CHRISTIAN MEDICAL JOURNAL OF INDIA

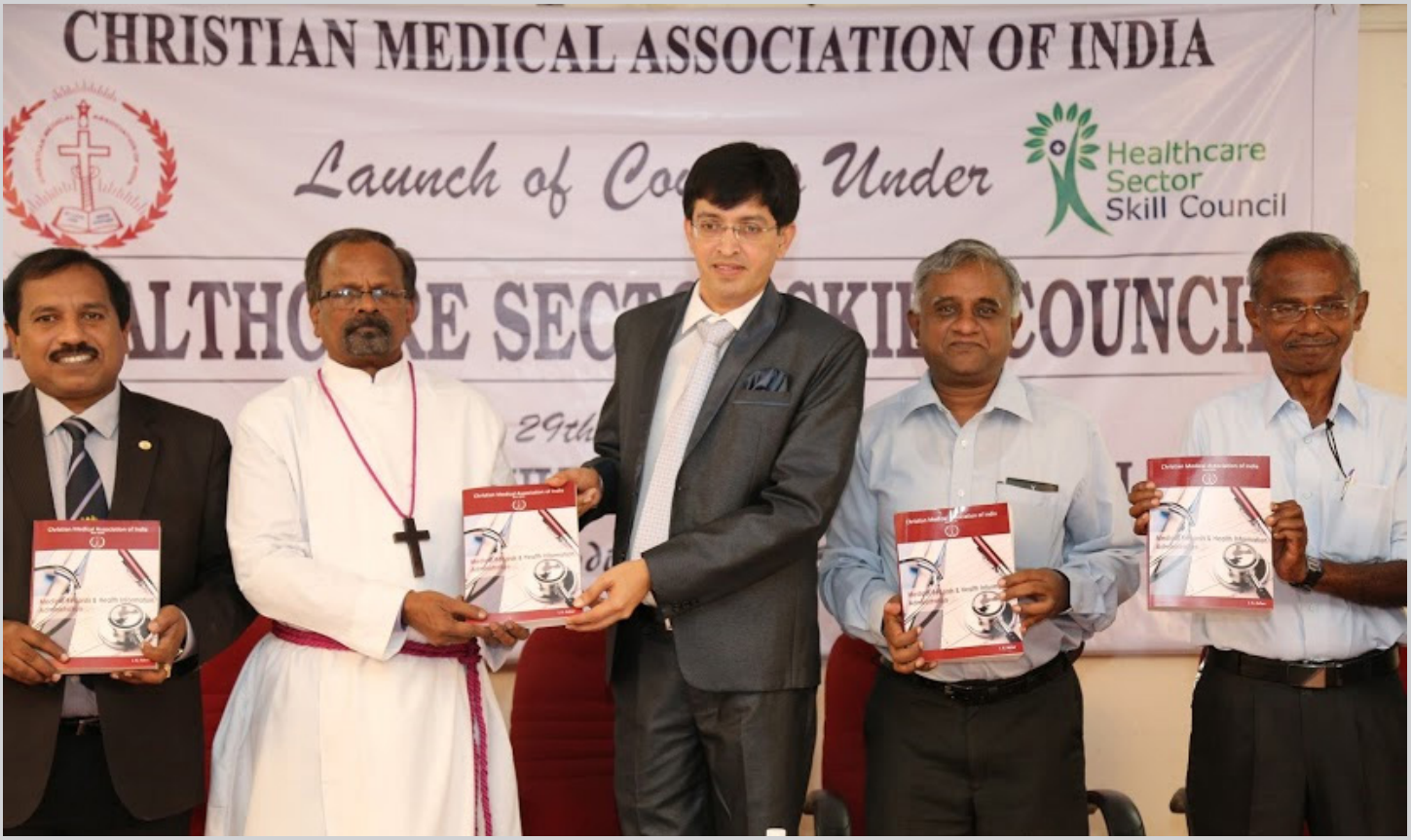
CMJI

A Quarterly Journal of the Christian Medical Association of India

VOLUME 31 NUMBER 3 : JULY - SEPTEMBER 2016

Mission & Transformation

CMAI - HSSC
Short Term Training Programme



The Healthcare Sector Skill Council (HSSC) is a Not-for-Profit Organization, registered under the Societies Registration Act, 1860. The Council has been promoted by the Confederation of Indian Industry (CII), National Skills Development Corporation (NSDC) and Healthcare Industry, under Quality Council of India. The key objective of the Council is to create a robust and vibrant eco-system for quality vocational education and skill development, and employments in Allied Healthcare Sector in the country. In addition, the Healthcare Sector Skill Council aims to serve as a source of information on healthcare sector with specific reference to Skill and Human Resource Development in India. The council has proposed to bring-in a major change in the recruitment pattern so as to give preference to HSSC certified trainees / workforce.

Christian Medical Association of India has signed a MoU with HSSC to be their training providers and promoters through their vast network across the country. In our maiden effort, 10 of the CMAI training centres have received HSSC's affiliation to provide training in 4 short term courses, namely (1) General Duty Assistant, (2) Medical Laboratory Technician, (3) Diabetic Educator, and (4) Vision Technician.

Now, Government of India has approved a sum of Rs.10,000 for all successful HSSC candidates as ex-gratia from the Prime Minister's PMKV fund. The Gulf Cooperation Council [KSA, Oman, Bahrain, Qatar, and UAE] has recently approved HSSC Qualifications for employment. This has opened a way for our HSSC certificate holders to get employed in GCC member countries.

The opportunity of conducting these CMAI training course is open to all institutions that fulfil the requirements designed by the Academic Committee under AHP section of CMAI and Healthcare Sector Skill Council (HSSC), subject to the condition that they are organizations committed to human resource development in the healthcare sector. These institutions are expected to abide by the rules and regulations of the CMAI/ HSSC who will then consider the recognition of training centres on receipt of a written request in the prescribed form from the centre.

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Mission and Transformation

LETTERS / ARTICLES FOR CMJI

We invite your views and opinions to make the CMJI interactive and vibrant. As you go through this and each issue of CMJI, we would like to know what comes to your mind. Is it provoking your thoughts? Please share your thoughts with us. This may help someone else in the network and would definitely guide us in the Editorial team. E-mail your responses to: **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 in a CD by post. Authors may please mention the source of all references: for e.g. in case of journals: Binswanger, Hans and Shaidur Khandker (1995), 'The Impact of Formal Finance on the Rural Economy in India', Journal of Development Studies, 32(2), December. pp 234-62 and in case of Books; Rutherford, Stuart (1997): 'Informal Financial Services in Dhaka's Slums' Jeoffrey Wood and Ifftah Sharif (eds), Who Needs Credit? Poverty and Finance in Bangladesh, Dhaka University Press, Dhaka.
- Articles submitted to CMAI should not have been simultaneously submitted to any other newspaper, journal or website for publication.
- Every effort is taken to process received articles at the earliest and these may be included in an issue where they are relevant.
- Articles accepted for publication can take up to six to eight months from the date of acceptance to appear in the CMJI. However, every effort is made to ensure early publication.
- The decision of the Editor is final and binding.

LETTERS

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

GENERAL GUIDELINES

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

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EDITORIAL

TRANSFORMING MISSION

Dr Nitin Theodore Joseph

With its origin in the Latin word *mitto* which means 'to send', the word 'missions' has been traditionally used to signify the sending of believers to harvest all souls for Christ. The Great Commission of Jesus at the end of His earthly ministry, "Go… make disciples of all nations and baptize them…" is the basis of missions. Interestingly Jesus spoke of missions even at the beginning of His ministry, "The harvest is plentiful, but the labourers are few; therefore pray earnestly to the Lord of the harvest to send out labourers into His harvest" (Matt.9:37, 38). We also read in Luke 9:1, 2 that Jesus, after empowering His disciples sent them out "to proclaim the kingdom of God and to heal." Missions, therefore is at the very core of our faith. Sadly we seem to have lost our focus on missions and the word 'missions' has been increasingly used by people of other faiths.

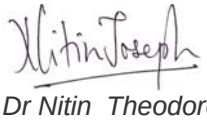
Likewise 'transformation' too is a loaded word with strong roots in the Bible. In Rom.12:1, 2 Paul writes that we are to present our bodies as holy and acceptable living sacrifices to God. We can do this only if we do not conform to the world but instead we are "transformed by the renewal of our mind". The word 'transform' comes from the Greek *metamorphoo*, from which we also get the word 'metamorphoses', denoting a complete change of condition and form. Just as an aquatic tadpole completely changes to an amphibian frog and the both have no resemblance to each other whatsoever; we too are expected to exhibit complete transformation in our attitudes, perspectives and dealings when we commit ourselves to the work of Jesus.

In CMAI this year, was one of our sectional conferences. I am sure all those who participated in these conferences were enriched and blessed. For the first time, CMAI jointly hosted the South Asian Congress of the International Christian Medical & Dental Association at Kolkata along with the Evangelical Medical Fellowship of India. The theme was 'For such a time as this' from Esther 4:14. This is a run up to the ICMDA World Congress at Hyderabad in 2018. CMAI also partnered in the Joint Conference of the Nepal Christian Medical & Dental Association and the Healthcare Christian Fellowship International at Lalgadh in Nepal.

As you go through the pages of this issue may you find time to introspect in your own lives and reflect on your commitment to missions. Isaiah had a majestic vision of heavenly worship which he records so well in Isaiah 6. He then hears the voice of the Lord, "Whom shall I send, and who will go for Us?" The immediacy of Isaiah's response is so fascinating, "Here I am! Send me". Louie Giglio in the classic, *Finish the Mission* asks 3 questions:

1. Have you seen this God?
2. Have you ever felt that desperate and been touched by that grace?
3. Did you hear God when He said, "Whom shall I send?"

He further says that, "you can't be near the cross and not hear God say that." What is your response?



Dr Nitin Theodore Joseph

TRANSFORMING COMMUNITIES

K John Amalraj

The recent history of missions and church growth in India highlights several success stories of mass movements of people deciding to follow Christ. This is noteworthy as cross-cultural Indian mission workers from several parts of the country, built on the foundations of the western mission work reached the remotest parts of our country. Indian mission workers have pioneered into remote villages to serve the needy while the government officials are yet to find 'pucca' roads for politicians to drive-in to mobilize votes.

In the last few years, India has witnessed the most remarkable economic change that is beginning to redefine the image of India. We need to visit the hundreds of towns present across India that are becoming nerve centres of urban transformation of a pre-dominantly rural country. The Indian missions and churches cannot remain a mute spectator to these changes but have to come to the forefront and be involved in the wholistic transformation of India.

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The word 'transformation' has been used extensively in the Christian circles and often it has been reduced to one aspect of change – which is either spiritual or physical. We do not often talk about whole person transformation – which comes through an encounter with Jesus Christ.

