Community Health Learning Programme 2008

Source: Community Health Cell

A Report on the Community Health Learning Experience

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COMMUNITY HEALTH CELL

Community Health Learning Programme

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REPORT

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ACKNOWLEDGEMENT

This report is a brief account of my reflections, insights and new learning's that took place during my journey for the past 9 months through the Community Health Learning Program. I am glad to state that this event in my life was a significant milestone in my growth as I celebrate the silver jubilee of my religious life. I believe the paradigm shift in my attitude & life will definitely have a better effect in the post jubilee years. At this juncture I wish to acknowledge my indebtedness to all those who had been a source of inspiration & support to me during the infancy of my journey.

I am immensely grateful to all the staff of CHC- administrative, technical & supportive – who helped me with their generously. I would not allow this report to appear without paying special thanks to Dr. Sukanya, my mentor who provided me the best opportunities to gain a wider knowledge & experience in community health as well as gave time to express my feelings freely, bearing with my tantrums on all occasions.

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WHAT MADE ME JOIN CHLP?

I am a trained nurse by profession, belonging to a congregation which has its origin in Menzingen, Switzerland. Having a post graduate degree in nursing with specialization in pediatrics, I always worked in the Congregation's institutions except for three years where I worked as Nursing Superintendent at the St. John's Medical College Hospital, Bangalore. On completion of my term of office in the above institution I was requested to move to our own institution as the principal of the nursing school at Kamagere, Kollegal in 2006. It was then that I expressed my desire to work in community health and so to give me an opportunity to do the same. My Provincial responded saying that now there is an urgent need of my service in the nursing school and later on she will give me the opportunity to go for community health services. Reluctantly I moved from one institution to another.

Being content & restful are essential qualities of a fulfilled person. And I have not got such an experience yet. The end of 20th century and the beginning of 21st have heralded a sea change in India's social and economic conditions. These changes & the consequent disparity in the country disturbed me very much and it gave an impetus to reflect on the realities & also to look into myself. The desire to serve the poor originated within me since the last few years. The congregation itself was in the process of re-examining its charism. The charism of any congregation gives direction and purpose of its existence and one needs to evaluate periodically whether the mission of its members is moving away from its charism.

MY ORIGIN

My congregation is of international character and is spread in all the continents of the world has its head office (Generalate) in Switzerland. The head of the congregation is called the "General" and she is supported with 6 members called the "councilors." Under the generalate there are "provinces" in various countries consisting of group of members. The Head of each province is called "The Provincial". The General, Provincial & the councilors are elected by the members using a secret ballot during the get together called "Chapter". The chapter is also meant for evaluating its growth, relevance of its mission, whether any change is needed and its direction. Such chapters are called study chapters. Such forums are represented by the members.

The congregation came to India in 1806. In Asia there are four provinces- three in India & one in Srilanka. The first Indian province was in Kollam district in Kerala. Gradually for administrative purpose the province was divided into three Provinces based on geographical location in1990 as - South Indian province consisting Kerala & Tamilnadu, Central Indian province comprising Karnataka, Andhra Pradesh & Orissa and the North Indian province with UP, MP, the North East, Jammu& Kashmir. I belong to the Central Province.

PARADIGM SHIFT IN LIFE

The year 2006 was also a significant time in the life of Asian provinces as we celebrated the centenary year of its presence in India. During this time we were also in the process of ongoing search for meaning, relevance and direction for our mission. Province evaluations by outside agencies, change of leadership in the province, study chapter in the province etc. took place during this period.

In the year 2007, I also got an opportunity to attend the General chapter of the congregation held in Switzerland. The chapter message echoed in my ears to change the direction of my mission. For it called for every one's attention to re-invent the Founder's Charism, works were human rights & dignity are not upheld and work for a transformed society. Personal prayer & reflections disturbed me very much for I knew that my life as a disciple of Christ needs to be reoriented after His example- for He was always on the side of the poor.

All these events made me to reflect a while, to renew our vision & commitment and to look ahead with hope. The provincial chapter also enabled us as a province to reinvent the charism. During this time the members were helped to look back at the original charism with which the founder had begun the congregation and whether we the present members move on the same direction. The style of functioning of two of our hospitals in rural areas of Karnataka was not at all satisfactory both in the quality of service as well as in its economic growth. And so we decided to make certain changes in the implementation of the mission activities specially the functioning of our hospitals. Action plan taken is as hereunder:

Shift of focus from institution based health care to health promotion through education & conscientization of the people.
Integrated approach to health & socioeconomic development.
Identify & stop practices which are not in line with promotion of human dignity & human rights.
Establish close link between institution and locality.
Appoint more lay staff and relieve sisters for non-institutionalized ministries.

I was waiting for an opportune time to relieve myself from the position I was holding. In two years time God had made it possible and I got the opportunity to move out.

A co-incidence occurred and I had to make a choice. Both affected my personal life and I had to make a willful decision. It was my silver jubilee year and I had to be with my friends in deep & open sharing of our past 25 years in religious life. All of us unanimously decided that we shall not have the usual way of ritualistic jubilee celebration in the province rather we could have a fruitful get together at Nainital in the northern part of India. Since most of my friends in North Province are in academic teaching in schools and their vacation is in the month of June/July we decided to gather together at that time. And it was at the same time CHC had called for applications for the fellowship training program (CHLP). Thus the ball was in my court and I had to make a choice. Friends on one side discouraged me saying never again we would get the chance to be together in the

next 25 years of life. **But I felt an urgent need to respond to a "Call within a Call".** I felt the need to answer few important questions such as

1. Where do I need to spend most of my time? – In hospital, College/school or in Villages.
2. Which group of people I want to work with? - The better off or the poor.
3. Do I want to continue with the present activities the way they are or do I want to bring about a change in my role?
4. Do my authorities support me if I want to change the direction of my work or do I need to work with another group?
5. Am I willing to go through the personal struggle which such work may involve?

And therefore, I joined the CHLP to explore these questions within me.

INSTITUTIONS IN THE PROVINCE

The two hospitals in Karnataka were the mission stations of Indian province in 1970s. These hospitals were founded by the inspired founders in response to the felt need of the time - to reach medical care to especially the poor in the rural areas of Kamagere & Chikmagalur who were not being served by the available services at those times. Over a period of time these hospitals lost their focus due to varied reasons. Among those most important was the developments in the country's economic & health policy which forced the administrators to set certain trends within our hospitals.
In 1990s our hospitals developed in response to the "Market Economy". "Mission of healing" changed to "Clean floor& white sheets". The only way to make enough money to run the hospital without regular doses of foreign donation was to shift the focus on the paying patient.

"Mission Economy" managed to beat "market economy" with the support of large grants from foreign mission & regular infusions of donated drugs & hospital technology. As times changed and foreign infusions dwindled, we were forced to explore alternative methods to make budgets balance. Tapping local resources became imperative. Thus many adapted the Robinhood principle. This stimulated market economy forces which caused many dilemmas in our hospitals such as

- Number of poor patients (referred to as 'Paul') decreased in mission hospitals because services to the rich (referred to as 'Peter') increased.
- General wards were no more free wards and the patients had to pay more than they can
afford which led to greater social stress, indebtedness and family crisis.
- 'Peters' made more pressure on hospital management to provide better services,

greater
facilities & more luxuries in private wards.
- 'Peters' make greater demands on the time & skill of hospital staff.
- Junior staff complain that the seniors are more preoccupied with neurotic demands of the
paying 'Peters' while they are left to manage the life & death crisis of 'Pauls'.
- General wards began to look duller and shabbier due to constraints in maintenance funds.

