a group or collectivity and which largely inspired by values proposes a precise orientation to the historical action of this group or collectivity'. Houtart speaks of ideology 'as a system of explanations bearing on the existence of the social group, its history and its projection into the future, and rationlising a particular type of power relationship'. The legitimation that an ideology provides

to a social group 'is never absolutely logical, but contains emotional elements which are capable of motivating men and giving them a feeling of security'. Ideology is thus a fundamental element in the culture of every human, ethnic, social or even religious group. In this modern sense, ideology always includes in a more or less explicit manner an understanding (analysis) of society, a vision of the future, and a choice of strategies and tactics. Understood in this way, the concept of ideology can be used for both a small group (trade union, political party etc) and a whole society or nation. They foster the interests of a particular group in society, and promote a specific socio-economic and political organisation. They can be classified as Reactionary (turned towards the past), conservative (supporting the statusquo), Liberal (proposing minor and gradual changes), and revolutionary (aiming at radical changes in society). In socio political analysis of a given society, it is important that one should critically examine all ideologies and evaluate the exact role they play in each society and social group.

As study of the role of the meaning system in the present day India will reveal that it makes most, if not all, of the poor blind, though have eyes; deaf, though they have ears; and dumb, though they have tongues. We realize that lack of power economic, political and social . re inforced by the meaning system, makes them live in a 'culture of silence'.

The meaning system is used for socialization. Socialization is process, through which a person all through his life, especially in his early years, learns and internalises the socio-cultural elements of his society under the influence of experiences and of social agents and, consequently integrates them in his basic personality and adapts himself to his social environment. One needs to become critical towards the socialization process to become free and capable of objectively looking at the impact of the meaning system on ones thought and action.

The poverty and misery we see in India today is the result of an unjust social organisation supported by an unjust meaning system; and development would mean the creation of a more just society.

The following facts and figures will enable us further to understand the reality we are living in today:

AT THE NATIONAL LEVEL

Health

20% of urban population have 80% doctors, and 90% hospital beds, 80% engineers, administrators and executives, where as 80% of rural population have only 20% doctors, 10% hospital beds and 20% engineers, administrators and executives. Life expectancy at urban areas is 65 years where as in rural area is only 50 years.

India's percapita consumption of drugs is one of the lowest, Rs. 7.50 per annum, compared to

Rs. 310 in USA
Rs. 233 in WEST GERMANY
Rs. 252 in JAPAN
Rs. 78 in UK

- 8 out of every 10 Indians have little or no access to modern medicine.
- India has the highest mortality rate 139/1000, among the Asian countries.
- There are about 60 million children malnurished.
- In India diahrroea kills 3 children every minute or 1.5 million each year. Every second an Indian child is exposed to it.
- while vitamin A defficiency blinds 30,000 children annually and vit D. defficiency affect 15% of Indian children, the combined sale of vit A &D account for only 3% of total vitamin sales.
- There are an estimated 3.2. million leprosy patients in India.
- Tuberculosis is the number one killer disease and it accounts for about 3% of the 1 crore annual death in India.
- 20% of the maternal death is due to anaemia. The mortality rate among the infants weighing less than 2.5 k.g. is as high as 75% because of anaemia.

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- Severe degree of anaemia have been detected in 12% of pre school children.
- 90 million are supposed to be in the polio danger zone and 13 million are added to this figure every year. 80% victims are below 3 years and 15% below 5 years.
- There are 2.5 lakhs totally blind children. about 1.8 are partially blind and 2.5 are deaf.
- 9 million blind persons in the country, Out of this 5 million could be cured by proper surgical interference.
- 40 lakhs suffer from impaired hearing.
- 5 lakhs are orthopaedically handicapped. 20 lakhs are mentally retarded (Indian express.Sept 9, 1983)
- In 1979 the doctor population Ratio was 1:4400 in India. But the actual ratio in the rural area was 1:20,700 and in urban 1:1,300. Hospital bed population ratio is 0.49 for 1000 population.
- A student of medicine spends a total of Rs. 1 lakh for his studies. In the meantime the government spends 1.5 lakhs on the same student. When a doctor leaves the country for better wages he deprives India of 1.5 lakhs of rupees.
- The number of doctors in 1947 was 47,500 and in 1980 is 2,53,631.
- 90% of the Indian women do not have maternity facilities.
- Out of the annual health budget, 1/5 of the total goes to the rural sector, while 4/5 goes for maintaining sophisticated facilities. Out of the total budget outlay, 75% goes for salaries and maintenance, 12% towards transport, 12% towards drugs and 1% for innovative experiments.
- According to a study done by world council of churches (WCC) on 6000 outpatients in different parts of India on one particular day in 1973, it was revealed that, out of this 6000 patients, only 5% needed a doctor,

  15% needed auxiliary health personnel's help

  15% needed home care

  65% needed no medical care. Only self curing diseases.

- According to the latest UNICEF study (Dec. 1983) in all the developing countries taken together, one lakh children die every three days.

- In 1980, out of 5,76,000 villages in India only 97,000 villages were provided with safe drinking water.

Poverty

According to 1981 price scale a person who doesn't have Rs. 3 for a day is considered to be under poverty line. The value of one rupee was 100 paise in 1954, but 0.24 paise in 1981. In 1983, according to the Reserve Bank of India the value of one rupee is 0.18 paise. According to the 1981 census, in 1979-80, 48.44% of the Indian population was under poverty line. In 1983 it is calculated that 52% will be under poverty line. However, 75% of the rural population is under poverty line, according to a study done by Reserve Bank.

- The poverty line expenditure per persons per month:

In	1961-62 was	Rs.	18 to 20
"	73-74		35 to 40
"	1978	Rs.	62
"	1980	Rs.	75 to purchase the following items.

4 ounes of grain
3 " pulses
4 " milk
1.5 " sugar
1.2 " oil, exclusive of expenditure on health care education and housing. This means that, government itself accepts the facts that in 1981 there were 331 million people in our country who didn't have Rs. 75/- a month!(govt.census)

- The average wage of the agricultural laboures is less than Rs. 4/- in India.

- A world bank survey says India, Pakistan, Bangladesh, Sri Lanka, Malasya and Thailand has stepped to the position of a fourth world.

Land distribution Pattern

Besides income inequality, another structural feature common to underdeveloped countries is a general lack of progress in redistributing the land.

- According to the report of the government 1977-78,
  the potential surplus acres of land is 22 million.
  Out of this declared surplus is 41 lakh
  " taken possession of 26.5 lakh.

and distributed 18.3 lakh acres to 13.22 lakh beneficiaries.

- The marginal farmers constitute 73% of all farmers and cultivate only 23% of land.
- Large farmer operating over 10 hecters of land are 3% and cultivate 26% of the land.
- The top 5% of our rural families own 40% of land where as the bottom 50% own only 4% of the land. In the overall picture of our country, the top 10% own 65% of the land. They are politically the most powerful group.
- 85% of the politicians come from agricultural background, but 2/3 of them own above 10 acres and 38% of the politicians more than 25 acres.
- More than 50% of the assets in 1971 belonged to the top 10% of the rural populace, ownership of assets enabled them grabbing of the lions share of agricultural inputs. The top 23.3% who account for 70% of the land could take 68% of the expenditure on agriculture; 82% of improved machinary, 64% of investment in wells, 78% share of other forms of irrigation and 67% of fixed capital of farms etc. in 1971 (sixth plan).

Education

The literacy rate - 32.1% (1981) 20% of children in India do not go to school 50% who join the school leave it in the first standard. 60-75% abandan it before Std. V & VIII. 15% reach class XII.

Less than 1% finishes college degree. Over 70% of girls (11-14yrs) are not attending schools. 78% of women in the country are illiterate. The absolute number of illiterate women rose from 161 million in 1951 to 251 million in 1981 (Census 1981)

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More than 50% of the students in professional colleges come from the top 10% 60% of the UGC funds go to 7 elite universities, and only 40% for other 99 universities.

There are also socially disadvantaged groups such as the economically poor, scheduled castes and scheduled tribes, whose children are on the periphery of the schooling system. About 30% of SC children (Boys 20% and girls 56%) and 56% of ST children (Boys 49% and girls 70%) are yet to receive elementary education.

Despite a net work of over 6.5 lakhs schools and colleges, the employment of over 3 million teachers and an annual budget of the order of Rs. 3000 crores it has not been possible so far for the education system to achieve the goal of universal education of all children upto the age of 14 as enshrined in the Directive principles of the constitution.

The real benefits of our school system go to the top 30% of our population. They occupy 70% of the places at the secondary stage and 80% at the university level.

Employment

Unemployment and under employment is a major problem of the people of Asia. 40% is un or underemployed. In India full time unemployment is almost unknown. Our poor are the working poor, but their works doesn't lead to gainful employment. Unemployment at the end of the,

I five year plan was	53 lakhs
II "	71 "
III "	96 "
IV "	176 "

From 1960-69 the daily wages for casual male labourer in Pubjab, Haryana, Delhi, Himachal Pradesh went up by 89%, but the consumer retail price went up by 93%.

Income

The top 10% get 33% of the total national income. The bottom 50% get 7.8% and the lowest 20% get 0.8%.

High profit yieling industries and commercial undertakings are owned and controlled by the private sector.

Company	1972 Assets	1972 Profits	(in crores) 1976 Assets	1976 Profits
Tata	641.9	48.9	980.7	56.1
Birla	589.4	45.8	974.6	118.8
Mafatlal	183.7	14.6	256.5	25.9
Kirloskar	86.46	4.03	152.4	13.09

- 80% of all our IAS, IFS, and IPS come from the richest 10% of the people of India.

Housing

- It is said that 70% of the rural people live in huts, with grass, leaves or reeds roofing.
- According to the annual report of the works and housing ministry (1881-82) the number of families requiring housing was 12.5 million families. The entire outlay for construction assistance in the VI plan is Rs. 186 million aimed at benefitting 3.6 million families.
- In all the metrapolitan cities, especially Calcutta, thousands of people lives on pavements.
- In Bombay the cost of a luxury flat is Rs. 40 to 90 lakhs. Even bunglows costing not less than 3 crores, with swimming pool, bar, banquet room, conference hall etc. are not rare here.

Tax system

	1947	1951	1983
direct tax	52.7%	36.4%	25%
indirect tax	47.3%	63.6%	75%

Only 0.8% of the people in India pay direct taxes. Big and middle income groups largely evade paying taxes.

- According to Dastur, when you drink a cup of tea costing 20 paose, you pay an indirect tax of 14.5 paise.

At the International Level

Widespread malnutrition is a common feature in all the Asian countries. 15/100 born every minute in developing countries will not live to see their first birthday. Medical care will be available to only 10 of the 85 who survive. 25% of the survivors

will suffer from malnutrition during the weaning period.

- In Asia, 20% of the population are seriously under nourished.
  30% without safe water or health care
  40% unemployed or underemployed.

- The developing world has 75% of the world's population, but only 10 % of the world's wealth.
  - 11% of world education spending.
  - 30% of the food grains.
  - 17% of the world's GNP.
  - 13% of the world's energy consumption.
  - 18% of the world's export earnings.
  - 8% of the world's industry.
  - 6% of the world's health spending.

- Have infant mortality 50 times higher.
- Every second victim claimed by death is a child below 6 yrs.
- Consume only 12.5% of world's produced wealth.
- Get only 20% economic growth of the world and 2% of world's research.

- Rich nations dominate International trade, international policies, International organisations, international judiciary institutions,

- Nutritional studies have shown that in 1939, 39% of the world had less than 2000 calories per day. In 1972, 60% had less than this. Practically all these were in the developing countries.

ARMS RACE

Economists have calculated that in the united states the rate of profit is between 8 and 12% in civil industry; where as in Military industry it is between 30 and 40%. But a U.S.senate committee which looked at the turnover of 131 monopolies in the military industrial complex, found that 57 of them had a rate of 50%, 48 more than 100%, 3 approximately 500, and one company to a rate of 2000% of profit over the capital invested.

"Every gun that is made, every warship launched, every rocket fired. signifies in a final sense, a theft from those who hunger and are not fed, from those who are cold and are not clothed". (Dwight D.Eisenhower)

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"The build-up of arms in large parts of the third world itself causes growing instability and undermines development.....more arms do not make mankind safe, only poorer (The Brandt Commission 1980).

"There must be a way coming down the hill, of de scalating,.... The only solution is not to give us more arms for our security, but give us more security so we can have less arms.
(Moshe Dayan 1976)

The largest major weapon exporting countries 1977-1980.

USA	24,893	Germany	1,712
USSR	15,755	Norway	724
France	6,213	Netherlands	536
UK	2,141	Brazil	421
Italy	2,273	Israel	367

The 10 largest major weapon importing countries 1977-80

Iran	3446	Libya	2107
S.Arabia	3133	S.Korea	1987
Jordan	2558	Greece	1900
Syria	2311	Italy	2167
Iraq	2172		

On an average it costs about the same

To arm and train one soldier	to build 1 modern bomber
as it does to educate 80 children	to wipe out small-pox over 10 yrs period.
	to build 4,50,000 modest homes.

- The world health organisation spent around $83 million over 10 years to eradicate small pox in the world. That amount is less than two hours of global military expenditure.

- To eradicate Malaria - the killer disease that claims the lives of one million children every year. Some $ 500 million are needed. That amount is less than half of what is spent every-day for military purposes.

- The United Nations declared the 1980 is the International Drinking Water supply and sanitation decade. The aim is to achieve adequacy in clean water supply and sanitation for people in the developing countries by the year 1990. This requires some 80 million a day for 10years, equivalent to 80 days of military expenditure over a 10 year period.

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- Asian countries in general spend more for their military forces than for health and education combined.

An international team of specialist commissioned by the United Nations has con   that the low-income countries of Asia could improve their per capita consumption by as much as 47.6% with an even a partial reduction in military expenditures through out Asia.

All these studies show that the gap between the rich nations and the poor nations is widening as time goes on. That is why Don Helder Camera said: Today 85%, tomorrow 90% rot in misery to make it possible for the conomic comfort of 15% today and tomorrow 10% of the world's population.

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COMMUNITY HEALTH DEPARTMENT
C H A I

A

1. Extent of inequality in the world today:

a. In 1850, 3/4 of the world's population possessed 5/8 of the world's wealth.

In 1975, 2/3 of the world's population possessed 1/8 of the world's wealth

b. Whence came this uneven distribution of the world's resources?

"The tilting of the balance in favour of the West has come about in the last 130 years........through the gun, through colonial plunder, slave trade, slave labour, child labour, racial discrimination, the creation of a dispossessed proletariate, and the destruction of the soul and life-style of many peoples."

(S.Rayan)

c. The growing gap between the rich nations and the poor had already been pointed out by Barbara Ward in the 1950's but the gap continues to widen:

"Today 85% and tomorrow 90% rot in misery to make possible the economic comfort of 15% today and 10% tomorrow"

(Heder Camara)

d. The result of this inequality is the ABSOLUTE POVERTY of millions in the "fourth" world:

- 1/3 to 1/2 of the two billion human beings in Asia, Africa and Latin America suffer from hunger and malnutrition.

- 1/5 to 1/4 of their children die before their fifth birthday, and millions of those who do survive lead impeded lives, due to brain damage, stunted physical growth and sapped vitality due to undernourishment.

- The life expectancy of the average person is twenty years less than his counterpart in the affluent world; that is, he is denied 30% of the life-span of one born in the developed nations: he is condemned at birth to an early death.

- 800 million of these people are illiterate and, despite continued expansion of educational opportunities, even more of their children are likely to be so.

e. Julius Nyerere, President of Tanzania, has warned the rich nations: "Poverty is not the real problem of the modern world, for we have the knowledge and the resources which will enable us to overcome poverty. The real problem of the modern world, the thing which creates misery, wars and hatred among men, is the division of mankind into rich and poor".

f. It is not so much the question of some having more to eat or better clothes to wear, while others cannot provide even the basic requirements; it is rather the power that this wealth gives to some to dominate, to oppress and to exploit the others. In so doing, the rich and powerful justify themselves: "We deserve this wealth and power: we have put our God-given talents to use and have worked hard. If the rest of the world is lazy, shiftless and ignorant, we can't help that."

2. Extent of inequality in India today:

a. While we often and with some justification, blame all our problems on the greediness of the affluent, developed nations, the same ever-widening gap between the "haves" and the "have-nots" appears here even

b. Within our population of upwards 600 millions of people, roughly 250 million live below the "poverty line", that dividing line that demarcates bare minimum of survival for an individual. This is the bottom 40 per cent. Another 250 million live just above the"poverty line" of human survival. the remaining 15-20 per cent, in an ascending pyramid represent the wealthy, dominant classes with power, position and quality education: the raw material for further exploitation of the others.

c. In rural India, the top ten per cent own 50% of the land, while the bottom 50 per cent own 4%; top ten per cent get 1/3 of annual income of the nation, while the bottom 50% get less than this amount for all of their numbers. 0.1% of the population owns more than half the wealth of the area.

d. The poor are organised, without political power, and are taken advantage of. A slum dweller admits: "Even to get a sweeper's job, we have to pay a bribe of Rs.200/-"

e. The very poor (bottom 40 percent) have less than Rs.40/- per month to spend. Most cannot read or write.

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FEW GUIDELINES TOWARDS SOCIAL ANALYSIS AT MICRO LEVEL

Fr Yvon Ambroise

If one is engaged to develop society, one should first of all be able to identify the forces operative in the society, to see how they are operating, the linkages they have and the potential forces they would gain in several areas of life. This process can be realised by an analysis of the society in a critical way to unveil the hidden mechanism in it. Very often society looks on the outside something else than what it is really in its core. A simplistic outlook can easily say that society is O.K. while there are several negative forces operating within it to upset the s ciety. All these can be unearthed only by a process of social analysis.

If a social worker does not have recourse to a critical social analysis due to his ignorance, he is likely to undermine the positive forces and join hands with the negative ones without his knowledge and even against his own intention. Hence the social analysis is a must.

Social analysis can be equated with a diagnosis done by a doctor. In order to find out the cause of any disease the doctor asks questions on the several parts of the body and links the data obtained into a logical explanation. The cleverer the doctor is, the more connections he knows between several parts and hence asks pertinent questions about those parts, similarly, a social Analyst tries to find out the data on the different parts of society and links them with a logical explanation to find out the underlying problems in a society. The different parts of society can be said to be :

Economic system, social system, political system, ideological system, religious and cultural system, educational system, health system, etc. To make a social analysis all these systems must be looked into and analysed. We take each system and see a certain frame work to analyse the system.

Economic system can be defined as one which contains all activities pertaining to the immediate survival of man. In order to analyse these activities, first of all the main source of economic activities must be identified.

The main sources could be agriculture, fishing, animal husbandry, industry and hunting. One must identify whether there is one or more than one source of income for the particular group we are dealing with. After identifying these sources one must go to a detailed analysis of each one of them. For example, we shall take agriculture and analyse it.

Agriculture has land as the basis. Hence one should find out: the structure of ownership, the structure of the interaction of different groups arising out of the ownership and the structure of the distribution of the produce. These three would reveal the economic dynamics present within the system.

Taking the structure of ownership we may find that there are three major groups :

- The group that owns maximum land;
- The group that owns enough land; and
- the group that owns nothing at all.

While trying to describe these groups vague or relative and comparative terms such as many persons, some persons, a few, more should be avoided. One should give the approximate numbers in every category, e.g. 5 families owning 50 to 100 acres, 10 families owning 10 - 50 acres, 30 families owning 1 - 10 acres, 50 families owning no land. This gives one a picture as to who is the biggest group in the village.

As for the structure of interaction between these groups, we must try to see the mechanism used by one group over the other. Let us take a person owning fifty acres. With the physical labour of his own family and without hiring workers he may cultivate himself only around three acres of paddy cultivation. The rest of the 47 acres are there. In order to cultivate these 47 acres he needs the collaboration and work of the landless labourer. Hence he is actually dependent on the landless workers who are free to go to another man or to migrate outside or to undertake any other work such as road-making.

In order to ensure his cultivation the rich man devises mechanism to see that the landless labourer would depend on him. Hence he tries to absorb all the surplus from the landless by several mechanisms to make him dependent on him. Low wages,

giving loans with exhorbitant interest (120% to 300%) a year bonded labour, having liquor shops in the workers' area, celebrating festivals and encouraging people to spend, are some of the mechanisms of the rich class to absorb the surplus from the landless and make him dependent on landlord and be obliged to come for work. This is what we call exploitation. In this way the cultivation of the 50 acres are assured for the rich class. By these mechanisms the landlord makes the landless depend on him thereby reversing the original position.

As for the structure of distribution of the produce we go into the analysis of the wage system, how it is given, in what form and at what seasons. A comparison could be made to different places and to the rate fixed by the government. If tenancy system is followed the terms of division of the produce along with the terms of help rendered during the cultivation have to be analysed.

After having analysed it one must go into the system of marketing and transport. The role of intermediaries, the money lending system with reference to marketing, the time of sale of produce, etc. have to be analysed here. Thus all these when analysed gives one an idea of how the economic system is functioning.

Taking the social system one has to analyse how the society is stratified as high and low. Here two logics are operative; the class logic and the caste logic. The notion of class, presupposes the equality of man as the base and that inequality came out in the social process. The notion of class is based on achievement which today would include moeny and education. Hence social mibility in terms of the upward one as well as the downward one is possible. Competition and grouping of the members of the same class into a solidarity group are charac-terictics of the class system.

Caste is based on birth and has the philosophy that man is born unequal and dies so. Everything is determined by one's birth. Upward or downward mobility is possible only after one's death i.e. in the succeding lives.

These two systems operate together intermingled. Hence one has to find out which element : the caste or the class one, that

is dominating in a particular society and go into the analysis of its causes.

The political system represents the collective decision making process. One has to examine the way a representative is selected from the grassroot level to make collective decisions and laws. Thus this system can be legislative wherein the laws are made, Judiciary which clarifies whether the law applies to a particular case or not and the executive. The executive ordinarily functions through the government officers in charge of executing these laws and decisions. In extra-ordinary circumstances when they cannot do their functions Police is provided to do so. This political system of representation could be handled by some groups with a specific ideology promising people that they would exercise that power to their benefit. This is the political party. When the representation is done by political party or parties it becomes party politics. All these elements have to be analysed.

The cultural system would be analysed when one analyses the system of values. Thus when we make a critical analysis of all such systems and link the data obtained into a logical explanation, there is a social analysis of a particular social reality. It pin-points the forces and mechanisms operative, the way they are operating, the groups who enter into operation in an advantageous or disadvantageous way, the ideology used, etc. One is able to get a picture of the society along with its main problems.

Social analysis cannot be learnt only by theoretical means but by a practical field work. Social analysis is an ongoing exercise and that one should not feel complacent at the very first attempt. The first analysis only opens new questions and data to be searched for. Thus the finding in-depth of new data can even change the analysis one made before. One should always keep searching. This develops critical consciousness.

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DEVELOPMENT

CHIT/P-4-

Development can and for too long has been understood as economic development alone, where the main emphasis is on increased production and income. According to this definition the main objectives of development is to increase the GNP without bothering to see who is benefitting from this increase.

In most of our countries, this is the kind of development, which has been going on. The emphasis has been on increasing production. As a result of this emphasis production has increased in many of our countries through green revolution, or industrialisation. The benefits of this development have, however, not occured to everyone equitably. In many developing countries the rich have become more rich and the poor have either remained where they were or at times have even become poorer. This trend is quite visible at the village level. The above concept of development is very narrow and thus unacceptable.

Development has many aspects - economic, social, cultural and political. There should be equal emphasis on all these aspects. Along with economic development, there should be better distribution of resources and means of production. The decision making power should not be in the hands of a few people only. Participation of the majority in all aspects of development is necessary in this concept of development.

The word 'development' can be divided into "Develop' 'Men' 'T'; Develop men or women to think together to understand the reality and to grow fully. Growth of individual alone is detrimental to society.

Development is a continuous process of change leading the awareness of one's present state of life and bringing him to a higher level of life. It is a growing activity between persons who feel the necessity for development, and persons who want to work for their own development. It is also said that development is a continuous process towards complete humanization by loving one another without selfish motiveness.

What is development:

1. "Development is a process by which both persons and societies come to realize the full potential of human life in a context of social justice, with an emphasis on self-reliance, economic growth being seen as one of the means for carrying forward this process".

From this it is implicit that development

(a) is of people and can be achived only by them. Others can only be enablers.

(b) is of people in community with the direction and control in the hands of local leadership

(c) is a process in the context of relationships and a total

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life style consciously evolving towards growth.

(d) is sustained through funtional indigenous institutions developed from and responsive to the local situation of the people.

(e) is an integrated process requiring harmony between people's and between people and nature; between the present and the future; between the social, economic and political factions.

(f) is interdependent; the fulfilment of all people depends on the development of all.

2. Development is: - growth with redistribution
- awareness of people of their problems, power and the potential they have in working together.
- to 'de-envelop' people from the bonds of oppressions and powers that suppress them.
- being our brother's brother and not only his keeper
- respect for the individual's dignity, self image and self esteem.

In development we are looking for:

(a) participation by all people
(b) equitable distribution
(c) effective and efficient utilization of human as well as natural resources.
(d) The growth, in dignity, of the individual in the context of his family, environemnt and community.

Development is therefore a continuous and dynamic process that brings about structural and institutional changes.

It must through these changes provide an equal opportunity for all to participate in decsion making in the economic, social, cultural and political spheres.

A question of power

This conept of development with emphasis on distribution and social justice requires some funds, mental changes in the social, economic and political power structure in our societies. It requires changes in social relationships. It requires reducing the power of some and increasing the power of others.

The elite in our societies is not interested in this kind of development, because it would mean reduction in their property and power. The elite is ofcourse not willing to give up its power and position to others.

The kind of development we have in mind cannot avoid conflicts. However, structural change might not necessarily mean shedding of blood. In fact fundemental change should be tried in a peaceful way. But it might not always be possible. Violence is almost always star.. d by those who do not want fundamental change. They violently resist reduction in their power, privilage and property. The poor have to resort to violence often in self-defence. Development would mean struggle and we cannot avoid it.

- COMMUNITY HEALTH DEPARTMENT

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PEOPLE's PARTICIPATION IN HEALTH

Some decades ago, development of undeveloped communities meant doling out food, clothes, medicines and money to the poor who were just passive recipients. Gradually a realisation came that this was a bottomless pit which would never fill. So came the concept that 'people' should work for their own improvement. However it was soon realised that people could not be made to work unless they were involved in the process of development. Thus came the idea of people's participation.

There are three questions I want to ask:

1. What do we mean by people's participation?
2. Who are the 'People'?
3. Is people's participation possible in community health?

Different people have different meanings for people's participation. Some project workers say that there is overwhelming people's participation in their peojects; thereby meaning that the people are taking benefits of the programme. Does merely taking benefits of the programme or participating as beneficiaries mean people's participation?

Some call it people's participation when the people are receiving benefits not as charity but are paying or rather are forced to pay for the benefits. Does such payment for services mean people are participating? Then people are very actively participating in the whole of the commercial system today where everybody pays for whatever he or she gets. Then can compulsory payment for the benefits, which is glorified as 'economic contribution of the people to the programme' be a hallmark of people's participation?

A very successful community health project claims that 'the villagers collectively constructed a road from our hospital to the village so that our health team would reach the village', and foreigners are much impressed by this 'people's participation'. One however finds that the road was constructed by the labourers of the village in 'food for the work' programme and the villagers were mainly paid labourers.

The same community health project says, "our village health workers have been selected by the people of the village and our project has a people's committee as advisory board. 'Though this is meant to be participation by the people in decision makingon closer enquiry, one finds that almost every V.H.W.was selected by the head of the village and two or three influential persons and the project staff. The people's committee consists of established leaders and the rich people of that area. Does the decision making power given to the few rich and established leaders of the village and mutely followed by the rest of the villagers mean people's participation? By this definition the whole political system today has very wide people's participation.

Obviously all these are not examples of people's participation.

The last point takes us to the next question, 'who are the people'? This is quite a tricky and political question. A big power invades a small nation and puts its 'yes man' in power and says people of this nation have invited us to liberate them. Do mere heads of government mean people? A rich man who also heads the Gram Panchayat takes a decision as to who should be the VHW from that village. Is he the people?

The male head of the family says 'the tradition of our family requires women to remain in purdah and all people approve of this tradition'. Is he the whole family or are the males alone, the people?

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No ! In all these instances decision makingdoes not represent the desire of all the people, definitely not of those who have no voice and freedom to speak but who very badly need an opportunity to take part in the decision making to ensure that it is in their interest and not to oppress them.

Thus I have tried to show what is not people's participation and who are not 'the people': If this is not people's participation then what is it? Who are the people?

Probably everybody born as a human being has a right to be included in the 'people', be it the oppressed or the oppressor.

But for operational purposes, we will have to say that the oppressed, the exploited and the needy should have priority in the comprehensive definition of the people.

When these people understand the situation and issues by critical consciousness and take part in decision making, implementation and evaluation of programmes and take the responsibility of the work as well as share in the benefits....it becomes people's participation.

There cannot be genuine people's participation without a proper political atmosphere and educational process. Even then true people's participation may be a distant goal.

Prerequisites of people's participation

Today's political and socio-economic system is directly opposed to real people's participation. How can there be a true people's participation when women have no equality, the poor have no strength to assert and the oppressed have no opportunity to participate in the decision making of the political system? When we, the enlightened elite citizens of the society have no scope to participate in the affairs of the nation except to vote for the best of the available bad choices once in 5 years or to write a letter to the Editor once in a while, how can those who are weak, poor, oppressed and ignorant, really participate?

It is obvious that the real people's participation is a distant dream to be achieved by a process of economic, political and cultural liberation.

When one views the objectives and the claims of people's participation in community health projects one cannot help but laugh. The present system of anti-participatory. Moreover there are more vital fields in which people would prefer to participate first. Health is a low priority issue.

The expectation that people will participate in a real sense in a mere community health programme is unrealistic. This conclusion is also supported by the experience of numerous workers in community health who have learnt it the hard way that people cannot be mobilised and organised through and for health work. It does not mean that there should be no efforts towards people's participation in health programmes, All efforts to involve the people the people, especially the needy and the oppressed in making decisions and their implementation should be made. This will marginally help a participatory culture to be created. But it must be realised that people's participation is essentially an objective of political and educational process, and health work has only weak political implications. If community health work is a part of political activity, it will get it's backing and advantage. But without a proper political context, not much of genuine people's participation can be achieved in community health work alone. Hence people's participation per se cannot be a primary objective of a community health programme.

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If people's participation is real and genuine, one should not talk of people's participation in the project's health programme but of the project's participation in the people's health programme. But realistically this cannot happen through the health process alone.

Some workers use another misguiding term, 'community participation' in community health programmes. There are two obvious fallacies. One, there is no organised entity as 'community' in the villages today. There are individuals, families, castes, classes, political groups and one cannot create communities out of such individuals and groups for the purpose of and through mere community health work (though community health work might marginally help this process). Secondly, though claims are made of having achieved community participation, in reality only the existing social organisations (Panchayats, etc.) and established leadership are involved in decision-making. We have already seen that such leaders alone are not the people and hence they cannot replace the community.

Economic self-reliance: Why ?

Another popular fashion-word is 'economic self reliance', commonly used as a criterion of evaluation and boasting feature by many agencies and projects in community health. How did this come to be given such an importance that it has almost become an important objective of community health programmes? The workers keep on desperately running after this objective, forgetting that economic self-reliance is not the purpose of their work and they cannot afford to sacrifice their original purpose i.e. to improve the health of the vulnerable people.

With growing realisation in the developed (exploiter) world that mere doling out of food and clothes cannot permanently improve the life of the poor in the undeveloped (exploited) countries, a concept was born that people should be given such economic programmes which can generate income for themselves and hence they don't have to depend on outside help eternally.

Self-reliance Logic

Fine! Good policy! But then this has to be an objective of economic programmes to be achieved through economic activities. This has been implicitly accepted in the field of community health also. This has caused, tremendous diversion and confusion and a time has come to challenge this assumption. There are many reasons. When a community health project tries to become economically self reliant, it adopts two methods.

(a) It starts charging the rich to gain more income, (the so called 'Robinhood' method). Ultimately this results in the community health project becoming dependent on rich clientele for it's economic self-reliance. To satisfy this clientele comes the sophistication, X-rays, E.C.G., more indoors, more specialization, and more and more workers and time to cope up with all this. Also come in the unscientific, unethical practices like giving unnecessary injections, tonics, mystifying the symptomatic relief etc. to draw and retain the paying patients.

The rich class is much more shrewd than community health projects. It is almost never dependent on this community health project alone for its own health care (though occasionally individuals may need and seek such curative services, such examples don't prove that the whole class is dependent on community health projects). They almost always get their health needs fulfilled through the commercial private health system.

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Only in very remote places, persons from such class might depend on community health projects. Thus the community health project becomes dependent on the rich class for its income and survival rather than otherwise. This brings gradual changes in the priorities, strategies, methods, behaviour, and relationships of the community health project and it ends in serving primarily the needs and priorities of the rich.

An analysis of the clientele of most of the mission hospitals, who in an attempt to become economically self reliant started charging the cost of the treatment to patients, shows that ultimately they ended with two maladies. They were underutilized, and were utilized predominantly by the rich class.

Sathyamala from VHAI has described (Health For The Millions, February 1980) how she saw atmany places voluntary hospitals half empty, beds occupied by the rich, who only could pay the charges: and the next door Government hospitals and dispensaries-inefficient, low quality, corrupt but still overburdened, full of poor patients. What an irony ! Then why should dedicated missionaries run such hospitals ? Even the private commercial health care system (eg. Jaslok Hospital) can do and does the same role. Then where is the difference?

(b) To raise income, the second strategy adopted is to charge the poor more and more in an attempt to make them pay at least the cost of the treatment. We have already seen how it results in elimination of the poor from the curative health care. 60% of admissions in a hospital of a famous community health project which claims to be economically self reliant project. Remaining include rich and poor from the project area but again in what proportion ? The hospital is mainly utilized by the rich.

An argument forwarded is that the poor are given primary health care through VHWs financed by the income generated from the rich in the hospital. It means the VHWs givenelementary care in the village to the poor and rich also but doctors and hospitals are mainly for the rich. Such discriminatory strategy becomes inevitable when community health project accepts the objective of economic self reliance and tries to raise the income through health programmes.

It is true that the poor also should be charged a little for health care so that they do not become objects of charity and pity. Also, if they are charged they feel that they have paid for health care and so the care must be of some quality, earned by them. It is common experience that the poor also value such treatment and advice for which they have paid. But this logic is then taken to its extreme that the poor should pay the whole cost of treatment, which is pretty high in the present system. The poor, already exploited by the present economic system have very little resources on which community health project further puts its claim.

An argument is often put forward that the poor also have the capacity to pay for curative services. They manage to mobilise the resources when you make it compulsory for them to pay. This is the philosophy of the private doctors. Once, when I put this argument before a poor man, he said "Look Doctor Sahab!. If I am ill and dying and if you press me for charges I shall sell my house. My family shall starve and then only I will be able to pay your money. But if I do it does it mean I had the capacity to pay you ? "

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When this objective of economic self reliance is almost thrust on the community health projects in the voluntary sector by funding agencies let us ask a few questions.

Who is self-reliant today ?

Is the government self-reliant in the sense it generates all its necessary income by productive activity ? No ! It depends on squeezing the people by taxes, direct and indirect. None of the welfare programmes of the government are selfsufficient.

Are the funding agencies-self reliant ? In spite of decades of working, all of them continually depend on donations from people in the developed countries. They do not generate their own income by an economic programme run by themselves, even though their main field of work is fund raising.

Funding agencies can raise money through Western capitalism. However this capitalistic system depends, at least partly on the developing countries for its market, and remember, the market is the source of income for capitalism.

It is unrealistic to expect in such a situation that community health projects should be able to generate enough income to become economically self sufficient.

Health and education are the responsibilities of the state and society, as is law and order. Voluntary agencies enter in it because the government cannot do it adequately for the people. The government gives free health care to all, specially to the poor. Then why should the voluntary community health projects charge poor patients to whose rescue they claim to have come ?

Many community health projects tacitly accept this objective of economic self reliance under increased pressure by funding agencies and they are forced to either deviate from their primary objectives or to do various manipulations and show that they are economically self-reliant. This includes artificially swelling the health income, (some times by selling the donated drugs or by including the farm income) or by hiding certain expenditures of health programme. Some projects reduce the expenditure by underpaying their staff. All these compulsions come because of the acceptance of the criterion of economic self-reliance.

Having observed closely many community health projects in India and abroad, and following our own experience. I wish to say that no community health project which is predominantly preventive and educative in nature and which serves mainly the poor can become economically self-reliant. All such claims need to be reexamined because they create illusions.

Projects should try to generate income either through economic programmes or from committed supporters who have money to donate for the cause. Such income generation will make it less dependent on outside aid. This cannot however be the primary objective of community health work.

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FALSE LIMITATIONS

Another aspect which community health projects should not uncritically accept is trying to see that the per capita health expenses in their community health programme is equal to that of the government. Government spends a lot of money on wrong priorities and allocates meagre resources for health due to which the poor mainly suffer. Voluntary health projects need not take it as their responsibility to show ways to fulfil health objectives within the false limits set by the government. It usually means deprivation of the poor. What voluntary agencies could be doing is to decide the minimum health care every person should get and try to show the ways of doing it at the low cost level whatever that cost should be compared to the government's per capita health expenditure. This is the way by which one can press a system to mend its ways. Voluntary health projects should not try to fit into the system's false limitations. While deciding the minimum health care, the nation's economic standard (GNP or per capita average income) should be taken into consideration but not the per capita health expenses by the government. Otherwise we land up with the solutions and ways of community health care which are less than minimum to the real needy.

(This is a slightly abridged version of an article that first appeared in MFC Bulletin, April 1981. Reproduced here courtesy MFC-Ed. HFM. MFC is to publish this and other important articles in a book form. For details contact MFC or us).

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INVOLVING LOCAL LEADERS

In the workshop, we have often discussed the importance of involving local leaders in our Community Health Programme. Let us briefly review who these leaders are, why it is important to involve them in our programme and how to recognize them in the community.

WHO ARE LEADERS?

There are two kinds of leaders: formal and informal leaders.

Formal Leaders are persons who have been appointed or elected to fulfil certain administrative responsibilities for the whole village. They hold a recognised post and may or may not be paid for it.

Examples: (i) Sarpanch, Panchayat Members, Tehsildars or Revenue Collector etc. These leaders are part of the government's administrative structure.

(ii) In certain tribal areas each village may elect its own headman and committee members to help the headman. These may or may not be a part of the government structure.

Informal Leaders are people whom the community respects and trusts. People go to such leaders when they have a problem or need advice.

Examples:
- The people may go to the pujari for all religious matters
- The people may take the opinion of certain village leaders when there is a family dispute
- The people may goto the faith healer (Bhuva, Badwa) when there is some illness in the family
- The people would take the advice of the dai in matters related to pregnancy and child birth

It is thus clear from the above that informal leaders have a lot of influence in all important matters in the community. The people look upon them as knowledgeable and having a sound judgement.

WHY SHOULD WE INVOLVE ALL THESE LEADERS IN OUR PROGRAMMES?

Both formal and informal leaders have a lot of power in the community and are able to influence the decisions of the people. In some cases people simply follow a trusted leader, in others, leaders can get people to participate in an activity by creating awareness.

Leaders arealso capable of forcibly getting the participation of the people by threats and in extreme cases by actual violence.

It is important for us to work with both kinds of leaders. Formal leaders may or may not have (Eg: Vishalnagar Case) the trust of the community. But it is important that they be informed of, and if possible involved in all our activities because these leaders are usually the most powerful in that they could have a strong economic hold on the people.

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Informal leaders, on the other hand, may be more trusted by the community and can be of great help to us if their cooperation is sought. They can also influence the community against our work if their involvement is not sought.

Let us now look at some of the ways in which local leaders can help or hinder our work.

1. Gaining the trust of the people

   When we enter the community as outsiders it is natural that the people may question and be suspicious of our motives. Here, if the local leaders, especially the informal leaders, understand our reasons for wanting to work with the community they can help us to gain acceptance with the people. This way, they will also help us get more information about the people, finding out the needs of the community etc.

   - A Team of Health Workers wanted to start a Leprosy Control Programme and cover a whole block. All the team members were new in the area. At first, the people of the nearby villages looked at them with distrust. The team, realising that they needed the trust of the people to achieve the aim of their programme, made an effort to contact all the village Sarpanches of the block before starting their work. They also tried to find out who were the influential people in the most important villages, started to befriend them and, in the process explained their reasons to be there and what they expected to achieve. In no time the team felt that people started to look at them in a different way and came forward to help the programme. One of the most important local informal leaders became a strong supporter of the programme, considering himself as part of the team and helping them in their numerous difficulties.

2. Help in specific activities

   There are many ways by which local leaders can help us in our activities. They can be very helpful in planning and implementing all our programmes. For example, they can be most useful in involving the community in collecting information for the baseline survey, getting the community to decide on a particular plan of action and in helping to evaluate the success of our programmes. Leaders can help to raise resources from the community for programmes and can take on a great deal of responsibility to see that programmes are run smoothly.

   - A group of health workers in a tribal area had been doing health and development work for 3 years. They had built up a good relationship with the people during this time. In the third year, a severe drought occured in the area and a funding agency gave them funds for a drought relief programme. The money was used to buy seeds which did not require much water to grow.

     A committee of 4 persons chosen by each village took the responsibility for the proper implementation of the scheme in each of their villages. Within two days the committees had drawn up an impartial and

accurate list of beneficiaries with their land holdings and the quantity of seeds required by each. The committee members along with the health workers purchased the seeds. The distribution was done in a systematic manner and proper records were maintained by each committee. Twenty five villages (with 900 families) benefitted from this programme.

Just as local leaders can be a great help, not involving them can also hurt our programme. We have seen that their support can help us gain community acceptance and participation. Several case studies which we have discussed in the workshop have shown the harmful effects of non acceptance by the community. However, it is important for us to take into account the various factors in a village situation and not be completely taken in by whatever a leader says (remember the case study - Hidden Motives).

HOW TO RECOGNIZE INFLUENTIAL LEADERS?

In your visits to the village, you will probably find that certain people's names are often mentioned in answer to questions like:

1. Who are the important people in the village?
2. Whose opinion do you respect?
3. Whose advice do you follow?
4. Who settles arguments within or in between families?
5. When there is an illness in the family, whom do you go to?
6. Who are the first persons to do something when there is serious trouble in the village?

These people whose names you hear often are probably those with leadership qualities and respected by the community. You must remember that you must ask the above and related questions in different sections of the village otherwise you may not get a complete picture. Thus, in a village with different caste groups it is most likely that each caste group has its own elders and leaders who influence that caste group more than the leaders belonging to the other groups. This is an important point for you to remember.

Keeping ones ears and eyes open i.e. by listening and observing people, events, situations, during village visits, you can identify informal leaders and also check the information you have on individual leaders.

- In a village of south India, a team of health workers identified very quickly the formal leaders. It was also easy for them to find out the informal Caste Leaders. But it took them several years to realise that the Harijans of the village had great trust in one of their young men and that, in fact this young man was one of the most powerful leaders of the Harijans. This fact came to light when the Harijan colony was burnt down and help had to be organised to rebuilt it. He was the only one who could control the grief of the people and encourage them to rebuild the colony altogether, those who had not suffered from the fire helping those who had lost everything.

TO SUMMARIZE :

We have seen that it is important to involve local leaders in our Community Health Programme because they are powerful and can make decisions that result in the success or failure of a programme. Community participation, so essential for the success of our programmes, is usually decided by the community leaders.

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ANALYSIS OF THE PRESENT HEALTH CARE DELIVERY SYSTEM IN INDIA

To start with, let us examine the rationale and relevance of an analysis of the existing health care delivery system.

Let us have a look at the following statements based on authentic statistical information:

India has the highest mortality rate - 139/1000, among all the Asian countries.

In India diarrhoea alone kills 3 children every minute or 1.5 million each year. Every minute an Indian child is exposed to it.

Infant mortality rate of India is 125 (1978).

There are about 60 million children in India who are malnourished.

There are an estimated 3.2 million leprosy patients in India.

Tuberculosis accounts for 3% of the 1 crore annual death in India.

Severe degree of anaemia has been detected in 12% of preschool children.

90 million children are supposed to be in the polio danger zone and 13 million are added to this figure every year.

Of these, 80% victims are below 3 years and 15% below 5 years. There are 2.5 lakh totally blind children. There are about 1.8 lakh partially blind. There are another 2.5 lakh who are deaf. Of the 9 million blind persons in the country, 5 million could be cured by proper surgical interference.

All these are certain important indicators of the health status of India's 70 crore population. India adores tenth place among the industrialized nations of the world. Planners and leaders narrate success stories of various development programmes and the progress achieved in various sectors. But the lot of the common man and the labourer continues to be the same and becomes worse even. The ill-health and the high death rate are but the manifestations of the miseries that majority of the population undergo in this country. Here it rightly follows that development and health are integrally related. At the very outset of this discussion let us try to situate the sick man in the context of this socio-economic situation prevailing in India.

