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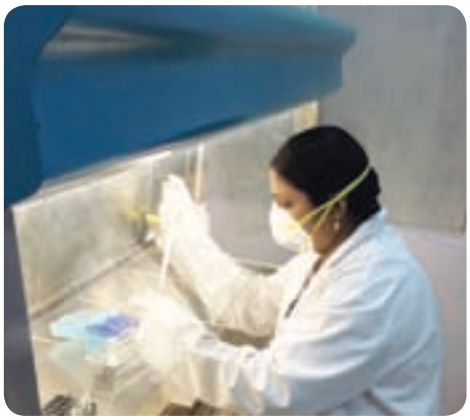
Communicating Health
Since 1895

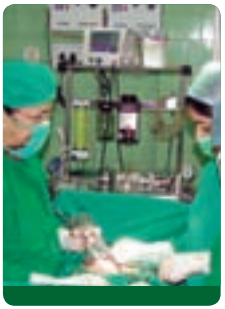
CMJI

A Quarterly Journal of the Christian Medical Association of India

VOLUME 30 NUMBER 3 : JULY - SEPTEMBER 2015

Skill Development for Health





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Skill Development for HEALTH

LETTERS TO THE EDITOR

Dear Sir,

My wife and I are very thankful for sending CMJI on time. We both are very much interested in receiving CMJI because it is a wonderful journal, which gives us different views of CMAI. It provokes our thoughts definitely. We read your inspirational and encouraging articles page by page.

Nahum Masih & Suniti Masih

Dear Doctor,

Hope you are doing well.

I was thrilled to accidentally find a copy of CMJI (April to June issue) and read your editorial. Flipping through the pages gave me great knowledge about HAI which I never thought of in my life so far. It was so good.

I was also happy to see many pastors writing about different aspects of Medical ministry. If you can send me the topics for the upcoming issues, I will also try to write some article for CMJI. To see samples of my writing you can click on the link below to see the devotional blog which I am writing.

Yours in Christ

Rev John Jebaseelan

Dear Sir,

Whatever written in the CMJI is not only for the earthly life but for this eternal as well. I am really interested to receive it regularly. It is a blessing to me.

Thank You
Yours in Christ

Ms Ngaikhodon

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? The next issue is on the subject "Biennial Conference". 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: **ronald.l@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 on 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

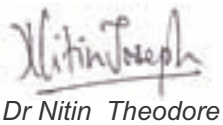
SKILLED FOR GREATER WORK

Dr Nitin Theodore Joseph

Much has been written about the Theology of Work. In the first chapter of the Bible we see God Himself at work, creating the heavens and the earth *ex nihilo* and giving it shape and order. This is a model for us to get skilled and work in order to be productive and beneficial to society. When God created Adam He placed him in the Garden "to work the ground and keep it in order" (Gen. 2:15, The Message). Cain became a tiller of the ground and Abel became a shepherd. Later in the book of Genesis we read that Jubal was the first skilled musician who played the flute and the harp, Tubal-Cain was a skilled craftsman of bronze and iron. God trained Noah to become a ship builder. After the flood Noah became a farmer and planted a vineyard. Nimrod was a mighty hunter who also built six cities including the familiar city of Nineveh. Moses was trained in skills of warfare in the Pharaoh's palace but God sent him off to the wilderness to unlearn all that he had learnt and then sent him back to deliver Israel from Egyptian bondage. Throughout the Bible we read of skilled men and women who impacted those around them and did the work that God had assigned for them. Peter, Andrew, James and John who were fishermen became "fishers of men". Luke was the prototype of a 'medical missionary'! Paul financed his evangelistic work by his job of tent making. Lydia was a lady entrepreneur and served Paul and his associates. Jesus too must be a skilled carpenter assisting Joseph before He began His evangelistic ministry. When the Jews persecuted Him for healing on the Sabbath, Jesus said, "My Father has been working until now, and I have been working" (John 5:17). We must have all heard the term "full time ministry". I believe every believer is in full time ministry using his/her skills and spiritual gifts for the glory of God.

The latest UN report states, that with 356 million individuals in the age group of 10-24, India has the world's largest youth population despite having a smaller population than China. An article in 'The Hindu' stated that by 2020, India is set to become the world's youngest country, with 64% of its population in the working age group. With this as its focus the National Policy on Skill Development under the Ministry of Labour has set an ambitious target of skilling 500 million people by 2022 in order to make this huge workable population employable. The current capacity of skill development programmes is only 3.1 million. This issue of CMJI is to address this important aspect and how we in the Christian health care sector can contribute in this endeavour.

This issue is also the last one of the Biennium 2013-2015 and I wish to thank everyone who has contributed towards this journal in different ways. A special thanks to the "Communications Team" of CMAI who did a marvelous job. We now focus on the Biennial Conference at Jaipur Rajasthan, a city which is full of history, architecture and art. I am sure you will be enriched by this conference and I look forward to meeting you there.



Dr Nitin Theodore Joseph

THEOLOGICAL EDUCATION AND RELEVANCE OF CLINICAL PASTORAL SKILLS

"Where there is no counsel, purposes are disappointed; But in the multitude of counsellors they are established". Proverbs 15:22 ASV

Rev Sharath C David

The challenge in Theological education in India is to be relevant and build skills of students so that they excel in the ministry to which they are called. The clinical pastoral skill comes handy for young budding ministers to be relevant in challenging situations and clinical settings.

When a theological student completes his/her theological studies their confidence level is low. They are less confident, struggle in situations and not sure as to how to minister in difficult circumstance. This happens as they lack experience and trust in one self and in his/her ability to handle situations. At times they need help from a senior to come and help them when they are stuck or not confident in handling and managing issues or situations. It comes with lot of experience, skills, knowledge and wisdom. It is here they need training, support of seniors and peers to build confidence in spiritual formation of ministry. Clinical Pastoral Education stands out as a useful system of learning for one to get firsthand experience and develop ministerial credentials as a young minister.

The dangers are over confidence, taking it for granted, procrastination, allowing matters to drift and not strategically and systematically approaching a problem. The danger is not learning skills using universal standard methodologies but doing things using one's own method which may not be universal standard ways and skills that are commonly used. For instance, counseling is mostly listening but more often pastoral counselors are more advisors than counselors.

In today's context we have 'practical exposure' content in theological education curriculum. But rarely do they affect the way we learn except for an introduction or visionary process that occurs. It does not give hands

on experience and growth as the student is not given independence, freedom, support and care. In theological reflection and internalization what has been learned needs a systematic, strategic approach for learners to pick up and fine tune themselves. It can happen only in a medium of trust, responsibility and challenge, when a do or die situation is thrown across candidates to pick up such skills.

Three areas interaction CPE model would focus for learning

Clients

The patients or clients are the people from whom we learn the art of counseling and care. My supervisor used to remind us that patients are our teachers and connect emotionally with them.

Peer

The co learners, their support and reflection help us to give multiple ways of looking at a problem and also help us to see our self-more objectively and learn.

Supervision

The supervisor plays an important role to see that the learning takes place or that the group works towards goals set by them. Whenever they are stuck or not able to progress the supervisor intervenes to smoothening learning process.

These are important aspects for one to learn, develop skills and gain confidence, to face bigger challenges.

What is Clinical Pastoral Education (CPE)

To learn how to be relevant and help people who are in distress, facing illness, terminally ill and suffering and to help them find comfort and meaning.

CPE is hands on practice, clinical supervision and academic study. Students are treated as interns who learn how to listen, minister to the sick effectively. This clinical experience helps budding ministers to effectively engage with patients and their loved ones. It also helps them establish rapport, maintain eye contact, pay attention and respond to both verbal and non-verbal communications.

We use simple tools for pastoral care ministry to be effective allowing God to do the rest.

- Counseling - Listening –Responding - Caring
- Presence of God- It gives a great feeling that God watches over and cares for the individual.
- Bring God's word, which speak by itself to people who are suffering

Prayer- communicating and understanding and making people talk to God and intercede on behalf of them.

This is taken from the internet and these are some interesting remarks, what the students have made, after having gone through the Clinical Pastoral Education experience at Health Care Chaplaincy in the USA.

"HCC's CPE program was one of the best educational experiences I've ever had. I went into the program thinking it was primarily about learning how to minister to people in a hospital setting. I did learn about ministry in hospitals, but more importantly, I came away personally transformed. CPE was about who I am. A great combination of theory and hands-on training along with personal supervision and group work. It helped me identify and build on my strengths while also challenging and helping me grow in my weaknesses. I am better equipped for ministry because of CPE". – Christine Lee

This clinical experience helps budding ministers to effectively engage with patients and their loved ones. It also helps them to establish rapport, maintain eye contact, pay attention and respond both verbal and non-verbal communications.

"HCC's CPE program offered me critical skills in learning how to relate to patients, to other clergy, and to myself. I have never experienced such a rich, reflective and intense process as the CPE program. Now as a rabbi, I use the lessons I learned in CPE every day as I connect to students and fellow worshipers." – Rabbi Eli Kaunfer

"After working in the field of religious education with a focus on sacred music for a number of years, I decided to explore my longstanding interest in the chaplaincy. I was privileged to take three units with HealthCare Chaplaincy, and it is not overstating it to say that they were transformative for me – these courses are what ignited my passion for chaplaincy and provided a sound professional foundation which I continuously draw upon. The quality of the instruction and supervision were outstanding." – Margo Heda

Here's what HCC's faculty has to say

"Students experience different family systems and values at work as well as diverse expressions of spirituality and theologies." – John Valentino: Former Director, Clinical Pastoral Education

"Our CPE symposia are important – two times a year we bring together roughly 100 students and staff, from many religious denominations and diversified economic,

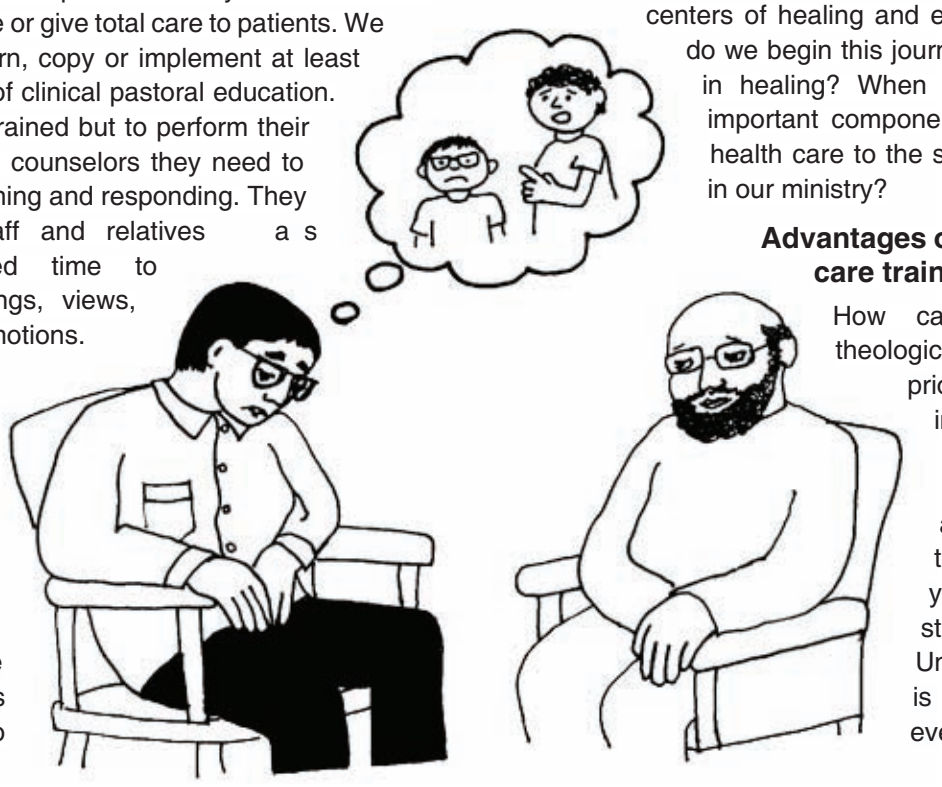
lifestyle, cultural and ethnic populations, to learn together from experts and to benefit from this contact with each other. Our topics have been cutting edge: palliative care, integrative medicine, cultural competence." – Rabbi Dr. Bonita E. Taylor: ACPE Supervisor, Clinical Faculty, and Director, Jewish Chaplaincy Education.

