MEDICAL SERVICE

they must increase : we must decrease ● let my people go ● you did it to me ● smoking ● to pull down and build new ● child survival here and now ● what's new in health care management

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contents

Dear friend,

Birth of Jesus aroused different responses in different people.

The shepherds were overwhelmed with joy
as they foresaw their liberation at hand.

The wisemen left everything
in order to start on a search to find Him

The powerful Herod was in panic
and he tried to do away with the potential threat

In our times,

Do the one crore forty lakhs of infants
born yearly in our land
receive a warm welcome to our midst?

What is our response
to the three thousand one hundred fifty infants
being crushed to death everyday by our insensitivity
and lack of political will?

MAY THE CHILD JESUS
STIR AND AWAKEN US
TO THE ''SILENT EMERGENCIES''
OF THESE LESS PREVILEGED INFANTS
AT THIS CHRISTMAS
AND IN THE COMING YEAR

In solidarity with you and your endeavours
in this direction during 1986.

EDITORIAL

'WHO DO PEOPLE SAY I AM'

'Who do people say I am?' Jesus paused this question in Caesare Philippi.

2000 years later a similar question surfaced again in Lucknow at the 42nd National Convention of the Catholic Hospitals. The question: 'Who do people say we are? or more appropriately whom do people say we serve?

One of the answers came from the Union Deputy Minister for Health and Family Welfare (see Box on page 5). The other came from Mr. David Haxton one of the speakers on the second day, (see box on page 6). Both overwhelmingly flattering and both inviting participation and seeking alliance.

The question came back more powerfully at one of the seven half day workshops and from there to the plenary session.

There were several attempts at answering this question. Inconclusive as the answers are every participant I hope carried the question home to ponder over it, to answer for herself or himself and for one's own institution, congregation, association diocese and the church.

For more than 200 hospital administrators, doctors, pharmacists, nurses and health professionals who assembled in the capital of India's most populous state this basic and perhaps uncomfortable question raised again and again at the convention should be the torch that they carry home and bequeath to their friends.

Of what significance is our presence in the health scene of this country if we cannot make an impact on one out of every ten children who dies needlessly in the very first year of his birth?

Or on the thousands of children who are maimed or disabled or are born idiots due to easily preventable diseases?

Is not this a corollary to the question
"who do people say I am?"

They must increase : We must decrease

Convention calls for parish based health action—a report by Augustine J. Veliath

"We are not just an association of hospitals and dispensaries. We are the health wing of the church, the largest health care organisation in the world. Health is the basic human rights guranteed by the Indian constitution. Denial of health is denial of the kingdom of God".

Tough word in the given circumstances, but not unexpected from a convention that was discussing "silent emergencies of our times."

For the key note address delivered by none less than the Dr. Harcharan Singh, the Advisor to Government of India on Health had painted the grim scenario in its true color.

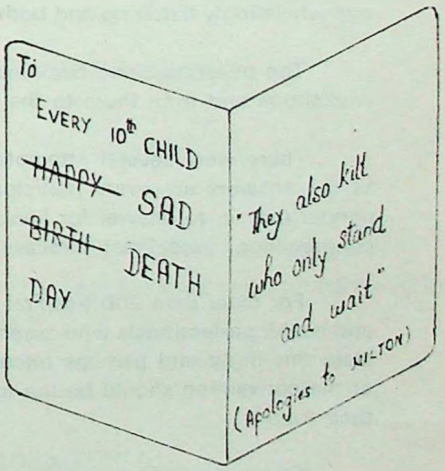
He reminded the audience during the time the previous speaker addressed the meeting (about 30 minutes) 200 children had died in India of needless and preventable causes. One out of every ten infants born fails to celebrate his most coveted first birthday. This is unacceptable.

In 1971, 9 to 10 million people crossed over to India from what was then East Pakistan. Overwhelming world opinion then endorsed military action on the part of India as no country can carry such a load. We ourselves add about 14 million children year after year. One out of ten of these children die before her first birthday. Two others die in the next two years.

Most of those death are preventable. There are many no cost and low cost solutions to these overwhelming problems. Home based diarrhoea management, universal immunisation, improved infant feeding practices, mothers monitoring their own children's growth are some of those techniques; Dr. Singh pointed out.

We have worked miracles in the past. We have eliminated small pox from the face of the earth; we have added 22 years to life expectancy and brought down death rate from 27 per thousand to 11 per thousand.

A Different Birthday Card



Inviting the catholic institutions to participate in the universal immunisation scheme, the new Union Deputy Minister for Health and Family Welfare Mr Krishna Kumar assured us that the portals of the Health Ministry is open to CHAI and other voluntary organisations. He said soon the Ministry will invite important health care organizations, CHAI among them, to participate in Child Survival and health related activities. 'You are welcome to take over the Primary Health Centres and the Government will allow the same financial allocations provided to Govenment PHCs, he said.

Largest

Mr. S. Krishna Kumar, Union Deputy Minister for Health.

"The Catholic Church is the single largest health care organization in the world. Its role in India has been pivotal.

"The priests and nuns and other Church workers are working in difficult terrains and remote rural areas, sacrificing their personal comfort and rendering devoted service."

"Our approach has to be that of a mass movement and in this government and voluntary organizations have to be co-partners."

Presiding over the inaugural function Dr. Alan de Lastic, Bishop of Lucknow spoke of the unutilised resources within the community. Schools, he said provided the best example.

Dr. C.M. Francis, Director of Continuing Education Christian Medical College, Vellore, raised a few soul searching questions (please see article on page 13). Dr. George Joseph stressed on true christian response of the followers of 'the woundeds aviour' in a world where death and illness seem to be having a field day.

Describing the Catholic Church as a major ally in promoting child survival revolution, Mr. David Haxton, Regional Director for South Asia UNICEF stressed action was feasible here and now. He outlined what our institutions can do right now and how the priests, the religious and parish communities support them.

Painless, Fearless births

Dr. Leboyer, the well known French expert and author of Art of Breathing was a special guest at our convention. According to him painless and fearless child births are possible. If the child comes into this world with the feeling that it is beautiful to be born the feeling is likely to stay.

A woman who is fully relaxed and is trained to fix her attention somewhere else during the child birth can make this possible.

Breath and sound are the two keys to birth becoming an ecstatic experience. Breath, not merely the physical act of breathing, but as Prana as understood in India is deeply connected with life. Religions know the significance of inner sound. The *Aum* of the Hindus and the *Amen* of Christians are not too far apart.

If a woman learns to awaken her inner sound pregnancy becomes a pilgrimage. Continued training allows you to reach to what is more beautiful than the sound itself — Silence genuine silence where the minds stops acting. Tanpura the Indian musical instrument is to sound, what rainbow is to light.

Pain is not a necessity. What is experienced as pain is the *intensity*. Once the woman learns to ride "the waves" this intensity itself can be ecstasy.

Dr. Leboyer cautioned against what we learned from the West. Deliveries in clinical situations are usually done in a hurry, because the assisting doctor at that moment is confronted with his own birth trauma.

This year the convention participants had seven different workshops to chose from:

I. **Strategising for IMMUNISATION**

and

Communicating Diarrhoea Management to Mothers lead by Dr. Valerian P Kimati, Health Section, South Asia Region.

(An issue of Medical Service will be devoted to this subject)

II. **Community Health**

Fr. Thomas Joseph
Sr. Mariamma
Mr. John T Samuel
All from the community health team of CHAI

III. **Child Care Priorities**

Dr. K.R. Antony
CHAI

IV. **Health Care Management : What's New**

Mr. Sam Thangraj
Development Consultant, New Delhi

See article on p. 33

(*Continued on page 7*)

Major ally

David Haxton, Regional Director, Unicef.

(I am here) "mainly to learn from the almost unequalled richness of experience in health-care under the inspiration of the Roman Catholic Church.

I am not surprised that in 1973, five years before the Alma Ata Declaration on primary health care, your Association chose for a similar annual convention the theme : Health for the Millions.

I am aware that your member units have struggled, particularly in the years that followed, to make this slogan a reality. You have recognised earlier than most others that hospital care and other ways of dispensing medicines, are only a small part of health promotion.

Encouraging reports appear periodically how your health workers, in association with the nuns and priests spread out even in remote areas, have tried to organise communities of optimal size in compact areas, regardless of religious affiliation, and engaged them in the effort to rebuild their lives through better access to the means of health."

ACTION POINTS FOR PARISH COMMUNITIES

Can our parish community ensure that every infant in our parish area is immunised before his/her first birthday?

Can we inform every mother in our parish/area about preparing and administering salt sugar solution to children with diarrhoea?

Can we ensure that every infant in our area is fed adequately by insisting that he/she receives breast-milk from the first hour of birth and receive supplementary feeding from four months onwards?

Can we ensure that all children under five in our area are weighed and that the children whose growth is declining receives special care.