Development means the satisfaction of the basic needs of the poor who constitutes the world's majority; at the same time, development also means ensuring the humanization of man by the satisfaction of his needs for expression, creativity, and the capability for deciding his own destiny. Here again the stress is on the poor man - the satisfaction of his needs and ensuring the removal of all dehumanizing forces and enabling him to be master of his own destiny. Health forms one of the basic needs of man; and more than

that, sound health is primary for human existence. The first part of this paper presented few instances showing the grave denial of this right to existence. The 'Alma-Ata' declaration of the International Conference on Primary Health Care (organised by WHO, Sept. 12,1978) also reaffirms the importance of health and goes even further to state that health is essentially a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. If viewed against this background, provision of"health for all" which is a declared objective of WHO and that of the Government of India, demands of comprehensive state of national welfare based on equity of distribution in which none denies the right of the other for health. Hence health demands the good harmony of social, economic, political, cultural, and religious forces conducive to the promotion of healthy existence of man.

In the existing society, the health care system is part of the wider social, political and economic system. The social, political or economic capability is not equally distributed. According to the 1981 census, 48.44% of the Indian population are below the poverty line. Unofficial calculations, which often picture the real state of affairs, suggest the figure to be 75%. This figure goes on increasing. According to 1981 price scale, a person who does not have Rs. 3/- a day is considered to be under poverty line. This phenomena is due to the anomalies of the distribution system which prevents the poor from meeting his needs. In the wider economic and political relations, the health system alone cannot be thought of as being isolated. Unequal distribution of health care facilities denies the right to sound health to the majority of our population. Social and economic inequalities and powerlessness prohibit the people from the knowledge and the capacity to afford the health care of their family the pregnant, the children, the adult and the aged. Hence, inequalities exist at two levels - (a) in the distribution of the health care service (b) in the capacity of the people to afford to maintain good health. Precisely, these two areas constitute the central theme of this paper. We shall follow a sequence and order based on the points given below:

a. The present health care delivery system in India and its distribution in the rural and urban centres.

b. Availability of these facilities to different economic classes and medication practices.

c. Problems of medical personnel in rural areas.

d. Manufacture and distribution of drugs.

Prior to the discussion on the above let us have a brief look at our national health policy.

Our National Health Policy

The constitution of India aims at the elimination of poverty, ignorance and ill-health and directs the State to regard the raising lĕvel of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, specially ensuring that children are given

opportunities and facilities to development in a healthy manner. Hence with a view to providing health for all by 2000 AD., the Government of India has revised its health policy in relation to the economically under-previleged sections of the Indian population, and especially those in the rural areas who constitute 80% of the total population. The revised statement on the National Health Policy covers areas as population stablization, reorienting medical and health education in relation to the health needs of the rural and urban poor, need for providing primary health care with special emphasis on the preventive, promotive and the rehabilitative aspects, reorientation of the existing health personnel, promotion of indigenous and other systems of medicine, etc. The policy statement considers the problems of nutrition, food adultration, quality of drugs, water supply and sanitation, environmental protection, immunization programme, Mother and Child health service, school health programme, occupational health service, medical industry and medical research as areas deserving urgent attention. All these are geared to providing all the citizens of India sound health, especially those in the rural areas who forms India's majority of population.

Yet alarming statistical figures glare at us. We have to admit that the existing health care delivery system does not cater to the needs of the majority of the people. The poor and the under-previleged, especially those in the rural areas, form the majority of the victims of ill-health. We have to admit that based on this status-quo we have to implement one by one the meaningfully laid down policies of our National Health Policy. Now let us pass on to discussions on the various points mentioned already.

(a) Health Care Delivery System in India:

i. Administrative set up at the Centre, <u>State and District levels</u>

The official organs of health at the national level consist of (1) The Ministy of Health and Family Welfare (2) The Directorate General of Health Services (3) The Central Council of Health.

The functions in the union list for the ministry of health and family welfare are international health relations and administration of port quarantine, administration of Central institutes, promotion of research and research bodies, regulation and development of medical,pharmaceutical, dental and nursing professions, establishment and maintenance of drugs standards, immunisation & emigration, regulation of labour and working of mines and oil fields, co-ordination in the States and other ministries for promotion of health. For functions in the concurrent list both the Central and State ministries are jointly rosponsible. They are prevention of extension of communicable diseases, prevention of adulteration of food stuffs, control of drugs and poisons, vital statistics, labour welfare, etc. Both Centre and State Governments have simultaneous powers of legislation.

The Directorate General of health services is the principal advisor to the union Government in both medical and public health matters. The functions are surveys, planning, co-ordination, programming and appraisal of all health matters in the country. In brief, the specific functions are international health relations and quarantine, Control of drugs standards, management of medical stores depots, post graduate training, medical education, medical research, Central Govt. Health Scheme, national health programmes, Central Health Education Bureau, health intelligence, and maintenance of National Medical Library.

Since many health subjects fall in concurrent list, continuous consultation, mutual understanding and cooperation are necessary between Centre and States. The Central Council of Health, constituted of the State ministries of health with the union minister as the chairman, looks into these. Briefly, the functions are - to consider and recommend broad lines of policy in matters related with health, to make proposals for legislation, to recommend to Central Government for distribution of grants-in-aid to States and to review the utilization of that, to establish organisations for promoting cooperation between State and Central health ministries.

II. At the State Level

The health subjects generally fall in three headings - federal, concurrent and state list. The state has complete autonomy for the functions prescribed in the State list. Generally, this includes the provision of medical care, preventive health services and pilgrimages within the State. And, the State is the ultimate authority responsible for all the health services operating within its jurisdiction.

In all the States the management of health sector comprises of the State Ministry of health and the directorate of health. The State Ministry of health is headed by a minister of health and family welfare. In some States the Health Minister is also incharge of other portfolios.

The Director of Health Services (known in some States as Director of health and medical services) is the chief technical advisor to the Government on all matters relating to medicine and public health. He is also responsible for the organisation and direction of all health activities.

With the advent of family planning programme, in some States, the designation has been charged to Director of health and family planning. In some States a separate Director of medical education is also appointed to be in charge of medical education. The Director of health and family planning is assisted by a suitable number of assistant director, whose appointment may be either on regional basis or functional (specialists in different branches of public health) basis.

III. District Level

There are wide differences in the pattern of district health organisation. The following types are seen (a) One district chief, one District Medical Officer of health, assisted by two or more deputies. (b) Two district chiefs - in this set

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up the civil sugeon/District Medical Officer looks after the district hospital, and sometimes all medical facilities in the district, and the District health Officer is incharge of public health.

People's Participation

The rural local self Government of India, 'Panchayati Raj' institutions are meant to ensure people's participation for the various welfare programmes including health. Panchayati Raj institutions are elected bodies. It functions at three levels:

1. Panchayat - at the village level
2. Panchayat Samithi - at the block level
3. Zilla Parishad - at the district level.

The appointed persons of the Government infrastructure at the district and the block level are the implementing agencies. The local self Government functions as a supervisory and coordinating body.

ii. Health Care System - distribution

The health care system of India may be defined as the"industry which provides health services (health activities) so as to meet the health needs and demands of individuals and the community." It operates in the context of the socio-economic and political system of the country. It is represented by the 5 major sectors or agencies which differ from each other by the health technology applied and by the source of funds for operation. These are:

I. Public agencies

1. Primary Health Centres
2. Hospitals - Rural hospitals
   - District hospitals
   - Specialist hospitals
   - Teaching hospitals
3. Health Insurance Schemes
   - Employees State Insurance
   - Central Govt. Health Scheme.
4. Other agencies
   - Defence Services
   - Railways.

II. Private agencies

1. Private hospitals, Polyclinics, Nursing homes and dispensaries.
2. General practitioners and clinics.

III. Indigeous Systems of Medicine

- Ayurveda and Sidha
- Unani & Tibbi
- Homeopathy
- Unregistered practiticners.

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IV. Voluntary Health Agencies.

V. Vertical Health Programmes.

I. Primary Health Centres: The primary health centre is defined as an "institution for providing comprehensive (i.e. preventive, promotive and curative) health care services to the people living in a defined geographic area. It seeks to achieve its purpose by grouping under one roof or coordinates in some other manner all the health work of that area". It is the minimum infrastructure for the delivery of health care services to the rural people. The scheme started in 1952. The Centre is usually located at the headquarters of the Block, and serves the population of the Block coming upto 80,000 to 1,20,000 spread over in about 100 villages.

To bring the services closer to the people 'sub-centres' are established at the rate of one sub-centre for every 10,000 population. At present there are 5372 PHC's and 37,775 sub-centres (1979). The PHC provides accommodation for an outdoor dispensary, a consultation room, accommodation for MCH/FP services, minor surgery, a small laboratory and a ward of at least 6 beds, out of which 4 are maternity beds. Since the PHC is not equipped to deal with complicated medical, surgical and obstetric and gynaecological cases, it is linked up with the subdivisional and district hospital in the region where X-ray, laboratory and specialist services are available.

Function of PHC:-

1. Medical Care
2. MCH and Family Planning
3. School health
4. Improvement of environmental sanitation with priority for providing safe drinking water and disposal of human wastes.
5. Control and Surveillance of Communicable diseases.
6. Collection and reporting of vital statistics.
7. Health Education
8. National Health Programmes - as relevent
9. Referrel Services.

Health Team

P H C:

Medical Officers	2	Computer	1
Compounder	1	Auxillary Nurse midwife	1
Sanitory Inspector	1	Driver	1
Health Inspectors	2	Ancillary staff	2
Extention Educator (F.P)	1		

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Sub Centre:

Health Worker Female (HWF)	- 1	
Health Worker Male (HWM)	- 1	
Health Assistant (Male)	- 1	(for 4 HWM)
Health Assistant (Female)	- 1	(for 4 HWF)

The PHC thus provides a team work to the health problems of the community.

The sub-centres are established at the rate of one per 10000 population. Health Planners visualise one sub-centre for a population of 5,000 or even less, in the near future, when resources permit.

A sub-centre with a population of 10,000 would yield:

i. Target population for family planning	- 1,500
ii. Deliveries	- 400
iii. Infants	- 400
iv. Pre-School children	- 1,500
v. School children	- 2,500

2. Hospitals:

Apart from primary health centres, the present organisation of medical care by the Govt. sector consists of Rural Hospital, International hospitals (2 to 3 lakhs population), District hospitals (1 to 2 million), specialist hospitals (eye, TB, leprosy, cancer etc.) and Teaching Institutions.

In addition mobile hospitals are also under trial.

Difference between Hospitals and PHC's:

Hospitals	PHC's
- Curative	- Curative, preventive, promotive and all integrated
- No particular catchment area	- Catchment area - 80,000 to 1,20,000 people of about 100 villages
- Only curative staff	

3. Health Insurance

Limited only to Govt. employees, eg., ESI., Central Govt. Health Scheme.

4. Other agencies: Medical services to employees of Railways, Defence personnel etc.

II. Private agencies

There are private hospitals, clinics, dispensaries and private medical (allopathic) practitioners.

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III. Indigenous system of medicine: The practitioners of indigenous system of medicine - Ayurveda, Sidha, Homoeopathy, etc., provide the bulk of medical care to the rural people.

IV. Voluntary health agencies: They occupy an important place in Community Health Programmes. They supplement and guide the work of official agencies. Eg. - Indian Red Cross Society, T.B. Association of India, Family Planning Association of India etc.

V. Health Programme in India: Since India became free, several measures have been undertaken by the union government to improve the health of the people. Prominent among these are a number of vertical health programmes known as National Health Programmes which have been launched by the Central Govt. for the control/eradication of communicable diseases, improvement of environmental sanitation, nutrition and rural health. Eg. - National Malaria Eradication Programme, National T.B. Control Programme, VD Control Programme, National F.P. Programme etc.

The following table gives the number of hospitals and PHC's in India.

1. Number of hospitals and dispensaries	- 17607	(1977)
2. Number of PHC's	- 5372	(1979)
3. Number of Subcentres	- 37775	(1979)
4. Hospital Beds	-449212	(1979)

This table represents the totals at the all India level. These do not, however, represent the rural and urban split up figures.

In spite of all the schemes briefed in the previous paragraphs, eight out of ten Indians have little or no access to modern medicine. The number of doctors in 1980 was2,53,631. A WHO study mentions that India has sufficinet number of doctors. But the problem is the lack ofadistribution system which equally gives importance to rural and urban areas.

Thus the existing health personnel can hardly meet the needs of the people. The ratio of the hospital bed and population, is 0.49 per 1000 population. The doctor population ratio is 1:4400. When taking split up figures for the rural and urban areas, rural area has the ratio 1:20,700 and the urban area has 1:1,300. Thus the rural folk suffers seriously from lack of enough number of doctors. 80% of the Indian population live in villages. But 80% of our health care facilities and personnel are in the urban entres catering to the needs of a minority of the Indian population (20% of population). This fact explains the ill-health of the majority of Indian population. The very same fact explains the high incidence of infant mortality, spread of communicable diseases and high death rate. The Indian child succumbs to death due to some diseaseswhich are generally preventive if sufficiently cared for at the proper time.

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Here again, the reason could be attributed to the general inaccessibility of the Indian population to the health care facilities in spite of continued establishment of hospitals both in the government and private sector.

(b) Availability of health care facilities to the Poor:

We have already seen the disparity in the distribution of health care facilities and the doctor population ratio for the rural and urban areas. As mentioned already, this disparity itself is one of the main reasons as to why majority of our population - poorer sections of the society dwelling mostly in rural areas - are denied the right to adequate health care.

Government and private health care services are available in India. As already mentioned the Government has started some rural health programmes. But certain impediments stand in the way as:-

a. Lack of participation of the people - which develops a certain apathy and disinterest towards the Governmental programme, thus affecting seriously the desired objective of being of help to the very same people. Co-operation of the people and the health personnel is vital.

b. There is a certain attraction to work in the urban areas and the health personnel lack the motivation to work in the rural areas. This is a very clear phenomena found everywhere. This problem is dealt with under a separate heading. Hence when the medical officer or health worker is placed in a rural area he will not commit himself fully but will try for a transfer to the more convenient urban centre.

c. In the annual budget allocation, sufficient funds are not available to the rural centre for the purchase of medicines and the maintenance of other facilities of the health centre. Lack of follow up thus gravely affects the health programmes. 75% of the budget allocations are for maintaining staff, 12% for transport, 12% for drugs and 1% for innovative experiments. When we take rural outlays it is seen that they are remarkably lesser when compared with the corresponding urban allocations.

The Constitution of India has considered health care as a basic need of the citizens and has assured that it should reach to the people. But the people cannot expect good service from the Government health centres. Poor maintenance and lack of facilities are two main reasons. Health care centres as PHC's and sub-centres present a very poor show. District hospitals also do not come upto to the mark. Medical colleges and sophisticated Governmental institutions are generally equipped with all the modern medical accessories with specialists for each branch. Medication at these Centres are, however, controlled by money power. Corruption has eroded public life and health care institutions are also no exception to this phenomenon. Private

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practice of Government doctors worsen the situation still. All these form a vicious circle in which the poor man is denied of his right to proper health care. Thus proper medical care remains unaccessible and unapproachable to the poor. This is the case of the subsidized Government run medical institutions.

Another area for health care is the private sector. Different private agencies are running hospitals though out the country. As a non-state-supported system this has to be self-supporting. It has to make its own funds to have enough stock of the rapidly progressing varied modern drugs, to give high salary to the doctors and to maintain the large buildings and sophisticated equipments. High costs of institutionalization, sophistication and specialization have to be met from its own resources. They cannot help but adopt a commercial line. The private sector offers efficient service. But this works only with money. Depending upon the seriousness of the disease and the use of medicines, specialists and modern equipments the service charges go up. Comfortable and hygeinic accommodation is assured on payment of sufficient money. The poor, who is handicapped with the lack of money, is denied the services of this efficiently working private health care centres.

The treatment provided to the patients right from diagnosis and the medication practices followed in our health institutions are far from the real life situations and economic conditions of the poor. The diagnosis process itself grabs whatever little earning the poor may have. Then the poor finds it impossible to afford the highly priced prescriptions that follow. It is sad to note that little effort is made to research on a treatment and medication process that suits this poor nation. The present medication practices cater to the benefit of the drug industrialists and the commercialized health care institutions and not to the care of the people.

Apart from these economic factors there are certain social and cultural factors which prevent the poor from giving sufficient attention to their health and approaching health care institutions. Their concept of health and disease are very much misleading. They are not health conscious. Rural experiences of various health teams suggest that a villager considers himself sick only at a later stage when the disease has made its full appearance. Again certain diseases are taken for granted that they will not create serious threats to the general physical well being. In certain remote villages their first resort is 'Hoja', certain superstitious practices based on 'Manthra' and 'Magics'. Modern medicine is the last and final resort, often due to the compulsion of few who had had some experience with modern medicine. Certain diseases as chickenpox are considered to be the blessing of certain goddesses. Lack of awareness regarding hygiene, food preparation, sanitation, drainage, care during pregnancy, conducting delivery, care of infants are only a few instances which show how certain cultural practices and lack of education seriously affect the life of the poor. Coupled with this socio-cultural factors are the economic incapability of the poor

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to approach the commercialized modern medicine. Distance to the medical centres and lack of enough competent medical personnel in backward areas make the situation still worse. Problems connected with the dearth of competent personnel are being dealt with under the next heading.

c. Problems of medical personnel in rural areas:*

The training and motivation of the health personnel is very important as regards rural health work. Speaking of training, just like any other branch of education, medical education also should be sensitive to the social environment of the community which it seeks to serve, and constantly adapt itself to the changing requirements. The motivational part of the person is greatly influenced by the content and value orientations of the training. In the paragraphs that follow the descriptions are mainly about doctors, since, in the present set up, even in the rural areas, the graduate doctor remains the chief person as regards health care.

The present medical educational system is strictly hospital based and westernized and hence the doctors do not inherit an aptitude or attitude to work in the circumstances and atmosphere of rural India. The doctors also lack an understanding of the social, cultural and religious concepts of health and disease in rural India as well as the attitudes and practices concerned with food, child-birth, child care and general health care. Similarly there have been very many traditional systems of medical care. The modern system of medicine takes much time to gain acceptance in Indian villages. It is a basic question of cultural difference. Also it should be noted that certain traditional ways of health care are advisable for certain diseases. Thus it counter acts the many adverse effects of modern medicine. The modern medical education does not consider these cultural factors in health care. And also, generally a modern doctor has but contempt for the "uncivilized, uneducated" villager in the place of respect as an individual.

Apart from these, a doctor working in rural area is exposed to the following problems:-

- Inadequate living conditions and inability to maintain an urban standard of living which most medical students become used to.
- Poor or relatively poor financial remuneration and/or allowances/compensation.
- Problems of adjustment when accompanied by wife and young children, especially the education of the latter.
- Objection of families to rural work especially because of a lower social status in the profession.

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* This part of the paper was prepared after closely referring 'Trends in under-graduate medical education in India', prepared by Dr. Ravi Narayan.

- Social isolation because of an inability to fit in with the simple rural way of life, (more pronounced when the doctor comes from a predominantly urban background) Lack of rapport and contact between urban and rural communities to an extent, which makes a doctor feel completely 'out of place' or 'cut off' in the rural areas.
- Intellectual isolation and inadequate opportunity to maintain professional compentence or to gain post graduate experience under supervision.
- Problems of political interference in work and often poor relations with local government officials, leading to frequent transfers.
- Problem of interpersonal relationships with other members of the team, especially when many are older to him and have had longer contact with the local people.
- Presence and, often, professional competition with practitioners of other indigenous systems of medicine.
- Another major obstacle to attracting doctors to rural areas is the attitude of the medical profession to rural work, especially in the light of the present day 'ideal' of specialist practice in the large cities. This reflects a general trend towards an intensely materialistic orientation of the medical profession. Consequently, the preparation and motivation for rural work in the medical college curriculam has always been inadequate.

Now, with this we shall pass on to another important area of concern 'DRUGS'.

(d) Manufacture and Distribution of Drugs:

The structure of drug industry embodies all the essential features of the industrial economy of India. Thus, like in the case of any other industry, profit orientation, monopolization, promotion of multi-national corporations, complimentary role of public sector etc., are seen here also. Drug costs represent 40-60% of the total health care expenditure in developing countries like India. In developed countries the corresponding figure is only 10-20%.

Let us have an enquiry into the reasons for such an undesirable state. Let us now examine some of the evil effects the industrial and commercial nature of drug manufacturing brings in:

Production for profit:- Just like any other industry here too production is based on demand and hence profit. Since majority of the Indian people are below the poverty line they find it hard to purchase medicine. The per capita consumption of medicine in India is only Rs. 5/-. According to 1973 calculation, 80% of the drugs produced in India are bought by 20%. The rest of the population shares only the remaining 20%.

Monopolies:- According to 1973 calculation, out of Rs.370 crores worth of drugs produced by 2300 firms in India. Rs. 296 crores worth of drugs were produced by 110 firms (4% of the total). Of these 110, 28 are foreign owned or

collaborated firms and they account for 40% of the total production. Always production is meant for profit. Artificial scarcity is created by few monopolies coming together. This is to increase the price. If the full capacity of the factories are utilized the common man would have got medicines at a comparatively low price. The monopolies decide the price which does not at all correspond to the real cost of production.

eg: Bulk selling price of chloramphenicol is 3 times its production cost.

Tetracycline it is 2.7 times.

Retail price will be still higher

Chloramphenicol - Bulk selling price - Rs. 400/- kg
Retail price - Rs. 3,050/- kg

For Vit. B_{12} the retail price is 20 times the bulk selling price.

For Vit. C the retail price is 5 times the bulk selling price.

Corresponding figures for Folic acid & Tetracycline are 9.2 and 4.5 times respectively.

Multinational corporations:- As stated earlier, they account for 40% of total production. In pricing they are still worse.

Eg. while we import Librium at Rs. 312/-kg it is produced by a Swiss firm in India for Rs. 5555/- kg.

Another foreign firm was charging Rs. 60,000/-kg for Dexamethasone which was later reduced to Rs. 16,000/-kg.

Another usual practice is that the subsidiary of the foreign firm in India buys the penultimate product from its parent company at high rates, makes the final product, stamps it as made in India and sells it at fantastically high rates. The aim of production and research either in India or abroad remains that of maximizing profits.

Public Sector:- The public sector do not curb the fraudulent practices of the private firms but they compliment it. One example could be that Hindustan Antibiotics Ltd. sell Streptomycin at Rs. 345/- kg in retail, where as the same medicine is sold to private sector at Rs. 195/-kg which in turn takes the profit.

Another public sector firm sell 54% of its bulk production to private firms. Just like other fields of industry here too public sector sells its semi-finished products to the private firms which take huge profits on the finished products. Thus the people's taxes are used to make profits to few giants. All these are some of the examples to show the fraudulent practices in drug industry. The data regarding the pricing had been of 1973 - 1974 period. After that the

situation might have become worse or in few exceptional cases improved little. It has yet to be found out. The data presented above are a few indicators as to how the drug industry exploits the common man. With the development of pharmacology and chemical engineering it is possible to distribute comparatively cheap drugs on a large scale to all needy. But the social organization of our economy is such that the aim of production becomes profit oriented.

Advertisements: The advertisements cheat the people miserably. Even medical practitioners are deceived by attractive advertisements of different medicines. A case of deception of the common man by advertisements could be "breast-feeding". The people are attracted by baby-foods and there had been instances to show that while a poor man had even no sufficient income to feed his family he resorted to baby-foods thinking of breast feeding as secondory.

Use of Drugs: The promotional practices of drug companies, aimed at maximizing profits, have been directly counter to the health needs of the poorest. The brunt of wasteful spending falls on the poorest, as the rural dispensaries run short of vital life saving drugs. Apart from promotion of unnecessarily expensive, but necessary drugs, doctors are also encouraged into wasteful over prescribing of non-essential tranquilizers, symptom- allaying drugs and tonics. Similarly drugs freely promoted in the absence of distribution controls can also cause serious dangers.

The existing system of quality control of drugs is not satisfactory. 600 drug inspectors in India have to check 30,000 drug formulations. The beurocratic defects worsen the situation still- decision making, implementing decisions, etc. The marketing of most brand - named drugs especially by the multinationals in the third world works against the health of the poor. Also, drugs banned in the west or used under severe restrictions always continue to be liberally used in India eg. anabolic steroids, analgin etc.

Bearing in mind the very limited effectiveness of drugs and curative medicine in tackling the health problems - malnutrition, infections and parasitic diseases - public funds would be far better spend on preventive health measures and the basic primary health care infrastructure. For this, WHO estimates that 200 genuine drugs would be more than sufficient to meet the health needs.

Orientation towards "appropriate use of drugs" has to yet be developed. Our prescription practices have to be modified according to the needs of the people. Our choice of drugs for stocking in the pharmacy should be according to this. Most important of all, the emphasis has to be on people taking responsibility for their health and avoiding these drugs as far as possible and using those "non-drug therapies" that have been recognized to have good therapeutic effect. Education and awareness as to how to avoid disease and then how to handle it appropriately at the lowest possible cost is the crux of our approach in low cost appropriate health care.

<u>Conclusion</u>:- A brief enquiry has been made into the general edistribution of health care facilities and health personnel in India. Availability of service to the rural (poor) population has been the core of the discussion, since the problems of villages represent the problems of the entire country. Health care in India is being situated in the context of the existing socio-politico-economic realities. Problems and issues have been raised in this context. It is hoped, these would serve as certain indicators in the search for the right type of health services for this underdeveloped country.

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HEALTH STATUS OF INDIA

After almost thirty-five years of planning, we may ask whether, and how much, India has progressed. Only true facts can answer this question. Achievements and failures should be neither magnified not played down, as it is often done. This handout therefore uses the available data . and gives an overall picture of the present health situation, taking into consideration both the achievements and the failures in their f naked forms.

TABLE I

Health Indicators & Birth/Pop. Growth Rates.

Year	Birth Rate	Death Rate	IMR	Life expectancy at birth	Pop. Growth Rate
1941-51	39.9	27.4	134	32.1	12.5
1951-61	41.7	22.8	146	41.3	18.9
1961-71	41.2	19.00	138	45.6	22.2
1980	33.3	12.4	127	52.1	20.9

Mortality Rates

India's health standards are still extremely low. Compared to developed countries and several developing countries, the death rate and IMR of our country remain quite high, and its life expectancy rather low. On all these grounds, the health situation of India is far below the Asian and world average.

TABLE 2.

International Comparisons Around 1978

Country/ Continent	Birth Rate	Death Rate	Pop.Growth Rate	IMR	Life expectancy at birth
Africa	46	17	29	142	49
Asia	31	12	19	93	58
Brazil	37.1	8.8	28.3	77	61
China	26,7	10.2	16.5	45	65
Cuba	28.9	5,9	22.1	19.3	73
Egypt	37.6	10.5	27.1	101.3	53
India	33.3	14.2	20.9	127	52
Malaysia	30.7	6.3	24.4	31.8	53
Pakistan	46.8	16.7	30.1	126	50
Srilanka	29.9	7.8	22.1	45.1	65
USA	15.3	8.8	6.5	14	74
USSR	18.1	9.6	8.5	27.7	70
World	29	11	18	91	61

12. Compiled from HS 1982, P.24; HS 1981, PP.189-91; "1982 World's Children Data Sheet", Population Reference Bureau Inc. & UNICEF; and World Bank, "Health", PP.72-3.

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The importance of environmental hygiene is recognized by all. It has even beenestimated that 60 to 70% of India's health problems would disappear withxx safe drinking water and sound sanitation. Following table tells us how deplorable and alarming is the situation! About 83% of the urban population has some provision for protected water supply, but "only about 64,000 (10.4%) villages have adequate water supply of acceptable quality (40,000 of them have been provided with these facilities during the plan periods). About 214,000 (34.7%) villages have adequate but unprotected sources; and 153,000 (24.9%) are problem villages (i.e. villages with inadequate water supplies or infested with endemic cholera, guinea-worm and other health hazards)."

TABLE 3

Water Supply & Sanitation

		Population %
Protected water supply	Rural	10
	Urban	80
Sound excreta disposal	Rural	2
	Urban	34

Tuberculosis: About 9 Mn.people suffer from active T.B. out of which 2.24 are infectious.

1980 - 6.1 lac tuberculosis cases and 8,962 Deaths on an average. About 5 lac Deaths every year.

Leprosy - 1/3 of world's Leprosy is in India.
50% ofthe population of India is at risk.
1971 - 3.35 million Leprosy cases
1981 4 " " "

25% infectious, 25% have deformities.

Fialaria

1953 25.9 million
1976 236.13 million
174 million live in villages.

Sexually transmitted disease : - 20 million suffer from it and number is increasing.

Mentally retarded: 20 million

Mentally ill 4-5 million out of which 1.5 million need Institutions , 3 million need tratment.

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Blind 9 million
6 million need surgery
1 million new cases of catract added each year.

25,000 children become blind every year, on account of vitamin A deficiency. 2-150% of/children /all suffer from milder form of Vitamin A deficiency.

Women & Children
Below 15 years - 265 millions in 1983,40% of total population.
Children under 5 year,
15% of total population , 1/3 of total deaths is in children.
50% of infant deaths occur below one month of age.
Only 20-30% babies are born with the help of trained doctors & Midwife.
30% of the new born in Inda have less than 2.2 kg weight at birth. Average weight at birth . in poor families 2.8 kg in rich class it is 3.2.kg. 75% of pre school children are below 75% of standard weight of well nourished children.

60,000 women die every year in India due to childbirth. 20% suffer from aneamia. 6 million abortion takes place annually. 4 million of them are induced.

No.of children born on an average to an

Indian women	are	4.8
USA	"	1.9
Cuba	"	2.3
USSR	"	2.4
China	"	2.5

Malnutrition 65% of Indian in lower income group suffer from malnutrition.
1973-60 million are badly malnutraised.

Infants - (0-1 yr)
P.E.M. - 1.5%
Vitamin A deficiency 0.55%

Vitamin B complex deficiency not reported.

Preschool
P.E.M - 0.23%
Vit.A.Deficiency 4.0%
B.Complex " 4.6%

School Children
P.E.M. 0 - 40%
Vit.A Deficiency : 10.0%
B.Complex " 11.7%

Womens
Vitamin A deficiency : 5.99%
B.Complex " 3.8%
Aneamia - 30%

P.E.M. : Protien - Energy - Malnutrition.

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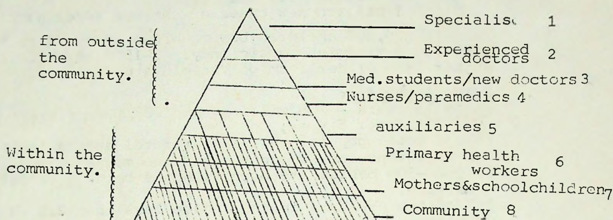
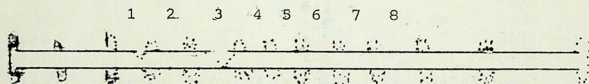
contd..

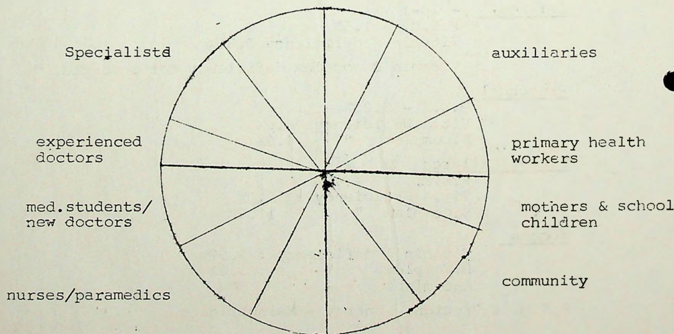
HEALTH CARE PYRAMID



David Werner:
Contact/Aug 1980/57

HEALTH CARE CONTINUUM





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ANALYSIS OF THE PRESENT HEALTH CARE DELIVERY SYSTEM IN INDIA.

Forty years after independence India on the road to development is now facing a serious crises, India's population continues to grow at an alarming rate and the health conditions of the masses remain distressingly low. Our health services are manifestedly inadequate and ineffective, especially in rural areas and fail to cover 70 to 80% of our population.

India is the 11th poorest country in the world with the 2nd highest population of 762 crores (1986). India's infant mortality rate is still a deplorable 105/1000. 1.5 million children lives are taken by diarrhoea alone. There are more than 60 million children in India who are malnourished; four million cases of leprosy of which 15% are children less than 14 years. Tuberculosis amounts for 9 - 10 million cases of which 2 - 3 million are open cases. 50% of all lactating and pregnant mothers suffer from anemia. Children affected by polio are on the increase; more than120,000 are affected of which 80% are below 3 years of age and despite the efforts towards universal immunization the numbers keep growing. One million (11,18,948) and more of the population is disabled due to one reason or the other. All these are important indicators of the Health Status of the Indians.

And after 4 decades of post Independence planning we may ask whether and how much India has progressed. Only true facts can answer this question. Achievements and failure should be neither magnified or played down as it is often done. The institutional and manpower growth of our health care system is impressive. We now have a ministry of Health and Family welfare at the centre and in the states, large departments of public health and medical organisations and institutions. Excellent specialized facilities are available for cardiac diseases, cancer and neurological and nephrological disorders. A huge infrastructure of hospitals, dispensaries, subsidiary centres, community health centres, Primary Health centres has been built. The number of health professionals and paramedical workers have remarkably increased. The number of institutions and practitioners in the Indegenous system of medicine indicate a considerable though less striking growth. Though many of these health institutions and personnel serve the upper and middle classes in todays' society, they could be put to better use. We have every right to be proud of these achievements. Yet one must also look at the negative side of the health situation and acknowledge that "our failures are even more glaring than our successes. Inside our big hospitals and private nursing homes, we find modern amenities, highly qualified experts. Outside their walls, poverty and disease march bleakly over the landscape." A deeper study of martality rates, disease patterns and conditions of children and women reveals a distressing situation. The poor coverage and inbuilt inequalities of our health system are other key elements of this deplorable and unjust situation.

Every human being possess the right to life and health and to the necessities of life, including proper medical services. With its commitment to justice, liberty, equality and fraternity, the Constitution of India clearly recognizes the Governments' responsibility for health.

The world at large and India in particular continue to experience "the poverty of health in the midst of scientific abundance" and glaring inequalities in health resources. While basic health services remain inaccessible to more than the two thirds of humanity and millions of poor die of easily preventable diseases, the rich enjoy even more specialized facilities. Most villages have no proper health personnel and services, while cities are saturated with doctors and medical centres, Health which is claimed to be right of every individual is in reality a privilege of the relatively few wealthy.

The Alma Ata delegates at the International conference in Sept. 1978 saw health as a fundamental human right and stated that "The attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. It strongly affirmed the need of primary health care to achieve an acceptable level of health by all people by the year 2000 and to reduce todays gross inequalities which are 'politically, socially and economically unacceptable'.

According to the 1984 statistics 37.4% of India's population is below the poverty line, unofficial calculations however suggest a much higher figure. Dr. Mahler gave the call "Health for all by the year 2000 A.D." at the 1977 WHO. According to him 'the present realities of the 3rd world are simply unacceptable. There is little joy in life now nor any kind of justice for a child condemned to disease or early death because of the accident of birth in a developing country... There is no rationale that can defend a system that withholds the gift of health and care from nine tenths of a nation's population'. 'Resources distribution in the medical sector is such that 80 to 90% of the resources go to meet 10 - 15% of the health problems. Social and economic inequalities and powerlessness prohibit the people from the knowledge and the capacity to afford the health care of their family. In equalities exist at two levels :

1. In the distribution of the health care services
2. In the capacity of the people to afford to maintain good health. These two areas make up the central theme of this paper. We shall follow a sequence and order based on the following points.

a. The present health care delivery system in India and its distribution in the rural and urban centres.

b. Availability of these facilities to different economic classes and medication practices.

c. Manufacture and distribution of drugs.

Our National Health Policy :

The Government adopted a new "National Health Policy" in August 1983 and recomitted India to "the goal of 'Health for all by 2000 A.D! through the universal provision of comprehensive Primary health care services".

The policy confirms the trend in favour of restructuring the health services emphasising community, preventive and promotive health linked to a hierarchy of referral services and integrated with human development and poverty alleviation programmes. People must be required to take health into their own hands

through community health volunteers, traditional birth attendants and practitioners of indegenous medicine, all of them trained and equipped to make appropriate interventions at given livels backed up by supporting services. The efforts must be to move from expensive hospital, drug based curative services, largely confined to the middle and upper urban strata, to reaching health to the people where they are and in particular, to vulnerable segments and backward regions......

An analysis of the National Health Policy reveals some striking difference with the 'Health for all documents'. First the Government emphasis is much more on poverty alleviation that on the reduction of inequalities and the organization of the oppressed to defend their rights. The policy does not speak even once of social justice in health and in other fields. The essential pre requisites to attain the goal 'Health for all' are completely bypasses, there is no definite and far reaching programme to promote community participation in important matters. There is no radical change in the health budget, while insisting on Primary Health Care, the policy is concerned with private practice, paying clinics and the establishment of specialist centres. The attainment of 'Health for all' is intimately related to the eradication of poverty, inequality and ignorance. There can be no lasting solution to the country's health problems, unless and until the illnesses affecting the society at large are tackled side by side.

Health care delivery system in India :

The challenge that exists today in many countries is to reach the whole population with adequate health care services and to ensure their utilization. The large hospital which was chosen for the delivery of health services has failed in the sense that it serves only a small part of the population. Therefore it has been aptly said that these large hospitals are more ivory towers of disease than centres for the delivery of comprehensive health care services.

Administrative set up at the Centre, State, and District level :

The health system in India has 3 main links i.e Central, State and Local.

I. At the Centre :

The official organs of the health system at the national level consists of :

1. The Ministry of Health and Family Welfare
2. The Directorate General of Health Services
3. The Central Council of Health and Family Welfare.

1. The union ministry of health and family welfare is headed by a cabinet minister, a minister of state and a deputy health minister. There are political appointments. The union ministry has the following departments :

i Department of Health
ii Department of Family Welfare

The functions of the Union Health Ministry :

a International Health relations and administration of post Gurantine.

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b Administration of central institutions

c Promotion of research through research centres and other bodies

d Regulation and development of medical, pharmaceutical, dental and nursing professions.

e Establishment and maintenance of drug standard.

f Census, collection and publication of other statistical data.

g Emigration and Immunization

H Coordination with states and with other ministries for promotion of health.

It is the responsibility of both the centre and state for

1 Prevention of extension of communicable disease

2 Prevention of adulteration of foodstuffs

3 Control of drugs and poisons

4 Vital statistics

5 Labour welfare

6 Ports other than major

7 Economic and social planning

8 Population control and family planning

2. <u>Directorate General of Health Services</u> :

The director general of health service is the principal advisor to the Union Government, in both medical and public health matters. The General functions are survery, planning, coordination, programming and appraisal of all health matters in the country. The specific functions are :

a International health relations and quarantine

b Control of drug standards

c Medical stores depots

d Post-Graduate training

e Medical education

f Medical research

g Central Government Health Scheme

h National Health Programmes

i Central education Bureau

j Health Intelligence

k National Medical Library

3. <u>Central Council of Health</u> : A large number of health subjects fall in the concurrent list which calls for concurrent list which calls for continuous consultation, understanding and cooperation between the centre and the states.

The functions of the Central council of Health are :

a To consider and recommend broad lines of policy in regard to matters concerning health in all its aspects.

b To make proposals for legislation in fields of activity relating to medical and public health matters

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c To make recommendations to the Central Government regarding distribution of available grants-in-aid for health purposes.

d To establish any organisations invested with appropriate functions for promoting and maintaining cooperation between the central and state health administration.

II <u>At the State Level</u> : There are 25 states in India. In all the states the management sector comprises the state ministry of health and a Directorate of Health. The State Ministry of Health is headed by a Minister of Health and Family Welfare and a Deputy Minister. The Director of Health service is the chief technical advisor to the State Government on all matters relating to medicine and public Health. He is also responsible for the organisation and direction of all health activities. A recent development in some states is the appointment of a Director of Medical Education in view of the increasing number of medical colleges.

III <u>At the District Level</u> : The principal unit of administration in India is the district under a collector. Most districts in India are divided into two or more subdivisions each taken care of by an Assistant or Sub Collector. Each division is again divided into taluks. Since the launching of the community development programme in India in 1952, the rural areas of the district have been organised into community development blocks each with approximately 100 villages and a population of about 80 to 1,20,000 under a block development officer. Finally there are village panchayats which are institutions of rural local self-government. The urban areas of the district are organised into the following :

- Four area committee
- Municipal boards
- Corporations

Under the multipurpose workers scheme, it has been suggested to the states to have an intergrated set-up at the district level by having a chief medical officer with three deputy CMO's. The recent working groups on health for all by 2000 A.D. recommended that the District Hospitals should be converted into district health centres each centre monitoring all preventive, promotive and curative services of one million population.

The Panchayat Raj is a 3 tier structure of rural local self government in India.

1. At the village level the Panchayate Raj consists of

   a) The gram Sabha
   b) The Gram Panchayat
   c) The Nyaya Panchayat

2. At the block level the Panchayate Raj consists of Panchayat Samithi. The Panchayat Samithi consists of all Sarpanchas.

3. The Zila Parishad is the agency of rural local self government at the district level.

<u>Health Care of the Community</u> :

The frontiers of health extend beyond the narrow limits of medical care. Health care covers a broad spectrum of personal health services ranging from health education and information through prevention of disease, early diagnosis and treatment and rehabilitation.

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Two major themes have emerged in recent years in the delivery of health services :

a) Health service should be organised to meet the needs of the entire population and not merely selected groups. Health services should cover the full range of preventive, curative and rehabilitation services.

b) The best way to provide health care to the vast majority of rural people and urban poor is to develop effective Primary Health care services supported by an appropriate referal system.

Levels of Health Care :

1. Primary Level. The first level is usually the point of contact between the individual and the health system, where primary health care or 'essential health' is delivered. The primary health care insitutions in rural India are the primary health centres and their subcentres. Although there is a vast network of primary health centres and subcentres in the country, experience over the past three decades has shown that PHCs and their subcentres have not been able to meet effectively the minimum health need of the vast majority of the rural population. In orderto remedy this defect, the government of India in 1977, under its new Rural Health Scheme, adopted an alternative strategy of delivering primary health care through the agency of village health guides (community health workers). The CLW is a volunteer from the village itself and is selected by the village community. Besides providing primary health care, the village health guide or CLW bridges the cultural and communication gap between the rural people and the organised health sector.

2. Intermediate level : At this level more complex problems are dealt with. The sub divisional/district hospitals mainly constitute the second level. They also provide support to the primary health care institution.

3. Central Level : This comprises 'Tertiary Care' or super - specialist care. This is provided by the central level institutions (e.g. Regional Hospitals, Medical College Hospitals) They not only provide highly specialized care but also sustain primary health care as part of a comprehensive national health system.

Health Care Services :

Thehealth care system is intended to deliver the health care services. It operates in the context of the socio economic and political framework of the country. It is represented by five major sectors.

I. Public Sector

1. Rural Health Scheme
   Primary Health Centres
   Sub Centres.

2. Hospitals/Health Centres
   Community Health Centres
   Rural Hospitals
   District Hospital/Health Centre
   Specialist Hospitals
   Teaching Hospitals

3. Health Insurance Scheme
   Employees State Insurance
   Central Govt. Health Scheme

4. Other agencies
   Defence Services
   Railways

II. PRIVATE SECTOR :

1. Private Hospitals, Polyclinics, Nursing Homes and Dispensaries
2. General Practitioners and Clinics.

III Indigenous systems of medicine :

1. Ayurveda and Siddha
2. Unani and Tibbi
3. Homeopathy
4. Unregistered parctitioners

IV. Voluntary Health Agencies

V. Vertical Health Programmes.

PRIMARY HEALTH CENTRE :

Health planners in India have visualised the primary health centre and its subcentres as the minimum 'infrastructure' for the delivery of health care services to the people in rural areas.

FUNCTIONS OF THE PHC :

a. Medical care
b. MCH and Family Planning
c. Improvement of environmental sanitation with priority for providing safe drinking water, disposal of human wastes.
d. -Control and surveillance of communicable diseases
e. Collection and reporting of vital statistics
f. Health education
g. National Health Programmes
h. Referral services
i. Training of village health guides, health workers and health assistants.

Health team at PHC :

Medical ifficers	- 2
Compounder	- 1
Sanitary Inspector	- 1
Health Inspectors	- 2
Extension Educator (FP)	- 1
Computer	- 1
ANM	- 1
Driver	- 1
Ancillary staff	- 2

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At each sub.centre

Health worker (f)	- 1
Health worker (M)	- 1
Health assistant (M)	- 1
Health Assistant (f)	- 1

The PHC thus represents a TEAM approach to the health problems of the community.

