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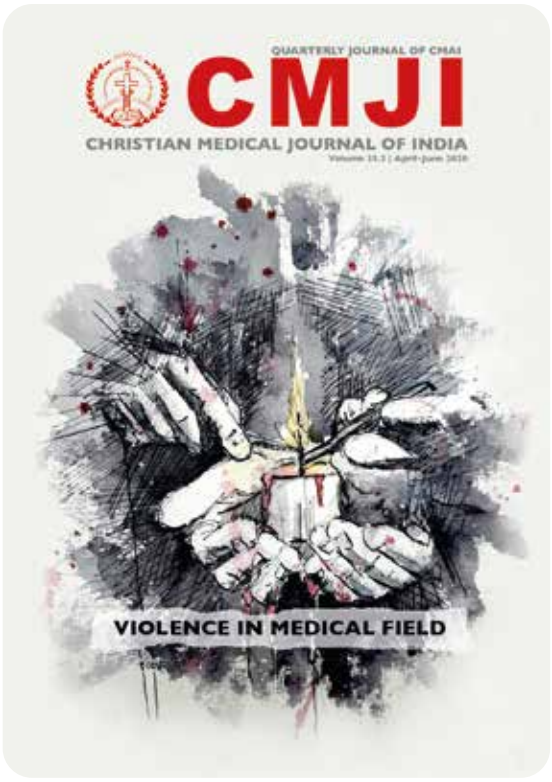

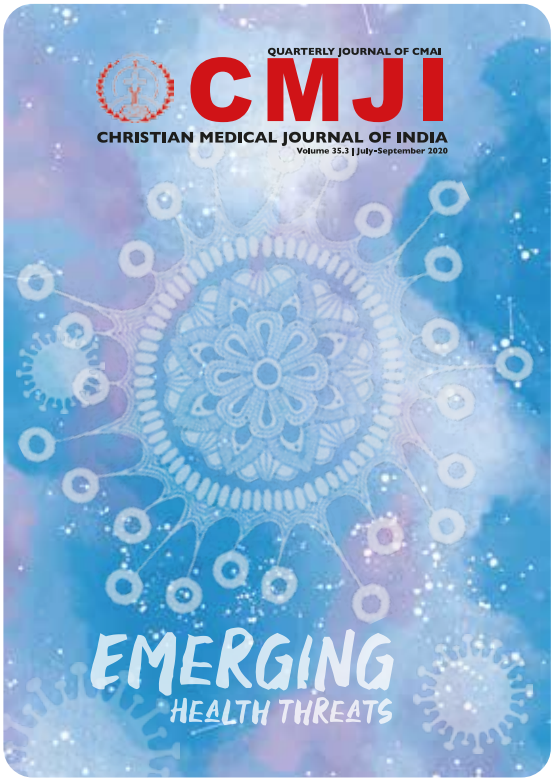

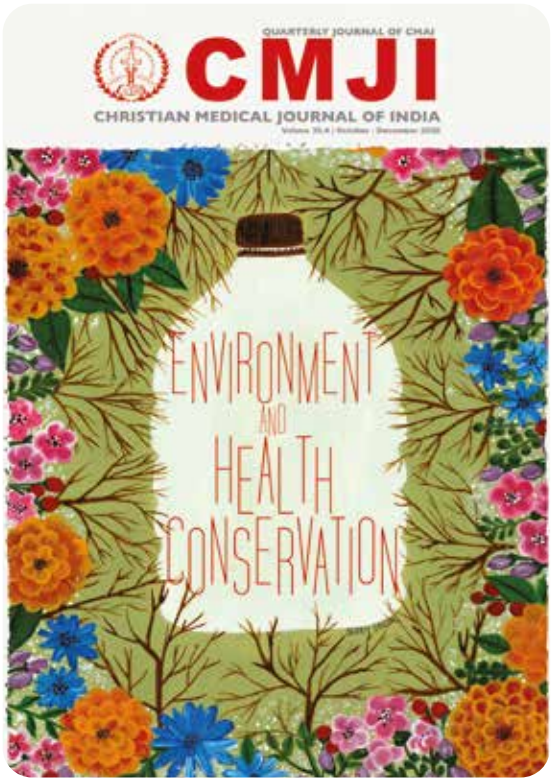

CHRISTIAN MEDICAL JOURNAL OF INDIA

CMJI

A Quarterly Journal of the Christian Medical Association of India

VOLUME 35 NUMBER 1: JANUARY - MARCH 2020

Join Hands with us in the Healing Ministry

CHRISTIAN MEDICAL ASSOCIATION OF INDIA

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Building a just and healthy society

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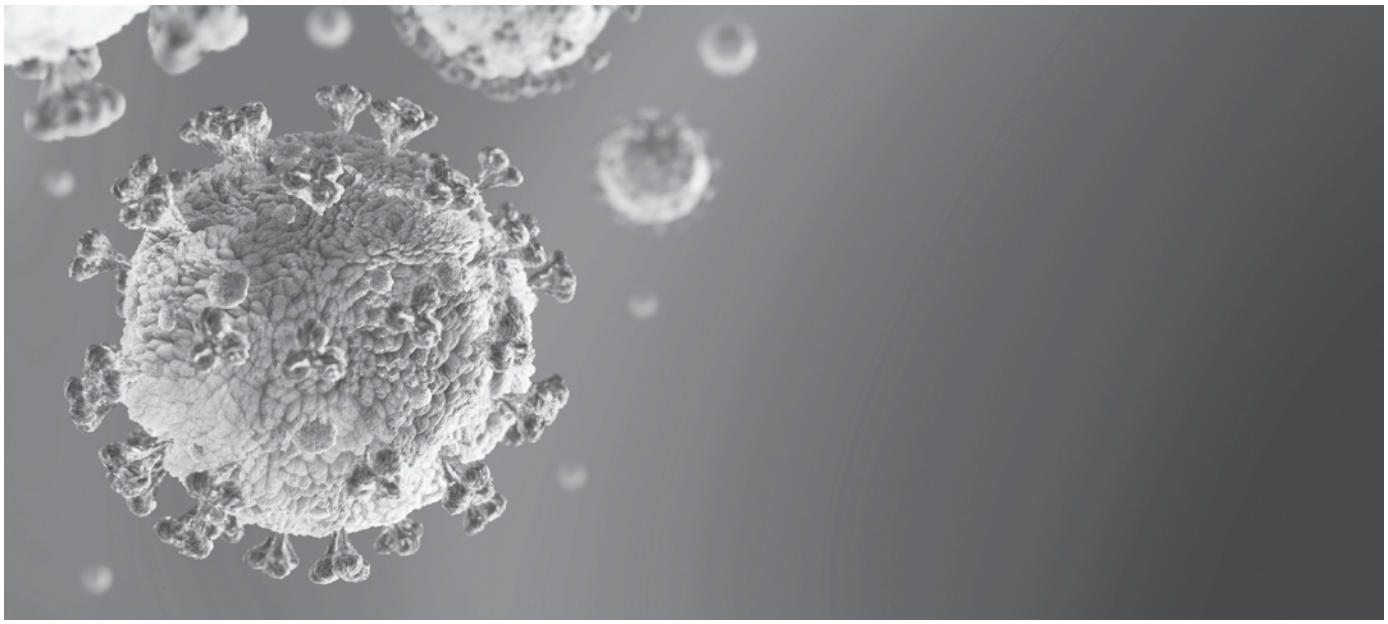

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We invite your views and opinions to make the CMJI interactive and vibrant. As you go through this and each issue of CMJI, we would like to know what comes to your mind. Is it provoking your thoughts? Please share your thoughts with us. This may help someone else in the network and would definitely guide us in the Editorial team. E-mail your responses to: cmai@cmai.org

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CMAI welcomes original articles on any topic relevant to CMAI membership - no plagiarism please.

- Articles must be not more than 1500 words.
- All articles must preferably be submitted in soft copy format. The soft copy can be sent by e-mail; alternatively it can be sent in a CD by post. Authors may please mention the source of all references: for e.g. in case of journals: Binswanger, Hans and Shaidur Khandker (1995), 'The Impact of Formal Finance on the Rural Economy in India', Journal of Development Studies, 32(2), December. pp 234-62 and in case of Books; Rutherford, Stuart (1997): 'Informal Financial Services in Dhaka's Slums' Jeoffrey Wood and Ifftah Sharif (eds), Who Needs Credit? Poverty and Finance in Bangladesh, Dhaka University Press, Dhaka.
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- Every effort is taken to process received articles at the earliest and these may be included in an issue where they are relevant.
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- The decision of the Editor is final and binding.

LETTERS

- Readers of CMJI are encouraged to send comments and suggestions (300-400 words) on published articles for the 'Letters to the Editor' column. All letters should have the writer's full name and postal address.

GENERAL GUIDELINES

- Authors are requested to provide full details for correspondence: postal and e-mail address and daytime phone numbers.
- Authors are requested to send the article in Microsoft Word format. Authors are encouraged to use UK English spellings.
- Contributors are requested to send articles that are complete in every respect, including references, as this facilitates quicker processing.
- All submissions will be acknowledged immediately on receipt with a reference number. Please quote this number when making enquiries.

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EDITORIAL

Eucharistic Approach to Life and Pandemic

Rev. Arul Dhas T.

In many Biblical passages, praising God and giving thanks to God are part of human experience even in the context of threats, dangers and calamities. We can find an example even as we read a very popular Psalm 34 which was written when David was running to escape from his enemy. "I will extol", "praise", "glorify" and "exalt" are some of his expressions in the midst of pain and danger. It is not new to stalwarts of faith in the Bible. Even our Lord Jesus Christ, in the midst of pain and betrayal, gave thanks to the Father (during Eucharist). One might wonder whether this is the pattern we need to face the Covid-19 situation in our land and in the world. Is there anything I can thank God for in the midst of calamities? Is there any reason we should praise Him when there is fear, death and loss of different kind? It looks as if this is the only way we can approach calamity in life: Beauty of approaching life and its struggles with gratefulness, An Eucharistic approach to life and pandemic.

Well, the plan for this CMJI is to focus on the theme of the Healing ministry Week this year: "Let us consider" (Hebrew 10:24). 'Let us consider how we may spur one another on towards love and good deeds'. We wanted to explore from different sections and representations of our network. The articles are coming from different perspectives and professionals highlighting what can be done in a pandemic situation to spur one another. We have two articles which are already published in Christian Journal of Global Health which will be so useful for our members and partners in the mission.

The devotional article by Rev. Paras Tayade talks about three different approaches to suffering drawing inspiration from John 9. Dr. Nitin Joseph emphasizes how Christian healthcare professionals and organizations can be beacons of hope during this crisis to bring forth healing and wholeness. Dr. Anuradha Rose highlights lessons we learn and the ethical dilemma and responsibilities of Christian healthcare professionals at the time of COVID 19.

Dr. Barbara Isely from her musical experience focuses on the way music plays pivotal role in our health and in the society's health. Mrs. Mercy John discusses different ways nurses can play an important role in approaching the Corona crisis. Mr. Sunny Kuruvilla would like to see the employees, patients, partners and local community and church as Missionaries of Pandemic. Dr. Vilas Shende highlights important ways of encouraging one another in a hospital setting. In the last article by Prof. TS Ravi Kumar is inviting the readers to arise and persevere in faith as soldiers of the Lord in the healing ministry. This journal also has a book review of a latest book "Beyond the Bougainvillea" by Dr. Glenn Kharkongor.

It is our prayer that all those who read this journal will be informed, strengthened and inspired to the healing ministry further during this times of pandemic.

With best wishes and prayers

Rev Dr Arul Dhas T
Editor

CHRISTIAN RESPONSE TO SUFFERING

Rev. Paras Tayade

Corrie ten Boom, a holocaust survivor, after her release from the concentration camp, became a world-renowned speaker. She spoke particularly on the theme of forgiveness, this, even though she had lost her father and sisters in one of the concentration camps. It is said that as Corrie travelled and spoke to various audiences around the world, she would often speak with her head down as if reading her notes. In reality, she would be working on needlepoint. At the end of her talk which described her hardships and the atrocities that she and her family had to bear at the hands of the Nazis, she would lift her needlework and reveal the underside of the fabric, which looked like a mess with no design or discernable pattern. And she would say, "That's how we see our lives. Sometimes it makes no sense." Then she would turn the needlepoint over to reveal the finished side and comment "This is how God views your life, and someday we will have the privilege of seeing it from His point of view."

So often, we judge life based on what we know and what we understand forgetting that we do not have the complete picture to fully comprehend what is transpiring around us. So often what we see in our life as tragic may be a part of God's larger plan for His Glory and our maturity.

The Gospel of John chapter 9, records for us a story with a similar theme. It is the story of a man who had been blind from birth. A tragic story of human suffering yet Jesus's response to the man's plight is "…this has happened so that the work of God might be displayed in his life." (Jn. 9:3) This story is a powerful reminder that human suffering is often multi- dimensional. Human beings with finite knowledge, at times, are not able to fully comprehend why we have to endure suffering. The Bible teaches however, to focus, not on the why but the what. What does suffering teach us, what should my response be, to my suffering as well as the suffering of those around me? This becomes pivotal, all the more, for those of us who are involved in the healing ministry. Be it medical professions, allied health professions or chaplains who encounter human suffering as a part of their daily routine. Furthermore, in our contemporary situation, as we grapple with the pandemic of the corona virus, the issue of suffering and our response to it becomes all the more vital.

John 9 not only highlights the wonderful work of God's healing amid human suffering, but it is also a reminder of our responsibility to those around us who are hurting and are in pain. The study of John 9 reveals three categories of responses to human suffering. These three responses stand in stark contrast to each other. It was Ann Lander who poignantly commented "There are only three types of people: those who make things happen, those who watch things happen, and those who say, what happened?" As those involved in healing ministry, John 9 presents to us, both, a word of warning and a word of encouragement. A warning not to be those who only watch and question things; and an encouragement to be doers who would put their faith into action. Let us look at the three responses from John 9.

1. The Shirkers

John 9 begins by telling us that as Jesus and His disciples were walking they saw a man who was blind from birth. On seeing the blind man, the disciples raised a question to Jesus asking "Rabbi, who sinned, this man or his parents that he was born blind?"(vs. 2) I am sure this was not the first blind man that the disciples had encountered in their life. However there may have been something very moving or pathetic about this man that promoted the disciples to raise this theological question. The tragedy is that the disciples only wanted to provoke a theological discussion without really doing anything about his situation. The first category of people that the passage presents to us, are 'The Shirkers', those who would happily pass the buck to someone else rather than take responsibility to make a difference. It is important to note that the disciples by this time had already seen Jesus perform many wonders. He had turned water into wine Jn. 2:1-12, healed the nobleman's son Jn. 4:46-54, healed a lame man Jn. 5:1-17, fed the five thousand Jn. 6:1-13, and had even walked on water Jn.6:16-21. They could have easily turned to Jesus and requested

him to intervene in the situation by healing the blind man. On the contrary they chose to analysis, scrutinize and even criticize the man's situation by saying that it was sin that had brought this suffering upon the man. Even though they had access to the greatest source of power to rectify the issues they chose to debate about it. This is a constant danger for Christian theologians. We chose to talk when we have the power to change. Theologizing has its legitimate place however, it can never compensate for action. True theology must lead to action. The challenge confronting the Church today, particular in the wake of the pandemic and the heart wrenching situation of the migrant workers and daily wagers, is to respond tangibly and not offer mere lip service.

2. The Questioners

The Pharisees are the second category of people that this passage presents to us, as those who questioned anything and everything that did not fit into their neatly worked out schema. The sudden and miraculous healing of the blind man displaced everything the Pharisees knew about God, sin, suffering and adherence to law. One of the key objections that they had against this healing was that it was done on a Sabbath. Their argument was "This man (Jesus) is not from God, for he does not keep the Sabbath." (vs16) They questioned the healing; raising doubts over the fact that the man was even blind in the first place (vs18). When that was established, they began to discredit the One who had healed him, all because this did not fit into their worldview. When the Pharisees encountered the blind man, we see a lot of questions being raised; his healing sparks a lot of debate. The missing element in this whole narrative is the excitement and the joy of celebration over a transformed life? Instead of rejoicing with the blind man, whose entire life had been radically transformed, the Pharisees are desperately trying to rework the facts so that their lopsided theology stays intact. The Pharisees completely misunderstood the purpose of the Sabbath when they used it as an excuse to justify their positions. We need to honestly ask ourselves this question - Are we guilty, at times, of using the scripture to justify our position? Of course we must not accept everything uncritically but neither should we reject everything just because it does not fit into our preconceived notions of how things should be. So often, we, as Christ's followers are known for our harsh judgment rather than our compassion and sensitivity to those who are hurting. The Bible exhorts us to rejoice with those who rejoice and weep with those who weep. (Rom 12:15) The idea is to empathize with the people around us, to connect with them at their level of joy or pain.

3. The Doer

Jesus stands in sharp contrast when compared to the disciples and the Pharisees. When confronted with suffering, He refused to stand at a distance and be a mere spectator. He also refused to be bound by dead traditions. Jesus, on the contrary, was moved by compassion, he exercised his authority to make a difference in the blind man's life. The significant aspect of this miracle is not what Jesus did namely the healing of the blind man but rather how he did it? Jn. 9:6 tells us that "…he (Jesus) spit on the ground made some mud with the saliva and put it on the man's eyes." Now, why did Jesus use this particular method to heal the blind man? The healing miracles in the Gospels clearly demonstrate Jesus' ability to heal the sick without even touching them. In Matthew 8 when the Roman centurion approached with a request for his sick servant, Jesus simply said the word and the servant was healed. However, in this case, Jesus deliberately performs an action to bring this healing to pass. Could it be, that Jesus was knowing and willingly violating the man-made laws and regulations pertaining to Sabbath, to demonstrate that in God's view human worth and dignity is much more significant than a dead adherence to the law? In the act of spitting on the ground and getting his hands dirty Jesus was setting an example for his followers. A reminder that the appropriate response to suffering often involves us getting our hands dirty as we strive to make a difference in the lives of people. There is always a cost to pay, at times someone or the other will be rubbed the wrong way. However, this is a part and parcel of our calling to be the salt and light of the world.

Similar to the blind man, our world is steeped in pain and suffering. Jesus' response reminds us that God does not cause suffering but in His sovereignty, every suffering can have a divine purpose. We often encounter people who lay at the intersection of affliction and God's preordained choice to turn those afflictions into occasions that reflect God's Glory. Healing ministry comprises not only of healing the body and mind but also healing the perspective; to help people recognize that in God's hand our tragedies can be transformed in celebratory moments of God's glory.

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THE COVID-19 PANDEMIC:
DEFINING THE CLINICAL SYNDROME AND DESCRIBING AN EMPIRICAL RESPONSE

Abstract

The novel corona virus infectious disease, COVID-19, is a pandemic now and is raging through several continents, posing a challenge to health-care systems of all the countries and disrupting lives and livelihoods across the world. The facilities for virus testing are available for only limited numbers in each country and each country excludes a large number of potentially infected subjects because the lab test is done for only certain categories. Nearly 80 % of those infected will, therefore, go undiagnosed. There is an urgent need, therefore, to define the clinical syndrome so that practitioners at the primary and secondary levels can make a confident, clinical diagnosis and proceed to manage patients early and effectively. Chloroquine and hydroxychloroquine, both antimalarials, have shown promise in limited trials in France and China. They are inexpensive, have been around for several decades in the prevention and treatment of malaria, have well-known side-effects and, in the short-term, safe for use. We propose that practitioners make a preliminary clinical diagnosis of the COVID-19 syndrome based on simple clinical criteria and lab tests and proceed to manage patients and protect other family members and contacts by using isolation measures and short regimens of these anti-malarial and other medications, anticipating results of more clinical trials.

Key Words: COVID-19, clinical syndrome, empirical therapy, hydroxychloroquine.

Introduction

The COVID-19 pandemic sweeping across the world is continuing to take a heavy toll in terms of human lives and is threatening the global economy. It is currently spreading rapidly across several continents, and the peak is yet to come. The variable sensitivity of the polymerase chain reaction (PCR) based tests employed, different criteria for testing in different countries, limited availability of the testing facilities, and the high cost of testing will result in under diagnosis.[1] Therefore, alternative approaches that do not rely on testing everyone with fever and cough with PCR are necessary in low- and middle-income countries.

Diagnosis

In clinical medicine, a syndrome may be diagnosed using specific clinical and commonly available laboratory criteria, especially when the situation is a medical emergency and treatment is urgent. To cite a common example, empirical use of antibiotics, pending culture reports, is standard practice in treating sepsis syndrome, and completion of a course of antibiotics is indicated if there is a clinical response, even if the cultures eventually turn out to be negative.[2]

In the face of a pandemic, the possibility of contact with infected patients (typical epidemiologic setting) is a very important element for defining the clinical syndrome. When a disease has a high, attack rate, a clinical diagnosis may provide a more sensitive approach than a lab test. Further, in the context of resource poor countries, only select patients are tested by PCR. Therefore, relying only on laboratory tests for a diagnosis of COVID-19 will grossly underestimate the true disease prevalence and incidence.

In view of this, it is reasonable to assume that every individual that meets the clinical case definition inclusion criteria is presumptively positive for COVID-19 and to treat as such. This will provide a more sensitive approach and ensure that most of those who actually have the disease are detected and treated. Such an approach will be in the best interests of both individual patients and the community as a whole. In the public health systems

of countries like India, where access to lab tests is more difficult than access to an outpatient consultation, this approach would be easier to implement.

While the WHO case definition[3] is simple to use, it does not give adequate importance to fever which is the most common symptom[4] and ignores smell and taste disturbances that appear to be unique to this viral illness.[5] In the COVID-19 clinical syndrome, fever is observed in > 95 % of individuals and selecting this symptom as a criterion will ensure that the clinical definition will have good sensitivity. Sudden, otherwise unexplained loss of smell and taste[5] occurs in about 34% of COVID-19 patients and including this unique symptom will confer greater specificity for the clinical diagnosis. In the light of these arguments, we recommend that the clinical syndrome be defined using criteria as listed below:

Mandatory criterion:

Fever of three or more days duration without other obvious localizing symptoms such as dysuria, skin, or soft tissue infections

Major criteria:

1. Dry cough
2. Sudden recent onset loss of smell and or taste sensation (anosmia due to nasal block and sinusitis to be excluded)
3. Physical findings of crepitations on chest auscultation
4. Chest X Ray showing peripheral patchy infiltrate (not lobar pneumonia or cavitating lesion)
5. Respiratory rate > 25/minute

Minor criteria:

1. Diarrhoea
2. Severe headache, body aches (myalgia)
3. Fatigue and lassitude
4. Normal or low normal total WBC count and lymphopenia (Lymphocytes < 20 % on differential count)

Epidemiologic setting:

(When there is community spread this criterion may not be useful):

1. Travel within the past four weeks to or from any other country or a big crowded city in the country.
2. Visit within the last four weeks to a crowded place such a bus stand, railway station, movie theatre, airport, place of worship, etc., without a mask and or without maintaining a physical distance of two meters
3. Contact with a case of COVID-19 at home or at work-place.

The clinical syndrome can be presumed if, in the presence of the mandatory criterion (fever), the following criteria are met:

1. Presence of one epidemiologic setting along with two major criteria or one major criterion and two minor criteria
2. Even in the *absence of the epidemiologic setting,* the presence of three major criteria and two minor criteria or two major criteria and three minor criteria

Where available, a positive PCR lab test, in combination with the clinical syndrome criteria, offers confirmation of diagnosis while a negative PCR test does not necessarily negate the diagnosis due to less than optimal test sensitivity. In fact, PCR and CT thorax combined have higher sensitivity than either test alone for diagnosing serious COVID-19 infection.[6]

Therefore, in resource poor settings, we can consider two groups of subjects:

a) those having the COVID-19 clinical syndrome (large numbers)

b) cases confirmed by PCR testing (smaller numbers)

For those with the clinical syndrome, if feasible, nasopharyngeal swabs, or even throat swabs can be sent to a regional laboratory for confirmation. In endemic malarial zones, malaria should be excluded by a rapid test and peripheral smear.

Isolation and Prevention of Spread

Pending results, clinical management should be initiated as set out below:

Isolate affected subjects at home for a period of 21 days (three weeks). Get a younger member of the family aged less than 45 to be the primary care-giver. A detailed isolation procedure at home, as spelt out below, has to be strictly followed to prevent within family spread. Other family members, in particular, the elderly, those with diabetes, and cardiac disease should also home quarantine for four weeks (to allow for incubation period and duration of viral shedding) to prevent serious disease in them. Younger family members can go out to get essential requirements but wear a mask when they do so and maintain a physical distance of two meters from others to prevent community spread. (See Appendix A for our example of home isolation procedure).

Any member of any family that develops a fever, cough, and cold should not panic and go to hospital unless there is significant breathing difficulty. Other respiratory viruses such as influenza (5-20 % of the population each year)[7] and the common cold are highly prevalent

and must be considered in the differential diagnosis. The hospital may be crowded with other sick patients who may have COVID-19. It is essential that every household has simple medications such as paracetamol for fever and an antihistamine such as pheniramine or cetirizine which may minimize sneezing and limit nasal discharge. These supplies are better issued to individual households by the local civil administration and or by local non-governmental agencies with instructions for use, so that crowding at hospitals and medical shops is avoided. The mobile phone number of an individual in the family can be made available to the proximate primary or secondary level hospital so that the lab test reports, when they arrive, can be communicated. A designated mobile number at the health care facility can be provided to the family. The family can contact this number in the event of any worsening or questions. The follow up information can be recorded on spread-sheet.

With the crowded living conditions in most middle- and low-income households, these quarantine measures will prove to be major challenges; isolation may not be possible in poor households living in one or two rooms. The local administration needs to face this reality and design isolation facilities near home, such as a school building, if possible. The Government and non-governmental organisations (NGOs) should ensure essential supplies to these quarantined families so that they can effectively practice what is recommended.

Treatment

The antimalarial drugs, chloroquine and hydroxychloroquine (HCQ), have shown some efficacy in *in-vitro* experiments. Limited observational studies using HCQ in infected subjects in France and China have been shown to reduce virus load and also hasten virus clearance from two weeks to six days.[8,9] The proposed mechanisms of action of these drugs[9], such as interference with adhesion of virus to cell surface receptor, inhibition of viral replication by increasing the pH in the endo-lysosomes, and an anti-inflammatory action (to reduce cytokine production and immunologically mediated inflammation), imply that the drugs may be of use early in the course of infection as well as in the delayed cytokine storm. [10]

However, in the absence of controlled clinical trials in severe cases of COVID-19 pneumonia, some suggest that these drugs should only be used in randomized controlled clinical trials.[11] Major clinical trials have just started, and the results will probably be available only after about 12 weeks by which time the pandemic may be waning.[12]

Physicians working in endemic malarial zones have good experience with these drugs. However, in non-endemic zones, HCQ is commonly used for rheumatological disorders and for malaria prophylaxis in travellers. In New York and other hot spots for COVID-19, physicians have started using these drugs on an empirical basis for treating severe COVID-19 pneumonia. In countries such as India, adequate supplies of chloroquine and HCQ are available, and the Government and NGOs can cope with the demands for these drugs during this pandemic without compromising supplies of the drug for patients with rheumatological disorders who need the drug.

In rural settings, for reasons mentioned earlier, physicians may need to resort to syndromic diagnosis and institute empirical management protocols for sick patients, and if there is good clinical improvement, complete the course of HCQ. Perhaps based on the safety profile of once weekly doses of the drug in malaria prophylaxis, the relatively short duration of time for which chemoprophylaxis may be required, the suggested dosage schedules, which are similar to doses used for malaria (treatment and prophylaxis), and the potential for reduction of infectivity, the Indian Council of Medical Research (ICMR) has recommended prophylaxis with HCQ for frontline health care workers and household contacts of SARS-CoV-2 positive subjects.[13]

When a physician chooses to use HCQ for either empirical treatment for COVID-19 or chemo-prophylaxis as per Government guidelines, due precautions are mandatory for the elderly, those with diabetes and cardiac disease, in whom dosing has to be modified to avert potential side effects of the drug. An outline of suggested empirical treatment, chemoprophylaxis, monitoring, and precautions is detailed below:

Empirical HCQ Treatment

(Effective dose for treatment derived from pharmacokinetics-based computer assisted modelling)[14]

Hydroxychloroquine 200 mg, 2 tablets, Q12h (total 800 mg) on day 1 followed by 200 mg, 1 tablet, Q12h (total 400 mg per day) for 4 more days.

a. Youngsters without any risk factors: Monitor progress of clinical illness daily (over mobile phone). Maintain a database on a spread-sheet, and avoid HCQ in mild to moderately severe disease.

b. Avoid HCQ in those with chronic renal or liver disease.

c. In subjects with diabetes mellitus:

- While on HCQ, treatment, reduce dose of anti-diabetic

drugs by 25 -30% in order to avert hypoglycaemia.

- Institute home monitoring or field monitoring of blood sugars by glucometer during HCQ treatment. Further dose adjustment of anti-diabetic drugs can be based on plasma glucose values
- Once the treatment course is finished, over the next 3-7 days get back to the previous stable dose of oral anti-diabetic drugs and or insulin

d. Those with cardiac disease on medication:

Look at the drug list, check for potential drug interactions, and make a considered decision in consultation with the attending cardiologist. Baseline ECG (focus on corrected QT interval) and ECG on alternate days until course is over would be useful; however, this may necessitate hospital admission. Monitor serum electrolytes and magnesium and correct hypokalaemia and hypomagnesemia when detected.

Zinc Supplementation

In vitro studies have shown that intracellular zinc, when present in sufficient concentration, inhibits viral replication and chloroquine acts as an ionophore, facilitating transport of zinc from extracellular to intracellular compartment. Therefore, elemental zinc of 50 mg per day, orally, once daily can be co-prescribed with HCQ.[15,16]

Use of Antibiotics

In order to treat secondary bacterial infection which occurs in about 50 % of COVID- 19 cases, Azithromycin 500 mg, once daily, for 5 days or Amoxicillin/potassium-clavulanate 625/125mg Q12 hourly, for 5 days (common antibiotics used for treating community acquired pneumonia) may be added at the discretion of the treating physician based on a persistent fever > 38 degree Celsius and productive cough persisting beyond 5 days.

Convalescent plasma for severely ill COVID-19 patients

Encouraging observational reports in small numbers of patients have aroused wide-spread interest in the use of convalescent plasma for severely ill COVID-19 patients on ventilators.[17] Randomized controlled clinical trials have commenced with this treatment approach. In general, in viral illnesses antibody response is much brisker in those who have a clinical illness than in those with asymptomatic or subclinical illness.[18] Patients with clinically diagnosed COVID-19 syndrome may be the ones with the highest titres of antibodies. Utilising the syndromic approach may help identify potential plasma donors in resource poor settings. Since those with the clinical syndrome will be the larger number than those with PCR-proven SARS-CoV-2 infection, a physician can select willing individuals who have recovered from the clinical syndrome for checking on antibody titres prior to plasmapheresis and, thus, reduce costs.

Preventive Treatment

House-hold contacts of the subject with clinical diagnosis of COVID 19 syndrome (During the lock down period in India, household members will predominate), those working or interacting closely with the index case in the workplace (such as grocery store, post office, bank, etc.) and those in migrant groups amongst whom one individual has been presumptively diagnosed to have COVID-19 clinical syndrome or confirmed to have COVID-19 by PCR will be the contacts.

Regimen for household and other contacts (as per ICMR advisory[13]):

HCQ 200 mg, 2 tabs, twice daily (800 mg per day) for day 1 followed by 200 mg, 2 tabs, once a week (400 mg per week) for the next several weeks

Preventive treatment for contacts starts as soon as the clinical case is diagnosed. If not, it can be started any time up to day 14 of presumptive diagnosis in the index patient. Long-term side effects, like retinopathy, are dose and duration dependent and are unlikely during these short-term treatment protocols.

Conclusion

Protocols by the Kerala, Tamil Nadu, Maharashtra State Governments, and the guidelines from the All India Institute of Medical Sciences, New Delhi, adequately cover management of confirmed cases. We highlight the need to address the clinical COVID-19 syndrome, where PCR testing may not be performed because of the restrictive selection criteria for PCR testing or lack of availability. For such a syndromic approach to be effective would require a quick nation-wide implementation during the shelter or lock-down period.

Governments and NGOs in other middle- and low-income countries involved in responding to the health care challenge posed by COVID-19 should consider implementing the syndromic approach. They should mobilize material and human resources and medication to do this quickly through their networks of healthcare professionals.

We note the use of HCQ has not yet been established in clinical trials and in the results of the multinational and multi-centric clinical trial “Solidarity”[12] will probably not be available until after the pandemic. We should be closely monitoring the latest evidence for HCQ, but in the

absence of data from controlled clinical trials and given the expected burden of mortality from Covid 19, the treatment of the clinical syndrome and use of chemoprophylaxis for contacts of the presumed COVID-19 syndrome (rather than only confirmed cases and their contacts) seems important in countries and settings with resource constraints.

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Appendix A: Home Isolation Procedure (from Thirumalai Mission Hospital)

The clinically diagnosed COVID-19 patient should wear a mask, wear full sleeves, and cough or sneeze only into a disposable tissue or into the crook of the elbow and not into the hand. He should be in a well-ventilated single room preferably with an attached bathroom, not shared with others. Where there is a need to share a bathroom, the surfaces that the patient has touched should be cleaned with dilute bleach or soap and water and mopped dry after use by the affected person. The patient's toilet kit (tooth-brush, shaving kit, etc.) should be kept separate and other house-hold members avoid coming in contact with these items of personal use. The patient's clothes should be washed thoroughly with soap and water daily, dried, and kept separate for him/her to re-use. Bed linen should be similarly washed and dried at least once in 3 days and kept separate. If the patient is using a mobile phone, it should not be shared with others and the surface wiped clean carefully with tissue moistened with hand sanitizer 3-4 times per day. Other family members also use a mask all the time at home and maintain a physical distance of two meters from the patient, avoiding physical contact such as shaking hands, patting on the back, hugging, etc. The household members should avoid visiting others and not allow visitors until the quarantine period is over. Communication with others outside the family should be by phone or messages (SMS). If there are people above age 65 in the household, ensure that they follow all the precautions that have been advised for the affected patient. Only younger unaffected members of the family (Age <45) should go out for buying provisions, wearing a mask when going out to shops, maintaining the critical physical distance of two meters from other people on the road and in the shop, and avoiding standing in groups to talk. Children in the house can play indoor games with other family members, read, paint, and listen to or play music for pastime. Children should also wear masks and maintain a physical distance of 2 meters from the affected individual. Every member of the household should practice frequent and thorough hand washing with soap and water after they come in contact with door knobs, lift buttons, and other potentially contaminated surfaces. If there is a care-taker for the elderly, it is the responsibility of the residents of the house to instruct the care-taker to wear a mask all the time, to use a pair of gloves while working, to sanitize gloves at the end of the work, to practice thorough hand washing with soap and water after they have finished their work and before they help elders, to avoid unnecessarily hanging around in common areas, and to abstain from work for 3 weeks if the care taker or his or her family member has a febrile illness. It is important that care-takers are paid their wages when they or their family members fall sick.

HOSPITAL READINESS FOR COVID-19:
THE SCENARIO FROM INDIA WITH SUGGESTIONS FOR THE WORLD

Abstract

Lessons learned from Italy regarding hospitals and health care facilities as important sources of disease spread for COVID-19, and ways to mitigate this in India and other countries.

Key Words: COVID-19, hospitals, mitigation, low income countries.

We have learned that recently, in two hospitals in India, emergency surgical procedures were performed on patients and healthcare personnel got infected with SARS-CoV-2. These surgical patients developed COVID-19 pneumonia in the postoperative period, and succumbed. In these hospitals, a large number of health care professionals got infected. This had led to a lock down and containment situation of these hospitals. These incidents have provided many important lessons for the medical profession, other healthcare workers, administrators, and health ministries.

If asymptomatic individuals during the incubation period develop COVID-19 in the postoperative period, there are only 2 possibilities: 1. Their infection was nosocomial; or 2. They were already infected on presentation. In either situation community level spread is occurring. In option one it would represent silent infection in medical staff or other admitted patients.

The Experience in Italy

Italian doctors, after their heart-rending experiences with COVID-19, made a plea in NEJM Catalyst; their article carries the following messages for the rest of the world in the approach to COVID-19 pandemic1:

1. The virus is exploiting centralized health care systems of the current era in a large number of countries.
2. Once you keep admitting very sick patients with high viral load, the hospital becomes a reservoir of the virus. Health care personnel acquire infection and unwittingly become vectors, who spread the infection to their patients and this leads on to further community spread. So, hospitals become hot-beds of SARS-CoV-2 infection.
3. A good number of health care professionals contract and some succumb to the infection they contracted in the hospital.
4. Physicians generally are skilled in treating individual patients and often make decisions in the interest of the patient as a whole rather than one symptom or abnormality. For example, in a difficult to control diabetic the physician may accept suboptimal control of blood sugars in order to avoid hypoglycaemia which can be life threatening. Similarly, in a pandemic, the way the medical profession should respond is to do their level best to consider the population as a whole and keep the population healthy. They need to think differently in order to achieve this. This approach is likely to reduce overall spread of COVID-19 and reduce overall mortality.
5. If you do not follow this approach, the human toll becomes huge as in Italy, Spain, and the US.
6. They recommend home based care as far as possible (mild and moderate COVID 19 cases, including those who have early COVID-19 pneumonia who need oxygen with home oxygen if needed, under the care and supervision of the family physician. This will minimize potential for contamination of hospitals.
7. There is a place for a fully isolated, well-equipped COVID-19 centres with all tertiary facilities manned by a committed team to take care of those who need positive pressure ventilation.