"The Queen's attention had first been directed to the plight of Indian women by a visit she had received in 1881 from Miss Elizabeth Beilby, a young, rather headstrong medical missionary home on leave from the Church of England mission at Lucknow in northern India. Miss Beilby had been attending the wife of the Maharajah of the small princely state of Punna, and had been entrusted by the Maharani with a message to be delivered in a locket directly into the Queen's hands. The message was a plea for help. The rules of seclusion which bound both Hindu and Muslim women meant that they were forbidden to see any men other than close relatives, and this applied to medical men as well. Since virtually all doctors, Indian or European, were male, this meant that large numbers of middle- and upper-class Indian women were effectively cut off from medical help. The situation was particularly acute with regard to childbirth, from which men were rigorously excluded and which was generally conducted by a low-caste ritual birth attendant known as a dai. Dais had no formal training, and while they were usually capable of handling normal births, they could not avert appalling suffering when deliveries developed complications. The result was a terribly high rate of mortality among both women and children. The Queen was shocked by what Miss Beilby told her, and determined that something should be done. …"

There was not just a need for health care but also for social transformation so that the seclusion of women can be removed. This leads to the transformation of the society. Physical needs, natural disasters and human misery will continue to generate opportunities for engaging with communities. It is when such needs exist that people are also drawn to other needs.

Christian service has gained acceptance in the country and has been praised by many. However, the false propaganda of the communal forces is creating a public opinion, wherein people have begun to suspect our motives for social work. We have to admit the fact that whether we have the motive to convert or not, our good works positively influences the benefactors and results in conversion. We have no need to be ashamed of this.

Khushwant Singh writes, “Christians won converts largely from the poor and the deprived sections of our society which after centuries of neglect and disdain found people who are willing to care for them. It was gratitude rather than force of inducement that made them opt for Christianity”. Even though it was gratitude that added to our numbers, the role of the Holy Spirit in conversion cannot be ruled out. If only gratitude has made people opt for conversion, then why are the numbers that benefited through our institutions much more than the actual numbers that have added to our community? There are always the ‘nine out of ten’ who receive the benefit but forget to show gratitude to the giver. Therefore, those who are converted are those who are touched and transformed by the Holy Spirit. Transformation is the work of the Holy Spirit and not of any human effort.

They had all things in common, met the needs of all individuals. There were no institutions, but a community of believers that reached out to the needs of the community. This community life is still a high ideal for us.

Yet, in the present context, we need to ask the pertinent question. How much of our present work really transforms our nation? Is it not true that at times our work deals with the symptoms of the disease alone? Have we fallen into the trap of institutionalizing our acts of compassion? The vision of transformation seems to be lost. Most of our schools, colleges, hospitals, orphanages and rehabilitation centers have become employment opportunities. We have missed out the role of the Holy Spirit in our institutionalised service to the community.

Bishop Leslie Newbigin, writes that “the Spirit is not the domesticated auxiliary of the Church, he is the powerful advocate who goes before the Church to bring the world under conviction.” We need to allow the Holy Spirit to go before us and bring our society under conviction before we can see any transformation. Community work in itself cannot transform our society unless through the power of Holy Spirit a transformed community life within our Churches facilitates the ministry of the Holy Spirit to our nation.

The book of Acts records the life of the early Christian community that was transformed and was transforming others. Due to persecution, the scattered believers spread over the Roman Empire preaching the word. Soon there was a revival in different areas, activating the apostles who had remained in

Someone said that if only Christians lived like Christ, Indians would have long ago accepted Christ. We have done so much for others in the name of social service but failed to build a model community life inside our Churches.

Jerusalem. They sent out representatives to find out more and strengthen the new believers. (Acts 8: 4). The secret of the success of these scattered believers was the extraordinary community life they had learnt to live in Jerusalem. They had all things in common, met the needs of all individuals. There were no institutions, but a community of believers that reached out to the needs of the community. This community life is still a high ideal for us. It is these small communities that began to attract others, wherever they were scattered. An unbelieving Greek writer Lucian living in the second century (AD 120-200) wrote, "It is incredible to see the fervour with which the people of that religion help each other in their wants. They spare nothing. Their first legislator (Jesus) has put it into their heads that they are brethren." Tertullian, one of the early Church fathers, during the same period writes, "It is our care for the helpless, our practice of loving kindness that brands us in the eyes of many of our opponents". What a beautiful description of the transformed Christian community! The Church was a transformed community that attracted the outsiders and onlookers. Someone said that if only Christians lived like Christ, Indians would have long ago accepted Christ. We have done so much for others in the name of social service but failed to build a model community life inside our Churches. More than all our institutions, a transformed community could have reached out more effectively.

Transformation of a nation does not take place only by forming worship groups or discipling individuals to follow Jesus Christ. There are several areas of influence in a society and Christians must be actively involved in each area. We need to envision transformation in the market places and work places. We need to make the workplace our prayer altars where Christian professionals serve as priests for our co-workers interceding for their needs. It is the workplace that needs to become our pulpits to share the reason for our faith. Most of the 'lost' people are not far away, they are within our workplaces and in the marketplaces. There are more ministry opportunities in the workplace than inside church buildings.

Proclamation of the transforming good news has been left to professionals for too long. Proclamation has also been divorced unlawfully from the practice of our faith

expressed through community service. Proclamation is the duty of every believer in the Church. Proclamation and practice should once again join. Proclamation includes the practice of our faith. The practice of our faith includes proclamation. We need to involve every believer in this task. We need to transform devotees in our churches into disciples of Jesus Christ. They need to learn to live a transformed community life that can reach out to the needs of those around them everyday. This will bring into focus the role of the Holy Spirit in our personal life and in our ministry.

Repeated natural disasters in our land, not only give us opportunities to serve our nation, but also remind us of our calling and duty to intercede for our land. God calls every one of His people to humble themselves, pray and seek His face, and turn from wicked ways, so that he may hear our prayer, forgive our sins and heal our land. (2 Chronicles 6&7) Sins need to be dealt both in our lives and in the lives of our society. We need the ministry of the Holy Spirit to expose our guilt and help us to confess our sins. We need to allow the Holy Spirit to minister through us to our societies. We need to be transformed, so that our nation can be transformed. We need to be forgiven, so that our nation can be forgiven. We need to be healed, so that our land can be healed. This transformation is the work of the Holy Spirit. This must start with me so that I can reach out to the needs around me and transform my society.

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REFERENCE:

https://www.questia.com/magazine/1G1-135841113/saving-india-through-its-women-sean-lang-tells-of

TRAINING COMMUNITIES FOR TRANSFORMATION

In Jehanabad, Bihar a non-formal school for Mussahar children (a Maha-Dalit community) is thriving where children – who otherwise did not have the opportunity nor the means to study are learning every day through the initiative of the local church who worked alongside the community to bring in awareness and change. What is the role of training in this and how does the start of a non-formal school for marginalised children link with training programmes?

Ms Lalbiakhlui Rokhum

Mr Achhe Lal Yadav

The Evangelical Fellowship of India Commission on Relief (EFICOR) began its journey in building and equipping individuals, organisation and church groups in 1979 when the EFICOR Training Unit was started. The vision was to provide strong faith foundations for involvement in social concern ministries and to equip trainees with sound development knowledge and skills and also to research and influence thinking on issues that affect the poor and marginalised. EFICOR defines training as "A process by which we intervene to change people's lives towards involvement in Kingdom concerns".

The Training process has evolved over the years based on the need and the changing development scenario. At one stage training was given so that organisations and individuals could effectively 'do' or implement development projects and programmes in communities. This has changed into equipping churches and individuals to be 'change agents' or 'catalysts for change' in the communities where they live and work. One of the key foci is now on building and equipping the local church to respond and to bring transformation within the communities where they are.

In training communities towards a change, one of the

new initiatives that EFICOR has started is the "Parivartan Model" – a model of teaching, based on the UMOJA module (initiated by Tearfund UK). In the Parivartan Model the whole chain of transformation starts by envisioning and mobilising the local church to be the catalyst for change. EFICOR works with church leaders and one key person called the 'Training Facilitator', whose capacities are built so that they can work within their own church to understand the reason for being involved in the community from a faith perspective. Churches are encouraged to have regular studies to understand the reason for getting involved. This also generates the energy, the motivation and the passion to bring transformation in the community.

The Training Facilitators from the churches are given training at regular intervals on different issues like Creation Care, HIV and AIDS, Right To Information and Government Schemes, Domestic Violence, Anti-Human Trafficking etc. They then pass on this learning to their church members who can then have a deeper understanding of the needs within their community and equip them with knowledge of how the issues can be confronted. Often, awareness simply leads to knowledge of a problem which quickly fades away when we turn a blind eye to it – but the purpose of building capacities is to enable action and to have passion to address the issues.

Building capacity for action can have the danger of a group of people thinking that they have the answer to all problems and going in as "Saviours" or "heroes" to set right a problem thus creating a situation where those who 'receive' remain indebted and dependent on the 'helpers'. As EFICOR trains churches, through the Parivartan Model, to work in their specific community, focus is also given on training them to build and/or strengthen relationships with the local community, meet with community leaders and decide with them on what action must be taken in the community. Thus it becomes not a 'church initiative' but an initiative that is taken by the community. Local art forms like street skits, games, and stories are used to make the community think about their problems and how they will address them by using their own local resources. Once the local church and community gets a clear vision of working together, they start planning on working on the issues. The focus is also on addressing the issues using local resources – either raising funds from within the community or accessing provisions from the government. Together as a united community the work begins to bring in transformation.

Regular meetings of the leaders are encouraged to plan, prioritise and start new initiatives. EFICOR monitors, mentors and continues the process of building the capacity

of the leaders so that the process of transformation does not stop at one initiative. EFICOR also builds the capacity of the church and community leaders on various social issues and trains them to facilitate similar training in their region. It also provides exposure for cross learning and replication of the new learning and good community practices.

As a result of the initiative to build the capacity of the church and community leaders many communities have seen transformation happening in their communities. 11 communities started non-formal schools in Delhi, Palamu, Rajpura, Lucknow and Jehanabad, all with their own resources. In each centre the average number is 30. Every day the children learn alphabets, numbers, tables as well as moral education. There is gradual improvement in the children's lives. The children are also being assisted to enrol in the local government primary schools.

The communities also work on improving the infrastructure of their villages by accessing government schemes - in 2 communities the members applied for a concrete road to be constructed and a 500 meter road was sanctioned in one village and in another Rs. 30,00,000 was sanctioned by the government and the road is under construction. Even the improvement of the livelihood and income of the community has been seen – in a village, the church and community leaders assisted 45 women to avail a loan to start a small micro-enterprise. 18 community members were sent for nursing training of which 15 completed successfully and 2 are working in a hospital earning Rs 5000-7000 per month. In Palamu region of Jharkhand the community worked together to install a hand pump ensuring safe drinking water for that village and even contributed money for the repair and maintenance of the same.