Can we ensure that all T B and leprosy patients are identified and that they receive continuous uninterrupted treatment until they are whole.

Can we ensure that every village in our parish/area have at least three drinking water sources?

Can we introduce low cost latrines and other sanitary measures in each of our villages?

Can we ensure that undernourished and malnourished, particularly pregnant women and children receive food supplements like vitamin A, Iron, Iodine, Folic Acids etc.

Can we take measures that lessen the drudgery of women by measures like smokeless chulha.

Can we introduce appropriate income generating programmes for the community, especially for the families with the least income.

THEY MUST INCREASE WE MUST DECREASE

THE FOCUS MUST NOW BE ON THE PARISHES

(*Continued from page 6*)

V. **Patient Support Systems : Holistic Dimensions**

Sr. Pauline Yadav

Holy Family Hospital, New Delhi

See next issue of Medical Service

VI. **Legal Aid and Health Professionals**

Fr. P.D. Mathew sj

Indian Social Institute, New Delhi

(See next issue of Medical Service)

VII. Myths about Food and Hunger

Mr. Korah Mathen

Lalbhai Trust, Ahmedabad.

Workshops were very highly appreciated and the subsequent group and plenary discussions and convention resolution reflect the impact of these workshops.

LUCKNOW DECLARATION

We, the representatives of Catholic health institutions of India consisting of doctors, nurses, pharmacists, hospital administrators and health activists representing around 1900 member hospitals and health care institutions, gathered at St. Fidelis School, Lucknow from 10 — 14, November 1985 for the 42nd National Hospital Convention :—

— reminding ourselves that we are not just an association of institutions but the health wing of the Church in India

— recognizing that health is a basic human right guaranteed by the Indian Constitution and a denial of health is delaying if not denying of the Kingdom of God.

— having in mind the overwhelming emergencies that stare at the humanity every day particularly (very specifically) in the form of needless child deaths and the preventable damage done to their future health and well being

— recognizing the efforts of our big and small institutions all around the country and pointing that these efforts can be linked together with that of various allies going to scale of national impact; resolve that We:

1. respond to the call of child survival and development by strengthening, expanding and linking up the efforts of our communities and institutions. In this regard we welcome the launching of Universal Immunisation programme. We, through our member institutions and their infrastructure, express our willingness and keenness to collaborate with the Government in this endeavour.
2. draw up a health policy which will include a code of conduct for our professionals and institutions. We authorise the Executive Board to take necessary steps.
3. increasingly identify ourselves with very poor and make available primary health care to all in the neighbourhood of our institutions. Low cost health care facilities may be provided within the existing institutions and outside them.
4. prepare appropriate communication materials that are required to inform, educate, and persuade win over institutions communities, community leaders, health professionals to principles and practice of community health.
5. take the initiative to catalyse the formation of central or regional puchasing agencies to ensure the availability of essential drugs and health accessories.
6. draw up appropriate plans to be in partnership with schools, associations, like minded action groups and governments in promoting community health.

LET MY PEOPLE GO

Dr. C.M. Franci's Report on the Workshop on "Towards a People Oriented Drug Policy"

The convention was preceded by a workshop on Drugs as a follow up of 1984 convention. Like the Bangalore convention the workshop highlighted the complete hold, the all powerful pharmaceutical industry has over the profession, the prescribing habits of doctors, production pattern of drugs, and over the dissemination of information.

Drugs will continue to become more expensive inaugurating the workshop Dr. M.M. Dhar, Director of Central Drug Research Institute, Lucknow said.

Dr. Dhindel, the Drug Controller of U.P. then outlined the developments in the drug industry. What was a 10 crore industry has grown into 2000 crore a year industry and yet essential drugs are in short supply. Though Hathi Committee had already favoured a restricted drug production programme and that too in generic names the country has done very little in that direction.

Mr. Mira Shiva, from VHAI, who is also the coordinator for Drug Action Net work of India described how shortage of vitamin A not only blinds 40,000 children a year but also is responsible for 12 per cent of the infant mortality in the country.

She highlighted the need for a good national formulary, which is updated frequently. She gave the examples of U.K. and other countries, including developing countries.

This was followed by talks by Mr. S. Srinivasan, Coordinator LOCOST, Gujarat and Mr. M. Sarcar of West Bengal V.H.A. who gave the examples and experiences of Gujarat and West Bengal respectively. By judicious bulk purchase, the price can be brought down.

Mr. Augustine Veliath of CHAI spoke on drug information and drug action and exhorted the members to see that they are not exploited by the drug companies. This was followed by an open discussion with clarifications and questions and answers.

The members then broke up into four groups for discussion on three issues which had been identified. At the end of the workshops, the rapporteurs presented the recommendations of the groups.

The workshops found that essential drugs are often not available. Examples were given of common drugs against tuberculosis and leprosy. Production is often less than the quantity of drugs required.

Each member institution must have a formulary containing the essential drugs. The

lists given in Medical Service or 'Contact' could be used.

It was recommended that the manufacturers must be made to produce the more essential drugs. Since the new Drug Policy was about to be announced by the Government of India it is necessary to ensure that the policy be people oriented. The Members of parliament and other influential people must be contacted by CHAI and member institutions.

CHAI could catalyse the formation of one or more central or regional purchasing agencies, to make use of the purchasing power of our institutions to buy economically the essential drugs so that the benefits may be passed on to the community. The same purpose could be served by co-operative movements.

Purchasing Power

There were suggestions of starting fair price shops under the Government at Primary Health Centres, or under our health centres in the rural areas, to make drugs available at reasonable, price even in the remote areas. Problems as to who will manage the fair price shops and the impact of the rules and regulations will have to be studied.

The availability of essential drugs in the remote areas was tied up with the availability of health personnel. One deficiency noted was that of qualified pharmacists. A suggestion was made about the possibility of CHAI starting a school of pharmacy or other appropriate courses.

The institutions of CHAI should collaborate with the Government in all the health activities and especially with the immunization programmes launched by the Government. The Government should be requested to supply the vaccines, as and when needed; representation should be made to the Government.

One question which came up again and again was about the banning receiving gifts and samples from medical firms. The members were of the opinion that the institutions should not be carried away by the pressures put on by the medical representatives or the glossy advertisements put out by the manufacturers.

Drug Authority

There was discussion about the more liberal use of home remedies and traditional medicines. The members should be open to the use of more effective medicines used by other systems of medicine.

The members resolved that 'banned' or 'bannable' drugs should not be used. Some proposed a boycott of such firms. The members wanted information regarding the alternatives for the banned drugs.

The drugs are under the Ministry of Chemicals, Petroleum and Fertilisers. It is necessary that the Ministry of health should be equally, reasponsible. A central drug Authority with enough powers might be the answer.

The prescribing of drugs should be by generic name; the pharmacist sholld be free to substitute if a particular brand is not available.

There is need for quality control and checking. The Government or CHAI must set up facilities for checking the quality.

It is necessary that correct information must reach the institutions, regarding the drugs and the reactions or contraindications. Regional groups could exchange information with one another. Information is being made available by CHAI, VHAI, Pune Journal of Continuing Education and others. It is necessary

to motivate doctors and others to use proper drugs.

There was a suggestion that the concept of essential and rational drugs should be included in the medical curriculum.

Dr. K.B. Mathur, Deputy Director of Central Drug Research Institute spoke on the development of new drugs and drug utilisation. It is necessary to educate people against indiscriminate use of drugs. Dr. P.K. Sarkar of the Drug Action Network of India and Mr. Augustine Veliath spoke on the topics of "role of doctors to achieve health for all by 2000 AD in India" and on "communicating with patients and consumer education". These talks were followed by discussions and a "fish bowl" on the "drug action strategies for CHAI". These discussions and conclusions reinforced the findings of the workshops.

You did it to me

— Dr. C.M. Francis

The Catholic Hospitals, dispensaries and health centres in India had been providing good medical services for a long time, when such services were rare and poor in the country; they were well known for the quality of care and the sympathy for the sick and the suffering.

With the advances in science and technology, the emphasis changed to the provision of sophisticated and expensive technologies for the diagnosis and treatment of diseases. The tender, loving care which was the hallmark of our institutions receded to the background.

Today, there is a worldwide change in the concepts of health, health care and health care services. There is a rude but welcome awakening. We are becoming aware that more and more sophisticated equipments and more and higher specialists with the modern technologies (many of which are inappropriate even in the affluent countries) do not necessarily provide the answers.

The earlier assumption that we are on the right track and all that was needed was a good deal more of the same things and that we will be able to achieve our goals, if more funds are provided, is proving to be wrong. There is a growing realisation that what we need is not more of the same but something "qualitatively different".

We are caught in the desire for modernisation, which unfortunately has been equated with the provision of expensive diagnostic and therapeutic technologies to the exclusion or, atleast, reduction of many other important qualities. We often try to imitate the West, little realising the irrelevance of these processes and procedures to our situation (often after they have been discarded in the West). The expenses involved make our budgets to haywire.