An Approach to Hospital-based Mitigation

There is an old saying originating from the Bible (Luke 4:23) “Physician, heal thyself!” In the current COVID-19 context, this can be rephrased as “Healthcare worker, protect thyself.” If healthcare professionals are depleted because of COVID-19 or if the health-care force is demoralised because of personal risk and fear, the situation can become extremely difficult to handle.

How can we handle a catastrophe of this magnitude? How would a humane, caring person in the interest of community justice approach this problem?

1. Ensure alternative avenues of management for chronic non-communicable diseases (NCDs) and restrict regular out-patient department (OPDs). Patients with NCDs are vulnerable people who should not be coming to hospitals potentially contaminated with the virus — for their own safety – but need ongoing management to prevent other causes of morbidity and mortality. Reduce crowding in the hospital, and limit avoidable workload of an already stressed group of healthcare staff.
2. Mobile telephone/telemedicine-based counselling for patients with chronic illness through their usual caregiver with the understanding that if there is a medical emergency, they will have to access a safe hospital not frequented by COVID-19 patients.
3. Home delivery of medications to avoid elderly coming out of their homes. They should be cocooned (reverse quarantined). When necessary, physicians wearing personal protective equipment should undertake home visits — instead of patients coming to hospitals when their illness is of low/moderate severity and not life-threatening. For example, utilizing mobile services, community acquired infections can be managed at home without a hospital visit.
4. Multiple hot-lines should be manned round the clock by appropriate health personnel to provide medical advice and counselling. Tertiary level and medical college hospitals must serve as resource centres for practitioners in order to guide them in caring for complex problems, for example, complicated diabetes, hypertension, community acquired infections, etc.
5. Where there is a functioning and reliable system, samples for lab tests should be collected at home, in a dedicated community level blood collection facility, or in a well-equipped mobile van for remote villages. Samples are then transported to the lab and the results of tests communicated to concerned practitioners.
6. Use a syndromic approach to diagnose COVID-19.2 Then treat such patients and prevent spread to their family members using appropriate home isolation and other prophylactic measures.
7. PCR or Rapid tests used only for confirming diagnosis when it will affect care, or for well-designed and ethical studies, so that resources saved can be put to better use.
8. Dedicated ambulance services with adequately protected personnel to carry sick infected subjects to a dedicated COVID centre.
9. Have separate emergency facility for patients with acute respiratory problems. A dedicated team with appropriate personal protective equipment should see these patients. Those needing admission for respiratory failure should be admitted to a separate ICU facility for COVID-19.
10. Major hospitals in either private or public sector can be designated to take on the management of the town and surrounding villages and to set up a model system of referral and management in the surrounding areas.
11. Importantly, continue to manage emergencies in non-COVID patients, who need hospital-based care in a separate facility manned by a different set of healthcare personnel. In other settings people are dying from late presentation after being encouraged to stay away from medical facilities.
12. Every patient coming to hospital for any emergency should be considered to be potentially infected with SARS-CoV- 2 and all the staff strive to take suitable precautions (respiratory as for COVID-19 and universal as for HIV).
13. Where safe, non-urgent surgical procedures should be postponed Each patient going for surgery to have a screening PCR on a nasopharyngeal swab and Ig M antibody (as soon as it is available widely) and lab report to be seen before taking up for surgery, similar to the present system in place for hepatitis B, C, and HIV. As even this will miss out a proportion (~10 %) of SARS-CoV-2 infected patients3, respiratory precautions as for COVID 19 and universal precautions as for HIV infected patients will be mandatory for every surgical patient and procedure.

Conclusion and Future Hope

The pandemic will eventually wane when around 50-60% of the population have been infected and developed immunity.4 This may take a few more months. During these crucial months ahead, medical professionals

should ensure that they safe-guard their health and at the same time put in their best efforts to tend to the sick and suffering.

We make these suggestions based on our significant clinical experience and understanding of the evidence so as to inform the approach of hospitals in India to this pandemic. We also feel that the above suggestions could be applicable to other middle- and low-income countries which are trying to cope with this pandemic.

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QUO VADIS, TERRA?

Dr.Nitin T. Joseph

Who would have ever imagined when we sang our favourite Christmas carols last year that we would not be able to meet for a corporate church celebration of the glorious Day of our Lord's Resurrection? When we exchanged our New Year greetings of good health and prosperity with our friends and relatives would we have believed if someone were to say that these wishes would be vanity? Worship that was restricted to the confines of a church building is now not possible at all. Innovations in worship services are now common place. Online worship services are erroneously called "virtual" by some and I don't agree that is a good description. When people have gathered together in one spirit and one purpose to worship the living Lord can only physical separation justify it to be called unreal or virtual? These and so many other questions come to our minds during these times of uncertainty. We have realised that very few things actually are urgent and we may actually have to redefine "emergencies". Acronyms like ASAP and STAT that are so part of our medical jargon seem redundant. As someone correctly put it that "the world is closed for repairs", as if rebooting to factory settings!

We have realised that very few things actually are urgent and we may actually have to redefine "emergencies".

The pandemic of Covid-19 and the subsequent lock down has resulted in manifold inconveniences. While most of us must be in the security of our homes with a fairly reasonable stock of our necessities, the plight of daily wage workers, migrant labourers and those in the unorganised sectors is phenomenal. Being separated from one's families for extended periods and more so in such a time of crisis and uncertainty and with no guarantee of their wages and livelihood in the days ahead the lives of several thousand brethren looks very bleak. The world leader and the country with perhaps the best health care in the world USA, is unable to come to terms with this virus and at the time of writing this article, the cases of Covid-19 are climbing towards the 9,00,000 mark with nearly 46,000 people dead already. In our country the numbers are increasing at an alarming rate and people are talking of the "avalanche ahead" after the lock down is lifted. One can only speculate the consequences of this period of industrial inactivity. Our economic growth which was already limping in the last 3-4 quarters before the pandemic is projected to further nosedive in this fiscal year.

I don't think anyone has experienced such times in the past. Even during the World Wars, the pandemic of Spanish Influenza, the Great Depression and recently the pandemics of SARA and H1N1 the mortality and fear were not so intense. The enemy was known and there were weapons and ammunition available to combat the enemy. However, today we are faced with an enemy that is visible only with ultra-magnification and we yet have no vaccines or drugs against it. Most people are of the view that people will suffer either from the result of the economic depression or mental depression due the virus itself. The idea of trying to develop "herd immunity", especially among those under 50 years of age who have the capacity to fight the virus fairly effectively, by gradually opening up those areas that are not designated as "hot spots" and continuing with social distancing, prohibiting social gatherings and maintaining safety of the elderly and those with co-morbid conditions sounds logical and encouraging, but is it practical in a country like India with all its challenges?

As health professionals we have been traditionally taught the "cause and effect" of illnesses. We are aware of microorganisms that spread tuberculosis, leprosy, malaria, polio, cholera, typhoid etc and we can advise people of how we can stay away from these infections and also tackle infected cases. We can also educate people the causes and prevention of non-communicable diseases like diabetes mellitus, hypertension, heart disease and also mental illness. Even the dreaded HIV can be prevented by education against sexual promiscuity, drug abuse and safe blood transfusions.

But the Corona virus has added an entirely different dimension. It has not even spared monarchs, heads of governments, politicians, film stars and the affluent class of society. While the debate of whether the origin of the virus was in the Wuhan Institute of Virology or the Huanan Seafood wet market will continue, we must be ready for the long haul.

There are also many theorists who send/forward their opinions of whether this pandemic is the doing of the Devil or the act of God. Suddenly there is a lot of interest in those portions of the Bible that are otherwise conveniently ignored by preachers. Is this the beginning of the 7 seals mentioned in John's Revelation? Is this the Tribulation? Are we close to the Rapture? All the opinions seem very convincing and that leads to a lot of doubt, debate and division. I am sure you will agree that Psalm 91 has become the "Psalm of the Season"! While the religious philosophers and enlightened theologians can continue to debate, we as Christian healthcare professionals need to look for ways and means to address the effects of this pandemic, to alleviate the suffering and to be soldiers at the forefront. We read of so many cases all over our country of violence against doctors and nurses who are involved in the management of this disease. This is just obnoxious and inexplainable. Reports of doctors who are turned out of their rented homes and even not awarded a decent burial are shattering to say the least. We certainly don't expect claps, clanging of plates or even the status as martyrs.

We as healthcare workers must support our government agencies to address this issue. I am happy that the Christian Medical Association of India is dialoguing with the government leaders at the very top to formulate policy and protocols. The hospitals and personnel in our network can be excellent places for quarantine of mild cases and as Covid-19 care hospitals. There are several encouraging reports of how our mission hospitals are responding to the crisis. Many are providing meals and dry rations to those in need. Masks are prepared and distributed to people. One hospital is also preparing Personal Protection equipment in-house and using them while treating patients. CMAI is helping coordinate the purchase and distribution of PPE kits etc. Counselling services to those who are affected by the disease and its effects is also a need of the hour.

Christian healthcare professionals and organisations must be beacons of hope to provide holistic health in this supposedly hopeless situation. The WHO definition of health that we studied, "the state of complete physical, mental, social well-being and not merely the absence of disease or infirmity", suddenly seems so true in this time of physical and mental sickness with social-distancing added to it! As we live through these times of uncertainty I am reminded of a hymn by Frances "Fanny" Jane Crosby who became blind in her infancy and then went on to live to the ripe age of 95. She wrote nearly 8500 hymns in her lifetime and this hymn is perhaps one of her less popular ones:

Rescue the perishing, care for the dying, snatch them from pity from sin and the grave;

Weep o'er the erring one, lift up the fallen, tell them of Jesus the mightysave.

Though they are slighting Him, still He is waiting, waiting the penitent child to receive;

Plead with them earnestly, plead with them gently, He will forgive if they only believe.

Down in the human heart, crushed by the tempter, feelings lie buried that grace can restore;

Touched by a loving heart, wakened by kindness, chords that are broken will vibrate once more.

Rescue the perishing, duty demands it, strength for thy labour the Lord will provide;

Back to the narrow way, patiently win them, tell the poor wanderer a Saviour has died.

In the midst of this gloom and despair let us look upon this situation to live out our faith. Put our faith in action, not just hearers but doers of our faith. The Jesus model was of reaching out to the poor, the needy, the marginalised, the ostracised, the have-nots of society. Let us reach out to our neighbourhood who are beyond the walls of our churches and institutions with much needed help, support and hope. After all,"our hope is built on nothing else than Jesus' blood and righteousness".

"Then the King will say, 'I'm telling the solemn truth:Whenever you did one of these things to someone overlooked or ignored, that was Me- you did it to Me'" (Matt.25:40, The Message)

The hospitals and personnel in our network can be excellent places for quarantine of mild cases.

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LESSONS FROM SURREAL TIMES.....

Dr. Anuradha Rose

It has been a surreal time for the world. Across continents cultures and beliefs, the world is for once united, facing a common threat. Every day the news is filled with stories of new numbers of people infected with the n-COVID 19 virus, deaths of fathers, mothers, uncles , aunts grandparents and sometimes children reduced to mere numbers. Many have become numb to the countless stories of human tragedy and suffering experienced by mainly the poorer sections of all countries. Through this emerge stories exhibiting the best and the worst of human behavior.

In the medical profession, all we have strived for in the field of ethical care of patients has broken down in the current pandemic. Much of this is due to the methods used in implementing the Epidemic Act which is in force and the directives issued periodically by the Government, with the intention to prevent being overwhelmed by the pandemic.

There has been a complete loss of autonomy, shared decision making and confidentiality in the doctor patient interaction. Many hospitals practicing ethical medicine have always tried to include patients and their families in deciding the best options for treatment and prognosis. Gone were the days when paternalism was the prevalent practice and patients were instructed. Now in a matter of days, patients diagnosed to have COVID 19 have no choice on testing for the disease, confidentiality of test results and the post-test treatment. Patients with other diseases have very little choice on where they seek treatment, choices now governed by availability of transport and availability of doctors. As much of the situation is evolving and the response of the medical community is heavily affected by the directives announced by the Government.

The dignity and respect of the dead has been compromised due to family's inability to respect the wishes of the dead and inability to carry out religious and funeral rituals.

There is a complete loss of rapport building mechanisms, conventional communication methods, and ways to reassure patients. Medical isolation of patients to protect others has meant that patients go through this illness entirely alone and sometimes die alone without family by their side. Doctors traditionally try to communicate with patients and relatives with compassion to reassure them and help them to cope with illness. Several teams such as social workers and chaplaincy help patients cope. With the advent of the pandemic all these methods are restricted. COVID 19 patients cannot even see the faces of their health care providers which dehumanizes the whole patient health care provider interaction, increasing anxiety, distrust and sorrow. Coping mechanisms are severely compromised in this current situation.

Cost of care and resource allocation mechanisms are being reconsidered. In mission hospitals, many patients are middle class to poor. The current economic situation has made health care even more inaccessible financially to patients. Hospitals are also facing a huge financial crisis making subsidizing health care a difficult option. Doctors are forced to rethink what would have been routine concessions for the poor. Resource allocation is in danger of being favorable to the patients able to pay for services.

The news reports and the reports from the medical community about health care workers getting infected and sometimes dying has changed the way the health care workers interact with patients. In many hospitals fear is a daily presence in the doctor patient interaction, compounded by fact that the administration of some hospitals are insensitive to protection needed by the health workers in the front line. It has changed the way the community treats the hospital workers, with distressing news reports of doctors being the new "untouchables" in society. All this has added the distrust between society and the health care workers.

The most distressing aspect of this COVID 19 illness is the inability of health care works and family members to provide sufficient comfort for the dying due to isolation needs. The dignity and respect of the dead has been compromised due to family's inability to respect the wishes of the dead and inability to carry out religious and funeral rituals. After the advent of respiratory support for the sick, the way we face death has changed from being in the presence of family, in the familiarity of one's own home, to a cold clinical ICU. Many efforts have been made to allow the dying as much comfort from family members, clerics and counselors. In the COVID situation patients die alone.

Societal tragedies are heart breaking. Families separated by the lack of transport, some walking or cycling hundreds of kilometers to reach their families, leaving behind uncaring cities and irresponsible employers.

In the face of this rather dismal situation there are stories of love, sacrifice and the indomitable human spirit. An Italian catholic priest offered to be allowed to die, to enable a younger person to obtain a ventilator. Doctors and nurses all over the world willingly working long hours, putting themselves and their families at risk to tend to the sick. People have been generous to provide for basics like food and medicines for those not fortunate enough to have an income in this time. A family in Kerala sold their property to feed the sick. Young people who have never made a meal for themselves are now cooking for whole communities of stranded patients and laborers and unfailingly delivering packed food, and miraculously the funds to sustain these activities are available in answer to the sincere prayers of those who care.

Young people who have never made a meal for themselves are now cooking for whole communities of stranded patients and laborers and unfailingly delivering packed food, and miraculously the funds to sustain these activities are available in answer to the sincere prayers of those who care.

How do we as Christians respond to this situation?

We need to pray. In no other time has the world needed our prayers as now. As Abraham pleaded to God to for the city of Sodom to be spared, we have to pray for Gods mercy and grace on our sinful world. As is in 1 Corinthians 2:5, our faith should rest not in the wisdom of men and science, mathematical projections of the future, but in the power of God. While we are called on to be prudent to avoid infection and infecting others, we should not allow irrational fears of infection and death govern the way we behave with others, especially patients. 1 Thessalonians 4: 16-18 holds a glorious promise for those who believe in Christ.

The pandemic has not changed the way Christians ought to behave. We are called to exhibit the love of Christ through our lives, to feed the hungry, cloth the naked and tend to the sick. For centuries Christians have been known to care for the sick and suffering, and Christian missionaries were the first to care for people with the dreaded diseases of old such as leprosy and HIV.

The pandemic has given us an opportunity to examine our way of living, to reach out beyond our selfish wants and to make a difference in the lives of others. There are many who are hungry, unemployment making it impossible to feed their families. There are many who are hungry for a caring voice, a human touch, separate from their families far away. There are many in the line of duty, fulfilling the duties placed on them by the government and society who will also like to be safely in their homes with their families. We are called to be the ones providing food for the hungry, comfort for the lonely and reassurances for the anxious. For those of us in the medical profession, we are now called to be the family of patients alone in COVID wards, the son or daughter for the elderly, the parent for the child, the priest for the distressed or the doctor for the suffering. Let us rise to our calling and be a blessing.

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SINGING: A PATH TO LOVING

Music is an often underutilized gift from God. Two aspects of singing can help us follow Jesus more closely in our loving:

1. The act of singing, especially singing in groups, and
2. The words of songs that are sung.

Dr. Barbara Isely

Singing in a Group

The very act of singing makes us feel good. It energizes and makes us happy to be singing with other people.

Physiological Effects

Many researchers have worked to identify what happens physiologically when we sing together. The research is from wide-ranging disciplines – music therapy, psychology to neurology. Because of diverse approaches, few of the tantalizing results are well replicated. Tracing original research is limited by no access to a professional library, and few refereed articles are online. See limited references below.

The act of singing has several positive physical effects that appear more in group singing than in singing alone. Most of us have experienced feeling joyful or relaxed after a good session of singing with other people. Research indicates physiological effects such as increased endorphin levels and improvement of the immune function.

Other physiological effects of singing together, such as synchronized heart beats lead to strong group cohesion that can strengthen other activities by the group. Singing together informally and forming or joining a singing group or choir are enjoyable, easy, and powerful ways to build loving teams and families.

Include Everyone – A Loving Act

Music groups can negatively impact excluded individuals. Competition and the myths of talent and non-singers lead to exclusion of some persons. NEVER tell a person, especially a child that they cannot sing; even professional singing teachers have been mistaken.

Making the blessings of singing available to all is a first step in loving through music. Desire and effort to learn can overcome "talent" or "lack of talent." "Talent" is often merely what was learned from previous exposure to music.

A seeming inability to sing can be overcome by experience with music and good teaching. Unloving labeling by other persons and lack of opportunity, not lack of talent, leads to "non-singers." Take the first step to help a person sing by believing they can, and you will have taken a step to be more loving.

The very special sound of group singing does not depend on solo quality voices; every singer adds to the overall choral sound. A group of weak singers can produce a very special, unique sound that can be far more beautiful than a single good singer. A strong, overly loud singer, no matter how good, can spoil the group sound. Persons who are firmly convinced they cannot sing can be included on guitar, drum, bells, tambourine, or clapping. Inclusion of the weak or supposed "non-singer" is an exercise in loving, in accepting every child of God. As we include everyone in our singing, we grow to recognize that in all situations every child of God has some gift that contributes to the whole.

Improve Singing in Your Group

Strong singers can gently and easily help others improve their singing. Know that ability to sing well is a gift from God to be lovingly shared.

Some weak singers are not aware of pitch – the high and low of the sound of music. Use "God Is So Good" to teach pitch: in the first three word repetitions the

pitch has the same pattern (note, repeat, skip up, step down). The whole pattern rises in pitch on the second and third repetitions. The fourth repetition does not follow the pattern. Help weak singers by calling attention to the pitch and/or accurately moving a hand up and down with the pitch. The same song is useful to teach how to change volume, increasing or decreasing volume with each repetition.

Echo songs help improve singing by focusing listening. "God is Everywhere" is a song where the group echoes the leader. It is online with excellent karaoke videos; search *"New Hope Music God is Everywhere."*

Words of the Songs

Most of us have had music and words suddenly, without apparent reason, go around and around in our head. This phenomenon has a great potential for good or evil, so pay close attention to what is sung or heard. Words can comfort, energize, and focus on what we are called to do, or distract and lead us astray.

The Familiar

Singing Amazing Grace is wonderful and comforting. I played it for my grandmother a week before she died. And she wept with joy, remembering her father, whose favorite hymn it was. This hymn linked across four generations in a special moment. I happily remember my pastor father singing it in the pulpit, rocking up on his toes on "When we've been there ten thousand years." Each of us has special memories and feelings of comfort stimulated by singing familiar songs. This is good.

However, good memories and comfort may also limit how a song guides our journey in following Jesus. If I focus only on my good feelings and family memories of Amazing Grace, I miss much meaning, and my singing may be far from praise and a focus on discipleship. While being strengthened to love by the warm feelings of comfort and in assured salvation, I may miss the challenge to think on how I may now be blind and in need of seeing some new aspect of my following Jesus.

The familiar, the habitual can comfort us to face difficulties. However, if familiarity keeps us from fresh thinking about how to love as we face daily challenges, we may also need to step into the unfamiliar. Awareness of limits of familiar songs is not a criticism of the actual words themselves, but of how comfort and habit may cause us to miss important ideas.

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The New

Well-chosen, new or unfamiliar old songs can move us from a self-absorbed rut. Many recent songs speak specifically to today's real situations that challenge our loving – homelessness, the environment, drug abuse, greed and unnecessary consumption, thoughtless aping of popular culture, especially the focus on self. Unfamiliar songs can catch our attention to the depth that loving requires as we strive to follow Jesus.

As new songs are chosen, some singers may resist, especially if they do not read music. However, new songs can be easily learned from online sources. A few links below lead to songs that provide fresh insights on how to love as we strive to follow Jesus in our daily lives.

Links to Songs

Here are a few old and new songs and websites with many songs. Simple URLs or easily typed words in italics are links. A search on the typed words gives the intended link as the first suggestion, unless stated otherwise. If you want to learn a song, also searchYouTube.com to see if someone has posted a video.

Sound the Bamboo 2000 cca.org is an amazing, multi-cultural hymnal with hymns from Asian and Pacific cultures, including 39 from India. *The Christian Conference of Asia* website posts many of the tunes in their music gallery. The physical hymnal must be purchased and is not available during the COVID-19 crisis. Nevertheless, it is worth buying,and is a valuable, and uniquely Asian resource.

Hymntime.com provides audio accompaniment, words, printed music for 14,200 old and new hymns. You can search by words, writer, tune names, or topic. Here are a few:

- *O Young and Fearless Prophet, hymntime.com*
- *Father Make Us Loving, hymntime.com*
- *God of the Strong God of the Weak, hymntime.com*

Several current lyricists make available their contemporary texts to familiar tunes.

- *carolynhymns.com leads to words and audio on the COVID-19 crisis among others.*
- *New Zealand Methodist hymns With Heart and Voice nwhymns.com*

Ralph Merrifield is a generous composer/lyricist who makes his many songs available in print, audio, and karaoke video files.

God is Everywhere NewHopeMusic.com
The Fruit of the Spirit is Love NewHopeMusic.com
God Made You NewHopeMusic.com
I Will Walk in the Ways of the Lord New HopeMusic.com

Colin Gibson is another generous composer/lyricist. In the first and third suggestions that come when you search on the next words, you will find words and a lovely video.

Dunedin Nothing is lost on the breath of God Colin Gibson.
Love is a miracle Colin Gibson
Dunedin New Zealand Colin Gibson hymns

The *New Zealand Hymnbook* Trust published several excellent hymnals with inspiring new hymns in recent decades. Digital copies of the hymnals and some audio files can be purchased online. *https://pgpl.co.nz*

Dr. Barbara Isely

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THE YEAR OF THE NURSE-MIDWIFE AND THE YEAR OF CORONA:

A NURSING PERSPECTIVE PROVOKING ONE ANOTHER TO LOVE AND GOOD DEEDS

Ms. Mercy John

Dear sisters and brothers, my nursing colleagues and all my fellow health care workers; especially those who are at the front-line in combating Covid ; those who are weighed down with the burden of caring for people suspected or confirmed to have Covid; and those of us who worry for our families back home; and worry for ourselves …

At times like this, the Word of God stands only too clear and it is our privilege and right to take hold of it - for ourselves, our faith and our need to encourage those around us.

We stand on the brink of something unprecedented. When it was war, it was something far away, on the borders of the country, affecting limited people. When it was a flood or an earthquake, it was sad, but affecting somebody else. When it was malnutrition or malaria, again it was not for people like us. Even in December 2019, it felt like faraway China which is affected by the Corona virus. And then some European and American nations far away. But today it is staring us in our faces! The distant enemy is here, before each and every one of us. We are dealing with a different kind of world war – not with guns, bombs or nuclear stuff, but something unseen to the human eye - 0.06 micron size! Even the countries with the biggest armies and defense budgets are finding themselves vulnerable and exposed. Now it's lockdown, job-losses, disruption in education, anxiety, fear, hunger. But it is also a time of coming together, forgetting old differences; creativity and innovation, sharing ideas, preparations for the unfamiliar!

We are a 200-bedded hospital (CHB – Christian Hospital, Bissamcuttack) in a relatively remote part of south Odisha; 200 km from the nearest ICU and 400 km from the nearest Covid testing facility. So it is all between us, God and our patients! On the one hand, we have to prepare for Covid; on the other hand, we have to care for hundreds of other patients coming to us for delivery or emergency surgery or Tuberculosis, Dengue, Malaria, Diabetes, Hypertension etc. Any of them (and us) could also potentially have the infection, and so neither can it be business as usual, nor can we shut our doors to the needy and sick. I would like to share with you some small things we have done in our hospital in our CHB Covid Preparedness and Response approach; and some of the lessons we are learning in the process.

The CHB COVID-19 Preparedness & Response Initiative includes the following :

A. Hospital Preparedness and Response : As of date, this includes :

1. A 13-member CHB Task Force that leads the initiative was set up in mid-March 2020.
2. Education and Training of all Hospital Staff on COVID – including classes for all staff, and Webinar-based education for Health professionals
3. Procurement of PPE and other needed hospital supplies for the management of general and COVID patients, in the context of the epidemic
4. Production of CHB-made PPE materials : The following items have been researched, designed and are being produced in-house :
    a. Face Masks including Cotton Cloth masks for patients and their relatives and CHB Cloth and Polypropylene Masks for staff in patient care areas
    b. Individual Pouches for each staff : to submit masks for sterilization daily : 20 x 15cm of 25 gsm Polypropylene
    c. PPE Hood, Gown, Apron and Shoe Covers made of Polypropylene
    d. PPE Face Shields made transparency sheets

5. Re-organisation of Hospital Services for Patient Care in General Zone and Isolation Zone :
   a. Setting up of a Patient Triage at the entrance and a fast-track Fever & Cough Clinic for those with zrespiratory illnesses
   b. Re-organisation of the Emergency Dept, OPD and Wards to continue to serve the regular patients
   c. Setting up of a defined Isolation Ward with 2 beds, expandable to 24 beds.
   d. Setting up a Staff Care Center – where staff members come to change into scrubs and then at the end of duty have a shower and change back into street clothes to go back home clean

B. Mask For All Campaign to decrease community transmission pressure around us :

CHB launched this idea on 30 March 2020, about a week before WHO, CDC, GoI and others recommended it. It made common sense. Cloth was procured, about 50 local tailors were recruited and trained and masks were produced and are now being distributed. For the town, it is undertaken in partnership with a local club, AFSA.

As of date, over 22,000 masks have been distributed with instructions for use and 50 tailors have become experts at stitching masks and can now earn their livelihood with this. The aim is that it becomes a people's movement - if all the infected, known and unknown, are wearing masks, the risk of transmission from them decreases. From the 6th of April, we made it compulsory that anybody entering our hospital campus has to wash their hands with soap and wear a mask (a mask is available at the triage for Rs 10).

What are the lessons we are learning through this process?

Preparedness and Team Work :– Whatever was occurring in China, was spreading from person to person very fast and there was a high mortality associated. So early in January 2020 we had a general staff meeting to inform all staff and to discuss what little we knew of the new disease. Subsequently it reached India. We realised that even though we had some knowledge, we were not ready with equipment to face the onslaught. The CHB Covid Task Force meets almost daily to re-assess and lead the response. In the nursing department – we changed the uniform from white sarees to salwar-kurta with coats. We also decided to produce our own Personal Protective Equipment (PPE) using locally available materials, mostly cotton cloth from local shops and polypropylene from a defunct bag-making factory. So we have been researching, innovating, designing and making our own PPE for all our staff who will be involved in the care – doctors, nurses, lab techs, ward aides and cleaning staff. It is wonderful to see the camaraderie of the staff and willingness to pitch in and do whatever is needed – in terms of cutting, designing, stitching, cleaning, fixing, etc. We even do our testing of materials made through washing machines, autoclave, microbiology cultures, and looking at pore size through microscopes, etc.

Care for your staff : This is one thing which is most important especially at this time. It will be the doctors, nurses and paramedics who are at the forefront of the action – especially for the patients who will come to the casualty, labour room and OPD. As administrators and leaders, it is our bounden duty to ensure that our staff (and also their families) is protected to the best of our ability. Care involves spiritual, mental, cognitive, physical, and psychological (for once these are not just a string of words in the health definition – they are real and stand out starkly). We have been talking with them, encouraging them to discuss their fears and doubts, praying with them, encouraging them – these are just some ways to help boost their (and our) morale.

Lead from the Front: What are we called to do in this situation – for us, as nurse leaders, educators and practitioners. This is the time to stand up and be counted. Not with fear, but in the strength of our Lord. Can we put our money where our mouths are? Can we translate our classroom teaching into practice? Or do we think that the bedside care is “only for the staff nurses, but I am a tutor”? That is cowardice. A teacher or administrator of nursing must be more deft in practice and brave. With our students at home, all the tutors along with other staff are involved in cutting, stitching, trying on PPE etc. Now that we have finalized our design and created a checklist, the next step will be to train all our staff to don and doff PPE – nurses, doctors, nurse aides and cleaning staff.

Do we know how to lead from the front? Are we involved in preparation by way of things, skills and intelligent systemic changes? Do we care for ourselves and each other? Are we resilient or crumbling under the pressure? Dear ones, if God is for us - on our side – who or what can be against us? Go forward in that faith – that whatever be it – we are in God’s hands!

Secure the right equipment, ensure training and set aside fear. These are essential points which we will have to constantly keep at. Be responsible for oneself and for others.

Powerful Will : As nurses we should have a powerful will. A will to get things done; a will to make sure things are set right to face any situation. In the existing pandemic, we cannot accept a ‘chalega’ attitude. We should be reasonable, intelligent and thinking two steps ahead and do the best we can.

Professionalism, Selfless devotion and great resilience: We have learnt considerable theory in our student days. Much is practised and some is laid under the carpet. Shortcuts can lead to disaster for us and our colleagues. We need to spruce up our isolation techniques, of course hand-washing, cough/sneeze etiquette, etc ; in short, we have to be more professional in our approach.

We have had classes, discussions, small group discussions with regards to procedure / system change, prayed with them, etc. We have involved the staff in preparation of the PPE. All the staff has been provided masks and now we are covering their families too. It is critical to hold the team together, and we are unable to do that without prayer. So until Covid actually gets here, we have a brief, ten minute devotion every morning together in our spacious auditorium, with a 20-minute update on Covid and our response activities and responsibilities. This helps keep everyone focused and tuned in.

I would ask each of you to please read the piece by Aaron Mishler entitled ‘There is no emergency in a pandemic’. We need to stay safe to be able to continue to serve. Let us encourage each other, be compassionate and provoke each other to stand firm in the love of the Lord. God bless us all through this historical period.

Ms. Mercy John, Principal, College of Nursing, Christian Hospital, Bissamcuttack, Odisha

MISSIONARIES OF THE PANDEMIC

Auto Raja, the founder of Bangalore's *New Ark Mission,* once told me about a church which participated in his large mission of supporting the destitute. The pastor asked each member of the congregation to carry one vegetable each to church the following Sunday. The next Sunday, as requested, parishioners arrived each carrying a vegetable. One brought a potato, another brought a carrot, some brought bhindi and so on. Each parishioner brought just one item each! At the end of the three services that Sunday, the church had collected several cartons full of vegetables for the mission. Everyone experienced the joy of giving. Each person gave a very small amount, but together as a family of God, they were able to say "mission accomplished". While the church carries on its mission, individuals too, are doing their missions with the church. A church filled with missionaries!

Mr. Sunny Kuruvilla

It is very common for people to feel drawn to institutions with great visions and missions. It is also possible for individuals to work with a *mission hospital* without having a sense of its mission. This Covid pandemic has taught us some important lessons on carrying out our mission as individuals involved in the healing ministry. It also showed us how to network with others to ensure the mission. Covid posed questions like "Who else is interested in our mission? "Who else's mission have we been involved in over the years? Are there other models to accomplish the same mission?"

This pandemic calls us to reengineer our mission as healthcare providers both at the individual level and at an institutional level. As staff at mission hospitals we are often comfortably placed under the blanket vision and mission of our institutions. This is because there is no reason to find a personal meaning for the traditional mission that is there for a long time!

This pandemic brought many unknown or less known individuals and organizations to the limelight. We saw many unusual faces step up to inspire others with ingenious thoughts and ideas.

This pandemic brought many unknown or less known individuals and organizations to the limelight. We saw many unusual faces step up to inspire others with ingenious thoughts and ideas. Individuals who were not part of active missions proved their solidarity through leadership, comradery and kindness. A strange situation such as this has brought us together for a higher purpose and with God's grace we will overcome it.

This is the time to embrace changes and finding new 'missionaries' in our mission. This is the time to redesign the future of our hospitals with this rich experience. Bringing in new leaders and networks, involving community and church are the new vistas of inclusiveness for an effective mission.

This pandemic will help us find likeminded individuals to align with us to make our healing ministry more effective. Therefore as mission hospitals, this is an opportunity to review our mission, objectives and strategies.

I have listed out some instances of the most impacted groups proving their power of influence and innovation.

Employees

This pandemic has reminded us that our employees are our biggest asset and investment. During this unusual period, they have carried out our mission by forgoing their privileges and benefits. They stood with the institution to face the challenge. I was told that a senior consultant from a mission hospital decided to bear the cost of a ventilator by paying his salary in monthly instalments to the vendor till the price of the machine is met. In another hospital, a group of doctors jointly financed protective gowns for the entire clinical staff. The mission hospital staff have worked multiple duties, taken up additional responsibilities and played unusual roles to provide the best possible patient care in these times. Our

people have proven that each of us is a missionary; ordinary men and women with extraordinary life missions!

We should maintain this momentum and stand tall with this zeal. Let our missionary staff take the institution forward. Let them review, redefine and rejuvenate the mission of the institution so that we can be relevant to our generation. This will be a paradigm shift from the institutional driven mission to the individual owned mission!

Mission hospitals found partners or sponsors to work within the community and the links we have developed in this period will be the roots for the coming days.

Patients

One patient recently called to offer funds to buy some PPEs! Another patient called and offered to come and cook food for the staff on hospital premises! We have experienced the solidarity of our patients in understanding the kind of missions we are involved in and have developed a new perspective on healthcare services especially in the non-profit sector.

We heavily depend on our patients for our revenue. Though our revenue model relies on cross subsidies, paying patients ensure that our mission is sustained. In this period we were not able to have the usual number of patients. Therefore our revenue was also affected. Our patients reminded us once again how important they are to us.

When some of our hospitals opened new platforms such as tele and e-consultations, there were many takers. Home-based sample collection and home delivery of medicines too have been ongoing. With increasing numbers, post this pandemic, we will see our patients in greater roles.

In addition to hospital-based care, community outreach and mental health support are going to be major areas of need.

Mercy drops opened for the community

Training the police force

Partners

Covid provided a reason for networking with government agencies, service providers, vendors and contractors. Sharing the mission through partnership did wonders in most places. Mission hospitals found partners or sponsors to work within the community and the links we have developed in this period will be the roots for the coming days. I am sure some of us found they are interested not only in business but also in partnering for a cause. Corporate social responsibility (CSR) of business firms have reached out to healthcare organizations by supplying personal protective equipment or sanitizers or funding for medical equipment.

Local community and Church

What was the response of the local community towards us during this season? India, along with other countries have appreciated the excellent work of their healthcare staff through various interesting methods. We saw an increased awareness about our commitment and the risk healthcare staff takes was widely acknowledged during this period. Longstanding challenges like attacks on hospitals and healthcare workers were discussed, even leading to changes in statutory provisions.

We in turn, must thankfully acknowledge the joint initiatives by local communities and churches to support mission hospitals. This incredible manifestation of the mission must continue.

The post Covid days offer promising opportunities to strengthen the role of the church in mission hospitals. This is an area that we need to develop further. The opportunity also holds true for networking with the neighbourhood and in the community at large. Volunteers from the community are effective catalysts in establishing our mission.

Lessons

To be effective in our institutional mission, we need people to own it and the community to work with us. There are several people and agencies interested in our missions when we share it with others. Empowering others is the key. Introspecting on our stand as an institution is necessary in the light of Covid experience. This will help us be more inclusive in carrying out our mission and also influence our strategies while reaching out to the community.

We have a lot to do in the post Covid days. Wherever necessary, strategies have to be reviewed, priorities have to be changed and networking has to be strengthened. The role of other partners in our mission should be recognized and their missions aligned with ours for an effective way forward.

Mr. Sunny Kuruvilla
Associate Director
Bangalore Baptist Hospital

"LET US CONSIDER..."
BEING PROFESSIONALLY COMPETENT, SOCIALLY RELEVANT AND SPIRITUALLY ALIVE

"Let us be concerned for one another, to help one another to show love and to do good."

Hebrew 10:24

Christianity is a faith which God intended to be lived and practiced by caring for others, encouraging others and to be encouraged by others are both central to the life of an obedient Christian professional.

