A CERTAIN CONFUSION

You may have noticed that C.H.C. LINK seems to have gone out of circulation. No, there hasn’t been a strike, but a journey to Tanzania to the M.K.H. Inter-Regional Assembly at Maua, in the foothills of Kilimanjaro.

Here delegates from Malawi, Angola, Ethiopia, Uganda, Nigeria, U.S.A., Kenya, Brazil, Ireland and England and, of course, Tanzania, met to share their own unique experiences, problems and concerns; to pray and reflect together on the "signs of the times". Our "community is called to show forth the love and compassion of Christ who came to heal and liberate". So we searched together as to how we would go forth and heal in today's world.

We listened deeply to reports from each country on our traditional apostolics, (mainly hospitals) primary health care, other new ventures, our option for the poor, and justice.

Regarding P.H.C., it emerged that there is a heightened awareness of its philosophy, and we are gradually becoming more involved in it. But existing with this there is a 'certain confusion' as to what P.H.C. really is.

Several issues of LINK have stressed one or other angle of P.H.C. but this one will go back to the declaration of Alma-Ata.

Here the essence and philosophy of P.H.C. was spelt out, and the participants came to see that their goal was "an acceptable level of health for all people of the world by the year 2000".

Later LINKs will look at one or other aspect of P.H.C. and at the new levels of understanding emerging since 1978.
DECLARATION OF ALMA-ATA

I. The Conference strongly re-affirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III. Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII. Primary health care:
1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive

...continued on p.7.
PRIMARY HEALTH CARE

1. evolves from

THE COUNTRY’S
SOCIO-
ECONOMIC
POLITICAL
SITUATION

reflected in

ITS COMMUNITIES

2. addressing the
MAIN PROBLEM

PREVENTIVE
CURATIVE
REHABILITATIVE
SERVICES

3. including

FOOD SUPPLY
AND NUTRITION

WATER SUPPLY
AND SANITATION

HEALTH EDUCATION

MOTHER AND
CHILD CARE

IMMUNISATION
AND FAMILY
PLANNING

PREVENTION
CONTROl
TREATMENT
OF LOCAL
DISEASES

PROVISION OF
ESSENTIAL DRUGS
P.H.C. also involves

Agriculture

Education

Food

Animal Husbandry

Industry and Public Works

Housing

P.H.C. promotes Self Reliance

How?

by Participation in

Planning, Organising

and

Operation and Control of P.H.C.

How?

by using Local, National, and other available resources

So developing the ability of communities to participate
P.H.C. should be SUPPORTED

by mutually supportive REFERRAL SYSTEMS

AIM?

COMPREHENSIVE CARE FOR ALL

BUT PRIORITY TO

WHO?
Those who can afford? NO!
Those only in town? NO!
but THOSE MOST IN NEED!

7. P.H.C. relies on HEALTH WORKERS

ALL SUITABLY TRAINED

In what?
Do their own thing?
No! not only that-
-to work as a team
-and respond to the expressed needs
of the community!
BUT WHY?
If FIC includes all medical care and prevention could we not all continue to train for and work in hospitals? We would still be fulfilling our option towards PHC?

IT'S A QUESTION OF BALANCE.

Hospitals take 90% of money and trained people

About 80% of people cannot avail of their services
BUT WHY?

When writing of the philosophy of P.H.C. is community participation, self reliance, culture, training for specific tasks and the need to work with other disciplines stressed so much?

Again it is a question of balance – Being trained to work in hospitals, as many of us are, we know how to do our own job. We also know something of the role of other professionals. We can move from hospital to hospital, from country to country and take up our hospital role, almost like taking a set part in a play, with not too much adaptation being necessary. Of course we consider the language and customs of those who come to us, but only as it affects what we do for them.

But if we accept that hospitals are not the only means of health care, and that 80% of people in the world never need them; that health care in the community will prevent millions suffering sickness and distress; that to promote health in its fullest sense is the great aim and purpose; then some will want to put their feet on the other side of the scale.

Carl Taylor, recently retired Chairman of the Department of International Health, John Hopkins University, said a few months ago "We have to work as colleagues under and with local people. Every project should increase the capacity of local people to undertake similar projects for themselves. They should have local decision-making responsibility and be related to local institutions."

When asked what were the primary challenges that we face, he replied: "Two of the main challenges we face are the two pillars of the Alma Ata Primary Health Care Conference – community participation and intersectoral cooperation. The challenge in both of these areas is that we need more of a multidisciplinary approach - with anthropologists, economists, agricultural experts and demographers working with health professionals. We have learned a lot about what has to be done, but we don’t know much about how to go about it. In learning how to apply general principles to local situations, there is need for what I call adaptive research, in which you take the basic principles and learn how to make them relevant to local culture, to local needs, to local health systems and to local personalities. In doing that, we need a more systematic methodology to develop what is appropriate in local situations."

Then he was asked how he saw the role of hospitals in the primary health care movement. He answered:

"We had a conference on that subject last November at Karachi. At Alma Ata, we did not stress hospitals because we were afraid they would swallow up the movement. Now that the primary health care movement is established, and has developed a certain amount of momentum, it seems important to begin to work on hospital relationships, especially in regard to referral patterns. An important aspect is the concept of regionalization and systematizing the catchment area facility of health centers and hospitals. Specific functions will have to be worked out in mutual relations between the primary, secondary and tertiary facilities. In addition to referral, mechanisms are needed for getting health professionals out from hospitals into the communities, both for their own education and because it may simplify the referral rather than having patients do all the travelling. In the relationships between hospital and health center staff, a two-way educational process can be established. Field research needs to take into account the entire health system."

...continued from p.2.

referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need:

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world’s resources, a considerable part of which is now spent on armaments and military conflicts.
WALK WITH US IN OUR SEARCH

"Help us discover our own riches; don't judge us poor because we lack what you have.
Help us discover our chains; don't judge us slaves by the type of shackles you wear.
Be patient with us as a people; don't judge us backward simply because we don't follow your stride.
Be patient with our pace; don't judge us lazy simply because we can't follow your tempo.
Be patient with our symbols; don't judge us ignorant because we can't read your signs.
Be with us and proclaim the richness of your life which you can share with us.
Be with us and be open to what we can give.
Be with us as a companion who walks with us - neither behind nor in front - in our search for life and ultimately for God!"

**********

COURSES

1. At Institute of Child Health, London:
   1.) Practical Nutrition for Mothers and Children. (7 - 11 March, 1983).
   2.) Planning of Immunisation Programmes (25 - 29 April 1983).
   3.) Paediatric Priorities. (4 - 8 July, 1983).
   Details from:-
   Mrs. Lynda Campbell,
   41 Highfield Road,
   Purley, Surrey CR2 2JJ. U.K.

   For doctors and health personnel responsible for health care of children, who may be training others for P.H.C. Details from:-
   Dr. W. Cutting,
   Dept. of Child Life & Health,
   University of Edinburgh,
   17 Hatton Place,
   Edinburgh EH9 1UW.

3. Traditional Healing and Contemporary Medicine,
   Apply to:-
   N.C.I.H.,
   2121 Virginia Avenue N.W.,
   Suite 303,
   Washington D.C. 20037.
IS THERE ANY DIFFERENCE

between P.H.C. and what we've been doing for years with our mobile clinics? In fact, you could say the patient got as good treatment as if they had been in O.P.D., because everything O.P.D. provided, we provided from our Land Rover.

Well, LINK 15 mentioned that the two pillars of P.H.C. are -
- community participation and
- intersectorial co-operation, and I would add
- a change in attitude in those of us who are used to working in hospitals.

So if we wanted to ask ourselves

ARE WE REALLY DOING P.H.C.? 

1. Is it really where the people are?
2. Does it respect the culture?
3. Is the community participating in the planning and opening of the health care?
4. Have we trained any of the community for specific tasks which will promote health?
5. Are we aiming to achieve self-reliance as far as possible?

WORKING WITH OTHERS -

6. Are we working with others involved in health care, other Voluntary Agencies, Government and even traditional healers?
7. Do we recognise the need for different levels of health care and respect them?
8. Do we work with other disciplines - those in education, agriculture, water, animal husbandry, and so on.

AND OURSELVES -

9. Are we sharing our knowledge (or hoarding it?)
10. Has our thinking and attitude changed?
11. Do we see ourselves as really part of the Christian community, and the overall community, bearing "witness to the kingdom of love, justice and peace".
   Const. 1.11.
TANZANIA
HANANG VILLAGE
HEALTH PROJECT

This project came into being through the initiative of some M.M.M.'s who saw that curative services in hospitals, even though incorporated into the formal Government Health System, were not producing long term health benefits.