Glamour of technology and super specialty began to creep in.
- As profit margins from services to Peters increased the staff is motivated to a culture of over investigations, over prescription with its resultant iatrogenesis.

In order to balance the budget and to continue the vocation it was necessary to increase unnecessary investigations, unnecessary prescriptions, increase the length of stay in hospital. Since there was better profit margin for non-essential drugs the doctors started prescribing "brand drugs". Companies provided greater unethical trade discounts. Doctors are paid larger sums "over & under" table since they are the best contributors to the profit margin. The management tries to generate enough money to meet the increasing costs of medical care. Unable to get committed professionals to work and the ignorance of the administrator sisters forced them to imitate the corporate hospitals in the country. Thus our hospitals with a mission disappeared.
"All Truths Are Easy To Understand Once They Are Discovered. The Trick is To Discover Them"- Galileo

The readings from Health Advocate series written by Dr. Ravi Narayan and the questions he posed to the mission hospital management helped me to reflect further due to its relevance in the context of our hospitals. I felt the need to reform our hospitals and open it to the community, to respond to the community's requirements, bringing about the necessary reorientation in its technology, organization and management.

'We need to have the courage to see the new demands & new challenges as a welcome stimulus & leaven for a new transformation & a new healing of our mission. We are at a crucial cross road in our common histories. We need to grasp the opportunity. Let us not forget that change always causes pain & also conflict. If the institution is to stay relevant to its context then the truth must be faced: our resources have to go in to building structures & networks that support our primary aims'

MY LEARNING OBJECTIVES

Short Term objectives

- To equip myself with the knowledge of the society with special interest on the marginalized and voiceless community.
- To understand myself better.
- To gain some field experience with other organizations which are involved in community health activities.
- To identify my area of interest in terms of "Community Health" and its dynamics.

Long Term Objectives

- To transform our Mission Hospitals true to its purpose by being more sensitive to the health needs of the poor and to be more committed to promote good health.
- To inspire and motivate nurses to improve the health care system and to be more patient oriented in their career.
- To strengthen the existing social activists & the movement within the congregation

STRATEGIES TO MEET THE OBJECTIVES

- Work closely with CRHP-Hanur (Comprehensive Rural Health Project) and spend more time with the marginalized families to understand their life style, problems faced and their concerns.
- Spend time with the Low Cost Effective Care Unit (LCECU) and Community Health And Development (CHAD) in CMC Vellore, Sr. Prabha, Jharkand,(CHABIJAN) Catholic Hospital Association in Bihar, Jharkand Andaman & Nicobar, Jan Swasthya Sahayog (JSS) Bilaspur, and learn more about the organizational work in the areas of community health.
- Interact with likeminded people who are already animating such initiatives in these organizations which I visit.
- Pay attention to and document issues that affect the community's health.
- Review those and learn more about an area of interest and focus my future work.
- Meet with counselors/mentors to know more about myself.
- Read and get inspired by reading on various articles and books written by persons who have made a paradigm shift in their life.
- Closely assess the loop holes at least in one of our hospitals and suggest measures to reorient.
- Meet the nurses in our hospitals in groups and make them aware of their call.
- Start community health nursing classes for nursing students in our nursing school to make them aware of their social consciousness.
- Expose nursing students to realities in Dalit colonies, SC/ ST villages.

- Discuss about the present health care system in our country in Sister Friends circle.
- Create adequate awareness in them about the need to make a shift in their attitudes and services.
- Identify and motivate young enthusiastic sisters to get trained in CHLP.
- Encourage doctors in our hospitals to prescribe locost medicines.
- Organize training program for small group of sisters on community health approaches.
- Provide exposure trips to those who are motivated for community health projects.
- Actively participate & support Sr. Aquinas' efforts within the congregation to go for a paradigm shift in our healthcare services.
- Plan and implement awareness programs with the help of resource personnel to build the movement within the congregation.

THE ORIENTATION PROGRAMME

The five weeks orientation was scheduled by Community Health Cell for all interns who volunteered to undergo the Community Health Learning Programme (CHLP). This period extended from 2nd June to 5th July 2008, almost five solid weeks. Many topics on social issues and lessons we had in our formal education were reviewed. Meaning of health, community etc are perceived in a broad sense and there is an urgent need for making a paradigm shift from purely biomedical understanding of health to social context. We had to unlearn many of our learning's. It was interesting to learn these concepts in a newer way by allowing ourselves to scrawl through the road to understand the determinants of health.

During orientation we were also made aware of our own strengths, essential skills needed and the values to nurture ourselves if we have to work in a community. Topics on health system in our country and states in particular, public health approach to control diseases were an eye opener for most of us. Health policy and the role of economy on the health revealed the reality one has to face.
The whole group visited few centers like comprehensive rural health project Hanur, Sakhi in Hospet, Jagruthy Mahila Sangathatan at Pothnal in Raichur to understand the dynamics of Community health being introduced by various people with passion for communities health. In short after the orientation all of us have been boosted up with our interest on community health, health activist, advocacy, making a paradigm shift in our own personal life etc.

During this time we were also introduced to many CHC alumni as well as friends of CHC. Their examples and live narrations on their success as well as failure stories energized us differently. We also got exposure to various organizations like IIS (Indian institute of Science)

earlier known as ASTRA, FRLHT (Foundation for Revitalization of Local Health Tradition), CBR Forum. These short visits have enabled the group to learn that it is possible to achieve health for all by every one and India has the resources and persons if one search for them.

The following table shows the organizations I visited to get practical learning experience

PLAN OF ACTION

Period Of Time	Place	Org/ unit	Mentor/Resource person	Observation Done
July 14- 16	Bangalore	CBR unit of APD	Mr. Janardhanan	Institutional as well as community based rehabilitation of disabled
Aug 1- 14	Vellore	LCECU(Low-cost Effective Care Unit)	Dr. Sara B	Functioning of a low cost and effective care unit of CMC.
Aug 25- 28	Bangalore	MILANA	Mrs. Jyothi Kiran	Family support network of people living with HIV AIDS (PLWHA)
Sept 14- 29	Vellore	CHAD & CONCH	Dr. Jaya Prakash & HOD of Comm. H	Mission oriented hospital & the community health activities.
Oct - Nov	Chhattisgarh	J S S Ganiyari, Bilaspur.	Dr. Ravi D'Souza	Poor oriented, hospital medical care & community health centres.
Nov 16- 22	Jharkhand	Catholic Health Association of Bihar, Jharkand, Andaman & Nicobar(CHABIJAN)	Sr. Prabha	Animating community Health workers.
Dec 18- Jan 20	Hanur	Holy Cross CRHP	Sr. Gloria.	Implementation of various govt; projects.

FIELD PLACEMENTS

Christian Medical College (CMC), Vellore

I was privileged to work with various departments/units of CMC which dealt with Community Health & development activities from 1st–15th August 2008 and 15th–28th September 2008. A detailed description on my learning in each field is given below.

Low Cost Effective care Unit (LCECU), CMC Vellore

This unit known as the Ida Scudder ward was established in the year 1981 bowing to pressure to respond to the massive needs of Vellore town. It is run by committed people, and provides services for the poor.