I would like to narrate a true incident which happened to a friend of mine. He had started on a fairly long journey by road. Even before he had covered one-fifth of the distance to his goal, he found that his purse was stolen; he had also lost his way; the route he was following was taking him away from his destination.

Are our hospitals in the same situation?

Have we lost or squandered the money by the purchase and use of these expensive gadgets?

Have we lost our way?

Goals : There seems to be a dichotomy between our professed goals which are explicitly stated and to which generous lip service is provided all the time, and the hidden, implicit goals which we really pursue. Our professed goals state that we shall provide health care with equity, if not equality and respecting the dignity of the person, irrespective of the social status or capacity to pay. We talk of serving the poor.

Do we?

Or, are we busy serving the well-to-do preferentially, so that we can

'survive' or

increase our assets,

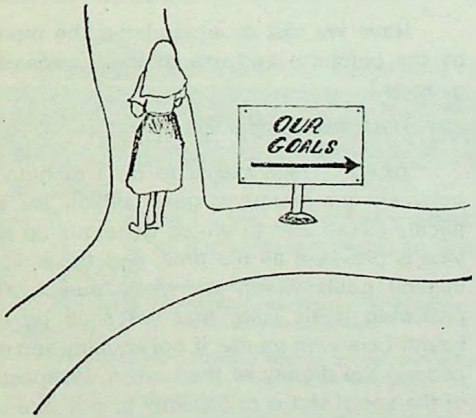
influence,

power or

prestige?

Is there a divergence between what we are doing and what we ought to be doing? We must give up double-think and double-talk.

Do our hospitals have an assumption that we should serve the well-to-do as a priority and the provision of health care for the under privileged and the poor should be thought of to the extent possible, only after the demands of the well-to-do are first met; otherwise, how can we make enough (?) money to run our hospitals? Are we prepared to cut down the conspicuous expenditure, so that with our limited resources, we can provide adequate care for the needy people? I have nothing against the provision of health care for the well-do-do. It is good. They need our services and can pay for the services. We can and should make use of the finances so gained to take better care of the poor. But we should have our priorities right.



Where are we going ? Away from our decleared goal

Beneficiaries : Our hospitals should state, beyond any shadow of doubt, who the beneficiaries will be. There are complaints that the largest number of beneficiaries of the Catholic hospitals (as other institutions) are the rich and the influential. There is also a tendency for their numbers to increase, edging out the poor. We should carry out a little exercise and see who the actual beneficiaries are at present. We can then set our goals and the timeframe in which to achieve them.

If at present 80 percent of the inpatients are paying fully or partially, we may like to place the goal of reducing this to 70% (and the remaining 30% too poor to pay anything) within the course of the next 3 years. We may also consider the possibility of establishing more cost-effective peripheral units, making them accessible and free to the poor.

Many of our hospitals have expanded the technological facilities, providing super-specialities, making them so costly that we have effectively driven out the poor. Health care programmes should really benefit, in planning as well as implementation, the poor and deprived people living in rural areas or urban slums.

The talisman that Gandhiji had suggested is very relevant in this context "Whenever one has to decide the priority or desirability of a plan, one must always relate it to the extent to which it will actually benefit the poorest and the lowliest of the low". It has been beautifully put and urged by our Lord when he said "Whenever you have done it to the least, you have done it for me".

Technologies : The world is witnessing tremendous expansion of technology — good, bad and indifferent. Most of them do not make any significant improvement in health care and are discarded soon.

The policy adopted so far (and this is true of all spheres of life, including health) has been to consider technology as sacrosanct. We have tried to introduce in India, the most sophisticated technology the world has discovered (though often at a time when others are giving it up) on the assumption that our people should have nothing less than the absolutely first rate available anywhere else in the world. We buy them and often are unable to use them because there is no one to operate them or repair them, when they break down.

The choice of technology is extremely crucial because it affects priorities, target groups, investment levels and the character of the personnel. A higher level of technology requires a larger investment; it needs a more trained and sophisticated specialist and technologist whose services have to be bought at a huge price. The benefits of the costly technology tend to accrue to a smaller and more privileged social group.

William Wordsworth pointed out two types of the wise : THOSE THAT 'SOAR' UPWARDS TO THE STARS AND THOSE THAT 'ROAM' FAR AND WIDE ON THIS EARTH. Can we have both? While we look for the higher technologies, can we also provide the larger number of people, needing the minimum acceptable? Do the use of these technologies tend to reduce the humane qualities for which our hospitals had been well known?

Health is a fundamental human right. It is also a world wide social goal. People have the right and the duty to participate individually and collectively in attaining health and maintaining it. It is our duty to help them in this task.

Health indicators : Many indicators are in use as indices for health monitoring, though none of them are fully satisfactory. They do not directly measure the state of health; they give indications in an indirect way, pointing to the lack of health.

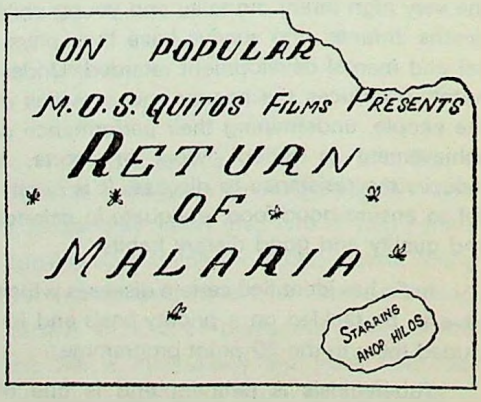
One of them is infant mortality rate. While it is only 10 — 20 per 1000 live births in the developed countries, it is about 105 per 1000 in India being greater in the rural areas than in the urban. The average life expectancy at birth is about 75 years in the advanced countries, while it is only 56 years in India. India lags behind even our neighbouring countries like Sri Lanka in the health status.

Health and Development : More than 300 million people in this country are trapped in the vicious cycle of poverty, illiteracy, malnutrition and disease; they are below, what is popularly known as the poverty line, which itself is very low. It provides for mere sustenance.

A good system of health service will have to be an integral part of a wider programme to improve the standards of living of the people and will have to be linked to programmes of abolishing poverty, improving production, better distribution of food and universal basic education.

Socio-economic factors : Health and socio-economic problems are intimately interlinked. There are tremendous disparities and the gap between the haves and havenots is increasing. The economic situation has a direct bearing on health. The gross national product may not reveal the disparities between different groups of people; it does not indicate the degree of equality in the distribution of resources. Yet, it is a crude economic indicator for health. Countries with a high national product have a low infant mortality rate and high life expectancy.

The opposite is true for countries like India with low per capita gross national product. The prospect for the growth of the gross national product is not bright in the near



future. Greater efforts are needed to ensure better productivity and much better distribution.

Morbidity and mortality : Most deaths in India still result from infectious diseases. Illness due to infectious diseases is enormous and especially so in childhood. About one tenth of the life of an average person is seriously disrupted by diseases. The infectious and parasitic diseases are chronic and debilitating. Almost all the childhood infectious diseases could be prevented by immunization, but the present coverage by immunization is low.

Diarrhoeal diseases are very widespread and often with serious and fatal consequences, though it need not be so especially now with the easily available oral rehydration therapy. A large proportion of people has no dependable access to sufficient, safe drinking water and adequate sanitary facilities.

Incidence of malaria, which had been brought down dramatically in 1965 has shown a resurgence. It has also brought about resistance to drugs and resistance of the vector to the pesticides and greater efforts are now needed.

Undernutrition afflicts many millions, and is one of the main contributing causes to the very high infant mortality and young child deaths. Infants who survive have their physical and mental development retarded. Undernutrition reduces the energy and activities of the people, undermining their performance or achievement in school, work or sports. It reduces the resistance to disease. It is essential to ensure good food, adequate in calories and quality and good dietary habits.

India has identified certain diseases which have to be tackled on a priority basis and included them in the 20-point programme:

Tuberculosis is rampant and is one of the major killers as also responsible for morbidity. Our efforts at controlling it inspite of the national and district programmes have not been successful. Since B.C.G. vaccination has proved to be not successful in preventing tuberculosis, case-finding and case-holding are most important. Our institutions should collaborate with the Governmental efforts in reducing the prevalence from the current 20 per 1000 population. Voluntary institutions can profitably utilise the shorter therapy, which can lead to better compliance and more complete treatment.

Blindness is also a big scourage, though most of it is preventable, with adequate intake of Vitamin A and cataract removal.

Leprosy is a socio-medical problem. The Christian hospitals and centres have been in the forefront in solving this problem. Renewed vigorous efforts with the multidrug therapy should be made to control, if not eradicate, this disease.

Accidents are among the ten highest causes of death. They also result in disability and loss of income. The care of injured and disability and loss of income. The care of injured and disabled people uses up considerable resources.