In Indian scenario - how CPE like training can help our hospitals?

Our hospitals though pioneers in healthcare have not evolved with time and kept pace with needs. We are truly archaic in many of our intervention for healing and one of it is pastoral care or spiritual care to patients, relatives and staff. I may be strong in my remark as I envisage that our hospitals have truly ignored the aspect of spiritual care to the sick and suffering and spiritual care givers were not trained and up to date in offering spiritual care.

Our understanding of spiritual care or chaplain's role in hospital is just playing music, distribute tracts, organize morning devotions or plan special meeting. Probably this has crept into our system due to the missionary era and its impact. That era has gone and a new era has dawned and we have not woken up to the challenges of the present times.

Our institutions are nowhere close to excelling or give minimum pastoral care to patients. It may be due to lack of desire for excellence or give total care to patients. We have refused to learn, copy or implement at least the western model of clinical pastoral education. The chaplains are trained but to perform their role as professional counselors they need to know the art of listening and responding. They value patients, staff and relatives as people who need time to express their feelings, views, predicament, and emotions.



The bedside clinical pastoral care is looked as an opportunity to introduce our faith rather than strengthen client's faith; whereas it is a gross mistake to use sickness as an opportunity to make any religious alteration and should not be in the agenda. Allow God to work in that person and God will make him ask about your faith because you are there as His representative. Patient asking about our faith, beliefs, system is only a byproduct of our ministry to the sick & suffering and it is not a time to influence, introduce or confuse them with religious options. Sow the seeds of love and allow God to germinate and make a lasting impression on the individual. Just show how much you care, love and respect the individual through listening and showing your concern.

As a professional and experienced counselors one should know his role and responsibility as to how to help people and minister to them, take them to a supreme faith and a belief system that they can be proud of.

They value patients, staff and relatives as people who need time to express their feelings, views, predicament, and emotions.

A qualified minister can address problems by connecting emotionally with the patients and show them ways to address or approach a problem and face it. Also accept one's limitation and inadequacies in the context of sickness and terminal illness.

For ministers CPE is a model/way of learning to minister to the sick and suffering effectively without hurting or making people uncomfortable in their time of sickness & ill health. CPE can truly improve quality of care from a holistic perspective making our hospital truly centers of healing and excellence. When do we begin this journey of excellence in healing? When do we add this important component to our holistic health care to the sick and suffering in our ministry?

Advantages of true pastoral care training

How can the church, theological colleges prioritize and give importance to this aspect of ministry which is pivotal and important to our budding young theological students? In the United States it is compulsory for every theological

student to go through mandatory CPE basic unit to graduate one unit of CPE which is much practice centered to give hands on realistic experience to students to manage, counsel and minister to people going through crises due to sickness or life changing events. It is important for our churches to emphasize this area of training for theological students and the hospitals to equip themselves as centers where this training can happen.

Learning CPE model is very simple. It is said patients are your teachers. Co-students or peers are ones who give support and add variety to the learning experience. The supervisors are the experts in the field to see that learning takes place. It is a unique system and technique to learn and it uses impact as a learning process in times when we are impacted and then we analyze the reason behind that. It is through learning, reflecting and sharing and improving. So the learning impression it makes is permanent and lasts a life time. It is also emotionally draining, spiritually testing ones faith and theologically grounds one life's to reality. Every experience is a great learning process for ministers who have calling and commitment to serve people when they go through suffering, sickness and crises.

How can CMAI help in developing our centers as places of excellence - in spiritual care?

We need to convince ourselves for the need to be technically correct and to have sound pastoral care training. There has to be an ISO like standard or yard stick to measure and maintain quality and certify our pastoral careers. We need to create awareness and educate among our patients to demand such care when they go through sickness and crisis.

The future

It is not a hopeless situation but we have a long way to go in creating an infrastructure and atmosphere giving such quality pastoral care to the sick and suffering. The uppermost priority in this regard is to keep training and develop ministers for this specialized ministry. Future looks bleak but hope is that drives us to accomplish something for God.

If every church /theological college and mission hospital take it as their priority for the next 10 years it can be accomplished. We need the vision and direction, God's guidance and respond to people in need like the Samaritan but not walk away saying this is not my responsibility or area of calling.

We all are called into this one vineyard of God as laborers. We need to have these important skills to be effective ministers in the Lord's vineyard.

Rev Sharath C David
Secretary, Chaplains Section CMAI

ROLE OF COMMUNITY COLLEGES IN IMPLEMENTING THE NATIONAL SKILL QUALIFICATION FRAMEWORK

The Concept of Community College


Dr Xavier Alphonse, S J

The Community College Movement in India was started in 1995. It is 19 years old. It aims at the **Empowerment of the Disadvantaged** through appropriate skills development leading to gainful employment, thus making a qualitative difference in the lives of the urban poor, rural poor, tribal poor and women in collaboration with local industrial establishments and potential employers, community leaders after taking into account the opportunities available for employment and self-employment in the local area.

Community College is a College with a difference. Community College aims at the Empowerment of the Poor, Marginalized and Disadvantaged sections of the Society, promotes skills development (Knowledge (Information)-Theory 30%, Attitude 40% and Skills 30%), makes people fit for life and fit for a job, matches education with employment and self-employment opportunities. It is a community effort collaborates with Industry, Employers and Community Leaders, responds to Industrial, Employment and Social Needs.

Community College teaches – Life-Skills, Communication Skills, English, Computing Skills, Work-Skills, Hands on Experience, Preparation for Employment. Community College is education for Livelihood and capacity building.

The key words of the Community Colleges are Access, Flexibility in Teaching and Learning, Cost Effectiveness (minimum fees), equal opportunity and Quality in Training. Community College responds to the Un-employability problem. Community College is Local Specific. Community College is an opportunity College. It gives hope and opportunity to those who otherwise will not have an opportunity. Community College Motto is "Including the Excluded and Giving the Best to the Least". Community College helps the individual to discover his / her own talents and capacity – Discovery Channel. Community College is transformative education – Social change, alleviation of poverty through employment and income generation. To Kneel, To Feel, and To Heal.

Need for the System

India is on the grip of a demographic opportunity. It is today one of the youngest nations in the world with more than 62% of the population in the working age group (15-59 years), and more than 54% of the total population below 25 years of age. The country's population pyramid is expected to "bulge" across the 15–59 age group over the next decade. It is further estimated that the average age of the population in India by 2020 will be 29 years as against 40 years in USA, 46 years in Europe and 47 years in Japan. In fact, in next 20 years the labour force in the industrialized world will decline by 4%, while in India it will increase by 32%. This poses both a challenge and an opportunity. To reap this demographic dividend which is expected to last for next 25 years, India needs to equip its workforce with employable skills and knowledge so that the youth can participate productively to make India a developed economy.[1]

The Census projection report shows that the proportion of population in the working age group (15-59 years) is likely to increase from approximately 58% in 2001 to more than 64% by 2021.

Education has continued to evolve, diversify and extend its reach and coverage since the dawn of human history. Every country develops its own system of education to express and promote its unique socio-cultural identity

besides meeting the challenges of the times to encase the existing potential opportunities. India, at present, is recognized as one of the younger nations in the world with over 50% of the population under the age of 30 years. The Census projection report shows that the proportion of population in the working age group (15-59 years) is likely to increase from approximately 58% in 2001 to more than 64% by 2021 which is about 30.8 crore during the period. It is estimated that by about 2025, India will have 25% of the world's total workforce. But beyond 2025, with increased life span due to advanced medical care, the numbers of the aged will begin to increase substantially and consequently the window of opportunity is only between now and 2025. In order to harness the full demographic dividend, India needs an education system, which is of high quality, affordable, flexible and relevant to individual as well as to the society in general and the economy in particular. Thus, it calls for substantive use of technology uninhibitedly and establishing closer relation between education and the life of the people for providing opportunities by way of life-long learning.

India has a population of over 120 crore and a workforce of around 51 crore, to be able to provide employment to such a large number of people, the numbers of which is more than the entire population of countries like USA, is more than a daunting task and is going to get even more challenging with the population growing by more than 2% every year. With the current levels of unemployment being around 4.6 crore, it is likely to grow to anywhere between 5-6 crore in the next 8-10 years. To put this in perspective, these numbers are more than the entire population of countries like France, Italy and the United Kingdom. In terms of demographics almost 35% of Indians are younger than 15 years of age, whilst 18% fall within the age group of 15-24. The median age in India is 24 years, which makes it one of the youngest populations in the world. This in itself throws up huge challenges in terms of demands on the education and employment systems.[2]

National Skills Qualifications Framework (NSQF)

Ministry of HRD, Government of India had issued an Executive Order in September 2011 for National Vocational Education Qualification Framework (NVEQF). Subsequently, Ministry of Finance, in pursuance of the decision of Cabinet Committee on Skill Development in its meeting held on 19th December, 2013, has issued a notification for National Skills Qualifications Framework (NSQF) which supersedes NVEQF. Under the National Skills Development Corporation, many Sector Skill Councils representing respective industries have/are being established. One of the mandates of Sector Skill Councils is to develop National Occupational Standards (NOSs) for various job roles in their respective industries. It is important to embed the competencies required for specific job roles in the higher education system for creating employable graduates.