Between 1975-1977 Sr. Jeanne Lynch and Martha Collins, working with the District Medical Officer and District Health Officer did the research and foundation work. Meanwhile Sr. Joseph Anthony searched for funding. Towards the end of 1976 the project was then approved by the Tanzanian Government.

Since then the project workers have been fortunate to have a Mary Knoll Sister and a Holy Ghost Brother working with them for a time - At present Srs. Margaret Gannett, Catherine Nakintu and Mechtilde, forming a small community at Babati, help run the project with their Tanzanian colleagues.

The purpose of the project is to improve the health status of rural villages by utilising the present social and political structure and by encouraging self reliance and village cooperation.

I asked Sr. Margaret to write something about Hanang - and so she did -

THE WAITING GAME

Something Sr. Jeanne said in a letter gave the inspiration for this title 'The Waiting Game'. It seemed a good title for an article on the Hanang Project. We always seem to be waiting for something - usually for somebody else to do something - waiting for people to come to a meeting, for health principles to 'catch on', waiting for a letter from the funding agency, waiting to hear the Government's future plans for the Project, waiting for petrol to arrive in Babati, and so on. Perhaps it is something the same in all primary health care work. After all it is essentially something people must do for themselves - MMs may be initiators, advisors, motivaters, supporters or what have you, but our main role is to stand by while other people make decisions and carry them out.

Preparations - From the beginning this project was a 'waiting game'. The first ideas were written up and given to delegates at the 1974 Chapter, but it was 1977 before the project started. The three years in between were a kind of Advent during which nothing seemed to happen. Actually a great deal was happening in the area of negotiations with Church and Health authorities, and with the funding agency. Without this period the Project would not have been born.

Beginnings - First contacts were made with the villages in January 1977 and in May of the same year 4 Pilot Villages were chosen, one in each of the four administrative divisions of Hanang District. A survey was carried out in each village and a man and woman chosen to be trained as village health workers.
Training - These 8 trainees began their training in June 1977. As more villages came into the Project, five larger groups of trainees followed the original eight, until, in all, 192 trainees had passed through the school. The training was evaluated and modified as the project progressed, but basically it was the same for all and lasted for 2 years. During the first year the trainees underwent four one month classroom sessions followed by training in the field i.e. in their own villages. The second year was spent in the villages except for the last month which was spent in the classroom doing a refresher course and final examination. Those who passed the exam received certificates qualifying them to:-

Teach health in the villages
Treat minor illnesses
Give first aid
Assist at MCH activities
Supervise environmental hygiene in the villages
Represent health interests on the village committees

Yes! - to be teachers. During training the VHMs were taught how to teach adults and children, by teachers; in consequence they are excellent teachers.

Village Health Leaders - The first group of people to be taught by the VHMs were the Village Health Leaders. The Project is based on the smallest village unit, the ten house cell. The health leader is trained to teach health in her own unit and to report on births, deaths, and some common diseases to the village health worker.

Information Gathering - this has always been an important aspect of the Project. In developing countries it is always difficult to collect health statistics. Registration of births and deaths is not compulsory and disease statistics are based on patients who present themselves at recognised treatment centres. So a system which could be a model for the whole of Tanzania was set up, in order to gather and process information on health from the villages. During their first field work period, the VHMs carried out a census in their villages and pin pointed the main health problems. They send monthly reports on diseases and health activities to their Divisional Health Leader.

Nutrition - During the second field work period, a nutrition survey was carried out in the trainees' villages. Children from 0-10 years of age were examined and those showing signs of malnutrition were identified and subsequently followed up by the VHMs. Following the surveys, food demonstrations were given in the villages.

Maternal and Child Health - Mobile MCH clinics were started in 10 villages, it had been hoped to cover 32 villages but this was not possible. These clinics are run by the staff of the nearest hospital or health centre, transport being provided by the Project. Dareda Hospital staff rounds three of these clinics in addition to four mobile clinics of their own.
Divisional Health Leaders. The VHWs are not left on their own in their villages. They receive support and help from their Divisional Health Leader who visits them in their villages and meets them altogether every month for a report on activities, and a discussion of their problems. Two of the DHLs are Health Assistants with formal training, the other two are 'lay men' who have received training and experience through the Project.

Headquarters - Here you will find those of us who keep the Project running - when we are not in the field ourselves. Communications are an important part of our work - we like to let everybody know what we are doing, not only at village level, but also at ward, division and district level. The support of officials at these various levels is essential for the survival of the Project, and its work in the villages. Our Officer Manager and typist are never out of a job.

Our Present Situation - moving towards integration in the overall plan for village health work in Tanzania by:
- supporting the health work while we wait, by meetings, seminars, and village visits. Also by attending Divisional VHWs meetings when the Field Officer may give some teaching.
- holding monthly seminars for the VHWs on some aspect of their work.
- Visits to 4-4 villages each month by headquarters staff, depending on the availability of petrol and the state of the cars. During these visits we assess the efforts made by the village to promote its own health, through visits to the homes - On the day following we meet the village committee and discuss our findings and their problems.

Challenges (The positive aspect of problems). One of these is the lack of material and moral support for the VHWs found in some villages. Another is the falling off of the activities of the Village Health Leaders. Others arise from the poor economy of Tanzania and indeed of the World.

Consolations - The enthusiasm of the staff for the project, the interest and dedication of most of the VHWs many of whom have worked for 3-5 years without remuneration. Over 70% are still with the project and amongst those who have left, some did so for reasons of ill health and some for higher training. Few went 'to the towns'. Another thrill - the arrival of 6 bicycles from Holland, and the knowledge that 4 motorcycles are on the way from USA. The faces of the VHWs who received the bicycles reminded me of my own 8th birthday when I received my first bicycle!

The Future is in the hands of the Lord. Integration should not be too difficult theoretically at least! In other districts the Government will train 10 or 12 VHWs each year and be able to expand slowly. Here they have 122 VHWs trained and active, ready to be 'taken over' and this is a big task. At the time of writing the future is not clear - we are waiting and perhaps that is a good thing to be doing.

Sr. Margaret Garnett.
VILLAGE SAFARI

Laurena and I went with the Hanang Team on an official village visit. The driver, Mze Ali, with Sr. Margaret and Sr. Catherine, Laurena and I left Babati early in the morning, picking up Mrs. Goli, nutritionist on the way. We stopped at Magogo, fifty minutes away on a rough road to pick up Leonard, the Project Leader for this Division, and also the Medical Assistant from the Health Centre.

Then off across the Rift Valley - sand and dried grass. The occasional Barabaig with beautiful features, brown cloth slung casually over the body, earrings and spear - passed by on the sandy track over the dried earth.

After some miles we came to Mawara, a village of 297 houses, and we all poured into one of them - Chairs were quickly found. The Headman was introduced, the two village health workers Martini and Lansi arrived and we sat in silence waiting for the Chairman of Education and Culture - When he came Leonard, the Divisional Leader introduced each member of our now eight person team to the Headman and others - Graciously he said who would go with who on the house to house visits - I was to go with Martini.

So we set off with our information check lists, with headings such as
- number of children under 5 years
- those with weight cards - B.C.G....
- Water source - ? boiled.
- Malnutrition - food eaten.
- cleanliness
- latrines - or choo inspected
- rubbish pit also seen.
- the house - and so on.

Everywhere the families expected us, greeted us and talked about these things.

The sun beat down as we went along and we became hotter and hotter. There had been no rain for many months and everything including the clay on the walls of the houses was dried up - We kept going until 4 p.m., the appointed time and on our return were invited to share in a welcome meal, of rice and sheep stew. Never had food tasted better. A few hours and several punctures later, we drew water from the well, lit the primus and enjoyed our tea together in the good company of the team as dusk fell.

The next day we returned to the village to discuss the findings with the people, and hear each other's problems - It was 4 hours before all had been said!
I WALKED AGAIN

around the beds in three Children's Wards in Tanzania and Uganda recently - Again I had the same shock that I received over 20 years ago the first time I saw them.

They were all there - only worse than before -
- the inflamed eyes of those with measles
- the resigned eyes of those with severe anaemia -
- the vacant eyes of those with diarrhoea and dehydration.
- the fretful eyes of those with high fever
- the non-seeing eyes of those with meningitis
- the watchful eyes of those with osteomyelitis
- the waiting eyes of the hungry

"Malnutrition is the underlying cause" the staff said to me "this is why they are so ill, and food is very scarce".

WHY MUST SO MANY BE MALNOURISHED?

Is it only that "food is very scarce".

IS IT JUST?

What are they doing about it?