Dr. Vilas Shende

The book of Hebrews encourages Christians to be strong as rock in their faith. When persecution and fear put pressure on us, our response should be to "hold fast" to the truth. This is not a blind faith. On the contrary, most of the content of this letter is evidence supporting the fact that Jesus Christ is, in fact, God's ultimate plan for our salvation. Our own personal faith is crucial to that endurance, which is why the writer has time and gain warned readers not to be lazy or careless about their spiritual growth (Hebrews 3:13). We should not respond to difficult times with fear or doubt but we should embrace a confident faith and look to encourage fellow professional Christians to do the same. This means proactively calling other Christians to not just "believe," but to act out in love and good deeds.

Have you ever ***considered*** how you can do this? (To consider means to think about, decide, or keep in mind.) To spur one another toward love and good deeds, or to encourage someone can a big impact in their life. I think often we don't realize what a huge difference some small bit of encouragement can make in someone's life.

The following are few easy Ways to encourage and Spur One Another on Toward Love and Good Deeds

- Call someone just to tell them that you remember them
- Speak life-giving, positive, uplifting words to person going through difficult situation
- Tell someone how they inspired you
- Let someone know you are praying for them
- Give a sincere compliment
- Tell the janitor/maid/cleaning professional/ maintenance worker that you appreciate them
- Show appreciation to your co-worker and particularly subordinate
- Visiting neighbor when he/she is sick and or lost someone dear to him/her
- Taking leadership in helping someone who is in problem/difficulty and needs help from others
- Requesting someone you know who can help someone in need due to his/her position

What does it means to be professionally competent?

It is the habitual and appropriate use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit

of the individual and community being served. Competence builds on a foundation of basic clinical skills, scientific knowledge, and moral development. Competence depends on habits of mind, including attentiveness, critical curiosity, self-awareness, and presence. Professional competence is developmental, impermanent, and context-dependent.

How it is important to be professionally competent?

Maintaining **professional competence** allows individuals to continue to learn throughout their career, to develop their technical skills, and to keep pace with creativity and innovations.

How one should be socially relevant?

The need for *sociology* to become socially relevant is now being articulated by professional sociologists that the discipline should be *valuefree* allows sociologists to serve and promote the *social values* of others, a vital sociological endeavor requires more. To be socially relevant, it is essential that the discipline become consciously valuerelevant, not valuefree.

What does it means to be spiritually alive?

The characteristics of those who are alive spiritually and mature in Christ, as compared to those who are spiritually dead, are profound. The following are some of the salient characteristics of those who are alive spiritually:

1. They earnestly seek fellowship with God as well as with people in our society. These folks are easily recognizable for their zeal for all things pertaining to God and godliness. They epitomize the words of Jeremiah: "You will seek Me and find Me, when you search for Me with all your heart" (Jeremiah 29:13). They are those who "love God with all their heart, soul, mind, and strength. They love their neighbor as themselves" (Mark 12:30-31). They are known for their love for one another (John 13:35), and wouldn't hesitate "to lay down their lives for friends" (John 15:13).
2. They are highly sensitive to sin. The spiritually alive person is truly mindful of the sinful realities in their life. They strive to "walk in the Light as He Himself is the Light" (1 John 5:7). They "confess their sins" (1 John 1:9). They know that to live for God is to be holy (1 Peter 1:15-16) which means being totally devoted or dedicated to God. They know assuredly that they have been set aside for His special use and set apart from sin and its influence.
3. They're known for their strict obedience to the Word of God (1 John 2:3). Obedience to the commands of God produces assurance — the confidence "that we have come to know Him."

Some of the best examples in the bible regarding concern for others and showing professional competence, social relevance and spiritual alertness are as follows:

i) Good Samaritan Luke 10:25-37

The history of the feud between Jews and Samaritans is as old as 722 B.C. The year the Assyrians conquered Israel and took most of its people into captivity. Shortly afterward the invaders brought in Gentile Colonists to resettle the land. These foreigners brought with them their pagan idols, which the remaining Jews began to worship alongside the God of Israel. Intermarriages also took place. The Samaritans were descendants of these Jews who mingled with the Gentiles. Therefore the other Jews despised the Samaritans.

It was such a man that became the neighbor to the fallen Jew. Did he know the Law of Moses? Jesus didn't tell. But he said this, "But a Samaritan who was traveling came to where the injured man was, and when he saw him, he felt compassion for him." Then Jesus closed the story with another question. "Which of these three do you think was a neighbor to the man who fell into the hands of robbers?" The Lawyer knows the answer but he cannot even bring himself to mention the man's race. He is picky about his neighbors. He answered, "The one who had mercy on him." Jesus said, "Go and do likewise." By telling this parable Jesus wanted us to understand how one should be concerned for others with an attitude of being professionally competent, socially relevant and spiritually alive by sincerely completing the task of even helping a stranger in need.

- Eternal Life is an inheritance of God reserved for those who love him. But we cannot say we love him if we refuse to show mercy to people.
- Our love for one another truly reveals our love for God. To show mercy and be a neighbor to the needy is the act of that love.
- Be a neighbor to anyone in need. Don't divide people as neighbors and non-neighbors based on their race or behavior because God created everyone in his own image.

ii) Healing the paralytic at Capernaum is one of the miracles of Jesus in the Gospels in Matthew (9:1–8), Mark (2:1–12), and Luke (5:17–26). Jesus was living in Capernaum and teaching the people there, and on one occasion the people gathered in such large numbers that

there was no room left inside the house where he was teaching, not even outside the door. Some men came carrying a paralyzed man but could not get inside, so they made an opening in the roof above Jesus and then lowered the man down. When Jesus saw their faith, he said to the paralyzed man, "Son, your sins are forgiven."

"When they could not come near to him for the crowd, they removed the roof where he was" They chop a hole in the roof to lower their friend into Jesus' presence. In the typical house of that day, the roof would be flat, supported by beams laid across the walls, and composed of a mud/thatch mixture. People would sometimes sleep on the roof during hot nights, and the roof would provide a private retreat from a busy household. There would usually be a ladder standing outside to permit access to the roof. Getting a paralyzed man up the ladder would be no small task, and would require courage on the part of the paralyzed man. Chopping a hole in the roof would be a bold means of solving the problem of access to Jesus. Some scholars say that it is easy to repair a mud/thatch roof, but it is difficult to patch any roof so that it doesn't leak. This damage is not trivial. It involves "a major demolition job"

"Jesus, seeing their faith" The faith that Jesus sees is not simply intellectual assent or emotional feeling, but is manifested in determined, visible action. Jesus can read people's hearts, but he doesn't need to do so here. The faith of these men is out in the open for all to see.

Holistic health practitioners are **professionals** who provide **holistic health**-related services and can include counselors, doctors, nurse **practitioners**, nutritionists, therapists and other **healthcare professionals**. The health professionals need to carry emotional intelligence/ quotient (EQ)while performing their role of helping others in effective and efficient way. EQ is the ability to recognize and manage our emotions judicially and empathetically while dealing with others. It is a developed skill to manage interpersonal relationships. Although extremely important, this skill is not taught in schools and not considered as an integral part of education, unfortunately! The accepted notion is that EQ is only important for people pursuing administrative courses. Most of us learn this skill from our experiences during our life time. However, many of us don'tfeel the need to value it and then, when some unusual thing happens, a chaos of reactions ensues! Eventually everyone becomes aware of the importance of empathy and kindness towards others but we are caught totally off guard when it comes to reacting to a crucial or critical situation. Medical professionals are no less susceptible to this kind of reaction. While declaring a serious condition or death of a patient, some doctors just get overwhelmed with the stress and fail at open communication. Similarly, patient's relatives or close ones can have overtly emotional reactions and doctors/ other staff get distracted managing this psychotic or off the head type of behavior of that person. Many times sympathy wins over empathy! And when it comes to health, lending support whether physically, mentally, socially or financially, is jeopardized. So, do we have any solution for this? We can certainly follow the line of action taken by Jesus Christ while helping people in need and his teaching for being concern for others. We can also test our EQ by asking ourselves simple questions. For example, when I hear about any tricky or serious situation about our close ones, do I listen carefully and lend a helping hand or I cry, shout and get angry? Do I keep calm and look for the alternatives or do I get palpitations with anxiety? Do I extend support in any possible form to the actual sufferer or I find excuse to run away from the reality? Rather than showing empathy towards the victim, do I expect sympathy for myself from others? Good thing is comprehensive initiative of being professionally competent, socially relevant and spiritual alertness can be self-learned by mindful observation and keeping calm. We can let the bad news sink in the mind gradually, controlling the anxiety by prayer and meditation. We can get more empathetic, kind and resourceful towards others with self-control. Listening to your own mind and body without causing self-harm is the key!

In today's societal context health is complete physical, mental, social, spiritual, educational and environmental state of wellbeing of a person, family or community as a whole and not just an absence of disease or infirmity. This is respecting and considering holistic dimension of any individual or group for their sustainable development. As professional Christian health worker let us consider to see our goal of reaching eternal life for self and others in our society, understand the obstacles, create a positive mental picture, clear your mind of self-doubt be developing strong EQ, embrace the challenge/difficulties/problems, stay on track to conquer over them and show the world you can do it by following Jesus footsteps with God's blessing.

Dr. Vilas Shende
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ARISE, THOU THE SOLDIER OF THE LORD

Prof. T. Samuel Ravi Kumar

3 You therefore must endure[a] hardship as a good soldier of Jesus Christ.

4 No one engaged in warfare entangles himself with the affairs of *this* life, that he may please him who enlisted him as a soldier.2 Timothy 2:3-4 (New KJV)

It was 3 pm at the Emergency Room, another hour for the nurse to complete her shift. She was assigned in Triage area where one has to prioritize the patients according to the severity of illness and refer them for immediate care or to wait for further management. As the nurse glanced she saw a well-dressed person standing in the queue. The appearance did not give a clue as to the severity of the illness; for a moment the nurse was weary in feeling that this well dressed person who does not appear sick is delaying care for the other patients in the queue.

Meanwhile the nurse's mobile gave a vibrating sound, as she was not to use it on duty, she just silenced it remembering her kid whom she had left in her neighbor's house to be picked up after duty. By this time the well-dressed person in the queue had moved forward and was standing in front of the nurse. She was reluctant to see him first as there were more patients standing in the line. Besides she asked the person about the complaints, the presentation was head ache. With no obvious distress seen in the person she called for the next person to come in as she kept checking the Blood Pressure for this well-dressed man. The nurse was taken a back and asked her colleague to recheck the BP, yes it was confirmed the BP was 190\100. The patient was rushed in for further management to prevent hypertensive crisis.

Have you met such "well dressed person" in your life? With no signs on the outside but working under high pressure within. Have been like the tired nurse with many pressures around her causing "Weariness". We all rise up in the morning praying to do good for others but at the bedtime prayer we kneel with guilt in not having the opportunity to do good.

Health care Team in a scenario of pandemic is at war. The war is between the Macro and the Microorganism. We at this occasion are called to serve as the soldier of Jesus Christ. The frontline care givers such as the Emergency personnel and many other critical care Zone personnel have to strategize themselves as soldiers in war. Let's look at some salient Biblical guidance in this regard.

She was reluctant to see him first as there were more patients standing in the line. Besides she asked the person about the complaints, the presentation was head ache. With no obvious distress seen in the person she called for the next person to come in as she kept checking the Blood Pressure for this well-dressed man.

1. Well-dressed person

Appearance is deceptive. Go by the system of care and love. Paul in his Epistle to Galatians states "And let us not be weary in well doing: for in due season we shall reap, if we faint not". **(Gal 6:9)** Goodness, being considerate of others, compassion requires perseverance and persisting relationship with our Lord and savior Jesus Christ. We live in a world of weariness, tired of environment, responsibilities, task fulfillment and accountability.

2. Hold fast the profession of our Faith

Let us hold fast the confession of our hope without wavering, for He who promised is faithful. And let us consider one another in order to stir up love and good works, Hebrews 10:23,24

Let us hold fast the profession of our faith **without wavering**; (for he is faithful that promised) And let us consider one another to provoke unto love and to good works.

Hold fast requires **commitment.** You cannot hold fast or be steadfast unless you are strongly convinced in, unless you are in strong relationship. The classic examples of Biblical personalities who were strongly committed and continue to good, in spite of hardships were, Moses, Esther, Nehemiah and so forth. They were considerate of people unknown to them, considerate to the people who even rebelled against them simply because there was a bonding between them and the people through the Love of God almighty. As a soldier our primary responsibility is to serve the commander who has called us to serve and for the purpose he has called us for. In this contemporary world do we have such bondage with Christ in order to love and do good in spite of our weariness?

3. "Without wavering"

Persistence is the positive way of looking at "without wavering". There is a narration concerning Rabbi Akiva (Akiba) on persistence.

Akiba was tending his flock in the hills of Judah. He became thirsty and went to his favorite brook in the hills to take a drink. As he was drawing the crystal clear water in his palm and putting it to his mouth, something caught his eye. He saw drops of water falling on a huge stone – drip, drop – and directly where the drops were falling; there was a deep hole in the stone. Akiba was fascinated. He gazed at the drops, and at the stone. "**What mighty power there is in a drop of water,"** the shepherd thought. "Could my stony heart ever be softened up that way?"

Every simple act that you perform in emergency, not as a ritual but with steadfast love fulfills the will of our Commander.

Philippians 2: 3 – 8 The Humbled and Exalted Christ

At this cross road in contemporary living the challenge presented to us through the word of God is towards

- Same mindset as Christ Jesus
- Humility
- No selfish Ambition
- Each of you to the interests of the others

Be persistent in doing good to your environment, people and to animals as well, such acts of kindness becomes your system of thinking.

4. "Consider one another"

The opening scenario saw a tired nurse, guided by experience in the field saw a life being saved simply because she performed what she was trained for, she performed what the system has directed her to do. Relook at the same from the perspective of our everyday living. A spontaneous response to consider one another is much more powerful than a deliberate effort to reach out to people. We saw in the life of our Lord and Saviour Jesus Christ, simplicity to reach out to people, lived among them, he walked around doing good as it was within him. The call for us today is the same mindset as it was in Christ that of love. Be it anywhere the response has such a call.

The act of consideration and doing good has few approaches

Points to ponder for the Emergency personnel (Tired soldiers)

a. Faith: He who calls you is faithful, who also will do it.1 Thessalonians 5:24

You are not a Vagabond but a pilgrim in his ministry, and you are not alone. If you want to sing do so with this hymn. No never alone, he promised never to leave me alone

Perseverance: Suffer hardship with me, as a good soldier of Christ Jesus.**2 Timothy 2:3**

But you, be strong and do not lose courage, for there is reward for your work."

2 Chronicles 15:7

Fellowship: Bear one another's burdens, and thereby fulfill the law of Christ.

Galatians 6:2

To conclude being considerate with concern is not an option, it is running in life with a purpose in Christ.

Philippians 2:16 Holding forth the word of life; that I may rejoice in the day of Christ, that I have not run in vain, neither laboured in vain.

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"LIFE LESSONS FROM CHAPLAINCY!"

Rev. Alex Peter

There is an old saying, "*Life is so Uncertain*!" But which is more appropriate to say - Life is uncertain or Life situations are so uncertain? I think life situations are very uncertain and in midst of uncertain life situations God's life in us is still certain and must keep on moving forward. On March 3rd when I received Rev. Arul's email to write an article for forthcoming CMJI, everything was so certain. But in last one month our world has changed and we are living in an entirely different life situation.

All of a sudden life has become a ride in a giant roller coaster. All these years of my life in ministry I served as a chaplain – first as a student's chaplain, then as a youth chaplain and now as a Hospital Chaplain. And My friends jokingly say – Surely, I will retire as a Hospice Chaplain. But during all these years in Chaplaincy Ministry, has exposed me to some very uncertain life situations of Human existence and also taught me some very valuable lessons. Here are four of these lessons - small conversations between you and me:

Peaceful Pain:

None of us want to go through pain. But irony of life is – "*Pain will always be there. Its unavoidable.*" So, is it not better to get peaceful with pain? But is it possible? Yes!!!! It's very much possible. Only thing you need to know is the different types of pain.

Pain leading to Joy: This pain is caused by hard work or constant persistence to accomplish something, like an effort taken in exam preparation or labor pain of a mother. When you go through such pain then wait for the rewards and be thankful and enjoy that moment of achievement.

A Pain requiring Change: In our lives there are always some warning signs. When a pain demands change then take it as a warning sign and change. It's all a matter of making different choice.

A pain because of Loss: If you ask what are the most important 3 things in your life than the answer is "*Certain People*", "*Certain Moments*" & "*Certain Opportunities*". And what happens to you when you lose them? It's damn painful. If anything like that happens just remember that, that chapter of your life is over. Find peace in someone else, some other moment or some other opportunity

An Unexplainable Pain: But the most difficult ones are the pain which have no explanations or answers. If you are going through something like that than keep on searching for answers. If you get an answer than well and good. And if you won't, then also keep on searching without any grudge, bitterness or craving. One thing is guaranteed you might not get the answer for your question but you will surely get the answers for some other questions of your life, which you even never thought of. And that is your blessing.

Relationship Goals:

Now a days it's a big trend of setting goals. But it feels really weird when I hear – Relationship Goals – Friendship Goals – Love Goals…… And what types of goals are set? Wearing same colored dresses! Going out every week! ……. List is just endless. But can a relationship be achieved by setting some goals? By pursing such goals, you may get some good pics for Instagram and Facebook, but not a genuine relationship. Relationships cannot be achieved by setting goals, as they are not a task or a chore to be completed or finished. Any genuine relationship is formed only on 3 things:

Love: Love is an "*Intentional Decision*". And as per that decision whether you are happy or annoyed, Successful or failed, Growing or Fallen apart you are going to stick together. Love is growing together and accepting the truth that most of the things we are experiencing & doing in a particular relationship is first time in our life. So be compassionate to each other & be in love.

Trust: Trust has two sides

Accepting someone's trust on you and keep on proving that you still trust worthy even when you fall

Putting your trust on someone being patient and giving someone the chance to carry the burden of your trust. Sometimes it's damn heavy!

Honesty: Honesty is accepting two truths:

Neither me nor you are perfect, but together we can have a perfect life with all imperfections. Only two broken pieces of glass can make a single piece.

God's life is impossible without relationships. When you connect with someone, you are keeping them alive and when someone is connecting with you, they are keeping you alive. Together you and me are "*Ambassadors of God's Life.*"

Anxious Hope:

Have you ever had "*Anxious Hope*"? You might be thinking – "*Now what's that*?" How can be someone anxiously Hopeful? To be true in 99% of our experiences we are hopeful yet anxious. We desire the things to happen yet we are not sure. That is why instead of saying "*Damn Sure*!" we say "*I Hope So*!" Have you ever thought, "Why are you not sure?" Anxious Hope is always derived out of sum of possibilities & probabilities. It's a mere assumption and assumptions can go wrong anytime. The outcome is you are anxious even Hopeful. It's very irritating.

Don't connect your happiness with excitement; instead connect it with peace. If the ultimate aim of involvement in any experience is to get peace then you will end up being happy.

On the other hand, there is "*Sure Hope*". Anxious Hope is an assumption but the Sure Hope is a life Style and it requires 4 things in your day today living:

Finding God's Presence in every experience of your life.

Deriving meaning to stand straight out of every experience.

Getting purpose to move forward from every experience of life.

Being sure that things will happen in your life maybe not in a way you want but surely in the way God wants.

Bottom line is – "*Hope is not looking forward for your desires for your life being fulfilled, instead being completely sure of God's desire for your life being fulfilled.*" So Don't be anxious instead always be Hopeful.

Excited for Excitement:

Have you ever gone through anything like – You were browsing through Facebook and saw someone's pics and suppose they were looking very happy, enjoying every moment of life and you started feeling jealous and started thinking, "See that guy is also happy and I am not!" Have you ever thought why?

It's very true that, the ultimate aim of involvement in any life experience is to be happy. But then also happiness is either elusive or just momentary. Have you ever thought why? If you connect happiness with "Being Excited for Excitement" happiness will always be elusive and momentary. Because you cannot be excited for everything in your life and every experience of your life also not going to give you excitement. So what is the right Mantra?

Don't connect your happiness with excitement; instead connect it with peace. If the ultimate aim of involvement in any experience is to get peace then you will end up being happy. And for that three truths in life must always be followed:

Emotional Processing: There is a weird thing about our negative emotions. They are generated because of the outside people and situations but they cannot be processed by changing or removing those outside people & situations. Instead you have to process them inside yourself. Learn to face and process your damn negative emotions!

Relational Belonging: Our fear of "*Being Lonely*" tells us one truth: "Those who belong to us and those to whom we belong are the very foundation of our existence." Hang on to them for life & don't lose them on any cost!

Soulful Connection: We have only two things which connects us with God – Our Physical Body created by God and our Soul coming from God. And that soul has three promises from our God for our divinely created body:

Fret not – He Loves you!
Faint not – He holds you!
Fear not – He keeps you!

Peace be with you!

Rev. Alex Peter is an ordained Clergy of Mar Thoma Syrian Church and at present serving as a Chaplain in Fellowship Department of Christian Medical College, Ludhiana.

THIS WAS SUPPOSED TO BE THE BIG YEAR, LORD

Dr. Lisa Choudhrie

This was supposed to be the big
year, Lord
2020, a double score
A year never seen
One like never before.
We made our projections
We made our plans
Did some number crunching,
Hmm, even asked for Your hand
Of wisdom and blessing
Insight and overseeing
To give You praise
In all we do
Lift our work
as an offering to You!

But now a quarter
Of this year is nearly o'er
We're wounded, dying
bleeding and oh so sore...
Covid 19 has taken
our world by storm
We're stunned and shaken
In agony and torn.
Lockdown measures
to 'flatten the curve'
Our plans are crushed
lying destroyed in the dirt.

What's the meaning, Lord?
Where do we turn?
Have we made our idols?
You, have we spurned?
Our work, our skills,
our knowledge, our selves?
Have we exalted them
Far above, Yourself?
It seems its time
for us to look deep
Into our hearts
for us to see
That what we've become
Makes You weep.

Our widows, our orphans
Our poor are broken
We've become robots
Bereft of Your compassion.
This time out, realign our beings
Back to you, our Source of living.
That we reflect Your heart of love
Execute justice and mercy from above
That we never forget
that ash to ash, dust to dust
There's no dodging,
Go, this way we must.

THE STORM

Dear Jesus
There's a storm brewing outside
Wind blowing, claps of thunder, grey clouds hanging low
Ominous..
And the wheat golden and ripe in the field?
All loss for the farmer? Again?

How can you sleep?
Don't you care if they drown?

There's a storm in the world today, Jesus
A tidal wave of craziness
Masked folks everywhere
Isolation, quarantine, triaging, lonely deaths
A pandemic like we've never seen before

How can you sleep?
Don't you care if we drown?

There's a storm in my heart today
Clouds of heaviness, winds of fear
It's so close to me now, Lord
My friends and my family
Not anonymous care givers anymore..
Some on the frontlines, some potential patients…

How can you sleep?
Don't you care if we drown?

But You care
You hear, You see, You love
You're in the storm with us

Lord, touch us with Your scarred hands
Hands that bring healing
Give us Your peace
Take over the wreckage and loss
And breathe new life into us
You are our hope
You are our peace.

Masks

They said, 'one layer is enough for now..'
Save the three layered masks,
for when the tsunami hits us..

What about masks for the ones who really need them?
Masks for the multitudes trudging wearily on their way home
Bereft of dignity, money, basic necessities...
Homeward bound for hours and miles- the end never in sight..

What about masks for the ones who really need them?
The mothers in labour, the ones in pain
The cancer patients breathing their last
one layer or three layered- who cares?

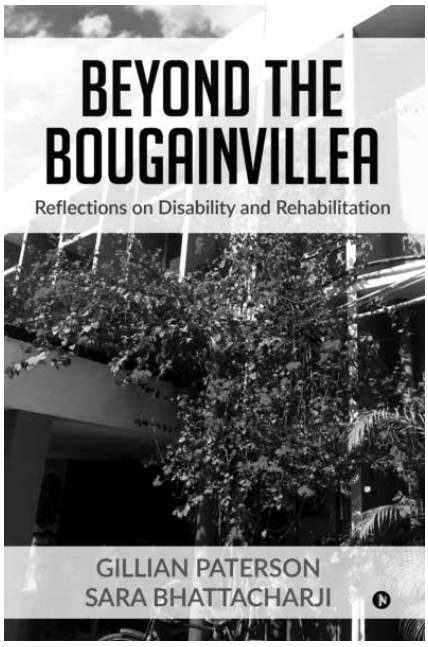
What about masks for the treating team?
A mask a -million layers thick
'Don't just protect me, dear God
Protect my loved ones too...
My little children innocent and sweet
My parents with so much life ahead of them to live...'

Dear Jesus,
Can I unburden myself at Your feet?
Get rid of my masks
Just be free to be me..?
You don't need PPE- you reassure
You've taken them all
My grief, hurts, pain,

So I drop them
here and now
Facades covering up cracks
Make up hiding scars

And I find rest for my weary soul
Comfort for my wounded spirit
In you and in you alone

TRANSFORMING THE LIVES OF THE DISABLED



Gillian Paterson and Sara Bhattacharji
Notion Press, Chennai, 2020
103pp. Rs 500.

This slim book says much more than it seemed to promise.

The story of 'Rehab' needed to be written. 'Rehab', for those who know, is the Rehabilitation Institute of Christian Medical College, Vellore. It is a multi-disciplinary centre, started in 1966, for the long-term care of disabled persons, once they are over the acute phase of their illness or injury. The mainstays of treatment are counselling, occupational therapy, and physiotherapy. 'Rehab' was the first institute in India for the holistic care of the disabled.

But there's much more to 'Rehab'. The authors narrate the stories of several patients whose lives have been transformed. There is Anna, a mother of four, recovering from a stroke, Meena a two-year old girl with polio, Saleem, paralysed from the waist down after a motorbike accident and many more (real names have not been used).

After being healed, some have found work or become entrepreneurs. Though paralysed, Edward set up an online mobile business with a small grant and tops up mobile phones. Kumaresan is a nationally known athlete and is internationally ranked in shot put and discus. Patients who have left 'Rehab' to continue their lives stay in touch with the Institute. One such occasion is the 'Rehab Mela', an annual three-day event of games, food and festivities. Accommodation, makeshift kitchens and a pandal are arranged by the Institute. The floor of the pandal is a thick bed of sand covered with colourful plastic sheets. In the evenings there are cultural performances, debates, literary competitions. Friendships are made and renewed, and confidence is boosted.

'Rehab' is not an ivory tower. It has an active community-based rehabilitation program (CBR), started in 2002. A team of volunteers trained in their communities, carry out surveys, refer patients, follow-up with home-based care, and support and educate families with a disabled person.

There is much more in this inspiring book. It is interspersed with Bible verses and motivational quotes. Here is one of them that I found to be deep with meaning:

"I thought that my voyage had come to its end at the last limit of my power, that the path before me was closed, that provisions were exhausted, and the time come to take shelter in silent obscurity. But I find that thy will knows no end in me. And when old words die out on the tongue, new melodies break forth from the heart, and where old tracks are lost, new country is revealed with its wonders." Rabindranath Tagore, Gitanjali 37.

Glenn C Kharkongor

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VIOLENCE IN MEDICAL FIELD

Join Hands with us in the Healing Ministry

COME JOIN US AS MEMBERS

CHRISTIAN MEDICAL ASSOCIATION OF INDIA

CMAI is a national network of health professionals and institutions promoting a just and healthy society for all irrespective of religion, caste, economic status, gender or language

- CMAI has over 10,000 Christian health care professionals and over 270 institutions representing various denominations.
- CMAI builds individuals to be technically sound, spiritually alive, and socially relevant, in fellowship and with a Christian perspective on health and development.
- CMAI is the health arm of the National Council of Churches in India(NCCI).

WHAT DO WE DO ?

- Build capacity to respond to the current and future health care needs
- Advocate for innovations, create evidence and promote policy change
- Work closely with the churches, civil society and the government
- Build alliances for health action on a national scale
- CMAI influences other networks and alliances on thinking change in health systems practices in India. We partner with national and international agencies to promote this objective.

OUR PUBLICATIONS

- Christian Medical Journal of India (Perspective)
- Life for All (Newsletter)
- Footsteps (Development) English & Hindi (A Tearfund publication distributed by CMAI)

COME JOIN US

The core of CMAI is its members- individuals and institutions. Individual membership consists of five professional groups - Doctors, Nurses, Allied Health Professionals, Chaplains and Administrators. Each section comes together for conferences, workshops, a time of fellowship to learn from, to share with and to encourage each other spiritually and professionally.

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Building a just and healthy society

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CONTENT

LETTERS / ARTICLES FOR CMJI

We invite your views and opinions to make the CMJI interactive and vibrant. As you go through this and each issue of CMJI, we would like to know what comes to your mind. Is it provoking your thoughts? Please share your thoughts with us. This may help someone else in the network and would definitely guide us in the Editorial team. E-mail your responses to: cmai@cmai.org

Guidelines for Contributors

SPECIAL ARTICLES

CMAI welcomes original articles on any topic relevant to CMAI membership - no plagiarism please.

- Articles must be not more than 1500 words.
- All articles must preferably be submitted in soft copy format. The soft copy can be sent by e-mail; alternatively it can be sent in a CD by post. Authors may please mention the source of all references: for e.g. in case of journals: Binswanger, Hans and Shaidur Khandker (1995), 'The Impact of Formal Finance on the Rural Economy in India', Journal of Development Studies, 32(2), December. pp 234-62 and in case of Books; Rutherford, Stuart (1997): 'Informal Financial Services in Dhaka's Slums' Jeoffrey Wood and Ifftah Sharif (eds), Who Needs Credit? Poverty and Finance in Bangladesh, Dhaka University Press, Dhaka.
- Articles submitted to CMAI should not have been simultaneously submitted to any other newspaper, journal or website for publication.
- Every effort is taken to process received articles at the earliest and these may be included in an issue where they are relevant.
- Articles accepted for publication can take up to six to eight months from the date of acceptance to appear in the CMJI. However, every effort is made to ensure early publication.
- The decision of the Editor is final and binding.

LETTERS

- Readers of CMJI are encouraged to send comments and suggestions (300-400 words) on published articles for the 'Letters to the Editor' column. All letters should have the writer's full name and postal address.

GENERAL GUIDELINES

- Authors are requested to provide full details for correspondence: postal and e-mail address and daytime phone numbers.
- Authors are requested to send the article in Microsoft Word format. Authors are encouraged to use UK English spellings.
- Contributors are requested to send articles that are complete in every respect, including references, as this facilitates quicker processing.
- All submissions will be acknowledged immediately on receipt with a reference number. Please quote this number when making enquiries.

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EDITORIAL

Improving or Deteriorating?

Rev. Dr. Arul Dhas T.

As a healing community, are we growing in relationships? Or deteriorating? Even though all of us are together, some of us are deeply involved in providing health and others at the receiving end. The dividing mark between these two group is not very clear physically and spiritually. In giving we receive; in receiving we give. Our lives and works are so intertwined with each other.

Time and again we experience breach in the trust between health providers and receivers. We, ministers of healing, take relationship for granted at times. Trust develops between communities and ministers of healing by giving – giving our time, energy, care, etc. Often we build this safety into our systems through the occasions of fellowship, discussions, conversations, and other methods.

This issue of CMJI comes with this burden. We rejoice and celebrate the trusting relationships. We are ready to identify when there is a deterioration or breach in our relationships. Any kind of violence is due to eroded relationships. Has there been violence in the medical context? How do we understand them and address them?

The articles “Healthcare Professionals and Communities”, “The Trust Quotient of Mission Hospitals”, “Legal risk for Medical Professionals”, “Interprofessional relationships: A Biblical Perspective” and “Role of Family in the Healing Process” and the Interview which are featured in this issue are put together with the intention of looking at the trusting relationships from different perspectives. Our prayer is that the reading and reflections due to this issue will facilitate and promote better relationships between the ministers of healing and the communities.

With best wishes and prayers,

Rev. Dr. Arul Dhas T.
Editor

5C'S OF PSALM 23

Rev. Paras Tayade

Psalm 23, without a doubt is one the most read, memorized and recited passage of the bible. No matter what our situation may be, Psalm 23 has something to offer to each one of us. The first five words of this Psalm are the foundation on which everything else hinges. David is affirming that 'Because God is his shepherd therefore he is not in want'. David highlights four blessings that are a result of his relationship with God.

1. Contentment (Vs. 2-3)

It is human nature to think that the grass is always greener on the other side. As a counter view David is saying when the Lord is our shepherd, we can be satisfied where we are, in what we are doing and in what we have.

2. Comfort (Vs. 4)

Christian life is not just about green pastures and still waters. It also involves walking through the valley of death. Yet God's assurance is that we are not alone as we go through difficult times, but he is our Immanuel; God who is with us, even in our darkest hour.

3. Confidence (5)

David expresses his confidence in God protection. God is more than able to protect us, so much so that we can sit with our enemies and yet know that they can't harm us.

4. Communion (Vs. 6)

David began this Psalm by stating his relationship with God and he ends it by affirming that this relationship is an everlasting one.

5. Challenge

The challenge this Psalm presents to each one of us is to know the Shepherd in an intimate way so as to share in the blessing that David expresses here.

"Yet God's assurance is that we are not alone as we go through difficult times, but he is our Immanuel; God who is with us, even in our darkest hour."

Rev. Paras Tayade
Faculty at Union Biblical Seminary, Pune
Teaching Counselling in the Christian Ministry Department and is currently pursuing his Doctoral studies from FFRRC, Kottayam

In this exclusive interview with Dr. Bimal Charles, former General Secretary of CMAI we speak about the effects, impact and challenges of Violence in Medical Field. Interview by Christopher N. Peter, Lead- Department of Communications of CMAI.

Q. Why do you think that the trust is lost?

A. Even today, GDP allocation for healthcare is less than two percent. Which means that while the Government is unable to provide quality healthcare to everyone, those who could afford went to the private hospitals. In late nineties, standards came in bringing insurance companies, NABH and all services of hospitals were to meet standards and quality. So we saw that the costs rose and unfortunately, it was the patients who began to suffer. Hospital which was a place of trust witnessed a massive change.

Q. When the trust is lost, what happens?

A. Healthcare and hospitals are a place and safe haven of trust. We are unfortunately headed in a wrong direction. It seems that it is tough to go back in time now. So when the trust is broken the manifestation is in many different ways.

Q. Trust is build when truth prevails. When there is no trust, how do we hold steadfast with truth as a value?

A. It is here that we can be different from other hospitals in the private sector. People generally know that we are not in this for money and our ethical values are better than any other institutions. Like I have always said that our mission hospitals have a bright future because over a period of time this truth has eroded. Now there is very little understanding what this truth is. Most often the truth is not told. Having said that, I would say that there is so much that can be done in our institutions on what is proper, correct and ethical. When you do that you will have to tell the truth boldly and then gradually people and the community will trust the hospital.

Patients come to mission hospitals because they trust us with their lives and most

importantly they know that we will not exploit them as we have been telling the truth. But the point is that we have to tell what is real without camouflaging it by stating assumptions that this may happen or not happen. We have to come forth boldly and share our limitations and how within those the hospital would perform medical duties. If this communication is given properly and documented, then I believe that people will begin to trust us more in days to come.

Q. Please talk about litigation?

A. The government has enacted laws to protect healthcare providers, property and the life of workers. Some organizations are aware of it and unfortunately there are many who are not. However, the law also needs to be enforced by the law enforcement agencies but small institutions in rural areas are not only unaware but also scared to approach the law.

Q. How can a mission hospital protect itself?

A. Create a standard operating protocol by the hospital management. Those in frontline like guards, the receptionists, the nurses on duty and junior doctors have to receive standard training programmes. They have to be prepared how to respond in case of a physical attack on the hospital.

Let's say if somebody dies at the hospital. In that case how to break the news? who breaks the news? whether a junior or senior doctor breaks the news and what all precautions have been taken and what precautions have been taken to protect oneself physically before breaking the news. These according to me are system issues. We can definitely learn from those experts who have created such systems and especially those who have experienced these type of challenging times. For instance, like a code could be developed which is known to the entire hospital staff and the management. So that when needed, immediately everybody acts accordingly in a time when one needs to protect himself/herself, the staff and the property from a physical attack.

Q. What legal process can protect the institution and what our hospitals should be aware of?

A. A legal person has to be involved to inform the hospital and guide on the processes to keep the hospital protected legally. So I would say that our institutions have to be well aware of what is happening but the best would be would say prevention. Most often we get caught in consumer protection act as well as in violence situations because our people do not communicate properly. So to start with someone should be responsible in giving proper communication to the patient and the relatives. The staff has to have a proper checklist of communication points like type of disease,whatis the condition, possible outcomes, how much would it cost, related consequences, etc. Additionally, every communication is properly documented. Like there are standard consent forms and you should ask people to sign them. Also looking at your location and language a translated copy of the consent forms also should be made available at the hospital. Lastly, there should be adequate back-up in case of any untoward case.

Q.Why are institutions unable to communicate effectively in this regard?

A. See, our mission hospitals are struggling and struggling even for survival. So very often they don't have the latest equipment, best expertise and resources. Sometimes they try to help patients themselves along with guiding them to go take a treatment from some other facility. We should try to refrain from that and just speak the truth and state if the hospital is not able to take care of a patient then refer to another hospital.