From mobilising and building the capacity of individuals to building the capacity of a whole church and community – training can change lives. While it is possible that implementing a multi-million dollar project can bring in transformation; equipping and training communities can also bring transformation. The Mussahar children in Jehanabad can now dream of a future and will now have the opportunity of going to a regular school – all because a church and a group of community leaders were trained to identify the need and were equipped to address that need.

Ms Lalbiakhlui (Kuki) Rokhum,
Director – Training and Mobilisation, EFICOR &
Mr Achhe Lal Yadav, Co-ordinator – Church Relations, EFICOR

TRANSFORMING CHURCHES TOWARDS INCLUSIVENESS

But Jesus said to him, "A man once gave a great banquet, and invited many; and at the time for the banquet he sent his servant to say to those who had been invited, 'Come; for all is now ready.' But they all alike began to make excuses. The first said to him, 'I have bought a field, and I must go out and see it; I pray you, have me excused.' And another said, 'I have bought five yoke of oxen, and I go to examine them; I pray you, have me excused.' And another said, 'I have married a wife, and therefore I cannot come.' So the servant came and reported this to his master. Then the householder in anger said to his servant, 'Go out quickly to the streets and lanes of the city, and bring in the poor and maimed and blind and lame.' And the servant said, 'Sir, what you commanded has been done, and still there is room.' And the master said to the servant, 'Go out to the highways and hedges, and compel people to come in, that my house may be filled. For I tell you, none of those men who were invited shall taste my banquet.'" Luke 14: 16 - 24

Fr Thomas Ninan

It is not by accident that Christ narrates this parable, but rather with due intention. Exclusivity was a reality during His time among the Jewish communities, among His followers, particularly His disciples and so it is during our times, both within and outside the Church. This parable intentionally points towards inclusivity, particularly in the form of the householder welcoming those, who were not part of his initial list of guests invited for the banquet. The poor, the maimed, the blind, the lame and those in the highways and hedges, they all found space at the great banquet of the Master. Particularly noteworthy are those in the highways and hedges, who have to be compelled to come to the banquet. These are people who are forsaken by the dominant communities, who out of necessity are in the highways to make a living, because they found no room, no space, no hope among the dominant. They are a people who have given up hope to be part of the dominant, hence the reason for them to be compelled to come to the banquet of the Master. It is not because the invited guests did not come that the Master makes extra efforts to invite those from the streets, rather it is in the nature and plan of the Master to have both sit at His banquet table and share. There is no doubt in the mind of the Master to find space for those from the streets around His banquet table, in fact they are those guests with whom He doesn't have to try too hard to come for the banquet as He knows them well. The 'invited' seem to be a cause of concern for the Master because of their other commitments, they are not a priority over the others. The compelling of those on the streets to come for the banquet is more because of their hesitancy to come for a banquet amidst prevalent attitudes of the dominant towards those on the streets. The Master is clear in His mind about such situations; there is no room for such attitudes in His house. This parable implies that our journey of realisation of being inclusive starts from today. When our Master is inclusive in nature, how can we, the followers be of a different nature?

NCCI Quadrennial theme

The National Council of Churches in India (NCCI) has chosen the theme "Towards Just and Inclusive Communities" for the next quadrennium (2016 – 2020).

Olga, a transgender from Chennai, sharing at the workshop in Arcot Lutheran Church, Tirukoilur

At the Quadrennial Assembly of the NCCI in April 2016 at Jabalpur, BP Thiagarajah in his devotional series on "Solidarity and healing in fractured and conflicted societies" called upon a renewed purpose towards doing theology.

I believe that because theology is our shared work, part of our responsibility is to listen to our neighbour's story. Remember they are sharing how God is speaking to them. You honour their testimony by giving them your attention and your non-judgmental acceptance of the truth they disclose.[1]

This laid emphasis on the fundamental aspect of an inclusive church, where God's voice and presence is appreciated through journeying together with our neighbour, who in many ways is different and distinct. Besides recognising the need for inclusivity towards sexual minorities, the theme compels us to engage with other crucial issues as well, such as injustices and exclusivity in the context of caste and ethnic bigotry, patriarchy, globalisation, fascism, the disabled, the migrants, asylum seekers, ethnic and religious minorities, the elderly, the children, the people living with HIV and AIDS etc. Here, we focus upon the issues related to sexual minorities, namely the LGBTI communities.

Inclusivity related to Human Sexuality and Gender identities - ESHA Experience

At ESHA (formerly Ecumenical Solidarity for HIV and AIDS), we have come a long way since formulating the NCCI Policy guideline on HIV and AIDS for the churches in 2008. Today we are in Phase V of the Project, where we are specifically looking at engaging the churches and theological institutions (particularly the Senate of Serampore affiliated) to make them inclusive with regard to gender and sexual minorities. Year 1 of this phase, our work with five churches (the Salvation Army, Western Territory; the Church of South India, Coimbatore Diocese, the Church of North India, Amritsar Diocese; the Arcot Lutheran Church and the Kerala Council of Churches) and eight theological colleges, has given us much learning about our diverse context and about possibilities ahead. Amidst much apprehensions and stigma, we had encouraging moments of life-sharing and worthwhile discussions on scriptures. We learnt that, because of the way we have engaged with scriptures through all these years, which often were blind and insensitive to realities of pain and suffering, there are communities

Maya, a transgender from Kochi, sharing at the workshop for Kerala Council of Churches at a CSI church in Kochi.

Daniel, an Intersex from Mumbai, sharing at a workshop with Kerala Council of Churches at the Orthodox Theological Seminary, Kottayam

that are left out at the margins, wanting for dignity and basic necessities of life. We found serious gaps in the biblical understanding of sex and gender which often did not take into consideration the evolving medical and biological understanding of human sexuality. The literal understanding of the Bible has often led the churches into having judgemental attitudes towards the sexual minorities, who unfortunately are struggling with their biological realities since their birth. These voices from the gender minorities gives a glimpse of their harsh realities- most of them on the streets begging or into sex work in order to just make a living...

"I feel like I am a rat in a cage, wanting to free myself from this lifelong imprisonment."

"Every day is a struggle for me, starting my day with condemnation, ridicules, abuses....till the time I walk into my room. Even at home, I have no one who can understand me."

"If you think and believe that you are made by God, what makes you think we are created by someone else? I am born out of the womb of the same mother you are born from as well. Who gave you the right to decide what my gender and my sexual preference should be?"[2]

When medicine and scientific technology are still evolving in their understanding of the human body, how can we claim that our understanding of the Bible is superfluous and without change? A careful discernment of the way we understand scriptures, based on the right understanding of the biblical context, and a wholesome theological application of the text, to the realities that surround us, is a feasible way ahead while engaging with issues related to gender diversities and sexuality. Our journey in this regard, has to necessarily start from the context around us, rather than from the text. A holistic, life – affirming approach and understanding of the bible will help us take meaningful steps ahead in becoming a blessing to our neighbour on the streets.

Our experiences so far have been nothing short of overwhelming. Those from the sexual minorities, who accompanied us to share in churches and theological colleges, for the first time in their life felt welcomed and listened to. Many misconceptions and apprehensions regarding them were overcome through their real life sharing and discussions. There were tearful responses in many places when they listened to their painful stories. The pictures show a glimpse of such workshops we have had.

Conclusion

Churches as the "salt of the Earth" and as the "royal Priesthood", continues to evoke a unique identity of being accessible to the whole Creation and humanity in particular. Exclusivity in this context is rather a contrasting identity, which would come as stumbling blocks in fulfilling the churches' actual function. The flags of exclusivism are more rampant today within the churches and outside, as if it were a much decorated aspect of faith, all in the name and defense of faith and tradition. The voiceless, the marginalized, the stigmatized, the poor and the others in need, continue to knock our door, actively and passively, for an answer, both inside the church and on the streets. It is in this context that we need to consider being inclusive, as individuals, as families, as a community and as a Church, to uphold and celebrate life, wholeness and dignity.

Note: We welcome your feedback. Do write to us at NCCI – ESHA, frthomas.ninan@gmail.com .

Fr Thomas Ninan
Associate General Coordinator
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1. Rt Rev Daniel Thiagarajah, "Solidarity and healing in fractured and conflicted communities" in *the National Council of Churches Review* , Vol. CXXXVI, No. 6, July 2016, p14.

2. Translated from the sharing of representatives of the LGBTI communities during the ESHA workshops with churches and theological colleges during July – September 2016.

FROM OUR ARCHIVES

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

Vol. XVI No. 3 - MAY 1941

1941

THE MISSIONARY TRAINING OF MEDICAL MISSIONARIES

Missionary training, while emphasizing this contribution of service, should also show how to apply the teaching of Christ on this aspect of Christian living. While we work we ought to be able to explain the Christian message in the act. In teaching medical students we should constantly explain the Christian ideal that lies behind and is a reason for all medical service. At the hygiene talk in the village we should not teach health measures simply from the point of view of the health and benefit of the individual, but demonstrate the Christian ideal of helping the community, the family and the new generation. In infant welfare clinics, while we instruct the mothers in healthier ways of feeding and caring for children, we must also point to the Christian ideals of home life, the Christian parents' responsibility for their children's spiritual development as well as their physical health. In the men's social welfare clubs we must translate the team spirit and fair play, the Red Cross training and so on into terms of Christian service to the community. This practical application and teaching of Christian ideals in the ordinary course of our work is easier for us practical minded medicals than conducting set Bible classes and evangelistic services. We are at our best in action, working while we talk.

Welfare work, which is a comparatively new branch of medical service, has a valuable contribution to make to the Christian community. Missions have in it a magnificent new instrument for building up Christian family life, which is apt to be a weak side of the Church's life. It includes contact with the young parents' group, training of Christian midwives, care of the young mother before, during and after the birth of the child. The regular contact with the mother in the infant welfare clinic, over a long period, provides excellent opportunities for teaching Christian ideals in home life. Since the development of our welfare work amongst men as well as women I have become aware of a need for information and literature of an altogether new kind. Parents ask to be taught together, they ask for sex instruction to pass on to their children.

There is a demand for teaching on home economics, on the Christian attitude to debt and to saving, on the Christian ideal of the dignity of work, on the Christian attitude to politics, on the guidance and upbringing of children.

There is opportunity in these parents groups for both men and women medicals to make a contribution of great value in building up Christian family life. Again, in welfare work one learns something of the innumerable customs relating to birth, death, puberty and so forth, many of which are still retained by Christians and many of which, especially in matriarchal organizations, tend to weaken Christian family life. Of these customs the Church knows too little, but regarding them the medical missionary ought to be able to give opinions of value to the Church.

In the parents group the medical missionaries find it simple to impart sex instruction. Modern psychology has taught us that the sex instinct should be treated in exactly the same way as the other instincts, and that control, not repression, of all the instincts should be learned from the early years of life. But, to begin with, the young parents need teaching about the simple scientific facts of physiology and anatomy regarding sex and marriage. They must be helped to build up the Christian family ideal and to train the child in the home from its earliest years in the control of all the instincts and their sublimation through the Christian ideal.