Objectives Of NSQF

I. The objectives of the NSQF are to provide a framework that:

a. Accommodates the diversity of the Indian education and training systems
b. Allows the development of a set of qualifications

for each level, based on outcomes which are accepted across the nation

c. Provides structure for development and maintenance of progression pathways which provide access to qualifications and assist people to move easily and readily between different education and training sectors and between those sectors and the labour market
d. Gives individuals an option to progress through education and training and gain recognition for their prior learning and experiences
e. Underpins national regulatory and quality assurance arrangements for education and training
f. Supports and enhances the national and international mobility of persons with NSQF-compliant qualifications through increased recognition of the value and comparability of Indian qualifications

II. The NSQF is a quality assurance framework - it facilitates the awarding of credit and support credit transfer and progression routes within the Indian education and training system. It seeks to help everyone involved in education and training to make comparisons between qualifications offered in the country and to understand how these related to each other.[3]

The Role of ICRDCE

The Indian Centre for Research and Development of Community Education (ICRDCE), Chennai is an initiative of Jesuit Madurai Province and ICRDCE Trust of Chennai. It was started in January 1999. It is a facilitating and coordinating agency for Community Colleges in India. It has been involved in the preparation, establishment, monitoring and evaluation of 343 Community Colleges in 19 States of India. It has also trained 2,178 teachers. The Centre has conducted 144 Workshops & Consultations involving 2,478 organisations, 6,283 participants and has also organised 12 important National Consultations/ Conferences with 1,591 participants. It has also prepared the basic curriculum material and supplied to all these Community Colleges. It has published 44 books and Textbooks on the movement and 94 articles in the leading educational journals of India and abroad on the concept and implementation of the system. The Centre also has an up-to-date documentation on the movement by way of newspaper clippings, video, audiotapes, CDs, photographs, etc. and lobbing with State and Central Governments for the recognition of the Community College System.

Types of Community Colleges:

1. NGO Community Colleges: These Colleges are in existence for the last 19 years conducting one year Diploma programme. There are 343 such Colleges in 19 States of India in which 214 colleges are associated with ICRDCE, Chennai. They are managed by NGOs, organizations/trusts/societies etc. They have trained about 1,20,000, students in the last 19 years out of which 90% have got jobs and are drawing salary from Rs. 3,500 to Rs. 35,000. The unique achievement of the movement is the empowerment of the disadvantaged groups leading to the up gradation of their educational standards resulting in alleviation of poverty. A profile of 1,09,869 students attending from inception different parts of India shows that Women 71%, Married 11%, Widows and Deserted women 2%, have so far benefited from the movement. Eighty Eight per cent come from socially backward groups (SC, ST, MBC, BC). Eighty per cent are economically poor (monthly family income is below Rs.3,000/) and Ninety Four per cent educationally weaker sections or cannot go for further education (School dropouts, below 10th, 10th passed, 12th passed). A breakup by way of religion shows that 60% are Hindus, 28% are Christians, 10% are Muslims and 0% are Other Religions (Buddhists, Sikhs and Jainism). 751 physically challenged students have passed through this system and come out with flying colours. These colleges are Tie up with 2680 Industries and Commercial Organizations for internship and Placements

Entry level qualification for these colleges is 8th, 9th, 10th standard passed or failed, 12th Standard passed or failed. No age bar to join these Colleges. These Colleges are following 1,2,3 & 4 NSQF levels upto Diploma programmes in Community Colleges and all these Colleges are facilitated, coordinated and monitored by ICRDCE, Chennai. No funding has come from the Government. The advantage of these Colleges is that they are reaching the disadvantaged people (rural poor, tribal poor, urban poor, women and other marginalized sections of society including prisoners).

The **Tamilnadu Open University (TNOU)** has recognized 221 Community Colleges as per Government order (GO (Ms) NO:163). The State Government of Tamilnadu has issued a Government Order (GO) recognizing the system in May 2008 and a few NGO Community Colleges are affiliated to **Manonmaniam University, Tirunelveli, Tamilnadu.**

In other parts of the Country the curriculum will be recognized by **National Skill Development Corporation (NSDC),** New Delhi through the Ministry of Skill Development. The Department of SKILLS ministry directed ICRDCE to collaborate with NSDC for the above approval. **ICRDCE will be considered as a National Resource Centre for Community Colleges**

(NRCCC) based on the experience of the ICRDCE, Chennai for the last 16 years in promoting the Concept and Implementation of the Community College

2. UGC Community Colleges: There are **240** (150 Last Year + 90 in the Current Year) Community Colleges all over India under UGC. They have been selected by the Selection Committee appointed by the UGC and through interface meeting between Colleges and UGC. These Community Colleges will conduct Certificate - 6 Months, Diploma - 1 year and Advanced Diploma - 2 years. The minimum qualification of students for admission is 12th passed.

So far 1000 students are undergoing in the UGC Community College System according to the data available with ICRDCE Chennai in the four states of India such as Tamilnadu, Karnataka, Kerala and Andhra Pradesh as on April, 2015

Recognition of the Diploma and Advanced Diplomas given by UGC Community Colleges ***"The College concerned should itself award Diploma / Certificate under its own seal and signature after a written authorization from the affiliating university. However, the college should mention the name of the affiliating university and the scheme on the award."***[4]

3. Bachelor of Vocational Degree - UGC has started the B.Voc degree in its 2f and 12B Colleges in India in the XII Plan Period (2012- 2017). 127 Colleges conduct Certificate course - 6 months, Diploma - 1 year, Advanced Diploma - 2years and Degree - 3 years. So far around 900 students are undergoing the B.Voc Degree Programme according to the data available with ICRDCE, Chennai. in the four states of India such as Tamilnadu, Karnataka, Kerala and Andhra Pradesh (April 2015).In this system, the students will have multiple exit and entry points.

4. Kaushal Kendras - Realizing the importance and the necessity for developing skills, the University Grants Commission has introduced the scheme for the establishment of **Deen Dayal Upadhyay Centres for Knowledge Acquisition and Upgradation of Skilled Human Abilities and Livelihood (KAUSHAL KENDRAS)** in the Universities and colleges during the XII Plan with the objective of development of skills among students and creating work ready manpower on a large scale. The KAUSHAL KENDRAS will endeavor to maintain a pyramidical structure of student enrolment with respect to Diploma, Advanced Diploma, B. Voc and further studies. [D.O.No.F.4-10/2014 (NSQF)].[5] There are 68 KAUSHAL KENDRAS Intuitions which have been awarded by the UGC to the Arts, Science and Engineering Technology Colleges and Universities (48 College are funded by UGC and 18 Colleges are Self-financing Institutions) all over India as on 7-7-2015.

The Mandate of the UGC Community Colleges, B. Voc Centres and KAUSHAL KENDRAS is to follow NSQF Level 5 onwards. The Skill Component Curriculum must cover the Quality Packs (QPs) of the NSDC. The Quality Packs based on the NSDC direction, with the guidelines of NSQF. Hence Community Colleges play an important role in NSQF implementation.

Qualification Pack (QPs)

The National Occupation Standards (NOS) are laid down by employers through their Sector Skill Councils. A set of NOS, aligned to a job role, called **Qualification Pack,** would be available for every job role in each industry sector. SSCs aim to create a qualification pack for every popular job role which further drives both the creation of curriculum and assessments - NOSs and QPs for job roles in various industry sectors, created by Sector Skill Councils (SSCs)[6]

Conclusion:

The concept IS secular one, transcending religions, castes and languages and regions. It is truly a nation - building and capacity building exercise. ICRDCE has achieved a significant networking of all groups: Hindus, Muslims, Christians and all other service minded NGOs and organizations. The Concept is taking different shapes and directions to be accepted by the NGOs and regular Arts and Science College which have 12B & 2(f) Status. we hope to make the connection and link between NGO Community Colleges and B. Voc Degree Colleges through credit transfer following NSQF promoted by the Government of India.

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SKILL DEVELOPMENT AND HEALTH SECTOR

India requires 18 lakh skilled nurses and 65 lakh allied health care workers by 2020 according to a study by Public Health Foundation of India (PHFI) for the Ministry of Health and Family Welfare

India requires 18 lakh skilled nurses and 65 lakh allied health care workers by 2020 according to a study by Public Health Foundation of India (PHFI) for the Ministry of Health and Family Welfare

Dr Bimal Charles

A closer look at the competencies and skill sets as available in the current scene indicates we are doing well in our mission to develop skilled human resources for the sectors in the past decade. In general, every day we come across information on accidents due to ignorant doctors, inadequately skilled paramedics and other healthcare human resources unable to manage normal functions and emergencies in health care services. This is a real threat to the wellness maintenance, disease prevention and management of illnesses both acute and chronic for the burgeoning population and the fast growing health care sector in India.

Indian demographics are changing fast with a significant increase in younger population offering a huge demographic dividend in the immediate future while populations are ageing in other countries. India also has a growing ageing population with life expectancy graph climbing to higher levels. People live longer with better health interventions, housing, and living accessories both medical and social support structures. This is very true for the burgeoning middle class as they earn more, use health services more. The improvement in technology has contributed much to the services and its efficiency. Hospital stay has shortened drastically thanks to technology driven non-invasive surgical interventions and diagnostics.

While technology has improved services in urban India, the rural services still lacks access to services health care technology and human resources to deliver services.

The unique nature of health care sector is that any amount of technology cannot replace the need for human intervention in health care sector. More the technology, more the need for skilled human resource. This is especially true for India and in the years for the globe. It is also important to note the human resources use in health care sector for medical interventions need higher level of skills and understanding of the human body and behaviours. Above all, the level of integrity and ethics practised while handling medical devices and human cannot be compromised and not acceptable by any standards. It is necessary that all these attributes are covered in any curriculum and training process and skill validation used.

CMAI institutions are eminently placed to develop human resources for allied health work force in India. CMAI started allied health training 55 years ago when there were minimal Para medical personnel in India. The purpose was to train for the expanding medical mission stations in India. We have expanded the array of skills developed among the paramedical sciences adapting to the needs for services delivery and to support doctors for their services, be it diagnostic, intervention, or support services like rehabilitation and counselling. The Central Education Board (CEB) set up by CMAI has done phenomenal work in coordination, design of new training courses, validation and certification of training. As the nation never had a paramedical board CMAI had to offer its own certification, well-accepted by others in service delivery and overseas government. The acceptance in the government is still a dream as the health is a state government's prerogative and the organisation of paramedical courses is only in infancy. It is possible that we could have a design and roll out of a validated accreditation in the next five years.

The Government of India has established the National Skill Development Corporation (NSDC) as an autonomous entity to develop skills among the youth for gainful employment. There are several sectorial skills

that are under consideration, ranging from vocational trades to health sector skills. The health sector in NSDC started very recently in 2011, has grown pretty fast to develop curricula and validation mechanism, and has independent assessment mechanism for training courses and institutions. The competency certification offered by the skill council is a much required one for our network. The certification is aligned to occupational standards for safety.

Major Issues in developing health

We need trainers well equipped with all attributes to train and mentor young people with basic skill to start with. A quality mint brings our quality coin/ currency. If the quality of the mint is inadequate it is not possible to produce quality health care workers. The quality of health care workers is critical for quality of medical services. This is critical as life and death decisions, actions are decided by the diagnostic results read and interpreted by doctors. Very often these decisions are facilitated by allied health care workers and nurses. For example, if a decision on blood group and cross match depends on results provided by lab technician then it is critical him or her to know how to do the technique accurately. We have no accurate data on medical errors like these in India. We can quote several examples like these in diagnostics and other technical areas including prescription interpretation, administration of medicines in wards, surgical theatres etc. We wonder how much of thought has gone into this issue as we have no data and therefore we don't know the quantum of errors contributed by health care workers who are poorly trained and validated.

