

TWO THOUSAND AD AND BEYOND

CONTEXTUAL AND POLICY LEVEL ISSUES IMPORTANT FOR THE FUTURE HEALTH RELATED WORK OF THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

Findings of the Policy Delphi Method of Research

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CONTENTS

1.	Background
2.	The Policy Method
3.	The Study Process
4.	Findings - Contextualising the work of CHAI Predicted economic, social and political trends in the country and their impact on health
5.	Findings - Contextualising the work of CHAI Major health problems and issues likely in India during the fifteen years ahead
6.	Findings - Important policy issues concerning CHAI in the future
6.1	Basic Premises of Health Work
6.2	Important Health Problems in the Country that CHAI could Respond to
6.3	Components of Health Care and Health Action to be Promoted
6.4	Broad Strategies of Intervention
6.5	Constituencies/Groups for Focus of Activities
6.6	Redefining Roles in the Present and Future Context
6.7	Organisational Aspects Important for Effective Function ing
7.	Conclusions and Recommendations
8.	Bibliography

1. BACKGROUND

CHAI in partnership with DELPHI Panelists looks ahead for a meaningful role

* situated in the broader context of the situation in India

* relating to the health problems and issues likely in the next 15 years

* identifying priority areas in its work and its functioning.

The Policy Delphi Method of research was an important component of the CHAI Golden Jubilee Evaluation Study. It was employed to identify broad contextual and policy level issues that would help CHAI in its planning for the future. Key policy issues and options are now available for consideration by CHAI as it plans its future policy for the next 15 years. The policy Delphi method “rests on the premise that decision makers are not interested in having a group generating decisions, but rather have an informal group present all the options for their consideration”. (4)

The method was thus utilized in order to attain the second aim of the study viz.,

“To explore possible roles, the Catholic Hospital Association of India could play in the future, in the context of, the national situation and the national health policy, and as part of the voluntary health sector” (1)

The specific objective of the study pertaining to this reads as follows :

“To determine the views of a select group of individuals regarding the possible future role of CHAI with particular reference to:

- i. its mandate;
- ii. its role in the broader Indian scene, and
- iii. the role it can play in Asian and other countries.

Regarding methodology, the project proposal stated,

“Views of an additional group of 50-75 people outside of CHAI, from diverse backgrounds (health and non-health, church and non-church, NGO and government) will be elicited. The Delphi technique for forecasting or futurology will be utilized”.

2. THE POLICY DELPHI METHOD

The Delphi method of research was developed initially in the nineteen sixties, based on earlier experiments. During its early years it was used primarily for technological forecasting, particularly in the areas of defence, industry and business. It uses several geographically separated experts to make forecasts about the development of new technologies and their impact and also to estimate the future markets for technologies / commodities.

The method which hypothetically takes advantage of

both the logical left half of the brain and its processing of factual information and the more intuitive right half, generated a lot of interest among futurologists in general. The past decade has seen it being used for a variety of different purposes. Thus there is the "Classical Delphi" used by the Rand Corporation in the USA for defence purposes in 1964 and still used for technological forecasting. Modifications have developed to suit different purposes as for instance the "Decision Delphi" and the "Policy Delphi". The method is therefore still in a process of evolution.

The Delphi method is a group method utilizing persons with known expertise and experience in the field. It performs functions similar to a committee, but is different in that :

- a. Anonymity is maintained, thus avoiding identification of an opinion with a person.
- b. Repeated rounds of questionnaires are used viz., two to five, depending on the purpose.
- c. The questionnaires not only ask questions, but provide information and controlled feedback or summarises of responses of the panelists.
- d. A statistical group response for different options / issues is also provided.
- e. Respondents are given the opportunity to react to and assess differing viewpoints.

The Policy Delphi Method is utilized for the analysis of policy issues and is not a mechanism for making decisions. It is thus a "forum for ideas". Arriving at a consensus is not an objective, though a rating is obtained. It in fact tries to explore opposing views on the various issues. It is therefore an organized method for correlating views and information

pertaining to specific policy areas and for allowing the respondents the opportunity to react to and assess differing view points. It tries to ensure that all possible options have been put on the table for consideration.

Reference :

1. Linstone, H.A. and Turoff. M., 1975 (Eds)
2. The Delphi Method - Techniques and Applications
3. Addison - Wesley Publishing Company, Reading, Massachusetts

3. THE STUDY PROCESS

After an initial period of getting references and meeting people to study and understand the method, keeping in mind the specific needs of CHAI for which purpose it was being used, the main steps followed in the study were as follows :

1. A list of possible panelists (participants in the study) was drawn up by the CHAI study team, the Advisory Committee and the CHAI team. It was optimal to have about 40 panelists and therefore the first selection was more than double this number. This included people who had expertise and experience in diverse fields so that CHAI could benefit from a broad perspective. Panelists also were chosen from different backgrounds viz., secular, church related (Catholic, Protestant, Orthodox), religious and lay, governmental and non governmental. A grid was drawn up to ensure representation of different disciplines / work streams viz., coordinating agencies, policy makers, medical college

professionals, (educators of health personnel), community medicine / community health practitioners, nursing, educationalists (non-medical), management professionals, social scientists, theologians, communicators, lawyers / advocates, politicians, etc.

2. Letters of invitation and participation forms to 108 selected persons were sent out in April 1992 giving a tentative time framework of the study. 49 panelists agreed to participate as panelists in the method.
3. They represented all the different components of the grid except policy makers of the government and the Church hierarchy.
4. The first round of material included a background note on CHAI outlining the type and distribution of its membership, its aims and objectives, organizational structure, the headquarters and its departments / units, funding thrusts in the 1980s and a few important points from history.

A brief note about the Policy Delphi Method and the list of confirmed panelists was also circulated.

5. The first round questionnaire was sent along with the above in May 1992.

The first question was used to evolve a group scenario of the important economic, political and social trends which many occur in the coming fifteen years that would have an impact on the health status of people in India. This

provided the broad contextual picture, generated by the panelists within which the health work / interventions of CHAI would be located. This issue was not to be explored further.

The major health issues and problems of the people of India likely in the next 15 years was also explored. This formed the more specific context to which CHAI was responding in its work.

Initial ideas from panelists on what should be the issues that CHAI should take up as areas of priority in its future work during the next fifteen years were also elicited.

5. A reminder regarding the 1st round was sent in early June (11.6.92) and by end June, we received 35 responses (two additional ones came later) i.e., the response rate was 73%, summaries of the responses to the first two questions viz., concerning contextual issues were circulated to panelists on 27.6.92 and 4.7.92.

6. Responses to the specific question regarding priority issues that CHAI should take up, were used to develop the second round questionnaire mailed on 4.7.92. This covered seven broad areas viz.,
 - i. Basic premises of health work / underlying assumptions that must be considered by CHAI for their future work(perhaps as a statement of philosophy)
 - ii. Important health problems / issues that CHAI could respond to.

- iii. Types of health action / health work that CHAI should promote.
- iv. Need to clarify constituencies / groups on which CHAI should focus its activities.
- v. Organizational aspects or mechanisms that could be introduced or strengthened to enable effective functioning.
- vi. Strategies of work or interventions needed to implement its objectives and priorities.
- vii. Need for role identification.

Thus all panelists were requested to respond to the spread of ideas that emerged from the first round. Panelists also rated each item using scales that were given for each question. These were regarding importance for most and desirability / necessity for some.

It was also attempted to generate further debate on areas of differences that were emerging eg.:

- a. focus of activity primarily towards membership vs a possible larger role.
 - b. Focus on community based, non-institutional health interventions as against provision of good quality medical care based in hospitals and dispensaries that are accessible to the poor.
7. A first reminder regarding the second round was sent in early August. The same response rate of 73% (37) was received for the round as well.

8. At this point the study team who were also coordinating and involved with other aspects of the CHAI study were asked to write a discussion document for the 49th Annual Convention to be held in October 1992. This document drew from all components of the CHAI Study and was entitled "Seeking the Signs of Times". It was to be used for regional and profession group meetings of CHAI members that were planned during the Golden Jubilee year.
9. Contextual issues raised in the first round were given in a chapter "Directions from Delphi".
10. Analysis of the second round was also made available to all CHAI members in January 1993 as an additional background note used for regional / group meetings.
11. The complete analysis of the second round was reported in early February 1992. At this stage it was felt that since a sufficient spread of ideas had been generated to serve the purpose of CHAI, the Policy Delphi Method was closed with this round.

12. It was also felt that it would be useful to share the ideas generated from the method with the members of CHAI, and to get members rating of issues that were specific to CHAI. Therefore, a modified version of the second round questionnaire was developed with a common rating scale. This is being given to participants of all the regional meetings.

Thus at the end of the year, before the Jubilee Convention, we will also have members views about these issues which touch on several crucial areas regarding the work and functioning of CHAI.

4. FINDINGS - CONTEXTUALISING THE WORK OF CHAI

Economic, Social and Political Trends in the country and their possible impact on Health

(This is an analysis of responses of Delphi panelists to question one of the first round of the Policy Delphi Method. This report was prepared and circulated to panelists on the 27th of June 1992).

To facilitate collation and reading we have separated the three factors, though in reality they are closely inter-related. There is therefore some overlap.

4.1 ECONOMIC TRENDS

These were foremost in the responses and are described first.

Twenty six panelists (80%) felt that the new economic policy recently introduced would continue for sometime and would have an overall adverse effect on the health status of people and on health care services. A summary of the broader economics related scenario and health impact is given first and later the more specific impact on health care services.

4.1.1 National and International Economic Scenario

- a. With the new economic order we are now in a unipolar world. The economically advanced and industrialized nations are coming together and dictating terms. The underdeveloped / developing nations will keep on seeking grants / aid / loans and gradually become overdependent and impoverished. International trade has always favoured the advanced nations since the Second World War. The situation will be worse in the unipolar world as there will be no bargaining power at all.
- b. These new trends have been variously described as globalization of the economy, moving towards a more capitalistic form of

- production and distribution, free market economy, the neo-liberal model of development, the Americanisation of our economy etc.
- c. International agencies like the World Bank, IMF, IDA, IFC, and ADB have become tools of exploitation, determining national policies.
 - d. All this has been added on top of our already mismanaged economy running on deficit financing and with a parallel economy in black money over which the government has no control!
 - e. There are very few options with the new policy. We will have devaluation, privatization, liberalization, an increase in exports, a decrease in imports, an increased need for repayment of foreign loans, and a decrease in government spending. Unscrupulous middle men and women will play havoc.
 - f. Decreased government spending will occur primarily by a reduction of expenditure in the services and development sectors as other changes in government spending would cause an upheaval among the organized labour and elite minority. Thus several panelists felt that subsidies to health, education, housing and other services will reduce. There will be a reduction of budget allocation per

person for health.

- g. This economic process will benefit the business and industrial community to become richer, with marginal benefit to the organized sector of labour. There will be a more affluent middle class. However, the majority comprising the marginal farmers, workers in the unorganized sector, landless labourers, and daily wage earners will not be benefited. Among them the children, women and the illiterates will be the sufferers. Poor people (s) everywhere will lose control more and more of the ability to determine their livelihood and lifestyles. Their health status will deteriorate and they will be unable to avail themselves of the services of privatized health, education, etc.

4.1.2 Poverty

- a. It was widely felt that the gap between the haves' and have-nots' would increase due to inequitable distribution of resources.
- b. Impoverishment and the absolute number of poor would increase.