FROM OUR ARCHIVES

The Journal of the Christian Medical Association of India

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1966

A TEACHING MISSION AT THE MEDICAL COLLEGE AND HOSPITAL, VELLORE

After long weeks of exacting planning and wide-flung preparation, the Teaching Mission to the Christian Medical College and Hospital, Vellore was about to begin. It was the evening of Sunday July 17th. …

The opening service was conducted by Rev. Sanjeevi Savarirayan, General Superintendent, CMC Hospital, then the Bishop got up to speak and we experienced our first taste of his lucid and brilliant expositions. We were to sit at his feet for a week; it was going to be a big experience, which he himself compared not in aptly to a marathon race. On this first evening, the Bishop brought before us *Jesus*… the *name we preach,* 'Jesus not as a name from the past, but as "our great contemporary", leading the march as world history moved forward to its consummation.'…

Now and during the week, the Bishop drew a picture of the contemporary Christ against the enormously-swiftly changing conditions of our day. He said 'All this exhilaration of change is but the reflection of Jesus' urgent mission from His Father to set men free, to bring them to the adult maturity in which they can answer freely and intelligently the definite invitation to be the sons of God'.

To some of us it seemed symbolic of the week of Mission, when the Christian hope was put so newly, so clearly before us, that the menacing darkening clouds above our heads because suffused with the red gold -lights of the hidden sunset before we left the Auditorium.

In a great College and Hospital, work cannot slow down to accommodate, other activities even a special Mission, and the main addresses were given in the evenings, first at the College, then at the Hospital, four miles away. In between were very many and very varied opportunities for the Bishop and Missioners to meet Staff and Students in groups… Non-Christian took a good share in these sessions. Some personal talks, pursuing the same burning topics, went on far into the nights of the week.

Again and again our thoughts came back to the subject. 'Do we need to retain "Christian", in our College and Hospital title, and if so, what is its content?' The deepest point we reached in this discussion was that, though all good Hospitals many repair men's bodies, in Christ alone is there light on deeper issues of life and death, and we have also to witness and interpret at that level…

As might be expected, again and again during the week we were brought up against the problem of personal relationships – vital in any Christian Community, intricate and demanding in a great institution like the CMC Hospital, Vellore – Staff, Students, Seniors, Juniors, Missionaries, nationals – the endless interplay of relationships, where so many of us felt we had failed. At the staff retreat in taking the subject that 'If we walk in the light we have fellowship with one another', the Bishop said:

'It is out of deep inward acceptance of responsibility for one another that there can come a kind of life in which we learn to trust one another, and out of that trust for one another comes real fellowship – so that whether any colleague is opposing me of backing me up, I know that basically he is helping me to find God's way for myself and for the whole fellowship…

PREGNANCY AND MENTAL HEALTH MANAGEMENT

Severe mental health problems including bipolar disorder and psychosis occur during pregnancy or in the first year after giving birth compared to other phases in a woman's life. It may progress more quickly after giving birth.

Mrs Sheela V

Other less worrisome mental health problems may also turn into something grave and serious during pregnancy. Though this may not necessarily happen to you, everyone is different, with different triggers that may result in their illness.

Symptoms of Mental illness

Symptoms of mental illness during pregnancy are similar to symptoms that may occur otherwise. Some may be symptoms in pregnancy, for instance, anxious or negative thoughts about the pregnancy or the baby, changes in your weight and shape may be hard to accept, particularly if you have had an eating disorder.

Sometimes pregnancy-related-symptoms can be confused with symptoms of mental illness. For example, broken sleep and lack of energy are common in both pregnancy and depression.

Some find it more difficult to cope with the changes and uncertainties that pregnancy brings. For some women, it can be a very happy and exciting time. While others may have mixed, or negative feelings about being pregnant. However, most women worry about how they will cope with having a baby.

Common concerns in pregnancy

- Changes in your role (becoming a mother, stopping work)
- Changes in your relationships
- Whether you will be a good parent
- Fear that there will be problems in the pregnancy or the baby
- Fear of childbirth
- Lack of support and being alone
- Feeling down and anxious
- Baby blues
- Postpartum depression

What treatment is available for mental health problems during pregnancy?

The best treatment for you will depend on the type and severity of the illness you have experienced. Both medication and psychological therapies (talking treatments) can help.

It is very important that you do not stop the medication suddenly, unless suggested otherwise by your doctor. Stopping treatment suddenly can cause people to relapse quickly. It can cause side-effects and it may be best for you to continue medication during pregnancy.

Medication: It is important to discuss medication with your physician or psychiatrist. They will give you the information you need to help you decide what is best for you and your baby. You may decide to continue, change or stop your medication.

If possible, you should talk to your doctor before you become pregnant. However, many pregnancies are unplanned. It is very important that you do not stop the medication suddenly, unless suggested otherwise by your doctor. Stopping treatment suddenly can cause people to relapse quickly. It can cause side-effects and it may be best for you to continue medication during pregnancy.

Some medications have been used during pregnancy for many years and a few medications are known to cause problems in some babies. In many cases, there is not enough information to be absolutely sure that a treatment is safe.

If your illness is not treated, this may cause more harm to the baby than the effect of the medication. Untreated mental illness may cause a number of problems.

Psychological therapies: A talking treatment may be helpful for your mental health problem. This may, for some women be used instead of medication. Others may need a talking treatment as well as medication.

Some psychological therapies services will see you through more quickly if you are pregnant. Your doctor can advise you about referral in your local area.

What if I have had mental health problems in the past, but am well now?

You should be referred to a mental health service if you are pregnant and have ever had:

- serious mental illness, such as **schizophrenia, bipolar disorder,**
- schizoaffective disorder or severe depression postpartum psychosis or severe **postnatal depression**
- severe anxiety disorder such as O**bsessive Compulsive Disorder**
- an eating disorder such as anorexia/bulimia

Treatment:

What your Physician can do

Your doctor can help you think carefully about the advantages and disadvantages of choosing a particular medication. In order to make this decision, you will need to think about:

1. How unwell you were before pregnancy
2. How quickly you became unwell when you stopped medication
3. Medications you have taken in the past
   - What treatment has helped you the most?
   - Have some medicines that caused side effects?
   - Updated information about the safety of certain medications during pregnancy.
4. What might happen if you are unwell during pregnancy? This includes:
   - You may not take good care of yourself.
   - You may not attend appointments with your midwife. This means you may not get the care you need.
   - People who use drugs and alcohol may use more when unwell. This can be harmful for your unborn baby.
   - You may need a higher dose of medication if you become ill. Sometimes you may need two or more medications to treat a relapse. This might be more risky for your unborn baby than if you take a standard dose of medication throughout the pregnancy.
   - You may need in-patient treatment.
   - You may still be unwell when your baby is born
   - You may then find it more difficult to care for your baby. It may also affect your relationship with your baby.

If your illness is not treated, this may cause more harm to the baby than the effect of the medication. Untreated mental illness may cause a number of problems. Research studies have found that babies are more likely to have low birth weight if their mothers have had depression during pregnancy. Untreated mental illness can also affect a baby's development later on.

Look for the positive things in your life

Suggestions to improve your mental health

- look for the positive things in your life, however hard that may seem
- involve your partner or someone you're close to during your pregnancy
- make time to relax
- be open about your feelings
- ask for help with practical tasks like grocery shopping and household chores
- find out about local support groups (find mental health services around you)
- eat well (find out more about healthy diet in pregnancy)
- find time to have fun
- organize small treats every day, such as a workout or a coffee with friends (find out about exercise in pregnancy and keeping fit and healthy after the birth)
- Reduce your alcohol intake after delivery. You should stop drinking if possible or reduce to not more than 1-2 units, once or twice a week.Eat a healthy, balanced diet
- Stop smoking (ask your midwife or GP about 'stop smoking' services).
- Find some time each week to do something that you enjoy, improves your mood or helps you relax.
- Let family and friends help you with housework, shopping etc.
- Exercise (ask your midwife about exercise in pregnancy and local exercise classes).
- Discuss any worries you may have with your family, your midwife or GP.
- Get regular sleep.

Try to avoid

- doing too much – cut down on other commitments when you're pregnant or caring for a new baby
- getting involved in stressful situations
- drinking too much tea, coffee, alcohol or cola, which can stop you from sleeping well (find out more about alcohol, medicines and drugs)
- moving your house
- being too hard on yourself or your partner

To conclude, if you have had a severe mental illness, it is helpful to have a meeting to plan your care during pregnancy. Many other sources of help and support are available for pregnant women and new mothers. This will vary depending on where you live. Your midwife and health visitor should be able to tell you what is available in your area. A balanced approach is needed. Mental health professionals of both sexes should work to meet the challenge.

Sheela V, Lecturer
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THE 1ST AGNES HENDERSON ORATION

(Instituted By Mure Memorial Hospital, Nagpur)

On September 24th 2016, Mure Memorial Hospital celebrated the 151st Birth Anniversary of Dr Miss Agnes E Henderson. Dr Agnes E Henderson was born on 24 September 1865 to Sir William Henderson & Mrs Elizabeth Henderson in Aberdeen, Scotland. She was founder of Mure Memorial Hospital (MMH), Sitabuldi, Nagpur which is serving people of central India since 26 June 1896.

Dr Agnes came to India as a Medical Missionary in 1891 as per the wish of her mother. She spent 6 months in Mumbai to learn Marathi language so that she could communicate well with the local people and understand their problems.

She started a 1 bed clinic in Mahal area in Nagpur and later established 24 bedded maternity hospital in the current campus at Sitabuldi in 1896 as the patients load increased. She used to visit nearby villages of Nagpur on bullock cart and used to conduct her clinics with this cart. Along with maternity care in the hospital she continued to have community work in nearby villages and towns surrounding Nagpur, Vidharbha and even in the nearby state of Madhya Pradesh. As the hospital was constructed by the generous donation of the Mure family she named the hospital as ***"Mure Memorial Hospital".*** *She dedicated her life for the suffering people of India. She worked tirelesssly when Nagpur and surrounding area was affected by plague. Even though she worked so hard to establish MMH and did so much for the community and people of central India, her name is not well known among people. Her motto of service was to* ***"Serve in Love"*** *for the glory of God. She always kept herself at a very low profile, working selflessly for the people in need.*

On this occasion, an oration program was held at Hospital campus - "1st Dr Agnes Henderson Oration & Dr Agnes Henderson Memorial Award Conferment". The Theme of the oration was ***"Development of the Nation; holistic health of the people and challenges before our society".*** *Dr Mrs Kusum Masih who is working for more than 45 years in rural area of Chhattisgarh state as committed medical professional at grassroot level was invited to deliver the oration. Her story and sharing of experiences inspire many of us to think about those who are really in need especially medical services.*

1st Dr Agnes Henderson Oration, September 2016 by Dr Mrs Kusum Masih

Dr Kusum Masih

I am grateful to Dr Vilas Shende and his team for this opportunity and recognition to deliver the first Dr Agnes Henderson Memorial Oration. An exceptional lady who set examples and standards for all the future generations to follow, I am honoured and humbled to be called on to share my experiences at this platform in her honour.