Training infrastructure

If we need to produce skilled automobile mechanics we need repair shops which have cars with worn out parts, tools for repair and facilities to repair. The same applies to medical repairs too. If we need to fix human medical conditions we need medical institutions with good patient load for observation, shadow learning and other infrastructure that facilitate learning process and practice skills. We have skills labs which offer skills practice which minimise practice on human subjects. However no skill lab can replace an interaction with humans. Unfortunately experiences of past decade are not very positive. Unregulated growth of medical training institutions have contributed to poorly skilled health care workers including doctors who lack several basic skills required to offer quality service. Mismatch of demand and supply of nurses and distribution has resulted in wastage and unequal distribution resulting in exploitation of nurses. The opportunity cost of producing poorly skilled youth would be several millions.

Unfortunately experiences of past decade are not very positive. Unregulated growth of medical training institutions have contributed to poorly skilled health care workers including doctors who lack several basic skills required to offer quality service.

Access to Training

The youth aspiring for a job role in health sector need to have information, guidance, funds and support to complete basic training. This is possible if health care training centres invest time and energy to develop training facilities. Most often health care training centres are based in urban locations and they do not see training as a great need or an activity that make economic sense unless it trains doctors or nurses whose parents have deep pockets to satisfy the greed. The government approved rate for private medical training in Punjab is Rs 5.25 lakhs just for first year with upward increase every year going up to Rs. 9 lakhs in the final year for MBBS degree. This is pretty steep for medical education. And for nursing it's about Rs 1 lakh per year. The fee for allied health sciences varies from state to state with no standard fee structure. Therefore youth from rural area do not have access to this education unless parents or family support their training and migration to the urban setting. India needs training institutions in the rural to understand rural medical issues and reduce the cost of training. Since there are not many medical institutions in the rural it becomes almost impossible to have access closer to rural homes.

Training Methods

The digital technology can help reduce the duration of training and the need for lecturers replacing age old board and chalk. However it becomes a challenge to teach from a central location as the internet availability and the consistency in quality needs further improvement. However a blended model of teaching can solve this issue. This would help standardise curricula and course content. The major issue would still be tutors who can demonstrate skills, mentor attitude, breathe values and inspire commitment into future health care workers on whom the life of the nation's wealth depends on.

Validation of Training

Validation of medical training varies across states

and accreditation institutions. The medical training accreditation if offered by universities, boards and private sector institutions. There are no single standards defining and validating standards for skills for health personnel. While graduates can pass the examination, their standards vary as examiners can have brought their subjectivity and personal variations to exam halls, especially in assessing skills.

Occupational Safety Standards

As the use of technology increase in health care industry it becomes necessary that occupational standards are maintained and to train and validate trainee skill sets on national occupational safety standards and norms. This requires standard evaluation parameters. A movement is yet to take off in medical skills training as a norm. Enforcement of such practices requires coordination across several institutions and ministries

Monitoring Skill development training

Since there is lack of monitors and uniform policies for monitoring it is often compromised and institutions that exploit ignorant students exploit the condition. It is pertinent to note there are several fly by night operators that have thrived due to lax policies in the unregulated private sector on health care education resulting in high levels of non-employable graduates.

Way forward

The government is toying with the idea of entry level exams following graduation for medical graduate which will help standardise medical practice across the country. Introduction of credits for continuing medical education will improve and sustain skills for doctors. The same model could be used for nurse and allied health care workers as well. India needs several categories of allied health care workers and in the shortest possible time. It is necessary NGOs and charitable societies with infrastructure, capability and commitment are included in the wider agenda of health care skill building for the youth from rural India. This will ensure wider scaling up is achieved at a much reasonable cost and ensure recruitment, training and placements. NGOs could also work with government hospitals at district and block levels to enhance volumes as government facilities offer infrastructure and facility for skill training. Adequate funds allocation to subsidise training would encourage youth to take health care skill training in the future.

Dr Bimal Charles
General Secretary, CMAI

SKILL DEVELOPMENT IN INDIA – A WAY FORWARD


Ms Indira Kurapati

As India progressively moves toward becoming a knowledge economy, it has become imperative for its work force to acquire and upgrade skills that are relevant in the emerging economic environment. Today only 25 percent of the graduates are considered employable by Employers. Firstly, the need of the hour is a deeper connection between the Academia and the Industry. The Programs need to be industry specific and prepared in consultation with the industry experts to impart training which would actually enable the candidates to work effectively on job in terms of domain knowledge, technical skills and soft skills. Secondly, education and training has to be from the Learner's perspective and thus there should be a change in the teaching/training pedagogies that suit the student's requirements, their preferences and backgrounds. Thirdly, the approach in imparting training needs to be practice oriented instead of theory focus. The practical way can be adopted by encouraging the students in applying learning in their day-to-day personal lives, discussions around real life business/industry cases, on-the-job experiences, exposure visits and so on.

Skill development is one of the essential ingredients for India's future economic growth as the country transforms into a diversified and internationally competitive economy. Skill development is going to be the defining element in India's growth story. The country had just two per cent skilled workforce compared to 70 per cent in the U.K., 74 per cent in Germany, 80 per cent in Japan, and 96 per cent in South Korea.

According to the (National Skill Development Policy) the current capacity of the skill development programs is 3.1 million. India has set a target of skilling 500 million people by 2022. Major challenge of skill development initiatives is also to address the needs of huge population by providing skills in order to make them employable and help them secure decent work. This will also inculcate dignity of labour and create greater awareness towards environmental, safety and health concerns. Skill training should ensure a job for those who seek it. The placement ratio will be monitored and placed in the public domain by agencies involved in skill training.

Demand for skills in the market

As the proportion of working age group of 15-59 years will be increasing steadily, India has the advantage of "demographic dividend". Harnessing the demographic dividend through appropriate skill development efforts would provide an opportunity to achieve inclusion and productivity within the country and also a reduction in the global skill shortages. Large scale skill development is thus an imminent imperative.

This is not as much due to lack of monetary investment as it is a predicament about grossly inefficient execution. The government already spends several thousand crores every year on skill development schemes through over 18 different Central government Ministries and State governments. The need of the hour is to improve resource utilisation and find solutions that can address the systemic and institutional bottlenecks constraining the sector.

Departments of skill development in India

India has developed a National Skill Development Initiative which aims to empower all individuals through improved skills, knowledge, nationally and internationally recognized qualifications to gain access to decent employment and ensure India's competitiveness in the global market.

Ministry of Skill Development and Entrepreneurship was established by the Prime Minister recognizing the importance of skill development in India. The Ministry is responsible for co-ordination of all skill development

efforts across the country, removal of disconnect between demand and supply of skilled manpower, building the vocational and technical training framework, skill up-gradation, building of new skills, and innovative thinking not only for existing jobs but also jobs that are to be created.

The Union Budget 2015 paved way for the launch of a much-awaited National Skills Mission to complement Prime Minister Narendra Modi's 'Skill India' and 'Make in India' exhortations.

Policies

National Policy on Skill Development and Entrepreneurship 2015 seeks to create an ecosystem of empowerment by Skilling on a large Scale at Speed with high Standards so as to ensure Sustainable livelihoods for all citizens and to place India in the comity of front ranking entrepreneurial and innovative nations.

National Skill Development Policy 2009 - Policy on National Skill Development has been formed to create opportunities for all to acquire skills throughout life, and especially for youth, women and disadvantaged groups, to enable effective coordination between different ministries, the Centre and the States and public and private providers and to develop a high-quality skilled workforce/entrepreneur relevant to current and emerging employment market needs. This policy will link skills development to improved employability and productivity.

Skill development in healthcare

Most low to middle income countries (LMICs) have to cope with a wide range of health problems that interfere with their future economic development. Even in countries where the economy is booming, such as India, health inequalities are widening and health care is becoming unaffordable. Health is improving more slowly in many LMICs than in richer countries, increasing international health disparities. A trained workforce of health professionals is essential but, for many reasons, there is currently a lack of adequate capacity.

Allied Health Professionals (AHPs) play a critical role and are the support pillars of the healthcare team. The largest skill gaps in AHPs were in computer/IT-related skills and other important soft skills necessary to communicate efficiently with the patients and their family members. Relatively, they had better core clinical skills. The computerization of patient records and digital analysis of test results makes it imperative for AHPs to be proficient in IT related skills. According to a study published in Business Standard 2014, India has a shortage of around 6.4 million allied health professionals.

A government body for skill development in the health sector is ***The Healthcare Sector Skill Council (HSSC).*** The key objective of the Council is to create a robust and vibrant eco-system for quality education and skill development in paramedics and allied healthcare space in the country. In addition, the Healthcare Sector Skill Council serves as a single source of information on healthcare sector with specific reference to Skill and Human Resource Development in India.

Future of Skill development in health sector

Although occupational classifications vary across the globe, little has been done in India to estimate the need and to measure the competency of health care providers beyond the doctors and nurses. Augmentation of skilled healthcare workers at all the levels is necessary to ensure quality and improved access to healthcare services.

CMAI has been deeply committed to provide ethical and quality health care services through its member institutions and building quality and efficient health care professionals through training

The demand for Allied Health Professional is increasing and many students especially from economically weaker section have been encouraged to take up allied health courses through promotion of poor students fund initiatives by various health educational institutions.

There are corporate companies investing money in the healthcare sector by partnering with health organizations in the public and private sector to establish education institutions and provide training to the students. GE Healthcare along with its partners aims to train and contribute 100,000 skilled healthcare workforces to strengthen India's healthcare system over the next five years. This workforce will include newly trained, certified employable professionals for allied health care services as well as skill enhanced healthcare professionals who are in the system already. National Skill Development Corporation India, through the Healthcare Sector Skills Council, is playing a key role in defining curriculum for these courses and supporting accreditation.

CMAI has been deeply committed to provide ethical and quality health care services through its member institutions and building quality and efficient health care professionals through training. CMAI's first ever AHP course started

in 1927. Since then it aims at the empowerment of the disadvantaged through appropriate skills development leading to gainful employment, thus making a qualitative difference in the lives of the underprivileged from urban, rural, tribal and women for employment in the local areas and abroad.

The need of the hour is to upscale our existing trainings to match up with the pace the newly born educational institutions are gearing.

Role of Christian Healthcare Institutions in Skill Development

Christian organizations play a pivotal role in supporting the underprivileged and the marginalized to make their living better by training them and enabling them to earn their livelihood. Institution such as Don Bosco Training Institute set up non-government Industrial Training Institutions (ITIs) affiliated to National Council of Vocational Training (NCVT) and offer courses under the Craftsmen Training Scheme.

The Indian Centre for Research and Development of Community Education (ICRDCE) is a facilitating and coordinating agency for Community Colleges in India. It has been involved in the preparation, establishment, monitoring and evaluation of 336 Community Colleges in 17 States of India. It aims at the empowerment of the disadvantaged through appropriate skills development leading to gainful employment, thus making a qualitative difference in the lives of the urban poor, rural poor, tribal poor and women in collaboration with local industrial establishments, potential employers and community leaders after taking into account the opportunities available for employment and self-employment in the local area.