4.1.3 Agriculture, Forestry

- a. The agriculture sector will move towards cash crops rather than essential foods. This would

further deplete available food stuffs for the poor, especially the rural poor, leading to greater malnutrition.

- b. Pressures of modernization, deforestation and replacement with fast growing trees like Eucalyptus (used widely in social forestry programmes) would cause decreased precipitation, decreased rain, decreased water table, increased droughts and floods and therefore also an increase in water borne diseases. Deforestation would also cause loss of top soil decreased fertility of soil, decreased production of food, malnutrition and starvation.

4.1.4 Industry

- a. The present liberal industrial policy will lead to proliferation of all kinds of industries throughout the country, causing pollution related health problems. The government will not have adequate machinery, or the will, to safeguard the environment.
- b. The new economic policy would bring about a growth in consumer based production geared to the world market. This would have the following results, namely

- lack of attention to local needs, which will affect the poor badly.
 - Growth of large national and multinational agencies, throttling the small scale industries, resulting in increased unemployment. Breakdown of mental health could also result.
 - Large scale environmental destruction with resultant health hazards and avoidable deaths.
- c. The technological model of development will be pursued vigorously to meet middle class needs. It will have ill effects on health eg., increasing power (energy) needs will be met by coal (highly polluting) or dams (dislocating people) or through nuclear plants (causing hazards due to radiation).
 - d. The opening of markets to multinational companies will result in increased availability and consumption of more chemicalised, preserved foods, and artificially flavoured and coloured foods. This will cause dietary imbalances and increased cancers.

4.1.5 Lifestyle changes

As already indicated above, the market economy and growing consumerism will affect lifestyles of the middle class and create consumerist compulsions for the poor eg., there will be a loss of traditional food habits.

4.1.6 Changes in Budgetary Priorities

- a. Changing attitudes to social concerns and the reduced availability of resources for welfare will affect the quality of nutrition, education etc., and consequently health, particularly of high risk groups.
- b. There will be a diversion of funds from the basic needs like health to the para-military forces.

4.2 Comments regarding the impact of these economic forces on health care services were as follows:

4.2.1 Commercialisation and Privatization

- a. Several panelists predicted an increased commercialisation and privatization of medical / health services.
- b. This is already evident in the rapid proliferation of private polyclinics and in the Apollo Syndrome.
- c. There will be a further mushrooming of corporate “business health centres” with expensive, high tech facilities along with consumerist promotion and values.
- d. This will be promoted by the leaders of the country at the cost of basic health services.
- e. Health professionals in general, and medical

professionals in particular, have succumbed to the commercialisation of curative services.

- f. Only the profitable services will flourish eg., new drugs and diagnostics and certain higher specialities.
- g. The affluent middle class will create a demand on the system for these type of services. They will be mainly urban based.

4.2.2 Accessibility

- a. Medical facilities will marginally increase, with little or no accessibility to specialised or super-specialised services for the majority of the people, particularly the poor.
- b. The cost of diagnostic and curative medical services will keep on going up at a galloping rate. Many services presently affordable to common people will go beyond their reach in 10-15 years.
- c. Church based groups providing health services will compete with the private sector to retain their “market share”. Overall, less attention will be paid to lower income groups.
- d. There will be an increase in health insurance schemes for the public.

- e. There will be less money for the health sector in the government budget. This will mean that health care will be neglected. The poor will suffer the most and have less access to medical services.

4.2.3 Type of Medical Care

- a. As indicated earlier, there will be an increase in the expensive, technological facilities, benefitting fewer people at the apex of the pyramid. These will primarily satisfy the caregivers. There will be increased dependency on the medical system by people to maintain their health, rather than promotion of self reliance.
- b. Presently, the government health care system is hardly working, partly because of shortage of funds. It will be unable to cope with increased demands and pressures on the system in the future. Rural and tribal health care may suffer.
- c. There will be increasing dependence on pharmaceutical multinationals at the cost of indigenous and traditional health care systems.

4.2.4 Pharmaceutical / Medical Industry

- a. There will be a sharp rise in drug prices due to the unjust claims of intellectual property rights.
- b. The pharmaceutical industry will now have a

greater say in the setting of priorities by the State and in determining the direction that health and medical services will take.

- c. There will be increased large scale experiments of new drugs on the poor.
- d. There will be an increased pushing of mechanistic procedures.

In summary, so far, there will be a greater need for health services for the poor, while paradoxically, access to health services will be limited to the privileged group only.

4.2.5 Health Personnel, their education and aspirations

- a. There will be an increasing commercialisation of education in health sciences, with a proliferation of capitation fee based, educational institutions turning out untrained or improperly trained health personnel lacking motivation. Their education will be inappropriate to the needs of people.
- b. Doctors, nurses and other medical personnel seeking jobs in India or abroad for a better salary and living conditions may often fail to develop and maintain a correct attitude to their profession and its practice.

- c. Communicable diseases would be eradicated or controlled but there would be an increased incidence of heart diseases, diabetes, cancer etc.

4.2.6 Other Factors

- a. One panelist felt that improvement in education is an important factor affecting health. Economic improvement and reduction in population growth are often associated with improved educational status, particularly of women.
- b. It was felt that urban migration encourages industry improving the GNP, thus helping in bringing about economic growth.
- c. AIDS could cause a depletion of the workforce with massive economic losses.

4.2.7 Additional Perspectives

- a. Another panelist suggested that health was not totally dependant on economic, political and social issues alone.
- b. It was felt that the questionnaire was not formulated to find out objectively the causative factors of health and sickness, so that one can ascertain in which direction to move in the future.
- c. It was felt that the economic and social status of people in the world and in India would rise

independent of any political system. However haves and have-nots would increase.

4.3 SOCIAL TRENDS

4.3.1 Urbanisation

- a. The process of increased urbanisation will continue and will be a major factor affecting the health of individuals.
- b. There will be a continuing extension of big cities. The urban poor have a lower health status than the rural population.
- c. Adequate facilities will not be available for this group. Sanitation problems garbage piles, over crowding insufficient civic services lead to degeneration of quality of environment, subhuman conditions and more ill health.
- d. Slum lords and mafias further deprive families in slums of their earnings, resulting in further deterioration of health.
- e. Increasing pollution due to industries.

4.3.2 Demographic Changes

- a. The health status of women is going to decline as the sex ratio over the years is going from bad to worse. Social pressures and the low value for women and girl children will continue for

sometime.

- b. The increasing number of the elderly will bring about a major shift in health service needs.
- c. Further increase in population will put greater pressure on existing services, with the result that they will be less efficient. It will result in deterioration of other available resources.

4.3.3 Family Types

- a. The single or nuclear family system will be more common.
- b. The breakdown of the family unit would bring most of health care from homes to the service sectors.

4.3.4 Education

- a. As mentioned earlier improvement in education particularly of women, may easily be the most important factor affecting the health of people.

4.3.5 Role of Media

- a. Television will play a major role in the social lives of people leading to greater consumerism.
- b. For example, advertisements will bring an

attitudinal change with respect to food stuffs, moving people away from healthy natural foods to junk foods.

- c. With a new culture dominated by TV propaganda, old values systems will be replaced.

4.3.6 Values / Spirituality / Religion

- a. The sense of community will loose ground and a narrow sense of individualism will thrive.
- b. Several health and related problems stem from common ills like man's confusion, lack of identity and responsibility, materialism, humanistic beliefs, false values and lack of spiritual strengths.
- c. There will be a progressive erosion of values in social life.
- d. The most disturbing element in the present social condition is moral degradation. From the highest offices of the country, including the politicians, and the bureaucracy, it has gradually started lengthening its tentacles to all types of social institutions and social services. A majority of the so called intelligentsia are willing to make any kind of compromise in their life for personal gain and prosperity. The system of accepting "capitation fees" alone has opened up a flood gate of corruption. Tax avoidance, unscrupulous trade and business practices have crept into the social service institutions in a significant manner. Even institutions related to various religious bodies are

not free from dubious practices. The tiny minority who try to stand against such a wave are labelled as “unsmart” and “outdated”.

Socio economic maladjustment is resulting in increased social tension and violence of various forms. Mental disorders are on the increase. Many modern health problems originate from social problems eg., drug abuse, AIDS, Sexually Transmitted Diseases, etc

- e. Churches will lose their popularity. There will be many more splinter groups of Christianity.

4.3.7 Cultural Changes

- a. There will be accelerated cultural alienation leading to abandonment of traditional systems of medicine and of traditional food practices.
- b. Many will follow a westernised way of life.
- c. There will be a continuing marginalisation of sections of the population, including of dalits.

4.3.8 Change in Life Styles

- a. There will be an increase in smoking, drinking of alcohol, a change in dietary habits and an increased use of vehicles.
- b. Changed life styles will alter the epidemiological

scenario of the country. The problem of chronic non-communicable diseases will increase, while most communicable diseases will be eliminated or controlled.

- c. Need patterns and health patterns will change.
- d. There will be increased levels of tension and stress (NB : This is not related to life styles alone).

4.3.9 Fundamentalism / Separatism

- a. Regional, ethnic, linguistic, communal and caste conflicts will lead to large scale victims who will have to be treated. This is already happening in Jammu and Kashmir, Punjab and other places.
- b. Religious consciousness, probably without god experience as love, and the consequent communalism could be on the increase affecting social and individual life and health.
- c. The associated problems of mental health and adjustment will need greater attention.

4.3.10 Social Problems

- a. Social problems like crime, delinquency and prostitution will increase.
- b. There will be increased social disharmony and social tension.

4.3.11 Awareness

- a. The awareness of people will grow and a sort of helplessness may grow leading to greater unrest and violence. This will be exploited by vested economic and political groups.
- b. The public are going to be more aware of their rights to medical services. There is likely to be more litigation in the health field.
- c. Consumer protection councils will make all government jobs less attractive than now, causing even currently employed personnel to leave the government service.

4.3.12 Social Trends – the positive side

- a. Educational levels and coverage will increase. Therefore the need for freedom and better living standards will be on the rise.
- b. Science and technology will be increasingly at the hands of people with techniques and skills to improve life.
- c. Greater focus on ecological and gender issues in public policy is a positive trend.

4.4 POLITICAL TRENDS

4.4.1 International

- a. Politically we are not going to be as

autonomous in the future, as we are today.

- b. There will be greater neo-colonial exploitation through the oppressive “new world order”.
- c. India will be more and more subject to one new world order, dictated by the West and Washington, with the cooperation and cooption of the local elite.
- d. The fall of communism in Europe will adversely affect the concept of national health insurance in other parts of the world.
- e. Changes in the Soviet Union will have an impact on political parties.
- f. The relationship with the United States of America will not be very good as our country works toward greater self sufficiency and development.
- g. A disturbing element mentioned was that some politicians, though small in number, serve the interests of the foreign nations.