Community Health Centres : A few PCH's have been upgraded to CHC's which has been established for coverage of one lakh population with 30 beds and specialized medical care services in gynaecology and obstetrics, pediatrics, surgery and medicine. It has been recommended that one of the doctors at the community centre level may be from one of the locally acceptable traditional systems of medicine and one of them must possess public health qualifications and experience.

2) HOSPITALS : Apart from the primary health centres, the present orgination of health services by the Government Sectors consists of rural hospitals, district hospitals, specialist hospitals and teaching institutions.

a. Rural Hospitals :

It is now proposed to upgrade the rural dispensaries (allopathic/traditional systems of medicine) to primary health centres. At present a good number of PHCs are located at tehsils/taluka head quarters which also have hospitals. Such PHCs may be shifted to the interior rural areas.

b. District Hospitals : There are proposals to convert the district hospitals into District health centres. Hospital differs from a health centre in the following respects.

	Hospitals	Health Centre
1	Curative services	Preventive, promotive and curative
2	No catchment area	Has a definite population 80,000 to 1,20,000 to cater to
3	Curative staff	'Mix' of medical & Paramedical workers.

3) HEALTH INSURANCE : There is no universal health insurance in India. At present it is limited to industrial workers and their families. The Employment State Insurance Scheme provides comprehensive medical care to industrial workers. The central Govt. Health Scheme provides comprehensive medical care to central Govt. employees. The above two schemes cover two large groups of wage earners in the country.

4) OTHER AGENCIES :

1 Defence services have their own organization for medical care to defense personnel. The railways provide comprehensive health care services through the agency of Railway hospitals, Health units and clinics.

2 Private Agencies : Private practice of medicine provides a large share of the health services available. The general practitioners constitute 70% of the medical profession. They provide mainly curative services. Most of them tend to congregate in urban areas. The private sector of the health care services in not organized.

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3 Indigenous systems of medicine : The practitioners of indigenous systems of medicine eg. Ayurveda, Siddha provide the bulk of medical care to the rural people.

4 Voluntary Health Agencies : The voluntary health agencies occupy an important place in community health programmes. The type of service rendered by voluntary health agencies have been classified as :-

i Supplementing the work of official agencies

ii Pioneering - new ways and means of doing new things. Research is one form of pioneering.

5 Vertical Health Programmes in India :

Since India became free, several measures have been undertaken by the government to improve the health of the people. Most of the programmes have been aided by the International Health Agencies such as the WHO, UNICEF, USAID, Rocketeller Foundation etc. These vertical health programmes have been launched for the control /eradication of communicable diseases, improvement of environmental sanitation, nutrition and rural health. e.g. The National Malaria eradication programme, Diarrhoeal Diseases, Control Programme, National filaria Control Programme, National T.B. Control Programme etc.

Availability of Health Care Facilities to the Poor

Widespread poverty, malnuturtion and ignorance, insufficient and or unsafe water supply and many other evils still plague the countryside. Our health services do not cover the 70 -,80% poor.

The prevalent model of health care is irrelevant for several reasons. Instead of responding to the specific problems, needs and aspirations of Indians and being attuned to their customs and traditions, and taking into account their local medicines and practitioners, the western system mainly responds to the socio economic conditions and disease patterns of developed countries; It neglects the indigenous systems of medicine and uses, highly specialised personnel, sophisticated technology and costly drugs.

The following table gives the quantitative aspect of available health facilities :

No. of hospitals	-	7474 (1986)
No. of hospital beds	-	535735 (1986)
No. of community health centres	-	711 (1986)
No. of PHC's	-	8496 (1986)
No. of dispensaries	-	26842 (1986)
No. of subcentres	-	94918 (1986)

This table represents the total at the all India level - besides there has been a definite increase in number over the past 5-6 years, these do not represent the urban and rural split up, nor does it indicate its functioning and availability to the poor masses. Eight out of ten Indians have little or no access to modern medicine. The number of doctors in 1984 was 2,97,228. A WHO study mentions that India has sufficient number of doctors. But how equally are they distributed and how many doctors are available to the rural population ? The doctor population ratio in the urban areas is 1:1;300 and in the rural 1:20,700.

The rural population who make up 80% of India's population are deprived of health facilities while the 20% of the urban population enjoys 80% of medical care and facilities. This partially explains the widespread ill-health prevailing in the villages. The reason for this disparity in medical facilities may be due to :

- Lack of participation and cooperation by the people in Government health programmes.
- Improper allocation of funds; 75% of the budget is allocated for maintaining staff; 12% for transport; 12% drugs and 1% for innovative experiments. The budget allocated for the rural areas would be even less.
- Medical personnel, especially doctors are reluctant to serve in the rural areas for more than one reason. Most often due to:
- Inadequate living conditions in the rural centres.
- Family problems, education of children etc.
- Want of social life.
- Intellectual isolation and inadequate facilities for maintaining professional competence.
- Problems of political interference by local government officials etc.
- Presence of and unhealthy professional competition by local practitioners and those practicing indegenous systems of medicine.
- The present trend of privatization and commercialization of the medical profession is too strong a temptation to the young medico, made worse by a lack of motivation for the right values in life.

Annually 12,000 or more fresh doctors are added to the already existing number of doctors so unequally distributed among the rural and urban population. The medical profession has become so commercialised that manyayoung student would use any means, pay any amount of capitation fees to get into medical college with the feeling that one has got into one of the best money making ventures of today. And to make matters worse the training and motivation given in today's medical colleges is strictly hospital based, case oriented and not patient oriented, westernised and sophisticated. The Indian trainee doctor is not exposed to a real understanding of the social, cultural and religious concepts of health and disease in rural India and the many traditional systems of medical care. The attitude of most doctors towards anything Indian would be one of contempt with unconcern for the uneducated poor village. The motivation given to a person depends on the content and values orientations of the training given to them.

The private sector has an important part in the country's health care system of which the Church's role is of significance. Initially the Church launched out in caring for the health needs of the people especially the poor and with funds from abroad etc. - most often free medication and care was available to the really poor but through the years with increasing privatization and commercialization of medical care with increasing price of modern drugs; higher salaries to doctors; maintenance of massive buildings; sophisticated equipment etc. a shift in priorities has taken place and today the Church's health care is by and large no longer for the real poor but only for those who can afford to pay.

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Apart from the economic factors, the poor are also illiterate and hence not health conscious. Their concept of health and disease is masked by their superstitions and wrong beliefs that prevent them from accepting and availing for themselves existing health facilities.

Drug and the Health Care System

The drug industry in India today is like any other industry, profit oriented, with monopolization and promotion of multinational corporations. The role of drugs in the eradication of disease is limited. Modern medicines and drugs cover only a small minority of the people in the poor societies. It is known fact in India that among the marketed 60,000 drugs, more that 60% of them are either irrational, unscientific, useless, harmful or banned.

Essential drugs, which can cope with the overwhelming problems even in relatively sophisticated societies, number around 200. But for the villages and the urban slum-dweller great miracles can be achieved with fewer than 30 well chosen drugs. But this is precisely where the interest of the drug industry wanes. The drug industry is concerned with profits first, like any other business, not with the health needs of the majority.

An analysis of the marketed drug formulations show that vitamin preparations accounted for 15% of the total number of formulations - the largest single group of drugs marketed. 9% were tonics or deficiency drugs; 5% tranquilizers and sedatives; expectorants 5%. All these items together are vigorously sold under popular brand names with high pressure advertising and sales promotion campaigns. Most of the basic ingredients required for these preparations have to be imported eg: in the case of cough syrups and tonics, none of the basic ingredients in these formulation is produced in India.

While anti-infections and antibiotic drugs account for 21% of the total, their production generally falls short of the quantities required to treat the widely prevalent diseases cured by them.

There is also a growing suspicion that the people of the third world are infact being used as 'guinea pigs' for extensive testing of certain drugs which is now virtually impossible to do in the developed countries. The reason why these blatant malpractices continue may be due to :

i) ineffective, inadequate and corrupt drug machinery facilitating easy introduction of harmful drugs in the market. Every state in India has its Food & Drug Administration. With a few exceptions, most of these are badly managed with poor testing facilities and lack of trained personnel. They are alos subject to administrative interference and political pressure.

ii) The enormous power and influence wielded by the drugs industry enables it to stall, tone down and even overcome the orders and regulations proposed by several organizations, committees and individuals.

iii) The pharmaceutical industry in India does not have to face law suits and pay damages to the affected parties. The principal reason for this is the poor level of consumer awareness and absence of well organised consumer protection movements.

iv) In a situation likethis, one would expect doctors to play a critical role in controlling the excesses of the drug firms, but the close ties between the medical profession and the pharmaceutical industry in such that they feed each others pockets. Probably the single most important part of drug promotion is sampling : free samples to doctors which has been lavish and degenerated into a rat race among manufacturers. Sample drugs are dispensed by most GP's and may be even charged - through acquired free - Roomfull's of drugs have been acquired by some doctors and later sold to wholesalers. Doctors also accpet substantial gifts from drug companies. Most doctors after leaving medical college depend on medical representatives for information about drugs. A large number of people resort to self-medication and almost all drugs are easily available over the counter.

With such a situation existing in the medical world, what about those destitutes numbering hundreds of millions below the poverty line probably accounting for more than half of the Indian population ? Most likely they will simply be bypassed. But everything will continue to be done in the name of the poor, the deprived and the weak.

In conclusion :

Our efforts should be towards humanized health care, humanised living and humanized development of people. We are a country with the World's third largest medical man-power. We are signitatory to the Alma Ata Charter of 1978. We are acknowledged as a Third World Leader - yet ....

It is here where more than half of its people live below the poverty line; where 80% ormore children are malnourished; where half of the world's T.B. patients are; one third of the world's leprosy patients are struggling to survive; where 1.5 million children die of diarrhoea and 40,000 children go bling annually due to lack of Vit A! What has gone wrong and where ?

" You know sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial redpiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing and then another yell. Again and again, without end, goes the sequence. You Know, I am so bust jumping in, pulling them to shore applying artificial respiration, that I have not time to see who the hell is upstream pushing them all in ".

Irwing Zola.

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BOOK OF NUMBERS

Chapter I

Every 3rd person in the world without safe and adequate water supply is an Indian

54% of India's population has access to drinking water. Of these 80% are urban; 47% are rural

Every 3rd leprosy patient is an Indian. Of the 1.2 crore leprosy patients in the world, India accounts for 40 lakhs. The prevalence rate per 1000 population is 5.7

Every minute 3 children die of diarrhoea.
One child in ten dies of dehydration
ORT saves the lives of 500,000 children a year

Every 7th person in the world is an Indian
India's population is 762 m.
Every year 13 m population added.

To maintian present levels India requires :

127,000 extra schools every year
65,000 new houses and
3.5 m new jobs every day.

One in every 3,000 children in India contract diabetes

Chapter II

12.5% Death rate in India - Rural 13.7; Urban 7.8

33.8% Birth rate - Rural 35.6; Urban 27.0

54 Average Indian's life - expectancy - Female 54.7; Male 54.1

105 infants out of 1000 die in infancy
IMR in urban areas 66
IMR in Rural areas 113

Out of 100 infants who die, 13.7 die of acute respiratory illness.

131 of 1000 girl infants born die in infancy

418 Mothers die for every 100,000 live births

40,000 Indian Children go blind every year due to Vit A and protein deficiency.

India has the world's highest figures for child labour
17.36 m child labourers - according to Planning Commission
20 m - according to Unicef (44 m Unofficial fig.)
60% of them are below 10 years.

Chapter III

For every 1000 males there are 935 females in India, except in Kerala where for every 1000 males there are 1032 females

An average Indian woman walks 1400 kms a year for firewood

Percentage of Central Government expenditure allocated to :

Health	2.4
Education	1.9
Defence	20.0

Percent of population below absolute poverty level :
Urban 40; Rural 51 ---- Unicef figures
Urban 27.7; Rural 39.9 ----- Govt. Figures

106	Medical Colleges
8496	Primary health centres
297228	Doctors
170880	Nurses
8000	Pharmaceuticals companies
45,000	Drug formulations in Indian market today (Unofficial fig. 63,000)
7474	Hospitals
4093	Government Hospitals
3381	Private hospitals

Indian Systems of Medicines(ISM; Ayurveda; Unani; Siddha)

2.91	lakh regular practitioners
13,294	dispensaries
1,665	Hospitals
18,179	beds
97	Ayurveda Colleges
18	Unani Colleges
1	Siddha College

Chapter IV

Chapter IV

1.5 million die of diarrhoea in India every year

1.5 million are born with genetic disorders

2.5 million infectious tuberculosis cases any given day

2.5 million fresh cases of T.B. every year

2.5 million people in India are affected by hook worm

3420000 Blind / partially blind

5430000 Locomotor disabilities

7500000 affected by mental disorders

12 million disabled in India

85% of children in India suffer from some degree of malnutrition

1.2 billion: annual turnover of drug companies in 1981 is 1.2 billion rupees

Source :

1 Health Information of India 1986 - Central Bureau of Health Intelligence

2 The state of the World's Children - Unicef 1987

3 Newspaper clippings

* * * * * * * * * *

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NATIONAL HEALTH POLICY

The approach of our ancient medical system was of a holistic nature, which took into account all the aspects of human health and disease. Nevertheless, due to the influence of the west, it has been reduced to curative, an urban-biased, top-down and an elite-oriented approach. This improvements have to be made to combate BLINDNESS, MALARIA, DIARRHOEAL DISEASES, LEPROSY, TB etc.

In order that our health service are to be effective, there arises the need for transfer of knowledge, simple skills and technologies to health voluntaries who are selected by the communities. Moreover, primary health care must be provided with special emphasis on preventive, promotive and rehabilitative aspects together with other systems of indigenous medicines, such as AURVEDIC, UNANI, SIDHA, HOMEOPATHY, YOGA, NATUROPATHY, etc. Hence the large stock of such health manpower could be utilised for promoting an effective health care services in India.

Besides these aspects, attention to be paid in the other aspects such as a well developed distribution of low cast food, of acceptable quality, available to every person especially to the rural poor, prevention of food adulteration and maintenance of the quality of the drugs, safe drinking water, proper environmental sanitation, immunization programme, a well planned maternal and child health services to reduce morbidity, disabilities and mortalities so as to promote better health.

Production of life saving drugs under their generic names especially for the treatment of TB and leprosy are to be within the reach of the rural poor who suffer mostly from these diseases. The use of low cast and no cast indigenous and herbal medicines are to be encouraged.

Nevertheless, when we critically analyse this statement, we see that very little efforts have been made in the promotion of low cast drugs for example, nearly 40 to 60 million people suffer from endemic GOITRE through its prevention is so cheap by using iodized salt which is not available to the people in need. In the same way, more time and money are spent to produce expensive drugs than the production of Vitamin A, the deffiency of which lead to blindness as 30,000 million children suffer from

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SOME VITAL STATISTICS OF INDIA AND SELECTED STATES

ANNUAL LIVE BIRTH RATES

1. The Crude Birth Rate

The Birth Rate is defined as "the number of live births during a year per 1,000 estimated mid-year population. "It is given by the formula:

$$\text{Birth Rate} = \frac{\text{Number of live births during the year} \times 1,000}{\text{Estimated Mid-year population}}$$

India	1980	1981	1982
Combined	33.7	33.9	33.6
Rural	35.1	35.6	35.3
Urban	27.8	27.0	27.6
Andhra Pradesh			
C	31.0	31.7	30.8
R	32.0	32.7	31.7
U	26.9	27.5	27.4
Orissa			
C	31.6	33.1	33.4
R	31.9	33.4	33.6
U	29.0	29.3	30.8
Utter Pradesh			
C	39.4	39.6	38.6
R	40.3	40.8	39.9
U	33.0	31.5	32.5
Kerala			
C	26.8	25.6	26.0
R	27.0	26.0	26.4
U	25.5	23.5	24.2

contd...

2. Death Rate

Death rate is the most important of all vital statistical rates pertaining to mortality. It is defined as the number of deaths per 1,000 estimated mid-year population, in one year.

$$\text{Death Rate} = \frac{\text{Number of deaths during the year} \times 1{,}000}{\text{Mid-year Population}}$$

India	1980	1981	1982
Combined	12.6	12.5	11.8
Rural	13.7	13.7	13.1
Urban	7.9	7.8	7.3
Andhra Pradesh			
C	11.3	11.1	10.4
R	12.4	12.2	11.6
U	6.8	6.5	6.0
Orissa			
C	14.3	13.1	13.0
R	14.9	13.5	13.5
U	7.9	7.9	7.9
Utter Pradesh			
C	16.6	16.3	15.1
R	17.6	17.3	16.3
U	10.3	9.9	9.4
Kerala			
C	7.0	6.6	6.6
R	7.1	6.7	6.6
U	6.5	5.8	6.2

3. Infant Mortality Rate

It is the number of infant deaths under one year of age per 1,000 live births in any population in one year

$$\text{I.M.R.} = \frac{\text{Number of deaths under one year of age} \times 1{,}000}{\text{Total Live Births in the Year}}$$

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Infant Mortality Rate

India	1980	1981	1982
Combined	127	120	114
Rural	137	130	124
Urban	74	72	65
Andhra Pradesh			
C	117	106	92
R	127	114	103
U	66	65	40
Orissa			
C	133	149	143
R	137	154	150
U	80	86	62
Utter Pradesh			
C	177	162	159
R	184	168	167
U	114	104	99
Kerala			
C	42	43	40
R	45	45	41
U	29	30	34

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Reference: Health Statistics of India 1984,
Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi.

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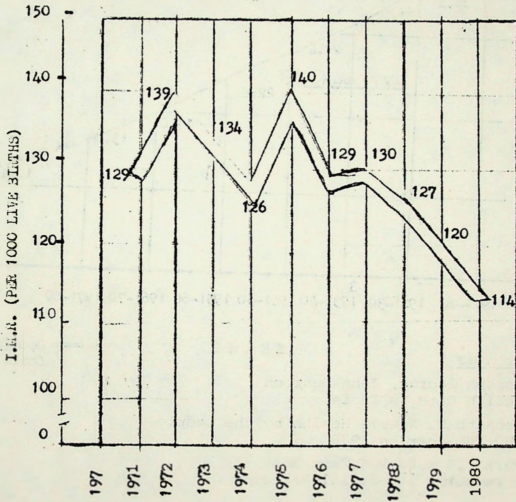
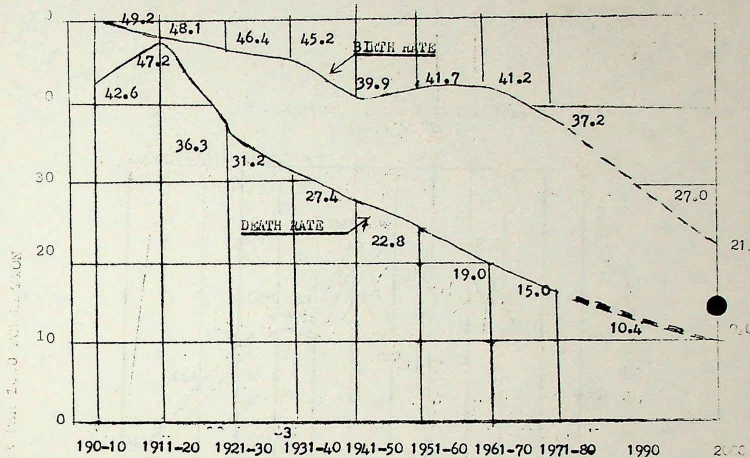


+ SRS ESTIMATES

BIRTH & DEALTH RATES IN INDIA
1901-10 to 2000



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DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III. Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII. Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

..3..

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually suportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII. All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX. All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X. An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, detente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

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HEALTH FOR ALL AN ALTERNATIVE STRATEGY

The existing model of health care services

Since the health care services were first organised by the British administrators, they totally ignored the indigenous belief systems, life styles and health care institutions as well as the practices which formed an organic unity, eg. indigenous medicine and its practices. Hence instead of building on these foundations and evolving a new system more suited to the life and needs of the people with the help of modern science and technology, they decided to make an abrupt and total change by introducing the western system of medicine. This created a wide gulf between culture and tradition of the people on one hand and the health services on the other. It also prevented the valuable contributions which the Indians could have made.

Nevertheless, this type of health care system first began to provide health care services to the people who lived in the towns and the cities and mainly they were profitable for the rich and the elite of the Indian society. Moreover, this urban biased, top down and elite oriented approach of the British period still continue to dominate the health services in spite of the introduction of primary health centre during the past 30 yrs, which extents it services to the rural areas though may be in theory to a great extent.

Moreover, the British administrators were mainly [illegible] with providing curative services by concentrating on putting up or constructing hospitals, dispensaries and medical colleges as well as in training doctors and nurses. They did introduce programmes to improve environmental sanitation in towns and cities.

The urban biasedset up also resulted in the concentration of hospitals in the towns and cities as there are over 6,168 hospitals in India and about 4,50,000 beds which consume enormous amount of the national budget mainly for the salary of the health personnel eg. 75% of the national income is spent for the salary and maintenance.

Hospitals and Primary Health Centres

	1950-51	1960-61	1971-72	1979
Hospitals and dispensaries	8,600	12,000	14,438	17,607
Primary Health Centres	-	2,800	5,195	5,423
Sub-centres	-	-	32,218	40,124
Hospital beds	1,13,000	1,85,600	2,98,304	4,49,212

	1947	1980
Medical colleges	29	106
Doctors registered	47,500	2,53,631
Dental colleges	4	15
Dentists	1,000	7,419

Outlays on Health Sector

5 yrs plans	Total (in million of Rs)	%of total plan outlay
I	1,009.0	4.98
II	2,378.2	4.58
III	2,255.6	2.60
IV	4,335.3	2.14
V	7,960.0	2.13

Moreover, the system depends too much on doctors who have received western type of training which is not suitable to our Indian situation and who are not willing to work in rural areas. Injections and drugs are becoming status symbols of a consumer society. The cultural alienation of the medical profession has led to over sophistication. This also led to over production of drugs and doctors which has led to expansion of ill-health.

Population	660 million(1979)	Rural 80%	Urban 20%
Doctors	235,631	20%	80%
Doctors-population ratio	1:4500	1:20,700	1:1,300

	1950	1977
Number of hospitals	6,168	17,607
Hospital beds	1,13,000	4,49,212

Distribution

Urban 90%

rural 10%

Number of nurses	7,000	1,20,401

Distribution

Urban 90%

Rural 10%

J.P. Naik in his book on "An alternative system of Health Care services in India" says that the unfortunate aspect of the post independence administration is the over emphasis on bureaucracy and failure to involve the people intimately in development. From 1921-47 Mahatma Gandhi had mobilized the people and involve them not only in the national struggle for freedom but also in several constructive programmes like removal of untouchability and promotion of village industries and handicrafts. Hence, if this type of involvement have been continued in post independent era, our development would have taken definitely a different dimention.

We find also that the largest segment of the population does not earn enough to have purchasing power to provide themselves with even 1500 calories per day per head. 1980 report says that Rs. 660/-/head/annum and various surveys by various agencies show that the largest majority in rural area live on about 50 np./day/head. This has resulted therefore in medical care being out of the reach of the common man and the forces which cause ill health are primarily socio-economic factors.

Hence, are the present health care plans including "Health for all an alternative strategy" relevant to the needs of the country? What is our response?

Reference: (1) Health for all an alternative strategy

(2) An Alternative system of health care services in India by J.P. Naik.

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EVOLUTION OF THE HEALTH CARE SYSTEM IN INDIA

The Indian tradition of State intervention in health care is quite old. During the reign of Asoka in 3rd Century BC, the state established medical centres for man and animals, undertook planting of medicinal herbs and trees, and supply of potable water through wells along the highways. In modern times a major role of the State in health care service has universally been recognised and accepted.

Historically, modern health service owes its beginning to the British presence. The first legislation, the Quarantine Act, was introduced in 1825. But real concern for a state operated health service appeared after the 'Indian Mutiny' of 1857, when the safeguarding of the health of the troops and the European civilians became a political necessity. All health measures had only this objective. But the prevalance of endemic and epidemic diseases eventually forced the government to do something for the Indian civil population which relied on traditional indegenous forms of medicine.

In the health sector the British did not leave any significant legacy of an infrastructure. Therefore, a beginning from scratch had to be made after independence. What was left by the British was an exhaustive plan called the Bhore Committee Report, a small network of civil hospitals, a few medical colleges in premier cities and a network of military and railway hospitals. No rural health infrastructure of any significance existed at the time of independence. The expenditure of the British state was meagre.

In 1947 India had :

17654	Medical graduates
29870	Licentiates
7000	nurses
750	health visitors
5000	midwives
75	pharmacists
1000	dentists

The Government of independent India was faced with the choice of either expanding the existing health services along the pattern set by the British or to make radical changes so as to meet the

needs of the ordinary masses. During the freedom struggle, the National leaders had recommended "a National Health Scheme which would provide free treatment and advice to all those who require it and to pay special attention to the health needs of the villagers". But the old colonial tradition of having an urban, curative and privileged class orientation of health service was perpetuated.

The Indian constitution in its 'Directive Principle of State Policy' has vested the state with responsibility for providing free health care services to all citizens. Article 47 clearly states the State's responsibility to raise "the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". But the VII Schedule allocates almost all responsibilities to the provincial government. But health care includes adequate nutrition, safe water and sanitation, healthy environment, education, employment etc. Solution of these is necessarily dependent on the economic system and political programme of the Union Government.

Health Planning in India : Health planning in India is part of socio economic planning. The guide-lines were provided by a number of Committees dating back to the Bhore Committee in 1946.

Bhore Committee, 1946 : In 1943 the Government of India appointed a Committee, known as Health Survey and Development Committee (popularly known as Bhore Committee after its chairman Sir Joseph Bhore). The Committee submitted its report in 1946 and put forward, for the first time, comprehensive proposals for the development of a national programme of health services for the country. The committee proposed preventive work as the "foundation" and the "countryside as the focal point", and emphasised the importance of PHCs for providing curative and preventive health services to the rural areas. The report stressed the need to develop the Primary Health Centres in two phases in the short term programme i.e. 10 years, it recommended a PHC for every 40,000 population and the long term programme a PHC with a 75 bed hospital for every 10,000 to 20,000 population. The recommendation included intergration of preventive and curative services at all administrative levels and introduction of preventive and social medicine in all medical colleges. The committee also relied on western medicine and gave no importance to Indian system of Medicines (ISMs). The committee's report continues to be a major national document and has provided guidelines for national health planning in India.

Mudaliar Committee, 1962 : found the quality of services provided by PHC's inadequate and recommended strengthening of the existing PHCs before new centres were established.

Chadah Committee 1963 : was appointed to study the arrangements necessary for the maintenance phase of the National Malaria Eradication Programme.

Mukherji Committee, 1965 : was appointed to review the strategy for the family planning programme.

Jungalwalla Committee, 1967 : studied the problem of integration of health services and elimination of private practice by Govt. doctors.

Kartar Singh Committee, 1973 : To study and make recommendations on i) the structure for integrated services.
ii) the feasibility of having multipurpose, bipurpose workers.

Shirvastav Committee 1975 : to derive a suitable curricular for training a cadre of health assistants so that they can serve as a link between qualified medical practitioners and multipurpose workers and to suggest steps for improving existing medical education. The most important recommendation of this committee was that primary health care should be provided withing the community itself though specially trained workers so that the health of the people is placed in the hands of the people themselves. This led to the launching of the rural health scheme and the programme of training community health workers during 1977-78.

Unicef|WHO joint health policy termed "Basic health service as "a network of coordinated peripheral and intermediate health units capable of performing effectively a selected group of functions essential to the health of an area and assuring the availability of competent professional and auxillary personnel to perform these functions". National health planning in India was based on the Bhore Committee and the UNICEF/WHO health policy. So a network of primary health centres and sub-centres was established throughout the country.

Five year Plans : In the first plan period the state spent an average of Rs. 39.40 crore per year which was only 2.2% of total Govt. expenditure. Much less than what the British Govt. had been spending. At the end of the first plan, besides 725 PHCs there were 3307 hospitals, 7100 dispensaries in India, the

majority of hospitals belonging to the State.

In the II five year plan the expenditure on medical and public health more than doubled and this pattern continued in each subsequent plan, except during the (plan holiday) and the IV plan when growth rate of health expenditure showed a drastic decline. Health facilities too increased but they were biased in favour of urban areas. With the launching of the Minimum needs programme, from the IV Plan onwards rural health infrastructure began to receive some significant attention.

Table (I) HEALTH PLAN OUTLAYS & PRIORITIES
(Rs. in Cr. & % in brackets)

	Programme	FYP I (1951-56)	FYP II (1956-61)	FYP III (1961-66)	FYP IV (1969-74)	FYP V (1974-79)	FYP VI (1980-85)
1	PHCs & Rural health,	25 (17.86)	23 (10.2)	61.7 (18.05)	76.49 (6.6)	12[illegible].3 (5.44)	576.96 (8.[illegible])
	Hospitals & Dispensaries		13 (5.8)		89.29 (7.7)	132.75 ([illegible])	
2	Control of Communicable diseases.	23.1 (16.5)	64 (28.44)	70.5 (20.63)	127.01 (10.99)	265.09 (12)	524 (7.76)
3	Education, Training & Research	21.6 (15.43)	36 (16)	56.3 (16.47)	98.22 (8.5)	111.16 (5.06	720.09 (10.67) (items 3–5 combined)
4	ISM	.4 (.29)	4 (1.78)	9.8 (2.87)	15.83 (1.37)	25 .07 (1.13)	
5	Other	20.2 (14.42)	6 (2.67)	11.2 (3.27)	28.19 (2.4)	27.29 (1.23)	
	Health sub-total	90.3 (64.5)	146 (64.89)	209.5 (61.29)	435.03 (37.64)	681.66 (30.86)	1821.[illegible] (26.97)
6	Water Supply & Sanitation	49 (35)	76 (33.78)	1[illegible]5.3 (30.81)	407 (35.22)	1030.68 (42.64)	3922.02 (58.08)
7	Family Planning	7 (.5)	3 (1.33)	27 (7.9)	315 (27.26)	497.36 (22.5)	101[illegible] (14.95)
8	Health total	140 (100)	225 (100)	341.8 (100)	1155.53 (100)	2209.7 (1.00)	6753.07 (100)
9	Plan total	2356	4800	7500	15902	39322	97500
10	Health to plan	(5.94)	(4.69)	(4.56)	(7.27)	(5.62)	(6.93)
11.	Health sub - total to plan	(3.83)	(3.[illegible]4)	(2.79)	(2.74)	(1.73)	(1.87)

Table (I) gives plan outlay in the Health Sector and Table (II) gives Health facilities in India. However, looked at in terms of percentages the share of health in the total plan has decreased consistantly from plan to plan with 3.83% in the Ist plan to 1.87% in VIth plan ! Family Planning, water and sanitation always got a high priority and even gained more importance in successive plans whereas control of communicable diseases received much lower priority from the IV plan onwards in terms of percentages spent. The total expenditure on water - sanitation from I to IV plan was 855 crores. Out of this 566 crores was spent in urban areas and 289 crores in rural ie. 66.2% in urban and 33.8% in rural areas. This in a country where 80% of the population live in villages !

(Refer table II on page 6)

Health infrastructure is very poor even today, especially in rural areas as seen from table 2. The best indicator of health care facilities is the number of hospital beds per population. The earliest year for which this break-up is available is 1956 when 28% of all hospital beds (Govt. and Pvt.) we re located in rural area that had 80% of the population. This declined to 13.7% in 1974 clearly showing that rural areas had been neglected grossly in terms of investment in health sector. Even where PHCs∠added over the years has not been adequate for the rural population. Between 1966 and 1984 the ratio of PHC to population has remained constant at one PHC for 80,000 population. There has been a similar stagnation in hospital - population ratio also.

Health for All by 2000 A.D.

The GOI endorsed the WHO target of "Health for All By 2000 A.D." which called for the following intermediate goals :

1985 - Providing right kind of food for all;
1986 - Providing essential drug for all;
1990 - a) Providing adequate basic sanitation for all;
b) Providing adequate supply of drinking water for all;
c) Immunization of children against six common diseases namely, measles, whooping cough, tetanus, diphtheria, polio and T.B.

The targets for 1985 and 1986 remain unrealised. 'food for all' was already a goal of the Indian State since adoption of the Constitution. 3 1/2 decades has not brought that goal anywhere nearer. Regarding medical intervention the facts are as follows : (see page 7)

∠ are concerned it is clear that the number

TABLE II : HEALTH FACILITIES IN INDIA

(selected years)

Year	No of Hospitals	Population Per Hospital (In lakhs)	No of PHCs	Rural Population Per PHC (In lakhs)	No of Beds	Population Per Bed	Percent of Rural Beds	Percent of Hospitals Owned by the State	Percent of Beds Owned by the State	No of Dispensaries	Percent of Dispensaries Owned by the State
1951	2694	1.3	-	-	117000	3199	NA	NA	NA	6515	NA
1956	3307	1.2	725	4.4	157000	2554	25.0	NA	NA	7100	NA
1961	3094	1.4	2565	1.4	230000	1930	NA	NA	NA	9406	NA
1966	4147	1.2	4631	0.8	304000	1628	NA	NA	NA	10236	NA
1971	3976	1.4	5112	0.8	331000	1673	NA	NA	NA	10897	NA
1974	4014	1.5	5283	0.8	355461	1668	13.[illegible]	62.6 (16.0)	69.5 (16.2)	10200	NA
1982	6805	1	5739	0.9	504538	1405	17.2	50.8 (44.3)	68.1 (26.7)	16754	60.9 (14.1)
1984	7181	1	7210	0.8	536370	1378	17.43	49.3 (45.3)	68.1 (26.7)	21780	51.8 (29.6)

(Figures in brackets are percentages in private sector; the remainder is facilities owned by local bodies)

1. State medicare is practically free to all without discrimination from millionaire to pauper;
2. There exists a strong and ever growing private sector of medicare consisting of hospitals, nursing homes, clinics, dispensaries which constitute 3/4ths of the medicare field.
3. State medicare institutions are disproportionately concentrated in urban areas and rural institutions meant ostensibly for comprehensive health care, have mostly turned into curative agencies.

Medicare is provided to the industry workers through the Employe State Insurance (Medical Benefit) Scheme financed jointly by the workers and the employers, Union and Provincial Govt. and medical profession, and operated by the provincial govts. Services are rendered for sickness, maternity and employment injury. This scheme can be viewed as a forerunner of national health service.

The health of a community is measured by certain parameters Eg : infant mortality rate, death rate, life expectancy at birth, sanitation, per capita consumption of food and safe water. In the context of such parameters, India has made steady progress in the post independence period. But in terms of international standards the health situation is still precarious and alarming.

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AN OVERVIEW OF VARIOUS SYSTEMS OF MEDICINE IN INDIA

All ancient civilizations developed their own systems of medicine : Ayruveda, Arabic, Egyptian, Greaeco-Roman, Chinese, etc... Most of them have been practiced in India to some degree. While western medicine or allopathy has been on the scene in India for only about 200 years it has entrenched itself and grown. But now there is a growing awareness of traditional systems like the ayurveda. The Indian system starts with the rigveda in 2000 B.C. and is known as Ayurveda.

Ayurveda in sanskrit means "the science of life". According to ayurveda there are three constituents in the psyiological system called 'doshas'. They are 'vayu'(wind), 'pitta'(bile) and'kapha'(phlegm). Good health results from an ideal balance between the three factors. The ayurvedic physician evaluates the patient and sets right the balance by means of drugs, diet and practices.

There is a predominant 'dosha' in one's constitution and this decides which foods and activities are suited for the person. Ayurveda teaches exercising the highest care in selecting what is wholesome in the matter of food, conduct and behaviour. It does not treat a person in parts. The body is dealt with as an integral unit.

In India today there are

243153 practitioners of ayurveda
1452 ayurvedic hospitals
11100 ayurvedic dispensaries
97 ayurvedic colleges.

Sidha The Sidha system which resembles ayurveda is said to have originated from the sage Agastya with its records in Tamil and is practised almost only in Tamil Nadu and Kerala.

There are

11509 Sidha practitioners

2

105 Sidha hospitals
311 Sidha dispensaries
1 Sidha college.

Unani Unani Tibb came to India as early as the 13th century with the Persian scholars fleeing from Persia and Central Asia. With the support of the Mughal emperors, this system of Arab medicine took root in India under the name 'Unani' which is derived from the Sanskrit 'yavana' meaning Greek. It was the Greek 'father of medicine' Hippocrates who laid the foundation of the Unani system more than 2000 years ago. It is based on the Hippocratic theory of humours. Each person is a combination of four humours - blood, phlegm, yellow bile and black bile. One's temperament is sanguine, choleric, phlegmatic or melancholic depending on which of these humours predominates. The Unani physician treats a person's body as one unit and not the symptoms of the disease. It holds that the human body has its own regenerative powers. Medicine is given to help these regenerative powers to surface once again. There are in India today

28021 Unani practitioners
98 Unani hospitals
860 Unani dispensaries
17 Unani colleges.

Homeopathy Unlike other indigenous systems of medicine, there is controversy on whether homeopathy can be classified as'traditional medicine'. It is neither ancient as ayurveda or Unani nor is it native to India. But it has been so widely practised in India that the government recognises it as a traditional system of medicine. In the 18th century, Hahneman a German physician founded the principles of homeopathy. A basic principle of homeopathy is 'like cures like'. To strengthen the patients' reative powers, he is given a drug known to imitate the particular symptoms observed. In homeopathy it is not the disease that is cured but the symptom it generates in a particular individual.

In India there are today

122173 homeopathic practitioners
121 homeopathic hospitals
2163 homeopathic dispensaries
112 homeopathic colleges.

Naturopathy Holds that good wholesome food, enough sleep, exercise and no tension are prescriptions for good health. The main aim of nature cure is to prevent disease. It teaches a person the principles of balanced living. The body has natural ways to counter the onset of disease. The aim of treatment should be to assist nature in eliminating toxins from the blood. Suppressing the symptoms by medicine, only results in the basic disease becoming chronic.

In India today there are

97 naturopathy practitioners
10 naturopathy hospitals
26 naturopathy dispensaries.

Yoga Therapeutic yoga is basically a system of self-treatment. In any medical system the primary reliance is on medicine. In the yogic system this external agent is not needed at all - rather, it is the patient himself whose personal understanding, practise and care cures his disease. It ensures health by physical and mental purification through control of mind and body.

In India today are

3 yoga hospitals
6 yoga dispensaries

Acupuncture is a system of treating disease by penetrating needles to know points of the body selected according to the disease. Like the traditional chinese medicine system, the principles of acupuncture are based on the concepts of Yin and Yang, the universal opposites. Ill health is due to an imbalance between Yang(male, sun, sharp, strength, warm, positive) and Yin (female, moon, dawn, quiet, cold, negative) and acupuncture is designed to restore the balance. The art of acupuncture is widely known for its pain relieving abilities.

Acupuncture was introduced to India in 1959 at Calcutta by the late Dr. B K Basu a member of the Dr. Kotnis Medical Mission to China.

Allopathy The allopathic system of medicine was introduced into South India by the Portuguese in the early 16th century. It was spread by the doctors of the East India Company & European Missionaries. The allopathic system made major breakthroughs in acute infections, immunization and surgery.

However its costs are high, it makes people dependent on drugs, the side effects of its drugs and abuse of drugs are all drawbacks of this system

Today in India there are

297228	medical practitioners
7474	hospitals
26840	dispensaries
106	medical colleges

Modern medicine had brought hope for everybody once. But now people all over the world are looking for alternatives :
In the west there is a growing demand for "alternative" herbal remedies and in the Third World it is now accepted that cheap readily available remedies should replace expensive western drugs on the market. Almost 70% of our people cannot afford the high cost of drugs and diagnostic proceedures of allopathy. Traditional medicinesare being recommended as an added component to India's health care system because they are cheap and do not have the side effects associated with allopathic treatment.

Sources

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42.12

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AN OVERVIEW OF DIFFERENT COMMUNITY HEALTH PROGRAMMES IN INDIA (MODELS AND APPROACHES)

1. INTRODUCTION

Community health approach to health care has been widely recognised as the right alternative for ensuring health to the poor millions in developing nations. In India too, governmental as well as voluntary efforts are made for the promotion of community health. In the evolution of health care system, this approach has emerged through a process of dialogue between the medical and the social sciences in an effort to make the health care system relevant and responsive to the socio-politico-economic realities in the society. Again, in the process of evolution and formulation of community health in terms of its principles, philosophies and methodologies, various models have been proposed and practised. In this paper an attempt is made to categorise these models into four, each with its own characteristic features.

Further, each model with its characteristics could be explained as following a certain approach in community health. These approaches are broadly divided into three. An understanding of these three approaches could give us a frame work to assess as to which approach each models follows. Another interesting correlation is that each of these three approaches reflects a certain philosophy of development work.

In the following paragraphs an introduction is made into such an analytical overview. In the latter part of this paper the four models with their characteristics are listed out. Under each model, the particular approach into which it fits into it is also given with certain indicators of assessment.

2. DIFFERENT MODELS IN COMMUNITY HEALTH

A study of the ongoing projects and the literature available on them reveals that in India there exists different models/types of community health products. They fall under four major categories. Each one is run by different types of institutional set ups as big hospitals, small hospitals, rural dispensaries, or run by non structured voluntary health/action groups. Again, each model is unique in terms of infrastructure, services rendered, needs met, and the results achieved. It would be clear from the forthcoming table. (P9 —)

3. DIFFERENT APPROACHES IN COMMUNITY HEALTH

Three apprcaches have been identified in community health. They are : Medical approach, health extension approach, Comprehensive approach.

a) Medical approach :

Considers health as the absence of diseases brought about by medical intervention based on modern sciences and technology and sees the role of the community (the people) as responding to the directions given by the medical professionals. It has its roots in the medical model of health care which believes that the eradication of ill health depends on doctors and medicines.

b) Health extension approach :

Based on a critique of medical approach. It accepts WHO defination of health as the total physical, mental and social well being of the individual. Mere advancement of medical technology and the sophistication of services would not bring health to the majority of the people - especially the poor - and that the approach should be a planned re-distribution of health care facilities to reach the vastness of the society. The approach also advocates other socio-economic uplift programmes to enable people to benefit from health care facilities. Preventive care is also emphasized.

c) Comprehensive approach :

Views health, the concept of total well being in the context of the situational realities of the individual. This concept is elaborated by stating that health, the state of total well being, is also a human condition which does not imporve either by providing more services or mobilizing the community for providing more health services. It improves only by having the community take control and responsibility for decisions about how to mobilize, utilize and distribute services and resources. Here community is the subject, decision maker. It is a process of conscientization* organisation and capacitation of the community for action. It has bearing on the social, economic, political and cultural dimensions of human life, in the sense that the approach strives to bring about changes in them so that there would emerge a society where human life would be more healthy in the complete sense of the word.

4. COMMUNITY HEALTH AND THE DIFFERENT APPROACHES IN DEVELOPMENT :

Development work is based on certain analysis of the backwardness of the people. According to the analysis, different philosophy of development work are arrived at. They are mainly three approaches : Modernisation approach, welfare approach, and social justice approach. In the context of speaking about different approaches in community health work, it would be worth mentioning these approaches. It is interesting to note that reflections of these approaches are found in the three community health approaches.

a) The modernization approach analyses poverty as the lack of enough production and it makes efforts to gear up production through advanced technology in the field of agriculture and industry. It believes that the results of modernization would trickle down to the lower strata of society.

b) The welfare approach recognizes different classes and castes existing in the society. It is due to the co-existence of development and under development in the society. This state is accepted as a normal reality. Efforts are made to alleviate the sufferings of the poor through organizing relief and charity work. People are passive receipients here. Recently there has been some changes in this approach and it recognizes the participation of the people and the mobilization of their resource. Programmes also have improved remarkably from relief work to development programmes aimed at the uplift of the poor, through income generating programme, literacy programmes, vocational training etc. The poor continues to exist and the disparity between the rich and the poor also continues as a reality. Statusquo is not disturbed.

c) In social justice approach a critical analysis of the society employed and poverty and backwardness are understood as man made historical reality. The reasons are attributed to the various forces and the dynamics at work in the society. Poverty is precipitated as a result of injustice. Justice could be brought in only through a restructuring of the society. It could be achieved through empowering the people through awareness building and organization. Ultimate development of the poor would mean fair distribution of the means of production, living wages, consumption of good food, availability of public amenities, practice of human values as love, cooperation and unity.

It becomes clear that the analysis and approaches of development work has co-relation with that of community health work, characteristics of modernization approach are reflected in medical approach and features of welfare approach find expression in health planning approach. Social justice approach goes well with, comprehensive approach in terms of its analysis and approach.

5. THE FOUR MODELS AND THREE APPROACHES IN COMMUNITY HEALTH

As mentioned already the community health programme existing in the country could be classified into four based on the characteristics. The following table would give that. Under each programme a note is made as to which approach of community health it belongs to. To make it clear six indicators are given based on which this assessment is made. These indicators are :

- role of health services
- role of professional
- role of community worker
- Community participation
- Evaluation & Financial support.

For each approach these indicators show different explanations.