With changes in life style and increased longevity, the degenerative diseases are on the increase. Deaths from cardiovascular and pulmonary diseases and cancer are on the increase. There is a steady increase in mental disorders and in social pathology such as alcohol and drug abuse.

Smoking is one of the gravest man-made evils; it is the prime example of man's greed. The producers, distributors and retailers are aware of the havoc cause by smoking; so also the advertisers. Multinational and Indian firms exploit man's weakness by advertisements, the main focus of which has been turned now to the developing countries, because the developed countries are slowly,

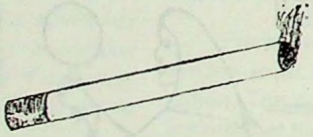
but surely acting against smoking through education and legislation. Smoking is the cause for many serious, crippling diseases of lung, heart and blood vessels. The association for lung cancer is well-known. Even the unborn baby is affected. Can we remain silent spectators of this tragic drama?

in another society where the bulk of the people is illiterate. The Catholic institutions are in a happier position because many congregations and orders which run hospitals and health centres have educational institutions also. If a combined effort is made, our health problems will be solved better.

SMOKING

Who is mocking whom?

Match A	with B
MANUFCTURERS	GOVERNMENT
DISTRIBUTORS	PEOPLE
RETAILERS	MEDICAL PROFESSION
ADVERTISING AGENCIES	HEALTH EDUCATORS
GOVERNMENT	UNBORN BABIES
SNOKERS	LUNGS
	HEARTS
	BLOOD VESSELS



All your answers are correct.

Education : Literacy is a major factor in promoting health. It enables the people to understand their problems and ways of solving them. Whereas the adult literacy rate in the advanced countries is almost 100 per cent, only about 35 percent are literate in our country. The nature of the health care system in a society where every individual receives a good basic education will be very different from those

Comprehensive health care : Our institutions have been providing curative care of a reasonably good standard, though there is considerable scope for improvement. Many of our institutions have also started providing certain amount of preventive care. Some of the better institutions are now involved in promotive care and a few in rehabilitation.

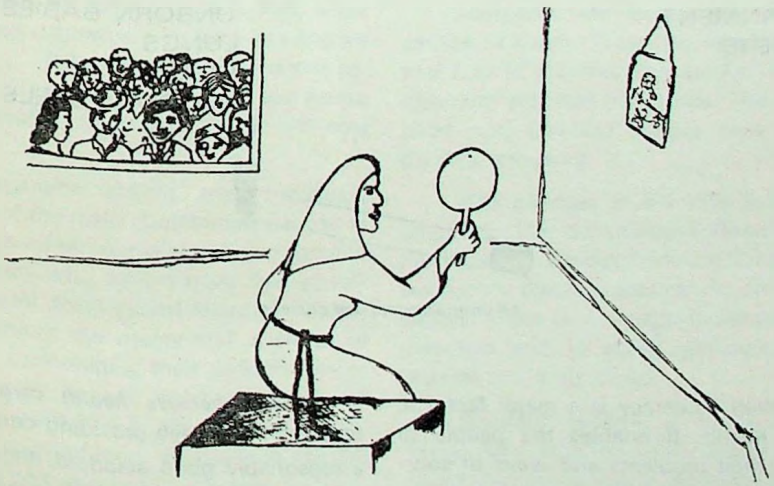
Medical Care : There is need for good medical care to treat the sick and suffering. To alleviate pain and suffering, to heal the sick and make them whole again should always be one of our major objectives. Improvements can be made such that we make the procedures effective and efficient, discarding obsolete measures. According to the data released by the socio-economic monitoring system of the American Medical Association, 37 per cent of the physicians surveyed adopted new procedures during a twelve-month period; most of them also dropped certain procedures that they had been providing earlier. Improvements in medical care are taking place fast all over the world.

Our hospitals should adopt procedures which are more effective and cost efficient. This can be done only by continuing education of the health professionals. All categories of health workers need updating of knowledge, skills and attitude.

Most of our hospitals have good infrastructure and many of them can function as referral hospitals, which is an essential prerequisite for good primary health care. The hospitals should also see to it that, either directly or through other village health workers, they provide primary health care to the entire neighbourhood in which the hospital is situated; adopting villages is a good idea.

The Catholic hospitals have been, to a large extent, characterised by the excellent nursing care by the religious sisters who form a good proportion of the nurses, and by example, the lay nurses. We should build on this great asset of service. They can and should provide compassionate, loving care.

One area which is important is the proper and rational use of drugs. The market is flooded with all kinds of drugs: the India drug market has about 30,000 formulations, compared to less than 3,000 in the Scandinavian countries. The drugs are being pushed by aggressive marketing. Many of them are useless and quite a large number positively harmful.



MIRROR, MIRROR tell me who are our BENEFICERIES

It is seldom that the Government bans a drug (because of the pressures and lobbying

by the manufacturers) ; but even when banned, they continue to be marketed and used. Recently, there was a prosecution in the High Court of Kerala. We can expect more and more such prosecutions when banned and unnecessary drugs are used. Can each of our hospitals have a reasonable formulary and stick to the drugs contained in it?

Preventive Care : Prevention is very effective and the Government have now taken up, in all seriousness, the expanded programme of immunization. A few days ago there was a report of a very large number of deaths from the complications of measles from Tamil Nadu. These deaths could have been prevented by immunization and the complications avoided by good care. Our hospitals and health centres should be in the forefromt of immunisation. Detailed schedules are available and they should be followed up.

St. John's Medical College and now the Catholic Hospitals Association have been training community health workers. They are committed people, motivated by the urge to be of better service. More of such training programmes, especially in the local languages, must be started. The services of these Community Health Workers can be used effectively in providing care and especially preventive care at the periphery. Some of them may become 'liberators of the people'. It is all to the good.

In addition to primary prevention, our institutions can participate effectively in secondary and teritary prevention. An example can be the detection of essential hypertension on routine health check-up or when the blood pressure is measured when the person had come with some other illness. We can advise the patient with respect to his dietary and other habits such that the hypertension is controlled and does not lead to symptoms and signs of disease. Or again, when an illness has occurred, we can institute prompt measures such that disability does not occur, as in cases of pulmonary diseases.

Many of the diseases are water-borne or water-related. We might think that we can do little in this area. This is not true. As knowledgeable people, we can create an awareness of the need for safe drinking water, good drainage, disposal of waste and prevention of pollution of water; from this awareness can arise action by the people, which can solve the problem. Similar is the case with respect to control of air pollution. Can we not raise our voice, united with the community, against this vitiation of nature?

Among specific population groups, the protection of the health of mothers and children should get our priority because of the special biological and psycho-social needs inherent in the process of human growth which must be made to ensure the survival and healthy development of the child.

Concerning the elderly, the process of aging with its increased risk of disease underlines the need for a healthy life-style and the preventive measures become all the more important.

Promotive Care : Everyone of our institutions must become places of health education. The people should be made aware of actions that they can take to promote their own health; they should be motivated to undertake such action and become agents of change. Without it, the efforts at health care will not be effective in making the people healthy.

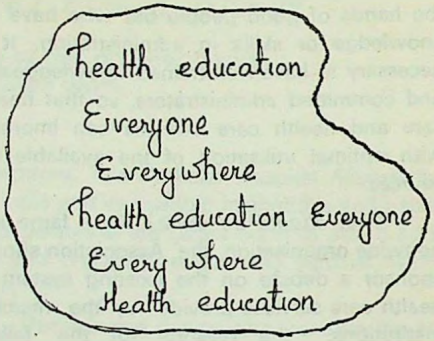
Health is dependant on adopting optimum life styles; when we transgress the laws of good living, we pay the penalty of disease. Regular habits, proper nutrition, self control and proper exercise are important. Where the individual is allowed every licence like smoking, overindulgence in alcohol, overeating leading to obesity, sedantary habits, he or

she needs correction through medical or other intervention.

The declaration of Alma-Ata on primary health care mentioned education concerning prevailing health problems and the methods of preventing health problems and controlling them as the first of eight essential components of primary health care. The obstacles which impede individual and community action for health range from lack of knowledge of basic hygiene, cultural taboos, unhealthy life-styles and insufficient encouragement of cultural factors that promote health to inadequate and ineffective health education, motivation and public information efforts, all too often operating in isolation from the mainstream of the health systems. Aggressive advertising of products such as cigarettes and baby food formulae, harmful to health usually overwhelms the feeble educational efforts aimed at fostering healthy life-styles particularly among the young.

Our hospitals have a large number of health workers, from the Medical Superintendent to the helper. Everyone of them can be a health educator. We also usually have a large captive audience, who have to spend time in the hospital, as patients or relatives and friends of patients. We should be able to utilise this opportunity (some are already doing so) of health education (in addition to patient education), by showing slides, distributing pamphlets, giving appropriate talks or by videotapes and films.