What impressed me & my learning in LCECU

The unit provides limited service for men, women & children at minimal cost by committed persons. All doctors here are general practioners with a post graduation in Family medicine. Patients are provided a simple in- patient facility and low cost medicines. Physical facilities are narrowed down to the extent that patients from above poverty line may not utilize the hospital. Only essential investigations are advised to perform. They are also provided with free mid day meal. Patients who needed higher form of treatment are shifted to CMC hospital in consultation with concerned Head of Departments. As the system is in place since many years people accept the routines of the hospital functioning and they feel that this hospital is theirs. The creativity & managerial capacity of Dr. Sara Bhattacharjee is commendable. Other than the routine hospital works they also organizes periodical training programs especially for the patients with chronic illness such as Diabetes, Hypertension etc. Similar initiative could be adopted in one of our hospitals. What we need is committed & socially oriented doctors, sisters and financial back up of our own.

Community Health And Development (CHAD)

This is a secondary care hospital on the Bagayam campus founded in the year 1947. CMC's community health department's activities are based on CHAD hospital. It started with just 10 beds and now is a full pledged 120 bedded general secondary care hospital. The department runs a full-scale, integrated health & development program, serving more than 90- odd villages that make up the development block of Kaniyambadi. It also provides a context for the teaching of community health to medical, nursing and paramedical students. I could work with them for four days and observed various activities of the department. It provided a village- focused primary health service mainly with the help of a part time community health worker trained by them. The service included MCH, immunization, health education and mobile clinic. Basic surgery and casualty, re-hydration & leprosy units, sterilization clinic and treatment for simple ailments are provided for at CHAD hospital. More complex matters are referred to the main hospital in Vellore town.

CONCH- (College of Nursing, Community Health)

For five days I joined the students for community clinical posting to observe the community health department of college of nursing. When they established this program, it was determined to prove that you can be not-a doctor but a woman and still run a successful community health scheme. College also provides a PG course for nurses called FFNP (Fellowship family Nurse Practice)- 1yr. After the training these nurses are able to provide combined care clinic in hospital as well as in community set up.

Group of students are taken to different villages under various Primary Health Centers (PHC) under the able guidance of senior tutors and conduct morbidity clinic along with ANC. Patients who require further management are referred to main hospital, LCECU or CHAD hospitals. Those who want the government services are requested to attend one day consultation to the above hospital and given the prescription to govt: hospitals.

Association for Physically Disabled (APD)

From 14th July 2008 I was an observer in the above institution for three days. APD is a non-governmental organization in Bangalore with a history of 50 years of its existence. Its main objective is to empower persons with disability by the person become active contributor to the society in which she/ he lives. Disabled people are an oppressed & marginalized group in society. It could be regarded as "apartheid of disabled people" as people do not have access to the same opportunities as others simply on the basis of a physiological characteristic. But what is observed in APD is that their intervention is not primarily focused on the individual disabled person, trying to bring about normalization, cure or care. Instead it involves removing the barriers that prevent disabled people from exercising their right to participate in society, in other words, it involves challenging the disabling world.

More than ten thousand people with disability of any sort are helped out by this organization. It has got institutional as well as community based services for providing education, therapy & vocational training and employment services for disabled people. They concentrate more on people belonging to poor socio economic background irrespective of rural or urban setting. I was astonished to see the functioning of this private organization.

Key Learning from APD

- Where ever community participation is encouraged, community development is possible sooner.
- Community health is mainly enabling the people in a locality to be empowered. Charity is not what people need but empowerment. Make people to be independent rather than leaning on you.
- We as a private NGO could make use of all opportunities to make a linkage with the government. Thus we receive logistic, organized and financial support from the government to materialize our dream.

Milana

This is a nongovernmental organization started in the year 2000 run only on projects support, mainly Action Aid backed family support network for the holistic development of children & of people living with HIV in Bangalore. Later on their focus changed to families of people living with HIV known as family support group. They are now networking with many NGOs such as Asha Kiran, Snehadan, Arunodaya, Asha Foundation, Freedom Foundation etc.

I was privileged to associate with them on 25th & 26th August 08. There were about 13 women in this organization who go the families of People Living with HIV AIDS (PLHA) giving counseling, and other support especially to children. Currently the MILANA co-ordinates with government organizations too. The organization compiled its name from the following.

M – Meeting place which provides a space for infected /affected families to come to share & understand the challenges facing their lives.

I - Inter action where members receive counseling for confidence building and develop a peer support.

L - Learning for empowerment is an integral part of the network. Children are encouraged to go to school irrespective of their HIV status.

A - Acceptance of status of HIV and to address discrimination issues collectively.

N - Nutrition for health is the key slogan of Milana. Nutritional support is provided to the families.

A - Articulation to break the culture of silence among women and help ascertain their rights within family, community and society at large.

My Observations & key learning

- Positive women were truly empowered after coming in contact with MILANA.
- When ever developmental programs are taken up, look for its sustainability.
- Wherever networking with govt; as well as private NGO is possible make use of the opportunities for the growth & development of your own organization.

Jan Swasthya Sahayog (JSS) – Bilaspur, Chattisgarh

JSS (People's Health Support Group) was registered in Delhi by a group of socially conscious health & allied professionals, many of whom underwent training together at the AIIMS, New Delhi. Not satisfied with a techno-centric, hospital based vision of tertiary health care, the group decided to base itself in a rural area, and evolve a people- centric, community based model of primary health care. The group now includes alumni from the prestigious CMC, Vellore as well, and consists of an epidemiologist, 2 community health experts, a research immuno-chemist, two pediatricians, a physician, a surgeon, a gynecologist, an ENT specialist, a medical microbiologist, an Ayurvedic physician and a consultant on organic agriculture. This core team is supported by 80 staff.

Why they Choose Bilaspur?

JSS team moved to Bilaspur in 1999.Then it was part of MP, a state with one of the poorest health indicators in the country. In 2000 it became part of the new sate of Chattisgarh. Bilaspur district has a large tribal population, a large forest cover, and poor health and socioeconomic indicators. It is considered as a backward district in terms of its social & economic development, ranking 9th in the Human Development indicators out of the 16 districts of the state. Seasonal migration to other parts of India in search of employment is a regular & grim feature of rural life. Bilaspur is underserved in terms of health care & community health services which is reflected in the poor health indicators of the district.

My impression & learning from JSS

I was placed in JSS for a month from 9.10.08 and it was a wonderful experience for me. The commitment with which the doctors do the service is commendable.

Most Patients feel that the hospital is for them. Quality care is provided at an affordable cost.

Doctors at JSS have found enough & more funds to execute their services both in hospital as well as in community centers even though they are not getting adequate number of trained personnel to work with them. Remoteness of the place is posing a major problem in getting paramedical staff. But that is accommodated to a great extent by giving training to local people. Appropriate technology is utilized in the best way. Even though rural folk who are illiterate are trained to be health care providers, quality is not jeopardized. Even in remotest areas where there is no transport facility the sample slides for malaria detection is done with the help of school children. Available bus service is made use for this purpose. Slides are sent through the school children to the bus driver & he delivers them to JSS hospital at Ganiyari in the morning. They, in turn return the report of the slide to the health worker with the same bus driver when the bus returns to the village in the evening. And the health worker initiates anti malarial on the same day if the case is positive!

Both of our hospitals are in remote villages. Our great struggle is getting good doctors with commitment for the poor. I need to look in to the possibilities of getting good doctors and the strategies to sustain them.

Motivate the sisters in our institute to transform our hospitals as pro poor and make it relevant in the present age.

Kindly refer to Annexure for details of activities of JSS & the appropriate technologies developed by them.