Opportunities in Skill Training

There is a tremendous opportunity for Christian institutions to offer skill training for livelihood of youth which can be placement driven.

CMAI has initiated short term trainings to mainstream the youth into the formal organized jobs. The course modules are designed carefully with industry inputs to keep in tune with the changing demands of the allied health sciences. The courses will be certified by Healthcare Sector Skill Council and National Skill Development Corporation. Such initiatives could be partnered with corporates seeking their Corporate Social Responsibility funding sources.

Other institutions offering skill training are

YMCA offers computer and tailoring, embroidery and handicraft training especially for women in remote villages. Through the training program around 1250 women and girls have been benefited under their income generation program.

Rural Unit for Health and Social Affairs, RUHSA, was initiated by Christian Medical College, Vellore, to cater to the destitute and the marginalized community providing healthcare service, provisions for economic development and community empowerment. RUHSA is actively involved in training rural youth through its community college to pursue a better living standard.

Recognizing the importance of skill development in India, the State and Central Government offers various schemes on training school leavers, SC/ST and women on skill training to improve their employability.

India needs trained professionals to sustain its growth trajectory and the demand is growing every year. While the global population is ageing rapidly, India, with one of the youngest populations in the world, is at a strategic advantage with regards to demographic dividend. There is a wide gap between the skills required in industry and those provided by the education system. Let us rise to this need and involve ourselves in 'Skill Development for Health' of our country.

1 Chronicles 22:15-16 – *"Moreover, there are many workmen with you, stonecutters and masons of stone and carpenters and all men who are skillful in every kind of work. "Of the gold, the silver and the bronze and the iron there is no limit. Arise and work, and may the Lord be with you."*

Ms Indira Kurapati
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SOFT SKILL IN NURSING CARE

We must recall the days of our initial years at nursing school where our teachers taught us the importance on how to talk to the patients politely and be pleasant.

Ms Jancy Johnson

Nursing has come a long way since the days of Florence Nightingale and her pioneering actions that define her as "The Mother of Modern Nursing". One thing that has not changed, and is unlikely to change anytime in the near future is the presence of illness and its effect on people.

A recent visit to one of the hospitals to meet my friends' relative made me to think about the importance of communication in nursing practice. The patient was admitted for his diabetic wound and he was also awaiting a kidney transplant. Early next morning the nurse approached him with a needle to give a prick on his middle finger to check his blood sugar. As I was observing both the nurse and the patient I could not help but notice this rather emotionless exchange. Neither a smile nor a word of greeting was offered to the patient by the nurse. This is an all too familiar scenario in today's hospitals in and around the country.

As I was observing both the nurse and the patient I could not help but notice this rather emotionless exchange. Neither a smile nor a word of greeting was offered to the patient by the nurse.

We as part of the medical profession have lost the sensitivity that the human factor brings. Our logic may say it is a routine procedure for him but a word of comfort or a smile on our face can make a world of difference in the lives of many of our patients if we are in touch with empathetic inner selves. Effective communication requires an understanding of the patient and the experiences they express. It requires skills and simultaneously the sincere intention of the nurse to understand what concerns the patient. To understand the patient alone is not sufficient but the nurse must also convey the message that he/she is understandable and acceptable.

More often nurses get too busy in the wards and sometimes it is not possible to attend on all the patients, so they need to prioritize it accordingly. Patients may not realize why the nurse did not attend on him immediately. Here, effective communication can change the whole attitude of the patient. A few words which explain the reason for the delay can really comfort the patient. Communication between nurses and patient is a process that begins with the first contact of the two and lasts as long as the therapeutic relationship. The nurse, who wants to create the right relationship with the patient, must win him/her from the first moment.

Is our education system adequate in training our nurses to meet all the demands of the health care system? How much of our focus is on soft skills? We give a lot of importance for technical skills and ensure that many hours of training are put in this area. In this age of micro chips where a lot of focus is on optimum use of technology and high level skills, it is easy to forget our basics. My recent study on leadership competency of nurse leaders and its effect on its subordinates showed that the nurse leaders scored minimum in decision making and communication. However all of them scored excellently in their professional skills. I agree that we need competent professionals with good knowledge in this fast growing scientific world. But in order for the nurses to be successful in their work, they have to learn communication and interpersonal relations in their education. They need to learn the various aspects and applications of communication in various fields of nursing. In this context it is understood that emphasis must be placed on the importance of communication between nurse and patient and nursing education must focus on communication skills of nurses.

It is high time that our nursing curriculum need to look more seriously in these non-clinical skills too. In this era with the rise of high level technologies we must not forget the fundamentals of nursing. We must recall the days of our initial years at nursing school where our teachers taught us the importance on how to talk to the patients politely and be pleasant. In this new climate of healthcare delivery, nurse coaches who practice from a holistic framework are partnering with patients to achieve health and wellness goals. No matter where holistic nursing is practiced, nurses must continually develop knowledge and skills in all aspects of their practice because holistic nursing is a way of thinking, reflecting, practicing, and of life. As a way of life personally and professionally, self-care becomes and is incorporated into one's existence.

Indian Nursing council has recently changed its policy on licensing. It is a good move towards better quality that unlike the past, nurses are not given license to practice unless they upgrade their knowledge periodically. Nurses are now required to renew their license every five years. Nurses should definitely have their clinical skills enhanced to the latest methods in effective medical care. CMAI is partnering with Care India in enhancing clinical skills of ANM staff in Bihar state. It is vital that nurses should be excellent in clinical skills in delivering patient care. CMAI has successfully completed a pilot project in enhancing the clinical skills of grass root level nurses in Bihar and currently the project has been extended to entire state after realizing the importance of the contribution of grass root level nurses in bringing down the MMR and IMR levels.

At the same time we cannot neglect the other soft skills like communication, decision making, interpersonal relationship, and leadership skills, etc. When we think of holistic care, all these skills would be part and parcel of it. A holistic nurse is a licensed nurse who takes a "mind-body-spirit-emotion-environment" approach to the practice of traditional nursing.Holistic nurses are often described by patients as those nurses that "truly care." While there is nothing inherently wrong with being task-oriented or goal-oriented in your nursing care, if a nurse is overly task-oriented or appears severely rushed, it can leave patients feel as if they were just a bed number or a diagnosis or worse, a burden. What matters is having the intention to care for each patient as a whole and being present for that patient while you can. Holistic nursing can be practiced in any healthcare setting. Thus we realize how vital these skills are to effective and therapeutic care in nursing.

Why do we see that the airlines always announce their delay in take-off and landing? We are often reassured and feel confident when there is some member of the air crew effectively and gently communicating the details of our flight or other arrangements. This is human psychology where every individual seeks personal attention. The fact that no one tells you the reason for the delays in attending on them during an ongoing process makes you feel that you are not important nor your time has no value. But in the health sector we totally forget its importance. Sometimes little things can make a great difference in the patient's experience.

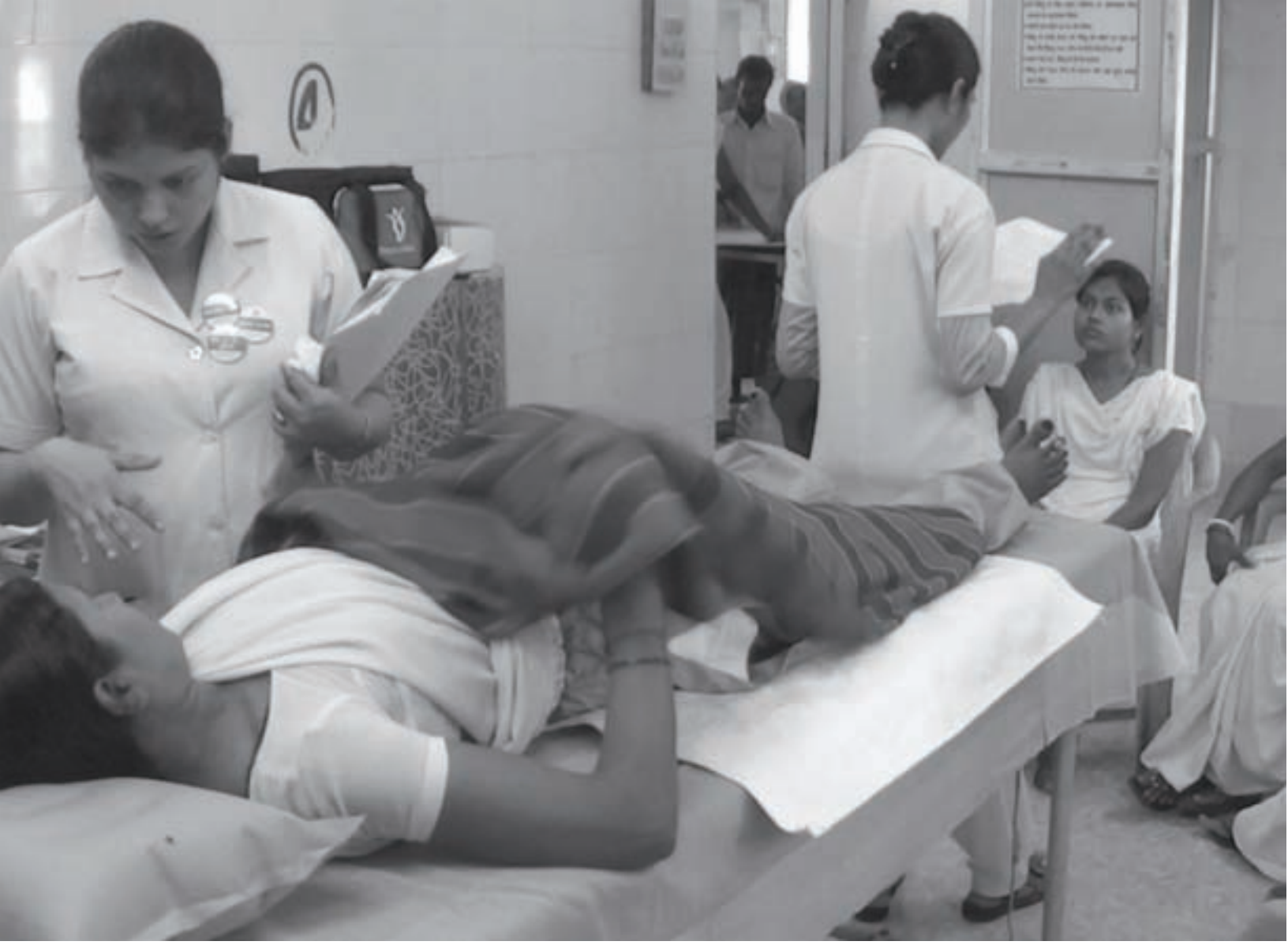
Is decision making an important skill for all nurses or is it only for the nurse leaders? The fact is that, each and every nurse has to take decisions on very short intervals some even life changing for an individual. They need to find

alternate ways of doing things in unforeseen situations. Critical thinking in nursing is an essential component of professional accountability and quality nursing care. Critical thinkers in nursing exhibit these habits of the mind: confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance, and reflection.