Rehabilitative care : It should be our endeavour to provide rehabilitation. It can take many forms, including educating the patient, his or her family or his or her employer. It could also be through re-training for a more appropriate job or to carry out his daily routine. Good placement programmes can help by finding suitable jobs, which can be performed efficiently by this person.



Spirituality : In the mad rush for so-called modernisation and imported technology, do we tend to forget the eternal values? India has a strong spiritual heritage. It is our duty to foster it, understanding the higher purpose of life. Our Lord went about healing people and making them whole, physically and spiritually. We, the followers must try to emulate His example, seeing in each person the divine presence. This will make us show respect for the person and not see him or her as a broken down machine, needing repairs. Our efforts in every field should be permeated with moral, ethical and spiritual values.

Care of the terminally ill : An area which needs increasing attention is the care of the terminally ill. Francis Bacon said: "I conceive it the office of the physician not only to restore the health but to mitigate pains and dolours; and not only when such mitigation may conduce to recovery but when it may serve to make a fair and easy passage. It is even more true for our hospitals because more and more people are spending their last days in the hospitals. Do we give them our loving care? Or, do we interfere with them unnecessarily with useless heroic measures.

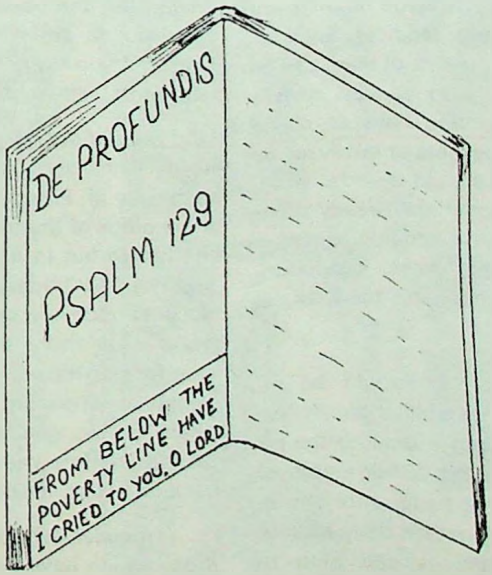
Hospital administration : To achieve all those which have been stated, we need committed and dedicated people for the healing ministry. We also need good administration

and management. Often, the institutions are in the hands of good people but who have no knowledge or skills in administration. It is necessary to have well-trained, knowledgeable and committed administrators, so that health care and health care services can improve, with optimal utilisation of the available resources.

What should be done? As a large nationwide organisation, the Association should sponsor a debate on the existing system of health care services provide by the member institutions, the reasons for the failure to provide the needed care and the general principles and programmes which must characterize our institutions. The association should set up a competent group to prepare a draft plan of health care services. It should provide the details which tend to be ignored. The member institutions should review their health care system with the aim of meeting the health needs of the people, for primary care and referrals. The most promosing aspect is that many persons involved in providing health care, are aware of the need for drastic changes. This awareness should be extended to larger numbers and translated into action so that all our institutions become willing partners in progress to be true agents for health. A wise poet of our country said, long ago, that there are three classes of people:

> The lowest do not begin for sheer fear of failure
>
> The middle ones begin but stop as soon as difficulties arise
>
> The highest begin and never abandon, inspite of repeated blows from difficulties, till success is won.

To what class does this Association belong?



TO PULL DOWN AND BUILD ANEW

—Fr John Vattamattom looks at the prophetic role of the Church's health work

Catholic Church is the single largest organisation in the world in providing health care. This is true to a great extent even in our own country even though we form only a tiny minority in India. With 2000 and odd health care institutions we are certainly contributing a major share in the country's health care efforts, particularly in remote rural areas.

"Union gives Strength" — was the catch-word with which 43 years ago this organisation began in a very modest way with 16 religious sisters. It was the dream of Sr. Mary Glowry, belonging to the congregation of Jesus, Mary and Joseph, an Australian doctor turned nun, the founder of the Catholic Hospital Association of India, that Catholic hospitals and health care institutions to be at the service of people particularly the needy and the poor and the poorest of the poor.

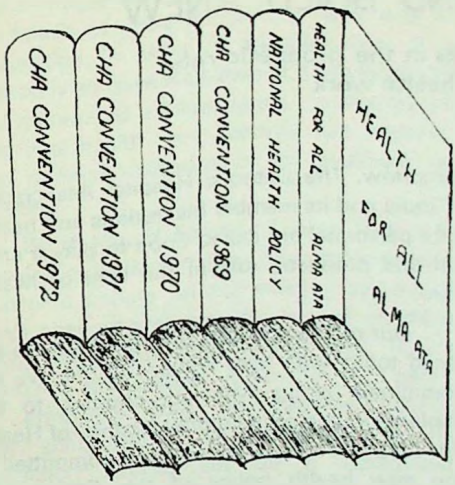
The hard realities which she saw, i.e. people dying particularly women and children without proper health care, brought out another dream, ie., the establishment of a Catholic Medical College, in order to train health care personnel to meet the needs of our insttutions particularly in rural areas. This dream was later on realised in what we have today, the St. John's Medical College, in Bangalore. All these point out to one reality, i.e. our commitment to carry on the mission of Christ as our Association's motto is "The Love of Christ Compels us".

It is this compulsion, this urgency that throw open many a challenge before us as we stand, so to say at the cross roads, after 42 years of dedicated service, to find our way out, to forge ahead with added enthusiasm and commitment, to meet the challenges of tomorrow. The Catholic Hospital Association of India and its member institutions and health care personnel are called upon to play a critical and prophetic role in the field of health care.

Our role is a critical one, because we are faced today with hard realities of life. We are committed, along with our country, to the implementation of the global strategy of Health For All by 2000 AD. We are also committed to the new health policy of the Government which is a challenging document, and if implemented, we can achieve our goal of health for all by 2000 AD. At the same time we are also aware of the constraints that block the implementation of this health policy because of the inadequacy of the present health care system, the medical education system and the nurses training system wich caters more to the elite classes.

We also have to play a prophetic role because of our commitment to Christ's own concern for the people. We need to stand for justice, love and human values. At a time when values are thrown to the winds, corruption, unethical practices etc. are rampant, particularly in the medical field, we need to stand for values. Our prophetic role is all the more clear when we are only a tiny minority in our country.

Because of this specialised roles we have to play in the future, my dear friends, our this year's convention assumes greater importance. The theme we have chosen is the "Silent Emergencies of our Times — Our Response". We shall spend these coming two days in analysing some of these silent emergencies and fixing up our priorities.



The subject is not new. The world discuses it, the nation has its own plan. We ourselves talked about it for many years.

One way we respond to these emergencies and that which requires continued and added care and attention is the promotion of Primary Health Care or Community Health which is of vital importance in our country. It is gratifying to see, and I am very happy to inform that this has been so dear to CHAI, from its inception. This concern was that prompted the founder of CHAI to organise ourselves as a force. Over the years this has been stressed and stressed again. And today we have a full fledged department with necessary qualified staff, though we are aware of our limitations as against the demands of the time. This concern for Primary Health Care and Community Health was repeated year after year during conventions in the past. Following are a few examples:

"The CHA accepts the goals implied in the concepts of Community Health, and agrees to give priority to projects that help to further this development in health care" — Convention 1969

"The theme 'Effective Hospital in the Community' was chosen for the dual purpose of emphasising that a hospital is a health centre, meant to meet the community health needs, preventive, curative, rehabilitative and promotive — and bringing to focus the necessity for operating such a unit as an effective organization" — Convention 1970

"The CHA considers the promotion of Community Health, which includes the preventive, educational, and curative aspects, also mental, emotional and spiritual health, as a primary objective of our Association and of each member hospital, dispensary and health centre". —Convention 1971

"The CHA considers the promotion of Community Health as one of the primary objectives of the Association and of each member hospital, health centre and dispensary. There should be a certain priority of emphasis for care of children under five years of age. Patient retained health record cards should be encouraged. Our Association gives priority to service in areas of greatest need, such as the widely neglected rural communities and the deprived sections of the cities." — Convention 1972.

Friends, what I was trying to do was to place ourselves in the present context basing on the past in order to look ahead for a brighter future. Let us all open ourselves to the spirit that is guiding us; let us listen to His promptings, let us also open our ears to listen to the groanings of the people who are neglected, poor, oppressed; let us open our eyes to see the miseries of the people around us, the malnourished, the voiceless, the children that are blind because of lack of proper nourishment, lame due to polio; let us extend our arms with a healing touch with Christ like concern following the example of our Master.

Let us have a good look at ourselves as an organisation of long standing, perhaps the biggest and oldest in the world in the field of health care in the private sector as individual institutions, as individual health care personnel. Let us see where we stand. Let us read the signs of the times and see our role in the field of health care. Let us realise our great strength. Let us make use of it in loving service to others. Let us spend these two days with a sincere search, search for values, search for relevance. Because, as our motto says, "The Love of Christ Compels Us" to do so.