Contexulized Retreat in Anandwan

Introduction: Anandvan (Forest of Joy) is a village in Warora in Maharashtra. Baba Amte a visionary and socially conscious man and his family lives here. He belonged to a high class Hindu family, a lawyer by profession. One day while returning from his office he met with a leper and there was complete transformation in his life. He left his job, broke the caste

and culture and began to live with people in Anandwan for the welfare of lepers, the blind, deaf & dumb. At the age of 83 he passed away but Samidha his wife still lives in this village continue with Amte's legacy. His son works with Medha Patkar the renowned social activists and another as a doctor in a rural area in Nagpur following Amte's foot steps.

Impressions & Inspirations

When you begin to live for the marginalized totally, money begins to flow.
Break the caste, culture, traditions by your life itself and you will begin to see changes around you.
Amte did not do charity for the down trodden but empowered them to the fullest.
He left a legacy behind and people in Anandwan continue it.
Anandwan is self sufficient with a hospital, school including special school for deaf & dumb, college, market. Every family has their own farm for their sustenance.
There is no temple, mosque or church but they are people with spirituality and live a happy life.
There are no supervisors but every one does their responsibilities by themselves.

Holy Cross Comprehensive Rural Health Project (CRHP)

This organization originated in 1997. This is the dream of an individual sister in the province called Dr. Sr. Aquinas who was graduated & did her PG from a reputed catholic medical college in Bangalore. She is a visionary who took courage & risk to travel through the roads less traveled. I was with them after the midterm evaluation of community Health learning program from 18.12.08 to 20.01.09. During our orientation program itself all interns were given a chance to visit this place.
Since one of the strategies adopted to fulfill one of my learning objectives I have gone to them for a second time.

Observations made & Activities participated in

Lack of experienced sisters to take up village mission causing anxiety & non-cooperation among themselves.
Developmental activities are not gaining a momentum.
Ignorance & incapability of the sisters are being exploited by few staff of the organization.
Need for more sisters to volunteer for such mission.
Few activities of National Rural Health Mission (NRHM) like

- Community Monitoring
- Facilitating ASHA (Accredited Social Health Activists) training program
- Formation of Voluntary Health & Sanitation Committee in each panchayath

National Child Labor Program (NCLP) & Karnataka Child Labor Program (KCLP) in which following activities are done.

- Residential Bridge Course
- Day Bridge Course

When child is ready to resume regular school, she/he is being main streamed to a regular school and follow up is done.

- Skill Training for children within 14- 18 yrs.
- Health Promoting schools
- Formation of Children's parliament.
- Formation of School Development & Management Committee (SDMC) in all rural schools.
- Visits to Anganvadies to promote its maximum utilization.

Watershed program (continued)

Holy Cross Hospital, Chikmagalur

This is one of the "Mission Hospitals" about which I have reported in the initial part of this report. I spend 2 weeks time in the community near to this hospital.
One of my objectives to undergo CHLP is to transform this hospital to a community based rural hospital. So I did spend time observing the functioning of certain of its departments, interacting with administrative and other staff, patients who came etc looking for the possibilities of making changes where ever needed. I also visited few near by villages concentrating on their health needs, health care facilities available for them & other developmental activities possibly could taken up etc. Since times spend is too short a period I would return to this community and continue my effort to do a SWOT analysis to achieve the goal.

TRAININGS & WORKSHOP ATTENDED

August 19- 21 Attended 3 days workshop on- Health as Human right at ISI, Bangalore. This workshop was organized by CHC for members from various NGOs in northern Karnataka. Topics discussed were on Liberalization, Privatization & Globalization and their effect on health.
August 29- 31 Workshop at Vishranthy Nilaya, Bangalore. Organized by CHC in collaboration with Asia Monitor Resource centre, Hongkong & Corporate accountability Desk, Chennai. Workshop was attended by various NGO representing organized & unorganized workers from all over India. Discussed on "Community Health & Environmental Survey Skill share. (CHESS)
Sept 5- 7 Workshop on "Praxis of Communication" by Dr. Mohan Despande in CHC, Bangalore. Very interesting sessions on different and simple ways of communicating health tips to the rural folks.
December 4-5 CHC's Alumni Workshop at Navaspoorthy Kendra, Bangalore. This was organized on the occasion of CHC's silver Jubilee. Many alumni have shared their journey through community health, various dimensions of community health, challenges faced, achievements gained etc.

Jan 23-24 Special training on International Fund raising & Proposal writing by Nice Foundation at Chennai. Topics covered were

a. Formalities involved in writing a project proposal of NGO.
b. How to write an effective project proposal?
c. Structure of a project proposal.
d. Where proposals fail etc.

NEW LEARNINGS ABOUT COMMUNITY HEALTH

Earlier I knew human anatomy and now I understand the social anatomy and it's linkage with health. Disease is the product of economic, social & cultural environment. So it is essential to change this environment to improve the health status of the people. ie "paradigm shift" to social biology of health - from biomedical understanding of diseases to social context of health.

- Community health is mainly enabling the people in a locality to be empowered.
- Began to appreciate the value of empowering women & children in a community
- Began to appreciate the role of caste, class & gender in relation to health & development.
- Water, sanitation, nutrition and gender discrimination are the major health determinants.
- became aware that some sections of the society are made to / forced to make certain choice in the way they enjoy health.
- the ignorance of the poor are always exploited, especially the women.
- in all disasters whether it is natural or man made, it is always the women & children who are affected the most.

Looking inward

I became more aware of the vastness of my ignorance.

Most often I drew conclusion on the reason why people are unhealthy and I blamed the victim. But in reality it is not so.

Values such as equality, justice and openness to dialogue etc are very difficult to practice and these cannot be taught but to be lived out and to be caught by others.

While talking to any group it is essential to know & use the language/ terminology of the people.

When I desire to work in community I need to identify with the less privileged and must be willing to make a lot of changes within myself.
Value of undergoing small training programs based on health issues.
It is possible to run a low cost effective care unit in a village.
I began to appreciate the truth that every attempt to do anything good need not be always successful but believe that somewhere something has begun to change for good.
People whom I want to serve will open up themselves & share with me on various real issues only if they begin to see that I am on their side. So it is essential for me to spend enough time with them in village in building relationships.
Human resource from the community itself can be trained to perform the task of professionally trained personnel.
Choose an appropriate time to bring up a subject/ issue when it is meaningful to them.

To be an effective Community Health Worker
I need to develop my skills along with the human aspects in me. Just be a good/nice person is not enough.
I need to be aware of my weakness/limitations along with my strengths, so that I can grow further.
Values such as equality, justice and openness to dialogue etc are very difficult to practice and these cannot be taught but to be lived out and to be caught by others.

Inspirations Drawn From Readings

Readings from various books, write ups, articles, reports etc and the sharing of personal experiences done by mentors and resource persons were a source of inspiration, encouragement & support for me.

A. **Taking Sides**: The choices before the health worker By- Dr. Sathyamala et al
By reading this book, certain of my doubts were clarified. Those are the following:

Why don't people understand that it is for their own good to get treated early? a question usually asked by health provider. But the decision to seek relief from illness depends on people's perception of the severity of the illness. A person may not seek medical help because of the expense involved.

Why do people have faith in local healers ? In most rural areas in India illness is still seen as a result of falling out of harmony with the universe. The local healer operating from within the same set of beliefs therefore provides a satisfying answer to the question of why disease has occurred. Modern medicine explains disease as being caused by germs.

Why don't people in rural areas have access to health services? This impression is due to – experience of overcrowded hospitals, under staffed PHCs or inadequately stocked sub centers. The adoption of the western model of health care together with the interest of

various powerful groups in society is responsible for the severe imbalance that exists in our health services.