Q. In case of an act of violence, who bears the brunt at the hospital first?

A. In a violent situation, the front liners get affected first. Normally, it is the nurses and the junior doctor. It is not fair unless we prepare them properly so that we can protect them. Not only that it is important for people to be alert as well. Staff at entrance and at reception have to alert because in a given situation a group can enter the hospital premises and gather slowly.

Q. Please talk about the local relationships, reputation and goodwill of the hospital with authorities, political parties, media, administration, business community, etc.

A. In the past these relationships were maintained. Our leaders in the past were very good in creating and maintaining these relationships. The local community felt lot of pride in associating themselves with their mission hospital. However, the hospitals create a physical wall around the campus which converts into a mental wall distancing them from the community.

We have to interact with everybody and engage with the local culture of the location or region. It is crucial for the leadership of the hospital to interact with the local community. Invitations to various festivals should be respected and attended by the staff. Interact with the district superintendent of police, district collector and the local politician. The CEO or the chief manager of the hospital has to regularly interact with the outside community despite having or not having latest equipment and facilities. Once you have a relationship then trust follows and when there is trust then you are protected. It is then the objective and purpose of our healing ministry can be effectively communicated and understood.

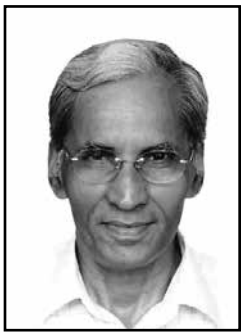
Q. What about the role of patient's family?

A. The role of family is really important because when someone is sick and suffering in the hospital, then it is the family that takes a decision. They play a critical part as in case of an issue or a problem it is the family that brings involvement of other family members and the community. It is the family that influences those they are connected with outside and at times in order to avoid paying for the treatment. Therefore, the hospital has to keep their communication with those family members who are closely related to the patient and keep this documented and recorded for defense in the future.

Q. The role of media?

A. We have to adapt to the situation. Relationship with media comes as a part of mission hospital's relationship with the outside world. Mostly, the hospitals are not prepared to interact and engage with the media. There is a way you talk to the media. There is a way you tell the truth to the media. We should not feel shy from media, in fact, we should know how to address the media persons, present our case to them, respond to their queries without getting scared of them and tell the truth. We also have to be cautious of the media and share knowledge and wisdom with the media. All of these approaches does not come naturally and requires practice and guidance. In time, these efforts will be noticed and then the senior media persons and representatives will respect the mission hospital and support in the future.

THE TRUST QUOTIENT OF MISSION HOSPITALS-AN OBSERVATION DURING THE COVID-19 SEASON



Dr. M.C.Mathew

I remember hearing my parents talk between themselves, when I fell ill during my childhood, that 'There is no mission hospital close by to go to'. They both had vivid memories of going to the Thiruvella Medical Mission hospital in central Kerala, to which they went whenever they or their parents had any health need. That hospital was their first port of call for all their medical needs. They spoke highly of the care and conveniences the hospital offered. Since my parents relocated in North Kerala, they did not have access to that hospital during my childhood.

As a medical student, I had acquaintances with Achalpur Mission Hospital, where Dr. Howard Searle spent several years; Paddar Mission Hospital where Dr. Victor Choudharie spent his life time of service and the Christian Fellowship Hospital, Oddanchatram, where its co-founder Dr A.K.Tharien spent his life time, developing health care facilities for the rural community. Anna and I worked for a while at the Christian Fellowship hospital and N.M.Wadia hospital, Pune, in the late nineteen seventies after our graduation, which gave us an opportunity to get to know why a mission hospital is the spontaneous first choice of many, when they have health care needs.

I was on a phone call the other day with Dr Sedevi Angami of the Christian Institute of Health Sciences and Research (CIHSR), Dimapur. He told me the several COVID 19 awareness programme the hospital staff was engaged in, in the community and hospital. The fear and anxiety about contracting the corona infection was high in the community that they even stopped coming to the hospital for their regular health care needs. The awareness campaign by visiting homes, church groups, restaurants, public places, village gatherings, etc. by the hospital staff helped in building confidence in the community to return to the hospital for their health care needs. Now, although the hospital is offering care for the COVID 19 patients in the same campus, the regular patients have resumed coming to the hospital. They now know of the care and attention with which the hospital has prepared itself to contain the spread of the COVID infection. Even the government of the Nagaland has adopted the protocol of care advocated by the CIHSR for prevention and treatment of COVID 19 infection. I followed up this conversation by talking to a friend, to get a feel of the role of CIHSR in Dimapur and near-by places. His response was that, 'People feel secure and confident when they come to CIHSR. Many travel long distance even from the adjacent north eastern states to reach the hospital'. His reason for this was that, people have come to believe that the hospital practices medicine 'honestly, ethically and altruistically'.

During a recent conversation with Dr Ravi George of the Asha Kiran Hospital, Lamptaput, which welcomes patients from the tribal belt, he shared a fascinating story. As early as

in March, when the news of the possibility of COVID 19 outbreak reached the hospital, the hospital team decided to convert the training centre, which is a stand-alone building away from the main hospital, to welcome and admit the COVID 19 patients as and when needed. This involved financial outlay, which for a hospital that normally needs external support for the maintenance of the hospital looked too ambitious to attempt. The training centre needed partition, staff needed protective kit, the ward needed extra beds and patients needed subsidised or free medical care. That was when, Dr Johny Oommen of Bisamcuttack mission Hospital offered to share their resources to help them to get it started. He introduced them to a donor, who was looking for genuine hospitals wanting to upgrade their capacity for the care of the COVID 19 patients.

“The Nepal-Bihar border having been closed following the national lock down, the hospital anticipated the local community to approach the hospital for regular health needs, which meant that they needed a separate facility for the patients of COVD 19.”

The donor having examined their financial statements and satisfied by the mission of the hospital, offered a generous grant to make all the provisions needed to run a COVID 19 in-patient service. Although the patients from the tribal community, who normally access the hospital by using the public transport or jeeps, could not come since the transport system was non-functional following the national lockdown, the hospital was reaching out to them through the wayside clinics and home visits. It is yet another story of trust. Even a new donor trusted a mission hospital unconditionally, to fund its project! The tribal community has confidence in the hospital, because they are familiar with the child care centres, literacy programmes, village health centres, women’s support initiatives, etc the hospital runs for the last 25 years now.

I was keen to know how the community around the Duncan Hospital, Raxaul, responded since the outbreak of the pandemic in that region. I got in touch with Dr Santhosh Mathew, who until recently was located at the Duncan hospital. He shared with me the efforts of the hospital to prevent the staff from getting infected and prepare a protocol of practice to offer affordable and effective care for the COVID 19 patients from the local community. The Nepal-Bihar border having been closed following the national lock down, the hospital anticipated the local community to approach the hospital for regular health needs, which meant that they needed a separate facility for the patients of COVD 19. The hospital took a proactive step well in advance that they would remain available to the local community. Seeing the abundant caution that the hospital was taking not to mix the regular patients and the COVID 19 patients, the local community, after a short while of staying away from the hospital, returned trusting the hospital in its intent to follow good practices. The Orthopaedic surgeon and the Managing Director of the hospital, Dr Prabhu Joseph seems to have mentioned to Dr Santhosh, that he had a heavy load of operations to do, apart from the accident and trauma surgery he was normally doing, during this period. This benefitted the hospital as the drop in the income at the hospital could be compensated

for through the regular services provided to the local community. The local patients did not get ostracised because the Duncan Hospital was looking after the COVID 19 patients. Instead they came to trust the hospital for their concern to protect them from COVID 19 while visiting the hospital. Dr Santhosh attributed these changes on account of the habit of prayer of the staff and the cordial consultation and collaboration between the staff to evolve a Duncan model of COVID 19 care for Bihar.

I was keen to get an overview of the way the community responded to the initiatives of a mission hospital located in a south Indian city. The telephonic interview with Dr Naveen Thomas of the Bangalore Baptist Hospital, gave me some significant impressions about the high level of trust the local community has bestowed on the Bangalore Baptist Hospital. The hospital was in a dilemma as to how they would manage the regular work load, when the government took away 50 percent of their beds for the care of the COVID 19 patients. This meant that the local patients 'feared' to come for their regular health needs to a 'COVID hospital'. This led to a drop in the number of patients visiting the hospital and the income. The increase in the salary for the staff, promised for April had to be kept in abeyance. Even the regular salary could not be paid in full to which the staff responded in a magnanimous way. Since all the steps to contain the infection from spreading beyond the COVID care area was made known widely, the patients for regular health care started to return. Dr Naveen talked about the team spirit he observed during this difficult time and commented his colleagues for their steadfast efforts to run a COVID service without disturbing the regular health care services too much. The local community knew the Baptist Hospital as their 'friend' at all times. A young consultant working in the hospital for a year, having observed the trust many patients have in the hospital told me, that 'The patients come to the hospital believing that, they have no other better place to go to'.

"Even the regular salary could not be paid in full to which the staff responded in a magnanimous way. Since all the steps to contain the infection from spreading beyond the COVID care area was made known widely, the patients for regular health care started to return."

The trust quotient is high among people who come to a mission hospital. This has been for fifty or seventy five years or more and continues to be so even now. The mission hospitals function across many geographical areas, both in the rural and urban areas. Wherever they are located, the community around a hospital finds it as a safe place to go to for their health care.

Late Dr K. N. Nambudiripad, a former director of the Christian Medical College, Ludhiana and a neurosurgeon of repute used to say that the 'X' factors which endear people to a mission hospital are, 'competency, communication and compassion'. I believe that the human resources in the mission hospitals are of high calibre. The professionals in the mission hospitals take considerable effort to listen to patients and share with them the details of procedures, out of due respect to their autonomy. I have some personal experiences of the hospital staff going out of their way to make patients and relatives feel comfortable by consoling them and offering practical help.

While talking to Dr. Christopher Moses of Jalna Mission Hospital, I discovered another dimension of this trust quotient which people repose in the mission hospitals. The local community gathered together to help the hospital, having seen the efforts of the hospital to create a separate ward for the COVID 19 patients. A generous gift was given by the local community to the hospital to subsidize the cost of care of those, who were financially burdened.

Even Dr Moses was surprised by this. He had not known that there was so much goodwill towards the hospital from the local community! The local community was perceptive of the fact that although Dr. Christopher and his wife Dr Shobha, are older in age, they ignore the risk they carry and are in the forefront, giving leadership to the team in the hospital.

The hospital is able to do the COVID testing in the hospital itself, which has enhanced people's opinion about the hospital's resolve to provide the best service for the local community.

Our mission hospitals have earned the trust of the people whom they serve, because the hospital staff live and exercise their mission of, 'not to be ministered unto but to minister' spontaneously and cheerfully.

Dr. M.C.Mathew, Emeritus Professor of Developmental Paediatrics and Child Neurology, was a former editor of the CMJI and president of the CMAI.

CMJI with this edition will engage with artists to commission them for creating the Cover Design. This work of art will add visual value to the theme. The original art piece will be available for purchase by an individual member or a member institution. For this edition, we spoke with Rajesh Kumar Gogu who created this painting on Violence in Medical Field.

CMJI: Dear Mr. Gogu, thank you the beautiful art work. Please tell us about yourself?

I am Rajesh Kr Gogu, currently heading the exterior design team at Maruti Suzuki. Painting has been a hobby for me since childhood. After joining the corporate world, I had stopped painting but picked up the brush again to inspire my daughters to paint.

CMJI: What inspires you?

Bringing a canvas to life reminds me of how God created everything out of nothing. So, when I sit in front of a canvas it reminds me of my creator and his creative act. Similarly, every painting I make is an act of worship, however big or small the subject maybe.

CMJI: The artists love the beauty of Canvas and colors. It has it own space and yet the digital world embraces and promotes art more effectively today. Your thoughts please?

Paints on canvas is a traditional medium which has been there for hundreds of years. It has its own charm and has timeless beauty. Along with time and advancement in technology, art has also been embracing the new media that are available. Both traditional and digital art have their own unique way and advantages in expressing the artists' creativity. It's upto the artist to choose which medium best represents his creativity and ideas. In these changing times, the artists often need to embrace digital medium to reach and promote their art.

CMJI: So looking at the painting you've created for the cover page, tell us what came to your mind?

The brief that was given to me was "violence in the medical field". There are many doctors in my family. In fact, when one of my cousins was studying medicine I used to visit him quite often and spent a lot of time in the hospitals and

with other medicos. I saw first-hand how they treated the patients and their commitment to make the patient live and get better again. They don't give up.

The first thing that came to my mind was how delicate life is and how the doctors are life savers who dedicate themselves for that cause so that out light continues to glow for another day. I hope people can see that in this art and my prayer is that violence against doctors would reduce drastically.

CMJI: CMAI is trying to promote artists through this publication. What would you like to tell your fellow Artists?

It's wonderful to see that CMAI is using art to highlight the relevant issues or causes of the medical field. It's a good initiative and I commend you for that. I encourage artists to engage with CMAI and use this as a stimulus to not only bring out your creativity but also to make people think.

A picture is better than a thousand words. But in today's world the attention span is just few seconds even for that picture. I believe a painting can grab the attention of the viewer for few more seconds from the visual chaos we experience on a daily basis. We have that power to stop the eyes moving on to another visual content. So, I encourage artists to use it for a good cause like this.

CMJI: What does your process involve? Does the work evolve or your start with an idea and take it to the finish?

It depends, sometimes I have an idea before even I start painting and I use the Digital medium to compose and try out different options before I actually paint it. Other times, I paint and then repaint to improve. With this cover page, I was very clear what I wanted to paint, even the colours and the mood I wanted to capture. Sometimes, it's not that easy. It's a creative struggle and I love that process. I often run the ideas by my wife and kids (10 & 6 years), they are my first critics and based on their feedback I do changes. For us, art is a family affair :-)

CMJI: Where can we find more about your work?

You can find my art on Instagram @gogu.art.

Note: Those interested in buying the art work kindly write to us at cmai@cmai.org

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LEGAL RISK FOR MEDICAL PROFESSIONALS

Mr. Abraham Mathew

Which doctor (or any professional, for that matter) has not had a friend ask for medical advice through a text message on Whatsapp? It is almost commonplace nowadays for friends and extended family to borrow your expertise. But are you liable for advice that was given gratuitously, without physically examining the patient, or considering their medical history?

While the law doesn't not permit recipients of free treatment to sue medical service providers, these lines could be blurred with tele-health becoming more prevalent; a 'patient' could claim consideration for services in many ways. But for this article, we will look at traditional medical services, and the legal risks faced by doctors.

Patients can potentially proceed against doctors in several ways – a complaint with the Medical Council, criminal proceedings, and much more commonly, a complaint before the consumer courts.

Consumer complaints against doctors are becoming much more common. However, it is important to point out that unlike in most other cases, where courts are pro-consumer, in medical negligence cases, courts are typically more protective of doctors. It has been held repeatedly by the Supreme Court that if a doctor has adopted a practice that is considered "proper" by a reasonable body of medical professionals who are skilled in that particular field, he or she will not be held negligent only because something went wrong.

> **"It has been held repeatedly by the Supreme Court that if a doctor has adopted a practice that is considered "proper" by a reasonable body of medical professionals who are skilled in that particular field, he or she will not be held negligent only because something went wrong."**

In a recent case, surgery was performed on the lower back area of a patient. She continued having back-pain, and six months later, a different hospital conducted a scan to discover that there was a cyst on the upper area of the spinal cord. Now, the relevant question was whether the cyst developed subsequent to the first operation; and simultaneously, whether the surgery on the lower portion, L4 & L5, was actually successful, which is why, it did not show abnormality. In such a case, the judge decides by analysing the doctor's recommendation for the scan which formed the basis for the first operation. (That still leaves the question of whether the cyst at D5 existed at the time of the first operation, but one has seen that in such cases, doctors get the benefit of doubt).

This, and so many other episodes, show how proper

documentation – with regard to symptoms, suggested treatment, information about side-effects, etc - can come to the aid of the doctor. Equally important is adherence to well-established procedures.

The kind of adventurism exhibited by the protagonist in the beginning of the Malayalam movie “Ayaalum Najaanum Thammil’ where the doctor operates on a minor without parents’ consent is best avoided. Unless, of course, it can be justified why the doctor had to act in haste – such as the treatment of a victim of a serious accident. Again, the test is whether a reasonable doctor would act the same way in a similar situation.

Courts are also alive to the different sinister motives behind filing of cases. In another recent case, it came out during cross examination that an ayurvedic ‘doctor’ who had treated the patient subsequently had offered to conduct a case against her former (allopathic) doctor, in exchange for 50% of whatever compensation was awarded by the Court. It cannot be underlined enough that medical professionals should take adequate care (but definitely not encroaching on paranoia – you are only expected to prove a reasonable standard of care).

So then what are the cases that typically land doctors and hospitals in trouble? These are, broadly speaking, cases where on the face of it, it can be seen that there was negligence on the part of the doctor. A prominent case from Delhi comes to mind, where the doctors allegedly operated on the left leg, when the surgery was required on the right leg.As it turned out, the Medical Council gave a rap on the knuckle for the junior doctors, while exonerating the senior

doctor. However, the patient appealed to the High Court which then interfered in the case.

Another example comes from Calcutta where a patient was refused treatment for not depositing money, even though he was covered by insurance for a sum higher than what was demanded. While being taken to another hospital, the patient expired, and the hospital was found guilty of negligence. One shouldn't forget the case of Dr Kunal Saha, who lost his wife, a psychologist, due to a serious case of negligence – the hospital had given an excessive dose of steroids during treatment. The Supreme Court finally awarded over Rs 11 crore in compensation, including interest. All these cases are examples of consequences that flow from gross and palpable negligence. They shouldn't be seen as the norm in such cases, but doctors must be vigilant against giving room for such instances.

Doctors may also be exposed to criminal liability – mainly under 304 of the Indian Penal Code for having caused death due to their rash and negligent act. The Supreme Court has clarified earlier this year that this section cannot be invoked against doctors unless there is a high order of negligence. In addition, Sections 80 (accident while doing a lawful act without criminal intention or knowledge) and section 88 (act done in good faith for the benefit of another, and where the patient has given consent) protect doctors in a majority of cases that come under this section. If a doctor opts for a riskier procedure, but which has a higher chance of relief for the patient (after explaining the nuances to the patient, and obtaining consent), the mere fact that the procedure was unsuccessful does not give rise to liability.

"If a doctor opts for a riskier procedure, but which has a higher chance of relief for the patient (after explaining the nuances to the patient, and obtaining consent), the mere fact that the procedure was unsuccessful does not give rise to liability."

Another area that can be litigated more harshly in the days to come is the violation of patients' privacy. With the advent of tele-health, doctors may have to take additional steps to ensure the confidentiality of patients records (including being alert to the possibility of their devices being hacked). The new announcement of Health IDs for patients could bring in further complications. With patients entire medical history available to the treating doctor, it will (hypothetically speaking) be presumed that the doctor has studied it all before suggesting a treatment.

The author is an advocate practicing in Delhi, and a qualified Chartered Accountant, and can be reached at matabrahamc@gmail.com.

Mr. Abraham Mathew
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INTERPROFESSIONAL RELATIONSHIPS: A BIBLICAL PERSPECTIVE

Mrs. Priyadarsini John

In the Bible we find God revealing Himself as a relationship nurturing God. The opening pages of the scriptures point to God finishing off the first surgery and seeing the outcome of His surgery called out it is "good". Further He enjoyed the communion with the first man and woman in His eco-system and perhaps set the framework for relationship building between different stakeholders. Maintaining good interprofessional relationships with co-workers is an integral part of work satisfaction and retention of health care workers.

Healthy Work Environment: A healthy environment is essential for hiring, performing and retaining high calibre staff. As the word gets around of the culture of the organisation/ hospital good staff either gravitate to or away. Thus, hiring best in class talent is impingent on ensuring a healthy environment is cultivated. A work context that is surrounded by people who are concerned about each other, willing to cover for each other, lift each other up, ensures an effective work ethic and together a high quality service is emergent for the patients who are under the care of the hospital staff. An enabling and positive environment in turn leads to minimal attrition and higher retention of staff as it contributes to a sense of staff wellbeing which ranks highly alongside the monetary benefits. In fact, studies have shown that the atmosphere and significance of nurse- physician relationships determine nurse satisfaction and retention.

> **"A work context that is surrounded by people who are concerned about each other, willing to cover for each other, lift each other up, ensures an effective work ethic and together a high quality service is emergent for the patients who are under the care of the hospital staff."**

Conflicts and its adverse impact: Relationships need to be cultivated, nourished, weeds removed and watered with care to foster a long-term bond. A healthy relationship is a pre-requisite for a productive outcome in any area of life. Where two or more individuals work together conflicts are bound to arise. Disruptive behaviours ranging from verbal abuse to physical and sexual harassment[1] are known factors that adversely impact effective relationship within the hospital eco-system.

Very often it's our desire for power and position, pride or jealousy towards our co-workers that create conflicts. This is true of nurses and physicians and such conflicts often leads to poor teamwork/ inhibit effective collaboration,

result in poor attitude towards patients and delivering poor quality of patient care. It affects the accuracy, safety and outcomes of care causing frustration among health care workers. It hampers interprofessional effectiveness; lead to lack of cooperation and collaboration among co-workers, diminished teamwork, decreased creativity and adversely impact productivity.

Perhaps, the best way to deal with conflicts is to confront it constructively rather than allow it to fester that runs the risk of blowing out of proportions.

Gleaning the scriptures point to 5 Ps that are perhaps crucial to enjoy meaningful Inter-professional relationships:

1. Principle
2. Peace-loving
3. Politeness
4. Privacy
5. Prudence

I Principle:

Biblical readings present a basic tenet that is fundamental to building and nurturing relationships. When this principle is followed it leads to relationships flowering and when this is flouted it invariably results in relationships souring.

Honesty: Every relationship is to be handled truthfully, without guile. The Bible admonishes us to speak the truth in love. Honesty calls for speaking the truth; there is no compromise on the truth; during the day-to-day conversations within the nurses or between the nurses and doctors there are numerous opportunities for resorting to lies. Lies breaches trust and erodes relationships. While the truth is to be spoken it is to be spoken in love; the intent and the intonation while speaking are equally important and needs to be clearly expressed. The need is to be authentic, frank and candid. Wounds

when they arise because of speaking the truth needs to be nursed with care and love lest it turns septic. The Scriptures say:

Ephesians 4:15 Instead, speak the truth in love, we will in all things grow up into Christ Himself, who is the head.

Ephesians 4:25 Let each one of you speak the truth with his neighbor

Proverbs 10:9 Whoever walks in integrity, walks securely

II Peace-loving:

When conflicts arise and they will, the question is do we react or respond? Reaction is operating in the natural where we invariably retort without thinking through and often this is an emotional outburst. The need is to defer the natural reaction and temper it down with a response. The response is a thought through rational rather than emotional revert. Here we benefit as the situation does not aggravate but gets alleviated. The driving force here is the precedence of peace and harmony over conflict and hatred. Often conflict arises owing to a high sense of competition. Competing does not help but collaboration does; synergizing the strengths of each other and functioning as a team ensures we make ourselves as channels for the peace of God to flow through. Deal with differences peacefully. How do we deal with it?

1. Prayerfully: We have a God who is ever ready to listen to our cries, address our plight and intervene on our behalf. He can do things beyond what we can imagine or ask for. Taking our challenging situations to Him in prayer will ensure we are not dealing with the difficult situation at hand from a human standpoint but are leveraging the divine strength.

2. Discern the spirit and deal with conflicts: Often conflicts stem from ulterior motives, hidden agendas or incompetence. Recognising the reasons behind is fundamental to addressing them effectively. Sense the primary reasons and you should be able to handle them appropriately. E.g. if the conflict is a function of hidden agenda exploring the issue with the concerned individual in love will help progress towards resolution. Should this not work raising it to the relevant authorities may be the option to resort to. The Scriptures say in:

“Taking our challenging situations to Him in prayer will ensure we are not dealing with the difficult situation at hand from a human standpoint but are leveraging the divine strength.”

Colossians 3:15: "Let the peace of Christ rule in your hearts, since as members of one body you were called to peace.

Ephesians 4:3: Unity of spirit through bond of peace

III. Politeness:

It is to be considerate of others. In a world where often, my interests override others' interests the Bible admonishes us to hold others of high esteem than ourselves. Consideration for others is expressed in our dealings in the form of respect for and holding others' perspectives with the same level of dignity that we hold ours. It is to treat everyone equally; nurses treat each other equally; doctors treat the nurses as equals in terms of standing although functionally the nurses may take orders from the doctors. Often in a high paced, high stressed environment such as the ICU or OT's there is every possibility for tempers to rise and one often can end up losing one's cool. It is imperative that we exercise politeness and soon this will be noted, and others will reference us as role models as we

exercise restraint in all our dealings. Remember the scriptures:

Colossians 4:6 says Let your conversation be full of grace, seasoned with salt so that you may know how to answer everyone.

Proverbs 22:11 speaks about speaking graciously

Mathew 7:12 talks about doing to others what you want others to do unto you.

IV. Privacy:

Inevitably when working with colleagues in a professional environment, personal relationships of friendships gets formed. Such relationships are founded on trust and must be maintained sacrosanct. One of the ways trust manifests itself is through privacy/ confidentiality. Matters shared in private by colleagues need to be kept confidential. Any attempts to publicise privately shared information will lead to breach of trust and result in strained relationships. Maintaining confidentially shared information under wraps helps co-workers to bond, share problems and enhance professional working. Thus, keeping the sanctity of such confidences is important. However, note that that the confidences do not breach integrity. The Scriptures say:

Proverbs 11:12-13 a man of understanding holds one's tongue, does not gossip and betray confidence but a trustworthy man keeps a secret.

Proverbs 10:9 the man of integrity walks securely.

V. Prudence:

The quality of being prudent, or wise in practical affairs as by exercising caution, demonstrating discretion while dealing with others in a professional environment ensures that we do not jeopardise personal relationships. Prudence is a hallmark of maturity. Relationships can be brittle and if they are not handled with caution they may very well slip and break. Thus, considering if what we are to say are examined in the light of the following three questions:

1. Is it the right thing to say?
2. Is it the right time to say it?
3. Is it the right way to say it?

Ensuring these questions are answered will enable us to exercise restraint on things not to be said or employ skill in saying it the way it is to be said and ensure the timing is just right.

The Scriptures say in:

Mathew 10:16 Be wise as serpents and harmless as dove

Proverbs 13:16 In everything the prudent acts with knowledge but a fool flaunts his folly

In closing remember what you do not want done to yourself, do not do others. Albert Einstein who said, " only a life lived for others is a life worthwhile" Let us nurture professional relationships that are mature, that weathers the storms and that edifies and builds each other. May God grant grace!

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ROLE OF FAMILY IN THE HEALING PROCESS

Blessed is he who has regard for the weak; the LORD delivers him in times of trouble. Psalm 41:1

Ms.Rogina Savarimuthu

Family is first institution that God created to have communion with (Genesis 1). He created a man and a woman put them together and said “This is good". God himself longed to have relationship with man and he visited them daily in the Garden of Eden. Violence was not God’s intent of creation or emotion. It was an outcome of man’s sin.

Ms. Jemimah Jayakumar

Family is not just a physical association it is a complex emotional union. Family is the bond that we are born with. All of us love to belong to someone. There is peace when the complex is undisturbed. This complex is currently undergoing a process of profound change, due to continuing global changes that have occurred in recent decades, these changes threaten structural stability, bringing consequent changes in patterns of health and wellness to the family life cycle. Violence: Violence means the actions or words that are intended to hurt people. There is use of extreme force. The use of force on people or objects. But Bible call us to be messengers of peace and portals of love. In James 1:19-20 Paul urges every fellow believer in Christ to be swift to hear, slow to speak, slow to wrath.

Sickness and Family role disruption: Each family member plays a vital role in maintaining the harmony in a family, be it child or a responsible adult. Sickness is never an anticipated event in a family. When a member of a family falls ill and is hospitalised. First of all, the family is traumatised along with the patient. It is a nightmare when the person is critically ill.

Family The pivot

1) Family Vs illness

a) Acute or short-term Physical Illness

Family has been already described as an integral system. So, illness of a member can threaten the system. The result of threat of this system can include fear, distress, feeling of weakness, and lack of hope, which can lead to physical and emotional exhaustion. For this reason, each intervention that decreases the effect of these pressures, benefits family. Even a small illness like a respiratory infection or a fall disrupts the role of the sick member requiring role changes with in family. The degree that family is affected by illness of one of its members depends on:

- The role of the sick person in the family.
- Age of the sick individual as well as the family members
- The emotional bonding among family members.
- The financial stability.
- Perceived severity of the illness
- Availability of treatment options
- Physical suffering and pain

Presence of family during a person’s sickness strengthens the positive emotions enhances a

holistic approach which brings the best outcome.

b) Chronic or Rehabilitation requiring Physical Illness

When a person is hospitalised for a long-term or has a debilitating illness, the family encounters profound stress. Much so when the outcome is expected to be fatal. Family constitutes an important source of psychological and emotional support for hospitalized patients. The most important activities family can carry out during hospitalization of one of its members are as follows:

- Maintaining communication with patient and relatives.
- Providing spiritual, emotional psychological and financial support.
- Collaboration with health care professionals in therapeutic process.
- Participation in the planning and provision of patient care

c) Psychiatric Illness

In any psychiatric illness, along with the stress of chronic illness the family faces the stress of social stigma. Apart from managing the stigma the family is expected to play a vital role in recovery of the individual. According to the National Institute on Drug Abuse (NIDA), there is a correlation between the amount of social support a person has and their potential for relapse; those with less support are more likely to relapse. Hence family undergoes a lot of role changes when a person is under psychiatric care.

d) End of life Illness

End of life care is a novel concept with historical approach. This enhances individual and family preparation not just involving emotional, social or financial preparation but also role change adaptation of family members e.g. a son assuming father's role in family taking care of family needs.

2) Family Vs Sick Person

Illness debilitates the person's ability but presence of family provides an important source of psychological stability for the sick person, as well as a source of support for better recovery. The role of family, friends, and relatives is of vital importance for the maintenance of quality of life in hospitalized patients with chronic problems because family can satisfy basic needs of the sick person in the hospital to a large extent.

3) Family Vs Health Care Providers

It is a routine for a health care provider to be in hospital but it is a one-time incident and a dread for family. Patients and family are exposed to a place consisting of medicines, tubes, injections, blood, sorrow, pain and fear that cause utter confusion. Only positive hope that keeps them going is the hope that they are in the best place of care under the skilled hands. The family always looks forward for people who offer a positive outcome. This places the Medical team in a vulnerable position that even a small spark can burst out into big flames. Building a positive trust and friendship helps the medical team to overcome the positive expectation and to present reality to the family.

4) Family Vs Role disruption acceptance

As the patient is recovering, this is only the beginning of the journey for the family. They have questions, thoughts, and concerns about how the life they once knew has now gone on standby. Including the family in the treatment plan is important, and just taking the time to listen to the questions and concerns from the patient and family means so much. Even if an answer cannot be given, just the fact that their concerns were listened to and addressed goes a long way with the healing process. Providing realistic expectations helps build trust.

Violence

1. Violence within family

Family first struggles with in itself with the demands of sick person and later acclimates to violence as a method to compensate the role disruption. Chronic stress due to role disruption leads to blame game. Obvious physical violence may be absent within health care setting but a subdue emotional disconnect is noted among the family members due to inability to accept reality. With any chronic incurable illness, it is not just the family but even the extended family suffers emotionally because of the pain noted in patient's family. Each family member often is at different stages of grief. And they respond to others be it their own family member or an outsider in a manner influenced by the grieving stage which further complicates the family dynamics.

2. Violence with others or Health care Members

Each member of in the family anticipates a speedy recovery, while it might be a slow or bad prognosis they might become frustrated. Even trivial issues can result in violence and most often displaced onto the health care provider.

The health care setting serves a place to exhibit fierce emotions due to the vulnerable environment. Inability to trust the health care professional leads to violence. The Occupational Safety and Health Administration (OSHA) reports that in each year from 2011 to 2013, U.S. healthcare workers suffered 15,000 to 20,000 serious workplace-violence-related injuries; serious injuries are those that require time away from work for treatment and recovery. Indian Medical Association has reported that 75% of heath care professionals face verbal or physical abuse in hospital premises and fear of violence was the most common cause for stress for 43% doctors. The highest number of violence was reported in the department of emergency care and Intensive Care units. According to the findings, data of the past five years showed that the escorts of patient committed 68.33% of the violence. In India, 62% of doctors who answered a survey reported that they were unable to see their patients without any fear of violence, and 57% had considered hiring security staff at their workplace. This has increased anxiety among the health care professionals.

One of the authors of this article was taking care of a client who was on 2L of oxygen through nasal prongs. Due to the client's disease condition it was contraindicated to administer 100% oxygen. The father of the client said "you are stingy! My son needs oxygen. I will pay whatever it costs." Yet the nurse refused to administer 100% oxygen in benevolence to the client. There was tension in the air, the client's father pushed the nurse and increased the oxygen supply but at last we lost the Client in spite of all efforts to save him. The family members blamed the health care team and were in a rage to beat the treating team members.

As the data serves as an eye opener, the health care profession is in need of a plan to address this increasing violence with in the health care setting.

3. Violence with Society

Any sick person leaving the hospital either well or sick or dead leaves a greater impact on the society. The society forms an impression regarding the care at the hospital. During recent Pandemic time the health care setting is overflowing and there is heavy loss of human lives. Thus, giving an impact that the health care delivery is inadequate. The type of disease condition (contagious and stigma) determines the society's reaction towards convalescent client, family or the deceased. Continuing research with failure of breakthrough has also

led to frustration among the community. Such situations lead to violence not just with the hospital unit but with the Government system and within society.

Key to Resolution and Restitution

1. Communication

Isaiah 50:4 says The Sovereign LORD has given me a well-instructed tongue, to know the word that sustains the weary. He wakens me morning by morning, wakens my ear to listen like one being instructed. The Lord himself trains us when we wait on him. Also in Ephesians 4:29-32 we read "Let no corrupt communication proceed out of your mouth, but that which is good to the use of edifying, that it may minister grace unto the hearers". We are called to speak with grace in every situation. Patient's hospitalization is not a pleasant thing for any individual in family, since it can cause crisis in family due to dysfunction and instability. In order to avoid a crisis in family, it is important to estimate all the needs of family and address them. Main needs include needs of knowledge, emotional needs, and personal needs.

Assessing and connecting with family requires effective communication. Using the beatitudes of Christ helps us become better professional than others.

- Be open to discuss the needs of family
- Encourage behavioural flexibility in stressful environment
- Acceptance of physical changes of patient for e.g. Loss of a limb or disfigurement after burns
- Use illness as an opportunity to promote family bonding and resolve any disputes among members
- Therapeutic communication with Health team members promote overall well being

2. Co-operative Planning

Wright and Leahey assert that nursing care for the family can be seen from two perspectives:

i. The one that is focused on the affected individual and that is part of a family context from which it cannot be separated; seeing the individual the figure and the family the foundation.

ii. The one that focuses on the individual and the family simultaneously, under the premise that when one of their members is affected, the whole family is altered, and therefore requires care.

The second perspective proposed by Wright and Leahey is the one that today must be strengthened from public policies and health practice, in order to preserve the family unit as an integrated system. Once a health care professional strengthens the family, the need for reassurance from health care team reduces. This leads to trust and acceptance of the team. The family's norm in planning needs to be taken into consideration. In India mostly it is the family members who take the decisions on health care planning. While in other Countries the sick person themselves take part in decision making on their own health. When planning care it is vital to understand the family's decision taking pattern.

A middle aged man was admitted in the ICU, his admission into the ICU was out of visiting hours in the night. He had very less time on earth. His adolescent son approached and requested the nurse to allow him to be with his dying father. In-spite of varied opinions from the team members, the son was allowed to stay with the dying father. Less than an hour the father entered eternal life. His son stated "thank you for allowing me! I was near my father during his dying. I can be at peace. Considering the family as a unit yet focussing on individual needs by

going an extra mile helps the health care team gain more trust.

3. Enabling the Role compensation

As Bible guides in *Colossians 3:13,* we are called to bear with one another and, if one has a complaint against another, forgive each other; as the Lord has forgiven you, so you also must forgive. The lord asks us to bear with one another in times of good and bad. The family bonds are better explored when the roles are defined clearly. When the role of a member is lost due to illness, willingness to take up the roles and share the burden among each other should be encouraged. Also, when preparing a family for the role compensation we must ensure it is equally shared by members. This helps to promote optimistic outlook to the new role.

4. Community follow up

Even though the family role is disrupted due to hospitalisation the family ends up being part of the society and lives in a community. Helping them adjust to the roles at the community level helps in better coping and avoids violence. Many NGO's provide after care follow up and assistance to families in distress. Family can be introduced to NGO schemes like assistance in child education, monetary assistance in setting up self-employment with in the limited ability of family, cattle fund etc.

Conclusion:

Global changes and transformations in the family set up continue to provide new challenges every day to the health care profession. The important thing about all this is the degree of awareness that all the entities involved and the measures of action and correction that are taken along the way. We as health care professionals must address the needs of patients, their care givers and integrate the care into a dynamic and family centred one. Once we ensure the family is able to function at the lowest cost for the expected quality of life with satisfaction, we can proudly say we have competently cared for a family from the time of illness to the recovery. As stated in 1 Corinthians 12:26 If one part suffers, every part suffers with it; if one part is honoured, every part rejoices with it. It is our responsibility as health care professionals to help families be honoured and rejoiced.