"Today we are"

Today we are committing ourselves before the entire world: we are committing ourselves to preventing, during the next five years, the deaths of 60,000 children every year. To achieve this, we are going to put all the resources of our nation, under the leadership of the Ministry of Health, behind a Plan for Child Survival.

This plan will be the most spectacular advance in Colombia's health for many years ..

We are going to reach each house, each one of our 3.6 million children under five years of age.

We are going to reach them in order to work with them, and with their families, towards implementing simple actions of proven effectiveness in the protection of children's health.

We are going to distribute oral rehydration salts to all corners of Colombia so that no children die from diarrhoea.

We are going to keep immunizing our children until there are no more cases of vaccine-preventable disease.

We are going to give food supplements to our children, to babies under two, and to pregnant women in nutritional danger. And we are going to provide adequate treatment to children suffering from acute respiratory infections.

But above all we are going to make an even greater effort with all the mass media, with the participation of all of you, and of the entire community, to educate fathers and mothers so that they acquire simple knowledge and simple methods for guaranteeing the health and life of their children.

President of Columbia as quoted in:

"THE STATE OF THE WORLD'S CHILDREN 1986"

Child Survival Here and Now

David P. Haxton UNICEF Regional Director for South Central Asia

I accepted with pleasure the invitation to participate in this convention mainly to learn from the almost unequalled richness of experience in health-care under the inspiration of the Roman Catholic Church.

I am not surprised that in 1973, five years before the Alma Ata Declaration on primary health care, your Association chose for a similar annual convention the theme: Health for the Millions.

I am aware that your member units have struggled, particularly in the years that followed, to make this slogan a reality. You have recognised earlier than most others that hospital care and other ways of dispensing medicines, are only a small part of health promotion.

Encouraging reports appear periodically how your health workers, in association with the nuns and priests spread out even in remote areas, have tried to organise communities of optimal size in compact areas, regardless of religious affiliation, and engaged them in the effort to rebuild their lives through better access to the means of health.

The concept of holistic health, embracing the dimensions of social, economic and moral development, owes not a little to the practical philosophy that guides you in your daily work. It is thus natural for us in UNICEF to look upon you as a major ally in the conquest of ill-health especially of children and mothers.

You have chosen for this convention the theme: *Our Response to the Silent Emergencies of Our Times.* I would like to invite your pointed attention to one such emergency and to the many-sided response to it, that is feasible in our own time. In doing so I shall focus mainly on India which has the largest national aggregate of victims of this particular emergency.

As you know the health system in India is large and fairly developed and continues to grow. I understand there are over 660 thousand registered medical practitioners from different health disciplines, in addition to well over a million other health workers of one kind or another including traditional birth attendants. The public health expenditure per capita has doubled in the course of the last decade. And the number of privately organised hospitals and health centres has been steadily increasing.

In spite of all this, one out of every 10 babies in India dies before his first birthday. Two more die before the fifth birthday. This rate of infant and child mortality is unacceptably high by any standard — medical, ethical or international. This emergency is silent only in the sense that it is dispersed in space and time, it happens mainly among the lowliest and the lost, and therefore mostly muted. Before the emergency can be ended, we must make it heard. The silence must first be broken.

A high infant mortality rate is a reflection of many aspects of the social, economic and political environment. There are two familiar schools of opinion on the means to change the adverse situation. One view sees structural impediments coming in the way of any lasting situational improvement. Another view puts economic growth as a precondition for social development, including a reduction in infant and child mortality rates.

While changes in the skewed structure of society as well as growth of the national

economy are essential to assure proper human development, it is inconceivable that infants and children should wait upon either, for meeting the simple basic needs of their natural healthy growth. More so at a time when neither economic development nor social reordering seems to be picking up pace. This is the context and reason why UNICEF seeks to mobilise opinion, resources and action, to come to the rescue of children at risk — despite present poverty and social inequalities. As the children of the materially poor survive and grow up better fed, healthier and better educated, economic development will naturally be hastened and social inequalities are bound to weaken. Different priorities can thus be harmonised.

The poof of this prospect can be seen in the community health projects organised by committed health workers, including some members of your Association, in different parts of India. Some of them are hospital-centred while the others are community-based. The mix of activities may vary depending on the local needs and resources but almost invariably, they have a basic orientation towards the primary health care approach, with accent on prevention — prevention not only of suffering but equally of an irreversible loss of time, money, material resources, peace of mind, and above all, human potential.

The concept of community health is perhaps still in its infancy in India, but the initiative taken by some of the community health projects hold the promise of steady spread and durable effect. For example: the training and equipping of traditional birth attendants; training of community health workers to identify high-risk mothers and infants for intensive care; greater attention by communities to environmental sanitation; training of health workers in home management of diahorrea; equipping health workers in antenatal and infant care, especially immunization and basic education in health and nutrition.

Some have gone farther to tackle the deeper sources of malnutrition and ill-health through awareness and capacity building, through cooperative organisation of productive activity. Health workers, communicators, educators and social workers have taken a lead in establishing such basic services, often with professional help from outside, sometimes with government support. In areas of such activity, poverty may not have disappeared, but its hold has loosened, infant mortality rates have come down, communicable diseases have been controlled, nutritional status has improved, levels of literacy have risen. To multiply these local successes on a national scale is the developmental answer to silent emergencies.

In meeting this challenge your Association has a distinct opportunity to set an example.

The times appear propitious to make a bold and renewed initiative. The National Health Policy, passed by Parliament in December 1983 seems to make a valuable distin. ction between conventional medical services and simple health related technologies More and more people recognise that modern medical services are too expensive for the generality of the people even when these are appropriate to their health needs. There are, in contrast, inexpensive and scientifically sound alternatives to safeguard child health and development.

It is encouraging therefore to see that the seventh national plan aims at universal immunization by 1990.

Also, a national programme for home-based diahorrea management is being launched, to reduce diahorrea related child deaths by half by the end of the dacade.

Another national commitment seeks to iodinate common salt in endemic areas of iodine deficiency which puts some 120 million or more people at risk in India. The inverse relationship between iodine deficiency and brain development, in the womb and early childhood, has been brought out only recently. In parts of eastern Uttar Pradesh and Bihar, some 4-15% of all children born are in danger of mental retardation to the point of becoming cretins. The health profession, not to speak of the public opinion, is yet to respond in any significant way to this *"silent epidemic"*.

Roughly half the children and mothers of India may be anaemic to an extent that significantly depresses physical and mental efficiency. A nationwide programme, is ye of crystallise on anaemia. But that need not come in the way of the non-government sector taking a determined initiative in areas of their active presence.

Every Priest in Columbia asks this question to every child brought for baptism. Can we not do the same ?

The risks that I have touched upon are by no means an exhaustive list of threats to child life and development. There are others like Vitamin A deficiency, perhaps more extensive in its spread among the population and in its damage to the human system than hitherto suspected. Not only does it lead to degrees of blindness in the very young but is also destructive of the lining of the alimentary, respiratory and urinary channels, fuelling the interaction of infection and malnutrition.

Peculiar to each environment there are numerous other obstacles to child life, like respiratory infections which take a heavy toll in child health and child lives.

Maternal malnutrition, as an impediment to child survival and development, is highlighted by the fact that about a third or more of all children born in India have a birth weight below 2.5 kg, which means some 7-10 million children each year. Such babies are three times more likely to die in infancy than babies of normal weight at birth. It is a deeply disturbing inference that about 18% of all deaths in India are contributed to by low birth infants. Clearly, infant mortality is unlikely to be lowered significantly unless birth weights can be increased.

Perhaps, among all the possible responses to factors threatening child-life, the most natural, the least difficult and the most important is allowing the infant access to his mother's milk. While we await legislation of the Indian National Code for protection and promotion of breastfeeding, many of its principles are violated by manufacturers of breast milk substitutes, by advertising media and, I regret to add, by hospitals themselves.

For example, hospitals ought to encourage "rooming in", to initiate breastfeeding within the first hour of delivery and to minimise separation of the new born from the mother even in cases of abnormal delivery and operative intervention. Equally, the health system ought to encourage the use of home-made weaning foods from the age of 4-6 months in addition to breastfeeding — as a matter of greater priority than "medical" attention.

I mentioned earlier, the opportunity that presents itself to a health network such as yours. You have the strength not only in technical manpower but uniquely in the social concern, motivation and credibility provided by thousands of parishes. Centered on this local presence, community health projects can come into their own, provided people are organised and made aware of their inherent capacity to preserve and promote health even in adverse circumstances.