Why don't doctors work in rural areas? Social back ground of medical students - in the past majority come from well to do middle class or upper class. Middle class value of success- success in medicine means getting a job in big urban hospitals, doing research, acquiring more & more degrees through specialization, financial gain etc.

[Details can be obtained in the annexure of this report]

Why don't people implement simple health message?
Health workers try to change practices and beliefs that they consider harmful to the health of the individual. These practices are usually related to nutrition, personal hygiene & sanitation. Most people still believe that human beings have little control over events affecting their lives. But the underlying assumption in health message is that human beings can control disease. So there is a tendency to reject these information and the messages are either ignored or forgotten.

Adaptation takes place only when evidence in favor of new information increases to such an extent that it is no longer possible to reject it. If enough evidence is not built up people will continue to behave in the old way. When changes are related to customs & beliefs, people are not willing to change as it causes too much disturbance.

Resistance to change also may be due to obvious disadvantages that may escape the reasoning of an outsider. For example, the advice of 'Eat more than usual in pregnancy' is perceived by the women as a risk of having a big baby, difficult labor or LSCS. Similarly, the advice of smokeless Chula instead of open wood fire for cooking in houses resulted in infestation of the thatch of the roof by white ants! Another reason why health messages are not implemented is due to the helplessness of people to make changes in their lives.

How did doctors of modern medicine come to exercise complete control over all matters related to health? Limitations of modern medicines etc:

[Please see annexure]

Summary

This book has made me see why poor fall ill so often. It convinced me about the central role of inequality in ensuring that many people remain poor. The book also shows how attempts at providing health care to the poor invariably fail because of overall economic and social forces that try to maintain the existing inequality in society. It may seem that poor will continue to be poor and that we can do very little to change this. But this train of thought is neither true nor useful.

All through history, they have struggled against their poverty & against oppression. The democracy that we enjoy, the recognition of human rights & laws that guarantee freedom of expression and life is the result of centuries of collective struggle by the poor against inequality. The world in its current form has been shaped mostly by the struggles of the poor against the rich.
In today's context, with he rapid spread of globalization and privatization, the amount of burden on the poor has increased several times. Many poor and marginal farmers have lost their lands and many have lost their livelihood. Even the right to safe drinking water has been lost. In this context, where the poor seem to be continuously loosing, fighting against exploitation seems like a lost cause. But there is still a lot of reason to keep up our hopes. A large number of people's organizations, political and social movements have sprung up across the world.

The Peoples Heath Movement (PHM) is an example of such & is a world wide coalition of a large number of community organizations, voluntary organizations and people's movements working to ensure that heath care reaches the poor.

B. Health Advocacy - Series of critiques of present day health scenario - By Dr. Ravi Narayan

Reading of these articles helped me to draw conclusions about the present scenario of our hospitals. How it has deviated from its original purpose for which it was established. It also helped me to learn that while we are in leadership positions especially in public institutions we need to be in touch with the day to day changes taking place in the society and how we need to be oriented to the vision & charism. Unless we are passionate about our goal we may easily and blindly shift our focus.

At the initial sessions in CHLP I expressed guilt feelings about my involvement in the institutional life in the yester years. Then Dr. Ravi Narayan himself consoled me saying that there is nothing to be regretted about the past rather you look at your system with a different spectacles!

I began to look at the various health organizations where I was sent for my field placement as to how a hospital can be pro poor and what we need to change in its functioning.

[A detailed description about each of those articles can be found in the Annexure of this report]

Will there be Mission hospitals in 2000AD?

Various developments in the country's health policy as well as disturbing trends within voluntary sector have made the author to question. In 1960s- St.X hospital, as charitable mission hospital's vallue orientation or saintliness had eroded. Private sector, profit oriented hospitals have developed in response to the "Market Economy".

Looking Within – Hospitals & Health

The model of health services that we have uncritically adopted from the industrially advanced societies of the west has its inherent fallacies. It tends to distort the basic values of life and ultimately affects the happiness of the people. Over professionalisation increases costs and reduces the autonomy of the individual. How many of our hospitals are ready for a challenge?

NGO & the Govt: working together

Voluntary agencies including mission hospitals had played a role in health care in pre independence time. But in the first three decades of post independence the linkage between them & govt health services was- "peaceful co-existence" with very little collaboration. In 1982 , the National Health Policy was formulated. The article questions how successful has the voluntary sector been in receiving organized, logistic & financial support from the government in the context of the National health policy.

Robinhood Principle – Robbing Peter to pay Paul

All mission hospitals were started by their inspired founders to reach medical care to those sections of the society that were not being served by the available services of their times. "Mission Economy" managed to beat "market economy" with the support of large grants from foreign mission & regular infusions of donated drugs & hospital technology. As times changed and foreign infusions dwindled local mission hospital managements were forced to explore alternative methods to make budget balance. Tapping local resources became imperative. Thus adapted Robin Hood principle- Robbing Peter to pay Paul. This stimulated market economy forces which caused lot of dilemmas.

But you cannot rob Peter for the needs of Paul in the long run. So the author concluded the article proposing the following commandments to make the mission hospitals relevant.

The new Commandments

1.Thou shall not discriminate between Peter & Paul
2.Thou shall look beyond Peter's purse.
3.Thou shall adapt hospital culture to the realities of Paul and not the whims of Peter.
4.Thou shall investigate, intervene & treat both Peter & Paul rationally.

5. Drug pusher or healer – What are you?

In this article Dr. Ravi speaks about the drug & pharmaceutical situation in India. The doctor- drug producer axis as the major villain & the prescribing practices of doctors as the key culprit. Even within voluntary sector of health care drug pushers far outnumber the healers. The commercialization of the medical system has led to many doctors over prescribing costly drugs or recommending unnecessary tests.

6. Overcoming new challenges

A very thought provoking question he asks in this article is – Will you be a floor mopper or a tap turner? The medical & nursing professions have long been floor moppers, using drugs technology to floor mop the overflow of illness and disabilities in the community. With the knowledge of preventive medicine being limited this seemed the most logical response & therefore, the clinically oriented drug- technology- dispensary- hospital oriented healing ministry developed. But medical knowledge has grown & our knowledge of diseases has also improved greatly. Many of the preventable causes of illness are known & tap turning off skills developed to varying levels of competence. Are we ready to become tap tuner off or are we going to continue to floor mop?

7. The healing ministry at the cross roads – Towards a paradigm shift

In this, he challenges us to see the healing mission in a new light. A paradigm shift has to take place in the social biology of health.

Paradigm shift components are:

	Moving from	Towards
1.	Problems of individuals	To problems of communities
2.	Limited pathological, intracellular understanding of diseases	More dynamic behavioral/societal context of health
3.	Concept of illness as a disease process requiring treatment	Ill health as a social process requiring a care system & strategy
4.	Preoccupation with providing packages of services	More dynamic enabling/empowering process where individual/community exercises its right to health & its responsibilities for its maintenance
5.	Concept of patients as just beneficiaries of professional	People as participants of a joint operation, where consumer

	intervention	control & autonomy of consumer decision making has become more significant.
6.	Concept of the doctor/nurse being the centre stage of the process	Doctor/nurse being part of an expanding health team working for a common social goal

Readings from the above series helped me to make a fresh look at the problems that all "Mission Hospitals" especially our hospitals are facing. It also illustrated the dilemmas that we undergo currently. Got some idea about where we have failed as a health care institution & what change we need to make in order to make our mission relevant in the present scenario. I wish to express my profound gratitude to Dr. Ravi for his inspiring & thought provoking articles & I congratulate him for his farsightedness in predicting the plight of mission hospitals. If only many of us would understand its significance and catch its vision!