NO! WHAT ARE WE DOING ABOUT IT?

Because do something we must.

First to
- UNDERSTAND the causes of MALNUTRITION
  - then UNDERSTAND the causes IN THIS PLACE
  - then UNDERSTAND and BELIEVE there are ways of working with the local people to do something effectively about it
  - then DO IT

WE'LL START NOW and continue in later LINKS.

FIRST

THE EFFECT OF INFECTION ON NUTRITION

The following are some points from the recent Nutrition Workshop - Institute of Child Health - Dr. Andrew Tompkins.

FACTORS - AGE - more malnourished children in 2nd year.
SEASON. Rainy - Stress food short and women away working farms - Just after rains stress of increased diarrhoea and measles.

ACUTE DIARRHOEA
- about ½ due to ROTAVIRUS
- about ¼ due to E. COLI
- 6% due to CHOLERA
- the rest - other causes

ORAL REHYDRATION WORKS
because the SUGAR stimulates the absorption of sodium and water, ESPECIALLY in rotavirus and cholera infections.

THE PROBLEM - those with ROTAVIRUS lose more weight and gain it back more slowly because the virus affects food absorption - and so the appetite -
PROTRACTED DIARRHOEA

May be due to giardia infestation - and will improve with metronidazole (Flagyl). If lab. facilities doubtful or absent then give it.

MEASLES

causes malnutrition because of
- fever
- mouth lesions, possibly with secondary infection which are painful - so refusal to eat and drink
- if Vit B (riboflavin) deficiency ulceration of mouth may follow.
The nutritional effects persist for a long time.

TREATMENT

NORMAL HYDRATION
Local sugar/salt solution
Assurance
Continue if breast fed
Give food as soon as possible
"Return if doesn't improve or if gets worse"

MODERATE DEHYDRATION
Weight child in kgs.
1 UNICEF or WHO packet/litre water
Give 20ml x wt in kg every 4-6 hours
Reassess regularly

SEVERE DEHYDRATION
UNICEF solution
20ml x wt in kg over 1 hour Transfer for I.V. or I.P. fluids

MAKING SALT AND SUGAR WATER

CLEAN BOILED WATER

one level
tea spoon of salt

Salt and sugar water

SALT AND SUGAR WATER

about 1000 ml or one litre

1. UNICEF/WHO packets valuable because they:
   a) Contain sodium bicarbonate -
      If you have UNICEF packets keep for those severely dehydrated who really need the bicarbonate (If not available use sugar/salt solution)
   b) Contain potassium - In this order, coconut milk, banana, limes and oranges also contain potassium -

3. Malnourished children on this solution may become oedematous - its not due to too much fluid but due to extra salt - so reduce the salt content of the fluid.

• BREAST FEEDING AND SOLID FOODS
   The "appetite is poor" - so discuss with the mother about foods the child likes - and about offering frequent small feeds. If refusing drinks remember the naso-gastric tube.

• IF PROTRACTED DIARRHOEA

• METRONIDAZOLE for giardiasis
  Give 3 times a day for 5 days
  At each dose give
  Children over 25 kg 1 tab. (200 mg) If no weighing scale
  "  15-25 kg ½ tab. (100 mg)
  "  under 15kg ¼ tab. (50 mg)
  - 8 years upwards
  - 3-7 years
  - under 3 years
SO INFECTION → MALNUTRITION

Of course the arrow isn't only one way, it's a

vicious circle - It's good to take a stand somewhere and break into the circle. Both, of course, are associated more with POVERTY. So this is really a poverty question - We need to work with all kinds of people, who may differ from us in belief, nationality and culture, but who also have the same aims -

You are sent out to be among people of different cultures, religions and ideologies - Be with those who suffer, the oppressed, and those on the margin of life. Const. 9.6.

By the way can anyone tell me who wrote "Help us discover our own riches", LINK 15 p6?

EVALUATION

We keep hearing how important this is - and if we don't evaluate we may continue along the wrong track for quite a time without realising it - It just occurred to me that the word means "What are the values in what we are doing? Do they really express the values I feel in my heart and believe in?"

You could apply the questions on page 1 to the Hanang Project - It gets pretty high marks and some of the questions cannot be answered as we haven't all the information here -

Remember big projects like Hanang can excel on certain points, especially when national plans favour self reliance, community participation and Government integration - But smaller more lonely projects express values that the larger ones cannot.

I want to thank all who have written in case I cannot do it individually. Those working in Kenya are marvellous for their reports - Thank you Mrs. Ann, Kipsaraman, Kathleen from Aror, Geraldine and Paschalia from Machakos and Rita from Kokuma - I will try and share what you are doing in LINK.

A missive from the creeks of Irela was a welcome surprise, news doesn't leak out from there too often! I appreciate the difficulties -

Dr. Peter Hardus who worked with us in Anua, and later in P.H.C. in Tanzania will soon be finished doing Ophthalmology in Holland - He hopes to live in Holland but do 1 - 2 months a year in less developed countries - on a regular basis. Let me know if you would like his address.

Talking of eyes, I have also heard from Jack Swartwood of the International Eye Foundation that he has "Primary Eye Care Charts" - I will send for one, and let you know more about them -

COURSES

- PRIMARY HEALTH CARE IN THE CONTEXT OF SOCIAL JUSTICE.
  Aug. 1-6, 1983. Apply to Education Desk, National Mission Centre, Orwell Road, Rathgar, DUBLIN 6.

  Initiation into a Planning P.H.C. apply Director of Short Courses. Dept. Adult and Higher Education University of Manchester - Oxford Road, Manchester M13 9PL.

- LEARNING TO COMMUNICATE
  short and long courses - Cross-Cultural Communication Centre, Selly Oak Colleges, Birmingham, B29 6LO. England.

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Sr. Pauline Dean,
there seem to be different themes about ways to bring HEALING - HUMAN DIGNITY - PEACE - GROWTH - LIFE - FREEDOM, but I realise that in my mind they are in compartments.

yet they are all interlinked and are focussed on one-ness in God. I wonder is this the Wholistic – or Holistic Approach?
Many of us have long hospital experience!
and - diseases were studied
- conditions were researched
- we discovered what was needed - some medication, an operation, a different
diet, physiotherapy
- we told the patient, and arranged for it to be done.

We were the operators - the doers
and the people - the patients (on the whole) accepted it all. They were the objects
of the exercise.

It's very easy to transfer this attitude to P.H.C.
The prevention of disease has been studied and researched.
It has been discovered (in many instances) how to prevent them.
The techniques are known and written up.
We've tried telling the people,
but it doesn't work! Health hasn't improved and there is more hunger and malnutrition
now than 20 years ago.

Why? Perhaps you'd like to ask yourself or your group
that question before reading on.

What occurs to me is:-
- The patient in hospital - is there - in hospital and "what was needed" was also
there in the same place.
Millions of groups and communities are not near enough to those "who know".
- Those communities who are near enough to health professionals either "don't
listen" or "don't obey"!

Why? That's what we should ask ourselves - Maybe food, water, or a roof is
uppermost in their minds.
Sometimes we realise this and then say we've found the UNDERLYING CAUSE of the
disease or malnutrition -
- It's lack of water - overcrowding - poverty - poor land - lack of fertiliser -
lack of employment.
But very often even these are the SYMPTOMS - not the CAUSE - there are often other
factors underlying them.

We need to become conscious of all this.

We need CONSCIENTISATION.
Of course people and communities need it too - but let's not forget we need it!
"Conscientisation means an awakening of consciousness, a change of mentality
involving an accurate, realistic awareness of one's locus in nature and society; the
capacity to analyse critically its causes and consequences comparing it with other
situations and possibilities and action of a logical sort aimed at transformation." 1
"Conscientisation develops our critical faculty - we go from "this is just how things are" attitude to searching for why they happen".

Conscientisation is concerned with REALITY. People are regarded as SUBJECTS capable
of developing their critical faculty about issues linked to their everyday life, and
acting to transform their situation.
"Conscientisation is a process - it involves reflection and problem solving
together." 2
To gether?

Yes – we are the ones "who know" and they also are the ones "who know". We have our expertise, and they have theirs.

I can remember my surprise when we were asked to write down facts under these two headings:

<table>
<thead>
<tr>
<th>OUR EXPERTISE</th>
<th>COMMUNITY’S (PEOPLE’S) EXPERTISE</th>
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</thead>
</table>

We were surprised how many factors came up for the right hand column!

In most countries

now the idea of the COMMUNITY HEALTH WORKER (CHW) has taken hold -

Depending on where you are and the lifestyle they may be: Village Health Workers Street Health Workers Group Health Workers Clan Health Workers etc.