Your hospitals and health centres can promote a series of innovations, supportive of people-based primary health care. For example, the National Code on breastfeeding could even now be faithfully and rigorously implemented in your hospitals, health centres and community health projects. A similar effort could be made in heralding the practice of a strict code for essential drugs, of which principles and examples are available. Every contact of the hospital with a child or woman could be used to check and ensure that immunization of pregnant mothers and young children is proceeding to schedule or has been completed. Every child brought to hospital with diahorrea could be welcomed by a drink for oral dehydration before initiating any other procedure. The occasion could also be used for training the mother, or other family member, in the preparation and administering of the salt-sugar solution. In fact, the orientation of the hospital could shift from medical practice to health practice.

And in this the social support through parish priests and the nuns could make the difference. The number of community health projects could be increased by activating the people themselves through social communication and community organisation, and without having to resort to monetary investments on any large scale.

Your Hospital Can

Implement national code on breastfeeding

Practise a strict code of essential drugs

Use every contact with a child or woman to check and ensure that pregnant Mothers and Children are immunized

Welcome every child with an oral rehydration drink

Train mothers and other family members to prepare and administer Salt Sugar Solution

And above all shift from medical practices to health practices

Every Church-related health unit and health worker could assume the educational and promotive responsibility for the health of all the people living in their own defined geographic area. To the extent government or other health facilities are available in the area, the common responsibility becomes easier to discharge through a cooperative working relationship. Indeed the search for allies could and should go beyond the health sector and involve, through patient striving, the range of public and private agencies active, one way or another, in the area — government institutions, the business community, the school system, professional groups, social workers from sister religions or of secular persuasions.

The aim could be to ensure that all the elements of primary health care, as spelt out in the Alma Ata Declaration, are built up in steady progression, starting with *primary child health care*. When the community, the health professionals, the hospitals and the Church have rallied to the support of the child, we would have left behind issues of child survival, and be concentrating on child development.

The message I would like to leave with you today is that this need not be a distant dream but feasible as of now: and achievable, in a country of India's strength, ahead of the century's end.

What's New in Health Care Management

— Sam Thangraj

As CHAI attempts to work out "Strategies for Tomorrow" through its 42nd National Convention and Workshop, this paper is an attempt to identify what is new, or rather what is relevant to health care management. This is by no means a detailed discussion of issues but only an effort to identify issues and factors that should lead to detailed discussion.

A popular definition of health is the one given by WHO : "A state of complete physical, mental and social well being and not just absence of disease and illness." The WHO-UNICEF Conference in Alms Ata considered Primary Health Care (PHC) as an ideal vehicle to deliver such a health for all by the year 2000. While emphasising PHC as "essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and country can afford." Such a PHC, according to the Conference, should include:

1. Education about prevailing health problems and methods of preventing and controlling them.
2. Promotion of food supply and nutrition.
3. An adequate supply of safe-water and basic.
4. Maternal and child health including family planning.
5. Immunization against infective diseases.
6. Appropriate treatment of common diseases and injuries.
7. Provision of essential drugs.

In as much as the Conference pointed out that good health is a fundamental human right and its attainment a most important worldwide social goal, the realization of the goal requires the interaction of the health system with many other social and economic factors. Provision of PHC, like politics, becomes the question of "who gets what, when, where and how." This is particularly so as the interaction of social and economic factors that influences the power relationship within the international system and within a country as well as a community has implications for health care management.

This would mean that while a country like India has the capacity and technical skills to provide PHC to all by the end of this century, its policies and efforts are to a very large extent influenced by the structure and process of the political system of which health sector is a part.

Before this is discussed further, it is necessary to identify other issues such as the interaction of health with environment and ecology, the importance of child development and the need for appropriate policy for the provision of essential drugs. These issues need to be linked with human resources development so that PHC becomes a real process of full community participation, and is not affected by social, economic and, therefore, political factors.

Once these issues had become inherent aspects of health care management it would lead to awareness of PHC by all sections of people in the country leading to provision of health to all. Let me mention these issues briefly.

SPELL ELEMENTS FOR PRIMARY HEALTH CARE

Education on Health

Local disease control

Epidemiology

Maternal and child Health

Essential Drugs provision

Nutrition and food supply

Treatment of Minor diseases and ailmets

Safe water supply and sanitation.

It is generally assumed that while there exists socially and financially effective technologies to provide PHC, the main obstacles are related to political and organizational factors. A clearer understanding of health system in India is an important aspect of health care management. As Dr. Imrana Qadeer points out, inspite of "an extensive infrastructure, an army of trained personnel and well equipped institutions for research and education" and despite "professed commitment to serve all — specially the poor," the system has many inequalities — inequality of distribution, inequality of access, inequality of participation and inequality of health status.

Such inequalities have arisen because it is politics that determines who gets what, when, where and how. And politics, of course, is concerned with people and more importantly with economics. "The science of economics pre-supposes a given political order and can not be studies in isolation from politics." In as much as economics pre-supposes a particular order that involves the creation and distribution of wealth, it also pre-determines the process of development. As politics determines the development process and channels it in the direction intended to serve the interest of the dominant groups, the exercise of power through the distribution of resources becomes a major factor in health care management.

The inequalities and characteristics of the health care system that find expression through its processes such as the provision of PHC, particularly to those in rural areas, are the manifestations of the science of economics through the political system. It is no wonder, therefore, 79% of the Indian population who live in the rural areas is served only by 30% of the hospitals, 20% of the doctors and 10% of the total number of beds.

Seen through a holistic perspective one could see the importance of issues related to environment and ecology to development in general and the management of health care in particular. Ecology is very much the core of environme nt and is concerned with the full spectrum of human life, including physical resources, necessary to its existence. Since the health sector interacts with social and economic sectors, it is necessary to understand the effect of population on resources such as food and energy, its impact on their production, consumption and management together with the use of appropriate technology for self-reliance.

At the same time, the creation and protection of a safe environment are essential to PHC. Any of the aspects of PHC mentioned earlier could suffer in an unhealthy environment. In the absence of environmental health programmes the elimination of poverty, hunger

and diseases is likely to suffer in the process of development.

Environmental health issues exist on three levels. The first level deals with health effects, the second with comfort, convenience, efficiency and esthetics and the third level with natural resources and the ecosystem as Prof. Emil Chanlett points out. Environmental health programmes that do not address each level while attempting to improve particular conditions may fail. A community that needs help act on all these three levels and do not respond to programmes that they perceive as being too narrow or insensitive to important factors.

While a detailed analysis of these three levels would involve considerable time, it is necessary to emphasis the importance of the first level as it has effect on the health of all. These effects are biological pathogens which cause infective or parasitic diseases resulting in physical deformity, malnutrition, severe disease and death. Toxic chemicals are some other factors. Though, unlike biological pathogens, they are considered to be controlled relatively easy at the point of use or discharge, the tragedy that occurred in Bhopal when MIC from the Union Carbide Factory leaked and its continuing effects are too fresh in our memory to be recollected.

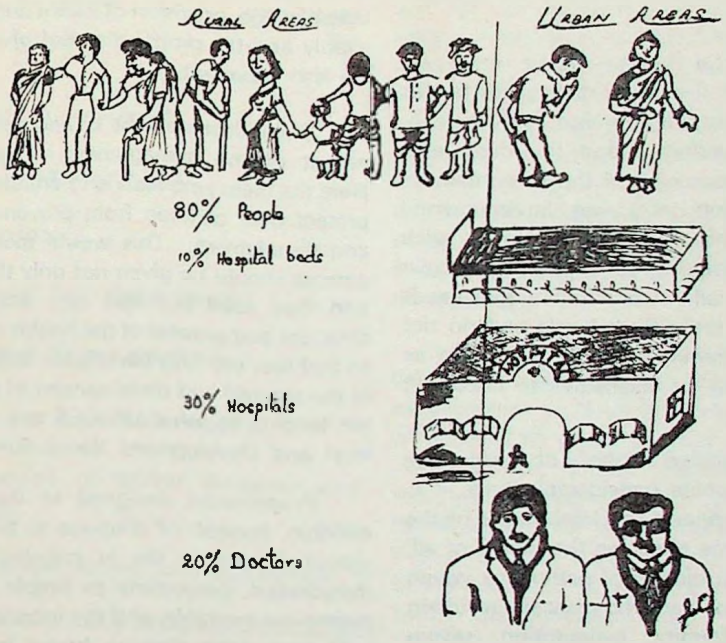
But then, this is not the only way that toxic chemicals pollute the environment and effect health. They also reach food through fertilization, food processing and storage. In this age of consumersim, the significant increase in the use of organic chemicals from everything in plastic wrappers to heat exchange liquids has increased the risk to health that exposure to these chemicals entails.

The various environmental health measures needed to attack these first level diseases should design to stop the transmission of biological disease and the control of chemical discharge. The isolation and disposal of human sewage, provision of a safe drinking water supply and the proper disposal of solid waste are also important.