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RELATIONSHIP BETWEEN HEALTHCARE PROFESSIONALS AND COMMUNITIES: *Urban and Rural settings*

Rev. Dr. Arul Dhas T.

86 year old Paediatrician Dr. Devadas from a place near Tiruchy, Tamil Nadu passed away in late July 2020. He was a very popular doctor and was loved by common people referred to as "Five Rupee Doctor" since he charged only Rs. 5/- for his consultations. When I made a search about in the internet recently, I came to know that there was a doctor in Kolkota and another in Karnataka just like Dr. Devadas charging people with very minimal and nominal amount as consultations.

Why do such doctors charge a small amount when so many are keen to charge a heavy amount? Many of them have justification saying that they have spent so much money for their medical studies. They have spent so many years of intensive studies and therefore they should be considered eligible to receive a huge amount as their consultations. This argument goes powerful in many corners, not only in the healthcare setting. People's worth is assessed based on the 'investment' they have made in terms of the years of study and the money they had spent to get to the position they have 'climbed'.

> **"He was a very popular doctor and was loved by common people referred to as "Five Rupee Doctor" since he charged only Rs. 5/- for his consultations."**

There seems to be a gap in the thinking of professionals – specifically healthcare professionals. In a community, different people are given different talents and opportunities. They make use of them and get to a position. In the midst of all these, there is an understanding of 'calling' for everyone of us. Every member of the community is called to be somebody and to do something for the betterment and health of the community. Accumulation of power and wealth at the cost of others' tragedies and misfortunes cannot be seen as right, healthy and God-given.

Relationship among the community members is an important aspect of life and fulfilment. Even though there are so many inequalities in the community with regard to our gifts and talents, the members of the community should not work towards widening the gaps, rather work for the oneness and togetherness.

The doctors, nurses and allied health professionals should be seen in the light of this backdrop. Are they not part of this community who have same responsibility of working for the health and wellbeing of the community? Sadly, many who do 'well' in their life/ are 'successful' in life do not see themselves as part of this community. People like Dr. Devadas definitely wanted to be part of the community and see the wellbeing of the community.

Hospitals began as establishments to care for the weak, sick and the suffering. They symbolised how hospitality should be in a community. However, when the ministers in the hospitals began considering themselves as more important than others, a division began emerging. Many even started building hospitals and started studying healthcare courses looking at them as great 'business' options. Slowly the oneness and trust people had on the healthcare providers and professionals began deteriorating. When I asked a patient who travelled nearly two thousand kilometres to consult a doctor, he said that he needed an honest opinion whether the surgery is needed or not. On the one hand it is good to have a second opinion, on the other hand if this is necessitated by lack of trust, there is something wrong fundamentally.

Healthy relationships are demonstrated by care, compassion, equal treatment, respectful consideration, mutual trust and so on. Focussing on profits, desire on embellishments, accumulating for oneself and lack of respect and care definitely are indicators of an unhealthy community. Commercially motivated health establishments are sign of a disintegrated community. In today's world we see many health care institutions making good 'profits' which benefit the owners and the founders.

The leaders of the community take responsibility towards the wellbeing of its members. In a community, people are together in all seasons. If there is a crisis, members gather around and try to help one another. Church is a body of believers who are united in different manners in

the pattern of Christ, the Lord and Savior. Church in general takes care of every part of the body. The health of the members is the responsibility of the church. This should be the scenario among the Christian community. Healthcare professionals are part of the community and they have a special responsibility to heal and work for the wellbeing of others.

Investigations in the healthcare setting:

When an institution buys an expensive medical equipment, it plans for its returns. Therefore even when a particular medical test is not indicated, since the equipment is available, since money is needed for the institution, sometimes since the professionals want to practice a defense medicine, they order for the investigation. The ordinary patient ends up paying a huge amount for the 'unnecessary' investigation. When the healthcare professional acts ethically that builds up relationship between the community and the professional. In today's mission context, the mission hospitals need to go extra mile, move against the normal current in the society to remain as the beacon of hope in the communities. The distinction between what is needed and what is not needed gets blurred due to our distractions – emotionally and spiritually.

Focus on the clinical examinations and the art of history taking:

Many of the health issues are handled well by examining the patient well and paying attention to what he/she says. Many do not understand that the cornerstone of clinical diagnosis is history taking. History taking also provides opportunity to build relationship, communicate care in the midst of listening. In our training programmes of the healthcare settings, as mission hospitals we need to emphasise the need for clinical diagnosis with careful history taking. This will definitely bring the trust back in our setting.

Communicating the plans about the future:

Often the elite do not see the need to communicate to the ordinary people what is in their mind about the future of the community. Every ordinary member of the community is a stakeholder in our health seeking society. The strength of the community is as good as the weakest member just as the strength of the chain is as good as the weakest link. Even though it is sometimes cumbersome, it is needed at the larger interest of the community to share our plans and the decisions. During the COVID 19 times, there was a good amount of cooperation between the leaders and the community. One reason could be that there was a good communication between the leaders and the community regarding the plan of action. Even in a context of uncertainty, good communication helps to build relationships.

Difference between urban and rural settings:

Because of the nature of urban contexts, the healthcare professionals face additional challenges. Trust level in the urban settings is normally less simply because of the enormous number of people in the urban settings. Migration of people towards the urban settings is common among the ordinary people and among the professionals. The reasons could be varied. We could see this operating even in the mission hospitals. The relationships in rural hospitals are different from urban hospitals. However, our attempts to understand the other person irrespective of the settings will pave a long way towards healthy communities.

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CLINICAL CRITERIA FOR DIAGNOSIS OF COVID-19

(By MS Seshadri, T Jacob John; 8-6-20)

COVID-19 is the disease caused by the infection with SARS-CoV-2.

In otherwise healthy adults the clinical diagnostic criteria are as follows:

Major Criteria

Group A:

1. Fever ≥ 3 days
2. Persistent dry cough
3. Sudden onset loss of smell with or without loss of taste

Group B:

1. On chest auscultation, crepitations
2. Resting respiratory rate of ≥25 per minute
3. Pulse oximeter showing oxygen saturation ≤ 94 % on room air

Group C:

CT scan or chest X Ray showing patchy peripheral infiltrates or bilateral ground glass appearance, without lobar consolidation or cavitary lesion

Minor Criteria:

1. Headache/body aches/myalgia
2. Severe fatigue/lassitude
3. Diarrhea
4. Conjunctival irritation -- pink eye with or without secretions
5. Skin lesions - maculopapular erythematous, urticarial or vesicular non-pruritic
6. WBC count: normal or low normal total count; but lymphocytes ≤20%

Diagnosis using the above criteria:

Either:

Three Major criteria, if they include at least one each from Group A, Group B and Group C.

Or:

In the absence of, or non-availability of, Chest imaging criterion (Group C), at least two Major criteria from Group A, at least one Major criterion from Group B and at least two Minor criteria

In elderly or those with co-morbidities, clinical features may vary from the above

These subjects may have any of the clinical features listed under Major or Minor criteria, or, may have only subtle features of low grade fever, delirium, postural instability and drowsiness. If any of these subtle features occurs, it is mandatory to do pulse oximetry (Major No. 6) and a Chest CT scan or X Ray (Major No.7) and if either is positive, to assume the diagnosis of COVID-19 and initiate treatment in a hospital.

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Christian Medical Association of India

BEYOND COVID-19

CMAI STORIES FROM FIELD & REGIONS

During COVID-19 lockdown and even much later, lack of employment opportunities made it impossible for Saraswati* and her husband Ramesh* (a *daily wage labourer*) to sustain themselves financially. They are meanwhile expecting a child. Saraswati is in her eighth month of pregnancy. Ramesh is unable to get any work.

They together visited Nireekshana (AIDS Care, Education & Training) Center accessible from their village. They met the officials and shared their plight.

The staff included them in the team which is locally creating innovative products at the center for COVID-19. Saraswati learnt how to make liquid soap and phenyl. She also received 10 liters of soap which she made herself in order to sell and generate some income. Saraswati and Ramesh are grateful to attain an income-generating skill and feel confident. Saraswati has also received nutrition support and medicines from the center.

Nireekshana (AIDS Care, Education & Training) Center, is a member of Christian Medical Association India. CMAI is the health arm of the National Council of Churches in India, a 100 plus year old network of more than 270 mission hospitals and 10,000 plus healthcare professionals.

To know more about CMAI's Mission Hospital (MI), please visit **www.nireekshanaacet.org**

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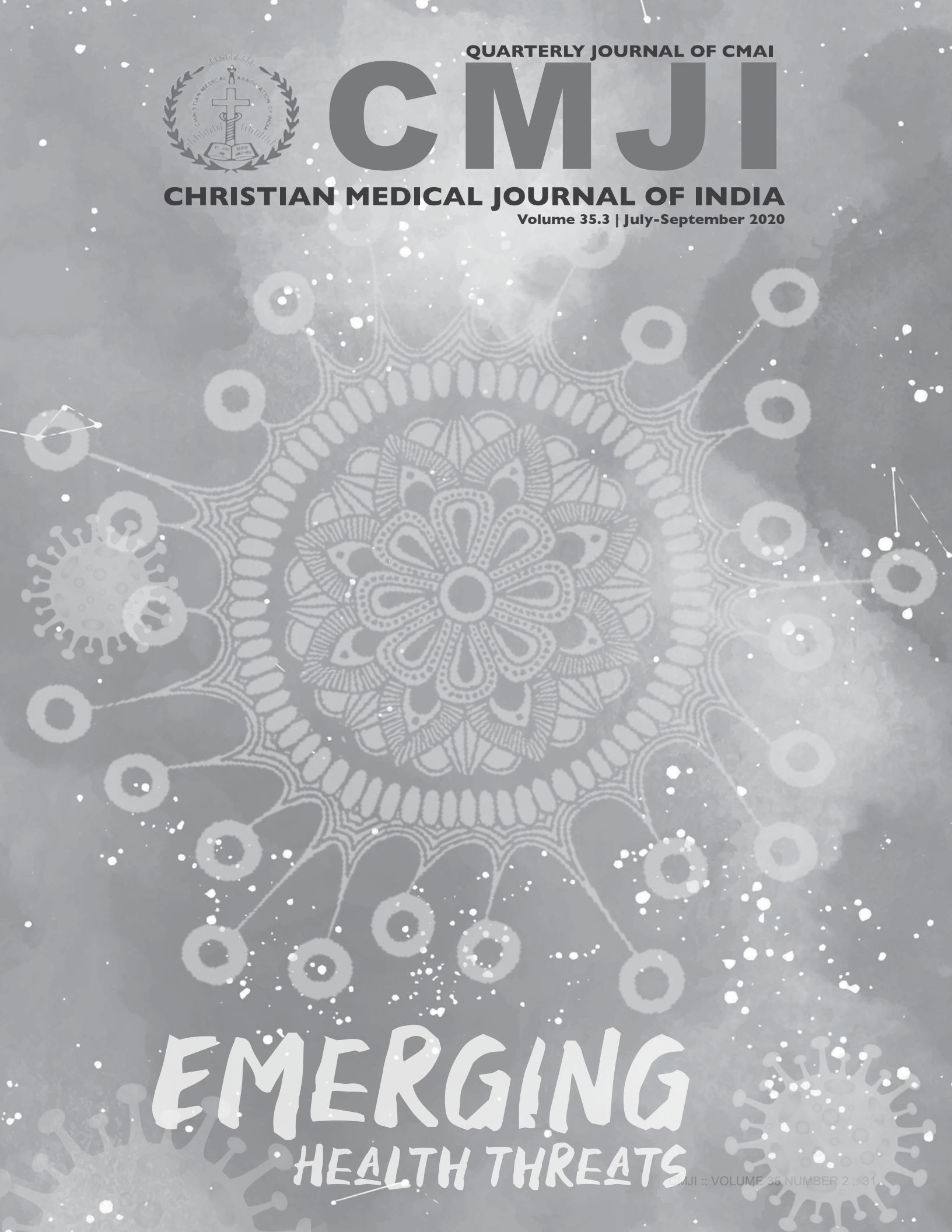

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CMAI is a national network of health professionals and institutions promoting a just and healthy society for all irrespective of religion, caste, economic status, gender or language

- CMAI has over 10,000 Christian health care professionals and over 270 institutions representing various denominations.
- CMAI builds individuals to be technically sound, spiritually alive, and socially relevant, in fellowship and with a Christian perspective on health and development.
- CMAI is the health arm of the National Council of Churches in India(NCCI).

WHAT DO WE DO ?

- Build capacity to respond to the current and future health care needs
- Advocate for innovations, create evidence and promote policy change
- Work closely with the churches, civil society and the government
- Build alliances for health action on a national scale
- CMAI influences other networks and alliances on thinking change in health systems practices in India. We partner with national and international agencies to promote this objective.

OUR PUBLICATIONS

- Christian Medical Journal of India (Perspective)
- Life for All (Newsletter)
- Footsteps (Development) English & Hindi (A Tearfund publication distributed by CMAI)

COME JOIN US

The core of CMAI is its members- individuals and institutions. Individual membership consists of five professional groups - Doctors, Nurses, Allied Health Professionals, Chaplains and Administrators. Each section comes together for conferences, workshops, a time of fellowship to learn from, to share with and to encourage each other spiritually and professionally.

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Building a just and healthy society

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LETTERS / ARTICLES FOR CMJI

We invite your views and opinions to make the CMJI interactive and vibrant. As you go through this and each issue of CMJI, we would like to know what comes to your mind. Is it provoking your thoughts? Please share your thoughts with us. This may help someone else in the network and would definitely guide us in the Editorial team. E-mail your responses to: cmai@cmai.org

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- Contributors are requested to send articles that are complete in every respect, including references, as this facilitates quicker processing.
- All submissions will be acknowledged immediately on receipt with a reference number. Please quote this number when making enquiries.

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Healthcare OR Health

We who are in the ministry of healing tend to equate 'health' and 'healthcare' often. In a close reading one can understand quickly that there is a huge gap between these two terms. Health encompasses the wholistic wellbeing of individuals, people groups, nations and the nature. Instead of keeping health as our focus, we are guilty that we have kept healthcare as our keyword.

Even in healthcare, most often focus is on treating illnesses of people. Many institutions, organisations, establishments, hospitals, clinics, pharmaceuticals, insurance companies and medical industries which claim to work for healthcare actually work for sick-care. It is important therefore to understand the difference and to commit ourselves for the health of the nations. To understand and experience the function of the Healing God and to align ourselves to the same function is, therefore, our calling as individuals and as institutions.

Articles in this issue invite us to pay attention to the emerging health threats and the way we need to address them for the sake of health of the nations. It is not enough to talk about healthcare. We need to identify the factors contributing and hindering health. Even the healthcare systems should include in their agenda what is their response to the emerging threat to health in our land.

We are also grateful for two senior health professionals who have given interviews in this issue regarding how they have been working towards health and healing of people.

During this season of Advent, may we wish you all a meaningful and appropriate Christmas celebrations. May the sacrificing God who voluntarily chose to become one among us brighten our lives so that we find and experience salvation. We also want to wish you a blessed and healthy new year 2021. May Christ's radiating love flow through our lives as we make steps through our institutions to bring forth healing and wholeness to people.

Rev Dr Arul Dhas T
Editor

Rev. Arul Dhas T.

EHA NURSES AT THE FRONTLINES, PLAYING A VITAL ROLE DURING THE INTERNATIONAL HEALTH CRISIS, COVID-19

With the recent outbreak of Covid-19, healthcare related communities have been working tirelessly. And an irreplaceable role has been played by nurses. Despite not often being in the limelight they have showed determination, selflessness and care for the world.

The World Health Organization declared 2020 to be the "Year of the Nurse and Midwife" a celebration of the 200th birthday of Florence Nightingale (1820–1910). It was completely unexpected that this would also be the year of an International Health Crisis, a Covid-19 pandemic! This has brought out the need for more nurses in the country. They have been the leading soldiers in this time of this crisis, fighting the pandemic out in the front line. It is a time that we need to be together to fight this Covid-19 crisis.

Mr. Vinay John

The Covid-19 pandemic in India is part of the worldwide epidemic of coronavirus disease 2019 (Covid-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The first case of Covid-19 in India, which originated from China, was reported on January 30, 2020.

The Emmanuel Hospital Association hospitals (EHA) are located in the below-mentioned States of India, the number of corona cases may vary in each district but I have retrieved State-wise data on Covid-19 from MyGov dashboard on July 23, 2020. EHA is a Fellowship of Christian individuals and institutions committed to the ministry of healing in the name and spirit of Jesus Christ. Today EHA manages 21 Hospitals, 6 Nursing Schools, Palliative Care Services, and 40+ Community Health and Development Projects in some districts of Assam, Bihar, Chhattisgarh, Delhi, Jharkhand, Madhya Pradesh, Maharashtra, Uttarakhand, and Uttar Pradesh. The Vision Statement of EHA is summarized as: "Fellowship for Transformation Through Caring."

The Nursing Department of Christian Hospital Chhatarpur, one of the Emmanuel Hospital Association units, implemented a series of efficient and meaningful measures to obtain good results in Covid-19 transmission control. I am sharing my experience, observation, and involvement as a member of the nursing team.

Preparation and Quarantine Measures

The management of Christian Hospital Chhatarpur held a meeting in March 2020. Following this, they immediately established a Covid-19 transmission control leadership team with the medical, nursing, and administration leaders. The Principal, Nursing Superintendent, Nursing Tutors, Ward in-charges and Staff Nurses took it seriously and started the preparations and training programme for Covid-19 transmission control. As the nursing professionals' leader, the Principal and Nursing Superintendent immediately conducted an awareness programme about the Covid-19 transmission control measures, uses of the masks, handwashing techniques, social distancing, and uses of the sanitizers and health education pamphlets to teach the patients and their relatives. The nurses were divided into two groups with seven days of continuous work followed by seven quarantine days, which was an additional protective measure for the staff. This provided the staff time for recovery and decreased the risks of direct exposure.

Opening of Flu Clinic and Respiratory Ward

The management of Christian Hospital Chhatarpur has selected Community Health and Development Projects staff (Prerana and Kishangarh Watershed Programme) to do Triaging and run the Flu Clinic at the hospital entrance. The registration department was moved near the Flu Clinic so that all the patients coming to the OPD

India States	EHA Hospitals	Confirmed Cases	Deceased	Mortality (%)
Assam	3	26,772	64	0.23
Bihar	2	30369	217	0.71
Chhattisgarh	2	5968	29	0.48
Delhi	1	126323	3719	2.94
Jharkhand	2	6485	64	0.98
Madhya Pradesh	2	24842	770	3.09
Maharashtra	2	337607	12556	3.71
Uttarakhand	2	5300	57	1.07
Uttar Pradesh	5	55588	1263	2.27

would have to register at the entrance gate. The recording of their history, and their assessments were done in the Flu Clinic. Patients having any symptoms of fever, cough, breathing difficulties, and if they had a travel history, were sent to the respiratory ward for further evaluation by the Consultants/Medical Officers. The rest of the patients who did not exhibit such symptoms were sent to the regular Out-Patients Department.

Selecting Nursing Staff

While selecting the nurses for the respiratory ward, the nursing department prioritized the nurses who have experience managing a department. In addition to this, they were required to have a minimum of one-year work experience, good physical health and are expected to be good in nursing techniques and skills. Nurses are currently managing suspected cases in the respiratory ward, but in the future, confirmed cases would be admitted in the Covid-19 dedicated ward. Nursing staff who have experience in managing a department will be working in the Covid-19 dedicated ward. At the later stages, after the training, all nurses should be able to work in the Covid-19 dedicated ward as per the schedule.

Planning for a Good Support System

It looks like Covid-19 transmission will continue until the government finds vaccines or treatment for the coronavirus. Nurses in the general ward, maternity ward, and respiratory ward are going to have a massive workload, and due to this overwork, some nurses may experience burnout. To ensure sufficient nursing staff to provide quality care in the Covid-19 dedicated ward, the nursing department will have to reassess the workload and personnel requirements in the entire hospital. The nursing department is thinking of establishing a good staffing pattern, a good number of skill-mixed staff, and several senior or specialized nurses to work in the Covid-19 dedicated ward. Any nurse experiencing discomfort would be replaced after reporting to the people concerned.

Online and On-Site Training

Presently, there is no effective treatment regimen for Covid-19, and the number of suspected or confirmed patients is increasing. The nursing department needs to regularly conduct intensive training for all nurses, irrespective of their area of duty. This will provide future nurses who will be placed in the respiratory ward or next Covid-19 dedicated ward. Due to social distancing, few nurses need to receive on-site training in the present situation while other nurses should receive online training. Thus, all nurses will be ready to start working as and when required.

Safety of the Nursing Staff

When first entering the Covid-19 dedicated ward, new nurses need to be accompanied by nurses with working experience in the respiratory ward or covid-19 dedicated ward. For every shift, a nurse from the hospital will be responsible for supervising disinfection and protection work in the ward. Besides, the head nurse should do night ward rounds, thereby ensuring the proper protection of nurses.

Priorities

The Flu Clinic, Respiratory Ward, and Covid-19 dedicated ward are the first-line regions in Covid-19 transmission control hospitals. A budget and supplies plan needs to be formulated, and stocks need to be appropriately maintained. Medical equipment and supplies, especially Personal Protective Equipment (N95 masks, latex/nitrile gloves, goggles, protective face shields, and scrubs), sanitizers, disinfectants, need to be restocked timely according to the requirements.

Encouragement

Given this situation, the nursing department heads have to lead from the front and encourage nursing staff at the frontline every day. We are aware of the nurses' difficulties, such as long working hours resulting in a dry throat, long periods of mask-wearing resulting in chest tightness, allergy to the protective gown, and about the risk of infection to their family members. Despite these challenges, we make an effort to keep their spirits high through motivation, devotion, and constant prayer.

Conclusion

As nurses with considerable expertise in health care, we are very proud of EHA nurses everywhere as they provide services during the current pandemic. And while nurses are our most valuable asset during this crisis, they are not exempted from experiencing unintended consequences such as accidental exposure to the virus or physical and psychological fatigue. Efforts are underway to ensure that all nurses have the proper Personal Protective Equipment to care for patients while protecting themselves.

Nurses will always be on the front lines caring for the community in a significant way beyond our current pandemic. Nursing's presence is a real cause for celebration, both during and beyond the Year of the Nurse and Midwife 2020.

I am grateful to my colleagues who comprise the dedicated team of leaders, the Principal, Mrs. Rekha John, the Nursing Superintendent, Mrs. Elizabeth Johnson, Mr. Jone Wills, the Managing Director, and Dr. Tony Vikas Bishwas, the Medical Superintendent and the Doctors' and Nurses' group at Christian Hospital Chhatarpur.

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Mr. Vinay John, M.Sc.(N)., MBA
Nursing Director EHA

THE DIRECT IMPACT OF COVID-19 ON TUBERCULOSIS RESPONSE

Ms. Blessina Kumar

The year 2020 started off like a science fiction movie. As news of Corona emerged along with news that was many times unfounded, panic loomed large. Added to this was the whatsapp messages and social media platforms like facebook which became our 'CDC' and 'ICMR' news bulletins.

Going back a couple of years to 2018 when the landmark UN high-level meeting at the UN General assembly on TB had very ambitious commitments from heads of state. Ending TB by 2030 seemed somewhat possible. India, the country with the highest TB burden with 2.9 million people diagnosed with TB each year decided to End TB by 2025 and announced it to the world.

The recently launched [1]WHO Global TB Report is sobering and highlights the lack of progress by countries with South East Asia having the highest burden and India topping the list.

Presently, the world struggling to come to terms with the new normal and everything that goes with it, work from home, virtual health care, virtual class rooms, and an awful lack of mechanisms to cope with social isolation slowly reflecting in increasing issues of mental health. While the cost of this is still being measured, we are seeing the increasing damage due to the way COVID-19 was and is being addressed. The maximum impact of this pandemic is falling on the poor and the marginalised starting with the migrations, reverse migration, human trafficking, malnutrition, health facilities and resources diverted to Covid, to name a few. It is still continuing.

A global survey[2] conducted by Civil Society and community partners, with a focus on TB, clearly delineated the impact of COVID 19 on people affected by TB.

The findings of the survey offer a grassroots perspective of how COVID-19 is impacting five key stakeholder groups: people with TB, frontline healthcare workers, program and policy officers, TB researchers, and TB advocates.

People with TB:

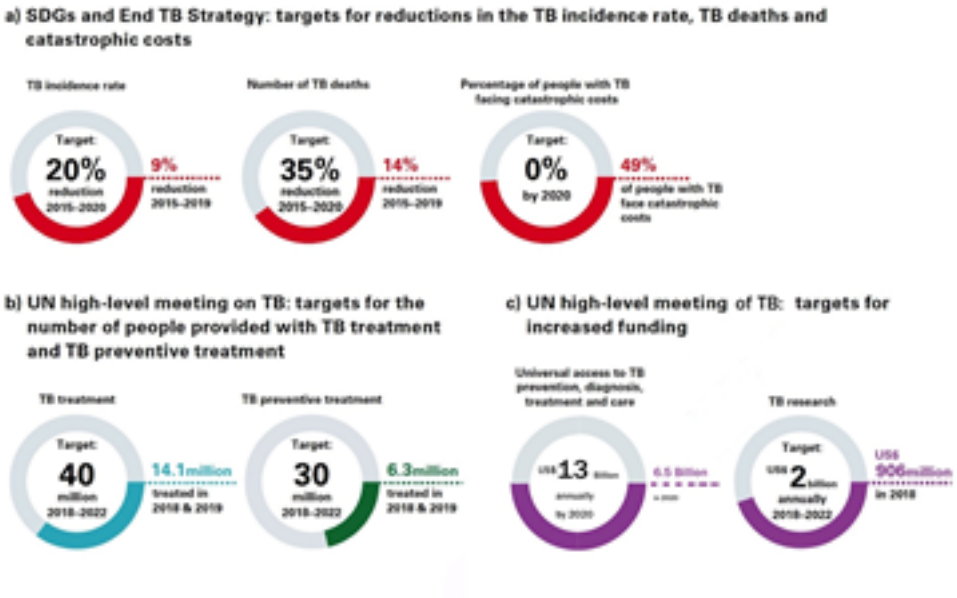
Kenya (n= 159) and India (n= 58) reported significant challenges in accessing TB services during the pandemic and associated lockdowns. Difficulty in finding transport to access TB care, changes in TB services, and fear of contracting COVID-19 during a healthcare visit were presented as key barriers. People with TB also reported experiencing increased stigma because of the similar symptoms of both respiratory diseases. While in most cases people with TB have been given additional TB medicines to continue treatment at home, they expressed a clear and urgent need for immediate non-medical support, including nutritional, economic and psychosocial support.

Frontline Healthcare Workers:

TB frontline healthcare workers (n=150) reported significant reductions in TB care due to the pandemic. Main reasons for interruptions were related to the redeployment of essential resources and personnel to respond to the public health crisis at hand and generally weak health systems struggling to cope with an influx in demand on services. Participants from around the world reported a lack of personal protective equipment (PPE) and shared how the unsafe and challenging working conditions were resulting in low morale and mental health issues. There is an urgent need for increased support including investment in PPE, personnel, supplies, and tools, as well as innovations in programming to offer quality digital and community based care.

Policy and Program Officers:

Responses from policy and program officers (n = 115) revealed that TB services and program resources have significantly reduced because of the pandemic. TB notifications have drastically decreased and personnel are being redeployed to respond to COVID-19. Participants from the US and Global Fund implementing countries reported decreases in people with TB accessing care, as well as increases in stock-outs or delays of TB medicines. Contributing factors to interruptions of TB programs included programmatic capacity, stigma and fear, human rights violations, and other psychosocial factors that impeded people with TB from accessing TB services.



Program adaptations are being made and need further financial support to increase and sustain the innovative mechanisms being deployed, such as telemedicine and family/community based care. Significant investments that being made now to respond to COVID-19 should be leveraged to strengthen the TB response.

TB advocates:

Individuals employed with civil society or non-governmental organizations working to end TB, or who identified as a TB advocate or TB survivor from Global Fund implementing countries (n = 270) expressed much concern for TB advocacy and people with TB because of the pandemic. Diverted attention to COVID-19 from politicians and media was reported to be seriously affecting advocacy work. Participants also raised alarm bells about people with TB not being able to access care and social support, and community support groups not being able to reach affected communities during lockdowns. Human rights issues, including stigma, economic inequalities, food insecurity, and fear were raised as key challenges in responding to COVID-19 and TB. To respond to the challenges at hand, advocates called for a strengthening of TB affected communities' capacity and engagement in the fight to end both the epidemic and pandemic.

The biggest difference is that COVID does not differentiate between the rich and poor, upper class and middle or lower class and caste. Unfortunately TB does. It affects the poor and undernourished, people living in crowded settings, all leading to the reason for the decades of lack of attention to TB.

TB Researchers:

TB researchers from around the world (n = 73) reported significant interruptions in TB research related to a diversion of personnel, equipment, and funding to COVID-19 over TB. Survey participants repeatedly noted existing lab space and infrastructure being closed during lockdowns or repurposed for COVID-19. Similarly, respondents experienced reduced access to research participants due to immobility during lockdowns. There is a unified demand from TB researchers for additional and continued resources for TB, and for research investments in COVID-19 to be leveraged for TB. TB research and infrastructure is currently being leveraged for COVID-19 related research.

Moving Forward

Covid-19 has impacted TB services but also provides opportunities. The need is to leverage the attention and response for COVID to work for TB. Both are similar in many ways. The biggest difference is that COVID does not differentiate between the rich and poor, upper class and middle or lower class and caste. Unfortunately TB does. It affects the poor and undernourished, people living in crowded settings, all leading to the reason for the decades of lack of attention to TB. The headline of a recent article read, 'The biggest monster is spreading and it is not the Corona virus!'. TB remains the biggest killer.

The 10 priority recommendations of the UN Secretary General's 2020 progress report on TB for actions needed to accelerate progress towards global TB targets very clearly articulate the resource needs. And for the very first time combating stigma and discrimination as well as promoting human rights are a part of the End TB narratve along with meaningful engagement of civil society, communities and people affected by TB. Recently I had the opportunity of being

Countries need to be supported to report data accurately without worrying about being seen as failures. Countries are trying to adopt MAF and fill in the checklist but need guidance and support in moving forward to action.

the keynote speaker at the UN General Assembly side event on TB. I summarised the speech with 3 asks and one crosscutting issue.

Funding- Invest invest invest!!!

TB funding has reduced significantly, specially in the past 6-8 months, and in the same time Billions of dollars have been made available for COVID. This is great but not at the cost of TB! We cannot turn away from TB, not now not for anything else. TB remains the biggest killer, and as leaders, do not shift your focus away from TB. Lives depend on it.

Civil Society and Communities can be part of the decisions on how, who and where this investments are most needed.

2. Research- I heard recently that in the past 6 months there have been more

than 70,000 papers on COVID, 5000 clinical trials for COVID. We cannot allow TB being left behind. Rapid research and new tools are urgently needed. Newer safer oral drugs to replace the painful injections with terrible side effects and a rapid uptake of the ones already available. Despite WHO guidance to do away with injections, in TB we are moving at snails pace and every minute delayed is a life lost!

3. Support to countries- The Health Systems around the world are weak and ill equipped to simultaneously respond to TB and COVID epidemics.

Countries need to be supported to report data accurately without worrying about being seen as failures. Countries are trying to adopt MAF and fill in the checklist but need guidance and support in moving forward to action. We have seen encouraging progress from Indonesia in terms of the TB budget which increased by a threefold and there has been some progress in EECA region as well.

Crosscutting - The biggest cross cutting barrier to progress is STIGMA. We need you at the highest level to be actively engaged in stigma reduction.

If we truly want to realise our collective dream of ending TB in the near future we need to hold ourselves accountable to the commitments made and follow them upwith strong ACTIONS!

I would like to end with a paraphrase of a quote from Mahatma Gandhi,

“Recall the face of the poorest and weakest person you have seen, and ask yourself if the step you contemplate is going to be of any use to him/her, will he or she gain anything by it, will it restore to him or her a control over his/ her own life and destiny.”

I call on you to recall the face of a TB patient when you take your next step.

Ms. Blessina Kumar
CEO Global Coalition of TB Activities

JOB OPPORTUNITIES WITH THE LEPROSY MISSION TRUST INDIA

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TLMTI is the oldest and largest leprosy-focused non-governmental organisation in India and is headquartered in New Delhi. The organisation works with people affected by leprosy and other neglected tropical diseases (NTDs), people with disabilities, and marginalised communities, especially women.

TLMTI has a diverse set of programmes – Healthcare, Sustainable Livelihood, Community Empowerment, Advocacy and Communication, and Research and Training. These programmes are implemented through 14 hospitals, six vocational training centres, five residential care homes for elderly persons affected by leprosy, nine community empowerment projects, and a molecular biology research laboratory spread across 10 states of India. www.leprosymission.in

At TLMTI, we believe that only by working together with people affected by leprosy, people with disabilities, underserved communities and our supporters and partners, we can bring holistic healing, social inclusion and dignity for all. Hence, we implement our programmes across the country working with various partners. They include Central and state governments, the World Health Organization (WHO), International Federation of Anti-Leprosy Associations (ILEP), corporates, faith communities, grassroots-level organisations think-tanks, and national and international development and research bodies.

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COVID-19 PANDEMIC ACCELERATING NEED FOR PERSON CENTRED CONTINUUM OF CARE AND PATIENT ENGAGEMENT

CARE: **C**ovid-19 pandemic **A**ccelerating need for person centred **C**ontinuum of care and patient **E**ngagement

Dr. Oommen John

India enforced a strict nation-wide lockdown starting 24th March with an aim to reduce the spread of infection and prepare the health systems capacity for the pandemic. The Government of India issued advisory for those with chronic conditions to avoid visits to healthcare facilities for non-emergency consultations, as the risk of complications and deaths due to COVID-19 was higher among those with underlying co-mordbidies. The World Health Organization has highlighted that restrictive measures and travel restrictions to reduce the spread of infection during epidemics impact specifically the people living with NCDs by limiting their activity, ability to secure healthy foods, and access to preventive or health promotion services. Some of the challenges faced by health authorities during the early phases of a pandemic caused by an emerging infectious disease agent such as the novel corona virus or SARS COV 2 are the uncertainties and unpredictability of its impact on health delivery systems. Since this novel virus belonged to the family of corona virus that primarily presented as an influenza like illness, the health care delivery systems were geared to treat a viral illness that predominantly presented with classical manifestations of a flu like illness and the anticipated complications were respiratory distress syndrome, multi organ failure and sepsis. These assumptions therefore informed the policy around health systems preparedness resulting in the rush for increasing intensive care beds and procuring ventilators.

Capacities in Rural Hospitals:

Most hospitals located in rural and underserved areas often do not have the luxury of modern day ICUs that rely on probes, piped oxygen, continuous monitoring gadgets and machines designed to prolong life while draining families of their entire lifetime earnings. They rely on human hands for palpating the pulse, eyes that read the pain on the face and words to comfort when modern medicine nothing much to offer in certain conditions or terminal stage of a malignancy. As these remotely located hospitals are not capable of attracting super specialists or retaining them long term, care delivery is through locally available healthcare professionals who through years of learning to listen to the patients have mastered the art of caring. Surprisingly enough, many of the disease-causing agents seem to vacate their human abode when they notice their hosts (persons whom they have infected) receiving respect and care with dignity. In essence, what most rural mission hospitals offer is personalized care that results in a superior personal user experience in the place of the “packaged” super specialist delivered care that their urban counterparts sell.

Expectations and Surprises:

COVID-19 illness caused by the SARS COV2 virus like its cousins was expected to cause an influenza like illness lasting a fortnight to a month and rendering those infected protected for the future as antibodies against the virus were developed during the course of the illness. However, among those with high-risk health conditions such as diabetes, hypertension, and cardiovascular diseases the clinical course was expected to be stormy. These conditions collectively and conveniently termed as co-mordbities predisposed them to a metabolic milieu that rendered a fertile ground and as a runaway for the cytokine mediated inflammatory responses to take off. Enhancement of the surge capacities in healthcare delivery settings was aimed that those needing high dependency care and ventilator support in those developing respiratory distress syndrome. While the policy makers were concerned, the health and other multi-disciplinary experts with rich experience of delivering acute episodic, compartmentalized and organ focused care developed novel strategies such as large camps for delivering oxygen for those diagnosed with hypoxia, mass production of ventilators etc. A large majority of those

infected by the SARS COV2 virus remain asymptomatic and similarly majority of those with symptoms experience a clinically mild course of disease and were advised to manage at home. It was anticipated that most people who had mild symptoms would recover quick and would bounce back to their normal routines as they would from about of viral fever or flu as it is popularly known. However, a small number of persons approximately 10%, who had a mild form of COVID19 disease continue to experience a range of symptoms ranging from lack of energy, disturbances of sleep, extreme fatigue, difficulty in carrying out routine tasks, hair fall, joint pains, mood disturbances and some of them even experiencing memory loss. As per the current definitions, those who complete 14 days after initially testing positive with or with a repeat testing are considered as recovered. Though labelled as recovered, an estimated 7 Lakh Indians are likely to be experiencing these long term symptoms after an acute infection by SARS COV2 virus, these symptoms collectively are being recognized as "Long Covid" a term coined by patients who are experiencing these.