Let’s call them here CHWs. The main point is that the professional health workers as such, do not attempt to communicate with everyone. Why?

- because it's impossible with the numbers
- because they haven’t the community expertise

The CHW is a bridge between the health professionals and the community. They are from the community, and so have their expertise and they are trained for their special role by specially orientated health professionals.

What is their special role?

What are they expected to be and to do? All agree they must be people respected by their community, rooted in their community who already have some part time work.

The following is largely taken from “National Experience in the Use of Community Health Workers”.

Their possible tasks are - home visits, environmental sanitation, provision of water supply, first aid treatment of common ailments, health education, nutrition, maternal and child health, family planning, communicable disease control, community development activities, referrals, record keeping and collection of data on vital events.

The issue is, what function the CHW can effectively perform considering the level of education, the type and duration of training, the health needs of the community and the size of the population he or she is expected to cover.
If the CHW is not given the type of training that will enable him to tackle both health and other developmental problems, he will, in the long run, have very little or no impact on the health status and well being of the community. Improvement in health will be insufficient without improvement in the underlying social and economic conditions. Therefore a CHW's duties should not be confined to health work, but should relate, as much as possible to the many aspects of social and community life that affect a person's well being.

TEAM WORK

It has been realised by many countries that the CHW working alone cannot cover the full range of functions that could be assigned to him. The tendency, therefore is to the development of "Primary Health teams" to share responsibilities.

In Somalia a primary health team may comprise a CHW, a traditional birth attendant, (TBA) and a MCH assistant. In fact in most countries TBAs are being trained and integrated into primary health care teams. The inclusion of the traditional healers is lagging behind. You may have seen David Werner's film taken in Mexico. Several traditional healers are shown during their 'new' training.

The possibility exists that if the traditional healer is not integrated into the PHC system, he might be antagonistic to the CHW - and also make others fearful to attend him.

Some programmes have persuaded villages to start a 'Village Health Committee' to support the CHW's. But many villages - or streets (if a town) - or groups already have some committee. This may not be called the "Village Development Committee" but that is often the function. As any health worker does not work alone in an isolated field, neither should the CHW's. So perhaps it is more fitting that the CHW's are supported by a more general development committee than just a health committee.

In one project the planners gave the role of the CHW more emphasis than the village development committee. The CHW was seen by the health professionals as the agent for change in the community. But this did not fit in with the community's conception of him. They considered the CHW the servant of the community and not a leader as in that society leadership comes from older more influential members. The role of the CHW then had to be redefined.

In order to maintain harmony, the functions of each will necessarily have to be determined jointly by the health professionals and the community.

One Sister who wrote to me a couple of weeks ago said she thought that the combination of committed, active village leaders and a weak CHW gave better results than a committed active CHW and weak village leaders!

COVERAGE

The size of the population covered by the CHW varies widely. Its influence by a number of factors, the most important of which are the range of activities performed by the CHW, and whether the CHW is working alone or as part of a team. Another factor is the distribution of the community.

Little evaluation has been done on this - but in one project it was thought 1:500 population was the optimum but up to 1000 can be successful.

When it is stressed that above all the CHW should be a good communicator and an integral agent for change, not only for health care but for the awakening of his people to their human potential and human rights. Then adequate time is required for this communication.
SELECTION OF CHW’S

Criteria to be considered are:
- the ability of the trainee to see and understand the problems likely to face him or her, the ability to learn and to apply what is learnt in concrete situations.
- previous experience of service in the community
- acceptability to the community
- maturity
- a sense of responsibility and dedication.

AGE of the CHW

Experiences from most countries show that more mature middle aged men and women, who are good opinion leaders, perform more satisfactorily than young CHW’s, the National Experience Report goes on to say.

I know in my experience of training people we preferred the bright young ones. But this is different from any other training we have been involved in. Once trained the person will be left much more to rely on their own inner resources than anyone training in hospital work.

SEX of the CHW

There are usually cultural preferences in different areas. If a great deal of travelling is involved men may be preferred. In many places both men and women are trained.

LITERACY

Again views as to the importance of literacy vary. Most countries require a minimum level of elementary education. But in the Jamshed project in India and a programme in the Gambia illiterate people were trained.

It is noted too that these people have a "remarkable capacity for recall". An analysis in the Philippines showed that CHWs with lower educational levels, but mature and with some health experience and with deep rooted ties in the community made better CHWs.

If those with secondary education are selected there is a high risk that they will soon be on their way for higher training!

ALREADY WORKING

Many programmes will only accept those who have already found some work. It may be close to hand e.g. farming their own land. Even if the person is landless those who have searched around and found some means of livelihood, even through only part time and meagre, are more likely to do better than those who have given up looking for a means of livelihood.

CHW’s are nearly always part time.

To be continued ...........

REFERENCES


2. From notes on Conscientisation by Peter Oakley.


From Aror, Kenya, Sr. Kathleen
Donnelly writes - "In some areas
HEALTH COMMITTEES are formed. Two
representatives are elected for each
village, usually a man and a woman.
They meet regularly and have talks on
health education and discuss the
problems in their area. The idea is
to create an awareness in the whole
community as to what they can do to
improve their standard of living. In
one area the members of the Health
Committee, the local chief and the
Village Health Worker (VHW) went to
each village to talk to the people on
health. This made a big difference in
the numbers of women and children
attending the M.C.H. Clinic and in the
I.B. patients coming for their
treatment."

That's interesting, as here the Health
Committee is for an area not for the
village. She continues:

The VILLAGE HEALTH WORKERS visit the
homes and understand the problems of
the people. They encourage the
people to improve their environmental
hygiene by their example. Having a
latrine, boiling their water and having
a small demonstration given at their
homes. These young people are
working very hard to improve the living
standards of the people. Home visiting
is one aspect of their work that can
involve many hours of climbing over
rocks in the hot sunshine.

In another mountain situation in
Guatemala Sr. Mary Annels said "Each
group has to look at its own needs.
What kind of person is needed? In our
mountain situation we need someone who
can do all curative and preventive
medicine. We have catechists,
midwives, agriculture promoters - a
team - that all work together.
Basically we have a lot of people
trained in sitting around thinking
about problems. Then they work
together. One of the group can help
in specific needs and yet can still
work together with the others."

That phrase "sitting around thinking
about problems" reminded me of a letter
from Sr. Joanne Bierl and Mairead
Gorman who are getting to know the
Borana nomadic people in Sidamo,
Ethiopia.

"First, both of us are feeling more at
home with the Borana, our grasp of
language increases, our understanding of
Borana culture and nomadic attitudes
increases ......... we have a long
way to go but we have made a start. I
have become addicted to curdled milk at
room temperature (as a child I could not
eat my cornflakes without fresh cold
milk) and can chew roasted coffee beans
like a native -! More importantly,
why we have been sent here shortly
becomes clearer ........ just to "be"
here; to help meet the needs of everyday
life and to help provide some kind of
effective health service. Our daily work
is not high powered or impressive.

........... I am sure 50% of our time is
spent listening to the neighbours trying
to meet the immediate needs of a people
barely on subsistence level."

This, of course is the vital stage
before any plans - projects - CHWs.
SPECIAL DIET FOR DIARRHOEA

WHEN YOUR BABY HAS DIARRHOEA, GIVE HIM:

1. Sugar & Salt Mixture
   - Follow this recipe.
   - Mix a fresh batch each day.
   - Protects Baby From Dehydration.

2. Breast Milk
   - Continue to breastfeed as usual.
   - Protects Baby From Infection.

3. Solid Foods
   - Continue foods like boiled rice or rice & grated potato, not watery paps.
   - Give extra food for 2 days after diarrhoea ends.
   - Protects Baby From Malnutrition.

Helps keep your baby STRONG, HEALTHY AND HAPPY.
The markedly reduced in size visual aids reproduced on p7 and here are from The Gambia. They had a 2 year campaign to reduce infertile diarrhoea and deaths from dehydration - using the news media.

The campaign used radio broadcasts, printed materials and in-service training of health workers of all types who worked in the community. They were taught how to teach mothers to make salt sugar solution, how to give it and what solid foods to also give.

Each of these trainees were given 10 sets of posters and 10 flags so as to train 10 volunteers from 10 villages. These were chosen by the village, and when trained flew the flag outside their house!

Result - the mortality and clinic attendance for diarrhoea was markedly reduced.

(The 'Julpearl' bottles in the poster above are those most commonly available - each is 300ml).

St. Pauline Dean M.N.M.
DO YOU GET UNEASY

When you hear words like 'share index', or 'the basic money supply measure'. I do. I don't know what they really mean and I feel I should.

has cleared the air for me - What is it? An oil slick? E.T.? It's a diagram of the anatomy of society from Fr. John O'Connell's Workshop on Justice in August.