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* Conscientization is "an awakening of consciousness, the development of a critical awareness of a person's on identity and situation, a reawakening of the capacity to analyse the causes and consequences of one's own situation and to act logically and reflectively to transform that reality"

(David Millwood)

MODEL I

A - CHARACTERISTICS

Type of institution/ Infrastructure	Nature of Services Rendered	Needs met	Result - Qualititative changes
Capital intensive, highly sophisticated and institutionalized big hospitals. Mobile medical team with doctor & medicines	- Extensive service from hospital. - Curative care - Running village clinics. - Referral service, free medicines. - Weekly or fortnightly visits.	- Treatment of minor physical ailments. - Referral and free transportation to the hospital.	- People become more conscious about sickness and medicines. - more patients in the hospital - feeling of dependence in the people, demanding free services. - Shift from home remedies and indigenous medicines.

B - THE APPROACH FOLLOWED

The approach followed is medical approach- The following are six indicators which would help us to make an assessment on that :

Indicators	Explanation
a) Role of health service	- means to improve the health status of the people
b) Role of Medical Professional	- Key to the programme - manager, planner, problem solver, coach, consultant, clinician, leader, teacher, evaluator.
c) Role of community health worker	- a means by which medical advances could be applied more rapidly and effectively.
d) Community participation	- A means to ensure more acceptibility and utilization of services.
e) Evaluation	- Based on analysis and interpretation of statistics which reflect the scope and results of applied medical science and technology.
f) Financial support	- needed to create, expand and maintain the service.

MODEL II

A - CHARACTERISTICS

Type of institution/ infrastructure	Nature of services rendered	Needs met	Result - qualititative changes
Capital intensive, sophisticated and institutionalised small hospitals. Medical team with or without doctor.	- Extension services. - Curative and preventive care - Village clinics - Referral services - Medicines at reduced rates - weekly or fortnightly visits. - Health education - MCH programmes/immunization - Village health workers with medical kit.	- Treatment of minor ailments - referral and free transportation to the hospital - personal and environmental hygeine.	- People meeting in groups - Learn some preventive methods - More patients in the hospital - Learn that they can do something about health.

B - APPROACH FOLLOWED

The approach followed is Medical approach. But there are certain changes, in the sense that it is not strictly Medical approach. There is an inclination towards Health Extension Approach.

Indicators	Explanation
a Role of health services	- means to improve the health status of the people
b Role of medical professional	- Medical professional continues to be the key personnel. But, para medicals gain a role here.
c Role of Community Health Worker (CHW)	- Along with being a person to ensure more community acceptability for medicines, CHW also imparts preventive health education.
d Community participation	- a means to ensure more acceptability to medicines as well as a means to disseminate ideas of preventive health education.
e Evaluation	- Based on analysis and interpretation of health statistics that shows the scope and result of applied medical science as well as the effectiveness of preventive health education.
f Financial support	- needed to create, expand and maintain the service.

MODEL III

A - CHARACTERISTICS

Type of institution/ infrastructure	Nature of services rendered	Needs met	Results-Qualitative changes
Rural health centres manned by nurses, not institutionalised, still very much structured. A team composed of a nurse and social worker.	- Preventive, promotive and curative - Community health workers with simple medicines. - Health Education, Adult Education - Small income generating projects - Kitchen garden - MCH + Collaboration with Govt. and other agencies - village meetings and discussions on different problems - promotion of collective action.	- Better environmental sanitation. - M C H Services - Supplementary income for a section of the population.	- People become aware of the importance of preventive medical care. - Less patients to go to the hospital - Better child care - People try to see health in relation to economic backwardness. - Develop more interaction among the groups, mahilamandals. - People became aware of their collective strength.

B - APPROACH FOLLOWED

The approach followed is health extension approach. The following indicators would make it clear.

Indicators	Explanations
a Role of health services	- as it views that good health isthe result of planned health services, experts from other fields as economists, social workers, etc., are also involved to make services effective.
b Role of medical professional	- The medical professional is viewed as a component rather than key. Further, experts from other disciplines are also involved - economists, social workers, etc. Attempts are also made to include community leaders.
c Role of Community health Worker	- CHW is considered as an agent of change - and works as a multi purpose worker which include medical services, prevention, public health work, health education, nutrition education, food production and housing improvements.
d Community Participation	- Participation of the community is considered important because it provided a resource base, a means to mobilize more resource - personnel, money and material. Mainly it involves the community leaders.

e Evaluation	- Concerned with assessing whether a programme with a variety of activities (ranging from health to economic development programmes) provides the most benefits in terms of health improvements for the least amount of resources.
f Financial support	- Used to build small health centres and to generate community resources - man power, moeny and material. The programme has to be made self supporting.

MODEL IV

A - CHARACTERISTICS

Type of institution/ infrastructure	Nature of service rendered	Needs met	Results-qualitative changes
Rural health centres/ action groups Flexible and non structured. One team composed of a nurse and activitist.	- Services aimed at building healthy communities. - Community diagnosis - Critical understanding of health & its relation to unjust social order. - Awareness building through non-formal education programmes. - Organising the people for collective action. - Exposing social illness - Formation of Action groups, Mahila mandals, youth clubs, village committees, farmer's club, Trade unions. - Demanding services from the Govt. from health as well as other departments. - Identifying and training village animators. - Promotion of low cost and simple home remedies.	- Basic needs met by the people through their organized efforts. - Better services from the Government.	- Participation and collective action of the people to build up a healthy community/ society. - Increased self confidence and independency - Faith in their own power to fight for a healthy society - Health is considered as a right and duty and at the same time seen as a political issue. - People struggling against social injustices. - Cooperation among the people based on critical understanding of social realities. - New forms of politics and new forms of people's movement. - Alternative indigenous medical system developed.

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B - APPROACHES FOLLOWED

In this model the comprehensive approach is followed. The following explanation would make it clear.

Indicators	Explanations
a Role of health services	- The concept of health is totally integrated into the socio-political fabric of the community. Hence health services are a part of a strategy (or an entry point for development and a tool in process of community growth.
b Role of medical professional	- Since the role of health service is to enable change in the existing social structures (to bring about equity of opportunities and services), the profession is viewed as a resource - an enabler, educator and a stimulus. The community is the decision maker which defines the role of the professionals and the professional is accountable to the people.
c Role fo community health worker.	- Community health worker (CHW) is an agent of change, an educator, a volunteer selected by the community. Uses health work primarily as a means of bringing about change in the attitudes and behaviours, and in the long run, social structures through health and development activities. Thus, CHW works towards social justice and social, political and economic equality as well as carrying out the health and traditional community development tasks. CHW could be better called community level worker (CLW) since the work is total development work.
d Community participation	- Community participation in health is a step which will help people gain control over their own lives by collectively working towards making the socio economic and political structures compatible with and conducive to health and development of the poor. It starts with awareness building and organisation. Community is the decision maker in the community programme and through such involvements they go through a process of learning to live together, think together and work together and take control of policies which affect their lives.
e Evaluation	- The community is the evaluator - it is participatory evaluation methods-community decides on the objectives, priorities and methodologies of the process. The development worker, as an enabler helps the community and works with them. The evaluation itself is the tool and a method for community awareness, self determination and growth. In the entire process, stress is laid on the qualitative aspects of the people and the effort at bringing about changes in the existing health delivery system and the establishment of alternative models of the people.
f Financial support	- To spark off a programme finance is needed. But the goal is to start a programme which is able to be sustained through community contribution and commitment not through outside finances. The investment is in education, rather than technology and expanded services. It also means money to identify and develop indigenous resources in terms of man power, materials and support. In terms of health aid, it looks for seed money. Maximum efforts are made to make use of Govt. funds but not at the cost of allowing them to dictate terms. It should never hamper the community in its process of growth towards awareness and organisation.

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CONCLUSION :

Community health is a term understood and interpreted in different ways by different people. This is due to the differences in the analysis of the ill health. Based on one's analysis the programme that is initiated would confirm to a particular approach and philosophy.

This paper, we think, would help the implementors of community health programmes as well as those who intend to start one to develop a still more reflective understanding. This understanding blended with our commitment to the poor would help us all to make our involvement more meaningful.

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- community diagnosis -> approaches

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AN OVERVIEW OF DIFFERENT COMMUNITY HEALTH PROGRAMMES IN INDIA
(MODELS AND APPROACHES)

I. INTRODUCTION

Community health approach to health care has been widely recognized as the right alternative for ensuring health to the poor millions in developing natives. In India too, governmental as well as voluntary efforts are made for the promotion of community health. In the evolution of health care system, this approach has emerged through a process of dialogue between the medical and the social sciences in an effort to make the health care system relevant and responsive to the socio-politicao- economic realities in the society. Again, in the process ofevolution and formulation of community health in terms of its principles, philosophies and methodologies, various models have been proposed and practised. In this paper an attempt is made to categorize these models into four, each with its own characteristic features.

Further, each model with its characteristics could be explained as following a certain approach in community health. These approaches are broadly divided into three. An understanding of these three approaches could give us a frame work to assess as to which approach each models follows. Another interesting correlation is that each of these three approaches reflects a certain philosphy of development work.

In the following paragraphs an introduction is made into such an analytical overview. In the latter part of this paper the four models with their characteristics are listed out. Under each model, the particular approach into which it fits into is also given with certain indicators or assessment.

II. DIFFERENT MODELS IN COMMUNITY HEALTH

A study of the ongoing projects and the literature available on them reveals that in India there exists different models/ types of commuhity health products. They fall under four major categories. Each one is run by different types of institutional set ups as big hospitals, small hsopitals, rural dispensaries, or run by non structured voluntary health/ action groups. Again, each model is unique in terms of infrastructure, services rendered, needs met,and the results achieved. It would be clear from the forthcoming table.

III. DIFFERENT APPROACHESIN COMMUNITY HEALTH.

Three approaches have been identifyed in community health. They are : Medical approach, health extension approach, Comprehensive approach.

(a). Medical approach: Considers health as the absence of diseases brought about by medical interventions based on modern sciences and technology and sees the role of the community(the people) as responding to the directions given by the medical professionals. It has its roots in the medical model of health care which believes that the eradication ofiill-health depends on doctors and medicines.

(b) Health extension approach: Based on a critique of medical approach. It accepts WHO defenition ofhealth as the total physical, mental and social well being of the individual. Mere advancement of medical

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technology and the sophistication of services would not bring health to the majority of the people - especially the poor - and that the approach should be a planned redistribution of health care facilities to reach the vastness of the society. The approach also advocates other socio- economic uplift programmes to enable people to benefit from health care facilities. Preventive care is also emphasized.

(c) Comprehensive approach: Views health, the concept of total well being in the context of the situational realities of the individual. This concept is elaborated by stating that health, the state of total well being, is also a human condition which does not improve either by providing more services or mobilizing the community for providing more health services. It improves only by having the community take control and responsibility for decisions about the how to mobolize, utilize and distribute services and resources. Here community is the subject, decision maker, It is a process of conscientization* organization and capacitation of the community for action. It has bearing on the social, economic, political and cultural dimensions of human life, in the sence that the approach strives to bring about changes in them so that there would emerge a society where human life would be more healthy in the complete sense of the word.

IV. COMMUNITY HEALTH AND THE DIFFERENT APPROACHES IN DEVELOPMENT:

Development work is based on certain analysis of the backwardness of the people. According to the analysis, different philosophy of development work are arrived at. They are mainly three approaches: Modernization approach, welfare approach, and social justice approach. In the context of speaking about different approaches in community health work, it would be worth mentioning these approaches. It is interesting to note that reflections of these approaches are found in the three community health approaches.

(a) The modernization approach analyses poverty as the lack of enough production and it makes efforts to gear up production through advanced technology in the field of agriculture and industry. It believes that the result of modernization would trickle down to the lower strata of society.

(b) The welfare approach recognizes different classes and castes existing in the society. It is due to the co-existence of development and under development in the society. This state is accepted as a normal reality. Efforts are made to alleviate the sufferings of the poor through organizing relief and charity work. People are passive receipients here. Recently there has been some changes in this approach and it recognizes the participation of the people and the mobilization of their resource. Programmes also have improved remarkably from relief work to development programmes aimed at the uplift of the poor. through income generating programme, literacy programmes, vocational training etc. The poor continues to exist and the disparity between the rich and the poor also continues as a reality. Statusquo is not disturbed.

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*Conscientization is "an awakening of consciousness, the development of a critical awareness of a person's on identity and situation, a reawakening of the capacity to analyse the causes and consequences of one's own situation and to act l logically and reflectively to transform that reality" (David Millwood)

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c. In social justice approach a critical analysis of the society is employed and poverty and backwardness are under stood as man made historical reality. The reasons are attributed to the various forces and the dynamic at work in the society. Poverty is preaipitated as a result of injustice. Justice could be brought in only through a restructuring of the society. It could be achieved through empowering the people through awareness building and organization. Ultimate development of the poor would mean fair distribution of the means of production, living wages, consumption of good food, availability of public amenities, practice of human values as love, cooperation and unity.

It becames clear that the analysis and approaches of development work has correlation with that of community health work, Characteristics of modernization approach are reflected in medical approach and features of welfare approach find expression in health planning approach. Social justice aprroch goes well with, comprehensive approach in terms of its analysis and approach.

V. THE FOUR MODELS AND THREE APPROACHES IN COMMUNITY HEALTH

As mentioned already the community health programme existing in the country could be classified into four based on the characteristic. The following table would give that. Under tach programme a note is made as to which approach of community health it belongs to. To make it clear six indicators are given based on which these assesment is made. These indicators are: role of health services, role of professional, role of community worker, Community participation, evaluation and financial support. For each approach these indicators show different explanations.

MODEL I.

A. CHARACTERISTICS

Type of institution/ infrastructure	Nature of Services Rendered	Needs met	Result- Qualitative changes.
Capital intensive, highly sophisticated and institutionalized big hospitals. Mobile medical team with doctor a medicines.	- Extension service from hospital. - Curative care. - Running village clinics. - Referral service, free medicines. - weekly or fortnightly visits.	- Treatment of minor physical ailments. - Referral and free transportaion to the hospital.	- People become more conscious ab[illegible] sickness and medicines. - more patients in the hospital - feeling of dependence in the people, demanding free services. - shift from home remedies and indigenous medicines.

B. THE APPROACH FOLLOWED.

The approach followed is medical approach. The following are six indicators which would help us to make an assesment on that.

Indicators.	Explanation.
a. Role of health service	- means to improve the health status of the people
b. Role of Medical Professional	- Key to the programme- manager, planner, problem solver, coach, consultant, clinician, leader, teacher, evaluator.
c. Role of community health worker	- a means by which medical advances could be applied more rapidly and effectively.
d. Community participation	- a means to ensure more acceptibility and utilization of services.
e. Evaluation	- Based on analysis and interpretation of statistics which reflect the scope and results of applied medical science and technology.
f. Financial support.	- needed to create, expand and maintain the service.

MODEL . II

A. CHARACTERISTICS

Type of institution/ infrastructure.	Nature of services rendered.	Needs met	Results- Qualitative changes.
Capital intensive, sophisticated and institutionalised small hospitals. Medical team with or without doctor.	- Extension services. - curative and preventive care. - Village clinics - Referral services. - Medicines at reduced rates. - weekly or fortnightly visits. - Health Education - MCH programmes/ immunization. - Village Health Workers with medical kit.	- Treatment of minor ailments. - Referral and free transporation to the hospital. - personal and environmental hygeine.	- people meeting in groups. - Learn some preventive methods. - More patients in the hospital - Learn that they can do something about health.

B. APPROACH FOLLOWED

The approach followed is Medical approach. But there are certain changes, in the sense that it is not strictly Medical approach. There is an inclination towards Health Extention approach.

Indicators.	Explanation.
a. Role of health services.	- Means to improve the health status of the people.
b. Role of medical professional	- Medical professional continues to be the key personnel. But, para medicals gain a role here.
c. Role of Community Health Worker (CHW)	- along with being a person to ensure more community acceptability for medicines, CHW also imparts preventive health education.
d. Community participation	- a means to ensure more acceptability to medicines as well as a means to disseminate ideas of preventive health education.
e. Evaluation	- based on analysis and interpretation of health statistics that shows the scope and result of applied medical science as well as the effectiveness of preventive health education.
f. Financial support	- needed to create, expand and maintain the service.

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MODEL .III.

A. CHARACTERISTICS

Type of institution/ infrastructure.	Nature of services rendered.	Needs met.	Results - Qualitative changes.
Rural health centres manned by nurses, not institutionalized, still very much structured. A team composed of a nurse and social workers.	-Preventive, promotive and curative. - Community health workers with simple medicines. - Health education, Adult Education - Smallincome generating projects - kitchen garden - M C H - Collaboration with govt and other agencies. - village meetings and discussions on different village problems. - promotion of collective action.	- Better environmental sanitation. - M.C.H. Services. - Supplimentary income for a section of the population.	- people become aware of the importa[nce] of preventive medical care. - Less patients to go. to the hospit[al] - Better child care. - people try to see health in relati[on] to economic backwardness. - Develop more interaction among the villages, formation of small info[rmal] groups, mahilamandals. - people became aware of their collec[tive] strength.

B. APPROACH FOLLOWED.

The approach followed is Health Extension approach. The following indicators would make it clear.

Indicators.	Explanations.
a. Role of health services.	- as it vews that good health is the result of planned health services, experts from other fields as economists, social workers, etc- are also involved to make services effective.
b. Role of medical professional	- The medical professional is viewed as a component rather than key. Furth[er], experts from other disciplines are also involved - economists, social workers, etc. Attempts are also made to include community leaders.
c. Role of Community Health Worker	- CHW is considered as an agent of change - and works as a multi purpose w[orker] which include medical services, prevention, public health work, h[ealth] education, nutrition education, food production and housing improvements.

d. Community participation. - Participation of the community is considered important because it provi a resourcebase, a means to mobilize more resource - personnel, money ar material. Mainly it involves the community leaders.

e. Evaluation. - Concerned with assesing whether a programme with a variety of activiti (raging from health to economic development programmes) provides the mos benefits in terms of health improvements for the least amount of resour

f. Financial support. - Used to build small health centres and to generate community resources - man power, money and material. The programme has to be made self-supporting.

MODEL . IV

A. CHARACTERISTICS.

Type of institution/ infrastructure	Nature of service Rendered.	Needs met	Results - Qualitative changes.
Rural health centres/ action groups. Flexible and non structured. One team composed of a nurse and activist.	- Services aimed at building healthy communities. - Community diagnosis. - Critical understanding of health and its relation to unjust social order. - Awareness building through non-formal education programmes. - Organizing the people for collective action. - Exposing social illness. - Formation of Action groups, Mahila mandals, youth clubs, village committees, Farmer's club, Trade unions.	- Basic needs met by the people through their organized efforts. - Better services from the government.	- Participation and collective acti of the people to build up a healt community/ society. - Increased self confidence and independency. - faith in their own power to fight for a healty society. - Health is considered as a right duty andat the same timeseen as a politcical issue. - people struggling against social injustices. - Cooperation among the people base on crticial understanding of soci realities. - New forms of politics and new for peoples' movement. - Alternative indigenous medical sy developed.

- Demanding services from the Govt. from health as well as other departments.
- Identifying and training village animators.
- Promotion of low cost and simple home remedies.

B. APPROACHES FOLLOWED

In this model the comprehensive approach is followed. The following explanation would make it clear.

Indicators.	Explanations.
a. Role of health services.	- the concept of health is totally integrated into the socio-political fabric of the community. Hence health services are a part of a strategy(or an entry point) for development and a tool in process of community growth.
b. Role of medical professional	- Since the role of health service is to enable change in the existing social structures(to bring about equity of opportunities andservices), the professio is viewed as a resource- an enabler , educator and a stimulus. The communit is the decision maker which defines the role of the professionals and the professional is accountable to the people.
c. Role of communityhealth worker.	- Community Health Worker(CHW) is an agent of change, an educator, a volunteer selected by the community. Uses health work primarly as a means of bringin about change in the attitudes and behaviours, and in the long run, social structures through health and development activities. Thus, CHW works towards social justice and social, political and economic equality as well as carrying out the health and traditional community development tasks. CHW could be better called, community level worker(CLW) since the wrk is total development work.

d. Community participation.

- Community participation in health is a step which will help people gain control over their own lives by collectively working towards making the socio economic and political structures compatible with and conducive to health and development of the poor. It starts with awareness building and organization. Community is the decision maker in the community programme, and through such involvement they go through a process of learning to live together, think together and work together and take control of policies which affect their lives.

e. Evaluation.

- The communityis the evaluator,- it is participatory evaluation methods-community decides on the objectives,priorities and methodologies of the process. The development worker, as an enabler helpes the community and works with them. The evaluation itself is a tool and a method for community awareness, self determination and growth. In the entire process, stress is laid on the qualitative aspects of the people and the efforts at bringingabout changesin the existing health delivering system and theestablishment of alternative models of the people

f. Financial support.

-To spark off a programme finance is needed. But the goal is to start a programme which is able to be sustained through community contribution and commitment not through outside finances. The investment is in education, rather than technology and expanded services. It also means money to identify and develop indigenous resources in terms of man power, materials and support. In terms of health aid, it looks for seed money. Maximum efforts are made to make use of government funds but not at the cost of allowing them to dictate terms. It should never hamper the community in its process of growth towards awareness and organization.

b

CONCLUSION:

Community health is a term understood and interpreted in different ways by different people. This is due to the differences in the analysis of the ill health. Based on one's analysis the programme that is initiated would conform to a particular approach and philosophy.

This paper, we think, would help the implementors of community health programmes as well as those who intend to start one to develop a still more reflective understanding. This understanding blended with our commitment to the poor would help us all. to make our involvement more meaningful.

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CHURCH RELATED COMMUNITY HEALTH PROGRAMMES
YESTERDAY AND TODAY (AN OVER-VIEW)

Types of institutions engaged in C.H. Programme	Infrastructure	Sergices Rendered	Need s met	Result
TYPE I Capital intensive, highly sophisticated and institutionalized big hospitals	Mobile medical team with a doctor and medicines	- Extension services - Carative care - Village clinics - Referral service free medicines - weekly or fortnightly visits	- Minor physical ail ments - Free transportation fro the seriously sick	- people became more conscious of their sickness - More patients in the hospital - Feeling of dependence - Demand for more free services. - Shift from homeremedies and indigenous medicines.
TYPE II Capital intensive, sophisticated and institutionalized small hospitals	Mobile medical team with or without a doctor	- Extension service - Curative and preventive care - Village clinics - Referral service - Medicines at reduced rates - Weekly or fortnightly visits - Health education - MCH programmes/immunization - Village health workers with medical kit.	- Minor physical ailments - Free transportation for the seriously sick - Personal and enviornmental hygiene	- People meeting in groups - Learn some prevention methods - More patients in the hospital - Learn that they can do something about health.
TYPE III Rural health centres manned by nurses; no institutionzed, still very much structured	a team composed of a nurse and social workers	- Preventive, promotice and curative services - VHWs with simple medicines	- Good drinking water	- People become more confident in their power.

.....2/-

		- Health educations, Adult Education - Small income generating projects - Kitchen garden - M C H - Collobration with Govt. and other agencies - Village meetings and discussions on different village problems - Promotion of collective action	Better environmental sanitation - M . C. H.	-Develop more interaction among the villagers - Less parients to go to the hospitals. - Better child care - Mahila Mandals
TYPE IV				
- Rural health centres/action groups - Flexible and not structured	-One team composed of a nurse and activists	- Services aimed at building healthy communities - Community Diagnosis - Critical understanding of health and it's relation to the unjust social order. - Awarness building through nonformal education programmes. - Organizing the people for collective action - Exposing social illnesses.	- Basic needs met by the people themselves - Better services from the Govt.	- Participation and collective action of the people to build up a healthy community/society. - Increased self confidence and independency - Faith in their own power to fight for a healthy society.

.........3/-

- Formation of: Action groups
  : Mahila Mandals
  : Youth clubs
  : Village Committees
  : Farmers' clubs
  : Trade unions.

- Demanding new services from the govt. and better services from the existing govt. health institutions

- Identifying and training village animators

- Promotion of low cost and simple home remedies

- Health is considered as a right and duty and at the same time seen as a political issue.

- People struggling against social injustices.

- Co-operation among them based on critical understanding of social realities.

- New forms of politics and new forms of peoples' movements.

- Alternative indigenous medical systems developed.

Community Health Department

C H A I

CHURCH RELATED COMMUNITY HEALTH PROGRAMMES
YESTERDAY AND TODAY (AN OVER-VIEW)

Types of institutions engaged in C.H.Programme	Infrastructure	Services Rendered	Needs met	Result
TYPE I				
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.... 2/-

		- Health educations, Adult Education - Small income generating projects - Kitchen gardens - M C H -Collaboration with govt. and other agencies - Village meetings and discussions on different village problems - Promotion of collective action	- Better enviornmental sanitation - M C H	- Developmore interaction among the villagers - Less patients to go to the hospitals - Better child care - Mahila mandals
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- Health is considered as a right and duty and at the same time seen as a political issue

- People struggling against social injustices

- Co-operation among them based on critical understanding of social realities

- New forms of politics and new forms of peoples' movements.

- Alternative indigenous medical systems developed

Community Health Department
C H A I

DUPLICATE

COMMUNITY HEALTH AND THE HEALING MINISTRY OF THE CHURCH

Fr. John Vattamattom SVD
Executive Director.

1 Introduction

Representatives of 134 nations, including India, gathered together at Alma-Ata in the USSR on September 12, 1978 and agreed on the terms of a solemn declaration pledging urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. Thus a new era dawned in the history of health care of mankind. An ambitious target of a 22 year plan was announced to achieve HEALTH FOR ALL by the year 2000 AD. This major International Conference, jointly sponsored by WHO and UNICEF threw open a challenge, redefining the whole health care system and the concept of health itself. It also made it very clear that health is no more an isolated factor and it is not also a mere absense of sickness.

Health, on the other hand, is the state of total well being of individuals, families and communities - physical, mental and social.

We need to add yet another aspect i.e. the SPIRITUAL WELL BEING, an aspect which was absent in the definition provided by WHO. The declaration alsospeaks about the responsibilities of all concerned in maintaining the health of every one.

In this exercise my attempt is to bring out briefly the various aspects and implications of this new approach to health-care. In doing so I am only taking a layman's approach as I am also aware of my limitations. Hence what I am saying is subject to criticism and corrections.

2 Understanding the Concept

The term Community Health is today, perhaps, more misunderstood than understood. Hence it is necessary to have a correct understanding of this. For that the term health itself has to be understood properly. Since health is not an isolated factor, it cannot be defined in a few words. It has to be understood in its relation to man and his environment Since both these are complex and complicated any attempts to define health or Community Health becomes all the more difficult. However I shall try to present how it has been understood in the recent past at various levels.

A simple way of understanding of the term Community Health would be by comparison to the definition of democracy i.e. health of the community, for the community and by the community. In this people are not mere passive recipents of certain services rendered to them but they are active partners in the decision making and implementation of all that is required to maintain the health of individuals, families and communities.

It can be measured by the capacity of the people to take decisions and their undertaking of the responsibility for the decisions they make. In other words in positive terms it is building up of a healthy community, an in negative terms

it is getting rid of social evils, imbalances and injustices and whatever it is that hampers the growth of a healthy community.

HEALTH IS SO PRECIOUS A COMMODITY THAT IT CANNOT BE ENTIRELY ENTRUSTED TO SOME SPECIALISTS, IT IS THE RIGHT AND RESPONSIBILITY OF INDIVIDUALS, FAMILIES AND COMMUNITIES.

2.1. W H O

The definition given by WHO is that it isa state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. As I have already mentioned, earlier, we need to add also the dimension of spiritual well-being without which the definition would not be complete

2.2 Primary Health Care has a lot to do with community health. According to the Alma-Ata declaration, it is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community, through their full participation and at a cost the community and the country can afford to maintain, at every stage of their development, in the spirit of self-reliance and self-determination

2.3. Health for all by the year 2000

Dr. H. Mahler, Director General of WHO explins as to what it means, in relation to Primary Health Care and also Community Health. "It is not a single, finite target: it is rather a process leading to progressive improvement in the health of all people. The concept of health for all in this process will be interpretted and adapted differently by each country in the light of its social, economic and even political characteristics, the health status and the morbidity patterns of its population and the state of development of its health system.

It does not, of course, mean that in the year 2000, or before that, doctors and nurses will provide medical care for everybody in the world for all their existing ailments; nor does it mean that in the year 2000 nobody will be sick or disabled. It certainly cannot be envisaged in purely technocratic terms, such as doctors, nurses, hospitals, drugs, X-ray equipment and so forth. Health for all does not mean just more of all these. The idea that "more of the same" will solve our problems is no longer valid.

What health for all really means is that health begins at home in schools and at work places. It is there, where people live and work, that health is created or broken. What is really means is that people will use better approaches than they do now for preventing disease and alleviating unavoidable disease and disability and have better ways of growing up, growing old and dying gracefully. It certainly does mean that there will be an even distribution of whatever resources for health are available and that much greater efforts will be made to apply what is already known on the promotion of health and the prevention and control of disease. It also means that essential health care will be accessibleto all individual and families in a way acceptable to all of them, which they can afford and with their full involvement.

IT FINALLY MEANS THAT PEOPLE WILL REALISE THAT THEY THEMSELVES HAVE THE POWER TO SHAPE THEIR LIVE AND THE LIVES OF THEIR FAMILIES, FREE FROM THE AVOIDABLE BURDEN OF DISEASE AND ARE AWARE THAT ILL-HEALTH IS NOT INEVITABLE"

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2.4 The Pontifical Council, Cor Unum, on Primary Health Work

Even before the Alma-Ata declaration the Church also has given clear cut directives in understanding the concept of Primary Health Care and community health.

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 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 practise community medicine.

The mission that we have been given is a call for a true conversion of our hearts and also of our methods. Secularisation is spreading in people's hearts from the industrialized and technological world to the developing (world) countries. We need to be converted all the time in order to bear witness as Christians to the sick who, through our work will discover the love of Christ. The rapid development in the field of health service technology has often meant installing expensive equipment in the hospitals, requiring a large number of staff for a relatively low number of patients while in many of the same countries in the world up to 80% of the population are still without healthcare services. 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

Let us ever be mindful of the fact that service to the sick begins and continues to operate through the patient's human environment.

Community Health Care is, therefore, part of the comprehensive pastoral work of the church.

Christians are citizens just like anyone else, and must be committed to the struggle against under development. The example and the teaching of Christ and the exhortations of the Popes shed light on this commitment and serve as a guide and encouragement to them in their work which they undertake for the love of God and their fellow-men. If they work in the field of medicine and nursing, the evangelical reflection mentioned as the beginning will lead them to ongoing conversion of heart to provide a better service on behalf of a suffering members of Christ and to awaken the communities of men to their responsibilities in this area.

While this new primary health care policy is taking shape, members of the religious congregation must take a good hard look at the current conditions under which they are working in order -- where necessary-- to re-direct them. It some times happens that as a result of changes which not everyone is necessarily aware of, too many of them work in hospitals and health centres that have become too expensive for the majority of the population, and are only within reach of the pockets of a certain "elite" who can afford them. In this case the leaven is too far removed from the loaf.

2.5 The New National Health Policy of Government of India

As a follow up of the Alma-Ata declaration our country which was also a signatory of the declmation, brought out a new health policy which again gives us sufficient directives.

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The Constitution of India envisages the establishment of a new social order based on equality, freedom, justice and the dignity of the individual. It aims at the elimination of poverty, ignorance and ill health and directs the State to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, specially ensuring that children are given opportunities and facilities towards development in a healthy manner.

The existing situation has been lagely engendered by the almost wholesale adoption of health man power development policies and the establishment of curative centres based on the Western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in our country The hospital based, disease and cure-oriented approach towards the establishment of medical services has provided benefits to the upper cursts of society, specially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas. Furthermore the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of health care. The existing approach instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems, The prevailing policies in regard to the education and training of medical and health personnel, at various levels, has resulted in the development of a cultural gap between the people and the personnel providing health care. The various health programmes have, by and large, failed to involve the individuals and families in establishing a self-reliant community. Also, over the years, the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes.

Presently, despite the constraint of resource, there is disproportionate emphasis on the establishment of curative centres - dispensaries, hospitals and institutions for specialised treatment - the large majority of which are located in the urban areas of the country.

A dynamic process of change and innovation is required to be brought in the entire approach to health manpower development thus ensuring the emergence of fully integrated bands of workers functioning within the "Health Team" approach.

2.6. Statements by the C B C I

If the various statements made at the CBCI - Catholic Bishops' Conference of India level are indicators, the church in India is also equally aware of the situation. The concept of health is very much linked up with those of justice economic situation etc. The Church has no other alternative than to uphold certain values that will recognise human dignity and fight against all forces that will hamper this. As early as 1972 the CBCI made the statement. ' The CHURCH SHOULD ACTIVELY INVOLVE ITSELF IN REMOVING CONCRETE CASES OF INJUSTICES HAPPENING IN THE SOCIETY IN WHICH IT EXISTS". This was following a statement by the Synod of Bishops in Rome in 1971: "ACTION ON BEHALF OF JUSTICE AND PARTICIPATION

IN THE TRANSFORMATION OF THE WORLD FULLY APPEAR TO US AS A CONSTITUTIVE DIMENSION OF THE PREACHING OF THE GOSPEL"

Specifically on the health sector the CBCI stated in 1978. " We want our health services to take primary health care to the masses, particularly in the rural areas and urban slums Catholic hospitals and dispensaries should stress the preventive and promotive aspects of health care. Specifically, we would urge them to join hands with the civil authorities in their programmes for the eradication of leprosy.

"Our health out-reach programmes may demand a change in the routine especially of religious communities of men and women involved in this work, and their formation should prepare them to meet the new spiritual challenges that are posed".

Discussing the situation of our country today, CBCI Commission for Justice, Development and Peace in which health is a component, in its meeting in January 1983 made our option very clear when it said:

"The Commission being conscious of:

a. the situation of massive poverty of over 60% of our people.

b. the unjust structures which maintain and prepetuate it;

c. the injustices perpetuated on the weaker section of the people;

considers it imperative to reaffirm our commitment to the poor in limitation of Christ's preferential option for the poor.

The creative struggle of the people to bring about a new society invites us to enter into critical collaboration with people of all religions, idealogies and agencies who strive for a just society.

A meaningful participation in this struggle calls for:

a. a serious analysis of society with tools of social science and in the light of faith:
b. taking a definite and un-ambigous stand on various issues.

c. initiating concrete action programmes for change.

As a credible sign of this process the Church initiates sections for justice within its own structure. In this context participation of all sections of people especially of the laity is of vital importance."

"With this orientation in view the Commission proposes the following priorities of work in the field of health:

1. Promote Community Health Programmes on a priority basis.

2. Train health care personnel with a bias to rural health programmes. In this connection, it is of utmost importance to reorient doctors, nurses and para-medical personnel in our institutions and programmes in Christian values".

2.7. Life and Teachings of Christ

We are all so familiar with this that any elaboration of it would be unnecessary. Two outstanding passages among many which He specifically mentioned about the purpose of his coming and which have direct reference to our present context are John 10:10 and Luke 4:16-20.

2.8 CHAI'S Philosophy and Vision of its Community Health Programme

The Community Health Department of CHAI also felt the need for a correct understanding of its role in the field of health. All the points mentioned above were the basis for its conclusions. Accordingly we believe that:

1. In a country like India, so vast and varied, where 80% of its population lives in the rural areas and about 90% of the country's health care system caters to the need of the urban minority, a new orientation and re-thinking of the whole health care system is the need of the hour.

2. Health is the total well-being of individuals, families and communities as a whole and not merely the absence of sickness. The demands an environment in which the basic needs are fulfilled, social well-being is ensured and psychological as well as spiritual needs are met. Accordingly a new set of parameters will have to be considered for measuring the health of a community such as the people's part in decision making, absence of social evils in the community, organising capacity of the people, the role women and youth play in matters of health and development etc., other than the traditional ones like infant mortality rate, life expectancy etc.

3. The present medical system with undue emphasis on the curative aspect tends mainly to be a profit oriented business, and it concentrates on 'selling health' to the people, and is hardly based on the real needs of vast majority of the people in the country. The root causes of illness lie deep in social evils and imbalances, to which the real answer is a political end, understood as a process through which people are made aware of the real needs, rights and responsibilities, available resources in and around them and get themselves organised for appropriate actions. Only through this process can health become a reality to the vast majority of the Indian Masses.

4. The concept of Community Health here should be understood as a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right. Thus it is beyond mere distribution of medicines, prevention of sickness, and income generating programmes.

3. CURRENT SITUATION/AREAS OF CONCERN

After having considered the various understandings of the concept of Community Health in relation to man and his environment, I would only mention in brief the current situation of the health care system in our country. For fear of being too lengthy I shall not elaborate any of the points. There are a number of areas of concern based on the present situation.

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3.1 Allocation of budgets and health care personnel

Today in our country 80% of the health budget and nearly 90% of the health care personnel are utilised in urban areas where only 20% of the population lives while, where 80% of the people live, health care facilities are negligible and in some areas totally absent. What about the distribution of men and money in this field with regard to the Church?

3.2 Total absence of or lack of safe drinkingwater facilities in more than 300,000 of our villages, after 37 years of Independence.

3.3 Imported Health care system still prevailing in our country.

3.4 Ever increasing cost in health care delivery beyond the means of any average person let alone the really poor

3.5 Ever growing unethical practices in health care delivery system by indiscriminate practitioners and over prescription of drugs, unnecessary investigations and even performance of surgery etc. merely for increasing income for the institutions.

3.6 A medical education and nurses' training system which are imported and geared to taking care of the elite. Health care personnel, particularly doctors trained under this system become rather a 'marketable commodity' than Christ-like apostles to the sick.

3-7 Nuclear War: a threat to Health

Medical evidence of the possible destruction of our present civilization in the event of a nuclear war is becoming irrefutable. Nuclear war coulddestroy in a single stroke the achievements of thousands of years of human effort. Could a commitment to "Health for all" include an increasing pro-life, anti-war commitment?

4. FUTURE OF HEALTH CARE APOSTOLATE IN INDIA

From all that has been mentioned above a relevent question may be raised, i.e. what is the role of the Church in the field of health in India? To answer this question is not easy as the field itself is so complex. Health care is a field in which the Church in India has been busy for over a hundered years. With more than 2000 health care institutions all over the country run directly by the dioceses or religious congregations, the volume of work being done by the Church is enormous. With one well established medical college and more than hundred nurses' training institutions we train every year an army of health care personnel and add to the already existing ones in the field. With these tremendous resources at hand the Church in India can bring about a new revolution in the field of health as it is expected of us also. In order to do this we need to commit ourselves to certain priorities. If our commitment is similar to that of Christ i.e. "PREFERENTIAL OPTION FOR THE POOR" The Chruch will have to take to heart the community Health programme and make it a movement. Any movement is dynamic and to make community health a movement it has to be motivated by the complete involvement of the people. The Church will have to give the lead through her organisations at various levels. What is urgently needed is that the Church takes an official stand on the side of the common man by promoting Community Health as a movement.

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5. CONCLUSION

" "The medical establishment has become a major threat to health. The disabling impact of professional control over medicine has reached the proportions of an epidemic" Wrote Ivan Illich at the beginning of the introduction to his book "Limits to Medicine". Though strange to read it points out to a certain reality that exist today in the field of medicine and health care. Yet committed as we are to the cause of the people of God especially that section whom Christ also preferred, we need to bring about a change in the present system. As Dr. Ravi Narayan wrote in the May-June issue of our journal, Medical Service: "With the increasing emphasis on 'Primary Health Care', we are all in on an increasingly important quest for PRIORITIES. We have to seek. clean water before antibiotics, food before vitamin pills, vaccination before kidney machines, mother's milk before powdered babyfoods mixed with dirty water, and health for villagers and slums before more hospitals for the affluent suburbs of capital cities". This is a commitment to Christ's preferential option for the poor. This is a commitment to Community Health as a movement. This is a challenge before the Church in India which we will have to take if we want to be relevant to today's situation in our country.

THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

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MINISTRY OF THE CHURCH IN HEALTH SERVICES

Introduction :

"Action on behalf of justice and participation in the transformation of the world fully appear to us as a constitutive dimension of the preaching of the Gospel".

- Synod of Bishops 1971

"Behind the revolutions of our day, is man's struggle for human dignity. Christ is at work here and we cannot proclaim Him to contemporary man if we do not participate in this struggle. In such participation we have to work with men of all faiths and no faith. Christian living is, in this sense, living in response to the WORD and to the world. It demands the conscious transcendence of our limited groups solidarities and moving towards the new humanity which is free from all discriminations".

- National consultation on the role of Church in contemporary India, 1966.

"If we wish to be faithful to Christ and take up this attitudes with regard to our fellowman, we must work for the over all 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".

- Pontifical Council Cor Unum, Document on Primary Health Care Work, 1978.

"The mission that we have given is a call for a true conversion of our hearts and also of our methods. Secularization is spreading in people's hearts from the industrialized and technological world to the developing world countries. We need to be converted all the time in order to bear witness as Christians to the sick who, through our work, will discover the love of Christ. The rapid development in the field of health service technology has often meant installing expensive equipment in the hospitals, requiring a large number of staff for a relatively low number of patients, while in many of the same countries in the world, upto 80% of the population are still without health care services.

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 conjuction with the public services, where this is allowed.

Let us ever be mindful of the fact that service to the sick begins and continues to operate through the patient's human environment. COMMUNITY HEALTH CARE IS THEREFORE PART OF THE COMPREHENSIVE PASTORAL WORK OF THE CHURCH".

- Cor Unum Document, 1978.

"Presently, despite the constraint of resources, there is disproportionate emphasis on the establishment of curative centres - dispensaries, hospitals institutions for specialised treatment - the large majority of which are located in the urban areas of the country .... A dynamic process of change and innovation is required to be brought in the entire approach to health man power development ensuring the emergence of fully integrated bands of workers functioning within the "Health Team" approach".

- New National Health Policy, 1982.

"The demand for justice has been one of the dominant notes of this half of the country. Perhaps no other period in History has witnessed a greater denial of justice also .... 'The Church, bearing within itself the pledge of the fullness of the Kingdom, views with joy the present concern for justice and with anxiety the grave threats to justice all around us. It is her endeavour to interpret the implications of the Gospel message of justice and peace in the varying situations being unfolded in the course of the human pilgrimage on earth. She has to be the 'Leaven' and the 'salt' of the earth in the confusion likely to prevail in the search for justice".

- CBCI, 1978.

"The Church should give its whole hearted support to the peaceful social changes taking place in the country by verbalising its support of any efforts made for bridging the gap between the rich and poor.

"The Church should actively involve itself in removing concrete cases of injustices happening in the society in which it exists".

- CBCI, 1972.

"We want our health services to take primary health care to the masses, particularly in the rural and urban slums. Catholic Hospitals and dispensaries should stress the preventive and promotive aspects of health care. Specifically, we would urge them to join hands with the civil authorities in their programme for the eradication of leprosy.

Our health outreach programmes may demand a change in the routine especially of religious communities of men and women involved in this work, and their formation should prepare them to meet the new spiritual challenges that are posed".

- CBCI, 1978.

" The commission being conscious of :

a the situation of massive poverty of over 60% of our people;
b the unjust structures which maintain and perpetuate it;
c the injustices perpetuated on the weaker section of the people;

considers it imperative to reaffirm our commitment to the poor in imitation of Christ's preferential option for the poor.

The creative struggle of the people to bring about a new society invites us to enter into critical collaboration with people of all religions, ideologies and agencies who strive after a just society.

A meaningful participation in this struggle calls for :

a. a serious analysis of society with the tools of social sciences and in the light of faith;
b. taking definite and unambiguous stand on various issues;
c. initiating concrete action programmes for change.

As a credible sign of this process the Church initiates action for justice within its own structure. In this context participation of all sections of people especially of the laity is of vital importance".

- CBCI, 1983.

"With this orientation in view the Commission proposes the following priorities of work, in the field of health :

1 Promote Community Health Programmes on the Priority basis;
2 Train health care personnel with a bias to rural health programmes. In this connection it is of utmost importance to reorient doctors, nurses & para-medical personnel in our institutions and programmes with Christian values.

3 A commission could be set up to study the prevailing conditions and problems, attitudes and values of doctors, nurses, para-medical personnel and other employees.

- CBCI, 1983.

The relevance of quotations cited above can be viewed by different people differently depending on the concept of health one has. One thing is getting more and more clear that health is no more an isolated factor and it is not merely the absence of sickness but the total well being social, physical, mental and spiritual of individuals, families and communities. It is in this sense that the above quotations have their relevance when dealing with ministry of the Church in Health Care.

Health care is a field in which the Church in India has been busy for over a hundred years. With more than 2000 health care institutions all over the country run directly by the dioceses or religious congregations, the volume of work done by the church is enormous. With one well established medical college and more than hundred nurses' training institutions we train every year an army of health care personnel and add to the already existing ones in the field. With the emphasis since some years on the field of community health, a new army of village level health workers (called under different names) are trained and they are in the field. We have also national organisations, under the auspices of the Church, dealing with various aspects of health care i.e. the Catholic Hospital Association of India, Catholic Nurses' Guild, Catholic Doctors' Guild, Natural Family Planning Association of India etc. This certainly shows the richness of the resources at our hand. The question will have to be asked is are all these properly utilised for the best interest of the people of God in India particularly the vast majority of them living in rural areas and urban slums.