C. Whose Ministry? A Ministry of Health Care for the Year 2000. By – Gillian Patterson

The book was written in the context of the largest Christian institution namely the CMC Hospital in Vellore founded in 1990 by an American missionary to meet the need for Indian women to train as doctors & midwives. But it is not about CMC.

Summary & Lessons Learned

Reading this book also gave me the parallel thoughts same as that of readings on Health advocacy series emphasizing the need to look at the relevance of our health care institutions namely our two hospitals. Of course it looks from a Christian perspective. It prompts me to develop a model health care delivery system in our hospitals which could be supported by our own resources. We could also charge well over cost price for high specialty services & use the surplus to finance to its community health programs & some free treatment.

The book is solely about the dilemmas that confront all institutions engaged in heath care delivery in the 1990s where ever they were. It is about the needs & resources and the problems of bringing together. In the light of the ethic of "wholeness," it explores some of the ideas that surround a Christian approach to healing. It questions the relevance of voluntary institutions in a changing world & what it is about institutions in general that make them so resistant to change within themselves. Following statements & questions which she puts forward gave me further insight on our healing ministry through institutions.

* If we go on pouring our energies in to the service of anachronistic structures, it is a recipe for lingering suicide.
* What is our approach to healing – Wholeness?

* How our institutions can stay relevant in a changing world & what it is
that make us so resistant to change within ourselves?
* Voluntary agencies all over the world are struggling to define their role. So also we. Are we meant to fill the gaps in govt: provisions, or may be to replace it?
* Are we not called to help people to fight exploitation, corruption & incompetence?
* Are we to apply sticking plaster to the world's wounds or to tackle
sickness itself: the political & economic structures that produce poverty & oppression?"

Emphasis on Community Health in the words of Mahatma Gandhi "the soul of India is in the villages. Understand that the roots of health lie not in hospital but in the village community.

Gillian Patterson observed that ministry to the whole human situation is important and that the health or wholeness of the individual is dependant on a confident economically strong community.
As I read through, the following text caught my attention and it seems to be very true in our context.
Change always causes pain & also conflict. If the institution (church) is to stay relevant to its context then the truth must be faced: our resources have to go in to building structures & networks that support our primary aims.
If we go on pouring our energies in to the service of anachronistic structures it is a recipe for lingering suicide.
When a society ceases to respond to the plights of its poorest or most marginalized, it has in fact started to die, although it may not know it yet.
Who then is ministering to whom? It is the long, slow agonizing business of learning to live together in love, of acknowledging the alien as one's neighbor, of recognizing the full humanity of others, of facing truths even where these are uncomfortable, of allowing ourselves to experience the pain of human need in the hope that we ourselves may be redeemed.

D. Signs of the Times

In this chapter the author speaks about the origin of CMC as the product of its time. And she adds on success may follow success & you get the feeling that this will go on for ever. But the other side of the coin is this- if the power structures change, if the mood of the time shifts then the climate that seemed so favorable before may turn hostile. It is these moments in an institution's life, and the ways it responds to them, that determine its ultimate survival or demise. If it chooses to ignore the new situation, refuses to grapple with the issues raised, it will become irrelevant & die. It must strike a balance between two opposing principles: on the one hand, a coherent vision of it's own ethos & purpose, supported by a staff who understand & shares that vision; and on the other hand, the courage to change in response to the signs of the times.

To conclude through this book she looks at ministry, especially Christian ministry, and tries to establish a model that is compatible with justice, peace and the integrity of creation

and all it stands for. And she says that there are no answers for any of us. But it does suggest ways in which we might address the problems.

E. Joothan- A Dalit's Life by Valmiki

Joothan means scraps of left on plates that are given to Dalits to eat. The story of a Dalit shows the tremendous injustice done on the Ddalits which has been their heritage for centuries. A Dalit's life is excruciatingly painful, charred by experiences. Even in nothingness the Dalit shared love, concern & care. When everyone is sharing the same situation, they forget the past grudges & were sharing their belongings with each other.
A Glimpse of the hard days of Dalit in the past is narrated in this book-
Even while writing exams a Dalit is thirsty he cannot drink from a glass. The peon pours water on cup hands from way high up; otherwise their hands touch the glass!
A Dalit is kept outside of extracurricular activities as a spectator!
Howsoever much you study---- you still remain a Chuhra! - Attitude of non Dalits to a Dalit.
Dhobi says to a Dalit" we don't wash the clothes of Chuhra- Chamars nor do iron. If we do so Tagar (other caste) won't get their clothes washed by dhobi & we will loose our roti"

It makes me to think that one can somehow get past poverty & deprivation but is impossible to get past caste. Caste follows one right up to one's death.
This story also shows the impact of education on Dalit. How he overcame contempt, humiliation, and violence to gain an education & finally joins the Dalit intellectual.

ANNEXURE

Summary: (Taking sides by Dr. Sathyamala)

This book has made me see why poor fall ill so often. It convinced me about the central role of inequality in ensuring that many people remain poor. This book also shows how attempts at providing health care to the poor invariably fail because of overall economic and social forces that try to maintain the existing inequality in society. It may seem that poor will continue to be poor and that we can do very little to change this. But this train of thought is neither true nor useful.
The poor have never been passive. All through history, they have struggled against their poverty & against oppression. The democracy that we enjoy, the recognition of human rights & laws that guarantee freedom of expression and life is the result of centuries of collective struggle by the poor against inequality. The notion of a welfare state , ideas of gender equality, ideas of non- discrimination based on caste or race are all ideas that have come out of people's struggles.

The world in its current form has been shaped mostly by the struggles of the poor against the rich. The rich have consistently tried to robe the poor of their rights, means of livelihood, natural resources and often even lives. The poor have in turn consistently tried to stop the rich from doing so and have fought to earn for themselves and other fellow beings basic human rights to live a life with dignity.

Sometimes the poor win, and this leads to more equal society with lesser poverty and better health, education and income levels for all. Sometimes the poor loose & they lose many of their rights and livelihood resources. At any given time the poor win or loose depends on their overall strength & organization as well as how well organized and mobilized the rich are. What is more important is how much they win or lose. Even when the poor lose, if they put up a stiff struggle, they loose lesser. Putting up a stiff struggle against exploitation is important in itself- it always lead to a gain.

In today's context, with he rapid spread of globalization and privatization, the amount of burden on the poor has increased several times. Many poor and marginal farmers have lost their lands and many have lost their livelihood. Even the right to safe drinking water has been lost. In this context, where the poor seem to be continuously loosing, fighting against exploitation seems like a lost cause.

But there is still a lot of reason to keep up our hopes. The poor have begun to organize themselves much more effectively in recent years. A large number of people's organizations, political and social movements have sprung up across the world.

Even as the rich are spreading their tentacles across the world, the resistance to the rich is also becoming global. Local movements are becoming stronger & more aware. They are joining together with other similar movements across the world to form world wide resistance movements, helping each other resist oppression and inequality. The people's

movements against the WTO, the World Social Forum, and Peoples Health Movement are 3 such world wide movements.

The Peoples Heath Movement (PHM) is a world wide coalition of a large number of community organizations, voluntary organizations and people's movements working to ensure that heath care reaches the poor. In India alone, there are over 2000 organizations across the country that is part of the PHM. Many of these organizations are working to both reach heath services to the poor as well as to generate the awareness and public pressure on the state to fulfill its health for all promise.