First, he asked us some questions, one for each group, and they were most interesting to discuss and write up - So here they are - you can do them and they relate to the country in which you are working - living.

What are the MAIN SOURCES OF WEALTH.
How is it distributed and why is it like that in your opinion?

What is the basis of POLITICAL POWER?
Who are least represented in the country?
Why?

What are the most important VALUES AND SYMBOLS manifested in the society in which you work?
Where did they originate?
How are they transmitted?
Read on - when you've answered the questions.

Here is a summary of the points we came up with, but put in order by John.

Remember we represented many varied countries.

**SOURCES OF WEALTH**  -  **ECONOMIC POWER**

- agriculture - often mainly cash crops
- industry - profit orientated - close-downs if profit better elsewhere
- huge populations - Friedman talks of 'human capital'
- multinational corporations
- World Bank

**THE BASIS OF**  -  **POLITICAL POWER**

- political parties - dictatorships - socialists, communists, capitalists
- the military - police
- liberation groups - minority groups (some)

**CULTURAL VALUES**  -  what gives meaning to our lives

- prestige - education - health
- 'take what you can get', bribery
- extended family, elders, many wives, rituals, practices, ancestor worship, spirits, burial rituals, hierarchy of work, some regarded as high, others low. Transmitted through the family, chiefs, fear, education of system, masquerades, mass media, religion, story telling.

We began to see that as the body has SYSTEMS - respiratory, digestive, circulatory and so on -

So society is also organised into SYSTEMS -

- the POLITICAL SYSTEM
- the ECONOMIC SYSTEM
- and the CULTURAL SYSTEM

Continued on p.7.
WHAT IS OUR ROLE IN P.H.C.?

When Fred Abbatt from the Liverpool School of Tropical Medicine joined the workshop he listened to the experiences of those already involved in P.H.C.

He then commented that in hospitals we are the direct providers of health care - but in the examples given our role appears to be more one of:

- training
- supervision
- and management

of the people providing the health care.

He stressed there can be no universal, international or even countrywide detailed plan of training.

But the FUNDAMENTAL PURPOSE of training programmes may be identical. He asked us to reflect - and gave us a choice of 4 to choose from:-

1. To provide a general education for life.
2. To provide an introduction to the various medical and scientific principles.
3. To prepare people to carry out a job.
4. To maintain a staff, the influence and the prestige of a group of health workers.

We all opted for No. 3!
So we are training people to carry out a job, or a series of jobs.

But what these jobs are will vary in every area in every place as localities, people, social and political conditions, climate, diseases vary.
COULDN'T WE JUST

Teach them all we know
- just the way we were taught
AND THEN LET THEM GO AWAY
AND APPLY IT?

That's what a lot of us would like to do - but the fact is
- we've forgotten 95% of all we were taught!
- they're not going to USE much of what we remember
- they're going to need to know things we never learnt!
(so we'll need to learn them too!)

NOT MORE COURSES?

HANG ON A MINUTE

Just sit down and make a list of the things you think the CHW should be DOING - better still if
2 - 3 people can do it together.

Then when you have your list - (as we got ours in our groups) ask yourself
WHAT DOES THE C.H.W. have to learn in order to DO THOSE THINGS?

We found we had words and phrases like
"finding out the needs of the community"
"teaching health education"
"encouraging mothers to....."
"encouraging farmers to....."
"motivating villagers to improve sanitation"

Many of these had the theme of COMMUNICATING

So Fred said

SKILL is COMMUNICATING
is the PRIME QUALITY of a C.H.W.!

So if that is a skill they should acquire -
Then it is a skill we must learn to impart!
FACTORS CONCERNED WITH REACHING
A description of the Job

1. OBSERVE HEALTH NEEDS and WANTS
   - Identify most common diseases which C.H.W. can do something about.
   - Look at housing, environment, water, sanitation.
   - Food, appropriate.
   - From this come up with something for C.H.W. TO DO

2. READ OFFICIAL JOB DESCRIPTION
   - i.e. the Governments training plan - Usually generalised like 'promoting health' but check you are consistent with the idea.

3. NOTE RESOURCES OF REST OF SYSTEM
   - Either Western or traditional.
   - Who will your C.H.W. refer people to? What agricultural or educational people around?
   - What simple drugs available.

4. OBSERVE CURRENT JOB
   - If there are already some C.H.W.'s, see what they actually do.

5. DISCUSS IDEAL JOB
   - From the list of tasks you get the lists of skills, facts and attitudes needed.

When you know THE JOB you can plan the TRAINING COURSE -
topics, methods, timetable and evaluation.
LOOK AGAIN AT YOUR LIST

You may find that even an ideal C.H.W., couldn't possibly do everything in your ideal job list.
You have to start somewhere so.....

Must learn is the target.
These are the things every student must learn to be competent in his job.
Surrounding that are many things that are useful to learn and others are nice to learn.

Teachers can encourage students to learn these things by using books and life experience, but the teachers main responsibility is to decide what the student must learn and make sure the students do learn it.

In world wide experience it is found that the jobs to be done can be grouped under certain headings - Fred Abbatt then gave us five steps to be taken in relation to each job.
These actions are similar to the steps taken in treating a patient. Collect data - history and physical examination - and so on.
Here it is:-

<table>
<thead>
<tr>
<th>COLLECT DATA</th>
<th>ANALYSE DATA</th>
<th>REACH DECISIONS</th>
<th>TAKE ACTION</th>
<th>COMMUNICATE DECISIONS</th>
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</thead>
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<td>IMMUNISATION</td>
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<td>CONTROL OF DISEASE</td>
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<tr>
<td>TREATMENT OF COMMON CONDITIONS</td>
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<td>PROVISION OF ESSENTIAL DRUGS</td>
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</table>
The systems of society continued -

**POLITICAL SYSTEM**

The STATE - GOVERNMENT

- Liberal democratic
- Socialist
- Communist

Political parties - element of STRUGGLE
- struggle employers and employees
- pretend there is no struggle, but there is!

important "hidden"

There's always some struggle -
- either to KEEP IN POWER
- or to CHANGE IT!

**LEGISLATIVE** - concerns law and order

**EXECUTIVE** -

**JUDICIAL** -

To keep law and order — police — army — prisons
Their task is TO PRESERVE THE SYSTEM

**ECONOMIC SYSTEM**

Basic things going on are

- PRODUCTION - e.g. food, clothing
- CONSUMPTION

PRODUCTION = AGRICULTURE/INDUSTRY

SERVICES

Services = police, army, politicians, drivers, sisters

WEALTH - income
- house and where it is
- factories - mines - companies
- access to education -
  and also the family you belong to!

**CULTURAL SYSTEM**

beliefs and values

Ideologies operating behind each system.

Practices and behaviour patterns transmitted by
- family - church - Islam, schools - language
- traditions & customs
- entertainment - sport, an outlet for tribal instincts
- song and dance - the need for celebration

**POLITICAL** **CULTURAL** **ECONOMIC**

Here are the three systems —
but how are they LINKED?
As Christians we're trained not to talk about 'class' because the word implies struggle, and we are all brothers and sisters with one Father - but struggle is there!

RICH - owners and controllers

MIDDLE - skilled work in industry, agriculture and services

WORKING CLASS - sell their labour - they have nothing else to sell

MARGINALISED - exist on the dole.

To be continued.

I must admit this LINK is a rather rushed one.

For various reasons my free time has been short.

Many thanks for the letters, these may not be answered individually this time - Next time will be better.

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**Books**

- Teaching for Better Learning - W.H.O. Geneva 1980 -
  by the same Fred Abbott who gave us the workshop.
  An excellent and very clear book for anyone training P.H.C. workers.

- The State of the World's Children
  UNICEF - from TALC
  An up-to-date picture - They suggest that recent advances offer four vital ways to improve child health

Sr. Pauline Dean
ENOUGH & THEORY!

Let's learn from those in the field.
The selection and planning the training of Community Health Workers (C.H.W.s) was discussed in the last two LINKS now we learn what happens in practice.

FROM KENYA

First from Sr. Rita Kelly at KAKUMA - Here is an example of a group who run a hospital and also supervise dispensaries, run mobile clinics and since 1981 have trained primary care workers.

"It is a situation which is changing all the time - It is easy to say the C.H.W.s will be elected by the village Committee, but our villages are artificial communities and not settled communities, in fact the people in many villages do not trust each other - They are used to an independent life within their own 'dai' or families - We do not know how long we will have these villages for; as soon as the people have sufficient animals they may lead a nomadic life again - But a lot of children are attending school now - whether these children will want to return to their parents' life style, we do not know.