I got my inspiration from my father, Dr Nelson Beer Singh who was a medical doctor and showed me what dedication and serving the needy meant in the community. It was by his example and guidance that I decided to take up medicine as a career. All through my schooling I kept hearing that 80% of my nation lives in the villages, with little or no medical facilities. Also the medical care in town remained out of reach for the underprivileged. Out of all the medical graduates every year not even 20% wanted to serve in the rural areas. But through God's will I was offered a position at a village in MP (now Chhattisgarh) at Evangelical Mission hospital, Tilda, immediately after graduation. Here I got an opportunity to learn and manage all medical and surgical emergencies including women and child health. After 10 months of service, I was posted in Evangelical Mission

Hospital, Baitalpur, at request, where a missionary, Dr Ruth Catton, had reopened a 25- bedded hospital as a Maternal and Child Health & Family Planning Project. I got to learn a lot from her, who, being a paediatrician herself, understood the importance of maternal and child welfare.

Dr Catton being a native of Michigan, USA was not fluent in Hindi or the local dialect of Chhattisgarhi. Consequently, I had to do most of the translation for her while dealing with the patients or even the staff. Being a rural belt, illiteracy was widespread. Hence it was important for proper communication between the doctor and patients to ensure correct compliance.

In the 70's there were very few roads even fewer public transport and poor connectivity. The available roads were not motorable. In the absence of buses and a railway station, the only means to travel comprised of bullock carts and bicycles. There were paddy fields all around which could only be crossed on foot. Sometimes very sick patients were carried on *'charpai'* made of ropes and bamboo and were carried by men on their shoulders. The rainy season was the worst period with almost no access to our hospital except by foot.

The electricity supply was erratic and unreliable. During long nights of power failures we sometimes had to treat or even operate under the lantern. I have personally taken several deliveries and LSCS under kerosene lamp. The staff and doctors had to rely on these kerosene lamps and torches to be able to work. As the hospital is quite lusciously covered by flora on 3 sides, poisonous snakes and scorpions were a continual danger. Flash lights or lanterns were a necessity in the dark.

During long nights of power failures we sometimes had to treat or even operate under the lantern. I have personally taken several deliveries and LSCS under kerosene lamp. The staff and doctors had to rely on these kerosene lamps and torches to be able to work.

I saw the need in the community, when social beliefs and taboos cost human lives. Complicated delivery cases, badly handled by village women and treated by quacks were brought in at the end stage. We witnessed numerous intra-uterine foetal deaths or ruptured uterus due to careless and wrong management by village elders. Blood donation was and still is considered bad for the health. Due to the lower social status of a woman in a family it is also considered redundant. I lost a patient due to post-partum haemorrhage from unavailability of blood. She delivered twin female babies which the father was unable and unwilling to care for. We nursed the infants in the hospital for about a year, till we could find a suitable family willing to adopt one of the babies. The other was then taken home by the father.

Post-partum dehydration and starvation was a common sight. I saw maternal deaths due to the practice of not feeding the woman anything for 5 days post-delivery. Water was not given. Special herbal concoctions were made. Babies were fed by other lactating women in the family during this period. Things were particularly bad in the summers when fever and dehydration claimed so many lives that I got used to seeing women in shock who died at the steps of our hospital.

Malnutrition also was rampant in this part of the country. Neonates who were not on mother's milk were fed diluted cow's milk as milk powder was expensive and mistrusted. This caused widespread diarrhoea and malnutrition. I saw many underweight children who were not given anything except mother's milk till the age of 1 or above. The iron

supplements were also frowned upon and refused by the villagers under the belief that it caused the baby's size to grow preventing a normal delivery. Hot fermentation and abdomen massage are considered good for the baby's digestion and supposed to accelerate cord shedding. Use of mustard *(sarso)* oil caused local skin lesions/pustules and in extreme cases the massage led to intestinal rupture of the newborn. Even now if the newborn develops jaundice, a piece of gold or twig of *Amarbel* is tied on the hand/neck to treat it. The infant is wrapped in old rags for the first 5 days till the 'chatti' is celebrated and the mother and child are given a bath, food and new clothes. Due to this practice, our hospital provides new napkins and frocks to all new-borns. After years of educating and awareness and harsh measures now at least the mother is given something to eat post-delivery. But water, either to drink or take a bath still remains evil in their eyes.

In the village Health Programme we made ready-to-eat food packets in the hospital by involving the health workers. These were then distributed door-to-door. Special care was taken to make them available in houses with children. We actively held antenatal and well-baby clinics in the nearby villages.

Adopting and instructing about new ways of contraception is highly challenging even now. They prefer aborting unplanned pregnancies instead of practicing contraception. Villagers are reluctant to use temporary measures of spacing. Females are still hesitant to opt for sterilization after 2 or 3 kids. Antenatal check-ups are ignored and deemed unnecessary. The concern only focused on the TT shots provided by govt. Home deliveries are still preferred over health care centres. High infant and maternal mortality rates are a result of such practices of attempting high risk pregnancies at home.

All of the above difficulties and need in the community motivated me to take up obstetrics and gynaecology as my specialty. Therefore soon after I had my children, I left for CMC Ludhiana for my post-graduation. It was not easy for me, as my youngest was only 3. But my husband promised to look after my 3 kids and motivated me to pursue my education. My mother-in-law then, at the age of 60yrs took over the responsibility for caring for my family. She took a Voluntary Retirement from the post of the Nursing Superintendent from TLM Hospital, and refused to take an extension just so that my children were not neglected. In the small village of Baitalpur there weren't any good schools. The nearest city Raipur remained 80 kms away. Since my husband and me were unable to spare time or energy to scout for schools, their grandma shifted to Raipur and admitted my girls to decent schools. In the absence of funds, they had to make do in a small quarter with minimal facilities, but neither she nor my kids ever complained. It was heart-breaking for me to see them suffer, as I remained helpless to be able to send the kids to boarding. After 7 years we could finally afford to send the girls to a boarding school. We still had to struggle to make ends meet with 3 kids in boarding. My son's school fee alone being double of what we paid for the girls combined. My husband made an extra effort in our farm with multiple crops of rice and wheat so that we could get all the help we could. At a time when the local farmers only believed in manual labour and traditional farming, my husband introduced machines and newer methods of farming. He spent a huge amount of his time educating the local farmers. Even the Agriculture Officers commended his efforts and he was awarded the Best farmer in the block.

As a result of being active in the local community we were able to reach out. In the village Health Programme we made ready-to-eat food packets in the hospital by involving the health workers. These were then distributed door-to-door. Special care was taken to make them available in houses with children. We actively held antenatal and well-baby clinics in the nearby villages. We did numerous awareness, health care and immunization

The ill equipped centres and lack of trained personnel still give way to medical negligence. The staff quarters and electrical and water supply need to be improved and maintained for 24hrs medical assistance.

camps in the area for a span of about 15-20 years. Finally with the government opening up Primary health care centres and anganbadis in these villages we now have limited the Community Programmes.

In my region of Chhattisgarh, with low per capita income and low literacy rates, health education and awareness is important at all levels. Extensive health education needs to be merged in the middle and high school curriculum with the focus being educating the girl child. Personal health and hygiene needs to be made a priority. The condition of the govt Primary or Higher secondary schools in my region is pitiful. Due to the lack of teachers and volunteers it ignores the health education part. The recent ruling of compulsory promotion till class 5 and no board exams in 8th class have further deteriorated the standard of education. Hence, singular stress has to be put on the quality of education. Also early marriages which prevent most girls to pursue higher education needs to be stopped. Marriage age should be scrutinized and couples encouraged to be financially independent so as to be able to make informed decisions about their family's health and wellbeing. In many castes polygamy is still allowed. If the wife does not conceive, or has a female child, the husband is free to marry again. Also the woman is physically and mentally tortured if she's unable to do enough manual labour in or outside her home.

I remember an incidence when a woman was brought with around 70% burns on the entire body. She was burnt by her husband, who never visited her even once. Only her father-in-law stayed in the hospital in the fear that her death will cause a lawsuit against his son. She was left alone for long periods of time with no food or water. On several occasions during her month long admission, I or the staff brought her food. She finally recovered and her hospital bill was settled with the help of a local MLA and she was sent home in the hospital vehicle.

With no blood banks in our area and no anaesthetist we were forced to refer her to the nearest town which was 35kms away. The strict norms of blood bank requirements, the unpredictable electrical supply and the socio-economic status of most of our patients have prevented us from applying for a licence yet.

Times are changing now. The Govt Primary health centres and the sub-centres have a responsibility towards providing health care in remote areas. Things still need to improve though. The ill equipped centres and lack of trained personnel still give way to medical negligence. The staff quarters and electrical and water supply need to be improved and maintained for 24hrs medical assistance. Toilets still remain neglected. How can safe deliveries happen in these centres if the above amenities are absent and every case is referred to higher centre after 5 pm??

There is provision for free vehicle facility available for all pregnant women in the area called the *"mahtari"* express for all who need treatment/ check-ups in the local centres or have to be referred to higher centres. But if the patient refuses to go to the govt aided institute then the service is denied for any private or mission Hospitals. In these cases patients have to arrange their own vehicle which is difficult.

Recently we had a patient who after hours of labour was made to walk till our gates due to unavailability of transport. She was almost in shock due to pain and dehydration. On examination she was found to have a ruptured uterus and anaemia. With no blood banks in our area and no anaesthetist we were forced to refer her to the nearest town which was 35kms away. The strict norms of blood bank requirements, the unpredictable electrical supply and the socio-economic status of most of our patients have prevented us from applying for a licence yet.

According to me, our hospital should be now recognised as a secondary health centre by the govt. whenever the nearby PHCS and mini PHCS refer us cases it should be reimbursed by the health authorities. Also the local village motivators, called *'Mitanins'* who bring women to hospitals and encourage hospital deliveries and sterilizations should be financially aided. This will encourage the practice. Anti-snake venoms and anti-rabies vaccines should be made available to all health centres free of cost. Also generic drugs like anti- hypertension and anti-diabetes medicines should be provided to centres at nominal rates as these are chronic diseases of the poor and the old when both money and assistance is in short.

In the modern day and age of cell phones and internet, the focus should be on availability of sound transport and drugs in all health care centres, small and large alike. We, as mission hospitals are also short on personnel. I have been managing with the 3-year Chhattisgarh trained doctors who cannot practice independently. For the past 2 years I have had no MBBS or PG doctors. All emergency calls which require specialist care have to be managed by me alone.