4.4.2 National

- a. Several panelists raised the issue of political instability and inadequacy. It was felt that there is hardly any political party with the goals of good government based on a policy or sense of direction. And there is no reasonable chance of continuity. Health will be one of the difficult areas which cannot be improved in a developing country without political will and stability. Unless of course, effective health care is possible outside the governmental system.
- b. There will be greater criminalisation of our politics.
- c. Political power is grabbed at whatever cost.
- d. There will be negative political activities confusing and confounding the average person at the grass roots level. At present there are many political parties working in an aggressive and competitive way, each decrying the other party and the party in power in a particular state, making it difficult for constructive and progressive work to be undertaken to completion in the overall interests of the people and country. People at the grass-roots who need the services of health personnel will not get it as there will be artificially created hurdles.
- e. With political instability at the national level and other separatist / fundamentalist movements and divisive forces of language and caste working on a political level, health and social welfare

- programmes for the marginalised will be most affected
- f. There is a serious fear that communalism is on the ascent. If by any chance, such parties gain control, the whole political life will change. This would seriously affect all voluntary agencies, especially as foreign money for social services will be seriously curtailed. The church will be asked to remain within the four walls for Sunday worship and not to enter the field of health or education.
 - g. The principle of “divide and rule” is being used by politicians of all ideological colours. Communalism is dividing the poor also, so that they are unable to get together in an organised movement and fight or struggle for their rights, with regard to health and other basic human necessities.
 - h. Political support to corruption and dishonesty at all levels of the government health care delivery system, forces people to go to non-governmental and private agencies.
 - i. Politically it will be the moneyed who run the country.
 - j. There will be efforts by the marginalised groups to take to extremism.

- k. The organised might of the organised sections will resist efforts to mobilise the unorganised millions.
- l. A strengthening of the conservative agenda of the current government will set the climate for national development. Health budgets will be reduced.
- m. Politics and politicians in the country have earned a very negative image because of the degraded form of political culture pursued since 1947. Honest politicians interested in the welfare of common people cannot survive. They will be attacked mentally and physically even - all under the Gandhian veil of non-violence. People who protest get labelled as terrorists and disruptionists. Most nefarious socio-economic violences are skillfully protected by the guardians of the country, with no punishment meted out.
- n. The overwhelming majority of politicians are self-seeking. The odd idealists here and there cannot give their work the shape of a movement to bring changes.
- o. It was felt that the left wing is totally unnerved by recent political changes in the international scenario. They never did have a big say in Indian politics, neither is any significant change expected. The right wing is divided into two basic groups viz., social democrats and the ultraright. The so

- called social democrats have substantially lost popularity and power as they could not demonstrate social interest, they did not try to distance themselves from the self-seeking (investor class of) politicians. Gradually their image was tarnished. The emergence of fundamentalist forces could be even disastrous. But people are more or less tired with both Gandhian and non Gandhian democrats, they are aware about all the big promises since 1947, and opt for a change in the coming elections. There is reason to believe that the fundamentalist group may try to change and adapt to secure their position in Indian politics. It is the unscrupulous who are jumping into it, their attraction is big money, big name are jumping into it, their attraction is big money, big name (may be due to notoreity), big position in society. All black deeds, stupidity, failure could be covered up quickly by the miracle touch of "money force".
- p. It was also expressed that Indians, as people in Soviet Russia and other countries, will hate violent social movements and Marxist analysis, separating or focussing on the poor or weak alone, creating an imbalance in approach to social issues and so to health issues.
 - q. There will be stabilisation of the Government by

the Congress as a political party.

- r. Rightist and communal forces will be on the increase. Several panelists felt that the latter will affect health services adversely.
- s. It was felt that the decline of trade unionism will make it possible for hospitals to run without too much labour trouble.
- t. The growing disparity between haves and have-nots caused by inequitable distribution of resources shall result in social tension, strife, disturbance, de-stabilisation, increased criminal activities seriously affecting quality of life.
- u. More specifically regarding effects on health services, it was felt that at a national level, there will be an increasing political consciousness and literacy. Hospitals will need to give more personalised care.
- v. There will be an increase in student movements.
- w. The total absence of a positive national interest by the leaders in the public services and the various sectors that contribute to the health of people is a negative factor.

4.4.3 Regional

- a. Problems of separatism especially in border states may intensify.
- b. Instability of government at the regional level (as is already happening in the North-East, Punjab and Kashmir) will affect health care services (government and private) and health status too.
- c. There will be increasing autonomy to the states. This will require hospitals to satisfy local needs and abide by local laws.
- d. There will be increasing consciousness among tribals and dalits. Assertion by ethnic groups and subgroups, politically and economically, resulting in increased autonomy by / for such groups. These demands and needs will have to be satisfied by hospitals / health services.
- e. There will be a greater awakening among the marginalised, especially dalits, tribals, and backward classes. It would mean their participation in social, political and economic processes in the country will become a demand, and justly so. People centred, participatory health care processes will be the demand.
- f. It was feared that increased regionalisation will lead to intolerance of people from other regions

in the country.

4.5 EFFECTS ON HEALTH / HEALTH CARE – due to a combination of the various factors (other than those already mentioned)

4.5.1 Basic Factors

The basic factors influencing the health status of the population and contributing to the quality of life are water supply, sanitation, housing, food (nutrition), environment, education (awareness), and overall socio-economic conditions (including safety and security). Trends in the different factors are :

4.5.2 Water Supply

Some quantitative improvement in coverage (through tube-wells etc.) is expected. But maintenance of quality (safe, potable water) will not occur in the next ten to fifteen years. Mortality is already reduced, but morbidity due to water borne diseases will remain high.

The two other views were that due to deforestation and increased water utilization for agriculture, the availability of drinking water will become critical, leading to increased water related diseases.

4.5.3 Sanitation and Housing

Presently committed resources for this sector are meager as compared to the need. There could be a marginal improvement in this. However incidence of

air borne diseases relating particularly to housing, will remain high.

4.5.4 Nutritional Status

There could be a major breakthrough in food production. However chances of improvement in nutritional status of the poor are low. Withdrawal of subsidies will cause further rise in food prices – the impact on pulses and oilseeds has already created havoc. Production farming methods and technology – hybrid seeds, irrigation, use of chemical fertilizers and pest control methods. The distribution system is also faulty. There is increased export of food items to meet the foreign exchange crisis. The lot of the common people will therefore remain unchanged.

4.5.5 Environmental Degradation

This will continue. The small movements here and there are like ripples that will not develop into a tide in the near future. Manifold effects on health will result.

4.5.6 Education (Awareness)

There will be improvement in literacy rates, but there is cause for pessimism regarding real “education”. The new education policy and the system promotes mass production of technocrats. There is a neglect of the humanities and overemphasis on science and technology, which will produce more technologically

knowledgeable “inhumans”. Schooling facilities for the poorer sections will be inadequate. The government schools are already overcrowded and in a poor state.

The holistic approach to health is practicable in an educated society only.

4.5.7 : There will be an increase in tobacco related diseases including cancer, respiratory tract and cardiovascular diseases. The huge profit margins of the cigarette manufacturing companies are clear evidence of this.

4.5.8 : The pandemic spread of HIV and AIDS could result in the reversal of the gains of other health programmes. A conservative estimate is that over one million people are effected by HIV.

4.5.9 : Increased cancers and other diseases due to industrial pollution, and dumping of industrial waste

including nuclear waste, from rich countries into the Third World.

4.5.10 : The increasing complex drugs in the market will be used and prescribed indiscriminately, so that iatrogenic or medicine induced illness will increase, for example allergies, and side effects / adverse drug reactions.

4.5.11 : Ethical problems relating to the use of modern medical technology have already surfaced, for example provision of services for diagnosing and eliminating the female foetus.

4.5.12 : Wholesale adoption of allopathy, without critical evaluation will create new health hazards and economic exploitation.

4.5.13 : The weaker sections will realize that unless they have a significant say in the running of health services, they will be cheated of their rights to health, as in education.

4.5.14 : Monopoly in the medical system – in our vast country, there is room for many levels of health workers, who need to be trained and deployed to do their jobs responsibly and competently. With a strong support system (up and down and sideways) and with good team leadership, the impact on health will be positive. However, professional councils do not want to change with the times, and continue to act

selfishly in isolation, for fear of losing their monopoly.

5. FINDINGS - CONTEXTUALISING THE WORK OF CHAI

MAJOR HEALTH ISSUES AND PROBLEMS OF THE PEOPLE OF INDIA LIKELY IN THE NEXT FIFTEEN YEARS.

This is an analysis of responses to the following question of the first round of the policy Delphi Method viz., What are likely to be the major health issues and problems of the people of India in the next fifteen years?

The panelists, listed out a wide range of problems and issues that would be significant to the health scenario in the next fifteen years in India. Some ideas seemed to be of much greater concern to a larger number, than some others which were brought up by one or more participants only.

During the analysis the responses were classified as follows:

- i Specific health problems
- ii Broad health issues

- iii Health care issues - broad and specific

The classification was arbitrary to allow for a more comprehensive understanding of the responses. Most of the panelists had not used such a distinction and their list of ten or more ideas had combinations of all these subsections. While listing the more frequent ideas initially, we have included all the responses in the scenario to represent the wide range and diversity of concerns. There is some overlap between sections but, this is inevitable in an exercise of this nature.

HEALTH SCENARIO IN INDIA IN THE NEXT FIFTEEN YEARS

The health problems of the people of India will show a complex epidemiological picture in the years ahead. While we shall continue to have problems relating to poverty, poor hygiene, poor nutrition and poor environment, we shall increasingly experience the problems of development, affluence and modernization. New diseases will come up along with the resurfacing of other disease problems with newer trends and patterns. While this 'double burden' of disease will severely stretch our limited resources, our ability to deal with the situation will be hampered by the broader socio-economic, political, cultural factors emerging on the national and international scene that will determine our development, welfare and health policies.

5.1 SPECIFIC HEALTH PROBLEMS

The significant health problems that we will have to tackle in the years ahead, will be :

5.1.1 Nutrition Related Problems

This will include under-nutrition, which will continue to increase due to a variety of factors viz., poverty, increasing population, deforestation, and the effects of the new economic policies of the government on the poor. These will be further complicated by increasing adulteration and chemicalisation of our foods, the promotion of junk foods by the food industry, and decreasing state / governmental intervention in nutrition programmes.

5.1.2 Waterborne Diseases

This will include diarrhoeas and dysenteries, gastroenteritis, typhoid, cholera, hepatitis B and parasitic infestations. While rural areas will continue to be affected due to inadequate resources for sanitation, urban areas including metropolitan cities will not be spared due to grossly inadequate services. This may be further compounded by increasing waterlessness due to indiscriminate harvesting of the water table, destruction of natural forests, monopolizing of water resources by commercial interests, urbanization and cash cropping.

5.1.3 Communicable Diseases

Some of the major communicable diseases like malaria, tuberculosis, leprosy, kalazar, acute respiratory infections and preventable childhood diseases will continue to take their toll. While resources / knowledge are available for their control and prevention, these are neglected or inadequately utilized and complicated by the problems of inadequate therapy and problem of resistance. With decline in public health measures and health care investment by the State, national programmes for these diseases will suffer.

5.1.4 Non-Communicable diseases

Chronic, non-infectious health problems such as heart disease, hypertension, diabetes and cancer will increase due to the present mode of development. This will occur especially in the middle classes with changes in food habits and life styles, increase in stress, smoking, obesity, sedentary occupations and an ageing population.

5.1.5 AIDS

This was predicted to become a major public health problem due to (i) neglect of measures in hospitals to prevent spread, (ii) breakdown of values and taboos that have determined sex behaviour, (iii) change in sex hygiene and habits, (iv) infected blood donors,

(v) increased migration and tourism, (vi) ineffective control measures, (vii) lack of proper awareness, (viii) present apathy about the problem and time lost in recognizing its significance. Other sexually transmitted diseases will also increase for some of the above reasons.