So the Community are asked to choose a boy or girl of standard seven education.
The training and the work they will do is discussed - The community build a house for the trainee during the training.
"Sometimes it works - We pay the wage - Everyone asks will they be self reliant in two years - in now way at present.
The people themselves are just barely existing - We are trying to help them to be as self sufficient as possible - It is a very slow process with more 'downs' than 'ups'."

Their work is:-
1) Diagnosing and treatment of common conditions e.g. malaria, coughs, wounds etc.
We are allowed to give them 12 drugs, so they are taught about these 12 drugs and how to use them.
2) Prevention of the diseases we see in Turkana and Health Education.
3) First Aid.
4) How to help in MCH Clinics.
5) Home Visiting where they encourage people to build latrines, burn their rubbish and so on.

Health Committees - "In each place we have tried to encourage these. In places where there are good leaders the people have improved their housing by using the stalks of harvested Sorghum. Wells and latrines have been built -

WORKSHOPS
We had a 6 week course and a 2 week Refresher course this year.

Cont....
WORKSHOPS Cont....

All members of the health teams have a 3 phase (1 week each) course in teamwork and methods of Health Education using the Psycho-social method - Posters appropriate for Turkana were designed and are now used for Health Education.

 Sr. Kathleen Donnelly reports from ARDR Health Centre -

Their COMMUNITY HEALTH PROJECT aims are to raise the standard of living by
1. Preventing preventable disease.
2. Improving environmental hygiene.
3. Encouraging the growing of more nutritious crops -

TUBERCULOSIS is one of the major preventable diseases. Slowly with health education the attitude of the people towards this disease is changing - In a recent survey only one person saw the disease as hopeless and incurable, where before many had this attitude.

The role of the V.H.W. is invaluable in this area - They visit the homes and trace the contacts, teach the people how the disease is spread and can be prevented - It is important for the patient to have the help and understanding of his family to encourage him to take his treatment for the full length of time.

B.C.G. All babies born in the Health Centre are given B.C.G. and those born at home are encouraged to get B.C.G. at the first clinic held in their area. There is now 95% B.C.G. coverage of all children under 5 years.

HEALTH COMMITTEES. In some areas these are formed - In one area the members of the Health Committee, the local chief and the

V.H.W. went to each village to talk to the people. This made a big difference to the numbers of mothers and children attending MCH clinics and in the T.B. patients coming for their treatment.

VILLAGE HEALTH WORKERS

- visit the homes and understand the problems of the people.

- they encourage people to improve environmental hygiene by THEIR EXAMPLE - i.e. having a latrine, boiling their water and milk, keeping their compound tidy and rubbish free and having a demonstration garden.

- they meet at the Health Centre one day a month to discuss and share ideas and plan the teaching programme for the following month.

- home visiting can involve many hours of climbing over rocks in the hot sunshine.

They are working very hard to improve the living standard of the people.
TO REALLY LIVE!
WHAT DOES THAT MEAN?

In Old Testament times to really live meant living IN HARMONY - IN JUSTICE which comes from:-

FIDELITY TO A RIGHT RELATIONSHIP

- WITH GOD
  - See their daily prayers - the psalms. Ps. 10; Ps. 146.

- WITH NEIGHBOUR
  - The Hebrews always saw themselves not as individuals but as a family, a community - This was characterised by concern for the neighbour, especially the marginalised. Job 29:11-20; Deut. 15:7-9; Jer. 22:13-19; Is. 3:14-25.

- WITH THE LAND
  - a people so long landless saw Yahweh's gift of the land as a sign of his benevolence, and they had great respect for it. Is. 62:2-4; 65:21-23.

AND THE SIGNS OF JUSTICE WERE

PEACE

PROSPERITY

and FERTILITY OF THE LAND

Deut. 6:1-3; Ps. 112:1,3-5,9.

The problem is that not all who faithfully try to have this harmonious relationship with God, the neighbour and the land enjoy peace and prosperity

Job came to the realisation that to be just is to be open to the world as gift and to God - as mystery. Job 38-42.

See how the prophets Jeremiah, Amos, Ezekiel and Isaiah cried out for justice!
Many, many years later

MARY spoke the most revolutionary words - a moral/cultural revolution.
- he has routed the proud of heart.

- he has pulled down the princes and exalted the lowly.
- a political/social revolution.

- the hungry he has filled with good things, the rich he has sent empty away.
- an economic revolution.

Not surprising that her son chose to read Isaiah 61:1-2 as his manifesto:

```
He has sent me to bring the good news to the poor,
to proclaim liberty to captives,
to the blind new sight,
and to set the downtrodden free. Lk. 4:18.
```

The Kingdom then is active in the world, transforming and confronting the powers of darkness in the world.

Fr. Donders said recently “What does justice really mean in Africa? In our own works we cannot isolate ourselves from situations (land issues etc.) that create problems - We must be involved with various groups in these areas - There is a shade of difference between expatriate and African understanding of justice issues - What is important is both the individual and the community together - Within that society there are two points of reference -

1) Every human being within his family should be able to be self-reliant.
2) Society also has a duty to ensure that self-reliance.

In Capitalistic society the individual is the point of reference while in other societies e.g. Communist, it is the community.

Traditional African society strikes a balance between these two.

When trying to change attitudes we must be aware of a given culture. In western society we do not understand Christ when he says He is the trunk and we are the branches, we say it is beautiful, but do not take it as a real description of our situation - We see it as a moral obligation to love one another, but Christ says love others because we are together -
POLITICAL

CULTURAL

ECONOMIC

Remember LINK is with the systems of society?

HOW CAN THESE BE A CAUSE OF INJUSTICE?

● POLITICAL STRUCTURES

When people become wealthy, they want things to stay as they are, and they have a powerful say in politics. Laws made tend to support the status quo.

If you're in the lower income group or marginalised you feel "the laws are keeping us down" - The powerful say "the laws preserve the stability in the country" - (it really means their stability!)

● CULTURAL STRUCTURES

The DOMINANT CULTURE supports the political and economic structures through:-

- ASSUMPTIONS - "we're all born equal in this democratic society" - but are we? If you're born in a slum, or are brought up by a single parent, or if your family all live in one room, if your parents have no job - Are you equal?

- VALUES and ATTITUDES
  "Well what can you expect of that lot?"

- PROMOTED by MEDIA
  e.g. the stock exchange is on the news twice a day, but not the housing statistics or unemployment statistics. The media promotes what is thought to be more important.
  - also promoted by EDUCATION which does not encourage a critique of society.

- AND LEGITIMISED BY RELIGION
  The response to poor marginalised people often is:- "Stay where you are, life is short, hang on until you die, then everything will be alright." We've legitimised it.
Social Structures - the class system, or how we relate to one another depending on what we 'do'.

- Owners - land - capital
- Entrepreneurs - capacity to 'make' money
- Managers
- Services - security - trade - professional - civil servant
- Producers - industry, agriculture, crafts - 'workers'
- Unemployed and marginalised

This pyramid is kept in place by a number of forces:

So whatever issue we are considering e.g. world hunger we could consider the:

Structures at four levels
- Economic: Primary or family
- Social: Local community
- Political: National
- Cultural: International

But it is also vital to consider the history leading up to it. These structures were not "given" by God, but made by man.

So when looking into the history and structures at four levels - we're coming to social analysis.

Ref. 1. This section taken mostly from "Social Analysis in the Light of the Gospel". S. Healy and B. Reynolds.

2. Fr. Donders - Notes taken from an address to M.M.M. Kenyan Regional Assembly 1982.
Kipsaraman

is situated at the end of the Tugen Hills in North Baringo. Population around 40,000 people. The Primary Health Care Project was started from the Clinic six years ago, in order to improve the quality of life by the usual P.H.C. aims. Sr. Ann McLoughlin writes, "Right from the start we recognised that Health Education was a priority - so we trained 12 Community Health Workers chosen by their communities - and we have held refresher courses -

Their work consists of home visiting, group discussions, especially with women's groups, attending Barazas (public meetings) giving talks in schools, following up I.B. defaulters and how they organise small seminars for the Health Committees - These have then gone into action promoting the digging of latrines and making kitchen gardens.

Traditional birth attendants have been trained and supported. Staff have taken part in Natural Family Planning seminars.

In last years report they look at the results of these years of work. "Often progress we see is a big improvement in the health of the under fives - The majority have completed their vaccinations and very few are underweight. Much of this is due to the MOBILE CLINIC. In one place where we recently started the people take their animals in with them at night for fear of thieves - The flies follow - They feel that this, combined with the severe poverty and drought is the cause of the many eye infections especially trachoma -

Water pots made of cement and sticks.