This hospital was given new life and direction by Dr. Ruth Catton and she trusted me with the same responsibility. I have tried for the past 20 years to uphold my end. We sponsor candidates for under graduate and post graduate courses but unfortunately we have not been able inspire them for a lifelong commitment. I am hopeful to find qualified personnels for the specialised courses to keep the hospital up and going with the same dedication and like-mindedness to carry the hospital forward.

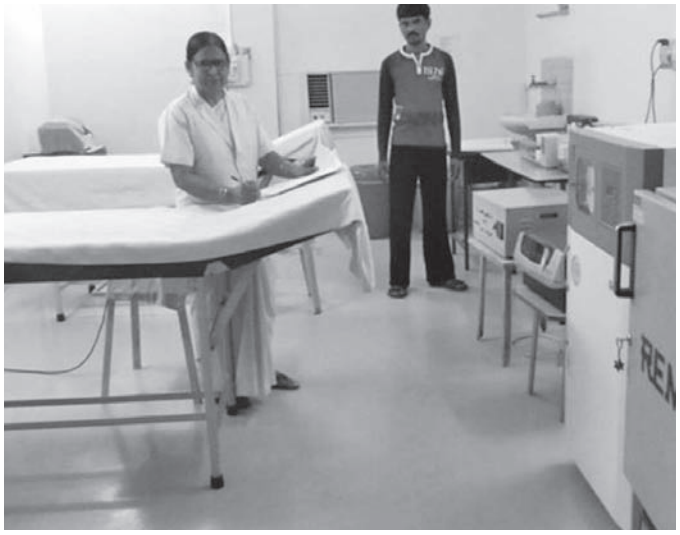
Dr Vilas Shende
The Director, Mure Memorial Hospital, Maharashtra

EVANGELICAL HOSPITAL KHARIAR

History And Introduction

Dr Ms Nibedita Pramanik

The Evangelical Hospital-Khariar is a hospital located in the Nuapada District of Orissa, India. It is currently the leading non-government health institution in the State of Orissa and Eastern Chhattisgarh, and it provides the best medical care for each patient that enters the hospital, regardless of income. The hospital has been serving the rural community in Orissa since 1930, when it was founded by Reverend Herman and Mrs Marie Feierabend of Evangelical and Reformed church of North America,



now called the United Church of Christ, USA and at present under the management of Church of North India. The first doctor was a lady licentiate in medical practice from CMC, Ludhiana. Since the 1970s, the Church of North India oversees the operations of the hospital, and continues to keep a close relationship with the Evangelical Hospital-Khariar. A member of the Christian Medical Association of India, and affiliated with the Church of North India and Global Ministries in the United States, the hospital caters to the needs of surgical, obstetrical and gynaecology with a total of 110 beds. The church conducts morning worship services, patient visitation and counseling, and it comforts the bereaved. Not only does the hospital cure patients and prevent disease, the hospital makes all attempts to impart the knowledge of God in order to benefit the wholeness of the person. Over the years there was a gradual growth, but from year 1970, it became a much larger organization.

Mission

The Evangelical Hospital Khariar is located in one of the most backward districts of India catering to the medical needs of the poorest of the poor. The mission is to give the best medical care possible even to the poorest of the poor. Our belief is that, though a patient is poor , he is still entitled to the best medical treatment possible, and our efforts and finances has been directed towards achieving this. The motto of this hospital, is taken as our mission statement is- Christ commands “Heal the sick and say, the kingdom of God has come close to you.” Luke 10:9

Vision

In the mid-twenties, the missionaries working in this mission field lost two of their children. This unfortunate incident brought about a need for medical care among the people of this area, which led to the establishment of the hospital. The aim was to not only cure, but also complete healing of the person. It is also our aim to educate people on health and talk about the love of Christ.

Management and staff

Evangelical Hospital-Khariar annually serves over 3,645 in-patients, 27,000 patients through outpatient services, regularly occupying approximately 90 of its 110 bed capacity each night, and performs 1,821 surgeries. The hospital staff consists of 9 physicians, 72 nurses and medical support staff – including 20 nurse midwives, and

14 general staff members, including a full-time chaplain.

The hospital was turned over to the Church of North India by the mission board when the church union took place on 29th November, 1970. The health work of Church of North India is divided into different boards and the evangelical hospital Khariar comes under the supervision of Eastern Regional Board of Health Services (ERBHS). The hospital is recognized by DMET, Government of Odisha and the staffing of the hospital is laid down as per the rules of the health department, Govt. of Odisha. Therefore, this is a fully registered hospital with the license to run a blood bank, USG and pharmacy, and has been approved by the pollution control board with a certification from ISO 9000 as well.

Facilities and services

The hospital is working toward better serving their patients and improving the health of the community through obtaining a Chemiluminescense Analyzer, CT scanner, Radio Therapy Unit, a Blood Bank Cell Separator, and adding additional trainings for paramedics.

1. Surgical – a. General Surgery
   b. Laparoscopic surgery
   c. Urology including trans-urethral surgeries
   d. Orthopaedics including hemiarthroplasty
   e. Basic lung and thoracic surgery
   f. Plastic and reconstructive surgery
   g. Head and neck surgery
   h. Pediatric surgery
2. Obstetrics and Gynaecology
   a. All obstetric operations
   b. All gynaecology surgeries including oncology surgeries, both abdominal and vaginal
   c. Uro Gynaecology
   d. Infertility management
3. Pediatrics including neonatal management
4. Psychiatry including ECT
5. Medical Management including emergencies and visitation by Cardiologist
6. Dental surgery
7. Physiotherapy

Facilities

1. Outpatient services
2. In-patient services
3. USG with Colour Doppler
4. ECG, Treadmill and Pulmonary Function Testing

The hospital prepares the candidates for examinations leading to the membership of the Christian Academy of Medical Science.

5. X-rays including digital x-ray, plain and contrast, portable x-rays, c-arm image intensifier.
6. Licensed blood bank with ICTC Centre and ELISA Lab
7. Laboratory services – hematology services with automated urine analyser, CBC analyser
   - Microbiology with culture facilities
   - Biochemistry with auto analysers, Chemoluminescence immunoassay (Beckman coulter) and ABG
8. Special care units
   - Pediatrics including neonatolgy with foetal warmer
   - Adults with facilities of ventilators, oxygen, monitors with NIBP, Infusion pumps, body guards and defibrillator
9. Two operating rooms with CSSD and central oxygen and nitrous oxide
10. Three labour rooms- clean, infected and bio – hazard patients
11. Fully mechanized laundry with two horizontal washing machines and spin dryer.
12. Physiotherapy unit with most of the equipment and 2 physiotherapists
13. Dental department with two dental chairs, x-ray and 2 dentists.
14. Fully licensed pharmacy
15. Two 100 KvA generator for back up during electricity failure.

The Evangelical Hospital-Khariar is committed to adding new technologies and medical equipment for better diagnosis and treatments.

Community Health Services

All the patients who come to the hospital are exposed to the various health care needs of the individual. The Staff specifically talk to the relatives and the patients regarding family spacing, maternal and child health care, immunization and health education. It is practically impossible to go into the interior villages where one has to walk at times maybe 10-12 km and very few are willing to do this work no matter what the motivation is.

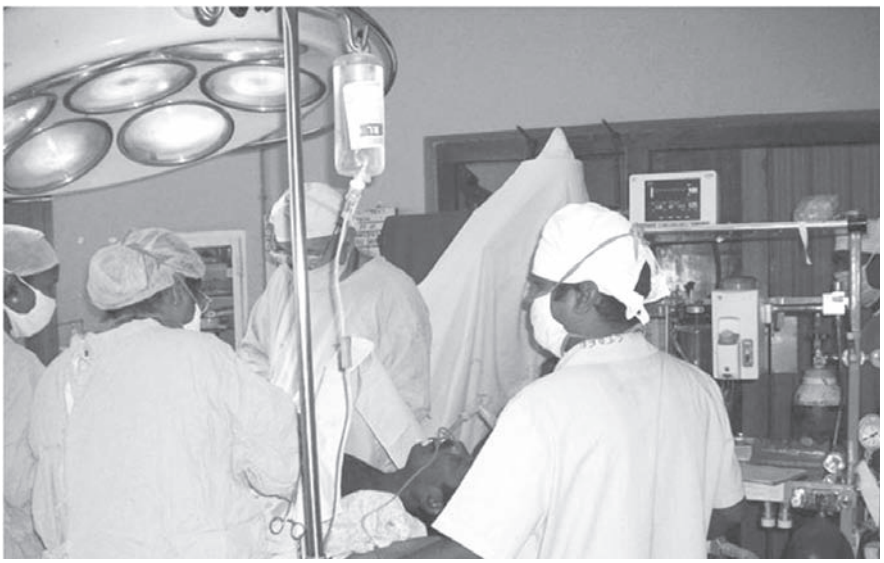
Education Facilities For Staff Of Hospital

- **English Medium School -** The hospital has started an English Medium School to meet the educational needs of the children of the staff.
- **Oriya Medium School** - up to Class VII is now operated by the hospital for the children of staff and for the children living in the surrounding village.

Teaching Programs

Physician Education

The Christian Medical Association of India (CMAI) offers a post-graduate program in the discipline of Family Medicine. The Evangelical Hospital is one of the few mission hospitals in India to be recognized as a training center by the Christian Medical Association



of India for its students. The hospital prepares the candidates for examinations leading to the membership of the Christian Academy of Medical Sciences. Two classes are held per week in various disciplines of medicine. A Journal club is held once a week and bedside clinical teaching is done almost every day. The Evangelical Hospital, Khariar has also been recognized by the Medical Council of India for House Job in the discipline of Medicine, General Surgery and Obstetrics & Gynecology.

Nursing Education

(a) The hospital was inspected and recognized as a training center for the training of nurses in the discipline of Operation Theatre Technique.
(b) The hospital now jointly runs a Nursing School with Tilda Hospital where the facilities of the hospital are used as the training ground for the students of Tilda.

Projects

Projects and new plans are put into effect whenever finances are available.

Future plans and dreams

There are many dreams including the dream of turning this into a mini CMC. However, this is subject to availability of committed medical personnel.

Opportunities for doctors and students

There is a crying need for specialist doctors and junior medical officers. All this is a dream and also a necessity if our witness needs to continue. Medical students are encouraged to come and spend one-two weeks with us once they enter clinical area. Students are already coming here for their peripheral posting from our sister medical college at Ludhiana.

CONTACT DETAILS

Dr Nibedita Pramanik
Director, Evangelical Hospital Khariar
Phone number- 7683986933
E-Mail: ehkhariar @ rediffmail.com,
ehkhariar@gmail.com

POSTAL ADDRESS

Evangelical Hospital Khariar
At Post – Khariar, District – Nuapada
Pincode 766107, Odisha

How To Get There?