Moving beyond Acute and Chronic disease focus to Continuum of Care:

Healthcare delivery systems in India and in most other low and middle income countries are fragmented and narrowly focused on disease centred acute episodic care delivery. With increasing life expectancy and effective medical interventions that help people diagnosed with many life threating illness to live longer, there is a growing population of people who live with chronic conditions that require long term care. Further, many persons with chronic conditions have multiple morbidities and in most settings, people with chronic conditions seek care from hospitals or in the urban context from standalone specialty centers. A person with multiple chronic conditions therefore would need to meet several specialists in the same hospital or make several hospital or specialty clinic visits, resulting in multiple medications leading to polypharmacy. These add a huge burden to people who are aging and live on limited resources. Also in the context of the emerging economic situation that threatens livelihoods especially in rural areas, health care delivery cost optimization would be a priority for hospitals to consider.

The ongoing pandemic has clearly demonstrated that the current models of care delivery are not capable of meeting emerging health threats. Moreover, these models are expensive, inefficient and unsustainable in the long term. This calls for a paradigm shift in the current thinking and operational strategy of healthcare establishments. It also provides opportunity to venture into reimaging health care delivery services, using co-design approaches through learning about the expectations from people who use the healthcare delivery services to develop newer care pathways for chronic conditions.

Towards a new normal in healthcare:

As people experiencing the long terms effects of COVID19 infection start seeking care in hospitals, would the current care delivery mechanisms be able to provide any solace? Especially as many of these symptoms are non-specific and therefore are unlikely to be diagnosed through the traditional reductionist approaches or routine laboratory and imaging based work ups. As the emerging body of evidence suggests, the SARS COV2 infection itself and the lived experiences of those having diagnosed with COVID19 appear to be etching devastating scars on the very fabric of the lives of those who have gone through the anxiety, uncertainty and unpredictability of the clinical course. "Brain Fog" as some have labelled it is yet another concern among many others such as increased risk for blood clotting (thrombotic) events. Some of them might probably need home based care and comforting reassurances over several months may be even years and maybe even rehabilitation and reskilling and adapt to a new reality of their state of health. These persons need more than a diagnostic test to identify the root cause or a diagnostic label or be grouped it into a known "syndromic cluster" or "manifestation" of an organ damage, they need a listening ear, a caring reassurance and a shoulder to lean on while they limp along to full recovery. Would the mission hospitals rethink how the unspoken needs of these silent suffers could be met? Would the clinicians have the humility to admit that they don't really know what exactly the pathological mechanisms are or that they don't have all the answers to the clinical challenges in front of them. Admit that they feel as vulnerable as those experiencing these symptoms do. In doing so, the network of rural and remote health delivery establishments might be rewriting the fundamental principles of care in a healthcare delivery ecosystem that is devoid of trust or transparency and thereby establishing the new normal that has been the aspiration of everyone.

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IMPACT OF LOCKDOWN ON MIGRANTS IN BIHAR

Mr Abraham Dennyson

At 20:00 hrs, on the 24 March 2020, the Prime Minister of India announced a 21-day lockdown of the country beginning midnight, in an attempt to stop the spread of the Covid19. The four-hour notice resulted in unprecedented migrant (labourers') distress. COVID-19 and the total lockdown impacted the lives in obvious and hidden manner. Within a week of lockdown tens and thousands of migrants were on the road, trekking back to their homes, hundreds of kilometres away from their workplace. This demonstrated the immediate distress of job loss and insecurity with none to defend. Once they reached their respective states the impact seemed to have disappeared from the consciousness of the country. The media had done its bit and moved on to the next story. Several NGOs including our network were at ground working with the migrants and their families, addressing their needs.

In the past 10 years of my experience in Bihar, I have noticed every second home among the lowercase community has a migrant worker in their family. This is due to lack of employment opportunities in rural Bihar, coupled with increasing labour markets in other parts of the country. Underdevelopment and backwardness of the State is reflected in the higher dependency on agriculture, lower agricultural output, skewed distribution of land, higher incidence of landlessness and lack of industrialization.

Underdevelopment and backwardness of the State is reflected in the higher dependency on agriculture, lower agricultural output, skewed distribution of land, higher incidence of landlessness and lack of industrialization.

By early June 2020, government sources noted that about 3.5 million migrants had returned to Bihar. By mid July 2020, we members of the Arukah Network (CHGN)-Bihar Cluster have supported close to 55,000 families with cash transfer/ food relief, sanitary and hygiene kits in over 500 villages across Bihar. Arukah Network (CHGN)-Bihar Cluster is group of people who work collaboratively to serve their communities. Cluster members work to build relationships, support one another, share in training, and form partnerships. The aim is to increase the health, wellbeing and happiness of our communities, and ultimately, to inspire wider systems and social change. We celebrate local strengths rather than pinpointing weaknesses. We recognise that we all have something to offer, and so development need no longer be about 'donors & beneficiaries', 'haves & have-nots', or 'us & them'. In the cluster network, there is only 'us'.

We as core group when reviewing the migrant crisis felt the need for concerted medium to long term interventions to help the migrant community. To plan the strategy, we decided to do a joint needs assessment across the state. Members were invited to be part of the survey; World Vision India (WVI), Gospel Echoing Missionary Society (GEMS), Evangelical Fellowship of India Commission on Relief (EFICOR), Emmanuel Hospital Association (EHA), Children United for Action, The Leprosy Mission (CUFA TLM), and Forum for Social Initiatives, Archdiocese of Patna, participated in the survey by collecting the data. This was a typical example of what the network could achieve; data was collected from 25 blocks in 15 districts. In a matter of two weeks members were able to collect 1183 survey responses.

This study found 66% male migrated for work alone and about 6% migrated as family. Industrial centres in North India have become preferred destination compared to earlier agricultural centres. The survey showed that 51% of the migrant labour were returning from 4 destination states Gujarat, Maharashtra, Delhi, and Haryana. I have witnessed this during my Community Health work with EHA in Madhepura Christian Hospital, that able-bodied men seek work after the local agriculture season and set on a circular migration. This temporary migration leaves them as well as the family

left behind, highly vulnerable. Due to regulatory and admirative procedures, they are rarely full citizens in destination states or workplace.

Children left behind are vulnerable to violence, abuse, or exploitation. Fear, anger, and feelings of rejection are common among such children. Children lose the guidance, care, and authority of their parent/s. The gross enrolment ratio (GER) of the scheduled caste youth in higher education stands at 9.3%. For example, Uttar Pradesh has 6491 colleges in the state, while Bihar has only 744. (AISHE, 2015-16). In Bihar 33.1% of population belong to the socially disadvantaged groups, Muslims, Scheduled Castes and Scheduled Tribes. The dysfunctional educational system puts higher education out of reach for these disadvantaged groups. Many children dropout of school and end up becoming unskilled labourers. There are number of stories of household with chronically sick or differently abled, that are willing to send their young children for work to support their family.

Of migrants who returned during lockdown three quarters worked as unskilled labourers. 20% do skilled work like masonry, carpentry, cooking, driving, electrician etc. Among the skilled group only 1% have had formal training. Since returning, 40% of them said they have no idea how they will tide over this pandemic -jobless situation and a similar number wanted to go back to agriculture or agriculture labourers. About 15% wanted to be self-employed in trades like carpentry, tailoring, electrician, vegetable vending, grocery/petty, and barber shops. There is shifting of people towards agricultural farming job which increased by 5%, now at 12% as main source of income. Another 12% of them are jobless and only 1% of them see MGNREGA as main income source.

71% (n=836) of the respondents use WhatsApp. 47% (n=560) use more 2 or more social media apps on their smart phones. Migrants come back with skills and experience which can be used for community transformation and accessing their entitlements for their community. Very often it takes the leadership of one person to mobilise the community or make a difference in the village.

98% of the migrants have Aadhar card, 45% have more than one type identity cards (e.g. Aadhar + Voter Card). Less than half, 41% possessed voter cards. It will be important to help migrants involved in the political process so that their voice is heard, and their issue becomes priority for the policymakers.

The survey found that 10% is not planning to return while a total of 70% would return to destination for work within a year. This indicates serious lack of employment opportunities in rural Bihar. All main income source for the migrants has diminished including labour opportunities.

It was found that since the lock down hunger increased among the migrant families. Before the lockdown 89% of migrant families used to take three meals a day, since lockdown, this is reduced more than half (41%). 8 families had one meal a day before lockdown and this has gone up more than four times since lockdown to 36 families having only one meal a day.

Bihar Government by middle of April 2020 claimed they had transferred Rs.1000/- each to 94.85 lakh ration card holders of across the state, however 72% of migrants surveyed did not receive this amount and 33% did not receive the 5Kg free grain (PM Garib Kalyan Ann Yojana) promised by the central government.

Since lockdown, the number of families who had no access to any type of health care increased eight times (n = 106) and those opting health care from traditional healers and “Jholachap” doctors has increased by two times (n =207).

53% of them received the ex-gratia payment of Rs 500 in their women’s Jan Dhan account. 23% of migrants reported that they received the Rs. 1000/- monetary assistance for stranded migrants from Bihar government. 40% of them said they were not aware of such provision.

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Out of the 900 children who were enrolled in ICDS, a high number of 76% did not receive the cash transfer. However, it has been reported that in some places the money is transferred to AWW and dry ration are been distributed among the children.

Only 9% (n=100) of migrants or their family members got employment under NREGA scheme since lockdown. 8%

"Gap in food and nutritional requirements for women and children are obvious, service providers need respond in innovative ways during this time of pandemic."

(92) of the migrants did not have job cards. 6% of the respondents said that the NREGA wages are disbursed in timely manner and 65% (n=773) felt that is not the case. 61% (n=724) of migrants said they did not receive the PM Kisan Samman Yojana, instalment of Rs 2000, while 26% said that either they are not registered or not eligible. Only 18% of migrants have access government health insurance (Ayushman Card – PMJAY).

Delivery of government relief and services during COVID-19 for among the migrant families, is something to be desired. Gap in food and nutritional requirements for women and children are obvious, service providers need respond in innovative ways during this time of pandemic. From among migrant returnees skilled personnel can be identified to advocate and work for improved access to government schemes. Skilled people also can be identified to be self-employed in their trade and create opportunities in their villages. Bihar is endowed with land, water, and human resources. Large portion of human resources is unskilled and work in unorganised sector. Agriculture sector is unable create enough employment opportunities in Bihar hence migration is unavoidable. Systems for safe migration needs to be ensured.

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NCDs IN THE TIME OF THE PANDEMIC: PERSPECTIVES FROM PRIMARY AND SECONDARY CARE SETTINGS IN RURAL TAMIL NADU

Burden of NCDs and COVID in India

Ms Anu Oommen

India and many other Low- and Middle-Income Countries (LMICs) have been struggling with the double burden of disease, brought about by the epidemiological transition (change from traditional causes of premature mortality such as communicable, maternal, neonatal and nutritional diseases -CMNNDs, to Non-Communicable Diseases - NCDs). There is a wide variation within India, with certain states in more advanced stages of this transition (e.g. Tamil Nadu, Kerala) compared to others, with rapid changes even in those states with currently lower NCD levels. According to the Global Burden of Disease (GBD) data, NCDs contributed to 61.8% of all deaths in India, compared to 27.5% due to CMNNDs. Diabetes, Ischaemic Heart Disease, Chronic Respiratory Disease, Cerebrovascular Disease and Cancers contribute to most of the NCD related morbidity and mortality.

India is now reeling under the COVID-19 pandemic, superimposed on the 'epidemic' of NCDs. The high burden of NCDs, the growing COVID-19 pandemic and the ensuing nationwide and global lockdowns, have together created an immense healthcare burden on already struggling LMICs. India, as of September 2020, had the second highest number of reported COVID-19 cases, with a reported mortality rate of just under 2%. Due to its large population, even a small percent of infected, leads to large numbers of infections and deaths.

Links between NCDs and COVID 19

Multiple studies have shown that People Living with NCDs (PLWNCDs) are at a higher risk of acquiring and dying from COVID-19, which may be causally or incidentally associated. As age is also associated with NCDs, it is not surprising that COVID-19 mortality is higher in the older age groups. Besides the disease itself, the public health responses to the pandemic, taken by governments (e.g. prolonged lockdowns), health facilities and communities also impact PLWNCDs.

The following are some of the ways in which there are associations between NCDs and COVID-19:

Increased incidence of COVID-19, severity of illness and mortality due to COVID-19, in those with NCDs. PLWNCDs are also more likely to experience increased stress due to multiple comorbidities, risk factors and fear of COVID-19.

Disruption in all levels of intervention for NCDs.

a) Primary prevention:

Increase in behavioural risk factors such as alcohol/ tobacco use, physical inactivity, unhealthy diet and stress because of lockdowns, as well as lack of emphasis on preventing these risk factors (focus on prevention of COVID-19).

b) Secondary prevention:

Disruption of screening services (as screening of apparently well persons would not be a priority during an epidemic) will lead to late detection of chronic conditions such as cancer, diabetes etc.

c) Tertiary prevention:

-Disruption of treatment/continuation of care for chronic diseases due to transport issues, facilities overwhelmed by COVID-19, primary care disruption, escalating costs of treatment, loss of financial stability in many families, which could predictably to lead to increased deaths, complications and disabilities. Financial hardships due to the loss of wages and the looming recession will make it harder for those with chronic diseases to sustain treatment. A study by interns in RUHSA, among diabetic patients (unpublished), found that nearly two thirds had missed their routine appointments, with unavailability of transport being the most common reason.

-Disruption of palliative and rehabilitative care: the terminally ill and disabled are more likely to experience discontinuity of care due to the responses taken by governments and communities to the pandemic.

Mitigation of the combined effects of NCDs and the pandemic: a few examples

COVID-19 is an example of a dramatic, catastrophic public health emergency that has affected all countries worldwide, at around the same time, leading to unprecedented responses. In the face of sudden, unavoidable emergencies, mankind has risen to the situation by responding in different ways, with the wisdom and resilience that characterize man's image as being one like his Creator.

Some of the ways in which CMC's peripheral rural centres have tried to adapt to the situation, are outlined in Table 1. Similar measures and much more, have been taken by other primary and secondary health care settings across the country, in low resource settings, e.g. measures taken by LCECU, CMC Vellore (Primary Care for India's urban dwellers living in informal settlements during the COVID-19 pandemic, Abraham et al, September 2020, AJGP).

Empowering communities for prevention to reduce the incidence of NCDs, can ensure that NCDs do not compound the effects of other disasters.

The Community Health and Development (CHAD) program which serves the surrounding rural communities and a tribal area (Jawadhi hills), and the RUHSA (Rural Unit for Health and Social Affairs) department, CMC Vellore followed the underlying principle of ensuring that those with chronic diseases did not lose continuity of care during the lockdown and the ongoing pandemic, during which their increased vulnerability is widely recognized. Both these programs have a primary care component (routine village visits by health workers and nurses, with monthly mobile clinics), as well as a secondary care hospital. At a time when many private clinics and hospitals were shut down, these hospitals were kept open with precautions such as spacing waiting areas, guiding febrile patients to fever clinics, etc. Although there were financial difficulties in providing concessional treatment as was done previously, steps taken by CMC to cut costs and raise funds internally and externally, helped continue subsidised care to the neediest.

While home visits in the CHAD program have been stopped temporarily, mobile clinics have been functioning regularly, ensuring health education and necessary precautions to prevent COVID-19.

Home delivery of medicines including in a difficult to access tribal area, made possible due to the efforts of community volunteers and staff and the availability of a list of such patients, ensured that PLWNCDs did not miss their chronic medications. Having a system of *patient retained chronic disease cards* with names of medications, also enabled patients to obtain medicines at pharmacies or nearby clinics and to serve at least to some extent as a travel document for transport to hospital.

Palliative care in the CHAD program was provided through phone consultations, to assess need for medications (e.g. pain killers), as home visits were avoided to reduce transmission of COVID-19 through health care providers.

As PLWNCDs were also likely to be affected by lower access to food, CMC's three peripheral units (RUHSA, LCECU and the CHAD program) also responded by making provisions for supplying food grains/ cooked food to most vulnerable families.

Weaknesses in the health system exposed during this period indicate the pathways that are needed for the future, to ensure that we are better prepared for similar situations.

Future directions

With increasing environmental changes and increasing man-environmental conflicts, it is very likely that there may be similar future threats to global health. Wars, natural disasters and disease outbreaks can have the same devastating consequences on the entire population, with higher effects on vulnerable populations. We need to learn lessons from this experience, by sharing our responses and planned recovery pathways, and together devise safety nets to help mitigate the effects of such situations.

Primary prevention

Empowering communities for prevention to reduce the incidence of NCDs, can ensure that NCDs do not compound the effects of other disasters. Lifestyle medicine approaches to enable healthy lifestyles, through exercise, healthy and sustainable dietary choices, and coping strategies (e.g. through investment in spiritual and emotional aspects of health), would decrease morbidity and mortality due to NCDs. Healthy settings at workplaces, home and the community will enable people to make the right choices for health. Awareness regarding the health, mental and economic losses due to addictions

to tobacco, drugs and alcohol also need to be stepped up. Secondary care hospitals with primary care outreach work, have the opportunity to do many these activities, that large tertiary hospitals cannot.

Secondary prevention

Ensuring regular screening for common NCDs including cancers, will help detect early disease and possibly lead to cure, leading to lower susceptibility to new infections. With screening now being available or meant to be available, through the national program for NCDs, it should be possible for all Indians everywhere to avail these services, and if not available, to raise the demand for them.

Tertiary prevention

Universal coverage for basic treatment, example access to medicines for those with stable NCDs, through well-functioning primary and secondary care settings, both public and private (such as mission hospitals and other charitable organisations), including mobile services for remote locations will ensure continuity of care. Leveraging digital and other technology for enabling chronic care, example through telemedicine, needs to be explored more in populations where these are now increasingly available and affordable. Maintaining patient databases including phone numbers, seems to be a necessary step for ensuring continuity of care and communication.

Conclusions

It is exemplary how mission-run secondary hospitals and primary care programs have risen to the occasion compassionately, with God's guiding hands, protecting the interests of the marginalised and vulnerable populations around them, while handling their own struggles to stay afloat in this storm of health and economic torrents. It would be useful for organisations that have found practical solutions to share these with others in similar settings, to 'encourage one another for good works' and so that 'no one tires of doing good'.

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YOUTH AND MENTAL HEALTH IN THE CONTEXT OF COVID-19: A PASTORAL PERSPECTIVE

Rev. Dr. A Israel David

As we deconstruct and decode the theme and Context of COVID-19 we realise that there are many very significant terminologies. Let us begin with the context of COVID-19 which has at least four stages; pre-COVID or lockdown, the lockdown period, unlocking stages and the post COVID. In the Indian context- COVID accompanied by locusts attack on agriculture, impact on economy, tension on Indo-China border, super cyclone, change of labour laws, tremors and much more has continued to cause disruption in our lives.

In this scenario, referring to the recent media stories and articles the huge impact on mental health is witnessed during lockdown and covid19. Mental Health is a state of well-being in which the individual realizes his or her abilities , can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community. It is pertinent to know what is the state of wellbeing, who are these individuals who are getting affected, what is the impact on their abilities and what can be the obstacles to help them realize these abilities. We should be aware that how can one cope up with the normal stress of life and yes if there is a new normal then how do we gauge it. We are aware of working joyfully, productively and fruitfully but today we also have to understand how the youth looks at productivity and is getting affected by the challenges.

Let us look at our youth, namely the youth who are able to 'Work from Home' and the Youth who 'Work For Home'. Hindustan Times newspaper on May 27th 2020 printed -Pandemic creating 'lockdown generation' as one in six youths stop work". These are the real fears of losing work opportunities, losing career options, the fear of being left behind and a massive increase in youth unemployment which affect the young men and women. The need of belongingness, the fear of missing out, loss of living space, forced to be present, in proximity and loss of mobility are some of the fears that trouble our young generation.

The key notable points are:

The uncertainty to perform and the question of ability

a. Impact on Education due to the uncertainty of exams, results and promotion
b. Triple shock from the crisis of employment (lost), education (delayed) and training (unable to complete)
c. The impact of online classes and the digital divide

The Anxiety of Losing the Youth-hood

- Fear of prolonged impact on future
- The physiological impact due to gaining weight, eating disorders, skewed sleeping patterns and missing out of physical togetherness.

The Issue of Productivity

- Less work leading to alternative ways of spending time
- The peril of pornography and addiction to substance alcohol
- The pressure of productivity and quality

Reaffirming the Youth

- The ekklesia which is in the process of rebooting itself should be aware of to which youth group they are called to respond first without ignoring the other
- Reaffirming the commitment to focus on the youth group who are 'work for home'- the marginalized, the subaltern, the so called outcaste, the migrants, the labours, found on the streets, the labelled and the so called 'sinners', the rural population
- The youth in the context of COVID-19 are not the ones do not belong to the community who flies in charted flights from Bhopal to Delhi and able to send their pets in flights from Delhi to Mumbai

- But who cycled 1200 kilometres with the ailing father, the Mashesh Jenas, the dying ones, those who lost their childhood and losing the youth-hood
- We are called out (Ekklesia) to reboot our focus towards these youth
- Preferential option for the poor and rural youth
- It is a call to the church to reboot her pastoral care towards these youth

Companionship as PARADIGM for Pastoral Care

- Though, both groups need healing, the church needs to make an informed choice
- Pastoral community- from silence to presence - Safeguarding justice- Charity to solidarity- becoming a companion-creating the sense of availability
- Moving along with (not substituting) clinical response- Theological and biblical paradigms-Being informed by sociology, anthropology, psychology and theology
- Spiritual nurturing has to be emphasised. God as a companion
- Towards self-actualization-bring back hope- becoming the representative of the presence of divine

Recommended Pastoral Practices

- Responding to social systems-the larger contexts- towards intra, interpersonal and social healing
- Focusing on constructive handling of conflicts- Responding to both internal and external conflicts
- Wholistic/wholeness- family as a system- not youth in isolation-
- Enabling the youth to respond to the present-moving from the past and leaving the future?
- Communication- Information to Influence- positive (may not be new normal-back to normalcy) –space for expression-Listening-talking- feeling
- Exploring-to feel safe –adapting not adjusting to changes –discovering alternatives
- Reassuring- answering- being practical –forgiveness
- Helping to help themselves-personal rational responsibility- shared responsibility
- The church needs more will power to move from 'blaming' to 'understanding' the youth
- Establish support groups –being close –digital resources
- ABCD model- Achieving a relationship- Boil down (deconstruction) the major problems- Constructive action plans (construction) - Develop on going plans

Rev. Dr. A. Israel David, Associate Professor of Pastoral Counselling, Faculty Dean and Dean of Doctoral Programme, Union Biblical Seminary

INTERVIEW OF DR KATUMALLA SHOBA

Ophthalmologist, Mary Lott Lyles Hospital, Madanapalle, Chittoor, AP

Introduction

Mary Lott Lyles Hospital, Madanapalle was established in 1911 by Rev. Dr. Jacob Chamberlain. As a medical missionary from Reform Church of America, he came along with the Scudder's to Madanapalle in 1865 also bringing Christianity to the region. Like a medical missionary he conducted camps and worked in the towns. Mary Lott Lyles Hospital was established only for women and children.

Nursing school was established in 1912. It is a 220-bed hospital and the only hospital in the surrounding region making it one of the most famous hospital in the Southern Karnataka, Northern Tamilnadu and Madras presidency. From year 2000 to 2014 the hospital faced lot of crisis as it was without patients, during that period only 20 staff were working in the hospital. There were no doctors.

At present what are the main services or work done by the hospitals?

In 2014 a new Bishop requested us to help them to re-establish this hospital. Along with my husband we took over started with orthopedic, ophthalmology, Ob/Gynae and established a lab.

Please tell us about the reach of the hospital to nearby villages and districts?

We cover around 150 km in radius population because most of the people in Madanapalle and surrounding area would have been born here.

When you joined how many doctors were there in the town around the hospital?

We have 75 Nursing homes 150 doctors around, but this hospital is known for giving healthcare over the last 100 years.

How did COVID effect the hospital?

We were very fast in taking action, in December itself when it started in Wuhan, we were assured that it would

soon hit India. So, we started talking about its drugs etc. in the month of January and February 2020. We started with triaging our patients with sanitizer etc. even before it was announced in the country in March and were the first one to prepare our own sanitizer using the WHO formula because it was very expensive to buy from outside. We had thermal scanner before itself in the hospital. So, we had a small triaging area outside at the registration. So, whoever patients came in, we would take travel history of patients at that time and check with thermal scanner and put sanitizer. If we found anyone with fever etc., we use to keep them in a separate clinic called flu clinic.

In March it was complete lock down in AP and most of the hospitals and private nursing homes were also closed. May be all the doctors were worried at that time. But MLL was the only hospital that was running along with the government hospital.

Please share your experience about the COVID block at your hospital.

As the government didn't give permission till August ending to any private hospital to take COVID patients and till then only government hospitals were looking after the COVID patients. If they were sick the government hospital would refer the patient to Tirupati. But because of the number was high in August that's when the government gave permission to some of the hospitals who had the facilities. So, with the help of the local MLA & MPs we were able to create a separate block for COVID.

We have only separate blocks at the hospital and so about six months before we were planning to work on an ICU, so we put up a manifold for oxygen and cylinders which was of great use. We have established another new block with 40 beds and out of these 27 beds have oxygen support facility. We again invested in the COVID block, in less than a week's time it was and by September we started treating COVID patients.

Initially there was a decrease in number of patients due to social stigma, but once they came to know that COVID block is separated from the normal block they started coming to the hospital. Now the patients in the OPD have also increased, thankfully.

I am really very proud to share that our hospital is the best hospital in the entire Chittoor district. Out of the 25 hospitals working for COVID, Mary Lott Lyles Hospital has been always ranked in the first place.

Kindly share some impact stories of individuals at Mary Lott Lyles Hospital.

We had a retired judge living 60-km away from the hospital who along with his wife. After 5-6 days he became severely ill, and as we didn't have any COVID ICU, we told their children to shift him to a better hospital. However, the family insisted to continue the treatment as they had a lot of trust in us. Reminding us about how forty years ago when his wife had delivered all their children at this hospital which created a greater bond with the doctors and nurses. So, the whole night we did our best to treat him and by God's grace the next day he was alright. After 10 days both husband and wife were discharged, and they left retaining the same bond and trust with us.

Another story reminds us of a female patient who came along with 11 relatives who were diagnosed with COVID. That time in local hospitals and at small locations if a patient got fever, they won't even do the testing and they start giving drugs used for COVID as normal drugs like paracetamol. However, we treated all her relatives as per their needs and diagnosis. So some got home-quarantined and others So, this family too left happy and the fairness in the treatment they received.

Did you get any opportunity to collaborate with a CMAI Member institution?

Yes, we are a small mission hospital. Baptist Hospital and CMC Vellore are of great help to us. Dr Naveen Thomas in Baptist Hospital is my classmate and Dr David Peter is also my classmate. So, I look forward to them for any help and of course CMAI helped us with the PPEs which is of great use for us, I must thank you all for the effort. I also called Mr. Vijay to get more PPEs free of cost. We have also got 100 more PPEs from Baptist hospital.

Management protocol are all from CMC Vellore. We are in touch with Dr Priscilla Rupali who is a Professor in the Department of Infectious Diseases in CMC Vellore. We have their management COVID book, which is of great use beyond that also we call them more information.

Apart from Baptist and CMC there is one more hospital called RDT Hospital in Bathalapalli, AP which is not a member of CMAI they are also been a great help to us in terms of COVID.

Please share of the challenges at the hospital.

As you are aware that at small locations we always lack in human resources. So as soon as we started COVID block, we needed younger group of nurses, initially, people were not comfortable going to the COVID block, so I used to put myself on duty. Even though I am an ophthalmologist, but I used to go along with the medical officers during night duties.

Our own staff children who are into medical education like Nursing, BSc etc., but due to lockdown were contained at home. So, we trained them as a support staff in the

administration area and in food area etc. and paid on daily basis. So, we created work for them and utilized their abilities. We had other doctors and nurses also but then we required other staff also, so we used these young children. We trained them and used their expertise.

Anything more would you like to share.

In the first 3 months i.e. March, April & May we couldn't give salaries to our staff on time because of the lockdown. Then when we started this COVID block in September & October with the help of local politicians we were able to cope up the situation. Lots of people are quite weary of the politicians and I am certain that they also realised if the hospital is working genuinely, then helping in time is also necessary.

Heads up!!!

It's time
Open doors
Let in the light
Can't go on
Pretending
That everything's alright..

Storms in my head
Auras
Surreal
Beautiful
Pounders
Blinding pain
Lighting
Thunder
Rain..
I'm a migraneur
That's my new name...

Overwhelming anxiety
Feels as if
I'm unprepared
For life
And how it'll hit me..
Worrying
Ceaselessly
Trying to control
Everything
Everybody
Dreading
Tomorrow
And what it'd bring
Catastrophic thinking
Concerning everything..

Coping
Struggling
Easy days
And tough
Mood swings
Weepy spells
'Black dog'
Life under
A grey cloud..

Abysmal darkness
Unending tunnel
No glimmer
No flicker
Of light
Helpless
Hopeless
Given up
No end
In sight..

Severe pain
With nothing to show
No fracture to fix
No surgery required
Crazy behaviour
Hating myself
For being this way
Hurting myself
The ones that I love...

Unable to do
The simplest of tasks
Getting out of bed
Brushing my teeth
Taking a bath..
Everest like
Impossible
Tears unending
Sadness
Blackness
Just crying
And crying..

Being bombarded
Suicidal thoughts
Grotesque images
Of all sorts
Trying to function
Hold it together
Paste a smile
Wipe the tears
Blow the nose
One more time…

Half of me
Hating myself
Degenerated state
This shell of myself
While the other half
Unable to
Understand
Comprehend..

Treatment atlast
Medicines
Kind professionals
Diagnoses
Counseling

Cloud lifting
Able to breathe
Peace in my mind
Get back to me..

That part of me
Hidden away

Show off
My personality
Pretend
All's well
Multi-talented
Perfectly..

I mean I'm a doctor
Pathologist, please..
Evidence based
medicine
Not
'this is how I feel'..
I'm a wife
A mum
Many hats to wear
Perfection demands
Excellence
Everywhere..

But the anxiety
Right there
Can't think
Can't breathe
Mind like a washing
machine
Stuck
Endless repeats..
Spinning around
The same thoughts
'so much to do..'
'how will I do it all?'
And then
'so much time'
'what will I do?'
And dealing with people
And their personalities
How to prevent
Arguments
Criticism
Rubbing each other
The wrong way…
'help….
I don't know what to do..
Can't handle this…
Somebody help me
please…'

Now I'm older
Greyer
Wiser
Larger in size
Now I know
One life
We all get

Help each other
Not ostracize..

Needless suffering
Silent diseases
Afflicting our mind
We
Our children
Our loved ones
Are one of a kind
Can be affected
Any stage
Any time..

Help those
Who need it
Let them know
They're not mad..
No place for shame
There's help available
There's a name
For what
they're going through
Just an illness
Of the mind..
Not simply
A 'loose screw..'

My supportive
Spouse
Been there with me
In the tough times..
Prayed with me
Held me close
Wiped my tears
Never let me feel
I'm a kill joy
No matter what
Hung in with me
Down the lonely roads..

When Jesus walked
This world
Among the many
He healed
A demon possessed man
Cutting himself
Living in the tombstones
This man
Stands out in relief!!!!

Jesus healed him
Sweet release
The man begged

' Lord let me
Go with you..'
Jesus said
'My child, go,
tell the world
What has been done to you'

And I hear
Jesus
Looking at me
Tenderly
'You've been there
Living hell
You know
How it feels..
Go!!
Spread the news
Testify..
Speak out
Loud
Bold'

This is my story
All who read
Pass it on
Be safe places
Listen
Heed
The warning signs..
Lives are precious
Minds too
Gentle souls
Need love
His touch
Jesus the Healer
For
Bodies
Souls
Minds
For
Me and you…

Lisa Choudhrie

INTERVIEW OF DR SEDEVI ANGAMI

Christian Institute of Health Sciences and Research (CIHSR) Dimapur, Nagaland

Introduction of the Member Institution

The Christian Institute of Health Sciences and Research (CIHSR) is based in Dimapur, Nagaland. It's a public and private partnership institution. EHA, CMC Vellore and the Govt of Nagaland have partnered together to start this institute for a common cause. It is a secondary hospital with approximately 200 beds. It has educational courses like DNB PG courses in Family Medicine, surgery and Medicine, college of nursing and also has few Allied Health Sciences courses from which are with CMAI and some are with the Nagaland University.

CIHSR also partners with CMC Vellore for CLHCT and CHPC programmes and PGD Family medicine. They also run a small centre for Children with special needs in partnership with several organisation, churches and govt. We also have small palliative care unit and Community Health dept to do outreach work.

Please share how this pandemic affected the hospital?

COVID has brought a lot of difficulties to the us but also brought many opportunities. In the beginning, everyone was apprehensive hearing the news about the pandemic. However, we trained around twenty people from various areas as a Rapid Response Team. They in turn started training our other staff members which helped in spreading awareness about the pandemic. There were times when we faced difficulty in getting the PPE's and other materials. However, these trained staff helped in producing materials in-house also procuring the materials which were not easily available.

As there were no testing centres in Nagaland, we took initiative to start a COVID test centre in consultation with the government. In result of that we were able to have two centers, in our hospitals at Dimapur and Kohima.

Then we also created an isolation ward for the COVID -19 patients. As there was lot of panic in the community before the lockdown, we were able to conduct around 20 workshops in several parts of Dimapur with the help of several organization and churches, village councils, etc. We also developed educational materials to spread awareness about the quarantine centre, isolation centre, prevention, etc. We have been instrumental in providing support to the government in many ways like, setting up and running the quarantine centre, etc.

More than 50 staff were affected by COVID but all recovered in time. Due to which we had to close down the hospital for two weeks leading to deferment of salaries but we successfully reimbursed by the month of September

What are the opportunities you had in this time?

It raised fantastic opportunities like we got opportunities to engage with the government through which we also got lot of networking opportunities. We were able to demonstrate that as an institution can be of great help to the community and to the government and also to the churches. It gave the opportunity to develop training teams who could conduct workshops and further develop many more teams. This situation also helped us to think more about spiritual growth which helped us to create a team who can work on a strong spiritual curriculum for a dynamic spiritual growth.

Reaction of the community when workshops were conducted?

Right now, it will be difficult to share about the response from the community as we are yet to receive feedback about the programmes. However what we can say for sure is that overall these workshops were welcomed by everyone in the community.

Please share in case you were able to collaborate with another member hospitals of CMAI during this time?

Due to the lockdown period, we were unable to collaborate with other nearby hospitals. Although, there were times when we could take care of nearby hospitals and whenever the contact was possible. They required help like manpower etc. we were able to cater to such needs to Tezpur, Makunda, Alipur, etc.

Any other experiences you can share with our readers?

All the hospital staff who stayed in rented accommodations were asked to leave the house. This had led to a very sad situation as our staff suffered. So, we had to keep them in the hospital and provide with all the necessities. There was a lot of stigma and discrimination in the community. So, I addressed this matter and reached out to the Bishop and other authorities to explain that the situation in the community had potential to destroy the peace of the community. Simultaneously, we kept organizing activities making attempts to remove stigma by spreading awareness.

What is the present situation at the hospital?

We are elated to share that we are back to the normal situation. People are now confidently coming for their treatment. I definitely would like to commend the CMC courses which have been instrumental and helpful for our awareness programmes and also empower a lot of people in the process.

PANCYTOPENIA: AN UNEXPECTED OUTCOME

Introduction

Pancytopenia is a common haematological entity in which all three major formed elements of blood (red blood cells, white blood cells and platelets) are decreased in number [1]. It's encountered in our day-to-day clinical practice causing serious and life-threatening illnesses, ranging from megaloblastic anaemia, simple drug-induced bone marrow hypoplasia, to fatal leukemias and bone marrow aplasias [2]. Not only common causes but some of the other rare causes are hemophagocytic syndrome, Mycobacterium Avium complex, Tuberculosis (TB), among others [3, 4, 5]. Hence, it is critical to rule out the severity of pancytopenia and the underlying pathology to determine the management and prognosis of the patients. In view of extreme rarity, this paper focuses on a patient who presented as fever with pancytopenia, showed a myriad of haematological findings like extensive purpuric rashes all over the body and henceforth, was admitted under haematologist, with possibility of leukaemia and turned out to be TB.

Case report

A young 24 year old male from Hyderabad, India was presented to the St. Theresa multispecialty hospital with a history of on and off high-grade fever for 3 months associated with evening raise, chills and rigors. He also had altered bowel movements for a month and epistaxis. He was previously admitted in other hospital for 5 days before coming to our hospital and developed petechiae in both upper and lower limbs and trunk in 3 days of admission. He also had hematuria, reduced urine output and nausea for 2 days. He received 2 units packed red blood cells (PRBC), 6 Units single donor platelets (SDP) transfusion and platelets were raised. He was suspected primarily of acute leukaemia, TB involving marrow, non-Hodgkin or Hodgkin lymphoma and conservatively managed with tetracycline and B- lactam antibiotics for broad spectrum coverage but found no improvement. He was advised referral to our hospital's haematology centre for further evaluation. In our ER department, the patient had Ecchymosis all over body, multiple Ecchymotic patches, splenomegaly on palpitation, nose bleed, and gum bleed (Fig:1). He had marked loss of appetite, and had lost weight. He denied long-standing cough, headache, altered sensorium or blurred vision. No chest pain, syncope, shortness of breath (SOB), cold or vomiting. There were no known comorbidities. His past medical history was unremarkable. He is a third year engineering student, and no history of smoking or drinking. He denied any family history, past history or contact history of tuberculosis.