We have given the Health Committees a copy each of "Where there is no Doctor" as there is usually some one who can read English in the group.

When a road under construction is completed an area with no health services at all will be open - In this valley there are many endemic diseases such as trachoma, malaria, kala-azar and I.B., as well as measles and whooping cough. Vaccination will soon begin.

At base in Kipsaraman women do come to deliver their babies but afterwards go home - as they have no beds! (If they had there would be less training of C.H.W.s and P.H.C.)

At the Nutrition Centre the numbers are reduced - This is partly due to agricultural improvements locally - Secondly mothers know a lot about child care and are really trying hard to look after them well. Thirdly measles, whooping cough and polio are no longer present, due to the mobile clinic and the children have B.C.G. to prevent tuberculosis.

Fourthly the children are treated for worm infestation every 6 months - So all these factors have eliminated malnutrition.

THE CITRUS NURSERY at Poi is growing paw paw, lemons, oranges and grape fruit - The mothers are encouraged to plant fruit trees. Vegetable seedlings and Coffee plants are also available to help to generate income.
NIGERIA

- From IERELE word comes that there are congenial meetings with the 'male midwives' - This is a great break-through. In Cross River State Sr. Teresita described the 'Conferring' of the T.B.A.'s at Uru Akpan. "The spirit between the nurses and the T.B.A.'s was really great - They put on a sketch, one patient delivered by a "trained" T.B.A. and the other by a "non-trained" T.B.A. The difference was striking!" From Ibadan Sr. Maura writes that she and others have been involved in development education/leadership programmes - Some people have done three or four phases already, returning to their base each time to put into practice what they have planned.

After so many years living in Nigeria, Sr. Maeve Powell now works in IRELAND at Coolmine Therapeutic Community which offers drug users an opportunity to live without drugs - Maeve became a 'Phase 1' Resident in Navan for some time to share the experience as far as possible with the drug abusers - A key principle at Coolmine is self-help, and this is achieved through a range of group work. Familiar phrases!

THE GAMBIA

we hear from Mrs. Heddy Gabbidon, the Health Visitor who worked in their Oral Rehydration Programme (LINK 17) "I think if all health workers try to write out the little they know about Health and Nutrition and tie our waists to help the poor and the disabled we'll soon cut down the morbidity rates - I suggest that health workers should sacrifice to live with the poor and disabled and help them towards their problems, rather than sitting in offices with bluffy attitudes."

PHILIPPINES

Sr. Carol, writes "This is my heart's desire to work among our people by this kind of health approach. Now that I'm back working in my own community I would like to be associated with C.H.W. LINK and work in these ideals on community health care.

In this troubled time in our country we need your support - Even in this work of C.H.W. we are branded as subversive - Please be one with us in our desire to help the poor - Your literature gives us encouragement."

NETHERLANDS

Dr. Peter Hardus who worked with us in Nigeria and later returned to Tanzania has recently finished his ophthalmic training - He offers his services during some summer months and writes "In a possible programme there will be no costs for the hospital.

Do not be worried about housing: a bed and food will do for a short period."

His address: P. Hardus, HET NARDUSBOER 16, 7576 WH OLDENZAAL, Netherlands.

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FOR UNTO US A CHILD IS BORN
UNTIL US A SON IS GIVEN

MAY HE BRING YOU PEACE AND LOVE

PAULINE
IN OUR EXPERIENCE we're aware of situations of poverty, hunger, landlessness, ignorance, inadequate water supplies, disease, lack of basic health facilities, lack of education facilities, and too many children dying -

SOCIAL ANALYSIS

is an attempt to look at the basic structures causing this REALITY - it's saying "WHY".

Remember LINK 19?

But this is not all - we've forgotten

GOD is IN every reality

GOD SPEAKS to us in every reality
**HOW** do we do this?

A good way is to base it on the **CYCLE of EXPERIENCE**

Experience

Planning

Sharing

Generalising

and inserted in the **REALITY of GOD**

**EXPERIENCE** that is the 'lived' experience - what people are feeling - undergoing - For us, we ask with whom are we living our experience - Whose experience is being considered - and whose left out.

**SOCIAL ANALYSIS** - remember we bring our values to this -

**THEOLOGICAL** REFLECTION - looking at it in the light of the Word of God, the Church’s social teaching - new insights - open to the Spirit -

**PLANNING** - who is participating in it? Just ourselves?

- We must move from ANECDOTES of our experience → ANALYSIS "Why?"
- Social Problems are LINKED - so we must look at "THE WHOLE".
WHAT JOBS should C.H.W.'s do?

W.H.O. has named eight elements essential in Primary Health Care (P.H.C.)

1. Education concerning health problems.
2. Adequate water supply and sanitation.
3. Promotion of food supply and proper nutrition.
4. Maternal and child health including family planning.
5. Prevention and control of locally endemic diseases.
6. Immunisation against the major infectious diseases.
7. Provision of essential drugs.
8. Appropriate treatment of common diseases and injuries.

It would take a TEAM to cover all this.

not a part-time C.H.W. alone -
Of course the VILLAGE or LOCAL COMMITTEE play a part -
and a SYSTEM OF SUPPORT IS VITAL

SO IN ANY ONE PLACE

WHAT JOBS should the C.H.W. do?
Every place is so different - Factors creating this difference are
- terrain and climate - hilly, flat, desert, isolated, in forest, drought-
- population - in villages, scattered, cities, nomadic.
- community - closely knit - in streets - rival factions.
- communications - good roads - impassable roads.
- type of community - some educated - illiterate
  farming - nomadic - factory workers.
- problems and needs the people experience -
- disease patterns

When the place and the community are known...

After Government approval obtained - approach the leaders -
of all sectors of the people (not forgetting the poor) and do
a diagnosis of the community's needs and problems.
(See LINK No. 7)

If the outsider does it with members of the community - two
or three men and women it is more effective.

Building up a map of the area as the survey proceeds helps to
locate places of special need.
Recently we looked at the NEEDS and PROBLEMS in an area - MARAGOLI and also the RESOURCES and OPPORTUNITIES in the community.

Here are some of the points that came up:

<table>
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<tr>
<th>NEEDS/PROBLEMS</th>
<th>RESOURCES/OPPORTUNITIES</th>
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<tr>
<td>Land shortage</td>
<td>Respect for family and culture -</td>
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<tr>
<td>Overcrowding</td>
<td>People know their problems</td>
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<tr>
<td>Large families</td>
<td>People willing to work</td>
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<td>High infant mortality</td>
<td>Good womens' organisations</td>
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<td>Falling productivity of land</td>
<td>4 groups in the community get together before starting something</td>
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<td>Hunger</td>
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<td>High cost of schooling</td>
<td>Leaders - elders - some of rich elite</td>
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<td>Unemployment -</td>
<td>Traditional healer</td>
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<td>Young leaving the area</td>
<td>Land basically fertile</td>
</tr>
<tr>
<td>Divided community - rich elite -</td>
<td></td>
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<tr>
<td>and others poor</td>
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Perhaps the greatest resource was the fact the people knew their problems and in a sense had already done a PROBLEM ANALYSIS or SOCIAL ANALYSIS.

They knew the land shortage and falling productivity was due to the land tenure system whereby the male children of the family each received an equal share of the land on the father's death - so the farms were getting smaller and smaller.

The small farms resulted in low productivity, hunger, high infant mortality - so they compensated with large families, whom they couldn't afford to send to school - who left the area - a vicious circle.

WE can also bring resources - and these are
- skills and expertise
- the ability and will to train others
- some basic equipment.

IT IS THE 'MARRIAGE' OF THESE RESOURCES
(as John Rankin says!)

THE COMMUNITY'S AND WHAT WE BRING

That together will tackle the problems

BUT It is all too easy, having reached the basic causes and mulling over the history to discuss these facts over and over again. A sense of powerlessness may descend.
THEOLOGICAL REFLECTION gives us the insight and the power to move on -
Consider the example above - with a divided community, rich and poor, hunger, shortage of land and a high infant mortality.
Often the readings of the day speak to these situations - If not search yourself.........
and "Follow me!"

So then we look forward and
("We" means the community and ourselves together - so we are all committed to the plan)

THE PLANNING PROCESS

BASIC QUESTIONS
1. Where are we now?
2. Where do we want to be -
   - a picture of how it could be in 2, 3, 5 and 10 years time.
3. How do we get there -
   - What aims and objectives.
4. How are we doing?
   - How will we evaluate as we go along?