5.1.6 Problem of Mental Ill Health

These will include the whole range of stress related disorders, psychosomatic and psychological problems, suicides, dementias and other mental health disorders.

They will be caused by (i) increasing stress, (ii) effects of urbanisation and increasing unemployment, (iii) family breakdown (iv) increased social disparity and dissatisfaction (v) increased competition (vi) loss of meaning / significance of life, (vii) breakdown of family and traditional support systems, (viii) increased family and community violence (ix) breakdown of values (x) increased miseries in an economy of lopsided distribution and security (xi) reduction in vital faith and motivation (xii) lack of positive powerful myths to sustain society and breakdown in the ideals of honesty, compassion, socialism and nationalism.

5.1.7 Addictions and Substance Abuse Problems

These will include problems related to narcotic and

hallucinogenic drugs, alcohol and tobacco. The problems will increase due to (i) increased tensions (ii) breakdown of religion and values (iii) profiteering by pushers (iv) changing cultural values, and (v) inadequate efforts to create awareness, prevent or control the problem. Some of the factors described above will also contribute to the increase in the problem.

5.1.8 Pollution Related Diseases, including allergies, asthma and other hazards

These will increase due to increasing environmental pollution of air, water and soil by chemicals and other hazards, (ii) adulteration and harmful additives in food, (iii) pesticides and other occupational hazards (iv) inadequate dumping of nuclear and industrial wastes (v) increased pollution by fuel burning and smoking (vi) increased covering up of facts by commercial interests and (vii) inadequate measures for prevention and control.

5.1.9 Disabilities and Handicap Problems

This will be a major problem particularly affecting children due to (i) inadequate pre-natal care and immunization programmes (ii) neglect of curable blindness (iii) increased drug iatrogenesis (iv) genetic diseases, and (v) decreased mortality. This problem will be further compounded by breakdown of

traditional family and other support systems and inadequate intervention or non-availability of better solutions / methods for handicap care, putting a strain on the families and increasing the distress of the affected children.

5.1.10 Health problems of the Aged

Problems of the aged (geriatric problems) will increase due to an ageing population caused by increased longevity. There will be a consequent increase in the number of neglected, lonely, depressed, inadequately cared for old people. As in the problem of disabilities mentioned above, this will be complicated by a breakdown of traditional family support systems especially the joint family system.

5.1.11 Iatrogenic Diseases

This will get greater recognition in the future as a new and increasing problem in the country. These medical, drug-related problems arise due to (i) indiscriminate medication, (ii) over-prescription (iii) gunshot therapies (iv) irrational drug therapy (v) use of spurious drugs, (vi) inadequately tested drugs being introduced into the market, and (vii) the unbridled advertisements of pills, among other related factors.

5.1.12 Accidents

Both road traffic vehicular and occupation related

accidents will increase due to urbanisation, industrialisation and increase in transportation and travel. This will be further compounded by increasing violence in society – social conflicts, at the work place, on roads and in the family.

At work apart from accidents, occupational hazards will also increase a great deal.

Apart from the above 12 major groups of diseases and problems which the panelists commonly identified a few other problems were mentioned. These included (i) more rheumatic fever and related heart conditions in children (ii) ulcers and piles, (iii) iron deficiency anemia (iv) iodine deficiency (v) resistance to drugs (vi) chronic ill health and sub-optimal functioning in daily work particularly among women. Some of the participants emphasised that many of these problems would primarily affect the poor and among them women and children would be even more affected.

5.2 BROAD HEALTH ISSUES

Related to the above groups of specific health problems and contributing to them (as mentioned above), or complicating the situation further, the panelists listed a number of health issues that would gain significance in the next fifteen years. These are

given below :

5.2.1 Environmental pollution and deterioration of ecology, with consequent effects on health and quality of life. This will be of air, water and land and affect both rural and urban areas.

5.2.2 Challenge of Environmental Sanitation

Inadequate provision of safe potable water, poor sanitary facilities or solid wastes management, including disposal of garbage and night solid due to inadequate resources and increasing disparities. Large segments of the population will be denied this basic requirement for good health.

5.2.3 Urbanization and its consequences / contribution to the health the urban poor

The problems of slums will probably become unimaginable due to inadequate planning, inadequate financial resources, inadequate housing and lack of government concern or abilities for providing essential amenities to slum dwellers. There will be increased migrant labour, increase of the urban poor, increase in urban stress, unemployment and all the related consequences.

5.2.4 Breakdown of family

Many panelists have predicted increased family

breakdowns due to problems of divorce, separation and other marital problems. Increased family disorganisation and violence and break up of the traditional joint family system and support systems will have consequences on the mental health of people, as also on the family's ability to handle its health problems, especially in the care of children, the aged and the handicapped.

5.2.5 Ethical issues in medicine and medical care

These will become very important and will cover the whole range of issues such as *in vivo* and *in vitro* fertilization, human organ transplantation, use of foetal tissues, euthanasia, trading in human organs for transplants, with poor people becoming cheap suppliers, drug misuse, overuse and so on. Medical ethics and values will be increasingly focussed upon.

5.2.6 Rational Therapeutics

The growth of multinationals in the pharmaceutical industry, the increase in medical consumerism and the factors of the market economy are expected to increase the problems linked to drugs. Exploitation by the drug industry and increasing dependence on western technology at the cost of self reliant

indigenous knowledge is predicted. Unbridled advertisement of medical drugs and tonics will contribute to aggravating the problems.

5.2.7 Population Issues

The problem of increasing pressure of population growth coupled with high illiteracy and its consequences on resources and health have been predicted. There will be need for increasing efforts in family planning and population control, but these will be complicated by family planning issues which include newer contraceptives, female foeticide, abortion, infanticide, invivo/invitro fertilization, effects of abortion / sterilization health, especially of women and so on.

In addition to these broad issues some panelists added the following to the list.

- i. Influence of international politics and their adverse effects on health related problems.
- ii. The paradox of longer life span but poorer quality of life.
- iii. Increase in more incurable ailments - caused by high technology power generation, radiation related gadgets like microwave, TV and computer terminals, reactors and nuclear installations.

- iv. Irrational and non-consistent political decisions about alcohol use / prohibition policy leading to increasing death due to poisoning from spurious brews.
- v. The issue of control of technology and the type of multinational operations in India with its implications from the perspective of medical ethics and the development of indigenous research capabilities and foreign exchange.

5.3 ISSUES OF HEALTH CARE

As distinct from the specific health problems and broad health issues outlined earlier, panelists also identified many key issues which may be classified as health care issues or issues significant to the development of health care service systems that could respond to the evolving health scenario. These included :

5.3.1 Health care planning - challenges and problems

This would include a host of questions and issues :

- i. Inadequacy of comprehensive health care planning at national level and overall lack of coordination.
- ii. The dilemma of basic health care vs. sophisticated health care - problems of perspective.
- iii. Increasing inappropriateness of existing health care service and non-availability of basic health

- care services for the majority.
- iv. Pressure on limited resources of a complex epidemiological situation in the future i.e., diseases of poverty and diseases of development modernization occurring side by side.
 - v. Increasing rural - urban disparities
 - vi. Increasing government priority to high technology medical care.
 - vii. Inadequate planning of secondary health care.
 - viii. Universal access to health system, particularly to the poor.
 - ix. Effective referral system beyond primary health care / centre.
 - x. Need for greater clarity in content, direction, objectives and strategies of public health policy.
 - xi. Clarifying role of public / private / NGO philanthropic groups in development of services. Harmony with autonomy within a negotiated overall framework of policy and priorities.
 - xii. More equitable distribution of health care delivery corresponding to population distribution and need.

5.3.2 Costing and Financing of Health Care - The issue of investment

These would include issues like :

- i. Less and less government allocation of funds for health care.
- ii. Tightening belt and increasing austerity - affecting welfare and health investments.
- iii. Rising prices of food, drugs and equipment.
- iv. Higher cost of treatment, beyond the economic capabilities of the majority.
- v. Escalation of cost of drugs and equipment by MNCs in the name of quality, intellectual property rights etc.
- vi. rise of consumerism and the market economy.
- vii. Increasing privatization / commercialisation of health care.
- viii. The question of affordability of higher technology medical care.
- ix. The quest for cost effective medical care.
- x. The challenge of organising self-financing and self-reliant systems, including health cooperatives etc.

5.3.3 Health Personnel Development - challenges and problems

This will include on the one hand inadequate supply of the right type of doctors to run the system because :

- i. medical education remains inappropriate for our needs.
- ii. Mushrooming of medical colleges and declining quality of medical education
- iii. Over-specialisation among doctors and inadequate availability of GPs.
- iv. Lack of committed medical personnel.
- v. Medical profession becoming a lucrative business rather than a service profession with doctors becoming very money minded.

On the other hand, there will be a lack of intermediate people with medical expertise as well as lack of village based health workers. There will be need for seriously re-looking at categories of health training including doctors.

5.3.4 Rational Drug Policy

The availability of adequate drugs for the health care delivery system must be ensured by a rational drug policy that clearly identifies roles and limits for drug production, availability, distribution and sale for the government, multinational and small industry sector and controls medical advertisement as well as misuse, overuse of drugs.

5.3.5 Primary Health Care Issues

The commitment to Health for All (HFA) through Care,

will include the challenge of providing:

- i. Primary Health Care services - accessible to all
- ii. Primary education for all
- iii. Minimum housing facilities for all
- iv. Increasing health education and health awareness building, in the community and particularly in schools.
- v. Need for appropriate technology in health care.
- vi. Need for increased accountability of government health care services.

5.3.6 Secondary/Tertiary Care Issues

These will include the issues of affordability of high technology medical care, priorities and need for appropriate choices at different levels. Quality of care will also become important. This concept will need definition as well as the development of a system of quality assurance.

5.3.7 Health Education

This will be an important issue and will have to be actively pursued to develop more positive health attitudes and capacities towards attaining good health at all levels and stages of life.

The school systems will need to be more involved in this effort. Consumers also need to be made more aware of the available services. Care will have

to betaken not to allow health education efforts to become commercialised.

5.3.8 Integration of medical systems

There will be need to integrate various health systems, western and indigenous, into an overall system of service delivery with mutual learning and even fertilization between systems. For this the inadequate emphasis and promotion 'of other systems will have to be changed towards a more supportive development standardising, regulating, researching and priority setting in these systems.

Efficacy of indigenous systems of medicine and research on herbal medicines and home cures will become important issues.

5.3.9 Research in Health Care

Issues for greater research in the new health scenario will be:

- i. research into alternative approaches to medical and health care including efficacy of other systems.

- ii. deeper study of social psychology to understand health behaviour.
- iii. increased focus on womens' health issues.
- iv. increased research into holistic health care and related issues.

5.3.10 Towards Holistic Health

Finally the issue of ' holistic/wholistic health in-the context of a positive wellness model will ecome increasingly important with stress on the five basic dimensions of self responsiblity,'nutritional awareness, environmental-sensitivity, physical fitness and stress awareness and management. This will have to be build on our own rich heritage and culture of positive health especially in the Ayurveda and Yoga systems.

The overall health scenario painted by the panelists may appear somewhat stark and bleak but looking at it from a more positive angle one could conclude that the scenario of health and health care in the next fifteen years will need, a creative, multi dimensional, multi disciplinary and holistic response and this will be the greatest challenge facing health organisations such as CHAI by 2000 AD.