1. COMMUNITY HEALTH :

CHAI has definitely committed to this cause for the coming years. And we do hope to do something thereby contributing our share to achieve the goal set by WHO and accepted by our country, i.e. Health For All by 2000 A.D. This we hope to achieve through our member institutions and others, and with the cooperation, help and guidence particularly from the members of the CBCI and CRI. We have now an eight member team for the promotion of Community Health. The team has worked out a philosophy and vision for our community health programme and a broad plan of action.

2. Promotion of Pro-Life Activities :

Efforts will have to be made by all concerned to bring an awareness about the seriousness of this all important aspect of life. CHAI will be taking some definite steps in this regard in the coming years.

3. Pastoral aspect of health care :

This is a field rather neglected by the Church. Complaints about even rude behaviour by the Staff towards patients in our health care institutions are not a rare phenomenon. Then the question is, have we given them the necessary training and orientation ? Keeping this in mind CHAI organises seminars for health care personnel from time to time. It is our plan to develop a separate department in CHAI to meet this crying need in our country. We also plan to organise regular residential course for Chaplains etc. in the future.

Against all what has been mentioned, particularly the various documents mentioned, the following suggestions are put forward for Justice, Development and Peace in General and the health section in particular. In this connection, it was very meaningful to have put the health section with commission for justice, development and peace.

1. To have an evaluation of our existing institutions for education, training and services in the field of health in accordance with the present concept of health mentioned in the documents (of also the CHAI documents)
2. Community Health Programme accepted as a priority should be promoted in all the Dioceses. The members of the CBCI and CRI should accept this end and make it known to all our health care institutions.
3. In order to implement this, St. John's Medical College, National Organizations like CHAI, NEPAI, CARITAS INDIA, IGSSS etc. will have to plan together in collaboration with other organisations in the field such as VHAI, CMAI, ISI etc.
4. Possibility of organisations like, CHAI, Catholic Nurses' Guild, NEPAI to work together will have to be explored, for better effect and to avoid any unnecessary duplications.
5. The teaching of the concept of Community Health based on the various documents dealing with the subject should find a place in the Curricular in Seminaries and Religious formation houses.

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6. In this connection this commission will have to work in collaboration with the commission on Seminary Training etc.
7. This commission should also work in collaboration with the commission for Laity and Family.

These are a few suggestions, however practical they may be which came to my mind. The implementation of them may be difficult but necessary if we want to respond to the needs of the time. We all agree that making statements (for which we seem to be experts in this country) alone will not solve the problems. We need to translate them into action, which is by far difficult. But we are left with no choice but to do it if we want to be meaningful to the society today and faithful to the gospel message. Let me conclude this with another quotation, this time from Ashok Menta.

"We must reclaim 900 million people (the number is more now) of the world who are today in a state of abject depression. This human reclamation requires a peculiar type of social engineering. This is to my mind the big challenge that all people, all men of religion, all men of God have to face. And if it is the proud claim of the Christian Churches that they have that spiritual understanding, that spirited agony and that spiritual out glow is greater than that of other men of God, it has to be proved, as I said in the crucible of life itself. If it is the claim of Christians that even to this day they feel the agony of Christ on the Cross whenever humanity suffers as it were, it has to be proved, in action and not by statement".

Fr John Vattamattom svd
Executive Director
Catholic Hospital Association of India.

23-11-87/200

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OUR VOCATION ......A CALL

God's call is freely given. It signifies choice, a breaking with all humanities, and mission.

If God calls, it is in order that we correspond with His plan of love, to make known to us His will to stir up in us a response of love and to send us on a mission.

It is in response to God's call that we have committed ourselves to live and to serve - our vocation

The call is a direct command which God addressess to a person whom he has chosen for Himself, and whom He destines for a particular work in His plan of salvation.
Gen. 12:1, Ex 3:10-16, Jerl. 4-9

When God calls, He sends; He gives a mission Gen 12:1; Ex 3:4-11, [illegible]-22; Is 6:9, Am 7:15

Sometimes, seized with fear, the person called tries to evade the call. Ex 4:10ff; Jr.1:6, 20:7-18, Jn 1-4.

Sometimes acceptance is instantaneous Gen. 12:4, Is.6:8. But in his fear as well as in his generosity, in his power to resist as well as to respond, the person called is completely given over to the Lord in all His truth, and for each one, according to the situation in which he is placed at the time of the call, there is a personal response to this will of God, setting him apart for God's work.

Come! Jesus calls many to follow Him. (Mk. 3:13; 10:21; Lk 9:59-62) The account of the calling of the Apostles demonstrates well the personal character and the supremacy of the choice of Jesus, taking with Him "those He wanted" to accomplish His work. Mk. 3:13.

His preaching is also a call to follow Him in a new way of which He possesses the secret Mt. 16:24. The call is a choice 'to be His companions' Mk 3:14, and a sending in His name to be His witnesses Mk 6:7-13.

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How Paul and Peter understand the call:	Rom. 4:17, 1 Pet.1:3:11
Every Christian life is a vocation:	Rom. 8:16
Purpose of God's call:	ICor. 1:26,2:5,Eph 4:14
Community of this call the church	2Jn:1

Entering by grace with the mission of Jesus, like His followers of all ages, our apostolic identity and spirituality refer to an act of 'being sent' not as to a mandate, but as to an invitation to a privileged relationship which bears witness to intimate friendship and a shared idea.

To follow God is to take the road by which He led His people. At the time of Exodus; to pass through the desert into the promise land. This is what fedelity demands.

To follow Christ is to walk the road of the Paschal Mystery, the path He trod for us so as to lead us from death to life; it is to share His destiny. This is not done without breaking ties without taking risks.

SENT: The one who is sent is someone entrusted with a mission. After God had sent the Prophets, God sent His Son, who in His turn, sent His desciples, empowered by the Holy Spirit, to continue to carry out God's work or plan.

"I am sending you" this phrase is at the heart of every prophetic calling (Ex 3:10; Jr. 1:7, Ezk 2:3ff, 3:4ff) Each one responds to the call of God according to his personal temperment. Isaiah offers himself: "Behold here I am, send me" (Is. 6:8) Jeremiah accredit his mission (Ex 3:11ff); he tries to refust it. (Ex. 4:13) he complains bitterly (Ex 5:22); but finally, all obey (Am 7:15). This consciousness of a personal mission received from God is an essential trait of the true prophet.

Reflection: Each day the invitation comes
To find yet deeper meaning in the missionary call;
It urges me to go beyond myself,
To widen the horizons more and more,
To enter into true communion,
With "the other", my neighbour;
This means embracing His mentality,
His language, His culture,

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His Very Heart............
Universality means setting self aside,
Putting others first, being open all the time.

Again, each day it also bids me seek
The deeper aspects of that other call:
To live as a true "sister" in community
With all the self-surrender that implies;
The welcoming smile, the sympathetic ear,
Whole hearted acceptance of each one,
The sensitivity to signals; promptness to forgive
With self-effecing love,
Accepting to be overlooked oneself.

Yes, day by day I must confront this challenge,
To seek new depths of union in my life with God,
Letting my heart be opened wider yet
To the dimension of universal love
A love that liberates and heals
An all-transforming love.....
For love is greater far
Than my poor heart.

Ps. 138 (139).

Song. Come follow me.........

COMMUNITY HEALTH DEPT.
C H A I

CATHOLIC HOSPITAL ASSOCIATION OF INDIA

EVANGELISATION MEANS PROCLAMATION OF THE GOOD NEWS OF SALVATION TO THE POOR.

Its signs are: The Blind see, the Deaf hear, the Dumb speak, the Lame walk, the Captives are set free and the oppressed are liberated. (LK 4, 18; 7,22).

The Blind: The Poor were unable to see the powers and forces which dominate and exploit them because the Elite, to keep up their status quo, never let them see the reality of domination and exploitation. They brainwashed them, with the words of "Humility, service, obedience, blessed are the poor, the will of God etc..,".

See: Now they see, because critically aware of these forces which dehumanise and exploit them and they see also the ways and means which put them in the path of liberation and progress.

The Deaf: For the people who were conditioned to live in perpetual slavery and suppression the words, freedom, equality justice and human dignity meant nothing because they never experienced these realities. As a result they were deaf to them.

hear: Now they hear, they understand the meaning of human dignity freedom, equality, justice and development. Their ears are attuned to these realities because they already experience them in their common discussions and action programmes and in their co-operative living.

The Dumb: Centuries of suppression and Domination made them silent. They were not allowed to express their opinions. They had only to listen, do and die. As a result they were afraid to open their mouth, thoughts, ideas and feelings. Others thought for them, spoke for them and decided for them thus made them Dumb.

Speak: Now the silent masses are getting organised and have gained the courage to express their thoughts, ideas and feelings boldly. They discuss their life problems above all take their own decision.

The Lame: The age old master, servant relationship made the poor depend on their masters for every thing. Their masters never let the stand and walk on their own feet. They remained as children continuously depending on their "benefactors" for every thing.

Walk: Now they are confident to stand and walk on their own feet independently as adults. They will never allow themselves to be crippled by any dominating and exploiting powers, because now they know that it is in walking on their feet they and their children are going to achieve their development.

The captives: The social, economic, political, cultural and religious systems favoured the Elite and kept the poor in fear, poverty and illiteracy and made them blind and deaf to the dehumanising and exploitive factors.

are set free: The critical understanding of these systems librate them in their thoughts and attitudes and motivates them to struggle for their liberation and progress with hope. Thus they are no more passive victims of exploitation but courageous agents of change and commited architechts of their own destiny.

This movement from darkness to light, ignorance to knowledge, slavary to freedom is called salvation. Through a process of action-reflection-action...... the poor are already experiencing this reality. They were blind, now they see, were deaf, now they hear, were dumb now they speak, lame now they walk. Thus this action reflection programme becomes good news to the poor though apparently it is a bad news to the Elite, the Masters, because the poor challenge their dehumanising thoughts and systems. If the Elite are not prepared to change their evil ways they will never be able to experience the kingdom of God, the Kingdom of Equality, Justice, Truth and Brotherhood." They have eyes, but they do not see. They have ears but they do not hear..."

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THEOLOGY OF LIBERATION

This is not an academic treaties on theology. A pragmatic and analytical approach will be used in this paper.

For an ordinary man in the street or in the village, theology is not a very respectable word today. This is not because there is any misgiving about God - Theos - but because the theological approach has come to mean a mere recitation of certain propositions, dogmas and faiths, with out any concern for their relationship to reality. Theology is not an experience to them, neither do they turn experience into theology.

The history of theology, and for that matter Christianity is well-known for its continued accommodation and adaptation of the changing historical circumstances and to a large scale social movements. But today the social transformation and situations are of a different order than it was in the past. Now, is it possible and up to us to accommodate and adapt?

In the socio political environment in which we exist today, the Church is called upon to fulfil its salvitic mission. This environment is vastly different from what it was ten years ago.

Latin America :

The theology of liberation developed in Latin America during the 1960s, through an outgrowth of both the changing political climate on that continent, and of the liberalizing trends which took place in the Catholic Church as a result of Vat. II. Vat. II sharpened with in the Latin American Catholic community a concern for the poor. For the Christians here, the gospel became a revolutionary document. Jesus was the Liberator, who placed himself squarely on the side of the poor and the oppressed against the forces of injustice and exploitation. To follow Jesus for these people was to identify as He did and to work with the poor for the Liberation of all, who suffered from injustice.

Although untill recently the church in Latin America was closely linked to the established order, it is beginning to take a different attitude regarding the exploitation, oppression and alienation, which prevails here. Individual christians, small communities, and the church as a whole are becoming more politically aware and are acquiring a greater knowledge of the current Latin Americal reality, especially in its root causes. The christian community is beginning to read politically the signs of the times in Latin America.

The Advocates of the Latin American Liberation theology vehemently asserts their right to evolve a theology out of their own experience. But the traditional and established theologians are sceptic about it on the ground that theology is made too much anthropoligical.

Situation in the Church :

The Church in the first centuries, with its minority

status in society and the consequent pressures from the non-christian world, was very sensitive to the action of Christ. (They shared everything in common .... Acts --4. 32-35)

But this situation of the christian community changed in the fourth century. Instead of being marginated and attacked christianity was now tolerated (Edict of Milan - AD 313), and quickly became the religion of the Roman State (Decree of Thessalonica, 381 AD). The proclamation of the gospel was then supported and protected by the political authority. This gradually changed the manner of conceiving the relationship of mankind to salvation. By the middle ages, when the church was co-extensive with the known world of that time and deeply pervaded it, christians had the vital experience of security and tranquility, and that we proclaimed that outside the church, there is no salvation. To be for or against Christ came to be fully identified with being for or against the church. This still prevails in the church and that we have fully forgotten the "Mission aspect" of the church (To be the salt and light of the world). Today we are more aware of our self sufficiency, and that christ is made to speak what we want him to speak.

The church was more concerned about the number of people saved, (New conversions without giving profound reflection on salvation) and naturally the church tried to work out the roles which it has to play in this process.

In the early centuries of the church, theology was closely linked to the spiritual life (realm). This theology was monastic, and therefore characterized by a spiritual life removed from worldly concerns. The christian spiritual life in the early centuries was thus characterized by withdrawal from the world, (world, devil, body) (Lack of love not a sin) and it was presented as the model way to sanctity.

But with St. Thomas Acquinas, theology began to be characterized as an intellectual decipline, born of the meeting of faith and reason, and it was considered as a rational knowledge.

But gradually, we are realising that salvation is not something other worldly in regard to which the present life is merely a test. (The kingdom is among you) Salvation in this real sense means communion of men with God and the communion of men among themselves. The church must cease considering itself as the exclusive place of salvation and orient itself towards a new and radical service of people.

All the same, can the church be a prophet in our day, if she herself is not turned to Christ. She doesn't have the right to talk against others, when she herself is a cause of scandal in her interpersonal relations and her internal structures? We cannot talk of the church of the poor without being a poor church; and that is just what we are refusing to be - in our life style, transport facilities, our homes and the property we own.

The church has for centuries devoted her attention to formulating truths and meanwhile, did almost nothing to better the world. In other words, the church focused on orthodoxy and left orthopraxiz in the hands of non-members and to non-believers.

The fact that there is an interlocking of interests between the institutionalized church and the dominant class of society constrain her involvement in the work of genuine liberation. In order to be more responsive to people's aspirations, she needs to dissociate herself from the dominant class by giving up her interests. She is so much linked with such system, almost as partners in a marrage (Church the sprouse of Christ).

In the 19th and 20th centuries, a new awakening is slightly visible in the attitude of the church. Pope Pius XII, John XXIII's 'Mater Et Magistra', 'Pacem In Terris', Paul VI's 'Populorum Progressio', in all these development - integral development of man - is considered. Gaudium Et Spes (Vat.II) uses the term 'liberation' on two occasions. 'Populorum Progressio' speaks clearly of building a world where everyman, no matter what his race, religion or nationality, can live a fully human life, freed from servitude imposed on him by other men or by natural forces over which he had no sufficient control.

In the words of Congar, if the Church wishes to deal with the real questions of the modern world, it must begin a new chapter of theologico-pastoral Epistemology. Instead of using only revelation and tradition as starting points, as classical theology has always done, it must start with facts and questions derived from the world and history. So theology itself has to be liberated from every form of religious alienation. A theology which is not up-to-date is a false theology.

Theology has to be linked to the praxis, and should fulfil a prophetic function, in so far as it interprets historical events, with the intention of revealing and proclaimin their profound meaning. It has to be a theology which is open in the protest against trampled human dignity, in the struggle against the plunder of the vast majority of people, in liberating love, and in the building of a new, and fraternal society (Kingdom of God).

We believe it to be our right and duty to denounce as evil and sinful; Inadequate wages, lack of food, exploitation of the poor, suppression of freedom etc. It is here that we often makes the mistake, many of us, of considering this a political attitude, and therefore outside our sphere. Yet, Christ's own prophetic action and fidelity to truth certainly presuppose an inevitable involvement in politics.

The commitment to the creation of a just society and, ultimately to a new men presupposes faith, hope and love and confidence in the future. (Example of Abraham, Moses ... Heb. 11)

We have to build a church which is both in its preaching and practice committed to the poor, to the weak, and to the exploited.

God in History:

The God whom we know in the Bible (history of Bible) is a Liberating God, a God who destroys myths and alienations a God who intervenes in history in order to break down the structures of injustice and who raises up prophets in

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order to point out the way of justice and mercy. He is the God who liberates slaves (Exodus & Egypt) who causes empires to fall down and raises up the oppressed.

In the dawn of human history, God was seen as a transcendental being (Mountain) and then a universal being. Then the concept of God changes (Exodus - Arch) to localization and he was seen as linked to a particular people (Israel). And then it gradually extends to all the people of earth (Amos: 9/7; Is. 41:1-7) Is.40:20-25, entire book of Joshua). To love Yehoa (or to know Yehoa) is to do justice to the poor and the oppressed. Prophets criticizes the worship that is devoid of the touch of reality. "Though you offer countless prayers and sacrifices, I will not listen. There is blood in your hand .... cease to do evil and learn to do right, pursue justice and champion the oppressed; give the rights of orphan, plead the widow's cause. (Is. 1:10-17)

Our encounter with God occures in our encounter with men, especially in the encounter with those whose human features have been disfigured by oppression, despoliation and alienation, and who have 'no beauty, no majesty'."

(Is.53:2-3)

This becomes more clear in New Testament. Through humanity, each man has become the temple of God.(St.Paul) We meet God in our encounter with men, we encounter him in the commitment to the historical process of mankind. In St. Mathew's Eschatological discourse, 'the least of my brethren (25:40) designates all the needy; whoever they may be, and not only christians or a particular group of people.

The spirituality of liberation will centre on a conversion to the neighbour; the oppressed, and the exploited. Conversion to the Lord implies the conversion to the neighbour. This means a radical transformation of ourselves, ie. thinking, feeling, and living as christ, present in exploited and alienated man. It means to commit oneself to the process of liberation with an analysis of the situation and a strategy of action. The christian has not done enough of conversion - ie. commitment to the neighbour, to social justice, to history.

In the New Testament Christ is presented as the one who brings us liberation. Christ the saviour liberates man from sin, which is the ultimate root of all disruption of friendship, and of all injustice and oppression. Christ makes man truly free, that is to say, he enables man to live in communion with him, and this is the basis for all human brotherhood - the Kingdom of God.

In this perspective, sin is not only an impediment to salvation in the after life. In so far as it constitutes a break with God, sin is a historical reality. It is a breach of the communion of men with each other, it is a turning in of man on himself, which manifests in the withdrawal from others. Because sin is a personal and social infra-historical reality, a part of the daily events of human life, it is also, and above all an obstacle to life's reaching the fullness we call salvation.

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Christ came and proclaimed the Kingdom of God which meant a society where, fraternity, justice and love prevails, i.e. complete communion of men with God and of men among themselves.

The poor of whom Jesus speaks and who surrounded him are the truly poor, the hungry, the afflicted, the oppressed, and all those for whom society has failed to provide a place. Through this solidarity with the poor, Jesus proclaimed his Father's love for all mankind - and he was persecuted!

Towards a New Theological approach for India:

The situation in India as we have seen, is so dehumanizing that no christian can idly stand by and call himself a follower of Christ. All the same the traditional response of the church to this situation is still inadequate. The young people engaged in social action in India today are really surprised to find that the kind of Jesus they have met in homilies and catechism classes becomes irrelevant in the actual life situations of the people.

The picture of Jesus transmitted through monastic spectacles, who prefers order and quiet, lots of prayer, and minimum commitment to dangerous issues, and who feels at home amidst flowers and incense, and likes to dwell in well constructed monastic houses surrounded by high walls, is out-dated for India, and is irrelevant to committed people.

To start theologizing for the exploited, we have to move out of our institutions - church structure - which silences the prophetic voice of the Bible.

Theology as a function was always present in society, - India and elsewhere - but at a certain moment in history, there arose a professional class of theologians. It must have been because the society had reached a stage of surplus production, when some no longer needed to work with their hands and could take some other persuits. Some began to use this leisure to theologise. Without being conscious of it, their theology was bound to be a class theology, because such theologians depended on the upper class for their maintenance. This is true not only of theology, but of the social sciences as well. (In China professors doing manual work).

It is natural that every type of society produced a theology to legitimize the position of the new dominant class. So we had a feudal theology, a capitalist theology, and now we are trying to produce a socialist theology.

The Church in India has become so much inward-looking (status, position, institutions) that it can never heal itself. The 'mission' entrusted by Christ is not found here. We have to proclaim the gospel - also to the rich, hoping that some atleast may be converted. In addition, we have to realize that announcing the 'good news' also means announcing the 'bad-news' to some. The 'blesseds' have to be accompanied by the 'woes'.

As Paulo Freire says, According to the oppressed, to be a man is to be like the oppressed. This is true in

theology also. The oppressed have internalized the God of the oppressor - which in fact is not the real God (Death of God theology).

For an authentic theology for India, and Indian situation, it has to start from the daily day experiences of the common man in India. The imported western theology can only perpetuate and stabilize the situation in India today.

Conclusion:

God acts in history for human liberation, from every form of oppressive condition - including the opression of poverty, racism, sexism, and colonialism. Liberation theology is thus a theology of salvation for the whole person. Liberation Techology takes its roots in the lived historical experience of a people. It demands an adherence to it more than just an intellectual commitment. It demands a conversion to a new way of life.

Community Health Dept.

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SOME GUIDELINES ON WHY AND HOW TO MAINTAIN A VILLAGE DIARY

A diary is a note book in which we write down regularly, the significant happenings in our life. It is a personal account of our thoughts, feelings and observations of events which we consider important to us.

Similarly, a village diary is a record of significant events which we have seen or heard about during our village visits. It is also a record of our own thoughts, feelings and observations about our village.

Why do we need to keep a village diary?

1. It helps us to see the change in our villages over a period of time. This changes could be:

    - in people's attitude towards us
    - in people's living habits
    - more unity in the village etc.

Eg: After working for a number of months in a village the local dai brings a pregnant woman to us for examination. This could mean that the dai has finally accepted us as persons who will help per and not try to take away her livelihood. She has changed her attitude towards us!

2. It helps us to see the change in our own attitudes and behaviour towards the people we are working with. Over a period of time we may have:

    - developed greater trust in the people.
    - understood the reasons for certain habits in the village
    - learnt how to resolve conflicts in village meetings etc.

3. The above points are extremely useful in evaluating the effect of our community health Programme. Changes in attitude and behaviour are different to evaluate, so making note of significant events in the village can help us see the change over a period of time.

4. A village diary can help a new member of the team familiarize herself with all that has beenhappening in the village. It will help her to get to know the finer details of the village in a shorter time.

How do we maintain the village diary?

1. Keep a separate diary for each village.
2. Note down the date of the visit.
3. Below the date give a short summary of the visit. This should include the following:

    (a) Any significant event like discussions with the Sarpanch, village leaders, quarrels in the village etc.,

    (b) Any observation and tentative conclusions drawn from the observation;

    (c) Plan of action if any for the next visit.

4. All village meeting mustbe recorded even if they are routine meetings.

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5. Make it a habit to fill in thevillage diary immediately after the visit, otherwise you will forgetto note down important points.

6. It is necessary to record every single visit to the village.

Read the sample from the diary of "Bhedia" village on this page. This will give you an idea of how tomaintain your village diary.

N.B.: One of the expectations of the CHIT course is that each teamkeeps a record of their village visits in the form of the village diary.

The Diary of a Health Team: Village Bhedia

March 4th

Today Radha and I visited the village. We talked to the Panchayat President (Name- Ramaiah). We met him just as he was leaving the house. We explained to him about the kind of work we would like to do in thisvillage. He did not seem very interesred. I think he was getting late. Any way he has promised to be in at home next week when we come. We also met the school teacher. He gave us tea. His wife is quite nice. She could help us in future with our work.

March 11th

Radha was not well; so I took Shanti with me to visit the village. We met Mr. Ramaiah, the Panchayat President. He asked about Radha. He has been interested enough to recognize us. We talked about our dispensary in Janakpuri. He wants us to start a dispensary in this village. We did not promise him anything much. As we were talking some more people joined us. One was the school teacher. The other was the Gram Sevak. The Panchayat President has promised to call a meeting next month as all the people in the village are busy with the harvest now. We were again invited to the teacher's house. Some of the village women came to the house to see us out of curiosity. They seemed happy to see us. We noticed a lot of children with Vit. A deficiency (Bitots spot)

March 18th

We went straight to the teacher's house. Some/of women were waiting for us in that house. One of them was pregnant and had swelling of the feet. We gave her advice and asked her to come to the health centre or send her husband to get the medicines. The other women in the group said that there was no one to take care of them when they had a problem and we discussed the problems a pregnant woman faces. Quite a good visit.

March 25th

We met the panchayat President to fix up a date for the meeting. The date for the meeting is April 1st. We also met some people in thevillage and told them about the meeting. Everyone in the village seems to be in a good mood. They have had a good harvest.

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April 1st

Meeting at 7 p.m. We had to wait for an hour for the people together. I was getting impatient. But Radha said that this is the way in the village and the people did not mean to be disrespectful when they didn't turn up on time. The Panchayat President said that they needed a dispensary in the village and has agreed to let us use the school building for the clinic. The people will pay for the medicines but if someone cannot pay the Panchayat President will stand guaranteed. (I think he wants to stand for the next election also). We discussed with them that our aim in working in the village is to improve the general health conditon and not for curative work alone. I dont think they understood very clearly what we meant but seemed quite cooperative and open. I think it will take time. We did not discuss about a village health worker etc.

April 22nd

Didn't enter the last two weeks' visits. I was very busy. We are conducting a weekly clinic, but it is getting to be a problem. We don't have a jeep and there is only one bus that reaches the village at 7 a.m. and leaves around 8.a.m. The teacher suggested that we go in the evening stay overnight and leave the next morning. We will have to discuss it with the other team members.

April 29th

We have decided to stay over night in the village. We will try it for a month and see how it owrks. The vist was very good. We staryed in the village at night. All the women gathered after dinner and we sang some Bhajans with them. One problem in this village seems to be the drinking water. The women have to walk 3 miles to fetch water. We discussed with the Gfam Sevak. We are planning to meet the BDO this week. The Gram Sevak will accompany us-

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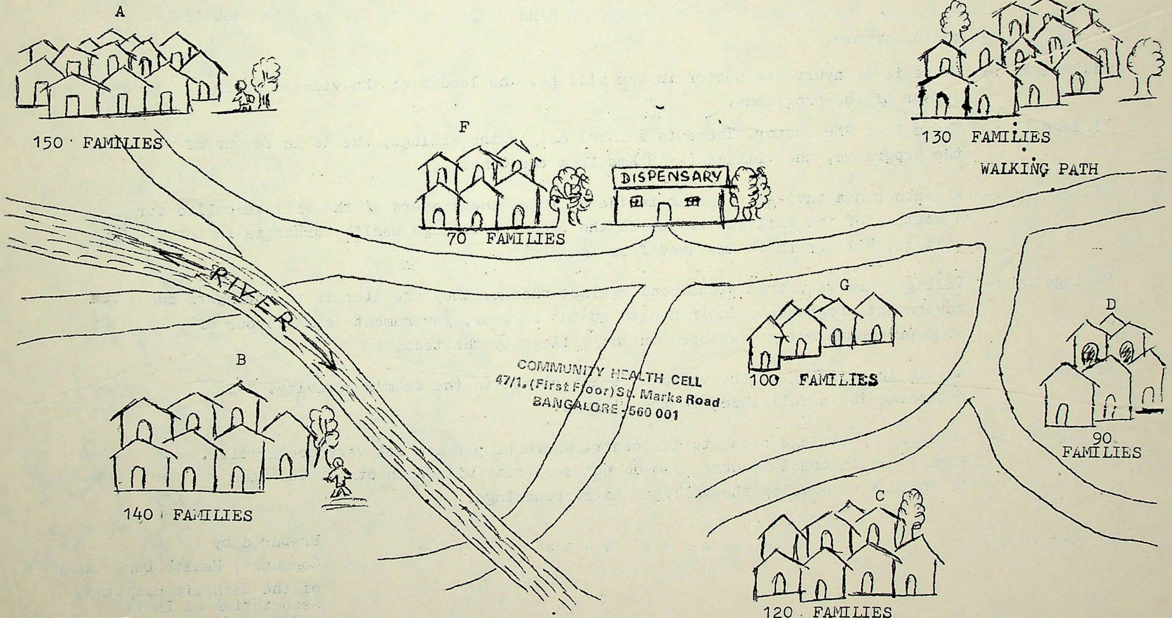
CHOICE OF A VILLAGE FOR COMMUNITY HEALTH PROGRAMME



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From your experience, as well as from the insights you have received during these days please choose a village from among the 7 villages in this map, for initiating a Community Health Programme. On the next page, some more information are available on each village.

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SELECTION OF VILLAGES TO START A COMMUNITY HEALTH PROGRAMME

By now, you and your team would have decided the location of the Community Health Programme to be attached to your Health Centre, discussed the staffing pattern and resources needed for it. Now, you have to decide in which villages to start the programme and what to do there.

To select villages for the programme we would propose the following procedure:

A. Study the different villages situated in the target area, their needs, population, and resources;

B. Select villages for starting the Community Health Programme.

A. Study the different villages situated in the target area, their needs, population, and resources:

Visit all villages situated in the target area.
In each village:

i. meet all officials and leaders;
ii. find out, informally, the socio-economic-politico-religious structure;
iii. find out what organisations are already existing: Mahila Mandal - Youth Clubs etc.;
iv. find out resources which can eventually be used for the programme;
v. find out readiness of the people to change.

B. Select villages for starting the Community Health Programme:

Once we have gathered information on all the villages of the target area, we will have to decide which are the most appropriate villages for us to start our programme in. We must not take too many villages to start with, and, at this point, it is good to remember that Community Health Programmes require regular and prolonged village visits. The number of villages to be taken will have to be decided according to the availability of staff to be involved in the programme.

When selecting villages it is important to remember that:

- the chosen villages should be of a manageable size. This would mean villages with about 1000 to 1500 people. Bigger the village bigger the difficulties we will find in it. In some area it would perhaps be difficult to find villages with 1000 people. Then we would, of course, choose smaller ones. Still when choosing we must remember that we would like our services to go to the greatest number of people.

- It is important to choose a village where we will be almost sure of the interest of the people and where we find them ready to involve themselves in the programme.

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- It is important for the programme to have, from the beginning, the support of the leaders, informal and formal ones.

- the choice of first village is important. We should start in villages where people are more responsive to our ideas. Such villages may not necessarily be the most needy ones. If we start in a village ready to accept change and if we succeed, then the nearby villages will want the same for themselves. It will then be easier for us to reach the very needy villages which are our actual target.

Once the villages are selected, you must:

i. intensify visit to these villages. They must be visited regularly at least once a week, preferably on the same day each week. These visits should be utilized to find out the real and felt need of the people;

ii. if possible, organise village committees with representatives of all groups present in the village;

iii. involve the people in detailed planning - fix up with them realistic objectives to be implemented.

At this stage, these objectives could be:

- health survey of under five children to determine future priorities of the under five children programme;
- complete general datas on the village so as to be in a better position to identify the weakest group or the poorest families in the community. This study would help for planning activities to solve related problems;
- selection, by the community, of possible candidates to be trained as Village Health Workers;

iv. during the weekly visits the professional staff will deal with

- minor ailments
- ante-natal care

CONCLUSION

During the residency course in Community Health we repeatedly emphasised the need of involving the peole in the programme from its beginning. After all, the problem of a village are the problems of the people living in it. It is, therefore, normal that the people should be part of the possible solution of that problem. It means that:

- we must know the people's problem
- we must know the local resources available in the community
- we must be ready to discuss with the people, understand them, find out their readiness to accept change
- we must plan the programme with the people
- we must involve the people in the implementation of the programme
- we must regularly discuss the result of the programme with the people

The Community Health Programme you plan to have must be a People's Programme, meant to meet the People's need and helping People to find a feasible solution to solve these needs. It should never be "your" programme.

Prepared by: * * * * * * * * * *
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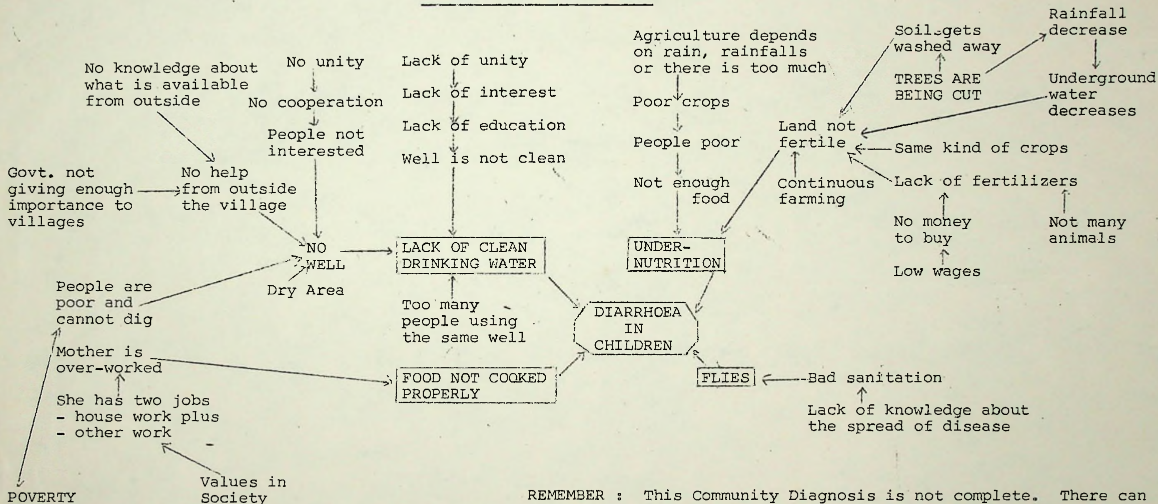
Voluntary Health Association of India,

42-15

COMMUNITY DIAGNOSIS

of Diarrhoea in Children



REMEMBER : This Community Diagnosis is not complete. There can be many more reasons which lead to diarrhoea in children. Find out the actual reasons from the people in each of your villages. A complete diagnosis leads to a complete treatment.

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BASE LINE SURVEY

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In the process of selecting our target area and then the specific villages in which we will work, we would have found that the people of each village live with a number of problems. As a team of health workers, we have to find out which of these problems are more important to the community. A good way to find out this information is by conducting a baseline survey. Such a survey helps us to determine the initial health status of a population.

What is a baseline survey?

A survey is a systematic way of collecting information about the community. The baseline survey is done before we start a comprehensive Community Health Programme. Because this survey gives data about the health status of people before the programme is started it is called a baseline survey. The baseline survey is done ONLY ONCE.

The baseline survey can help us in:

1. assessing the health needs of a community
2. enabling local leaders to become more aware of the health conditions in their community
3. increasing the community's awareness of the health problems facing them
4. setting objectives for a comprehensive community health programme with the community
5. identifying the 'At Risk' population (that needs special care)
6. evaluating achievements and draw backs of the programme and resetting priorities at a later stage.

When to do a baseline survey?

We should do the baseline survey

A. AFTER WE HAVE

1. selected the villages we want to work in
2. intensified visits to these villages

also

B. AFTER THE COMMUNITY

1. has had time to understand our motives
2. has realised the need for a community health programme
3. has understood the concept of community involvement
4. has understood why we want to do a survey and know how we will use the information collected.

When the staff of a health centre does a survey before they know the community and the community knows them, people misunderstand the purpose of the survey. The people may resist and give false information, distrust the staff, and ill feelings on both sides can be generated. The staff may even decide to discontinue work in the village. It is therefore very important that the community be well prepared before doing the survey.

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Who does the survey?

We are likely to get more accurate information if we ask members of the community to do the survey. Help of the following groups or individuals can be taken:

1. School teachers
2. Members of local youth clubs, Farmers' Clubs, Mahila Mandals - etc.
3. Local leaders both formal and informal
4. The village health worker (if the community has already chosen one)
5. Any interested member of the community

It is important that the people chosen to do the survey have a good relationship with a majority of the people.

What information do we collect?

The health status of a community is reflected in the health of the mother and child, as these are two of the most vulnerable groups in the community. Therefore to begin with we collect information about these groups. If we want to start a specialized programme such as programme for leprosy control, TB control, etc., data can be collected for these purposes also.

How to record the data?

We can use a note book or register for this purpose. You can record the baseline data in the first pages of this register. A sample table giving the information to be recorded is attached at the end of this paper. (Table I).

The information for each family should be entered under each of the headings.

Some Definitions:

House Number is the same as Malaria Survelliance House Number.

Family is a group of people

- who are blood relatives;
- living under the same roof;
- and sharing the same kitchen.

If the people are living in the same house, but have 2 kitchens, they are considered as two separate families. In this case, it should be recorded as follows:

S. No.	H. No.	Head of Family
4	15	Ganesh Chand
5	15	Babulal

......3/

Head of Family - The person who takes all major decisions in the family. (If in a family the son earns but the father takes the decisions, the father is still considered head of the family)

How to use the data collected?

1. Total all the columns at the end of each page. Then make a grand total for each column so that you have the total figures for the village.

Total of column 2	=	Total number of households
Total of column 5	=	Total population of village
Total of column 6	=	Total number of married women in the reproductive age group
Total of column 7	=	Total number of pregnant women at the time of the survey
Total of column 9	=	Total number of children 0-1 years (Total number of births in the last year)
Total of column 10	=	Total number of children 1-5 years
Total of column 9+10	=	Total number of under fives
Total of column 11	=	Number of children already immunized
Total of column 12(a)	=	Total number of deaths in children between 0-1 year in the last year (infant mortality)
Total of column 12(b)	=	Total number of deaths in children between 1-5 years
" " 12(a) + 12(b)	=	Total number of deaths in children between 0-5 years
Total of column 12(c)	=	Total number of maternal deaths
" 12(a)+(b)+(c)+(d)	=	Total number of deaths in the village

Guidelines for checking if the collected information is correct:

If our results differ greatly from the average figures given below, it is because:

either the figures do not tell the whole story which may be due to

- unsupervised work
- faulty addition of the figures
- faulty questions used
- Harijan quarters or some other part of the village not visited
- small village, chance variation from the average

or the village is much different from the average which may be due to

- progressive village or block, district or state
- previous health work done in the area
- some other cause

......4/

Average figures for a population of 1000:

1. Number of houses – 125 to 200

2. Number of women in the reproductive age (15 – 45 years) – 200 (15 – 20% of the population)

3. Number of children between the ages of 0-5 years – 150 (15% of the population)

   This figure may be higher in areas where nutrition is good or family planning services are poor. This figure may be lower in areas where veneral disease (which causes sterility) is high, or where there is poor nutrition.

4. Number of malnourished children between the age of 0-5 years – 90 to 120 (60 to 80% of under-five population)

5. Number of children born per year – 30 to 40

6. Number of pregnant mothers in one year – 45 to 60 (1½ times the number of births in the village)

7. Number of obviously pregnant mothers at any one time in a village (after 6 months of pregnancy) – 10 to 13 (1/3 of the number of births in the village)

8. Cases of tuberculosis:

   a. Number of people with sputum positive tuberculosis – 2 to 8
   b. Number of people with sputum negative tuberculosis – 11 to 17

9. Number of people with leprosy – This may vary from 0 to 25 or even more.

How to set priorities on the basis of baseline data?

Eg. 1. If there is a high infant mortality due to diarrhoea, then the priorities would be:

   a) health education of mothers on the importance of rehydration drink;
   b) to improve the drinking water supply of the village.

Eg. 2. If 90% of the married women are in the reproductive age (15 years to menopause) and the average number of children per family is four, family planning programme should be a priority.

It is important to discuss the findings of the survey with the community before any definite strategies are planned. Programmes planned with the community have a greater chance of success.

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BASELINE SURVEY

Field	No.
Date	1
Serial No.	2
House No.	3
Name of Head of Family	4
Total No. of members	5
Married women 15-45 with husbands alive	6
No. of pregnant women	7
Family Planning acceptance	8
No. of children: 0-1 yr	9
No. of children: 1-5 yrs	10
Immunization Received: DPT 1	11
Immunization Received: DPT 2	
Immunization Received: DPT 3	
Immunization Received: POLIO 1	
Immunization Received: POLIO 2	
Immunization Received: POLIO 3	
Death in last 1 year: 0-1 yr. (12a)	12
Death in last 1 year: 1-5 yrs. (12b)	
Death in last 1 year: Maternal (12c)	
Death in last 1 year: Others (12d)	
REMARKS	13

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I M M U N I Z A T I O N

In our country diarrhoea is the first major cause of death in children. Communicable diseases like diphtheria, whooping cough, tetanus, polio, tuberculosis and measles from the second major cause of death. The tragedy is that the illness and death due to communicable diseases can be easily prevented. Immunization is a simple and an inexpensive way of doing this.

A child gets whooping cough only once. When a child gets whooping cough his body makes a substance called antibodies. These antibodies fight against the germs of whooping cough and kill the germs. After these germs die, the antibody remains in the body of the child for a long time. Later at any time if the germs of whooping cough enter this child's body again, the antibodies that were produced earlier, fight against the new germs and kill them. This child does not fall ill with whooping cough again. In other words the child had developed immunity (resistance) for whooping cough. In the same way, our bodies can develop immunity (specific antibodies) for each of the communicable diseases listed above.

There are different ways by which our bodies develop immunity:

1. Passive Immunity: The antibodies for a particular disease are supplied ready made to the body. This can be done in two ways:

(a) Natural Passive Immunity: The mother passes her antibodies to the baby in her womb. The antibodies are also supplied to the child through the breast milk of the mother. Eg. Antibodies for Tetanus, Measles.

(b) Artificial Passive Immunity: The antibodies are taken from an immune person or immune animal and injected into the person who needs it urgently.

Passive immunity is a quick way of transfering immunity from one person to another. The effect of this king of immunity does not last for long in the person who receives the anti-bodies. The is because the antibodies are destroyed quickly and the body does not know how to produce its own.

2. Active Immunity: The body develops this immunity in two ways:

(a) By getting the actual disease (infection): In the example of whooping cough given earlier, we saw that a child gets a disease and makes its own antibodies. A well nourished child will be able to make the antibodies faster than an under nourished child. This is why the severity of the disease is less in a well nourished child.

(b) By Immunization: In this a small quantity of the germs of a disease are injected purposely into a person. The body of the person responds in the same way as it would to a disese i.e. by producing antibodies. After this the body has enough anti-bodies to fight against the actual infection.

The germs we inject for immunizing are called vaccines. These germs can be killed (dead vaccine) or made weak (live vaccine) The method of injecting the vaccines is called Vaccination or Immunization.

Examples of live Vaccines: (Germs that are made weak but are alive)

Polio,
Measles,
Tuberculosis.

Examples of deal vaccines: (Germs that are killed)

Diphteria
Whooping cough
Tetanus.

In active immunity the body takes a little longer to produce antibodies but the antibodies last longer as compared to passive immunity.

POINTS TO REMEMBER ABOUT IMMUNIZATION

a. Age. We must try and immunize children before the usual age when they have the disease. Eg: Maximun number of children get diphtheria between the age of two and five years. So children should be immunized against diphtheria before they they reach the age of two. As a general rule we must immunize all the children before the age of one. Very young children below three months of age are not good at making antibodies and they already have ready-made antibodies from the mother. So one must not immunize children too early. There is a best age to give every vaccine and we must try and immunize our village children at the right age. (however, when we start an immunization programme we might find many older children who have not received the vaccines at the right age. We should still immunize them.

b. The right number of doses: Each vaccine has to be given in the right number of doses as recommended. If we reduce the number of doses of the vaccine, its effect is lessened. Eg: BCG vaccine(for tuberculosis) needs to be given in two doses whereas DPT vaccine has to be given in four doses. Wtih each dose of the vaccine the amount of antibodies produced increases and its effect lasts longer.

c. The right interval between doses: (Time between doses): For each vaccine the right interval between doses is different. If the doses of a vaccine are given too soon then the child will not develop a strong immunity. The interval between the first and second dose is most important. If the gap between the first and the second dose is too long, then the first dose is ineffective. This child should be considered as a new case for immunization.

d. Strong the vaccine: This is very important. If the vaccine not stored properly the vaccine will get spoilt. Spoilt vaccines are useless. A spoilt vaccine will not be able to stimulate the child's body to make antibodies.

ALL VACCINES MUST BE STORED AT THE RECOMMENDED TEMPERATURE

Live Vaccines get spoilt faster than dead vaccines because the live germs in the live vaccine die quickly if the vaccine is not stored properly.

e. Expiry date: Each bottle of vaccine has an expiry date written on the lebel. This means that the vaccine should not be used after the expiry date. Before both buying and using the vaccine CHECK THE EXPIRY DATE.

f. Preferably do not immunize children during the rainy season.