On examination, he had pallor and was mild icteric. He had temperature of 98.6°F at the time of admission. He had cervical lymphadenopathy. His cardiovascular and respiratory system examinations were unremarkable; his blood pressure was 110/80 mmHg and pulse of 136 beats per minute. Respiration rate was 20 breaths per minute and on auscultation found no abnormal breath sounds. His abdominal examination revealed a soft, non-tender abdomen with mild hepatosplenomegaly, soft in consistency. He did not have features of meningism. The results of his neurological examination, including higher functions, were unremarkable. His fundus examination was not done

On admission, patient was started on Normal saline 75ml per hour empirically after blood and urine were taken for cultures. He was treated with proton pump inhibitors (PPI), intravenous injection vitamin B12, ondensetron, cefoperazone and sulbactam, was subsequently added to the treatment regimen. He received 1 unit PRBC and 2 units SDP transfusion. He continued to have high fever spikes, and his condition deteriorated. Complete blood count revealed anaemia with haemoglobin of 7.3 g/dl (reference range 11.0–17.5), Total leucocyte count (TLC) 3100 (reference range 4000–10,000) with neutropenia of 72.3%, and a low platelet count of 1700µl (reference range 150–450). Pancytopenia and reactive lymphocytes with profound neutropenia and moderate thrombocytopenia were evident in the patient's blood workup. His C-reactive protein level was 1.14mg with an erythrocyte sedimentation rate of 135 mm in the first hour. His blood culture and urine cultures were sterile. His chest radiograph was unremarkable. His renal function was normal. He had a low serum albumin level (2.1 gm/dl) with a normal prothrombin time. Liver Function Test (LFT) showed mild hyperbilirubinemia. His liver enzymes were elevated (alanine aminotransferase 22 U/L, aspartate aminotransferase 45 U/L), and his serum bilirubin level was 1.24 mg/dl. His lactate dehydrogenase concentration was 1620 U/L.

His lipid profile showed serum LDH was 680 U/L, other parameters of iron profile was normal. Serum B12 was normal and was decrease in folic acid. His hepatitis profile, malaria film, dengue film, Widal test, Coombs test and human immunodeficiency virus serology was negative. Ultrasonography (USG) neck showed multiple left supra clavicular nodes, largest measuring 4x4cm. The high-resolution computed tomography (HRCT) chest was unremarkable.

On further evaluation, family history was taken again and found history of TB in the patients younger brother who died 2 years ago. A histological examination of lymph node biopsy was done (Fig/Table).. The cartridge- based nucleic acid amplification test (CBNAAT) showed multi drug resistant TB (MDR TB). Cervical node biopsy showed rifampicin resistant strain of mycobacterium tuberculosis on CBNAAT sample. In addition, the result of his Mantoux test was positive. Patient was started on standard antituberculosis treatment (ATT) and made a rapid clinical improvement with improvement in the blood picture. The patient was started on standard MDR-TB regimen, including isoniazid, pyrazinamide, ethionamid, clofazamine, levofloxacin, and ethambutol and multiple SDP and PRBC transfusions in view of bleeding manifestations.

Discussion

Tuberculosis (TB) is the third common cause of death in India [6]. Approximately, 3 out of 10 (27%) cases worldwide belongs to India [7]. This infection not only affects the lungs but can also affect other organs through lymphohematogenous spread. Extrapulmonary tuberculosis is often delayed in its diagnosis due to its nonspecific presentation and symptoms varying according to the affected site of infection [8]. This paper reports a case of a young boy with pyrexia of unknown origin (PUO) who presented with peripheral cytopenia and high inflammatory markers. He had positive Mantoux test results and negative chest radiograph. Our patient showed recovery with anti-tuberculosis treatment (ATT). This case report is quite unique in that it describes a rare but recognized presentation of disseminated tuberculosis with pancytopenia and an excellent response to the treatment following prompt diagnosis.

While the incidence of active pulmonary TB has declined due to prompt diagnosis and treatment, the incidence of extrapulmonary TB remains constant because of the delayed diagnosis owing to very nonspecific presentations [9]. Bone marrow examination is the best in confirmation of differential diagnoses of disseminated tuberculosis with absence of pulmonary lesion and presence of hematologic findings. Bone marrow biopsy may reveal granulomata in one half of cases, but anemia, leukopenia, and monocytosis show in 80% of cases [10]. TB is one of the most common causes of bone marrow granulomas constituting 6–48% of the cases where in cases of miliary tuberculosis its 33–100%; caseation is uncommon (29%), and presence of acid-fast bacilli detected by Ziehl-Neelsen staining is rare [11, 12].

Furthermore, as diagnosis remains a challenge to the treating physician due to protean manifestations of disseminated tuberculosis, history taking also plays a key role. A careful and detailed history helps in evaluating the possible outcome. Any patient who presents with PUO with peripheral cytopenia in an endemic region has to alert the physician to the possibility of TB, and prompt investigations including bone marrow need to be carried out [13, 14].

TB rarely presents with pancytopenia and thrombocytopenia is more common in patients with disseminated tuberculosis. Fast recovery of peripheral blood counts with ATT indicates no underlying haematological disease [15]. Aetiology of pancytopenia in disseminated or extrapulmonary tuberculosis can be due to hypersplenism, nutritional deficiency, malignancy, infiltration of the bone marrow by caseating or noncaseating granulomas, or hemophagocytic lymph histiocytosis (HLH), tumours causing reversible or irreversible fibrosis [16]. Mukherjee A, et al. reported that normocytic normochromic anaemia was the most common abnormality observed [17].

Another possible mechanism of pancytopenia in Tb is infiltration of the bone marrow by noncaseating or caseating granulomas causing reversible or irreversible fibrosis [18]. A study reported patients with disseminated or miliary tuberculosis with granulomas in the bone marrow had bone marrow histiomonocytosis, peripheral monocytopenia, and severe anaemia, in contrast to patients with disseminated or miliary tuberculosis without granulomas [19]. In addition, Pancytopenia in disseminated tuberculosis is multifactorial and can be due to hypersplenism, which was doubtful in our patient because his splenomegaly was mild and would not justify for such severe degree of pancytopenia. Maturation arrest due to disseminated tuberculosis is rarely known to cause pancytopenia [14]. Henceforth, identification of correct cause will help in applying appropriate therapy.

Conclusions

Due to nonspecific remains disseminated tuberculosis stands as a diagnostic challenge. This case report presented a patient with fever with cytopenia, a normal chest radiograph, and positive Mantoux test. Poor prognosis of disseminated tuberculosis is due to delay in diagnosis owing to lack of specific clinical features. Wang *et al.* described that simultaneous culture and histopathological examination of bone marrow in diagnosing disseminated tuberculosis is more sensitive than just performing a mycobacterial blood culture [20]. The favorable outcome of our patient was probably due to good history taking and prompt diagnosis with early initiation of ATT. Hence, it is to remember, common diagnoses are commonly correct and rare diagnoses are rarely correct.

Ashish Chauhan, Harika Reddy &
Papabathini Shireen Salome
Department of Medicine,
St Theresa Hospital, Hyderabad, India

CMJI with this edition will engage with artists to commission them for creating the Cover Design. This work of art will add visual value to the theme. The original art piece will be available for purchase by an individual member or a member institution. For this edition, we spoke with Ms Rebecca Pearson who created this painting on Violence in Medical Field.

-Please tell us about yourself.

I'm Rebecca Pearson, an artist, writer, and entrepreneur based in Bangalore. Creativity and communication are two of my biggest strengths and I've put the two together and founded a creative branding agency called Five Stones Media House, that helps brands 'create giant impact'.

-What inspires you?

People and nature inspire me most. To see the fullness and beauty of God's creation, especially in faces of people and flowers give me immense joy.

-The artists love the beauty of Canvas and colors. It has its own space and yet the digital world embraces and promotes art more effectively today. Your thoughts please?

I love that technology is a friend of art and it's given artists tools and platforms that they didn't have before. I think canvas and paints have their own charm and digital art its own. One isn't better than the other, they're equally creative and inspiring to me.

-So, looking at the painting you've created for the cover page, tell us what came to your mind?

Infectious diseases aren't the easiest subject to articulate through art. But I love drawing patterns and playing with watercolors, even digitally. The shapes of viruses depicted microscopically looked like beautiful patterns and so I used that as inspiration. Also, the colors blue and purple evoke confidence and security, something I believe we all really need this year.

- CMAI is trying to promote artists through this publication. What would you like to tell your fellow Artists?

Deeply touched by what CMAI is doing here with artists. I think Christian artists need a platform and a voice and I think the way CMAI is doing it is wonderful.

- What does your process involve? Does the work evolve or your start with an idea and take it to the finish?

Every artwork has a process that is a different story. Sometimes I struggle with a concept, sometimes it flows out of me easily. The key is to allow yourself to take time with the work that you're doing and not rush it.

- Where can we find more about your work?

I sell my paintings on www.beckyleepearson.com and also take commissioned orders for personalised artwork if reached out to directly on beckyleepearson@gmail.com

Are you looking for an opening in a mission hospital?

Advertise in the Classified Section in the CMAI newsletter – LIFE FOR ALL, and on our CMAI website: www.cmai.org

Take bold steps for change. This is what Mahatma Gandhi taught us. Christian Medical Association of India, established in 1905, was one such bold step taken by the missionary doctors who dared to serve this country. Even today, young doctors, nurses, allied health professionals, administrators and chaplains have followed the trodden path of the missionary movement which was started 115 years ago.

One cannot do it alone. But together, we can. If you are a medical or nursing graduate, if you are a professional in the health sector or a theology graduate, you need fertile ground to sprout and bloom.

CMAI is a large Christian membership organisation in the Indian health sector. We offer training programmes, platforms for sharing knowledge, opportunities for leadership building, and avenues to excel in your career.

If you haven't become a member, become one today.

CMAI member institutions work in the remotest parts. You will see a different geography of India where people suffer due to lack of proper medical care, children die of malnutrition and young mothers who need education in rearing children.

Dare to reach out to the place where people with commitment such as yours are needed to make a change.

YES,
It possible! You are needed indeed.

Write to us:
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QUARTERLY JOURNAL OF CMAI

CMJI

CHRISTIAN MEDICAL JOURNAL OF INDIA

Volume 35.4 | October - December 2020

Join Hands with us in the Healing Ministry

CHRISTIAN MEDICAL ASSOCIATION OF INDIA

COME JOIN US AS MEMBERS

CMAI is a national network of health professionals and institutions promoting a just and healthy society for all irrespective of religion, caste, economic status, gender or language

- CMAI has over 10,000 Christian health care professionals and over 270 institutions representing various denominations.
- CMAI builds individuals to be technically sound, spiritually alive, and socially relevant, in fellowship and with a Christian perspective on health and development.
- CMAI is the health arm of the National Council of Churches in India(NCCI).

WHAT DO WE DO ?

- Build capacity to respond to the current and future health care needs
- Advocate for innovations, create evidence and promote policy change
- Work closely with the churches, civil society and the government
- Build alliances for health action on a national scale
- CMAI influences other networks and alliances on thinking change in health systems practices in India. We partner with national and international agencies to promote this objective.

OUR PUBLICATIONS

- Christian Medical Journal of India (Perspective)
- Life for All (Newsletter)
- Footsteps (Development) English & Hindi (A Tearfund publication distributed by CMAI)

COME JOIN US

The core of CMAI is its members- individuals and institutions. Individual membership consists of five professional groups - Doctors, Nurses, Allied Health Professionals, Chaplains and Administrators. Each section comes together for conferences, workshops, a time of fellowship to learn from, to share with and to encourage each other spiritually and professionally.

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Building a just and healthy society

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Since 1895

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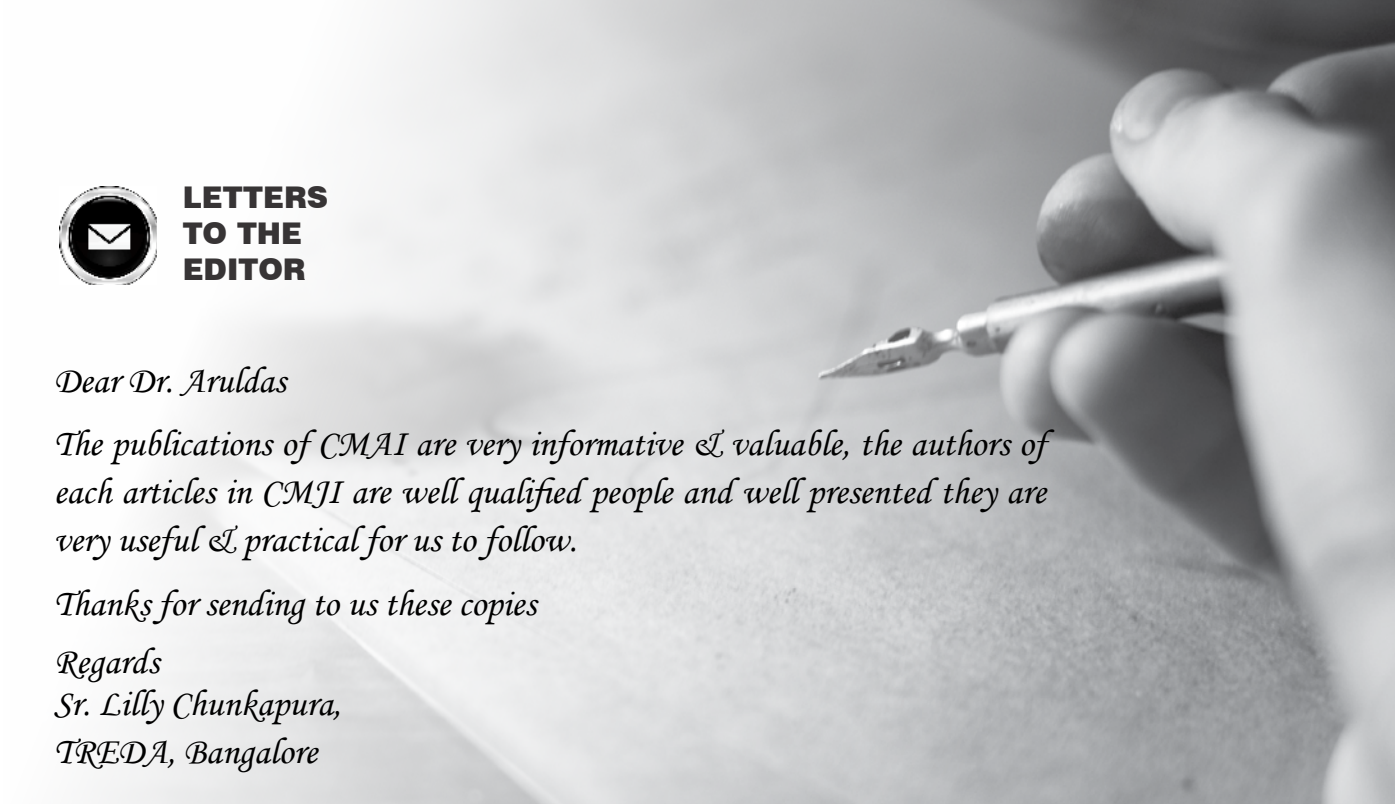

LETTERS TO THE EDITOR

Dear Dr. Aruldas

The publications of CMAI are very informative & valuable, the authors of each articles in CMJI are well qualified people and well presented they are very useful & practical for us to follow.

Thanks for sending to us these copies

Regards
Sr. Lilly Chunkapura,
TREDA, Bangalore

LETTERS / ARTICLES FOR CMJI

We invite your views and opinions to make the CMJI interactive and vibrant. As you go through this and each issue of CMJI, we would like to know what comes to your mind. Is it provoking your thoughts? Please share your thoughts with us. This may help someone else in the network and would definitely guide us in the Editorial team. E-mail your responses to: cmai@cmai.org

Guidelines for Contributors

SPECIAL ARTICLES

CMAI welcomes original articles on any topic relevant to CMAI membership - no plagiarism please.

- Articles must be not more than 1500 words.
- All articles must preferably be submitted in soft copy format. The soft copy can be sent by e-mail; alternatively it can be sent in a CD by post. Authors may please mention the source of all references: for e.g. in case of journals: Binswanger, Hans and Shaidur Khandker (1995), 'The Impact of Formal Finance on the Rural Economy in India', Journal of Development Studies, 32(2), December. pp 234-62 and in case of Books; Rutherford, Stuart (1997): 'Informal Financial Services in Dhaka's Slums' Jeoffrey Wood and Ifftah Sharif (eds), Who Needs Credit? Poverty and Finance in Bangladesh, Dhaka University Press, Dhaka.
- Articles submitted to CMAI should not have been simultaneously submitted to any other newspaper, journal or website for publication.
- Every effort is taken to process received articles at the earliest and these may be included in an issue where they are relevant.
- Articles accepted for publication can take up to six to eight months from the date of acceptance to appear in the CMJI. However, every effort is made to ensure early publication.
- The decision of the Editor is final and binding.

LETTERS

- Readers of CMJI are encouraged to send comments and suggestions (300-400 words) on published articles for the 'Letters to the Editor' column. All letters should have the writer's full name and postal address.

GENERAL GUIDELINES

- Authors are requested to provide full details for correspondence: postal and e-mail address and daytime phone numbers.
- Authors are requested to send the article in Microsoft Word format. Authors are encouraged to use UK English spellings.
- Contributors are requested to send articles that are complete in every respect, including references, as this facilitates quicker processing.
- All submissions will be acknowledged immediately on receipt with a reference number. Please quote this number when making enquiries.

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EDITORIAL

GOD'S GOODNESS, LOVE & HEALING

Rev. Arul Dhas T.

What a joy it is to experience the hand of God in our land as we continue in the ministry of healing!

In the midst of the ongoing pandemic we see our institutions witnessing to Christ's love so faithfully. Of course, we do have challenges; but God's love is more powerful. We see our efforts are bringing fruits at personal levels and institutional levels. As followers of Christ, in the healing ministry we see many getting healed through our humble attempts. We thank God for God's goodness.

Christian Medical Association of India continues to unite the people of God in healing ministry. Even this issue of CMJI comes with prayers and best wishes to all those who are involved in showing Christ's love to the needy, suffering and sick.

It is our hope that the articles in this volume will be useful to all the readers. The devotion in this issue comes as lessons from the special disciples of the Lord – Joseph of Arimathea and Nicodemus.

The first article highlights the advance of technology as a new determinant of health. The research study about the Sahariya tribe of Baran District in Rajasthan serves as a case of inspiration to many contexts in our land. This has a special reference to environmental health and women empowerment.

In a context where good leadership is lacking even in Christian healthcare setting, the article on "Good Leadership" helps us to focus on the excellent characteristics of a good leader and leadership. This has a special note on the difference between boss and leader. A reflective note on the emerging viruses helps us to see the mysteries of nature and its creator God. "Christian response to Disasters" highlights the constant question many of us have "Why suffering?"

As we face more health challenges, leadership challenges and human resource challenges, we continue to depend on God as our provider, leader and inspirer. It is our prayer that Christ who rose from the dead will empower us to be fit instruments in His hands for the ministry. May the same attitude of Jesus be in us as we accomplish our task as God's calling.

I am grateful to all the contributors, CMAI staff and editorial team for all the hard work, time and commitment to bring this issue out.

Rev Dr Arul Dhas T
Editor

DEVOTIONAL - SECRET DISCIPLES COMING TO THE LIGHT

The gospel narratives tell us about two secret disciples who followed Jesus.

Who are they?

They are Joseph of Arimathea and Nicodemus.

We read about them in the Gospel of John chapter 19.

Secret Disciple - Joseph of Arimathea

Jesus son of God, was buried. His body was placed in a tomb. A tomb that belonged to Joseph of Arimathea. He was a rich man and was an honored member of the Jewish high council. (Mk. 15:43)

As evening approached, there came a rich man from Arimathea, named Joseph, who had himself become a disciple of Jesus.

Mathew 27:57 says, Joseph himself had become a disciple of Jesus. In the past he had been afraid to speak against the religious leaders who opposed Jesus; now he is bold, courageous to go to Pilate and ask for Jesus' body to be buried.

We see an interesting fact here:

The disciples who publically followed Jesus fled but a disciple who secretly followed Jesus came forward boldly to do something that was right.

He along with another secret disciple of Jesus - Nicodemus wrapped the body of Jesus in a clean linen cloth and laid

When Nicodemus met Jesus for the first time, Jesus told him: "just as Moses lifted up the snake in the desert, so the Son of Man must be lifted up…(Jn. 3:14)

the body in the tomb. Subsequently, a stone was placed in front of the tomb.

Secret Disciple - Nicodemus

Nicodemus had a long conversation with Jesus at the beginning of Jesus' ministry. (Jn. 3). Jesus spoke to him about the need to be born again.

When Nicodemus met Jesus for the first time, Jesus told him: "just as Moses lifted up the snake in the desert, so the Son of Man must be lifted up…(Jn. 3:14)

We find him again in Jn. 7:50 he was trying to question the decision of Jewish high council regarding Jesus. Although his opinion was not heard, he did not give up his association with Jesus.

Remember at both times Nicodemus chose to come at night. Probably this time, he was coming to the light. He was ready to receive God's free gift of salvation by faith in Christ.

Reflection & Introspection

We thank God for the ministry of Joseph and Nicodemus. They were willing to follow Jesus by: – and find the way the truth and the life in Jesus.

They gave their utmost respect and honor to Jesus. They gave themselves to Jesus.

Remember, the tomb of Joseph became the Open tomb for the world today.

And we see the light streaming from that tomb. The open tomb still leads many to the Light of Life.

Rev. Dr. Finney Alexander, Sr. Chaplain,
CMC Vellore

INCREASED TECHNOLOGY ENVIRONMENT AS A NEW DETERMINANT OF HEALTH

In today's world, technology is all pervasive and has, in a way invaded all areas of our life including health. Thus, it is imperative that increased technology environment has to be added to the traditional list of health determinants.


Benhur Rao

Innovations in drug delivery systems, advances in diagnostic tools and other medical devices have been occurring with regularity over the years. And healthcare professionals are able to access these innovative technologies and cascade their benefits to the patients quite effectively. In the Indian context, in the past, only a small proportion of our population was able to access and afford these innovations and hence the impact of technology in diagnosis and treatment had been rather limited for most Indians especially in rural areas. Now the situation is changing with the penetration of technology into the farthest corners of the country. Wherever there is Wi Fi and wherever there are smart phones in use, the benefits afforded by technology have the potential to be a game changer in health care both at the prevention as well as at the treatment stage.

The good news is that access to mobile technology has already begun to be considered as a major determinant of health across the world and India will not be far behind. And it all starts with awareness.

In essence, there are the three "A" s to be considered for increased technology environment to be truly considered as a major determinant of health. These are Awareness, Accessibility and Affordability

Awareness is getting people to know what is available in the market, make them realize how technology can help them to make the right choices, live healthy and to take preventive action in order to be disease free. There are many Apps available for tracking and monitoring health parameters and anyone with a smart phone can access them in an instant. Social media campaigns can help in making people aware of what is available.

Accessibility to technology may be more challenging in places with poor connectivity and this can affect the outcomes. With the coming of the next generation of Wi Fi devices, a greatly improved mobile network across the country and with the introduction of vehicles with built in SIM cards, the situation is bound to change. Ambulances will now be able to transmit real time patient data from the moving vehicle to specialists in distant hospitals that can potentially be a life saver during the golden hour.

Affordability is always a critical factor while accessing technology. One solution could be telemedicine to bring down the cost and to give convenience. Also, in the wake of the Covid-19 pandemic, telemedicine in general has assumed greater prominence. ICU telemedicine can benefit both large hospital systems and smaller individual hospitals. In addition, telemedicine can deliver care asynchronously, remotely, and virtually unlike large-scale brick-and-mortar medical facilities that invest enormous capital in the delivery of synchronous, in-house, in-person care.

In India, over 1.6 lac babies die each year due to the lack of CPAP (Continuous Positive Airway Pressure) therapy, as most premature babies are not born in high-end hospitals with access to an NICU (Neo-natal ICU). Now we have an Indian device, the Saans® the first CPAP system in the world that is completely infrastructure-independent. This is a life saver in places with erratic electric supply and a lack of highly trained personnel. Easy to use affordable innovations like these are the way forward if we have to harness technology and make it a health determinant in our country.

Artificial Intelligence (AI) based proactive alert systems for monitoring patients are coming into more frequent use and AI algorithms have saved hundreds of lives over the years. Systems now available in India such as the Dozee® monitor heart rate and its variability,

If every phone that is sold is compulsorily enabled with an App that can provide first aid information on how to manage dehydration or snake bite, resuscitate a drowning victim and handle various other emergency situations, it could be a game changer to many of those affected.

blood pressure, respiration rate, oxygen saturation, sleep stages, stress and recovery, snoring index and restlessness. Thus, AI systems act as a contactless health tracker and contactless remote patient monitoring for post discharge home patient monitoring, patient monitoring for chronic condition management and as a proactive health monitoring for geriatric care. Over time increased usage and economies of scale will make them affordable to most people in need of such care.

The current pandemic has brought with it a slew of contact tracing Apps like the Arogya Setu. Following their successful roll out we hope that governments and institutions are able to develop Apps for preventive and emergency health care. If every phone that is sold is compulsorily enabled with an App that can provide first aid information on how to manage dehydration or snake bite, resuscitate a drowning victim and handle various other emergency situations, it could be a game changer to many of those affected.

The future is certain to see an exponential rise in access to mass media and new emerging technologies and with it health literacy and health care from primary to tertiary are going to ride the technology wave. Government, health organisations and companies will certainly propel the use of this technology and as a fall out of this, the increased technology environment will certainly make it a new determinant of health.

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FUEL EFFICIENT COOK STOVES, A MEANS TO TACKLING ISSUES OF DEFORESTATION, CLIMATE CHANGE, HEALTH ISSUES AND WOMEN EMPOWERMENT –
A STUDY ON THE SAHARIYA TRIBE OF BARAN DISTRICT IN RAJASTHAN.

Abstract

The use of biomass burning – i.e. firewood from forests, is the main source of cooking energy of the Sahariya community, a Particularly Vulnerable Tribal Group (PVTG), from Kishanganj block of Baran district in Rajasthan. The forests in the area have dwindled over the years, as per the Rajasthan state forest reports. The people's perception of the reasons for degradation of forest in the area, indicates the role of local people in deforestation, mainly for local construction and household cooking energy needs. The dwindling forests have aggravated the struggles of Sahariya women in fetching firewood from long distances. Emissions from traditional biomass burning for cooking energy, contributes to health issues and the issue of climate change.

This paper presents the study of Sahariya tribal households from Baran, who were provided with a fuel efficient cookstove, and the benefits assessed in terms of emission levels of particulates - PM_{10} and $PM_{2.5,}$ methane (CH_4) and Poly-aromatic hydrocarbons (PAHs). The results indicate that emission levels were reduced within the prescribed standards and households were able to significantly reduce their firewood requirement. This reduction in the household emissions and reduction in firewood requirement observed in Sahariya community, can be a pragmatic solution in the collective efforts of tackling the issue of deforestation and also a positive contribution towards reducing emissions of carbon particulates and GHGs from rural households. The co-benefits include reduced stress levels among women, as firewood requirement is reduced, and improvement in overall health of family members from improved indoor air quality.

Salmon Jacob

Keywords: Sahariya tribe, forest, air pollution, health issues, climate change, fuel efficient cook stoves.

Introduction:

Air Pollution caused by open fires in traditional chulas (stoves) using biomass fuels, contribute significantly to the atmospheric concentrations of carbon particulates[1] and greenhouse gases leading to issues of global warming, climate change, along with causing health concerns related to respiratory infections particularly among children under 5 years and women. The World Health Organization estimates that indoor air pollution contributes to nearly 4.3 million deaths annually[2].

According to the Census data of 2011, about 85% of the rural households in India, still use firewood and chips as cooking fuel[3]. The study published in Lancet Planetary Health journal estimates that 1·24 million deaths in India in 2017, which were 12·5% of the total deaths, were attributable to air pollution, including 0·67 million from ambient particulate matter pollution and 0·48 million from household air pollution[4]. Nearly, 39% of early neonatal stillbirths were attributed to cooking fumes (National Centre for Biotechnology Information)[5]. Furthermore, open fires using biomass fuels contribute significantly to global greenhouse gas emissions due to incomplete combustion.

There is consistent evidence that indoor air pollution causes acute lower respiratory infections (ALRI) in children under five, particularly pneumonia, and chronic obstructive pulmonary disease (COPD), chronic bronchitis and lung cancer among adults[6]. In additional to this, there is emerging evidence that links indoor air pollution to low birth weight[7] and prenatal mortality among

infants, due to carbon monoxide (CO) inhalation among pregnant women and young children, as well as ear and respiratory infections, tuberculosis, nasopharyngeal and laryngeal cancer, cataract (blindness) and cardiovascular disease.

According to the study report published in 'Swasti – Health Catalyst' (December 2018), titled, "Why the Sahariyas", it highlighted that the Sahariyas are the most frequent victims – in terms of infection rates and mortality - in the country, for Tuberculosis (TB)[8]. Ravi Prakash, (2016) from his study published in the Journal of Infection and Public Health, mentions that Tuberculosis (TB) is emerging as a serious public health concern in Sahariya tribe[9].

Similarly long term exposure to methane (CH_4) and poly aromatic hydrocarbons (PAHs) also affects child development, including harm to the developing heart, brain and nervous system[10]. It is also associated with episodes of headaches, coughs, shortness of breath, lung inflammation, decreased lung function, worsening of asthma and other respiratory diseases, cardiac arrhythmia, increased risk of heart disease, heart attacks, stroke and even cancer.

Children generally absorb proportionally higher doses of smoke pollutants which makes them particularly vulnerable to damaging health effects. Smoke pollution can cause permanent impairment of children's growing as well as organ and immune system development[11]. Thus, significant reductions of these diseases can be achieved, particularly among women and children, by reducing the indoor air pollution.

Research Methodology:

The study was conducted in Kishanganj block of Baran district, in Rajasthan state, which has a high concentration of the Particularly Vulnerable Tribal Group (PVTG) – the Sahariyas. Out of the 181 revenue villages in Kishanganj Block, 136 villages are inhabited by Sahariya tribe. So 10 villages from among the 136 Sahariya villages was selected randomly for the study. The villages taken up for the study were Radhapuram, Barooni, Gopalpura, Rajkheda, Chandergarh, Bamandeh, Gordhanpura, Daulatapura, Phelu Ki Tapri, and Kagla Bamori.

Thirty Sahariya households from each of the 10 selected villages were selected randomly as sample units, and the data was accordingly collected from a total sample size of 300 households. The Sahariya community being a homogenous group, the sample size of 300 households provides a good representation of the community. A pre-structured schedule with open and closed end questions were used for the research. Secondly, indoor air quality from 8 selected villages were tested through independent NABL accredited labs, with a total of 48 samples, before and after the introduction of the clean cookstoves in these villages.

Results and Discussion:

Kishanganj block in Baran district of Rajasthan, historically had a good presence of forests, and over the years it is seen that the quality of the forests have dwindled due to various reasons. According to the Rajasthan state forest Reports in 2001[12], the dense forest area in Baran district was 226 sq. km., while in 2003[13] the data was differentiated into Very Dense Forest (VDF) and Moderate Dense Forest (MDF) area. As per the 2003 data, it is seen that there is 0 sq. km. of VDF, 136 sq.km of MDF and a total forest area of 1140 sq. km. Similarly in the year 2017, it is seen that the total forest area is 1013 sq. Km.[14] indicating a reduction of more than 125 sq. Km. of forest land in the district. This is an indication of the forest degradation issue in the district.

The field observations have indicated that 99% of the households in the study villages of Kishanganj block, use firewood as their energy sources for meeting the household cooking energy needs. The local perception of the reasons for the dwindling of the forests, were estimated based on the response from 300 households from 10 villages taken up for the study – inhabited by the Sahariya community-, wherein the major reasons for the forest depletion that were reported included timber merchants, clearing of forests for agriculture, firewood etc., as shown in figure no.1. It is interesting to note, that most number of people felt that the major reason for the degradation of the forest, was the felling of trees for local construction needs as well as firewood requirements for household energy needs.

The degradation of the forests have made the task of fetching firewood, even more difficult for the Sahariyas, as they need to travel longer distances away from their habitation areas, to fetch the needed firewood. The respondents were asked a comparison of the distances they needed to travel fetch firewood from the forest 30 years back and the distance they travel at present to fetch the firewood. The results are presented in figure no. 2. The graph in figure no. 2 indicates that 30 years back 37% of the households were able to get the required firewood from within 100 meters from their house. Also overall 86% of the households were able to get their required firewood from within 1 km distance from their homes, 30 years back. This gives an indication of the green cover and the healthy forests that existed in that area, and supported the needs of the people. On the contrary, at present 78% of the households collect their

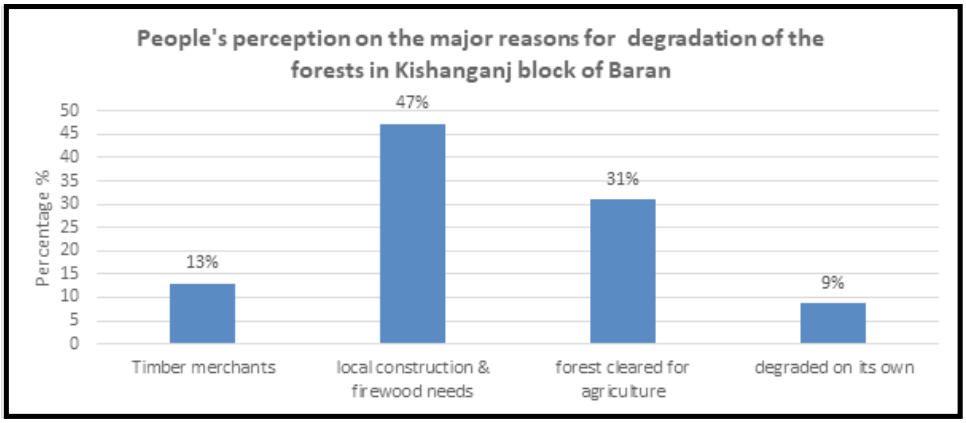

Fig no. 1: People's perception of the major reasons for degradation of the forests in Kishanganj block of Baran district.

firewood from a distance of minimum 2 km to 4km away from their homes, and out of this group of people 37% of the households got their firewood from a distance of about 3 to 4km away from their homes. This is an indication of the degradation of the forest resources of the area, over a period of 30 years.

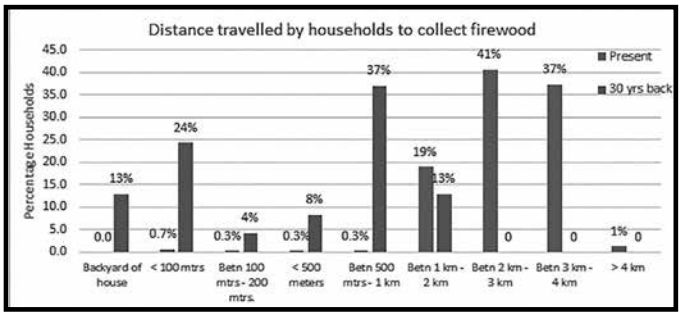

Fig No. 2: Distance travelled by households to fetch firewood – 30 years back and at present

World Vision India, working among the Sahariya tribal community, made an effort as part of its developmental programme, to provide fuel efficient woodstoves in some of the Sahariya inhabited villages of Kishanganj block of Baran, towards tackling some of the issues related to environmental degradation, women empowerment as well as improve the health of the community, during the years 2014-15. The fuel efficient woodstoves are designed to improve the combustion efficiency of the woodstoves and thereby significantly reduce the firewood requirement as well as reduce the smoke emitted from these woodstoves. These stoves require only dry twigs, which usually fall off from trees, as against the bigger blocks of wood used in the traditional open stoves.

According to the graphs shown in figure no. 3 & 4, it is observed that 95% of the users of the fuel efficient stoves have found it beneficial in terms of the reduced smoke emissions, reduced firewood requirement and the comfort of cooking. About 73% of the households felt that the firewood requirement for a day's cooking reduced by 50% - 60% as shown in the graph above.