Learning to provide safe and quality health care requires technical expertise, the ability to think critically, experience, and clinical judgment. The high-performance expectation of nurses is dependent upon the nurses' continual learning, professional accountability, independent and interdependent decision making, and creative problem-solving abilities.

Let your light so shine before men, that they may see your good works, and glorify your Father who is in heaven (Matthew 5:16).

Each Individual is created in the image and likeness of God. They need to be treated with dignity, respect and



love. A Christian nurse's primary responsibility is to give tender loving care or in other words reflect the love of Christ through their care. Preach the Gospel and if necessary use words (Francis Assisi).The love should be reflected in our deeds. Physical illness cannot be cured only with medications .The holistic care involves physical, social, emotional and spiritual well being. Jessika Gore in her article "Holistic and spiritual care" quotes - Nightingale believed that the crux of the healing environment of nursing was to provide touch, kindness, and other comfort measures while also attending to the patient's physical needs (Frisch, 2007).

Effective nursing will continue to evolve as nurses incorporate holistic principles and practices into their personal and professional lives, and as the needs of patients and society evolve. Whatever be the setting or the time, holistic nursing will retain its focus on healing the whole person—the very foundation of holistic care.

Ms Jancy Johnson
Secretary, Nurses League - CMAI

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CHRISTIAN ACADEMY OF MEDICAL SCIENCES (CAMS)

A BETTER SOURCE OF SKILL AND DEVELOPMENT IN MEDICAL FIELD

The Christian Medical Association of India (CMAI) was established in 1905 as one of the pioneer association of healthcare professionals. CMAI, over the period of many years, added various medical allied sections as per the need of time and the society to be relevant for emerging social problems.

Dr Deepak Kamle

CMAI started Doctors section in 1905, the Nurses section in 1918, Allied Health Professional section in 1963, Chaplain Section in 1986, Administrators section in 19XX.

The Doctors Section added a new training programme for CMAI. The basic thrust was promoting a wholistic health. Before Independence, there were around 720 Christian mission hospitals in India. At present almost 360 mission hospitals closed down mainly due to lack of qualified doctor to run the hospitals. CMAI then took a lead in upgrading the skills of the present MBBS doctors to a postgraduate level. CMAI then collaborated with Tribhuvan University Nepal for Post graduate Studies. CMAI came forward and started Christian Academy of Medical Sciences in 1989.

The main aim of Christian Academy of Medical Sciences (CAMS) was:

- Keep Mission Hospitals self-reliant and sustain with their own manpower
- Help Mission Hospitals in stabilizing Human Resource Development programme
- Upgrade the knowledge, skills of Christian doctors serving in rural areas.
- Give chance to Medical doctors to do postgraduate studies in their fields
- Provide a platform to talented, hard-working, sincere Christian doctors, who otherwise are deprived of post-graduate studies due to non-availability of opportunity
- To improve skills of rural mission hospital doctors

CAMS runs two Post-graduate Medical Courses, first M.D. (General Practice) affiliated and conducted by Tribhuvan University Nepal which is of three years and second one is a Fellow of Christian Academy of Medical Sciences (FCAMS) of CMAI which is of three years. During this period, these candidates (Doctors) gets an opportunity to study and work in the best and reputed Christian teaching hospitals to see and handle very serious complicated patients as well as get hands-on training experience. All these students were trained in Emergency Medicine and other allied Medical and Surgical subjects.

In order to fulfill the mission of preparing Christian postgraduate degree holding doctors since 1989, a total of 94 Christian doctors were registered under this programme, out of which 64 successfully completed course and passed, 14 discontinued the course due to their personal reasons, 6 candidates just completing their course waiting for the results, 03 candidates completed tenure and are yet to appear for final exams and 7 candidates are on roll.

CAMS IS COMMITTED TO GIVE A SHORT-TERM POSTGRADUATE TRAINING EITHER IN-SERVICE OR FELLOWSHIP COURSES WHICH WILL BE MORE USEFUL TO MISSION HOSPITAL DOCTORS

All doctors trained under CAMS are working in 64 different Christian mission hospitals so that CMAI could revive, rejuvenate 64 Christian mission hospitals through CAMS programme by providing qualified postgraduate doctors. It is interesting to understand that all 94 registered students were the sponsored students from various Christian organizations all over India.

CAMS is committed to give a Short-Term postgraduate training either in-service or fellowship courses which will be more useful to mission hospital doctors like:

- Endoscopy
- Laparoscopy for Surgeons
- Ultrasonography
- Anesthesia
- CME for In-Service Training
- Research and Publications
- Medical Tourism

CAMS uses peripheral non-clinical centre as a training centre. There is a need to increase the number of peripheral centre for wider reach and those trained under CAMS can act as a Guide/Co-Guide and improve educational standard.

As an important advocacy and capacity building initiative of CMAI, CAMS plays an important role in sustaining the mission hospitals by preparing doctors for them. CAMS has motivated all the graduates to go back and serve their parent institutions. They voluntarily rendering their services in 64 Christian hospitals.

Dr Deepak M Kamle, MS, FRSH, FCAMS
Coordinator CAMS, CMAI

TESTIMONY

My experiences with CAMS has been good. I am a third year student. Now studying in Oddanchatram at Christian Fellowship Hospital near Dindigul. My experiences in the medical field is quite good in comparison to what I had before. Thanks to CAMS program for arranging for this degree and fellowship program for us students also combining our studies with MD(GP) affiliated to Tribhuvan University, Nepal which a very prestigious degree for Nepal.

I will be working in a tribal belt in Gujarat, where health care facilities are too poor and scarce. Thanks to the Spanish Jesuits Priests and Carmelite Missionary Sisters who have brought up the educational status of the uneducated people of that place. Hoping that my training will be able to do good to the medical needs of my people in this medically underprivileged part of my country.

Thanks to CMAI and all those who are selflessly working for it in making this a reality. May God bless us all for working in his vineyard and bring forth abundant fruits.

Thank you
Sr Dr Shiny CM

TESTIMONY

It is difficult to start and write something about CAMS programme. As many different outgoing graduates has different opinion like acceptance of the course by institutions and Government etc.

To me these are not issues at all as I had only one target to revive the hospital. To start how this programme has helped me to work effectively the following lines will clear anybody. As our Hospital was almost at the verse of closer I joined as a MO soon after my internship. It was very hard time for me to deal with different cases and different issues.

I had an opportunity to join CAMS programme in 1994 and had postings in different Christian Medical colleges and different Mission Hospitals. Met great and caring teachers almost in all departments like surgery, medicine, obstetrics & gynecology.

I must mention my teachers Dr. AS Fen who taught me surgery and Dr Malati Yadav who took extra care to sharpen my skills in paediatrics. Dr K Vergish and Dr Paul Emmanuel from ODC fellowship Christian Hospital taught me medicine and Obg & gynaecological surgeries respectively.

Today I am glad to share and tell my fellow friends if you have a heart to work in rural mission hospital don't miss the chance. Glad to revive the hospital and works. Today in our district this small mission hospital attracts for OBG &GYNECOLOGY surgeries as well general surgeries. Today I am glad to share that I could able to support 3 students to study medicine, many more nurses and technical support staffs. I must say this good work is carried out only because I had a privilege to undergo CAMS training programme.

Rohibiam Iswary, Medical Superintendent, Parkijuli Christian Hospital

FROM OUR ARCHIVES

The Journal of the Christian Medical Association of India, Burma and Ceylon

Vol. XV No. 6 - 1940

THE TRAINING OF WORKERS FOR THEIR PROFESSIONAL RELATIONS WITH THE LAY COMMUNITY

(Being parts of a paper read by Miss Chapman at the CMAI Conference at Ootacamund).

This is a huge subject indeed and, if I may, I will endeavour to confine myself to one small part of it. *The question of training the Trainees for rural work for their professional and social relations with the educated part of the community.* Let me emphasise that in rural work, if the worker is to have any social life at all, it will be with the educated part of the community.

It is sometimes very difficult for a young worker to realise that the social relationship may never override the professional relationship. If she (or he) has not sufficient knowledge and understanding of what constitutes professional conduct, very difficult situations may arise. For not only should she have knowledge and understanding of what constitutes professional conduct but must be able to lead those amongst whom she lives to appreciate and care for it.

This last year I have had many conversations and much correspondence both with lay people and medical workers on this subject, and in it all there run two definite thoughts:

1. Educated people who are quite keen on health work are not willing to co-operate unless they understand very clearly the reasons for what they are asked to do.
2. Our workers are not sure enough themselves and are not convinced themselves of the reasons underlying professional conduct.

Nor have they sufficient knowledge and understanding of the various modes and ways of infection and how to combat these in a community which is not entirely made up of medical workers and patients. If the educated members of the community are not going to co-operate in the quarantine of infected or suspected contacts, unless they understand the why and the wherefore, and if patients will hide the truth from a medical worker lest that worker tell the community what is the matter, is it not essential that workers should be thoroughly taught how to respect the confidence of the patients and yet at the same time so gain the confidence of the community that gradually there may be built up knowledge on which to base a community habit which will give privacy to the patient and yet protect the community from the dangers in their midst?

Let us look at the background of rural work in India. We find that the conditions encountered by a to-day's trainee, going from a modern hospital to a rural district, are much more difficult than those of, say, 25 years ago. Twenty-five years ago a man or woman going out to the equivalent of country practice or district nursing could put into use most of the learning acquired in their training schools. The equipment and medicines that they knew how to use were not fantastically expensive and the income of the average person was certainly no lower than it is to-day. To-day trainees have had little practical experience in obtaining the necessary degree of skillfulness in the applications of the cheap treatments of a former day. Nor are they accustomed to using so freely the wide range of mixtures of comparatively cheap and crude drugs which were used then. So when they go to the country, and expense prevents them using either the equipment or the complicated proprietary drugs to which they have become accustomed, it is not to be wondered at that they suffer from a greater feeling of helplessness and of being wasted than their fathers did.

This in itself makes for poor work.

FROM OUR ARCHIVES

The Journal of the Christian Medical Association of India
Vol. XL - No 9, September 1965

Medico-Clerical Team Work

In recent years there has been a noticeable coming together of the two professions most intimately concerned in the care of the sick. A statement on 'Medicine and the Church' approved by the Council of the BMA in London issued in 1947 concluded as follows:

Health is more than a physical problem, and the patient's attitude both to illness and to other problems is an important factor in his recovery and adjustment to life. Negative forces such as fear, resentment, jealousy, indulgence carelessness play no small part in the level of both personal and natural health, For these reasons we welcome opportunities for discussion and co-operation in the future between qualified medical practitioners and all who have a concern for the religious needs of their patients'.

Subsequently in 1956, in a memorandum of evidence submitted by a special committee of the BMA to the Archbishop of Canterbury's Commission on Divine Healing, the question of co-operation between doctors and clergy was again considered. The Committee recognised the difficulties involved in such co-operation but referred to its gradual development through individual contacts between family doctors and parish ministers, as well as occasional joint meeting held under local BMA auspices.