The poor are becoming aware of how they are getting exploited. They are organizing to stop the exploitation. People's organizations are gaining a voice & political power. It is time to join these movements & to strengthen them. It is time to join the struggle against poverty & exploitation. It is time to create a new world built on equality.

Few interesting lessons on modern medicine and the medical education are written by her in her book which is of interest to any of us. Have a look at it.

Why don't doctors work in rural areas?

Social back ground of medical students – in the past majority come from well to do middle class or upper class. Middle class value of success- success in medicine means getting a job in big urban hospitals, doing research, acquiring more & more degrees through specialization, financial gain etc.

The overall focus of medical education is on training students to deal with disease after it has occurred. Little attention is given to a study of the social condition in which disease originates. Nor is emphasis placed on a study of the conditions that are needed to create a disease free environment.

The technical content of medical education is also such that it helps in the process of alienation from rural. By the time the medical students complete their training, they know very little about the most prevalent diseases in the country that are more common and more important especially among the poor people in our country. This is because most text books used are written in foreign countries.

These books focus on the health problems that are common in their countries. They see no value in finding out why poor people are unable to eat well? Why they are unable to seek early treatment? To answer these they just introduced PSM (Preventive & Social Medicine) subject in medical schools!

Also medical colleges do not prepare students to work in conditions found in rural health centre. Medical students fail to develop knowledge/ skill of making diagnosis through observation, history taking & physical examination.

In short Medical education in our country does not prepare doctors to work in rural areas. Job description of a PHC doctor is quite unaffordable for a graduate.

In a health care system based on modern medicine, doctors play a vital role in all aspects of medical care. It is very difficult for anyone to challenge their authority. Medical knowledge & skills are restricted to a very small minority. This restriction really comes from the pattern that was established in western countries more than a100 yrs ago. At that time modern medicine was neither so advanced nor so complicated. The control over knowledge & practice of medicine actually came into being because of the economic interests of doctors, who eliminated competition from all other healers by colluding with powerful groups in the society of that time.

This pattern was adopted by India too, when modern medicine became the officially recognized system of medicine in our country. In India, doctors of modern medicine gained a monopoly over the practice of medicine with the aid of legislation. As a result of this, in our country the following changes took place:

Private practice is legally allowed.

There is no restriction on the fees charged by the private practitioners.

More doctors go in to private practice than into government service

The govt is unable to make doctors to work in areas which require medical services most.

Even though several committees have stated that medical education is not suited to meet the health needs of the majority, the content of medical education continues to focus on the medical needs of a minority of the people.

Doctors continue to demand complete obedience from patients & continue to prescribe treatments, irrespective of whether the patients are able to afford them or not.

Indian doctors continue to look down on all non - allopathic systems of healing.

Here too doctors continue to promote modern medicine as the only answer to the problem of ill health, even though modern medicine as it is practiced today is not in a position to deal with the primary causes of disease in our country.

Limitations of Modern Medicine:

If we look at the problem of ill health in a population, there are two aspects to deal with the problem of diseases. One is to deal with disease after it has occurred. The other is to prevent disease from occurring. ie, disease process & disease causation.

Modern medicine developed powerful remedies & therapeutic techniques (drugs, surgeries) to deal with disease within the human body. Preventive measures such as vaccination & chemoprophylaxis also dealt with disease at the individual level and through this attempted to manipulate the environment. None of the techniques of modern medicine attempted to control disease at the primary level, ie; social level.

Modern medicine has used scientific principles to develop interventions at the immediate level and it also has the potential to develop rational & scientific ways of controlling disease at the social level. But as long as modern medicine serves the economic interests of a few, it will not explore its potential in developing alternative ways of coping with disease.

Health Advocacy- by Dr. Ravi Narayan.

A. Will there be Mission hospitals in 2000AD?

Various developments in the country's health policy as well as disturbing trends within voluntary sector have made the author to question. In 1960s- St.X hospital, as charitable mission hospital's value orientation or saintliness had eroded. Private sector, profit oriented hospitals have developed in response to the "Market Economy". "Mission of healing" is changed to "Clean floor& white sheets" the only way to make enough money to run the hospital without regular doses of foreign donation is to shift the focus on the paying patient to balance the budget in order to continue the vocation is to increase unnecessary investigations, unnecessary prescriptions, increase the length of stay in hospital better profit margin for inessential drugs. Companies provide greater unethical trade discounts. Doctors are paid larger sums "over & under" table since they are the best contributors to the profit margin. Many institutions close down especially at peripheral as they are not able to generate enough money to meet the increasing costs of medical care. Unable to get committed professionals to work, mission hospitals with a mission is disappearing.

B. Looking Within – Hospitals & Health.

The model of health services that we have uncritically adopted from the industrially advanced societies of the west has its inherent fallacies. It tends to distort the basic values of life and ultimately affects the happiness of the people. Over professionalisation increases costs and reduces the autonomy of the individual. These weaknesses of the system are now being increasingly realized in the west and attempts are made to remedy them. But we continue to persist with this model. Why is it that our hospitals are so westernized and elitist that they produce a culture shock to many of our patients particularly those who come from the lower socioeconomic classes in the poor whom we want to serve? Prof. D. Banerji of JNU asks: "starting as an inward looking, market-dominated, technology- oriented institution, a hospital opens itself to the community, to respond to its requirements, bringing about the necessary reorientation in its technology, organization and management". How many of our hospitals are ready for this challenge.

C. NGO & the Govt: working together.

Voluntary agencies including mission hospitals had played a role in health care in pre independence time. But in the first three decades of post independence the linkage between them & govt: health services was- "peaceful co-existence":- very little collaboration. In 1982 National health policy reviewed. How successful has the voluntary sector been in receiving organized, logistic & financial support from the govt:?

D. Robinhood Principle – Robbing Peter to pay Paul.

All mission hospitals were started by their inspired founders to reach medical care to those sections of the society that were not being served by the available services of their times. "Mission Economy" managed to beat "market economy" with the support of large grants from foreign mission & regular infusions of donated drugs & hospital technology. As times changed and foreign infusions dwindled local mission hospital managements were

forced to explore alternative methods to make budget balance. Tapping local resources became imperative. Thus adapted Robin Hood principle. This stimulated market economy forces which caused dilemmas such as

- Number of poor patients decreased in mission hospitals because services to Peters increased.
- General wards are no more free wards but they had to pay which is more than they can afford, lead to greater social stress, indebtedness and family crisis.
- Peters made more pressure on hospital management to provide better services, greater facilities & more luxuries in Pvt: wards.
- Peters make greater demands on the time & skill of hospital staff.
- Junior staff complain that the seniors are more preoccupied with neurotic demands of the paying Peters while they are left to manage the life & death crises of Pauls.
- General wards began to look duller& shabbier due to constraints in maintenance funds. Glamour of technology and super specialty began to creep in.
- As profit margins from services to Peters are increased the staff are motivated to a culture of over investigations, over prescription with its resultant iatrogenesis.

But you cannot rob Peter for the needs of Paul in the long run.

The New Commandments:

Thou shall not discriminate between Peter & Paul

1.Thou shall look beyond Peter's purse.

2.Thou shall adapt hospital culture to the realities of Paul and not the whims of Peter.

3.Thou shall investigate, intervene & treat both Peter & Paul rationally.

Accepting these commandments will give the mission economy another chance.