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IMMUNIZATION IN CHILDHOOD

1. BCG VACCINE: This is to prevent the child from gettin g tuberculosis. There are different opinions about its effectiveness. As there is evidence that it is effective in children we still give it. It is a live vaccine.

When should it be given: The first dose of BCG should be preferably given at birth or soon after birth. The second does is given at 5 years of age (school-going age)

Preparation: BCG vaccine comes in ampules as a Freeze dried* vaccine in a powder form. The powder has to be dissolved in saline before it can be used as a vaccine. In our local PHC we have vaccinators specially trained for giving BCG vaccination. We must get the BCG vaccine and the help of the vaccinator from our PHC.

Points to remember about BCG vaccination:

- The powder and the solution must be kept in a refrigerator.
- The vaccination should not be given in bright sunlight and should be preferably given in a room or at least in shade.
- The ampules and filled syringes should be covered with black paper when not in use.
- The vaccine must be used the same day it is dissolved in the saline. At the end of the day, if any vaccine is left, this should be thrown away. It should not be used for the next day even if kept in a refrigerator

What happens when BCG vaccine is given:

When the vaccine is given a small lump is formed at the site of the injection. This lump disappears after half and hour. About the 3rd week after the injection has been given, the siteof injection becomes a little thinkened and the place is painful to touch. This thickness slowly increases to the size of a pea. By the 6th week the thickness becomes soft and pus is formed. The pus then escapes leaving an ulcer. The ulcer slowly heals and forms a scar.

We must inform the mother about the changes that occur at the site of the injection and reassure her. Sometimes an abscess might from at the site of the injection. This usually heals on its own. If the abscess does not heal, remove pus with the help of a needle and syringe (aspiration).

BCG Vaccine should not be given to:

- children who are known to have tuberculosis.
- children who already have a scar on the arm
- severely malnourished children
- children with severe skin disease
- acutely ill children.

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* Freeze dried means the live vaccine is frozon so that germs stay alive. Then it is dried and powdered for use.

2. COMBINED VACCINE FOR DIPHTHERIA, WHOOPING COUGH AND TETANUS (TRIPLE VACCINE OR *DPT VACCINE)

This vaccine is given to all the children below five years of age. It contains killed germs and so can be kept for a longer period of time. The advantagesof the combined vaccine are:

- more antibodies are produced.
- the effect lasts longer.
- the children are given less number of injections.

When should it be given:

Four doses are given , The best is if the doses are given as follows:

First dose : when the child is 3 months old
Second dose : 4 to 6 weeks after the first dose.
Third dose : 4Oto 6 weeks after the second dose.
Fourth dose (Booster dose) : when the child is 1.1/2 to 2 years old.

(In rural areas it may not be possible to give all the four doses. In such areas the first and second dose must atleast be given. The interval between the first and second dose should be between 8 to 12 weeks. If possible the booster dose should be given 1.1/2 years after the second dose) @

Points to remember about DPT vaccine:

- DPT vaccine must be kept in the refrigerator between 4°C to 10 °C. DO NOT FREEZE THEM SOLID (Don't keep in the freezer.) Also DO NOT KEEP IN THE DOOR OF THE REFRIGERATOR. This destroys DPT.

- Shake the bottle before using and leave it for 3 minute. if the liquid is clear, then the vaccine is useless. Send it back.

- At room temperature DPT loses its value in 4 days.

- Keep the vaccine away from heat and light.

What happens when DPT is given:

Normal Reaction: In children there will be a slight to moderate pain at the site of the injection. Some children also might develop a mild fever. Mothers must be warned about this pain and fever. You can also give antipyretic (acetaminopheon) to the children with fever . (for dosage see page 414 of 'Where there is no Doctor)

Abnormal Reaction: Some children might develop high fever and convulsions. This is due to some unknown factor in the whooping cough vaccine. THESE children should not be given the next doses of DPT.

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*DPT is - D for Diphtheria
P for Pertussis or Whooping cough.
T for Tetanus.

@ World Health Organization recommends that only 2 doses of DPT be given. The first dose 4 weeks after birth and the second dose 100 weeks after birth.

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DPT vaccine should not be given to a child

- with a history of convulsions or other nervous system disorder.
- with fever or infectious disease.
- with allergic disease.
- with skin disease
- getting steroid drugs

3. COMBINED VACCINE FOR DIPHTHERIA AND TETANUS (DT VACCINE):

Whooping cough does not affect children after the age of 5 years. So children above the age of 5 years should receive only DT vaccine. This comes in bottles containing 10-20 doses. Only one dose of DT is given at the age of 5-6 years.

Same Precautions to be taken as for DPT vaccine.

4. POLIO VACCINE:

This vaccine is given orally (by month). It is a live vaccine and therefore gets spoilt easily.

When should it be given:

Three doses are given. The best is if the doses are given as follows.

First dose : when the child is 3 months old.
Second dose : 4 to 6 weeks after the first dose.
Third dose : 4 to 6 weeks after the second dose.

Children above the age of eight years normally do not require polio vaccine.

(The latest dosage recommended by CMC Vellore is to give 5 doses of polio vaccine at the interval of 4-6 weeks between each dose)

Points to remember about Polio vaccine:

This is a live vaccine and has to be stored with extra care.

- The vaccine must be kept at a temperature of - 20°C. That means, when the vaccine is transported from the institure where it is manufactured, it should be kept on dry ice or a freezing mixture. When it is in a centre, it should be kept in the freezing compartment of the refrigerator and when it is taken to the village it should be kept in a flask containing a lot of ice.

- The vaccine should not be frozen and thawed repeatedly, That means that the vaccine must be taken to the village only when we are sure that we will get enough children to finish all the doses in the bottle.

- The vaccine must not be kept near the stove etc.

- Polio vaccine must be preferably given in a room or in the shade of a tree. (Do not give it in a hot humid, crowded room).

- The vaccine can be given by a dropper or a spoon. The dropper or spoon is sterilized by boiling in water for 20 minutes. It is then cooled by keeping in ice cold water. The dropper or spoon should also be carried with the vaccine in the flask to the village.

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- DO NOT USE CHEMICAL DISINFECTANTS like lyson, dettol, savalon etc. FOR STERILISING THE SPOON OR THE DROPPER.

- The vaccine must not be diluted with water, milk or honey before giving it to thechild.

- We must advise the mother not to breast feed the child atleast for 4 hours before and after the child has been given polio vaccine.

- The child can be given water and other food instead of breast milk during this time.

- The child MUST NOT BE GIVEN HOT MILK, HOT WATER, OR HOT COFFEE FOR ATLEAST HALF AN HOUR AFTER THE VACCINE HAS BEEN GIVEN.

What happens when polio vaccine is given:

It is an oral vaccine and it does not have any effects like fever, pain etc.

Polio vaccine should not be given to children with:

- high fever
- vomiting
- diarrhoea
- who are on steroids.

5. MEASLES VACCINE:

It is a live vaccine like polio vaccine. Right now it is not widely available in India. But we hope thatin a few years time it willbecome as common as DPT and Polio vaccine.

It comes in a powder from (just like BCG va ccine). This powder has to be kept in the freezing compartment of the refrigerator. The solution to dissolve the vaccine comes in an ampule and has to be kept inside the refrigerator but not in the freezing compartment.

To use the vaccine, take the cold solution and the powder of the measles vaccine to it. THIS LIQUID VACCINE MUST BE USED WITHIN ONE HOUR.

When should it be given:

Only one dose is given. This is given between the age of 9 months and one year. (Best time 9 months). It is given as subcutaneous injection. One dose contains 0-5 ml of vaccine.

Points to remember about Measles Vaccine:

The same points in terms of storage for polio must be followed.

What happens when the vaccine is given:

- the child might develop fever within 8 to 9 days.

- The child might also get mild measles (rash).

Measles vaccine should not be given to children.

- who have already had measles.

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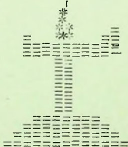
CONCLUSION:

In this paper, so far we have discussed the different ways in which a child's body can fight against communicable diseases by producing antibodies. In order to effectively produce antibodies against infection, children need to be immunized at the right age, given the right number of doses of the vaccine and these must be given at the right intervals. Details of using each vaccine have also been given.

Communicable diseases spread easily from one person to another. This means that one child with a communicable disease can give the infection to many other children in the village. As our aim is to protect asmany children as possible from communicable diseases, it is important that we immunize as many children as possible at the same time. In most places children are immunized as and when they come to the clinic. This practice does prevent the individual child has been immunized, but does not protect the other children in the village. In such a village an *epidemic of a communicable disease could easily break out. TO PREVENT AN EPIDEMIC, we must immunize atleast 90% of all children under five years of age in the village.

We may find that there are many undernourished children in the village. When a child is undernourished it is more likely to get a communicable disease. These children also get a more servere attack of the disease. In fact the child's life can be in danger because the disease will create further undernutrition. Therefore undernourished children must be immunized.



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* Epidemic means that an unusually large number of persons get the same disease at the same period of time.

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LIBERATING EDUCATION

We observe today a big crisis in the education system. Today there are in the world 800 million illiterate adults. The ideal to combat this illiteracy would be a basic and popular education.

Development is not only related to economy. It also has a very important social dimension. The goods produced to inrease the economy of a country cannot belong to only a few. Developmenthas to be considered a political question as it is necessary to make certain changes in society. Education would then be converted into a political force. The consciousness of the oppressed nations in awakening, opening new perspectives for the future. Before this pin-pointed need, "education" as such cannot be considered but only as a process of liberation.

The perspective of Liberating Education ought to orientate the educative process as a whole; make objectives concrete; relationship between educator and educated, evaluate and revise a whole series of existing educative systems.

Formal Education and Liberating Education : To understand better the success of liberating education, we ought to know the most important features. Objectives of Formal Education to progressively integrate sectors, each time wider, of the population in the existing society; to reinforce the existing structures; the decisions are made by a group which is in power or at its service. Literacy will not be a process of liberation if the ways of carrying it out are not changed.

The consciousness of the educated will be converted into reflections and shadows of the groups that hold the power of decision. Formal education does not challenge, it gives ready formulas. A confrontation could provoke the risk of awakening the consciousness of all these who can't say anything.

The educators express their opinion plan, make options. The educated passively assimilate what the others have created. What they learn does not help them to awaken in themselves a critical consciousness or the possibility of creativity. The teaching does not come from a reality lived by the individual, group or people. There isn't a transforming action. Formal education is paternalistic and passive, not applicable to adults. Formal education is based on a mechanical concept of the consciousness which has to be filled because it is empty.

Liberating education on the contrary tries to awaken and develop in the educated a critical consciousness by which they will be capable of - interpreting and evaluating - dialoguing and confronting with other groups- committing themselves to transform society to get mere liberation. Liberating education wants to make men capable of critising situations living in a society created for all, in which man is at the service of all giving of himself to the maximum. It wants to capacitate men to make history and live the process of their liberation. One of the most important points in the liberating education will be to acquire a critical consiciousness through which man gets a certain perspective of the universe that surrounds him, discovering himself and seeing himself capable of living a reality interrogating and interpellating it, thus capacitating himself for a global consciousness and from this point we can synthesize it.

To understand well the present reality, it is necessary to be conscious of the experience and the reality of the personal and collective past. This return to the sources illustrates much the reality in which we live. After the analysis described previously, the consciousness wants to go further and transform an existing reality. For this transformation to be efficacious, it is necessary to be aware of the elements that work in the change. From this awareness, we can concretise the form of beginning the change and the instruments to attain the objectives and to see that the projection is converted into a reality.

As we have earlier observed, nobody educates or conscientizes himself alone. Conscientization does not consist in communicating something elaborate to the others who ought to assimilate and adopt it. Conscientization signifies confrontation, dialogue, effort to communicate and collaboration.

From all that we have said, we can resume from a pedagogical point of view as follows :

1. Education cannot be communication in one direction. This pedagogy does not give place to the process of human consciousness and in some way bars progress. The educative problems cannot be elaborated but with the group, from the experience of the group and of each of its members.

2. The educator makes himself the animator. The animator motivates the group or the community in which he finds himself that they may be conscious of their experience to analyse, to interpret, to systemise, to get a vision of the while and project it. Without an animator to initiate the start, it is difficult to get a group moving. The animator does not impose his point of view but confront and dialogues with the group. It should not come from his own experiences but it should be from the felt needs of the group.

In the beginning, it is advisable that the animator should be one out of the group. But depending on the rate at which the group increases this consciousness, a member of the same group will take charge of the animation. This confrontation can increase and can be made by one group to another, one community to another, by different cultures and peoples. When there is an animator in the group, he ought to withdraw the moment the option is made and he ought to respect the decision of the group even if their decision leads them to a failure. Thus, at the moment of evaluation the group will be conscious of its limitations and errors.

Sometimes an option is not be the best, but the only acceptable one depending on circumstances. What is important is that they can play a strategic role in the transformation stage always looking at the goal. Opting limits us. We cannot choose all the ways at the same time. Through an option man recognises his existence in the world, his finiteness and his limitation. When we opt we run a risk. We decide for a future that still doesn't exist but our responsibility will be to make it a present reality.

The option as we have said is a risk but at the same time an act of overcoming and freedom. Through an option a man assumes his responsibility and his realisation.

The Transforming Action : Through conscientization we project a new situation that is above the present situation but through action it begins to exist and becomes a reality.

The transforming action is indispensable for liberating education. It is called to change the relations between men, structures of group and of society. The action is not always at the service of liberation. The action can limit, dominate and anual, or it may not be consequent to the conscientization and the decisions taken. The transforming action may need a reorientation but it has to be coherent to the conscientization and the option only in case the elements have changed so much that they ask for a deepening into conscientization and new options. It is indispensable to opt for a type of action that is transforming and that signifies a true commitment. This newly orientates the existing educative systems. Reflection and action are necessary in this process. Starting from a transforming action, conscientization can be more critical and fruitful. Summarising - Education is a process of liberation that consists fundamentally in living with the others - a critical conscientization, liberating options, transforming actions, critical evaluation.

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I. THE BANKING CONCEPT OF EDUCATION AS A MEANS OF OPPRESSION

A. It is characterised by narration.

1. Subject - teacher; object - student - receptacles

2. Contents are lifeless; reality is motionless

3. Seniority of word - leading to memorization.

B. It becomes an act of depositing instead of communication

1. Teacher - knowledgeable; student - ignorant (an attitude of oppression).

2. Teacher thinks students are taught about.

3. Teacher talks, students listen meekly.

4. Teacher disciplines, students are disciplined.

5. Teacher chooses, students comply.

6. Teacher acts; students have illusion of acting.

C. It serves the interests of the oppressors because:

1. It regards men as adaptable, manageable beings.

2. It minimizes the students creative power.

3. It does not stimulate critical faculties and its content with a partial view of reality for the oppressors think that the more the oppressed can be made to adapt to a situation the more they can be dominated.

4. It does not trust man, a teacher does not seek to be a partner of his students because doing so would undermine oppression and serve the cause of liberation.

5. It trains men to fit into the world the oppressors have created by teaching that man is a spectator, not a re-creator.

6. It is a necrophile or death-loving because it attempts to transform men to objects uncreative and inorganic. Hence, it condemns strikes of workers and uses violence to put down the strike.

D. Hence, those truly committed to liberation must reject the banking concept and adopt one which is a concept of men as conscious beings since liberation is an action and reflection of men upon the world to transform it and cannot be just another deposit to be made in men.

II PROBLEM OF USING EDUCATION AS A MEANS OF LIBERATION

A. It aims to pose men's problems in their relations with the world :

1. It embodies communication not transfer of information.

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2. It is not intent on objects alone.

B. It breaks the vertical patterns in banking education through dialogue.

1. Teachers and students become jointly responsible for a process in which all grow.

2. Objects for cognition are the objects of reflection by himself and the students.

3. Students are critical co investigators in dialogue with their teachers.

4. Teacher presents the materials to the students for their consideration and re-considers his earlier considerations as the students express their own.

5. The teacher creates together with the students the conditions for true knowledge.

C. • It involves constant unveiling of reality.

1. it strives to make consciousness of reality emerge;

2. it stimulates critical intervention in reality;

3. it denies that man is abstract, isolated and unattached to the world;
4. it develops man's power to perceive critically the way they exist in the world with which and in which they find themselves;
5. it is set on demythologizing
6. it considers dialogue indispensable
7. it acknowledges man as a historical being.

D. It affirms men as beings in the process of becoming - as uncompleted beings with a likewise unfinished reality.

E. It is revolutionary futurity :

1. it roots itself in the dynamic present and does not believe in permanence or a well-behaved present nor a predetermined future;
2. it is prophetic and hopeful ;
3. it looks at the past only to understand as a problem that can be criticised or transformed. (Any situation in which some men prevent others from engaging in the process of inquiry is one of violence);
4. it presents the present situation as a problem that can be criticised or transformed. (Any situation in which some men prevent others from engaging in the process of inquiry is one of violence);
5. it is directed towards humanization - which is man's historical vocation - a process which is carried out in fellowship and solidarity. Attempting to do this individually results in <u>having more</u>.

F. It believes that man subjected to domination must fight for emanicipation.

G. It cannot serve the interest of oppressors.

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1. No oppressive order allows the oppressed to question.

H. Revolutionary leaders must use this method in the revolutionary leaders process, they cannot use oppressive tools for humanization.

Community Health Cell
CHAI Golden Jubilee Evaluation Study
Policy Delphi Method - Response to Question-1 of first round

27th June, 1992.

A SUMMARY OF RESPONSES CONCERNING ECONOMIC, SOCIAL AND POLITICAL TRENDS IN THE COUNTRY AND THEIR POSSIBLE IMPACT ON THE HEALTH STATUS OF THE PEOPLE

To facilitate collation and reading we have separated the three factors, though in reality they are closely inter-related. There is therefore some overlap.

I. ECONOMIC TRENDS :

These were foremost in the responses and are described first.

Twenty-six panelists (80%) felt that the new economic policy recently introduced would continue for sometime and would have an overall adverse effect on the health status of people and on health care services. A summary of the broader economics related scenario and health impact is given first and later the more specific impact on health care services.

A. National and International Economic Scenario

1. With the new economic order we are now in a unipolar world. The economically advanced and industralised nations are coming together and dictating terms. The underdeveloped/ developing nations will keep on seeking grants/aid/loans and gradually become overdependant and impoverished. International trade has always favoured the advanced nations since the Second World War. The situation will be worse in the unipolar world as there will be no bargaining power at all.

2. International agencies like the World Bank, IMF, IDA, IFC and ADB have become tools of exploitation, determining national policies.

3. All this has been added on top of our already mismanaged economy running on deficit financing and with a parallel economy in black money over which the government has no control!

4. These new trends have been variously described as globalization of the economy, moving towards a more capitalistic form of production and distribution, free market economy, the neo-liberal model of development, the Americanisation of our economy etc.

5. There are very few options with the new policy. We will have devaluation, privatisation, liberalisation, an increase in exports, a decrease in imports, an increased need for repayment of foreign loans, and a decrease in government spending. Unscrupulous middle men and women will play havoc.

6. Decreased government spending will occur primarily by a reduction of expenditure in the services and development sectors as other changes in government spending would cause an upheaval among the organised labour and elite minority. Thus several panelists felt that subsidies to health, education, housing and other services will reduce. There will be a reduction of budget allocation per person for health.

7. This economic process will benefit the business and industrial community to become richer, with marginal benefit to the organized sector of labour. There will be a more afflnent middle class. However the majority comprising of marginal farmers, workers in the unorganized sector, landless labourers and daily wage earners will not be benefitted. Among them the children, women and the illiterate will be the sufferers. Poor people(s) everywhere will lose control more and more of the ability to determine their livelihood and lifestyles. Their health status will deteriorate and they will be unable to avail themselves of the services of privatised health, education etc.

B. Poverty

1. It was widely felt that the gap between the 'haves' and 'have-nots' would increase due to inequitable distribution of resources.

2. Impoverishment and the absolute number of the poor would increase.

C. Agriculture, Forestry

1. The agriculture sector will move towards cash crops rather than essential foods. This would further deplete available food stuffs for the poor, especially the rural poor, leading to greater malnutrition.

2. Due to pressures of modernization,deforestation and replacement with social forestry programmes using fast growing trees like Eucalyptus would cause decreased precipitation, decreased rain, decreased water table, increased droughts and floods and therefore an increase in water borne diseases. Deforestation would also cause loss of top soil, decreased fertility of soil, decreased production of food, malnutrition and starvation.

D. Industry

1. The present liberal industrial policy will lead to a proliferation of all kinds of industries throughout the country, causing pollution related health problems. The government would not have adequate machinery, or the will, to safeguard the environment.

2. The new economic policy would bring about a growth in consumer based production geared to the world market. This would have the following results, namely

   a) ignoring of local needs, which will affect the poor badly,

b) growth of large national and multinational agencies, throttling the small scale industries, resulting in increased unemployment and breakdown of mental health,

c) large scale environmental destruction with resultant health hazards and avoidable deaths.

3. The technological model of development will be pursued vigourously to meet middle class needs. It will have ill effects on health eg., increasing power (energy) needs will be met by coal (highly polluting) or dams (dislocating people) or through nuclear plants (causing hazards due to radiation).

4. The opening of markets to multinational companies will result in increased availability and consumption of more chemicalised, preserved foods, and artificially flavoured and coloured foods. This will cause dietary imbalance and increased cancers.

E. Lifestyle Changes

1. As already indicated above the market economy and growing consumerism will affect lifestyles of the middle class and create consumerist compulsions for the poor eg., there will be a loss of traditional food habits.

F. Changes in Budgetary Priorities

1. Changing attitudes to social concerns and the reduced availability of resources for 'welfare' will affect the quality of nutrition, education etc., and consequently health, particularly of high risk groups.
2. There will be a diversion of funds from basic needs like health to the para-military and military sectors.

Comments regarding the impact of these economic forces on health care services were as follows

G. Commercialisation and Privatization

1. Several panelists predicted an increased commercialisation and privatization of medical/health services.

2. This is already evident in the rapid proliferation of private polyclinics and the 'Apollo Syndrome'.

3. There will be further mushrooming of corporate "business health centres" with expensive, high tech facilities and consumerist promotion and values.

4. This will be promoted by the leaders of the country at the cost of basic health services.

5. Health professionals in general and medical professionals in particular have succumbed to commercialisation of curative services.

6. Only the profitable services will flourish eg., new drugs and diagnostics and certain higher specialities.

7. The affluent middle class will create a demand on the system for these type of services. They will be mainly urban based.

H. Accessibility

1. Medical facilities will marginally increase with little or no accessibility to specialised or super-specialised services for common people.

2. The cost of diagnostic and curative medical services will keep on going up at a galloping rate. Many services presently affordable to common people will go beyond their reach in 10-15 years.

3. Church based groups providing health services will compete with the private sector to retain "market share". Overall less attention will be paid on lower income groups.

4. There will be an increase in health insurance schemes for the public.

5. There will be less money for the health sector under the government. This will mean that health care will be neglected. The poor will suffer the most and have less access to medical services.

I. Type of Medical Care

1. As indicated earlier there will be an increase in the expensive, technological facilities, benefiting fewer people at the apex of the pyramid. These will primarily satisfy the caregivers. There will be increased dependancy on the medical system to maintain health, rather than self reliance.
2. Presently, the government health care system is hardly working, partly because of shortage of funds. It will be unable to cope with increased demands and pressures on the system in the future. Rural and tribal health care may suffer.

J. Pharmaceutical / Medical Industry

1. There will be a sharp rise in drug prices due to unjust claims of intellectual property rights.

2. The pharmaceutical industry will now have a greater say in the setting of priorities and in determining the direction that health services will take.

3. There will be increasing dependance on pharmaceutical multinationals at the cost of indigenous and traditional health care systems.

4. There will be increased large scale experiments of new drugs on the poor.

5. There will be an increased pushing of mechanistic procedures

In summary, so far, there will be a greater need for health services for the poor, while paradoxically, access to health services will be limited to the privileged groups only.

K. Health Personnel, their education and aspirations

1. There will be an increasing commercialisation of education in health sciences, with proliferation of capitation fee, educational institutions turning out untrained, unmotivated health personnel. Their education will be inappropriate.

2. Doctors, nurses and other medical personnel seeking jobs in India or abroad for a better salary and living conditions may often fail to maintain/develop a correct attitude to their profession/association.

L. 1. Three panelists (9%) felt that the economic trends at present and those likely during the next 10-15 years were positive. It was felt that market economy would increase income and money flow. More people would be brought above the poverty line. There would be an increased production of goods. There would be increased and better transportation. All these would affect the health status positively.

2. There would be a growth of hospitals in the corporate sector, greater professionalisation in hospital/health management and the development of insurance as a means of third party payment.

3. Communicable diseases would be eradicated or controlled but there would be an increased incidence of heart diseases, diabetes, cancer etc.

M. 1. One panelist felt that improvement in education may be the most important factor affecting health. Economic improvement and reduction in population growth are often associated with improved educational status, particularly of women.

2. It was felt that urban migration encourages industry, improving the GNP and thus helping in bringing about economic growth.

3. AIDS could cause a depletion of the workforce with massive economic losses.

N. 1. Another panelist suggested that health was not totally dependant on economic, political and social issues alone.

2. It was felt that the questionnaire was not formulated to find out objectively the causative factors of health and sickness, so that one can ascertain in which direction to move in the future.

3. It was felt that the economic and social status of people in the world and in India would rise independant of any political system. However haves and have-nots would increase.

O. One panelist did not comment on the economic aspect.

II. SOCIAL TRENDS

A. Urbanisation

1. The process of increased urbanisation will continue and will be a major factor affecting the health of individuals.

2. There is an extension of big cities and the urban poor have a lower health status than the rural population.

3. Adequate facilities will not be available for this group. Sanitation problems, garbage piles, over crowding, insufficient civic services lead to degeneration of quality of environment, subhuman conditions and more ill health.

4. Slum lords and mafias further deprive families in slums of their earnings, resulting in further deterioration of health.

5. Increasing pollution due to industries.

B. Demographic Changes

1. The health status of women is going to get worse as the sex ratio over the years is going from bad to worse. Social pressures and the low value for women and girl children will continue for sometime.

2. The increasing number of the elderly will bring about a major shift in health service needs.

3. Further increase in population will put greater pressure on existing services, with the result that they will be less efficient. It will result in deterioration of other available resources.

C. Family Types

1. The single or nuclear family system will be more common.

2. The breakdown of the family unit would bring most of health care from homes to the service sectors.

D. Education

1. Improvement in education may easily be the most important factor affecting health, particularly education of women.

2. However, the quality of education and values promoted by it could be questionable.

E. Role of Media

1. Television will play a major role in the social lives of people leading to greater consumerism.

2. For eg., advertisements will bring about an attitudinal change with respect to food stuffs,moving people away from healthy natural foods to junk foods.

3. With a new culture dominated by TV propaganda, old values systems will be replaced.

F. Values / Spirituality / Religion

1. The sense of community will loose ground and a narrow sense of individualism will thrive.

2. Several health and related problems stem from common ills like man's confusion, lack of identity and responsibility, materialism and humanistic beliefs, false values and lack of spiritual strengths.

3. There will be a progressive erosion of values in social life.

4. The most disturbing element in the present social condition is moral degradation. From the highest offices of the country, the politicians, the bureaucracy, it has gradually started lengthening its tentacles to all types of social institutions and social services. Majority of the so called intelligentsia are willing to make any kind of compromise in their life for personal gain/prosperity. The system of accepting "capitation fee" alone has opened up a flood gate of corruption. Tax avoidance, unscrupulous trade and business practices have crept into the social service institutions in a significant manner. Even institutions related to various religious bodies are not free from dubious practices. The tiny minority who try to stand against such a wave are labelled as "unsmart" and "outdated".

   Socio economic maladjustment is resulting in increased social tension and violence of various forms. Mental disorders are on the increase. Many moderr health problems originate from social problems eg., drug abuse, AIDS, STD etc.

5. Churches will loose their popularity. There will be many more splincer groups of Christianity.

G. Cultural Changes

1. There will be accelerated cultural alienation eg., leading to abandonment of traditional systems of medicine, traditional food practices.

2. Many will follow a westernised style of life.

3. There will be a marginalization of sections of the population including dalits.

H. Change in Life Styles

1. There will be an increase in smoking, drinking (alcohol), and an increase in levels of tension.
2. Change in dietary habits and increased use of vehicles.
3. Need pattern and so health pattern will change.
4. Change of life style will change the epidemiological scenario of the country. The problem of chronic non-communicable diseases will increase, while most communicable diseases will be eliminated or controlled.

I. Fundamentalism / Separatism

1. Regional, ethnic, linguistic, communal and caste conflicts will lead to large scale victims who will have to be treated. This is already happening in Jammu and Kashmir, Punjab and other places.

2. Religious consciousness, probably without god-experience as love, and the consequent communalism could be on the increase affecting social and individual life and health.

3. The associated problems of mental health and adjustment will need greater attention.

J. Social Problems

1. Social problems like crime, delinquency and prostitution will increase.
2. There will be increased social disharmony and tension.

K. Awareness

1. The awareness of people will grow and a sort of helplessness may grow leading to greater unrest and violence. This will be exploited by vested economic and political groups.

2. The public are going to be more aware of their rights to medical services. There is likely to be more litigation in the health field.

3. Consumer protection councils will make all government employees to be more accountable. This may make government jobs less attractive than now, forcing even currently employed personnel to leave the government service.

L. Social Trends

On the positive side

1. Educational level will be on the rise. Therefore need for freedom and better life style will be on the rise.

2. Science and Technology will be increasingly at the hands of our people with techniques and skills to improve life.

3. Focus on ecological and gender issues in public policy.

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III. POLITICAL TRENDS

A. International

1. Politically we are not going to be as autonomous as we are today.

2. There will be greater neo-colonial exploitation through the oppressive "new world order".

3. India will be more and more subject to one new world order, dictated by the West and Washington, with the cooperation of the local elite.

4. The fall of communism in Europe will adversely affect the concept of national health insurance in other parts of the world.

5. There is a chance of a stable government. Changes in the Soviet Union will have an impact on political parties. Relationship with United States will not be very good as our country tries for self-sufficiency and development.

6. Another highly disturbing element is that some politicians, though small in number, serve the interests of the foreign nations.

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B. National

1. Several panelists raised the issue of political instability and inadequacy. There is hardly any political party with the goals of good government based on a policy or direction. And there is no reasonable chance of continuity. Health will be one of the difficult areas which cannot be improved in a developing country without political will and stability. Unless ofcourse, effective health care is possible outside the governmental system.

2. There will be greater criminalisation of our politics.

3. Political power is grabbed at whatever cost.

4. There will be negative political activities confusing and confounding the average person at the grass roots level. At present there are many political parties working in an aggressive and competitive way, each decrying the other party and the party in power in a particular state, making it difficult for constructive and progressive work to be undertaken to completion in the overall interests of the people and country. People at the grass-roots who need the services of health personnel will not get it as there will be artificially created hurdles.

5. With political instability at national level and other seperatist/fundamentalist movements and divisive forces of language and caste working on a political level, health and social welfare programmes for the marginalised will be most affected.

6. There is a serious fear that communalism is on the ascent. If by any chance such parties gain control the whole political life will change. This would seriously affect all volunteer agencies, especially as foreign money for social services will be seriously curtailed. The church will be asked to remain with the four walls for Sunday worship and not to enter the field of health or education.

7. The principle of "divide and rule" is being used by politicians of all ideological colours. Communalism is dividing the poor also, so that they are unable to get together in an organised movement and fight or struggle for their rights, with regard to health and other basic human necessities.

8. Political support to corruption and dishonesty at all levels of the government health care delivery system, forcing people to go to non-governmental private agencies.

9. Politically it will be the moneyed who run the country.

10. There will be efforts by the marginalised groups to take to extremism.

11. The organised might of the organised sections will resist efforts to mobilise the unorganised million.

12. A strengthening of the conservative agenda of the current government will set the climate for national development. Health budgets will be reduced.

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13. Politics and politicians in the country have earned a very negative connotation because of the degraded form of political culture pursued since 1947. Honest politicians interested in the welfare of common people cannot survive. They will be attacked mentally and physically even - all under the Gandhian veil of non-violence. People who protest get labelled as terrorists and disruptionists. Most nefarious socio-economic violences are skillfully protected by the guardians of the country, with no punishment meted out.

14. The overwhelming majority of politicians are self-seeking. The odd idealists here and there cannot give their work the shape of a movement to bring changes.

15. The left wing is totally unnerved by recent political changes in the international scenario. They never did have a big say in Indian politics, neither is any significant change expected. The right wing is divided into two basic group social democrats and ultraright. The so called social democrats have substantial lost popularity and power as they could not demonstrate social interest, they did not try to distance themselves from the self-seeking (investor class of) politicians. Gradually their image was tarnished. The emergence of fundamentalist force could be even disasterous. But people are more or less tired with both Gandhian and non Gandhian democrats, they are aware about all big promises since 1947, and opt for a change in the coming election. There is reason to believe that the fundamentalist group may try to change and adapt to secure their position in Indian politics. New forces are not at sight, no sane person amongst the intelligentia are willing to enter into politics. It is the unscrupulous who are jumping into it, their attraction is big money, big name (may be due to notority), big position in society, all black deeds, stupidity, failure could be covered up quickly by the miracle touch of "Money force".

16. Indians, as people in Russia and so on will hate violent social movements and Marxist analysis, seperating or focussing on the poor or weak alone, creating imbalance in approach to social issues and so to health issues.

17. There will be stabilisation of the Government by the Congress as a political party.

18. Rightist and communal forces will be on the increase. Several panelists felt that the latter will affect health services adversely. [illegible]

19. Decline of trade unionism - this will make it possible for hospitals to run without too much labour trouble.

20. The growing disparity between haves and havenots caused by inequitable distribution of resources shall result in social tension, strife, disturbance, de-stabilisation, increased criminal activities seriously affecting quality of life.

21. There will be an increasing political consciousness and literacy. Hospitals will need to give more personalized care.

22. There will be increased student movements.

23. Total absence of a positive national interest by the leaders, in the public services and the various sectors that contribute to the health of people.

C. Regional

1. Problems of seperatism especially in border states may intensify.

2. Instability of government at the regional level (as is already happening in the North-East, Punjab and Kashmir) will affect health care services (government and private) and health status too.

3. There will be increasing autonomy to the states. This will require hospitals to satisfy local needs and abide by local laws.

4. There will be increasing consciousness among tribals and dalits. Assertion by ethnic groups and subgroups,politically and economically, resulting in increased autonomy by/for such groups. Their demands and needs will have to be satisfied by hospitals/ health services.

5. There will be greater awakening among the marginalised, especially dalits, tribals, and backward classes. It would mean their participation in social, political and economic processes in the country will become a demand, and justly so. People centred, participatory health care processes will be the demand.

6. Increased regionalisation will lead to intolerance of people from other regions in the country.

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IV. EFFECTS ON HEALTH/HEALTH CARE – due to a combination of the various factors (other than those already mentioned)

1. Basic Factors

influencing the health status of the population and contributing to the quality of life are water supply, sanitation, housing, food (nutrition), environment, education(awareness), overall socio-economic conditions (including safety and security). Trends in the different factors are :

2. Water Supply

Some quantitative improvement in coverage (through tube-wells etc.,) is expected. But maintenance of quality (safe, potable water) will not occur in the next ten to fifteen years. Mortality is already reduced, but morbidity due to water borne diseases will remain high.

The two other views were that due to deforestation and increased water utilisation for agriculture, the availability of drinking water will become critical leading to increased water related diseases.

3. Sanitation and Housing

Presently committed resources are meagre as compared to the need. There could be a marginal improvement in this. However incidence of air borne diseases will remain high.

4. Nutritional Status

There could be a major breakthrough in food production. However, chances of improvement in nutritional status of the poor are low. Withdrawal of subsidies will cause further rise in food prices - the impact on pulses and oilseeds has already created havoc. Production costs are rising disproportionately due to use of improved farming methods and technology - hybrid seeds, irrigation, use of chemical fertilisers and pest control. The distribution system is also faulty. There is increased export of food items to meet the foreign exchange crisis. The lot of the common people will therefore remain unchanged.

5. Environmental Degradation

Will continue. The small movements here and there are like ripples that will not develop into a tide in the near future. Manifold effects on health will result.

6. Education (Awareness)

There will be improvement in literacy rates, but there is cause for pessimism regarding real "education". The new education policy and the system promotes mass production of technocrats. There is a neglect of the humanities and overemphasis on science and technology, which will produce more technologically knowledgeable "inhumans". Schooling facilities for the poorer sections will be inadequate. The government schools are already overcrowded and in a poor state.

The holistic approach to health is practicable in an educated society only.

7. There will be an increase in tobacco related diseases including cancer, respiratory tract and cardiovascular disease. The huge profit margins of the cigarette manufacturing companies is clear evidence of this.

8. The pandemic spread of HIV and AIDS could result in the reversal of the gains of other health programmes. A conservative estimate is that over one million people in India are affected by HIV.

9. Increased cancers and other diseases due to industrial pollution, and dumping of industrial waste including nuclear waste, from rich countries into the Third World.

10. The increasingly complex drugs in the market will be used and prescribed indiscriminately, so that iatrogenic or medicine induced illness will increase, for example allergies, side effects.

11. Ethical problems related to the use of modern medical technology have already surfaced, for example provision of services for diagnosing and eliminating the female fetus.

12. Wholesale adoption of allopathy, without critical evaluation, will create new health hazards and economic exploitation.

13. The weaker sections will realise that unless they have a significant say in the running of health services, they will be cheated of their rights to health as in education.

14. Monopoly in the medical system - in our vast country, there is room for many levels of health workers, who need to be trained and deployed to do their jobs responsibly and competently. With a strong support system (up and down and sideways) and with good team leadership, the impact on health will be positive. However professional councils do not want to change with the times, and continue to act selfishly in isolation, for fear of loosing their monopoly.

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DEVELOPMENT

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Development can and for too long been understood as economic development alone, where the main emphasis is on increased production and income. According to this definitinn the main objectives of development is to increase the GNP without bothering to see who is benefitting from this increase.

In most of our countries, this is the kind of development, which has been going on. The emphasis has been on increasing production. As a result of this emphasis production has increased in many of our countries through green revolution, or industrialisation. The benefits of this development have, however, not occured to everyone equitably. In many developing countries the rich have become more rich and the poor have either remained where they were or at times have often become poorer. This trend is quite visible at the village level. The above concept of development is very narrow and thus unacceptable.

Development has many aspects - economic, social, cultural and political. There should be equal emphasis on all these aspects. Along with economic development, there should be better distribution of resources and means of production. The decision making power should not be in the hands of a few people only. Participation of the majority in all aspects of development is necessary in this concept of development.

The word 'development' can be divided into "Develop' 'Men' 'T'; Develop men or women to think together to understand the reality and to grow fully. Growth of individual alone is detrimental to society.

Development is a continuous process of change leading the awareness of one's present state of life and bringing him to a higher level of life. It is a growing activity between persons who feel the necessity for development, and persons who want to work for their own development. It is also said that development is a continuous process towards complete humanization by loving one another without selfish motiveness.

What is development:

1. "Development is a process by which both persons and societies come to realize the full potential of human life in a context of social justice, with an emphasis on self-reliance, economic growth being seen as one of the means for carrying forward this process".

From this it is implicit that development

(a) is of people and can be achived only by them. Others can only be enablers.

(b) is of people in community with the direction and control in the hands of local leadership

(c) is a process in the context of relationships and a total

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life style consciously evolving towards growth.

(d) is sustained through funtional indigenous institutions developed from and responsive to the local situation of the people.

(e) is an integrated process requiring harmony between people's and between people and nature; between the present and the future; between the social, economic and political factions.

(f) is interdependent; the fulfilment of all people depends on the development of all.

2. Development is: - growth with redistribution
- awareness of people of their problems, power and the potential they have in working together.
- to 'de-envelop' people from the bonds of oppressions and powers that suppress them.
- being our brother's brother and not only his keeper
- respect for the individual's dignity, self image and self esteem.

In development we are looking for:

(a) participation by all people
(b) equitable distribution
(c) effective and efficient utilization of human as well as natural resources.
(d) The growth, in dignity, of the individual in the context of his family, environemnt and community.

Development is therefore a continuous and dynamic process that brings about structural and institutional changes.

It must through these changes provide an equal opportunity for all to participate in decsion making in the economic, social, cultural and political spheres.

A question of power

This concept of development with emphasis on distribution and social justice requires some funds, mental changes in the social, economic and political power structure in our societies. It requires changes in social relationships. It requires reducing the power of some and increasing the power of others.

The elite in our societies is not interested in this kind of development, because it would mean reduction in their property and power. The elite is ofcourse not willing to give up its power and position to others.

The kind of development we have in mind cannot avoid conflicts. However, structural change might not necessarily mean shedding of blood. In fact fundemental change should be tried in a peaceful way. But it might not always be possible. Violence is almost always star...d by those who do not want fundamental change. They violently resist reduction in their power, privilage and property. The poor have to resort to violence often in self-defence. Development would mean struggle and we cannot avoid it.

- COMMUNITY HEALTH DEPARTMENT

DIFFERENT APPROACHES TO DEVELOPMENT

In India, especially after the independence, we see thousands of individuals and groups engaged in the field of development either full time or part time. To be a social worker or development worker, to some extent adds to ones status and position in society today. In spite of all these countless efforts we hardly see any significant changes in the life of the nation as a whole. A national net work for a concerted effort in the field of development is yet to be evolved.

A close look at these groups and individuals in the field of development will show us that their understanding of poverty and the corresponding approaches to development varies and in certain cases diametrically oppose each other. Though one cann't question their good will and sincerity of purpose, we should know that, mere good will and a sense of sacrifice and committment do not indeed suffice to make our contribution to development and social justice meaningful.

The approaches commonly adopted by different people in the development field can be classified into three. They are :

1) Welfare approach;
2) modernization approach
3) social justice approach

All these approaches proceeds from a clear and definite analysis and understanding of poverty or underdevelopment, however scientific or unscientific the analysis may be.

Before we proceed further, let us be clear about certain initial facts.

1 Our ability to identify factors and forces that create wealth and poverty determines our ability to tackle the problem.

2 Each one of us has an understanding of poverty and underdevelopment, whether at the conscious or sub-conscious level. We may have never formulated it, but a closer look at our work will reveal it to us. Always the solutions and methods adopted, follows from our analysis.

3 Our understanding of underdevelopment and analysis of the problems are largely influenced or conditioned by our own socio-economic background.

Our preception of reality is conditioned by our position in the society. Thus the causes of poverty identified by the rich may not be the same as those indicated by the poor.

1) The Welfare Approach :

This approach is deeply rooted in the mentality of religious minded people and humanists and is favoured by many private agencies and governments in both developed and in developing countries. The fabulous investments in men and money that welfare enjoys, compels us to reflect seriously on whether it deserves it or not.

In this approach, development and under development are considered as two parallel realities that have always co-existed, and that will always co-exist. Here poverty is accepted as a normal result of forces outside the control of man. These forces are identified as natural and supernatural. Here the symptoms are treated with a rather fatalistic approach, rather than the root causes of the problem with a critical analysis. Natural forces are seen as disasters, epidemics, earthquakes, cyclones, floods, draughts, etc. over which man has no control. In the supernatural sphere, man's status in life is seen as predetermined. It is his fate, it is in the plan of God, and explanation of poverty reflects a religious tone. Development workers with this understanding regrets poverty, but accept it as fate.

People who see poverty as created by forces outside the control of man, see little possibility for change. The solution is seen as a sharing of material goods and talents by the blessed and privileged, and the acceptance of these goods and services by those who are in need of them. The disposition advocated is a basic contentment with one's state of life. Work for the poor assumes the nature of alleviating the suffering of the poor rather than eradicating poverty itself. Development work here becomes an ongoing relief or charity, characterised by 'dolling out' benefit to the poor people according to their needs. (Giving the man the fish) It is often a spontaneous response to a situation with little effort made to identify and tackle the root causes of the problem.

And in the recipients, it often develops attitudes of dependence, laziness and passivity and sometimes creates division among the poor. It always diverts the attention of the poor from the real issues and anaesthatizes them.

Even a limited study of the history of the welfare approach and a superficial analysis of the functioning of society reveal that most of the evils treated by the welfare approach are the inevitable by products of certain forms of social organization.

2) Modernization approach

Like the previous approach modernization too rests on a certain understanding of poverty and under development. The cake, they say has to be bigger before it can be shared. So in this approach increased production and economic growth is stressed, to remove poverty. Here it is implied that people are poor because there is not enough production of goods. Modernization approach relies on industrialization and on rather sophisticated and capital intensive technology. Family planning compaigns are also of prime importance to keep down the birth rate and thus to promote economic growth.

Here development is seen as the successful utilization of resources, natural and human. Such an understanding stresses the need for patience, hard work, self descipline, sacrifice investments and quality education, needed for the production of bigger cake. Under development is seen as the result of the slow and inadequate establishment of the system of production and consumption present in the developed countries. To a great extent modernization then means westernization - following closely the methods and patterns of the developed. The advanced countries become the guides of the developing countries. On the cultural level it leads to the acceptance of the ideals of western countries and the adoption of their attitudes and values.