In Australia such meetings under BMA auspices have been held in Melbourne and local doctor-clergy groups in Sydney and Adelaide have been meeting for some years. They have been linked together through the Australian Council of Churches under whose auspices an interstate clergy-doctor consultation was held in July, 1960. A report of this consultation has been published."

One particular aspect that has claimed the attention of these groups as well as the BMA Committee is that of hospital chaplaincy. As so much modern medicine is becoming centred on the hospital this has become a more urgent need. It has become apparent that effective medico-clerical co-operation requires in the first instance more medical knowledge on the part of the clergy. Training courses have now been set up in Melbourne and Sydney and recently Adelaide teaching hospitals for theological students and clergy, to prepare them for more informed pastoral care of the sick. The development of full-time hospital chaplaincies first in the mental hygiene department in Victoria, but now spreading to general hospitals in Melbourne, Sydney and Adelaide, reflects the pressure of human need in those institutions, requiring more specialised training than that available to most ministries of religion.....

One important implication of the greater participation of the clergy in hospital life is the maintenance of the proper balance between the human and scientific aspects of hospital practice. This is particularly important in teaching hospitals with their young medical students and trainee nurses entering medicines at a time of greatly increasing technical complexity when the human aspect is in anger of being overlooked. In the care of the sick we need both Greek and Hebrew traditions-reasons and faith; science and religion.

SKILL BUILDING FOR COMMUNITY HEALTH

Skills in reflective listening and effective communication are critical for working in community health.

"So Sanjay, I am keen to hear about one of your most positive learning experiences. Tell me about how it was positive and why it worked so well!"

Deepti was sitting opposite Sanjay, leaning forward to hear his thoughts, her face energised and interested. Observing them both, out to the side, Yomri was sitting taking notes, assessing how well Deepti was listening to Sanjay.

Dr Kaaren Mathias

Talking about what makes learning fun wasn't difficult for Sanjay. He started talking about his cricket coach, ten years ago, when he was studying in Inter-College. "Even though Mr Ansari made us work hard, he always had encouraging words for each of us. I remember after this terrible game where we were all bowled for less than 80 runs, we all felt so bad. But he came up to me and told me he noticed how I had continued to run fast while fielding, even though it was a dusty and hot summers day, perhaps over 50C in Chhattarpur. His attention to each of us as individuals and specific feedback really made me feel like trying harder the next time."

Skills in reflective listening and effective communication are critical for working in community health. Whether we're listening to community members and their assessments of community needs, or if we're meeting a Block Development officer to try to negotiate for genuine inclusion of people with disabilities – it is essential to communicate well.

After my six years at medical school, I somehow had the idea that being a health professional the critical component of my training was about my knowledge. Most of our exams and tests focussed on how much knowledge I could retain and regurgitate. Some of the 'softer' components of being a good doctor, such as being good at communication, showing empathy to patients and using creativity to help team members understand a concept were not discussed or assessed. Now, working in community health to change behaviours, and bring sustainable and transforming changes in communities, I see that building skills is far more important and perhaps more complex that increasing knowledge.

Some of the key approaches we seek to use in skill building workshops in our community health work in EHA include:

A. Small amounts of theory, large amounts of practice

In the reflective listening session I describe above, after a time of discussion about what is key to feeling like we've been listened to and heard, we went through a 10 – 15 minute powerpoint outlining what are the key skills in reflective and effective listening (body posture, summarising, reflecting, etc). We then spent over an hour working in groups of three. Each rotating opportunities to be the speaker, the listener and the observer. The observer had a pre-prepared sheet to assess and give feedback to the 'listener'.

B. Lots of interaction and participation

During the discussion time above we got into groups of three – and each group had to list three important attributes / skills of a good listener. When we got back together in a full group, we listed these and debated the relative merit of each skill.

C. Use of many /different styles of teaching and learning.

In workshops seeking to build skills in counselling with our community mental health teams, we have found it useful to show videos of different styles and approaches to counselling, to use role-plays to show different skills and techniques, to run sessions in the community where a counselling trainee is observed in a counselling session

and given structured feedback, and giving people books and articles to read around counselling. Each of these meets different learning styles and preferences, and diverse levels of literacy.

Some years ago I was involved in a malaria control programme in Latin America, that involved teaching people from remote tribal communities to perform blood smears and read a microscope slide to differentiate vivax and falciparum forms of malaria. Reading and lectures were never going to be great learning media for this group of 20 participants who were largely illiterate. As facilitators we had think hard how to build these skills without the fall back of textbooks and lectures. It was amazing to see how well this group responded to working in pairs, practical demonstrations, role playing, and using lots of drawing pictures. After a 20 day course all 20 participants were effectively taking blood smears, staining slides and differentiating the 2 key strains of malaria – and able to provide treatment for vivax cases, while referring falciparum.

We ensured that all participants could get online, and be supported by a team of 4-5 facilitators who could guide and support each individual. The specific and relevant feedback was the key.

D. Having fun while learning

Workshops and learning sessions where we play a game, chase each other with rolled up newspapers or draw pictures instead of writing dense notes make us feel much more enlivened and positive through the day of learning. Sometimes I fall in the trap of thinking " There is not much time and I must get through a large volume of material" and then go into the old ways of a lecture mode. Before long I notice half the group has glazed eyes and a few snores may be heard. Quickly I abandon the didactic teaching style, we play a game and return to a more participatory and creative way of learning. Its more fun for the trainer as well as the participants.

E. Spread the training over some time

When I have the luxury of a group of people/ team who all live in the same area it is really helpful to spread 4 days training over 2 months – with a day of training every 2 weeks. This gives opportunity to break skills into smaller steps and practice them in between trainings, before

introducing the next component. We used this recently with our community mental health teams co-located near Dehradun and Saharanpur, UP. We ran the training days on 4 consecutive Monday's and after each training we had an activity/ homework task that required working in pairs, assessment by a peer and assessing our own skills using a photo-copied framework.

Building skills is all the more challenging when working with participants who have not had a strong educational background or who may have limited literacy.

challenging when working with participants who have not had a strong educational background or who may have limited literacy. Skill building in community health needs methods that are participatory, creative, fun and use diverse teaching methods ensuring that participants get specific feedback. After teaching skills like this you may find yourself that you don't want to sit in on a boring lecture or sermon again. Let's all make learning more fun!

F. Giving detailed and specific feedback on skills

I found it very frustrating to get a grade of "B+" for an English essay at school and no further feedback about what was good or bad. How could I improve if I didn't get an indication of what was missing? It was much more useful to get a comment like:

"You start with a strong introduction and introduce your themes well, however paragraphs 3 and 4 do not have clearly developed argument and seem to say the same thing. Could you try ensuring each paragraph makes a single point and provides one example from the text that illustrates this point? I like your conclusion and also the succinct vocab in your 5th paragraph."

During a workshop last year that I co-facilitated with others, we focussed on building skills in searching for relevant information/ resources for project managers and programme leaders in EHA. We wanted to build skills in using appropriate search terms and using the right data bases to quickly locate information needed. We found that staff could quickly get better at choosing good search terms and locating the most useful documents with specific feedback in live time. We ensured that all participants could get online, and be supported by a team of 4-5 facilitators who could guide and support each individual. The specific and relevant feedback was the key.

Building skills demands much more of a teacher than passing on knowledge, which can be acquired with a textbook or an article to read. Building skills is all the more

Dr Kaaren Mathias is a specialist in community medicine and works with the Emmanuel Hospital Association (www.eha-health.org) as the Programme manager for Mental Health. She has been working on building her own skills in community health for two decades, and loves training and supporting others in this quest also. She lives in Mussoorie, Uttarakhand.

100 YEARS OF HEALING MINISTRY & TUBERCULOSIS CARE

AROGYAVARAM MEDICAL CENTRE, AROGYAVARAM

CSI Arogyavaram Medical Centre formerly known as Union Mission Tuberculosis Sanatorium is a pioneering institution in the treatment of tuberculosis in the country which has rendered Yeoman Service to the poor and needy to tuberculosis patients for the past 103 years. This is a prestigious institution of Church of South India in Rayalaseema Diocese and represents the symbolic union of the Churches of different Mission Boards in as early as 1912 when the different Mission Boards got united to reflect the Healing Ministry of the Church at Arogyavaram. This is situated about 5 kms from Madanapalli town in Chittoor District of Andhra Pradesh State.

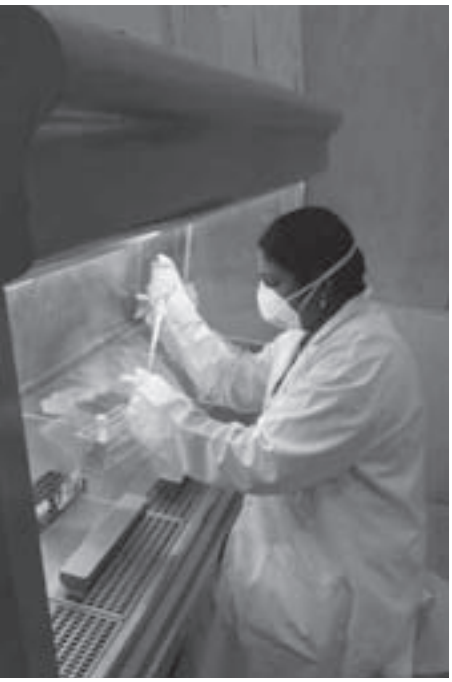
Dr B Wesley

Dr. Vincent Campbell, Missionary from London Missionary Society mooted the idea of tuberculosis sanatorium in South India.

Arogyavaram means "Health the Gift of God". The climate here is clean and dry, isolated from town, free from dust with cooler nights to ensure good rest and sleep for the patients. It is not exposed to heavy rain bearing winds nor is a place with heavy monsoon and it a moderately elevated place (about 2700 ft. above sea level). The land was once a forest and waste land and was abandoned by the forest department which has now become a pilgrimage for the people suffering with dreadful diseases like tuberculosis and HIV and AIDS. The tuberculosis sanatorium was declared open in 1915 by the Lord Pentaland, the then Governor of Madras. Dr. Christian Frimodt Moller a Danish missionary was the first Medical Superintendent.

This institution was actively involved in the treatment and research in the field of tuberculosis. The trial studies for Streptomycin, Rifampicin, etc. and BCG vaccination trial studies were conducted here. The first laboratory training programme in India was started here by Christian Medical Association of India.

At present it is functioning as a general hospital with 300 beds. 120 beds are reserved for free treatment of tuberculosis patients and 40 beds are reserved for free treatment of HIV and AIDS patients.



The current activities are:

- Tuberculosis Treatment & Control
- Community Care Centre for HIV / AIDS Patients
- General Hospital Services with Multi-Specialty
- Eye Care Services to the Poor & Needy
- Community Programme for Differently abled Children
- Community Out-Reach Programme
- Training in Radiography and General Nursing & B.Sc., Nursing
- Research Programme
- Schools - English & Telugu Medium
- School for Deaf
- Printing Press
- Carpentry & Tailoring Units
- Department of Religious Activities is an added strength of this Institution.