Child development is another important aspect of the management of health care. Here the main emphasis is to enable parents to protect their children from preventable death and disablement. This would mean that the parents should be given not only the information they need but also easy access to the structure and process of the health care system so that they can fully participate, among others, in the survival and development of their children leading to what UNICEF call Child Survival and Development Revolution.

Programmes designed to immunize all children, control of diarhoea so that children would no longer die or crippled by acute dehydration, particularly as simple and cheap means are available, and the increasing of natural immunities through breast feeding and better child bearing and rearing through child spacing, improving knowledge of weaning, nutrition and household hygiene form the basis for this Revolution.

The politics of the formulation of a policy to provide essential drugs is an issue that is becoming increasingly important in the management of health care. Since greater emphasis has been given to this topic in the Convention, there is no need for me to go further except to say that the role of the Multinational Corporations which to a large extent affect the formulation of a rational drug policy is in accordance with its own role in the political economy. The application of "location theory" relating to centralization of control within the Corporation to centralization of control within the international economy would mean that it enables the MNCs to weaken political control, escape national regulation and reduce options for develop-



ment such as formulation of rational drug policy in a Third World country.

If programmes related to various aspects briefly discussed above are to be very effective, it should be complemented by human resources development and use it to have the maximum impact at national level.

Human resources development needs to be implemented at three levels — at the national level so that it has maximum impact on the structure and process of the health system, at the level of provision of PHC through, among others, non-governmental organizations such as those present here and at the community level.

While human resources development at macro-level would enable the formulation and proper implementation of policies related to PHC, at the level of NGOs it should help to complement the efforts of the Government, experiment with new ideas and set out exemplars for the policy makers to see and follow. Human resources development at this level should aim to create among those involved an awareness of all issues, social, economic and political, related to development. In as much as these issues greatly influence the process of development those involved in the management of health care should be aware of their manifestations that find expression through Government policies.

At the community level, human resources development will help to spread knowledge related to all aspects of PHC, understanding of power relations based on sex and caste that affect the attitude and proper implementation of PHC and other development activities.

A health care management that would take note of these issues will have maximum impact if attempts are made to "link" such efforts. While "small is beautiful" it is not always effective. This is particularly so as isolat-

ed efforts are difficult to sustain over a period and would lead to dependency. However, a linkage would lead to what UNICEF call "going to scale."

Going to scale implies "a quantum change involving an extension of programme objectives to reach national coverage." It is also a "process of education, motivation and mobilization. It is a process of national mobilization and education to achieve an objective to which the majority of the population becomes committed." Needless to say that PHC is an objective to which the majority of the population has become committed or should become committed if their needs and demands can be articulated through their participation.

The members of CHAI here present are in a unique position not only to implement PHC because of their commitment and dedication but also to take note of some of the issues in health care management. I know that some of you are aware of these issues. If you could link together, involve yourselves in further human resources development, I am sure that you could become an effective instrument for "going to scale."

— SAMUEL THANGARAJ

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The Catholic Church

The Catholic Church has been a major ally in these efforts. Its 370 bishops and 5,000 priests, along with 14,000 monks and nuns working in clinics and hospitals, backed by newspapers, magazines and 120 radio stations, make it a powerful presence in Brazilian daily life. In 1985 the National Conference of Brazilian Bishops established a 'Pastorate of the Child' to disseminate child survival measures. The Pastorate is expanding this year to tackle an ambitious goal-reaching a million children under six in the impoverished north-east, where infant mortality is running at twice the national rate.

In other countries, the communications resources of organized religion—of the priests and the Catholic Church in Brazil, Colombia and El Salvador, of the imams and Muslim leaders in Indonesia, Oman, and the Philippines, and of the Buddhist priests in the villages of Burma and Sri Lanka—have also helped to bring new knowledge about child protection to many millions of parents, and from a most trusted source.

"THE STATE OF THE WORLD'S CHILDREN 1986"

New Board Members

Fr (Dr) Patrick Pais S.V.D. has been elected Vice President of the Catholic Hospital Association of India. He comes in the place of Fr Joseph Kavalippadan, who completed his second term with this convention.

Both the President and the Executive Director paid glowing tributes to Fr Kavalippadan from whose guidance and maturity the association has benefitted very much.

Rev Sr Cassia who made her mark in shouldering the responsibilities organizing the Convention was elected the second Vice President.

Fr K.C. George has the distinction of being the first board member representing the "seven sisters" of North Eastern Region.

Community Health

The 12th Basic course in Community Health Work which began on August 12, 1985 ended successfully on October 31st 1985. There are 21 participants (13 Religious Sisters, 7 Brothers and 1 lay person). The emphasis once more was to expose the participants to a lot of field, practical and clinical assignments. The major subjects covered were first aid, human biology, home nursing, basic lab skills, clinical postings, institutional visits, Natural Family Planning and rural mobile clinics. In addition there was a month's residential training programme at Bidadi PHC. The innovative features for this Course which were very successfully carried out, were — Child to child health education at the Bidadi secondary and high schools; Mother's motivation programme at Madya Dist; Nutrition demonstration at Bidadi and surrounding places; Socio-economic project reports covering all aspects of health and its relation to csio-economic factors, and Rural project planning as a follow up after their course.

In addition to all the above, they were exposed to a lot of clinical training at the rural mobile clinics, Maternal and Child health care at the MCH clinics of Bidadi and attending to labour cases in the maternity section of the rural centre. The Community Health Workers also visited the existing CHW's centres at Madya Dist. which are being run by our old CHW students, who had passed out earlier. In this manner, a practical demonstration of what their future work would be, was also included in this training programme. Pre and post evaluation of the course have also been conducted.

Vijayalakshmi Goes to School

Vijayalakshmi is a four year old cute girl, quite active and healthy, thanks to the Community Health work team of St. Thomas Hospital, Chettupattu. During their village visits, the Community Health workers met the mother of Vijayalakshmi and noticed primary complex of Tuberculosis in her body. Her mother followed the advice of the CHW and she is now a healthy girl ready to go to school next year.

With the aim, "Prevention is better than Cure", the Community Health Department was started in St. Thomas Hospital, Chettupattu in December 1982. A group of women were selected from various villages and training was given to them for a period of three weeks. These women were then sent back to their villages and they work at least two hours a day in their own villages by teaching other women about health, nutrition, hygiene etc. Every week these health workers come to the centre for their weekly meeting and sharing. Evaluation of work done and plans for future work are made during these weekly meetings.

At present there are 27 village Health Workers placed in 17 villages of Pernamallur Block of Vandavasi Taluk, North Arcot District. A total population of 11,000 people are served by these workers.

The Community Health Staff make their daily field visits and guide the Health workers. Immunization of children is arranged in all villages. Cases that need hospitalization are referred to the main hospital at Chettupattu for treatment.

The Community Health Department is now planning to arrange some staff members to stay in the villages and live with the people in order to be more effective in their Community, Health Apostolate.

Grass is green in this School

Our great Leader and Father of the Nation, Mahatma Gandhi, said "God comes to the people in the form of bread". With this in mind we take care of 10 villages and have started education, health, nutrition and development programmes.

We are much involved with the nonforma leducation of the school drop-outs in and around Devikapuram village since 1981; having trained 22 animators to help in this task of educating the children, we organise meetings for these animators once a month in our centre. About 500 children, school dropouts employed for grazing cattle and sheep or for various child labour, or those who have never gone to school, benefit by this education. These children are encouraged to continue their education programme and some of them have appeared for VIII Std. examination.

We have formed youth groups and Mathar Sangams in these villages. These groups have meetings twice a month at our centre. Our animators give them guidance and motivation. We have arranged one day Seminar, cultural items, competitions etc. for them and prizes were distributed. We have invited resource persons and Government officials to give them inspiring talks on different subjects. The women and the girls of the Mathar Sangams who are involved in development and education were given an excursion to another similar project at Tiruvannamalai where the women are engaged in handicrafts. This has proved a great encouragement to our village women to better their living conditions.

We have started a tailoring unit in 1984 where 35 to 45 young illiterate girls come regularly and learn cutting, embroidery and handicrafts. After training, these young girls are able to earn their own living with a sense of human dignity and self respect. In order to make them self-supporting we have provided sewing machines for 8 girls through bank loans. A trained teacher animates the group. A certain amount of moral instruction is also given.

Economic development projects are made possible with the aid of bank loans to purchase milk animals, cycles, petty shops etc. Realising the need of self-employment for a meaningful development we have started a silk cooperative with our animators. Here again we inculcate in them equality, justice and human dignity by making them share-holders of the Co-operative.

500 Mothers and Children under 5 years benefit by our TMCHE Programme. We take preventive measure for night blindness, measles, polio, typhoid etc.

Evaluating our work, we plan to give more emphasis to training of leaders and animators who will be responsible for social change and we do hope that our approach will touch the man as a whole, the community as a central focus in the process of liberation.

Sisters of Cluny Convent
Devikapuram