Those who can produce more are encouraged to the level best, with the contention that the benefits will 'trickel down' to all. This method of 'Backing the strong' (green revolution) is easily recognizable in our five year plans, government policies and in the projects run by voluntary agencies.

Even though impressive statistics can be given on the growth of agricultural and Industrial production, on the number of students enrolled in educational institutions, education and public services, a question could be asked : who progresses?

The rich, who only posses the purchasing power, with their demands, command and control the market, and often fund to imitate western standards of living. Industrialization responds to this demand and produces luxury articles which give higher rates of profit. The production is done at the minimum cost often introducing sophisticated and capital intensive technology, thus increasing unemployment. Poverty and unemployment place the workers at the mercy of the land-lords and industrialists, with low wages, and miserable and inhuman conditions of work. The state accentuates the situation by limiting or forbidding strikes. Whenever the labour force is so large and employment so scarce, favoritism and corruption unavoidably prevail. Extreme poverty drives poeple to borrow for their subsistence and social needs; money lenders prosper, for no bank or credit society would lend money in such circumstances. All this creates a vicious circle.

In a society where serious inequalities already exist a technological advance leading to increased productivity is likely to be limited to those endowed with superior wealth and social status to the exclusion of the poor majority' says the United Nations research institute for social development, Geneva.

The modernization approach, therefore, ends with the abundence of luxury articles and the scarcity of basic goods; with sophisticated technology and unemployment, low wages, debts and bonded labours. It produces the wealth of the few and the poverty of the many. The limited resources of the nation are thus used by a small groups for their selfish interests.

3) Social Justice Approach

The Failure of the modernization and welfare approach lead some to evolve a different approach to development based on a critical analysis of the various forces and dynamics at work in the society. It examines the organization of society and it's functioning at both micro and macro levels.

There is the conviction that non-economic factors that is the overall social context of society with its institutions and structures - Play a very important role in development. It tries to tackle the root causes of poverty and pays great attention to the proper distirbution of wealth. It does not accept mass poverty or under development as a fate. Modernization becomes important only when fare shares to the masses are possible. The root causes of under development according to this approach is injustice. If 85% of Indian population are below or just above poverty line, it is because 15% unjustly enjoy the results of the labour of the 85%.

In this approach one is convinced that deprived groups and nations can develop only in the context of a direct attack on poverty and a move for just distribution of wealth and power. Instead of depending dispropotionately on capital formation and move modern attitudes and values, development ultimately depends on land ownership, land utilization, employment, wages and the level of food comsumption. What would development mean in this historically created condition of under development. It means the restructuring of society! Efforts in this direction can be seen in Trade Union, (Balance of power in the production sector through collective bargaining) marketing co-operatives (challenge to the unscruplous exploitation of middleman) credit unions, (against money lenders) Mahila mandals (against low status of women). Always it was the awareness of injustice and exploitation in these cases that resulted in the organization of people at various levels. So in this understanding of development, the approach one would adopt will be awareness building which will definitely culminate in action.

Genuinely effective development work will have to challenge and re-organise the relations between the substructures in the society. The wealthy are the socially privileged, and the politically powerful. Power and privilege proceed from economic standing. Culture and religion seem to reinforce the interrelationship by providing sanctions andjustifications. A total transformation of these structures and support, is inevitable. In the economic sphere, this would mean policies geared to serve the needs of the people and not as at present, for the profit of a few. This would require that the means of production, land and capital be socially owned. On the social and cultural levels, this would mean relationships of equality between groups of people;

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New ways of thinking feeling and acting, collective promotion rather than individual promotion. On the political level, to evolve an organizational set up that makes possible real and effective decision making power for the people. Thus this approacn aims at a socialist society.

Unlike the previous two approaches to development, this one is a rather distributing approach, as it demands a commitment to struggle, and a struggle against the powerful dominant group; and it is no easy task. As development workers, what options does our above understanding leave us with? Can our sincere desire to alleviate the wretched misery of our countrymen express itself in meaningful actions that contribute to this process of collective awareness, collective organization and collective struggle?

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NON FORMAL EDUCATION

Education today:

Teacher-student relationship: I know; you don't know
I am active, you are passive.

Content: Past oriented
Bookish- memmorizing (capacity of descerning, criticising etc. are not developed. Only intelligence is developed)
-knowledge that is transmitted is the understanding of the society of the dominant group.
-banking education: You will be a producer for the dominant class. Hence education is given as far as production and consumption are concerned. More investment in Higher education.

Consequence: Create conformity: No creativity maintain the existing pattern of society.

The philosophy and methodology of Paule Freire have made a profound impact on educational thinking and models, expecially in the field of Adult Education. Paulo Freire distinguishes between a magical or unreflective way in which man may confront the world around him and a critical vision of that world. He wanted to reform the illiterates basic perspective on reality, which has usually been a prefound possimism and fatalism, by enabling him to gain awareness of his capacity to shape his envirenment and to acquire the means to do so. Literacy training shouldn't immense the pupil in his status, but rather give him the capacity to overcome it.

There is no education that is neutral. Education either functions as an instrument which is used to facilitate the integration of the younger generation into the logic of the present system and bring about conformity to it, or it becomes the practice of freedom, the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of tho world. The present education is for domestication, an instrument for the maintenance of statusque or a means for imposing the values and instrests of the dominant class.

In a society that is dominated, people are living in a culture of silence. The only way to understand the culture of silence is to see it as a totality that is itself part of a larger comples. We must also know the culture (or cultures)

of this larger complex, because it conditions the development of the culture of silence. Not that the culture of silence is not something created by the metrapolis (cente-periphery) in specialised laboratories and then shipped out to the dominated; nor is it a spontaneous generation on the spot. In arises from the interrelations of the oppressed and the oppressor. They are the result of structural relations between the dominator and the dominated. We must first see how dependence is a special sort of relationship that gives tise to two different way of being, thinking, expressing oneslef etc. That of the culture of silence and that of the culture that has a voice.

The relation between the dominator and dominated, exist in a broad social context. Some of them come about as the dominated assimilates the dominators cultural myths. . This dependent society is, by definition a silent society. Its voice is not a genuine one, but a simple echo of the voice of the dominator. The dependent society's silence under the directing society, is repeated in the internal relationships with in the dependent society. Its own power elites, who are silent under the dominator, silence the people too. Because the oppressed has internalized the oppressor.

Our education programme will depend very much on the attitude we have towards the illiterate. If we think that the illiterates are marginalized or moved out of the centre of the society. Our approach in adult education will be to bring them back to the centre. We will see them as stupid illiterates, who have strayed from the right path and we want to make them happy by giving them the gift of the world. With an approach like that literacy programmes will never enable a man to read freedom, becuase they fail to denounce society itself, which is depriving him of his right to speak. That is why it is so important to demythologise the reality a person lives in.

The fist phase of the method of education in an on the spot study of the context in which the illiterates live, in order to identify the common vocabulary and the probelm issues around which the process of reflection could develop.

Through information conversations, learn and listen to their vocabulary; observe the off-repeated topics of their conversations; especially their felt needs. Observe their world view i.e. their ideology, their mentality e.g. unemployment, low wages poverty and misery etc. Develop different lists of words, problems and situations for different villages (slums etc.).

The second phase involves the selection words from the vocabulary that has been discovered, 'those most changed with essential meaning and thus major emotional content, but also the typical expressions of the people.

Three criteria could govern this choice. The first is the capacity of the words to include the basic sounds of the language. The second is that vocabulary, when organised should enable the people to move from simple letters and sounds to more complex ones. The third criteria is that the words are chosen for their potential capacity to confront the social cultural and political reality. The words should provide mental and emotional stimulation, that they should suggest and mean something important. (eg. the word 'work' provokes a range of associations with the nature of human existence, economic functions, co-operation, unemployment, wages, etc.

The third phase of the method develops teaching materials. Paulo Freire speaks of two types of materials. One is a set of cards or slides which breakdown the words into parts for more careful analysis. The second is a set of cards of fictional or real situations, related to the words, which are designed to impress on the pupil through vision or image of the word, and also to stimulate his thinking about the situation that the word implies. The educator role in this is:

- To enter into dialogue with the illiterate about concrete situations.
- To offer him the instruments with which he can teach himself to read and write.
- To promote self discovery in the participants through exploring the dimentions of the teaching mate-rial used
- To promote dialogue, discussion and not monologue.

The livelier the discussion or debate, greater the number of ideas and implications drawn and the richer and move meaningful of the critical insight into the problem as well as memory of the word. The educator-Animator tries to get all the members of the group to participate by directing questions to them, prologning the discussion so that they will realize the deeper meaning of what was once for them an obvious, accepted reality.

The Paulo Freire method doesn't aim chiefly at literacy training, but at conscientization. It means an 'awakening of consciousness', a change of mentality involving an accurate realistic awareness of one's place in nature and society; the capacity to analyse critically its causes and consequences, achieve a deepening awareness both-of the socio cultural reality which shapes their lives and of their capacity to transform that reality. There is no conscientization if the result is not the conscious action of the oppressed as an exploited class struggling for liberation. No one conscientises any one else. The educator and the educatee together conscientise themselves.

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C H D TEAM

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ADULT EDUCATION AND DEVELOPMENT

H.E. Julius K. Nyerere, President , United
Republic of Tanzania and Honorary President,
International Council for Adult Education.
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We in this country have no special qualifications to host a conference on Adult Education--although we are very happy to do so! Many countries have had longer experience than ourselves in this work; many can point to greater success. There is only one thing we in Tanzania can claim, and that is that we are fully aware of the fundamental importance of education as a means of development, and as a part of development.

For development has a purpose; that purpose is the liberation of Man. It is true that in the Third World we talk a great a deal about economic development--about expanding the number of goods and services and the capacity to produce them. But the goods are needed toserve man; services are required to make the lives of men moreeaseful as well as more fruitful. Political, social, and economicorganization is needed to enlarge the freedom and dignity of men. Always we come back to Man--to Linerated Man--as the purpose of activity, the purpose of development.

But Man can only liberate himself or develop himself. He cannot be liberated or developed by another. For Man makes himself. It is his ability to act deliberately, for a self-determined purpose, which distinguishes him from the other animals. The expansion of his own consciousness, and therefore of his power over himself, his environment, and his society, must therefore ultimately be what we mean by development.

So development is for Man, by Man and of Man. The same is true of education. Its purpose is the liberation of Man from the restraints and limitations of ignorance and dependency. Education has to increase men's physical and mental freedom--to increase their control over themselves, their own lives, and the environment in which they live. The ideas imparted by education, or released in the mind through education, should therefore be liberating ideas; the skills acquired by education should be liberating skills. Nothing else can properly be called education. Teaching which induces a slave mentality or a sense of importance is not education at all--it is attack on the minds of men.

This is means that adult education has to be directed at helping men to develop themselves. It has to contribute to an enlargement of Man's ability in every way, In particular it has to help men to decide for themselves--in cooperation--what development is. It must help men to think clearly; it must enable them to examine the possible alternative courses of action; to make a choice between those alternatives in keeping with their own purposes; and it must equip them with the ability to translate their decisions into reality.

The personal and physical aspects of development cannot be separated. It is in the process of deciding for himself what is development,and deciding in what direction it should take his society, and in implementing those decisions, that Man develops himself.

For men does not develop himself in a vacuum, in isolation from his society and his environment; and he certainly cannot be developed by others. Man's consciousness is developed in the process of thinking, and deciding and of acting. His capacity is developed in the process of doing things.

But doing things means cooperating with others, for in isolation Man is virtually helpless physically, and stulitified mentally. Education for liberation is therefore also education for cooperation among men, because it is in cooperation with others than Man liberates himself from the constraints of nature, and also those imposed upon him by his fellow-men. Education is thus intensely personal in the sense that it has to be a personal experience--no one can have his consciousness developed by proxy. But it is also an activity of great social significance, because the man whom education liberates is a man in society, and his society will be affected by the change which education creates in him.

There is another aspect to this. A man learns because he wants to do something. And once he has started along this road of developing his capacity he also learns because he wants to be; to be a more conscious and understanding person. Learning has not liberated a man if all he learns to want is a certificate on his wall and the reputation of being a 'learned person'--a possessor of knowledge. For such a desire is merely another aspect of the disease of the acquisitive society--the accumulation of goods for the sake of accumulation of pieces of paper which represent a kind of legal tender for such knowledge, has nothing to do with development.

So if adult education is to contribute to developement, it must be a part of life--integrated with life and inseparable from it. It is not something which can be put into a box and taken out for certain periods of the day or week--or certain periods of a life. And it cannot be imposed, every learner ultimately a volunteer, because, however much teaching he is given, only he can learn.

Further, adult education is not soemthing which can deal with just 'agriculture', or 'health', or 'literacy', or 'mechanical skill', etc. All these separate branches of education are related to the total life a man is living, and to the man he is and will become. Learning how best to grow soy-beans is of little use to a man it it is not combined with learning about nutrition, and, or, the existence of education will promote changes in men, and in society. And it means that adult education should promote, change, at the same time as it assists men to control both the change which they induce, and that which is forced upon them by the decisions of other men or the cataclysms of nature. Further, it means that adult education encompasses the whole of life, and must build upon what already exists.

Changes and Adult Education

In that case, the first function of adult education is to inspire both a desire for change, and an understanding that change is possible for a belief that poverty or suffering is 'the will of God' and that Man's only task is to endure, is the most fundamental of all the enemies of freedom. Yet dissatisfaction with what is must be combined with a conviction that it can be changed; otherwise it is simply destructive. Men living in poverty or sickness or under tyranny or exploitation must be enabled to recognise both that the life they lead is miserable, and that

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they can change it by their own action, either individually or in cooperation with others

Work of this kind is not often called 'adult education' and it is not usually regarded as a function of Adult Education Associations or Departments. But neither is teaching a child to walk, or to speak usually regarded as 'education' ! It is only when a child does not learn these primary functions as it grows out of infancy that organized education takes over the task of teaching them in 'special schools' for the deaf or the otherwise handicapped. Similarly, whether or not institutions of adult education ought to be doing this fundamental work of arousing consciousness about the need for, and the possibility, of change, will depend upon the circumstances in which they are operating. In third World Countries such work often has to be done by someone, or some organization. It will simply be a matter of organization and effociency whether it is done by people called 'community development workers' or 'political education officers', or 'adult teachers'. What is important is that it is done, and that all should recognize it as a necessary basis for all other developmental and educational activities.

The same thing is true of what I would call the second stage of adult education. That is, helping people to work out what kind of change they want, and how to creat it. For example, it is not enough that the people in a village should come to recognize that something can be done about their endemic malaria--that it is not an evil which has to be endured. They also have to learn that malaria can be treated with drugs, or prevented by controlling mosquitoes, or that malaria can be dealt with by a combination of curative and preventive action. And all this must be followed up with action. Thus we have a whole series of educational activities all of which involve a learning process--an expansion of consciousness. The combination of them all is required if the development--of men and the environment--is to be life-enhancing. And all of them can be assisted by the activities of an educator.

The Scope of Adult Education

Adult education thus incorporates anything which enlarges men's understanding, activates them, helps them to make their own decisions, and to implement those decisions for themselves. It includes training, but is much more than training. It includes what is generally called 'agitation' but it is much more than that. It includes organization and Mobilization, but it goes beyond them to make them purposeful.

Thinking of adult education from the point of view of the educators, therefore, one can say that they are of two types--- each of whom needs the other. The first are what one might call the 'generalists'. They are the political activists and educators--whether or not they are members of, and organized by, a political party or whether they are community development workers or religious teachers. Such people are not politically neutral; by the nature of what they are doing they cannot be. For what they are doing will affect how men look at the society in which they live, and how they seek to use it or change it. Making the people of a village aware that their malaria can be avoided, for example, will cause them to make demands upon the larger community in which they live. At least they will demand drugs, or insect spray, or teachers; they will no longer be passive beings who simply accept the life they know. And if people who have been aroused cannot get the change they want, or a substi-

tute for it which is acceptable to them, they will become discontented--if not hostile--towards whatever authority they regard as responsible for the failure. Adult Education is thus a highly political activity. Politicians are sometimes more aware of this fact than educators, and therefore they do not always welcome real adult education.

The work of these 'generalists' is fundamental to adult education. It is after their work has been done--that is after a demand has been generated and a problem identified--that what might be called the 'specialists' can become effective. If you go into a village and explain how to spray stagnant water, and with what, you may be listened to with politeness; but your effort has been wasted, and nothing will happen after you have left unless the villagers first understand what the spraying will do, and why it is important. Of course, it is possible for the 'health educator' to give this explanation himself--prepared to do so. But his specialized knowledge can be more effective--and can be spread among a larger number of villages--if the people have already discussed and absorbed the reasons for anti-mosquito spraying, and developed a desire to learn how to do it for themselves.

It is at the level of this 'specialist' adult education that the division into health, agriculture, child care, management, literacy, and other kinds of education, can make sense. But none of these branches can be self-contained; their work must be coordinated and linked. The work of the agricultural specialist must be linked with that of the nutritionist and that of the people who train villagers to be more effective in selling or buying; and he may himself find the need to call upon-or lead the villagers towards--the person who can teach literacy. Adult Education in fact must be like a spider's web, the different stands of which knit together, each strengthening the other, and each connected to the others to make a coherent whole.

But in saying that I do not wish to imply that adult education has beginning and an end, or that it is necessary for a particular community or individual to travel along all the various branches of learning at a fairly simple level. The point I am trying to make is that mass adult education--which is waht most of us are concerned with in our working lives--must not be thought of as being in self-contained compartments, nor must it be organised into them. If the people's felt need is improved health, the health specialist must lead them into an awareness of the need for improved agricultural techniques as he teaches the elements of preventive medicine, or helps them to lay the foundations of curative health service. And the health specialist must have organisational links with the agriculture teacher, so that this new interest can be met as it is aroused--and so on.

But certain individuals or communities will wish to pursue particular interest further. The mass education must be of a kind as to show that this can be done, and to provide the tools with which it can be done. For example, it must lead to literacy (if it does not start with that); and it must incorporate access to books of different levels, even if it cannot include provision for more formal teaching. The mass education should also show people how to learn from the use of resources which are locally available like a nearby dispensary, a good farmer, local school teachers, and so on.

For mass adult education must be seen as a beginning--a foundation course on which people can build their own structures according to their own interests and own desires. And the adult education

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must demonstrate this function in his own activities---that is, by continuing to expand his personal knowledge through reading, listening to the radio, informal discussions, participation in physical development activities, and attendance at such other organized education courses as may be available.

The Methods of Adult Education

For all these are methods of adult education, and must be understood as such. Which one, or which combination, is appropriate at a particular time will depend upon many things. But one fundamental fact must underlie the choice made. A mother does not 'give' walking or talking to her child; walking and talking are not things which she 'has' and of which she gives a portion to the child. Rather, the mother helps the to develop its own potential ability to walk and talk. And the adult educator is in the same position. He is not giving to another something which he possesses. He is helping the learner to develop his own potential and his own capacity.

What all this means in practice is that the adult educator must involve the learners in their own education, and in practice, from the very beginning. Only activities which involve them in doing something for themselves will provide an on-going sense of achievement and mean that some new piece of knowledge is actually grasped ---that it has become something of 'theirs'. It doesn't matter what form this involvement takes; it may be a contribution to a discussion, reading out loud, or writing, or making a furrow of the required depth and width. What is important is that the adult learner should be learning by doing just as---to go back to my earlier example---a child learns to walk by walking.

There is a second very fundamental determinant of adult education method. It is that every adult knows something about the subject he is interested in, even if he is not aware that he knows it. He may indeed know something which his teacher does not know. For example, the villagers will know that time of the year malaria is worse and what group ofpeople--by age or residence or work place---are most badly affected. It is one the basis of this knowledge that greater understanding must be build, and be seen to be built. For by drawing out the things the learner already knows, and showing their relevance to the new thing which has to be learnt, the teacher has done three things. He has built up the self-confidence of the man who wants to learn, by showing him that he is capable of contributing. He has demonstrated the relevance of experience and observation as a method of learning when combined with thought and analysis. And he has shown what I might call the 'mutuality' of learning--that is, that by sharing our knowledge we extend the totality of our understanding and our control over our lives.

For this is very important. The teacher of adults in a leader, a guide along a path which all will travel together. The organizers and teachers in an adult education programme can be more than that, to be effective therefore they have consciously to identify themselves with those who are participating in it primarily as learners. Only on this basis of equality, and of sharing a task which is of mutual benefit, is it possible to make full use of the existing human resources in the development of a community, a village, or a nation. It is within this context of sharing knowledge that all the different techniques of teaching can be used.

The most appropriate techniques in a particular case will depend upon the circumstances, and the resources, of the learning community and of the nation in which it lives. For it is no good spending time and money on elaborate visual aids which need skilled

operators and electricity, if either the skilled operators and electricity is lacking in the village which wants to learn! It is no use relying upon techniques which need imported materials if you are working in a country which has a permanent balance of payments problem. And in a poor country the techniques used must be of very low cost, and preferably capable of being constructed out of local materials, at the place where the teaching will be done, and by the people who will teach and learn. Self-reliance is a very good educational technique as well as being an indispensable basis for further development.

The Organisation of Adult Education

This need to become increasingly self-reliant in adult education, as in other aspects of development, will have to be reflected in the organization of adult education activities. Obviously there is no 'ideal' adult education organization pattern to which all nations could, or should, aspire. The type of organization has to reflect the needs, and the resources, of each country, as well as its culture and its political commitment.

The one unavoidable thing is that resources have to be allocated to adult education. It will not happen without them! There is a regrettable tendency in times of economic stringency---which for poorcountries is all the time---for governments to economize on money for adult education. And there is a tendency also, when trained people are in short supply, to decide that adult education must wait---or to pull out its best practitioners and gives them more prestigious jobs and administration.

It would certainly a mistake to try to duplicate for adults the kind of educational establishment we have for children---either in staff or buildings. The most appropriate adult teachers are often those who are also engaged in another job---who are practitioners of what they will be teaching. But it is necessary to have some people whose full-time work is teaching adults, or organizing the different kinds of adult education. And those people have to be paid wages and given the equipment, and facilities, which are needed to be effective. How many of them there should be, and whether they should be in one educational hierarchy or under different specialised Ministries or Departments, will depend upon local factors, and will probably vary from time to time. Certainly we in Tanzania have not solved this kind of organizational problem to our satisfaction.

All this means that adult education has to be given a priority within the overall development and recurrent revenue allocations of governments or other institutions. And what priority it obtains is perhaps one of the most political decisions a government will take. For it adult education is properly carried out, and therefore effective, it is the most potent force there can be for developing a free people who will insist upon determining their own future.

Education arouses curiosity and provokes questioning---the challenging of old assumptions and established practices. An educated Ujamaa village, for example, will neither allow nor tolerate dishonesty among its accountants, or authoritarianism among its leaders, an educated population will challenge the actions of its elected representatives---including its President. May be this why adult education is generally the Cinderella of Government departments, or why its function is captured by newspaper, cinema, and television owners and editors with a personal axe to grind! And do not let me pretend that Tanzania is an exception to any of

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this. Our policy commitment to adult education is clear. But our practice, and our practitioners, are--to put it mildly--not above criticism!

But of course, even if a top priority is given to adult education, there are priorities within that priority still to be determined. Resources are always limited. In poor and backward countries they are laughably small in relation to the need. So choices have to be made between such things as generalised education, different kinds of specialized mass circulation of subsidised literature, residential education, the training of the educators and an increase in teachers untrained in techniques--and so on.

Once again, there is no 'best' choice or balance among all these necessary activities. What is appropriate will depend upon the existing level of knowledge and understanding in different fields, and upon the existing resources in men, in different fields, and upon the existing resources in men, materials, and equipment. In Tanzania, for example, we have now broken through the stage where miserable conditions were regarded as 'The Will of God'. Our present task is therefore primarily that of helping people to acquire the tools of development--the literacy, the knowledge of health needs, the need for improved production, the need to improve dwelling places, and the basic skills necessary to meet all these needs.

We are finding that the organization of this second stage is much more difficult, with our limited resources, to ensure that when people have learned a skill, the ploughs, and the carpentry equipment, and the survey levels, etc., are also where they are wanted and at an accessible price level!

But there is a saying that nothing which is easy worth doing, and it could never be said that adult education is not worth doing! For it is the key to the development of free men and free societies. Its function is to help men to think for themselves to make their own decisions, and to execute those decisions for themselves.

Given at the opening of the International Conference on Adult Education & Development, Sponsored by the ICAE, and held 21-25 1976, at Dar es Salaam, Tanzania.

The 400 participants from some 80 countries adopted, with permission, the text of Mwalimu Nyerere's speech as the Conference's own basic statement on the Objectives and strategies for adult education and development, to be known as the Declaration of Dar es Salaam.

// C O P Y //

BEYOND SOCIAL WORK

During their summer vacation, a group of students went to a village to help the villagers complete a well that they were constructing with government assistance. During their work there, the students discovered that the villagers were not receiving the necessary funds that they had been promised by the local Block Overseer to complete the well. That official wanted a bribe from the villagers before he would release the money. But, with student support and encouragement, the villagers refused to pay the bribe. The students began to investigate the situation while working side by side with the villagers. They discussed the question of rights with the villagers and urged them to take steps to seek payment of the required funds. The students told the villagers that if they (the villagers) decided to take action, they (the students) would accompany and support them in their efforts. Finally, the villagers got up enough courage to walk seven miles from their village to the Block Development Office. An equal number of students joined them. Villagers and students together demanded of the B.D.O. and his superior, the D.D.O., the payment of public funds owed for the completion of the well. The following day, both officials, perhaps expecting a polite, official welcome, drove to the village by jeep. The villagers greeted them with even stronger demands for the payment of funds owed them for the well. The following day, the villagers received the funds, and in the weeks following, further payments were made for the completion of the well.

ELIMINATING THE MIDDLE MAN

On the local bazaar day, villagers came from miles around into the central market place to buy and sell, and to meet their friends. There are four main roads leading into the bazaar from the surrounding villages. It has long been the custom for the town merchants to send their agents out along these roads to grab the fowl, grains, vegetables and fruits which village women are carrying into the bazaar to sell. By so doing, these agents prevent the women from reaching the bazaar with their goods, where they can bargain in order to get the best price possible. These agents then pay the simple village women a nominal sum for their wares - far below a fair price - and head back to town in time to enjoy a considerable profit for their trouble. Since this was a practice of long standing, the village women had grown used to this sophisticated form of stealing.

However, local high school and college boys and girls had become aware of the injustice in this practice and organised themselves into teams to patrol the main roads leading into the bazaar on the weekly market days. They protected the women from these agents some of whom they chased away. They explained to the village women that they deserved and could obtain higher prices for their produce, if they sold their items themselves in the bazaar. Within two months the roads were cleared of agents sent by the merchants.

On one occasion, as a result of their work, the students faced arrest by the police who had been called in by the merchants. However, a group of girls challenged the police to put them in jail for what they were doing. A crowd of about 200-300 people massed in front of the police station and the students had to be released.

This is an on-going issue, since merchants, often with police protection, continue to try to send their agents out on bazaar day to intercept the village women before they reach the bazaar. And students and villagers continue in their efforts to protect these women from being exploited.

LAND-GRABBLING

Tribal land cannot legally be transferred, by sale or otherwise, to non-tribals. The government can, however, grant authority to non-tribals to take over tribal land if, "in the judgement of the government,", such a takeover is required for "the national interest".

The area around Chaibasa is rich in natural resources. A mine owner was working on the edge of a village near Chaibasa. He discovered in his mine a very expensive type of stone. This stone was in great demand and brought a high price in Calcutta, where it was used in building luxury homes and office buildings. In order further to increase his profits, the owner decided to expand his mine and by so doing he threatened the very existence of the neighbouring village and its inhabitants, many of whom were employed in the mine.

The owner made a trip to Patna where he managed to convince the officials there and got the stone in question labelled by the government as "necessary for the national interest". Returning from Patna with the required permission, the mine owner frightened a few of the villagers into selling their land to him for the minimal legal rate of Rs.400/- per acre, whereas the actual value of the land was closer to ten times this amount. But he succeeded in convincing the people that if they would not sell him their land at the minimal rate, the police would in any case come to take their land from them, and they would receive no money at all.

But other villagers were not so easily hoodwinked. They organised themselves and, through sit-down's at the site of the mine, they tried to stop further work and resist the takeover of their land and homes. However, police came and drove them away from the work site. The owner, with police protection brought in workers from other villagers to keep the mine open.

A group from the threatened village informed the students of their problem and asked them for their help. The village was divided into various interest groups. The students decided to visit the village and study the situation as they spoke with the villagers. One of the village leaders, together with the students invited the mine owner to a meeting at which the issue could be debated. Even though the owner had twice warned the students not to interfere in "this private matter between me and the villagers", he agreed to come to the meeting. The students took the opportunity to expose the owner's tactics in getting the "legal authority" to expand his mine. The students followed up this meeting by organising a mass meeting of the entire village during which the villagers, encouraged by the presence and support of the students, rose one after another to denounce the owner and warn him against trying to expand his mine into their village.

As a result of these two meetings, the villagers made it clear to the mine owner that under no circumstances would they allow the mine to be expanded into their village. The owner, despite the fact that he had "the law" on his side - a law purchased in the [illegible] of his meeting with the necessary officials, gave up his [illegible]

OUTCRY AGAINST NEGLIGENCE

Late one night, a Calcutta-based truck struck a young student on a Chaibasa street. The driver fled, but not before another student noted down the number of the truck and also took a set of the truck's keys. (The driver drove off with a duplicate set.) The student immediately gave the number and keys to the officer on duty at the local thana. The officer first refused to take any action. Only after public pressure was brought to bear on the police were both the driver and the truck seized two days later.

In the meantime, the injured student was admitted to the local government hospital in a conscious condition. Two days later, however, his condition took a serious turn and he was operated on. He never regained consciousness. The necessary medicines were not available in the hospital, so students had constantly to go and buy what medicine they could find in the local bazaar. One evening, the hospital ran out of oxygen and the students had to rush to Jamshedpur, some forty miles distant, to bring the needed oxygen. The student died the next morning.

During the week the student spent in the hospital, the truck owner never came forward to offer any form of assistance. Nor did the police make any efforts to bring him forward.

As a result of this negligence, an application was submitted to the D.C. in the name of the students of Chaibasa demanding that the S.P. be removed; that action be taken against the police officer on duty at the time of the accident; that action also be taken against the person in charge of medicine and oxygen supply at the government hospital; that action be taken against the driver of the truck; and, finally, that compensation be made by the truck owner to the family of the dead student. The application went on to say that should no response on these points be made within four days, the students would begin a hunger strike in front of the D.C.'s office.

The D.C. did not respond and so the students undertook a hunger strike, during which two of the students had to be hospitalised. They ended the strike only when the D.C., meeting with the students in his office, promised to deal with all the students' demands within a one-month period.

At the conclusion of one month, a student delegation went to meet the D.C. who informed them that he had nothing to report to them.

A week later, some 900 students marched on to the D.C.'s office for the D.C. had as yet done nothing in connection with the students' demands. The students met again, and contrary to a faction that wanted to turn violent, a core group of students decided to detain peacefully all the trucks of the Calcutta-based company coming into Chaibasa. That evening, one truck was halted. A few days later, the truck owner's son came to Chaibasa to begin negotiations with the students and with the family of the dead student regarding compensation.

When negotiations between the truck owner and the family of the deceased broke down, a Rs.250,000/- compensation case was taken out by the family against the truck company. This case is still in court.

As a result of the students' actions, the S.P. was transferred and the Civil Surgeon of the government hospital fled and was replaced by a new man with a new assistant.

PERSISTENCE WINS THE DAY

In a local village high school, with nine out of every ten students tribals, one hundred and thirty-two tribal students in classes IX and X and not received their government scholarships for between two and four years.

Organising themselves with the help of a student leader, two hundred students of this school marched on the Welfare office demanding either payment of their scholarship money or an explanation of why they were not receiving their scholarships. The Welfare Officer refused to speak with him individually. Finally, the students sent in a representative to tell the officer that if their scholarship money was not forthcoming, a larger group of students would be marching on his office. The officer immediately began to bargain with the student, but the student walked out of his office, refusing to deal individually with him. The students then went to the D.C.'s office and made an appointment with him for the following morning.

Next day, the students arrived late for their appointment after their three-mile walk from the village school. They made another appointment for the following week, but when they arrived at the D.C.'s office they were told that he had gone to Delhi. When they finally succeeded in meeting the D.C., he tried to give them various reasons why government scholarship money can be withheld from tribal students. However, when scholarship payments were next made, an additional ten percent of the original number of tribal students in that school, who had not been receiving their stipends from the government, did in fact receive the scholarships.

SAMPLE QUESTIONS TO INITIATE DISCUSSION

1. Would you agree with the actions taken by the students in these incidents? Why or why not?

2. Should students get involved to this extent in social issues, or are these imvolvements distractions from their studies?

3. What was the basic driving force behind the students' actions?

4. Should social awareness stop at a study of a situation or should it lead to action?

5. Are you aware of similar situations and issues in your own community? [illegible] What [illegible] to these injustices [illegible]

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PRIORITY THRUSTS OF CHAI

DECENTRALIZATION IN CHAI:

The Catholic Health Association of India (CHAI) has membership of 3128 health institutions spread all over India. More than 70 percent of these institutions are small health centres located in remote villages and tribal settlements. They were largely involved in institutional centred curative health care. It was not in line with the vision and mission of CHAI, which emphasis community based preventive health care. Thus CHAI took the responsibility of enabling its Member Institutions (MIs) integrating their existing curative care with village based preventive care. But it found it difficult in extending knowledge and technical support services to MIs based on their problems and needs as they differ from institution to institution in accordance with the socio-economic and cultural situation of the area where its is located. This led to the initiation of a decentralised process in CHAI seven years back.

Objectives

The objectives of the decentralization in CHAI are:

- To ensure that all MIs are actively involving in community based preventive health care.
- To identify and address region and area specific health issues more effectively through initiating a system of multi-level planning.
- To provide a platform for the MIs at regional and diocesan level for networking with church bodies like-minded NGOs for the collective action for health promotion.

Achievements

Decentralised Structures:

As part of decentralised administration, eleven regional units (ecclesiastical division) and 98 diocesan units have been created. The table below presents the distribution of the region wise distribution of the diocesan units and MIs.

REGION WISE DISTRIBUTION OF DIOCESAN UNITS AND MIs

Sl No	Regions	States	Diocesan Units	MIs
1.	The Catholic Health Association of Andhra Pradesh (CHAAP)	Andhra Pradesh	9	319
2.	The Catholic Health Association of Tamil Nadu (CHAT)	Tamil Nadu, Pondicherry	18	439
3.	The Catholic Health Association of Karnataka (CHAKA)	Karnataka	9	273
4.	The Catholic Health Association of Kerala (CHAKE)	Kerala	6	468
5.	The Catholic Health Association of Western Region (CHAW)	Maharashtra, Gujarat, Goa, Nagar Haveli	10	285
6.	The Catholic Health Association of Madhya Pradesh (CHAMP)	Madhya Pradesh, Chhattisgarh	6	308
7.	The Catholic Health Association of Bihar (CHABI)	Bihar, Jharkhand, Andamans	13	271

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8.	North Eastern Catholic Health Association (NECHA)	Arunachal Pradesh, Assam, Nagaland, Manipur, Meghalaya, Mizoram, Sikkim, Tripura	10	242
9.	Orissa Catholic Health Association (OCHA)	Orissa	5	129
10.	Rajasthan, Uttar Pradesh Catholic Health Association (RUPCHA)	Rajasthan, Punjab, Haryana, Jammu Kashmir & Himachal Pradesh, New Delhi, Uttar Pradesh, Uttaranchal	4	284
11.	West Bengal Catholic Health Association (WBCHA)	West Bengal	8	110
	Total		**98**	**3128**

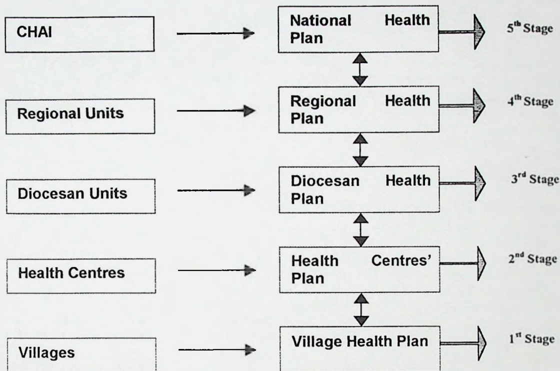
All the eleven regions have a minimum organisational and administrative. They are autonomous institutions registered under Societies Act, structure. Nine regions have projects of their own mobilising resources from different funding agencies. The regional units are actively involving in enhancing the competency of the MIs in the areas of promoting community-based health care.

The diocesan units formed are in the process of creating the infrastructure required to function as autonomous bodies. They have their own programme to meet the needs of the MIs supported by CHAI and the respective regional units. Development of projects and mobilisation of resources at the diocesan level is essential for the sustainability of the diocesan units and now the efforts are in that direction.

Multi – Staged Decentralised Planning

One of the strategies adopted for strengthening the decentralised structure as effective, responsive and vibrant in meeting the needs and problems of the MIs is the establishment and activation of multistage decentralised health planning. The five stages of decentralised health planning of CHAI is as given below.

Decentralised Health Planning



Networking

The regional units are networking with church bodies and like-minded NGOs for tackling the issues affecting the functioning of the health centres. They also participated in the People Health Assembly and signature, Campaign for Universal Accessible to Health Care. The regions – CHAT and WBCHA – succeeded in bringing together of the different actors of health, both Government and Non –government organisations for reflecting on the health issues affecting the poor.

Health Policy

The Orissa Catholic Health Association (OCHA) is developing a health policy for the region. The Catholic Health Association of Western Region (CHAW) has done a need assessment study for the region. Based on this study outcome the region is contemplating to evolve its health policy.

Future Thrust

Decentralisation provides opportunities for the MIs to come together at regional and diocesan levels for sharing their problems and needs and planning out actions and their implementation and made networking and collaborative work with church bodies and like-minded NGOs as a reality. Translating these energies into concrete programmes of action and create a definite positive health impact at the various levels is the future thrust of decentralisation.

CAPACITY BUILDING:

The creation of the Capacity Building team in CHAI four years ago is the direct result of the Organizational Development (O D) process initiated. It is based on the finding that mere training of the participants in selected subject area will not bring the desired change in the performance of the individuals and their organisations.

What is required more importantly is enhancement of the capacity of the individuals and organizations in discharging their responsibilities in the areas of their involvement. Accordingly capacity building is defined as a change in capability of an individual or a team or an organization and change of capability can be in any one of the combination of the following areas: behaviour, values and attitudes, know-how, application of knowledge and experiences and networking.

Objectives:

The objectives of the capacity building team are:

- To evolve and strengthen Regional Resource Team (RRT) in all eleven regions.
- To enhance the knowledge and skill of the regional and diocesan leaders in the areas of organizational perspective and governance.
- To ensure the active involvement of the regional and diocesan units and member institutions in health planning and management at their respective level.
- To re-engineer the health planning of the congregations so that the active involvement of the health centres of the respective congregation in community based preventive health care is ensured.
- To enable health professionals updating their knowledge and skill in the areas of health planning and management and community health promotion through organizing and conducting national level trainings.
- To produce and make available manuals, modules, reading materials and audio-visual aids for the community health trainers and practitioners.

Activities:

The important activities of the capacity building team are:

- Forming and strengthening RRT through selecting and training community health trainers and ensuring their availability to regions for organizing and conducting training related to community health. Presently nine regions have resource team.
- Extending knowledge, skill and technical supports to the regional and diocesan units and member institutions and ensure the evolvement of health planning at those levels. Four regions, nine diocesan units and 170 member institutions have already made a significant progress in this direction.
- Congregations are enabled to reorient their health plan. The congregations' health plans are evolved based on the plan of their health centres. The plans of the health centres, in turn reflect the health problems and needs of the poor people of the villages located in and around them. This planning practice has been achieved in nine congregations.
- Enhancing the knowledge and skill of the board members of the regional and diocesan units in governance and perspective building.
- Member Institutions are extended with technical, operational and organizational skills required to implement community health programmes.

- National level trainings in the areas of project planning and management, PME, community health, perspective building, rational drug therapy, participatory rural appraisal etc. In the last four years, a total of 532 health professionals have been trained in either one of the above said areas.
- Production of training manuals, booklets and charts. The manual on project planning and management has been already published. A manual on Making Development Organisation performing will be published shortly.

Future Direction:

The capacity building programmes, indeed, helped the participants to gain knowledge and skill in the subject areas of the trainings and enhanced their functional efficiency. However, the impact of these training the functioning of the organization from which the participants represented is limited. This problem will be overcome through giving more emphasis to capacity building of the organisation rather than the individuals. Moreover, a long duration health management training is thought of, which will meet the health man power requirement of the congregations.

CHAI'S EFFORT TO DEAL WITH HIV/AIDS;

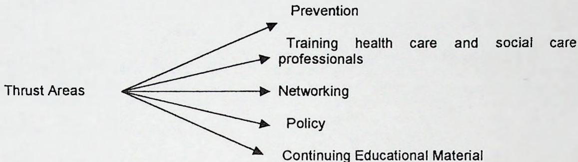
Involvement with HIV/AIDS work

As HIV/AIDS was becoming a serious health and social problem, there was an urgent cry from all quarters of the church to respond to this grave situation. Since CHAI is the structural body responsible for health, everyone looked up to CHAI for guidance and direction on HIV/AIDS.

Milestones of CHAI's growth with specific focus on HIV/AIDS

1993 –	AIDS Desk was formed "Think-tank" group
1994	CHAI's Policy on HIV/AIDS
1995	CHAI's Plan on HIV/AIDS
1996 – 1997	Personnel from the member institutions were trained to plan and initiate actions in their regions
1998 – 2001	- Developed human resources in care and support. - Networking with like-minded organizations for policy lobbying and advocacy.
2002 – 2004	The quality of life of the persons infected & affected with HIV/ AIDS is enhanced through a process of specific interventions such as implementers forum & promoting access to parallel system of medicine.

Specific Areas of Involvement:
CHAI approached the situation at various levels

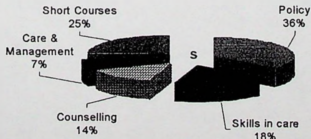


Prevention Prevention had been an utmost concern. CHAI had done pioneering work in the area of school health. Developed modules and innovative approaches for Life Skill Education in schools ad colleges with the collaboration of CRI in 1997- 1999.

Now we have been invited by Andhra Pradesh State AIDS Control Society to be the nodal agency for the school health programme in the state of AP for the non-government schools.

Training Training of the health care personnel with specific skills on prevention, counselling, care and management. About 650 persons have been trained and about 50% of them are directly involved in giving care while others have initiated activities along with their ongoing work.

Training Programmes & Participants trained



Networking
Networking with church related institutions, NGOs and Government agencies – such as APSACS for the school health programmes "Life Skills Education" and Drop-in Centers".

TB and Malaria Control Programme through the regional units. Training on microscopy through Government agency.

Collaborating and networking with other Churches for care and prevention Community Health Watch Groups.

Policy: Consultations were organized at Regional and National level to form policies.

1.*Common church policy*

Intensive efforts had been taken to network and collaborate with church bodies, church related institutions and NGO's to bring out a common church policy on HIV/AIDS. Prevention, care, management, counselling and training of personnel. This policy would be available in six months.

2.*Congregation and institution policy*

Policies to be made flexible to ensure that persons infected and affected are cared and supported. Consultations and discussions with 212 decision and policy makers of the member institutions were organized.

(St. Ann's of Luzen sought help in developing the policy and now they have started a center in Vijayawada, Andhra Pradesh for both men and women with HIV/AIDS).

Continuing Educational Material

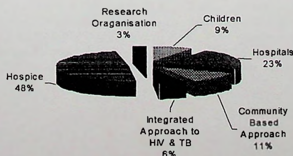
Through our interventions, there was a felt need for scientific and updated information among our membership. Personnel who have been trained by us are updated with the recent developments with continuing educational material on HIV/AIDS and the concerns and issues. This material is sent once in four months.

Impact

Nine years into HIV/AIDS work – we stop to look back and see if we have made a dent in the epidemic. Has our mission of Christian love reached to the forsaken one?

We feel content enough to say YES!! We made a dent in this epidemic through our love, service, and efforts.

The approaches and strategies used during the past nine years in the areas of prevention, training, networking, impact on the policies, and disseminating information enabled us to be instrumental in starting 35 organizations/ institutions in India for the care, support and management of persons infected and affected with HIV/AIDS.



Back in 1993 when the challenge of HIV/AIDS was hurdled at us, there was not even a single church related institution for the care and support of these most neglected and rejected ones. But today we are glad to see 35 institutions giving these services. One young sister from Mumbai says that she feels it is enough if we can allow them to die in peace and dignity.