Medical College Vision

It is visualized to establish an exemplary Medical College at Arogyavaram Medical Centre, which would impart a quality medical education par excellence. Considering the unanswered health needs of women in rural India it is also visualized to train more number of (70%) women doctors who are committed to serve the women in the villages.

The Government of Andhra Pradesh issued Essentiality Certificate in 2002.

Important Milestones of Arogyavaram Medical Centre

Arogyavaram Medical Centre is a Society Registered under Charitable Act of 1914 and it is exempted from Income Tax u/s 80G. The following are few milestones of AMC.

1912: The pioneers selected 260 acres of forest land and the then government assigned this land to start a sanatorium. The pioneers named this place as"Arogyavaram" (Health the gift of God).

1915: The Union Mission Tuberculosis Sanatorium was started to treat TB patients in a `isolated' area to prevent infection to others as `Sanatoria treatment' was thought of as the only service to help suffers from tuberculosis whose state seemed so helpless and hopeless. This was the first sanatorium in South India. Union Mission Tuberculosis Sanatorium was opened by His Excellency the Rt. Honourable, The Lord Pentland, Governor of Madras.

1918: The new postal area declared, 'Arogyavaram' meaning – Health, a gift of God.

1920: The Domiciliary care of TB was advocated by this institution.

1922: The first Thoracoplasty operation in India was done at this centre.

1927: Laboratory Technician course was started.

1928-29: Advanced Surgery was started by Dr R H H Goheen.

1939: Dr C Frimodt - Moller appointed Medical Commissioner, Tuberculosis Association of India, New Delhi. Dr P V Benjamin assumes charge as Medical Superintendent.

1939: Dr K T Jessudian joins the Staff

Dr J Frimodt-Moller joins the Staff.

1940: TDD Tuberculosis Diseases Diploma Course started; the first in India.

1940: July 19: Silver Jubilee

Opening of Recreation Hall and Patient's Library

1940: Opening of Lazarus Memorial Block at the Rehabilitation Centre.

1946: TDD affiliated to the Madras University.

1947: The pioneering survey for TB in the region was taken up by this institution in response to the government of India's request to study the immediate effect of BCG vaccination in Indian Children and a research unit called "Madanapalle Tuberculosis Research Unit" (MTRU) was started.

1947-50: The first Post Graduate course in tuberculosis (TDD) in India was started. The Former Medical Superintendents were chosen as advisors in TB to the Government of India.

1952: Pt. Jawaharlal Nehru visited this Sanatorium on 7th October 1952.

1955: The Honourable Smt. Rajkumari Amrit Kaur, the first Union Minister for Health, Govt. of India opened the Children's Hospital on 19th July 1955.

1975: The Union Mission Tuberculosis Sanatorium was converted into Arogyavaram Medical Centre as a General hospital with 350 beds. The then Governor of Andhra Pradesh, His Excellency Sri. S

Obul Reddy inaugurated Arogyavaram Medical Centre.

Since 1975:

Arogyavaram Medical Centre is working in the fields of general medicine, general surgery, obstetrics, gynaecology, ophthalmology, paediatrics, ENT, orthopaedics and community medicine.

1987: Society is renamed as CSI Arogyavaram Medical Centre with new Constitutional Byelaws with the majority of members from CSI Rayalaseema Diocese.

1990: Dr B Wesley was appointed as the Director and Mrs Sheela Wesley as the Nursing Superintendent.

1992: Platinum Jubilee was celebrated.

1995: Started Diploma in Radiography Course.

1998: AMC hosted General SYNOD of the Church of South India.

1998: The Then Governor of Andhra Pradesh Dr Rangarajan visited AMC and appreciated the work here.

1999: School of Nursing was started.

2000: Hosted National Conference of Student Nurses Association / Trained Nurses Association of India.

2000: Arogyavaram Medical Centre started a Care and Support Centre with 10 beds to provide wholistic care for the HIV /AIDS patients. Free Medical Care, Food, Counseling and Rehabilitation facilities are provided to the patients.

2002: Government of Andhra Pradesh has issued the essentiality certificate to start a Medical College at Arogyavaram Medical Centre. The construction work is over and we are waiting for

the Final Approval from the Medical Council of India. Out of 100 seats allotted by the government, 70 seats (70%) are reserved for women candidates.

2006: College of Nursing was started in this year with the permission of the Indian Nursing Council and the NTR University of Health Sciences. Every year, 50 students are admitted into B.Sc. Nursing Course.

2008: Care and Support Centre which was started in the year 2002, is renamed and started as Community Care Centre in April 2008 with an increased bed capacity of 20

2011: CT Scan and Digital X-Ray Units are installed and inaugurated on 19th July 2011.

2011: Centenary Main Gate is opened on 19th July 2011 as the Institution celebrated 99 years of Healing Ministry.

2012: Post Certificate B.Sc.(N) Course is started.

2012: 100 years of Healing Ministry was celebrated

2012: Research Program in Tuberculosis started in partnership with Cornell University – USA

2014: BCG Revaccination Studies started in Partnership with Indian Institute of Science, Bangalore – Department of Bio-technology. (Government of India)

Dr B Wesley is the Director of
CSI Arogyavaram Medical Centre, Arogyavaram

FUNDAMENTALISM, TOLERANCE AND BIGOTRY

In the parable of the Good Samaritan, Jesus portrays the Samaritan in a positive light (Luke 10: 25-37). The parable suggests that Jesus was able to see the good in people from diverse backgrounds, and even among those whom the Jews generally despised. Jesus' unconditional love and acceptance of Zacchaeus, a tax collector, is another example of Jesus' tolerance (Luke 19:1-10). Tax collectors were despised, as they worked for the Roman government and were generally considered corrupt.

Religious revival is often seen across many religions, cultures and countries. Nevertheless, such resurgence of religious thought is often different from earlier tolerant approaches to life and seems to espouse more fundamentalist interpretations of sacred texts. These trends raise many disturbing questions and demand introspection.

Are these new approaches truly fundamentalist in the best sense of the term? Do we, who hold such faith, truly believe in the superiority of our positions? Or are we threatened by other readings, which argue for liberal or different interpretations of life? Do such positions reflect our own insecurity and feelings of inferiority? Do they cover up our secret fears about our own lack of faith? Do we fear that we might ourselves succumb to materialistic world views or non-literal interpretation of sacred texts? Do we secretly envy other people's lifestyles? If we truly believe that we have found the Truth, should we then judge and condemn others who do not share our inclinations?

True faith demands a quiet confidence in one's belief system. It mandates an absence of resentment of alternative lifestyles. Self-assured world views should be associated with tolerance to different or variant ways of life.

Points for reflection

Are we intolerant of people who hold different beliefs?

Do beliefs, which are variations from our own, threaten our faith?

How can we increase our tolerance towards people who hold different beliefs?

Very often religious teachings, which exhort us to live ethical lives, become frozen in dogma and orthodoxy. We need to address everyday issues based on ethical principles we hold. This reflection is part of a series, which attempts to discuss such issues that focus on ethical living. Contributed by K S Jacob, Professor of Psychiatry, Christian Medical College, Vellore, Tamil Nadu 632002 India. Email: ksjacob@cmcvellore.ac.in

Does God Need Our Help? Cloning, Assisted Suicide and Other Challenges in Bioethics

By John F Kilner and C Ben Mitchell
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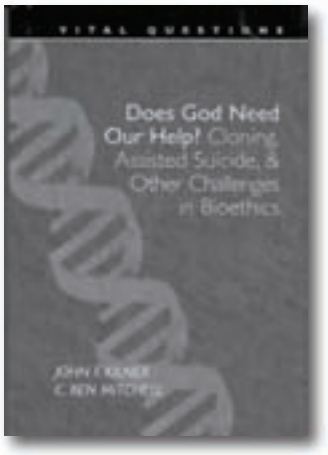

The idea of Bioethics is a very nebulous one with multiple thoughts from different persons on any given topic or situation. Every discussion on ethics raises many questions. The Vital Questions series is a project of The Centre for Bioethics and Human Dignity situated in Chicago, Illinois. According to the General Editor, Daniel Taylor, the goal of this book is to provide a substantial, accessible discussion of issues about which Christians need to know more. The series is intended to prepare a Christian mind for more faithful living.

Ethics is basically defined as moral principles that govern a person's behaviour or the conducting of an activity. Principles of ethics have guidelines for good behaviour by distinguishing between virtues and vices. Values and ethics are closely related. Without values, ethics have no base to stand on. There are various fields of ethics like business ethics and bioethics etc. Being in the healthcare field, bioethics is of great relevance to us.

"Bioethics helps us identify and evaluate the various ways that people think we ought to provide health care and use biotechnology." This is the premise of this book.

As Christian healthcare professionals, this book gives us important insights into the Christian perspective on Bioethics. It helps us to critically evaluate the ways we justify our actions and also gives biblical based guidance as to how we ought to live. It reminds us that though each one of us is different and raised in different environments there are certain core ethical guides that all who profess to be Christians must live by.

The subtitle in this book which gripped my attention was the call or maybe even the cry for a God -Centered Bioethics. Human – centered bioethics is dependent solely on human reasoning with given facts and logical consequences. But this at its heart is flawed, simply because humans are imperfect, sinful and flawed. Human standards by means of reasoning cannot replace the standards of God or His ways. As Romans 8:7 says "The sinful mind is hostile to God. It does not submit to God's law, nor can it do so."

So a biblical bioethics challenges us to recognise that we cannot live as we ought unless we are willing to look to God to provide a standard for our character and direction for our thinking. The three most central characteristics of this approach is that it is God- centered, reality bounded and love impelled. Reality bounded because we enjoy the freedom of choice that God has given us keeping in mind the fences of protection within which we can enjoy this freedom. The focus here must be on the freedom and not on the subscribed fence.

Love impelled because that is His commandment to us. 1 Corinthians says in 14:1 and 12:31 that we are to "follow the way of love", for it is "the most excellent way." In ethical terms, love impelled ethics seeks human wellbeing by doing of a deliberate action and not just expressing of a feeling. As those engaged in providing healthcare, this love must be expressed in the way we deal with those coming to us for care and comfort.

Keeping the foundation of all decision making firmly entrenched in these 3 central characteristics, the book goes on to discuss burning issues like cloning, surrogacy, assisted suicide, stem cell research etc. It warns that making decisions without this foundation can lead to consequences of great proportions. Resources are becoming scarce and society is becoming increasingly preoccupied with whatever promises the biggest benefits. This will lead to the most undesirable consequence of being unable to look at patients as persons. Advancement in technology will give birth to various options that will only lead to more bewilderment.

But, having described this inevitable scenario, the book ends on a note of hope. "If medicine and biotechnology can be shepherded in directions that protect and promote human dignity, the future may be bright." This is in line with the first and greatest commandment –to love the Lord with all our hearts, minds and strength- because then we will put our best efforts into our work to bring Him the glory. The second commandment - to love our neighbors as ourselves – calls on us to use our skills and biotechnology for human healing for the good of the patient.

Dr Priya John
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3rd Announcement

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