E. Drug pusher or healer - What are you?

In 1980 ICSSR, ICMR, Health for All study groups reviewed the drug & pharmaceutical situation in India. They identified the doctor- drug producer axis as the major villain & the prescribing practices of doctors as the key culprit. Even within voluntary sector of health care drug pushers far outnumber the healers. The commercialization of the medical system has led to many doctors over prescribing costly drugs or recommending unnecessary tests. We need to ask ourselves

Have you accepted the concept of an essential, selected, restricted drug list in your hospital?

Have you accepted the concept of generic prescriptions to prevent misuse & misinformation by pharmaceutical companies?

Have you stopped prescribing drugs whose only additional value is - a cosmetic embellishment Eg: a special flavor, elegant packing (a nice container).

Have you stopped promoting tonics- vitaminising effect on our sewage systems? What poor need is food & what rich need is health education to prevent over eating.

Do you have a policy against accepting physicians sample& other forms of inducements from medical companies including unethical trade discounts& offers?

Do you propagate simple home remedies, pharmacy based low cost preparations or locally available herbal remedies which are not integrated with the "market economy"?

Does your health centre offer various forms of non- drug therapies including holistic health, counseling& caring techniques?

Overcoming new challenges. The question you need to ask is – Will you be a floor mop per or a tap turner off? The medical & nursing professions have long been floor moppers, using drugs technology to floor mop the overflow of illness and disabilities in the community. With the knowledge of preventive medicine being limited this seemed the most logical response & therefore, the clinically oriented drug- technology- dispensary- hospital oriented healing ministry developed. Now medical knowledge has grown & our knowledge of diseases has also improved greatly. Many of the preventable causes of illness are known & tap turning off skills developed to varying levels of competence. Are we ready to become tap turner off or are we going to continue to floor mop, distracted & carried away by the glistening versions of floor mops being produced by the multinational medical industry today? Have you become little wiser today? The floor mopper in me had stressed the relevance of coronary care unit and promoted coronary bypass surgery till the tap tuner off in me took over to promote exercise, cycling diet modification, reduction in smoking and various other life style changes. The floor mopper in me promoted vitamins, pills, tonics, enriched fortified food in response to malnutrition but the tap turner in me took over to promote local food mixes, vegetable gardens to make our institutions more baby friendly. The question that I need to ask is Can I train nurses who are socially relevant & community oriented?

The healing ministry at the cross roads – Towards a paradigm shift.
We as mission hospital management, are we willing to be collectively challenged to see the healing mission in a new light? We have failed to internalize the new vision of health & health care. We are unable to comprehend the paradigm shift that has taken place in the social biology of health.

Activities Done by JSS

a Community health program, providing preventive and curative services, based on 104 trained VHW, elected by their respective villages, in 53 tribal villages.
Clinical services which include an outpatient clinic at Ganiyari, self sufficient with dispensary & radiology and laboratory services at an extremely low cost.
An inpatient ward with 15 beds and an OT complex providing high quality surgical services.
Three sub centers in 3 forest village clusters about 45-75 km from Bilaspur town, which serve more than 150 forest and forest –fringe village that are manned by 2 senior health workers each and are supported by doctor based outreach clinics every week.
Development, adaptation, validation of low cost health care and diagnostic technology appropriate to application in rural areas- by VHW, the community and by the public health centers. This has led to the creation of low cost diagnostic kits for diagnosis of anemia, urinary infections, detection of pneumonia by VHW, and sickle cell disease, among others. Also developed technology and aids for prevention of health problems like outbreaks of diarrhea with kits for detection of fecal contamination of drinking water, UV

based disinfection systems which can run on cycle power and modular kits for safe conduct of delivery & post partum care of mother & child.
Appropriate field & clinic based operational, observational, and action based research into priority public health problems particularly childhood illness, tuberculosis, malaria & leprosy.
Running training programs for other voluntary organizations & the government's health workforce.
Acting as a technical resource group for the govt: of Chattisgarh, the planning commission, other agencies.
Advocacy- JSS has been involved in advocacy for primary health care and rational pharmaceutical policy, as well as highlighting the centrality of chronic hunger as India's most important & persistent public health problem.
Extension of health center is in progress.

Appropriate Technology

Technology is necessary in health care at all levels, in prevention, diagnosis, in treatment and rehabilitation. In as much health care is an important tool in attainment of better health, the availability of appropriate health related technology is necessary for better health.

JSS has developed health related technologies for health care needs of the people with limited resources identified at the field level. These try to ensure the accuracy, if not more, as the prevailing ones and yet simple, acceptable and yet cheap & can be used in rural community. These can be used by all levels of health workers especially the most peripheral health workers to make diagnosis more rational and decrease misuse of drugs.

Kits Developed by JSS are:

- Diagnostic Kits for Urinary tract infection especially in pregnancy. Kit is based on detecting nitrite(as a surrogate for bacteria, which produce nitrite from nitrates present in urine) and the activity of enzyme leukocyte esterase, which is produced by the pus cells in urine(as a surrogate for pus cells).
- Measurement of anemia status. By measuring the PCV of centrifuged blood. Requires only a finger prick sample and can be done by semi skilled health workers.
- Measurement of anemia status using copper sulphate solutions.
- Diagnosis of sickle cell anemia based on conventional electrophoresis. It uses the agarose gel/ nitrocellulose paper as the medium.
- Sputum concentration system for increasing the sensitivity of microscopic diagnosis of tuberculosis. The technique is by using Ammonium sulphate- Sodium hydroxide technique. A kit useful at the community level for disease prevention:
- Microbiological testing of water and disinfection system

Diagnostic kits under field evaluation:

- **Glucose-** a dedicated calorimeter is used to read the developed color by glucose present in the plasma and O-toludine reaction.

- **Vaginal tract infections-** Uses a self administered absorbent testing pad which the woman can use to collect a vaginal fluid sample on her own. PH, KOH amine and leukocyte are performed.
- **Reproductive health test kit-** This kit incorporates the above tests as well and to diagnose the presence of vaginitis or cervicitis. It also includes pregnancy test, detection of protein urea etc

Equipment useful in diagnosis & evaluation in health care:

- Stadiometer- portable & inexpensive device
- Breath counter- For early diagnosis of pneumonia in children. The device is a microcontroller based counter, on a 9V battery, and records the rate of breathing by just pressing on a button and gives the output in form of red or green signal for abnormally high rate or otherwise.
- Easy to read thermometers- abnormal temperature range are colored red for easy use by health workers who have limited literacy level.
- Teaching stethoscope- It has 1 chest piece & 2 sets of earpieces, one each for the trainer & the trainee.
- Easy to read Blood pressure apparatus. This has the abnormal B.P ranges for both the systolic & diastolic values colored red. Thus enabling the health workers with limited literacy skills to measure the B. P.

Items useful at the community level for disease prevention and/ or treatment

- Mosquito repellant oil based on neem, DMPA and citronella
- ORS packets
- Appliance for breaking tablets into 3- 4 pieces for childhood medication
- Safe delivery kits for the mother, baby and the birth attendants.
- First aid kit for villages
- Soap- Saral mahua soap from mustard or kusumoil.

Nutritional Formulary

- Amylase rich flour- prepared by germinating cereals such as wheat, ragi & jowar. A complementary weaning food more digestable wih high nutritive value.
- Edible oil supplementation containing adequate oil for a week for a child to increase calorie density without increasing volume of food.
- Amla paachak- a ready source of Vit.C from Indian gooseberry.
- Choona namak- a dietary source of calcium. A therapeutic measure of calcium for pregnant & lactating women.
- Mineral mix- Necessary amount of supplementary potassium, zinc & magnesium in the form of sweet candy –can be consumed daily.