Besides the State, a number of different organisations and groups respond to the various health, health care problems and issues raised by the Delphi panelists. These issues need to be studied

and reflected upon on an ongoing basis by the CHAR board, executives and staff and by members at the level of their institutions or in regional/professionwise groupings.

Critical areas of intervention need to be identified, strategies drawn and then worked upon in a consistent manner, with a flexibility to adopt new priorities and methodologies.

6. FINDINGS - POLICY ISSUES IMPORTANT FOR CHAI IN THE FUTURE

The initial specific question pertaining to CHAI, posed to Delphi panelists, was "What should be the issues that CHAI should take up as areas of priority in its future work during the next fifteen years? Please list upto five in order of priority and give reasons as to why they are important".

Interestingly, besides identifying external' issues i.e., those affecting the health and lives of people which CHAI needs to address, other important internal' aspects were highlighted. These include basic philosophical assumptions and organisational aspects that would be crucial for the implementation of strategies in the thrust areas.

The wide spread of ideas that emerged fitted into seven broad groups. These were used to formulate the second round questionnaire. This was done so as to get a group response to all the ideas

and to generate further debate.

A summary of the group responses is given in the following pages. The group rating by the panelists for each of the items, expressed as a percentage of the highest possible score, is given in brackets. Items have been broadly categorised as:

- First Order Priority : Those with a group rating of more than 70% of the highest possible score.
- Second Order Priority : Group rating 50% - 69% of highest possible score.
- Third Order Priority : Group rating less than 49% of highest possible score.

These three categories could be considered as very important, important and slightly important respectively.

Additional comments by panelists have also been given.

The broad areas covered are as follows:

1. Basic premises of health work;
2. Important health problems in the country that CHAI could respond to;
3. Components of health care/health action to be promoted;

4. Broad strategies of intervention;
5. Constituency/groups for focus of activities;
6. Redefining roles in the present and future context; and
7. Organisational aspects important for effective functioning.

6.1.BASIC PREMISES OF HEALTH WORK

The following basic premises of health work need to be considered by CHAR for their future work. This could possibly be written as a Statement of Philosophy. There is a need for a clear “mission statement” that in a few lines states CHAI’s essential goal and strategy, that is acceptable to all. Once this is clear, other aspects of identifying thrust areas and strategies would fit into that mission. There was a high degree of agreement by panelists on most items. The first three items got almost a unanimous vote (above 90%).

Many of the aspects below form part of what could be called a new or alternative paradigm of health. They have emerged from the experience of several groups and individuals with the lives of people at the grassroot level. There is a distinct shift from the biological, mechanical, institutional model, to a people based and people centred method. This signifies a fresh understanding and approach to health and sickness.

First Order Priority (More than 70%)

6.1.1 Need to focus on a preferential option for the poor (92%)

To promote work in remote rural and backward areas, particularly of underdeveloped states, in urban slums, among tribal groups, margin lised groups, and indigent populations.

It was felt that there is an absolute need for a bias towards the poor. CHAI should highlight the needs of the poor and support efforts by groups to bring them to the centre stage.

This would also then lead CHAR to help evolve with theologians and interested people a spirituality that is based in the context of struggle for human liberation and social justice, a spirituality of commitment and solidarity.

6.1.2 Focus on the justice dimensions of health/health work (90%) and not only on health care service issues, to support and build the organisational capacity of people, to demand a more just health and social service system, to act as a counterveiling power to the pharmaceutical industry and to vested interests.

6.1.3 Focus on enabling/empowering people in health work (90%), to enable individuals to take care of their own health and be able to analyse and respond to their health problems themselves, to avoid everything that creates dependency and nonparticipation, to support a peoples’ health movement, to enhance liberation and growth of people, to increase community responsibility for health work.

CHAI cannot directly focus on enabling or empowering people in health. It can empower members/the church to empower the people/communities they work in.

The above three points could be considered as being highest priority, as they have a rating score above 90%.

6.1.4 Promotion of a wholistic approach to health (84%) i.e., harmony in body, mind, spirit, society and with the environment. This is closely related to the spiritual dimension of health. It is totally non-sectarian.

6.1.5 Promotion of community based, non-institutional health work (82%) i.e., to demystify medical knowledge, de-professionalise as far as possible, to build on peoples' health knowledge and practices and to be sensitive to their culture.

There is a need for greater focus on community health, but is a place for good institutional health care too.

6.1.6 To improve accessibility of the poor and underprivileged to medical/health care services (82%) viz., to good quality basic health services and to life saving bio-medical services.

It was felt that CHAI need not/should not focus on expanding institutional care, as it can be taken up by others i.e., by the private sector and government.

6.1.7 To develop a sense of understanding and caring

among health workers and in health institutions (78%)

This can be brought about primarily by member institutions.

Within institutions already existing and elsewhere the strength of CHAr/CHAI members should be caring and the demonstration of caring and concern in action.

6.1.8 The need to promote a sense of community and belonging as being critical to well being and wholeness (78%) by helping make people inter-dependant and concerned about each other. The primary responsibility for health care lies within the community itself - to take care of each other. Hence creating healthy communities - that receives, accepts, forgives, heals', and commissions is of the highest priority.

This is also thus related to enabling and empowering people, with a deeper dimension of inter-relatedness.

6.1.9 Therefore not surprisingly, the need to focus on the spiritual dimensions of health and healing (78%)

This is intricately linked to wholeness and a wholistic approach to health. Several of the points raised (1.1 - 1.4, 1.7 - 1.8) relate to spirituality, which was considered to be working towards making a dehumanised situation more human.

6.1.10 To nurture members of the health care team and provide means for fellowship and mutual support

It was also felt that an important premise missed earlier, was the focus on members of the health care team, *in its broadest sense*. If health team members are not able to maintain their motivation and to conform to their ideology, all else will fail. If they can be sustained and maintained, they will make headway in spite of deficiencies *in the rest of the system*. It is therefore important to nurture those involved *in ideologically oriented health work* and to provide means for fellowship and mutual support among themselves.

6.1.11 The need to focus on gender related issues (76%)

i.e., on women's health status, *their* access to health care and the impact of technology on women's health, among other factors.

Women's health and other gender related issues, especially in India, are intricately linked. Therefore CHAI can encourage discussions of patriarchy and its manifestations *in caste, class, ecological destruction, militarism and sexism*. It was reiterated that health issues cannot stand alone, without dealing with its relations with all other aspects. However it was stated by another panelist that this aspect could be considered as a part of preferential option for the poor and disadvantaged, as upper class women are likely to get good health care and enjoy a better health status.. One panelist felt this issue was not important for

CHAI.

6.1.12 To create an awareness on environmental/ecological issues as they relate to health (74%)

It was felt that these issues are going to be in the forefront by 2000 AD and therefore, knowledge about it must spread to the community at large.

6.1.13 To strengthen/foster self-reliance at all levels (73%)

by promoting herbal and home remedies, non-drug therapies, low cost care and appropriate health technology. dependance on drugs and the medical industry.

Second Order priority (50 - 69%)

6.1.14 To promote an integrated approach to medicine and health (68%)

by studying, understanding and using Indian and other systems of medicine, viz., Ayurveda, Siddha, Unani, Homeopathy, Acupuncture etc.

It was felt that an integrated approach does not help as it tends to lower the standards of medical care. A question was also raised as to whether it is ethical to promote herbal medicines unless they are proven more effective than placebos. The Question who should prove this was also raised.

Among the general comments were the following:

1. All the above points are important as components of a Statement of Philosophy on health, healing and wholeness by CHAI. However a prioritization is done and is necessary with the assumption that all cannot be addressed with equal emphasis. Therefore, some items though important in general have been given a lower scoring. (eg., C - insignificantly relevant) as they are not important as far as CHAI's future role as catalyst. Too many focus of attention will only dilute CHAI's work.
2. Many of the factors are also interdependent and interrelated. It would be important to identify the major plank or foundation for developing an equitable human caring system first. The next step would be to identify factors which are going to support, supplement or complement such a system.
3. It was also suggested that as we all grope in the dark, research would be a very important activity/attitude to be considered.

6.2 IMPORTANT HEALTH PROBLEMS IN THE COUNTRY that CHAI could respond to

The first round of the Delphi Method indicated the major health problems the country would be facing 15 years from now. Given the strengths and specificities of CHAI, the following important health problems in the country that CHAI could respond to, have been identified. They are arranged in descending order of priority according to the

ranking given by the panelists.

A. First Order Priority (more than 70%)

6.2.1 Women's Health Care (86%)

6.2.2 Child Survival (83.76%)

Through growth monitoring, oral rehydration, breast feeding, health education, nutrition and immunization.

6.2.3 Urban Health Care (73.07%)

6.2.4 Communicable Disease Prevention (73.07%)

It was felt that the scope of CHAI's work should be in those areas not covered by the growing government programmes. While communicable disease control is the responsibility of the government, implementation of programmes varies in different States and regions.

6.2.5 AIDS and STDs (73.07%)

This would include educational work for prevention and also developing hospices for AIDS cases to die in dignity.

6.2.6 Substance misuse (73.07)

This includes alcoholism, tobacco use and drug addiction.

Second Order Priority (50 - 69%)

6.2.7 Mental Health (68.46%)

Counselling including for people who are chronically ill, and in terminal care hospices. Promoting positive mental health is also very important

Mental health should be approached in terms of the individual, family and community psychology and sociology. It should not be too medically oriented.

6.2.8 Disability Care (67.56%)

Community based rehabilitation and prevention.

6.2.9 Occupational Health (64.86%)

Particularly of unorganised labour, women and the organised sector.

6.2.10 Care of the Aged (64.86%)

Geriatrics in hospitals/dispensaries, and also opening of houses/day centres for the elderly.

It was felt that the emphasis should be to help families accept their aged and encourage community/home based support and care of the elderly, not only as patients but as people.

This point was reemphasised by another panelist who mentioned that Indian culture had a system where children assumed responsibility for their old parents. "Do we need to ape the West and put our parents into Homes for the Aged. Instead teach people/children to look after their old at home".

6.2.11 Natural Family Planning / Population issues (63%)

Family welfare programmes, family counselling, with a mention by some panelists that NFP has not been successful. Though rated the lowest, this point merited a large number of additional comments viz.,

- NFP could have been presented as an independent item i.e., separate from population issues which certainly can be as A.
- population reduction issues should be approached more vigorously, as it is critical for the entire health sector. CHAI needs to take a bold initiative and go beyond NFP.
- population issues should be approached from a wider developmental, environmental and women's perspective.
- population growth should be altered and lowered in a balanced way. We need a Net Reproduction Rate where women has 2.1 children. Contraception and abortion pave the way for Minus or Below Replacement Rate and will lead us to pro-fertility procedures as in Scandinavian other countries, of In Vitro Fertilization (IVF) etc.

The great value of NFP is in preserving:

- a) women's health
- b) family stability (contraception and divorce are proportional) and
- c) respect for life.

This has not been studied or understood by CHAI. This is not a religious issue.

- NFP has an important role. There is a need for knowledge regarding up-to-date scientific methods.
- There is an urgent need to represent to Church authorities the view of a large number of health workers that NFP is not always feasible, hence need for search for other effective and less harmful methods.
- NFP is a failure. Can promote condoms which will prevent AIDS/STDs, as well as unwanted pregnancies.

There were several other valuable general comments, which are given below:

- a. CHAI could address important health problems' by a collective look at relevant statistical data and projection perhaps on a regional/state basis. Normative ranking would be inappropriate.