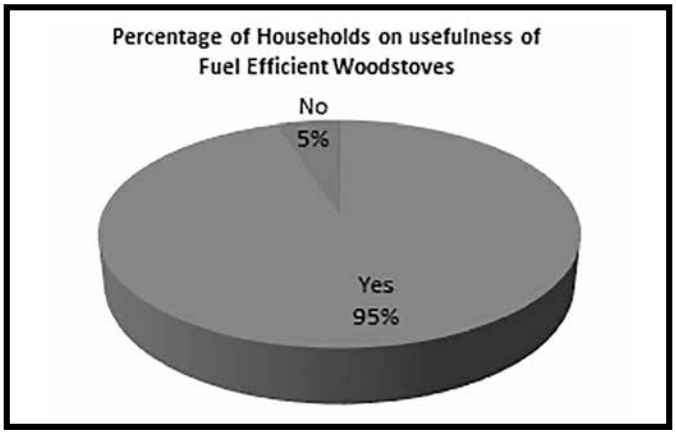

Fig no. 3: Percentage of households regarding usefulness of the fuel efficient woodstoves

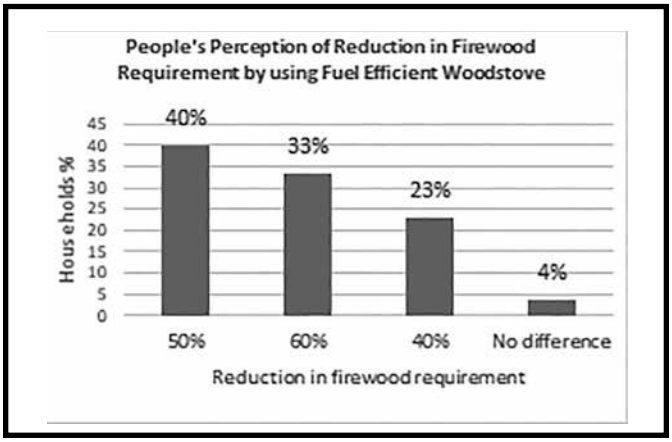

Fig no. 4: People's perception of the reduction in firewood requirement in fuel efficient woodstove

Table No. 1: Concentrations of for PM_{10}, $PM_{2.5}$, CH_4, and PAHs in Sahariya Households

Villages	PM_{10} conc. (µg/m3)		$PM_{2.5}$ conc. (µg/m3)		CH_4 conc. (ppm)		PAHs conc. (ppm)	
	Before	After	Before	After	Before	After	Before	After
Chandragarh	268	81	165	37.68	20	16.95	0.99	0.94
Felu Ki Tapri	235	82.03	152.5	42	25.5	2.2	2.1	1.42
Kagla Bamori	200	82.19	124	38.01	6.2	1.25	1.48	0.31
Gopalpura	203.67	84.02	126	41.95	6.3	3.3	3.82	1.26
Daulatpura	200.67	81.60	112.67	39.92	4.43	1.91	2.23	1.40
Gordhanpura	196.5	81.53	119.5	40.16	4.7	1.2	2.02	0.79
Radhapura	188	82.63	107.5	41.72	4.4	0.88	2.9	1.10
Barooni	195.33	79.62	121.33	39.06	5.47	5.03	2.07	1.43

The indoor air quality levels were tested for PM_{10}, $PM_{2.5}$, CH^4, and PAHs from 8 of the operational villages before and after the introduction of the fuel efficient stoves on various parameters, and the results are as shown in table no. 1.

The figure no. 5 to figure no. 8, shows the comparative graph of each of the parameters, before and after the introduction of the fuel efficient cookstoves. It was observed, that the indoor concentrations of $PM_{2.5}$ and PM_{10} levels inside the house were found to have reduced much below the prescribed indoor air quality standards, through the use of cleaner cooking practices. Similarly, the concentrations of methane (CH_4) and poly aromatic hydrocarbons (PAHs) were also found to have reduced well within permissible limits.

In India, as there is no separate standards for the indoor air quality, the results of the air quality recorded are compared with the ambient air quality standards prescribed by the Central Pollution Control Board of India. The standard limits for PM_{10} is 100 µg/m^3 and $PM_{2.5}$ is 60 µg/m^3.

The emission of methane gas from the traditional chulas though in low levels also contribute to the outdoor air pollution and has a high potential in contributing to global warming issues. The graph above indicates, that the use of clean cookstoves has decreased the methane concentrations in the indoor air, in comparison to the air quality while using the traditional open chulas.

Polycyclic aromatic hydrocarbons (PAHs) are a large group of organic compounds with two or more fused aromatic rings. There are several hundred PAHs; the best known are benzo[a]pyrene (BaP), Anthracene, Coronene etc. In the household context, PAHs are formed during incomplete combustion of fire wood, cowdung cakes and other biomass burning. These are carcinogenic in nature and in combination with higher particulate matter concentrations, they further increase the cancer risk and other respiratory illness [15]. Though there is no prescribed

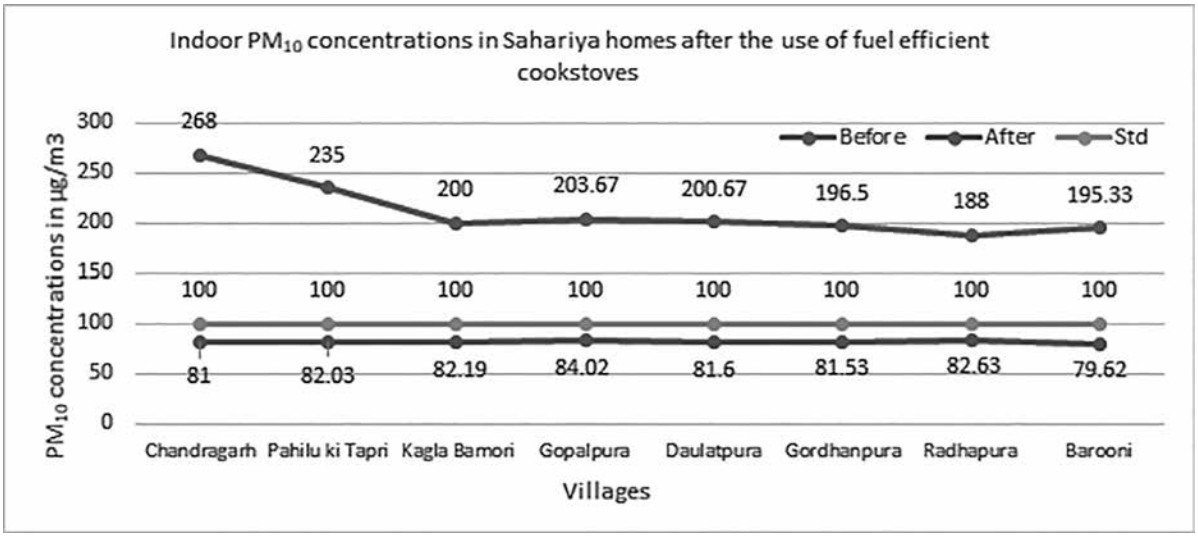

Fig no. 5: PM_{10} concentrations before and after clean cookstove intervention in project villages

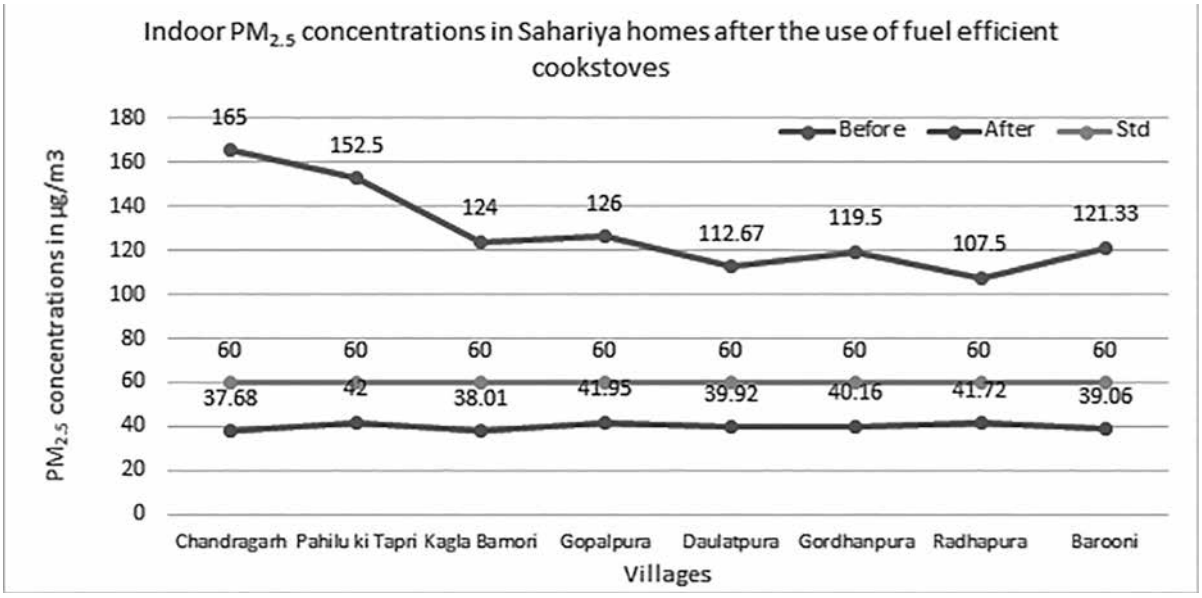

Fig no. 6: $PM_{2.5}$ concentrations before and after clean cookstove intervention in project villages

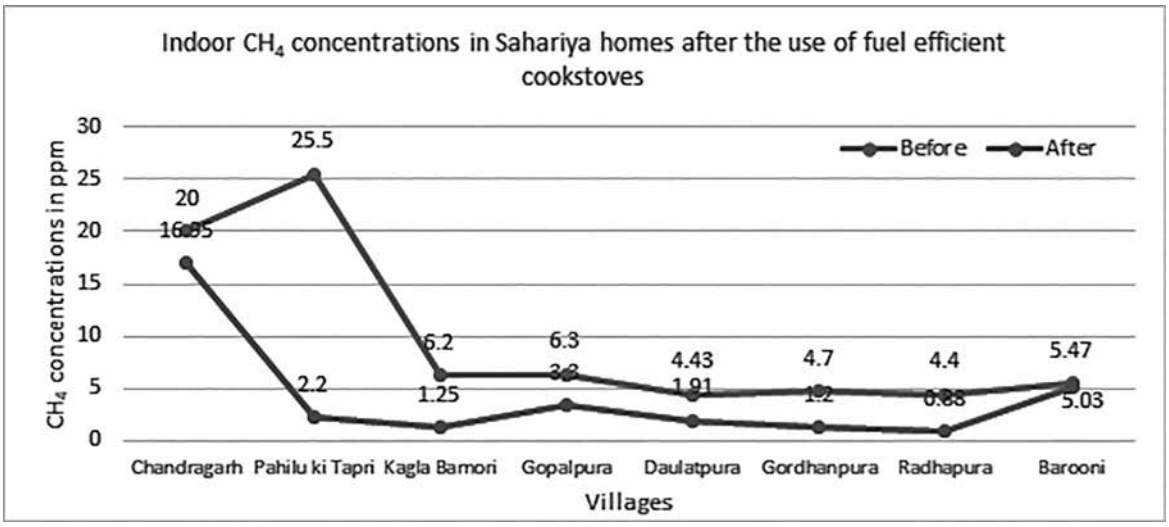

Fig no. 7: CH_4 concentrations before and after clean cookstove intervention in project villages

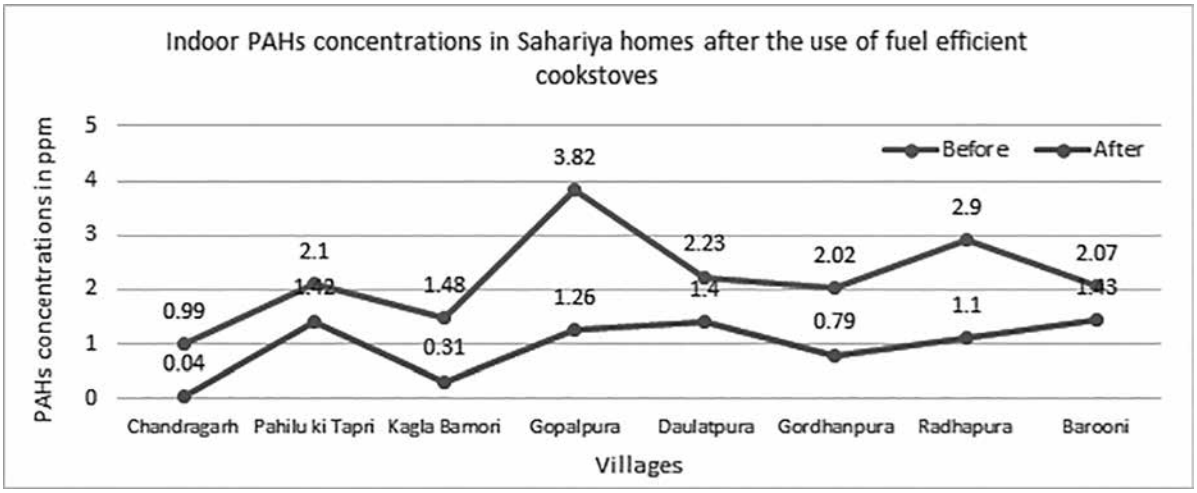

Fig no. 8: PAHs concentrations before and after clean cookstove intervention in project villages

standard available, for PAH exposure levels, the above comparative graph shows that the use of fuel efficient cookstoves have reduced the indoor PAH levels, thereby reducing the vulnerability of the household to health issues.

It was observed that out of the 300 respondents, 89% of the households expressed that there is an improvement in the overall health of the family members, with regards to issues of eye irritations, headaches, cough etc., on account of the improvement in the indoor air quality. There was however, no in-depth study on the health aspects, which is a potential for further research.

Conclusion:

A large section of the Sahariya tribal community, still depend on firewood, as their source of cooking energy – exposing themselves (particularly the children) to carbon particulates and other polluting gases coming from the smoke emitted from the chulas, leading to various health issues and also putting stress on the adjoining forest resources. In this context, it is important to look at pragmatic solutions to tackle these challenges, to ensure an environmentally sustainable and equitable development approach.

The Government of India, as part of its initiatives to tackle this issue, has launched the 'Pradhan Mantri Ujjwala Yojana'[16], in May 2016, which provides free LPG connections to BPL families in India. It is expected to spread the reach of LPG as cooking energy across the country. The concerted efforts to strengthen this programme in terms of the scale and sustainability of usage by the community, will be critical to ensure its success.

The present study on the Sahariya tribe and their dependence on the forest resources – particularly with reference to the cooking energy needs, as well as their vulnerability to various health issues due to exposure to smoke from the traditional chulas, demonstrates a pragmatic & environmentally sustainable solution. The results observed regarding the use of fuel efficient cook stoves for Sahariya households, show a very positive way forward in terms of tackling not only air pollution [in terms of concentrations of $PM_{2.5}$, PM_{10}, CH_4, PAHs], forest degradation, stress involved in firewood collection and associated health concerns, but also positively contributing towards addressing the issues of global warming and climate change.

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World Vision India

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GOOD CHRISTIAN LEADERSHIP

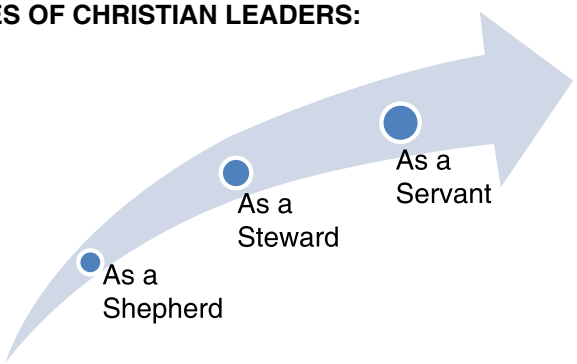
Mrs. Balqis Victor

President Theodore Roosevelt once said, "The leader leads, and the boss drives." The boss often plays the Boss card. They force obedience, strictly because of their position and status. But, as author and expert John Maxwell says, "Leadership is not about titles, positions or flow charts.. It's about one life influencing another."

We still suffer from leadership deficiency- in our nation, workplaces, churches and homes.

We have too many leaders who believe their position mandates their influence, rather than their influence enabling them to be effective in their position.

TYPES OF CHRISTIAN LEADERS:



A good leader seeks God's direction:

- Is there anything more important than he or she seeking God's direction?
- Proverbs 16: 1 says "The plans of the heart belong to man, but the answer of the tongue is from the Lord."
- Commit your work to the Lord, and your plans will be established
- The heart of man plans his way, but the Lord establishes his steps." A good leader seeks the Lord, commits his way to the Lord, and the Lord establishes the next steps.

A good leader is Modest, not arrogant:

- We have all encountered the "know-it-all" leader, the "submit-or-else" type of leader.
- Proverbs 16:5 says, " everyone who is arrogant in heart is an abomination to the Lord; be assured, he will not go unpunished." I don't know about you, but I definitely don't want to be referred to as an abomination to the Lord.

A good leader is a Pacemaker:

- Proverbs 16:7 says, " when a man's please the Lord, he makes even his enemies to be at peace with him." Yet so many leaders aren't interested in examining an opposing viewpoint or other ideas. We've lost the ability to empathize with others, and compromise has become a bad word. There is something to be said of sticking to principles.
- I believe God calls us to be steadfast. He doesn't however, call us to be jerks. And, when our "boldness" is interpreted as " coldness", we are not doing it right.

A good leader is fair and just:

- "Better is a little with righteousness than great revenues with injustice" (Proverbs 16:8)
- I believe in goals, and working hard to achieve them. But, the end always justifying the means is simply not true.
- A good leader is more interested in doing things the right way.

A good leader surrounds himself with honest, trustworthy counselors… then listens to them.

- Righteous lips are the delight of a king, and he loves him who speaks what is right" (Proverbs 16:13).
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- Righteous lips are the delight of a king, and he loves him who speaks what is right" (Proverbs 16:13).

LEADER IN THE MAKING QUALITIES

- Servant leadership: This kind of leadership, I believe is what God desires of us.
- Letting Go of Bossiness – This type of leadership gets us nowhere. God is ultimately

- Take Care of yourself as a Leader- Meaning…Take care of yourself spiritually and physically.
- Managing Stress & Emotions as a Leader – No doubt, this is a tough one, especially for women in leadership.

A good leader is a good learner:

- Proverbs 16:16 says, "How much better to get wisdom than gold! To get understanding is to be chosen rather than silver."
- A good leader should always be learning, growing and improving.

A good leader is humble:

- We've seen countless prominent examples of Proverbs 16:18: "Pride goes before destruction, and a haughty spirit before a fall." From politicians and celebrities to CEOs and pastors, many have grabbed headlines as their empires have fallen.
- "It is better to be of a lowly spirit with the poor than to divide the spoil with the proud" (Proverbs 16:19).

A good leader is sensible and kind:

- "Good sense is a fountain of life to him who has it, but the instruction of fools is folly. The heart of the wise makes his speech judicious and adds persuasiveness to his lips" (Proverbs 16:22-23). Being smart and sensible makes a good leader more persuasive and effective.

A good leader is slow to anger:

- We've all seen the in movies and television of the angry boss; the person who yells for no reason, barks orders and berates and demoralizes the staff.
- Perhaps you've even worked for such a person. The Bible says that "Whoever is slow to anger is better than the mighty, and he who rules his spirit than he who takes a city."

PERSONAL QUALITIES OF A GOOD CHRISTIAN LEADER:

- Above reproach (1 Timothy 3: 2, Titus 1: 6)
- Faithful to his wife (1 Timothy 3: 2, Titus 1: 6)
- Temperate (1 Timothy 3: 2).
- Self-controlled (1 Timothy 3: 2, 3:8, Titus 1: 8).
- Respectable (1 Timothy 3: 2).
- Free from the love of money (1 Timothy 3: 3).
- One who manages his own household well (1 Timothy 3:4, Titus 1: 6).
- Not a new convert (1 Timothy 3: 6).
- A good reputation with outside (1 Timothy 3:7).
- Not pursuing dishonest gain (1 Timothy 3:8, Titus 1: 7)

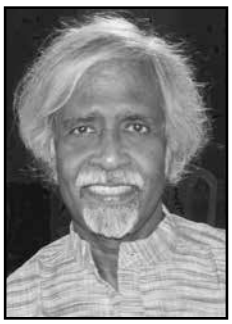
BOSS	LEADER
Demands	Coaches
Relies on authority	Relies on goodwill
Issues ultimatums	Generates enthusiasm
Says “I”	Says “we”
Uses people	Develops people
Takes credits	Gives credits
Places the blame	Accepts blame
Says to “go”	Says “ Let’s go”
My way is the only way	Strength in unity

- Not quick¬ tempered (Titus 1: 7).
- Not violent (Titus 1: 7).
- Loving what is good (Titus 1: 8). “
- Upright (Titus 1: 8).
- Holy (Titus 1: 8).
- Disciplined (Titus 1: 8)

According to Lao Tzu, “A leader is best when people barely know that he exist “ not so good when people obey and acclaim him, worst of all when they despise him. “ fail to honor, people they fail to honor you”. But of a good leader who talks little when his work is done, his aim fulfilled, they will all say, “we did it ourselves”.

Prof. (Mrs) Balqis Victor, College of Nursing, Christian Medical College and Hospital, Ludhiana, Punjab.

DID GOD SEND THE PANDEMIC? CHRISTIAN RESPONSE TO DISASTERS



P. Dayanandan

The year 2020 has been full of unknowns, new fears, and disruptions we never imagined. Why is the COVID-19 (coronavirus) pandemic killing millions across the globe? Some of us wonder how God can allow such painful experiences. Others assert that God does indeed send calamities to punish or to test people. For most of us in India, COVID-19 is the first experience of a serious pandemic with such a devastating impact on our lives. This viral disease seems to dwarf SARS, H1N1, and HIV. When large scale epidemics occurred in India in the past, there were Christians of extraordinary courage and compassion who responded by helping others. A look at their circumstances and actions can help us appreciate their work and provide a perspective on what we face today.

Anne Dayanandan

The story of one outstanding woman, Dr. Mary Rajanayagam, reveals steadfast faith in the face of devastating disease. Mary was an early graduate of the Madras Medical College in 1894, sponsored by the American Arcot Mission. While she was serving in Madanapalle the bubonic plague hit the area in 1903. Fearing for their safety, she sent her two young sons to stay with her sister while she cared for people—people of all faiths—stricken by the dreaded disease. Sadly, she too became infected and succumbed to the plague in March 1904. She was so loved by everyone that people of all religions and backgrounds joined her burial procession for a mile, braving the highly contagious disease. Like Mary Rajanayagam, the plague that broke out in 1897 took the life of a celebrated Indian woman, Savitribai Phule, and her son. Jotirao and Savitribai Phule were influenced by the teachings of Jesus and were pioneers in the fight against caste and racial discrimination. They worked to empower the oppressed, and educated girls and women.

Their choices lead us to some all-important questions: What do we believe about God and suffering? Did God send this pandemic as punishment, as well as other disasters, such as the tsunami of 2004? What alternative explanations can we look to? How is this pandemic changing our beloved church as an organization? What priorities are revealed by the history of Christians in our area when they faced a frightening health situation, even as we face today?

GOD and SUFFERING

Does God punish people with natural disasters and pestilence? - Some Christians are quick to declare that God punishes people with natural disasters and plagues because of our sinfulness. In the midst of the current pandemic as it kills millions of people, fundamentalist preachers scold and warn their flocks to repent. Some have accelerated their prophecy talks on end times, found on online platforms at all social levels. This worldview needs the presence of sinners amongst us so that 'the saints' can rejoice at the apocalypse. But the authoritative statement of Jesus tells us otherwise. When he was confronted by the question: “Rabbi, who sinned, this man or his parents, that he was born blind?” (John 9:2-3) Jesus declared “Neither this man nor his parents sinned.”

Did the tsunami kill sinners? - The day after Christmas in 2004 a devastating tsunami killed nearly a quarter million people and left tens of thousands suffering. Originating off the coast of Indonesia, it was the deadliest tsunami in recorded history. The response of many fundamental believers around the world was to declare that it was sent by God as punishment and as a warning against their evil deeds. The devastation and deaths were seen as God’s curse and his vengeful act against human rebellion. Others believed that the tsunami was sent for a greater good of bringing people closer to God, while some saw a clear sign of the last days of the world.

Did God send the Tsunami? - The damning declaration that God sent the tsunami was very confusing for Christians who believe in a loving God. How can an omniscient, omnipotent, and omnibenevolent God make people suffer? We tend to ask this question when we

Mary Rajanayagam & Savitribai Phule

suffer from serious illness, impending death, disaster, and misfortune. Theologians refer to this problem as theodicy. After the 2004 tsunami many young Christians struggled to understand this issue of theodicy - could God have permitted a tsunami that killed 230,000 people? Were sinners punished, as some fundamental people were saying? Student Christian Movement of India (SCMI) organized a public program on 4 February 2005: “Students for Science and Spirituality”. We suggested that the question should be rephrased to: 'Did the Son of God send the Tsunami?' (see People’s Reporter, Feb-March 10, 2005 and CSI Life, March 2005).

Did the Son of God send the tsunami? - The answer lies in the following set of questions: Would one who promised to offer life abundant cause death? How can one who ignored the stirring of the pool and healed the man by the poolside send a sea storm? Can he, who calmed the sea and walked on placid waters, rejoice in sending killer waves? How can one who healed and gave sight to people send disease and afflictions? Would he who multiplied the fish, bread and wine cause famine and thirst? Is it conceivable that he who made the nets burst with fish stop people from fishing? Would he who chose fishermen to be fishers of men, kill them by waves? Can Eternal Light bring darkness to the lives of the coastal people? Would he who loved the children and hugged them make orphans out of them? How can he impose burden after calling the heavy-laden to come to him for rest? Did he not want people to go free and not get caught in bondage? Can a shepherd who showed the way be a source of confusion? Did the Son of God who said that he came to save, not to judge and who was a loving friend of the sinners and adulterers, send the tsunami to punish people? Could he who came to give love and hope bring suffering and hopelessness? Could the Son of God bring hell after bringing the Kingdom of God on Earth?

No, God did not send the tsunami. God did not send the COVID-19 either.

The COVID-19 Pandemic is not an Act of God - Due to the COVID pandemic once again 'Sin' is in focus. Some preachers continue to say how wicked and sinful people are. They add, subtract and manipulate numbers in the Bible to predict an imminent Second Coming! Creating more fear in the hearts of people when they are already agitated due to the pandemic is an effective means of mind control. Many are guilty of profiting off this fear.

The Cross does cause suffering - There is only one kind of suffering that should be associated with religion. We will face hardships when standing up for justice, to help liberate the oppressed from every form of tyranny. The powerful exploiters, racists, and casteists will hurt people who dare to stand with the enslaved. One does not have to be a Christian to experience this pain. Thousands of non-Christians in India suffer for demanding justice, equality, and fairness. Christians associate this agony with the cross. "If anyone wishes to come after me, he must deny himself and take up his cross daily and follow me" (Luke 9:23). One of Bishop Masilamani Azariah's favourite verses of meditation was on this kind of suffering; real suffering made lighter because Jesus was sharing the yoke. “Come to me, all you who are weary and burdened, and I will give you rest. Take my yoke upon you and learn from me, for I am gentle and humble of heart; and you will find rest. For my yoke is easy, and my burden is light.” (Matthew 11:25-30).

OUR CHURCH: THEN and NOW

What is the essence of a church? – The corona virus pandemic is a wake-up call to learn what a church is all about. Churches have been shut as if the holy places have no power to stop the ultramicroscopic virus from entering. People cannot meet fellow Christians and sing together heartily in their familiar places of worship. Have we become lesser Christians because for months together we did not participate in the Lord's Supper in a church? Friends are eager to share youtube sites of any number of admonitions by televangelists. What will it take to re-establish the church we know with a hierarchy of elders, evangelists, deacons, committees, pastors and bishops? Many have wondered what really is the relevance of such a church. Churches must justify their existence as large bodies, restate what they have accomplished and what they plan to accomplish. As family members conduct worship at home do we understand anew 'the priesthood of all believers'? Do we see a deeper meaning in "For where two or three gather in my name, there am I with them”? (Matthew 18:20). Is this the time that Jesus was telling the Samaritan woman about: "believe me, a time is coming when you will worship the Father neither on this mountain nor in Jerusalem."? (John 4:21). As we join in worship online or in-person, how does it change our connectedness to God, to our church buildings, and to each other?

Some are content to be free from the organization of our large churches with structures dominated by people who enjoy power to control the lives of fellow Christians. Our imposing churches with altars and pulpits are often exclusively for the ritually privileged. Ritual hierarchy can be antithetical to the loving good news of Jesus. An artificial sanctity has been devised to hold on to power, to administer communion, or baptize a child. The lockdown measures to prevent the spread of infection have hopefully helped to open our minds and hearts to the essence of belief. Jesus "emptied himself, by taking the form of a servant, being born in the likeness of men." (Philippians 2:7). Jesus can be invited and seen anywhere, under a tree or in a courtyard. It is reassuring to learn about the early Christians: "Every day they continued to meet together in the temple courts. They broke bread in their homes and ate together with glad and sincere hearts" (Acts 2:46).

Courage born of Love - The COVID pandemic is a time for us to remember how Christian love motivated people to act during famine and outbreaks of smallpox, plague, cholera, and other life-threatening events. Christian compassion has been available to all people at all times, especially in times of suffering and need, without any motives of conversion. Maybe you know elders in your community who can recall previous disasters when neighbouring Christians took action. Their stories need to be remembered and recorded even as we witness the present COVID-19 crisis. Today Christians continue to serve their neighbours along with their non-Christian friends who share the core values of humanity, compassion, and love for all.

So, 'Did God send the Pandemic?' We needed to address this question because unfortunately, many people are preoccupied with such "end-time" issues rather than live in the present and address the everyday challenges of poverty, illness, inequality and injustice. There is a lesson to learn from the 100 year old stories of Dr. Mary Jothinayagam and the Phules who were influenced by Christian values. As a body their concern was healing the sick, caring for the abandoned, and consoling the bereaved— not questioning who sent the pandemics!

Excerpted from an article that can be requested from: p.dayanandan@gmail.com

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P. Dayanandan is a botanist who taught at the Madras Christian College and has carried out extensive research in several fields of plant sciences. Anne is a librarian, archivist, educationist, and reading specialist. Together they write and document the history of local Christian congregations and the contributions of Christians to society.

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EMERGING VIRUSES: SARS COV- 2 CAUSING COVID-19

*Images Courtesy: World Wild Life and Scripps Institute.

Since, the beginning of life on earth, viruses have played an important role in shaping our evolution and have often threatened our existence. A virus, in the simplest term can be defined as a small life form that can infect every other life form. Since viruses have adapted to a life of extreme parasitism they always look for hosts (like humans, bats and dog etc.) to propagate itself. The current pandemic COVID -19 caused by SARS CoV-2 virus is a classic example of what viruses are capable of. Now, the question on everyone's mind is what human activity could have contributed to this biological disaster? One is the consumption of exotic animals or game meat. This gives a chance for previously unknown animal viruses to jump into human population. This is what could have happened in the case of COVID-19. An animal virus from bats and a virus from pangolins (a form of ant eater) recombined into this novel coronavirus and jumped into human population by exotic animal trade in Wuhan, China. This has resulted in a global health crisis of an unprecedented scale that could have been easily averted.

Scientists are working on a cure (a drug or a vaccine) and public health experts are trying to contain the spread of this virus through quarantine, isolation, lock-downs, travel restrictions, social distancing and trade embargos. It is time for us to think how we can resolve the current pandemic and how we could prevent the next outbreak. Viruses will keep emerging and re- emerging unless we take concrete steps in disease control. Avoiding exotic animal meat from open wet-markets is one great step in that direction. De-skinning and de-furring these animals poses the greatest threat to the market vendors and their customers. Micro-cuts and abrasions sustained during the process can result in the transmission of these viruses from animals to humans. Similarly, meat obtained by hunting also holds a great element of risk; hence game meat could be avoided. Always consume meat from refrigerated sources or chain of stores connected with the processing industry. Many safety measures and checks ensure the products are devoid of such dangerous viruses. Food hygiene is an important measure in mitigating such outbreaks. This pandemic clearly outlines the consequences of contamination of the food chain. The butchering of the pangolins in the Hunan wet-market was the major reason an animal virus spilled-over to us. The vendors were the first to be infected, then their clients, the city and the whole world. This lesson comes to us with the stiff price of countless lives, economic loss and endless human misery. A virus that had no name, living in the bats and pangolins of China, has suddenly become a household name synonymous with death and destruction. It is time we wake up to the looming threat of emerging viruses.

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virologist@rediffmail.com

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CMJI in this edition has engaged with an artist to create the Cover design. *This work of art will add visual value to the theme. The original art piece will be available for purchase by an individual member or a member institution. For this edition, we spoke with Shiny Singh who created this painting on Environment & Health Conservation.*

CMJI: Dear Ms Shiny Singh, thank you for the beautiful art work. Please tell us about yourself?

I am an economist by profession and an artist by passion. I have dual eye towards societal needs and aesthetics. I experience tranquility while exploring God's creation. I love to challenge myself to try new things.

CMJI: What inspires you?

Nature, mostly flowers inspire me. It is marvellous to see the discipline and beauty in nature.

CMJI: The artists love the beauty of Canvas and colors. It has it own space and yet the digital world embraces and promotes art more effectively today. Your thoughts please?

I believe art is an emotion expressed on a tangible material. But sometimes, it becomes quite difficult to express it on canvas. Even the colours, an artist chooses, has an emotion or a feeling that the artist is going through. So, the digital world embraces and promotes such emotions because it provides a variety of options readily available. It is easier to express the accuracy of an emotion.

CMJI: So looking at the painting you've created for the cover page, tell us what came to your mind?

I was given a theme of 'plastic and environment'. I was guided by Chris bhaiya to make plastic bottles and leaves and flowers. So I positioned all of them in such a way that the plastic bottle is in the environment but separated by thorns.

I made thorns around the plastic bottle to depict the divergence between plastic and the blooming flowers

CMJI: CMAI is trying to promote artists through this publication. What would you like to tell your fellow Artists?

Join me in creating awareness through art

CMJI: What does your process involve? Does the work evolve or your start with an idea and take it to the finish?

The process starts with a vague idea in my mind, mostly influenced by my mood. Then it gradually evolves. I constantly take a step back and see if the overall art is coming together or not. So it does evolve.

CMJI: Where can we find more about your work?

You may check my instagram page - @shiny.art.world

Note: Those interested in buying the art work kindly write to us at cmai@cmai.org

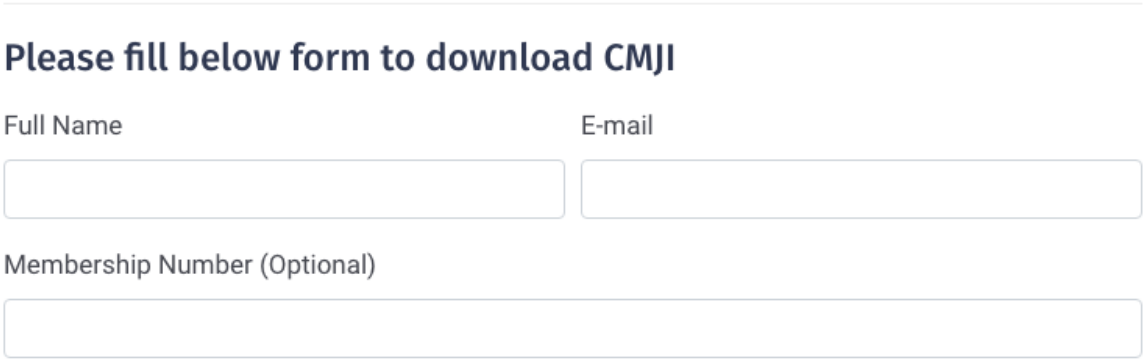
e-CMJI on CMAI Website

Dear Members,

CMJI as a quarterly journal and an official publication for Christian Medical Association of India, with its online presence today, brings a much wider reach, diversity, and a global reach. The print run of CMJI, for recent editions, due to the pandemic was held up by the editorial team and the leadership. We regret the inconvenience and wish to inform that we are working to provide our members with the printed copies of the editions.

Access to e-CMJI

In order to read and download e-CMJI on website, we have initiated a simple process. We require a Simple form to be filled up with Name and Email address, thereafter, you enter the Download Center.



Authorship

We accept primarily original articles authored by those who are closely involved with the theme of every edition. So, we also encourage you to come forward and contribute with an article for CMJI.

Advertisements

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Past 5-Year Editions

We are excited as you view both new and old editions (2015-2020) of CMJI. In case you require older editions please send an email to communication@cmai.org

We on behalf of CMAI editorial team, thank you for being our support and helping us in building a just and healthy society.

Regards

Editor - CMJI
Head Communications - CMAI

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Christian Medical Association of India

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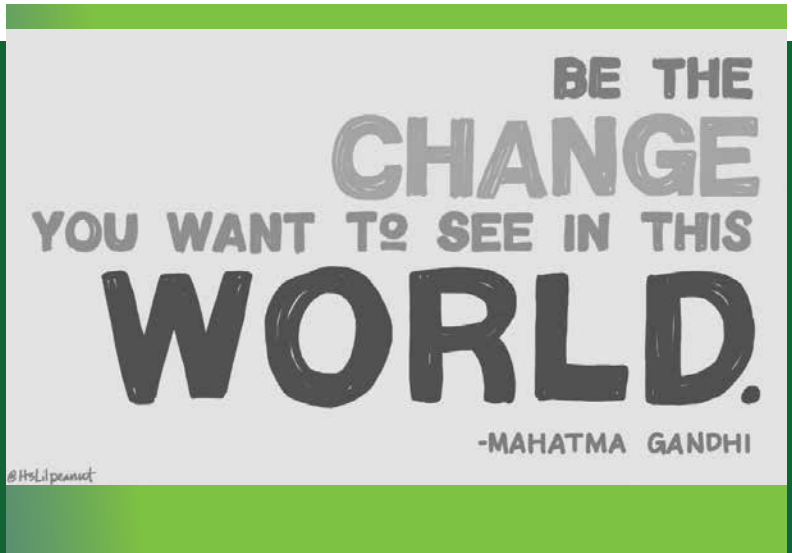

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