Institutional care has always brought criticism about the sustainability, feasibility and impact in the long run. However, when we look closely we found the impact the institutions have made:

- The institution facilitates acceptance in the community.
- The local community contributes in caring for persons with HIV/AIDS through volunteering to serve or meet their needs. Thereby through this process remove stigmatization.
- The organization facilitates to build back the lost relationships of the persons with their family and community.
- Promotes dignity of life.
- The experiences shared by our member institution working with HIV/AIDS have shown that institution/ organizations are instrumental in fostering community support in the course of time. (eg. Jyothi Terminal Care center)

The membership involved in HIV/AIDS works were initiated based on the needs of the people. The situation differs from state to state thus each organization is a unique model by itself. Some of them focus on children while others care for men and women.

Few approaches that have made difference.

Integrated Approach

Mukta Jeevan now has an integrated approach to communicable diseases. The pioneer institution by sisters of Helpers of Mary in Thane was started for the Leprosy patients. After the outbreak of HIV/AIDS as some of patients also are with HIV. The management adopted a mainstream approach to patient care. Patients whether with leprosy, TB or HIV/AIDS are isolated neither among themselves nor from their families and friends. The caregiver and visitors take universal precaution in the care and management of the inmates who live as a family there. There are men, women and children with and without infections.

The families are supported to eam their livelihood through various income generation programmes. The children are sent to the local schools.

Community Involvement

Jyothi Terminal Care Center - A hospice was started two years ago in Mumbai has about 40 inmates. There was a stiff resistance from the local community. They have even requested the hospice to be shifted. However, over a period of six months, the community observed that the patients were cared by the caregivers without fear or stigma. The carers also started going into the community and sensitizing them. The response was overwhelming.

The organization is now run solely on local contribution, which even includes food, clothing and medicine. The local community takes care of the dead. They perform the last rites according to the patient's wishes. The women folk of the community volunteer their services in the kitchens. A place, which was started as a hospice, has generated such a large community response.

Implementers Forum: A forum of organizations is envisaged at regional level of the members involved in HIV/AIDS related work. The main aim of the forum is to:

- ➢ Training and enhancement of skill development
- ➢ Establishing linkages/network with others working for HIV/AIDS
- ➢ Collaborate for specific issues such as gender sensitivity, care and support
- ➢ Updating and sharing of resources - material and man power.
- ➢ Support and care of the caregivers.

Some of our *learning and challenges* over the nine years are:

- As India is a vast country having different cultural, the problems presents and the approach needs to different.
- A significant finding is that the training programme enabled the members to address the concerns of the HIV/AIDS.
- There has been an attitudinal change among the membership and a considerable shift in the policy regarding admission for treatment.
- Some of the membership has made a shift from institutional care to community based care, which is foreseen as a positive development towards the mainstreaming of the persons infected and affected with AIDS.

New initiatives

- ➢ Based on our learning, the new initiatives envisaged are:
- ➢ Implementers forums
- ➢ Integration of HIV/AIDS to communicable diseases
- ➢ Research and promotion of parallel system of medicine
- ➢ Training on care and management
- ➢ Research documentation

Through the initiatives

- We hope to evolve care and support from the community-based organization and providing basic care and counselling at home.
- To establish much stronger network with national and international agencies working in this field to mobilize a massive effort against HIV/AIDS to meet this challenge adequately, efficiently and effectively.

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THE DISTRICT HEALTH ACTION FORUM (DHAF)

1. The Concept

The District Health Action Forum (DHAF) is a structure as well as a strategy for bringing together on a regular basis various stakeholders or actors (the state including local governments, non-governmental, academic and activist) involved in health for initiating dialogue and discussions, facilitating consensus in understanding health scenario, encouraging collective decision making and promoting joint action in health.

2. Objectives

The DHAF is useful in achieving the following objectives.

- Effect convergence of resources available in a district for promoting primary health care
- Promote a higher degree of utilisation of the existing (government, private and voluntary) facilities for primary health care.
- Activate the PRIs and strengthen them in their endeavours for promoting primary health care
- Create a responsive and responsible civil society to enter into meaningful negotiation with the power blocks for pro-poor policies and decisions on primary health care
- Build up the capacity of the community to deal with health problems
- Establish and ensure operations of regular arrangements for various stakeholders of health at different levels to enter into dialogue hold discussions and initiate joint action programme on health. (The DHAF primarily strives to establish regular arrangements at district level. Simultaneously or subsequently, similar sub-district level arrangements may also be brought into being).

Composition and Structure

The composition and structure of DHAF vary from district to district. The district level officers (DMO or DHSO and district officers for Malaria, TB and Leprosy) of the department of health, education, rural development, ICDS and public relations, members of CHAI, members of the Voluntary Health Association of India (VHAI), members of the Christian Medical Association of India (CMAI), representatives of district level NGOs involved in health and development, diocesan social service societies and human right movements, and leaders and functionaries of PRIs are now found as members in different DHAFs. The number of members in a DHAF is in the range of 20-25 organisations.

DHAFs also have Executive Committees where responsibilities are shared between government officers and others. The posts of President, Secretary and Treasurer are shared by NGOs, CHAI members and in some places even by the government officers.

Activities of DHAF

- Developed profiles of all actors in the field of health
- Worked out a detailed district health profiles.
- Dialogues and discussions on health problems
- Joint celebrations and campaigns
- Interventions to control outbreaks of epidemics
- Advocacy with PRIs
- Addressing specific health issues

- Developing joint plans of interventions in partnership with governments

- Capacity building of health activists and health care providers
- Extending support to PRIs in planning and implementing primary healthcare programmes
- Awareness building on epidemics and outbreak of other calamities and disasters
- Extend mutual support to the member-organisations of the DHAF to improve the efficiency of their ongoing activities
- Encouraging better utilisation of existing facilities for health care

Viability

The DHAF is a viable strategy because owing to the new developments in health sector, the state alone cannot in future provide health care, which thereby entails the involvement of others too in this sector. The credibility possessed by CHAI members, the openness of NGOs to the proposed strategy, the urgent need felt by PRI functionaries to get supported in many areas of local governance and an overall positive disposition of governments to collaborate with NGOs are factors favouring the implementation of the project or ensuring the viability of the idea.

Advantages

A new culture of mutual support and sharing of resources has started to develop among the stakeholders of health by creating the DHAF. This contributes to the social capital, which will enhance the efficiency in utilisation of available resources and thereby enable the members of the DHAF to serve its target population more effectively. Strengthening of PRIs and enhancing the capacity of both PRIs and village population is a long-term investment in health care. This will result in increased participation of the community in health care management and better collaboration of local governments and village community. The forum, if properly managed, can in long run emerge as a point of convergence of interest, resources and concerns that can create a new equilibrium in power dynamics at grass root level. The plans of action now being developed by the 14 DHAFs in the northern region aims at this. This is a contribution of very high order to social infrastructure that can as in the case of social capital multiply the efficiency of resources invested in promoting health. Similarly, the forum can function as a district level arrangement for health surveillance. Over and above, it ensures efficiency of the existing arrangements and systems for provision of primary health care without demanding more financial investment in this sector. Thus the DHAF in long-run, will effect changes in the capacity of the local community to manage health problems, strengthen the health care providers to address more effectively the health care needs of the population they are serving and increase the level of participation of all stakeholders in health care management. The ultimate result shall be improved health condition of the people in the target districts. When both social and material benefit accruing from DHAF is compared to the cost involved, it may be found that DHAF is a cost-effective strategy in deed. Besides, it can be a self-financed venture once it emerges as a full-fledged arrangement. A period of three to five years may be required for a DHAF to reach this stage of self-sustenance.

NGO · 3.

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The Catholic Health Association
- Bihar and Jharkhand (CHABIJ)

Vision & Mission

Vision

Envisage a Holistic Healthy Society with self-responsibility for its transformation

Mission

Ensure self responsibility for their own Health & Development.

Promote people s medicines, Traditional methods of health promotion treatment.

Join hands with people s movements & like minded Institutions

Work in partnership & fellowship with other NGOs

Collaborating with Government s programs & making use of its resources.

Catholic Mission in Bihar/Jharkhand

Beginnings of Catholic mission	: 1927	
Beginning of organized health care	: 1977	
No of Rural Health Centres	: 44	
No of Hospitals	: 08	
Current status		
Dioceses	: 14	
Health care centres/hospitals	0 – 6 bed	- 229
	7 – 30 beds	- 23
	31-50 beds	- 06
	above 50 beds – 06	

Major Strategies

1996 – 1999	Community Based Health Care "HEALTH FOR MANY MORE BY MANY MORE"
1999 – 2001	Empowering women, especially mothers "Har Mah Ho Khar Ki Baid" " Every Mother Be A Family Doctor "
2000 – 2003	Formation of Neighbourhood Healthy Communities (N H C) Integrated approch to Health Care
2000-2001	: Net working with Jan Swasthya Antholan – " HEALTH AS HUMAN RIGHT "
2000 – 2003	District Health Action Forum (DHAF)
2002 – 2004	" Food For All, Health For All" – Moving away from Drugs Doctor & disease to nutritional food, alternative medicines with peoples participations.

IN SEARCH OF A COMMUNITY BASED ALTERNATIVE MODEL OF HEALTH CARE

Origins of CHA in Bihar/Jharkhand

CHAI

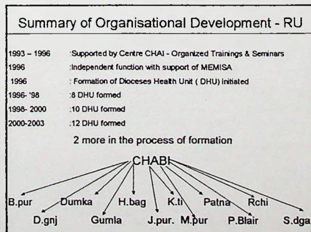
CHAP | CHABI | CHAKA | RUPCH | WEBCHA
CHAT | CHAKE | NECHA | CHAMP | CHAW

- Birth of CHABI : 4 May 1993 MIS - 260
- Renamed to CHABIJ : Jan. 2000
- Dependency on Centre : 1993- 1996
- Independently function : Since June 1996 with the help of MEMISA
- Membership : 282 (as per date)

Summary of Organisational Development - RU

1993 – 1996	:Supported by Centre CHAI - Organized Trainings & Seminars
1996	:Independent function with support of MEMISA
1996	: Formation of Dioceses Health Unit (DHU) initiated
1996- '98	:8 DHU formed
1998- 2000	:10 DHU formed
2000-2003	:12 DHU formed

2 more in the process of formation



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Continuation of Slide No.8

Achievements:-

a. Appointment of Diocesan Health Co-ordinators (D.H.C.) in 12 Dioceses

b. Regulated quarterly DHU meeting - updating of MIS

c. Diocesan Health Policy formulation & Under taking of people oriented Prgs.

d. Fixing standard Health Care for 0 – 30 bedded institutions

e. Prepared standing order for 0 – 6 bedded MIS

Neighbourhood Health Communities (NHC) 2000 - 2003

Achievements

- No of N.H.C Centres : 12 Old & 5 New
- No. of Villages covered in 12 centre : 125
- No. of Committees formed : 864
- No. of families profitted " : 4319
- No. of Dais trained " : 178
- No. of Dais Kit given " : 134
- No. of trained Vaids are in practice : 167
- No. of V.H.Ws trained " : 575
- No. of S.H. group formed " : 131
- Total savings " : Rs.725717
- No. of schools in Health education are given : 90
- No. of Health Fund formed : 15
- Total amount from Health Fund : 10540.50

Resources

Office	: Rented rooms at YMCA
Equipment	: one four wheeler, three two wheelers, computers 3 Nos., well equipped office & a Library
Personnel	: Eight

Continuation of Slide 11

- No. of families using Bednets using : 10000
- Balawadi Centre opened : 7
- No. of Kitchen Garden : 15
- No. of families doing agriculture after training : 125
- No. of families doing veg. Cultivation after trg. : 63
- No. of families making compost after trg. : 11
- No. of families doing fruits cultivation : 108
- No. of girls are studying tailoring : 8
- No. of Trees Planted : 3639

Continuation of Slide 9.......

Financial Support : NHC & Quality Upgradation - MISEREOR
: Food for All, Health for All (FAHA) – LWR
: Women's Development – Holy Cross Institute

Credibility with people, Govt. & Church :
: CHABI is an accepted member of Jhd. Ministry.
Jhd. States Health Policy was prepared by CHABI & Dr. Goel, St. Xavier's college, Ranchi

CHABI is invited to submit its Annual Reports to the R.B.C & Regional CRI ever year.

Continuation of Slide 12

- Chanalised from Govt.:
  1. Medicines received : 30000
  2. Immunization : 2400 children
  3. Polio Vaccination : 4200 "
- No. of help received from govt. project
  a. House constructed : 42
  b. No. of families received Loan : 108
  c. Well digged : 124
  d. Check Dam : 13
  e. Bridge constructed : 58

District Health Action Forum (DHAF) – 2001- 2003

Activities

Health resource mapping by people
Organizing and strengthening grass root level organizations for HEALTH AS HUMAN RIGHT
Networking with Government Health Authorities, Panchayat and Mandals at district & state level
Survey and surveillance on health issues
Identifying district specific health issues for action
Cleanliness and environmental protection campaign
Preparing an action plan for a definite period of time
Celebrating health related occasions and festivals
Consultation on participatory action for health
Seminars and workshop for imparting medical knowledge
Control of Communicable Diseases - Malaria, T.B., HIV/AIDs & , Blindness
Organising PEACE COMMITTEES – Village, District & State level

Advantages of Decentralization

- MIS strengthened & people oriented
- Beneficiaries are profiting more from activities
- MIS involvement more in community oriented activities
- More involvement of church authorities
- Better cooperation of Religious superiors.
- Formation of Diocesan Health Unit
- Better coordination among the Nurses
- Collaboration with other sectors – such as education, development & Pastoral.

Major Activities and Achievements

DHAF – Achievements

- Formulation of Jharkhand Health Policy
- Collaboration with NGO & G.O improved Relationship
- Better Planning with people at grass root
- Animation of government personnel & Resources
- Monitoring & Evaluation
- CHABI – an accepted active NGO by Jharkhand & Bihar Government

LIVELIHOOD & HEALTH PROJECT (LWR)
COMPACT PROGRAM

Achievements

Area of operation-no. of Panchayats	1
Total No. of villages	12
Total No. Population under care	4981
No. of Vaids Trained	64
No. of Dais trained	66
No. of VHWs trained	36
No. of Motivational W.S	24
No. of Leaders trained	113
No. of Farmers trained	45
No. of TOT participants	62
No. of S.H. Group formed	11
No. of Youth Committee formed	4
No. of Farmers Committee formed	7
No. of children Club formed	1

Achievements of R.U

Re writing of Bihar St. H. Policy
Formulation of Diocesan H. Policy
Better understanding between authorities and MIS
Involvement of Church authorities in Health Care
- Completed Health Profile
- Study of standard health care of MIS in Bihar & Jharkhand
- Upgradation of MIS
  - Technical
  - Functional
  - Structural

Campaign for Health as Human Right

Participation in Global Health March & People's Health Assembly in Dakha & Kalkatta
Formulation of Jharkhand St. H. Policy with other team
Re orientation of Religious Congregations

LIVELIHOOD & HEALTH PROJECT (LWR

Achievements :

Attitude towards life is getting positive changes
Secured clean drinking water
Improved personal & environment hygiene
Gender equity between Men & women in working area
Alcoholic problem reduced & better care for their families
25% improvement in Agriculture – Quality & Quantity
Self employment increased among women & youth
Migration of youth to cities controlled

Future Directions

- Quality Upgradation of members – Structural & Functional
- Food Security of beneficiaries to ensure Prevention of illness
- HIV/AIDS awareness through schools & colleges
- Open a Voluntary Counseling & Testing .... (VCTC)
- Communicable Disease Control
- Activating Gram Sabhas

Challenges Ahead

- Political Upheaval & unwillingness of Government to collaborate with NGOs (Churches)
- HIV/AIDS due to migration and mines
- Malaria Control
- Food security

N90-3.

CHRISTIAN MEDICAL ASSOCIATION OF INDIA

Plot No.2, A-3, Local Shopping Centre, Janakpuri, New Delhi 100 058

Healing Ministry Week: February 7-13, 2005

CMAI Day of Prayer: February 9, 2005

Healing Ministry Sunday: February 13, 2005

The Christian Medical Association of India
invites you to celebrate

The Healing Ministry Week 2005

and

The Centenary of the founding of the Medical Missionary
Association (1905 - 2005)

Theme: "Sharing the Abundance of Life"

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Healing Ministry Sunday : Order of Worship

February 13, 2005

Theme: **"Sharing the Abundance of Life"**

Call to Worship: *I will heal my people and will let them enjoy abundant peace and security. You will have plenty to eat, until you are full, and you will praise the name of the LORD your God, who has worked wonders for you.*

Joel 2:26 b, Jeremiah 33:6 a NIV

Opening Prayer: God our father, Son and the Holy Spirit. We thank you for your Son, Jesus Christ, the source of our life who has come into this world to give it more abundantly. Give us the strength and confidence to all your people who put their trust in Thee, through the weakness of our mortal nature we can do no good thing without Thee. Mercifully accept our prayers. Grant us the help of Thy grace that we may receive this abundance of life in our family life, social life, and in our life with You, Amen.

Opening Hymn : *"The Lord's my shepherd I'll not want"*

Praise and Worship

Leader: Father, we thank you for the abundance of life and healing available in your name.

All: **Praise you God, our father for you are the source of our life.**

Leader: We thank you for the abundance that you have shared with each of us.

All: **Praise you God, the Holy Spirit who gives us this privilege in our life**

Leader: We thank you for Lord Jesus who has made this possible for us through His life.

All : **Praise you Lord Jesus, for your springs of life in each of us**

Minister: We thank you God in three persons for the promise of abundance of life and healing and the promise of restoration for all of us.

All : **We praise and worship thee, O God the Father, the Son and the Holy Spirit. Amen.**

Confession

Leader : And now I ask you before God, who searches the heart and let us humbly confess our sins to the Almighty God who wants us to have and share the abundance of life.

Do you sincerely confess that you have sinned against God and deserved His wrath and punishment?

Then declare so by saying:

All: **I do confess**

Leader : Verily you should confess: for Holy Scripture declares: "If we say that we have no sin, we deceive ourselves, and the truth is not in us."

	Do you heartily repent of all your sins committed in thought, word, and deed? Then declare so by saying:
All:	**I do repent**
Leader:	Verily you should repent, as did the penitent sinners: King David, who prayed for a contrite heart; Peter, who wept bitterly; the sinful woman; the prodigal son, and others.
	Do you sincerely believe that God by grace, for Jesus' sake, will forgive you all your sins? Then declare so by saying:
All:	**I do believe**
Leader:	Verily you should so believe for Holy Scripture declares: "God so loved the world that He gave His only begotten Son, that whosoever believe in Him should not perish, but have everlasting life." Do you promise that with the aid of the Holy Ghost you will henceforth amend your sinful life? Then declare so by saying:
All:	**I do promise**
Leader :	Verily you should promise for Christ, the Lord, says: "Let your light so shine before men that they may see your good works and glorify your Father which is in heaven".
	Finally, do you believe that through me, a called servant of God, you will receive the forgiveness of all your sins?
	Then declare so by saying:
All:	**I do believe**
Leader:	As you believe, even so may it be unto you.
	Upon this your confession, Almighty God, our heavenly Father, who has given His only Son to die for us and for His sake for gives us all our sins, and have mercy upon us. To them that believe on His name He gives power to become the son of God and has promised them His Holy Spirit. He that believes in Him and is baptised shall be saved. Grant this, Lord unto us all. Amen.
The Word:	Deuteronomy 28: 1-14 Psalms 147: 1-20 (Responsive reading) Epistles 2 Peter 1: 1-11 St. John 10: 7-16
Sermon:	**Topic** "Sharing the abundance of life" Bible Passage St. John 10: 10-18
	Suggested outline for this sermon available on page 6 (The message to be preached preferably by a Health Professional.)

Intercession of Healing (A health professional leads the congregation in intercession)

	Healing Ministry Week – Litany 2005
Leader:	Eternal God, our Heavenly Father, we come to you as children coming to their parent trusting in your unfailing love and asking you to give abundance of thy blessing and beseech thee to hear our prayer.
All:	**Lord, Hear our Prayer**
Leader:	We plead for peace in this world and in our country. Bless the efforts of all the people and nations who work for peace and harmony in the world.

All: **Lord, Hear our Prayer**

Leader: Lord we pray to remove the barriers of different kind, which keep the nation and the land divided, broken and wounded. Healer of the nations, we pray for the churches and its healing ministry in the whole world. We pray your blessing on healing ministry week celebration that are being observed in different parts of the land this year so that it may be fruitful to the society in large.

All: **Lord, Hear our Prayer**

Leader: Merciful Father, we humbly beseech thee to enlighten the rulers of this land so that they may rule the country with just decision and earnestness. We beseech thee to heal the wounds of the nation and countries so that your peace may be felt in the world of your creation.

All: **Lord, Hear our Prayer**

Leader: Bless the healing service of the governments in different parts of the world and servants who are looking after the works so that they may render a fruitful service to the needy people of the respective area.

All: **Lord, Hear our Prayer**

Leader: Gracious Lord, we pray for your blessings upon Christian Medical Association of India and its service in different regions of the land for the one hundred years. Heavenly father, we pray for those who support their work and the help rendered to CMAI in carrying out its services effectively in needy areas and ask for your blessing in the years to come.

All: **Lord, Hear our Prayer**

Leader: We thank you Lord for the guidance you have given to the CMAI in the past, when it celebrates its hundred year of service in the land as an organisation and we thankfully remember all those who serve in the CMAI in different capacities by your grace. We pray for the CMAI Central office and officers and others who are in the services of CMAI in different capacities and ask your guidance so that they may be true to their calling.

All: **Lord, Hear our Prayer**

Leader: We pray for your enlightening gifts on mission hospitals and the staff there, their works and witness in India and help them to follow the model service rendered by the founding members. Heavenly father bless our hospitals, medical and nursing schools, healthcare setting in different parts of India. Heavenly Father, we ask for your guidance for the institutions that are facing problems of different magnitude so that they may find a solution to their problems by your grace.

All: **Lord, Hear our Prayer**

Leader: Father, we pray for the doctors that you may grant them the gift of calm hearing and the gift of healing. Father, we pray for the nurses that you may grant them the gift of patience and caring instincts and the gift of healing. Lord we pray for the Allied Health

Professionals that you may enlighten them to enlighten others. Master, we pray for the administrators that they may seek and give heed to the divine guidance in the midst of human management.

All: **Lord, Hear our Prayer**

Leader: Gracious Lord, we pray for the Chaplains that they may contribute healing to the suffering and gospel of hope through their ministry. Loving Father, move our hearts and hands at the sight of pain, suffering and despair of others so that they may see you through our actions.

All: **Lord Hear our Prayer**

Leader: Lord we pray for all who are in trouble, want, sickness, anguish of labour, peril of death or any adversity. Specially for those who are suffering for Thy name and for Thy truth's sake, comfort, O God, with Thy Holy Spirit, that they may receive and acknowledge their afflictions as the manifestations of Thy will.

All: **O Lord, we beseech Thee mercifully to receive the prayers of Thy people. Grant that they may both perceive and know what things they ought to do and also may have grace and power faithfully to fulfil the same. Through Jesus Christ, Thy son, our Lord who is the source of our abundance and the person to answer our prayers. Amen.**

Song: (Offertory) "*All the way my saviour leads me*"

(If the Eucharist is celebrated, kindly continue the liturgy of the communion service.)

Concluding Prayer

God, our heavenly Father, the source of our abundance. We thank you for blessing us through this worship. For the abundance we have received from you. Help us to go into the world and share this abundance to a world sick with sin and suffering, that you may remain in efforts in making our life meaningful and relevant in the situations where we need your abundant grace and mercy. May your presence with us bring about abundance in the contexts we struggle to bring justice and peace and prosperity. Amen

Benediction

Minister: The Lord bless thee and keep thee. The Lord make His face shine upon thee and be gracious unto thee. The Lord lift up His countenance upon thee.

May Grace and peace be yours in abundance through the knowledge of God the Father and of Jesus our Lord, and through the Holy Spirit. Amen.

Closing hymn: "Guide me, O thou great Jehovah"

Acknowledgements: *Prayer of confession: Lutheran order of worship Pg.48*
Benediction: Lutheran order of worship Pg.14

Suggested Outline for Sermon

Topic: ***"Sharing the Abundance of Life"***

Scripture: St. John 10:7-16

Aim

To help understand that God in Jesus Christ intention of His coming is to help us have abundance of life, as He is the source of our life and a God who heals and restores us to the original status for which we are created.

God in Christ is our source of the abundance of life. He expects us to exercise our trust in him to have this abundance of life that which is possible in this life and the life to come.

Goal

- To realise God is the source of the abundance in our life
- To help congregation members to know that God in Christ wants us to have abundance of life by becoming part of His kingdom, thus inviting us to have a share in the abundance
- To understand Jesus and His ministry's whole purpose is to have and share this abundance of life with others.

Introduction

The context of this passage in which Jesus claims "I am the Good Shepherd who is willing to die for the sheep." And also He says, "All other claims by others are not sincere but mine is true that you may have life and that life in abundance." Nobody has made such claim so far and it is the call of the creator to look after us with an agenda to satisfy us in this life with abundant life.

- **Abundance in Christ only for His Children**

"My sheep, hear my voice, I am the good shepherd. All the promises for the abundant life is only for His children who abide in Him, and exclusive for His sheep as the followers of the Good Shepherd. The exclusive status is not available to others except those who accept and follow Jesus Christ.

- **Abundance is a state of mind to experience**

Abundance is a state of mind. It comes from the security that we receive from God. His promises, assurance, salvation, protection, His pastures, nurture and nourish us to a state of abundance. The Zachaeus, the tax collector, had all facilities in life still he was not happy with his life. It is Christ's entry into his life that brought a transformation to abundance. He experienced abundance of life that day.

- **Abundance is possible in this life and life to come**

Many times we give up on life after abusing it and then say nothing can be done about it and eventually we spoil this life and the life to come. But meeting Christ can bring about a new outlook about God, His love, His concern and care for each one of us. The story of the Samaritan lady depicts this in John Chapter 4. Knowing that God loves and cares for us is a great feeling.

Conclusion

Christ, our creator and our source of life, alone can give us abundance. As we internalise God's demands and feed on in faith, we will be satisfied and that is God's agenda for each one of us whatever may be our status or stature in life.

"Sharing the Abundance of Life"

Healing Ministry Week Celebrations

February 7-13, 2005

CMAI Day of Prayer: February 9, 2005

Healing Ministry Sunday - Sunday School Corner

February 13, 2005

The Lesson Plan

Scripture Passage

John 6:1-15

Aim: To tell children that Jesus Christ is one who can give us plenty even when we don't have enough.

Goal: To help them understand that we need to share in order to receive.

Memory Verse:

Then Jesus declared, "I am the bread of life. He who comes to me will never go hungry, and he who believes in me will never be thirsty." John 6:35

The story:

Do you like going away into the country or to the seaside for a picnic? Mummy packs a picnic bag with all kinds of tasty food, chocolates, and juices, and off you go. (Use local things that people carry on a picnic.) When you have played some games and feel a bit tired, Mummy opens her picnic bag and you are so hungry that you soon finish up every scrap until nothing is left but some left-over for the dogs, birds and squirrels.

Long, long ago, in the country where Jesus lived, one day there was a very big picnic – so big that there were thousands of men, ladies and children. It was a nice grassy place, and not far away a lake sparkled blue in the sunshine. But the people did not look at the lake, or the grass. They looked at Jesus. He was there with His helpers, and He was telling lots of stories.

All the men, ladies and children stayed there all day, listening to Jesus. When evening came, they all felt tired and hungry. It had been a long hot day. There was one little boy who had come a very long way to listen to Jesus. He was tired and hungry too, but suddenly he remembered that his Mummy had given him some little loaves of bread and a few pieces of fish. So he looked around for some place to sit down so that he could have his food.

Jesus could see that everybody looked tired and hungry. He looked at them and felt very sorry for them. He said to His helpers, "Give these hungry people something to eat." His helpers were very surprised. They said to Jesus, "How can we give them something to eat? There are no shops here, and even if there were shops, we do not enough money to buy food for so many people."

One of Jesus' helpers named Andrew said, "There is a little boy here with some bread and fish, but he only has enough for himself." "Ask him whether he will give Me his bread and fish," said Jesus. The little boy was so glad to share his food. And Jesus took the bread and fish from him, and said, "Tell everybody to sit down on the grass."

When everybody was sitting down, Jesus said grace, and then He began to break up the bread and fish. He gave some pieces to each of His friends and they all gave them to some of the people.

When Peter had given out what he had, he went back to Jesus. Jesus was still breaking the little loaves and small fishes into pieces. He gave some more to Peter and Peter gave it to another group of people.

He gave some more to Andrew and Andrew gave it to another group of people. He gave some more to James and James gave it to another group of people. He gave some to John and John gave it to another group of people. He gave some more to each of his helpers and they all gave it to other groups of people.

They went on and on taking the bread and fish from Jesus and giving them to the people until everyone had had plenty to eat. The little boy had as much as he could eat as well. Jesus shared the little loaves of bread and the few small fish between everyone! Everyone had enough to eat.

Then Jesus said to His helpers, "We mustn't leave scraps of food on the hillside. Take some baskets and collect up all that is left over." So the helpers borrowed some big baskets from the people who lived in the country-next-door and they collected all the food that was left over. There was so much food that the helpers filled twelve whole baskets.

At last Jesus said to the people, "It's getting late now and it's time that you all went home." So they did. And as they went, they talked about the all the wonderful things that Jesus had said and done.

A prayer

"Thank you, Lord Jesus, for the little boy who through his sharing could satisfy a lot of people who were hungry. Help me to remember that you will always bring plenty of situations where there is shortage. Help me to share whatever gift or talent that I have. Amen."

Activity

Share this story with children and ask them whether they would like to offer their best to Jesus who multiplies and blesses hundred fold. Ask the children to enact the story.

CHRISTIAN MEDICAL ASSOCIATION OF INDIA
Plot No.2, A-3 Local Shopping Centre, Janakpuri
New Delhi 110 058

Invites you to celebrate

The Healing Ministry Week, 2005

And

The Centenary of the founding of the Medical Missionary Association (1905 – 2005)

On the theme

"Sharing the Abundance of Life"

Bible Studies

Healing Ministry Week Celebrations
February 7-13, 2005

CMAI Day of Prayer
February 9, 2005

Healing Ministry Sunday
February 13, 2005

To All Bishops, Pastors, Heads of Institution and Members of CMAI

Dear Partners in the Ministry of Healing,

Greetings to you in the name of Jesus Christ, the name from which every healing proceeds. It's my privilege to bring two booklets to you. Six Bible studies to be used during the week of celebration and an Order of Worship to be used on the healing ministry Sunday which includes a Sunday School lesson plan. In the same envelope, you will also find the poster.

This year's healing ministry week is special because 2005 also marks 100 years since the founding of the Medical Missionary Association. In the year 1905, missionaries involved in medical work in India came together at Miraj, Maharashtra to form the Medical Missionary Association (MMA), so that they could be supported and strengthened spiritually, technically and in fellowship with one another. It was renamed and formally registered in 1926 as the Christian Medical Association of India.

As we look back over the past century, we are truly grateful and acknowledge His faithfulness. He has blessed us abundantly, and it is from the abundance that we have received, we have been able to share with others. Therefore we find, in this centenary year of the founding of the Medical Missionary Association, that "Sharing the abundance of life" is the appropriate theme for the healing ministry week 2005.

The Christian Medical Association of India is celebrating the Healing Ministry Week along with the Catholic Health Association of India and the Commission for Health Care Apostolate of the Catholic Bishops' Conference of India. This broader partnership will enable many more congregations to learn about the Healing Ministry.

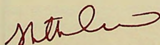
The week will be celebrated from February 7-13, 2005. February 9 is a special day of prayer and February 13 will be the Healing Ministry Sunday. Many institutions, congregations and organisations and individuals have earmarked the Healing Ministry Sunday collections to be sent to us in the past years and I take this opportunity to thank you for this partnership.

We would like to record our appreciation to the contributors of these Bible Studies. Our grateful thanks to Ms Esther David, New Delhi; Rev Al David Chaplain, Arogyavaram, AP; Rev Fr Alex, Executive Secretary, Commission for Health Care Apostolate CBCI; Rev Fr Thomas Ninan, CMAI and Rev Fr PA Philip, Vicar, St. Gregorios Orthodox Church, Janakpuri, New Delhi.

We are interested to know how you celebrated the Healing Ministry Week and Sunday in your congregations, institutions and health centres. We would appreciate your suggestions for strengthening this partnership, so that we can continue to have meaningful celebrations in the future.

With best wishes and prayers,

Yours in Him,



Rev Sharath David
Sr Programme Coordinator
Chaplain section, CMAI

ABUNDANCE BY ABIDING IN CHRIST THE SOURCE OF OUR LIFE

" Remain in me, and I will remain in you. No branch can bear fruit by itself; it must remain in the vine. Neither can you bear fruit unless you remain in me."

"Israel is a luxuriant vine", said Prophet Hosea (Hosea 10:1). This rich and meaningful concept of vine and branches is often found both in the Old and New Testament. The vine was almost the symbol of Israel.

Jesus says, "I am the true vine." The Greek word, 'alethinos' means real, genuine and authentic. Jesus is the true source of our lives. He invites everyone to 'remain' or 'abide' in Him, like 'a branch abides or remains in the vine', so that we in turn bring out fruit in abundance. Fruitless branches will end up in disaster! They will be 'cut and thrown into fire'. Abundance in life means a life that is truly and totally in communion with Jesus.

When we read this text from John 15:1-10, we notice that there is a word that is repeated almost 10 times. Can you identify that word? Yes, the word 'remain' or 'abide'. When school children are trained to write an essay, the teachers will never be happy if the same word is repeated in a paragraph over and over again. No good author or journalist will ever dare to do that either! But a great Evangelist like John does it! Why? What was the reason?

The root word for 'remain' or 'abide' in Greek is 'menain', and it is used in two contexts. First, when a branch of a tree attaches itself to its trunk, and receives everything for its growth and development, especially to bring forth new shoots, leaves and fruits, it is total dependence. Not even a minute it can remain separate! It is a profound and unique union. Such should be our communion with Jesus.

Second context is that of a child that is being formed in the womb of a mother. The child or the embryo truly and totally depends on the mother for its very being and existence. Like the baby in the womb, and its total dependence or 'remaining' in the mother, we need to remain or abide with Jesus. The abundance in life is the fruit of our abiding in Jesus.

Question for reflection:

Do I abide in Jesus? Am I in constant communion with him? Have I found the reason why I lag behind or lack efficiency?

Fr Alex
CBCI

LIFE IN ABUNDANCE IS EXPERIENCING CHRIST OUR HEALER

Life in abundance is received from Christ our source of life. There is no other source to experience the abundance of life. "If you knew the gift of God and who it is that asks you for a drink, you would have asked him and he would have given you living water."

The abundance of life to mankind is a gift from God. This needs to be requested and received from God who is our source of the abundance of life.

Meeting Christ in our daily life

The woman had the privilege of meeting Christ physically and knowing him spiritually to receive the gifts of God. We need to realise that in different situations and activities of life we can meet and experience Christ. He wants everyone to have a taste of Him by meeting Him, knowing Him and experiencing Him and accepting Him, which is equivalent to drinking the living waters.

Accepting Christ as the source who knows our life

Just being aware of situations does not lead us to the source of life. We need to go deeper in exercising our faith in every situation. Many times we have no control over situations. But Christ knows and He controls the situations for us. We need to be conscious and ready to recognise Christ and accept Him in every situation of our life.

Acknowledging Christ through our witness

Knowing Christ results in joy unspeakable which can only be expressed through our sharing about Christ. God is pleased with our intention to acknowledge Him in every situation even in the midst of people who do not know Him. Sharing and witnessing about Christ increases our readiness to live the abundance of life.

Experiencing abundance and healing

Knowing and experiencing Christ leads to healing and wholeness in one's life. "Indeed, the water I give him will become in him a spring of water welling up to eternal life." There is a sense of satisfaction and fulfilment when we experience the abundant life.

Question for reflection:

What is abundance of life to someone with a chronic/terminal illness like cancer/HIV/AIDS?

Rev Sharath David
CMAI

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SHARING THE ABUNDANCE MEANS SHARING CHRIST HIMSELF

" For if, by the trespass of the one man, death reigned through that one man, how much more will those who receive God's abundant provision of grace and of the gift of righteousness reign in life through the one man, Jesus Christ."

The theme for this day attempts to answer this question in Romans :15 – 17, St Paul finds 'Sin' as one of the causes for sufferings. He talks about the power of sin as it leads to the 'ultimate death'. The troubling question remains: Who can deliver us from this sin and suffering?

Thanks be to God. God shared, in fact, sent His only begotten Son Jesus Christ to us and through Him, we receive God's Grace which is power, strength and comfort to us in our suffering (Rom 5:15-17). The grace of God makes us strong when we are weak (2 Cor 12:8-10) and enables us to face the challenges in our journey. How was it possible for Jesus Christ to share His Grace with us? It is His willingness not to consider His 'Being God and equality with God' (Phil 2:6) but to lose His very identity.

As the suffering humanity needs this Grace of God, the biggest challenge for us is to choose between these two. Jesus said, "You are the salt of the World" (Matt 5:13). Salt can be identified in two ways. First it can be kept in a decorative container and placed on the table. It has a name, recognition and identity. Second, by the taste of salt in water/cooked food. It has no visibility, no name and no identity. But it has its own influence. If the Healing Community wants to share the abundant grace of God to the sick and suffering, it has to choose the second one. There is no other way. We are the answer to the unanswered question of the suffering humanity.

Questions for reflection:

1. What are the ways that God's grace can be channelised to the suffering humanity?
2. What are the sacrifices we need to make to be the Channels of God's grace?

Rev Al David Arogyavaram

ABUNDANCE OF LIFE IS JUSTICE NON-COMPROMISED

"And will not God bring about justice for his chosen ones, who cry out to him day and night? Will he keep putting them off? I tell you, he will see that they get justice, and quickly."

In the story of creation, God felt good at every stage of His creation. It was perfect and abundant. The deformation done by evil is reformed by the salvation work of the Son of God, Jesus Christ. The reformation was done to appropriate this to each one of us. The real transformation by way of reformation, which is given to us by Jesus Christ, is lacking in each one of us. Jesus tells the parable of the judge who did not fear God nor regard man and the poor widow who pleaded him to grant justice for her. Though he was unwilling at first he granted her justice later.

The wellbeing of a society largely depends upon the dispensation of justice. We can't characterise a society as abundant if justice is bruised or adulterated. Unrelenting and uncompromising justice is the hallmark of abundance. Affluence and abundance as a result of strangulating justice is not a healthy Christian approach. The pathetic scene of the contemporary world underlines this fact.

God gave Israelites the manna in abundance but He never wanted them to store the excess for the next day. We need to ask for our daily need and rest our hope in Him. God gives in abundance and instead of accumulating it for our own benefits, He expects us to share it with those in need.

The psalmist upholds the coexistence of justice and peace in Psalm 85:10-15. The world will be at peace only when justice prevails here. Amos also speaks about a life in abundance where justice is kept intact (Amos 5:11-13). "But let justice run down like water, and righteousness like a mighty stream." (V.24)

In His maiden speech at Nazareth Synagogue Jesus pleads for justice in the society. His whole mission is to restore justice and thereby ensure the establishment of God's kingdom in the world. Therefore, both the Old Testament and New Testament clearly states that justice is a precondition for abundance of life.

Questions for reflection:

1. Do you believe in today's pseudo-affluent society where abundance comes through sacrifice of justice?
2. What is your action plan for the restoration of justice in the society?

Fr PA Philip
New Delhi

SHARING MEANS RISKING AND VULNERABILITY

"Do not commit adultery. Do not murder., Do not steal. Do not bear false witness. Honor your father and mother."

The rich man's reply gives a clue about his familiarity with these conditions that Jesus places before him. His childhood and youth must have had a rich religious upbringing through what I would call an exemplary family atmosphere. Realistically we all are the products of our parental upbringing and to a large extent we continue to follow them as examples in most areas of our lives.

It is often the conflicts in life, which draw us towards Jesus. And it is during such times that He challenges us to take bold steps – steps that would lead us to life eternal. Here Jesus identifies sharing as one of the major tools that would help us on the road to eternal life. The greatest fear in the aspect of sharing is the risk and the vulnerability associated with it.

The Surrendered Life

The life of sharing indeed involves a life surrendered unto the will of God. It is indeed, a unique experience to realise that all that we are, our body, mind and spirit and all that we possess are bound by the perfect will of God. This would mean making oneself vulnerable to some harsh realities which one would rather not think of. It is a thin line that divides the two positions and it will always demand a commitment that requires to be renewed every moment of our life.

Call to Discipleship

There is a unique invitation towards discipleship. The conflict in the rich ruler is between two forces of discipleship, between his old far too familiar past and his unknown future – risky and vulnerable indeed, but with a promise that it would lead him to eternal life. Discipleship indeed is a journey, filled with conflicts at various points of life but a learning experience where one renews his life long commitment to become a disciple of Jesus. Sharing our life in Jesus brings us closer to the reality of eternal life as something that can be sensed and experienced here on earth and not as something that one needs to hope for.

Questions for reflection:

1. What am I missing in life?
2. Am I contented with life? If not, what is the reason?

Fr Thomas Ninan
CMAI

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Rev Sharath David
CMAI

Christian Medical Association of India

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From the General Secretary

Dear friends,

Every year, in the second week of February, we observe the Healing Ministry Week. This includes a week of Bible studies, a CMAI day of prayer, and the Healing Ministry Sunday. It is an opportunity for churches, congregations, institutions and individuals to be aware of issues related to health, healing and wholeness, and to be challenged by the need for healing around them. Started by CMAI in 1986, it is now celebrated jointly along with the Catholic Health Association of India and the Health Apostate of the Catholic Bishop's Conference of India as a joint effort to reach the church across the country.

This year's healing ministry week is special because 2005 also marks 100 years since the founding of the Medical Missionary Association. In the year 1905, missionaries involved in medical work in India came together at Miraj, Maharashtra to form the Medical Missionary Association (MMA), so that they could be supported and strengthened spiritually, technically, and in fellowship with one another. It was renamed and formally registered in 1926 as the Christian Medical Association of India.

As we look back over the past century, we are truly grateful and acknowledge His faithfulness. He has blessed us abundantly, and it is from the abundance that we have received, that we have been able to share with others.

It is appropriate, therefore, that in this centenary year of the founding of the Medical Missionary Association, "Sharing the Abundance of Life" is the theme for the healing ministry week 2005. As we complete one century and enter the next, let us continue to proclaim and share with all around us, the abundance of life He has given us.

We invite each one of you to share in this reaffirmation of our calling.

V. Aruldas

Dr Vijay Aruldas
General Secretary, CMAI

A fellowship of Christian health professionals and health institutes serving the churches in the ministry of health, healing and wholeness.
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ABOUT CMAI

As the official health arm of the National Council of Churches in India (NCCI), and a fellowship of over 330 Christian healthcare institutions and over 6000 individual Christian healthcare professionals across the country, the Christian Medical Association of India is the voice of India's Christian health work, and the only organisation of its kind in the world.

Started in 1905 as the Medical Missionary Association, and renamed and registered in 1926 as the Christian Medical Association of India, the CMAI works to strengthen the healing ministry of the church by working:

- with individual Christian healthcare professionals to make them spiritually vibrant, technically excellent and socially relevant.
- with Christian healthcare institutions to be ethical, compassionate, technically competent and reaching out the marginalised
- with churches and congregations to be involved in the healing ministry with those in need
- with the government and civil society as expert advisers and to advocate for a just and healthy society
- in special interest of need such as substance abuse, HIV/AIDS, women's issues, palliative care, involving congregations with needy communities, health of urban marginalised, community-based health financing.

CMAI brings out eight different quarterly publications: the flagship publication, *Christian Medical Journal of India* on Christian perspectives in health, and others on primary healthcare (circulation of 18,000), development, management, rational drugs, substance abuse, palliative care, network news.

Through boards and training committees made up of experts who give their time voluntarily, CMAI inspects and accredits institutions, conducts examinations and certifies candidates in:

- ANM and GNM nursing programmes (under the Indian Nursing Council)
- Nine allied health training programmes such as medical laboratory technology and radiology technology and counselling
- Clinical-pastoral training for chaplains
- PG medical training in multispeciality practice and palliative medicine.

CMAI's institution members include CMC, Vellore, CMC, Ludhiana, Miraj Medical Centre, MOSC Medical College, CRHP Jamkhed, and other mission hospitals and community health programmes in cities, towns and village across the country. CMAI's individual members, belonging to health related professions in government, private and mission institutions. It works through 13 regions in the country, and conducts retreats, workshops, conferences, consultancies etc. to strengthen Christian health work and witness.

We invite all Christian health professionals – Doctors, nurses, allied health professionals, administrators, chaplains, community health professionals and others interested in the healing ministry, to join as members. Details are available on the website www.cmai.org, or on writing to: The General Secretary, CMAI, Plot No.2, A-3 Local Shopping Centre, Janakpuri, New Delhi 110 058; E-mail: cmai@cmai.org