- b. There is a need for a wholistic approach - not a vertical' programmatic approach. If CHAI deals with these directly, the main objective of providing perspective, finding the best solution according to the context will become diluted. It could therefore provide consultative services in approaching the above problems according to a new perspective.
- c. CHAI should do a few things well. It is unrealistic for CHAI to undertake too many roles and functions and thus project a global, all embracing image.
- d. CHAI should take an organizing, coordinating, supportive and consultative role and not that of providing direct services.
- e. CHAI does not need to have such a large number of specialists in it to deal with all these problems. As it is, CHAI is tending to be too much of a bureaucratic set-up. There will be other organisations which can provide responses to specific health problems.
- f. The scope of CHAI should be in those areas not covered by the growing government programmes.
- g. Looked at from various angles all these health problems seem to get special attention in some form or other, in one place or other in India in the coming years.
- h. CHAI should take a wholistic approach, with primary focus on child survival and care of the aged.

- i. Emphasis should be on mother and child health and family and community education for health.
- j. Focus on wholistic health with spiritual values.
- k. Focus on community based, primary health care promotion.
- l. Iatrogenic problems also need to be considered.
- m. In terms of helping, guiding and providing technical support, all are important.

6.3 COMPONENTS OF HEALTH CARE / HEALTH ACTION TO BE PROMOTED

Various components of health care have been identified that need to be promoted by CHAI in its future work. These are listed below in descending order of priority.

A. First Order Priority (more than 70%)

6.3.1 Health education (92.79%)

Education for health using effective communication skills, developing effective material, public education regarding understanding of health.

Additional comments were regarding the importance of child to child and child to mother communication, need for clear basic messages, use of minimal reading material and increased use of art work.

6.3.2 Primary Health Care, Preventive and Promotive Health Care (90.09%)

Find ways of effectively implementing the 'principles and components of Primary Health Care towards Health for All.

6.3.3 Rational Drug Therapy / Policy (83.78%)

Introducing the concept actively in member institutions, campaigning at the national level.

It was felt that promotion of a Rational Drug Policy by CHAI is more important than working on rational therapeutics alone.

6.3.4 Community Health (81.08%)

Staffing of community health care units with mental health, spiritual health, social work personnel, besides medical and para-medical staff.

An additional comment was that it will be unrealistic to encompass all these functions.

6.3.5 Improving (81.08%) hospital/dispensary based

health care systems

This could be furthered by introducing spiritual and counselling methods, mental health care, health education, rational therapeutics, effective lowcost humane care, technologies that can be taken closer to the community and by making services accessible to the rural and urban poor. Keeping in view the growing privatization of health services, the small clinic and hospital member institutions of CHAI have an important role to play in the future.

It was felt that CHAI member hospitals should be models in this.

6.3.6 Involvement in determining training of health personnel (80.01%)

CHAR could work towards a more community oriented formation of health personnel;

Participate in evolving nursing curricula, eg., inclusion of women's issues, AIDS, addictions, role of new technologies etc.

The increasing specialisation in the nursing profession is making it competitive with allied professions;

Need for training para-professionals/non-professionals

for comprehensive health care work;

Participate in re-orienting, reorganising medical education to produce more socially sensitive physicians.

It was additionally felt that:

This is an important role and is not being done sufficiently by others. Education and training are weak areas of many organisations including CHAI.

Nothing much will come out of more community oriented formation and in reorienting medical education to produce more socially sensitive physicians. The professionals will not allow the training of para-professionals/non-professionals for comprehensive health care to develop as there are too many vested interests. These are also not the money spinners.

Training of para and non-professionals should not be connected to a hospital. Nor should they work as part of a hospital programme.

6.3.7 Medical Ethics (76.57%)

Issues relating to human fertility, abortion, end of human life, use of human organ and tissues.

It was felt that this area has been very biologically defined. Probably these are issues which perturb the Catholic mind. They need to be broadened.

Medical ethics should include health care issues. The more glaring issues - who gets care and who does not, multinationals and drugs, ethics in occupational hazards, environmental destruction etc., are wider ethical issues relating to health that need to be tackled. Malpractices need to be addressed.

There is a need to promote holistic human values in health work.

6.3.8 Research and Documentation (74.77%) of major health problems, health service research, and evaluation could be undertaken. Research in primary health care and in preventive health is important.

6.3.9 Management principles and skills in health (74.77%)

Planning, personnel management, improved service effectiveness, concept of total quality management, identifying performance indicators, developing management information systems, increasing inter-institutional cooperation are areas that could be pursued by CHAI.

Additionally, while management was considered important, there was a word of caution, otherwise our health care will look like business enterprise'.

6.3.10 Pastoral care / spiritual health (70.27%)

Training courses for lay and religious personnel on an inter-religious basis.

It was felt that publications in this area are also needed.

B. Second Order Priority (50 - 69%)

6.3.11 Traditional/indigenous health knowledge and systems /Alternative methods of healing(69.36%)

There is a need to develop a pharmacopeia for use by primary health workers and for their training, promote investigation and study, prepare teaching materials for members, and to integrate different systems of medicine/healing into health care services.

It was also felt that while this was crucial, there was a need for tackling the prevalent neo-colonial mentality that may resist use of these methods.

6.3.12 Lobbying for regulating the standard of operation of health services (69.36%)

This was considered very important, if it could be done. There is a need to cooperate with others in the process.

6.3.13 Understanding of public health principles and epidemiology (67.56%)

including the changing epidemiological scene in the country and its implications for health services.

Additionally it was felt that there is a need for understanding tropical diseases better and for adapting textbooks.

6.3.14 Health Care Financing (67.56%)

improved cost effectiveness, innovative models.

6.3.15 Multidisciplinary health team functioning (67.50%)

With equal respect for people from the different disciplines. Health planning now utilises a multidisciplinary approach and so do other elements of health management like organisation, and evaluation.

The pattern of religious always holding leadership positions in Catholic hospitals should change. More lay participation based on competence and commitment is needed. Christian presence cannot be due solely to the leadership and authority of the religious, but has to be in the whole health care team.

Additional general comments were:

- a. Much depends on the clear cut policies and resources that CHAI will have. All issues are inter-related.
- b. CHAI should promote those objectives that are necessary and extremely important, which other bodies cannot fulfill. Whatever has a multiplying effect at the national and regional levels should have priority in its objectives

and strategies.

- c. It must not duplicate the work done effectively by VHAI etc.
- d. Some of these issues are excellent, but beyond CHAI's abilities, like helping government hospitals, and research.

6.4 BROAD STRATEGIES OF INTERVENTION

Various strategies of work or intervention can be utilised to address major health problems and to promote health action. They would help CHAI to implement its objectives. Some of these have been identified by Delphi panelists and are listed below in descending order of priority.

6.4.1 Continuing education for members (88.28%)

Human resource development for various types of health workers through workshops, seminars, training programmes - to introduce greater professionalism into peripheral health care programmes of CHAI members.

It was suggested that workshops and seminars should be conducted by non-religious. The religious personnel should be exposed to the stark reality the common person faces.

6.4.2 Focus on and encourage/support members to move to work with the most needy, the marginalised groups and the most dehumanising health problems (88.28%)

This was considered a strength of Catholics.

It was felt that new initiatives should not include institutional health care approaches.

6.4.3 Networking with voluntary programmes of health care (82.88%)

at national, regional, local and international levels, increasing sharing and collaboration, avoiding duplication.

6.4.4 Evolving models/innovative programmes of health care (82.88%)

that would be viable, applicable by religious and non-religious workers, affordable and sustainable by the people, taking into consideration the socio-economic-political structures.'

It was felt that every little programme should be a model, based and developed according to the need of the area. The word "nonreligious worker" was not appreciated "since every worker in the field is religious' whether he/she is conscious of it or not".

6.4.5 Developing education / training models (82.88%)

in tune with our realities, at various regional levels in regional languages, to support the models developed and to cater to the vast majority of people still outside the health care system.

It was felt that these are weak areas of many organizations, including CHAI.

6.4.6 Appropriate health personnel development, meet new needs (80.18%)

This should be done while respecting the autonomy of members and agencies.

6.4.7 Advocacy/lobbying/campaigning for change at a national level (73.37%)

so that basic health needs, for example, clean water are satisfied for all, and for government to revise priorities to emphasise health services for the poor. Also against alcoholism, drug addiction, environmental degradation.

It was felt that advocacy should include the areas of women's health, respect for life, and natural family planning.

As a start, it was suggested that clean drinking water in villages covered by churches could be provided by placing wells in the village and not in the parish compound.

6.4.8 Re-assessment, reorientation, rejuvenation of Catholic resources in health care to the urgent priorities of the time (76.57%)

6.4.9 publications (74.77%)

more in regional languages to support community

primary health care workers; in English about healthy living, causes of illhealth, health hazards, drug issues etc.

It was felt that this should be pursued in areas not provided for already by VHAI (Voluntary Health Association of India), ISNFP (Indian Society for NFP) etc.

It was not clear why such a distinction was made in the focus between regional languages and English.

Keeping in mind that, a number of community health workers are illiterate, creative methods need to be developed.

6.4.10 Developing a capacity for policy level input into national health policies/plans (72.07%)

It was once again considered important to influence national policies.

6.4.10 Bold Media coverage (70.27%)

At the national and regional level to educate and inform people regarding components of at the health, causes of ill-health, what ails the system, etc. Use of audio-visuals should be emphasised. It was felt that media publicity should not be about CHAI. This should be attempted only "once we have set our house right".

6.4.11 Organising national/regional consultations and conventions (70.27%)

6.4.12 Intersectoral coordination(60.36%) in regions of the

work of memqers to demonstrate the need and scope in this area, and the need to get involved with non-health issues that impact on health, for example, water shed management, eco-farming, developing credit systems for poor and for women.

6.4.13 Make a conscious effort to maintain a simplicity of life style and structures within CHAI (59.45%).

Also encourage members to live in simple temporary dwellings. Present concrete structures make them far removed from reality.

We should promote a culture of simple life and not an affluent and materialistic life style. Th s could probably be encouraged by enrolling more lay members.

It was felt that if temporary dwellings in the long run are going to be expensive than simple concrete structures, the latter should be preferred.

Inexpensive dwellings are to be encouraged, but they should be compatible with health requirements of the occupants.

This is a matter which religious congregations and others should themselves attend to. If point No.3, is practised, simple lifestyles will follow.

Additional comments were:

Though desirable, there is a limitation to involvements.

CHAI will be effective if it limits itself to a mission and role and not by becoming too diffuse.

This is good, but is not CHAI's role.

It is important to link direct health services with related issues.

On the other hand inter-sectoral and even intra-sectoral transectoral coordination was considered very important.

Additional General comments regarding strategies of intervention.

a. one of the panelists suggested an alternative approach:

Instead of CHAI concentrating on particular issues in health and health care, the focus could be more on:

WHO?

- Catholic health professionals, lay people, health care institutions

- who see a role for themselves in health and healing and who need to acquire and maintain a faith based motivation.

WHERE OR FOR WHOM?

- Disadvantaged regions of the country;

Marginalised everywhere;

Unpopular segments of health care involving much suffering and dehumanisation.

HOW?