By air- Nearest airport is 200 kms away at Raipur, Chattisgarh.

By train- From Kantabanji or Titlagarh station, road transport to Khariar. Note- Don't mistake Charier road for Charier where this hospital is located.

Note- There is no railway station at Khariar. Nearest railway station is at Kantabanji or Titlagarh.

Kindly contact the above mentioned phone numbers in order to reach here without any difficulties.

Historical or tourist places

Hirakud Dam (Largest earth dam in the world)

Dr Ms Nibedita Pramanik
Director, Evangelical Hospital Khariar

HEALTHCARE COMMUNICATION: THE CORNERSTONE OF QUALITY

How an innovation in communication training started a revolutionary healthcare communication movement across the country

Every year, around 2% of a hospital's budget is lost due to medical error. It is estimated that around 70% of medical errors can be attributed to poor communication within the healthcare setting. Unfortunately, despite this, healthcare communication is hardly given any importance in medical education in India. This has created a huge and very dangerous gap in the communication skills of our healthcare workers, leading to thousands of completely preventable medical errors every day.

Dr Alexander Thomas

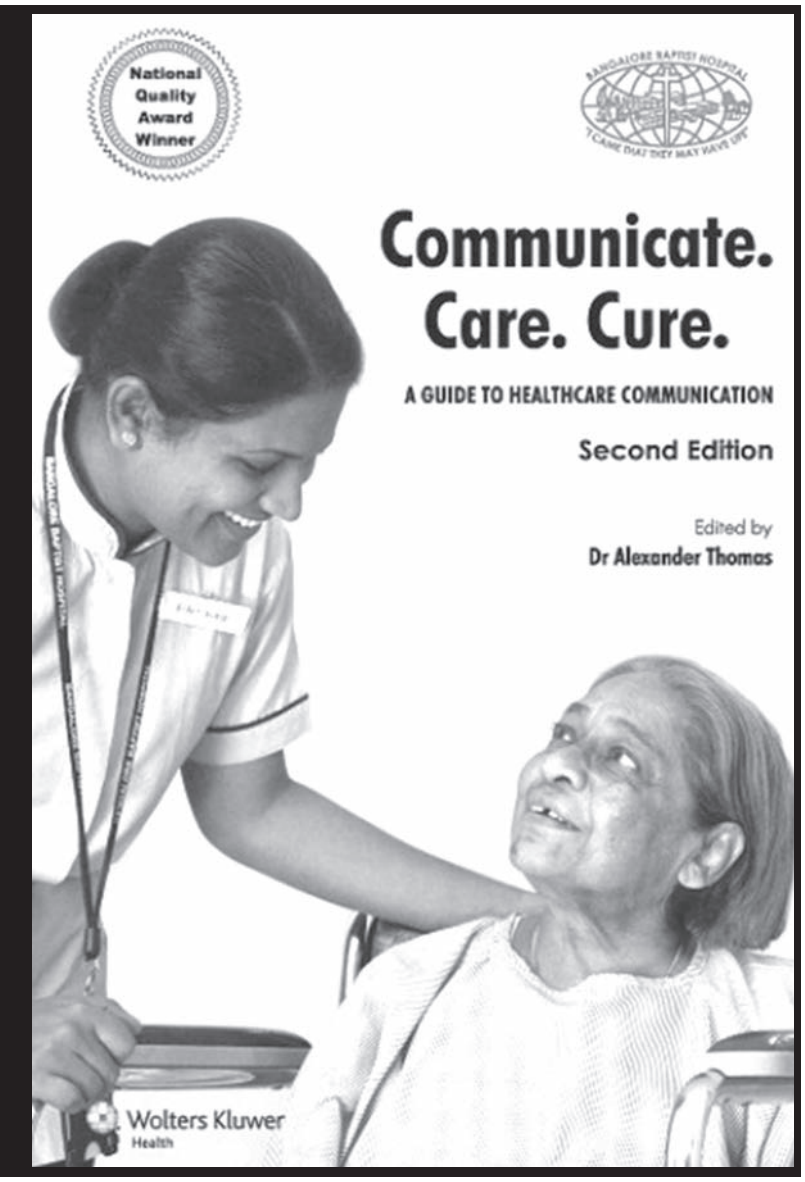
Dr Alexander Thomas, then Director (CEO) of the Bangalore Baptist Hospital (a 300-bedded mission hospital in Bangalore, India) realized that the situation begged the adoption of a sustainable, cost-effective model based on building expertise and experience in hospital staff. In a healthcare context, no communication training is provided as part of the curriculum in most medical, nursing or allied healthcare education programs. Therefore, Dr Thomas decided that it was time for an innovation to fill this niche. He deputed a team from the hospital to work with communication experts from the Mudra Institute of Communication, Ahmedabad (MICA) to develop a training program specifically for the healthcare context.

It aims to directly impact patient safety and quality in healthcare by improving communication in the healthcare setting. It has been tailored to meet the needs of all personnel in the healthcare sector, and not just medical professionals.

The modules of the training program were collected and synthesized into a volume titled *Communicate. Care. Cure. A Guide to Healthcare Communication* in 2012. Before this, there was no single publication in India on the role of effective communication for patients, healthcare-providers and healthcare administrators. This book aimed to be that publication, capturing the experiences of the different stakeholders involved. It was an immediate success, leading to the publication of a second edition in 2014. The second edition has 14 chapters dealing with all aspects of healthcare communication. Copies have been distributed widely, both in India and internationally. In 2013, the Bangalore Baptist Hospital was awarded the prestigious Quality Council of India (QCI) - D L Shah Award for this book.

A large number of queries about the book led to training workshops in healthcare communication being conducted across the country. This has mushroomed into a dynamic healthcare communication movement in India. Building on the success of the book, BBH partnered with the Consortium of Accredited Healthcare Organisations (CAHO) to train hundreds of master trainers from all over the country, who in turn trained professionals within their institutions in effective healthcare communication. The workshops were approved by the National Board of Examinations (NBE) for their post-graduate students. They have also been conducted in institutions of repute such as the Christian Medical College, Vellore. The training workshops gained widespread national recognition in the healthcare industry, and the initiative won BBH the QCI – D. L. Shah Award for an unprecedented second time in 2014.

After the success of the national workshops, an e-learning course titled *Communication for Better Healing* was



developed in partnership with CAHO and Wolters Kluwer India, a leading publishing and health information services company. This e-learning course, based on the book, is the next step in meeting the urgent need for increased awareness of healthcare communication. It aims to directly impact patient safety and quality in healthcare by improving communication in the healthcare setting. It has been tailored to meet the needs of all personnel in the healthcare sector, and not just medical professionals. Offering practical solutions to communication issues in healthcare environments, it addresses the challenges faced by the patient, the patient's family, the healthcare providers, healthcare administrators and support staff. Each module or chapter is replete with examples from the healthcare setting, brought to life through videos and animations. There are assessments at the end of each module to test the user's understanding of the course concepts and to demonstrate their application. With content delivered straight to the users, it removes the need to hold or attend expensive training conferences, thereby making it easily accessible to all.

Endorsed by the National Accreditation Board for Hospitals and Healthcare Organisations (NABH) and the National Board of Examinations, the book and training workshops are also recommended by the Nursing Council of India, the Association of Healthcare Providers of India, and the Government of Karnataka, among others. The increased emphasis placed on the issue healthcare communication by this initiative has led to the incorporation of healthcare communication among the NABH *Accreditation Standards for Hospitals (4th Edition).* This ensures that hospitals and healthcare providers that want to obtain accreditation from the NABH need to meet certain standards with regard to healthcare communication – a major step towards the delivery of quality healthcare.

With content delivered straight to the users, it removes the need to hold or attend expensive training conferences, thereby making it easily accessible to all.

Dr Alexander Thomas &
Divya Alexander (Research Associate)

Dr Alexander Thomas, Founder-Member and Executive Director of the Association of Healthcare Providers of India (AHPI), Founder-Member and President of the Association of National Board Accredited Institutions (ANBAI), Founder-Member and President of the Consortium of Accredited Healthcare Organisations (CAHO) and Consultant to the World Bank, has served the healthcare sector for over 30 years. He is a Member of the Board of the National Accreditation Board for Hospitals and Healthcare Organisations (NABH).

CHURCHES FOR SOCIAL ACTION
"No Act Of Kindness However Small Is Wasted"

What is a community? According to the foundations laid by our school, the definition of a community in an eighth grader text book is "A community is a group of people living in the same place or having a particular characteristic in common".

So what is a church community? A church community is a group of people living in the same city, town or village having a particular characteristic in common which is Jesus. Let's look at the characteristic of a Christian so that 'our' foundation is laid. A Christian exhibits the fruit of the spirit namely love, joy, peace, patience, faithfulness, kindness, goodness, gentleness and self-control. But do we love where everyone loves everyone? We say

- we are loving in nature only when you can love where there is no love.
- Filled with joy where there is no event to be joyful in the room
- At peace in the midst of a hurricane
- Patient with difficult people
- Faithful in spite of others unfaithfulness
- Kind and good when people are rude
- Gentle when they are harsh
- Self- controlled when all your emotions well up

Then the people will ask. Why do you care for me? That's the transformation right there.

'Love is the only force capable of transforming an enemy to a friend.'

Once you are 'converted' to the idea that the church has a responsibility to the community, the next question would be how we should go about it. It is always difficult to start or take the first step, be it writing an article as this or acting on a problem prevalent in society. We hesitate, scratch it out of our minds, or even if we dare to go ahead,there will be barriers by the Pharisees of the church arguing how we laymen are not responsible but it's the Mother Teresa's of the NGOs to whom the burden lies.

The article is not to argue with people about the reasons the church needs to work towards social action but it is about those churches that have a kindling spirit to do

something. Irrespective of what your stand is on the church responsibility towards the community, the church has a mandate and has a social action wing in every denominational church.

Christian Medical Association of India as the official health arm of the National Council of Churches in India has the mandate to equip the churches towards healing ministry. In order for the churches to respond effectively towards health, healing and wholeness, it is important to discuss, deliberate and take decision towards engagement in various aspects of the healing ministry. This discussion has been a focus with the churches internationally as well towards a deeper understanding of health, healing and wholeness and the responsibilities of the church.

CMAI is journeying in its project *'Christian health care network in India contributes towards building a just and healthy society'*. Our activities are in line with the 4 strategies of CMAI i.e. church relations, capacity building, justice and equity, and evidence, research and innovation.

This initiative, in the process will bring together Church leaders from various denominations to create a platform to discuss various ways to engage with the communities around them.