ITS VITALY IMPORTANT
- to do something about the basic causes
- but also to do something NOW
- that will work
- that we can succeed in -
- that is very important to the people

FROM ALL OF THIS -
There will be things
- the local leaders will do - the people will do.
- that we will do.
- the Community Health Workers will be trained to do.
and that's where this started

WHAT JOBS SHOULD CHW'S DO ?

FROM GUSSORO - a remote rural area of Northern Nigeria.
Sr. Aileen Doggett writes on

GUSSORO HEALTH FESTIVAL
"Lafiya Maniya Gbogbagun"
"Joining hands together for better health"

"This new beginning" - Rural health education programme came into action in 1981. Sister Pauline Connolly, M.M.M. was convinced that through rural health education people can be helped to become responsible for their own health and be self-reliant. We can also promote self-esteem so that the local people will become aware that they have a right to a better way of life. This could be a way of liberating them and helping them to overcome fears, taboos and oppressive situations.

"Hopefully the effort will generate a new hope and channel for drawing forth a spirit of fellowship in the community. A climate of confidence is created and expressed by cooperation of all for what is recognized as "theirs". The health of all becomes the concern of all and health is insured by close cooperation of all. The sick are supported by the community, restoration to health requires this social dimension which is presently recognised as part of Nigerian tradition".

(P. Connolly, M.M.M.)

There is no doubt about it - this approach calls for courage, conviction and faith. It is a way of insecurity, uncertainty and risk. To withdraw from the familiar to be with the unfamiliar is difficult and demanding. As Pauline writes, "Here we must travel slowly, listen deeply, pray and await the birth of the unexpected. We must be prepared for slow response, and through a living hope, things will grow patiently like the tree which little by little sprouts from a tiny seed". So having come to terms with the reality of the living out of this, Sisters Pauline and Therese Jane Ogu, M.M.Ms. came to live with the people in Guussoro in June 1981 with their eyes, ears and hearts wide open, and with the general aim of building a community of care and self-reliance through raising the level of their health by health promotion through the process of:
1. Awareness and education
2. Increased community participation
3. Organized community action
4. Self-reliance

I came to Guussoro on 7th October 1981 and having "followed" Therese around the villages for almost three weeks I was really impressed by how much the women had learned and knew after 2½ years of being with the Sisters. What struck me was how very aware they were of the health problems they had and how they could prevent most of their sickness if they had a clean water supply, proper sanitation and refuse disposal together with a good immunization programme for their children. They were convinced of all this in their heads - But as regards taking any action to dig wells or latrines or pits where they could dispose of their refuse, very few had taken any action.

They had done drama, song and dance with Pauline and Therese so I suggested the idea that each village (Angua) would perform a drama, song or dance about the sickness or problem which worried them most in their own Angua (village) and how they could prevent it. They took to the idea very well and Pauline and I were very happy when each of the eight Anguas chose a different topic - or aspect of a topic. We got such a good response we felt it would be a good idea to have "A Health Festival Day" where all eight groups would come together and perform so that they would learn from each other. This was very acceptable to them as a little competitiveness
goes a long way in motivating them. Pauline took four villages and I took another four. We had weekly practices with them - all of which I enjoyed and from which I learned a lot. Each day we would go for a practice and they would have changed or added something. This was a great learning process for them. They have a great love of drama, and as none of the women can read or write it was entirely their own which they made up as they went along. Few mistakes were easily corrected in the practices. I learned so much from each group; how they go to the native Herbalist/Doctor - the juju and discussion which follows - negotiation of the "fee" for the herbalist which can be quite large!, the behaviour and dress of the herbalists themselves. They use all things like small stones, feathers, and one had the bone of a cow! Another held a cock between his legs as he was sitting on the ground. They placed some corn in front of the cock and if the cock ate the corn the diagnosis was correct!!!! During one of the practices the cock escaped and could not be found, so they had to get another cock. This one refused to eat the corn! So the suspense was something! After waiting some time, and aware that I had to go to another village, I suggested we pass on to the next stage in the drama, but this was really frowned upon by the participants, and one woman ran to her compound and came back with a scrawny, squawking chicken - which devoured the corn!! So all was well - we could continue the drama!

Another group - mostly old women - were describing how the river water which they collect and drink each day is contaminated. They gave a detailed description in their own language of the various ways by which it is contaminated, most of all by the heavy rains when the river swells up. Last year one policeman was drowned and his "Rusting body" was floating down contaminating the water!! I thought this was very descriptive so I questioned my interpreter - Lawrence, "Is that what they really said?" He replied, "Well, Sister, according to their statement that is how they said it!"

Yet another group were displaying the problems of safe delivery. For the first woman, highly pregnant as they say, "about to deliver" - they called the herbalist/doctor who after much discussion about "conditions of service" came all dressed in official attire! and waved a squawking chicken over the woman. The traditional birth-attendant was helping the woman to deliver and all was well. Then another woman with twin pregnancy was brought but the herbalist would have nothing to do with this case because the woman was in difficulty - so the traditional birth-attendant sent someone for SIS-I-IA (as they call us) to come and help. In the drama, when they came to Sis-ita's house the "Sis-i-ita" had gone to Minna! What were they to do? Then one of the traditional birth attendants came forward and said, "Let us do as Sis-i-ita has taught us. So they proceeded to help the woman deliver as they have been taught by the Sisters, while actively participating and observing in home deliveries in their village, and after a short time the woman delivered twins! (These had been moulded by themselves from the clay they use for making pots). So there was great rejoicing!

Yet another group of women danced and sang the theme song for the festival, "Lafaiya Manaiya Gbodogun": When we join hands together we can help ourselves to have better health". The other groups included a village health worker teaching mothers how to make ORS (oral rehydration solution, i.e., sugar/salt solution). Topics taken by other groups included prevention of malaria and good hygiene.

The Chief, was very cooperative and invited us to have the festival on the village square beside his compound. So at one of our meetings with our women leaders we suggested that each group would come there during the week before the festival day to practice, in case they would be 'confused' or get stage-fright. They were very opposed to this suggestion as the secret of their drama would be revealed and others might copy them!

In Minna, 75km. from Gussoro, Pauline and I visited the leader of an educated group, and his wife and explained what we were trying to do. They
were really encouraging, responsive and enthusiastic! They would all come to Gussoro for the festival and provide the prizes. Each village had to get a prize: bars of soap and soap powder in a plastic bag. The leader of each group would divide the “prize” equally, as only they know how! So each village felt they did well, which indeed was true as each was unique.

On Sunday 11th December all began to assemble by 7.00 a.m. The festival began at 10 a.m. and finished at 4.30 p.m.!! There were at least a thousand people present. The men turned out in great numbers and they too were impressed by what the women could do. The atmosphere of the day was one of cooperation, joy, expectation and was really festive. In this Moslem/Traditional Religion place I could in some way feel the presence of God. It is really difficult to describe. It was a very happy and festive occasion.

Since the festival, nearly one month ago, people are still talking about it and now the men at last are coming forward and wanting to participate. They have, as they say, seen how the women have achieved something by “Joining hands together for better health”. Hopefully they will cooperate in the purpose of the festival, which was to bring them a step nearer to putting into action what they know and are convinced are necessary to prevent sickness and promote health.

We gave them a little time to think about it, discuss and reflect on what they learned from the festival, and already we hear they have organized themselves in their respective Anguas (villages) and want now to start digging wells, one in each village. They have also called us to come to see the place they have chosen (after much discussion) in each village where they want to start digging. The women and children are organizing themselves to trek to the nearby river to collect gravel and sand while the men are organizing the cement to line the well. Now we pray that as each group starts digging they will meet water. This is really a difficult task in this dry, hot land with so much rock. The digging is done manually to about a depth of 20 feet or more, and it can be so frustrating and discouraging if, having dug so far, they meet no water. They also have themselves decided that each compound will dig its own latrine. So it seems that after 2½ years of constant health education the women of Gussoro have convinced themselves and their men that a clean water supply with pit latrine are vital to prevention of many of their sicknesses.

It seems to me that the General Aims of this project are well on the way to being achieved. These aims of Awareness and education, Increased participation and Organized community action are certainly obvious. Self-reliance - a slow and tedious process is, we hope, somewhere in the future.

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**Courses**

**Tropical Child Health Unit**  
Institute of Child Health  
30 Guilford St. London, WC1N 1EH.

- Planning and Management of Diarrhoeal Disease Control Programmes (25 April - 2 May 1984)
- Organising Third World Primary Health Care - (21-25 May 1984)
- Paediatric Priorities (2-6 July 1984)

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Sr. Pauline Dean