- Whole person or wholistic approach;

- low cost, effective care approach;

- participatory with people accepting as much responsibility as possible;

- with a conscious foundation or motivation in faith, values or ideology on the part of the care giver.

b. priority areas of work should be based on objectives and philosophy of CHAI as well as on the national health policy. Thrust areas depend on the objectives and philosophy.

c. Let CHAI start work on a few of these strategies. There is a possibility that if all are recommended to CHAI, the religious authorities, who make decisions concerning CHAI will fill it with "specialists!" (generally from one state in India), and make it fit much more than it already is, into the mould of top heavy ecclesiastical bureaucratic structures.

d. A national consultation once in two years involving a wide range of experts, researchers, academicians, project

coordinators etc., is a must. If conducted properly, it will help in identifying important issues and prioritising them. An objective system of documentation and dissemination is also important.

e. CHAI will have to find that part of the health care system, where it can be most effective in coordination with other health care providers - both private and public. Spreading far and wide is best avoided.

f. Work on all 3 levels - local, national, global.

g. Link with CHAI of USA, Canada etc but keep away from policies of pro-life, pro-choice.

h. Keep a balance between institutional and community approaches.

6.5 CONSTITUENCIES/GROUPS FOR FOCUS OF ACTIVITIES

Given below is the rating given by Delphi panelists regarding

constituencies/groups on which CHAI should focus its activities. They are given in descending order of priority.

A. First Order Priority (more than 70%)

6.5.1 Developing/strengthening working links with other national level health associations 4.68%)

viz., with Voluntary Health Association of India, Indian Hospital Association, Christian Medical Association of India, Indian Society for Health Administrators, etc. These are important to achieve Health For All and to help in restructuring of health sectors in both the voluntary and non-voluntary sectors.

It was felt that co-operation is vital. There is a need for being inspired by and also inspiring others.

6.5.2 Interacting with/influencing government in and legislation (81.08%)

in association with the entire Voluntary Sector.

It was felt that its best possibilities are to network with other health action groups to influence policy formulation and to speak on behalf of the poor and voiceless.

A panelist felt that this was particularly important in family planning and abortion.

6.5.3 Better operational links with non-Catholic, secular health organisations (72.97%)

at the national, regional and local levels.

6.5.4 Focus Primarily on its membership (69.36%)

i.e., to support, strengthen and to challenge members. To meet genuine needs as felt by them, though they might be

in conflict with CHAR's most important agendas, but this is the only way that they can have a sense of belonging.

On the other hand, another panelist felt that it should not support those who aim at variances with the basic policies of CHAI.

It was also considered unfortunate that membership now is open only to catholics. Unless membership is open to people of all faiths which are "catholic" (universal) in nature and not fanatic, it was difficult to answer this question regarding constituencies.

B. Second Order Priority (50 - 69%)

6.5.5 Linking with development groups/volags at the grass roots (62.16%)

CHAI itself cannot deal with agencies at the grass roots, its members can.

Its best possibilities are to network with other health action groups to influence policy formulation and to speak on behalf of the poor.

6.5.6 Focus on society at large (57.65%)

mobilize public opinion. While it is important to influence society at large, this may be too broad and difficult a role for CHAI.

It may also be spreading efforts too thinly, However

strategies could be evolved along with other voluntary groups.

6.5.7 Supporting/working with activist groups/people's organisations (54.95%)

in different fields eg., environmentalists, women's movement, dalits, labourers, working children.

6.5.8 Developing functional links with government

One is not sure how lasting this can be with changing functionaries.

C. Third Order Priority (Less than 49%)

6.5.9 On Church membership (41.44%)

the lay congregation, the religious, the structures, the educational system.

It was also felt that the institutional hierarchy must be sensitized to the struggle of members in the area of health.

The focus on church membership should be only in as much as they can work for health care.

6.5.10 On Youth (37.83%)

Focus on youth can be one of the most important inputs. This age group wishes to achieve something, but they also

expect quick

results and want recognition, which older people rarely give. Associations are usually oriented to their own harmony and their own needs.

Youth are going to be the most important segment of the country and therefore we should take a lead not only for them in India, but also in SEARO and SOASE also.

Difficult to see what would be the special focus except for matters like use of alcohol and drugs.

6.5.11 Work at Parish level (28.82%)

This is the smallest unit, composed of families in a geographical locality that worship in a Church.

Perhaps CHAI could be a consultant (very close relationship) with a project to test some new ideas at this level.

CHAI can only work at the parish level if it is accepted by the Church. Someday the relationship between CBCI and CHAI needs to be worked out.

Given its present institutional base, it will be difficult for CHAI to operate at the Parish level.

Working at the parish level will get health care bogged down with ecclesiastical structures. This should be handled

by Diocesan and other agencies.

6.5.12 Playa role in South East Asian countries (21.62%)

This would need be alongside work within the country as well.

It was felt that CHAI has enough challenges and problems before it in India. It should not attempt at this juncture to play a wider role in South East Asia, except perhaps in sharing of information.

Another panelist thought it is good to begin co-operation South East Asian countries. There is much to learn experiences of people in the Republic of China.

It was also felt that if CHAI has something to offer, such relationships could be explored.

Working at the national level, trying to address large and complex health problems and relating to the professional needs of member institutions and health personnel is a difficult and challenging task. There are many expectations. There could be a blurring as to which groups or who CHAI should work with. The above ideas and rating by the panelists would help the decision making process.

There were some additional comments and new ideas

- a. As a national organisation, maintaining linkages with other agencies, government and members is important and

necessary. However it was felt that CHAI should not disperse itself over a large number of ,useful but unrelated issues. It should respect its limitations and not try to do everything and with everyone!

- b. CHAI should facilitate an active network of non governmental organisations committed to health of the people. It should be able to resist undesirable tendencies.
- c. There is a need to build a working linkage with Trained Nurses Association of India (TNAI) as this is the only professional association for nurses in India to keep them united at the national level.
- d. There is also a need for coordination with the following groups / specific interest areas
 - Medical Association - St. Luke's Association
 - Pastoral Care of the Sick;
 - Catholic Nurses Guild of India
 - Family Apostolate;
 - Community Health;
 - Mental Health.

e. It is very important to decide whether CHAI wants to be a truly professional body dedicated to health and social development or whether it just intends to be a spokesman of the Church, limiting its activities. '

f. This was considered to be really a function of resources. Given limited resources, it was suggested giving priority to linkages with the immediate health family and with the government sector and media - to reflect the policy framework.

g. Another panelist felt that CHAI should aim to sensitize and mobilise the whole body of believers (Catholic community) and through the involvement of the whole community, seek to impact on society at large. Focus on institutional activities alone will have highly localised effects, while the whole Indian society is feeling helpless, cynical and therefore uninvolved.

h. Middle aged women, not gainfully employed constitute an important segment which should be utilised, because they have nothing to do and have time and money and wish to be recognised. Their energies can be properly channelised.

i. The mandate to go and heal comes to the church from the Lord himself. Therefore the primary role of the congregation is to be an agent of healing in society, in the world and in creation. CHAI has to aim at renewal of the Church to make it a movement of the Spirit to heal.

6.6 REDEFINING ROLES IN THE PRESENT AND FUTURE CONTEXT

Keeping in mind the predicted broader socio-economic-political-cultural situation in India fifteen years from now

(Delphi first round) and the priority health problems and issues (Delphi second round) the Delphi panelists have suggested that the future roles that CHAI could play are as follows. They have been listed in descending order of priority and can be sub-divided into three broad groups.

A. First Order Priority (More than 70%)

- 6.6.1 Networking role, with like minded groups (83.78%)
- 6.6.2 Coordinating role, with/for members (79.27%)
- 6.6.3 Inspirational role, with/for members (78.37%)
- 6.6.4 Information/Communication role to members/public (78.37%)
- 6.6.5 Catalyst role with members/others (70.27%)
- 6.6.6 Trainers role with/for members (70.27%)

B. Second Order Priority (50-69%)

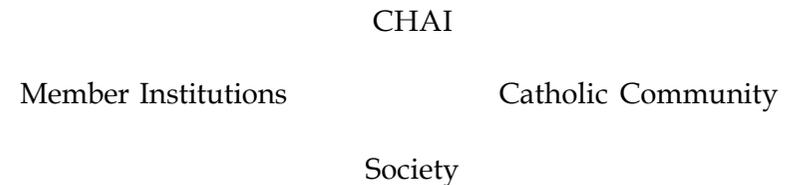
- 6.6.7 Technical support role to members (59.45%)

C. Third Order Priority (less than 49%)

- 6.6.8 Activist role with/supportive of people's organisations (44.14%)
- 6.6.9 Supplementary role to government through members (30.63%)

Additional comments were:

1. CHAI should network with other health movements and peoples movements in the country and act as a catalyst. It should be alert, flexible, open and competent enough to identify gaps left unattended by other bodies and to initiate appropriate action.
2. Contributions of NGOs as a coordinated movement can play a vital role in nation building. Hence CHAI's involvement is necessary and the role should be to create the strength of a movement and solidarity with groups movements become very important.
3. For its own work and the needs of its members all existing means of training and other available health resources should be tapped/used.
4. CHAI needs to be an expression of the catholic communities concern for health and wholeness in the nation. CHAI should facilitate the involvement of the co unity in this and must enable member insitutions to become involved with society in this way



The overwhelming consensus was to focus on the membership and provide a support which would / should include:

- ◆ A discernment, leadership and direction by CHAI
 - ◆ A focus on the country especially the marginalised
 - ◆ A coordinating and training role to make its members make a more meaningful contribution;
 - ◆ Exploration and experimentation with new future strategies;
 - ◆ A development of appropriate technology;
 - ◆ To provide a framework and prioritization of health issues;
 - ◆ Not be involved directly with field activities but to channel new ideas for dissemination to members;
 - ◆ Inspire and be a catalyst to its members.
6. The relationship with Government needs to be reflected upon further. This would include:
- ◆ While initially NGO/Church related health institutions pioneered medical services in response to need, there is a great need to encourage the government who have legitimately the mandate and responsibility for health care to do this, especially since they also have the resources (all NGO resources put together account for 5% of total expenditure on development - 95% is by government). CHAI members must recognise this need and move to new and difficult areas and be willing to move out and change.
 - ◆ Should supplement government in meeting unmet needs.

- ◆ Should avoid repetitive and unproductive work.
 - ◆ While supplementing government, it should not allow the work of its members to become an excuse for health policies not to care about the poor.
7. It should challenge neo-colonial exploitation in the health field. Without this all else will be idle. Ideas and models of imperialists will be imposed and the poor will have no choice.
8. While all these roles are important, it should always be cautious to be within the limits of its field.

6.7 ORGANISATIONAL ASPECTS IMPORTANT FOR EFFECTIVE FUNCTIONING

Delphi panelists have identified several organisational aspects or mechanisms that could be strengthened or introduced by CHAI to enable effective functioning. This is crucial if strategies of intervention in key areas are to have an impact. They are listed below in descending order of priority.

A. First Order Priority (More than 70%)

6.7.1 To define/redefine objectives (94.59%)

with the concurrence of members. It was felt this would be a good start.

6.7.2 Formulate clear strategies to achieve objectives (90.99%)

It was suggested that initially strategies need not be formulated too clearly. They should be developed gradually, leaving space for flexibility and for the introduction of new ideas.

6.7.3 Prioritize, make choices and work consistently and vigorously on them (84.68%)

A comment was that this would be scarcely possible considering the variety of important goals that have come up.

6.7.4 Set up a mechanism for reviewing/monitoring/evaluation the work done and implementation of recommendations (82.08%)

This should concern its own work and not that of members. It should be carried out only if it does not complicate matters.