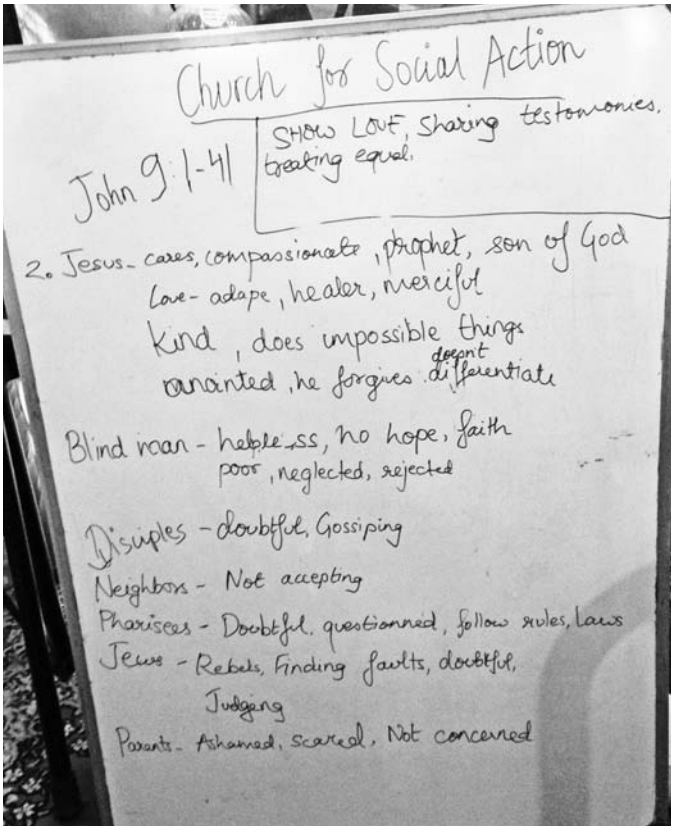
Our goal is to enhance the churches engagement in the community and for the church to reach out to the communities around them for holistic and inclusive actions.

Our objective in this initiative is for

- Churches to be aware and responsive to the concerns of the community.
- Churches to have a changed perspective or attitude about an issue or concern.
- Churches demonstrate a definite involvement or commitment in acting towards the community.
- Churches integrate the concerns in the general set of values, giving it priority.

We have

- Developed a training module (for Trainers) that will enable the trainers to train church leaders in the knowledge, comprehension, analysis and application of major concerns in the community.
- Developed an assessment tool that would determine and assess the churches level of inclusiveness and challenge them to move to the next level.
- Conducted Training of Trainers workshop across North, North East and South that enabled the trainers to facilitate churches and groups in knowledge, comprehension, analysis and application towards enhancing the inclusion of the church.



- The trainers have thereby implemented their action plan or even conducted another ToT in their organization or church.

The Tools used in the Workshop are:

1. Social Inclusiveness Tool
2. Contextual Bible Study
3. Appreciative Inquiry SOAR analysis (Strength, Opportunities, Aspiration and Result)
4. Action Plan Framework

The Contextual Bible study helps in relating the Bible to the context we are in, from issues like gender discrimination to communicable diseases to disability. This helps us understand what the Bible spoke about these concerning issues (The Bible does have all these issues) and how to view it in today's context. The quiz helps in unlearning the myths of issues that have been taught to us all these years based on facts and research. The inclusive tool is a tool that asks whether the church is active in awareness, reaction, action, integration, and dissemination and advocacy of a particular issue. It also touches on the head knowledge, the heart change and the feet action of a church. For example, a church is inclusive if they are *aware* of the issue of disability (head knowledge), the groups are aware of the issue of disability (heart change), the church has developed posters or written material to make the congregation *aware* (feet action) on the issue of disability.

The tool also has been developed in such a way that the action plan can be developed by the church through the tool itself. The tool is the skeleton to provide structure and support to the churches who want to do something and want to know how to go about being an inclusive church.

From our analysis of the churches we've interacted with, a lot of churches (North, North East and South) have worked with

- Communicable Diseases
- Gender Discrimination
- Disability
- Lifestyle Diseases
- Sexuality

There are churches who have begun some good work already; Koramangala Methodist church, Bangalore for instance have begun a palliative care unit in the church where they provide volunteer services for those in need of palliative care in their community.

We've interacted with many churches and organisations and most of them have not tried or given up on the denominational churches, due to challenge of working around the rigid structure of denominational churches. Participants found the Contextual Bible study very useful to help in understanding the Bible in today's context.

Concerns	Awareness	Reaction	Action	Integration	Dissemination, learning and Advocacy
Gender Issues	We as church leaders/ pastors speak about gender issues like violence, abuse, and roles and responsibilities of men and women equally in our church, youth and Sunday school.	We are able to respond to the need, based on the changes present in gender discrimination.	Our church developss bible studies / conducts special services dealing with issues specific to gender.	We have/ are aware of the policies addressing gender issues.	We as church leaders, members/pastors speak about gender issues in other churches.
	We as church leaders/pasors have discussions on gender violence and abuse in our house fellowship, youth groups and children's group.	We have members in our congregation who are able to address gender issues like trained counselors, doctors, social workers, etc.	We as church leaders/pastors are able to identify and conduct workshops based on the gender issues felt in our community.	Our church leaders provide a coping mechnism for its members by involving victims of gender issues in our church groups without discrimination.	We invite other church groups to participate in our activities with regard to gender violence and gender equity.
	Our church has information materials educating the members about gender issues.	We have a coordinator who addresses issues specific to gender.	Our church is able to find available resources/ services for the victims of gender discrimination.	We give opportunities to all members in our church to be leaders without any gender discrimination.	We contribute in voicing out the issues of gender violence and gender inequity to make a change in the society.
SCORE					

They were able to relate to the passages when it was pictorially depicted, questioned and explained, which became relevant to the current scenario. The tool helped them reflect on the strengths of their church and the opportunities they can develop with practical action points retrieved from the tool. For those churches that are already socially active we urge you to continue your work and keep challenging yourself to the next step.

As CMAI, we know our strength is our church network and hence have taken up the challenge of working with our churches. We hope our church understands the potential and resource pool we possess and how our professions can be used not just to sustain ourselves but also go beyond our inner-circle into the community we interact with as well. If we look into our own church you would have doctors, nurses, lawyers, marketing strategists, journalists, media persons, trainers, musicians, service oriented workers, army officers, pastors, electricians, plumbers, daily wage workers, etc. We just need to know what our church needs to work upon and we'd know it with the situation around us. It may be something as simple as raising money for a child's education, teaching kids who can't afford tuition, getting grocery or driving people who can't move out of their homes, fixing somebody's roof, providing furniture to a new family in the community or even dealing with deep issues like homosexuality, geriatric care, child abuse, divorce and drug abuse.

Though these may be huge issues that may look difficult to climb, we encourage churches to begin with work you can work your way through.

We can choose to be affected by the world or we can choose to affect the world.

Churches
Boro Baptist Church, Bangalore
Forgiven Church, Bangalore
Khasi Jain Christ Fellowship, Bangalore
Koramangala Methodist Church, Bangalore
Naga Christian Fellowship, Bangalore
CNI, St. Thomas Church, Delhi
Tanghlul Baptist Fellowship, Bangalore
Tanghlul Christian Fellowship
South Delhi Mizo Fellowship
East Delhi Mizo Fellowship
Chawnpui Presbyterian Church
Ebenezer Mar Thoma Church
Delhi Bible Fellowship Central, Delhi
Delhi Bible Fellowship West, Delhi
Seventh Day Adventist
Tilda Evangelical Mission Hospital, Chattisgarh
St. Peters Church, Bangalore
St. Martins Church, Delhi
SYNOD Hospital, Aizawl
Presbyterian Church, Manipur
Cathedral Church, Delhi
CSI Bellspins, Tirunelveli

Churches involved in Social Action

For one local village located high at the top of a mountain, transportation was a huge challenge. Travel from the village down to the state capital took two days on foot as the road was not even wide enough for a motorbike. Some points along the road were almost too narrow and dangerous even for walking.

The church wanted to do more to show God's love. They prayed and decided to take on the challenge of building a new road. They gathered with tools and shovels and started work. Within a very short time they had successfully completed 12 kms of the road! The new road was wide enough for not only motorcycles but cars as well. Transportation was now easy from the village to the main city, and the church gave thanks to the Lord for the transformation. (Success story of Reconcile World-Truth Centred Transformation)

Community Health Dept (Team),
CMAI

DR GLORY ALEXANDER
AWARDED
DR B C ROY AWARD

CMAI congratulates Dr Glory Alexander, Director, ASHA Foundation, Bangalore for the Dr B C Roy award for 2010, in recognition of her Outstanding Service in the Field of Socio-Medical Relief.

Dr Glory obtained both her graduate and post-graduate degrees from CMC Vellore, finishing MBBS in 1976 and MD in 1986. She was awarded the Madras University Gold Medal for her performance in MD General Medicine. She worked at Bangalore Baptist Hospital until 1998, when she left to start a HIV/AIDS-focused NGO, ASHA Foundation. Over the last 18 years, ASHA Foundation has impacted the lives of tens of thousands of people through its services: an AIDS helpline, adolescent health education in schools and for out of school youth, an integrated counseling and testing center, medical care and support, educational, nutritional, and medical support for children, the empowerment of women, prevention of mother-to-child transmission of HIV, a psycho social intervention for children living with HIV through residential summer camps, capacity-building of professionals, and HIV/AIDS research.

The award was presented by the President of India Shri. Pranab Mukherjee, in New Delhi.

Join Hands with us in Healing Ministry

COME JOIN US AS MEMBERS

CHRISTIAN MEDICAL ASSOCIATION OF INDIA

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

- CMAI has over 10,000 Christian health care professionals and over 340 institutions representing various denominations.
- CMAI builds individuals to be technically sound, spiritually alive, and socially relevant, in fellowship and with a Christian perspective on health and development.
- CMAI is the health arm of the National Council of Churches in India(NCCI).

WHAT DO WE DO ?

- Build capacity to respond to the current and future health care needs
- Advocate for innovations, create evidence and promote policy change
- Work closely with the churches, civil society and the government
- Build alliances for health action on a national scale

OUR PARTNERS

CMAI influences other networks and alliances on thinking change in health systems practices in India. We partner with national and international agencies to promote this objective.

OUR PUBLICATIONS

- Christian Medical Journal of India (Perspective)
- Life for All (Newsletter)
- Footsteps (Development) English & Hindi

COME JOIN US

The core of CMAI is its members- individuals, institutions and churches. Individual membership consists of five professional groups - Doctors, Nurses, Allied Health Professionals, Chaplains and Administrators. Each section comes together for retreats, workshops, conferences and campaigns to share resources.

For more information about our work and to download membership form visit our Website:

www.cmai.org or write to: cmai@cmai.org

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CMAI, Plot No.2,A-3 Local Shopping Centre
Janakpuri, New Delhi -110058 India
Tel: + 91(0) 11 25599991/2/3 Fax: +91 (0) 1125598150

We invite Christian health care professionals, join us as members

COME JOIN US AS MEMBERS

Building a just and healthy society