6.7.5 Increase internal cohesiveness between member institutions (79.27%)

CHAI is too loosely knit, with no clear corporate objectives.

It was felt that this would be necessary to really make an impact at a larger level.

CHAI should gradually move towards cohesiveness, but should avoid steam-rolling. The initiatives of a few should not be lost. The slower moving cannot be pushed too hard.

6.7.6 Decentralise and promote regional units and regional planning (74.77%)

These units can be reference points for members within the area.

A word of caution was that this should be attempted only if really feasible, otherwise bureaucracy would be multiplied.

B. Second Order Priority (50-69%)

6.7.7 Work out a health policy for Catholic health care institutions (63.96%)

(NB: This has been recently prepared by the CBCI Commission for Health Care Apostolate in 1992)

It was also felt that this was too preachy.

6.7.8 Encourage lay membership (54.95%)

It was unclear to a few panelists which people were being referred to by the term lay' viz., non-religious or nonprofessional persons. In this case a lay person is one who is not a religious nun or priest.

It was felt that lay membership would be encouraged if they are interested in the health perspective that CHAI has.

It would be a good idea if they are willing to work in some collaboration with others.

C. Third Order Priority (Less than 49%)

6.7.9 Change of name (29.72%)

viz., drop hospital from it, call it Catholic Wholistic Health Association or something similar.

Comments and ideas were as follows:

Six panelists suggested the name 'Catholic Health Association of India'

It will be good to omit the word 'hospital' in the name of CHAI but not lose the focus on health care.

Catholic Health Care Association of India was suggested as being more comprehensive. It would mean adding only another C in CHAI.

A change of name requires much reflection. What will be the perceptions of the member institutions - now largely hospitals? Will this be perceived as hijacking the organisation and its agenda?

Another felt that hospital should be dropped, but was not sure about wholistic.

Community of Healing and Wholeness' was a possibility.

Another panelist felt that a name change would not help.

If CHAI decides to visualise its role in a wider perspective - on the lines indicated by some panelists - then, it may not be a bad idea to change the name.

But at the same time, it is worth bearing in mind that by retaining the present name, CHAI will not be handicapped in any way in venturing into new areas, to be in tune with the changes occurring in many spheres of the country.

It was also felt that much depends on the policies and objectives. A mere change of name will not help.

A few further general comments are given below :

- a. A corporate objective or goal could be CHAI's mission statement. CHAI cannot do this for every hospital or religious society involved in health. However it may help them if requested.
- b. Forming objectives, policies and identifying priority areas are important at this stage of CHAI.
- c. All these points are more or less necessary and they can occur side by side, that is-they cannot be assigned mutually exclusive priorities.
- d. There is a need for thinking initiatives to be fostered among members so that they do not look at CHAI as some father figure.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 When the Policy Delphi Method was initiated, we ourselves as facilitators were stepping into the unknown. Most of the material on the method that we could find was not related to health. We were also pressed for time as the other components of the CHAI evaluation study that were being carried out simultaneously were even larger and more exhausting. However now that it is behind us, it has been an experience of learning and growth. Some of the panelists too have mentioned this and incidentally this has also been documented as one of the spin-offs of the method, which could even be considered as an additional objective.

The broad scope of what has emerged is valuable and would perhaps be useful not only to CHAI, but to all those with a concern for health and health related issues in India.

7.2 CHAI has already undertaken an important initiative in organising regional and professional group meetings during the Jubilee year to discuss findings of the study and to evolve plans of action for the national and regional levels. Members are thus participating in and contributing to the thinking process regarding the future of CHAI. During this process, they will also be responding to the ideas generated by the Delphi Panelists. A summary of the findings of the first round has been made available to them in the report "Seeking the Signs of the Times". Findings from the second round have been circulated to all members as an additional background paper. During the regional meetings, round two findings are briefly presented and discussed. This is

followed by members prioritizing these issues using a rating scale. At the end of eleven country-wide regional meetings, we would have a fairly representative picture of members' prioritization of these issues. The important ones can then be taken up for action.

Thus the most pressing agenda for CHAI after this elaborate process would be action based on the findings of the process of enquiry initiated by them; This will be necessary at all levels, but particularly by the Centre. Members in the field are health professionals, most often functioning under difficult circumstances. They have developed much experience and skill over time. However, several of them function with understandings developed when they were under training often 10-30 years ago. Several ideas from Delphi represent fresh or new understandings and approaches. These will have to be made available to members in ways that they may be operationalised. They may even be modified and built upon.

This would require a high level of competence and leadership from CHAI at the national level. Appropriate staff selection and staff development policies would need to be pursued.

7.3 While the issues raised in the section on contextualising the work of CHAI may not be entirely new, and perhaps also not absolutely true for some regions, it still could form an important reference point for members to view their work and their membership in an association like CHAI. It is primarily in the backdrop of the national situation

as it impacts on health, that belonging to a national organisation makes sense and also has a purpose. It is apparent from this section that complex and crucial forces help determine the health status of people. Provision of curative medical care by individual CHAI members is important to relieve pain' and suffering and to overcome periods of crises in the lives of people. However, when it is recognised that several of these ill health episodes are repetitive and preventible, then alternative strategies could be adopted. It does not seem unrealistic to expect a national level association, with the strength that CHAI has, to work towards making atleast a contribution to existing movements in the country that are addressing these larger issues. Infact one could go so far as to say that there is no option for CHAI and its members considering the belief system that they express allegiance to. Thus CHAI is called to make much more active, intelligent, strong hearted and strong willed efforts to gear up to face these challenges. These would need to be in alliance with similarly oriented pro-people groups on issues that could make an impact on the health and lives of people, if not immediately, atleast some years ahead.

CHAI could adopt creative ways by which an understanding of contextual issues could be furthered among its members. A situation analysis of the State (and possibly district) level could be undertaken by all regional units in the year following the Jubilee. This would need adequate preparation with the use of participatory methods. Health related data is available from Central and State Government bodies eg., Central Bureau of Health Intelligence, Ministry of Health & Family Welfare and also State Directorates of Health Services. U N I C E F

sponsored studies particularly regarding health of women and children are also available in several states. Similarly there is data available from several voluntary sector and private health and operation research groups. The research unit of CHAI in collaboration with the community health department, the zonal office and the regional units could facilitate this process. Delphi panelists could be invited as resource persons. The purpose of such an exercise could be to gain an understanding of the State level health situation and to identify a few areas on which members as a group could undertake action at the level of their institutions, but more importantly at District and State levels.

7.4 Major health issues and problems - emerging problems, fresh approaches

As mentioned above, utilising available, standard sources of information is an important way of understanding the magnitude of certain health problems at the regional and national panelists that could be termed emerging health problems and issues. These may not find a place in regular medical professional literature and they may not fit easily into earlier classifications. However they are recognised to be important, based on the experiences of a fairly large number of groups working at the grassroots, as being important for the lives and health of people. There are also several special interest groups who have generated a fair amount of data concerning them. Several areas identified here are those in which CHAI is not doing much, eg.,

- a. active measures to nurture members of the health team.
- b. promotion of a sense of community and belonging as being critical to well being and wholeness.
- c. Focus on gender related issues.
- d. Environmental / ecological issues
- e. Population issues, though it is well recognised by all.
- f. AIDS
- g. Disability care
- h. Health Education
- i. Health care financing etc.

CHAI will need to incorporate these and other areas identified into its training and continuing education modules. Though there has been some coverage in Health Action, publications alone may not be able to foster action, though it may be a vital support.

Advocating inclusion of these wider issues, including a situation analysis, into educational programmes run by members who undertake training of health personnel could be attempted.

Similarly, efforts are required regarding advocacy on some of these issues at a national level, along with other interested groups. This type of involvement has already been attempted in the area of lobbying for a rational drug policy, for practice of rational therapeutics, and in community health. While continuing support to this drug action' and to the promotion of a peoples' health movement, similar efforts could be made in other areas. For instance, CHAI is particularly suited to working towards promotion of

womens' health and gender issues, education for health and health awareness and medical ethics and values in health care.

All these areas are inter-related at a philosophical level and some input is already being made in them. However, greater efforts, requiring skill and competencies and more personnel would help CHAI make a more positive contribution in these areas, which are its strengths.

Similarly, there are already initiatives supported by CHAI in the area of holistic health, in the use of herbal medicines and other systems of medicine and in health work with the urban poor. These need to be further studied and strengthened and promoted among members in a planned manner. An initial workshop has also been held regarding promotion of positive mental health. This is a crucial area requiring follow-up.

Perhaps five or more such areas could be identified and taken up for intensive and extensive work during the next 3 years. Use could be made of Consultative Advisory Committees, so that staff can have access to people with experience and expertise in those particular areas. Staff could also attend workshops and short courses to further their own growth in these areas. However involving them in several issues simultaneously will hamper their work at the present stage and also result in fatigue, frustration and burnout.

7.5 While involvement in the promotion of specific areas of health care and health action are important, a major contribution of CHAI to its members and others could be in providing a pro-people perspective of health work and health action. This has been an area that CHAI has developed, particularly during the past 10 years. This should be continued and built upon. The basic premises of health work that have emerged from the Delphi panelists offer certain fresh ideas and formulations. These could be internalised and CHAI's statement of understanding or philosophy articulated. These perspectives of health and health work could form a core part of all the training modules and other activities of CHAI.

7.6 Regarding constituencies and groups on which CHAI should focus on, the Delphi panelists have given a high rating to strengthening working links with national level health associations and to influencing government policy making. The above links that CHAI has already developed with CMAI, VHAI, AIDAN etc., could be further strengthened at the regional level. CMAI members could form an important resource for continuing education for the small health centre members of CHAI in different parts of the country. CMAI also has many training programmes for nurses and allied health professionals. Modalities could be worked out as to how these can be linked to CHAI members, utilised by them etc. Similarly in the area of publications, production of health education materials in different Indian languages, advocacy on health issues, and in training, useful linkages could be built with VHAI. There are several other training, research and special interest groups in the country with whom networking could be pursued more actively by CHAI both

at national and at regional levels.

There is much further scope for CHAI, alongwith others in the voluntary sector, to interact with, to influence and be influenced by the government sector. Except for the period during the seventies, there has been minimal work done in this area. This ofcourse presupposes a certain professional capability to be able to function at this level. Efforts could be made to build this up, which could be acquired by actually getting involved.

Focus on CHAI membership and their needs could also be strengthened, in all its activities. A planned approach could be utilised, with focus on members who are in greatest need. Involving members in networking and CHAI policy formulation at the national and regional levels, could be done more vigorously. This will straightaway result in multiplying of CHAI's hands and capabilities several hundredfold. Through the study, we are convinced that the members have

immense strengths and potentials that have not been tapped adequately by CHAI.

7.7 Another key area that has been raised by the Delphi panelists, is the importance of organisational mechanisms for effective functioning. Functional mechanisms and structures are crucial if action on the large number of important areas of health that need to be addressed, has to be undertaken or else the many suggestions may remain good ideas that cannot be operationalised.

This development of mechanisms and of skills and capabilities and competencies may be time consuming, difficult and even frustrating. However there are perhaps no short cuts. Enough resources in terms of personnel and time would need to be allotted towards this. Keeping in mind that CHAI is a membership association and not an 'institution', utilising democratic methods would be important. Members too should have a sense of responsibility for CHAI and participate actively in and contribute to its growth in policy making and implementation.

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